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## **Optimal Adolescent Health to Improve Behavioral Outcomes for LGBTQ Youth**

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### **Introduction**

In 2011, a landmark report by the Institute of Medicine clearly demonstrated that lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals in the United States were more likely to report numerous health risk behaviors and adverse health outcomes than their heterosexual and cisgender (individuals whose gender identity aligns with their sex assigned at birth) peers (Institute of Medicine, 2011). This report also highlighted the importance of adopting a life course perspective that considers each developmental phase as an opportunity to intervene and improve the future health of LGBTQ populations. Adolescence is an important developmental period for all youth, however, for LGBTQ youth adolescence poses several unique challenges, as well as opportunities to provide skills and resources for healthy development.

The number of young people in the United States identifying with an LGBTQ identity has grown in recent years (England, Mishel, and Caudillo, 2016). New data from the General

Social Survey, a nationally representative survey collected every two years, shows that the number of people in the US identifying as bisexual doubled from 1.6% to 3.3% between 2008 and 2018 and the number people identifying as gay or lesbian grew from 1.1% to 1.7%. The growth is most pronounced among young people: between 7 and 8% of 18 to 34 year-olds in the US now identify as bisexual (Compton and Bridges, 2019). Data from the 2017 Youth Risk Behavior Survey (YRBS), a national, school-based survey finds also found that 8% of youth identify as bisexual and 2.4% identify as gay or lesbian (Johns et al., 2018). Given that some youth may not feel comfortable disclosing a gay, bisexual, or lesbian identity on a survey given in a school setting, this is likely an underestimate of the number of LGB youth. Data suggests that the number of transgender or gender nonconforming youth is also growing. A recent population-based survey found that 3% of high school students identified as transgender or gender nonconforming (Rider et al., 2018) and in the 2017 YRBS data set, 1.8% of youth identified as transgender (Johns, Lowry, et al., 2019).

This increase in the number adolescents who identify as LGBTQ has coincided with a number of advances in LGBTQ rights and protections, including the repeal of “Don’t Ask, Don’t Tell” in 2010 and legalization of same-sex marriage at the federal-level in 2015. Acceptance of LGBTQ people and support for same-sex marriage has also grown over time across all sociodemographic groups (Fetner, 2016; Pew Research Center, 2019). Some research suggests that the changes in social acceptance may actually facilitate LGBTQ identity disclosure (Charlton et al., 2016), which is occurring at younger ages among younger cohorts (Groves et al., 2006).

Yet despite increases in the acceptance of LGBTQ persons, and the growing number of people who identify as LGBTQ, LGBTQ youth still face substantial challenges to achieving

optimal health. LGBTQ adolescents continue to be more likely to report victimization, both at school and in their homes, compared to heterosexual and cisgender adolescents (Austin, Herrick, and Proescholdbell, 2016; Grossman et al., 2005; McKay, Lindquist, and Misra, 2019; Russell et al., 2014; Toomey and Russell, 2016). Data from the 2017 GLSEN National School Climate Survey, a nationally representative survey of youth in US schools found that 70% of LGBTQ youth reported verbal harassment based on their sexual orientation and 59% based on their gender expression; 29% of LGBTQ adolescents were physically harassed based upon their sexual orientation and 24% based on their gender expression; and 48% of LGBTQ students experienced cyberbullying (Kosciw et al., 2018). These experiences of harassment and victimization have implications for LGBTQ adolescents' ability to attend and participate in school activities: 34.8% of LGBTQ youth missed at least one day of school in the past month because they felt unsafe or uncomfortable; 75.4% youth reported avoiding school functions or extracurricular activities because they felt unsafe; and among LGBTQ students who were considering dropping out of school, 42% reported it was because of harassment at school (Kosciw et al., 2018).

High rates of harassment and victimization contribute to the consistent findings that compared to their heterosexual peers, LGBTQ youth are more likely to report depression (Hall, 2018; Marshal et al., 2011), alcohol and tobacco use (Corliss et al., 2008; Goldbach et al., 2014; Johns, Lowry, et al., 2019; Marshal et al., 2008; Rosario, Corliss, Everett, Russell, et al., 2014; Talley et al., 2014) and sexually transmitted infections and adolescent pregnancy (Charlton et al., 2013; Goldberg, Reese, and Halpern, 2016; Saewyc, 2014; Tornello, Riskind, and Patterson, 2014). New data on transgender youth show similarly high rates of risk behaviors; data from the 2017 YRBS, the first YRBS survey to include measures of gender identity, reveal that

transgender youth are more likely to report all substance use measures (alcohol, tobacco, heroin, cocaine, and opioid use), except marijuana, and an astonishing 34.6% reported attempting suicide in the past 12 months.

An LGBTQ identity, however, need not be a “risk” factor for depression, substance use, and sexual risk behaviors in adolescence. Increasingly, researchers have demonstrated that there are pathways that promote resiliency and healthy development among LGBTQ youth. For example, facilitating healthy parent-child relationships and parent acceptance of their LGBTQ child is a powerful protective factor for LGBTQ youth; it is associated with greater self-esteem, social support, lower rates of substance abuse, and improved mental health (Ryan et al., 2010). Unfortunately, for many LGBTQ youth, families may actually be a source of violence and rejection. The high rate of parental rejection is perhaps best demonstrated by the fact that up to 40% of homeless youth are LGBTQ, compared to approximately 8-10% of the gender adolescent population (Voices of Youth Count, 2017).

Unfortunately, researchers and policymakers cannot guarantee that every LGBTQ child is able to grow up in safe and accepting households. As such, schools are particularly important site for promoting resiliency among LGBTQ adolescents. LGBTQ students in schools with Gay-Straight Alliances (GSAs) and other policies that prohibit LGBTQ-based bullying report higher levels of classmate and teacher support and less bullying (Day et al., 2019). Policies that allow transgender students to use the bathroom of their choice in schools have been linked to lower levels of sexual assault of transgender students (Murchison et al., 2019) and LGBTQ-inclusive sexual education has been linked to lower rates of bullying, depression, substance use, sexual risk taking behaviors among LGBTQ students (Baams, Dubas, and van Aken, 2017; Blake et al., 2001; Day et al., 2019; Hatzenbuehler and Keyes, 2013; Hatzenbuehler, Schwab-Reese, et al.,

2015; Kosciw et al., 2013; Kull et al., 2016; Murchison et al., 2019), and provides similar benefits for heterosexual students (Proulx et al., 2019).

The contrast between the increasing number of LGBTQ youth and the continued high rates of victimization in schools and homes has been described by some researchers as a “developmental collision” that requires urgent, evidence-based action (Russell and Fish, 2019). This report outlines both the unique and shared risk factors for optimal health among LGBTQ youth, as well as several mechanisms at the family-, school-, and community-level that reduce exposure to violence and promote resiliency among LGBTQ adolescents.

**Are there unique aspects of optimal health and normative development that need to be considered to LGBTQ adolescents?**

Adolescence is a period during which young people develop and explore their sexual selves. Healthy sexual development, however, is more than learning how to avoid sexually transmitted infections and unplanned pregnancy; it also includes learning how to have respectful romantic relationships, establish healthy sexual decision making, and adopt self-efficacious behaviors when engaging in sexual behaviors (e.g. using condoms and contraception). The ability to explore romantic and sexual relationships in a safe and healthy context is critical for all youth, and in many ways, LGBTQ adolescents are similar to heterosexual and cisgender youth; LGBTQ youth thrive best in loving and safe homes, schools, and communities. Adolescence, though, is often when sexual orientation and gender identity disparities in health behaviors and outcomes begin to emerge and are linked to the stigma surrounding an LGBTQ identity and same-sex sexual behaviors.

Identity disclosure, or “coming out,” is a significant feature of development for LGBTQ youth. Understanding how LGBTQ adolescents differ from heterosexual youth in terms of sexual identity development, though, is somewhat tricky given that heterosexual and cisgender youth typically do not “come out” as heterosexual to their friends or family members. That is, because heterosexuality is considered the norm, it is expected that *all* adolescents are heterosexual unless they disclose otherwise. Moreover, unlike racial or ethnic minorities, most LGBTQ adolescents grow up in families with heterosexual and cisgender parents and siblings. This is an important distinction because family members may be uncomfortable, if not outright hostile, when discussing issues related to an LGBTQ teen’s sexual or gender identity. Deciding if, when, how, and to whom to disclose an LGBTQ identity is a difficult decision that these adolescents must make, with potentially long-lasting effects on health.

The age at which individuals disclose their identity is influenced by multiple factors including age of awareness of LGB identity, gender atypicality, and the level of internalized homophobia experienced by the individual (D’Augelli, Grossman, and Starks, 2005). Research that has examined developmental milestones among LGB youth has provided some insights into the ages at which these events typically occur: youth become aware of their same-sex attraction at around age 10, and first identity disclosure occurs around age 16, usually to a friend before a parent (Floyd and Bakeman, 2006; Floyd and Stein, 2002; Maguen et al., 2002). Younger cohorts of LGB youth are disclosing their identities at earlier ages than previous cohorts: For example, in a 2006 study, 18 to 24 year-old women were “out” to themselves at age 15.8 compared to 24.9 for women ages 55 and older, and “out” to others at age 16.9 compared to 28.4 for women ages 55 and older (Groves et al., 2006). The same study showed that men ages 18 to 24

were out to themselves at age 15 and out to others at 16.9, compared to 20.2 and 24.1, respectively, for men ages 55 and older (Grov et al., 2006).

Whatever age an individual decides to “come out,” the process is a central feature of identity integration and important for achieving optimal health (Corrigan and Matthews, 2003; Meyer, 2003; Watson et al., 2019). The process of identity disclosure and its benefits, however, are nuanced. In the best cases, identity disclosure can facilitate improved self-esteem and mental health, as well as lower the risk of engaging in substance use and sexual risk-taking behaviors (Rothman et al., 2012). Unfortunately, identity disclosure can also mean making oneself vulnerable to LGBTQ-targeted victimization and bullying (Kosciw, Palmer, and Kull, 2015). While many youth who disclose their identity to their parents are met with acceptance (D’Augelli, Hershberger, and Pilkington, 1998; Rothman et al., 2012), it should be noted that LGBTQ youth in supportive environments are more willing to disclose their identities to the people around them (Legate, Ryan, and Weinstein, 2012). LGB adolescents who disclose earlier have lower levels of internalized homophobia (Bry et al., 2017) and greater comfort ability with their sexual orientation (Floyd and Stein, 2002). Thus, the benefits of identity disclosure may be biased by the fact that many LGBTQ youth do so because they anticipate that they will *not* be met with negative reactions from their family members and friends.

Individuals who face challenges to identity disclosure and LGBTQ identity integration report more sexual risk taking behaviors and poorer psychological health (Rosario et al., 2006). Yet even in cases where there may be negative reactions to identity disclosure, there appear to be long-term positive benefits for LGBTQ persons (Russell et al., 2014). One study found that LGB youth whose parents knew about their LGB identity reported more verbal harassment based upon their sexual orientation, but higher levels of current family support (D’Augelli, Grossman, and

Starks, 2005), suggesting that disclosure may indeed introduce the potential for victimization, but ultimately is a pathway to improve relationships with family members. For those that are unable to disclose their identity to parents may require facilitating the formation of broader social support networks for LGBTQ adolescents.

Similar to LGB youth, identity disclosure is also a critical developmental step for transgender adolescents. Transgender identity disclosure can reduce cognitive dissonance, and allow transgender youth to access resources and social support to improve their mental health (Riggle et al., 2011). The process of transgender identity development varies across studies, but for many transgender youth, there is a sense of always feeling as if their gender identity and sex assigned at birth were not aligned (Kuper, Wright, and Mustanski, 2018). Data from the 2015 U.S. Transgender Survey suggests that majority of respondents disclosed their gender identity between the ages of 16 and 25 and that just under half first started transitioning between the ages of 18 and 24 (James et al., 2016). Similar to LGB adolescents, transgender identity disclosure may also leave transgender youth vulnerable to victimization, rejection, and harassment by peers and family, particularly those that are more gender nonconforming (Grossman et al., 2005). Hearing transgender narratives at earlier ages allows trans youth to make sense of their own experiences and increase their self-acceptance (Levitt and Ippolito, 2014). Supportive families are also important for transgender adolescents' mental health; transgender youth who disclose their identity and transition socially (that is, their parents used pronouns that reflected the child's gender identity, allowed them to dress in their preferred way) report mental health outcomes similar to their cisgender siblings (Olson et al., 2016).

Pubertal onset can be a particularly difficult period for many transgender adolescents. The development of secondary sex characteristics (e.g., breasts, facial hair) may be viewed as an

inconvenience for some, for others though, it can be devastating (Kuper, Wright, and Mustanski, 2018). In many cases, medical interventions, such as gonadotropin-releasing hormone (GnRH) analogues, also referred to as puberty blockers, can provide much-needed relief from gender dysphoria. Not all transgender and gender nonconforming individuals desire medical treatments, but among those who do, being unable to access these interventions can be particularly difficult (Kuper, Wright, and Mustanski, 2018), and many transgender youth do not have insurance that covers hormonal therapies (Nahata et al., 2017). Limited research has examined the long-term effects of hormonal therapy, but data from a Dutch research group has found that puberty suppression via the use of pubertal blockers improves mental health and general functioning (de Vries et al., 2014; de Vries et al., 2011). Given the high rates of suicidality among transgender youth in the U.S., and the potential benefits of hormonal therapies, more research is needed to assess both the short- and long-term risks and benefits of these therapies and increase accessibility.

### **Shared Risk Factors**

Many of the risk factors that impact health among LGBTQ youth are shared with their heterosexual and cisgender peers. LGBTQ youth, however, often experience these risk factors at a higher rate. Bullying and victimization are pervasive issues in the lives of LGBTQ adolescents and the reduction of exposure to violence is necessary to address health disparities (Hughes et al., 2014; Johns, Lowry, et al., 2019; Kosciw et al., 2018; Reisner et al., 2015; Toomey and Russell, 2016). For example, the 2017 GLSEN report found that 87% of LGBTQ students experienced some form of harassment or assault at school (Kosciw et al., 2018). Data from the 2017 YRBS shows that among LGB youth, 27% reported electronic bullying, 33% reported

bullying at school, 22% reported sexual assault, and 17% reported physical dating violence compared to 13%, 17%, 5%, and 6%, respectively, of heterosexual youth (Johns et al., 2018). Higher rates of bullying and victimization among LGBTQ youth have been linked to several dimensions of optimal health including increased tobacco, alcohol, and drug use (Coulter et al., 2015; Huebner, Thoma, and Neilands, 2015; Johns et al., 2018; Phillips et al., 2017; Rosario, Corliss, Everett, Reisner, et al., 2014), depression (Hall, 2018), and ability to attend and participate in school activities (Kosciw et al., 2018).

LGBTQ adolescents are also more likely to report childhood physical and sexual abuse (Friedman et al., 2011). While the negative consequences of childhood abuse apply to all youth, group-level differences in exposure to early life victimization can set off a chain of negative health behaviors and conditions that differentially place LGBTQ adolescents at risk for adverse health behaviors and outcomes. Studies show that in the general population, childhood abuse and neglect are associated with substance use and sexual risk behaviors, including earlier age at sexual debut (Downing and Bellis, 2009; French and Dishion, 2003; James et al., 2012). Multiple studies have found that lesbian and bisexual girls are more likely to report earlier age of sexual debut, as well as lower rates of condom and contraception use than heterosexual girls (Charlton et al., 2019; Poteat, Russell, and Dewaele, 2019; Riskind et al., 2014; Rosario, Corliss, Everett, Reisner, et al., 2014; White et al., 2016; Ybarra et al., 2016). Given this constellation of sexual risk behaviors, it should be unsurprising that bisexual and lesbian girls are also more likely to report adolescent pregnancy than their heterosexual peers (Charlton et al., 2013; Choukas-Bradley et al., 2015; Goldberg and Halpern, 2017; Goldberg, Reese, and Halpern, 2016; Herrick et al., 2013; Hohman-Billmeier, Nye, and Martin, 2016; Lindley and Walsemann, 2015; Lowry

et al., 2017; Paschen-Wolff et al., 2018; Riskind et al., 2014; Saewyc et al., 1999; Tornello, Riskind, and Patterson, 2014).

Studies have also found that higher rates of exposure to violence influence sexual risk taking among gay and bisexual boys: A recent metareview of sexual risk taking among adolescent men who have sex with men found that 44% reported anal sex without using a condom in the past 6 months, 50% did not use a condom at last sex, and 32% reported using drugs or alcohol in their last sexual encounter (Valencia et al., 2018), these condom use rates are lower, and the drug use during sex rates are higher, than those observed among heterosexual adolescent men (Kann et al., 2011; Martinez, Copen, and Abma, 2011). And although many risk factors are shared between heterosexual, cisgender, and LGBTQ youth, these risk factors do not necessarily stem from the same root-causes. That is, many times LGBTQ youth are targeted specifically because of their stigmatized identity.

### **Unique Needs**

There are multiple risk factors that uniquely impact optimal health among LGBTQ adolescents. These additional stressors are often characterized as “minority stress” (Meyer, 2003; Meyer and Frost, 2013). That is, in addition to the day-to-day stresses all people experience, LGBTQ persons also experience other unique forms of stress due to their stigmatized sexual or gender identity. Examples of minority stress include both targeted victimization and rejection because of one’s LGBTQ identity, internalized homophobia, and stigma consciousness (i.e. the anticipation that someone will treat you negatively if they know you are LGBTQ). Minority stressors have been linked to multiple dimensions optimal health for LGBTQ youth: For example, internalized homophobia and negative disclosure reactions are associated with tobacco,

alcohol, and other substance use (Blosnich, Lee, and Horn, 2013; Goldbach et al., 2014; Rosario, Schrimshaw, and Hunter, 2009), as well as depression (Marshall et al., 2011).

It is often because of LGBTQ-related stigma and minority stress that LGBTQ adolescents are unable or unwilling to disclose their sexual or gender identity to peers, parents, and healthcare providers. This limits their ability to achieve optimal health, particularly in the domain of sexual and reproductive health. For example, because of LGBTQ stigma, some adolescents engage in heterosexual sex as a form of “stigma management” to avoid difficult conversations around their sexuality (Saewyc et al., 2008). That is, LGB youth may seek out heterosexual relationships in order to avoid suspicion from parents and peers that they are gay or bisexual, placing LGB girls, in particular, at risk for a teen pregnancy. Moreover, LGB youth who have not disclosed their sexual identity to peers or parents report staying in abusive relationships for fear that their abusive partner will “out” them (Gillum and DiFulvio, 2012).

Facilitating identity disclosure to health care providers is also necessary to improve LGBTQ sexual health. Unfortunately, many adolescents are hesitant to disclose their identity to providers because of previous negative experiences, or the fear of negative experiences, in clinical settings (Fuzzell et al., 2016; Hubach, 2017; Keuroghlian, Ard, and Makadon, 2017; Kitts, 2010; Meckler et al., 2006). The lack of disclosure in clinical settings is particularly problematic given the paucity of LGBTQ-specific information provided in sexual education programs in school. This means that many LGBTQ youth are not provided with relevant sexual health information from reliable sources.

For LGBTQ teens who have disclosed their identity to parents, they may find that their parents are woefully unprepared to discuss same-sex sexual safety with their teens (Flores et al., 2018). In clinical settings, studies have shown that in some cases, providers may actively provide

*misinformation* about STI risk and the need for pap tests. For example, one recent study found that providers counsel women that they do not need to worry about HPV or other STIs because they are having sex with women (Agenor et al., 2019). Additionally, some research has found that providers assume that because a girl or woman identifies as bisexual, lesbian, or queer, that she does not need contraceptive counseling (Estes, 2017; Everett et al., 2019). This is especially problematic given that almost all bisexual and lesbian girls report male sexual partners, and they are more likely to report earlier age of sexual debut and teen pregnancy than heterosexual girls (Charlton et al., 2013; Everett, 2013; Riskind et al., 2014; Tornello, Riskind, and Patterson, 2014).

A smaller body of research has examined sexual and reproductive health among transgender and gender-nonconforming adolescents (Leonardi et al., 2019; Nahata et al., 2019). This research is often limited by the fact that few large data sources include measures of gender identity, particularly in surveys that include adolescent participants. New data from the 2017 YRBS, the first to include measures of gender identity, shows that compared to cisgender adolescents, transgender adolescents were more likely to report having had sex before age 13, not using a condom during last sexual intercourse, and not using any contraceptive method to prevent pregnancy (Johns, Lowry, et al., 2019). And while some transgender adults may have gender-confirming surgical operations that remove the possibility of pregnancy, such operations are rare among transgender youth. Other forms of hormonal therapies are more likely to be used in adolescence improve gender dysphoria. These gender-affirming hormonal therapies may induce amenorrhea, but they are not contraceptives, yet some transgender youth are told by providers, inaccurately, that they are (Light et al., 2018). This means that many transgender

youths are at risk for pregnancy, but are not using contraception, nor being provided with contraceptive counseling (Abern and Maguire, 2018).

Taken together, the research on shared and unique risk factors highlights the need to address LGBTQ-related stigma to improve adolescent health. Increasingly, researchers have focused on how to achieve health equity by documenting the factors that lead to resiliency and resiliency promotion among LGBTQ adolescents (Kosciw, Palmer, and Kull, 2015; Mustanski et al., 2014; Russell, 2005).

### **Effective Elements**

Facilitating resiliency and optimal health for LGBTQ population requires taking a multi-level, or an “ecological” approach that incorporates effective elements at the family, school, and community level. LGBTQ youth face threats from multiple sources, thus a multilevel response approach is required for several reasons (Hall, 2018). First, like heterosexual and cisgender youth, parents are important sources of social support. Because some LGBTQ adolescents experience rejection from parents when they disclose their sexual or gender identity, broader social support systems including peers, teachers, and community centers are essential. Second, some LGBTQ youth may not have disclosed their sexual or gender identity to their parents or peers because they fear rejection. As such, these youth may not feel comfortable accessing LGBTQ-specific resources for fear of being “outed.” Establishing school-based protective policies and inclusive sex education provide benefits to all students, including LGBTQ students who are not “out.” Finally, multiple studies have documented how state- and national-level policies can influence LGBTQ adolescents’ development by creating inclusive social environments in which LGBTQ youth can learn and grow.

*Social Support:* Many of the protective factors that matter for LGBTQ youth also matter for heterosexual and cisgender youth. Developing close and loving relationships with family members are crucial for the healthy development among LGBTQ youth (Ryan et al., 2010; Snapp et al., 2015). These relationships can improve the mental health of LGBTQ youth, reduce the likelihood of using tobacco and alcohol, and reduce sexual risk-taking behaviors (Armstrong et al., 2016; Bockting et al., 2013; Kuper, Wright, and Mustanski, 2018; McConnell, Birkett, and Mustanski, 2016; Watson, Grossman, and Russell, 2019). While several studies have documented that negative or rejecting relationships with parents are associated with adverse health outcomes (Rothman et al., 2012), there is broad evidence that parents can also be a positive influence on LGBTQ youth (Bouris et al., 2010). For example, parent acceptance is associated with lower risk of engagement in sexual risk behaviors among adolescent men who have sex with men (Garofalo, Mustanski, and Donenberg, 2008). Using prospective data, other research has found that parent support and the quality of parent-child relationship mediates the relationship between sexual orientation and substance use (Needham and Austin, 2010) and depression (Teasdale and Bradley-Engen, 2010) in young adulthood. Social support from family members and peers has also been shown to benefit transgender youth by reducing psychological distress (McConnell, Birkett, and Mustanski, 2016) and promoting health behaviors (Bockting et al., 2013; Kuper, Wright, and Mustanski, 2018; Taliaferro et al., 2019). Connecting parents to resources like the “Family Acceptance Project” or their local PFLAG organization can help parents learn how to support their LGBTQ child.

For youth who do not have supportive parents, peers can be additional sources of social support that buffer against parent rejection (Hall, 2018; Higa et al., 2014; Parra et al., 2018).

Religious institutions can also play a potentially role in providing social support. While many LGBTQ youth report experiencing stigma and discrimination in churches (Hamblin and Gross, 2014), gay-friendly churches can combat stigma and support religious LGBTQ youths' spiritual development (Gattis, Woodford, and Han, 2014; Higa et al., 2014).

*School Climate and School-Based Policies:* Unfortunately, it is not always possible to guarantee that LGBTQ youth have loving and supportive parents. There is substantial evidence, though, that the school environment can be a powerful leverage point for improving the health and wellbeing of LGBTQ teens. Adolescents spend a large amount of their time in school settings and with teachers and classmates. LGBTQ students who report feeling safe at school and connected to their teachers are at lower risk of substance use (Gower et al., 2018). Alternatively, hostile school environments are associated with more victimization, lower self-esteem, and poorer school outcomes for LGBTQ adolescents (Kosciw et al., 2013).

Research has documented that there are several ways to achieve safer school environments for LGBTQ youth including establishing Gay-Straight Alliance (GSA) clubs, designating "Safe Space" areas for LGBTQ youth, and implementing anti-bullying policies that specifically mention protections for LGBTQ youth. GSAs and other LGBTQ-focused policies have been linked to increased classmate and teacher support, and lower rates of bullying and victimization (Day et al., 2019). In one study of Wisconsin schools, the presence of a GSA was associated with less truancy, fewer sexual partners, less smoking and drinking, for LGB students (Poteat et al., 2013). Survey data from LGBTQ young adults reveals that the presence of GSAs in high school is associated with lower levels of depression and substance use in adulthood (Heck, Flentje, and Cochran, 2013; Toomey et al., 2011). The presence of GSAs also serves to moderate the impact of state-level policy changes. For example, a study using longitudinal data

from California schools during the Proposition 8 campaign in 2008, a state-level proposition that would ban same-sex marriage in the state of California, found that in the year leading up to the vote, there was an increase in homophobic bullying across all schools, however, the presence of a GSA in a school was associated with a smaller rise in homophobic bullying than in schools that did not have a GSA (Hatzenbuehler et al., 2019).

Anti-bullying policies that specifically provide protections for LGBTQ youth have also been linked to lower risk of suicide for lesbian and gay youth (Hatzenbuehler and Keyes, 2013). It is important to note that in this study general anti-bullying policies did not reduce suicide risk for LGBTQ youth, it was only when the policy made specific reference for protections for LGBTQ students that it was protective. Students who lived in states with a higher concentration of LGBT supportive policies, such as GSAs and safe spaces in schools, also report lower risk of suicide (Hatzenbuehler et al., 2014).

For transgender youth, harassment at school and concerns about safety are pervasive (Kosciw et al., 2018; McGuire et al., 2010). The presence of GSAs and anti-bullying policies in schools have been shown to provide even *greater* benefits for transgender students (Greytak, Kosciw, and Boesen, 2013). There are also additional concerns around gender-segregated spaces for transgender youth. In a 2019 study, researchers found that transgender and gender nonconforming students in schools that did not allow students to use bathrooms and locker rooms that aligned with their gender identity were more likely to experience sexual assault than students who were able to use the bathroom or locker room of their choice (Murchison et al., 2019). Evidence also suggests that teacher willingness to intervene to stop harassment, in conjunction with protective policies, can help transgender and gender nonconforming students feel safe in their school environments (McGuire et al., 2010). And in fact, teachers are more

willing to intervene if there is a GSA or an anti-bullying policy in place at the school (Swanson and Gettinger, 2016). Establishing a GSA, in conjunction with teacher and administrator training on LGBTQ issues and intervention strategies, can therefore reduce bullying and victimization for LGBTQ students (Poteat and Scheer, 2016). Moreover, LGBTQ affirmative school environments are better for *all* adolescents, including heterosexual youth: both heterosexual and gay and lesbian youth report less binge drinking in LGBTQ supportive environments (Coulter et al., 2016). Thus, not only is there nothing lost by implementing these policies, there is much to be gained for all students.

Despite mounting evidence that shows there are several school-level policies that improve LGBTQ health, uptake and implementation of these policies has been slow (Demissie et al., 2018). Given the body of evidence that demonstrates both the high rates of victimization, alcohol, tobacco and substance use, depression, suicidality, and sexual risk behaviors among LGBTQ youth *and* the effectiveness of LGBTQ-inclusive policies in school settings, it is paramount that these policies are adopted and enforced at a national level to protect our nation's LGBTQ youth. This will require significant coordination between policy makers, teachers, and parents; but the alternative is unacceptable in light of the evidence of their efficacy.

*Sex Education:* School-based sex education (sex ed) is another mechanism through which LGBTQ adolescent health can be improved. Medically accurate sex ed has benefits for all adolescents and has been linked to delayed first sex, as well as contraception and condom use (Lindberg and Maddow-Zimet, 2012). Sex ed in schools, however, has been shown to have more far-reaching benefits than just providing youth with information on avoiding STIs and adolescent pregnancy. More broadly focused sex ed curriculum provides an opportunity for students to develop self-esteem, self-efficacy and establish long-term patterns for healthy romantic and

sexual relationships (Schalet et al., 2014). For LGBTQ youth, providing medically accurate and inclusive sex ed in schools is particularly important. As stated before, many LGBTQ youth have not disclosed their sexual or gender identity to their parents or providers and it is unlikely that parents or providers are providing unsolicited information on how to engage in safe same-sex sexual relationships. Moreover, even in cases where youth have disclosed an LGBTQ identity, many parents and even some providers, are unprepared to provide relevant and medically accurate safe-sex information (Abern and Maguire, 2018; Agenor et al., 2019; Estes, 2017; Fuzzell et al., 2016). As a result, without LGBTQ-inclusive sex ed, many LGBTQ youth are not provided with sexual health information at all, leaving LGBTQ youth vulnerable to HIV transmission (Fuzzell et al., 2016; Kubicek et al., 2010) and pregnancy (Estes, 2017).

An LGBTQ-inclusive sex ed program has several notable features. First, it does not assume that all students are heterosexual or cisgender. This means discussing and recognizing the full range of sexual and gender identities with which students may identify. Second, inclusive sex ed recognizes LGBTQ persons throughout discussions of how to establish healthy sexual and romantic relationships, rather than relegating LGBTQ issues to a “special topic” discussion at the end of the curriculum. Inclusive sex ed curriculum may also be one of the few, if not only, places LGBTQ students are recognized in formal school settings. Thus, it provides an opportunity for LGBTQ youth to feel validated and supported by their teachers and schools (Fields, 2008). LGBTQ students who do not see themselves recognized in sex ed report feeling “silenced” by teachers and in cases where they attempted to ask questions about same-sex sexuality in the classroom were told to be quiet, limiting their ability to gain sexual health information in school settings (Gowen and Wings-Yanez, 2014). Inclusive sex ed in schools is also an opportunity to combat misinformation, such as that HPV and other STIs are only transmitted through

heterosexual sex (Agenor et al., 2019) and that puberty blockers are a form of contraception (Abern and Maguire, 2018; Light et al., 2018).

The benefits of inclusive sex ed for LGBTQ adolescents are more far-reaching than just reduced sexual risk behaviors; a study using the 2015 YRBS found that LGBTQ students in states that had some elements of an inclusive sex ed curriculum reported less bullying, fewer depressive symptoms, and fewer suicidal thoughts than those that did not have inclusive sex ed (Proulx et al., 2019). Other research has shown that in schools that provide LGB-sensitive instruction, LGB youth reported fewer sexual partners and less substance use than LGB students without LGB-sensitive instruction (Blake et al., 2001). Alternatively, a 2012 study showed that in schools that use abstinence only sex ed LGBTQ students reported more harassment than those that had more expansive sex ed curriculum (Kosciw et al., 2012).

In light of the lack of real or perceived relevant information, many LGBTQ youth turn to the internet to access sexual health-related information (Currin et al., 2017; Pingel et al., 2013). While internet sources can be unreliable, some data suggests that the internet can be leveraged to provide adolescents with medically accurate and inclusive sexual health information, and that online sources of sex ed are of significant interest to LGBTQ adolescents (Magee et al., 2012). Moreover, these online programs not only increase LGBTQ adolescents' sexual health knowledge, but also improve other dimensions of sexual health such as communication skills and self-efficacy (Mustanski et al., 2015). These are critical skills for LGBTQ youth to develop as multiple studies have found they are more likely to experience intimate partner violence throughout their lives than their heterosexual and cisgender peers (Dank et al., 2014; Halpern et al., 2004).

LGBTQ students want more inclusive sexual education that includes discussions of how to develop healthy relationships and provides them with resources they may access outside of the classroom that are medically accurate and inclusive (Gowen and Wings-Yanez, 2014). Currently, only nine states require inclusive discussion of sexual orientation in schools (California, Colorado, Delaware, Iowa, New Jersey, New Mexico, Oregon, Rhode Island, Washington) and three states require *negative* information on LGBTQ identities (South Carolina, Texas, Alabama). Thus, there are many opportunities to enact change.

Clinical Settings: Clinical interactions are also a space that could be used to improve the health and well-being of LGBTQ adolescents (Fuzzell et al., 2017). Reliable sex ed resources on the internet show promise for improving sexual health, but some youth may not feel comfortable accessing these websites at home or in other public spaces, such as a library or school. Healthcare providers can serve as a valuable resource to all youth, but especially to LGBTQ adolescents who may not be able to ask sexual health related questions in other settings. LGBTQ youth want physicians to ask more open questions about sexuality, to feel safe disclosing their sexual or gender identity to their providers, and for their healthcare providers to be more comfortable talking about issues related to their sexual orientation and gender identity (Dodson and Langer, 2019; Fuzzell et al., 2016; Hubach, 2017; Kitts, 2010). Current medical training provides few opportunities for medical providers to discuss LGBTQ issues in their curriculum, which can lead to feelings of discomfort and awkwardness in clinical interactions (Fuzzell et al., 2017). More training, including mock interaction sessions with LGBTQ adolescents may a way to increase cultural competency among healthcare providers. There are also simple things that can be done to make medical spaces feel more inclusive; having materials in the office specific

to LGBTQ youth, or the display of a “safe zone” sign in the office, for example, are ways to facilitate disclosure in the office and to increase patient comfort (Fuzzell et al., 2016).

*Community-Based Resources and State Policies:* A growing body of research is also documenting how the social environment, at both the community- and state-level, can improve LGBTQ adolescent health. Having a Pride Center allows LGBTQ teens from different neighborhoods or schools to gather in a communal space, share their experiences, and support each other (Higa et al., 2014). Community centers can also hold events such as “Queer” or “Pink” Prom that allow LGBTQ youth to celebrate their sexual and gender identities in ways that may be prohibited in their schools. Other community factors such as the proportion of same-sex couples, presence of GSAs, and the proportion of registered democrats in a county have been linked to reduce suicide risk (Hatzenbuehler, 2011) and tobacco use (Hatzenbuehler, Wieringa, and Keyes, 2011) among LGBTQ youth.

State-level policies have also been linked to LGBTQ adolescent health. LGB youth that live in states that passed same-sex marriage legalization experienced reductions in suicide risk (Raifman et al., 2017). Other research has found that LGB students living in states with non-discrimination policies that are inclusive of LGBTQ people, such as non-discrimination employment and housing policies, have a lower risk of cigarette smoking and illicit drug use (Hatzenbuehler et al., 2013; Hatzenbuehler, Jun, et al., 2015). Changes in state laws that provide protections for LGBTQ persons are therefore a pathway through which to improve the health of LGBTQ youth.

### **Summary**

If recent trends continue, we will continue to see more youth identify as LGBTQ and at younger ages. And despite substantial challenges and high rates of victimization, many LGBTQ

youth thrive and find confidence and pride in their sexual and gender identities (Bry et al., 2018; Johns, Poteat, et al., 2019). It is incumbent upon us, however, to ensure that *all* LGBTQ adolescents have the opportunity to thrive and grow into happy and healthy adults. It is therefore imperative that we capitalize on the large body of research that has documented the factors, contexts, and policies that best support LGBTQ adolescents.

First, it is necessary to help LGBTQ youth develop broad social support networks. This includes helping parents understand and support their LGBTQ children. Resources like the “Family Acceptance Project,” PFLAG organizations, and LGBTQ community centers can help assist parents in strengthening their relationships to their children. LGBTQ community centers can also help LGBTQ teens develop friendships with other LGBTQ teens from different schools or neighborhoods, and expand their social support systems. Gay-affirming churches can also affirm LGBTQ adolescents’ identities and be a source of spiritual support for religious LGBTQ teens.

Second, schools should adopt anti-LGBTQ bullying policies, allow transgender youth to use the bathrooms and locker rooms of their choice, and establish GSAs and “Safe Spaces” in their schools. These policies can positively impact multiple dimensions health including lowering rates of depression, substance use and misuse, and sexual risk-taking behaviors. These policies also lower rates of bullying and victimization and facilitate peer and teacher support for LGBTQ students. This is particularly important for LGBTQ youth who have experienced rejection or harassment from their parents. Additionally, these policies have been shown to provide positive health benefits to *all* students, not just LGBTQ youth.

Third, schools should implement LGBTQ-inclusive sex ed curriculum. Not only does inclusive sex ed improve the sexual health of LGBTQ youth, it has been shown to reduce

bullying and victimization in schools, and improve other dimensions of optimal health. Inclusive sex ed in schools may be the only place LGBTQ youth are able to access relevant and medically accurate sex ed. At a minimum, schools should provide resources to online sources of accurate and reliable inclusive sexual health information, such as “AMAZE” (<https://amaze.org>), “Sex, Etc.” (<https://sexetc.org>), or “Rights, Respect, and Responsibility” (<https://3rs.org>).

Fourth, state-level anti-discrimination policies can be implemented to improve optimal health among LGBTQ youth. Currently, only 21 states prohibit employment and housing discrimination based upon sexual orientation and gender identity. There is no evidence that anti-discrimination policies have any negative effects for the general population, the economy, or any other demographic process, in states that pass such bills. Thus, there is no scientifically based reason to not provide employment and housing protection for LGBTQ people.

Each of these elements has been demonstrated to have a positive effect on LGBTQ adolescent health. Done together and applied universally, the promise of achieving optimal health for LGBTQ adolescents can be realized. The stakes are too high, many of the solutions actionable—and are already being applied in some schools and communities—to not expand their reach to every child. All kids deserve to grow up in safe and supportive environments. We have the tools and knowledge to make this a reality for LGBTQ youth.

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