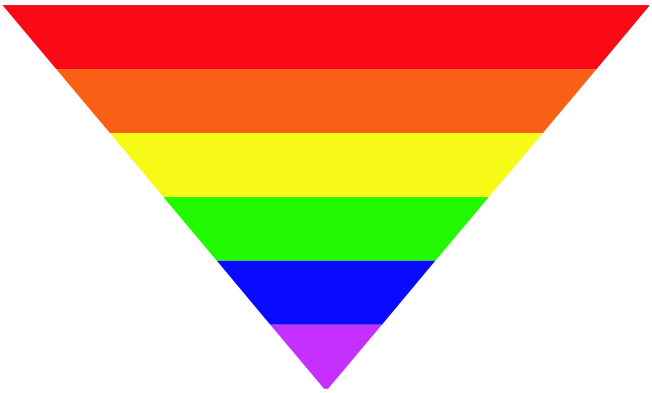
Working with Sexual Minority Youth



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INTRODUCTION

Sexual minority youth are an often neglected subset of the youth population, but a group who are often in substantial need of services from community health and human service providers. This report provides an overview of the concepts of sexual orientation, sexuality, gender, and gender identity, defines stigma and outlines its effects, describes the process of developing a sexual and gender identity, and discusses risk and protective factors that are the basis for potential adverse consequences such as substance abuse and mental health symptoms and disorders. The final section provides specific recommendations for making agencies more welcoming and inclusive of sexual minority youth, and provides some resources for further information.

This report was developed by LGBT-TRISTAR which is funded by a contract with the California Department of Alcohol and Drug Programs to provide free training and technical assistance for substance abuse treatment and prevention agencies throughout the state. More information about LGBT-TRISTAR is available on their website, www.lgbt-tristar.com, which includes a number of documents and handouts related to substance abuse issues among LGBT communities. This document is also appropriate for other health and human services professionals, such as physicians, nurses, social workers, psychologists, and those who work in juvenile justice or child welfare.

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MASSIVE CHANGES IN SOCIETY

Youth today are being socialized into a very different world than previous generations and many of the changes have made it easier to adopt or explore a minority sexual or gender identification. Overall, societal attitudes have altered so that a majority of people are now accepting of LGBT people, and a growing number are in favor of legalizing same-sex marriage or banning discrimination in employment. For example, in 15 years, the percent of people who favored same-sex marriage rose from 30% in 1992 to 38% in 2008. The changes have occurred at all levels of society, from the law to political discourses and pop culture; from education and business to health care systems.

Openly LGBT people are seen on TV everyday, from popular culture figures such as Wanda Sykes, Ricky Martin, Ellen Degeneres, RuPaul, and Tim Gunn, to serious news reporters Anderson Cooper and Rachel Maddow and politicians like Barney Frank. Contestants on reality shows are now openly LGBT, and many TV programs have ongoing LGBT characters. Athletes like John Amechi, former NBA player, and Martina Navratolova from tennis, are out and proud.

There have been many changes in laws and policies in the past few years. Sodomy laws, antiquated prohibitions against oral and anal sex were struck down by the U.S. Supreme Court in 2003 (Lawrence v. Texas), effectively decriminalizing same-sex behaviors across the United States. Several states have legalized same-sex marriage, media coverage of the "pregnant man," a transgender man, was mostly positive, and derogatory remarks about LGBT people are less often tolerated in the media than they were even a few years ago. When Constance McMillen, a high school senior, wanted to bring a same-sex date to her prom, the school cancelled the prom rather than seriously address the issue. The fact that this made headlines across the nation shows that we are making progress, albeit slowly.

In older generations, topics related to sexuality and gender variance were mostly taboo. Now same-sex marriage and transgender transitions are topics at dinner tables, in schools, and on serious news programs rather than just sensational talk shows. Parents can join PFLAG (Parents and Friends of Lesbians and Gays) in over 300 communities in the U.S., and LGBT people are welcomed in many religious communities, even ordained as ministers in a few.

In schools, there are now more than 3500 Gay-Straight Alliances (GSAs) nationwide. Many Fortune 500 companies offer domestic partner and same-sex couple health and other benefits to their employees, and many have LGBT pride days. More sexual minority individuals are finding acceptance in employment, and attitudes about careers that used to be considered unacceptable for LGBT people are changing.

The box below shows some national polling results from the Gallup Organization regarding changes in Americans' attitudes toward gays and lesbians in the workplace. The question was: "Do you think homosexuals should or should not be hired" for each of the following occupations.

	Should	Should Not
Armed Forces		
June 1977	51%	38%
May 2003	80%	18%
Elementary School Teachers		
June 1977	27%	65%
May 2003	61%	37%
Salespeople		
June 1977	68%	22%
May 2003	92%	6%
Doctors		
June 1977	44%	44%
May 2003	82%	15%
Clergy		
June 1977	36%	54%
May 2003	56%	39%

Isn't it interesting that we are still having national debates about gays in the military when 80% of people have no problem with it? The events that occur in local communities can be transmitted worldwide in an eyeblink via the incredible communication technologies available today. No longer do LGBT people in rural areas have to feel isolated and alone, with the thousands of options for online support and education. The internet has put access to sexually explicit entertainment media and medically accurate sexuality education available to everyone with a browser, but there is little or no media literacy training that helps children and adolescents interpret what they find on the internet. Ironically, at the same time as LGBT visibility has increased in the media and in society in general, school-based sexuality education has become more restrictive and rarely addresses same-sex sexuality at all.

These changes have made it possible for many youth to explore their sexuality and gender at younger ages, and for many to adopt sexual minority or gender variant labels and to thrive. Unfortunately, however, not all sexual minority youth have the support of families, friends, religious communities, or school peers, and still have to hide their desires and relationships. Too many still have to fear rejection, discrimination, harassment, and violence from the hands of others. Some who are courageous enough to be themselves, are ejected from their families, expelled from school, or beaten by peers. Sexual minority youth are more likely than heterosexual youth to experience harassment and threats which can lead to depression, suicide ideation and attempts, and anxiety disorders, and using alcohol, tobacco, and other drugs to self-medicate this emotional pain. They may also be engaging in unsafe sexual behavior as they explore their sexuality, but lack information about safer sex because school-based sexuality education in the past ten years has become a "just say no to sex" curriculum that ignores or pathologizes same-sex sexuality.

In health care, more professional organizations are issuing statements about improving the quality of life for LGBT individuals. Most professional organizations now include sexual orientation and gender identity in their human rights statements, and many of them have policy statements about same-sex marriage and reparative therapy (religious or psychological interventions meant to change one's sexual orientation). Recently, the American Medical Association (November 2009) issued a statement in opposition to the military's "don't ask, don't tell" policy. This is a big change, as less than 40 years ago, homosexuality was classified as a psychiatric disorder. After many studies found no link between sexual identity and serious mental illness, in 1973 homosexuality was removed from the Diagnostic and Statistical Manual (DSM). In 1980, however, gender identity disorder was put into the DSM. Same-sex identities were declassified and transgender identities were pathologized in less than a decade. Many LGBT researchers and activists have been organizing to remove gender identity disorder from the next version of the DSM. We will talk more about this later.

Finally, there are changes in the way that we view adolescent development. Ritch Savin-Williams (2007) proposed three eras of "gay youth" research. In the first stage, the 1970s and 80s, the gay teen was discovered. The first article on gay youth appeared in a medical journal in 1972, but was about young gay street hustlers—not exactly a representative sample of sexual minority youth. This led to a slew of studies about youth who used labels of gay, lesbian, or bisexual, and most of the studies were published in small specialty journals. These studies

pointed out the risk factors of peer and family rejection leading to mental health problems, sexually transmitted infections, substance use, and poor school performance. The first community resources began to appear, such as the Harvey Milk School in New York City (named after San Francisco Supervisor, Harvey Milk, the first openly gay elected official in the United States, who was assassinated by a fellow supervisor at City Hall in 1978). The Harvey Milk School offers a safe haven for youth who experienced harassment or violence in their public schools.

In the second phase, the late 80s and 1990s, the research seemed to focus almost exclusively on risk factors, particularly suicide. Better methodologies for finding sexual minority youth were beginning to be used, such as adding sexuality questions to existing school-based surveys, but the stigma of sexuality still affected response rates, so few of the studies were able to gather truly representative samples of sexual minority youth. Much of the research was done by health professionals with little education about adolescent development, so findings were interpreted according to adult standards.

The third phase, from about 2000 to the present, is a period characterized by better understanding of youth development, which led to a broader definition of sexuality that includes sexual behavior and attractions, rather than just sexual identities. It led to studies about many aspects of adolescent development, such as dating patterns and career choices and not just suicide risk or substance abuse. The third phase is also characterized by a greater balance between studies of resilience and risk, or sometimes expressed as risk and protective factors. We recognize that identifying protective factors is just as important as revealing the risk factors. If we use a strength-based approach to improving the quality of lives of sexual minority youth, we have to know what factors have protected so many youth from engaging in risk behaviors or having negative consequences. According to Savin-Williams, the goal for the future is “normalization.” That means that minority sexual identifications will be seen as just one more way that humans can differ, such as left-handedness or eye color.

This report reviews the research on sexual minority youth, including coming out or identity formation, risk and protective factors, the consequences of the risk factors, and possible interventions that can be adopted by individual providers and by treatment and prevention agencies or programs. Twenty years ago, there was hardly any information available, and now there is a substantial body of credible research upon which to base recommendations.

COMPONENTS OF SEXUALITY, GENDER, AND STIGMA

> *Sexual minority, lesbian, gay, bisexual, transgender, queer, questioning, homosexual, fluid, homo-flexible, gayish, pan-sexual, metrosexual, bi-anything, boidyke, queerboi, polygendered, down low, down E, trans, trannyboy, trans woman, trisexual, omni-sexual, bi-dyke, multi-sexual, homo-erotic, mostly heterosexual, same-gender loving, transmasculine, cis-gender, two spirit, hetero-flexible, same-sex attracted…*

Terminology about Sexuality and Gender

The term "sexual minority youth" has been used so far without explanation. The fact is, there is no universally accepted term to describe youth who are not completely heterosexual in their sexual identities, behaviors, attractions, or relationships. The terms above list just a few of the words that are currently used to describe sexuality and gender.

A common trait of youth in every generation has been to challenge old traditions. Youth today may reject the labels that their elders use, such as gay, lesbian, bisexual, transgender or transsexual. The baby boomer generation rejected the old terms like homosexual and sexual deviant, and stopped using "gay" to refer to all people with different sexualities or genders. This current generation of youth is more likely to reject labels altogether, describing their sexuality as something that is "fluid," dynamic and evolving. This idea is not really new, and can be found in academic writing about sexuality since at least the 1960s (e.g. Foucault, 1978). The theory is called postmodernism, and when applied to sexuality and gender, it is called "queer theory." Queer theory proposes that sexuality and gender are socially constructed rather than purely or even mostly biological, and that each individual creates their own unique identities that stem from the particular circumstances in which they live (Sullivan, 2003). Those circumstances include the political climate, religion, education, the law, medicine, and the media, as well as the more immediate and direct influences of family, peers, cultural group affiliations, and neighborhoods and the individual's unique personality. Identity labels are always in flux, and there is considerable variation in the slang terms used by those who differ by age groups, ethnicities, socioeconomic classes, and geographic regions.

In this presentation, we use the term sexual minority youth as a short-hand, although this term has many short-comings and few people use it to describe themselves. That is, few people say, "Hi, I'm J, and I'm a sexual minority." Some people object to the term "minority," and suggest that the majority of people experiment with their sexuality and gender to some extent, even if they do not openly adopt any of the labels associated with non-heterosexual identities. We use the term sexual minority youth because it is broad enough to include youth who use sexual identity labels as well as those who do not. In addition, the word "sex" is also used to describe the biological characteristics that define male and female, so sexual minority youth can include transgender and gender queer individuals as well. Think of sexual minority youth as the broad umbrella term that contains a wide diversity of sexual and gender identifications and behaviors.

In the next section, we will review the components of sexuality and gender, showing just how complex and confusing it is to operate within our societal expectations and become a sexual and gendered citizen of a particular culture.

Components of Sexual Orientation

Sexual orientation refers to a combination of biological, social, and cultural factors that influence our perceptions of ourselves as sexual beings and the kinds of partners to which we

are attracted (see Eliason, Dibble, DeJoseph, & Chinn, 2009 for a more detailed explanation of all the terms described here). As this point in time, we cannot say definitively whether one is born with a sexual orientation or acquires it sometime during the lifespan. The research is just not that clear for any sexual orientation, including heterosexuality. Sexual orientation has at least four components that are important to keep in mind when working with youth or adults:

- Identities (labels)
- Behaviors
- Attractions
- Relationships

Sexual identities refer to the way we think about or label our sexuality. Sexual identity is one of the many components of our self-concept, working in interaction with other social identities related to our sex/gender, race/ethnicity, social class, occupation, and family roles. Theories about adolescent development often focus on the youths' search for identity (Who am I?). Sexual identities refer to the words or labels we use to describe our sexuality to others. A sexual identity does not provide any information about specific sexual behaviors that an individual might engage in. Sexual identity is the "public" fact, not the private behaviors. Youth today may use any of the words in that long list of sexual and gender terminology, or they may create new words of their own.

Sexual behaviors are what we actually do. Understanding sexual behavior is complicated by the fact that not all people agree on what "sex" is. This was made evident ten years ago when Bill Clinton did something with Monica Lewinsky, and debates raged as to whether it was sex or not. There are still controversies about oral sex, masturbation, role-playing, and many other activities which some people consider as sex and others do not. Youth today are exposed to a much more sexually explicit media than previous generations, but ironically, do not necessarily get any more education about sexuality, at least at school, than their parents did. There is no such thing as "gay sex." Instead, there are a number of specific sexual behaviors that any single individual or group of people might do. If you work in a setting where you do education or interventions related to pregnancy, sexually transmitted infections or HIV/AIDS, then questions about specific sexual activities are warranted and much more helpful than questions about sexual identities.

In most of the research on the onset of sexual behavior, boys have been found to be more likely than girls to have same-sex experiences in adolescence and these experiences do not consistently predict their adult sexual identity. They may explain the experiences as curiosity, or sexual tension release, not as romantic. Girls, on the other hand, if they have same-sex experiences in adolescence, are more likely to report them as intimate or romantic relationships, and report a lesbian or bisexual identity as adults (although certainly not all). Girls' experimentation with sexuality is more likely to occur in college than high school years (Savin-Williams, 2007).

Behaviors may not be consistent with sexual identity—a man who identifies as gay may have recent or past sexual experiences with women, a self-identified heterosexual man may have

considerable same-sex experience, and a bisexual woman may never have had a sexual relationship with a woman. Many health care professionals use the terms MSM (men who have sex with men) and WSW (women who have sex with women) or WPW (women who partner with women) to reflect the lack of direct correspondence between sexual identities and sexual behaviors. If the purpose of your work is only to identify people who are engaging in same-sex sexual activities, then MSM and WSW are adequate terms, although bisexual health advocates have pointed out that it would be more accurate to say "men who have sex with men and women" (MSMW) and "women who have sex with women and men" (WSWM) (Miller et al., 2007). The point to remember is that during a process of sexual exploration, youth may be at risk for adverse consequences associated with both other-sex and same-sex activities, regardless of what terms they use to label their sexuality. Keep in mind that sex/gender of the partner is not a risk factor—only actual behaviors are on a continuum of risk. Some sexual behaviors are more conducive to the spread of infections than others, but it does not matter who the participants are, or what they call themselves.

Sexual attractions refer to the feelings or thoughts of arousal, regardless of whether we act on them or not. As far back as Kinsey's studies in the 1940s and 50s, there has been evidence that many people have same-sex attractions that they do not always act upon. Kinsey thought about half of the population experienced same-sex attractions at some point in their lives. It is more socially acceptable now to admit those attractions. Same-sex attractions may be a precursor to same-sex behavior, but not always (Diamond, 2008). The first sign of a gay, lesbian, or bisexual sexual orientation, may be a crush on a person of the same-sex. However, one study of heterosexual college men found that 10% of them had experienced same-sex attractions without affecting their sense of themselves as heterosexual (Cohen, 1999).

Pedersen and Kristiansen (2008) surveyed 2753 Norwegian youth, age 19-26, and found the following differences in response to questions about behavior, attraction, and identity:

	Boys	**Girls**
Identified as gay, lesbian or bisexual	2%	3%
Identified as not entirely heterosexual	6%	12%
Had sex with someone of the same sex in their lifetime	6%	8%
Had an attraction to someone of the same sex in their lifetime	8%	21%

Sexual and Romantic Relationships refer to who we choose to love, whether sex is involved or not. Some sexual minority youth may make distinctions between types of relationships—casual, romantic, serious. For example, they may choose to have other-sex girl- or boy-friends at school to avoid harassment and/or from genuine caring and friendship, but have more secretive sexual or romantic same-sex relationships. They recognize that some attractions are not sexual, like the "man-crush" that is the topic of so many comedy routines these days. The type of relationship has implications for providing information about safer sex practices.

Measuring Sexuality. If you provide treatment services for youth, it is important to collect information about sexuality. Ideally, you would have questions on an intake form or during history-taking sessions that deal with all four of these components. Appendix # 1 includes examples of questions that experts propose that researchers and service providers use to assess youth sexuality. In general, questions for youth need to include options for "not sure," or "questioning" as well as an open-ended invitation to use their own terms. Options for heterosexual identity need to include the word "straight" as some youth (and adults) do not understand the term heterosexual. If you work with a specific population who consistently use another term, such as Native American youth who use the label "two-spirit" or African American youth who refer to themselves as "same-gender loving," be sure to include those terms on your forms or in oral assessments. We will return to this issue later, when we talk about making forms and assessments inclusive.

So how many sexual minority youth are there? The answer depends on which component of sexuality you use as the measuring stick. The bottom line is that 15-20% of high school-aged youth have some degree of same-sex attraction or behavior, and that the number of "non-heterosexual" youth increases steadily across the adolescent years (Savin-Williams, 2007).

Components of Sex/Gender

We tend to think of sex/gender as simple—a matter of male or female. However, sex/gender is every bit as complicated as sexuality**.** In this section, we describe the three components that make up sex/gender:

- Biology
- Gender Identity
- Gender Expression

Biological Aspects of Sex/Gender. We typically use the term "sex" to refer to the biological factors that we use to label bodies as male or female, and "gender" to refer to the cultural expectations for people based on their physical sex. In reality, the two overlap to a great extent, so some scholars use the term, sex/gender systems to refer to them. There are certain biological functions that create the differences we label as "sex differences" and lead to labels like man or woman. *These include at least four components: genetics, hormones, the brain, and the genitals and reproductive organs.*

> **Component 1: *Genetics*** (Genes and chromosomes). Humans have 46 chromosomes in 23 pairs, one of which we call the "sex chromosomes." We think of the "typical" woman having an XX chromosome pattern and the typical man having an XY pattern. In reality, there are many other possibilities, including XO (Turner Syndrome), XXY (Klinefelter Syndrome), XXX, XXXX, XYY, and others. At this point, there is no evidence that any sex chromosome pattern is associated with one's sexual identities. Nor is there evidence of chromosomal differences on the other pairs of chromosomes that might be related to

sexuality or gender. In addition, the human body has thousands of single genes lined up on those chromosomes, and some researchers have speculated that there is a genetic basis for same-sex sexual orientations. These studies identified that in the families of gay men, there are often more gay male relatives than one would expect, especially on the mother's side of the family (Bailey & Pillard, 1991; Kendler, et al, 2000). One study found that about half of gay male identical twins shared a genetic marker on the X chromosome (the one that comes from the mother), suggesting that in some cases, there might be a genetic factor in the development of the sexual orientation (Hamer, et al, 1993). However, this study is far from conclusive, since it did not find a gay gene, just a marker that was shared by some of the gay brothers, not all of them. The studies of lesbians have been even less convincing, and thus far, there are no genetic studies of people with bisexual or transgender identities, much less those who say their sexuality is fluid. The failure to find a "gay" gene does not mean that there is no genetic component to sexuality, just that it is not a simple single gene or chromosome difference. It could be part of a complex gene-environment interaction, similar to other complex human behaviors like language.

Component 2: *Hormones*. The human body produces many hormones, some of which we have labeled as "sex hormones" because of their influence on reproduction. Sexual identities have little to do with reproduction, per se, so it is not clear whether hormones are at all related to the possibility of adopting an LGBT identity. Women have more estrogen and progesterone than men, at least during childbearing years (puberty to menopause), and men have more testosterone than women during the same time period. Testosterone seems to play a role in feelings of sexual desire, regardless of a person's sex or sexual orientation, but estrogen seems to have less connection to sexual feelings, and is more directly related to changes in the menstrual cycle. Hormones fluctuate greatly over the course of a day, month, and lifetime, making them very difficult to measure accurately, and study of hormones quite unreliable. Thus far, there is no evidence that LGBT people differ from heterosexuals on levels of these hormones, unless of course, they consume pharmaceutical hormones as many transgender individuals do.

Component 3: *Brain structures and functions*. Some researchers proposed that men's and women's brains have slightly different structures, leading to the differences in cognitive, sensory, and perceptual functions that are often reported as sex differences, such as better language development in women and better visuo-spatial skills in men. However, none of the studies that found structural differences between women's and men's brains have been replicated, and all of the skills labeled as sex differences are skills that can be altered by environmental factors, such as practice and training. If boys are given Legos and encouraged to spend lots of time building things with them, they are more likely to develop better visuo-spatial skills than girls who are given dolls to talk to. In addition, there are no conclusive studies that find any brain structure or functional differences between LGBT and heterosexual people.

Component 4. *Genitals and reproductive organs*. We all begin life with the same physical structures, and the default body type is female. If the body has a Y chromosome that activates testosterone and some other hormones during prenatal life, the body

> masculinizes, but essentially we come from the same core. Men develop "outies" and women stay "innies." There are huge variations in the appearance of genitals, and some children are born with genitals that are somewhere in between the typical extremes of male and female. Then there are internal organs. Women have a vagina, uterus, and ovaries; men have testes and a more obvious prostate. But people can lose one of these organs or be born without them, and still have a strong identity as a man or a woman.

In reality, we do not use any of these biological markers of sex to determine another person's gender. Instead we use the gender expression markers—the clothing, hairstyles, and other outward trappings of gender.

"Intersex" is a term used for biological conditions or physical variations that affect reproductive or sexual anatomy, sex chromosomes, or hormones. Another term for this is Disorders of Sexual Development (DSD). The term "hermaphrodite" is both inaccurate and considered offensive. The result of the physical variation is a person whose body does not fit the typical parameters of female or male. A person might be born with a body that looks female on the outside, but have mostly male-typical anatomy on the inside, or with genitals that seem to be in-between the usual male and female types—for example, a girl with a noticeably large clitoris, or lacking a vaginal opening, or a boy with a notably small penis, or with a scrotum that is divided like a labia. Some people who appear to have completely female external bodies are found to have XY chromosome patterns usually associated with a male body. They were born without testosterone receptors on their cells, so their bodies did not masculinize during prenatal development (a variation called androgen insufficiency syndrome). Some of these conditions are not noticed at birth, and only manifest later in childhood or around puberty, yet others are not identified unless the person seeks assessment for infertility or on autopsy. Some of these conditions require medical or surgical interventions, but many others do not. Some authors suggest that as many as 1 in 100 individuals have some form of intersex variation (Blackless, Charuvastra, et al., 2000). People with intersex variations may have lesbian, gay, bisexual, or heterosexual sexual identities and behaviors, and they vary as much as any other group on gender identity and gender expression. A few identify as transgender. Some people who identify as intersexed and heterosexual align with LGBT communities, because of the similarities of experiences of stigma, shame, and secrecy. For more information, see Accord Alliance (www.accordalliance.org), a website devoted to education and advocacy about intersex variations.

Gender Identity is the label or words we use to describe our gender to others. Gender refers to the socially-determined expectations for how a man or a woman is supposed to behave, dress, style hair, stand, walk, and talk. The expectations for women are different than those of men in every culture in the world, although there are some differences in what is expected of men and women from one culture to another. Gender socialization also affects things like career choices, hobbies, leisure activities, and many other human behaviors. According to gender socialization, if you were born in a female-sexed body, you should call yourself a girl or woman and act accordingly. Most children learn their own gender very early on—by about age 3, and can reliably label other people's gender by age 6-7. By mid-childhood, we have a sense of how well we fit into our culture's expectations for gender and label ourselves on a masculinity or

femininity scale. We talk about "girly girls" or say, "He's all boy," and everyone knows what we mean. Most of us are fairly comfortable with our gender assignment as male or female, however, some people have a gender identity that is not congruent with their physical body or assigned sex at birth. The terms often used to refer to these individuals are "transgender," "transsexual," or "gender queer." The medical establishment uses the term "gender identity disorder" to refer to people whose gender identity causes problems in functioning in everyday life, and "transsexual" for those who seek medical or surgical interventions to change their bodies. Here are the DSM diagnostic criteria (DSM-IV, 1994):

DSM Diagnostic Criteria for Gender Identity Disorder

A. *A strong persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).*

In children, the disturbance is manifested by four (or more) of the following:

1. Repeatedly stated desire to be, or insistence that he or she is, the other sex
2. In boys, preference for cross-dressing or simulating female attire; In girls, insistence on wearing only stereotypical masculine clothing
3. Strong and persistent preferences for cross-sex roles in make believe play or persistent fantasies of being the other sex
4. Intense desire to participate in the stereotypical games and pastimes of the other sex
5. Strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. *Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex*.

In children, the disturbance is manifested by any of the following: In boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities. In girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones,

surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. *The disturbance is not concurrent with physical intersex condition*.

D. *The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning*.

There is considerable pressure from LGBT communities to remove gender identity disorder from the DSM because it is stigmatizing and unfairly puts the blame for negative societal attitudes on transgender people. Unlike other DSM diagnoses, which allow people to get insurance to cover their treatment, rarely do people diagnosed with gender identity disorder get coverage for any type of gender transition, so there are no benefits from having this diagnostic category in the DSM.

As gay men and lesbians often reject the term "homosexual" because it was defined by the medical establishment, some people also reject "transsexual" and "gender identity disorder" as medical terms, not terms of a communities own choosing. Transgender is a term that was first used widely in the 1990s to describe people who want to make relatively permanent changes so that they can live as the gender with which they identify (Feinberg, 1996; Stryker, 2009). Some of the specific types of transgender identities and activities involved in transitioning (the process of aligning psychological and physical sex/gender) include:

- **Male-to-female transgender** (also written as MTF, M2F, trans woman, and trans female). These terms refer to people who were born into male bodies and assigned "It's a boy" at birth. Changing from male to female can include taking medications (one to block testosterone and one to add estrogen which softens the body and causes breast development), having surgeries (nose jobs, removing the Adam's Apple, breast implants, and genital surgeries to reshape the penis into a vagina and remove the testicles). It can also include legal name changes, voice therapy, electrolysis, and coaching about how to walk, sit, dress, and apply make-up. In other words, gender re-socialization into a woman. Genital surgeries for an MTF transition cost $7-24,000.

- **Female-to-male transgender** (also written as FTM, F2M, trans man, transmasculine) refers to people who were born into female bodies and labeled as girls at birth. They may also take hormones (testosterone to deepen the voice, build muscles, and grow facial hair), have surgeries (breast reductions or mastectomies, genital surgeries to create a penis), and coaching to act more like a man. Genital surgeries for FTMs are less successful than surgeries for MTF, and cost 2-3 times as much (around $50,000). Rarely does insurance cover the costs of any aspect of gender transition—the procedures are considered "cosmetic" treatments.

Not all transgender individuals seek surgical interventions or even hormone treatments. Some trans people still use the term "transsexual" to refer to anyone who wants to change their

gender, and this term can still be found in the psychiatric and medical literature much more often than transgender. "Gender queer" is the newest of the terms, and is very broad. It might include people who wish to permanently change major aspects of their being, or it might include people who feel that they do not fit gender stereotypes and want to challenge societal stereotypes, not change themselves.

Some people play with gender on a temporary basis. In the DSM, the term "transvestite" is a diagnosis in the section on sexual fetishes (attractions to objects/non-human things) and refers to heterosexual men who like to wear women's clothing from time to time, but have no desire to change permanently. Outside of medical literature, gay men who occasionally cross-dress are called "drag queens" (think RuPaul), and women of any sexuality who cross-dress are called "drag kings." Some people use the term "cross-dresser" to refer to them all. Other terms are "gender-benders," "gender transgressers," gender transcenders," and "gender crossers."

Finally, some people, because of their physical bodies or their gender expression, are difficult to code as male or female when we first see them. We sometimes call them "androgynous," meaning that they do not clearly fit into one gender or the other. People of any sexual identity or gender (heterosexual, LGB or T) may be androgynous.

Some people are more androgynous in their personality expression, blending male and female traits. There are measurements of psychological gender, like the Bem Sex Role Inventory, that has people rate themselves on how true gender-coded personality traits are for them. For example, "How true is it that I am: independent, yielding, shy, analytical, athletic, affectionate, etc." These characteristics are based on stereotypes about how men and women should behave.

As you can see, our outdated idea that sex/gender comes in only two distinct varieties--male/female and their corresponding expressions of masculine/feminine--causes all kinds of problems. Instead of being just two things, gender is multi-faceted and complex, on a continuum rather than being opposites. It may be our society's insistence that there are only two sexes and two genders that forces many transgender people to change their physical bodies to fit into those rigid notions. If we viewed sex/gender as a continuum, we would allow much more variation in how people look and act.

Gender Expression, which is also referred to as gender presentation, is the way that people choose to express their gender in public. It means the way we style our hair, choose clothing, whether we wear make-up or aftershave, how we sit, stand, and walk, the style of communication we use, and so on. We all have control over our gender expression, although we are not always conscious of making choices. Sometimes we strictly follow our socialization, but sometimes we make more deliberate choices about how to present ourselves. A man who wears his favorite pink shirt around the house, may not wear it to a football game because he fears he might be perceived as less "manly." A woman who would prefer to have short hair because it's easier to manage, might wear her hair long to be perceived as more feminine and avoid questions about her sexuality. In general, though, women have much more flexibility in gender presentation than men do.

Youth whose gender expression does not fit their physical bodies and assigned sex are often harassed at school and in communities, regardless of their sexual identities. Gender expression that disrupts the gender status quo is more severely punished in boys than girls in childhood. Boys who prefer to play with dolls and avoid rough and tumble play are often a source of distress to their parents and teachers, whereas tomboys are socially acceptable. By adolescence, however, girls are also expected to lose their tomboy ways and become more feminine. Studies of violence against sexual minority youth reveals that those with cross-gender expressions are more often victims of bullying at school (harassment, discrimination, and violence) than are youth with more gender-typical expressions (Friedman et al, 2006). We will talk about this in more detail later. It is important to keep in mind, however, that many sexual minority youth fit typical expectations for their gender during childhood.

> *Larry King, a 15 year old junior high school student in Oxnard, CA was shot in the head twice by fellow student, 14 year old Brandon McInenery. Larry came out at age 10, and often wore makeup and feminine attire to school. He had been bullied since 3rd grade, and often responded to it with provocative statements. He had asked Brandon, a frequent harasser, to be his valentine a few days prior to the shooting. Brandon, who told a friend of Larry's the day before the shooting to "say goodbye because you're never going to see him again," is being tried as an adult for premeditated murder and a hate crime. What do you think motivated this murder? What is so threatening about a boy in make-up? How can this type of situation be prevented in the future? (Appendix #2 gives more detail about this case for those who are interested in the complexities involved)*

Measuring Gender

The vast majority of assessment tools, intake forms, health surveys, and demographic forms have only one question about sex/gender: Are you male or female? As we have seen, this question prevents us from identifying the wide variations in sex, gender, and gender expression that exist among youth. At minimum, two questions are needed on forms:

- What was your assigned sex at birth? (male, female, intersex, other)
- What is your gender now? (male, female, transgender, other)

In a history-taking session, counselors might ask, "Do you have any issues related to gender that you would like to include in your treatment plan?"

Terms Related to Stigma

There are also a variety of terms that refer to the stigma of minority sexual and gender identifications. Sociologist Erving Goffman (1963) introduced the idea of stigma:

> *"Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories... When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his "social identity"... We lean on these anticipations that we have, transforming them into normative expectations, into righteously presented demands."*

In the simplest terms, stigma consists of negative attitudes and discriminatory behavior toward a group of people. A number of terms have been used to describe how stigma against sexual minority individuals operates on the individual and larger systems or societal levels.

At the individual level**, homophobia, biphobia, and transphobia** refer to the negative attitudes that individuals might have about gay and lesbian people, bisexual people, or transgender individuals, respectively. A phobia is an irrational fear of something that often manifests in anxiety and avoidance. There is a physiological component, such as sweaty palms, racing heart, and rapid breathing. Most of the time, negative attitudes about LGBT people are not actually phobias. And most of the time, they do not stem from fear—they can also come from lack of education, anger, feeling threatened, or a sense of superiority. For whatever reason, however, the term homophobia caught on, even though it is not very accurate. Attitudes about LGBT people are on a continuum, and are not always negative. For example, one study (Eliason & Raheim, 1996) found that attitudes of heterosexual people could be found across a continuum. Examples of actual respondent comments are given for each level of the continuum.

> **Hatred.** A small but dangerous minority of the population despises LGBT people and wishes them harm. These are the individuals who commit hate crimes or foment hatred and mistrust. For example, one man wrote on his questionnaire: "Having been approached by queers in the past…The first time…I was able to pound the crap out of the guy…the third time I knocked the person out."
>
> **Disgust/Repulsion**. This category comes closest to the psychological definition of a phobia, and refers to people who avoid LGBT people and issues, and feel emotional distress if they must deal with the issues. Example, "I find such lifestyles to be personally repugnant."
>
> **Disapproval**. Disapproval can arise from two different sources. The most common is religion, but it is important to note that formal religions vary widely on their attitudes about same-sex relationships and gender identity issues. Some are accepting and inclusive, and others preach that it is a sin to have same-sex relationships or attempt to change one's physical body. An example of this type of comment was "I clearly believe homosexuality is a sin and God punishes sin." And "I believe God created the family to be headed by a male and female, anything other is abnormal." The other form of disapproval has to do with ideas about the "natural" uses of the body. According to this viewpoint, heterosexuality is natural because it leads to reproduction, thus any behavior that does not facilitate procreation is "unnatural." This viewpoint also includes the idea that people are born male or female and should not try to change their gender. For

example, “I don’t care who people have sex with, but it’s unnatural to be other than heterosexual.”

Tolerance. This category is the “don’t ask, don’t tell” variety of attitude. People in this category often say things like, “I don’t care what people do in private, they just shouldn’t flaunt their sexuality in public.” Or “I don’t tell people I’m heterosexual, so why should gay people feel the need to talk about their private matters?” In reality, heterosexual people are allowed to be very open about their relationships. Some of us may feel that some heterosexual people are flaunting their sexuality—think of coverage of celebrity’s sex lives in the media!

Acceptance. Some people have a belief that everyone deserves equal rights under the law, and deserve our respect. For example, one person said, “I feel lesbian, gay, and bisexual people should be treated no differently than heterosexuals.”

Celebration. The final category is the belief that diversity is good, and that sexual minority individuals have made a unique contribution to society and we should not only accept, but be grateful that people are different from each other. A respondent in the study said, “Gay people are part of the social fabric of America. They need to be portrayed as healthy folks with a different orientation who do not represent a hateful threat to American values, but simply a healthy broadening of those values.”

The attitudes of individuals are maintained and reinforced by the systems in place in our society. These systems help maintain the status quo and sometimes protect people from consequences of their negative attitudes and behaviors.

At the societal level, the term **heterosexism** refers to the belief that only heterosexuality and male-female relationships are considered to be “normal” or “natural.” The term “heteronormativity” is also used for this concept. To be specific, the belief is that the only normal relationship is a legally married man who was born male and woman who was born female. This assumption is built into the dominant discourses of our society—into educational systems, the media, medicine, law, politics, religion, and so on. Heterosexism renders LGBT people and same-sex relationships invisible.

Maria is a 51 year old woman who has been in a committed relationship with Luna for 28 years. They live in a state where same-sex couples cannot marry. Maria is at the doctor’s office for a first gynecological exam with a new primary care doctor, and has to fill out the form. The question reads: Are you: married, divorced, separated, widowed, or single? What box should Maria check? How would you feel if there was no way to indicate that you were in a serious, long-term relationship?

Another example of heterosexism is the attempt by some to keep resources and information about same-sex families and individuals away from children. The American Library Association keeps data on banned books in the United States, and every year that list contains books about sexual minority individuals and families. For example, a children’s book entitled, *Heather has*

Two Mommies (by Leslea Newman, 1989) was listed as the 11th most banned book of the decade of the 1990s.

Gender Normativity refers to the assumption that there are two and only two sexes and therefore only two genders. This assumption is imbedded in daily living, from our division of public bathrooms into men's and women's rooms, to forms that only have two options, male or female, and imperatives at birth that we must assign a sex (It's a boy or it's a girl). It is reinforced by commercials on TV that segregate boy toys from girl toys, and target women for different products than men. It is reinforced at school, when the principal greets the students over the PA system with "Good morning, boys and girls," and the teacher has pupils line up by gender. We are taught from birth that the sexes are different, maybe even opposites. Gender normativity is based on the idea that our biological sex is what causes differences between those we designate as men and women, meaning that male sex can only express as masculinity and female sex only as femininity. Gender stereotypes have had harmful consequences for most people at some point in their lives, constricting their behavior and gender expression.

Negative attitudes on the individual level combine with forces on the societal level to produce negative consequences for the sexual minority individual, including:

- Social rejection and invalidation of personal identities and relationships;
- Harassment and discrimination (in employment, housing, education, leisure activities);
- Hate crimes: violence based on a person's perceived sexuality or gender.

Putting Together the Individual and Societal Level Influences: Minority Stress

Public health educator/researcher Ilan Meyer (2003, 2007) has proposed a model of minority stress that shows how the pieces of stigma fit together, and how stigma of different types operates in similar ways. The model of minority stress has three components**:**

1. **Internalized oppression** (feelings of shame, guilt, doubt, fear are embedded in the LGBT person's psyche from the constant exposure to negative stereotypes from birth on);

2. **Stigma** (fear of rejection, and lack of support can lead to isolation and alienation); and

3. **Prejudice events** (experiences of social invalidation, harassment, discrimination, violence).

Minority stress can occur in any stigmatized group (by race/ethnicity, immigration status, religion, etc), but manifests differently depending on the stereotypes about the group. Stereotypes differ depending on what group we are talking about, but the common elements of a stereotype include: 1) the implication that all people who belong to the group have these same characteristics, and 2) the characteristics are de-humanizing (making the group seem like second class citizens or less deserving of civil rights).

The Effects of Stigma on the Individual's Health

Internalized stigma. There are a number of terms that refer to this concept, including internalized homophobia (biphobia, transphobia), internalized oppression, and internalized stigma. The concept refers to the feelings of shame, guilt, self-hatred, and fear that can result if a sexual minority person believes the negative stereotypes based on sexuality and gender. It is difficult not to internalize at least some of the negative stereotypes about LGBT people, because we hear them repeated so often from so many different sources through-out our formative years. The person who absorbs these negative stereotypes but begins to have same-sex feelings or gender identity issues may feel depressed, guilty, fearful and anxious that others will find out, and they may engage in risky behaviors such as substance use to self-medicate the uncomfortable feelings. They may even think that suicide is their only option. We will talk more about this concept of internalized stigma in the next section on the coming out process, or how people adopt sexual and gender minority labels for themselves.

Stigma. This refers to the negative attitudes of other people, based on the judgments made about a person based on their perceived group memberships (stereotypes). For some groups, we have positive stereotypes and therefore, the group is not stigmatized. The more negative stereotypes there are about a group, the more likely that the negativity will manifest in both the behavior of individuals and in the laws and customs of society. One of the reasons that it has been difficult to change societal attitudes about LGBT people is the power of the stereotypes about LGBT people being sexual predators. Even though all studies find that people who molest children are predominantly heterosexual men, the stereotype about gay men as predators persists. One study in the Journal of Pediatrics reported that a child is 100 times more likely to be molested by a heterosexual man than a gay man (Jenny et al., 1994). In spite of this fact, the stereotype that links child molesting to sexual orientation persists.

Prejudice Events. Mays and Cochran (2001) collected some information on the experiences that sexual minority adults had with prejudice in their lifetimes. Here are some of the findings for sexual minority men and women compared to heterosexuals:

Lifetime Experiences	Lesbians	Heterosexual Women	Gay Men	Heterosexual Men
Not hired for a job	39%	17%	23%	19%
Denied or given poor medical care	7%	3%	3%	4%
Hassled by the police	5%	3%	18%	12%
Poor service at restaurants or stores	27%	11%	5%	9%
Called names or insulted	20%	6%	16%	6%
Threatened or harassed	15%	3%	11%	4%
Any experience of discrimination	58%	36%	51%	34%

In conclusion, stigma is the underlying factor that causes some sexual minority youth to have adverse consequences such as mental health symptoms or disorders or substance use disorders. A sexual orientation/identity or gender identity is not a risk factor for health problems. Instead, stigma, or societal attitudes and behaviors about minority sexual and gender identifications create the risk.

"COMING OUT" AND IDENTITY FORMATION

Are There Stages of Coming Out?

In the psychological literature, there are over two dozen stage theories about the processes involved in coming out as lesbian or gay, and only a few that deal with coming out as bisexual or transgender. These frameworks recognize that people may go through several different processes or have different reactions to their developing sexuality as they mature. They share some common themes, such as starting with a phase of confusion about one's sexuality, a phase of coming out to self and exploring the identity in secret, a phase of revealing one's sexuality to others, and a final phase of acceptance and integrating sexuality into the larger self-concept. Stage models are seductive because they simplify a complex process into a smaller manageable number of steps, but they are dangerous for the very same reason. They are simplifications and generalizations of a complicated and highly individual developmental process (Eliason & Schope, 2007).

All of these models stem from Erik Erikson's idea that the major developmental task of adolescence is a search for identity. Although identity development occurs across the entire lifespan, it is more intense and is a critical developmental transition during the adolescent years. Identity is a sense of self that is stable across time, a sense of inner unity and self-understanding. Writing in the 1950s and 60s, Erikson described homosexuality as a negative identity used to rebel against parents or society, but later psychologists re-defined it as a positive identity, one that is similar to adopting a racial/ethnic identity.

The most widely cited stage model comes from a psychologist named Vivienne Cass (1979, 1990). Her model has six stages:

- **Identity Confusion**: this stage begins with a recognition of same-sex feelings, and ends with a declaration to the self (I think I am gay, or I'm not gay—if the later, the process ends here). During this stage, feelings of tension, bewilderment, and anxiety are common. Youth are often confused about sexuality because their parents, teachers, and other authority figures never told them that some people have same-sex attractions, and we are not given any labels for this.

- **Identity Comparison**: once a person has a thought, "I might be gay," they compare themselves to the societal stereotypes about LGBT people, and start getting feedback from others, such as peers and family, to determine if they might be accepted or rejected if they reveal their identity. This stage might include accessing information from the internet, reading books about LGBT issues, or asking friends about their opinions.

- **Identity Tolerance**: the gay identity at this point is still a tentative one. In this stage, the person begins to make contact with LGBT individuals and communities to try out the identity. They are trying to find out what it means to be LGBT. The stage ends with a greater certainty that the identity is correct.

- **Identity Acceptance**: the contact with LGBT individuals and communities leads to a breaking down of stereotypes and a greater self-acceptance. The first three stages were mostly internal cognitive processes and secretive explorations, but in this stage, people begin to disclose their lesbian or gay identity to selective others. Usually, people begin with a supportive friend or sibling—someone they are fairly sure will be accepting. Often people at this stage notice a discrepancy—they are fully accepted and valued by LGBT individuals but have less positive reactions from heterosexual others. This discrepancy can lead to the next stage.

- **Identity Pride**: at this stage, people immerse themselves into LGBT communities where they feel accepted. They may join social and political groups, and may begin to challenge homophobia and heterosexism through education and activism.

- **Identity Synthesis**: in the final stage, people merge their public and private identities, and the gay identity becomes no more or less important than any other aspect of identity. They become equally comfortable in LGBT and heterosexual settings.

The first four stages are part of the internal process of coming out to one's self, and disclosure to others typically takes place in the last two stages. Cass' model was based on the recollections of gay and lesbian adults, most of whom were white and highly educated, remembering back to their own coming out process.

Influences on Identity Formation

Clinicians often find stage models useful in their work with youth, but the stages should only be taken as very rough guidelines for some of the issues that sexual minority youth may face. They are limited in many ways, based as they are on a Eurocentric male model of development. Many of the criticisms have come from feminists and scholars who work with youth of color, but even white, male, middle class youth cannot be easily reduced to a few stages of development. Stage models typically do not take into account the newer ideas of sexual fluidity

or resistance to labels that characterizes many youth today, they do not allow for flexibility or individual variation in the process, they do not address bisexual, transgender, or heterosexual identity, and they do not consider how sexual identity develops in the context of all the other forms of identity and the individual and external influences on the adolescent. Think of all the factors that may affect any individual's sense of their own sexuality. These influences include, but are not limited to:

- Religion (both local and the larger religious discourses)
- Racial/ethnic group membership and cultural beliefs about the nature of sex and gender
- Politics (local, national, international)
- Socioeconomic class status
- Gender socialization
- Laws (same-sex marriage, civil rights protections, age of consent laws)
- Community attitudes (local neighborhoods or ethnic communities)
- Peer norms and attitudes (community and school)
- Schools (do they have inclusive policies, LGBT support, comprehensive sexuality education, inclusive curricular and extracurricular components?)
- Parents (attitudes, level of education, gender expressions and sexualities, etc)
- Siblings and other family members
- Geographic region
- Health and disability status
- Immigration status
- Media (music, TV, movies, internet, magazines, news, celebrities behaviors)
- Generation
- Individual factors (cognitive and moral development, genetics and biological development, personality traits, physical development, etc).

People who are heterosexual may think that they are simply born with a heterosexual orientation, but in reality, all of the forces listed above have been working on the individual to socialize the majority of the population into heterosexual identities and behaviors.

Because there are so many influences on individual development the result is that each of us is unique. We may share many features in common with others, but probably not all. There is no one stage theory that can capture all the possible permutations of identity that are possible with this wide range of influences. In addition, heterosexual people have sexual identities and go through an identity development process as well, but very few theories address this (for an exception, see Eliason, 1995). Heterosexuality is taken-for-granted as the normative path of sexual development, but it is just as unique and quirky as sexual minority development.

Coming out as transgendered is called "transitioning," and involves taking steps to live as a person of the desired gender, as well as disclosing to others. Transitioning is a complex process that often involves accessing medical care, getting legal services to change the name, birth certificate, driver's license and other legal documents, and a host of other activities that help the person to learn to "pass" better as the gender with which they identify. Only a few researchers have explored the psychological processes that are associated with transitioning. Devor (2004) identified 14 stages of adopting a transgender identity, and Coleman et al (1993) suggested that there are two relatively separate identity processes, the first involving gender, and the second, sexual identity.

The next few pages provide examples of sexual minority youth with differing sociocultural backgrounds. Think about what the main challenges might be for each youth if they were referred to your agency, institution, or practice.

- Pedro is 16 years old, from a Mexican American family. His mother was born in Mexico, his father in the U.S. They are middle class and live in Sacramento, California and both are college educated. Pedro attends a mostly white school with a gay-straight alliance, and has already come out to a few of his friends. Religion is not a big part of his family, so he has not internalized many negative attitudes about same-sex behaviors or relationships. His family now moves to Southern California, and Pedro starts school at a campus that is mostly Latino and Catholic. What challenges might he face now?

- Lois is 17 and has cerebral palsy. She has normal cognitive skills, but quite impaired mobility, and must use a wheelchair to get around. Her speech is very slurred. Her parents have been very protective of her and still treat her as a child. She has been attracted to her best friend, Meg, for two years, and has not known how to talk about it. Everyone treats her as if she were asexual. She has become very withdrawn, and her parents bring her to treatment for depression.

- Matthew is 14 and part of a Mormon family in rural Utah. Since a very young age, he has felt like he should have been born a girl. He is attracted to boys, and knows that his family and religion condemn gay relationships, but he does not consider himself as gay because he feels female. He longs for the day when he can leave his family and religion

behind and explore this identity, but until then, he feels he must hide his feelings from everyone. His grades at school are beginning to plummet and he is referred to the school counselor.

- Linda is 16, from an Orthodox Jewish background, and is questioning her sexuality. Although her parents are quite strict, her grandmother has been her constant supporter and knows about her relationship with a girl from school. She lives in San Francisco, and has attended a sexual minority youth support group for over a year and feels well-accepted and supported in her life, in spite of having to hide her relationship from her parents. She wants to talk to a professional about her sexuality, but is concerned that you as her counselor, will reveal the discussion to her parents. What would you tell her?

- Jay is an 18 year old Muslim youth who is a senior in high school. His parents were born in Saudi Arabia, but he grew up in a medium sized city in the northeast U.S. He is a star football player and does well academically. He has a steady girlfriend, but also has casual sex with men at gay bars in a nearby town. He does not think of himself as gay, so feels no need to tell anyone about his encounters with men. Jay shows up at a clinic for symptoms of a sexually transmitted infection—what could the counselors there tell him about sexuality and safer sex practices?

- Sandy is a 17 year old from an indigenous American tribe in the Midwest, and grew up on a reservation. Her people were fairly isolated and able to maintain their old customs and beliefs, which included a role for a "third" gender. That is, some people were thought to be born with a combination of male or female spirits, and they were considered shamans, or healers for their tribe. Sandy has known from an early age that she fit this category, and that has been acknowledged by the tribal leaders. Now she lives in an urban area and identifies as "two spirit" meaning she was born with both male and female spirits. She has had relationships with both men and women, and is very comfortable with her sexuality. She has offered to volunteer where you work—in what ways could she be helpful at the agency, institution, or practice where you work?

- Sam is 12 and from a Chinese American family who are Buddhist and try to maintain Chinese customs and beliefs. Sam is caught between the generations—his parents are traditionalists and his peers are exposed to mainstream U.S. culture and media—and he is often conflicted about following his heart and following his parent's expectations. They put high value on him getting married and having children to continue the family line. He has had same-sex attractions for as long as he can remember, and has little or no interest in girls. He told one trusted teacher about his feelings, and the teacher told him he was too young to know about his sexuality, that he was just going through a phase that he would outgrow. How else could the teacher have handled this? Think of two or three possible responses to a young person who comes out as LGB or T.

- Shay is a 15 year old from Oakland, California, from an African American family and community. Although born female, Shay was a tomboy as a child, and at age 14, started

asking friends and family to use male pronouns. Shay's mother is supportive, but his father, a devout conservative Christian, has threatened to kick Shay out of the house if he does not give up this idea of being male. Shay is tolerated at school, because most of the classmates have known Shay as being tomboy or masculine most of their lives. Shay's father wants you/your agency to "straighten out" Shay. How would you respond to this request?

Racial/Ethnic Influences

We know much less about the sexual identity development of sexual minority youth of color than we do about white youth, because many studies have used sampling methods that do not capture racial/ethnic minority youth, or do not consider race/ethnicity as a significant factor. Another problem is that some researchers have done unethical studies in racial/ethnic minority communities in the past, and the historic memory of those abuses is still alive, resulting in ethnic minority individuals being less likely to volunteer for research studies even if great outreach activities are done in their communities. Another problem is something called "ethnic gloss." Studies that do attend to race/ethnicity often lump together people from very different groups into one category, thus washing out the uniqueness of each individual cultural group. Think for example of the category, Asian/Pacific Islander. Who is included in this category? Are all of these groups the same? The same thing is true of the categories Latino, Native American, African American, and White.

Some of the main differences that research has found between white sexual minority youth and youth of color have to do with the use of labels and the degree of disclosure of sexuality or gender. The few studies that do address the impact of race and ethnicity on sexual identity development are summarized below.

Edwards (1999) studied 37 African American men who have sex with men. Most of them did not self-identify as gay or bisexual, but were well-adjusted and healthy. They did not want their sexuality known, especially to family, but they were not ashamed of their same-sex behaviors. To them, concealing their sexuality was a healthy coping strategy that did not have negative consequences on their mental health.

Dube and Savin-Williams (1999) compared Latino, Asian American, African American, and white male youth and found:

- Latinos recognized same-sex attractions at the earliest age, Asian Americans at the latest age.
- Many African American men had sex with men before identifying as gay: few Asian Americans had sex before identifying as gay, and Asians tended to begin same-sex behaviors at the latest age.

- African American and White men were likely to also have sex with females during adolescence whereas Latinos and Asian Americans were less likely to have sex with women.

- African Americans and Asians were the least likely to be out, especially to family.

Rosario, Schrimshaw, & Hunter (2004) studied youth age 14-21 from New York City. The sample was 37% Latino, 35% Black, and 22% White (the number of youth with other racial/ethnic identities was too small to include). All of the youth identified as lesbian, gay, or bisexual. They examined sexual identity development milestones and found no differences based on racial/ethnic group on most of the indicators, such as the age of the first same-sex attraction, the age at which they first thought they might be LGB, the age of engaging in the first same-sex relationship, comfort level with their sexuality, or attitudes about same-sex relationships. There were a few differences, however, including:

- Youth of color were more certain about their sexual identities at the time of the survey. Black youth: 91%, Latino youth, 80%, and White youth, 67%.

- White youth had greater involvement in gay social activities.

- White youth were more comfortable with others knowing about their sexuality.

- White youth had disclosed their sexuality to more people.

A study of 3700 Asian/Pacific Islander high school students (Homma & Saewyc, 2007), including 91 sexual minority youth, found that family caring and a sense of belongingness at school were associated with higher self-esteem for sexual minority Asian Pacific Islander youth, just as they are for other racial/ethnic groups.

When there are racial/ethnic differences related to sexuality and gender, they seem to represent a public-private split. People of color tended to keep their sexuality in the private realm and were more selective about who they told. White LGB youth were more likely to be public about their sexuality. This difference might account for the misperception that same-sex identities are a "white thing." People of color are less likely to be public about their sexuality or gender, thus are less likely to show up on polls, research studies, talk shows, etc. Some studies also pointed out another potential difference. Youth of color may have an advantage that White youth do not have. Their parents and communities were more likely to have prepared them for dealing with racism, and the coping skills they learned may have generalized to coping with minority stress related to sexuality or gender. There are at least two other major factors that might explain racial/ethnic differences in the experience of identity development: 1) religion, and 2) cultural attitudes/beliefs about the nature of sex and gender.

African Americans and Latinos are more likely to belong to conservative or fundamentalist religions that still condemn same-sex identities and behaviors. For example, the National Longitudinal Study of Adolescent Health data show that nearly 50% of African American youth are Baptist (compared to 20% of white youth), 56% of Latino youth are Catholic (compared to

23% of white youth). Latinos are also much more likely than White youth to belong to Jehovah's Witness and Adventist churches, and African American much more likely to affiliate with Islam and African Methodist churches (Smith, 2007). When people say that African American and Latino communities are more homophobic than other groups, it may be because of the influence of these conservative religions, not race/ethnicity.

Secondly, there are different cultural understandings about the nature of sexuality and gender. In many Native American traditions, the concept of "two spirit" means a person who is different from male and female—a separate category of gender that combines male and female spirit. Each tribal group had a different term for this person, and in many tribes, these differently gendered people were considered healers or shamans. The differently gendered person could choose to have male or female sexual or romantic partners (Walters, Simoni & Horwath, 2001). In this conception, sexuality and gender are blended, unlike in western systems where they are separated into two independent concepts. At a conference of Native American sexual minority individuals in the late 1990s, a decision was made to adopt the term "two-spirit" to unify people who belonged to many different tribal traditions. Like many other terms, some people like it and use it, and others prefer terms of their own cultural heritage, use the terms in the dominant culture, like LGBT, or do not use terms at all.

In some Latino cultures, men are classified by their sexual behaviors—the dominant partner, the one who inserts, is not considered gay. Only the passive partner, the recipient, is labeled as different (Harper, Jernewall, & Zea, 2004). In many cultures, Asian in particular, the first concern for the individual is to fulfill family expectations of marriage and children, but the person might also have same-sex relationships as long as they remain hidden and unspoken in public. To be public about sexuality could bring shame to the family (Chng et al, 2003).

Research seems to conclude that all youth experience similar developmental stages or milestones in common that are related to one's internal development of a sexual or gender identity. The differences are typically in how public the individual becomes with their sexuality or gender. If sexual minority youth of color are more likely to experience homophobia, biphobia, and transphobia in their communities of color, and then experience racism in predominantly White LGBT communities, it makes sense that they would be more reticent about coming out in public.

One danger of focusing only on sexual identity or gender identity is the possible erasure of the other important factors in the individual's development. Kevin Kumashiro (2001) pointed out that this separation creates a false sense of racial/ethnic difference:

> *"any attempt to focus on 'queer' is simultaneously a process of separating queer genders and sexualities from other identities, thereby leaving unmarked those (nonqueer) identities that are traditionally privileged (such as White American and male identities)…Similarly, some civil rights movements based on race or ethnicity have excluded gender and sexual minority identifications, sometimes in a deliberate move to 'normalize.' LGBTQ identities are labeled as 'a white thing'*

> *and to adopt an LGBTQ identity as a person of color is to be a 'race traitor.'" (Kumashiro, 2001, p. 4).*

An Example of the Intersection of Racism and Heterosexism: The Down Low

In recent years, talk shows, political commentators, and researchers alike described a phenomenon among African American men of cheating on their female partners by having secretive same-sex relationships. These men did not identify as gay or bisexual. They were blamed for the very high rates of HIV/AIDS among African American heterosexual women, and the behavior was labeled being on the Down Low.

The problem with this is that some men (and some women) of every racial/ethnic group cheat on their spouses with same-sex or other-sex partners. It is by no means limited to, or more common, among African American men. Secondly, there is no evidence that this behavior is what has caused the higher rates of HIV/AIDs among African American women. The real culprit is racism, which affects education and resources to combat HIV/AIDS, and creates greater rates of poverty (Wolitski et al., 2006). It is so much easier to blame African American men (who have little power in society) than to blame and address the actual problems of racism and poverty, so African American men are scape-goated with this label. Activist Keith Boykin said:

> *"The down low fit perfectly into larger cultural dynamics because it confirmed stereotypical values that many of us already believed. For some whites, it confirmed their hypersexualized perception of black people, and for some blacks it confirmed their hypersexualized perception of gay men. Given society's stereotypical view of black men combined with societal beliefs about homosexuality, the story became more believable because it vilified a group of people we did not understand and many of us did not want to know." (Boykin, 2005, p. 151)*

Sex/Gender Influences

In most cultures, girls and boys undergo quite different socialization processes associated with gender stereotypes. In general, girls are allowed to be much more intimate, both physically and emotionally, with their friends, and they grow up learning to equate sex and love. This can blur the line between friendship and romantic relationship, making it somewhat harder for girls to figure out their sexual identities. In one study, when given choices of heterosexual, mostly heterosexual, LGB, or unsure, twice as many girls (6%) as boys (3%) said they were "mostly heterosexual" (Ziyadeh et al, 2006). Sexual minority girls also tend to slide back and forth between categories of lesbian and bisexual throughout their lifetimes (Diamond, 2008).

Boys, on the other hand, have much more clear boundaries around touch and emotional intimacy with other boys, and are taught that sex and love are two different things. There are

also the physiological differences. Sexual arousal in boys is much more evident than in girls. Boys can learn more quickly what turns them on, because they get erections. Girls take longer to figure what causes a physical arousal. In each decade since this data has been kept, girls come out at a later age than boys. The chart below shows average age for the first same-sex attraction by decade (from Savin-Williams, 2007):

Decade	Boys	Girls
1960s	14	17
1970s	13	16
1980s	10	14
1990s	10	12

The chart also suggests that another outdated idea about sexual orientation needs to be discarded. That is, the idea that sexual attractions and identities do not develop until puberty. It is often thought that children do not have sexual feelings until the biological changes of puberty—that the "hormones" of puberty are what causes the awakening of sexuality. However, in one study of LGB adults, they reported feeling different and having crushes on people of the same-sex at an average age of eight (D'Augelli & Grossman, 2001).

Age Differences in Coming Out

Ironically, all the changes in society have allowed children and adolescents to come out at an earlier age because they are exposed to information about LGBT identities and can put a label on their feelings earlier than people of previous generations. However, there are still dangers in coming out—the possible rejection, harassment, and violence directed at sexual minorities in our culture. One study (Friedman et al, 2007) found that coming out early as opposed to late in adolescent results in more risk factors. In this study, based on adult gay and bisexual men in the Urban Men's Health study (about 1400 men), they asked about adolescent experiences and categorized participants as early, mid, or late in coming out. We'll simplify by comparing the early to the late bloomers. The early group reported first same-sex attractions by about the 3rd grade, had first same-sex experiences around 9th grade, and decided they were gay or bisexual by 10th grade. The late group had first same-sex attractions around 8th grade, first same-sex experience around age 22, and decided they were gay/bi in their mid 20s. When the researchers compared them by some adverse events in youth and adulthood, they found differences in the groups:

Adverse Events:	Early Group	Late Group
HIV positive	22%	10%
Experienced forced sex before age 18	26%	17%
Were harassed for being gay	84%	65%
Gay-related victimization in past year	24%	15%
Were currently depressed	21%	12%

The early group may have come out before they had the cognitive and social skills for healthy coping. The exposure to harassment and the lack of education about same-sex sexuality available to them at the early age of coming out led to more adverse events. The problem is not that they came out too early, but that nothing at school or in their homes prepared them for the experiences they would have as sexual minority youth.

Combine this information about those who were aware of same-sex attractions early with the data from Savin-Williams about the average ages at which boys and girls report same-sex attractions, and what does this say about when issues of sexuality should be introduced in school? Data about "typical patterns" uses averages—that means if a study finds that boys have their first same-sex attraction at an average age of 10, about half of them experience attractions before the age of 10, and the other half after 10. The argument about sexuality education thus far has been that children less than age 12 or so are not cognitively or emotionally ready to discuss issues of sexuality. However, the data clearly shows that lots of children are already thinking about sexuality, and a small number are already engaging in some sexual activities by this age. It is no longer acceptable to wait until high school years to talk about these issues when many sexual minority youth are already thinking about their sexuality or gender in elementary school and some are already experiencing adverse events. Sexual orientation and gender identity can be discussed with even very young children without any discussion of explicit sexual behaviors. These are issues of "Who am I?" and respect for human differences, not of sexual behavior.

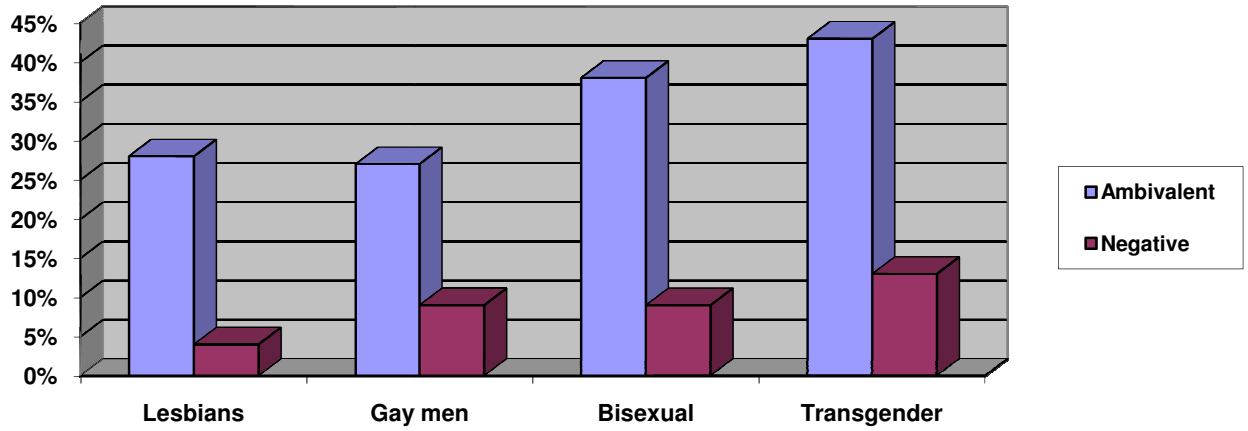
Coming Out to Professionals

If schools and parents are reluctant to talk to youth about sexuality and gender, can they turn to health care professionals, such as primary care providers for accurate information? Unfortunately, there are few opportunities for sexual minority youth to disclose to health care professionals. First, these professionals have to ask the right questions, and secondly, they must have the trust of the individual. For many youth, especially those not out to family, confidentiality is a major concern, and they fear that health care providers will tell their

parents. Another issue might be relevance. If they are seeing the dentist, they may not think their sexuality or gender is relevant, but if a young woman is seeing a gynecologist, her sexual identity and behavior is highly relevant. Even if youth do feel comfortable and come out to the provider, there is no guarantee that they have accurate information. Most medical and nursing schools have very little or no content about sexual orientation and gender identity (Eliason et al, 2009).

One study of sexual minority youth's experiences with primary care found that the majority of them (64%) wished that their health care providers would ask them directly about sexuality. They wanted them to know, but found the typical health assessment experience did not provide opportunities for them to bring up the topic (Meckler, et al, 2006).

Thus far, there are no studies about the attitudes of substance abuse professionals about sexual minority youth. A few studies have assessed substance abuse professional's attitudes about LGBT adult clients, finding about the same levels of negative attitudes as in the general population. One study assessed both negative attitudes and ambivalent attitudes. How might an ambivalent counselor approach a sexual minority youth? From a client's perspective, it may be easier to deal with a counselor who is clearly negative, than one who has ambivalent attitudes about sexual minority identifications. One study (Eliason, 2000) found that providers were more accepting of lesbians and gay men than bisexual and transgender clients, but that overall, there was considerable potential for uncomfortable counselor-client interactions. More counselors had ambivalent attitudes than overtly negative attitudes about each group, with well over half of the respondents having negative or ambivalent attitudes about bisexual and transgender clients.



In some research on the effectiveness of psychological treatments for substance abuse and mental health problems, the relationship between counselor and client has been noted to be one of the biggest factors in treatment success (Hubble, Duncan, & Miller, 2002). If one-third to over one-half of substance abuse counselors have negative or ambivalent attitudes, what effect will this have on their relationship with sexual minority clients/patients?

RISK AND PROTECTIVE FACTORS

As we noted earlier, the focus of most research has been on the risk factors, ignoring the fact that the majority of sexual minority youth are healthy and resilient. There are reasons, however, to consider the risk factors. Sexual minority youth are at higher risk than heterosexual youth for a number of potentially deadly risk factors. Some of the risk is preventable, as it is related to societal stigma and lack of education about sexuality and gender. In this section, we will consider the most often studied risk factors in sexual minority youth, beginning with a discussion of the two most significant settings in which stigma occurs. This stigma underlies the risk factors, and is often located in schools and in homes, the places where most youth spend the majority of their time.

We will begin with those two major settings that have some impact on all sexual minority youth, and end with two other situations that affect a smaller number of youth: homelessness and out-of-home placements, and coerced treatment of sexual orientation.

The School Climate

> *"I have learned that harassment in schools is a norm. Kids would scream 'faggot' as they saw me in the halls. None of the teachers said a word, and that is what scared me." (11th grade male, GLSEN, 2007).*

The largest study of school climate was conducted by the Gay, Lesbian, and Straight Education Network (GLSEN) in 2007 (Kosciw, Diaz, & Greytak, 2008). In this study, participants were recruited for an online survey. The respondents were aged 13-21, and all self-identified as lesbian, gay, bisexual, and/or transgender. This means we do not have data about youth who are questioning their sexuality or gender, or who do not use those labels, but it is the best data we have available at this time about the school climate. There were over 6000 participants from all 50 states and the District of Columbia. About two-thirds were white and one-third students of color, with female participants outnumbering male. The majority were still in grades 6 through 12, although a few had recently graduated. The survey instrument asked about safety issues in school, harassment, discrimination, friendly resources, and the potential consequences of an unsafe climate. Each of the questions was asked in two ways: related to sexual orientation and related to gender expression, recognizing that there may be differences. Sexual identities are only visible if the student discloses, whereas gender expression or presentation is a visible difference. When asked, "Do you feel unsafe at school because of your sexual orientation?" 61% said yes, and 38% said they felt unsafe because of their gender expression. Students who reported feeling unsafe were more likely to skip school because of this, at five times the rate of school absenteeism in the general school population.

The majority of respondents reported regularly hearing derogatory language:

- 90% heard the word "gay" used in a negative way (to mean, "that's stupid" or to put someone down) and 83% said that hearing this caused them distress.
- 74% sometimes or often heard homophobic remarks at school, most of which were not challenged by school authorities.
- 86% had been called names or threatened at school.
- 44% reported they had been physically harassed, such as shoved or pushed.
- 22% had been physically assaulted, hit or punched by another student.

Of those students who had experienced direct harassment or assault, 61% did not report the incident because they felt nothing would be done about it. Of those who reported the incident, indeed, one-third of the time nothing was done. Students who were harassed or assaulted experienced a decline in their school performance. Students who were rarely harassed and had not experienced assault reported a grade point average of 2.8, compared to a 2.4 for students who had often experienced harassment or assault.

Bullying

> *Associated Press: NEW YORK, April 9, 2009 – An 11-year-old Massachusetts boy, Carl Joseph Walker-Hoover, hung himself Monday after enduring bullying at school, including daily taunts of being gay, despite his mother's weekly pleas to the school to address the problem. This is at least the fourth suicide of a middle-school aged child linked to bullying this year. Carl, a junior at New Leadership Charter School in Springfield who did not identify as gay, would have turned 12 on April 17, the same day hundreds of thousands of students will participate in the 13th annual National Day of Silence by taking some form of a vow of silence to bring attention to anti-LGBT (lesbian, gay, bisexual and transgender) bullying and harassment at school. The other three known cases of suicide among middle-school students took place in Chatham, Evanston and Chicago, Ill., in the month of February.*

Many schools report problems with bullying. Bullying is defined as an intent to harm or disturb another person, repeated over time, and targets those who are less powerful than the bully. Bullying is often witnessed by groups of students, some of whom are aligned with the bully. It is not surprising to find that homophobic bullying is one of the most common forms, and this is done more often by boys than girls. In fact, some researchers (e.g. Pascoe, 2007) found that homophobia is part of many boys masculine socialization by peers, and homophobic taunts are used to control others and keep the status quo intact. Pascoe asserts "boys lay claim to

masculine identities by lobbing homophobic epithets at one another" (p. 5). Femininity in girls is not tied to homophobia in the same way, and as a consequence, most studies find that girls and women are more likely to be accepting of LGBT people than are boys and men.

In one study (Chasnoff & Cohen, 2003), 68% of 7th grade boys reported that they heard the word "fag" every day at school, used as a generic insult as well as being directed at those thought to be LGBT. Here is what one of the boys in the study said that helps to explain why so many youth use derogatory language. "*I call people fag all the time. You just walk up to them and say it right in their face. It just gives you, like a feeling of power."*

A recent study (Berlan et al., 2010) examined who were bullies and who got bullied in school, and found some interesting differences by sexual identity as shown below.

	Boys	**Girls**
Was a victim of bullying:		
Heterosexual	26%	16%
Mostly heterosexual	35%	25%
Bisexual	36%	26%
Lesbian or gay	44%	40%
Was a perpetrator of bullying		
Heterosexual	35%	14%
Mostly heterosexual	36%	23%
Bisexual	50%	34%
Lesbian or gay	11%	0

Girls who reported a lesbian identity were almost three and a half times more likely than heterosexual girls to be bullied; boys who were gay were two times more likely to get bullied than heterosexual boys. Those who were bisexual or mostly heterosexual were intermediate. An interesting finding was that many bisexual boys and girls were more likely to report being a bully at school than the other groups. Could it be defensive bullying? The numbers of bisexual students was very small, and the reasons for the bullying were not explored, so this question cannot be answered. Some authors have speculated that people who are in the process of exploring their identities are in the most vulnerable period of growth, and that they may act in homophobic ways to deflect unwanted attention to themselves until they figure out their identities on their own. Students who had adopted a lesbian or gay identity were much less likely to be bullies themselves, suggesting that they were more secure and accepting of their own identities.

What effect does this homophobic climate at school, and the high risk for bullying have on sexual minority youth? Rivers and Cowie (2006) reported findings of a three year longitudinal study of 190 LGB youth in secondary education in Great Britain and found out that: 50% had contemplated suicide at the time they were being harassed, 40% made an attempt; and 17% had symptoms of post-traumatic stress disorder at the time. Fortunately, the majority did not show drops in their self-esteem, and most of them remained positive about their sexuality, but the bullying affected them profoundly during their school years.

A study in Washington state found that three-fourths of LGBT students said that they avoided parts of the school building or grounds for fear of harassment, two-thirds had difficulty paying attention in class, one out of six had to change schools, and one in six dropped out because of the bullying (Reis, 1999). Yet another study (Birkett, Espelage, & Koenig, 2009) of over 700 7th and 8th graders found that most bullying was directed at youth who were questioning their sexuality. Students in this vulnerable point of development reacted with greater levels of depression, suicide ideation, drug use, and truancy than youth who had already adopted a sexual minority identification.

Clearly, bullying is a problem that must be addressed, because it underlies the power differentials and violence that characterizes so many adults in our culture today, who were never punished, and sometimes were even rewarded, for being bullies in school. The U.S. Department of Health Resources and Services Administration (HRSA) developed a tip sheet on reducing homophobic bullying in schools. This is available for free download from their website: www.stopbullyingnow.hrsa.gov

The Home: Family Acceptance

> *"I can accept my child is transsexual, but if I ever see him in a dress, I'll hit him"*
> *(parent of a transgender adolescent, Wren, 2002)*

Surprisingly there are only a handful of studies that have examined the role of the family in creating or exacerbating mental health problems and other risk factors among sexual minority youth. Eisenberg & Resnick (2006) found that family connectedness, or the perception of youth that they are cared about and able to talk openly with parents, was a significant protective factor against suicide, and was a stronger protective force than having a positive school environment. Obviously, parents and other family members are highly influential in the life of an adolescent. The bully at school is often a relative stranger or acquaintance and we don't expect to be liked by everyone, but parents are supposed to love and protect their children. Rejection by parents hurts a lot more than rejection by the school bullies.

One of the first studies to systematically examine the influence of parental acceptance was done by Caitlin Ryan and her colleagues from the Family Acceptance Project at San Francisco State University. They surveyed 224 LGB young adults, age 21-25, about their experiences with their parents. The study included about half white and half Latino youth, and was evenly split

between men and women. They all came from the San Francisco Bay Area, known to be more LGBT-friendly than most communities, and with more services for LGBT individuals.

Like many other studies of sexual minority youth, this group of individuals had a high rate of health problems, including over 40% with depression. The same number had made a suicide attempt at some point in their lives. Over 25% had contracted a sexually transmitted infection in their lives, over 40% were heavy drinkers in the past six months, over half had used illicit drugs in the past six months, and over half had a negative consequence from their drug or alcohol use. Each participant completed a family rejection behaviors scale with 51 items identified from previous research. Examples of **rejecting behaviors** included:

- Hitting, slapping, physically hurting the child
- Verbal harassment and name-calling
- Excluding the child from family activities
- Blocking access to LGBT friends, events, and resources
- Blaming the child when they are harassed or discriminated against (e.g., saying "you asked for it")
- Pressuring the child to be more masculine or more feminine
- Telling the child God will punish them
- Telling the child the parent is ashamed or them, or brings shame to the family
- Making the child keep their sexuality or gender a family secret

Men reported more family rejection behaviors than women, and there were no differences between White and Latino respondents. Men reported between 21 and 25 rejecting behaviors from their families, and women reported 18-20 rejecting behaviors. But the most important finding of the study is the data on the effect of rejection. Ryan divided the sample into those who experienced little rejection from their families, and those who experienced high levels of rejection. The differences in the reports of health problems were striking.

Risk measure	**Low family rejection**	**High family rejection**
Depression	22%	64%
Suicide attempt, ever	20%	68%
Drug use, past 6 months	42%	72%
Negative consequences from substance use	48%	69%
Unprotected sex, past 6 mos	23%	46%
STI, ever	24%	33%

Children of highly-rejecting parents were over eight times more likely to report making a suicide attempt, and six times more likely to be depressed than adult children of low-rejecting parents, showing the long-lasting effects of family rejection.

Transgender youth may face even greater rejection and concern from their parents, because gender expression is so much more visible than sexual identity. Parents fear what other people might think and worry for their children's safety. Some parents try to change their children via "tough love" methods. In one study of transgender youth (Grossman & D'Augelli, 2008), parents' verbal and physical abuse strongly predicted suicide attempts in their children, supporting Dr. Ryan's data with LGB youth.

Dr. Ryan is now testing an intervention with parents, by showing them this data about depression, suicide, and substance use. The vast majority of parents love their children and do not want harm to come to them. They have a misguided idea that they are helping their children by trying to direct them away from a minority sexual or gender identification. When shown how harmful their rejecting behaviors can be, however, they are often able to make dramatic differences in how they treat their children by reducing their use of rejecting behaviors, and increasing accepting behaviors. Examples of accepting or helpful behaviors that parents can use include:

- Talk openly to your child about their sexual minority identity
- Express affection so the child knows you love him/her
- Support your child's identity even if you feel uncomfortable
- Advocate for your child when society mistreats them
- Bring your child to LGBT events or organizations (like PFLAG)
- Welcome your child's friends and partners to your home
- Support your child's gender presentation

There is a booklet for family members on the Family Acceptance Project website that can be downloaded for your use, or you can order the print versions of the brochure from the website. This would be a good resource to have in any program that serves youth or parents, and is available at: www.familyproject.sfsu.edu

Runaways, Homeless Youth, Out of Home Placement

> *"I ran away a lot because my parents didn't like that I was gay. One time I had a physical fight with my dad and ended up in juvenile hall. Finally I got kicked out*

> *for good and put in foster care." (16 year old gay male, Wilber, Ryan, & Marksamer, 2006)*

Sometimes family rejection leads to running away, and puts the youth at risk for homelessness and all of the risks that accompany living on the street. Research indicates that 20-40% of runaway, homeless youth identify as sexual minorities (Ray, 2006). The paths into state care for sexual minority youth can include all the same reasons that put heterosexual youth at risk (such as dysfunctional, abusive, or absent parents), plus:

- Rejection by families after coming out;
- Illegal conduct (truancy, substance use) stemming from stress of sexuality or gender;
- School harassment leading to truancy or being expelled from school because of sexuality or gender (the sexual minority youth is blamed for disrupting the school climate);
- Being mislabeled as a sex offender (when parents file charges so that their child appears as a victim rather than a willing partner in a same-sex relationship).

Ryan and Diaz (2005) found that 42% of youth in out-of-home placements had been removed or ejected from their homes because of their sexual or gender identity. But there is no guarantee that the foster parents will be accepting of the adolescent's sexuality of gender. One study found that 78% of LGBT youth were removed from or ran away from their out-of-home placements because of hostility over their sexuality and gender. There are reports of sexual assault by staff members at group homes, as well as verbal and physical harassment by staff and other residents. In New York City, 56% of lesbian and gay youth in the child welfare system said they felt safer on the street than in foster homes or group residential settings (Mallon, 1999).

> *"A transgender youth was repeatedly beaten by boys in her group home. When she reported the abuse to her social worker, the social worker said, 'It's your own fault. Stop acting like a girl.'" (Wilber, Ryan, & Marksamer, 2006)*

Laws are slowing changing to add protections for youth in state care (Wilber, Ryan, & Marksamer, 2006). For example:

- A 2003 court case (Doe v. Bell) was decided in favor of a young transgender woman to be able to wear female attire in the all boy's group home in which she had been placed by the state.
- Also in 2003, California passed the first state law of its kind that banned discrimination on the basis of sexual orientation and gender identity in the foster care system.
- In 2005, the Kansas Supreme Court struck down a state statute that imposed harsher punishment for consensual sexual conduct between same-sex youth than between other-sex couples (State v. Limon).

- In 2006, Hawaii challenged the treatment of LGBT youth in correctional systems and banned the common practice of isolating LGBT youth "for their own protection," citing that the practice violated the due process rights of youth.

Coercion of Sexual Minority Youth into Treatment

> *"My parents tell me that there is something psychologically wrong with me…I'm a big screw-up to them, who isn't on the path God wants me to be on. So I'm sitting here in tears…and I can't help it." (16 year old gay male youth forced by his parents to attend an ex-gay program for teens)*

In February of 2006, a blog from a teen in Tennessee set off a national debate about sexual minority youth's rights. DJ Butler, 17 years old, reported that his parents drove him to a religion-based ex-gay program in hand-cuffs. Until the early 2000s, the ex-gay movement mostly targeted adults, who went voluntarily into ex-gay programs, but now, there is much more focus on recruiting among parents to bring their children, who often do not willing enter these programs (Cionciotto & Cahill, 2009). Is it reasonable for parents to coerce their children into programs to "cure" them of their minority sexual identifications? Can people change? These programs are called "reparative" or conversion therapy. Some are based on religion and involve mostly prayer and Bible study; others are more like psychotherapy, but are not based on research. Instead of research findings, these "therapies" are based on stereotypes and folk myths about LGBT people.

A study of 202 adults who had participated (willingly) in ex-gay programs (Shidlo & Schroeder, 2002), found that only eight felt that they had really changed their sexual orientation (and seven of those were currently ex-gay counselors who might have been invested in "proving" they had changed). Of the rest, many reported long-term harm from their participation in the programs, including harm in three areas:

1. **Psychological harm**. Participants reported high rates of depression and suicide attempts, low self-esteem, and sexual dysfunctions during and immediately after participating in these programs. Some people had been subjected to aversive conditioning, which paired electric shock or induced vomiting with sexualized images—those people reported having a very difficult time with those memories.

2. **Social and interpersonal harm**. These programs damaged relationships. Some people were told to cut off all their LGBT friends and lovers, eliminating their social networks. Others were coerced into treatment by parents and other family members, damaging those relationships. And in some cases, the therapists at these programs put the blame for the individual's sexual orientation on parenting skills, also affecting family-of-origin relationships.

3. **Spiritual harm**. 66% of the sample considered themselves to be religious, and reported that the failure of the programs to change their sexual desires led to a loss of faith, a sense of betrayal by their religions, and sometimes ex-communication from their churches.

The state of Tennessee investigated the residential program that D.J. Butler was sent to, but did not charge the program with any wrong-doing. Some researchers called this a form of child abuse whereas others said that parents have a right to influence their children. What do you think? At what age should youth have the right to refuse treatment?

ADVERSE CONSEQUENCES OF STIGMA

Stigma experiences take a toll on most sexual minority youth and adults, although the majority are resilient and have only temporary adverse consequences, usually around the time of coming out or transitioning. A subset of sexual minority youth will have serious adverse consequences such as substance abuse, mental health disorders, sexually transmitted infections, pregnancy, violence, and/or suicide ideation or attempts. These are summarized in this section.

Substance Use and Abuse

Almost every study that gathers information on drug and alcohol use finds higher rates of use, and more negative consequences from substance use among LGBT individuals. Many people use substances to reduce stress, but LGBT individuals also may be more likely to use substances to:

- **Allay fears about rejection from potential romantic/sexual partners**. Alcohol can be an excuse—"I was drunk and didn't know what I was doing."

- **Reduce anxiety about sexual performance**. LGBT people don't learn about same-sex dating "rules" so may feel more nervous, and in addition, have to overcome socialization from religion, parents, and peers that denounce same-sex behaviors.

- **Seek acceptance and a sense of belonging**. One of the few social institutions that are totally accepting of LGBT people are gay bars. When people congregate often in gay bars, they are provided with opportunities to drink and use drugs (and smoke). If youth meet most of their friends and partners in bars, they are more likely to encounter drinkers or users than if they meet people in other venues, leading to social networks that revolve around substance use.

Alcohol Use

Ziyadeh et al. (2006) studied nearly 10,000 school-aged youth and the relationship between sexual identity and alcohol use. The chart below shows the differences in alcohol use by sexual identity label.

	Girl's Sex Identity	Girl's Alcohol Use Past Month	Girl's Binge Drinking Past Year	Boy's Sex Identity	Boy's Alcohol Use Past Month	Boy's Binge Drinking Past Year
Heterosexual	88%	16%	13%	88%	15%	14%
Mostly Heterosexual	6%	37%	35%	3%	23%	26%
Lesbian, Gay or Bisexual	1%	52%	44%	1%	27%	30%

Many studies have found greater differences between sexual minority and heterosexual girls on drinking measures, and smaller or no differences between sexual minority and heterosexual boys. This may be because boys tend to drink more than girls in general, and even among studies of adults, young adult men drink at higher rates than women, regardless of sexual identity. However, there are differences in rates and types of illicit drug use among men by sexual identity. Several studies have found higher rates of drinking and drug use among respondents who are "mostly heterosexual" or bisexual, than among gay and lesbian respondents.

Marshal et al. (2009) studied nearly 11,000 youth from the National Longitudinal Study of Adolescent Health, a project that followed youth from about 7th grade into young adulthood. They found that sexual minority youth entered the study with higher levels of drinking than heterosexual youth, suggesting an earlier age of onset of drinking, and also found that sexual minority youth increased their drinking at a faster rate than heterosexuals over the adolescent years. This pattern was also found in youth who were "mostly heterosexual."

Few studies have examined the effects of racial/ethnic minority and sexual/gender minority identity on youth drinking. Balsam et al. (2004) compared Native American youth from New York City, two spirit compared to heterosexual, on rates of alcohol problems. The two spirit youth reported starting drinking at an earlier age (12.6) than heterosexual youth (14.7) and were more likely to report that they drank to manage their mood or relieve tension. Two spirit youth also reported higher rates of marijuana use (96%) than heterosexual youth (84%) as well

as use of other illicit drugs (sexual minority youth: 78% and heterosexual youth: 56%). A study of Asian/Pacific Islander youth (Hahm, Wong, et al, 2008) found that API sexual minority youth did not show increases in drinking, drug use, and smoking in high school, but did have higher rates of all of these than heterosexual API youth in young adulthood. This is consistent with the data that API youth come out at later ages.

Drug Use

Data about general population rates of drug use in youth comes from the school-based surveys and general population community-based studies that have included questions about sexuality. Thus far, none of them have sufficient questions about gender to be able to identify transgender students. The Growing Up Today study (Corliss et al., 2010) findings are summarized below for girls and boys separately.

For Girls:

Sexual Identity	Marijuana	Any Other Illegal Drug	Misuse of Prescription Drugs
Completely Heterosexual	19%	4%	6%
Mostly Heterosexual	43%	18%	17%
Bisexual	60%	31%	28%
Lesbian	50%	21%	17%

For Boys:

Sexual Identity	Marijuana	Any Other Illegal Drug	Misuse of Prescription Drugs
Completely Heterosexual	21%	6%	6%
Mostly Heterosexual	42%	15%	11%
Bisexual	39%	20%	16%
Gay	32%	13%	13%

For both boys and girls, the mostly heterosexual and bisexual groups show the greatest use of drugs, but all three sexual minority groups reported more drug use than heterosexual youth. Clinical populations of youth, the type that are more often seen in substance abuse treatment settings and the criminal justice system, not surprisingly have even higher rates of drug use. A

study of homeless LGB youth in Portland, Oregon (Noell & Ochs, 2001) found these lifetime rates:

Drug	Gay/Bi Male	Hetero Male	Les/Bi Female	Hetero Female
Injection drug use	43%	39%	40%	24%
Amphetamines	61%	70%	84%	62%
Marijuana	93%	97%	99%	91%
Inhalants	48%	44%	53%	39%
Cocaine	39%	46%	44%	37%
Barbiturates/sedatives	25%	20%	20%	19%
LSD	75%	72%	25%	28%

As with alcohol, there are more differences among girls by sexual identities than there are for boys. Some people think that sexual minority females are at low risk for HIV, but considering the high rates of injection drug use among the lesbian and bisexual women in this sample, it is clear that many do engage in risky behaviors.

Smoking

Nearly every study of youth that measured current and lifetime smoking found higher rates among sexual minority youth than heterosexual youth (Remafedi et al, 2008). The Growing Up Today Study (Austin et al, 2004) of over 10,000 youth found that among girls, those who were "mostly heterosexual" were 2.5 times more likely than heterosexual girls to smoke, and those who were lesbian or bisexual were 9.7 times more likely to smoke. For boys, the "mostly heterosexual" were also 2.5 times more likely to smoke than heterosexual boys, but the gay/bisexual boys had the same smoking rate as the heterosexual boys. One study of young urban sexual minority women (Herrick, Matthews, & Garofalo, 2010) found that 54% were current smokers. Smoking rates among sexual minority youth are among the highest of any subset of the population.

Tobacco and alcohol companies often target LGBT communities with free give-aways in bars, targeted advertising, and sponsorship of LGBT community events. The targeted advertising is particularly effective for youth early in the coming out process. In our culture, it is rare to see depictions of healthy sexual minority youth in the media, so when youth do see those images in ads, they are more likely to identify with those products, than are youth who regularly see themselves reflected in the media (Penaloza, 1996).

Mental Health Disorders/Symptoms

A number of studies have found higher rates of the types of mental disorder that are affected by stress—depression and anxiety—among sexual minority youth and adults, typically at about double the rates of these disorders in the general population of youth. Disorders that appear to have a stronger biological origin, such as schizophrenia and bipolar disorder, are found at the same rates in sexual minorities as heterosexuals.

The Healthy Young Men's Study (Kipke et al, 2007) of 526 men aged 18 to 24, who have sex with men found no differences in rates of depression by racial/ethnic group. African American, Latino, and White young men all had rates of current depression of about 20%. One study (McDermott, Roen, & Scoufield, 2008) reported that feelings of shame caused considerable distress for sexual minority youth, and led to self-destructive behaviors in many, including alcohol abuse and suicide attempts. Shame associated with the stigma of sexual and gender minority identifications may be one of the underlying causes of mental health problems.

Another factor that underlies mental health problems are perceived and actual experiences of discrimination, harassment, or violence (Almeida et al, 2009). The more experiences a person has or witnesses in others, the higher the level of distress or depression they tend to report.

Suicide Ideation and Attempts

Suicide is the third leading cause of death for people age 10-24 in the United States (CDC, 2009), and almost every study comparing youth by sexual orientation finds differences in rates of suicide ideation and attempts. Most attempted suicides among LGBT individuals occur during the adolescent or young adult years, and then the rates diminish after that to similar to the general population. The Healthy Young Men's Study found no differences in suicide ideation or suicide attempts in young men by racial and ethnic group.

Studies of suicide attempts report rates between 30 and 50% for LGBT people, compared to a rate of 5-8% in the general population (SPRC, 2008). In the few studies that try to ascertain whether these are serious attempts to end one's life, or "cries for help," several of the studies find that LGB respondents indicate that they were serious attempts, using lethal means (Remafedi et al, 1999; Rosario et al, 2005).

Studies of suicide ideation, or "thoughts of engaging in suicide-related behavior" also find higher rates among sexual minority individuals. In the general population of youth, about 15% report that they have had serious thoughts about suicide. In comparison, studies of sexual minority youth find rates of 30 to 70%. The highest rates of both suicide ideation and attempts occur during the early coming out process, at the time when an individual is thinking about disclosing to others and fears rejection and other negative consequences. Feelings of shame, guilt, and doubt are the highest early in the coming out or transitioning process, when youth have not yet "unlearned" the negative stereotypes.

Most studies only report the rates of suicide ideation and attempts, and only a few have suggested what the risk and protective factors might be. These include:

- **Family**. Recall the Family Acceptance Study that found family rejecting behaviors to be a high predictor of suicide attempts; another risk factor is having a close family member who attempted or completed suicide, and physical and sexual abuse in the family.

- **Peer Group**. Students who are victimized or bullied by peers are at higher risk. Students who are gender-non-conforming appear to be at higher risk for victimization, and thus, suicide, than those who are more gender conforming.

- **School**. Safety issues and perceiving that at least one adult at school cares are protective, whereas feeling unsafe and uncared for are risk factors.

- **Minority Stress**. All of the factors above can constitute external risk factors, which if combined with internalized oppression, can result in depression, anxiety, and substance abuse, which all increase the risk of a suicide attempt.

- **Gender Nonconformity**. Several studies have found that youth who do not fit typical societal expectations for their sex/gender are often targeted for bullying, and elicit more negative reactions from teachers and parents than youth who are gender typical. These factors may increase the risk for suicide (Ploderl & Fartacek, 2007).

The Trevor Project is a suicide hotline for sexual minority youth. Youth can access it via the internet: www.thetrevorproject.org or via a 24 hour helpline: 1-866-4-U-TREVOR.

Sexual Consequences: Sexually Transmitted Infections, HIV/AIDS, and Pregnancy

Most schools today do not provide comprehensive sexuality education. Instead, they rely on an abstinence only approach which basically tells students not to have sex until they either are adults or get married. The end result is that many adolescents will become sexually active without critical knowledge needed to protect their health, putting them at greater risk for sexually transmitted infections, HIV/AIDS, and unwanted pregnancies.

Adolescents and young adults have one-third of all new sexually transmitted infections in the U.S. (CDC, 2009). This is one area where there are racial/ethnic differences in sexual minority youth, with youth of color at significantly higher risk for getting a sexually transmitted infection and HIV. The reason for this has to do with lack of educational and other health care resources in communities of color to encourage condom use and other safer sex practices. The Healthy Young Men's Study (Kipke et al, 2007) found these racial ethnic differences in the rates of sexually transmitted infections and HIV, as noted below.

	African American	Latino	White
Lifetime rate of any STI	33%	17%	29%
HIV positive	6%	2%	2%
Of HIV positive, % who had difficulty accessing medical care	40%	25%	33%

A study of young urban women who have sex with women (Herrick, et al., 2010) found that 26% reported they had had anal intercourse with men, and this and other studies found a 2-10 times higher rate of pregnancy among sexual minority youth (Saewyc et al, 2008). It is understandable that bisexual and "mostly heterosexual" youth who report both same-sex and other-sex partners might report higher pregnancy rates, but even those who identify as lesbian or gay are at higher risk of pregnancy than heterosexual youth because of at least three reasons:

- They are more likely to run away and be forced to engage in survival sex work and/or be sexually abused in shelters or on the street;
- They report higher rates of sexual abuse experiences and coerced sex in adolescence. Sometimes this is punishment for their perceived sexuality;
- They are more likely to experiment with sex while trying to figure out if they are gay or lesbian.

In one school-based study (Saewyc et al, 2008) the researchers reported these rates of pregnancy by sexual identity.

Sexual Identity	% Males who Caused a Pregnancy	% Females who Experienced a Pregnancy
Heterosexual	1.2%	1.2%
Gay	5.7%	3.4%
Bisexual	7.4%	4.9%

Even among homeless, runaway, street-involved youth, the sexual minority youth report that they are more likely than heterosexual youth to engage in survival sex work, and were more likely to report inconsistent condom use and a greater number of clients (Marshall, et al, 2009). A good resource for young men who have sex with men is this fact sheet from the CDC:

http://www.cdc.gov/HealthyYouth/sexualbehaviors/pdf/hiv_factsheet_ymsm.pdf

Violence/Victimization

> *"On June 17, 2001, Fred Martinez Jr., an openly two-spirit Navajo youth, was bludgeoned to death by a White male in Cortez, Colorado. Navajo locals claimed this was another example of over three decades of race-motivated homicidal hate crimes in which Navajo youths are targeted to be murdered as a rite of passage for white youths. Gay activists raised concerns that this hate crime was…motivated by bias based on gender (transphobia) and sexual orientation (homophobia) (Balsam et al., 2004).*

We have already talked about some of the victimization that occurs in school and in families, but sexual minority youth are also more prone to be victims of violence in public places, committed by strangers or acquaintances. As the case of Fred Martinez points out, sometimes it is difficult to know whether the violence is motivated by racism, sexism, negative attitudes about sexual and gender minority individuals, or some combination of factors. This victimization can occur on the streets, in nightclubs, in police stations, homeless shelters, substance abuse treatment programs, mental health facilities, and even in supportive peer self-help programs like Alcoholics Anonymous and Narcotics Anonymous.

In one study (Poteat, et al., 2009), it was the young men who were questioning their sexuality who experienced the highest number of victimization experiences, followed by the questioning females. Lesbian, gay, and bisexual youth reported considerably more victimization experiences than heterosexual youth.

Transgender Youth Risks

Transgender youth may have some risk factors that are different from other sexual minority youth, and some that are the same. The shared experiences of stigma mean that transgender youth are subject to all of the risk factors listed above, but they might be even more likely to appear in transgender youth who are more likely to have visible differences. Hate crimes against trans youth and adults tends to be even more prevalent and severe than violence against lesbian, gay, and bisexual people.

Substance Use

A study of ethnic minority trans women (MTF) age 16-25 from Chicago (Garofalo et al, 2006) reported very high rates of past year substance use:

- Marijuana 71%
- Alcohol 65%
- Cocaine 21%
- MDMA 23%
- Hormones 61% (unique to transgender youth)
- Injected silicone 29% (unique to transgender youth)

When youth cannot access medical care for their transition, they may obtain hormones on the street, and not have information about appropriate dosages. The hormones might also be cut with other substances and impure. It is very important for treatment providers to help trans youth find educated health care professionals to guide them in hormone use. There is a mistaken idea among some trans people that taking higher dosages of estrogen (or testosterone) will speed up the transition or have greater effects, but higher dosages do not affect transition and can have serious adverse health effects.

In regards to injected silicone, some transgender individuals inject oils or silicone into their faces, breasts, or hips to get more "feminine" curves and appear more womanly. This is a dangerous practice—if the oil or silicone gets into the bloodstream, it can be fatal. The person can get serious infections at the injection site, and the oil/silicone will eventually sink to the feet as gravity intervenes. If the person shares needles for the practice, there is also the risk of spreading HIV and some forms of hepatitis. For transgender women living on the street, being able to pass as a woman is critical to survival.

Most of the studies of transgender individuals have focused on street outreach recruitment, and find that this group of homeless or marginally housed individuals often must turn to sex work to survive. Transgender women often have difficulty finding legitimate employment, so sex and drug trade work are the only options available to them. These are dangerous lifestyles in many ways.

Some studies find very high rates of HIV/AIDS in transgender street populations, especially transgender African American and Latina women (Nuttbrock et al, 2009). For transgender youth, lack of education and financial need combine to produce deadly results. Sex workers are also more prone to violence and victimization than people who are not sex workers. Transgender youth also have very high rates of suicide ideation (up to 80%) and lifetime suicide attempts (30-50%) (Clement-Nolle et al, 2006; Dean et al, 2000; Kenagy, 2005). They are also even more likely than other sexual minority youth to be homeless. One study of transgender street-involved youth in Chicago and Los Angeles found that 19% of the young trans women were HIV positive. As one respondent in that study said: *"we are exposed due to sex trade,*

usually with married men. Trans girls, particularly the young ones, have no idea of the risk of turning tricks—people offer more money not to use condoms"

Protective Factors

It is easy to get caught up in the risk factors, but we will end this section on the positive note. In order to reduce the risks for sexual minority youth, we could put some of our efforts into bolstering the protective factors. To review, those include:

School Factors:

- Having at least one supportive adult who cares
- Having a Gay-Straight Alliance or other support group or system at school
- Having anti-bullying education and a school committed to intervening with bullies
- Having a Safe Zone or similar training program to educate staff members about sexual minority youth issues

Family Factors:

- Freedom from family violence/abuse
- Acceptance by at least one trusted family member
- Feeling loved

Community Factors:

- Having resources for sexual minority youth
- Having inclusive and welcoming services for all youth at all community services and events
- Having a community norm of inclusion
- Being accepted and feeling included in a formal religion (spiritual and social support)

- Having a personal sense of spirituality/meaning in life

RECOMMENDATIONS

We will discuss four types of interventions that can be initiated to make agencies that serve youth more effective in working with sexual minority youth. The four types of interventions include:

- Agency level changes to make the climate more welcoming and inclusive
- Making forms and language inclusive
- Individual level changes via training and education of staff members
- Interventions for schools, peers, and families

Agency Level: Welcoming and Inclusive Environments

Sometimes it is helpful to ask a sexual minority youth or young adult to do a "walk-through" of your agency and help you spot the potential problem areas. Because of heterosexism, most of us take for granted that our climate is welcoming and do not see the examples of exclusion.

A client in an agency gets impressions of the climate even before they walk in the door. Here are some questions to ask about your agency, institution, or practice:

Advertisement of your services/Outreach activities

- Would a sexual minority youth have seen an ad or flyer for your services or know of your existence? Do you advertise or do outreach in any venues where they might be found?
- If you advertise or do outreach, are the materials inclusive of sexual minority youth? Would they read the brochure or flyer and say, "Yes, they know I exist."

Intake: Coming in the door to your services

- When a client walks in the door, are there signs of inclusion and welcoming? Those signs include the types of posters on the wall, the brochures in the rack, the type of

magazines or newspapers in the reception area, the language used by the reception person and the forms. Some agencies post their client rights statement in the reception area, stating that they do not discriminate on the basis of sexual orientation or gender identity.

- Do clients see themselves reflected in the faces of the staff members? Do the staff represent the communities served: by racial/ethnic group, approximate age, class status, genders, language, and by sexual/gender identities?

- Does the oral history-taking session or intake include places where a person is encouraged to disclose their sexuality, gender, or relationships, if they so choose? One former client reported that during the history taking portion of her admission to a mental health facility, the physician said, "You aren't gay, are you?" More typically, however, there are no questions about sexuality or gender identity.

- Are the reception or intake counselors skilled in confidentiality issues—do they ask clients if it is ok to record information about sexuality and gender on their official records? If the clients are minors, do they have discussions about confidentiality of discussions in treatment groups or individual sessions? Do they have discussions with youth about confidentiality related to parents?

There may be challenges to making agency/institutional level changes. For example,

A member of your board of directors is a devout Catholic, and is raising questions about the growing number of openly LGBT youth that your agency serves. He believes that the agency should focus on "youth who deserve services" and refer the sexual minority youth to other local resources. He is beginning to get support on board and community. How do you address this challenge?

Treatment Groups or Individual Therapies

- Do staff members intervene when other group members make derogatory comments about sexual minority youth? Do the counselors know how to respond when sexual minority youth talk about issues related to their sexuality or gender?

- Do staff members respect the name and pronoun choices of clients? If clients have adopted names other than their birth names, those should be honored. There is no reason that agencies must use "legal" names in treatment, even if they must be recorded on official records.

Residential or Hospital Inpatient Program Climate

- How are youth assigned to rooms? Is there any consideration of possible problems in roommate assignments? This issue is particularly critical with transgender clients who are early in transition. Safety needs to be the first consideration, but decisions need to be made with the client, not for the client.

- Are recreational activities "gendered?" That is, are boys expected to go to football games and girls to the mall, etc? Are there choices in activities and leisure activities, and no judgment placed on selection of activities?

- How are group dynamics monitored when residents are not in treatment groups or therapy? Who intervenes if derogatory remarks or harassment occurs in the evening?

  "Sam is an 18 year old, born female, but taking testosterone and asking to be called "he." You have a coed treatment program, but the residential unit is divided into a boy's wing and a girl's wing. What factors would you consider in the decision about where to place Sam?"

Aftercare Planning

It may be a challenge to find clean and sober support or mental health recovery support—mentors, sponsors, and support groups for sexual minority youth because substance use is so widespread in LGBT communities. And AA/NA and other support for recovery may not be welcoming of sexual minority youth in some communities. Resources for mental health support, such as NAMI (National Alliance on Mental Illness) may or may not be receptive to having openly LGBT members.

> *Alex, a 17 year old bisexual male youth, attended a Narcotics Anonymous meeting that is held every Wednesday night at your agency. He was told by the group facilitator and his sponsor, that NA was not the place to talk about his sexuality—that he should leave that "at the door," and focus on his drug use. Alex reports to you that he felt disrespected and made invisible. How would you respond to him?*

Forming linkages with local LGBT communities may be helpful. Recruit LGBT staff members, board of director's members, and consultants from the community who can help you identify those aftercare support systems, as well as run groups in treatment or help you with outreach to LGBT communities. If youth return to schools, find out if they have a GSA. PFLAG is another resource in many communities.

Forms and Language

The words used on forms and in oral communication are very important, and convey strong messages to sexual minority clients about inclusivity and respect. Examples of language include all the written documents and forms (intake forms, consent forms, client handbooks, client rights statements, etc) as well the type of language used to refer to individuals and communities.

Some examples of making language more inclusive include:

Typical term/phrase	**Inclusive language**
Spouse, husband, wife	Spouses and partners, significant others
Boyfriend, girlfriend	Significant other, romantic relationships
Marriage	Marriage, civil unions, and domestic partnerships; committed relationships
Male or female	Male, female, transgender, intersex, other
Sexual intercourse	Vaginal sex, oral sex, anal sex, etc. (be specific)
"Are you sexually active?"	"Are you sexually active with women, men, or both?" (and if the answer is yes, follow up with questions about specific sexual activities)
"Do you have a boyfriend?" (to girls) or "Do you have a girlfriend?" (to boys)	Are you romantically involved with anyone at this time? If yes, tell me about him or her.

Language in agency policies and procedures should also acknowledge sexual minority individuals. Do your human rights, nondiscrimination, or patient rights statements explicitly state that you do not discriminate in hiring, retention, admissions, or treatment access on the basis of sexual orientation or gender identity? Does your sexual harassment policy include harassment on the basis of sexual orientation and gender identity? What about employee benefit policies? Do they include domestic partners? If you have family programs, are the policies written with broad definitions of family that will include LGBT people's partners and families?

> *A 58 year old female staff member at your agency belongs to a very conservative religious group, and often asks her clients to pray with her during treatment group sessions. She recently asked a group to pray for the redemption of the soul of a gay male client. How would your agency handle a situation like this? How can personal religious beliefs be respected while at the same time requiring that religion be removed from the workplace?*

Training and Professional Conduct

Everyone who works in an agency needs basic cultural sensitivity training, including LGBT training, from the reception staff to the housekeepers, cooks, frontline counselors, and executive directors. Beyond just training, all staff members in service agencies need to behave in professional ways. Many youth have encountered well-intentioned, but damaging comments such as "You are too young to know for sure," or "This is just a phase you are going through." These comments are dismissive of the serious soul-searching that most sexual minority youth have been through before telling anyone else of their sexual or gender identity. In addition, far too many sexual minority youth and adults have experienced unprofessional treatment, such as counselors telling them they need to turn to religion to be cured, or seek psychological treatment to change their sexual orientation or gender identity. All professional organizations from the American Medical Association, American Psychiatric Association, American Psychological Association, National Association of Social Workers, and others, have denounced reparative therapies as unethical and potentially very harmful to clients. The professional work environment must separate church and state, and all staff members need to learn how to deal with all kinds of client identities and behaviors that go against their own personal beliefs.

An example of how a professional ethics code might include sexual orientation and gender identity is this one from the National Association of Social Workers:

> *"Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability."*

Interventions in the Community

There are many things that you can do to start including sexual minority youth into the agency, institution, or practice, and in your larger community. You can work with the local schools to start or support a GSA (gay-straight alliance), support anti-bullying policies, and support comprehensive sexuality education. You can work with families to start a PFLAG chapter or get involved with an existing one, for example, offer your agency for meetings of the group. You can download the brochure from the Family Acceptance Project, keep copies in your brochure rack, and use them in family groups and education. Your agency, institution, or practice can diversify definitions of family groups…include families in youth treatment, respect youth confidentiality, but also recognize that family for sexual minority youth, might be broader than just biological or legal parents.

You can make changes in your own agency, such as start a sexuality and gender discussion group for clients and families—this might be beneficial for many clients—those who have LGBT or other sexual minority family members and friends, as well as sexual minority clients themselves. Topics of the discussion groups might include many of the same topics covered in this training:

- What is sex?
- What is gender?
- What is sexual orientation or identity?
- What are the risks and benefits of sexual relationships?
- Why do people have sex (a recent article reported well over 100 reasons that college students provided for having sex)?
- Why are many people opposed to same-sex relationships? Where does the opposition come from?

You can also consider your treatment modalities—almost all forms of treatment can be made LGBT-inclusive with a little change in language and openness to discussion about the role of sexuality and gender in initiation and maintenance of substance use. For example,

- **12-step Facilitation**. Consider the role of sexuality and gender in creating the stress or stigma that impacted the initiation or maintenance of substance use. Allow clients to talk about these factors—recognizing the role of external circumstances may be helpful in reducing internalized oppression. There are also LGBT-specific AA and NA groups in many parts of the country. If there is one in your community, offer space in your agency for meetings. If there isn't one, start one with the help of an LGBT community member in recovery, or offer sexual minority youth web-based resources for online support (e.g.: http://www.gayalcoholics.com/aa-meetings.html).
- **Cognitive Behavioral**: This modality focuses on thoughts and how changing thoughts can change behaviors. Some clients may have thoughts of low self-worth and shame and guilt because of their sexual feelings or their gender differences. Helping them transform their thoughts into healing and acceptance may help reduce risky behaviors. Internalized oppression does not underlie all substance use in sexual minority clients, but it is a major factor for some.

For individual therapies, you can use the model of stages of coming out, as described by Vivienne Cass as a very rough guideline to understand what youth might be going through, or you can use a broader framework of common experiences or processes that might be involved in developing a sexual identity. This broader framework (from Eliason & Schope, 2007) works for all youth, regardless of what identity labels they use or don't use. The common experiences of developing a sexual or gender identity include such reactions/experiences as:

1. **Feeling Different**. Any child/adolescent who feels different from others may experience a sense of loneliness and alienation. Feeling different can stem from sexual abuse, from feeling that one does not "fit in," having same-sex attractions, or feeling different according to gender stereotypes, among others.

2. **Feeling Confused**. After our review of the components of sexual orientation and gender, some of you might feel confused! It is not easy to figure out all of these issues. Many youth are baffled by emerging new feelings. Comprehensive sexuality education at school would help, but if it is not available in your community, community health and human service agencies can create space for youth to talk openly about sexuality and gender and feel comfortable asking questions, rather than internalizing their confusion as shame and guilt.

3. **Identity Exploration**. Youth might try out identities and behaviors in an attempt to find themselves. Some forms of exploration are safer than others—reading about sexual orientation on an education website is much safer than having anal sex in the back room of a bar. Schools and community agencies can strive to create safer options for exploration for all youth via support groups, educational outreach, written materials, films, etc.

   > *Eric comes from a Vietnamese family. He got involved in gang activity last year, and was court-ordered to your treatment program from juvenile justice for possession and dealing of marijuana. As he becomes more comfortable with his counselor, he reveals that he is attracted to men, but does not know how to figure out his sexuality, or how to proceed with dating men. He is very shy and reserved, and at 17, has never been on a date of any kind. He is afraid to go to gay bars, and afraid to talk to his family about it. What would you suggest to him? What issues would you build into his treatment plan?*

4. **Disclosure**. Once youth decide that they are different and adopt a label for their sexuality or gender, they face the difficulties of disclosure. As professionals, we can take some of the stress out of disclosing to us by providing lots of opportunity for nonjudgmental disclosure. If the written forms have a box to check that fits the youth's identity, they may feel safer to fully disclose. In taking histories, we can ask questions about sexuality and gender, opening the door to disclosures. We can also respect their confidentiality and make sure that we ask them whether it is ok to talk to their parents about sexuality and gender. Heterosexual youth may also face difficult disclosures, such as telling parents they are pregnant or have a sexually transmitted infection, or need birth control.

5. **Labeling**. Sexual identities are quirky and highly individual, and no one should label another person's sexuality or gender. Allow clients to use the labels of their own choosing, as well as pronouns and names of their own choosing. Because the labels have different meanings, ask youth to explain what the label means to them. If a youth comes out, acknowledge it, even if you simply say, "Thank you for telling me."

Tamika, a 16 year old African American youth in your residential program for the past month, has often spoken about her boyfriend in groups. Today, in a discussion of relationships, she says that she is thinking of leaving the boyfriend because she is really attracted to a friend at school and thinks it will be a more healthy relationship. Other group members are shocked when she reveals that the friend is a girl. One of the other girls says, "You have no business talking about that stuff in here." How do you respond?

6. **Distrust of the Oppressor**. For those youth who have experienced anti-LGBT harassment, racism, sexism, ageism, or other forms of oppression, they may have a healthy distrust of the "system." Keep that in mind when working with youth, and earn their trust. Do not take it personally if they are suspicious at first.

7. **Internalized Stigma**. Almost everyone who grows up in our culture has absorbed some of the negative stereotypes about oppressed minority groups, including sexual minority youth who may have internalized the negativity into shame and guilt-based feelings. We all need to have education about the history and roots of racism, sexism, heterosexism, and gender normativity so that we avoid victim blaming. Helping youth to meet healthy role models from adult LGBT communities is a great start in reducing internalized stigma.

8. **Managing Stigma**. All people from oppressed minority groups have to learn to manage or cope with the stigma, because they will experience prejudiced people and unfair policies and settings on a regular basis. For some sexual minority youth, that will mean not revealing their sexuality or gender differences in public. For others, it means learning ways to be open and honest without having other people's ignorance or prejudices affect their well-being.

OTHER RESOURCES

This final section reviews some of the resources that might be helpful to you and your agency, institution, practice, or community. These websites list where you can find sexual minority youth services, have brochures, fact sheets, or other written materials you can use in your program, or are sources you can send sexual minority youth to for more information. These are just a sample of the web-based resources available today.

- **GLSEN: Gay, Lesbian, Straight Education Network** (www.glsen.org) In 1990, the Gay and Lesbian Independent School Teachers Network (GLSTN) was created as a volunteer group of 70 gay and lesbian educators. At that time, there were only two Gay-Straight Alliances (GSAs) in the U.S., and only one state with policy protecting lesbian, gay, bisexual and transgender (LGBT) students, and few resources for teachers or sexual minority youth. Soon chapters began to form across the country. GLSTN became a national organization in 1995 and in 1997, changed its name to the Gay, Lesbian and Straight Education Network, or GLSEN. Currently, GLSEN has registered more than

4,000 GSAs. GLSEN sponsors the *National Day of Silence* in which hundreds of thousands of students, teachers, and staff have participated at thousands of school campuses across the country. GLSEN also sponsors another annual event: *No Name Calling Week*, an event geared toward educating middle school students about the negative impact of bullying and harassment. GLSEN's website contains information about how to start a GSA as well as many resources for teachers and sexual minority youth.

- **PFLAG: Parents and Friends of Lesbians and Gays** (www.pflag.org). PFLAG began in 1972 when Jeanne Manford marched with her gay son in New York's Pride Day parade. After many subsequent requests from gay and lesbian people to talk to their parents, she decided to begin a support group. The first meeting of about 20 people took place in March 1973. In the next few years, similar groups sprang up around the country, offering support for parents with gay and lesbian children. By 1980, PFLAG, known as Parents FLAG, began to establish itself as a source of information for the general public as well as support for parents and family. In 1981, first national PFLAG office was established in Los Angeles. Also in the 1980's, PFLAG opposed Anita Bryant's anti-gay crusade and worked to end the U.S. military's efforts to discharge lesbians—more than a decade before military issues gained national attention. In 1990, PFLAG employed an Executive Director, and moved to Washington, DC. In the early 1990s, PFLAG chapters in Massachusetts helped pass the first Safe Schools legislation in the country, added the word "Families" to the name, and added bisexual people to its mission and work. By the mid-1990s a PFLAG family was responsible for the Department of Education's ruling that Title 9 also protected gay and lesbian students from harassment based on sexual orientation. In 1998, PFLAG added transgender people to its mission. Currently, PFLAG has programs such as **Safe Schools for All**, a **Scholarship Program**, a **Diversity Network**, **Bringing the Message Home**, and **Welcoming Faith Communities**.

- **FAP: Family Acceptance Project** (http://familyproject.sfsu.edu/overview). This website contains a very useful brochure/booklet for parents of sexual minority youth. This booklet could be used in treatment programs, schools, or prevention programs.

- **HRSA Anti-bullying Tip Sheet/Information.** (http://www.stopbullyingnow.hrsa.gov/adults/tip-sheets/tip-sheet-33.aspx). This fact sheet would be useful for schools and other agencies that deal with groups of youth.

- **The Trevor Project** (www.trevorproject.org). This group provides a crisis line and online information aimed at preventing suicide among sexual minority youth. The Trevor Project was founded by the creators of the 1994 Academy Award®-winning short film, *Trevor*, a comedy/drama about a gay 13-year-old boy who, when rejected by friends because of his sexuality, makes an attempt to take his life. When *Trevor* was scheduled to air on HBO in 1998, the filmmakers realized that some of the program's young viewers might be facing the same kind of crisis as Trevor, and began to search for an appropriate support line to broadcast during the airing. They discovered that no such helpline existed, and decided to form an organization to promote acceptance of lesbian,

gay, bisexual, transgender and questioning youth, and to aid in crisis and suicide prevention. The Trevor Lifeline was established and became the first and only nationwide, around-the-clock crisis and suicide prevention crisis line for lesbian, gay, bisexual, transgender and questioning youth. In addition, The Trevor Project provides online support to young people through the as well as resources for educators and parents.

- **The Matthew Shepard Foundation** (http://www.matthewshepard.org). Founded by Judy Shepard after her son, Wyoming college student, Matthew, was brutally beaten and left to die. The foundation is dedicated to preventing violence against other LGBT individuals through education. Judy Shepard is a frequent speaker at events, and the website contains many useful resources and links. There is also an online community forum for LGBT youth on this site as well as posters that could be purchased for agency walls, such as the ***Erase Hate*** campaign.

- **LYRIC: Lavender Youth Recreational and Information Center** (www.lyric.org) is located in San Francisco. Their programs are youth-driven, and fall under three areas: Community Building, Education and Economic Development, and Health and Wellness. They do workshops, trainings, educational sessions, art and cultural events, and recreational activities for sexual minority youth.

- **Advocates for Youth** (www.advocatesforyouth.org) addresses issues of sexual and reproductive health for youth in the U.S. and abroad. They include a section on LGBT youth with frequently asked questions.

- **SIECUS: Sexuality Information and Education Council of the U.S.** (www.siecus.org). SIECUS was founded in 1964 by Dr. Mary S. Calderone, who had formerly been the Medical Director for the Planned Parenthood Federation. In that role, Dr. Calderone was concerned about the lack of accurate information about sexuality for young people and adults. She and others committed to medically accurate sexuality education founded SIECUS and started developing curricular materials for teachers, brochures and fact sheets for youth and parents, and books about sexuality. They publish a sample age-appropriate comprehensive sexuality education curriculum for K-12 education and issue reports about topics such as types of sexuality education programming, current policy decisions related to sexuality, and new laws.

- **LGBT Community Centers** (there are 29 in California). The National Association of LGBT Community Centers (www.lgbtcenters.org) has a locator directory for all centers in the United States, as well as posting general information on LGBT community issues.

CONCLUSION

In conclusion, as our society slowly changes to one that is more accepting of sexual and gender diversity, youth will be able to explore their identities and come out or transition at earlier ages than in the past. They will not need to suffer in silence for years until they feel safe enough to be themselves. Until that day, all health and human services professionals who deal with youth need to become welcoming and inclusive of all youth who enter their doors. Most of the recommendations in this document can be made at no or low cost, and there are an increasing number of resources for training and education about sexuality and gender. There is no longer any excuse for ignorance.

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APPENDICES

Appendix #1: Sample Wording for Forms

The first three items are recommended by an expert panel of LGBT health researchers (Sexual Minority Assessment Research Team, 2009).

Self-Identification:

Do you consider yourself to be:

- Heterosexual or straight
- Gay or lesbian
- Bisexual

Sexual Behavior:

In the past (specify a time period) who have you had sex with?

- Men only
- Women only
- Both men and women
- I have not had sex

Sexual Attraction:

People are different in their sexual attraction to other people. Which best describes your feelings? Are you:

- Only attracted to females
- Mostly attracted to females
- Equally attracted to females and males
- Mostly attracted to males
- Only attracted to males
- Not sure

Other ways to ask questions about sexuality:

Are you sexually attracted to men? Yes/No

Are you sexually attracted to women? Yes/No

Which of the following best describes your sexuality?

- Completely heterosexual or straight
- Mostly heterosexual
- Bisexual
- Mostly gay or lesbian
- Completely gay or lesbian
- Not sure or questioning

Gender Questions:

Were you born

- male
- female
- other

Do you currently consider yourself

- male
- female
- transgender
- other

Questions for Oral Histories/Intakes:

Is there anything we need to know about your sexuality or gender to better serve you?

Many people have questions about their sexuality or gender that they would like to discuss in the course of their treatment. Is there anything you would like to include?

Appendix #2 : Case Study: Lawrence King

On February 12, 2008, Lawrence "Larry" Fobes King, a 15-year-old student in junior high school in Oxnard, California, was shot twice by fellow student, 14-year-old Brandon McInerney, and was kept on life support until he died two days later. McInerney was charged as an adult with premeditated murder with enhancements of discharge of a firearm and a hate crime. He is being held in lieu of $770,000 bail, and faces a minimum sentence of 53 years imprisonment to a maximum life sentence.

Larry was abandoned by his father and drug-addicted mother, and was adopted by the Kings. He had a history of school problems, including attention deficit disorder and had to repeat a grade. By the third grade, King came out as gay and began to dress in feminine attire on occasion. He began to be bullied by his fellow students. At the age of twelve, King was placed on probation for theft and vandalism. In November 2007, he was removed from his adoptive home and placed in a group home after he alleged that his adoptive father was physically abusing him, a charge Gregory King denied.

The bullying continued when King entered the seventh grade, and intensified when he began attending school wearing women's accessories and clothing, high heels and makeup. The school could not legally stop King from dressing as such because of a California hate crime law that prevents gender discrimination, although some teachers at the school thought that his clothing was in violation of school code, which prevents students from wearing clothing considered distracting. The school issued a formal notice to every teacher on January 29, 2008 via email. Written by eighth-grade assistant principal Sue Parsons, it read, in part:

> *We have a student on campus who has chosen to express his sexuality by wearing make-up. It is his right to do so. Some kids are finding it amusing, others are bothered by it. As long as it does not cause classroom disruptions he is within his rights. We are asking that you talk to your students about being civil and non-judgmental. They don't have to like it but they need to give him his space. We are also asking you to watch for possible problems. If you wish to talk further about it please see me or Joy Epstein.*[2]

Joy Epstein was one of the school's assistant principals, and also openly lesbian. Some people, including King's father, accused Epstein of encouraging Larry's flamboyance as part of her "political agenda."

Brandon McInerney was born in Ventura, California. His mother Kendra had a criminal history and was addicted to methamphetamine. In 1993, Kendra accused her husband William of shooting her in the arm with a .45-caliber pistol. In another incident, William McInerney choked his wife almost to unconsciousness after she accused him of stealing ADHD medication from her older son. He pleaded no contest and served ten days in jail and 36 months probation on a charge of domestic violence. Between August 2000 and February 2001, William McInerney had contacted Child Protective Services at least five times about concerns of his son living with his

mother. In 2001, he filed a restraining order against Kendra, and in 2004, Brandon was placed in the custody of his father, as his mother had entered a drug rehabilitation program.

McInerney attempted to recruit other students to assault King, but when no one expressed interest, McInerney then decided to kill him himself. The day before the shooting, McInerney, who had experience target shooting with the gun used in the crime, told one of King's friends, "Say goodbye to your friend Larry because you're never going to see him again"

On the morning of February 12, 2008, McInerney was witnessed repeatedly looking at King during a class in a computer laboratory. At approximately 8:15 a.m, McInerney shot King twice in the head using a .22-caliber revolver he withdrew from his backpack. Following the shooting, McInerney tossed the handgun on the floor and left the classroom. He was apprehended by police about seven minutes later five blocks away from the school campus.

Since McInerney has refused to speak to investigators, the motive for the shooting remains unclear. In July 2008, *Newsweek* reported that a day or two before the shooting King asked McInerney to be his Valentine in front of McInerney's friends. When McInerney endured teasing because of the incident, he told one of King's friends to say goodbye "because she would never see [King] again".

Teachers also showed sympathy for McInerney. "We failed Brandon," a teacher said. "We didn't know the bullying was coming from the other side—Larry was pushing as hard as he could, because he liked the attention."

In August 2008, King's family filed a claim against the School alleging that the school's allowing King to wear makeup and feminine clothing was a factor leading to his death. According to the California Attorney General's Office, however, the school could not legally have stopped King from wearing girls' clothes because state law prevents gender discrimination.

According to a *Newsweek* article published on July 19, 2008, some teachers also allege that assistant principal Joy Epstein was "encouraging King's flamboyance to help further an 'agenda'". When Epstein was later promoted to principal at another local public school, King's father described it as a "slap in the face of my family". The superintendent stated that the promotion was given because "she was the most qualified person for the new principal job".

On July 24, 2008, Judge Douglas Daily of the Ventura County Superior Court ruled that McInerney would stand trial as an adult with the decision being appealed. The trial is set for May of 2010.

> *[Discussion points: The parents blame the school for allowing Larry to cross-dress and accuse a lesbian administrator of having an agenda. Some blame Larry for provoking Brandon. Who is responsible and what can be done to prevent incidents like this in the future?]*

Appendix 3: Continuing Education Exam

Please print out this form, complete it, and **FAX to Gil Gerald & Associates, Inc., at (415) 501-9141**. We will contact you with the results of the exam and provide additional information for submission of the processing fee and receipt of a certificate for individuals who achieve a passing grade of 70% or higher.

Name: _____

Street Address: _____

City, State and Zip Code: _____

Email address: _____

Please keep me informed of course offerings: Yes _____ No _____

Phone #: _____

If Applicable, California Board of Behavioral Sciences License # _____

If Applicable, California Drug and Alcohol Counselor Certification # _____

Please select the *one best answer* for each of the following multiple choice questions, 1-40:

1. Bullying at school has been found to

   - € Be associated with suicide attempts in sexual minority youth
   - € Be associated with a drive to change one's sexual orientation
   - € Increase the sexual minority youth's self-esteem and coping skills
   - € Be declining because teachers are trained to intervene

2. Which of the following is a component of sexual orientation?

   - € Sexual identity
   - € Gender identity
   - € Genitals
   - € Gender expression

3. Compared to heterosexual youth, sexual minority youth are

   € More likely to experience or cause a pregnancy
   € Less likely to experience or cause a pregnancy
   € At about the same risk for pregnancy
   € More likely to miscarry an unwanted pregnancy

4. The term used to refer to medical conditions or variations that affect sex hormones, genitals, or reproductive organs is

   € Transgender
   € Intersex
   € Transsexual
   € hermaphrodite

5. A unique form of substance abuse found in transgender women compared to other sexual minorities is

   € Snorting of heroin
   € Injection of oils or silicone
   € Using methamphetamine for sexual enhancement
   € Combining Viagra and ecstacy

6. On the continuum of attitudes about LGBT people, a “don’t’ ask, don’t tell” philosophy is called

   € Disapproval
   € Disgust
   € Hatred
   € Tolerance

7. The term “FTM” means

   € A person born female who transitions to a male role
   € A transgender woman
   € A person with an intersex condition or variation
   € A transsexual female

8. Which statement about culture and sexuality is true?

   € Universally, all cultures have only two sexes, male and female
   € Most cultures are more open about communicating about sex than dominant U.S. culture
   € There are differences in the ideas about the very nature of sexuality and gender
   € The terms LGB and T are accepted in virtually every culture today

9. The first articles about gay youth to appear in the research literature were in the

   € 1940s
   € 1950s
   € 1960s
   € 1970s

10. An example of an individual-level form of prejudice is

    € Transphobia
    € Internalized homophobia
    € Heterosexism
    € Gender normativity

11. In regards to gender and coming out, most studies find that

    € Girls come out at an earlier age than boys
    € Boys come out at an earlier age than girls
    € Boys and girls come out at about the same age
    € The research is not clear

12. According to Kinsey, about ___% of the general population report a same-sex attraction in their lifetime.

    € 10%
    € 20%
    € 40%
    € 50%

13. Sexual minority females' rates of smoking have been reported as high as

    € 20%
    € 30%
    € 40%
    € 50%

14. The research on sexual identity formation

    € Shows that there are clear cut stages of development that start in mid adolescence
    € Describes mostly gay and lesbian identity but not bisexual or transgender identity
    € Equally accommodate people who come out at different ages
    € Include youth who do not adopt the labels like L,G, B, or T

15. Biological sex is made up of all of the following except

    € Hairstyles
    € Hormones
    € Genitals
    € Reproductive organs

16. The term "gay sex" refers to

    € A specific set of behaviors that are the most common in same-sex sexual encounters
    € A specific set of behaviors that are only performed in same-sex sexual encounters
    € Behaviors that any person(s) could perform regardless of sexual identities
    € Anal and oral sex

17. The Diagnostic and Statistical Manual of Mental Disorders (DSM) included homosexuality as a mental disorder until

    € 1943
    € 1953
    € 1963
    € 1973

18. Which statement about internalized stigma is true?

    € It affects only people who self-identify as LGB or T
    € It has decreased dramatically in recent years and affects only a small number of sexual minority youth
    € It comes from having direct experiences with discrimination
    € It affects nearly all sexual minority people to some extent at some point in their lives

19. Sexual minority youth are more likely to use and abuse alcohol and drugs because

    € The gene for sexual orientation is associated with the gene for alcoholism
    € Sexual minority youth are more likely to come from substance-abusing parents
    € Sexual minority youth are under more stress than heterosexual youth
    € All of the above

20. Jay chooses to wear dangly earrings, high heels, and eyeliner. This is an example of

    € Gender identity
    € Gender expression
    € Sexual behavior
    € Sexual identity

21. According to public polls, ___ of the U.S. population support having LGBT elementary school teachers.

    € 25%
    € 40%
    € 60%
    € 80%

22. Identifying transgender people on written forms would require

    € Adding “transgender” to the male and female options
    € Adding MTF and FTM to the male and female options
    € Asking 1 question about birth sex and 1 question about current gender
    € Asking about hormone use or gender reassignment surgery

23. What percent of the high school aged population report a non-heterosexual identity?

    € 1-3%
    € 5-8%
    € 10-12%
    € 15-20%

24. Reparative or conversion therapies

    € Work well for those who are motivated to change
    € Do not work well, but have few harmful effects
    € Have long term psychological, social, and spiritual harm
    € Have short-term effects (feeling like a failure) but no long-term effects

25. Approval ratings for same-sex marriage in the past 15 years have

    € Increased slightly
    € Stayed about the same
    € Decreased slightly
    € Decreased dramatically

26. Youth who identify as “mostly heterosexual”

    € Are more likely to use substances than “completely” heterosexual youth
    € Are less likely to use substances than “completely” heterosexual youth
    € Have the same rates of substance use as “completely” heterosexual youth
    € Have no consistent substance use patterns

27. Most stage theories of sexual identity formation begin with a period of

    € Pride
    € Comparison
    € Confusion
    € Synthesis

28. Comments such as “that’s so gay”

    € Are completely harmless
    € Are a sign that LGBT people are more accepted today
    € Are used mostly by sexual minority youth among themselves
    € Cause distress in the majority of sexual minority youth

29. The main difference that research has identified between sexual minority youth of color and white youth in terms of sexual identity formation is that youth of color seem to

    € Be more likely to be out to family
    € Be more likely to use terms like gay and lesbian
    € Be more like to be harassed about their sexuality by peers
    € Be more private about their sexuality

30. The idea that biological processes create two and only two distinct sexes is called

    € Gender normativity
    € Sexism
    € Heterosexism
    € Minority stress

31. Suicide attempts among sexual minority youth

    € Occur at about the same rate as among heterosexual youth
    € Are often “cries for help” rather than serious attempts
    € Occur at much higher rates than among heterosexual youth
    € Occur more often in gender conforming than gender nonconforming youth

32. A two-spirit identity refers to

    € A unique Native American concept that blends sexuality and gender together
    € The same thing as LGBT
    € A unique Asian/Pacific Islander term that corresponds to transgender
    € A term in reaction to the Christian idea of spirit

33. The term that is used to describe the process of changing one's physical body to match psychological identity is

    € Transitioning
    € Crossing
    € Coming out
    € bridging

34. Children who experience rejecting behaviors from parents are ____ times more likely to attempt suicide than youth who do not experience rejection.

    € 2
    € 3
    € 4
    € 8

35. The term "down low"

    € Is an accurate depiction of African American men's tendency to have sex with men behind women's backs
    € Is the major cause of high rates of HIV among African American women
    € Refers to acting heterosexual but really being gay
    € Is a way to blame a powerless subset of the population for social injustices

36. About ____% of homeless, runaway youth are sexual minorities.

    € 2-3
    € 5-8
    € 12-15
    € 20-40

37. One study found that youth who came out at an early age had more negative consequences than youth who came out later. The likely explanation(s) for this are

    € The younger the age of coming out, the fewer social support resources are available
    € The younger the age of coming out, the more likely it is to be only a phase
    € The younger the age of coming out, the more likely the sexuality is related to biological factors
    € All of the above

38. Stigma comes from

    - € Negative stereotypes about a group
    - € Biological differences between groups
    - € Experiences of harassment
    - € Deeply ingrained survival mechanisms for the human species

39. Sexual identity formation is influenced by

    - € Immigration status
    - € Religion
    - € Laws about sexual behavior
    - € All of the above

40. Treatment for substance abuse and mental health problems among sexual minority youth

    - € Need to address issues related to stigma
    - € Need to address the current symptoms, but should not address stigma
    - € Need to include full disclosure to the youth's parents or guardians
    - € Are best done individually because group members may be homophobic