A Teen Questioning His/Her Sexuality is Bullied at School

A Case Materials Guide

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Introduction

Educational Objectives

- Practice approaching adolescents in a sensitive and developmentally appropriate manner.

- Practice taking a thorough sexual history, including sexual orientation, in a non-judgmental way.

- Practice screening for depression, including comfort with asking about suicide/safety.

- Appreciate the increased prevalence of mental health issues that sexual minority adolescents face.

Purpose of the Materials

Most healthcare providers feel unprepared to address issues related to sexual orientation with their adolescent patients. [1] This is not surprising given that medical students in the United States receive a median of only five hours of instruction on lesbian, gay, bisexual and transgender (LGBT)-related health topics during medical school. [2] Adolescents with same-gender attraction or sexual behavior have greater physical and mental health care needs compared to their peers; [3] specifically, these populations have higher rates of suicidal behavior, [4] substance use, [5] and risky sexual behavior, including unprotected sex and sex under the influence. [6] As such, it is important for medical students to become comfortable discussing sexual orientation, and its related sequelae, with their adolescent patients. This case was developed in order to (1) allow students to practice interacting with an adolescent with same-gender attraction in the healthcare setting, and (2) expose students to the increased burden of mental health issues among sexual minority adolescents.
Development of Case Materials

The second-year Advanced Medical Interviewing (AMI) course at the University of Pittsburgh School of Medicine (UPSOM) utilizes standardized patient encounters to teach about and foster practice in higher-level communication skills that are necessary to navigate difficult patient encounters. A total of 12 cases used in the course cover a variety of topics aimed at helping students communicate with diverse patient populations, including parents of sick or dying children, people with disabilities, and individuals with substance abuse issues, among others. Other cases challenge students by presenting strong emotions or cultural differences. In 2011, the current course directors of Advanced Medical Interviewing identified that the way that health issues affecting sexual minorities were represented in the medical interviewing courses was an area in need of improvement. With the help of a standardized patient and medical student, both who identified as gay and had raised similar concerns about the medical curriculum, a case entitled “A Same-Sex Couple Copes with End of Life Issues” was introduced to the AMI course in 2012. Given positive anecdotal feedback from the students, faculty, and standardized patients (SPs) regarding this case, and a desire to expand the curriculum to include adolescent sexual minorities, UPSOM decided to incorporate a second sexual minority case into the AMI curriculum.

To guide the writing of the case, the authors conducted a literature review on topics related to sexual minority adolescents, and interviewed adolescents presenting at a drop-in session for sexual and gender minority youth at the Gay and Lesbian Community Center of Pittsburgh. To balance authenticity with foreseeable time- and skill- constraints in uncovering the necessary information in this case, the case was adjusted after the first SP training workshop, described below, to ensure appropriate information disclosure.

How the Materials Have Been Used

These materials have been used in the setting of Advanced Medical Interviewing, a course for second-year medical students at the UPSOM. In this course, students take turns interviewing standardized patients in a group, with a faculty member facilitating formative feedback. For this case, two to three students each have a turn to interview the patient over one 45-minute time period. Students are also provided with a syllabus before the course begins that includes supplementary materials regarding some of the techniques and challenges that may arise when interviewing specific patient populations, including LGBT individuals (provided in
These materials build on previous exposures to LGBT populations and their healthcare in the UPSOM curriculum. Specifically, there is a gender minority and sexual orientation half-day session during orientation week for incoming first year students. During this session, students learn about the spectrum and terminology of both sexual orientation and gender. There is an activity during which students use hand-held responders to anonymously answer questions about their exposures and beliefs regarding LGBT individuals. The breakdown of their responses is discussed in real-time. In addition, there is a panel of sexual and gender minorities who discuss how gender and/or sexual identity have impacted various elements of their lives, including relationships with family, friends, and health care providers. After the lecture and panel, students break into small groups to reflect on the session. Facilitators are given a list of discussion points to cover.

Following the Advanced Medical Interviewing course, students at UPSOM have an additional exposure to LGBT health in the Reproductive and Developmental Biology course at the end of the second year. During this course, there is a session in which the lecturer takes a sexual history from an outside volunteer who is a gender and/or sexual minority in front of the class. Students are able to review the interviewing skills they learned during this medical interviewing case by seeing them in practice again.

### Methods Used for Standardized Patient Training

SPs were required to participate in two workshops. During the initial four-hour workshop, SPs were exposed to the emotional impact of bullying, particularly in sexual minorities, to allow them to genuinely portray the case. First, personal experiences from the sexual minority adolescents interviewed by the case authors were shared with the SPs. Then, SPs participated in improvisation exercises: sense memory recollection of personal experiences dealing with bullying, improvisational conversations addressing incidents that were referenced in the case, as well as role-playing the bully and victim. Subsequently, SPs were given an opportunity to share personal experiences and/or experiences of friends or family members regarding the issues addressed in the case.

Following these activities, the learning objectives were discussed and the case was role-played. SPs practiced their ability to reinforce learner skills by his or her responses during the encounter, e.g., providing more information or relating more
openly when specific skills were used. If the learners did not utilize the skills identified, the patient would pull back from the interaction and give signals to the learner that his or her needs were not being attended to. The case authors, who have experience with the questions second year medical students might ask, portrayed the interviewing learners.

During the second two-hour workshop, SPs studied and portrayed the updated draft of the case, which incorporated feedback from the previous sessions, to gain more experience. During these role-playing exercises, the SPs also portrayed the learners so as to experience what it was like to interview Taylor Matthews.

**Methods Used for Facilitator Training**

Facilitator training for the AMI course occurs on a yearly basis, approximately one month prior to the course. Training takes place over a four-hour period of time; it is conducted by the course directors and provides course faculty with the opportunity to role-play in the facilitator role. This case was introduced into the curriculum during the 2013-2014 academic year. As such, it was chosen as a featured training case for the 2013 facilitator training sessions. Each faculty participating in the course was invited to attend one of two scheduled training sessions; during each session the case was portrayed by an SP, and a facilitator portrayed a medical student. The course directors and the case writers were present to answer questions and elicit feedback about the case content, while ensuring that the faculty members’ comfort with and confidence in the case were on a par with other cases used in the course.

To ensure understanding of the educational objectives described above, a “Facilitator’s Guide” was created and provided to all facilitators before the course began. The Guide lists the case objectives, a brief case summary, and suggestions for how the student could improve rapport during the interview. These include an emphasis on using non-judgmental and inclusive language, normalizing emotions, and reaffirming confidentiality. This guide was used by the facilitators to stay on track and to focus learning on the objectives as defined.

**Data to Support the Content and Efficacy of the Materials**

The authors conducted a review of the literature on sexual minority health topics specific to adolescents. Additionally, the authors informally interviewed adolescents presenting at a drop-in session for sexual and gender minority youth at the Gay and Lesbian Community Center of Pittsburgh. Given that mental health problems among
sexual minority youth are thought to be mediated by hostile social environments, [7] bullying is a central theme of the case.

Because the patient portrayed in this case is an adolescent who requires a doctor’s note for missing school, absentee policies from a public school in Pittsburgh, PA were incorporated into this case. The authors encourage that this case be adapted to reflect local policies.

Medical students who participated in the case (either interviewing the SP or observing) and the facilitators of this case were surveyed immediately after completing the case to determine whether the educational objectives were met and whether the case content was considered to be valuable material in the AMI curriculum. SPs who played the case were also surveyed to gather information about the quality of the case and training materials. In all, 139 out of 143 students (97%), 29 out of 29 faculty members (100%), and 9 out of 10 SPs (90%) completed surveys.

To assess the efficacy of the case, students were asked to rate how prepared they felt in six key areas of interest before and after participating in the case, using a five point scale (where 1=not at all prepared and 5=very well prepared). The key areas of interest included: communicating with patients about sexual attraction/preferences, communicating with patients about sexual orientation, communicating with patients about sexual behaviors, screening adolescents for depression, screening adolescents for bullying, and interviewing adolescents. Paired t-tests were used to determine whether the overall change in comfort level for each category was significant. Faculty members also rated the degree to which they felt the case prepared their students in the aforementioned areas, using a similar five point scale (1=not at all and 5=to a large degree).

The surveys revealed significant improvement in student preparedness for each area of interest (see table 1). Additionally, most faculty members felt that the case helped prepare students to a moderate or large degree for each category (see figure 1).

To determine whether the content of the case was perceived to be of value, medical students and faculty members were queried regarding the importance of four topics in medical school training: taking a detailed sexual history, screening adolescents for depression, screening adolescents for bullying, and interviewing adolescent patients, using a five point scale (where 1= not at all important and
5=very important). The surveys showed that the overwhelming majority of students and faculty members found these areas to be mostly important (a score of 4) or very important (a score of 5) (see figure 2).

The SPs were asked to rate the clarity of the written materials, helpfulness of training sessions, overall experience playing the case, and usefulness of the case in helping students’ communication skills on a five point scale (where 1= poor and 5=excellent). The case was well-received by the SPs, with the majority giving a rating of “very good” (a score of 4) or “excellent” (a score of 5) in each category (see figure 3). They were also asked how likely they were to want to play the case in the future and 100% indicated that they were “likely” or “very likely” to want to play the case in the future.

Student, faculty, and SP participants were also asked to list strengths and areas of improvement for the case.

**Strengths**
Both student and faculty respondents applauded the learning objectives of the case, with many commenting that the case content is not covered elsewhere in medical school training. A faculty member wrote, “Great opportunity for students to practice interviewing a teenager for sexual orientation, bullying, & mental health. Many windows.” Similarly, a student commented, “[the case] presented a unique set of situations/potential issues we haven’t really seen before, adolescence, depression, bullying, sexual orientation.” Another wrote, “It presents a very common and largely unaddressed problem…”

Another strength commonly highlighted in both the student and faculty responses was that the case helped the learners to self-reflect. A faculty member wrote that the case “helps students deal with their own anxiety about sexual preferences, depression.” This sentiment was echoed by student responses, such as this one: “It took me out of my comfort zone and forced me to address my weaknesses with this subject matter.”

The SPs frequently indicated that the case helped students improve their skills in communicating about difficult subjects. One SP wrote that the case “helps the students learn how to talk to people going through difficult situations with compassion.” Another SP remarked, “..this case works well by helping students realize that sometimes just being someone a patient can talk to can make that patient feel better.” Several SPs also indicated that the case materials were clear or straightforward. Similar to the student and faculty responses, many SPs also indicated that the case content, in particular the focus on sexual orientation and adolescents, was valuable.
Areas of Improvement
Faculty members, students, and SPs shared the concern that there was too much content to be adequately covered in the allotted time. Common suggestions for addressing this issue included allotting more time for the case, reducing the number of learning objectives, or helping learners more quickly access the important content areas in the interview. Suggestions for expediting the interview process included: 1) having the presenting complaint be a more specific symptom or scenario rather than “needing a note” (i.e. “hopelessness” or a follow-up after emergency department visit), 2) adding larger and more specific windows, and 3) expanding the introductory Learner Instructions to give students a specific indication of the content areas they are to explore in the encounter (i.e. “the social history” generally or specifically “the sexual history”). Some suggested that in addition to indicating a specific content area in the prompt, a brief tutorial about what constitutes an adequate social or sexual history could be presented as well.

While some mentioned concerns about the large amount of case content, several students and faculty members suggested adding more content to enhance the case and provide more opportunities to complete the case’s learning objectives. Suggestions included adding a more extensive substance abuse history, sexual behavior history, or depression symptoms/suicidality.
TableName 1: Mean Student Preparedness in Areas of Interest

<table>
<thead>
<tr>
<th></th>
<th>PRE-CASE Mean (95% CI)</th>
<th>POST-CASE Mean (95% CI)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Attraction</td>
<td>2.8 (2.7-3.0)</td>
<td>3.6 (3.5-3.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>2.8 (2.6-3.0)</td>
<td>3.5 (3.4-3.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Sexual Behaviors</td>
<td>2.9 (2.7-3.1)</td>
<td>3.3 (3.2-3.5)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>3.0 (2.9-3.2)</td>
<td>3.6 (3.5-3.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Bullying Screening</td>
<td>2.8 (2.7-3.0)</td>
<td>3.6 (3.5-3.8)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Interviewing Adolescents</td>
<td>3.1 (2.9-3.2)</td>
<td>3.7 (3.5-3.8)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

CI = confidence interval.

Student Preparedness was assessed on a five point scale (where 1=not at all prepared and 5=very well prepared).

Figure 1: Percentage of Faculty Members Rating the Case as Helpful for Preparing Students in Areas of Interest
Figure 2: Percentage who Perceive Areas of Interest to be Important in Medical School Training

Figure 3: Percentage of Standardized Patients Rating Case Aspects as Very Good or Excellent
Discussion of Data and Lessons Learned

Overall, the medical student learners, the faculty facilitators, and the SPs who worked with this case rated it highly. Students and faculty both agreed that working with the case furthered students’ comfort and preparation for communicating with sexual minority teenagers: skills that they uniformly agreed were both important and previously underrepresented in medical training. Though statistically significant, the absolute increase in student preparedness after working with the case was modest, and for most students, did not reach the “mostly or very well prepared” level. However, the advanced interviewing skills involved in this case require considerable practice to master and as such, we did not expect students to become “experts” by the end of a single session. Rather, the overarching goal of this case was to advance learners’ comfort and skill with communicating with sexual minority teenagers. We feel that the degree of increase is indeed significant since the positive effect on learners became evident to them after working with the case for only 45 minutes. Additional opportunities to practice these specialized skills are recommended to further improve student preparedness.

Although the case was very well-received by all parties in its presented form, we plan to use the feedback given by students, faculty, and SPs to further shape how we use this case in future communication skills teaching. In the context of the AMI course at University of Pittsburgh, in which one 45 minute session is allotted for this case, the third learning objective (screening for depression, including comfort with asking about suicide/safety) will be eliminated in future years to ensure that the facilitators and SPs will have sufficient time to address sexual history, including sexual orientation, in this case. In formats where depression screening is not covered elsewhere in the curriculum, however, including this learning objective is recommended as students significantly improved in their preparedness with this topic as a result of this case and both students and faculty indicated that depression screening is an important aspect of medical school training. In another effort to expedite case progression, more SP-initiated windows and prompts will be added to the case to allow learners to move through it more efficiently. In similar learning environments, where limited time is allotted to working with this case, these alterations may be helpful.

Due to student and faculty feedback, and a desire to expand the sexual history taking aspect of the case, more “positive” items on the sexual history (i.e. more sexual experiences) will be added to the case in future years. This will help learners become comfortable asking about, and responding to, patient disclosure of sexual activity. This is recommended for other courses who are hoping to have this case provide in-depth exposure to sexual history taking, including both sexual activity and sexual orientation.
Other possibilities that were considered based on case feedback were making the presenting scenario more specific (i.e. patient follow-up after ED visit), providing a more detailed prompt (i.e. obtain a social or a sexual history), or presenting educational materials before the case begins (i.e. how to take a comprehensive sexual history). However, these options were ultimately not incorporated into the case given a desire to retain the realistic challenges of interviewing adolescents who may present with vague symptoms and not be forthcoming with their complaints. Moreover, for the course in which this case was used, it is customary for the students to enter the encounters with an open-mind: that is, they are not given specific information about what the case is about or which parts of the history they should focus on from the start. Rather, it is the facilitators’ job to guide the students in the “right direction” in line with the case learning objectives, if they are not getting there on their own. That said, for those wanting to use this case to allow students to practice specific parts of the interview, it may be helpful to provide a detailed prompt or direct the learner to supplemental materials beforehand, including potentially providing a brief didactic about the key components of the history of interest.

This case could be adapted for use in clinical clerkships for third- and fourth-year medical students as well as for residents, fellows, and even faculty in certain settings, given the widespread discomfort in discussing sexual orientation with adolescents. Given the advanced interviewing skills required, however, this case is not recommended for beginning medical students. This case is also not recommended for learners who have not had any exposure to LGBT populations previously in their medical school curriculum. In these settings, an introductory lecture would be useful to introduce these topics and allow learners to ask questions. Along those lines, learners, and potentially faculty members, may have negative reactions during this case, particularly if they have had limited experience with LGBT populations. As mentioned above, our AMI course includes a second sexual minority SP case, in which a specific learning objective is to address and overcome prior biases and assumptions. Facilitators who have not previously had a case of this nature should allot time for reflection and discussion of emotional reactions to this case.

**Limitations**

While learners and faculty found this case to be helpful, we did not objectively determine whether the case improved learners’ skills in interviewing sexual minority adolescents. Because the AMI course at the University of Pittsburgh focuses on allowing learners to practice and troubleshoot interviewing skills in a “safe” and comfortable environment,
learners are provided with formative feedback rather than formally graded on their performance of specific skills. In settings where educators are interested in using this case for evaluation purposes or more comprehensively testing the efficacy of this case, an OSCE (objective structured clinical exam) would be useful.
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Facilitator’s Guide and Case Materials

Learner Instructions
Facilitator Notes
Standardized Patient Training Materials
Facilitator's Guide

Name of Patient: Taylor Matthews

Complaint: Requires note from doctor for missing school

Target Group: Medical students, physician assistant students, nurse practitioner students who have completed an introductory level medical interviewing course

Length of Patient Encounter: 45 minutes, can be adapted to be shorter or longer

Type of Case: Teaching, Communication, History Only

Learner Instructions
(to be shared with the interviewing learner prior to the interview)

You are a 3rd year student doing a rotation in an internal medicine clinic. You will be seeing a new patient, 18-year-old Taylor Matthews, who is here to establish a new PCP.

Facilitator Notes
(not to be shared with the learners)

Taylor Matthews is an 18-year-old high school senior who comes to the office because his/her school has required a doctor’s note for frequent absences. Although Taylor has been generally healthy physically, there are mental health and psychosocial issues leading to skipping school. In particular, Taylor has been struggling with feelings of isolation and hopelessness related to a same-gender attraction and bullying at school.

When the student begins to interview, Taylor will be somewhat hesitant, giving little personal information. Because there are several learning objectives to be completed in this case, do not hesitate to “time-out” a student who is not making progress in helping Taylor to open up. If the group has previously completed one of the other AMI cases that feature a reluctant patient, it may be useful to compare the strategies that have worked in various scenarios.

Strategies that will be particularly helpful with this patient include:

- Using a gentle questioning style, with pauses after questions to allow Taylor time to offer more information.

- Listening to Taylor’s story and allowing what he/she says to guide further questioning.

- Reminding Taylor that this is a safe space to share personal details confidentially since this is the first time that Taylor has seen an “adult” doctor.
- Acknowledging that high school can be a difficult time, and normalizing emotions.

- Acknowledging that there is a range of sexual attraction/orientation and using inclusive language when asking about Taylor’s sexuality.

- Not medicalizing Taylor’s mental health or sexuality. Learners will uncover more facts if they speak in terms that adolescents can relate to.

**The specific learning objectives for this case include:**

1. Practice approaching adolescents in a sensitive and developmentally appropriate manner.

2. Practice taking a thorough sexual history, including sexual orientation, in a non-judgmental way.

3. Practice screening for depression, including comfort with asking about suicide/safety.

4. Appreciate the increased prevalence of mental health issues that sexual minority adolescents face.
Standardized Patient (SP) Training Materials

Taylor Matthews
A Teen Questioning His/Her Sexuality is Bullied at School

Case Summary
You are Taylor Matthews, an 18-year-old high school senior who is coming to the office to establish care with a PCP. You missed ten days of school this year and have had your parents write you “sick notes” every day. However, after the last absence, the attendance counselor of your high school called you into her office and told you that you will need a doctor’s note for any future absences. Otherwise, you won’t be able to make up any of the work you miss. You are concerned that you will therefore fail your classes and be prevented from graduating this spring.

Although you have been generally healthy from a physical standpoint, there are mental health and psychosocial problems contributing to you skipping school. In particular, you revealed to your best friend that you were attracted to the same sex 5 months ago; your friend reacted poorly and told other students. Since then, you have been victimized at school related to rumors about your sexuality. As a result, you’ve been feeling down and hopeless.

Your challenge, as the standardized patient, is threefold:

- To appropriately and accurately reveal the facts about Taylor’s story, including mental health and psychosocial history
- To observe the learner’s behavior while you are performing this case
- To accurately recall the learner’s behavior and be prepared to give specific feedback based on the teaching points of the day

Presentation / Emotional Tone
You will be wearing casual attire.

You are initially wary because you have had bad experiences with adults recently, including teachers not defending you from bullying and your parents yelling at you. However, you certainly do want to address what has been going on, including asking questions about your sexuality, and would be very relieved to finally be able to talk with a trusted, nonjudgmental, and supportive person.

As such, when the learner first approaches you, you are somewhat withdrawn, making minimal eye contact. If the learner uses skills to make you feel comfortable, such as appearing concerned, being sensitive that there is more going on, and asking open-ended questions, you would begin to make more eye contact and to reveal more information. You would start with “testing the water” with responses that reflect your mixed feelings about discussing the situation (see below for some examples). However, once the learner uses advanced techniques to make you feel comfortable (see key learner responses below), your attitude would shift in that you would readily divulge your story.
Your answers to questions are generally succinct, without extensive elaboration; however, you may elaborate as appropriate to learner skill.

**Scenario Development**
In response to the question, “What brings you here today?” you quickly answer: “I need a note for missing school.” In response to the question, “So you are here to establish a new PCP?” you quickly answer, “I guess I need a new doctor now because I’m 18. But what I really need is a note from the doctor for missing school.”

If the learner follows up by asking why you missed school, you may shrug and say, “School sucks” or “It’s just easier to stay home.” If the learner asks whether you have been sick recently or what your symptoms are, you would respond vaguely that you “haven’t been feeling well.”

**Progression of Information Disclosure**
As you begin to feel more comfortable, you would answer questions about why “school sucks” or why you haven’t been feeling well by indicating that students have been bullying you (with statements such as “they’re just mean”, “they call me names all the time” or “I just don’t fit in anymore.”)

If the learner asks you to expand on these statements, you might say the following if you are somewhat wary that the learner is a trusted confidant (to “test the waters”):

“You’re just going to judge me too.” Or “You wouldn’t get it.” Or “You’re just going to rat me out to my parents.”

Once reassured with **one of the key learner responses below** (or another response that demonstrates that they really care about you), you would become much more comfortable. Note that a common sequence of events will be that the first learner struggles to fully gain your trust during the initial conversation; after the learner- or facilitator-initiated “time-out”, they would “time-in” and use one of the following strategies, after which point you would be much more willing to divulge information.

- Voicing concern regarding your situation and acknowledging that high school is a difficult time for many people. For example: “I’m sorry that you are going through this” or “Wow, that sounds really tough” or “High school can be a really challenging time.”

- Affirming that many adolescents have concerns that they feel uncomfortable talking about. For example: “It can be hard to discuss topics like this” or “I know these things aren’t often discussed but they can be very important to your health and wellbeing.”

- Reminding you that this is a safe space for you to share what is going on in your life including that your personal information cannot be shared with your parents (as you are 18 years old).
In response to one of these comments, you would become much more comfortable (perhaps even breathe a sigh of relief) and readily share the reason that you have been avoiding school: after you confided in your best friend that you are attracted to the same sex, he/she called you a “freak” and spread rumors around school. For the remainder of the encounter you would treat the learner as a trusted confidant.

Conversely, if the learner fails to display these skills, is condescending or judgmental, or becomes confrontational about your request for a note, you will indicate that the reason for you missing school is that your "stomach hurts sometimes", although it does not. If asked specific questions about this complaint, responses include: the pain is all over the belly, "just hurts sometimes" (if asked about "quality" of the pain), and comes and goes without any pattern. You are not sure what makes it better or worse, you haven't taken anything for it, you are not sure when it started or anything that might have led to it, and no one in your family has anything similar. You will follow this up with: "Okay... so can I get the note now?"

**Active Issues**
The two issues that you would like to talk about, once the learner establishes appropriate rapport, are sexuality and your mood. As such, if the learner does not specifically ask about these, feel free to ask questions yourself, i.e. “Is it normal to feel so down?” or “I’m not even sure what it means…Am I gay?” Likewise, if after establishing rapport, the learner says something like: “So I know you need a note, but is there anything else specifically you’d like to discuss so I can make sure we cover it?” you can use that as an opportunity to ask those questions.

**Sexual history:** You mostly feel attracted to people of the same gender, though you have not acted on this attraction. You are not sure if this means that you are “gay” or “a lesbian” because you have had some “crushes” on members of the opposite gender in the past, including fantasizing about a particular actor. Additionally, you dated someone of the opposite gender three years ago for about 9 months. You had oral sex (performed and received) with this partner but not anal/vaginal sex. You did not use a barrier. This experience was not enjoyable for you (“I just wasn’t really into it.”) Other than that, you have not had any serious relationships and have not had any other sexual experiences. There are 1-2 individuals at school whom you find attractive but you do not have any serious crushes and certainly have not told these individuals of your attraction. You feel ambivalent about your attraction to the same sex. You sometimes feel embarrassed and ashamed by it and wish you could change your feelings, but other times you feel that there is something “right” about it. You have never had any gyne/GU symptoms but have never been tested for HIV or other STIs.

**Learner questions/comments that you might anticipate, and the appropriate response, include:**

- "Are you attracted to men, women, or both?” It is important for learners to appreciate that there are different aspects of sexual orientation and people might not fit neatly into one box. An appropriate response would be (if you are female): “Well I
don’t know… I mean, I feel attracted to women now... but I guess I’ve thought about men before.”
-“Have you had sex?” or “Have you had intercourse?” or “Did you use protection?”
Note that part of taking a proper sexual history is that the learner needs to determine what specifically you have done and vague questions such as this can lead to confusion with the patient and learner having different definitions of these terms. Use a response that will allow the learner to elaborate (i.e: “What do you mean?”).

*If you are a female- your first menstrual period was when you were thirteen years old. You were irregular for six months before starting to get monthly periods. They last about four days and aren’t too heavy.

**Mood:** You may be asked a series of questions that comprise “depression screening.” These questions are summarized by the mnemonic SIGECAPS which includes asking about: sad or depressed mood and sleep disturbance, loss of interest in previously enjoyable activities, feelings of guilt or worthlessness, loss of energy, loss of concentration, changes in appetite or weight, “psychomotor agitation/retardation” (i.e. being jittery or moving less than usual), and suicidal thoughts. Of these, you would endorse having some difficulty concentrating. If a student specifically asks if you feel “depressed”, you would say “I’m not sure what you mean?” Once the student has practiced describing depression in terms more familiar to you, you would admit that you feel “down” or “sad”. You believe that you are the only person your age that feels these things and are accordingly hopeless and reluctant to reveal your feelings. You would answer the remaining screening questions in the negative, including that you do not want to hurt yourself or others, or think that you’d be better off dead.

**Past Medical History**
You are healthy and have no chronic medical conditions. Last month you had to go to the emergency department because you broke a bone in your hand punching your locker after you were bullied and quite upset by it. You lied and told your parents that you slipped on ice. They did not inquire further.

You had chicken pox when you were six years old. You had the flu when you were fifteen. Other than these two, you have not had other illnesses besides occasional colds.

**Medications**
You were told to take 600 mg of ibuprofen when you needed it when you were last at the ED. You took it one week and then stopped. (You haven’t taken it for a few weeks now.)

**Personal/Family History**
You live at home with your mother Teresa, father James, and two siblings, Lindsay and Paul. You are the middle child. Life at home has become increasingly stressful. You have been aloof and irritable around your parents as you are sure that they would be unsupportive of your same-sex attraction, maybe even disown you, because when your uncle/aunt came out as gay/a lesbian, they stopped inviting him/her to family functions. Also, they have been yelling at you for spending so much time in your room on your laptop, not talking to them, and not
caring about school anymore. You are hurt and angry that they have never tried to find out what is really going on with you. You feel that they have only continued to write you absence notes for school because the last thing they would want would be the shame of their child not graduating. Because of this tense relationship, and the fact that you don’t feel like you can be yourself, you have been increasingly antsy about wanting to move out of your parents’ home. You are hoping that this will be accomplished by going to college. You have sometimes wondered if you should just run away or move out although you are concerned about the financial consequences.

Teresa - 50 years old, no medical problems, uncomplicated deliveries, in menopause, is a dentist with a group practice

James - 52 years old, has high cholesterol (was diagnosed at 46) which has gotten better with medications, is a financial advisor at PNC Bank

Lindsay - 22 years old, senior at Dartmouth, majoring in business and Spanish

Paul - 12 years old, in 7th grade, plays soccer

You started realizing that you were attracted to the same sex about six years ago, and you’ve been struggling to come to terms with this because your parents and others in your community seem to think that people who are attracted to the same sex are unnatural. Up until 5 months ago, you mostly hung out with your same gender best friend Brandon/Bridget, whom you have been friends with since middle school. You finally told Brandon/Bridget about your feelings when you two were discussing who you both found attractive; s/he called you a freak and stopped being your friend. S/he also told others about your same-sex attraction. Since then, people have been verbally harassing you, calling you a “fag/dyke.” Whenever you go to change in the locker room for gym class, everyone starts whispering and leaves; you started changing in the private bathroom on the other side of school. A few months ago, you were surrounded by a group of students who started punching and kicking you. You had to fight your way out, although no major injuries were sustained. You saw that teachers were around but they didn’t come to help you. Since then, you haven’t felt safe at school and feel like no one there cares about you.

You recently have made profiles (with no pictures of your face) on several social media websites (meetme.com and facebook.com) where you have been able to talk with other young people who are same-sex attracted. Still, your conversations on these venues are superficial and you would feel embarrassed discussing the bullying and your down mood, afraid that others will judge you. You also are scared that your parents will look through your search history and find your profiles.

Lifestyle / Behaviors

Alcohol: You have never tried alcohol. The manager at the local pizza place was killed by a drunk driver three years ago, and you refuse to touch the stuff.

Tobacco: You bought your first and only pack of cigarettes when you turned 18, three months ago, after hearing that people found it relaxing. You tried one but didn’t like the taste; you haven’t had another since. Your mom found the pack and yelled at you. You know that they are bad for your health and don’t want a lecture about this; you were just looking for a way to feel better.
**Drugs:** You have not tried any recreational drugs. You have contemplated trying marijuana because you have heard it can reduce anxiety and doesn't have any real health risks. You wouldn't consider doing any "real" drugs.

**Diet:** You eat a diet typical for a teenager. You eat whatever they have for lunch at school: you aren't too picky. Your favorite food is chicken, you guess. You typically eat dinner with your parents (again, whatever your mom usually makes) although you recently have been leaving the table after 10 minutes to go to your room. You get yelled at for this frequently.

**Exercise:** You don't formally exercise and have never been involved in any formal athletics. Sometimes you walk through Frick Park to clear your head.

**Safety:** You do not feel safe at school due to the verbal and physical you have experienced. You do feel safe at home even though your parents yell at you since they have never threatened you.

**Spirituality:** You are not religious. Your family is Protestant but rarely attend church.

**Education:** You attended school* regularly up until you were bullied. You enjoy history most out of your subjects. If you are asked about who your teachers are or any more specific questions related to the structure of your school (i.e. from a learner who might have gone to the school), you will get nervous, ask if the learner is trying to rat you out to people in your school, and refuse to answer these questions. You've been a mostly A to B student, but your grades have started dropping to Cs since you have been missing school.

* SP Note: Learners may ask you what high school you attend. You can use the school that you went to or currently go to if you feel that a scenario such as the one described could reasonably occur there. If not, you can use another one that you are familiar with.

**Hobbies:** You bought a Yamaha acoustic guitar* with money you got from your grandparents for your 17th birthday and have been taking guitar lessons since. Your guitar teacher, Karen, is free-spirited, and you have thought about talking with her about what you have been going through. However, she went to high school with your mom, which makes you concerned that your personal information could get back to her. You don’t think you’re very good at guitar yet but you do enjoy learning classic rock and pop songs and are even dabbling in songwriting. You like listening to and playing music that "tells a story," particularly stories that resonate with your current situation.

*SP Note: If you play an alternate music instrument, feel free to use that here instead.

**Aspirations:** You are excited to go to college so you can escape your current stressors. You recently submitted applications; you did not submit any early decision/early action applications. Your essay was about the role of music in your life. You don’t have strong thoughts about where you would want to go or what you would want to study; you made the
decision based on a required meeting with the school's college counselor. All of the schools you applied to are out of the city: University of Maryland College Park (College Park, MD), Ohio State University (Columbus, OH), Ohio University (Athens, OH), University of Wisconsin - Madison (Madison, WI), and University of Vermont (Burlington, VT). You did do a tour of Ohio State's campus when Lindsay was applying to colleges but you don't really know anything about the others. You definitely could have spent more time working on your personal statement, but you found it hard to "market" yourself when you felt so down. You don't have any major job aspirations.
3

References

Appendix: Syllabus Materials

Sexuality and gender orientation, identity and expression

One specific group of patients whose unique experiences and challenges in the healthcare setting have only recently begun to be recognized are lesbian, gay, bisexual, and transgender (LGBT) individuals. Some examples of the unique situations that may be encountered by these patients are discrimination on the basis of sexual orientation or gender identity, varying recognition of relationships (i.e. marriage, civil unions, domestic partnerships) among different states and institutions, and specific medico-legal issues that are heavily impacted by the former two points. For these reasons it is vitally important that physicians ask open ended and gender non-specific questions about partners when exploring the history, particularly the sexual history. Asking questions such as “Please tell me about your past experiences with the health care system—what worked and what didn’t work so well?” is a nonjudgmental way to invite the patient to tell a story. Likewise, asking them to define their relationships rather than offering closed ended options (e.g. “Are you married?”; “What is your husband/wife’s name?”) will result in higher quality information exchange, as well set the stage for mutual respect and trust.

NOTE: Students are not expected to know the specific laws and policies regarding LGBT patients in healthcare, which vary by institution and state.

Sexual and gender orientation is an important part of the patient history that both patients and providers are often uncomfortable discussing. If addressed at all, sexual orientation tends to be assessed by the question: “Are you attracted to men, women, or both?” This question is frequently used in practice to assess the gender of the patients’ intimate partners: information that providers may use to determine a patient’s risk for sequelae such as sexually transmitted infections or pregnancy. However, sexual orientation encompasses more than just sexual behaviors. Furthermore, judgments and assumptions regarding a patients’ sexuality and behaviors are often inappropriately affected by assumptions about identity based on outward expressions of gender.

Current understanding of sexual orientation suggest that there are several dynamic concepts relating to identity that interact but are not necessarily dependent. Recent evidence points to the variations of gender identity and gender expression, as well as between sexual orientation, identity and behaviors.
Moreover, limiting the options to “same sex only,” “opposite sex only,” or “both sexes” ignores the fact that individuals may fall anywhere on a spectrum that includes in-between options such as “mostly opposite sex” or “same sex slightly more,” as well as other options such as “neither sex.” Additionally, sexual orientation, and certainly behaviors, may change over time.

While it is not necessary or practical to clarify the many aspects of patients’ sexual orientation in every clinical encounter, these factors may become important for clinicians to consider in certain situations. In particular, patients may have a discrepancy between their sexual attraction and sexual behavior that causes significant stress, impairment, and risk-taking behaviors. Additionally, patients (more so adolescent patients) may have questions regarding what their sexual attraction or sexual fantasies mean and whether they are “normal.” As such, it is important for providers to be aware of the various components and options and feel comfortable discussing these with patients in a nonjudgmental manner.

For More information on this and related topics:
LGBT legal protections and rights:
- http://www.lambdalegal.org/
- http://www.aclu.org/lgbt-rights
LGBT Health:
- http://www.cdc.gov/lgbthealth/
- http://www.healthypeople.gov/2020/ (search “LGBT”) More about gender and sexual identity and expression:
- http://itspronouncedmetrosexual.com/2012/03/the-genderbread-person-v2-0/