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Position paper

Recommendations for Promoting the Health and Well-being of Sexual and Gender–diverse Adolescents Through Supportive Families and Affirming Support Networks

The Society for Adolescent Health and Medicine

A B S T R A C T

Adolescent and young adult (AYA) health care providers (HCPs) frequently serve sexual and gender–diverse (SGD) youth. Sexual orientation refers to a person's sexual identity in relation to the gender(s) to which they are attracted. Gender-diverse, sometimes addressed as gender-expansive, persons are a subset of the population whose gender identity, expressions, or behaviors differ from those typically associated with the sex they were assigned at birth in the society in which they live. These constructs may develop separately, and terminology should acknowledge and include the broad range of SGD identities that exist. Although many SGD AYAs navigate the adolescent transition successfully and become healthy, happy, successful adults, the pervasive discrimination, stigma, bias, and disparities they face throughout society place many at risk for poor health and developmental outcomes. The resilience and risk profiles of these youth are further compounded by the intersectionality of the person's unique identities, including, but not limited to, race/ethnicity, religion, and language. Support for SGD AYAs is critical at all levels. The Society for Adolescent Health and Medicine (SAHM) encourages HCPs who care for AYAs and researchers to incorporate the impact of these developmental processes (and understand the consequences of concurrent potential discrimination) when working with SGD adolescents. SAHM also encourages HCPs to advocate for improved policy related to sexual and gender diversity within families, schools, the foster care system, and the juvenile justice system. Consistent with other professional organizations, SAHM rejects the mistaken notion that SGD identities are mental disorders and opposes the use of any type of reparative therapy for SGD adolescents.

Positions of the Society for Adolescent Health and Medicine

1. All HCPs should be trained to provide competent, inclusive, and nondiscriminatory care for sexual and gender–diverse (SGD) youth.
2. HCPs should promote family connectedness and acceptance of SGD adolescents.
3. HCPs should address and work to protect SGD youth from multiple forms of violent victimization and associated negative sequelae.
4. Foster care systems should implement policies to ensure the well-being of SGD youth.
5. Juvenile justice systems should implement policies to ensure the well-being of SGD youth.
6. Youth struggling with sexual orientation or gender identity should be offered affirmative therapeutic approaches. The Society for Adolescent Health and Medicine (SAHM) explicitly denounces reparative or conversion "therapy" as harmful and discriminatory practices.
7. Further research on all aspects of SGD adolescent health is needed to inform advocacy, training, clinical practice, and community interventions.

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Statement of the Problem

Given wider access to information and more positive media coverage, adolescents are coming out at younger ages than

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previous generations of SGD adults. Thus, HCPs are more likely to serve SGD adolescents in a wide range of settings. This offers opportunities to foster positive development, identify SGD youth at risk, and provide appropriate services. Although research and clinical practice have progressed over the past decade, there are still large gaps in knowledge and translation of existing knowledge into clinical practice and community policies. Providing the highest level of care for these youth requires adequate training (with an intersectional lens) of HCPs to ensure an understanding of sexual orientation and gender identity, the importance of family support and connectedness, the origins of risk behaviors, the impact of violent victimization, circumstances faced by youth in foster care and the juvenile justice systems, and the harms of reparative or "conversion therapy". Researchers, clinicians, and policy makers should consider these dimensions when interacting with all adolescents regardless of known SGD status to improve HCPs interventions, education, and community policy.

Methods

The stated positions result from a review of the scientific literature as well as expert consensus from specialists involved in research, teaching, and providing care to SGD adolescents.

Positions and Recommendations

Position # 1 All HCPs should be trained to provide competent, inclusive, and nondiscriminatory care for SGD youth

Sexual orientation and gender identity are multifaceted and dynamic parts of one's personal identity, especially in adolescence. Many SGD youth experience and fear discrimination in health care settings, in part, because of the lack of SGD-specific medical education [1,2]. By learning how to provide an affirming environment, HCPs can support positive adolescent development and increase resiliency. Training should normalize the evolution of dynamic SGD identities, teach how to ask adolescents how they self-identify, and emphasize flexible care guided by the youth's language and self-concept [1–6]. All HCPs should understand that most SGD youths are healthy and well-adjusted and approach the care of SGD youth through that lens [2–6]. The high-risk behavior exhibited by some, which should be identified and managed, more often reflects reactions to enacted social stigma, discrimination, and nonacceptance by peers and society [3,5].

Position # 2 HCPs should promote family connectedness and acceptance of SGD adolescents

Family connectedness is essential for healthy development of adolescents and has been shown to be an important correlate of positive health outcomes among SGD youth [7]. Although parents may react negatively to their child's SGD identity, research shows that many family relationships improve after parents become sensitized to their child's needs and well-being [8].

Research from the Family Acceptance Project has found that parental and caregiver reactions to an adolescent's SGD identity have a compelling impact on the adolescent's health and well-being [9]. Those who report high levels of family rejection were more likely to have attempted suicide, have high levels of depression, use illegal substances, and engage in unprotected sexual intercourse, compared with peers from families with no or low levels of family rejection [9].

Conversely, SGD youth who report family acceptance during adolescence show better general health and well-being than peers who do not report acceptance [10]. Specifically, family acceptance is associated with higher levels of self-esteem, social support, and general health and is protective against depression, substance abuse, and suicidal behavior in young adulthood. HCPs may help to facilitate disclosure by youth (if desired by youth) to their families and should emphasize the importance of providing support to their children [11].

Position # 3 HCPs should address and work to protect SGD youth from multiple forms of violent victimization and associated negative sequelae

SGD youth frequently experience violent victimization based on how their sexual orientation or gender expression is perceived by others. Bullying can range from verbal harassment to physical violence or sexual abuse. Victimization at schools and other social settings is common [12,13]. Data from the 2019 Youth Risk Behavior Surveillance indicate that SGD high school students had greater odds of violence victimization than heterosexual students across all surveyed indicators [14]. Among SGD males, the percentage reporting being threatened or injured with a weapon at schools significantly increased from 2015 (11.6%) to 2019 (15.9%), as did those reporting forced sex (8.0%–15.6%, respectively). A recent analysis of the 2018 Illinois Youth Survey demonstrated that transgender and gender-diverse youth experienced a higher frequency of both peer victimization and dating violence than their cis-identified peers [15].

The 2019 National School Climate survey by the Gay, Lesbian, and Straight Education Network showed that SGD students who experienced SGD-related discrimination at schools were more likely to have missed school in the past month and had lower grade point average, lower self-esteem, lower school belonging, and higher levels of depression [16]. Violent victimization independently correlates with past suicide attempts as well as sexual risk behaviors and substance use [17,18]. The association between victimization and depression/suicide risk is attenuated by family support and acceptance [19].

Limited data suggest that online friends can be an important source of social support, particularly for victimized SGD youth, although in-person social support appears to be more protective [13]. A recent meta-analysis provides evidence to support Gay-Straight Alliances in high schools as a means of protecting SGD youth from school-based victimization [20]. Inclusive antibullying policies, that is, those that include sexual orientation, have been significantly associated with a reduced risk for suicide attempts among lesbian and gay youth [21]. Data from the Gay, Lesbian, and Straight Education Network survey also showed that SGD youth in schools with an SGD-inclusive curriculum are less likely to feel unsafe than youth in schools without a curriculum [16]. However, most SGD students who were harassed or assaulted at schools did not report these incidents to school staff. The most common reasons for not reporting were doubts that effective intervention would occur and fears that reporting would make the situation worse. Most students who reported incidents of victimization at schools said that staff did nothing or told the students to ignore it; two in 10 students were told to change their behavior (e.g., to not act "so gay" or dress in a

certain way). This suggests a notable gap between lived experiences and the incidents that are reported by students [16].

Experience suggests that HCPs should screen youth for SGD-related victimization and associated effects [22]. HCPs, researchers, and policy experts should educate schools about the adverse health effects of violent victimization, the benefits of the presence of Gay-Straight Alliances on the campus, the importance of intervention to stop harassment when observed, and the importance of encouraging and supporting youth to report incidents. In addition, HCPs, researchers, and policy experts should continue to advocate for local, national, and international anti-bullying policies and legislation that includes sexual orientation and gender identity.

Position # 4 Foster care systems should implement policies to ensure the well-being of SGD youth

SGD youth are disproportionately represented in the foster care system [23]. SGD youth enter foster care for various reasons, including family conflict, mistreatment, or neglect related to their sexual orientation or gender identity. These youth may experience harassment, bullying, or violence by other children and staff in group and foster homes, especially when placed with caregivers who are poorly prepared to deal with their sexual orientation or gender identity [24]. Furthermore, they may also run away from foster homes and shelters, adding to the disproportionate numbers of homeless SGD youth, which are estimated to be twice that of their non-SGD counterparts [3,24].

Although no federal policies exist that explicitly provide protection for SGD youth in the child welfare system, some states have adopted nondiscrimination in statute or agency policy. Even in states with these protections, some SGD youth remain in precarious or unsafe situations [24]. There is limited emphasis on permanency services, reunification with family, adoption, or legal guardianship that leaves many SGD youth to age out of the foster care system in larger numbers than their heterosexual and cisgender counterparts [24].

In 2006, the Child Welfare League of America published the *Best Practice Guidelines for LGBT Youth Out-of-Home Care* [23]. These practices include creating an inclusive organizational culture, positive adolescent development, and placement in supportive family settings and safe care settings where SGD youth are treated equitably and receive quality health and educational services. *Getting Down to Basics*, a toolkit developed in a joint venture between Lambda Legal and Child Welfare League of America, provides guidance, practical tips, and information on a variety of issues that impact SGD youth including the adults and organizations who provide them with out-of-home care [25]. These guidelines can be applied in any country that provides foster care services for youth.

HCPs can help families, caregivers, and foster parents understand the need to reduce rejecting behaviors that put SGD youth at risk and increase supportive behaviors that promote well-being [26].

Position # 5 Juvenile justice systems should implement policies to ensure the well-being of SGD youth

There is a disproportionally high number of SGD youth in juvenile detention centers, accounting for up to 20% of incarcerated youth [27,28]. SGD youth of color experience high rates of incarceration, likely due to the intersection of structural racism and minority stress resulting in multiple levels of discrimination. Lesbian, gay, and bisexual youth in carceral settings report pervasive levels of sexual victimization by other youth, 10 times higher than that experienced by their heterosexual peers [27]. SGD youth are also more likely to be harshly disciplined or placed in isolation while incarcerated, which has negative effects on emotional well-being [28].

Transgender and gender-diverse youth face additional challenges. They may be housed in residential settings that do not align with their identity, contributing to emotional distress and safety concerns, including higher rates of sexual victimization than their cisgender peers. Furthermore, youth who are receiving or desire medical treatment such as gender-affirming hormones or puberty blockers often struggle to access such care in detention centers, despite recommendations that this essential care be provided [27].

On a global scale, same-sex relationships and transgender identities may be criminalized or illegal in certain nations, and youth may be incarcerated or detained for their sexual orientation and/or gender identity, even in the absence of other criminal activity [29]. These youth are at particular risk for victimization, homelessness, and death [29]. Similarly, immigrant and refugee SGD youth face high levels of victimization and inadequate medical care in immigration detention centers [30]. Professionals who care for youth should advocate for equitable policies and legislation both locally and globally to promote the health of SGD youth worldwide, including asylum seekers, refugees, and youth who reside in settings that criminalize same-sex behaviors and noncisgender identities.

In the United States, guidelines exist for serving SGD youth in group care facilities, including detention and correctional facilities [27]. Institutions should provide training for staff to develop and implement policies to protect incarcerated SGD youth. Facilities should provide access to gender-affirming care for transgender and gender-diverse youth, which may require consultation and collaboration with specialty HCPs. SGD youth should also be referred to appropriate programs to successfully continue medical care after release.

Position # 6 Youth struggling with sexual orientation or gender identity should be offered affirmative therapeutic approaches. SAHM explicitly denounces reparative or conversion "therapy" as harmful and discriminatory practices

SAHM recommends an affirmative therapeutic approach aimed to help adolescents explore their identities in a healthy, nonjudgmental, and nonstigmatizing manner. Affirmative care, which has been associated with improved mental health outcomes, involves individualized efforts to increase family and school support and reduce family, community, and social rejection.

Conversion or reparative "therapy" refers to the practice of attempting to change an individual's sexual orientation, gender identity, expressions, roles, or attractions from their current state to align with those traditionally associated with heterosexual, cisgender persons. Such efforts are inconsistent with goals to enhance family connectedness and provide affirming care for SGD youth to optimize positive life outcomes [1]. In 1973, "homosexuality" was removed from the Diagnostic and Statistical Manual of Mental Disorders, thus eliminating it as a mental disorder [31]. In 2018, "gender identity disorder" was reclassified as "gender incongruence" and removed from the mental health

section of the International Classification of Diseases, 11th edition [32].

Major professional associations, including the American Psychiatric Association [33], have issued position statements and resolutions denouncing conversion therapy [5]. An American Psychological Association review of 83 research studies on conversion therapy concluded that such efforts are not scientifically validated, contribute to harm, and do not change sexual orientation [34]. In a collaboration with the Substance Abuse and Mental Health Services Administration, an American Psychological Association scientific panel determined that conversion therapy with children and adolescents is potentially coercive, is not supported by credible evidence, and may place young people at risk of serious harm [35]. In addition, global organizations such as the Pan American Health Organization have condemned reparative or "conversion therapy", stating that such therapies "lack medical justification and are ethically unacceptable [36]." HCPs should help parents understand the negative impact of conversion efforts and promote affirming strategies which optimize the health of SGD youth [1].

Position # 7 Further research on all aspects of SGD adolescent health is needed to inform advocacy, training, clinical practice, and community interventions

We have highlighted protective factors and stressors faced by SGD youth. Despite this, we are still lacking critical information to fully understand the healthy development of SGD youth and to better manage the issues that arise during this process, including, but not limited to, intersectionality (e.g., race/ethnicity, religion, asylum seeking) and minority stress, highlighting the need for future research [3].

Summary

SAHM firmly believes that SGD adolescents fundamentally experience the same physical, developmental, and emotional hurdles as do their non-SGD adolescent peers. However, nonacceptance or victimization by peers, family members, or their community creates an added dimension of stress, which can lead to mental health problems and/or high-risk behaviors.

HCPs who work with adolescents should be trained to recognize the resilience of SGD adolescents and young adults and the internal and external stressors including the intersectionality of the many identities (e.g., race/ethnicity, religion, language) that form their persona. These factors modulate the risks they face. HCPs should offer adolescents and young adults robust support to promote self-acceptance and healthy growth.

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