Comparing Health and Mental Health Needs, Service Use, and Barriers to Services among Sexual Minority Youths and Their Peers

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Using a representative national sample (N = 20,745), this article explores health and mental health needs, service use, and barriers to services among sexual minority youths (SMYs) and heterosexual peers. *SMYs* were defined by ever having a same-sex romantic attraction or having a recent same-sex romantic relationship or sexual partner. SMYs accounted for 7.5 percent of the sample. Data were analyzed to ascertain prevalence of risks and explore group differences. Compared with peers, SMY self-reports indicated higher prevalence rates on all indicators of health and mental health need. SMYs reported more sexual activity, more sexually transmitted disease diagnoses, a higher perceived risk for HIV/AIDS, and more forgone medical care than peers. Also compared with peers, SMYs reported higher levels of anxiety, depression, suicidality, and physical and sexual victimization and higher rates of unmet mental health need. SMYs also reported greater concerns about confidentiality and were less likely to use school-based services. The majority of SMYs reported same-sex attraction only. Social work and other helping professionals should incorporate same-sex attraction questions into assessment protocols to target services for this population. School- and office-based providers must consider whether their services are welcoming and offer sufficient assurances of confidentiality to facilitate access by SMYs.

KEY WORDS: *health; LGB youths; mental health need; service use; sexual minority*

Community and population-based studies suggest that sexual minority youths (SMYs) (that is, youths who report same-sex romantic attractions or relationships or who identity as nonheterosexual) may be at higher risk for an array of poor health and mental health outcomes in comparison with their heterosexual peers. Recent studies conducted with population-based samples have provided compelling evidence that sexual minority youths (SMYs) experience victimization (Bontempo & D'Augelli, 2002; Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998; Russell, Franz, & Driscoll, 2001; Russell & Joyner, 2001); use alcohol and other illicit substances (DuRant, Krowchuk, & Sinal, 1998; Faulkner & Cranston, 1998; Russell, 2006; Ziyadeh et al., 2007); engage in sexual risk behaviors (Faulkner & Cranston, 1998; Garofalo et al., 1998; Saewyc, Bearinger, Blum, & Resnick, 1999); become pregnant or father a pregnancy (Saewyc et al., 1999; Saewyc, Pettingell, & Skay, 2004); and experience anxiety, depression, and suicidality (Faulkner & Cranston, 1998; Fergusson, Horwood, & Beautrais, 1999; Garofalo et al., 1998; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Remafedi, French, Story, Resnick, & Blum, 1998; Russell & Joyner, 2001; Udry & Chantala, 2002; Waller, 2005) at higher rates than their peers. Although factors contributing to these risks remain unclear, sexual minorities may be at risk of internalizing negative societal messages and may experience higher levels of stress due to stigma, marginalization, oppression, and having fewer family and community supports (Meyer, 1995, 2003). Adolescents in general often do not access basic health services and are the most likely age group to be uninsured (Klein, Slap, Elster, & Cohn, 1993). However, it is possible that SMYs experience additional barriers to health services due to stigma, marginalization, and discrimination (Mercier & Berger, 1989; Paroski, 1987; Travers & Schneider, 1996). Concerns about privacy and confidentiality may also deter SMYs from discussing their sexuality with health care providers, which could hinder appropriate health screenings and patient education (Allen, Glicken, Beach, & Naylor, 1998; Meckler, Elliott, Kanouse, Beals, & Schuster, 2006; Ryan & Gruskin, 2006).

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Service need and use among SMYs is poorly understood, partly because of limited large-scale data collection efforts that include sexual minority populations. To date, only one representative study has examined help seeking and service use among SMYs, and it found that SMYs were significantly more likely to use mental health services than were peers (McGuire & Russell, 2007). This study further addresses this knowledge gap by providing a comparative analysis of health/mental health needs, access and barriers to services, and the extent of unmet health/mental health needs between SMYs and their peers. The analysis addresses the following research questions: Relative to their peers, do SMYs

- report greater health and mental health needs?
- obtain health and mental health services at the same rates?
- forgo needed health care at the same rates?
- report the same barriers to health care services?
- access health and mental health services in the same settings?

METHOD

This study entailed a secondary data analysis of wave 1 data from the National Longitudinal Study of Adolescent Health (Add Health), a school-based, nationally representative probability survey. The sampling frame for the Add Health study was derived from a list of all U.S. high schools obtained from the Quality Education Database (Udry & Chantala, 2005). From this list, a stratified probability sample of 80 high schools and 52 feeder schools was selected. Among these 132 schools, 20,745 adolescents in grades 7 through 12 were randomly selected to participate in wave 1 of the in-home study (Udry & Chantala, 2005).

Wave 1 in-home interview data were collected on laptop computers, using youth and parent self-report questionnaires. Sections of the youth questionnaire containing sensitive topics (that is, substance use, violence, sexual activity, and mental health) were administered to youths via headphones using audio computer-assisted self-interview technology. Prior approval to conduct the secondary data analysis of the Add Health data for this study was obtained from the University of North Carolina at Chapel Hill Behavioral Institutional Review Board.

The Add Health study used a complex sampling design that stratified schools by size, type, region, location, and proportion of white students. However, the "nested" structure of the Add Health data (that is, students within schools) creates an analysis problem. That is, youth participants from the same school are likely to be more similar to each another (in terms of characteristics) than to students from different schools. These similarities mean that observations are not independent, which violates the assumption of independence in ordinary least squares models and results in incorrect standard error terms. To adjust for the nested design of the data, our analyses included "weight" variables available in Add Health. These weight variables were stratum (that is, region), cluster (that is, school), and a grand sample weight (for each youth participant).

Sample

The entire wave 1 sample of 20,745 adolescents included 1,821 participants who were subsequently added to the in-home study for specific purposes (for example, twins and genetics research). However, these 1,821 participants were not assigned a grand sample weight and therefore could not be included in our analyses. Thus, to address our research questions, we used only the sample of adolescents (n = 18,924) who initially participated in the in-home survey between April and December 1995. Among this 18,924-youth sample, we identified 1,388 (7.5 percent) SMYs and 17,456 (92.5 percent) peers. A description of the SMY and peer samples by sex, age, and racial/ethnic group is provided in Table 1.

We defined *SMYs* as youths who reported one or more of the following characteristics: ever having a same-sex romantic attraction, having a same-sex romantic relationship in the past 18 months, and having a same-sex sexual partner in the past 18 months.

Measures

Beyond SMY status, measures were biological sex, age, race/ethnicity, mental health need, mental health service use, unmet mental health need, health risk/need, health service use, service use setting, forgone medical care, barriers to health care, and unmet health need. Biological sex was measured as a dichotomous variable on the basis of respondent self-report. Age was measured as a quasi-continuous variable ranging from 11 to 21 years, based on the

Table 1: Demographic Characteristics of Weighted Sample (N = 18,924)

Characteristic	SMYs (n = 1,388) n (%)	Peers (n = 17,456) n (%)
Sex		
Male	721 (55.3)	8,527 (50.5)
Female	667 (44.7)	8,929 (49.5)
Age (years)		
11–14	293 (28.0)	4,743 (34.3)
15–17	819 (51.8)	9,806 (49.7)
18–21	276 (20.2)	2,907 (16.0)
Race		
White/non-Hispanic	681 (62.0)	9,257 (67.3)
Black/non-Hispanic	297 (17.5)	3,729 (15.8)
Asian/non-Hispanic	87 (3.1)	1,247 (3.7)
Native American/other	33 (2.3)	261 (1.3)
Hispanic	286 (15.1)	2,923 (11.8)

Note: SMYs = sexual minority youths.

nearest whole year of the respondent's self-reported age.

Race/ethnicity was measured as a categorical variable on the basis of a composite of two items: a dichotomous question asking youths if they were of Hispanic origin and a second item asking youths to indicate their race (that is, white, black, Native American, Asian, or other). The composite race variable combined these two variables into a five-category race variable: non-Hispanic white, non-Hispanic black, non-Hispanic Asian, non-Hispanic Native American, and Hispanic.

Mental health need was assessed using a series of questions that asked youths to report whether they had experienced depression symptoms in the past week, had experienced anxiety symptoms in the past year, had considered or attempted suicide in the past year, or had been physically/sexually victimized in the past year. The measure comprised the following mental health need indicators found in the data set: Depression was measured by an adapted version of the Center for Epidemiologic Studies Depression Scale (CES-D) (α = .87) (Radloff, 1977). Response values, ranging from 0 = rarely or none of the time to 3 = most or all of the time, were summed to create a composite score. Among adolescents, prior research suggests that CES-D scale scores of 24 in girls and 22 in boys are indicative of clinical depression (Garrison, Addy, Jackson, McKeown, & Waller, 1991; Roberts, Lewinsohn, & Seeley, 1991). Using the cutoff scores for clinical depression as a gauge, we created a dichotomous need for depression screening variable with a cutoff score of 20 or higher to indicate youths in need of depression screening or services.

Anxiety was measured by a six-item scale that we constructed on the basis of known clinical symptoms of anxiety. An alpha coefficient of .73 was derived for the anxiety scale, indicating an adequate level of reliability. Youths were asked about the frequency of anxiety symptoms over the past year using a five-point scale ranging from 0 = never to 4 = every day. Items were questions about poor appetite, difficultly falling asleep or staying asleep, trouble relaxing, moodiness, frequent crying, and fearfulness. Response values were summed for all six items, and a composite score ranging from 0 to 24 was created. A dichotomous variable with a cutoff score of 18 or higher was used to indicate youths in the top quartile (25 percent) for anxiety symptoms (that is, those who reported anxiety symptoms every day or almost every day). We considered these youths to have, at minimum, a need for health/mental health screening services.

A dichotomous suicidality measure was created using two items that asked about suicidal thoughts and suicide attempts in the past 12 months. Youths who reported they had seriously considered suicide or attempted suicide at least once in the past year were determined to have a need for screening/services.

Youth victimization history was measured as a dichotomous variable derived from six items asking whether a youth had experienced violent events such as being jumped, stabbed, or shot or had witnessed a shooting or stabbing. In addition, female respondents were asked if they had been the victim of forced or coerced sexual intercourse. If youths answered "yes" to any one of the items in the index, they were considered to have a recent history of victimization, which warranted a need for screening/services.

Mental health services use was measured by a dichotomous question that asked respondents if they had obtained mental health services (that is, psychological or emotional counseling) in the past year.

Unmet mental health need was measured by combining five mental health need indicators with an item that asked about receipt of mental health services in the past year. Thus, if youths had moderate to severe symptoms of mental health disorders

(for example, anxiety, depression, suicidality) and indicated no receipt of mental health services, they were considered to have an unmet mental health need.

Health risk/need was assessed by a dichotomous measure comprising a series of three dichotomous variables asking youths to indicate the following: (1) if they have ever had sexual intercourse; (2) if they believed they were at risk for contracting HIV/AIDS (low/very low risk versus high/very high risk); and (3) if they had ever been told by a health professional they had Chlamydia, gonorrhea, hepatitis B, syphilis, genital herpes, or HIV/AIDS. If youths answered "yes" to any of the three questions, they were considered to have a health risk/need.

Health service use was measured by a single dichotomous item that asked respondents to indicate whether they had obtained a routine physical exam in the past year, as recommended by current guidelines (Elster, 1998; Hagan, Shaw, & Duncan, 2008).

Service use setting was measured with a series of dichotomous items that asked youths who used health or mental health services to indicate the settings in which they obtained those services.

Forgone medical care was measured by a single dichotomous question that asked respondents if there had been a time in the past year when they believed they needed medical care but did not obtain care.

Barriers to health care was measured by a series of dichotomous questions that asked youths who reported that they skipped needed medical care to indicate what had prevented them from obtaining services. Youths could report one or more of 10 barriers: (1) did not know whom to go see, (2) had no transportation, (3) no one available to go along, (4) parent or guardian would not go, (5) did not want parents to know, (6) difficult to make appointment, (7) afraid of what the doctor would say or do, (8) thought the problem would go away, (9) could not pay, and (10) other barrier.

Unmet health need was created by combining two dichotomous variables, health service use and forgone medical care. The first item asked youths if they had received a routine health exam in the past year, and the second item asked youths if they had skipped needed medical care in the past year. If a youth provided a negative response to the health service use variable or an affirmative response to the forgone medical care variable, he or she was considered to have an unmet health need.

ANALYSIS

All analyses for this study used Stata SE (release 10) software, selected for its capacity to manage large, complex (that is, nested) survey datasets. We initially explored data by examining frequencies (for example, number of youths with health/mental health needs, number who used services) and by running bivariate correlations to determine whether statistical relationships existed between variables. In addition, we ran cross-tabulations to obtain percentages (for example, the percentage of youths using health and mental health services by setting) and conducted basic inferential statistics (that is, chi-square analyses) to determine statistically significant group differences between SMYs and their peers (for example, prevalence rates of suicide attempts).

RESULTS

Health Risks/Need and Unmet Health Need

The results of chi-square analyses of sexual minority and peer youths who reported a history of sexual activity, pregnancy, or a self-perceived high/very high risk of acquiring HIV/AIDS are presented in Table 2. Compared with peers, significantly more SMYs reported a history of sexual intercourse (52.3

Table 2: Percentages of Health Risk and Unmet Health Need among Sexual Minority Youths (SMYs) and Their Peers (N = 18,924)

Variable	SMYs (n = 1,388) n (%)	Peers (n = 17,456) n (%)	$\chi^2(1)$	p
History of sexual intercourse	690 (52.3)	6520 (36.1)	68.65	<.001
History of pregnancy (female only)	66 (19.1)	549 (16.9)	0.59	.445
Perceived risk for HIV/AIDS	129 (9.2)	897 (4.9)	20.65	<.001
History of STD or HIV	55 (8.1)	295 (4.4)	11.01	.001
Unmet health need	697 (50.7)	7975 (45.8)	5.87	.017

Note: STD = sexually transmitted disease; unmet health need = no health care visits in past year.

percent), a previous diagnosis of a sexually transmitted disease (STD) or HIV/AIDS (8.1 percent), and a high/very high self-perceived risk of contracting HIV/AIDS (9.2 percent). Female SMYs reported higher rates of pregnancy than female peers (19.1 percent versus 16.9 percent), though group differences were not statistically significant. Finally, a significantly higher percentage of SMYs than peers were determined to have an unmet health need, with more reporting either skipping needed medical care or not obtaining an annual doctor's visit in the past year (50.7 percent versus 45.8 percent).

Mental Health Need and Unmet Need for Services

Relative to their peers, SMYs reported significantly higher rates on all mental health need indicators. The numbers and percentages of youths who reported having a mental health need, using mental health services, or having a mental health need but not accessing services (that is, unmet mental health need) are presented in Table 3. The highest mental health needs among SMYs were suicide attempt (40.8 percent), physical or sexual victimization (37.1 percent), suicidality (22.2 percent), moderate to severe depression (19.8 percent), and moderate to severe anxiety (10.4 percent). A significantly higher percentage of SMYs than peers (19.8 percent versus 12.1 percent) obtained mental health services, but despite higher rates of mental health service use, significantly more SMYs (51.2 percent) than peers (36.7 percent) had an unmet mental health need.

Male SMYs reported significantly higher rates on all mental health need indictors and mental health service use than did male peers. Similarly, female SMYs reported greater mental health need and more service use than did female peers. Despite significantly higher rates of mental health service use, both male and female SMYs had significantly greater percentages of unmet mental health need than did their same-sex peers (46.7 percent versus 37.8 percent [male] and (57.9 percent versus 36.5 percent [female]). Overall, female SMYs had the highest rates of mental health need: physical/sexual victimization (37.9 percent), moderate to severe anxiety (18 percent), moderate to severe depression (26 percent), suicidality (29 percent), and at least one previous suicide attempt (46 percent). Notably, significantly more female SMYs reported having been the victim of forced or coerced sexual intercourse in the past year than did female peers (7.8 percent versus 3.3 percent).

Forgone Medical Care and Service Use Barriers

Compared with peers, significantly more SMYs reported that they had skipped needed medical care in the past year (25.1 percent versus 17.9 percent). Those youths who reported skipping needed medical care were asked to report what barriers had prevented them from obtaining services. A significantly higher percentage of SMYs than peers reported the following barriers to obtaining health services: did not want parents to know (15.7 percent versus 10.5 percent) and afraid of what the doctor would say or do (20.5 percent versus 15.0 percent).

In addition, a higher percentage of SMYs reported that they had skipped needed medical care because they could not pay (18.0 percent versus 14.8 percent), which suggests that financial challenges may be another salient issue with regard to access to health services for SMYs.

Table 3: Percentages of Mental Health Need and Unmet Need for Services among Sexual Minority Youths (SMYs) and Their Peers (N = 18,924)

Variable	SMYs (n = 1,388) n (%)	Peers (n = 17,456) n (%)	$\chi^2(1)$	p
Anxiety	126 (10.4)	812 (4.6)	30.79	<.001
Depression	285 (19.8)	2215 (11.9)	40.39	<.001
Seriously considered suicide	284 (22.2)	2131 (12.5)	58.59	<.001
Suicide attempt	109 (40.8)	593 (28.4)	10.55	.002
Victimization (physical/sexual)	505 (37.1)	4737 (26.2)	35.83	<.001
Mental health services (past year)	254 (19.8)	1942 (12.1)	33.92	<.001
Unmet mental health need	692 (51.2)	6597 (36.7)	70.43	<.001

Note: STD = sexually transmitted disease; unmet health need = no health care visits in past year.

Mental Health Service Setting

The numbers and percentages of sexual minority and peer youths who obtained mental health services among different settings are presented in Table 4. SMYs reported accessing mental health services significantly more often at private doctors' offices than did peers (49.0 percent versus 34.7 percent). Conversely, a significantly lower percentage of SMYs (23.1 percent) than peers (33.7 percent) reported obtaining mental health services at school. It is interesting to note that a higher percentage of SMYs than peers reported accessing mental health services at some other setting (21.9 percent versus 17.0 percent); however, it cannot be known from the data what other types of service settings were accessed by these youths.

DISCUSSION AND IMPLICATIONS FOR PRACTICE

The current study provides an overall profile of unmet health and mental health need, service use patterns, and barriers to service use among a nationally representative school-based sample of SMYs and their peers. This section discusses each of these finding areas along with implications for practice.

Victimization, Sexual Risk Behaviors, and Health and Mental Health Need

SMYs in the current study were found to be at significantly higher risk for both physical and sexual victimization. Female SMYs reported a significantly higher rate of sexual victimization (that is, forced or coerced sexual intercourse) than did their female peers (7.8 percent versus 3.3 percent). Higher rates of sexual victimization may, in turn, be associated with—although perpetration, whether it stems from bias or not, is in no way excused by—a higher prevalence of sexual risk-taking behaviors.

Indeed, our study found that SMYs reported a significantly higher prevalence of sexual activity (that is, sexual intercourse) and a significantly higher perceived risk for contracting HIV/AIDS than did peers. These findings suggest that SMYs may engage in what they perceived to be unsafe sexual activities (for example, intercourse without a condom), which may increase their risk for contracting STDs or becoming pregnant. These findings also support prior hypothesized links between SMYs and particular risks such as socializing in bars and clubs where alcohol is consumed and having fewer positive community supports (for example, welcoming schools, religious organizations, health/mental health providers) (Ryan & Gruskin, 2006).

Findings from this study particularly highlight the mental health needs of female SMYs, who appear to be at even greater risk for mental health challenges than their male SMY peers. Specifically, female SMYs reported higher prevalence rates of attempting suicide (46 percent versus 32 percent), suicidality (29 percent versus 16 percent), depression (26 percent versus 15 percent), and anxiety (18 percent versus 5 percent) than did male SMYs. However, both female and male SMYs reported about the same percentages of victimization (38 percent versus 37 percent). Among female SMYs, victimization experiences included sexual victimization, which was reported by 7.8 percent of female SMYs and 3.3 percent of female peers.

In addition, the mental health needs of female SMYs appear to be especially high, with only about 40 percent with a mental health need obtaining needed mental health care compared with about 52 percent of male SMYs and 63 percent of female peers. Indeed, a prior Add Health study that examined sexual orientation and suicide risk

Table 4: Percentages of Mental Health Service Use, by Setting, among Sexual Minority Youths (SMYs) and Their Peers (N = 18,924)

Variable	SMYs (n = 1,388) n (%)	Peers (n = 17,456) n (%)	$\chi^2(1)$	p
Private doctor's office	85 (49.0)	502 (34.7)	8.08	.005
School	45 (23.1)	465 (33.7)	5.26	.023
Community health clinic	20 (17.1)	198 (16.0)	0.07	.790
Hospital	20 (8.4)	125 (8.4)	0.00	.999
Other	36 (21.9)	252 (17.0)	1.54	.217

found girls who reported same-sex attractions or same-sex romantic relationships to be at greatest risk for suicidality (Russell & Joyner, 2001). Studies of lesbian, gay, and bisexual (LGB) youths who have attempted suicide indicate that they were more likely to have self-identified and come out to others at younger ages and to have had friends and relatives who attempted or committed suicide (Hershberger & D'Augelli, 1995; Remafedi, Farrow, & Deisher, 1991). They were also more likely to have been rejected because of their sexual orientation (Schneider, Farberow, & Kruks, 1989). LGB youths of color who attempted suicide were more likely to have dropped out of school and to have been rejected by their family of origin and forced out of their homes than were those who had not attempted suicide (Hershberger & D'Augelli, 1995). Given these findings, problems related to family acceptance, conflict with sexual identity formation, and societal pressure to conform to heterosexist expectations appear to be important factors to consider in relation to the mental health and well-being of SMYs (Ryan & Gruskin, 2006).

Service Use and Unmet Health and Mental Health Need

SMYs also reported a significantly higher percentage of mental health service use than did peers (19.8 percent versus 12.1 percent), a finding that is consistent with a prior study examining mental health service use among SMYs (McGuire & Russell, 2007) and with the adolescent help-seeking literature, which considers mental health need to be a major predictor of mental health service use among youths (Angold et al., 1998; Costello, Pescosolido, Angold, & Burns, 1998; Logan & King, 2001). The current study, however, found that despite higher rates of mental health service use among SMYs, a significantly higher percentage of SMYs with mental health need did not obtain services compared with peers (51.2 percent versus 36.7 percent). Thus, with regard to health and mental health service use among SMYs, the current study brings to light the extent of unmet health and mental health need in this population.

Female SMYs appear to be at especially high risk for not receiving needed mental health services. The current study found that only 42.1 percent of female SMYs with a mental health need obtained mental health services (compared with 53.3 percent of male SMYs, 63.5 percent of female peers, and 62.2 percent of male peers). This finding stands in contrast to literature suggesting that female adolescents generally have more positive attitudes toward help-seeking than do male adolescents (Schonert-Reichl, 2003). Indeed, both this study and a prior Add Health study examining sexual orientation and suicide risk found female SMYs to be at greatest risk for suicidality (Russell & Joyner, 2001).

Forgone health care is also a serious problem for SMYs, particularly in light of higher health risks and needs. Relative to their peers, significantly more SMYs failed to access needed medical care. This is a new finding that builds on prior research examining factors associated with forgone health care among adolescents (Ford, Bearman, & Moody, 1999; Lehrer, Pantell, Tebb, & Shafer, 2007).

Service Use Settings and Barriers to Service Use

The current study found that SMYs and their peers did not differ significantly with regard to where health care services were obtained. The majority of all youths (about 60 percent) went to a private doctor's office, whereas about 20 percent went to a community health clinic, and about 11 percent obtained routine physical exams at school. However, about half of SMYs (49.0 percent) who obtained mental health services went to a private doctor's office, a significantly higher percentage than was found among their peers (34.7 percent). At the same time, a significantly lower percentage of SMYs than peers obtained mental health services at school (23.1 percent versus 33.7 percent). These findings suggest that SMYs may tend to seek mental health services in settings that assure higher levels of privacy and confidentiality. Because school environments typically do not offer much privacy and confidentiality (for example, youths may have to leave class to talk with a counselor) and are places where bullying and victimization often take place, it is not surprising that significantly fewer SMYs than peers in our study obtained mental health services at school.

Indeed, our study found that SMYs differed significantly from peers in that their two reasons for not seeking needed medical care related to privacy and confidentiality concerns (that is, "did not want parents to know" and "afraid of what the doctor would say or do"). Again, these reported barriers reflect the greater desire for private and confidential services in the SMY population and argue for the importance of practitioners providing statements of

confidentiality assurance to their adolescent clients (Ford, Millstein, Halpern-Felsher, & Irwin, 1997).

Taken together, findings from the current study highlight the greatly increased risk of victimization for SMYs in the United States. The high rates of victimization for both male and female SMYs, together with the increased concern about confidentiality with providers and lower use of school-based services, should alert providers that much more needs to be done to effectively reach out to SMYs and develop welcoming services for and trusting relationships with them. Given the higher rates of sexual activity among SMYs, social workers and other providers should routinely create safe environments for all youths to talk about sexual orientation and sexual health. A multidimensional approach to discussing sexual orientation would include talking with youths about their romantic/sexual attractions, behaviors, and identities. The majority of youths in our SMY sample (82.6 percent) reported same-sex romantic attraction only, and half of these SMYs had unmet health and mental health needs. Therefore, the clinical importance of talking with adolescents about their romantic attractions (in addition to their sexual behavior and identities) is evident on the basis of our findings.

Furthermore, given the increased risk for mental health challenges among SMYs and increased concern regarding privacy and confidentiality, social workers and other providers should talk with youths about confidentiality and limitations to confidentiality, such as what social, health, and mental health issues will be shared with parents and what will not be shared with parents. This discussion may need to cover inadvertent ways that a youth's confidentiality might be compromised, including through insurance billing, parental requests to review a child's medical chart, or other mechanisms besides active provider disclosure.

Finally, social workers and other providers should provide routine screening for SMYs for symptoms of anxiety and depression, suicidality, and history of physical or sexual victimization, paying particular attention to female SMYs, who appear to be at especially high risk for having an unmet mental health need.

LIMITATIONS

Our study has several limitations involving sample and measurement issues. The Add Health data were derived from a school-based sample of youths and, therefore, excluded youths who were not enrolled in school during the data-collection period. This created a selection bias as the sample may not have included some youths at highest risk (for example, youths who are ill, pregnant, or may have been victimized at school and then dropped out). Nonstudent youths likely have greater health and mental health needs than do students and, depending on their circumstances (for example, homelessness, institutionalization) or resources (for example, lack of health insurance), may or may not be accessing health or mental health services.

With regard to measurement, it should be noted that the history of victimization measure was limited by a one-year historical time frame. This time frame might have excluded youths who were still experiencing the traumatic effects of victimizing events that occurred over a year before their completion of the survey. The victimization measure was also limited in that it did not include a measure of sexual victimization for male youths. Future studies need to incorporate a fuller picture of victimization experiences for both male and female respondents.

In addition, measures of service use did not indicate how many times youths had accessed services in the past year. Instead, these measures indicated only whether youths had accessed services on at least one occasion. Knowing whether services were accessed on more than one occasion would provide a more comprehensive understanding of youths' needs and patterns of service use. In addition, although more SMYs than peers reported that they had obtained mental health services in some other setting (21.9 percent versus 17.0 percent), the specific types of other mental health settings cannot be ascertained. Therefore, our study may be missing an important setting in which SMYs accessed helpful mental health services. Subsequent studies on mental health service use should allow youth respondents to specifically indicate what type of mental health services they have accessed.

Finally, the measure for sexual minority status in our study did not include one important dimension of sexual orientation: self-identity. Sexuality researchers have conceptualized sexual orientation as having three dimensions: desire, behavior, and identity (Laumann, Gagnon, Michael, & Michaels, 1994). Youths who participated in the Add Health study were not asked to identify or self-label their sexual orientation. However, our study included

two of these three dimensions of sexual orientation: desire (that is, attraction) and behavior (that is, romantic relationships and nonromantic sexual partners). Youths in the Add Health study were asked if they had ever had a romantic attraction to a male or female other, and responses were matched with respondents' self-reported biological sex. Similarly, participants were asked to list characteristics (including the sex) of up to three romantic relationship partners and up to three nonromantic sexual partners in the previous 18 months. These responses were matched with respondents' self-reported biological sex to determine youths who reported same-sex attractions, romantic relationships, or same-sex sexual partners (that is, SMYs).

If we consider adolescence a time when sexual identities are being formed, youths may more readily report same-sex romantic attraction and behaviors than self-identify as gay, lesbian, or bisexual. Moreover, many nonheterosexual youths are rejecting "traditional" labels and choosing not to self-label, or they are creating new self-labels such as "boidyke," "queerboi," and "multisexual" (Savin-Williams, 2005). Thus, although our sexual minority measure lacked a self-identity dimension, it encompassed two other dimensions of sexual orientation that may have included youths questioning their sexual orientation and youths who would identify as nonheterosexual. Adopting a multidimensional conceptualization of sexual orientation is important for both researchers and practitioners because it recognizes the experience and expression of sexual orientation through multiple dimensions. **HSW**

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