Guest Editorial

L.G.B.T: Let's Go Beyond Teeth

The onset of adolescence brings a host of potentially challenging conversations for the pediatric dentist. Personal hygiene, pregnancy, substance use, disordered eating, and safe sexual practices litter the minefield of young adulthood. Although rarely discussed, sexual orientation and gender identity are inextricably linked to these typical teenage topics. Children are discovering and disclosing their sexuality at younger ages, meaning these particular topics may be relevant sooner.[1] Not addressing this with your patient families, either directly or indirectly, could be doing your patients harm.

Youth identifying as somewhere between boy, girl, heterosexual, or otherwise are at risk for a litany of well-documented health disparities that include: suicidal ideation and attempts, substance use, harmful weight-control behavior, and sexually transmitted infections.[2-11] These health disparities are prolific and persistent enough that in October 2016, the National Institutes of Health (NIH) announced that sexual and gender minorities (**SGM**) are "formally recognized as a health disparity population for research purposes."[12] Recent literature suggests that supportive social surroundings, including the clinical setting, can have a significant positive effect on these outcomes.[13-15] As health care providers who strive to see our patients at least semi-annually from age one into young adulthood, pediatric dentists are in a unique position to witness all facets of development in real-time. Whether or not patients directly disclose their sexual or gender identity, we have an obligation to expand our cultural competence beyond current boundaries and open the dental home to provide a safe space for SGM youth.

The first step to providing culturally competent care to the SGM population is recognizing the difference between sexual and gender minorities. Acronyms like LGBT (lesbian, gay, bisexual, and transgender) seem like an identity catch-all; however, reality reveals it is far more complicated than four simple letters. Sexual minorities are defined as individuals who are attracted to members of the same sex and may identify as gay, lesbian, bisexual, or something other than heterosexual.[16] Gender minorities, including transgender, refers to gender identity that is different than what is socially and culturally expected based on sex assigned at birth. This is independent from sexual orientation, as gender minority individuals also identify as heterosexual or otherwise.[17,18] Sexual orientation and gender identity are both considered fluid developmental processes, with youth potentially vacillating between a variety of identities before emerging with a specific orientation. Even then, fluidity remains.[17] Some basic recommendations for developing a culturally competent approach can be found in the Figure below.

Although it may seem that acceptance of SGM is widespread, overall progress for this population has been slow and concentrated to the last 50 years or so. For the bulk of recorded history, SGMs were vilified as medical and social pariahs. Medical professionals classified various definitions of homosexuality as a mental illness until 1987, taking more than 25 years for gender minorities to shed the same stigma in 2013.[19,20] The 2015 United States Supreme Court decision legalizing same-sex marriage nationwide removed a number of barriers to accessing care for children of same-sex parents, including issues with custody, consent, and health insurance.[21-23] In 2016, the Department of Health and Human Services Office for Civil Rights finally offered much-needed protections specific to the health care arena, explicitly barring discrimination of LGBT people in any facility or program that receives federal funding, including private offices that accept Medicaid.[24] Given all of this apparent progress, what explains the persistent health disparities for this population?

Despite initial applications in mental health, the Minority Stress Model is frequently used to explain, at least in part, how stigma-induced social stress affects SGM health disparities in other venues. Briefly, the model explains that the experience of existing social stigma towards sexual orientation and gender identity may cause an individual to hide their identity and internalize this homophobia with the expectation that they will encounter rejection and physical or emotional violence.[25] Unfortunately, this

Figure. RECOMMENDATIONS FOR PROVIDING AN INCLUSIVE DENTAL HOME FOR SEXUAL AND GENDER MINORITY YOUTH

- On intake forms, provide one selection for "Sex at Birth" and a separate free space to write in "Gender Identity".[17]
- On intake forms, ask for "Legal Name" separately from "Name".
- Give patients choice and encouragement to select post-treatment rewards.
- Use gender neutral terminology. If uncertain, ask how patients prefer to be addressed.[17,31]
- Refrain making assumptions about sexual orientation based on outward appearance. For example: Female Patient: I'm going to homecoming this weekend. Doctor: Who are you going with? (Avoid: Are you going with your boyfriend?)[17,31]
- Research local resources for SGM patients and their families, and connect them when appropriate.[30,31]
- Place a rainbow decal or button in the door or a visible bulletin board, which can be a sign of acceptance and comfort to families.[31]

fear is not unfounded. Evidence exists that SGM patients have been refused treatment, been blamed for their health status, or have endured physical abuse.[26] Hiding sexual identity is common in the medical arena, with evidence to suggest that this stress can lead patients to delay routine care to avoid further stigma from providers.[27,28] Chronic stress related to this persistent fear can result in depression and suicidal ideation and attempts, with substantial evidence demonstrating increased risk among SGM youth.[13,14,17,18, 29] As a consequence of the recent political shift, civil rights advances for the SGM population in the United States have either already regressed or are in danger of doing so, perpetuating stigma for this vulnerable group.

The American Academy of Pediatrics issued the first statement on sexual minority adolescents in 1983, detailing sexual and gender identity development and associated health disparities.[17] Meanwhile, there is not **a single** mention of sexual orientation or gender identity in the American Academy of Pediatric Dentistry's professional guidelines, despite the fact that these children and adolescents are at increased risk for a number of health disparities with dental implications. Perhaps this should not be tremendously surprising: throughout our history as two distinct professions, it seems that dentistry can be slow to follow the lead of our medical colleagues, sometimes failing to blaze our own trail on pressing healthcare matters. Dentists often criticize our physician colleagues for ignoring the mouth and looking past the teeth. As the big authority on little teeth, it seems we occasionally have trouble looking past the teeth to consider the whole patient. Health disparities notwithstanding —whether we are aware or not—these children show up to our clinics and practices daily, only to face a host of potential barriers to culturally competent care: intake forms that force patients to select between only male and female, offering post-treatment rewards based on biological sex, or seemingly innocent conversation that in reality may be stigmatizing. We use traditional gender concepts daily and don't realize that to some of our patients, this may be a source of anxiety. Our patients deserve better. We are healthcare providers who prioritize **every** child, and as such, it is imperative that we deliver compassionate, inclusive care supported by the best evidence available.

Sincerely,

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