

LGBT Youth: Health Concerns, Services and Care

Caitlin Ryan

Lesbian, gay, bisexual and transgender (LGBT) youth have emerged only recently as a separate cultural group, during the 1990s. In earlier decades, relatively few youth self-identified or came out as LGBT since social sanctions and stigma contributed to severe repercussions and isolation, limiting access to supportive communities and awareness of sexual and gender identities. Although a range of lesbian and gay service organizations developed in large cities during the 1970s and 80s, only a handful addressed the needs of youth. By the 1990s, however, coming out during adolescence was becoming the norm. Growing numbers of LGBT youth support groups and Gay Straight Alliances (support and advocacy groups in high schools), coupled with increased awareness of homosexuality as a result of the AIDS epidemic, and the growth of the internet, have contributed to an emerging LGBT youth culture that has challenged existing health, mental health, educational and family service delivery systems to provide appropriate services and care.

Although researchers have documented a substantive decrease in the age of psychosexual milestones and self-identification as lesbian, gay or bisexual beginning with studies in the late 1980s, this information has rarely been included in provider training materials and professional literature (Ryan, 2000). Both professional training and school and agency policies infrequently address the needs and concerns of LGBT youth and their families. Only recently have some individual agencies, several States, and a number of school districts begun to implement policies and staff training to enhance services and care for youth related to sexual and, in some cases, gender identity. Appropriate policies and training are urgently needed to improve care for LGBT youth and those who are questioning their sexual and gender identity, and to prevent discrimination and victimization in school and community settings.

Identity Development

A core task for adolescents is identity development. For LGBT youth, this includes integrating sexual and gender identity, and for youth of color, consolidating these identities with race and ethnicity. Adolescence is characterized by experimentation, exploration and risk taking, and many adolescents become sexually active and explore use of alcohol and drugs. For youth who are learning to explore intimacy and sexuality, it is also a time of increased vulnerability, including risk for HIV infection. These experiences become more complex for LGBT youth who often negotiate them without guidance or help from adults who routinely provide support for children and adolescents. LGBT youth must also learn to manage stigma, a complex task regardless of age, and to cope with social, educational and community environments where victimization and harassment are normative.

Sexuality holds different meanings within each cultural

and ethnic group, and sexual identity is shaped by many factors, including attitudes, values, and beliefs about sexuality, stereotypes about gender and sex roles, religious values, responsibilities for childbearing, degree of acculturation into mainstream society, and the importance of family and ethnic communities in providing acceptance and support (Greene, 1994). Strong connections with family and ethnic community are needed to cope with racism and rejection within the broader society. At the same time, however, LGBT youth of color face homophobia and negative stereotypes within their ethnic communities and society, in general, and racism within predominantly white gay communities. Many LGB persons describe feeling pressure to choose or value one identity over another, while not feeling fully supported in any community (Chan, 1989; Espin, 1993; Loiacano, 1989; Morales, 1990). This is especially challenging for adolescents who are trying to meet the cultural demands of their family and ethnic communities, while negotiating age-appropriate tasks related to intimacy and relationships, and finding support for dealing with same-sex desires and gender variant identities.

Research on non-heterosexual youth has targeted young gay males, with few published studies of lesbian adolescents. Community based studies conducted over the past three decades have focused on gay and, more recently, lesbian youth, while population-based studies include larger proportions of youth who identify as bisexual, with much smaller proportions of gay and lesbian-identified adolescents. Little is known about bisexual identity during adolescence or whether adolescents consolidate a separate bisexual identity, and, to date, no studies have been published on bisexual identity during adolescence (Ryan & Futterman, 1998). Studies with a wider range of school-aged youth suggest that younger adolescents may be more likely to identify as bisexual or questioning, while older youth are more likely to identify as lesbian or gay (see, for example, Remafedi, Resnick, Blum, & Harris, 1992). Moreover, many lesbian and gay youth have heterosexual experiences before identifying as lesbian or gay, and some may identify as "bisexual" for a period of time while integrating a lesbian or gay identity, since they may perceive "bisexual" to be less stigmatizing.

Although research is limited, several studies have found more negative experiences and outcomes among bisexual youth, compared with lesbian and gay (or heterosexual) peers. For example, Hunter (1996) found greater negative perceptions about sexuality among bisexual teens in a study of identity, coming out and sexual risk behaviors among LGB youth, while Hershberger, Pilkington, & D'Augelli (1997) reported greater likelihood of multiple suicide attempts among bisexual youth, compared with lesbian and gay peers. In an analysis of data from representative school-based surveys in Massachusetts from 1995-99, Goodenow, Netherland and Szalacha (2002) found that bisexually-experienced male youth reported significantly higher levels of sexual risk and injection drug use

than heterosexual or gay-identified peers. This led them to conclude that "there might be a constellation of especially high risk behaviors and experiences among youth with bisexual experience" and many of the higher risk results attributed to gay or sexual minority youth may actually be related to bisexual behavior (Goodenow, et al., 2002, p. 207).

Sexual Orientation. Sexual orientation is a pattern of behavior, emotional and erotic attraction that is believed to be established in early childhood. However, many misconceptions exist about adolescent sexuality and behavior. For example, adults often perceive that adolescents are too young to understand sexual orientation, and believe that lesbian or gay identity is only consolidated during adulthood. Others are unaware that sexually active youth who identify as heterosexual may engage in same-sex behavior. To understand adolescent sexuality and health-related risks, it is important to realize that sexual identity is not always linked with behavior, and many youth who are sexually active with same sex partners do not identify as lesbian, gay or bisexual. In three large school-based studies, for example, only 30-55% of students who engaged in same-sex behavior identified as lesbian, gay or bisexual (Garofalo, Wolf, Wissow, Woods, & Goodman, 1998; Goodenow, et al., 2002; Remafedi, et al., 1992).

In addition:

- many lesbian, gay or bisexual youth are not sexually experienced;
- many sexually active lesbian and gay adolescents have heterosexual experiences;
- some youth may self-identify as lesbian or gay without having heterosexual or same-sex experiences; and
- heterosexual adolescents may have homosexual experiences (Savin-Williams, 1990b).

Moreover, the current generation of LGBT youth reports a great deal of fluidity related to their sexual and gender identities. Many resist labels as being too limiting or confined; some identify as "queer" or "pansexual" while others are not willing to be defined by a specific label. Many youth question their sexual and gender identities, particularly at younger ages, however, they are generally reluctant to discuss these concerns with providers, unless they are specifically asked or feel safe enough to do so. Little is known about the specific stressors and experiences affecting questioning youth; the first publication to begin to articulate their needs was published only recently (Hollander, 2000). Moreover, recent population-based studies indicate that the proportion of questioning youth is comparable to those who self-identify as lesbian, gay or bisexual (see, for example, Goodenow, et al., 2002). Understanding issues related to non-heterosexual identity and behavior has important implications for assessment, treatment and referral. Providers who work with adolescents should never make assumptions about an adolescent's behavior or identity, and should routinely screen for sexual and gender identity and same-sex behavior.

Youth who identify as lesbian or gay often describe feeling a sense of difference in early childhood, although many

do not generally relate these feelings to their developing sexuality. As they age, children experience many negative misconceptions and beliefs about homosexuality which they internalize, making it difficult for them to accept and integrate a non-heterosexual identity. In addition to feeling a strong sense of difference, many children who later identify as lesbian or gay describe gender-neutral or gender-atypical behaviors and preferences during childhood that further stigmatize them within family and peer groups.

Transgender Identities. Little is known about identity formation among transgender youth; moreover, transgender, as a cultural identity, is a recent development. Most of the literature on gender-atypical youth has focused on psychiatric adjustment and clinical issues, until the late 1990s when the first publications on transgender youth appeared in the professional literature, addressing social service needs (see, Mallon, 1999; Ryan, 2000). With the emergence of LGBT support groups and Gay Straight Alliances (GSAs) in schools, and increased awareness of gender diversity and identities, more teens are "coming out" as transgender during adolescence, rather than waiting until they are adults to do so. Because adolescence is also a time when pressure to conform intensifies, and expectations of adults and peers are reinforced by family, schools and other social institutions, transgender youth need a great deal of support to help them understand and integrate their sexual and gender identities, and to cope with harassment and abuse from family, peers and adults in a range of settings. Few studies routinely include transgender youth. Compared with those who identify as LGB, there are fewer transgender youth in most communities or programs that serve LGBT youth, which makes recruitment for research studies more difficult. At the same time, the convention of representing LGBT youth as a single homogenous group (and attributing results of studies conducted predominantly with gay youth to all youth) often obscures the lack of research and specific needs of transgender teens.

Transgender encompasses a broad range of gender non-conforming identities and behaviors, including transsexuals, cross-dressers, biologically intersexed persons, and "gender benders" who challenge gender norms for cultural or political reasons. Often confused with homosexuals, transgender individuals may be heterosexual, homosexual or bisexual. They also face significant discrimination in employment, housing and access to health care. Transgender youth report ongoing harassment and ridicule in school and community settings. Without support at home they may drop out of school, run away and often end up on the streets where they are at risk for exploitation, drug abuse, survival sex and HIV. Many are unable to find jobs because of gender nonconforming appearance, lack of education or job skills. Most information about transgender persons has been obtained from those (generally transsexuals) who sought counseling or services from gender identity clinics (Seil, 1996). Much less is known about the non-clinical transgender population, especially adolescents.

Prior generations of lesbians and gay men were much more likely to self-identify as lesbian or gay, beginning to share their sexual identity with others during adulthood, when they were independent and lived on their own (Table 1). Coming out during adolescence is very different for teens today who become aware of same-sex attraction, on average, at about age 10 and who identify as lesbian or gay during high school – on average, between ages 14 and 16 (D'Augelli & Herschberger, 1993; Herdt & Boxer, 1993; McClintock & Herdt, 1996; Rosario, Meyer-Bahlburg, Hunter, Exner, Gwadz, & Keller, 1996). The stressors are significant for youth who must learn to integrate a stigmatized identity, often without adult or peer support, and without accurate information or resources. Fear of sharing their sexual or gender identity with parents and other family members and fear of ridicule and rejection are primary concerns. LGBT youth must learn to negotiate complex psychosocial tasks at a time when they are dependent emotionally and financially on their families, have limited mobility to access external sources of support and fewer resources, including coping skills.

Many youth try to learn about their emerging sexual and gender identities while keeping their secret from families and friends which further increases isolation and stress. Some try to pass as heterosexual by dating, becoming sexually active with opposite sex partners, or becoming pregnant and fathering children. Others may use alcohol and drugs to cope with feelings of inadequacy, anxiety and stress. Coming out during adolescence and disclosing one's sexual identity to others promotes self-esteem while presenting considerable risk for LGBT youth. Youth who share their sexual identity with others report feeling better about themselves and are more comfortable being out at school and in their communities (D'Augelli, Hershberger, & Pilkington, 1998). However, they are also significantly more likely to be victimized at home, to experience more verbal and physical abuse from family members and to acknowledge more suicidality than those who have not come out to their families.

Youth who are rejected by their families are also likely to end up on the street where they are at high risk for exploitation and serious health and mental health problems. Homeless youth, in general, are at high risk for victimization, STDs, HIV, alcohol and drug abuse, suicide and mental disorders. In a given year, an estimated 500,000 to 1.5 million youth run away from or are ejected from their homes; of these, an estimated 200,000 are homeless and living on the streets (U.S. Department of Health and Human Services, 1999). Although the number of LGBT runaways and "throwaways" is not known, community agencies report a substantial proportion. For example, agencies serving street youth in Los Angeles have estimated that 25-35% were lesbian or gay, while in Seattle,

Table 1
PSYCHOSEXUAL MILESTONES
AVERAGE AGE EVENT OCCURS

BEHAVIOR/IDENTITY	MORE RECENT STUDIES (YOUTH) ^{1,2,3}		EARLIER STUDIES (ADULTS) ⁴	
	MALES	FEMALES	MALES	FEMALES
First awareness of same-sex attraction	9	10	13	14-16
First same-sex experience	13-14	14-15	15	20
Self-identification as lesbian or gay	14-16	15-16	19-21	21-23

^{1, 2, 3} D'Augelli & Hershberger, 1993; Herdt & Boxer, 1993; Rosario, et al, 1996

⁴ Troiden, 1988

40% of homeless youth were estimated to be gay (Kruks, 1991). Even among homeless youth, however, LGB youth are at highest risk. A recent comparison study of LGB¹ and heterosexual homeless youth in Seattle found that non-heterosexual youth (84% of whom identified as bisexual) experienced higher levels of victimization, used recreational drugs more often during the past 6 months, reported higher levels of depressive symptoms and higher levels of risky sexual behavior than heterosexual homeless youth (Cochran, Angela, Stewart, Ginzler, & Cauce, 2002). Family rejection also carries a very high price: In a random sample of street youth in San Francisco—nearly two-thirds of whom had been ejected from their homes—youth who reported that they could not go home were at highest risk for injection drug use, sexual coercion, unprotected and risky sex (Moon, Binson, Page-Shafer, & Diaz, 2001).

Learning when and how to safely disclose their identities with others, including parents, extended family members and ethnic communities is an ongoing process. Disclosure and integrating sexual, ethnic and gender identities present additional concerns for youth of color. In studies of ethnic minority LGB adults, many report the lack of support for all aspects of their multiple identities within mainstream, ethnic communities and LGBT communities which are predominantly white (Chan, 1989; Greene, 1994; Morales, 1990). Racism in mainstream and LGBT communities, and homophobia in mainstream and ethnic communities, make it difficult to find support, and generally require them to choose one identity over another rather than integrating multiple identities. The

¹As in many studies the proportion of transgender youth is very small; although transgender youth were included in the sample, only 1 youth in 375 identified as transgender.

challenging tasks of identity management are more complex and stressful for youth of color who struggle to find support and validation for all aspects of their emerging identities.

The emergence of the internet with websites and listserves for LGBT youth and young adults has provided a critical resource, particularly for youth who are more isolated or who live outside of urban areas where support groups and recreational programs are more frequently available. Without LGBT peers and safe places to learn about their emerging sexual orientation and gender identities, youth are at greater risk for isolation, depression, and exploitation by adults. Historically, many youth have sought out peers in places where adults congregate such as bars and unsafe public cruising spaces. An important aspect of LGBT support groups and GSAs is providing supervised, drug-free environments for recreation and socialization that are routinely available in a wide range of settings for heterosexual youth.

Health and Mental Health Concerns

Lesbian, gay and bisexual youth experience the same health and mental health concerns as their heterosexual peers, while having to deal with the health and social effects of stigma. Internalized as low self-esteem, poor self-concept or in the extreme as self-hate, internalized homophobia increases vulnerability and risk. In his work with Latino gay men, Diaz and colleagues (2001) found that homophobia has a devastating impact on self-esteem and psychological well-being and promotes negative coping through use of alcohol and drugs. At the same time, family acceptance and the presence of a gay role model during childhood are among the most important resiliency factors, and family acceptance is the most important protective factor against HIV infection (Diaz & Ayala, 2001). Few studies have focused on strength and resiliency among non-heterosexual youth. However, coping with stigma from an early age can promote problem solving skills that adolescents do not generally develop until later in life. In a study of psychosocial development and support, Anderson (1998) found that many youth perceived being gay as a source of strength that helped them deal with other challenging issues. He also found that formative experiences with racism helped youth of color cope with being gay.

Although most lesbian, gay and bisexual youth grow up to lead satisfying, productive lives, some are more vulnerable. Community-based studies conducted over a period of years show high rates of chronic stress, substance use, sexually transmitted diseases (STDs), victimization, suicidal ideation and attempts among a substantial proportion of LGB youth. More recently, several States and cities have included questions on sexual identity and/or behavior on school surveys of adolescent risk. These studies have found higher rates of sexual activity among LGB youth, including a larger proportion of sexual partners, earlier initiation of sexual intercourse, and a higher rate of sexual coercion or forced sexual intercourse than among heterosexual youth. Many sexually experienced youth who identify as lesbian or gay have opposite sex partners which increases risk for STDs, HIV and pregnancy. In one study, female youth who identified as bisexual or homosexual had significantly higher rates of pregnancy and physical or sexual abuse than heterosexual youth or those who were unsure about their sexual identity (Saewyc, Bearinger, Blum, & Resnick, 1998). Both youth and health providers are often unaware that some STDs can be transmitted between women, such as HPV, bacterial vaginosis and trichomonas. Moreover, lesbian adolescents may also have sex with gay or bisexual male friends, which increases their risk for HIV infection (Hunter & Schaecher, 1994).

HIV Infection

Adolescents are at high risk for HIV infection. One in four HIV-infected persons are under age 22, and prevalence among adolescents has increased significantly during the past decade, particularly among young men who have sex with men (MSM). Results from the Young Men's Survey, a multi-city study of HIV prevalence and risk behaviors in young men (ages 15-22) who have sex with men, found that 7.2% of youth were HIV infected, overall (Valleroy et al., 2000). Prevalence was higher among African-American (14.1%), mixed-race (13.4%) and Latino (6.9%) youth than among white youth (3.3%). Highest rates of infection were found in transgender youth (14.3%), and less than 1 in 5 (18%) youth who were infected knew their HIV status.

HIV education and prevention are critical, especially for youth of color. The importance of appropriate AIDS education for LGB youth is underscored by two recent studies in which AIDS education appears to be a protective factor. In one study, LGB youth were found to be significantly less likely than heterosexuals to receive HIV prevention instruction in schools (Blake, Ledsky, Lehman, Goodenow, Sawyer, & Hack, 2001). Conversely, LGB students who received highly sensitive HIV instruction were less likely to have had sex within the previous 3 months, had fewer sexual partners, and were less likely to have used alcohol and drugs prior to their last sexual intercourse, compared with LGB students in schools with no instruction, or with prevention education that was minimally sensitive to the needs of LGB youth. Another study of Massachusetts high school students found that AIDS education was associated with lower rates of multiple partners, unprotected sex and injection drug use (Goodenow, et al., 2002). However, Blake and colleagues found that only 1 in 5 schools throughout the State provided gay-sensitive HIV instruction that addressed the needs of LGB youth (Blake, et al., 2001).

Rates of HIV infection have been increasing steadily among young gay and bisexual youth and males who have same-sex partners. Given alarmingly high rates among youth of color and transgender youth, many of whom are also persons of color, targeted intervention programs are urgently needed to provide culturally relevant and clearly articulated prevention materials. Learning about health risks, and developing communication skills to negotiate safer sex is vital for LGBT youth since health promotion and prevention information that specifically discusses their concerns or even mentions LGBT youth is rarely included in brochures and educational materials from community agencies or school clinics. Health and mental health providers often fail to ask adolescents about same-sex behavior and identity, and youth are often too uncomfortable or afraid to raise concerns since such questions could expose them. Because LGB and questioning youth often learn about homosexuality and related health risks from informal or biased sources, many have misconceptions about their health needs and risks (Ryan & Futterman, 1998). For example, some lesbian youth may think they cannot become pregnant and gay male youth may not understand their risks for STDs. Providers are even less likely to ask about or include information about gender identity or dysphoria, so transgender or gender questioning youth are least likely to have their concerns discussed.

Although few studies have been published in the professional literature on transgender youth, research on adults shows many high risk behaviors for HIV infection, including multiple partners and inconsistent condom use, unprotected anal and vaginal sex, and needle sharing (Bockting, Rosser, & Coleman, 2000). Among transgender persons who use hormones to develop desired female or male sex characteristics, fear of ridicule and rejection, together with lack of health insurance and ongoing care, drive many to seek hormones on the street which increases risk for HIV infection from contaminated needles. In a recent community survey of transgender adults, 58% acknowledged acquiring hormones from friends or on the street, while only one-third (34%) reported obtaining them under the supervision of a physician (Xavier & Simmons, 2000).

LGBT youth are maturing, learning about intimacy and becoming sexually active in the context of the HIV epidemic. At the same time they are growing up in a culture in which premature death and chronic illness have become normalized. Many gay youth report feeling that HIV infection is inevitable and in spite of their efforts to protect themselves, many fear they will not be able to do so (Ryan & Futterman, 1998). The effect of the HIV epidemic on their development and sense of the future is substantial.

Victimization

As D'Augelli (1996) has pointed out, lesbian, gay and bisexual youth have few opportunities to explore their identity without placing themselves at risk for victimization. They lack supportive environments to socialize with other gay peers and to learn about their sexual identity, including protective and preventive behaviors, which increases isolation, and risk for HIV infection. Ironically, coming out, which has positive implications for mental health and self-esteem can also have negative consequences for gay youth by increasing their risk for harassment and abuse (D'Augelli, Hershberger and Pilkington, 1998).

Victimization is normative for LGBT youth. Community studies have consistently reported high levels of harassment and abuse. Anecdotal reports suggest that transgender youth are more frequent victims. However, the proportion of transgender youth is small, even in large community studies; for example, only 28 transgender youth (about 3.2% of the sample) participated in a national survey of school-related experiences of over 900 LGBT youth, recruited through LGBT support groups and online (Kosciw & Cullen, 2001).

Table 2

HIV INFECTION IN YOUNG MEN WHO HAVE SEX WITH MEN ¹

	YOUTH AGES 15-22 1994-1998 (7 U.S. CITIES)	YOUNG ADULTS AGES 23-29 1998-2000 (6 U.S. CITIES)
ETHNIC GROUP	PREVALENCE	PREVALENCE
Whites	3.3%	7%
Latinos	6.9%	14%
African-Americans	14.1%	32%
Mixed Race	13.4%	10%

¹Valleroy, et al. Young Men's Study, 2000-2001, CDC

Population-based studies of youth in schools show significantly higher rates of victimization among LGB youth, compared with their heterosexual peers (Table 3). In the Massachusetts Youth Risk Behavior Study, LGB youth were more than four times as likely to have been threatened with a weapon at school, more than three times as likely to have been in a fight that required medical attention, and nearly five times as likely as heterosexual youth to have missed school because they were afraid (Garofalo, et al., 1998). The more open youth are about their sexual orientation and the more gender atypical, the more likely they are to be victimized (D'Augelli, Pilkington, & Hershberger, in press).

In a survey of LGBT youth who attended high school and middle school from 48 states, 1 in 3 reported some experience with harassment as a result of their sexual orientation (about 10% said it occurred frequently), and an equal proportion said they had been harassed because of their gender expression (Kosciw & Cullen, 2001). Most youth (84.6%) reported hearing homophobic remarks from other students, while nearly one-fourth (23.6%) heard such remarks from faculty or school staff. Few faculty intervened when homophobic remarks were made – only 16.4% responded all or most of the time. Youth from rural and suburban schools reported feeling more unsafe than urban youth because of their sexual orientation. The prevalence of victimization in schools instills fear and dread in many LGBT youth, and can have a chilling effect on school climate, as the Human Rights Watch study of LGBT youth in schools has recently documented (Human Rights Watch, 2001). Moreover, not only non-heterosexual or gender nonconforming youth are targeted: Six percent of youth in a Seattle school survey who were targets of anti-gay abuse were heterosexual (Reis & Saewyc, 1999). And they were victimized because they were *perceived* to be gay. As the Human Rights Watch report pointed out, a hostile school environment is not conducive to learning and compromises students' education; such a climate can affect academic performance and career options by contributing to school avoidance and dropping out.

Mental Health Concerns

As with their heterosexual peers, lesbian, gay, and bisexual adolescents experience a range of mental health concerns that affect adolescents, in general. However, they are also at risk for stress and mental health problems related to stigma. Some youth experience pre-existing vulnerabilities, such as family violence and abuse, parental addiction and underlying psychological disorders, which exacerbate stress related to managing a stigmatized identity. Hetrick and Martin (1987) have suggested that youth with these experiences may constitute the majority of youth who attempt suicide or who develop serious substance abuse problems. LGB youth report chronic stress, particularly as this relates to fear about disclosure or exposure of their sexual identity. Rosario, Rotheram-Borus, & Reid (1996) found that coming out to parents, relatives and friends; having their sexual identity discovered; and being ridiculed because they were gay or bisexual were especially stressful events for gay and bisexual youth of color that increased emotional distress. Such events were associated with increased depression.

Although many LGB-identified youth are likely to be open about their sexual orientation with some trusted friends and

Table 3
LGB YOUTH
SCHOOL SAFETY CONCERNS ¹

	LGB STUDENTS	OTHER STUDENTS
REPORTED BEHAVIORS	PERCENTAGE	PERCENTAGE
Property damaged at school (past 12 months)	50.5%	28.7%
Threatened with a weapon at school (past month)	32.7%	7.1%
Fighting at school (past 12 months)	38.1%	14.4%
Skipped school because they felt unsafe (past month)	25.1%	5.1%

¹ Garofalo, et al., 1998

family members, D'Augelli et al. (in press) found that few (13%) were completely out to others while in high school, and nearly half (46%) were completely closeted. The earlier that adolescents were aware of same-sex feelings, identified as LGB and disclosed their sexual orientation to others, the more they were victimized in high school. Male youths were more frequent targets of abuse than females. Youth who were frequently victimized or who feared victimization reported more mental problems than those who were less frequent targets or who were less concerned about being abused. Compared with LGB youth in college, high school students are significantly more open about their sexual orientation and report more threats of violence and more physical attacks than college students reported when they were in high school (D'Augelli, in press). Predictably, LGB high school students show greater indications of mental health problems than college students. Moreover, victimization during high school is correlated with mental health symptoms, in general, and with post traumatic stress symptoms, in particular. Compared with heterosexual teens, LGB youth also demonstrate significantly more symptoms on standardized measures of mental health difficulties (D'Augelli, in press). However, such tests do not assess for gay-related stressors.

Suicide—*a significant concern for all adolescents—represents the third leading cause of death in youth ages 15-24 and the fourth leading cause of death in children, ages 10-14 (Hoyert, Kochanek, & Murphy, 1999). Far more youth attempt than actually complete suicide, yet past attempts are important predictors for completed suicide, and must be taken seriously. At least 1 in 5 youth who complete suicide appear to have been clinically depressed and more than one-third appear to have had a diagnosable drug abuse disorder at the time of death (Shaffer, 1988). Between 6 and 13% of adolescents have reported at least one suicide attempt (Garland & Ziegler, 1993). No one really knows how many lesbian, gay or bisexual youth actually commit suicide, but rates of suicide attempts and suicidal thoughts are consistently very high in a range of studies.*

School-based studies show that LGB youth were more than three times as likely to have attempted suicide during the past 12 months (Garofalo, et al., 1998; Reis & Saewyc, 1999), and nearly twice as likely to have developed a suicide plan – a serious indicator of suicide intent (Reis & Saewyc, 1999) as heterosexual peers. Studies of gay and bisexual suicide attempters show they were more likely to have self-identified as gay or bisexual and come out to others at younger ages (Hershberger & D'Augelli, 1995; Remafedi, Farrow, & Deisher, 1991) to have friends and relatives who attempted or committed suicide (D'Augelli, Hershberger, & Pilkington, 2001; Hershberger & D'Augelli, 1995; Remafedi, Farrow, & Deisher, 1991) and to have been rejected because of their sexual orientation (Schneider, Faberow, & Kruks, 1989). More than half (57%) of LGB youth who attempted suicide in one study reported that their attempt (or their first attempt if they had made several) was related to their sexual orientation, while 21% said that it was highly related (D'Augelli et al., 2001). Youth whose parents were perceived to be intolerant or rejecting reported more attempts. Gay and bisexual youth of color were more likely to have dropped out of school, to have been ejected from their homes and to have experienced more gay-related stress than non-attempters (Hershberger & D'Augelli, 1995). Family problems, conflict with sexual identity, gay-related stressors, and pressure to conform to gender norms and behavior are also associated with suicide attempts.

Substance Abuse

In school-based studies, LGB youth report higher rates of alcohol and drug use, and cigarette smoking, compared with their heterosexual peers. For example, they were more likely to use alcohol and other drugs, such as steroids, marijuana and cocaine (DuRant, et al., 1998; Garofalo, et al., 1998), to engage in high risk or heavy drug use (Reis & Saewyc, 1999), to have smoked cigarettes during the past 30 days (DuRant, et al., 1998; Garofalo, et al., 1998), and to have used smokeless tobacco (Garofalo, et al., 1998) than heterosexual youth. At the same time, however, population-based studies also include a much higher proportion of bisexual youth and recent studies have shown greater vulnerability among bisexual youth on a number of related variables (e.g., Goodenow, et al., 2002). So it is difficult to know how widespread substance use may be among all LGB youth, especially since some other community

studies of LGB youth show rates that are comparable to adolescents, in general (Herdt & Boxer, 1993; Lock & Steiner, 1999) or comparable on alcohol and other drugs, except marijuana (D'Augelli, et al., in press).

As Ryan & Futterman (1998) have pointed out, lesbian and gay youth use alcohol and drugs for many of the same reasons as their heterosexual peers: to experiment and assert independence, to relieve tension, to increase feelings of self-esteem and adequacy, and to self-medicate for underlying depression or other mood disorders. However, vulnerability is increased as a result of social isolation and the need to hide their sexual identity. As a result, they may use alcohol and drugs to deal with stigma and shame, to deny same-sex feelings, or to defend against ridicule or anti-gay violence. Teenage experimentation with substances can become habitual and lead to addiction. Moreover, adolescent substance abuse is considered to be the most frequently missed pediatric diagnosis.

Accurate assessment, prevention and early intervention are especially important for LGBT youth who often socialize outside of bars and clubs to connect with LGBT communities and young adults for whom substance use has become part of a shared cultural experience. Studies of gay male adults show comparable rates of alcohol use but higher rates of drug use, overall, than among heterosexual men (Stall & Wiley, 1988; Stall, Paul, Greenwood, Pollack, Bein, Crosby, Mills, Binson, Coates & Catania, 2001). In the first national large-scale household probability survey of men who have sex with men, Stall and colleagues (2001) found that one-fourth of young gay men (ages 18-29) used multiple illicit drugs and reported high risk sexual behaviors (one-half engaged in unprotected anal intercourse during the past year, while one-third reported unprotected receptive anal intercourse).

Little is known about the process of acculturation of younger persons into LGBT culture, but drug use is normative among a segment of gay men and some lesbians and transgender individuals, and for many gay men, in particular, drug use is linked with sexuality and sexual behavior. Methamphetamines and designer drugs, such as ecstasy and ketamine, are a component of sexual behavior for some gay men, including those who participate in circuit parties (multi-event weekend gatherings that include large dance events and other social activities). One of the few studies of circuit party attendees found widespread drug use (95% had used a psychoactive drug during the most recent party and 61% had used 3 or more drugs) and risky sexual behavior – about two-thirds were sexually active during events and half engaged in sexual intercourse, with 29% reporting multiple partners (Mansergh, Colfax, Marks, Rader, Guzman & Buchbinder, 2001). Nearly two-thirds of participants were age 34 and younger.

Teens and young adults may use alcohol and drugs to reduce tension and anxiety during social and sexual interactions. With habituation, sexuality may become linked with alcohol and recreational drug use and become a routine component of sexual arousal and behavior. Substance use during or before sexual activity can affect judgment, increasing risk for HIV infection. Because many learn about their sexual and gender identities and LGBT culture from adults, they are vulnerable to substance abuse and other risky behaviors, and

need positive role models and safe environments for socializing and recreation.

Ethnicity

Little information has been published on LGBT youth of color, and in many cases, providers merely extrapolate from research on adults to develop prevention strategies for youth. A recent analysis of the professional literature on lesbian, gay and bisexual youth from 1972-1999 found that only about 1% of journal articles published during this period in professional journals serving school practitioners addressed LGB youth (Ryan, 2000). Of these, only 3.6% focused on LGB youth of color, and none addressed transgender youth of color.

As noted earlier, the experiences of the current generation of LGBT youth are very different than that of individuals who came out as adults with little exposure to non-heterosexual culture during adolescence. Moreover, "queer" youth are developing a unique cohort, bounded by a celebration of diversity, rejection of gender norms and less tolerance for the invisibility and limited acceptance that has characterized the lives of many older adults. This is especially apparent among many LGBT youth of color who are challenging cultural stereotypes of homosexuals based on sex role norms and gender-based perceptions of gay people as "failed" or "defective" women or men who want to be a member of the opposite gender (e.g., Greene, 1994). Understanding the

meaning of same-sex behavior in ethnic minority cultures requires an appreciation of the importance of gender roles and traditional gender stereotypes and the role of culture in shaping sexuality, beliefs and values.

LGBT youth are creating a new culture apart from adults, while at the same time, youth of color are part of an ethnic culture that is informed by degree of acculturation to mainstream culture, role of religion, attitudes and beliefs about gender, childbearing, family and sexuality. Many youth are reared in immigrant families and are adjusting to a new mainstream culture with different social and gender roles, and media representations of sexuality. Herdt and Boxer (1992) point out that culture and same sex identities are constantly evolving. Within these cultures, non-heterosexual youth and adults construct a variety of identities to provide a cultural framework for same-sex desires and behaviors. Many do not identify with lesbian, gay or bisexual identities finding them too constricting or not culturally congruent. For youth and adults, family and ethnic minority communities provide a primary source of support and a buffer against racism in mainstream society. Although LGBT youth of color are experiencing increased visibility in mainstream gay communities, as psychologist Eduardo Morales (1990) has pointed out, they still struggle with racism and lack of validation from predominantly white gay communities and mainstream society in attempting to meet a range of social, educational, career development and support needs (Table 4).

Table 4
ETHNIC MINORITY LESBIANS AND GAY MALES
CHALLENGES TO INTEGRATING IDENTITY

	Ethnic Community	LGBT Community	Mainstream Society
POSITIVE	<ul style="list-style-type: none"> • Acceptance/validation of ethnic identity • Family and community support • Buffer for racism and discrimination experienced in mainstream society and LGBT communities 	<ul style="list-style-type: none"> • Acceptance/validation of LGBT identity • Access to community support • Access to information and LGBT resources (e.g., organizations, health services, etc.) • Potential for intimate relationships 	<ul style="list-style-type: none"> • National identity • Access to multiple social and cultural groups • Access to resources (e.g., education, employment, health & mental health services)
NEGATIVE	<ul style="list-style-type: none"> • Denial of homosexuality • Homophobia • Rejection based on sexual orientation & cultural gender norms • Invisibility 	<ul style="list-style-type: none"> • Racism and discrimination • Rejection based on ethnic identity • Invisibility 	<ul style="list-style-type: none"> • Racism and discrimination • Homophobia • Rejection based on ethnic identity, sexual orientation & gender identity • Invisibility

From: Ryan & Futterman, *Lesbian & Gay Youth: Care & Counseling*. Columbia University Press, 1998.

Although little has been published about ethnic families of LGB adults (to date, no studies have been published on LGB youth of color or LGB youth, in general, and their families), changes are occurring on how families interpret, respond to and incorporate non-heterosexual children into the family system. As LGBT people of color increasingly disclose diverse sexual and gender identities, families and ethnic communities will respond in new and different ways. Hom (1996) has observed some of these changes in her interviews with Asian parents of openly lesbian and gay adult children. Rather than claiming homosexuality as a western phenomenon or a result of assimilation in mainstream culture (a common response in earlier literature on ethnicity and homosexuality), these parents acknowledged the presence of non-heterosexual and homosexual identities in their culture, although many still associated gender role reversal with homosexuality. They also discussed having many of the same feelings experienced by white parents who learn that their child is lesbian or gay, including grief, anger, shame, concern that they may be to blame, perceptions that their child is going through a stage, concern about what others will think, and loss of a dream for their child's future.

Mothers, in particular, found that reading about sexuality and talking with other lesbian and gay people were extremely helpful, though not all were willing to discuss their concerns with others. Some discussed these issues with relatives and friends, while others did not. All parents interviewed had come to some level of accommodation with their lesbian or gay children, and some were very open about their acceptance. Since children influence their parents as much as they are influenced by them, greater visibility among youth will significantly impact how ethnic minority parents respond to their non-heterosexual children, which will affect extended families and others within their ethnic communities.

These issues have important implications for studying risk and health outcomes and for developing appropriate

interventions and prevention strategies. Concerns about shaming their families can affect the behavior of LGBT youth in a variety of ways. For example, some may limit involvement with their ethnic community to avoid embarrassing their parents, while others may separate their sexual, social and emotional lives which can increase risky sexual and substance using behaviors. In his studies of culture, sexuality and health risks among Latino gay men, Rafael Diaz (1998) has observed that sexuality is both culturally regulated and self-regulated. One of his most important premises is that risky behavior is both natural and meaningful in the cultural context of men who have been socialized to hide and compartmentalize their sexuality to avoid shaming their families, and to support cultural values and norms that privilege masculinity (machismo). Since homosexuality is perceived as a gender problem in Latino communities, and gay men are perceived as not being "real men," they are more vulnerable to cultural messages of machismo. These early social and cultural messages are internalized and eroticized, affecting attraction, sexual behavior and risk in adolescents and adults. Díaz found that many Latino gay men constructed their sexuality to create and restore a sense of masculinity, using sexual encounters to show their masculinity or to experience the masculinity of their partners through strong penetrative practices. Moreover, poverty and racism promote risk by undermining gay men's ability to self-regulate risk for HIV infection. Racism in the gay community further affects their ability to find support and to more fully integrate their multiple identities.

Policies & Practices for Agencies and Schools

Providers and programs serving adolescents and families have only recently begun to consider the needs of LGBT youth. This has usually occurred in large metropolitan areas with more extensive LGBT communities and targeted services for youth. The Institute for the Protection of Lesbian and Gay Youth (now

Hetrick-Martin Institute) was founded in New York City in 1979, pioneering the first social service agency for non-heterosexual youth. Five years later, Gay and Lesbian Adolescent Social Services (GLASS) was formed in Los Angeles to provide out-of-home care and support services for lesbian and gay children and adolescents. However, services for gay youth were rare, only emerging at a broader community level in the mid 1990s, after the National Youth Advocacy Coalition (formed in 1993) began to provide a national network with linkages to educational, social service and health-related agencies and institutions.

Key studies that helped identify support needs and developmental milestones of LGB youth and young adults were not published until the early 1990s (e.g., D'Augelli & Hershberger, 1993; Herdt & Boxer, 1993; Savin-Williams, 1990a), so awareness of their needs was limited. As more youth came out during adolescence and either disclosed their sexual identity or were perceived to be non-heterosexual by others, victimization at school increased their need for support and safe environments. Both Project 10, the first school-based counseling and support program (founded in Los Angeles) and the Harvey Milk High School (the first accredited public school for LGBT youth, founded in New York at the Institute for the Protection of Lesbian and Gay Youth) were established in 1984, following an earlier school-based support program in Philadelphia in 1980. However, these programs were singular in their ability to provide supportive school environments, and harassment and victimization had become normative in most school and community settings.

Impetus for change was generated by the emergence of the first Gay Straight Alliance (GSA) in Massachusetts in 1990, and the Massachusetts Governor's Commission on Gay and Lesbian Youth in 1992 which led to the first State legislation and statewide policy implementation to ensure safe school environments on the basis of sexual orientation. Since that time, more than 1,000 GSAs have been formed in schools throughout the country and 9 states have adopted legislation or regulations to protect LGB youth in schools (2 States protect youth on the basis of gender identity). While encouraging, these changes have been slow to evolve, particularly since most decisions related to education occur at the local level which means implementing change in 16,000 school districts nationwide.

Changes in health service delivery have also been slow to evolve. Although the first publication on gay youth appeared in the medical literature in 1972 (Roesler & Deisher), little attention was paid to their need for services and care until the 1990s. Lack of understanding of their health and mental health needs, particularly as these relate to risk for HIV infection, prompted the Health Resources and Services Administration (HRSA) to convene an invitational Conference on the Primary Care Needs of Lesbian and Gay Adolescents in 1994. The conference brought together experts in LGBT youth and adolescent health and mental health, with public health officials, representatives from the major professional associations and youth to identify barriers and strategies to improve services and care. Participants developed guidelines for primary care, mental health assessment and HIV-related care for lesbian and gay youth which provided a framework for the first resource guide on health and mental health care for lesbian and gay youth (Ryan

& Futterman, 1997/1998). Developing guidelines for care is a basic step. However, implementing them, ensuring training for providers, and encouraging them to ask key questions related to risk, sexual health, behavior and identity are critical in improving the quality of care and health outcomes for LGBT youth. The dearth of basic research on transgender youth, rapidly evolving dimensions of transgender identity and lack of consensus and standards for treatment of transgender adolescents adds to providers' confusion over appropriate care.

Creating Safe Environments for LGBT Youth

Schools have begun to create safe environments for non-heterosexual youth by developing and implementing policies to protect LGBT youth from harassment, violence and discrimination; training school personnel in violence prevention and response; and providing school-based support groups that promote diversity and tolerance. To date, less than one-fifth of the States legislate school safety for LGB youth and only two States protect students based on gender identity. In States without general protection, some school districts have developed policies and some administrators have taken a leadership role in individual schools. However, this leaves enormous gaps that affect millions of students and school personnel across the country.

Model anti-harassment policies define terms and clearly state who and what areas are covered, detail reporting of incidents, and define administrative responsibility and actions to be taken, including appeals. They also cover dissemination of the policy to inform students, staff, parents and the community, and clarify training and professional development responsibilities.

A primary concern for many students is the inuring frequency of anti-gay slurs. More than 9 out of 10 students surveyed in a recent national study report regularly hearing anti-LGBT comments at school, and 1 in 4 hear them from staff (Kosciw & Cullen, 2001). More alarmingly, few youth report that teachers or school staff routinely respond to bias-related comments or actions. Experiencing persistent, unrestricted anti-gay harassment and victimization normalizes these actions, suggests that curtailing them is futile and sends a message to LGBT students and to others who may be perceived to be gay or transgender that they could be next. Responding to harassment and discrimination based on sexual and gender identity in the classroom, playing fields or after school activities is perhaps the most important deterrent in reducing and ultimately preventing anti-LGBT bias in schools. In fact, an evaluation study of the Massachusetts Safe Schools Program found that students in schools that implemented one or more policy recommendations reported lower levels of homophobia and heterosexism, and sexual minority students reported higher levels of personal safety (Szalacha, 2001).

Guidelines for Transgender Youth

Although few schools have addressed the needs of transgender and gender non-conforming students in educational settings, guidance is available from States with laws that prohibit gender-based discrimination. The California Student Safety and

Prevention Act of 2000 protects students on the basis of “a person’s actual or perceived sex, and includes a person’s perceived identity, appearance, or behavior” (Title 5, California Code of Regulations) in all schools that receive public funds. This definition includes transgender as well as students who do not conform to gender stereotypes or who are perceived by others as gender non-conforming. The California Safe Schools Coalition Steering Committee is assisting with the development of guidelines for transgender and gender non-conforming youth for the San Francisco Unified School District. These guidelines are applicable for a range of health, mental health and support services provided for youth, and can be adapted for use in other settings.

Many transgender youth use gender variant or androgynous names and opposite gender pronouns to describe themselves. According to the guidelines, transgender and gender non-conforming youth have the right to be addressed by a name or pronoun that reflects their gender identity. Intentionally using an incorrect name or pronoun is a form of discrimination. Perhaps the most contentious issue in schools and public settings is use of restrooms by transgender youth. All youth have a right to safe and appropriate restroom facilities. This includes the right to use a restroom that corresponds with their gender identity. In some settings, staff restrooms, which are generally unisex, are made available to youth to eliminate conflict over use of public restrooms. The guidelines assert that schools can enforce reasonable dress codes to maintain a safe and orderly environment and maintain its educational mission. However, staff should respect a student’s right to dress in accordance with his or her gender identity.

School employees and staff have a duty to protect transgender and gender-atypical youth from harassment, and to respond appropriately when it occurs. In care-related settings, many transgender persons have received inappropriate care, have been ridiculed by providers, or have been refused care. As a result, many adults avoid mainstream providers and experience compromised care. Because youth are learning help-seeking and self-care behaviors and their interactions with providers shape their relationships with caregivers across the life course, providers should be aware that these experiences affect trust, willingness to disclose key information and potentially, health outcomes.

Providing Appropriate Care for LGBT Youth

Providing a supportive, non-judgmental environment is a primary component in signaling that an agency, provider or clinic is a safe place for non-heterosexual youth to seek care. This includes assuring youth of confidentiality about their concerns, asking about sexual and gender identity as a routine part of care, offering health guidance for same and opposite-sex behaviors (such as the frequency of heterosexual intercourse for lesbian youth), and pre-screening referrals for their knowledge and sensitivity in caring for LGBT youth. Even though adolescents may not disclose or discuss concerns about sexual or gender identity during an initial visit, providers can let them know that these are safe topics to explore through visual cues such as posters, brochures and books about sexuality in the office or waiting room. Because many non-heterosexual youth

are not comfortable picking up LGBT-specific literature, an effective way to target them and to provide a welcoming atmosphere is to include information about LGBT youth along with other client populations in general literature such as agency brochures.

Guidelines for screening and care are available elsewhere (e.g., Ryan & Futterman, 1998) and are beyond the scope of this publication. Whether they openly identify or not, LGBT youth are present in our caseloads, clinics and classrooms. Appropriate care for these youth does not require additional time, special skills or extensive training. Sensitivity in conducting routine interviews, an understanding of the impact of stigma and stressors that affect LGBT youth, and an awareness that not all youth are heterosexual will enable providers to assess and address their needs.

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