Original Publication

OPEN ACCESS

An Active Learning Module Teaching Advanced Communication Skills to Care for Sexual Minority Youth in Clinical Medical Education

Neha Bakhai*, Ryan Shields, Michael Barone, MD, MPH, Renata Sanders, MD, MPH, Errol Fields, MD, MPH, PhD

*Corresponding author: nbakhai1@jhmi.edu

Citation: Bakhai N, Shields R, Barone M, Sanders R, Fields E. An active learning module teaching advanced communication skills to care for sexual minority youth in clinical medical education. *MedEdPORTAL*. 2016;12:10449.

https://doi.org/10.15766/mep_2374-8265.10449

Copyright: © 2016 Bakhai et al. This is an open-access publication distributed under the terms of the Creative Commons Attribution-NonCommercial-Share Alike license.

Abstract

Introduction: Expert recommendations state that all physicians caring for youth should be trained in providing competent and nonjudgmental care for sexual and gender minority (SGM) youth. Despite those recommendations, there is insufficient training to prepare clinicians to provide culturally competent care for SGM youth. We created a 2-hour session to address communication skills critical to caring for SGM youth. The goals of the session were for third- and fourth-year medical learners to affirm, validate, and assess the mental health status of their patient, collaborate with a school counselor, support families in acceptance of SGM children, and provide them with relevant resources. **Methods:** The session utilized multiple active learning modalities including flipped classroom, small-group learning, and peer-to-peer instruction. Learners completed anonymous pre- and postsurveys that aimed to measure their comfort, self-efficacy, and self-reported preparedness in counseling adolescents questioning their sexual orientation. **Results:** Of the 42 learners who participated in the course over two academic terms, 40 (95%) completed the presurvey, and 39 (93%) completed the postsurvey. Learners demonstrated a significant improvement in self-reported knowledge, comfort, and sense of preparedness on all skill-based objectives and reported growth in their comfort and sense of preparedness for counseling adolescents questioning their sexual orientation after participating in the session ($p < .001$). **Discussion:** This session supports the development of key communication skills needed to provide competent and nonjudgmental care for SGM youth. It can be easily replicated at other health professional schools looking to improve the cultural competency of future clinicians around care for SGM patients.

Keywords

Communication, Cultural Competency, Active Learning, LGBT, Sexual and Gender Minorities, SGM

Appendices

- A. Competencies Addressed.docx
- B. Facilitator Guide.docx
- C. Pework Questions & Answers.docx
- D. Presurvey.docx
- E. Coming Out.mp4
- F. Student Handout.docx
- G. Take-Home Points.pptx
- H. Counselor & Physician Recording.MP3
- I. Postsurvey.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

By the end of the session, the learner will be able to:

1. List three ways to affirm/validate adolescents questioning their sexual orientation in a clinical setting.
2. Describe six key domains for assessing the mental health status of an adolescent patient related to social support and bullying.
3. List three important questions to ask a patient in at least three of the six key domains from Educational Objective 2.
4. Describe three ways to collaborate with a school counselor to support a patient's health.
5. Explain two communication techniques for working with families to optimize family acceptance and describe relevant resources to support the family.

Introduction

Sexual and gender minority (SGM) youth, a term including lesbian, gay, bisexual, transgender (LGBT), and questioning or queer youth and/or those engaging in same-sex attraction or behavior, experience

significant mental and physical health disparities.^{1,2} Their experiences of stigma, discrimination, and rejection in the health care setting and society contribute to disproportionate rates of depression, suicidal ideation, poor sexual and reproductive health outcomes, and substance use compared to heterosexual cisgender youth.³⁻⁶

Pediatricians and other youth care providers are expected to play a crucial role in supporting SGM youth and families, including assessing their mental health, partnering with schools to prevent victimization, and working with families to optimize family acceptance.^{5,7,8} In 2011, an Institute of Medicine report highlighted the important role of pediatricians providing sensitive care to SGM youth around their identity-related feelings and concerns.⁷ Then, in 2013, the Society of Adolescent Health and Medicine and the American Academy of Pediatrics both recommended that all physicians caring for youth should be trained in providing competent and nonjudgmental care for SGM youth.^{5,8} However, the lack of training in medical education remains a significant barrier to high-quality care for SGM youth. A 2011 survey of US and Canadian medical school deans revealed that only 50% of medical schools teach learners about LGBT adolescent health and that most content is taught during the preclinical years.⁹ Medical learners and physicians have cited discomfort in asking appropriate questions, poor knowledge regarding SGM health needs, and a lack of awareness of available community resources as challenges in supporting SGM youth in the clinic setting.¹⁰⁻¹²

In order to fill this societal and curricular need, we created this 2-hour active learning session as part of a larger student-led initiative to create a 4-year longitudinal SGM curriculum. The development of this effective session about critical communication skills for third- and fourth-year medical learners to use when caring for SGM youth was guided by seminal works from the Association of American Medical Colleges (AAMC)¹³ and the Fenway Institute.¹⁴ Among the tools within *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born With DSD: A Resource for Medical Educators*, the AAMC report, is a list of 30 LGBT/gender nonconforming/DSD (differences of sexual development) competency specifiers.¹³ Appendix A lists the 10 specifiers that this session addresses.

Additionally, this session builds upon existing MedEdPORTAL publications that use standardized patients to cover topics of sexual history taking¹⁵ and interviewing a bullied teen questioning his/her sexuality.¹⁶ Since this session targets learners in their clinical years, it uniquely moves beyond learners asking about sexual orientation to having learners affirm the patient's identity, learn techniques to communicate with family, and work across disciplines to support the patient.

Methods

At our institution, this session was delivered 4 weeks into an 8-week required pediatrics clerkship. By the time the learners participated in this session, they had completed a standardized patient exercise on the home, education, activities, drugs, suicidality, and sex (HEADSS) assessment¹⁷ and had had sufficient clinical patient experiences to make learning practical. Since this was an 8-week course, the learners then had the opportunity to implement learned skills in the remaining 4 weeks of the clerkship. However, this session could be implemented at any point in medical, resident, or professional training after basic history taking and communication skills are taught.

The session was facilitated by two adolescent medicine faculty members with expertise in SGM health and the pediatric clerkship director, who were all provided with the facilitator guide (Appendix B) prior to the session. The room for the session was set up for small-group work but was also large enough that all groups were in one room. Our session ran with our entire pediatric clerkship (20-22 learners) divided into four groups (five to six learners each). However, this session could also work for class sizes of eight to 12 learners. The room should also have a projector with audio for displaying various presentations and multimedia clips.

To maximize teaching of practical tips learners could use in the clinical setting when communicating with SGM youth and to optimize peer-to-peer learning, we utilized a modified flipped-classroom technique.

One week prior to the session, facilitators sent the prework assignment to students via email. Learners were asked review two articles that provided an overview of sexual and gender identity development, mental and physical health disparities, bullying and victimization, tips for creating a safe space in the office, and protective factors for high-risk behaviors among SGM adolescents.^{5,8} Within our online platform, they were then asked to submit open-text answers to six reading-based questions (Appendix C) and complete a presurvey (Appendix D). The prework took on average 45 minutes for learners to complete and was completed by 39 out of 40 learners.

The 2-hour session was broken up into four sections. The first section (15 minutes) began with a brief introduction by the facilitator followed by a video clip (Appendix E) as a launching point for the group work. This 2-minute video created by Physicians for Reproductive Health¹⁸ (used with permission) shows an adolescent patient presenting to his pediatrician's office with nonspecific abdominal pain because he thinks he may be gay. There are several do's and don't's purposefully included within the video, which helped generate discussion during a short debrief. Facilitated by a faculty member, learners discussed relevant clinical experiences they may have had and why it is important for a pediatrician to know this patient's sexual identity-related feelings and concerns.

In the second section (30 minutes), all learners were given a printed copy of the student handout (Appendix F) and divided into four groups. Each group was assigned a skill-based task to complete that met one of the four stated objectives. The tasks were created to be a continuation of the video clip as if the clinical encounter had continued. Group 1 was tasked with creating a role-play script between the physician and patient to affirm and validate the patient's identity. Group 2 was instructed to write three to four mental health-related questions in at least three of the stated domains (depression/suicide risk, anxiety, substance use, bullying, sexuality, self-harm). Group 3 had to prepare for a consult call to the school counselor and formulate five questions for the patient in order to better understand the extent of bullying occurring at school. Group 4's task was to create a role-play script between the physician and an anxious parent who is having a difficult time adjusting to her child's sexual identity. Groups 1 and 4 were given a list of phrases the patient or parent might say in order to guide their role-play scripts.

The third section (50 minutes) consisted of group presentations and discussions. The groups reconvened and presented their assigned tasks to the class, with an opportunity for faculty-facilitated discussion after each presentation. Sample responses for each of the four tasks are included in Appendix G. An audio recording of a physician conversation with a school counselor (Appendix H) was played after Group 3 presented, to emphasize key concepts. Facilitators may choose to use PowerPoint to guide the presentations or just do this orally. The share-out session enabled the learners to complete their take-home worksheet (Appendix F, p. 6) as a toolkit of phrases and communication techniques for future reference.

During the last section (25 minutes) of the session, facilitators answered any remaining questions and ensured all student worksheets were completed. Students were then given the postsurvey (Appendix I). Similar to the presurvey, the postsurvey asked students to rate 12 questions about comfort, self-efficacy, knowledge, and sense of preparedness in doing tasks covered in the objectives on a 5-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). The postsurvey also included an open-ended question about how the session would impact the students as future clinicians. Survey responses were analyzed using a paired *t* test. This study was deemed exempt by the Johns Hopkins University Institutional Review Board.

Results

This session was first implemented within the Johns Hopkins University School of Medicine curriculum in November 2015 and since then has been held every 3 months with each new cohort of pediatric clerkship learners. Of the 42 learners who participated in the course, 40 (95%) completed the presurvey, and 39 (93%) completed the postsurvey. Learners demonstrated a significant change ($p < .001$) in their knowledge of the four objective-based skills as well as comfort and sense of preparedness in counseling adolescents questioning their sexual orientation before and after receiving the intervention (see [Table](#)).

Table. Mean Likert-Scale Scores of Student Pre- and Postsurvey Responses^a

Item	M (SD)	
	Presurvey (n = 40)	Postsurvey (n = 39)
I feel prepared to counsel an adolescent who is questioning his/her sexual orientation in a clinic setting.	2.80 (0.82)	3.84 (0.68)
I feel comfortable talking with an adolescent about his/her sexual orientation in a clinic setting.	3.28 (0.93)	4.13 (0.62)
Objective 1: List three ways to affirm/validate adolescents questioning their sexual orientation.		
I know 3 affirming and validating statements I can make to adolescents who are questioning their sexual orientation in a clinic setting.	2.70 (0.88)	4.05 (0.68)
In a clinical setting, I would be able to provide affirming and validating statements to adolescents who are questioning their sexual orientation.	3.18 (0.87)	4.24 (0.75)
Objective 2: Know the key domains and questions for assessing the mental health status of an adolescent patient, related to social support and bullying.		
I know at least 3 questions to ask a patient to assess his/her mental health status, related to social support and bullying.	3.15 (0.95)	4.18 (0.73)
In a clinical setting, I would be able to assess the mental health status of an adolescent patient, related to social support and bullying.	3.28 (0.91)	4.13 (0.58)
I know 3 questions I can ask an adolescent to understand the extent of bullying in a school environment.	2.98 (0.86)	4.18 (0.61)
Objective 3: Describe ways to collaborate with a school counselor to support an adolescent patient's health.		
I would be able to call a school counselor and have a conversation about the mental health of my patient related to social support and bullying.	3.23 (0.80)	4.16 (0.68)
I would be able to work with a school counselor to support the mental health of my patient.	3.28 (0.72)	4.03 (0.72)
Objective 4: Demonstrate two communication techniques for supporting a parent adjusting to his/her child's sexual orientation and provide relevant resources to support the family.		
I would be able to have a conversation with a parent who is having a difficult time adjusting to a son or daughter's sexual orientation.	2.80 (0.72)	3.68 (0.75)
I would be able to respond to a parent's questions about their son or daughter's sexual orientation.	3.05 (0.81)	3.92 (0.75)
I would be able to discuss relevant resources with a parent who is having a difficult time adjusting to a son or daughter's sexual orientation.	2.50 (0.78)	3.92 (0.56)

^aAll *p* values < .001.

Student responses to the open-ended postsurvey question revealed three key findings. Learners reported they felt (1) more prepared and comfortable in initiating conversations about sexual orientation with patients, (2) more aware of health concerns that affect SGM youth, and (3) more aware of the importance of being mindful of these specific health concerns when taking care of SGM youth. The free responses also revealed that learners would like to receive more training and advice from experienced physicians on handling sexual orientation questions in clinic.

Discussion

After participating in this 2-hour active learning session, third- and fourth-year medical learners showed significant self-reported improvement in comfort, sense of preparedness, and knowledge of skills needed to care for SGM youth. Learners reported growth in validating a patient's identity, assessing a patient's mental health, collaborating with professionals outside the medical setting, and communicating with parents to improve parental acceptance and understanding. This session serves to support the development of key cultural competency skills needed to care for SGM youth, as outlined by expert recommendations.

Despite our success, this session has several limitations as presented here. The session was designed to build upon an inclusive sexual history taking session for first-year learners and the HEADSS assessment lesson learners had had at the start of the pediatric clerkship. It was further complemented by newly implemented sessions in the preclinical and clinical curricula, such as a facilitated small-group discussion on implicit bias and experiences with SGM patients in a clinical setting and a case study on counseling women who have sex with women in the women's health clerkship. Without this additional context, other institutions may have less success.

The evaluation of this educational session also has some limitations. Our learners were from a single institution and were a relatively homogeneous population, all having been through similar communications training early in medical school. While the student group tasks focused on skill building, our evaluation was of self-reported knowledge and comfort in translating these skills into the authentic clinical setting. We did not perform observed structured examinations, although each group presentation

did receive immediate feedback from faculty and peers. As we were limited to 2 hours, time did not allow for all groups to work on all four of the skill-based tasks, which may have affected self-reported postsurvey responses. However, through presentations by each group and facilitated discussion following the presentations, we were able to have all learners record the key take-home points from each task.

Despite these limitations, there is self-reported evidence that this session supports the development of key communication skills needed to provide competent and nonjudgmental care for SGM youth. It can be easily replicated at other health professional schools looking to improve the cultural competency of future physicians around care for SGM patients.

Neha Bakhai: Second-year Medical Student, Johns Hopkins University School of Medicine

Ryan Shields: Fourth-year Medical Student, Johns Hopkins University School of Medicine

Michael Barone, MD, MPH: Associate Professor, Department of Pediatrics, Johns Hopkins University School of Medicine

Renata Sanders, MD, MPH: Assistant Professor, Department of Pediatrics and Adolescent Medicine, Johns Hopkins University School of Medicine

Errol Fields, MD, MPH, PhD: Assistant Professor, Department of Pediatrics and Adolescent Medicine, Johns Hopkins University School of Medicine

Disclosures

None to report.

Funding/Support

None to report.

Ethical Approval

This publication contains data obtained from human subjects and received ethical approval.

References

1. *Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health*. San Francisco, CA: Gay and Lesbian Medical Association; 2001.
2. Russell ST, Everett BG, Rosario M, Birkett M. Indicators of victimization and sexual orientation among adolescents: analyses from youth risk behavior surveys. *Am J Public Health*. 2014;104(2):255-261. <http://dx.doi.org/10.2105/AJPH.2013.301493>
3. Lambda Legal. *When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People Living With HIV*. New York, NY: Lambda Legal; 2010.
4. Almeida J, Johnson RM, Corliss HL, Molnar BE, Azrael D. Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*. 2009;38(7):1001-1014. <http://dx.doi.org/10.1007/s10964-009-9397-9>
5. Levine DA; Committee on Adolescence. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*. 2013;132(1):e297-e313. <http://dx.doi.org/10.1542/peds.2013-1283>
6. Walch SE, Ngamake ST, Bovornusvakool W, Walker SV. Discrimination, internalized homophobia, and concealment in sexual minority physical and mental health. *Psychol Sex Orientat Gend Divers*. 2016;3(1):37-48. <http://dx.doi.org/10.1037/sgd0000146>
7. Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, Board on the Health of Select Populations, Institute of Medicine of the National Academies. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: National Academies Press; 2011.
8. Society for Adolescent Health and Medicine. Recommendations for promoting the health and well-being of lesbian, gay, bisexual, and transgender adolescents: a position paper of the Society for Adolescent Health and Medicine. *J Adolesc Health*. 2013;52(4):506-510. <http://dx.doi.org/10.1016/j.jadohealth.2013.01.015>
9. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA*. 2011;306(9):971-977. <http://dx.doi.org/10.1001/jama.2011.1255>
10. East JA, El Rayess F. Pediatricians' approach to the health care of lesbian, gay, and bisexual youth. *J Adolesc Health*. 1998;23(4):191-193. [http://dx.doi.org/10.1016/S1054-139X\(97\)00164-X](http://dx.doi.org/10.1016/S1054-139X(97)00164-X)

11. Kitts RL. Barriers to optimal care between physicians and lesbian, gay, bisexual, transgender, and questioning adolescent patients. *J Homosex*. 2010;57(6):730-747. <http://dx.doi.org/10.1080/00918369.2010.485872>
12. Lena SM, Wiebe T, Ingram S, Jabbour M. Pediatricians' knowledge, perceptions, and attitudes towards providing health care for lesbian, gay, and bisexual adolescents. *Ann R Coll Physicians Surg Can*. 2002;35(7):406-410.
13. AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development. Professional competencies to improve health care for people who are or may be LGBT, gender nonconforming, and/or born with DSD. In: Hollenbach AD, Eckstrand KL, Dreger A, eds. *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born With DSD: A Resource for Medical Educators*. Washington, DC: Association of American Medical Colleges; 2014:54-61.
14. Makadon HJ, Mayer KH, Potter J, Goldhammer H, eds. *The Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. 2nd ed. Philadelphia, PA: American College of Physicians; 2008.
15. Lee R, Loeb D, Butterfield A. Sexual history taking curriculum: lecture and standardized patient cases. *MedEdPORTAL Publications*. 2014;10:9856. http://dx.doi.org/10.15766/mep_2374-8265.9856
16. Gelman A, Amin P, Pletcher J, Fulmer V, Kukic A, Spagnoletti C. A standardized patient case: a teen questioning his/her sexuality is bullied at school. *MedEdPORTAL Publications*. 2014;10:9876. http://dx.doi.org/10.15766/mep_2374-8265.9876
17. Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. *Contemp Pediatr*. 2004;21(1):64-92.
18. Standardized case videos: adolescent reproductive and sexual health. Physicians for Reproductive Health Web site. <https://prh.org/teen-reproductive-health/standardized-case-videos-adolescent-reproductive-and-sexual-health/>. Accessed September 20, 2015.

Received: March 15, 2016 | **Accepted:** July 5, 2016 | **Published:** September 1, 2016