



## POLICY STATEMENT

Office-Based Care for Lesbian, Gay, Bisexual,  
Transgender, and Questioning Youth

## abstract

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The American Academy of Pediatrics issued its last statement on homosexuality and adolescents in 2004. Although most lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are quite resilient and emerge from adolescence as healthy adults, the effects of homophobia and heterosexism can contribute to health disparities in mental health with higher rates of depression and suicidal ideation, higher rates of substance abuse, and more sexually transmitted and HIV infections. Pediatricians should have offices that are teen-friendly and welcoming to sexual minority youth. Obtaining a comprehensive, confidential, developmentally appropriate adolescent psychosocial history allows for the discovery of strengths and assets as well as risks. Referrals for mental health or substance abuse may be warranted. Sexually active LGBTQ youth should have sexually transmitted infection/HIV testing according to recommendations of the Sexually Transmitted Diseases Treatment Guidelines of the Centers for Disease Control and Prevention based on sexual behaviors. With appropriate assistance and care, sexual minority youth should live healthy, productive lives while transitioning through adolescence and young adulthood. *Pediatrics* 2013;132:198–203

## INTRODUCTION

The American Academy of Pediatrics issued its first statement on sexual minority teenagers in 1983, with revisions in 1993 and 2004. Since the last report, research areas have rapidly expanded and hundreds of new publications have been produced about lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, including an Institute of Medicine publication entitled “The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.”<sup>1</sup> Being a member of this group of teenagers is not, in itself, a risk behavior and many sexual minority youth are quite resilient; sexual minority youth should not be considered abnormal. However, the presence of stigma from homophobia and heterosexism often leads to psychological distress, which may be accompanied by an increase in risk behaviors. Health disparities exist in mental health, substance abuse, and sexually transmitted infection (STI)/HIV. LGBTQ will be used whenever discussing studies and recommendations for all self-identified lesbian, gay, bisexual, transgender, or questioning youth. Many adolescents do not define themselves as a member of a sexual minority group but may have had same gender sexual

## COMMITTEE ON ADOLESCENCE

## KEY WORDS

sexual orientation, sexual identity, sexual behaviors, adolescents, sexual minority, homosexuality, gay, lesbian, bisexual, transgender

## ABBREVIATIONS

CDC—Centers for Disease Control and Prevention

HPV—human papillomavirus

LGBTQ—lesbian, gay, bisexual, transgender, and questioning

MSM—men who have sex with men

STI—sexually transmitted infection

WSW—women who have sex with women

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The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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behaviors (men who have sex with men [MSM] and women who have sex with women [WSW]). For this statement, the term “sexual minority” includes LGBTQ and MSM/WSW individuals.

## DEFINITIONS

Typically, a young person’s sexual orientation emerges before or early in adolescence.<sup>2,3</sup> Sexual orientation is referred to as “an individual’s pattern of physical and emotional arousal toward other persons.” Individuals who self-identify as heterosexual are attracted to people of the opposite gender; homosexual individuals self-identify as attracted to people of the same gender; bisexual teens report attraction to people of both genders. In common usage, self-identified homosexual people are often referred to as “gay” if male, and “lesbian” if female.<sup>4</sup> Many adolescents struggle with their sexual attractions and identity formation, and some may be referred to as “questioning.”<sup>2</sup> For other definitions, please see Table 1 in the accompanying technical report.

Gender identity and gender expression usually conform to anatomic sex for both homosexual and heterosexual teenagers.<sup>5</sup> Gender dysphoria refers to the emotional distress of having a gender identity that is different from natal sex. Many young children with gender dysphoria will resolve their dysphoria by adolescence, but others will maintain it and desire transition to the opposite gender. These teenagers are “transgender.”<sup>6,7</sup> Transgender people are often also identified by the natal gender and transition to the desired gender; MTF refers to males transitioning to females and FTM are females transitioning to males.<sup>1,5,7–9</sup>

Many adolescents who self-report as lesbian will still occasionally have sex with males, and many males who self-report as gay may have sex with

females; behaviors do not equal identity.<sup>1,10</sup> This range of sexuality may be reflected in the higher rate of teenage pregnancies experienced by WSW compared with their exclusively heterosexual peers.<sup>11,12</sup>

## HOMOPHOBIA, HETEROSEXISM, AND IDENTITY FORMATION

Homophobia and heterosexism may damage the emerging self-image of an LGBTQ adolescent.<sup>13–15</sup> Homophobia perceived by LGBTQ youth may lead to self-destructive behaviors.<sup>16</sup> Societal homophobia is reflected in the higher rates of bullying and violence suffered by sexual minority youth.<sup>17</sup> With proper support and guidance, the majority of LGBTQ youth emerge as adults with sexual identities that are associated with little or no significant increase in risk behaviors compared with other youth. These resilient young adults lead happy, productive lives.<sup>18,19</sup>

## HEALTH DISPARITIES FOR SEXUAL MINORITY YOUTH

Stigmatization, ostracism, and parental rejection remain common. Resulting struggles with self-image and self-esteem put sexual minority youth at risk.<sup>11,20,21</sup> Many sexual minority youth become homeless as a consequence of coming out to their families; sexual minority youth who are homeless may engage in riskier behaviors including survival sex.<sup>22</sup>

Significant health disparities exist for sexual minority youth related to depression and suicidality, substance abuse, social anxiety, altered body image, and other mental health issues.<sup>1,13,17,23</sup> Sexual minority youth suffer higher rates of depression and were more than twice as likely to have considered suicide.<sup>1,13,17,24–26</sup> Protective factors against depression, suicidal ideation, and suicide attempts

included family connectedness, caring adults, and school safety.<sup>27</sup>

Referral for “conversion” or “reparative therapy” is never indicated; therapy is not effective and may be harmful to LGBTQ individuals by increasing internalized stigma, distress, and depression.<sup>1</sup>

When sexual minority teenagers “come out” and acknowledge their sexuality as adolescents, there are often significant repercussions, especially victimization.<sup>1,4,17,28</sup> Even if not open about sexuality, 16% of MSM reported experiencing violence. Of adolescents who were open about their LGBTQ sexual orientation, 84% reported verbal harassment; 30% reported being punched, kicked, or injured; and 28% dropped out of school because of harassment.<sup>17,29</sup> Sometimes it is simply the perception that an individual might be LGBTQ that may lead to bullying, harassment, violence, injury, and homicide.<sup>30,31</sup>

Studies on the use of legal and illegal substances revealed significantly higher rates of tobacco, alcohol, marijuana, cocaine, ecstasy, methamphetamine, and heroin in sexual minority youth.<sup>1,17,32,33</sup> Use of club drugs (eg, cocaine, methamphetamine, ecstasy, GHB [ $\gamma$ -hydroxybutyric acid], ketamine, and LSD [lysergic acid diethylamide]) is especially concerning because of the association with unprotected sexual intercourse.<sup>34</sup>

Health disparities exist in sexual health outcomes with respect to HIV/AIDS, other STIs, and teenage pregnancy among LGBTQ youth. Sexual minority youth were more likely than heterosexual youth to report having had intercourse, to have had intercourse before 13 years of age, and to have had intercourse with  $\geq 4$  people. Gay or lesbian youth were about half as likely as heterosexual youth to have used a condom at the last intercourse.<sup>22</sup> During the past 15

years, reported rates of gonorrhea, chlamydia, and syphilis have trended downward for all adolescents, except for MSM.<sup>35–37</sup> One particular disparity is in HIV infection. Data from the Centers for Disease Control and Prevention (CDC) show that HIV rates continue to increase among young MSM 13 to 24 years of age.<sup>38</sup>

Information on sexual health disparities experienced by WSW is limited. High rates of STIs have been documented in lesbians and bisexual women with recent sexual contact with men, but there were also low but significant rates of STIs in exclusive WSW relationships. Viral infections, such as human papillomavirus (HPV) and herpes simplex virus infection, may be transmitted via exclusive female-to-female sexual contact.<sup>39,40</sup>

LGBTQ youth are less likely to report the use of hormonal or barrier contraceptives at last sexual encounter when having sex with the opposite gender.<sup>22</sup> Due to high rates of earlier sexual initiation, a greater number of partners, and less contraceptive use, WSW are at higher risk of teenage pregnancy than are teenagers who only have sex with the opposite gender.<sup>1</sup>

## HEALTH DISPARITIES FOR TRANSGENDER YOUTH

Challenges faced by such youth and the potential of family and societal disapproval increase the risk that transgender adolescents will experience mental health issues, substance abuse, and sexual risk-taking behaviors. Transgender people face alarmingly high rates of verbal harassment and physical violence, including at home and at school.<sup>1</sup> Transgender youth face significant mental health issues as a consequence, including depression and suicidality, anxiety, body image distortion, substance abuse, and post-traumatic stress dis-

order. Supportive families can buffer an adolescent from these negative outcomes and promote positive health and well-being.<sup>8</sup>

MTF transgender youth face even more sexual health disparities than other sexual minority youth, with very high rates of HIV and other STIs.<sup>41</sup> There were higher rates of STIs and HIV in African American and Hispanic, compared with white, transgender individuals.<sup>42,43</sup> Contributing factors included history of incarceration, homelessness, exchanging sex for resources, non-consensual sex, and difficulty accessing health care. Many had injected liquid silicone in their lifetime, with some sharing needles for hormone or silicone injection. Transgender individuals who purchase or obtain transgenderic hormones on the street or from the Internet may cause significant health problems if used improperly, even if they are pure.<sup>23</sup>

## PROMOTING SEXUAL HEALTH FOR LGBTQ YOUTH

Pediatricians and their office staff should encourage teenagers to feel comfortable talking with them about their emerging sexual identities and concerns about their sexual activities. Care should be confidential, and it is not the role of the pediatrician to inform parents/guardians about the teenager's sexual identity or behavior; doing so could expose the youth to harm.<sup>44</sup>

Pediatricians' use of gender-neutral terms can encourage teenagers to discuss any questions they have about their sexual behaviors or sexual orientation.<sup>19</sup> Table 2 in the technical report offers suggestions for gender-neutral questions.<sup>45</sup> Confidentiality must be emphasized.<sup>19</sup>

Teenagers who are abstinent should have their abstinence acknowledged and reinforced.<sup>19</sup> If the adolescent notes that they have engaged in sex-

ual activity, 1 classic question is "Are you having sex with males, females, or both?"<sup>46</sup> Table 3 in the technical report offers some additional suggestions for asking about specific sexual behaviors.

## STI/HIV TESTING AND PREVENTION

Recent guidelines from the CDC recommend assessing for STI risk including asking about the gender of all partners. Pediatricians should then make decisions about STI testing on the basis of the sexual behaviors identified by the sexual history.<sup>47</sup> Adolescents who have not engaged in high-risk sex should be tested once per year. However, adolescents with multiple or anonymous partners, having unprotected intercourse, or having substance abuse issues should be tested at shorter intervals.<sup>47</sup> Specific STI screening recommendations for MSM are described in Table 4 in the technical report. Because of the increased incidence of anal cancer in HIV-infected MSM, screening for anal cytologic abnormalities has been proposed.<sup>48</sup> Condoms should be encouraged for all insertive/receptive sexual activities.<sup>47</sup> WSW are at risk of acquiring bacterial, viral, and protozoan infections from current and previous partners, both male and female. STD treatment guidelines from the CDC recommend a frank discussion of sexual behavioral risk so that the physician can make decisions about which STI tests to perform. Additionally, because many WSW have also had sex with men, HPV vaccine and routine cervical cancer screening should be offered to women according to recommended guidelines. Condoms for sex toys and dental dam for oral-vaginal contact should be emphasized.<sup>47</sup>

The CDC recommends routine immunization of males and females 11 or 12 years of age with HPV-4; catch-up

immunization is recommended for WSW and MSM through 26 years of age.<sup>47,49,50</sup> HPV-2 has been approved for females 8 through 25 years of age.<sup>51</sup>

Because many teenagers who self-identify as LGBTQ may have sexual encounters that may not be predicted by their orientation, conversation about highly effective birth control methods and emergency contraception is important.<sup>11,12</sup>

## TREATMENT OF TRANSGENDER YOUTH

See the technical report for additional details on the medical and surgical transition of transgender youth. Supportive counseling is paramount to assist the teenager with any dysphoria and to explore gender roles before altering the body. The therapy consists of potentially delaying puberty with gonadotropin-releasing hormone analogs, then use of hormonal therapy, and finally surgery.<sup>5</sup>

## ASSISTING PARENTS

Another critically important role of the pediatrician is to assist parents of sexual minority youth. Pediatricians should acknowledge the parents' feelings but should provide information and support for the adolescent who has disclosed. Parents' reactions and attitudes may adjust over time, and the pediatrician should check in regularly and offer support to the entire family. Please see Table 5 in the technical report for resources to assist sexual minority youth and their parents and families.

## RECOMMENDATIONS

- Pediatricians' offices should be teen-friendly and welcoming to all adolescents, regardless of sexual orientation and behavior; this includes training all office staff and ensuring that office forms do

not presume heterosexuality of patients (or parents).

- If a pediatrician does not feel competent to provide specialized care for sexual minority teenagers and their families, he or she has the responsibility to evaluate families and then refer for medically appropriate care.
- Pediatricians who provide care to sexual minority youth should follow prevention and screening guidelines as outlined in *Bright Futures*.<sup>19</sup>
- All adolescents should have a confidential adolescent psychosocial history. Verbal histories and/or written questionnaires should use a gender-neutral approach. Screening and referral for depression, suicidality, other mood disorders, substance abuse, and eating disorders should be included.
- LGBTQ adolescents and MSM and WSW should have sexual behaviors and risks assessed and should be provided STI/HIV testing according to recommendations in the most recent sexually transmitted diseases treatment guidelines from the CDC.
- Contraception, including use of emergency contraceptives, should be offered to women regardless of their stated sexual orientation, and the importance of consistent condom/dental dam use should be discussed.
- Strengths, resources, and risks should be assessed, and targeted behavioral interventions should be implemented to allow the adolescent to maximize strengths and acknowledge and minimize risky behaviors.
- Pediatricians should be available to answer questions, to correct misinformation, and to provide the context that being LGBTQ is normal, just different.

- Transgender adolescents need to be supported and affirmed; they need education and referral for the process of transition and about avoiding the pitfalls of using treatments that were not prescribed by a licensed physician.
- Pediatricians should support parents in working through adjustment issues related to having a child who is LGBTQ while continuing to demonstrate love and support for their children.
- Pediatricians should support or create gay-straight alliances at schools and support the development and enforcement of zero-tolerance policies for homophobic teasing, bullying, harassment, and violence.
- Pediatricians should educate themselves about organizations that serve sexual minority youth and families in local communities and national organizations with information, support Web sites, and hotlines.

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## REFERENCES

- Institute of Medicine, Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press; 2011
- Spigarelli MG. Adolescent sexual orientation. *Adolesc Med State Art Rev*. 2007;18(3): 508–518, vii
- Glover JA, Galliher RV, Lamere TG. Identity development and exploration among sexual minority adolescents: examination of a multidimensional model. *J Homosex*. 2009;56(1):77–101
- Frankowski BL; American Academy of Pediatrics Committee on Adolescence. Sexual orientation and adolescents. *Pediatrics*. 2004;113(6):1827–1832
- World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. Minneapolis, MN: World Professional Association for Transgender Health; 2011. Available at: www.wpath.org. Accessed June 11, 2012
- Wallien MS, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. *J Am Acad Child Adolesc Psychiatry*. 2008; 47(12):1413–1423
- Zucker K, Bradley S. Gender identity and psychosexual disorders. *Focus*. 2005;3(4): 598–617
- Olson J, Forbes C, Belzer M. Management of the transgender adolescent. *Arch Pediatr Adolesc Med*. 2011;165(2):171–176
- Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, et al; Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2009;94 (9):3132–3154
- Igartua K, Thombs BD, Burgos G, Montoro R. Concordance and discrepancy in sexual identity, attraction, and behavior among adolescents. *J Adolesc Health*. 2009;45(6): 602–608
- Herrick AL, Matthews AK, Garofalo R. Health risk behaviors in an urban sample of young women who have sex with women. *J Lesbian Stud*. 2010;14(1):80–92
- Goodenow C, Szalacha LA, Robin LE, Westheimer K. Dimensions of sexual orientation and HIV-related risk among adolescent females: evidence from a statewide survey. *Am J Public Health*. 2008;98(6):1051–1058
- Almeida J, Johnson RM, Corliss HL, Molnar BE, Azrael D. Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*. 2009;38(7):1001–1014
- Walls NE. Toward a multidimensional understanding of heterosexism: the changing nature of prejudice. *J Homosex*. 2008;55(1): 20–70
- Chesir-Teran D, Hughes D. Heterosexism in high school and victimization among lesbian, gay, bisexual, and questioning students. *J Youth Adolesc*. 2009;38(7):963–975
- McDermott E, Roen K, Scourfield J. Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. *Cult Health Sex*. 2008;10(8):815–829
- Kann L, Olsen EO, McManus T, et al; Centers for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9–12—youth risk behavior surveillance, selected sites, United States, 2001–2009. *MMWR Surveill Summ*. 2011;60(7):1–133
- Saewyc EM, Honna Y, Skay CL, Bearinger LH, Resnick MD, Reis E. Protective factors in the lives of bisexual adolescents in North America. *Am J Public Health*. 2009;99(1): 110–117
- Hagan JF, Shaw JS, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
- Kipke MD, Kubicek K, Weiss G, et al. The health and health behaviors of young men who have sex with men. *J Adolesc Health*. 2007;40(4):342–350
- Coker TR, Austin SB, Schuster MA. Health and healthcare for lesbian, gay, bisexual, and transgender youth: reducing disparities through research, education, and practice. *J Adolesc Health*. 2009;45(3):213–215
- Physicians for Reproductive Choice and Health. *Gay, Lesbian, Bisexual, Transgender, and Questioning Youth*. 4th ed. New York, NY: The Adolescent Reproductive and Sexual Health Education Program; 2011. Available at: www.prch.org/arshep. Accessed June 13, 2012
- Berg MB, Mimiaga MJ, Safren SA. Mental health concerns of gay and bisexual men seeking mental health services. *J Homosex*. 2008;54(3):293–306
- Silenzio VM, Pena JB, Duberstein PR, Cerel J, Knox KL. Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *Am J Public Health*. 2007;97(11): 2017–2019
- Walls NE, Freedenthal S, Wisneski H. Suicidal ideation and attempts among sexual minority youths receiving social services. *Soc Work*. 2008;53(1):21–29
- D'Augelli AR, Grossman AH, Salter NP, Vasey JJ, Starks MT, Sinclair KO. Predicting the suicide attempts of lesbian, gay, and bisexual youth. *Suicide Life Threat Behav*. 2005;35(6):646–660
- Eisenberg ME, Resnick MD. Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *J Adolesc Health*. 2006;39(5):662–668
- Kelley TM, Robertson RA. Relational aggression and victimization in gay male relationships: the role of internalized homophobia. *Aggress Behav*. 2008;34(5):475–485
- Consortium of Higher Education LGBT Resource Professionals. Press release. Syracuse, NY: Consortium of Higher Education LGBT Resource Professionals; October 4, 2004. Available at: www.lgbtcampus.org/about/news-2010-10-04-deaths. Accessed June 13, 2012
- Lampinen TM, Chan K, Anema A, et al. Incidence of and risk factors for sexual orientation-related physical assault among young men who have sex with men. *Am J Public Health*. 2008;98(6):1028–1035
- Herek GM, Sims C. Sexual orientation and violence victimization: hate crimes and intimate partner violence among gay and bisexual men in the US. In: Wolitski RJ, Stall R, Valdiserri RO, eds. *Unequal Opportunity: Health Disparities Affecting Gay and Bisexual Men in the US*. New York, NY: Oxford University Press; 2008:35–71
- D'Augelli AR. High tobacco use among lesbian, gay, and bisexual youth: mounting evidence about a hidden population's health risk behavior. *Arch Pediatr Adolesc Med*. 2004;158(4):309–310
- Ridner SL, Frost K, Lajoie AS. Health information and risk behaviors among lesbian, gay, and bisexual college students. *J Am Acad Nurse Pract*. 2006;18(8):374–378
- Parsons JT, Kelly BC, Weiser JD. Initiation into methamphetamine use for young gay and bisexual men. *Drug Alcohol Depend*. 2007;90(2-3):135–144
- Benson PA, Hergenroeder AC. Bacterial sexually transmitted infections in gay, lesbian, and bisexual adolescents: medical and public health perspectives. *Semin Pediatr Infect Dis*. 2005;16(3):181–191

36. Kipke MD, Weiss G, Wong CF. Residential status as a risk factor for drug use and HIV risk among young men who have sex with men. *AIDS Behav*. 2007;11(suppl 6):56–69
37. Rudy ET, Shoptaw S, Lazzar M, Bolan RK, Tilekar SD, Kerndt PR. Methamphetamine use and other club drug use differ in relation to HIV status and risk behavior among gay and bisexual men. *Sex Transm Dis*. 2009;36(11):693–695
38. Centers for Disease Control and Prevention. Trends in HIV/AIDS diagnoses among men who have sex with men—33 states, 2001–2006. *MMWR Morb Mortal Wkly Rep*. 2008;57(25):681–686
39. Robertson P, Schachter J. Failure to identify venereal disease in a lesbian population. *Sex Transm Dis*. 1981;8(2):75–76
40. Lindley LL, Barnett CL, Brandt HM, Hardin JW, Burcin M. STDs among sexually active female college students: does sexual orientation make a difference? *Perspect Sex Reprod Health*. 2008;40(4):212–217
41. Clements-Nolle K, Marx R, Guzman R, Katz M. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention. *Am J Public Health*. 2001; 91(6):915–921
42. Nuttbrock L, Hwang S, Bockting W, et al. Lifetime risk factors for HIV/sexually transmitted infections among male-to-female transgender persons. *J Acquir Immune Defic Syndr*. 2009;52(3):417–421
43. Garofalo R, Deleon J, Osmer E, Doll M, Harper GW. Overlooked, misunderstood and at-risk: exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *J Adolesc Health*. 2006;38(3): 230–236
44. Perrin E. *Sexual Orientation in Child and Adolescent Health Care*. New York, NY: Kluwer Academic; 2002
45. Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr*. 2004;21(1):64–90
46. Kaiser Permanente National Diversity Council. *A Provider's Handbook on Culturally Competent Care*. 2nd ed. Oakland, CA: Kaiser Foundation Health Plan Inc; 2004
47. Workowski KA, Berman SM; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2010. *MMWR Recomm Rep*. 2010;59(RR-12): 1–110
48. Ho KS, Cranston RD. Anal cytology screening in HIV-positive men who have sex with men: what's new and what's now? *Curr Opin Infect Dis*. 2010;23(1):21–25
49. Centers for Disease Control and Prevention. FDA licensure of quadrivalent human papillomavirus vaccine (HPV4, Gardasil) for use in males and guidance from the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2010; 59(20):630–632
50. Centers for Disease Control and Prevention. Recommendations on the use of quadrivalent human papillomavirus vaccine in males—Advisory Committee on Immunization Practices (ACIP), 2011. *MMWR Morb Mortal Wkly Rep*. 2011;60(50):1705–1708
51. Centers for Disease Control and Prevention. FDA licensure of bivalent human papillomavirus vaccine (HPV2, Cervarix) for use in females and updated HPV vaccination recommendations from the Advisory Committee on Immunization Practices (ACIP). *MMWR Morb Mortal Wkly Rep*. 2010; 59(20):626–629