PedsCases Podcast Scripts

This is a text version of a podcast from Pedscases.com on the "Care for Pediatric LGBTQ Patients." These podcasts are designed to give medical students an overview of key topics in pediatrics. The audio versions are accessible on iTunes or at www.pedcases.com/podcasts.

Care for Pediatric LGBTQ Patients

Developed by Jocelyn Andruko and Dr. Melanie Lewis for PedsCases.com.
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Introduction

Jocelyn: Hi, I'm Jocelyn Andruko, a medical student at the University of Alberta. I'm joined today by Dr. Lewis, a Pediatrician and Professor here at the U of A. Today we will be discussing care for LGBTQ or Lesbian, Gay, Bisexual, Transgender and Queer, patients in pediatrics.

Let's start with a case:
Today you are seeing Jackie, a 15 year old girl, for a well-child visit. With her parents outside the room, you start a HEADDS history, and Jackie discloses that she is attracted to other girls. She has only come out to a few close friends, but is scared to come out to her religiously conservative family. She is dating an older student from school, and is starting to think about having sex. What supports can you provide her, and how can you ensure a safe space for her in your practice?

Objectives

Dr. Lewis: Our objectives today are to:

1. Review inclusive terminology
2. Define sexual orientation, gender identity, and sex
3. Reinforce confidentiality contracts with adolescent patients
4. Review critical aspects when taking a pediatric sexual history
5. Review critical aspects when taking a pediatric social history
6. Outline key management issues pertaining to the physical and mental health of LGBTQ youth.

So let's get started. What are some of the definitions and terms we should know?

Terminology

Jocelyn: When discussing gender and sexuality, there are really 3 different definitions that apply to each patient:

- **Sexual Orientation** is a person's feelings of sexual attraction. This includes *Heterosexual*, *Homosexual* and *Bisexual*, but also less common terms like *Pansexual*, a person attracted to all genders and sexes, or *Asexual*, a person who does not experience sexual attraction towards anyone.

- **Gender Identity** is a person's internal sense of masculinity or femininity. It exists on a continuum; no person is 100% masculine or feminine. A person is *Cisgender* if their gender identity aligns closely with their natal sex, *Transgender* if their gender identity differs from their natal sex, or *Androgynous* when they identify with both sets of traits. Some people identity as *Gender-queer*, which refers to an identity outside the man- woman binary, or *Two-Spirit*, an Aboriginal identity that implies the spiritual embodiment of both masculine and feminine traits and has a historical and religious context.

- **Sex** refers to a person's anatomy and physiology. A person may be *Intersex* if they were born with reproductive or sexual anatomy that doesn't fit those categories.

Sexual Orientation, Gender Identity and Sex are each distinct, not necessarily related, and exist on a continuum.

Dr. Lewis: Younger generations seem less likely to self-identify with traditional labels like gay or lesbian as they question their own sexual identity. Some may just identify as *Queer*, a catch-all term, while others may not choose a label at all.

Jocelyn: Don't be afraid to ask your patients to clarify if they use a term you don't understand. The most important thing is to listen to how they describe themselves, their partners and relationships and just follow their lead.

Risk Factors

Dr. Lewis: Historically, physicians receive little training in caring for LGBTQ patients, so many of these patients have been alienated from seeing doctors by misinformed or insensitive care. LGBTQ youth are an underserved population, and at greater risk than their peers for a number of health concerns.

Jocelyn: Most LGBT youth are happy and thrive during their adolescent years, but social history is still important, as social concerns can cause major health risks to kids. It is a good idea to explore the degree to which LGBT kids are out to their friends and family, and the amount of support they might expect from those close to them. This can strongly inform your approach towards screening for social and mental health risks. Take an especially detailed history from transgender children or those who are visibly

gender variant, as they could be exposed to a greater level of discrimination and violence.

When taking a sexual history, it is important to clarify, and not assume, what a queer patient means when they tell you they are sexually active. Take extra time to discuss safer sex with these teens, as their families, peers and schools may not have taught adequate information. For example, while teens in same sex couples are not at high risk of pregnancy, it is still important to prevent STI exposure through barrier methods, and to have regular STI screening if sexually active. HPV vaccination is still equally important for LGBTQ girls and boys. Despite significant work to reduce HIV incidence among gay and bisexual men, they are still disproportionately affected with it as well as most STIs, so proactive screening and counselling is a good idea.

Dr. Lewis: There are a number of mental health issues that should also be screened for in LGBTQ youth. Anxiety and Depression are both more common in these kids. Gay men are also more likely to have body image problems or eating disorders, which may present in adolescence.

Stigma, isolation and bullying are sadly not uncommon for these kids, and put a child at high risk of **mental illness**. LGBT youth are at more than twice the average risk for **suicide**, and that *doubles again if they have an unsupportive family*. **Illicit drug use** and **risky sex** behaviours, which are highly linked to depression and loneliness, are more common in the LGBT population, and may start in adolescence.

Jocelyn: Negative attitudes towards LGBT youth put them at higher risk for **violence**, including bullying and physical assault by classmates or family members. A violence screen is a good idea, especially for kids in unsupportive families or communities. **Homelessness** is also much more common among LGBT teens, who may be kicked out or feel unsafe at home. Of course, these each carry their own physical health risks.

Dr. Lewis: Unfortunately, as healthcare providers there is little that we can do to prevent or mitigate these stressors and their associated risks. Most important is to be a supportive, positive role model and ensure these kids are getting adequate healthcare contact.

<u>Sensitivity and Confidentiality</u>

Jocelyn: In order to address these risk factors, it's important to elicit sexual orientation and gender identity on history. To make kids more comfortable, and open to sharing these personal details, there are several things you can do:

- Use pronoun free questions for all kids, not just those who have already come out to you.
- Leading questions like "do you have a boyfriend" rather than "are you in a relationship" may stop patients from making disclosures.
- Asking social history questions in a normalizing manner also builds confidence and comfort, for example "Lots of queer kids experience violence from their peers

or family; do you feel safe at home?" rather than just "Are your parents hurting you?"

Dr. Lewis: When you run a clinic or are responsible for support staff like nurses or administrators, it is important to ensure that they also use correct terminology and pronouns. LGBT patients may "scan" the office for clues to determine how comfortable they feel sharing; posters, rainbow flags, brochures or "safe space" stickers could be extremely meaningful to these patients, while going unnoticed those they do not affect.

Jocelyn: The most important aspect here is to reinforce confidentiality, both before taking any adolescent history and whenever sensitive disclosures are made. Remind kids that you have no obligation or intention to share sensitive information, and they will feel much more comfortable discussing these topics with you.

Dr. Lewis: Of course, there are some limitations to confidentiality, and these should be made clear from the beginning of the interview. Physicians are bound to report any situations where a child is being harmed, or at risk of harming themselves or others. Otherwise, it is not within your duty as a physician to disclose this information. Parent consent is required for treatments or procedures that an adolescent does not have capacity to consent for. For example, if a transgender teen wants to initiate medical transition or suppress puberty, they must be able to do so as a "mature minor" if they do not elicit their parent or guardian's informed consent.

Conclusion

Jocelyn: That brings us to the end of the podcast. Here are some take home points:

1. Sexual Orientation, Gender Identity, and physical Sex are three distinct domains of sexuality, with a number of terms that define each.
2. In addition to the same basic health needs of other kids, LGBTQ kids should have a more careful mental health screen, and frequent STI screening if sexually active. Take extra time to discuss safer sex techniques and their importance. Risky sex practices and illicit drug use may be more common in this population.
3. Take a careful social history from these kids, including the degree to which they are out to their family and peers, and whether their parents and schools have been supportive. LGBTQ are at twice the risk of suicide as their peers, and this risk doubles again with an unsupportive family.
4. Develop an inclusive practice through routinely using pronoun-free questions and displaying brochures or rainbow flags. Children are more likely to make honest disclosures if they are made to feel comfortable.

Dr. Lewis: The most important thing is to be honest and respectful to your patients. A supportive role model is important for all kids, and those of sexual and gender minorities are no exception!

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Jocelyn: Thanks so much for listening, and stay tuned for an upcoming podcast about healthcare for transgender kids!

References

References available upon request.