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# Sexual and Gender Minorities (SGM)/(LGBTQ+) Transitional-Age Youth (TAY): Proclaiming Integrity, Legitimacy, and Certainty in the 2020's

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**Key Points**

- Healthcare providers should know there is no medically valid evidence that gender identity and sexual orientation can be altered through therapy and that attempting this may lead to decreased self-esteem, homelessness, depression, and suicidality.
- Delivering affirming care, free from heteronormative assumptions, by asking patients their chosen name and personal pronouns allows patients to speak openly about their health concerns leading to a trusting doctor-patient relationship.
- Physical and mental health issues such as substance use disorders, suicide, sexually transmitted infections (STI), unplanned pregnancy, and homelessness are all more common among SGM transitional age youth compared to same-age peers.
- Although SGM transitional age youth are vulnerable and experience health disparities, many are resilient and adapt to living in a society constantly faced with heteronormative adversity.
- A large survey of transgender adults (mean age, 23 years), who received pubertal suppression drugs as adolescents during treatment, had a lower odds of lifetime suicidal ideation compared to those who had no puberty blockers as adolescents in the course of their transgender care.
- Same-sex marriage became a federal law in 2015, but most laws protecting SGM people are at the state and local level. There are currently no federal legal protections for SGM regarding employment or housing.

## Introduction

The term "sexual and gender minority" (SGM) encompasses a variety of gender and sexual identities and expressions that differ from the majority (e.g., lesbian, gay, bisexual, transgender, questioning (LGBTQ+), as well as the "plus sign" capturing identities and expressions that defy discrete labels (e.g., queer, gender nonconforming)). The abbreviations LGBT and

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LGBTQ are frequently used in the medical literature and lay press. Sexual orientation and identity may be fluid during adolescent and TAY development. Adolescents may have same-sex attractions and fantasies but do not identify as gay, while self-identified gay teens may be sexually inexperienced. Moreover, transgender youth may express their sexual orientation as heterosexual, gay, or bisexual. (For a complete glossary of terms, please refer to Table 20.1.)

Surveying the prevalence of SGM Americans using a Pew Research Center phone survey of a random, nationally representative group of 35,031 US citizens, Smith (2015) found that 5% of men and women identified as lesbian, gay, or bisexual . The largest population-based survey in the United States on sexual orientation was conducted in 2012, which showed that 3.4% of the

**Table 20.1** Glossary of terms (hrc.org)

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| **Ally** \| A person who is not LGBTQ but shows support for LGBTQ people and promotes equality in a variety of ways |
| **Androgynous** \| Identifying and/or presenting as neither distinguishably masculine nor feminine |
| **Asexual** \| The lack of a sexual attraction or desire for other people |
| **Biphobia** \| Prejudice, fear, or hatred directed toward bisexual people |
| **Bisexual** \| A person emotionally, romantically, or sexually attracted to more than one sex, gender, or gender identity though not necessarily simultaneously, in the same way or to the same degree |
| **Cisgender** \| A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth |
| **Closeted** \| Describes an LGBTQ person who has not disclosed their sexual orientation or gender identity |
| **Coming out** \| The process in which a person first acknowledges, accepts, and appreciates their sexual orientation or gender identity and begins to share that with others |
| **Gay** \| A person who is emotionally, romantically, or sexually attracted to members of the same gender |
| **Gender dysphoria** \| Clinically significant distress caused when a person's assigned birth gender is not the same as the one with which they identify. According to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the term – which replaces gender identity disorder – "is intended to better characterize the experiences of affected children, adolescents, and adults" |
| **Gender-expansive** \| Conveys a wider, more flexible range of gender identity and/or expression than typically associated with the binary gender system |
| **Gender expression** \| External appearance of one's gender identity, usually expressed through behavior, clothing, haircut, or voice and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine |
| **Gender-fluid** \| According to the *Oxford English Dictionary*, a person who does not identify with a single fixed gender; of or relating to a person having or expressing a fluid or unfixed gender identity |
| **Gender identity** \| One's innermost concept of self as male, female, a blend of both, or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth |
| **Gender non-conforming** \| A broad term referring to people who do not behave in a way that conforms to the traditional expectations of their gender, or whose gender expression does not fit neatly into a category |
| **Genderqueer** \| Genderqueer people typically reject notions of static categories of gender and embrace a fluidity of gender identity and often, though not always, sexual orientation. People who identify as "genderqueer" may see themselves as being both male and female, as neither male nor female, or as falling completely outside these categories |
| **Gender transition** \| The process by which some people strive to more closely align their internal knowledge of gender with its outward appearance. Some people socially transition, whereby they might begin dressing and using names and pronouns and/or be socially recognized as another gender. Others undergo physical transitions in which they modify their bodies through medical interventions |
| **Homophobia** \| The fear and hatred of or discomfort with people who are attracted to members of the same sex |
| **Intersex** \| An umbrella term used to describe a wide range of natural bodily variations. In some cases, these traits are visible at birth, and in others, they are not apparent until puberty. Some chromosomal variations of this type may not be physically apparent at all |
| **Lesbian** \| A woman who is emotionally, romantically, or sexually attracted to other women |
| **LGBTQ** \| An acronym for "lesbian, gay, bisexual, transgender, and queer" |
| **Living openly** \| A state in which LGBTQ people are comfortably out about their sexual orientation or gender identity – where and when it feels appropriate to them |

**Table 20.1** (continued)

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| **Non-binary** | An adjective describing a person who does not identify exclusively as a man or a woman. Non-binary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all non-binary people do |
| **Outing |** Exposing someone's lesbian, gay, bisexual, or transgender identity to others without their permission. Outing someone can have serious repercussions on employment, economic stability, personal safety, or religious or family situations |
| **Pansexual |** Describes someone who has the potential for emotional, romantic, or sexual attraction to people of any gender though not necessarily simultaneously, in the same way or to the same degree |
| **Queer |** A term people often use to express fluid identities and orientations. Often used interchangeably with "LGBTQ" |
| **Questioning |** A term used to describe people who are in the process of exploring their sexual orientation or gender identity |
| **Same-gender loving |** A term some prefer to use instead of lesbian, gay, or bisexual to express attraction to and love of people of the same gender |
| **Sex assigned at birth** | The sex (male or female) given to a child at birth, most often based on the child's external anatomy. This is also referred to as "assigned sex at birth" |
| **Sexual orientation |** An inherent or immutable enduring emotional, romantic, or sexual attraction to other people |
| **Transgender |** An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc. |
| **Transphobia |** The fear and hatred of, or discomfort with, transgender people |

121,290 respondents age 18 years and older identified as LGBT. When looking at young adults age 18–29 years, 8.3% women and 4.6% men identified as LGBT. The 2015 CDC Youth Risk Behavior Surveillance System (YRBSS) [1] found that 11% of US high school students reported a sexual identity other than heterosexual (2% gay or lesbian, 6% bisexual, 3% not sure) and 6% reported same-sex sexual behavior. Of these youth with same-sex experience, 61% identified as gay, lesbian, or bisexual, and 14% were not sure.

## SGM Identity Development

Many SGM adolescents and TAY may experience struggles with their sexual and gender identity. It is quite common for them to experience internalized sexual prejudice (homophobia and transphobia), in which negative attitudes toward homosexuality and/or transgenderism are adopted toward oneself, leading to self-loathing. SGM youth can also manifest sexual prejudice externally, leading to the mistreatment of others who they perceive as sexual minorities. Both externalized and internalized sexual prejudice may lead teens and young adults to avoid sexual activity or adopt heterosexual activity.

Children as young as 2 years learn to label themselves and other children as a boy or a girl, and by age 4–5 years, they are able to understand that gender is a stable and lasting aspect of their identity [2]. Boys and girls have group differences in toy preference by as early as 12 months [3]. Some children experience not only gender non-conformity but also discomfort with their biological sex and therefore wish to be or are comforted by being perceived as the opposite sex (i.e., gender discordance). Many categories of gender discordance with developmental trajectories have been described. The differences are based on whether discordance begins in childhood, adolescence, or adulthood or is transient or persistent and whether individuals develop a same-sex or heterosexual orientation after transitioning to the opposite gender. Follow-up studies of prepubertal boys with gender discordance showed that cross-gender wishes usually fade over time with only 2–11% continuing into adulthood [4, 5]. A follow-up study of the natural histories of prepubertal girls with gender identity disorder (DSM-IV) reported that 12% of the young women had persistent gender dysphoria (DSM-5) as young adults and 1/3 to 1/2 identified as gay [6].

Children referred for assessment due to gender non-conformity may demonstrate gender non-conforming behaviors at a very young age, sometimes as early as 3 years [7]. Other persons may disclose a transgender identity later in adolescence or adulthood, without a history of gender

non-conformity in early childhood [8, 9]. Young children who are gender non-conforming or who identify as transgender may or may not continue to identify as transgender as adolescents and adults. In fact, there is evidence to suggest that for a majority of young children with cross-gender identity, this identity does not persist into adolescence [10]. At the time of puberty, their transgender identity may desist and perhaps evolve into a gay or lesbian sexual orientation [10, 11]. However, those who have persistence of transgender identity and/or worsening of gender dysphoria in puberty are thought to be much less likely to identify as cisgender through adolescence. Clinicians can use signs of worsening gender dysphoria at the onset of puberty as a diagnostic tool for persistent transgender identity and as a criterion for eligibility for medical intervention [12]. If these feelings present in adolescence, they usually persist into adulthood, leading to life-long efforts to become the opposite sex through cross-dressing, grooming, or sex reassignment through hormones or surgery [13]. Certainty about sexual orientation and identity – both gay and straight – increases with age, suggesting "an unfolding of sexual identity during adolescence, influenced by sexual experience and demographic factors" [14]. Although it may be difficult to tell on which developmental path a particular adolescent is at a given moment, a consistently same-sex pattern of fantasy, arousal, and attraction suggests a developmental path toward same-sex orientation in adulthood. Retrospectively, many gay men and lesbians report same-sex erotic attraction from youth onward [15].

## Minority Stress

Minority stress theory (Meyer 2003) [15] explains that health disparities experienced by SGM people will chronically cause social stress due to negative social attitudes and prejudice. Internalized homophobia refers to inwardly directing society's negative attitudes toward homosexuality, and perceived stigma is the extent that SGM people sense that people in the wider population hold negative attitudes toward homosexuality (e.g., homophobic abuse, exclusion, and discrimination) [16]. These stressors are said to have an additive effect on general psychosocial stressors and can negatively affect an individual's coping mechanisms. They may increase the susceptibility of same-sex-attracted people to develop problems with mental health and substance use [17]. Meyer (2003) concludes that gay men with high levels of minority stress are two times more likely to suffer from distress affecting their mental and physical health [15]. Lesbian, gay, bisexual, and other same-sex-attracted young people have been shown to be at a higher risk of mental health problems, including depression, anxiety, suicidality, and substance abuse, compared to their heterosexual peers. An online survey [18] in Sydney, Australia, recruited 254 same-sex-attracted TAY ages 18–25 years (254 women and 318 men) and found that internalized homophobia, perceived stigma, and experienced homophobic physical abuse were associated with higher levels of psychological distress and suicidal thoughts in the previous month. Perceived stigma and homophobic physical abuse were associated with reporting a lifetime suicide attempt, but the association between minority stress and substance use was inconsistent [18].

The concept of minority stress is not based on one congruous theory but is inferred from several social and psychological theoretical orientations. Hatzenberger et al. propose that sexual minorities confront increased stress exposure resulting from stigma which increases emotion dysregulation, social/interpersonal problems, and cognitive processes which facilitate the relationship between stigma-related stress and psychopathology [16]. They also found that sexual minorities are at increased risk for multiple mental health burdens compared with heterosexuals [16]. According to the National Coalition of Anti-Violence Programs (NCAVP) [19], LGBTQ individuals who also identify as racial and/or ethnic minorities represented 79% of anti-LGBTQ hate-related homicides in the United States, of which 14% were Latinx. Of the total survivors of anti-LGBTQ hate crimes, 29% were Latinx. These figures are likely to underestimate the true incidences because the NCAVP bases its statistics only on

cases for which it can confirm the identity characteristics of the victim. NCAVP also reports that LGBTQ Latinx individuals were more likely to experience online harassment, to be threatened, to experience robbery, and to experience violence by their employers [20].

SGM youth are at high risk for school victimization. In a 2011 national survey of 8584 LGBT students aged 13–20 years, 71–85% reported hearing sexual prejudicial remarks (e.g., "dyke"; "faggot"; "that's so gay") [21]. In the same study, 57% reported hearing such remarks from a teacher or staff member, 64% felt unsafe at school because of their sexual orientation, and 38% were physically harassed (e.g., pushed), while 18% were physically assaulted (e.g., punched, kicked, or hit with a weapon). The 8th biennial 2013 National School Climate Survey by the Gay, Lesbian, and Straight Education Network (GLSEN) [22] revealed that hostile school climates negatively affect educational success. LGBT students who experienced victimization and discrimination showed lower GPAs than students who had not (2.8 vs. 3.3) and were less likely to plan for college (92% vs 96%). School victimization has been linked to compromised academic achievement and school absenteeism, aggressive behavior, compromised emotional health, and suicidal ideation, substance use, delinquency, and aggression, particularly for boys [23]. Affecting attendance, 30% of these kids missed at least one school day per month because they felt unsafe [24]. School climate for LGBT youth was improved in schools with extracurricular gay-straight alliance groups [22] (see Table 20.2). SGM adolescents suffer higher rates of parental abuse and polyvictimization than their heterosexual peers. The Human Rights Campaign [25] polled 10,000 youth ages 13–17 years in 2012; 26% reported family rejection after coming out, 21% reported being bullied at school, and 18% were fearful for being "out." Some findings indicate that gender nonconformity in children accounts for at least a portion of the disparities in abuse. For example, Roberts (2012) found that gender non-conformity prior to age 11 years partly accounted for greater rates of child abuse and later rates of PTSD in early adulthood, both among children who identify as heterosexual and children who have a minority sexual orientation [26].

**Table 20.2** School bullying and SGM youth

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| Nearly 60% youth have no protections from bullying in school |
| 71.5% of US school districts have anti-bullying policies, but only 42.6% include sexual orientation, and only 14.1% include gender expression |
| Having strict anti-bullying policies and gay-straight alliances in place for 3 or more years significantly reduced suicidal thoughts and attempts according to a 2014 study |
| Only 10% of youth report that their school has a policy which includes SGM protections |

## Healthcare: Medical and Mental Health

According to the Dane County Youth Assessment Surveys in 2008–2009, multiple factors accounted for unsafe sexual behaviors in LGBT youth, including earlier age of first sexual encounter, increased number of known and anonymous sexual partners, lack of education on safe sex practices, ineffective use of condoms, and inadequate perception of sexually transmitted infection (STI) acquisition and testing [27]. One study on LGBTQ adolescents found that only 35% of the respondents had disclosed their sexual orientation or gender identity to their healthcare provider, with bisexual youth disclosing at lower rates (Meckler et al. 2006) [28]. Intrapersonal factors impacting disclosure may be especially pertinent among TAY, who may still be navigating and defining their identities and who may be more selective about disclosure. Also, sociodemographic characteristics of the patient, such as race and income, have been associated with nondisclosure among men who have sex with men (MSM), with African American and/or low-income individuals being less likely to disclose their sexual orientation to providers [28]. These findings suggest that rates of disclosure may vary, not only between different identity groups within the LGBTQ community but also based on racial/ethnic identity and socioeconomic status.

Another factor in LGBT health disparities is discriminatory treatment in healthcare settings. Surveys of both patients [29] and providers [30] reveal that LGBT people experience prejudicial treatment in clinical settings and that some providers exhibit anti-LGBT bias. As a result, many LGBT patients report culturally incompetent care or avoid visiting healthcare facilities for fear of receiving substandard care [30]. The lack of LGBT-inclusive cultural competency and clinical training for providers contributes to their widespread failure to discuss SGM issues with their patients, perpetuating invisibility of LGBT patients in clinical settings. SGM data collection is a key component of enhancing the ability of patients and providers to engage in meaningful dialogue in the exam room and to promote the provision of high-quality care for LGBT people [31]. Patient-provider discussions about SGM issues can facilitate a more accurate assessment of patient self-reported health and risk behaviors [32]. These open communications at clinics and hospitals are especially important, where LGBTQ youth find it difficult to share their sexual identities with their clinicians, and the lack of communication is responsible for the poor therapeutic alliance, poor illness-related education, inadequate scheduled screening for communicable diseases, and inadequate interventions to prevent STIs [33].

## Sexually Transmitted Illnesses (STIs)

SGM youth are more likely to engage in high-risk sexual behaviors leading to an increased incidence of STIs (sexually transmitted illnesses), e.g., syphilis, human papillomavirus (HPV) infections, and hepatitis in MSM [26]. The rates of gonorrhea, chlamydia, and HIV are two times as high in sexual minority youth compared to those in heterosexual men [34]. In 2016, the Centers for Disease Control and Prevention (CDC) [35] reported that new HIV diagnoses in the United States totaled 37,832 and that youth ages 13–24 years old accounted for 7807 (21%) of them. Most new HIV infections among youth occur among young men who have sex with men (YMSM), gay and bisexual men, with young black/African American and Hispanic/Latinx gay and bisexual men especially affected. Many of these youth do not know they are infected. Alcohol, methamphetamine, and other drug use are common among YMSM and can lead to risky sexual behavior resulting in STIs. Youth who developed HIV as children or adolescents tend to form close attachments to their adolescent care team and may have difficulty transitioning to adult care. Adolescent providers have stressed the importance of matching these patients with adult clinics that are comfortable treating LGBTQ+ young people [34].

## Health Outcomes

Transgender or non-conforming (TGNC) youth report poor health outcomes compared to their cisgender peers. The 2016 Minnesota Student Survey of 80,000 9th and 11th graders, 2.7% who identified as TGNC found that nearly 2/3 of TGNC students reported their health as poor, fair, or good versus very good or excellent, compared to 1/3 of cisgender students [36].

Other studies in children as young as 3–9 years old have found higher prevalence of anxiety and attention-deficit/hyperactivity disorder (ADHD) in TGNC youth [34]. The 2015 CDC Youth Risk Behavior Surveillance System (YRBSS) determined that 9% of American high schoolers attempted suicide in 2014. Rates of suicidal thoughts and suicide attempts of LGB youth were three to four times that of the general population. In one study of youth who identify as LGBTQ, 45% had experienced suicidal thoughts, and 35% had attempted suicide [37]. The developmental period following same-sex experience but before self-acceptance as gay may be one of especially elevated safety risks. Suicidal thoughts, depression, and anxiety are especially high among gay males who displayed gender non-conforming behavior as children. A study of 224 white and Latinx self-identified LGB young adults who reported high levels of family rejection during

adolescence showed that they were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report depression, 3.4 times more likely to use illegal drugs, and 3.4 times more likely to engage in unprotected sex than those who reported no or low levels of family rejection [38].

Given the high prevalence of HIV transmission among MSM, adolescent gay males are at high risk for HIV, as well as other STIs. Young bisexual and lesbian women, not factoring in race or ethnicity, are twice as likely to have a teen pregnancy than their heterosexual peers, and depression in adolescence may be more predictive of subsequent unintended pregnancy than depression at young adult ages [39]. Poor safe sex practices (i.e., no contraception) may be a result of low motivation to use protection secondary to low self-esteem, shame, or guilt about same-sex attraction.

## Substance Use and Dependence

Rates of drug use among SGM youth are higher than those of their heterosexual peers [40, 41]. For example, 56% of high school youth who identify as bisexual report past-month alcohol use, compared to 38% of their peers who identify as heterosexual [39]. Lifetime prevalence rates for heroin, inhalants, steroids, cocaine, and MDMA/ecstasy use are also higher among sexual minority high school youth compared to heterosexual youth. Sexual minority youth likely engage in drug use for the same reasons as their heterosexual peers, including prevailing peer and social influences. However, sexual minority youth must also contend with negative reactions to their minority status and a concomitant lack of social support from family, peers, and others [42]. Although drug abuse prevention programs focus on such risk factors as peer and social influences and stress, these programs largely assume a heterosexual audience [43, 44].

Substance use disorders, suicide, STIs, unplanned pregnancy, and homelessness are all more common among sexual minority youth [43]. Estimated prevalence rates of drug and alcohol abuse among LGBTQ people are 20–30%, compared to 9% in the general population [44, 45]. The odds of substance use for LGB youth were, on average, 190% higher than for heterosexual youth and substantially higher within some subpopulations of LGB youth: 340% higher for bisexual youth and 400% higher for females [44, 45]. Substances may be utilized in response to peer pressure in order to gain acceptance and to relieve emotional distress related to the effects of bullying, exclusion from support networks (e.g., friends, family), or internalized sexual prejudice or due to increased exposure to substances at venues where one's identity is being explored (e.g., night clubs) [46, 47]. Anabolic steroid (AAS) abuse is six times higher in gay males compared to straight adolescent males. Substantial sexual orientation health disparities exist in regard to the prevalence of AAS use, with sexual minority males reporting a lifetime rate of 21% compared to 4% for heterosexual adolescent males, over five times the rate [48].

## Depression and Suicide

It has been shown that adolescents and TAY who receive gender-affirming care, including puberty blockers and hormonal therapy, have lower rates of suicidal attempts and depression. Turban et al. (2020) completed a large cross-sectional survey of 20,619 transgender adults ages 18–36 years (mean age of 23, 45% assigned male at birth) which showed that those who received pubertal suppression drugs as adolescents had a lower odds of lifetime suicidal ideation compared to those who had no puberty blockers as adolescents in the course of their transgender care [49]. Also, self-reported peer victimization (for males and females), as well as parental rejection (for females/bisexuals), mediated the association between sexual orientation and depressive symptoms. Cross-sectional studies have found higher levels of depressive symptoms for LGB people, in comparison to heterosexuals, in adolescence

[50] as well as adulthood [51, 52]. Longitudinal studies on the topic are scarce, with exceptions relying largely on data from the National Longitudinal Study of Adolescent to Adult Health (Add Health) [53–55]. These studies found that, compared to heterosexual youth, same-sex- or bisexually attracted youth experienced elevated levels of depressive symptoms in late adolescence (age 16 years), which persisted into young adulthood (age 29 years). However, some empirical evidence suggests the contrary: that black sexual minority male youth report better psychological health (fewer major depressive episodes and less suicidal ideation and alcohol abuse or dependence) than their white sexual minority male counterparts [56]. A community sample of SGM TAY ages 16–20 years revealed that nearly 33% of participants met the diagnostic criteria for a mental disorder and/or reported a suicide attempt in their lifetime [57]. When comparing these findings to mental health diagnosis rates in the general population, about 18% of lesbian and gay youth participants met the criteria for major depressive disorder (MDD) and 11.3% for PTSD in the previous 12 months. Of the LGBT sample, 31% recounted suicidal behavior at some point in their life. National baseline rates for these diagnoses and behaviors among youth are 8.2% (MDD), 3.9% (PTSD), and 4.1% (suicidal behavior) [58, 59]. Much of what has been learned scientifically about sexual orientation and gender development in the last generation has occurred in parallel with societal changes in attitudes toward sexual orientation and gender roles. Biological, psychological, and social influences have been discussed in the literature over the past five decades with the leading theories shifting dramatically over that time.

## Biological Aspects

The neurohormonal theory suggests that prenatal sex hormone levels influence development of gender role behavior in childhood and sexual orientation in adults. While sex hormone levels during fetal development may influence childhood gender variance and adult sexual orientation, neither same-sex attraction nor gender variance is an indication for endocrine, genetic, or any other special medical evaluation. There is evidence of genetic influence on gender role in childhood and sexual orientation in adulthood from family, twin, and molecular studies. Bailey et al. (1993) and colleagues found that, among gay males, 52% of monozygotic co-twins were gay compared to 22% of dizygotic twins and 11% of adoptive brothers. There is little data on differences in neuroanatomy [60]. Some research studies have tested the hypothesis that sexual minority identity, in and of itself, is linked to atypical patterns of cortisol levels. Studies that have looked at diurnal slopes and acute reactivity of cortisol have generally not found that self-identified LGB individuals differ in their diurnal cortisol patterns from heterosexual individuals [61, 62]. Research questions that propose to address social group differences (e.g., LGB vs heterosexual) based on the endorsement of a single categorical social construct (e.g., sexual orientation) do not account for the *diversity of individuals within those groups*. Conversely, some researchers have reported differences when accounting for the dual categories of sexuality and gender. For example, lesbian and bisexual women showed higher and prolonged cortisol elevation to an experimental induction of acute social stress when compared to heterosexual women, but gay and bisexual men showed lower cortisol levels than heterosexual men throughout the duration of the stressor [63]. One possible way to investigate these findings might be to look at the *multiple forms of oppression* these individuals experience at the intersections of sexual orientation and gender. Understanding the tightly interwoven associations between the social constructs of sexuality and gender requires examining the shared and unique lived experiences of LGBTQ and heterosexual individuals [64].

## Psychological Factors

The last decade of research on LGBTQ youth has seen a gradual expansion from its focus on risk to the resources associated with resilience, "positive adaptation in the context of risk or adversity," e.g., race and poverty [65]. The inclusion of sexual and gender diversity as a source of adversity is relatively new in resilience research, and the dearth of studies does not spell out what adversities their study participants commonly experienced. Asakura et al. (2019) posit that LGBTQ youth might experience their everyday realities differently from their cisgender, heterosexual peers, and it might be rash to transfer knowledge of youth resilience in general to SGM youth. They surveyed a gender and racially diverse group of 16- to 24-year-olds about their life "stressors" to define their "resilience" [66]. All participants rejected the normative definitions of positive adaptation such as the "absence of psychopathologies" and "school success" and instead used the phrases "still struggling," "battling through," and "having your head above water." Overall, this qualitative study adds to research on risk and resilience by conceptualizing hetero-cis-normativity as a source of adversity and echoes the need for continued resources and further research (Asakura K et al. 2019) [66].

A similar qualitative study that explored the resilience of 13 transgender youth of color found that, despite experiencing racism and prejudice, the participants were often able to use social media to assert their identities and counter negative representations (Singh 2012) [67].

The distance created by online communication may also help to buffer the negative content LGBTQ youth encounter and provide opportunities for personal advocacy. For example, insults may feel less threatening to youth who can respond to them from the safety of their homes. Encountering negativity online may actually allow young people to develop and practice skills such as buffering, deflecting, or resisting homophobia and heterosexism [68]

For those raised in Evangelical Christian families, "coming out" may create a new psychological stressor, and for many, it can result in being ostracized by family members who believe that LGBTQ people are "sick, or sinners," who "should not marry, raise a family, or adopt children." A good number of these youth have been pressured to undergo "conversion therapy" or "sexual orientation change efforts" (SOCE), which entails aversive methods such as electric shocks, delivered when aroused by same-sex photographs, in order to change their sexual orientation or gender identity to heteronormative accepted standards. The youth exposed to this practice have suffered serious psychiatric disorders such as PTSD, depression, anxiety, and suicide. Attempts to change sexual orientation during adolescence are associated with elevated young adult depressive symptoms and suicidal behavior and with lower levels of young adult life satisfaction, social support, and socioeconomic status. Ryan (2020) interviewed 245 LGBT young adults ages 21–25 years, and more than half reported some form of attempt by their parents and caregivers to change their sexual orientation during adolescence. Thus SOCE is associated with multiple domains of functioning that affect self-care, well-being, and adjustment [38, 69]. The American Academy of Child and Adolescent Psychiatry (AACAP) Policy finds "no evidence to support the application of any therapeutic intervention operating under the premise that a specific sexual orientation, gender identity, and/or gender expression is pathological." Furthermore, based on the scientific evidence, the AACAP asserts that such "conversion therapies" (or other interventions imposed with the intent of promoting a particular sexual orientation and/or gender as a preferred outcome) lack scientific credibility and clinical utility. Additionally, there is evidence that such interventions are harmful. As a result, "conversion therapies" should not be part of any behavioral health treatment of children and adolescents. Table 20.3 lists 20 states that have laws banning conversion therapy (hrc.org).

However, according to the Williams Institute at the UCLA School of Law, an estimated 20,000 LGBT youth (ages 13–17 years) will receive con-

**Table 20.3** Twenty states have laws banning the practice of "conversion therapy" (including Washington, D.C., and Puerto Rico)

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|---|---|---|---|---|
| Massachusetts | Vermont | New Hampshire | Connecticut | Rhode Island |
| Maine | New York | New Jersey | Delaware | Maryland |
| Virginia | Illinois | California | Washington | Oregon |
| Nevada | New Mexico | Colorado | Hawaii | Utah |

version therapy from a licensed healthcare professional before they reach the age of 18 years in other states [70].

## Social Impacts

A 2014 Williams Institute study looked at the economic impact of SGM rights in 39 countries and 39 emerging economies around the world. They learned that the exclusion of LGBTQ people caused economic harm such as decreased productivity, lost labor time, underinvestment in human capital, and the inefficient allocation of human resources through hiring practices and education. The study also showed that expansion of SGM rights was correlated with higher per capita income and higher levels of well-being for everyone [71].

It is estimated that there are 1.6–2 million homeless youth in the United States and that 20–40% are LGBT. Given that LGBT youth comprise less than 10% of the general adolescent population, a disproportionate number of LGBT youth are displaced from their homes. Homeless sexual minority youth report high rates of substance abuse, suicide attempts, risky sexual behaviors (prostitution, unprotected intercourse), and sexual victimization [72]. Homelessness is one of the most common drivers of youth engagement in survival sex [73, 74]. Nationally, estimates of the proportion of runaway and homeless youth involved in survival sex range from 10% to as high as 50% [74]. Seeking refuge in shelters may perpetuate discrimination; many youth report maltreatment in this setting.

Recent research suggests differences in child welfare experiences for sexual minority youth. LGBTQ youth in foster care, when compared to their heterosexual peers, experience a higher number of child welfare placements and longer lengths of stay [75, 76]. The social stigma and discrimination combined with differences in child welfare experiences suggests that LGBTQ youth in foster care have an increased vulnerability for substance use and misuse. The rationale for a detailed focus on sexual minority youth stems from the likelihood that their young adulthood lives may be compromised as a result of factors related to representing a "largely invisible population within child welfare systems" [77]. Moreover, though the state of research on sexual minority youth during their involvement with child welfare is deemed "growing yet still insufficient" [78], research on their lives immediately following emancipation is virtually non-existent [79]. Spiegel et al. (2016) [80] studied information from the Chafee Act and the Children's Bureau 2011 Information Memorandum and data from one site of the Multi-Site Evaluation of Foster Youth Programs (MEFYP) study. They found that compared to same-age heterosexual peers, sexual minority TAY demonstrate significantly lesser functioning in education, employment, housing stability, and financial matters. They were more likely to experience financial hardships and indicate that they were "struggling to make it." SGM TAY were less likely to be "financially stable" or to have bank accounts and were more likely to use public assistance. For related functional well-being indicators, sexual minority youth were less likely to have high school diplomas/GEDs and work experience and more likely to experience homelessness compared to their heterosexual counterparts [80]. Services and programs for youth in care should be designed to address substance use and misuse prevention, housing stability, and independent living preparation needs unique to the youth and should address needs of sexual minority youth.

LGBQ Discrimination in the Workplace Scholars have documented a variety of disproportionate barriers to employment and discriminatory practices in the workplace against LGBQ individuals. Several studies matched résumés or job candidates on skill level but altered one key characteristic: implied sexual orientation. In all these studies, compared to the heterosexual job candidates, the LGBTQ job candidate received fewer interview invitations and was deemed less qualified for the position [81]. Furthermore, LGBTQ employees are vulnerable to direct and indirect forms of victimization in the workplace, such as being passed up for promotions or terminated from their position as well as experiencing verbal or physical harassment, derogatory comments, and discriminatory attitudes [83-86]. One policy report released in 2007 claims that anywhere between 7% and 41% of LGBQ people surveyed had been either physically or verbally abused in the workplace or had their property vandalized at work [81].

## Higher Education: College Campus Life

Approximately 10% of colleges and universities (320 campuses) have at least 1 paid professional staff or graduate assistant directing LGBT resources [87]. There has been a steady growth in the number of established LGBTQ centers at institutions of higher education since 1971, when the first dedicated space at the University of Michigan opened to serve gay and lesbian students [88] in varying degrees, and eventually inclusive of all SGMs. Data from the University of Wisconsin's HOPE Lab survey, entitled "Still Hungry and Homeless in College," reveals that transgender and non-binary students are more likely to face food and housing insecurity and homelessness, at rates significantly higher than their cisgender peers. Their findings are based on a survey of 43,000 students at 66 institutions in 20 states and the District of Columbia [89]. It includes more than 20,000 students at 35 4-year colleges and universities, as well as students at community colleges. LGB respondents faced higher risks of basic need insecurity compared to heterosexual students – with bisexual students at the highest risk of this group. Nearly 50% of bisexual respondents experienced food and/or housing insecurity, and over 20% bisexual community college students have experienced homelessness. Researchers think that these disparities seen in SGM students are linked to lower levels of family and financial support. These results are consistent with data recently released by Chapin Hall at the University of Chicago [90], which found that LGBTQ young adults had a 120% higher risk of reporting homelessness compared to youth who identified as heterosexual and cisgender. Colleges face increasing numbers of students with mental health problems [91]. Despite having access to campus services, only half of college students with mental health problems use supports [92, 93].

## Culture and Religion

Many adolescents and young adults have internal conflicts related to their religious upbringing because some religions are not accepting of LGBT people. Others are all inclusive (i.e., accepting of people regardless of race, culture, gender, and sexual orientation). Adolescents may be justifiably reluctant about "coming out" to families who may engage in rejecting behaviors based on their own religious and/or cultural beliefs. Latino, immigrant, religious, and low-socioeconomic status families appear to be less accepting, on average, of LGBT adolescents. It appears that it is not the sexual orientation or gender identity of the adolescents themselves but the characteristics of their families (their ethnicity, immigration and occupation status, and religious affiliation) that seem to make a difference in distinguishing between those that score high versus low on acceptance of their LGBT children [38]. In certain situations, healthcare providers should be cautious about recommending open conversations at home and instead should guide the patient to people and

organizations that may be useful sources of education and support (see Resources section below). While a small number of religious denominations have become more affirming of same-sex sexuality, the religious context remains challenging for some sexual minorities. The presupposition and normative standard of heterosexuality is salient and often unchallenged within Western society, and it can be reinforced within Christian religious contexts. Sexual minority individuals within these settings may be exposed to negative and condemning denominational teachings regarding their sexual attractions and behavior. This may lead to heightened frustration and confusion regarding their own values related to sexual behavior, attractions, faith, family, and the afterlife.

Dahl et al. (2012) did a qualitative study looking into the positive and negative experiences of sexual minority adolescents and young adults coming out within a Christian religious context [94]. Sexual minority adolescents and young adults are presumed to be going through the process of identity negotiation [95] and, as such, can provide more current information regarding their experiences. Researchers have highlighted the importance of context when considering the developmental experiences of sexual minorities, individuals who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ) or use another label of personal meaning [96]. One context, and a major socializing force in the United States, is religion. Seventy-six percent of Americans report a Christian religious affiliation, and approximately 4% of Americans describe a religious affiliation other than Christianity [97]. As such, developmental processes can be complicated for sexual minorities attempting to negotiate their sense of identity within Christian religious contexts [95, 97]. Research has also examined the relationship between sexual minority religiosity and substance use. These studies [98] found religious commitment associated with lowered levels of binge drinking, substance use, and risky sexual behavior in male gay and bisexual adolescents but not female lesbian and bisexual youth.

## Federal and State Law Protections

The Human Rights Campaign (hrc.org), founded in 1980, is the largest advocacy group in the United States fighting for LGBTQ legal protections at the federal and state level. Family Equality Council (familyequality.org) connects, supports, and represents the three million parents who are lesbian, gay, bisexual, transgender, and queer in this country and their six million children. They work to ensure equality for LGBT families by building community, changing hearts and minds, and advancing social justice for all families. The Lambda Legal Defense and Education Fund is the largest legal organization in the United States. Since 1973, the staff has worked to secure civil rights for gays, lesbians, and persons with HIV via education, public policy work, and litigation.

After years of lawsuits in district, federal, and the Supreme Court, same-sex marriage became a federal law in 2015. However most laws protecting LGBTQ people are at the state and local level. There are currently no federal legal protections for SGM regarding employment or housing. This means that one can be fired or evicted for being a SGM individual. Section 1557 of the Patient Protection and Affordable Care Act ("ACA") provides that individuals may not be excluded on the basis of race, sex, age, or disability from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity that receives federal financial assistance. However, the current administration has implemented a "proposed rule," which re-interprets Section 1557 to remove protections against discrimination based on gender identity and will most likely be challenged in the courts. The Equality Act, passed by the US House of Representatives on May 17, 2019, and gaining momentum in the Senate, would amend existing civil rights law – including the Civil Rights Act of 1964, the Fair Housing Act, the Equal Credit Opportunity Act, the Jury Selection and Services Act, and several laws regarding employment with the federal government to explicitly include sexual orientation and gender identity as protected characteristics (HRC.ORG).

## Summary

SGM TAY face multiple challenges on a daily basis, and most have experienced minority stress during their child, adolescent, and transitional age development increasing their risk of depression, substance abuse, and suicide. Many have also encountered job discrimination leading to unemployment and disillusionment, lower earned incomes, and higher rates of homelessness compared to their cisgender, heterosexual peers. Many SGMs have been rejected by their families because of their identities and sexual orientation, forcing them into homelessness and sexual survival behaviors. Their rates of life-threatening STIs outnumber their same-age non-SGM peers. Those SGMs who do attend college tend to select schools that are welcoming and that have LGBTQ centers on campus, providing support and a sense of community. Those who have religious beliefs but are banned from their own religious houses of worship can discover the many faiths that are inclusive of all genders and sexual orientation. The SGM TAY community is quite diverse and is represented by members of all cultures, races, and religions. More research is needed to understand the intersectionality of their similarities and differences which can improve care.

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## Resources

Resources for LGBTQ youth from the Harvey Milk School at the Hetrick Martin Institute. www.hmi.org

Gay Straight Alliance Network, provides information for youth activism. www.gsanetwork.org

Parents, Friends, and Families of Lesbians and Gays, support organization. www.pflag.org

Gay, Lesbian and Straight Education Network, supports school climate. www.glsen.org

Lesbian and Gay Child and Adolescent Psychiatric Association, includes extensive list of resources for adolescents, parents, and providers. www.lagcapa.org

Association for Gay and Lesbian Psychiatrists, information for patients and providers. www.aglp.org

Child Welfare League of America, information for LGBT youth in foster care or juvenile justice. www.cwla.org

Gay Lesbian Medical Association, resources for patients, families, and providers. www.glma.org

World Professional Association for Transgender Health, information and advocacy resource. www.wpath.org

GLBT National Youth Talkline 1-800-246-PRIDE (7743) (serving youth through age 25).

Video and social media messages of hope for LGBT youth. www.itgetsbetter.org

Information related to bullying of LGBT youth. www.stopbullying.gov/at-risk/groups/lgbt/

LGBTQ laws and protections by state. http://www.lgbtmap.org/equality-maps/conversion_therapy

Fenway Health, health center with focus on LGBT care, research, education, and advocacy. http://fenwayhealth.org/the-fenway-institute/

The Trevor Project, trevorproject.org