Fifteen-minute consultation in the normal child: Challenges relating to sexuality and gender identity in children and young people

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ABSTRACT
Lesbian, gay, bisexual and transgender (LGBT+) young people face several challenges in their daily lives, including specific healthcare inequalities. Negative societal attitudes towards sexual and gender minorities, and the effects of regular experiences of bullying and homophobia/transphobia exacerbate the normal trials and tribulations of childhood and adolescence. Barriers to accessing healthy activities, such as sport, are created by perceived stigma and real-life experiences. Healthcare environments are by default heteronormative and contribute to the isolation and exclusion of LGBT+ young people. Paediatricians are well placed to act on these healthcare inequalities and to advocate for LGBT+ youth, through simple changes to individual practice as well as system-wide improvements.

INTRODUCTION
Lesbian, gay, bisexual and transgender (LGBT+) youth face inequalities in both their access to and experiences of healthcare.1 As an organisation delivering a public service, the National Health Service (NHS) is bound under the Equality Act of 2010 to ‘consider the needs of different groups’ and ‘commit to tackling inequality’.2

Yet surveys of front-line NHS staff show that three in five staff do not believe sexual orientation is relevant to healthcare, and three-quarters of staff have not received any training in the health needs of patients who are LGBT+.1 Up to 20% of front-line NHS staff have heard colleagues express belief that being gay can be ‘cured’.3 This is not just an issue confined to the UK, and LGBT+ people face healthcare inequalities worldwide.4

Being LGBT+ does not in itself cause mental health problems or create healthcare inequalities. Rather the challenges are a result of the often-negative environments in which our LGBT+ youth are growing up. Understanding developmental features of sexual identity is important for clinical practice (box 1). It is also important to remember that sexual...
identity is different to sexual behaviour. The glossary and guide at the end of this article provides the definitions for key terms.

**HEALTHCARE ACCESS AND EXPERIENCES**

Inequalities in access to healthcare are driven by negative experiences and affect how patients present to healthcare services. LGBT+ people are more likely to present to emergency departments for health issues than they are to their general practitioner (GP). Only half of young LGBT+ people feel safe and supported in the NHS when it comes to their sexual and/or gender identity, and more than half have experienced NHS staff making incorrect assumptions about their identity. Barriers to accessing healthcare for LGBT+ youth include presumed heterosexuality and judgemental attitudes from healthcare staff.

For transgender people, healthcare services can be particularly challenging. A UK Government report found that the needs of transgender patients are not being met, with an approach described as discriminatory and in breach of the Equality Act.

**PUBLIC HEALTH AND PREVENTION**

**Drugs and alcohol**

LGBT+ youth are more likely to use drugs and alcohol than their heterosexual peers. Areas with LGBT+ affirming schools seem to have fewer heavy drinking episodes for all youth, regardless of sexual identity, compared with areas where LGBT+ is not addressed in schools or is addressed negatively—although further study is required to understand this association.

**Sport and exercise**

Sports clubs and exercise facilities, such as gyms and leisure centres, create significant barriers in access for LGBT+ youth. Homophobic experiences and gender-specific rules (including changing rooms and sports kits) are among the barriers cited by many LGBT+ youth as reasons for not participating in sports and exercise. These barriers often continue into further education and adult life.

**Diet and eating disorders**

There is an increase in prevalence of disordered eating in lesbian, gay and bisexual teenagers, including fasting, use of diet pills or laxatives and purging. Lesbians are more likely to be overweight than heterosexual teenage girls, with binge eating being a significant risk factor. Transgender teenagers are four times more likely than cisgender (non-trans) peers to have an eating disorder, and management is complicated as diet can be related to attempts to control development of unwanted secondary sex characteristics (eg, fat deposition patterns and menstruation).

**Teenage pregnancy**

Teenage lesbian and bisexual girls have higher rates of pregnancy than heterosexual girls. Compared with heterosexual teenagers, young lesbian and bisexual girls are less likely to perceive safe sex advice as applicable to them, are more likely to have risky sex with male peers and are more likely to have consumed alcohol at the time of their first sexual encounter. This surprising statistic highlights the importance of designing health education and public health programmes to be inclusive.

**Violence and personal safety**

Being open about sexuality and gender identity can also put young people’s safety at risk. LGBT+ teenagers are significantly more likely than heterosexual peers to be raped, physically attacked and threatened or injured with a weapon.

**SCHOOL**

School is a source of significant stress and abuse for many young LGBT+ pupils. Homophobic comments such as ‘that’s so gay’ are heard daily at school by 99% of LGBT+ pupils. Direct homophobic
bullying is experienced by over half of all LGBT+ pupils regularly.17

In schools where LGBT+ issues are addressed, information is often inaccurate, misleading or issues are addressed in a negative manner. Over half of LGBT+ pupils do not feel they have an adult they can confide in at school, and many schools block access to LGBT+ resources.17 A fifth of LGBT+ pupils report not feeling safe in school and truancy is common.17 Experiences and expectations of homophobia dissuade many young LGBT+ pupils from pursuing higher education.7 17

HOME
Despite recent steps forward in societal attitudes, home life can still be a significant threat to the health of young gay people. Over half of LGBT+ youth hide their sexual and/or gender identity at home, which most find distressing.18 Young people who keep their identity secret have higher rates of self-harm and are significantly more likely to plan or attempt suicide.18 Young people who ‘come out’ to their parents may be forced to leave home. LGBT+ young people make up at least a quarter of all homeless youth.20 There are extremely limited services for homeless LGBT+ youth.

MENTAL HEALTH, SELF-HARM AND SUICIDE
Depression and anxiety
Mental health problems are disproportionately present in LGBT+ young people compared with heterosexual/cisgender peers.17 19 Almost half of all LGBT+ pupils who experience homophobic bullying have symptoms consistent with depression and anxiety. Even when not bullied, 35% still have symptoms.17 This is far higher than the rates for young people in general, which are estimated by National Institute for Health and Clinical Excellence to be around 5%.17 Persistent experienced and actual discrimination contribute to ongoing stress (box 2).

Self-harm and suicide
The National Society for the Prevention of Cruelty to Children estimates that between 1 in 15 and 1 in 10 young people in general self-harm; however, over half of all LGBT+ youth self-harm.17–19 Up to three-quarters of young LGBT+ people have had thoughts of suicide,17 and around a quarter have attempted suicide.17 18 Due to the poor acceptance of differences between biological sex and gender identity in society, transgender young people often face extreme social isolation, discrimination and victimisation.1 Thus, at least a third of transgender youth attempt suicide.17 18 21 Suicide and self-harm are even more prevalent in LGBT+ black and minority ethnic youth.17 18 Help-seeking behaviours

Help-seeking and risk factors
The Queer Futures report18 explored lesbian, gay, bisexual and transgender (LGBT+) adolescents’ suicidal feelings, self-harm and help-seeking. Most young LGBT+ people only look for help when at a crisis point. The most common reason for not seeking help is not wanting to be viewed as ‘attention seeking’. Not wanting to reveal sexual orientation/gender identity is also a significant factor for young people not seeking help.

Help is most often sought from friends and the internet, with only a third of young LGBT+ people accessing their general practitioner (GP), and a fifth National Health Service (NHS) mental health services. Seeking help from GP or NHS services was usually motivated by someone else. Only half of LGBT+ young people seeking help from their GP found the experience helpful.

LGBT+ youth groups were significantly protective in self-harm and suicide risk and are the preferred choice of young LGBT+ people when seeking help. Online communication was preferred for receiving professional mental health support.

Transgender and gender-variant young people also criticised the long waiting times for gender identity clinics, and the challenging clinical process associated with these.

Help-seeking behaviours

Inclusive language
Inclusive language is a way of communicating that is free of words and phrases that reflect stereotype, prejudice or discrimination, and avoids assumption and exclusion of minority groups.

Examples:

‘Do you have a girlfriend/boyfriend?’ versus ‘Are you seeing anyone romantically?’ or ‘Do you have a partner?’

(to a parent) ‘How do you think your boy is doing?’ versus ‘How do you think your child is doing?’

Inclusive language also requires respect for chosen names and pronouns, particularly for transgender people. Pronouns (eg, she/her, he/him and they/them) are a crucial part of identity, and asking trans and non-binary youth what pronouns they would like you to use is important.

Box 2 Minority stress model and perceived stigmatisation

The minority stress model describes persistently elevated levels of stress experienced by people in stigmatised groups.22 There are a number of contributing factors which for lesbian, gay, bisexual and transgender (LGBT+) youth include social stigma, isolation, concealment of identity and the internalisation of negative societal attitudes.

LGBT+ youth report high levels of perceived stigma, as well as real-life experienced discrimination, which acts as a compounding factor for mental health symptoms.23 On a physiological level, minority stress and perceived stigma appear to modulate endocrine function. LGBT+ young adults have been shown to have blunted cortisol responses to stress events, similar to traumatic life events.24

Box 3 Help-seeking and risk factors

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and specific risk factors are also different for LGBT+ youth (Box 3).

**Compounding stressors**

Like all young people, LGBT+ youth experience the usual stressors associated with adolescence, such as academic and social pressures, illness and disability. For LGBT+ youth, these stressors may have a compounding influence on self-harm and suicidal feelings, compared with youth in general.

**PAEDIATRICIAN APPROACH AND INCLUSIVE HEALTHCARE**

Most LGBT+ youth are not ‘out’ to their doctors, although the majority would be open to discussing gender and sexual identity with doctors. The use of inclusive language for all patient and parent interactions is simple and effective (see Box 4). Not making assumptions about patients’ identities, and adapting the way we listen and speak, will reduce both experienced and perceived stigma and discrimination in healthcare.

Healthcare environments should be inclusive and visibly welcoming for LGBT+ patients and families. The use of posters from LGBT+ organisations such

### Box 5 Reducing health inequalities

**Inclusive healthcare environments**

- assure confidentiality for patients
- display posters and other resources that show support for lesbian, gay, bisexual and transgender (LGBT+) youth and families
- visibly signpost to local and national support organisations (eg, Stonewall and Gendered Intelligence) and external resources (eg, MindEd website).

**Holistic healthcare**

- understands developmental features of sexuality and their relevance to clinical practice
- includes discussions around emerging identities with all adolescents
- affirms any disclosed identity and offers acceptance and support wherever possible
- provides information and resources to any interested young people
- uses inclusive language in all patient and family communications
- ensures positive communication in referrals/clinic letters (eg, not including ‘transgender’ in a problem list).

**Community**

- encourages schools to be LGBT+ inclusive and affirmative, through antibullying campaigns, strict antihomophobia/transphobia policies and library resources
- promotes inclusive sexual health education.

**Education**

- seeks continuing education opportunities for healthcare professionals around sexuality and gender in young people
- advocates for LGBT+ inclusion in new development of healthcare programmes/campaigns
- seeks relevant LGBT+-related research opportunities in paediatric specialties
- Encourage inclusion of LGBT+ youth issues in undergraduate and postgraduate curricula.

### Recommended reading and resources

**Research**


Queer Futures Report—a detailed government-commissioned study on self-harm, suicide and help-seeking behaviour of queer youth in the UK. [www.queerfutures.co.uk](http://www.queerfutures.co.uk)

Trans Mental Health Study—an excellent comprehensive report detailing the lived experiences of trans people. [www.gires.org.uk/assets/Medpro-Assets/trans_mh_study.pdf](http://www.gires.org.uk/assets/Medpro-Assets/trans_mh_study.pdf)

Trans guidance for schools—guidance from Cornwall for schools to help trans pupils. [http://www.lgbtyouthcornwall.co.uk/images/TransGuidance/Transgender_Guidance_booklet.pdf](http://www.lgbtyouthcornwall.co.uk/images/TransGuidance/Transgender_Guidance_booklet.pdf)

**Resources**

Stonewall—the UK’s largest LGBT+ rights organisation. The website has several excellent resources. [www.stonewall.org.uk](http://www.stonewall.org.uk)

Gendered Intelligence—site for trans youth, including a range of resources for young people, professionals and schools. [www.genderedintelligence.co.uk](http://www.genderedintelligence.co.uk)

Gender Identity Research and Education Society—site includes a range of useful resources to improve lives of trans, non-binary and gender variant people. [www.gires.org.uk](http://www.gires.org.uk)

Mermaids UK—organisation supporting gender identity in young people. [www.mermaidsuk.org.uk](http://www.mermaidsuk.org.uk)

Albert Kennedy Trust—supports young LGBT people who are made homeless or living in a hostile environment. [www.akt.org.uk](http://www.akt.org.uk)

Rural GP Scotland—provides a range of resources for improving healthcare for lesbian, gay, bisexual, transgender and queer+ people in remote and rural areas. [www.ruralgp.scot/lgbtq-plus](http://www.ruralgp.scot/lgbtq-plus)

**Books**


*This book is gay*, by Juno Dawson—an invaluable book written for young people (but applicable to all) covering many aspects of life as a LGBT young person.
**Case answers**

**Case 1**

The paediatrician is unaware of the 13-year-old boy’s sexuality and has assumed that he is heterosexual. By using gender-specific words and phrases, the doctor risks alienating the boy and affecting the patient–doctor relationship. Assumptions and non-inclusive language add to the stigma and discrimination experienced by young lesbian, gay, bisexual and transgender (LGBT+) patients. This case highlights the importance of using inclusive language for all patient communication. Inclusive sexual health advice would also be important in this case. Biological parenthood is still a concern for young LGBT+ patients, although their responses may differ from heterosexual peers. A proper adolescent history with developmental assessment including sexual identity and behaviour might help the patient discuss his identity and build a better relationship with his paediatrician. LGBT+ youth also have higher rates of cancer-related behaviours, which could also be uncovered with an appropriate history.

**Case 2**

The 14-year-old transgender patient lives her life as a girl. Her medical records are still filed under the name assigned to her at birth, which the senior doctor continues to use. Misgendering causes significant distress to young trans people and is likely to seriously affect the patient–doctor relationship also.

It is inappropriate in this case for the junior doctor to ask invasive questions about the patient’s gender, as it is unrelated to her presentation. It would be appropriate to ask her what name she would like to be called, and which pronouns she uses. If a young person asks to be referred to as she/her, for example, then it is unacceptable to continue to use he/him (or anything else).

There are many times when it is not necessary to ask about a patient’s gender history. Someone presenting to accident and emergency with a broken arm does not need to be questioned about their gender identity or aspects of their transition. A transgender person presenting with abdominal pain, however, would probably require a gender history to be explored.

**Best practice**

Adapting approach to communication, given preferences for communicating feelings of self-harm and suicide, for example, is also important. Telemedicine could be explored to improve communication with LGBT+ youth in crisis.

Interprofessional communication requires attention to ensure issues are not inadvertently created. For example, not listing ‘transgender’ in the problems list of a clinic letter, but instead referencing this positively in the letter’s text. Better ways of recording sexuality and gender identity in healthcare records are also required.

**Research**

Further research is required to better understand the healthcare inequalities faced by LGBT+ young people. It is a challenging area to conduct good quality research, and there are several ethical considerations. Parental consent can sometimes be waived when including competent LGBT+ youth in research, as parental involvement could place young people at risk as well as introducing bias.

**CONCLUSION**

LGBT+ youth face several healthcare challenges relating to both physical and mental well-being. Paediatricians are well placed to play a vital role in advocating...
for young LGBT+ people and reducing the stigma and discrimination that create healthcare inequalities. All areas of child health can make improvements. Core education and simple practice changes are good first steps to address these inequalities.

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