considering reversible suppression of puberty using gonadotropin releasing hormone analogs at Tanner stages 2 through 3 for individuals with GID because this allows the adolescent more time to decide whether to begin cross-sex hormone treatment.

HOMOSEXUALITY

Identical twins (even twins raised in separate families) show a higher concordance rate for sexual orientation than would be expected by chance alone, but nowhere near 100%, as would be expected if genetics alone determined sexual orientation. Some studies have found differences in the size of certain brain regions in homosexual individuals, but the findings are inconsistent. The levels of androgens and estrogens have not been found to differ in homosexual and heterosexual adults. Although it is well documented that parents tend to treat boys and girls differently, if, or how, these interactions affect sexual orientation is unknown.

It is currently estimated that about 1% to 4% of adults identify themselves as homosexual. Given the prevalent negative societal attitudes toward homosexuality, these children are at high risk for having a negative self-esteem, being isolated, being verbally harassed, and often being physically assaulted. Although sexual behaviors, not sexual orientation, determine risk of sexually transmitted infections, homosexual male adolescents engage in high-risk behaviors despite the threat of infection from the human immunodeficiency virus (HIV). For medical and psychosocial reasons, health care providers need to provide an environment in which adolescents feel comfortable discussing their sexual orientation (Table 23-2).

Acknowledging that one is homosexual and disclosing it to one's parents is often extremely stressful. Although many parents come to accept their child's homosexuality, some parents, particularly those who view this behavior as immoral, may reject their child. Homosexual youth are at a high risk for homelessness. Adolescents need to be made aware that even parents who eventually come to accept their child's homosexuality initially may be shocked, fearful about their child's well-being, or upset about the loss of the adulthood they had expected for their child. Parents may need to be reassured that they did not cause their child to have a homosexual orientation. Likewise they may need to be informed that therapies designed to change sexual orientation not only are unsuccessful, but also often lead to the child having more feelings of guilt and a lower self-esteem. The health care provider should have knowledge of support groups and counselors who can discuss these issues with the adolescent or his or her parents when the information the health care provider offers is not sufficient.

The homosexual youth is affected by how homosexuality is addressed in schools, by peers, and by other community groups. Unbiased information about homosexuality is often not available in these settings, and homophobic jokes, teasing, and violence are common. It is not surprising that homosexual youth and adults have higher rates of anxiety and mood disorders than are found in the general population. Increased rates of substance abuse and suicide are reported. Health care providers have an important role in detecting these problems.

Although education about safe sexual practices should be part of all adolescent well-child visits, health care providers should be aware that certain sexual behaviors of homosexual males increase the risk of certain types of sexually transmitted infections. Anal intercourse is an efficient route for infection by hepatitis B virus, cytomegalovirus, and HIV. Proctitis caused by gonorrhea, chlamydia, herpes simplex virus, syphilis, or human papillomavirus may occur (see Chapter 116).

Table 23-2 Providing Supportive Health Care Environments for Homosexual Youth

Ensure confidentiality
Implement policies against homophobic jokes and remarks
Ensure that information-gathering forms use gender-neutral language (e.g., *partner* as opposed to *husband/wife*)
Ensure that one uses gender-neutral questions when asking about dating or sexual behaviors
Display posters, brochures, and information that show concern for issues important to homosexual youth and their families
Provide information about support groups and other resources for homosexual youth and their families

Adapted from Perrin EC: Sexual Orientation in Child and Adolescent Health Care, *New York, 2002, Kluwer Academic/Plenum Publishers.*

Chapter 24

FAMILY STRUCTURE AND FUNCTION

A family is a dynamic system of interactions among biologically, socially, or legally related individuals; families have a unique power to promote or interfere with health and development. When a family functions well, interactions support the physical and emotional needs of all family members, and the family serves as a resource for an individual member who is having difficulty. Alternatively the problems of an individual member or the interactions among members may prevent the family from meeting the physical or emotional needs of one or more family members or, in the worst-case scenario, may cause physical or emotional harm to a member of the family. These situations are often referred to as **family dysfunction.**

FAMILY FUNCTIONS

The functions that families carry out in support of their children can be categorized broadly as providing for physical needs, emotional support, education, and socialization (Table 24-1). Within these categories, all families have strengths and weaknesses. The amount of support that an individual child needs in these categories varies with the child's development, personality, temperament, health status, experiences, and stressors. Too much and too little support can interfere with optimal child health and development. Most cases of child abuse involve the failure of the family to provide a safe environment for the child and, in cases of neglect, inappropriate