

Providing Mental Health Services for LGBT Teens in a Community Adolescent Health Clinic

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SUMMARY. Providing mental health services in a public setting to adolescents who are lesbian, gay, bisexual, transgender and questioning (LGBTQ) can be difficult due to multiple potential barriers. This article describes the process of successful engagement of these adolescents into services at Mount Sinai's Adolescent Health Center (MSAHC), with emphasis on group treatment. MSAHC is one of the oldest adolescent focused centers in the country that integrates mental health services into primary care. Grant funding supports the center's mission to provide services to teens regardless of ability to pay. The screening process and mental health services available to these adolescents are described. Four

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different adolescent LGBTQ groups are reviewed, including how the groups were created and the goals of the groups. Problems encountered in the group process are outlined, each of which needed to be resolved in order to maintain the success of the group. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2004 by The Haworth Press, Inc. All rights reserved.]*

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In 2001, the Surgeon General, David Satcher, released a report on children's mental health services recommending that these services be made more readily available in primary care settings in order to improve access (Department of Health and Human Services, 2001). The Mount Sinai Adolescent Health Center (AHC) is one of the oldest adolescent focused centers in the country and has integrated mental health services into primary care since its inception over thirty years ago.

It has been estimated that only 20% of children and adolescents with mental illness receive services (Kestenbaum, 2000), which is likely due to lack of access and the stigma of attending a mental health clinic. Yet, it is also estimated that half of adolescent medical visits are due to psychosocial issues (Rappaport, 2001). In addition, it is likely that teens already feeling stigmatized—such as LGBT teens and HIV-positive teens—would be even less able to overcome the added stigma of attending a mental health clinic. The Adolescent Health Center normalizes the process of seeking mental health treatment by having it as an integral part of comprehensive services.

In New York State, adolescents are entitled to confidential reproductive and mental health care (Feierman, Lieberman and Chu, 1996), but in reality they may find it hard to obtain. Using parental insurance can generate bills and statements of benefits that come to the parents' attention and compromise the teen's confidentiality. This may be of particular concern for LGBT and HIV-positive teens. In addition, many adolescents in New York City are uninsured (Smith et al., 2000, McCormick et al., 2000). In order to provide services to those who are uninsured or unwilling to use their parents' insurance due to confidentiality risks, AHC has received funding through multiple grants to support the center's services.¹ These grants allow the center to provide services to teens regardless of ability to pay. AHC serves adolescents primarily from East Harlem and the South Bronx, but young people from all five boroughs attend the center.

AHC is an adolescent-focused environment that embraces diversity. The walls are outlined with multicolored handprints from staff and clients, including several rainbow colored hands. Among the various posters, which include pictures from the teen parenting program, and posters from drug abuse contests, there is one of a rainbow flag, and posters for both the girls and boys same sex groups which were each designed by the participants of these groups. Pamphlets on sexuality are readily available. The staff also reflect the diversity of the clients served.

All mental health services at AHC are provided through four teams. The primary care team, which also includes two social workers from our school-based clinics, provides mental health care immediately through our medical clinics when a medical provider refers a teen to one of our social workers. Most of the transgender teens who are in medical care and receive hormones are seen by this team. Other LGBT teens seen for medical treatment may also be referred. The health educators who provide HIV testing may also refer adolescents, especially if there are concerns regarding high-risk behaviors.

The Ryan White team also accepts immediate referrals, as above, for HIV-affected youth. When an adolescent has a positive HIV test, a Ryan White social worker is assigned, and this worker is part of the post-test counseling with the health educator. The Ryan White social worker facilitates the required services that the newly diagnosed teen needs. In addition, HIV-positive adolescents in medical service elsewhere are often referred to AHC because of the comprehensive, adolescent-focused mental health services, including two successful HIV-positive support groups for youth. Of the fifty positive teens currently in service, half are young males who contracted HIV through same sex encounters. HIV-affected adolescents are also referred through our mental health intake process, which is similar to the referrals for our other two mental health teams.

Adolescent clients can be referred directly for mental health services through a telephone intake process that schedules new clients for the two mental health teams. Referrals come from schools throughout the city, parents, social service agencies, and through the young people themselves, usually through word of mouth. During the first scheduled evaluation the client fills out the Adquest (Adolescent Questionnaire), which was developed at AHC in order to obtain the teen's view of their concerns and the issues they are interested in talking about. On the Adquest (Peake, 2000) there is one question on sexual orientation as follows:

How would you describe yourself? (Check any below)

Straight (Heterosexual)___	Bisexual___
Gay___	Transgender___
Lesbian___	Not Sure___

Of the 487 surveys processed, we have recorded the following results:

Ninety-five percent of the boys identified as being heterosexual, while 85% of the girls did. Seventy-four percent of white teens identified as being straight. Eighty-nine percent of African Americans and 91% of Latinos and West Indian/Caribbean identified as being straight. These surveys are reflective of the two mental health teams and do not include the LGBT teens or other youth seen in primary care or the HIV-positive adolescents involved in Ryan White.

All of AHC's mental health services are available to all AHC clients, which include individual, family and group therapy, psychological testing, psychiatric evaluation, and psychiatric medication management. In addition, some of the clients may participate in the center's vocational mentorship program, summer youth employment program, or our peer education program. Approximately fifty percent of the clients have serious impairment of functioning, indicated by a Global Assessment of Functioning (GAF) of 50 or lower. All the transgender youth and the HIV-positive youth receive a baseline psychiatric evaluation as part of their assessment package. Because group affiliation is a strong component of adolescent development and because very little has been written about group treatment in this population, this paper discusses the history of four adolescent LGBT focused groups developed at AHC. These are the Lesbian, Bisexual and Questioning² Girls Group, the Gay, Bisexual and Questioning Boys Group, the Transgender Tea Party, and the HIV-Positive Support Group for Gay and Bisexual Males.

THE LESBIAN, BISEXUAL AND QUESTIONING GIRLS GROUP

The Lesbian, Bisexual and Questioning Girls Group was started at the Adolescent Health Center because the girls requested it. Girls coming to the mental health program or the primary care clinic requested a group with girls like themselves, where they could openly discuss dating and sex, among other issues, without feeling "different." In the couple of years preceding the start of the group, AHC staff became increasingly aware that gay and lesbian youth are less likely to seek health care than heterosexual teens, and they are often reluctant to disclose for fear of being judged. Staff became more conscious of asking questions in a non-heterosexist manner and displayed materials designed for gay and lesbian youth, thereby demonstrating their willingness to be supportive. This environment facilitated the girls being able to ask for what they wanted and needed.

The purpose of the group was several-fold. A major developmental task of gay, lesbian and bisexual youth is adjustment to a socially stigmatized sexual

role and identity. The group was intended to facilitate support around these issues and encourage feelings of pride in their identities. These issues arose almost immediately, as the girls discussed their experiences of discrimination and gay bashing but also their determination to feel good about themselves. The group also gave the girls an opportunity to explore decisions regarding dating and sex in a safe environment. To improve their knowledge and risk-reducing skills in this area, a health educator, specializing in sexual health, visited the group on a regular basis to teach and answer questions. The group also focused on decision-making related to coming out to family and others. Questioning youth learned from peers that they were fine whether they ultimately felt they were gay, bisexual or straight and were relieved in not being told they were “just going through a phase.” The group gave some of its members an opportunity to meet other lesbian, bisexual and questioning girls for the first time, addressing feelings of isolation, not uncommon to gay people during their teen years. Group members spent much time discussing issues common to all teenagers. Knowing they would not be judged for their identity issues facilitated their comfort and openness.

The group met for several years with the same four to six core group members, as other members came and went. One of the group’s first tasks was to name the group. After much discussion, it was called “US,” which stood for “United Sexualities,” designed to welcome all. Initially, the group leaders led some icebreaker exercises but it quickly became clear that the girls would rather have less structure and raise issues themselves. The group met during the school year and broke for the summer every year. During the last meeting before the summer break, the group would do an activity, such as seeing a gay-themed movie or visiting a gay bookstore.

One of the challenges of the group was how to handle dating between group members. Initially the leader had a “no dating” rule due to concerns that relationship conflicts would not be openly addressed in the group and eventually members would drop out of the group. However, this rule was found to be counterproductive, as members began to date secretly. The leader was not informed and could not address the resulting conflict appropriately, which did result in some drop out. Once this rule was suspended, there has been more overt flirtation, but this is now more easily addressed and negotiated in the group.

Most of the girls were also in individual therapy, but some attended group only, and were not interested in individual treatment. However, when clients revealed risk behaviors that would benefit from a more intensive treatment, such as individual therapy, it was difficult to convince them of the potential advantage. Generally, these clients would then be seen by the group leader instead of being referred to another therapist for individual therapy.

Over time, the girls became supports to one another outside the group. They met on school holidays, attended each other's proms and visited agencies for gay youth together. When several of the girls began college, the group went on a hiatus. But, due to patient interest, it has recently been reformed with new membership.

GAY, BISEXUAL AND QUESTIONING BOYS GROUP

The gay, bisexual and questioning boys group developed as a result of providing individual and group psychotherapy to HIV-positive adolescents in the Ryan White program. The HIV-positive gay and bisexual patients stated that therapy helped them not only to address their medical issues, but also to come to terms with their sexual orientation and explore their sexuality in a safe and responsible manner. They felt that if they could process sexual identity issues before, or early on in their sexual experimentation, they might avoid HIV infection.

AHC staff began to identify HIV-negative gay, bisexual and questioning young men in their caseloads and referred these patients to be assessed for group. These young men were primarily Latino and African American from Harlem and Spanish Harlem and ranged in age from 16-22. Two months later, the Gay, Bisexual and Questioning Boys Group was born. The original facilitators were both openly gay men. It became clear to the facilitators that the group would have three main goals: to allow the young men to process, accept and integrate their feelings of same-sex attraction in an affirming and nurturing environment, to help them define and follow through with safer sex practices (all members had already engaged in sexual activity), and to develop "healthy" dating/relationship dynamics.

Most of the adolescents reported having sex in cruising areas in parks, clubs/backrooms, or meeting older men on the Internet and going over to their homes for sex. Sexual activity was disconnected from the rest of their lives as a way to distance and manage the overwhelming guilt and shame. These teens tended to avoid, inhibit, and cut off their same-sex attraction during most of the day, then resort to sexual exploration in situations and environments that were cut-off and disconnected from their "real life." The youth had quick, furtive sexual experiences that were fulfilling their sexual need in the moment, but the sexual experience occurred in a dissociated state, mired in guilt and shame.

It is in this state that the adolescents found themselves denying the necessity for using condoms and practicing safer sex that would lower the risk of HIV infection. Creating the group space for the gay, bisexual and questioning young men to share their thoughts and feelings with supportive peers and fa-

cilitators who normalized their internal experiences allowed the participants to accept their same-sex attractions and begin to create a self-defined identity as a gay or bisexual man. As comfort with sexual identity solidified in the group, members more fully self-identified in the world at large. As these young men began feeling increasingly comfortable identifying as gay or bisexual men, group conversations moved from a preoccupation with sexual fantasies and sexual encounters to a focus on dating, relationships, and love with other men. During this period, participants reported being less fulfilled by furtive encounters in the parks and other anonymous sex situations.

The group spent a great deal of time struggling with the question of sex versus relationship. Eventually, the group came to a consensus that one did not have to choose between the two but could have both. As the members began to lose interest in anonymous sex in risky environments, they ventured into meeting age-appropriate partners in more suitable environments. Participants expressed anger and frustration that their straight peers were able to meet potential dates almost anywhere, but they, as gay and bisexual young men, were forced to go to gay community centers/agencies/functions/clubs to meet other young men. The group began to focus on issues of meeting and dating men their own age. Most participants found it very challenging to relate in a nonsexual manner and to get to know the person before having sex. The group compared “normal sexual development” of their straight peers to their own experiences of meeting men just for sex and recognized the dangers and risks the group members had been taking. The group began to value dating as a preferred alternative to having a one-night stand, and group members began to see the possibility that they could lead a “normal life” just like straight adolescents; they could meet other males their age, date, fall in love, and have a family.

Throughout the group sessions, facilitators provided psychoeducation regarding HIV. Initially, the participants were reticent to discuss their thoughts and feelings about HIV, and simply listened to the facilitators present information. Most of the participants had a poor level of knowledge about HIV and its transmission. During the first couple of months, participants stated their belief that because they did not self identify as “gay,” they were not at risk. They also believed that because they had sex with married men in parks and other such environments, the men they had sex with could not have HIV, since they were not “gay” either. Others felt that as long as they were not anally penetrated, there was no real risk for HIV infection. Many members would smoke marijuana or drink alcohol before looking for sex, to help them cope with shame and guilt evoked by their same-sex attraction. Because of these factors, several of the youth had placed themselves at serious risk for HIV infection.

The facilitators provided psychoeducation regarding the basic knowledge of HIV transmission, reproduction, and treatment. The participants were sur-

prised by some of the information and experienced a more realistic understanding of the level of risk of their sexual practices. The facilitators spent two full sessions focusing on safer sex practices and eroticizing safer sex. At this point in the group process, members were very verbal and articulate about their sexual experiences and were able to actively absorb the information and understand that they could have sex that would be both fulfilling, and significantly decrease their exposure to HIV infection, by using, for example, condoms.

Eight months into the group, one of the members asked the group leaders to join him in his individual session during which he told them that he had just received a positive test for HIV that day. After revealing this, he dropped out of the group. His abrupt departure did not allow other group members to process the termination of his treatment with him. Group members expressed strong feelings of betrayal and abandonment by this member, which the leaders explored in depth. However, because the leaders were entrusted with the confidential information of the member's HIV status, they were also angry regarding some of the group members reactions. In group supervision, group leaders worked through feelings of helplessness and feelings that they had clinically failed this client and the group. In supervision, the group leaders were able to explore additional options to better handle this type of situation in the future.

Three years later, the Gay, Bisexual and Questioning Boys Group continues to provide an opportunity for young men to discuss their same-sex attractions and explorations, while minimizing their risk for HIV infection. Although the group facilitators and the patients who make up the group have changed, the commitment to provide a safe space for these young men to discuss their same-sex feelings and behaviors continues.

TRANSGENDER TEA PARTY

Several male-to-female (MTF) transgender adolescents have been followed at the Adolescent Health Center for feminizing hormone treatment and counseling. These young people, having had experiences of rejection and abuse related to their transgender identities, took much time to develop trust in their therapist and were initially apprehensive to meet one another. Feeling it would be beneficial for the adolescents to meet, the therapist and physician began to schedule these patients the same afternoon so they could get to know one another informally. For some time, these patients were in different stages of transitioning from a more masculine to a more feminine appearance. Eventually they were passing as females in their daily environments and all were exploring and struggling with the issue of disclosure, particularly in dating situations. To facilitate discussion, support, safe decision-making regarding dis-

closure, and to gauge interest in future group activities, a tea party was planned.

The transgender patients were reluctant to attend support or therapy groups. Part of this resistance was their desire “to pass” and not identify as transgender. However, in time, they decided they were willing to come to a tea party to get together with other transgender youth. The participants were permitted to choose snacks and spent time together planning the menu. At the party, they initially bonded over topics such as favorite music and stores, but then discussed school, their neighborhoods and experiences with hormones. They were aware their therapist wanted to facilitate a discussion of disclosure, a very charged subject for them, and they began to ask, in a general way, about each other’s views on this. When the group ended, they requested a monthly gathering and decided dating would be their next topic.

HIV-POSITIVE SUPPORT GROUP FOR GAY AND BISEXUAL MALES

As the clinic began to provide services for more and more HIV-positive gay and bisexual males, it became apparent that they could benefit from a group that would address issues specific to their sexuality. Contact with social workers from other agencies working with HIV-positive adolescents also indicated that there was a need for such a group in the broader community, and the group leaders decided the group should include youth referred by outside medical and mental health programs. The group began with the purpose of allowing the young men an opportunity for mutual support around health and psychosocial issues, as well as providing psychosocial education about sex, HIV, STDs, and medications.

Potential members are referred to the group by their therapists or doctors and screened by one or both of the facilitators before they are able to join. Confidentiality has been an important concern during the screening, as the young men often fear that other members will disclose their HIV status in mutual social arenas. This concern is addressed during the initial group screening and in the group whenever a new member joins. Once the young men realize they each have the same fears, they have more trust in their privacy being maintained. All members have agreed that the most important topics to discuss include medications and adherence, dating, sex, disclosure (to friends, family and especially partners), and support from family regarding HIV status, sexuality, and establishing independence. The length of time since members were first diagnosed varies. This serves to further enhance support of one another, particularly for those recently diagnosed. During the screening, and in initial group encounters, facilitators reiterate the importance of a “no dating” rule be-

tween members, as a reminder that the group is not meant to be a dating service, but rather a place for support and discussion.

Membership in the group has fluctuated, with members' busy schedules causing the majority of problems in attendance. Each member has voiced his feeling of connection to the group, and most of them have spent time socially outside of group sessions. Facilitators allow the members to decide what will be discussed each week, but regularly question them about their attendance to medical appointments, status of their blood counts and adherence to medications. Almost every session involves a lengthy discussion of dating and new partners, and whether HIV status has been disclosed. Members have been very open about this and have repeatedly helped each other make decisions about how and when to disclose, and how to negotiate protected sex with partners who do not know their status. The facilitators have been impressed with the young men's honesty and openness with each other, regardless of the more taboo subjects like anonymous sex, prostitution and unprotected sex. Group members generally agree that this is one of the few places where they are able to even voice their thoughts and feelings about such issues.

The group leaders had to actively set appropriate boundaries in order to maintain the safety of the group. For example, at one point a member became involved in an on-line video pornography business and several sessions were spent exploring the pros and cons of such involvement. When it became clear that this member was being paid extra money to refer other young men, and that he had taken another group member to sign up, the leaders became quite concerned. In the group leaders' supervision, it was decided to address this member individually. The group member was told the clinic would not allow recruitment and that this needed to be addressed in the group. Individual therapists of the group members were also informed, in order to allow the issue to be addressed individually with each member. This disruptive group member missed several groups after this limit was set, but the rest of the group was able to process what had happened and discuss at length why this caused concern for the group leaders and the clinic as a whole. Leaders emphasized the importance of members feeling safe to bring up any issues for discussion, without the risk of coercion or manipulation by staff or other members of the group.

The HIV-Positive Support Group for Gay and Bisexual Males has highlighted for the AHC staff the myriad issues that affect these young men daily, and how their sexuality and HIV status are intertwined. It serves as an important forum for them to discuss very difficult topics in a supportive and understanding environment, without fear of judgment. Each member has been able to hear how others are going through the same difficulties and thus find reassurance that they are not alone. It is hoped that with this support, the young men will be able to continue to learn the skills necessary for developing a

sense of self-worth and pride in their sexual identities, and that this will also encourage them to maintain their health and safety.

CONCLUSION

There are many potential barriers that can prevent LGBT and HIV-positive teens from receiving mental health care. New York State law requires that adolescents be able to receive confidential sexuality and mental health treatment. Grant funding allows these youth to be seen without fear of having confidentiality broken due to billing issues, and allows for comprehensive visits during which a teen can see a medical provider, health educator, nutritionist, social worker and psychiatrist all on the same day. Having comprehensive services in one location decreases the stigma of seeking another place for mental health services and provides for better integration of services for complex issues such as HIV.

An adolescent focused center helps young people feel more assured that their care is confidential, and sexuality issues and mental health issues can be addressed more openly as part of good care. Having a staff and physical environment that is reflective of the population being served, and that is warm and welcoming, encourages teens to bring up sensitive issues, as does not assuming a heterosexist bias when asking questions. It is also important to have a “critical mass” so that LGBT adolescents do not feel that they are “the only one.” Groups are a very powerful way of helping LGBT young people support each other.

Public funding provides the flexibility to run groups whenever needed, for as long as needed, without concern for limitations on the number of authorized visits. It is critical for programs to address as many of these barriers as possible in order to successfully address the unmet needs of this underserved population.

NOTES

1. Grants include a New York State (NYS) Department of Health (DOH) family planning grant, a NYS Office of Alcoholism and Substance Abuse Services (OASAS) substance prevention grant, a NYS DOH violence prevention and treatment grant, federal Ryan White funding for HIV infected/affected youth which is administered through state and city agencies, and a recent federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant for trauma treatment.

2. The term “questioning” has recently appeared in the literature (DeVries, 1998, Morrison and L’Heureux, 2001, Russell and Osher, 2001) but no source has been found which defines the term, and this term is likely being used in different ways. An excel-

lent book, *Lesbian & Gay Youth, Care & Counseling* (Ryan and Futterman, 1998), sheds some light on what the term encompasses:

Although the majority of adolescents are aware of their sexual feelings and some acknowledge sexual orientation during early adolescence, many do not consolidate sexual identity until their early 20s. Thus, adolescence for many lesbian and gay youth is characterized by indecision, uncertainty, and vacillation between heterosexual, bisexual or homosexual labels. (p. 29)

When youth are questioning or confused about sexual identity, vulnerability is increased, and support is particularly important. (p. 100)

In four surveys of young males, the prevalence of same-sex activity to orgasm ranged from 17-37%, however, the percentage who later self-identify as gay is much lower. Moreover, many adolescents who later identify as lesbian or gay may self-label as bisexual when they are younger. In a survey of lesbian and gay youth, ages 14-21, for example, more than half had previously identified as bisexual. (p. 106)

In addition, substantial variation exists across racial and ethnic groups concerning the social acceptability of exact orientations and identities (Dean et al., 2000), and for some in the African American community, “taking on a gay identity means giving up an African American identity” (Stokes and Peterson, 1998). The Centers for Disease Control and Prevention (CDC) has reported that as many as 24% of homosexually active African American men with HIV identified themselves as heterosexual, as well as 15% of Latino men (CDC, 2000). Given that the population at AHC consists of multicultural youth who may not have a solid sexual identity or may resist being labeled gay, lesbian or bisexual, offering the term “questioning” may be more acceptable to these adolescents and make it more likely that they would seek out the group to explore their sexual feelings.

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