

ORIGINAL ARTICLE

Adolescent Health Care Experience of Gay, Lesbian, and Bisexual Young Adults

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Methods: Subjects were 102 self-identified gay, lesbian, and bisexual youth aged 18–23 years. A confidential self-administered survey elicited demographic information, sexual orientation information, health care experiences, subjects' understanding of medical confidentiality during ages 14–18 years, and their suggestions for improving care to gay and lesbian adolescents.

Results: Two-thirds of subjects never discussed sexual orientation with their provider but reported a desire to do so. Fewer than one-half of subjects remembered being informed about their right to medical confidentiality; those who reported being so informed were three times more likely to have discussed their sexual orientation with their provider. Over 70% of subjects who reported not being informed about their right to medical confidentiality stated that they would have been more likely to discuss sexual orientation with their provider had they been so informed. Only 13 of subjects had disclosed their sexual orientation to their health care providers. Of these, only half of the males received information on human immunodeficiency virus prevention.

Conclusions: Health care providers may be failing to fully address issues of confidentiality and sexual orientation with adolescents, despite a decade of increased information on adolescent homosexuality. © Society for Adolescent Medicine, 1998

KEY WORDS:

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In the past 10 years there has been increased recognition in the medical literature of gay and lesbian adolescent patients and their special problems and needs (1–15). The prevalence of homosexuality is highly contested; studies are difficult to compare because there is no objective parameter which measures sexual orientation, with estimates ranging from 3% to 10% across men and women (16–18). The 1992 study of Remafedi et al. of 34,706 high school students found that 1.1% described themselves as bisexual or predominantly homosexual and 10.7% were “unsure” of their sexual orientation (19). The prevalence of bisexuality is more poorly defined, although it has been noted that more people self-identify as either heterosexual or homosexual than bisexual and that more females than males self-identify as bisexual (20).

To adequately care for gay, lesbian, and bisexual youth (referred to in the remainder of this article as “gay”), an understanding of homosexual identity development among providers of health care to adolescents is requisite. Troiden proposed a four-stage model for this process, which often develops during childhood and adolescence (21). Available

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research indicates that many gay adolescents are aware of their homosexuality by early or middle adolescence (roughly age 11–16 years), and that this awareness tends to arise at a slightly younger age for boys than for girls (21–23). It should be noted that homosexual experiences are not necessary for development of a homosexual identity; in one study, 8% of adolescent and young adult subjects had not had same-sex sexual activity, yet self-identified as gay (22).

Gay adolescents share many of the same developmental tasks as heterosexual adolescents. However, they are at increased risk for physical abuse (5,11), school problems (3,4,8,9,11), running away from home (3,6,8,11), other psychosocial problems, and depression and suicide (1,3,10,11). Gay male youth are also at high risk for contracting sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) (9). Several authors have recommended clinical approaches to this patient population (1,2,7,9,13,14,24,25) which include methods used in the overall practice of adolescent medicine. Most adolescent medicine experts agree that medical confidentiality is a cornerstone of effective adolescent health care and that lack of confidentiality is a barrier to care (2,25–28). A recent study of knowledge about confidentiality in 1295 high school students found that less than half of teens surveyed (43.8%) recalled being informed about privacy when they went to the doctor, and only one-third were aware of their right to confidential care for STDs and drug problems (27).

Although recommendations on the clinical approach to adolescent homosexuality exist in the medical literature, little is known about how primary care providers are dealing with gay adolescents in daily practice. Health care providers may avoid the subject of sexual orientation because of lack of training; a 1991 survey of 4-year medical schools found the mean amount of course time devoted to the topic of homosexuality to be 3 h and 26 min (29). Compounding this lack of training is a paucity of documented information on the gay adolescent's health care experience. In a 1993 study, gay youth were asked if they were able to talk to a personal physician regarding their sexual orientation. Nineteen percent of the males and 18% of the females responded affirmatively; no further questions were asked about medical care (30). Another study found gay adolescents to be uncomfortable going to "just any" provider; given a choice, gay male teens tended to choose a health care provider based on the provider's sexual orientation (preferring a homosexual pro-

vider of either sex), and lesbian teens tended to make the choice based on the provider's gender (preferring a female provider of any sexual orientation) (31).

Thus, a serious void exists in the literature describing the health care experience from the gay adolescent's perspective. The purposes of the current study were to: (a) describe the experience of gay adolescents with their health care providers; (b) describe subjects' experiences of discussion of sexual orientation issues and medical confidentiality; (c) elicit subjects' opinions on how care may have been improved; and (d) identify barriers to effective health care for gay adolescents.

Methods

Subjects

Inclusion criteria were self-identification as gay, lesbian, or bisexual and being between 18 and 23 years of age. Subjects were self-selected volunteers recruited through newspaper advertisements, posters, E-mail postings, and college- and community-based gay support groups in Colorado and Wyoming. Subjects aged 18–23 years were sought because their experience as 14–18-year-olds was believed to be better recalled than that of older adults. More importantly, this age group could provide the clearest information about clinical experiences in the past 10 years. Experiences occurring before the previous decade would be difficult to interpret because the majority of information about gay adolescents has appeared in the medical literature in the past 10 years.

Instrument

The survey instrument consisted of a confidential self-report, theory-driven, 32-item, written questionnaire. These items were generated by the investigators and reviewed by a community-based gay and lesbian youth services coordinator. The instrument was then tested on six eligible individuals to improve clarity, pertinence of questions, and completeness of response options. Most questions offered the subject a choice of responses, including a space for "other" responses and comments. There were also two groups of Likert-type questions. Content of the survey was categorized as demographic information, sexual orientation information, individual health care experience, medical confidentiality, and respondent opinions on how health care providers might improve service to gay adolescents.

The instrument was distributed via mail to individual subjects or to leaders of community or college support groups, and in person by the lead investigator attending community and college group meetings. The completed instrument was returned via mail or in person.

Human Subjects Issues

All procedures and materials were approved by a university human subjects committee. Each subject received a materials packet including a cover letter, the study instrument, a consent form requesting the subject's signature, and two postage-paid return envelopes. Subject confidentiality was protected by identifying the questionnaire and consent form with a code number, each document being returned in a separate envelope and stored separately. Questionnaires and consent forms were to be matched only in the event that a subject withdrew from the study (so that the subject's data could be removed from the database).

Data Analysis

The results of the 32 survey items were calculated as frequency distributions. Cross-analyses were then done comparing responses between relevant groups (e.g., between males and females and among different ages or respondents reporting different health care experiences). As some cross-analyses required the comparison of more than two mean scores, single-factor analysis of variance (ANOVA) was used for conducting tests on differences between means. Tests on differences between frequencies of categorical response were performed with the Chi-square procedure. All statistical analyses were conducted with the Statistical Package for the Social Sciences (SPSS). Open-ended comments were qualitatively analyzed by thematic content and categorized accordingly.

Results

A total of 210 surveys were distributed; of these, 107 were completed and returned, giving an overall response rate of 51%. Of the total returned questionnaires ($n = 107$), 15% were completed by individuals recruited through media, 25% by persons in groups contacted via telephone or mail (both regular mail and E-mail), and 60% by persons in community and college groups contacted in person. Although many

Table 1. Demographic Characteristics of Study Subjects

Characteristic	<i>n</i>
Gender ($n = 101$)	
Male	60
Female	41
Age (yr) ($n = 102$)	
18	20
19	21
20	23
21	12
22	12
23	14
Race/ethnicity ($n = 98$)	
Caucasian	75
Hispanic	12
African-American	2
Native American	4
Asian	1
Not listed/other	4
Community type ($n = 98$) (as adolescent)	
Rural (pop. <10,000)	17
Town (pop. 10–50,000)	17
City (pop. 50–500,000)	25
Metro Area (pop. >500,000)	13
Inner city	2
Suburb	24
Education level ($n = 102$)	
Some high school	2
High school grad or GED	24
Some college	64
Undergrad degree	12

eligible individuals declined participation after receiving a materials packet, no subjects requested to be withdrawn after submitting a completed questionnaire. Of the 107 subjects who returned questionnaires, 5 were excluded owing to missing data. Therefore, results are based on the responses of 102 subjects.

Demographic characteristics of the study subjects are presented in Table 1. One subject self-identified as transgendered, and so was not included in the data on sex. The mean age was 20.17 years. There was no statistically significant difference between mean age for males and females.

Sexual Orientation Information

Sexual orientation information is summarized in Table 2. A greater number of subjects self-identified as predominantly gay or lesbian than bisexual. More females than males described themselves as bisexual. Responses to questions about milestones of homosexual identity development also revealed significant

Table 2. Sexual Orientation Characteristics of Study Subjects, by Gender

Characteristic	Male	Female
Self-identification		
Gay or lesbian [n (% of total sex)]	51 (85)	26 (63)*
Bisexual [n (% of total sex)]	9 (15)	15 (37)*
Mean age (yr) (SD) at		
First same-sex feelings (<i>n</i> = 98)	10.1 (3.5)	11.8 (4.1)*
First self-identification as g/1/b [†] (<i>n</i> = 101)	12.6 (3.3)	15.5 (2.7)*
First same-sex sexual contact (<i>n</i> = 92)	13.6 (4.8)	15.6 (4.5)*
First told someone of g/1/b orientation (<i>n</i> = 99)	17.0 (2.5)	17.2 (2.6)

* Statistically significant ($p < 0.05$) difference between males and females.

[†] g/1/b-gay, lesbian, or bisexual.

differences between males and females (Table 2). Two males and six females (8% of the total sample responding to the survey item) reported never having had sexual contact with someone of the same sex prior to the time of the survey.

Health Care Experience

Two subjects reported that they did not receive any health care when they were 14–18 years old. Of the remaining subjects ($n = 100$), 65% reported having one main health care provider, 17% had two to five health care providers, and 17% had more than five health care providers during this age period. The majority (55%) received their health care in family practice settings. Almost one-third of subjects (28%) saw a variety of different providers in settings including military, large health management organization, urgent care centers, emergency rooms, specialists (e.g., dermatologist), or government-sponsored clinics. Only 17% of subjects reported seeing pediatricians during adolescence.

The majority (78%) of the 100 subjects who received health care as adolescents reported that they never discussed sexual orientation with their health care provider when they were 14–18 years old. Thirteen percent reported that they did discuss sexual orientation with their health care provider, and in fact disclosed their own sexual orientation to their provider. A small number of subjects (7%) reported that they discussed sexual orientation with their provider but only in general; they did not disclose their own sexual orientation. Only 2% reported that they did not remember whether they had discussed sexual orientation with their health care provider.

Of the 13 subjects who stated that they had disclosed their own sexual orientation to their health care provider, eight reported doing so after they were "certain" of their homosexual orientation, two

after they were "pretty sure" they were gay, and three when they were "still questioning" their sexual orientation. About one-half of these 13 subjects reported that they, themselves, had brought up the subject of sexual orientation, and the other half reported that their health care provider broached the subject of sexual orientation; most frequently, the provider did so verbally when the subject's parent was not in the room.

The 13 subjects (six males and seven females) who reported having disclosed their homosexual orientations to their health care providers were asked about several possible consequences of their disclosure and to record any related experiences; nine indicated that their health care provider assured them that they were normal, two indicated that their health care providers assured their parents that they were normal, two indicated that the health care provider "seemed to become offended," and two indicated that the information was discussed with their parents without their consent. Only three of the six male subjects reported that their health care providers talked to them about "safer sex." One subject reported that her doctor sent her some information on homosexuality later in the mail. Two female subjects stated that their doctors (both female physicians) told them that they were at high risk for contracting acquired immunodeficiency syndrome. One respondent stated that her provider noted her sexual orientation on the medical record against her will. None of these 13 subjects indicated that they were referred to a support group for gay, lesbian, or questioning teens, and none indicated that their parents were referred to parent support groups.

Seven respondents reported that they discussed their sexual orientation with their health care providers when they were 14–18 years old, but discussed it only in general without disclosing their own sexual orientation. Of these, four said they would not have

Table 3. Reasons Respondents Did Not Disclose Own Sexual Orientation to Health Care Provider When They Were 14–18 Years Old

Statement Presented in Questionnaire	<i>n</i>	% Responding Yes
I did not want to discuss sexual orientation in front of my parent.	79	74.7
My health care provider never asked me about personal issues.	80	73.8
I did not feel safe discussing sexual orientation with my provider.	81	60.5
Provider did not say she or he <i>would</i> be willing to discuss sexual orientation.	79	57.0
I was afraid the health care provider would tell my parents.	81	56.8
I did not think it mattered in terms of my health care.	81	53.1
When my provider talked about sex, she or he only talked about birth control.	79	49.4
I just did not want to discuss sexual orientation with my provider.	81	49.4
I assumed that my health care provider was against homosexuality.	80	48.8
I was afraid the medical office staff would find out.	81	39.5
I was afraid my health care provider would think I was mentally ill.	80	27.5
My parent was always in the exam room with me.	80	26.3
I did not like my health care provider when I was an adolescent.	80	23.8
I was afraid my provider would send me to a psychiatric hospital.	80	14.7
My health care provider made distinct homophobic remarks.	80	1.3

liked to discuss their own sexual orientation, and three said they would have liked to discuss their own sexual orientation with their health care provider.

Of the 100 subjects who received health care when they were 14–18 years old, 78% reported that they never discussed sexual orientation with their health care provider, and 2% reported they did not remember whether they had discussed sexual orientation. These subjects were asked if they would have liked to discuss sexual orientation with their health care provider when they were adolescents. One-third of the 77 subjects responding reported that they would have liked to discuss their own sexual orientation with their health care provider; another third indicated that they would have liked to discuss sexual orientation in general, but they would not have wanted to disclose their own sexual orientation; another third indicated that they would not have wanted to discuss sexual orientation at all with their health care provider. Thus, two-thirds of subjects did not, but reported a desire to, discuss sexual orientation with their health care provider when they were adolescents. Some reasons that subjects did not discuss their personal sexual orientation are presented in Table 3. Twenty-eight subjects added further comments regarding why they did not discuss sexual orientation with their health care provider. These comments were analyzed for thematic content and fell into these discrete categories: The doctor was a friend of parents; generally being uncomfortable and/or fearful; not being aware of their sexual orientation at that age; not thinking the health care provider could do anything to help; not thinking it was an issue; or received care at military hospitals. In

summary, a large majority of subjects who reported obtaining medical care did not discuss sexual orientation with their health care provider, although many reported that they would have liked to do so.

Confidentiality

More than half (65.3%) of subjects reported that they were not made aware of their right to medical confidentiality when they were 14–18 years old ($n = 98$). Only 22.4% reported that they had known about medical confidentiality during that age, and 12.2% reported that they did not remember. Of subjects who reported knowing about medical confidentiality at that time ($n = 21$), 24% disclosed their own sexual orientation to their health care provider. Of subjects who reported not having known about their right to medical confidentiality ($n = 64$), only 8% reported having disclosed their sexual orientation to their health care provider. Of this same group, 72% stated that they would have been more likely to discuss sexual orientation with their health care providers had they known about their right to medical confidentiality. Fewer than one-third stated that knowing about confidentiality would not have made them more likely to discuss sexual orientation with their health care provider.

Respondent Opinions on How Health Care Providers Might Improve Care to Gay, Lesbian, Bisexual, and Questioning Adolescents

Six possible methods to inform adolescent patients about their right to medical confidentiality were

Table 4. Respondents' Ratings of Methods Health Care Providers Might Use to Inform Adolescent Patients About Medical Confidentiality

Method Presented in Questionnaire	Very Good [n (%)]	Good [n (%)]	Poor [n (%)]	Very Poor [n (%)]
Your provider verbally informs you about the right to medical confidentiality at EACH VISIT. (n = 101)	58 (57.8)	29 (28.4)	6 (5.9)	8 (7.9)
A sign in the EXAM ROOM states that adolescents have the right to confidentiality in certain aspects of health care as long as there is no immediate threat to the adolescent's life. (n = 102)	50 (49.0)	25 (24.5)	14 (13.7)	13 (12.7)
A sign in the WAITING ROOM states that adolescents have the right to confidentiality in certain aspects of health care as long as there is no immediate threat to the adolescent's life. (n = 102)	48 (47.1)	24 (23.5)	18 (17.6)	12 (11.8)
A pamphlet about confidentiality is placed in the EXAM ROOM on a rack with other pamphlets on health care issues. (n = 102)	28 (27.5)	39 (38.2)	24 (23.5)	11 (10.8)
A pamphlet about confidentiality is placed in the WAITING ROOM on a rack with other pamphlets on health care issues. (n = 102)	28 (27.5)	37 (36.3)	25 (24.5)	12 (11.8)
Your health care provider verbally informs you about your right to medical confidentiality ONCE when you first become an adolescent. (n = 101)	22 (21.6)	42 (41.2)	28 (27.5)	9 (8.8)

presented, and subjects rated them on a four point Likert-type scale from "very good" to "very poor." These results are presented in Table 4. In summary, respondents rated direct verbal communication about confidentiality higher than written information and preferred that signs and pamphlets about medical confidentiality be in the examination rooms rather than the waiting room. Twenty-four respondents added written comments about how they could have better been informed about their right to medical confidentiality. Common themes included emphasis on verbal communication, combining verbal statements about confidentiality with written pamphlets, a written agreement about medical confidentiality between the health care provider and the adolescent, having medical confidentiality discussed in school health class, and making sure adolescent patients have the opportunity to be alone with the health care provider without a parent present.

Six possible methods a health care provider could use to let adolescent patients know that the provider is willing to discuss sexual orientation were presented, and respondents rated them on the same Likert scale. The responses are summarized in Table 5. In general, respondents favored clinic policies whereby adolescent patients are seen without a parent present, pamphlets on sexual orientation are placed in examination rooms versus in the waiting room, and the health care provider uses gender-neutral questions when taking a sexual history. Thirty-two subjects added written comments on how

their health care provider might have communicated a willingness to discuss sexual orientation. Common themes included bringing up sexual orientation in a nonconfrontational, casual, nondirect way rather than asking adolescents direct questions about homosexual feelings or experiences; not including sexual orientation in the discussion of "problem issues" such as drug use; no parents in room or giving the adolescent a choice about whether to have the parent present; not assuming heterosexuality; and making it clear that the provider is not against homosexuality. Three subjects implied in their written comments that even if their health care provider had used some of the above techniques, the subject would have to have trusted the provider on a more personal level before making any disclosure about sexual orientation.

Discussion

Despite a decade of increased recognition of gay adolescents, the current findings indicate that health care providers have yet to fully develop and disseminate a protocol with which to reach this high-risk group. Counseling and guidance from health care providers would likely benefit adolescents who are gay or questioning their sexual orientation. The current findings may indicate that a small minority

Table 5. Respondents' Ratings of Ways Health Care Providers Could Broach the Subject of Sexual Orientation

Method Presented in Questionnaire	Very Good [<i>n</i> (%)]	Good [<i>n</i> (%)]	Poor [<i>n</i> (%)]	Very Poor [<i>n</i> (%)]
In taking a sexual history, the health care provider asks you gender-neutral questions such as, "Have you begun to have sexual feelings about boys, girls, or both?" (<i>n</i> = 101)	46 (45.1)	35 (34.3)	13 (12.7)	7 (6.9)
A clinic policy whereby you are automatically seen by the provider without your parent present. (<i>n</i> = 99)	45 (44.1)	41 (40.2)	11 (10.8)	2 (2.0)
Pamphlets about gay/lesbian/bisexual issues in the EXAM ROOM along with the other health care pamphlets. (<i>n</i> = 102)	43 (42.2)	42 (41.2)	12 (11.8)	5 (4.9)
Pamphlets about gay/lesbian/bisexual issues in the WAITING ROOM on a rack with the other health care pamphlets. (<i>n</i> = 102)	35 (34.3)	35 (34.3)	24 (23.5)	8 (7.8)
Your health care provider brings up the topic of sexual orientation verbally by using a general statement such as, "Some people experience attraction to a person of the same sex. Have you had feelings like this?" (<i>n</i> = 101)	29 (28.4)	40 (39.2)	25 (24.5)	7 (6.9)
You fill out a confidential written questionnaire before being seen by the provider which includes "sensitive" topics such as drug use and sexuality issues (including sexual orientation), indicating with a check mark that you would like to discuss a particular issue. (<i>n</i> = 102)	25 (24.5)	48 (47.1)	20 (19.6)	9 (8.8)

of gay teens receive any guidance or education regarding sexual orientation, and that several obstacles inhibit the discussion of sexual orientation in medical settings.

This study involved a moderately sized convenience sample which differs in the following ways from those represented in the available literature on adolescent homosexuality: (a) It included a relatively large number of females; (b) it included a high proportion of youth with some college education (most likely a result of the number of respondents recruited from college-based groups); and (c) a large number of subjects came from rural areas even though no recruiting was done in rural areas (the sizable gay student group at a college in northern Colorado included many students from rural areas).

A smaller proportion of the respondents in the current study recalled being aware of their right to medical confidentiality than did subjects in a previous study of high school students (25). This may be because the current sample, being older, was recalling from up to 9 years prior to completing the survey whether or not they had been informed about confidentiality as adolescents, while the high school students were required to recall a maximum of 4 years prior to completing a survey. Both studies indicate that health care providers must make a greater effort

to inform all adolescent patients about their right to medical confidentiality.

Slightly fewer subjects in the current study had discussed their sexual orientation with a health care provider than in a previous study of gay youth (13% vs. 18–19%) (30). Because this group involved only 13 subjects, their experiences may indicate trends but cannot be generalized. Few of the respondents who did disclose their sexual orientation to their health care providers reported negative consequences of their disclosure. However, the responses indicate that health care providers may not be providing adequate guidance or referrals and may occasionally be violating medical confidentiality. No subjects reported that they were referred to a support group for gay, lesbian, bisexual, or questioning teens, or that their parents were referred to a parent's group, such as those organized by Parents and Friends of Lesbians and Gays. Such groups may not have been available during the period of query, particularly in rural areas. However, most subjects came from towns of $\geq 50,000$ population, metropolitan areas, or suburbs which often have such organizations available, so it is possible that their health care providers were unaware of existing groups. All adolescents should be educated on STD and HIV prevention, yet only one-half of the male subjects who disclosed a

homosexual orientation reported that their health care providers talked to them about safer sex and HIV. This indicates that crucial opportunities for HIV prevention in this especially high-risk population were frequently missed. A surprising health care provider reaction was reported by each of two female subjects: When they disclosed lesbian orientations, their providers (both female physicians) told them that they were at high risk for contracting AIDS, despite absence of data.

There are limits to generalizing the results of the current study. The small number of subjects answering certain questions make the related experiences particularly difficult to generalize. Although somewhat attenuated by using a confidential instrument, demand characteristics of survey content areas are likely to have influenced responses. Like previous studies of gay adolescents, this study was retrospective and self-reporting in design, which makes responses imprecise. There is also the issue of self-selection sample bias; as with previous studies, it is unlikely that this sample is representative of the gay, lesbian, and bisexual young adult population.

Conclusion

Gay adolescents have been found to be at disproportionately high risk for depression, suicide, and other psychosocial problems. Therefore, health care providers should identify these youth and provide support and guidance. Although the body of literature on adolescent homosexuality is increasing, it appears that health care providers are still failing to adequately address sexual orientation issues. The current study provides the gay young adult's perspective on their adolescent health care experience, information that was previously lacking in the literature. Major obstacles to effective medical care include gay adolescents' misunderstanding of their right to confidential care, fear of judgmental responses by health care providers, and concern that parents will be informed of their orientation without their consent. Suggestions to overcome these obstacles have been presented here. Health care providers can use this information to improve care to gay youth.

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