JOURNAL OF ADOLESCENT HEALTH 2002;31:407–416

ORIGINAL ARTICLE

How to Reach Sexual Minority Youth in the Health Care Setting: The Teens Offer Guidance

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Purpose: **To explore factors sexual minority youth believe make them feel safe in a health care setting.**

Methods: **Participants in three urban programs serving lesbian/gay/bisexual/transgendered and questioning (LGBTQ) youth engaged in a four-stage process to generate, prioritize, and explain their own ideas. In Stage III, 94 youth, aged 14 to 23 years, completed a survey comprised of the 34 highest rated items generated in earlier stages. Using a Likert scale, they answered, "How important are each of the following ideas in making you feel safe as an LGBTQ youth when you go for health care?" In Stage IV, youth discussed the results in focus groups. The Marginal Homogeneity Test divided the items into priority ranks and the Kruskal-Wallis test explored subgroup differences in item ratings.**

Results: **The 34 items were divided into six ranks. Five items shared the top rank: the clinician maintaining privacy, demonstrating cleanliness, offering respect, being well-educated, and being honest. The second rank was shared by the following: the clinician not talking down to patients, being a good listener, not downplaying patients' fears, being professional, holding a nonjudgmental stance of the LGBTQ lifestyle, and not assuming every LGBTQ youth has HIV. Interspersed among other ranks were items specific to the needs of sexual minority youth: the clinician not assuming LGBTQ sexual behavior was painful or dangerous; the clinician being educated about the gay lifestyle; clinician sensitivity to the needs of same-sex partners; staff sensitivity to the needs of closeted youth; having a choice of an LGBTQ provider; and the clinician not assuming heterosexuality. Youth who had not publicly disclosed their sexuality rated health information being offered in a private place higher ($p = .01$).**

Conclusions: **LGBTQ youth value the same clinician characteristics desired by all adolescents: privacy, cleanliness, honesty, respect, competency, and a nonjudgmental stance. They clearly describe what attracts them (e.g., clinicians educated about their lifestyle) and what offends them (e.g., equating their sexuality with HIV). Clinicians need to achieve and convey a higher comfort level in addressing the special needs of sexual minority youth.** © *Society for Adolescent Medicine, 2002*

KEY WORDS:
Access to health care
Adolescent
Confidentiality
Gay
Lesbian
Provider-patient relationship
Risk behaviors
Sexual orientation

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This research was supported by the Philadelphia Foundation, the Samuel S. Fels Fund, and the Mary D. Ames endowment.

Manuscript accepted March 26, 2002.

Many young people who face sexual identity issues lack support, which leads to isolation as well as high rates of sexually transmitted diseases [1–8], at-

Published by Elsevier Science Inc., 360 Park Avenue South, New York, NY 10010
1054-139X/02/$–see front matter
PII S1054-139X(02)00419-6

tempted suicide [9–14], school dropout [3,14–17], homelessness [14,16,18], and victimization [19,20]. Because many have heard others label their feelings as deviant, many choose to remain quiet rather than face rejection and abuse [21]. Although lesbian, gay, bisexual, transgendered and questioning (LGBTQ) youth have important health care needs, they may not risk the possibility of rejection in an effort to seek care. Because there are no external indicators of their sexual identities, they may be missed entirely unless clinicians learn how to make themselves available to them.

Sexual minority adolescents often fail to locate supportive adults (including clinicians) in whom they can confide [22]. The utility of their search for a responsible adult to help them is strictly dependent on the training, skill, and comfort level of the adult. Studies have demonstrated that 20% of school counselors feel they are not competent in counseling gay adolescents [23]. One-fourth of the school counselors reported that teachers seem to exhibit significant prejudice toward gay students, and 41% believed schools are not doing enough to help gay students adjust to their school environment [23]. The health clinician may be the only adult who interacts confidentially and repeatedly with an adolescent. When an effective relationship exists, the health practitioner is positioned to help youth navigate challenges and avert crises. Although teenagers offer complaints related to physical health, they often come in as a help-seeking gesture [24–27]. The effective clinician can serve as a portal of entry into a supportive network of services and providers that can help youth exploring their sexual identity.

Some have suggested that an integrated system of care involving school-based programs, multiservice youth agencies, and self-help groups could deliver appropriate educational, medical, mental health, and social support services for LGBTQ youth [3,9,28–30]. However, there is little information about how best to demonstrate that the needed support is available and then how best to deliver it in a desired manner.

The objective of this study was to gain an LGBTQ youth perspective about factors that determine whether they trust or feel safe with clinicians and clinical sites.

Methods

Population

The study population consisted of self-described LGBTQ youth who participated in one of three urban programs serving sexual minority youth in Philadelphia. Study participants were recruited from these centers by the facilitator at the time of each session.

Refreshments were offered in return for participation in the study's group activities. Survey respondents were not compensated. Youth were told that participation in the study was voluntary and that all information was held confidential. Formal consent was waived. The study was approved by the Institutional Review Board of the Children's Hospital of Philadelphia.

Table 1. Study Methodology

Stage	Method	Objective	n
I	Expert focus group	Frame questions in appropriate language	8
II	Nominal group Technique	Generate responses to 2 study questions	72
III	Survey	Assess importance of responses	94
IV	Open focus groups	Clarify responses	41

Study Design

This study utilized a four-stage, teen-centered approach. The mixed qualitative-quantitative methodology enabled youth to frame questions in Stage I in an exploratory focus group, generate ideas in Stage II utilizing the Nominal Group Technique (NGT) [31,32], prioritize their ideas in Stage III surveys, and describe the rationale behind their ideas in Stage IV explanatory focus groups. In each stage of the study, participants were asked to complete an anonymous questionnaire that asked for gender, age, ZIP code, race, ethnicity, and degree of "outness" (see below). Table 1 summarizes this hierarchical design.

In Stage I, eight youth from the leadership of the Attic Youth Center participated in developing the two study questions required for the NGT, which would be universally understood by all youth and capable of generating a broad range of ideas. The first question asked about clinician characteristics, and the second focused on aspects of clinical sites. This group also discussed and helped to design the "outness" scale used throughout the study. This scale asked youth to select whether they were: (a) "out to no one"; (b) "out to a few people"; (c) "out to some people"; (d) "out to most people"; or (e) "out to everyone."

In Stage II, the NGT allowed adolescents to generate and prioritize ideas based on the two study questions [31,32]. The formal structure of this tech-

nique encourages participation from all group members and minimizes facilitator influence. First, youth generate responses to the study question in a round-robin format designed to minimize ownership of ideas. After a process of clarification, not debate, youth independently vote on the ideas they consider most important. Fifty-six youth participated in eight NGT sessions to determine what was important to them about clinicians, and another 36 youth participated in six NGT sessions focusing on clinical sites. Twenty youth participated in both sessions. This process generated more than 344 ideas. Items among groups were compared and combined to achieve an overall weighted score.

In Stage III, youth from two sites completed a survey comprised of the 34 highest rated items from the NGT groups. The survey was written using the precise language of youth, and survey items were randomly ordered. The participants responded to the question, "How important are each of the following ideas in making you feel safe as an LGBTQ youth when you go for health care?" using a 5-point Likert scale ranging from 5 = "This is extremely important to me" to 1 = "This is not at all important to me." Demographic and descriptive data were collected from each young person during this stage. The mean Likert rating was calculated for each item.

In Stage IV, 41 youth participated in open focus groups to discuss the results of the survey. Groups of six to eight youth were gathered for each session, which lasted approximately 45 min. A total of six focus groups were conducted. The items from the survey were placed on a large board by order of their mean Likert ratings. Using consistent written guidelines among the groups, a facilitator guided the youth to offer meaning and context to the survey items. Because groups chose to discuss the topics that most interested them, some survey items were not discussed. All groups were audiotaped and transcribed.

Statistical Analysis

The items generated during the NGT sessions were given priority scores by the participants. Items that were conceptually the same among groups were combined. The 34 items with the top scores were used on the survey.

Mean Likert scale ratings were calculated for each item on the survey. These mean ratings were then ordered from most important to least important. The Marginal Homogeneity Test was used to rank these items by comparing each consecutive rating until a statistically significant difference was found ($p < .05$). Items that were not statistically significant from one another were assigned the same rank. The Kruskal-Wallis test compared differences in rankings among demographic subgroups.

The open focus group data are not appropriate for quantitative content analysis because the facilitator guided each group in the direction and duration of discussion regarding survey items. Therefore, the qualitative group data are used here to supplement the quantitative survey data. This information is included to provide clarification and enrichment of the survey results, in which the importance ascribed to them by youth can be objectively stated.

Results

The results of the Stage I expert focus group of eight youth leaders is best represented by the two NGT questions, their accompanying explanations, and the development of an "outness scale" used to describe youth. The questions were "What characteristics of a health care professional would help you to trust them?" and "What characteristics of a health care site would make you trust that the people in it can help you or serve you?" Following each question was a definition of health care professional, characteristics, and health care site. As part of Stage II, youth then developed 176 responses to provider characteristics and 168 responses to health care site characteristics. Because the top 34 rated items were used to create the survey for Stage III, the results of the NGT sessions are best presented as the items on the survey.

Survey Results

A total of 94 sexual minority youth completed the 34-question survey. Table 2 demonstrates the demographic characteristics of the youth that completed the survey. The participants ranged in age from 14 to 23 years, with 73% aged 17 to 21 years. Sixty-three percent of the respondents were male. Nineteen young people (20%) identified themselves as lesbians, 46 (49%) as gay men, and 22 (23%) as bisexual. A total of 66 adolescents (70%) said that they were either "out to most people" or "out to everyone." Seventy-one percent reported seeing a health provider in the last year and 90% had seen one in the last 3 years. Table 3 lists the 34 items on the survey by descending mean Likert ratings with their respective ranking by the Marginal Homogeneity Test. This test

Table 2. Demogaphics of Survey Participants[a]

Variable	Number	Percentage
Total	94	
Gender		
Female	33	35
Male	59	63
Transgendered	2	2
Age (years)		
14–16	10	11
17–18	27	29
19–21	42	45
22–23	13	14
Race		
African-American	26	28
White	45	48
Multiracial	7	7
Other	12	12
Orientation		
Bisexual	22	23
Gay	46	49
Lesbian	19	20
Other	2	2
Outness scale		
Out to no one	1	1
Out to a few people	13	14
Out to some people	11	12
Out to most people	35	37
Out to everyone	31	33

[a] Note that not all categories total to 94 because of missing data.

divided the items into six distinct ranks. Each ranking had between four and eight items that were not significantly different from each other but were significantly different from the items in the adjacent ranks.

The first rank contains items that relate to the provider's interaction with the young person, including confidentiality, respect, and honesty. It also includes the adolescent's concern that the provider is well-educated and pays attention to cleanliness. The concept of cleanliness also applies to the site and the instruments at the site.

The second and third ranks contain more desired qualities of providers' interaction style including ones specific to LGBTQ youth. They include not talking down to the patient, being a good listener, not dismissing fears, being professional, and treating patients with sensitivity. Also included in these ranks are the concepts of being nonjudgmental toward LGBTQ issues, not assuming that LGBTQ youth have HIV or engage in dangerous sexual behavior, being educated about the gay lifestyle, and understanding same-sex partner needs.

Most of the items in the fourth rank have to do with general site-specific characteristics. These include a discreet staff, the choice of a male or female provider, a racially diverse staff, and a site in a safe area. The items in the fifth rank have in common site characteristics that focus on LGBTQ issues. According to these items, the site should have LGBTQ posters, a choice of an LBGT provider, services focused on LGBTQ youth, and openly gay or lesbian providers. Among the contents of the final rank are two site-related items that are specific to LGBTQ youth: having a sticker indicating that the clinic is a safe place for sexual minority youth and having magazines oriented to LGBTQ youth in the waiting room.

Using the Kruskal-Wallis test, all of the items on the survey were examined for differences among demographic subgroups. These subgroups included age, gender, sexual orientation, site of survey, and score on the "outness" scale. There were very few differences among these groups. However, females were more likely than males to desire a provider who is the same gender ($p = .0001$), aware and educated about the gay lifestyle ($p = .03$), did not dismiss or downplay fears ($p = .04$), and is friendly ($p = .04$). Older teens were more likely to be concerned about information being discussed in public areas than the younger respondents ($p = .01$). Less "out" youth were more likely to want health information to be displayed in a private place ($p = .04$).

Focus Group Results

Concerns not directly related to sexual minority status receive highest priority. The groups were initially shown the list of items and asked for comments on the ordering of items. All groups quickly noted that general items were rated most highly, but issues specific to sexual minority youth received lower ratings. Youth were asked why these general items were prioritized when the question specifically asked about the factors that make LGBTQ youth feel safe when they go for health care. Most responded that they had the same basic needs as all youth and that meeting those needs was the prerequisite to meeting any special needs. It is important to note, however, that youth in the focus groups related many of the general issues to the special needs of sexual minority youth. This was particularly true of the items related to privacy, honesty, professionalism, and sensitivity.

The fact that LGBTQ-specific issues were not among the highest ranked survey items generated quite a bit of controversy. Several youth felt strongly that sexual minority-specific items did not

Table 3. Ranking of Items LGBTQ Youth Believe Will Ensure Their Safety

Item	Mean Likert Rating	Rank
The health care site, the instruments, and provider are clean.	4.75	1
I know the my information will be kept private and confidential.	4.72	1
I will be treated with respect.	4.70	1
The provider is medically well-educated.	4.69	1
People will be honest and up-front with me.	4.68	1
The provider doesn't talk down to me like I'm a child.	4.64	2
The provider is a good listener.	4.57	2
The provider should not downplay or dismiss my fears.	4.53	2
The provider is open-minded and nonjudgmental of the LGBTQ lifestyle.	4.47	2
The provider doesn't assume that every LGBTQ youth has HIV/AIDS.	4.46	2
The provider is professional.	4.39	2
People will speak to me in language that I understand.	4.35	3
I will be treated with sensitivity.	4.34	3
The provider does not assume that my sexual behavior is dangerous or painful.	4.33	3
I know that the provider is able to get me help/counseling when I need it.	4.30	3
The provider is aware and educated about the gay lifestyle.	4.27	3
Everyone at the site is friendly.	4.24	3
Patient information is not discussed in patient/public areas.	4.18	3
Providers understand that my partner is of the same sex, and they understand our needs.	4.17	3
Staff is discreet they are sensitive to the issue of being LGBTQ/closeted.	4.10	4
The provider seems like the kind of person who is willing to talk about issues around sex.	4.05	4
I am able to choose a male or female provider.	3.99	4
The staff is racially diverse, a melting pot of ethnicities.	3.90	4
I may choose to be open with one provider without fearing they will tell other staff or providers.	3.88	4
The site is in a safe area and there is security at the site.	3.84	4
Posters and heath information at the site include LGBTQ issues.	3.74	5
I have a choice of having an LGBT provider.	3.63	5
The site offers services that focus on LGBTQ youth.	3.62	5
The provider doesn't seem like he or she is too into using labels.	3.60	5
The site has some openly gay or lesbian providers.	3.52	5
The provider does not assume that I'm heterosexual/straight.	3.38	6
The site has a sticker clearly displayed that says this site is comfortable with LGBTQ issues (like a pink triangle or rainbow).	3.31	6
There are magazines in the waiting room for LGBTQ people.	3.29	6
Health information (pamphlets, brochures, etc.) is offered in a private place.	3.17	6

LGBTQ = lesbian/gay/bisexual/transgendered and questioning.

even belong on the list because being LGBTQ was not a medical issue. These adolescents stated that clinicians should focus solely on the presenting physical concern:

> ". . . What you do behind closed doors, or what you do in bed, that really isn't none of their business . . ." "if you're gay or whatever, that isn't their concern, their concern is to make sure you are healthy, and take care of your health, and that's it."

Facilitator field notes revealed that youth more comfortable with public awareness of their sexuality believed an informed clinician could deliver better care, whereas more secretive youth tended to state their sexuality was irrelevant to clinicians. A female subject exemplified the viewpoint that clinicians should be aware of their patient's sexuality:

> ". . .Lesbians have specific health problems that tend to be fairly common within the lesbian community. . . Alcohol use is much higher, smoking is much higher, and the fact that you're pretty likely not to get pregnant at some time in your life really does affect how your body works. And I'd like my doctor to be aware of that."

Clinician-related items that affect LGBTQ youths' perception of safety. The importance of privacy was discussed at length in all of the focus groups, generating more discussion than any other topic. Several survey items dealt directly with whether information would be treated as private (e.g., confidentiality, not discussing patient information in public areas, staff discretion, and fear of disclosure to other providers). Privacy issues were also raised repeatedly during discussions on professionalism, honesty, respect, and sensitivity. Fear was expressed about information, particularly related to sexuality, getting back to parents. Participants agreed that if they trusted clinicians to keep privacy, they would be more likely to share personal information. Several youth offered advice on how clinicians could reassure youth of confidentiality, one young person suggested:

> "If they said, 'everything you tell me now is just between you and me,' it would make me a lot more comfortable talking . . . If there was something, like an actual physical piece of paper from somebody saying that is my responsibility to keep whatever you are telling me confidential, then that would make me feel a lot better. And probably help me to say more to them."

Youth in every group agreed that clean clinicians, instruments, and sites are a top priority. They were afraid that diseases could be easily transmitted if cleanliness and sterility were not priorities.

> "You go the doctor to be treated for illnesses and if you go and things aren't clean and the person isn't clean you might pick up something else."
>
> ". . . if there was someone with HIV, I wouldn't know, but I wouldn't want to give them what I have because it could be deadly for them. And I would not want to come in contact with HIV if things weren't clean."

The survey respondents also rated the item "the provider is medically well-educated" quite highly. When asked how a person would know this, youth offered several ideas including getting recommendations from friends, family, or a trusted clinician. Several youth responded with concrete answers such as, "You can look at the door at his certificates and stuff." There was also support for the idea that how the clinician interacts with a patient is a good indicator of medical knowledge. One person offered, "If they seem like they're stupid, then that's when you take off."

Many youth felt that clinicians should have sensitivity training regarding the issues of sexual minority patients as part of their medical training. In particular, they believed that clinicians should have an understanding of how sexual orientation may impact on emotional health.

> ". . . sometimes a provider meet(s) a person who is dealing (with) a depression about their sexual orientation. And they just want to hurt themselves; they need some kind of assistance to help them with the mental situation. Now the doctor gotta pretty much know about the gay lifestyle, (and) where's the first place to look at to give this child support for whatever dilemma they're going through."

Although some adolescents stated that many sexual minority youth do not go to doctors because they perceive that doctors do not understand their needs, others told stories of positive interactions with clinicians. These had in common trust, respect, and the clinician's understanding of LGBTQ youth issues. The following is a description of one such relationship:

> "My doctor is really cool, he's never rude, any questions I ask him, he answers full right there to the T. And 'cause I came out last year, I started talking to him . . . I don't think there was a question that I have had, where I haven't asked him."

Although having an LGBT provider was near the bottom of the ranking, this issue was discussed at length in every group. Although the subject was interesting to most people, and important to many people, there was no consensus on the matter. Some youth said that having a gay or lesbian provider would make it easier for them to explain what was going on in their lives. Others stated strongly that only gay and lesbian providers could truly understand their perspective.

> ". . . when I go to an Ob/Gyn, she needs to understand that I'm a lesbian and I do not like anything penetrating my body. And as a female, that's what you are going to an Ob/Gyn for. So she would need to understand or be sensitive to that aspect of me. Because the only way she's going to get me on the table is to calm me down . . . But if she's a straight woman who enjoys penetration, she might be like, child, girl . . ."

It was clear, however, that for most youth the providers' understanding of LGBTQ issues outweighed his/her orientation:

> "It really doesn't matter if the person's gay or not, because as long as . . . they know about the gay lifestyle and what you're going through, it shouldn't really matter as long as they are gay-friendly."

Site-related items that may be attractive to LGBTQ youth. Generally, youth felt that symbolic efforts to enhance their comfort, such as displayed stickers or LGBTQ-oriented magazines, would make little difference to them. Although some stated these would indicate a gay-friendly, comfortable environment, others expressed fear that these items would give away their orientation. One discussion follows:

> "I think it's important because you put a little sticker on there, means you're gay-friendly, and that gays will want to go there."
>
> "Yeah, but that's like labelizing us. That's like the gayborhood; it's only for gay people."
>
> "I'm saying, just because you put up a sticker, not only gay people going to go there . . . Some people don't even know what that means. A rainbow? Oh and they walk right in."

Survey respondents rated the placement of magazines and health information lowest among all survey items. Nevertheless, these items generated some interesting discussion regarding who would, and who would not, access these materials. There was general agreement that closeted youth would be unlikely to take openly displayed materials. A solution seems to have been generated by the item, "Health information is offered in a private place." One youth explained why implementing this idea made sense to him:

> "I know a lot of people that don't want to pick up information if you walk in and there's a whole room full of people waiting . . . I think that should be in the room where you get examined. When you (are) done getting examined and getting dressed, you can just get your stuff. Pick up the pamphlets and leave. Brochures for HIV and STDs should be in the room with you, too, not outside in the waiting room with the rest of the public."

Actions that offend LGBTQ youth. Youth in every focus group recalled bad clinical interactions and stated clearly what offended them. First, they told of how many opportunities were lost when heterosexuality was assumed.

> "I think that with sexual minority youth, a lot of health care providers are very heterosexist, where they just assume you are heterosexual. And that's a big problem. They never really get to the point with that."

Youth also made it clear that the relationship suffers if a clinician reacts negatively when they reveal their sexuality. Youth described instances of doctors changing demeanor when they revealed their sexuality and even of leaving the room and being replaced by another clinician.

> "They changed in the middle of the conversation after they found out I was gay. They bring in the nurse or the nurse will bring in the guy because he was gay. And I was like 'How dare she bring in a gay guy for me to talk to and I was happy talking to her.'"
>
> "We were talking 'cause I had went for the appointment to talk about hormones, and she told me to hold on a minute and she didn't come back . . . On a certain level, I think it was okay for her to do that if she was uncomfortable, but she should have said . . . We have somebody who can help you better rather than just leaving the room and then have a completely different doctor walk in and not say anything about why. Bait and switch. That's f-d up."

Participants stated they are also offended when clinicians assume they are at greater risk for disease:

> "Are you going to get HIV tested? Don't think that just because somebody's gay that that means they have to have HIV . . . Don't place labels on people."

Finally, group members stated how offensive it was to receive sexual health information from a judgmental stance:

> ". . . when you tell them that you are gay, they be like—do you have oral sex and use a condom? WHY NOT?! They seem like they are jumping down your throat or something like that."

Discussion

All clinicians who care for adolescents see LGBTQ youth in their practices. These adolescents may remain hidden because they have not identified themselves as sexual minority youth to their provider, but they exist nonetheless. Estimates of the prevalence of homosexuality in the adult population range from 3% to 10% [33–35]. Similar frequencies have been reported in teens, with a much higher response of "unsure" with younger adolescents [2,36]. Youth who are unsure are likely to experience turmoil, much as youth who have self-identified.

The process of sexual identity formation may produce a great deal of stress and is often accompanied by victimization as youth face verbal and physical abuse at school and in their homes. The increased stress and victimization of sexual minority youth have been linked to the increase in health risk behaviors [13,14,17,19,20].

A growing literature recognizes the importance of meeting the needs of sexual minority youth and

offers advice and education in how to deal with LGBTQ adolescents [3,9,29,30,37]. In fact, the American Academy of Pediatrics has issued a policy statement on homosexuality and adolescents reaffirming practitioners' duty to provide comprehensive care for all youth, including sexual minority youth [38]. However, the existing literature approaches this issue from an adult viewpoint. There is little documentation of how these youth interact with the health care system from their perspective.

This study reports ideas that sexual minority youth consider important to them when interacting with clinicians and clinical sites. First, sexual minority youth prioritized most highly the same issues as all youth, as demonstrated by previous research with Philadelphia-area teens [39]. These issues include confidentiality, infection control, competency, respect, and honesty. They emphasized that these are the prerequisites of care for all adolescents, and first and foremost, they have the same needs as others. However, the youth explained that these issues become even more important in making them feel safe in discussing their sexual orientation. In particular, the assurance of confidentiality became a recurrent theme in the explanation of many of the other responses. Cheng et al. [40] reported that less than half of adolescents remembered ever talking about confidentiality with their health care provider. As important as this issue is to adolescents, in general, sexual minority youth who participated in this study emphasized repeatedly that disclosure of their orientation must be kept confidential.

Second, although participants in this study generated responses to questions about clinicians and sites, it was clear that when they consider safety in the health care setting, they prioritize characteristics and actions of the clinicians that serve them. They want clinicians who are nonjudgmental and honest, honor privacy, are good listeners, do not talk down to them or dismiss their fears, and treat them with sensitivity. The females in this study preferred to have female providers, but males did not indicate a preference; these findings are similar to those found in a study that sampled a cross-section of youth [41]. The youth care about diversity of the clinic staff and indicate that they appreciate knowing the site has some openly gay or lesbian providers. Although some youth prefer having an openly gay or lesbian provider directly serve them, most cared much more about the provider's knowledge and attitude about sexual minority youth.

Third, LGBTQ youth shared that they have issues specific to their sexual orientation that need to be addressed if they are to feel safe in a health care setting. They report that they must get a feeling from the provider that he or she truly understands and cares about their health before they decide to disclose their orientation. They need clinicians to be open minded, as well as educated about LGBTQ issues. Discretion is key to gaining their trust, especially if their family is known to the clinical practice. In general, they are not made to feel more comfortable just because the clinicians "appear" to be sensitive to LGBTQ populations by placing rainbow stickers on their door or providing LBGTQ magazines in the waiting room, although some youth appreciated the effort.

Finally, youth were clear that specific actions offend them and affect their satisfaction, as well as their likelihood of returning for care. They have a strong concern that they will be judged or labeled. They perceive that some providers equate homosexual behaviors with HIV/AIDS and resent that association. Similarly, they are offended by the assumption that their sexual behaviors are dangerous or painful. They tire of the assumption that they are heterosexual and report in focus groups that it is an assumption they often do not correct. All of these issues create lost opportunities for effective behavioral counseling.

Clinicians are among the few adults who can have a consistent and confidential relationship with an adolescent. An assessment of risk is key to maintaining health for this population [42,43]. Although many doctors express the desire to serve LGBTQ youth and acknowledge their important role, many are not confident in their skills and knowledge of the issues [44]. This may stem from a lack of training in this subject area. In fact, the average time spent on gay and lesbian health care issues in general in American medical schools is 3.5 hours, suggesting that better education in this area is needed [45].

To date, there are no studies that demonstrate conclusively that these recommendations will, in fact, result in an improvement in the health status of LGBTQ youth. However, in a recent article, Blake et al. [46] reported that gay-sensitive HIV instruction in schools results in lowered sexual risk behavior in gay and lesbian adolescents. Although this relationship might be explained by other factors, this does provide some evidence that open discussion of homosexuality positively influences the behavior of sexual minority youth.

There are important limitations with this study. First, the participants may not be representative of sexual minority youth. Seventy percent of the partic-

ipants categorized themselves as "out to most people" or everyone. It is quite possible that less "out" youth would feel differently about the issues discussed. However, because many sexual minority youth are not open about or fully aware of their sexuality, it is impossible to recruit a truly representative sample. Second, the mean age of the survey respondents was 19 years. Younger adolescents may have answered questions differently. Third, the youth in this study were all from a northeastern city or its metropolitan region. The issues that these adolescents face may be quite different from their rural and small-town counterparts and even different from youth from other metropolitan areas. Most importantly, this study explored sexual minority adolescents' perceptions of factors they believe would enhance their likelihood of feeling safe in a health care setting rather than outcomes.

Conclusions

To best meet the special needs of sexual minority youth, clinicians should be equipped with the interpersonal skills and knowledge desired by these youth. This study demonstrates that, from an adolescent's perspective, optimal interaction with sexual minority youth foremost requires the same interpersonal skills desired by all adolescents, as well as specific knowledge of how to address LGBTQ issues and, more pointedly, how not to offend LGBTQ patients. Future research is needed to explore whether providers educated to meet these needs produce better outcomes for sexual minority youth.

We would like to acknowledge the contribution of Drs. Thomas Dilling and Deborah Gill, who helped in study design and facilitated early focus groups. We would also like to thank Dr. Carrie Jacobs, director of The Attic, and The Attic's Youth Planning Committee for their support and guidance. Above all, we appreciate the adolescent participants who shared their views on how we can better serve them.

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