Envisioning an America Without Sexual Orientation Inequities in Adolescent Health

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This article explicates a vision for social change throughout multiple levels of society necessary to eliminate sexual orientation health disparities in youths. We utilized the framework of Bronfenbrenner's ecological theory of development, a multisystemic model of development that considers direct and indirect influences of multiple levels of the environment. Within this multisystem model we discuss societal and political influences, educational systems, neighborhoods and communities, romantic relationships, families, and individuals. We stress that continued change toward equity in the treatment of lesbian, gay, and bisexual youths across these levels will break down the barriers for these youths to achieve healthy development on par with their heterosexual peers. (*Am J Public Health.* 2014;104: 218–225. doi:10.2105/AJPH.2013.301625)

The articles that we have assembled in this special issue join a host of others documenting that lesbian, gay, and bisexual (LGB) adolescents experience health inequities that are driven by social determinants at multiple levels of influence.[1–4] Rather than taking this further evidence as cause for increased pessimism, we share our vision for social change that we believe would create an America where LGB adolescents are given the same opportunity for healthy development as their heterosexual peers. We are not naive in believing that such change will come effortlessly or instantly, but we do believe in the value of sharing these aspirations as a way of illustrating the profound benefits they would engender.

We begin by acknowledging that although transgender youths are not enumerated in the articles in this issue, health inequities have been described in a small number of studies with these youths.[5,6] As Youth Risk Behavior Surveillance (YRBS) data do not assess gender identity, the focus of our discussion here is on LGB youths. We believe many of the social changes we articulate in this commentary would be of tremendous value to transgender youths, but at the same time recognize that they have additional needs that may not be sufficiently met by the changes we advocate here for their cisgendered LGB peers (e.g., medical care related to gender transitions). We also point out that sexual orientation is a multidimensional construct including sexual and romantic orientations, identity labels, and the gender of sexual partners[7]; our use of "LGB" is meant to be inclusive of the both- and same-sex oriented parts of these distributions. Among youths, these dimensions are correlated but not perfectly overlapping,[8] and only recently have researchers begun to investigate how these multiple dimensions may be differentially related to health outcomes for LGB youths—a focus area of several of the articles in this special issue.

As an organizational framework for considering the multilevel determinants of health disparities between LGB and heterosexual youths, we utilized Bronfenbrenner's[9] ecological theory of development. This theory describes a multisystemic model of development that nests youths within increasingly broad systems that act either directly or indirectly, by shaping the environment. This model has been applied widely in prevention research with youths[10] and is consistent with the socioecological perspective espoused in the recent report of the Institute of Medicine (IOM) on the health of LGB and transgender (LGBT) people.[11] At the broadest level, Bronfenbrenner describes the macrosystem, or the overarching structural or societal norms. These norms are described as "blueprints" that influence multiple aspects of the individual's life and may be expressed at the ideological level or via written laws. The mesosystem includes the interrelations between the major settings in which the youths find themselves, and subsequently the impact of these interrelations upon the youths. Major settings in the mesosystem include local economy and work environment, government, religion, neighborhood, and mass media. The microsystem is composed of the relationships or contexts with which the child has direct contact, including romantic relationships, friendships and peer groups, and family relationships. Bronfenbrenner describes the relationships at this level as bidirectional (i.e., the child simultaneously has an influence on and is influenced by the individuals in his or her microsystem). Finally, the chronosystem reflects the effects of the passage of time, both for the individual and society at large. As it reflects the cumulative experiences a person has over the course of his or her lifetime, it is consistent with the life-course perspective articulated as 1 of the 4 guiding frameworks of the IOM report.[11] The chronosystem also reflects sociohistorical changes, such as the passage of laws regarding same-sex marriage.

Envisioning a future with thriving and healthy LGB youths will require change at all of these levels. Because of the dynamic interplay among these multiple levels, it is likely that changes at one level may alter determinants at other levels. For instance, institutional (e.g., discriminatory policies) and interpersonal (e.g., victimization) stressors engender maladaptive psychological responses (e.g., rumination, hypervigilance) that in turn predict negative mental health outcomes among LGB individuals.[12,13] Thus, preventing social forms of stress would eliminate the need to change individual coping behaviors. However, it is also possible that change in some contexts may be profound, even if the improvements do not resonate to other levels. For example, having supportive and accepting parents promotes resilient development across a variety of adverse contexts.

At the same time, our research[14,15] and experience show that family support is not enough to overcome the deleterious effects of LGB-focused bullying and victimization. We cannot just seek to buffer LGB youths against victimization because resilience in the face of adversity is not the same thing as health equality. Teaching LGB youths how to cope and adapt to adversity should not be the goal of fair-minded people who want the best for all children. Rather we need to directly address determinants at multiple levels if we want true health equity. To explicate this vision, we begin by articulating change at the broadest macrosystem level and then honing down to individual factors.

SOCIETAL, POLITICAL, AND INSTITUTIONAL CHANGES

The macrosystem refers to the broader culture—including the social conditions and institutional practices, policies, and structures—within which youths are embedded. We highlight 3 important components of the macrosystem as it relates to LGB individuals. First, in many societies, homosexuality is a highly stigmatized social identity. Two related constructs—sexual prejudice (also known as heterosexism) and compulsory heterosexuality—have been coined to describe the sociocultural environment surrounding LGB populations. Sexual prejudice refers to negative societal attitudes toward individuals who are members of a sexual-minority group,[16] whereas compulsory heterosexuality[17] refers to the pervasive social norm that heterosexuality is "laudable, normative, and prescriptive."[18(p51)] The second relevant component of the macrosystem, which in many ways stems from the first, is the set of institutional laws and social policies that currently regulate and often constrain the lives of LGB persons. Most notable among these is the Defense of Marriage Act, which, until it was recently overturned by the US Supreme Court, defined the institution of marriage as a legal union between 1 man and 1 woman, thereby denying same-sex couples more than 1000 rights and privileges that are available to opposite-sex couples.[19] Most states do not currently allow same-sex marriages. Other laws and policies that also affect the lives of LGB individuals include hate crimes protections, employment nondiscrimination, same-sex adoption, immigration equality, and antibullying. Third, religion is another social institution that shapes the macrosystems in which sexual minorities live. Indeed, expressed attitudes toward homosexuality are largely aligned with degree and type of religious affiliation.[20] For instance, a study that examined trends of polls conducted in the United States in the early 2000s found that a majority of US residents reported that advancement of LGB rights, such as legal recognition of same-sex marriage, clashed with their religious beliefs.[21]

Accumulating research indicates that the macrosystem powerfully shapes the health of LGB populations, including youths. Sexual-minority adults living in communities with greater antigay prejudice have increased risk of mortality compared with sexual minorities in low-prejudice communities.[22] Furthermore, LGB adults have higher rates of psychiatric disorders if they live in states that do not provide legal protections to sexual minorities in the form of hate crime laws or employment nondiscrimination policies.[23] Consistent with this research on adults, LGB youths who reside in counties that have less protective social environments for sexual minorities (e.g., fewer school districts with antidiscrimination policies, lower prevalence of same-sex couples) are more likely to attempt suicide[24] and to use tobacco[25] than are LGB youths who reside in more protective environments.

Similar findings have been observed with religious climates. In one study, researchers coded 85 religious denominations with regard to their stance toward homosexuality (e.g., whether the denominations blessed same-sex unions, allowed ordinations of gay clergy, and had doctrinal statements with explicit references to homosexuality as sinful). The authors then created a variable of the proportion of adherents to supportive denominations (e.g., Metropolitan Community Church, Quakers, and Unitarian Universalists) out of the total number of religious adherents in each of 34 counties in Oregon. Results indicated that LGB youths who lived in counties with a religious climate that was supportive of homosexuality had fewer alcohol-abuse symptoms and fewer sexual partners than LGB youths who lived in counties where the religious climate was less supportive.[26] For a world without sexual-orientation health disparities for youths to occur, LGB youths would never have to choose between the support of their religious organization and their innate sexual orientation.

Thus, existing research indicates that reducing sexual-orientation health disparities in youths must involve altering the macrosystem through the elimination of institutional policies and sociocultural practices that have an adverse impact on the lives of LGB youths. To be sure, such changes are under way, such as the recent repeal of the Don't Ask Don't Tell law and the recognition of same-sex marriage rights in an increasing number of states (currently 14 states plus the District of Columbia). But much work remains, including implementing policies that allow gay–straight alliances in schools,[27] as well as extending the reach of school policies beyond the 16 states that currently address discrimination, harassment, or bullying of students on the basis of sexual orientation.[28] In addition, researchers have called for greater attention to policies that influence institutions in which LGB youths are likely to be overrepresented, including the foster care and juvenile justice systems.[29]

EDUCATIONAL SYSTEM CHANGES

Of all possible ecological contexts influencing LGB youths, schools are often a focal point because of the accumulating data documenting inequalities in victimization and school climate, and the relation of these variables to later mental health and educational outcomes.[23,30–32] However, it is important to be mindful that inequalities present in schools are only reflections of inequalities present in the larger ecologic system, and school reform without reform across other systems will provide restricted benefit. Nevertheless, in order for youths to be free of sexual-orientation health disparities, school climate must allow all students to feel valued, respected, and accepted regardless of their sexual orientation.[33] Indeed, our article in the current special issue documents that LGB students living in states and cities with more protective school climates reported fewer past-year suicidal thoughts than those living in states and cities with less protective climates.[34]

There are numerous examples of conditions that are necessary to generate an affirmative

school climate. Many of these conditions have been detailed more fully by other researchers[35–37]; therefore, this article will not linger heavily on specifics and instead will attempt to summarize the core concepts essential to a positive school climate. First, safety from violence and victimization is essential for all students. This safety can be accomplished partially through strong antibullying policies that are enforced by teachers and administrators. In addition, as school staff require safety, employment policies that cover nondiscrimination by sexual orientation are also essential. Finally, LGB-headed families must also feel welcome; therefore, schools should ensure that their policies and procedures are inclusive to all families. Respecting and protecting LGB teachers and parents provides an opportunity to set positive norms that may then become reflected in student attitudes and behaviors.

In addition to safety, youths must also experience strong supportive relationships, in particular with their peers and adults within their school. Gay–straight alliances[38] are an excellent avenue for increasing supportive connections among LGB students and their peers, as well as communicating to the school community that diversity is valued. Student relationships to teachers are also essential. Because of their position and visibility within the school, teachers, staff, and administrators serve as role models for their students. In a school with an affirmative climate, adults would develop supportive relationships with all students, regardless of their sexual orientation. In addition, adults would be prepared for their role as leaders within the school. Teacher education courses and staff training would instill the importance of LGB issues in education as well as prepare teachers for conducting difficult dialogues around these issues.

Finally, school curricula that are inclusive of LGB issues serve as another significant marker of supportive school climates. California recently became the first state to require the addition of lessons about gay history to social studies courses. Unfortunately, significant barriers to the implementation of gay-affirmative curricula across most school districts remain—some districts specifically prohibit discussion of homosexuality (so-called "no promo homo" policies).

These examples are important first steps, but they are not a comprehensive summary of what is necessary to create environments that are safe and supportive of LGB youths. School climate will not change just because certain policies are adopted. Instead, real reform of school climate must be proactive and systemic. If school districts address these issues only in times of "crisis" (e.g., either when sexual minority individuals make their presence known to the school environment, or when legal action is threatened[39,40]), the damage has already occurred and will be much more difficult to repair. In addition, schools that teach very young students must also be included in this reform. Norms around acceptance of diversity are set early and become less malleable as adolescents age. As a consequence, concepts of diversity and respect that specifically address diversity in sexual orientation may be particularly important for middle and elementary schools.

If schools are successful, hallmarks of a safe climate would be that students would be more open to disclosing their sexual orientation without fear of retribution. Other important hallmarks of a safe climate would be that parents, teachers, administrators, and school board members could also be openly LGB without fear of repercussions. LGB issues would be commonly incorporated in the curriculum. Tackling these issues in schools is complex, and it will be impossible to ensure that mistakes are never made. Complexity does not justify inaction, however. If schools begin to address their weaknesses, as well as prepare themselves to engage in these complex dialogues and seek out resources when necessary, LGB youths will be on their way to living in a world that is safer and more supportive of diversity in many forms.

CHANGES IN NEIGHBORHOODS AND COMMUNITIES

Another important ecological context that influences the health and well-being of LGB individuals is the climate of the community or neighborhood in which a person resides.[41] Perceptions of LGB acceptance at the community level, such as workplace support, neighborhood gay-friendliness, and legal barriers to adoption for same-sex couples, have been linked to mental health outcomes.[42] In addition, preliminary research shows that LGB individuals feel greater attachment to their community when there is the presence of a local LGB organization.[43] By contrast, sexual-minority adolescents who reside in neighborhoods with higher rates of LGB assault hate crimes report more suicidal thoughts and attempts than sexual-minority youths living in neighborhoods with a lower prevalence of LGB assault hate crimes.[44]

Having a sense of belonging to the area in which you live is important for all individuals, but it can be particularly difficult for LGB individuals to find this sense of belonging. Rural areas are particularly challenging for sexual-minority populations to find supportive organizations because of the lower population density and lack of LGB civic infrastructure.[41] Even in dense urban environments, however, some city areas are more accepting of LGB individuals than others, and will be more likely to offer LGB-specific services.[43] Although many larger cities have gay-identified neighborhoods, these neighborhoods may cater to particular demographics, which has been suggested to further separate female-born individuals, racial/ethnic minorities, and other individuals from the LGB community.[43]

There are numerous qualities of neighborhoods and communities that demonstrate acceptance of LGB individuals. Although pride parades and strong LGB culture and visibility are hallmarks of community-wide acceptance, they typically only exist after a community develops a feeling of safety for all individuals despite their sexual identity or orientation. For this safety to develop, leaders in the community should be aware of the needs of their LGB community members and work to promote their safety. In particular, those involved in law enforcement and justice should receive training on the needs of the LGB community. In addition, for sexual orientation health disparities to disappear, access to LGB-competent health care[45] must be available no matter where youths live. LGB-specific health centers may be available in larger cities, but all health care workers who interact with the community must receive training in competent LGB health care. Fortunately several major health care associations and commissions have issued policies for training students in LGB health and respecting LGB patients (for examples see policies and guidelines of the

American Medical Association, the American Psychological Association, and The Joint Commission).[46–48]

ROMANTIC RELATIONSHIPS

In an essay on the legal recognition of same-sex relationships in the United States, Herek[19] outlined research indicating that married heterosexual women and men who are satisfied with their relationships tend to report better physical and mental health compared with their unwedded peers. The tangible resources and protections associated with marriage that improve health include those extending from the state and federal government. These include benefits, rights, and privileges ranging from Social Security survivors' benefits, employee benefits, and affordable housing programs. The provision of these statutory advantages to legally married couples offers greater financial security—a predictor of mental and physical health. In addition to their greater financial stability, married individuals report greater social support from others outside the relationship, especially from their family of origin, which contributes to their greater well-being compared with those who are unmarried. Along with these benefits of marriage, the institution creates deterrents to dissolving the relationship, which may lead to increased relationship stability and commitment. And lastly, one intangible benefit of marriage is the meaning it provides to individuals and couples as they seek to find their place in the social order. Unfortunately, these benefits of marriage are not afforded to many gay and lesbian couples in committed relationships because same-sex couples are not legally recognized in most states (currently, 30 states have constitutional amendments banning same-sex marriage).

The Institute of Medicine's[11] report on the health of LGBT people highlighted how the lack of legal recognition of same-sex couples negatively affects health care. Although reforms have been implemented with regard to medical leave and hospital visitation rights, employer-sponsored health insurance is not routinely extended to same-sex partners and may affect their access to affordable health care. Despite the reforms that have been enacted, some fall short of ensuring equal rights, benefits, and privileges to individuals in same-sex relationships. For example, the 2010 Family and Medical Leave Act was expanded by the US Department of Labor to allow employees unpaid leave to take care of their unmarried same-sex partner's children; however, the act does not extend this leave for partners to take care of each other.

Current laws and policies affect youths in 2 primary ways. First, the children and adolescents of same-sex parents, including adoptive and foster parents, are afforded differential care as their parents' rights may be limited by state law on 2-parent adoption and guardianship. Second, as LGB youths mature and enter into long-term, committed, same-sex relationships, they are denied the legal status of their heterosexual peers (i.e., marriage inequality) in most states. To address these inequities, legalization of same-sex marriage would grant LGB people the same rights, benefits, and privileges enjoyed by their straight counterparts. However, it is important to note that marriage equality and civil unions may have less influence on other aspects of family life, such as adoption and foster parenting. Adoption of children by lesbian and gay adults is regulated by a complex array of laws and policies; these often vary from one jurisdiction to another and, in relation to marriage equality, are subject to separate legislation in the United States.[49] For example, some jurisdictions in the United States (e.g., Mississippi, Utah) ban adoption by same-sex couples whereas other states (e.g., California, Massachusetts, Connecticut) prohibit discrimination on the basis of sexual orientation in matters of adoption and have laws that expressly permit the adoption of children by same-sex couples.[50]

Given the valuable tangible and intangible benefits that accompany romantic relationships,[51,52] it is not surprising that most youths, including LGB youths, desire to be in a relationship.[53,54] Of course most youths are not married, so the primary benefits to LGB youths of legal recognition of marriage is the knowledge that they are growing up in a world where their future relationships will be on equal standing with their heterosexual peers' relationships. In addition to changes in social policy relating to marriage equality, changes in community norms may also have beneficial effects on same-sex relationships, especially for youths. That is, access to legal marriage may change norms and beliefs about the value and attainability of long-term committed relationships. In a similar way, increasing visibility of healthy same-sex relationships—in families, communities, and the media—may allow youths to identify role models for their relationships. And lastly, parental and family support of LGB individuals, as well as the acceptance of their romantic partners, can have lasting positive effects on health and well-being.

One of the primary developmental tasks of adolescence is developing social skills and self-awareness related to romantic relationships, and we are only beginning to understand the life-course implications of LGB individuals having less access to romantic relationships during this critical developmental period. It is important to acknowledge the difficulties LGB youths face in finding romantic partners. Just like all adolescents, LGB youths spend significant amounts of time and attention focused on developing romantic relationships. For most youths, schools are the primary space for meeting romantic partners. As LGB individuals represent a small proportion of the overall population, as well as the relatively small numbers of "out" LGB adolescents in any given school, many LGB youths experience the lack of accessible romantic partners as extremely frustrating. This difficulty largely results from the fact that there are fewer possible partners for LGB youths, particularly at developmental periods where individuals do not choose the settings in which they spend time and when fewer adolescents publicly acknowledge their LGB status (compared with adults). Outside the classroom, some LGB youths turn to commercial gay venues (e.g., bars, clubs, bookstores) and the Internet to meet sexual and romantic partners, which may pose risks to their health and safety.[55] With these implications, we believe it is important for communities and other influential youth settings to create safe means for LGB youths to meet, socialize, and create developmentally appropriate and healthy romantic relationships.

CHANGES IN FAMILIES OF ORIGIN

Parents and families are often the primary influence on youths' gender and sexual socialization, sex roles, sexual attitudes, and sexual

behavior.[56] Parental support is essential to the healthy development of all children and adolescents, but perhaps particularly so for LGB youths,[57] who often lack support from other sources, including peer and classroom settings. For young people who come out as LGB or who demonstrate gender-nonconforming behaviors (see research by Rieger et al.[58] for a description of concepts and terminology), heterosexual parents are not always naturally equipped to understand or effectively support them.

Throughout adolescence, young people develop their self-concept, personal identity, and social skills, as well as their social support networks, based on their gender, family, cultural, racial, and ethnic reference points.[59] Often parents do not have the knowledge or skills to help their LGB children through this potentially confusing process of maturation. Moreover, LGB youths of color face additional stresses and challenges in integrating their sexual, cultural, racial, and ethnic identities.[59–61] For example, in a recent qualitative study of young African American gay men and their parents, participants described the struggle to cope with the multiple oppressions associated with their race and sexual orientation.[62] The intersection of these identities was particularly important, as they articulated experiencing difficulties as gay men to meet the expectations of masculinity maintained by their families and communities.

Research has documented the negative impact of family rejection on health outcomes for LGB youths. Compared with peers from families that reported no or low levels of family rejection, LGB young adults who reported higher levels of family rejection in adolescence were more likely to have been depressed, attempted suicide, used illegal drugs, and had unprotected sexual intercourse.[60] In addition, those who reported moderate levels of parental rejection were significantly more likely than those who reported lower levels of rejection to report depression and suicide attempts. In contrast to the research on parental rejection, others have found that parent–child relationship satisfaction and positive parental attitudes are associated with higher self-esteem and fewer depressive symptoms and suicidal behaviors among LGB youths.[63–65] Parental acceptance of sexual orientation is related to self-acceptance of one's own sexual orientation, particularly for youths who value parents as integral to their own self-worth.[66] This positive sexual-minority identity is related to self-esteem and psychological adjustment,[12] regardless of racial or ethnic background.[67]

On the basis of this research on the influences of parental support and rejection, there are clear directives for how parents and families can improve the health and well-being of LGB youths. Research suggests mid- to late-adolescence as a developmental period where family support has a profound effect on LGB youths' mental health,[14] suggesting that this may be a critical period for delivery of family education programs that increase parent support and acceptance of LGB children. In research conducted with families whose children demonstrated gender-variant behavior, the primary needs identified by parents were related to finding correct information and obtaining professional support, parenting strategies, and peer support.[68] In our discussions with parents of LGB children we frequently hear that parents have many unanswered questions about how to be the best parents they can be to their LGB children. They ask questions like, "I want to help my teenage gay son figure out how to date and meet a boyfriend, but I have no idea where to start." Such statements reflect not only the desire of parents to help equip their LGB children to face the amplified challenges of adolescent life, but also the need for help on how to do so. Research is urgently needed to create such programs and evaluate their effectiveness.[69] Mental health professionals, community organizations, and social and health care organizations should partner with researchers to create and evaluate such programs.

Health care providers and other organizations involved in the lives of children should help educate families about the impact of rejecting behaviors on LGB youths.[60] However, education and training of health care providers on LGB health is often minimal in many professional schools and training programs.[70,71] Policies requiring provider education in sexual-minority health would help the health care system to become more effective in providing affirming messages to the parents of LGB youths. One noteworthy policy is from the American Medical Association on the health care needs of the LGBT population and highlights the organization's leadership role in "educating physicians to recognize the physical and psychological needs of their homosexual patients."[46] Attending to the health needs of young LGB patients must involve provider training that focuses on the needs of the family system, all well as the individual youth.

For parents, it is impossible to predict whether their child will grow up to be LGB; as such, early negative comments pertaining to gender and sexuality are potentially damaging to youths struggling to define their identity. Health care and social service providers can offer anticipatory guidance and counseling that normalizes being LGB, as well as refer families for support (to organizations such as Parents, Families, and Friends of Lesbians and Gays), which can help make a critical difference in helping to decrease risk and increase well-being. Taken together, the research suggests that early home environments in which parents are accepting of sexual-orientation diversity and gender-nonconforming behaviors are crucial to the positive and healthy development of LGB youths.

THE INDIVIDUAL

Conditions within each of the various ecological systems described in the previous sections have a profound impact on the health and well-being of LGB young people. If conditions in each of these more distal systems were to change to eliminate sexual-orientation health disparities, then perhaps change at the level of the individual would be unnecessary. Because instead, in their current form these systems perpetuate, rather than eliminate, health inequities, changes need to be made at the individual level to minimize their negative health effects. We recognize that advocating the development of interventions that enact change within individual LGB youths might imply that they are responsible for the negative health outcomes they experience (as opposed to discriminatory social structures). However, until sociohistorical change has been achieved, LGB-tailored intervention programs are necessary to ameliorate the negative effects of societal oppression.

First, interventions should be developed to promote LGB youths' resiliency in the face of

chronic stress related to a sexual-minority status. Young LGB people are prone to developing deficits in emotion-regulation skills as a result of experiencing chronic stress at an early age related to the emergence of a nonheterosexual orientation.[70,71] Efforts to develop healthy emotion regulation and coping skills via school-based, family, or individual interventions may help LGB youths establish resiliency in the face of chronic stress. Techniques borrowed from Dialectical Behavior Therapy[72] may be particularly informative in developing interventions to instill more effective emotion-regulation skills. Furthermore, evidence from a study of young gay and bisexual men suggests that young people naturally establish resiliency by investing their self-worth in certain domains over which they have more perceived control, such as academic achievement, personal appearance, and competition.[73] However, overinvestment in these same domains is associated with certain costs, including social isolation, problematic eating, and emotional distress. The costs of erecting self-protective emotional walls against victimization across the life course are only beginning to be understood (i.e., potential difficulties in razing these walls so that healthy interpersonal relationships can develop later in life). Intervention efforts should attempt to build on this natural resiliency by aiding LGB young people to balance their self-worth across multiple domains, including an emphasis on increasing social support and building self-esteem. The ultimate goal is to develop coping skills that are effective both in adolescence and into adulthood, skills that are important for both LGB and heterosexual youths alike.

There is also an urgent need to tailor intervention programs to the unique needs of LGB youths, as well as the needs of specific demographic groups within the LGB youth population. Accumulating evidence indicates that the chronic stress experienced by LGB individuals can be accounted for by experiences that are unique to sexual minorities, including sexual orientation–based victimization, perceived stigma, and internalized homophobia.[70] In addition, a variety of other characteristics and experiences unique to LGB individuals increase the likelihood of exposure to chronic minority stress, including a younger age at coming out, negative reactions to disclosures of sexual orientation, and gender nonconformity. These various individual-level characteristics and experiences have been linked to myriad risky behaviors and health outcomes, including alcohol use,[74] internalizing mental health problems,[75] and suicide risk.[65] Health professionals working with this population must be aware of how these LGB-specific experiences influence exposure to stress to improve effectiveness of intervention strategies.

For example, cognitive–behavioral therapy (CBT) has been repeatedly found to reduce depression in youth[76] and adult populations[77] by engaging individuals in behavior change and reducing the impact of negative thought patterns. Variables specific to LGB individuals, such as perceived stigma because of one's sexual orientation, may lead an LGB young person to develop avoidance of certain behaviors or activities, establish negative thought patterns about the self and others, and ultimately to experience psychological distress. Use of CBT interventions could help reduce the impact of stigma on distress by encouraging the individual to re-engage in avoided activities to break their association with stigma. Furthermore, CBT interventions could help LGB young people to distinguish between maladaptive and realistic thoughts related to perceptions of stigma, and strategies could be developed either to alter maladaptive thoughts or to develop strategies for coping with realistic negative thoughts to reduce the impact of thought patterns on mood.

It is also important to consider that it may not be possible to completely eliminate LGB minority stress despite our best efforts to enact change in other ecological systems and to develop effective individual-level intervention strategies. Even in a society that is completely devoid of stigma, LGB individuals will face certain unique challenges that may promote chronic stress. For example, because LGB individuals represent a small proportion of the overall population, dating and establishing romantic relationships will likely always be more of a challenge than it is for heterosexuals because of fewer available partners. Moreover, it will always be more difficult for same-sex couples to have children than the average opposite-sex couple, as adoption or artificial insemination are a necessity for same-sex couples. Because of these and other actualities, LGB youths and adults may always experience some chronic minority stress and subsequently may be at disproportionate risk for certain negative health outcomes. These issues—not driven by discrimination but rather by biological reality—highlight the need to develop intervention strategies for LGB youths and adults that will help to minimize the effects of these challenges.

We end by returning to the chronosystem, which was implicated throughout our discussion in terms of life-course effects and sociohistorical changes. One important postulate of a life-course perspective is that early inequities are likely to accumulate over time, morphing from protracted stress and risky behaviors into chronic and serious diseases. This perspective draws from the concept of allostatic load—the idea that cumulative physiologic toll may be exacted on the body over the course of a lifetime of efforts to adapt to life's demands.[78] In fact, recent research has shown evidence of elevation in biomarkers for cardiovascular disease among gay and bisexual young adult men compared with their heterosexual peers (e.g., C-reactive protein, diastolic blood pressure).[79] As such, we argue that the impact of interventions to create health equity for LGB people will increase the earlier in development that they are delivered, when behaviors and health trajectories are more modifiable.

CONCLUSIONS

This is an exciting time to consider a world without sexual orientation–related health disparities in youths. Large-scale health studies are increasingly collecting information about sexual orientation as a demographic characteristic, and these data are being used to characterize health disparities and their social determinants—such as the articles in this special issue. Perhaps more importantly, federal and local resources are now being marshaled to remediate these health inequities. In the past several years we have seen exciting developments at the federal level, such as the release of a National HIV/AIDS Strategy that focused attention on young gay and bisexual men,[80] and funding from the Administration for Children and Families to the L.A. Gay and Lesbian Center to address barriers to permanency in foster care for LGBT youths.[81] Although

community-based programs have existed for decades to serve LGB youths, we are heartened by their more recent federal support.

Although the studies in this special issue document marked health disparities between heterosexual and LGB youths, we note that the existence of these disparities is neither inevitable nor intractable. For instance, one article in this issue demonstrated that peer victimization mediates the relationship between sexual orientation and various adverse outcomes[82] and another showed that victimization was associated with a syndemic of negative health outcomes,[83] suggesting that preventing victimization targeting LGB youths would lead to a concomitant reduction in health problems among this population. In addition, sexual orientation disparities in suicidal thoughts were nearly eliminated in states and cities with the most protective school climates (e.g., schools with a higher percentage of safe spaces),[34] suggesting a clear and achievable policy intervention that would help realize a world without sexual orientation health disparities. In this article, we outlined major determinants of LGB health at multiple levels—including policy, schools, neighborhoods and communities, families, romantic relationships, and individual—and discussed how continued change toward equity in the treatment of LGB youths across these levels will break down the barriers for LGB youths to achieve healthy development on par with their heterosexual peers. We urge researchers, policymakers, health care providers, and other organizations influential in the lives of young people to heed such recommendations. ■

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