1. EMBRACING THE RAINBOW: LGBTQ YOUTH NAVIGATING “SAFE” SPACES AND BELONGING IN NORTH AMERICA

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Purpose: While rainbows and safe space stickers have been a part of health care and school interventions promoting LGBTQ youth health and well-being, little research has been published describing how youth perceive and use the symbol. As part of a larger study on LGBTQ youth wellness, we explored youth perceptions of the rainbow and other symbols in creating supportive environments.

Methods: Self-identified LGBTQ youth (N=66; 14-19 years of age) in 23 cities across Minnesota, Massachusetts, and British Columbia were recruited through community settings and participated in audio recorded go-along interviews from November 2014 to July 2015. In go-along methodology, interviews are conducted while participant and researcher visit areas identified by participants to help understand environmental contexts. Access to resources and supportive persons were discussed, and youth were asked what kinds of visual cues helped them assess safety and solidarity. During the coding process, visual cues and the popularity of rainbows emerged as a common theme, and were selected for further constant comparative analysis. Guided by semiotics and symbolic interactionism frameworks, we reviewed and descriptively coded youths’ comments about visual cues, rainbows, and safe space stickers. Participants’ quotes are used to highlight key findings.

Results: Four themes emerged from participants’ shared perspectives: Navigation, Affect, Affiliation, and Limitations. The majority of participants who mentioned rainbows identified stickers or other kinds of rainbow markers as part of how they navigated towards medical, emotional, and social resources as well as supportive individuals such as teachers and counselors. A majority of youth expressed positive affect and associations with the rainbow. One stated, “I trust more, if I see the flag--the rainbow flag--and the LBGT signs. I trust that person more than if I didn’t see it.” Others chose to display the symbol to disclose their affiliation with the LGBTQ community. Youth identified rainbows as a recognizable and visible statement of solidarity, but acknowledged the limitations of the symbol. Youth noticed the rainbow, but its display was not always recognized as inclusive or enough to create supportive environments. For example, a trans participant highlighted, “[School officials] post safe spaces [stickers] all over, but there's no fucking safe space, honestly...Maybe for gay people, but trans? No.” Many youth associated rainbows with supportive teachers and LGBTQ friendly spaces, but few mentioned the symbol in connection with supportive health care providers.

Conclusions: Incorporating symbols, like the rainbow, in clinics and health centers in particular, may mark these spaces as safe for and supportive of LGBTQ youth. Most participants recognized and navigated towards these symbols. However, these displays should be backed up by the presence of knowledgeable, supportive persons sensitive to the needs of LGBTQ youth. Understanding the meaning of these symbols for youth may provide useful information for service providers working with this population.
**Sources of Support:** Funding was provided by the Eunice Kennedy Shriver National Institute Of Child Health & Human Development of the National Institutes of Health (grant #R01HD078470; PI: Eisenberg).

2.

**NONCONFORMING GENDER EXPRESSION IS A PREDICTOR OF BULLYING AND VIOLENCE VICTIMIZATION AMONG HIGH SCHOOL STUDENTS IN FOUR U.S. SCHOOL DISTRICTS**

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**Purpose:** In recent years there has been heightened attention to bullying and violence victimization in U.S. schools, particularly for lesbian, gay, bisexual, and transgender youth. Such social stressors are associated with adverse mental and physical health outcomes, including depression and suicidality. Less research has focused on bullying and violence directed at adolescents whose gender expression does not conform to societal expectations for masculine or feminine appearance and behavior (i.e., gender nonconformity [GNC]), across sexual orientations. The purpose of this study is to examine the association between gender expression and school-based victimization within an ethnically diverse probability sample of U.S. high school students.

**Methods:** Analyses include 5,503 public high school students (13-18 years) from the 2013 Youth Risk Behavior Survey in four school districts (Broward County; Chicago; Los Angeles; San Diego). Respondents were 51% Hispanic/Latino, 21% Black/African American, 14% white, and 14% another race/ethnicity. We used multivariable logistic regression, adjusting for the complex survey design and covariates (age, sex, race/ethnicity, sexual orientation), to estimate odds ratios (ORs) and 95% confidence intervals (CIs). We examined the association between self-reported GNC in three categories (most gender conforming [referent]; moderately gender nonconforming; and most nonconforming) and three forms of self-reported school-based victimization: being bullied at school in past year; missed school in past month due to feeling unsafe; and threatened or injured with a weapon at school in past year. We examined whether sex and sexual orientation modified the association between GNC and each outcome.

**Results:** Overall, 14% of respondents reported being bullied, 8% reported missing school due to feeling unsafe, and 6% reported being threatened/injured. Greater GNC was associated with higher prevalence of school-based victimization. In adjusted models, each level of GNC was associated with greater odds of bullying victimization relative to the most conforming (OR [95% CI]: moderately nonconforming=1.40 [1.18-1.68]; most nonconforming=2.01 [1.38-2.93]). The most gender nonconforming students also had greater odds of missing school (3.06 [2.10-4.44]) and being threatened/injured (2.79 [1.58-4.91]) relative to the most conforming. The association between GNC and missing school due to feeling unsafe was greater in magnitude for male than female youth (interaction p<.05). Effect modification by sexual orientation was not empirically supported.

**Conclusions:** In a sample of U.S. public high school students, we observed marked differences by gender
expression in being targeted for bullying and violence. Findings underscore the importance of including gender diversity in school-based bullying prevention programs and interventions seeking to mitigate social stressors that drive health inequities.

**Sources of Support:** ARG is supported by NIH R01-HD066963. JPC is supported by DA034753. SBA is supported by NIH R01-HD057368, NIH R01-HD066963, MCHB T71-MC00009, and MCHB T76-MC00001.

3.

**PARENTAL MONITORING OVER TIME BETWEEN HETEROSEXUAL AND SEXUAL MINORITY FEMALES**

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**Purpose:** Parental monitoring of an adolescent’s activities and whereabouts is associated with reductions in mental health problems in youth in general and may play a role in the well-documented mental health disparities faced by sexual minority females (SMF). Parental monitoring consists of several components: adolescent disclosure (youth disclosing to parents what they are doing), parental solicitation (parents asking their child for information), and parental knowledge (parents knowing where there child is). Previous studies suggest that parental monitoring may differ cross-sectionally between heterosexual and SMFs and have differential impact on adolescent behaviors. This study describes the longitudinal trajectories of parental monitoring components between heterosexual females and SMFs.

**Methods:** We recruited females ages 14 – 19 years old (n = 247) from adolescent medicine clinics in Columbus and Pittsburgh. Participants completed a comprehensive psychosocial questionnaire at the initial study visit and every 6 months afterwards. To assess the components of parental monitoring, we asked participants how many times they lied to their parents about where they were and who they were with (adolescent disclosure), how much they perceived that their parents tried to know their locations and activities (parental solicitation), and how much they perceived that their parents actually knew their locations and activities (parental knowledge). We constructed growth curve models to assess how these variables changed over a two-year time period in all participants. We then added an interaction term in each model to test for differences in absolute scores and trajectories of these components between heterosexual females and SMFs.

**Results:** In all participants, adolescent disclosure initially decreased but then increased as participants aged (p = 0.02) and parental solicitation and parental knowledge initially increased but then decreased as the participants aged (p < 0.001 and p = 0.004, respectively). Our interaction analysis showed that heterosexual females and SMFs had similar trajectories of adolescent disclosure (p = 0.12), but SMFs had consistently lower adolescent disclosure scores than did heterosexual females as they aged (p = 0.013). There were no differences in parental solicitation between heterosexual females and SMFs (trajectories: p = 0.35; scores: p = 0.6). Parental knowledge trajectories differed for heterosexual females and SMFs (p = 0.016), with parental knowledge decreasing as heterosexual females aged (p = 0.07), and initially increasing, then decreasing as SMFs aged (p = 0.029). Finally, SMFs had consistently lower parental knowledge scores than did heterosexual females (p = 0.008) as they aged.
Conclusions: SMFs over time were less likely to disclose their location and activities to their parents and believed their parents knew less about their location and activities compared to heterosexual females. This suggests that parental monitoring operates differently for heterosexual and SMFs as they progress through adolescence. Because SMFs may be less likely to disclose their behaviors to their parents over time because of a desire to hide their sexual orientation, interventions addressing mental health disparities should either consider the attenuated role of parental monitoring behaviors or directly address challenges in communication between SMFs and parents.

Sources of Support: R01 Grant #DA026312 and T32HP22240 Grant for Primary Care Research

4.

HEALTH CONCERNS IDENTIFIED BY TRANSGENDER YOUTH AND THEIR CAREGIVERS UPON PRESENTATION TO A TRANSGENDER CLINIC
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Purpose: Established treatment guidelines for transgender children, adolescents and young adults suggest multiple topics for patient assessment, education and medical care to be addressed at healthcare visits but patient and parent preferences are not known. We aimed to determine patient and caregiver preferences for topics to be discussed.

Methods: This is an IRB approved retrospective cross-sectional analysis of data originally collected as part of a quality improvement project. Initial-visit checklists (IVCs) for patients and caregivers to be completed at their initial visit to a transgender clinic were developed by incorporating guideline recommendations as well as family and patient input. The IVCs contained 31 items on the patient checklist and 26 on caregiver checklist. Topics that were included in the patient survey that were not included in caregiver survey are: information for caregivers, finding a job/employee rights, information for teachers, testing for sexually transmitted infections, and drug/alcohol/marijuana use. These checklists were separated into domains that physician, social worker, and both were likely to discuss. All patient caregivers present at visit could respond, however some patients over 18 completed checklists without parents. Data were analyzed with descriptive statistics that (1) describe the total number of items on the initial visit checklist endorsed by patients and caregivers, (2) identify the items most commonly endorsed by patients and caregivers, (3) describe the proportion of items endorsed by patients and caregivers that were in the social work domain versus the physician domain versus both.

Results: A total of 81 patient IVCs and 77 caregiver IVCs were collected. Non-respondents were eliminated, 76 patient IVCs and 72 caregiver IVCs were analyzed. Ages of patients ranged from 6-22 years, with mean age of 15.7 years. Of the patient checklists (n=76), the number of items endorsed ranged from 1-22 (excluding non-responders) with a mean of 9.1 items. Of the caregiver checklists (72), the number of items endorsed ranged from 1-20 (excluding non-responders), with a mean of 8.5 items. The top items endorsed by patients were: gender affirming hormones (76%), other medical treatments (75%), restroom/dressing room use (58%) and gender affirming surgery (58%). The top items endorsed by caregivers were: goals/transition (54%), safety at school (53%), and restroom/dressing room
use (53%). Of total items endorsed by patients, 37% (259) were in the physician domain, 42% (291) in the social work domain, and 20% (141) in both. Of total items endorsed by caregivers, 29.5% (181) were in the physician domain, 38.5% (236) in the social work domain, and 32.0% (196) in both.

**Conclusions:** At their first visit to a transgender clinic, caregivers most highly endorsed a desire to discuss concerns about safety, whereas patients wanted to discuss medical treatment. Both caregivers and patients endorsed restroom/dressing room use as one of their top priorities. Patient and parent priorities included both medical and social work domains, therefore social work involvement in a transgender clinic can be a critical asset to ensure patient education and may result in increased patient satisfaction and improved shared decision making.

**Sources of Support:** Faculty academic time and departmental time for analyses.

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**5.**

**BULLYING VICTIMIZATION AND EMOTIONAL WELL-BEING: IS THERE STRENGTH IN NUMBERS FOR VULNERABLE YOUTH?**

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**Purpose:** Poor emotional health and bullying victimization are especially common among vulnerable groups of youth, including those who are lesbian, gay, bisexual or questioning (LGBQ), overweight, or have a disability. Certain characteristics of the school environment (e.g. having a gay/straight alliance) have been shown to be protective against both bullying and poor emotional health among vulnerable youth, but there has been minimal study of the school-wide peer group and its potential association with these experiences. The present study examines whether the prevalence of similarly vulnerable peers is associated with emotional health of youth in vulnerable groups and if the adverse effects of bullying victimization are mitigated by the presence of these peers.

**Methods:** 8th, 9th, and 11th grade students (N=122,180) throughout Minnesota provided anonymous survey data in 2013. 84% of all public school districts participated, and 67% of enrolled students completed surveys. Two measures of sexual orientation, self-reported height and weight, and two measures of physical, mental, behavioral and/or emotional disability were used to identify vulnerable groups; the proportion of each vulnerable group in each school was used as the primary independent variable in multilevel analysis of emotional well-being (3+ internalizing problems, self-harm, suicidal ideation and attempts). Models adjusted for bullying experience and covariates, and interaction terms (victimization x proportion of vulnerable group) tested whether the presence of similar peers was protective for those who had been bullied. Separate models were run for each vulnerable group, and analyses were stratified by gender.

**Results:** On average, 8.1% of students were LGBQ (range=0-28% per school), 23.7% were overweight (range=0-57%) and 29.9% had a disability (range=9-81%). In adjusted models, greater presence of similarly vulnerable youth was, on average, protective against poor emotional health among LGBQ girls and overweight boys. For example, a 5% difference in the proportion of LGBQ students was associated with significantly lower odds of internalizing problems (OR=0.81, CI: 0.68, 0.96) among female LGBQ
participants. In contrast, greater presence of students with a disability was, on average, a risk factor for poor emotional health among students with a disability. Interaction terms indicated effect modification by bullying experience. Specifically, odds ratios of poor emotional health for those who had been victimized (vs. not) were smaller in schools with a greater proportion of vulnerable youth (all types), and in many cases became non-significant at schools with a large proportion of vulnerable youth.

**Conclusions:** In schools with a large proportion of LGBQ, overweight or disabled students, the well-known associations between bullying and emotional distress were no longer statistically significant. The presence and visibility of vulnerable youth may protect students through services targeting these youth, increased social support from peers and school staff, or shifting social norms towards greater acceptance and inclusion. Implications for bullying prevention programs, students, parents and school personnel will be discussed.

**Sources of Support:** Funding was provided by grant R40 MC 26815 from the Maternal and Child Health Research Program, Health Resources and Services Administration, US Department of Health and Human Services and a National Research Service Award in Primary Medical Care (grant T32HP22239).

6.

**UNDERSTANDING BARRIERS TO HEALTHCARE FOR TRANSGENDER YOUTH**

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**Purpose:** There are many barriers to healthcare for transgender youth that contribute to low rates of recommended treatment for this high-risk population. Dedicated multidisciplinary gender clinics are one promising strategy to improve coordination of care for transgender individuals; however, only a limited number of medical centers house such clinics. In addition, in spite of clear recommendations from experts, most clinics do not offer pubertal blockers or cross-sex hormones to youth who meet criteria. The purpose of this research study was to understand the barriers that transgender youth and their parents face when trying to access services such as mental health care, pubertal blockers, cross-sex hormones, and gender-affirming surgery, and to make recommendations for overcoming or removing those barriers.

**Methods:** We recruited 13 transgender youth aged 14-22 years and 16 parents of transgender youth in the Seattle, WA area through local clinics and listservs. Youth and parents had the option to participate in a semi-structured interview or focus group discussion. Eight of the parents were interviewed, while eight participated in one of two parent focus groups. Four of the youth were interviewed, while nine participated in one of two youth focus groups. Interviewer probes centered on participants’ experiences
Results: The majority of parents identified as white (88%), female (75%), and had either a college degree (44%) or some college or vocational school (44%). Parents’ average age was 49. Youth participants’ average age was 18 and each youth’s gender identity was different from the sex they were assigned at birth. Seven youth identified as male, three as female, and 3 as genderqueer or genderfluid. The majority of the youth identified as white (69%) and had completed high school or some college (77%). Seven of the youth had one or more parent who also participated in the study. Key themes that emerged during data analysis regarding barriers to care included: 1) difficulty finding knowledgeable healthcare providers with specific expertise and/or interest in working with transgender youth; 2) difficulty for young adolescents to access pubertal blockers and/or cross-sex hormones; 3) staff and providers not using patients’ preferred names and/or pronouns; 4) being made to feel uncomfortable or “not normal” by the healthcare system; 5) lack of a clinical protocol or “roadmap” for patients and providers; 6) lack of coordination of care among providers of different disciplines who care for transgender youth.

Conclusions: These results suggest many specific strategies that could be used to improve the healthcare experiences of transgender youth and their families. Pediatric centers should consider a dedicated multidisciplinary gender clinic and all healthcare centers should provide cultural humility training for staff and develop clinical protocols to improve care for transgender youth. These strategies will be used to inform the creation of a local gender clinic and will be evaluated in future research.

Sources of Support: Center for Diversity and Health Equity at Seattle Children’s Health Equity Grants program, Seattle Children’s Clinical and Translational Research Faculty Research Support Fund program.