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**APPEARANCE IDEALS AND EATING DISORDERS RISK AMONG LGBTQ COLLEGE STUDENTS: THE BEING OURSELVES LIVING IN DIVERSE BODIES (BOLD) STUDY**

Allegra Raboff Gordon, ScD, MPH<sup>1</sup>, S. Bryn Austin, ScD<sup>2</sup>, David W. Pantalone, PhD<sup>3</sup>, Rose Eiduson, MPH<sup>4</sup>, Rachel Rodgers, PhD<sup>5</sup>, Alison M. Baker, MPH<sup>2</sup>

<sup>1</sup>*Boston Children's Hospital, Harvard Medical School*; <sup>2</sup>*Boston Children's Hospital, Harvard T.H. Chan School of Public Health*; <sup>3</sup>*University of Massachusetts Boston*; <sup>4</sup>*Boston Children's Hospital*; <sup>5</sup>*Northeastern University*

**Purpose:** Lesbian, gay, bisexual, transgender, and queer (LGBTQ) adolescents and young adults experience elevated risk for eating disorders. Dissonance-based body image interventions have been successful in addressing eating disorders symptoms by decreasing susceptibility to societal appearance ideals and resulting body dissatisfaction. However, interventions have not been adapted for diverse LGBTQ populations. To inform the development of a tailored body image intervention, we explored how societal appearance ideals are perceived by and influence eating disorders risk factors among LGBTQ college students.

**Methods:** This formative study comprised a quantitative survey (n=58) and six focus groups (n=30) with LGBTQ students recruited via flyers, events, and listserves at two urban New England universities (one private, one public). Participants were undergraduate students (mean age 19.7 years). The sample was 74% cisgender (i.e., non-transgender) female, 15% cisgender male, 3% transmasculine, 5% non-binary, 3% another gender identity; 37% identified as people of color. Guided by minority stress theory and a sociocultural model of eating disorders risk, survey and focus group topics included identities, appearance ideals, experiences of discrimination, and disordered eating behaviors. Focus group recordings were transcribed, double-coded, and analyzed using a deductive thematic analysis approach.

**Results:** The majority of survey participants (80.4%) reported experiencing at least one form of discrimination in the past year, and 60.9% reported at least one disordered eating behavior. In focus groups, participants identified traditional media, social media, LGBTQ-specific media, dating apps, and family as sources of appearance ideals. Four key focus group themes emerged. (1) Appearance ideals interact with sexual and gender identity development (e.g., "Even [if] they're questioning if they're gay or not... now they're seeing all these pictures [on social media]. And it's like, 'Okay, I can either be very muscular or very thin, because that's the right way to do it!'" ). (2) Appearance ideals are inextricable from LGBTQ stereotypes ("There's the expectation that [bisexual women] want everyone, or you want to have threesomes. But no matter what their expectation of me is, I'm somehow not fitting it because I'm not thin enough or... curvy enough or trying to look sexy enough"). (3) Identities and intersectionality: Appearance pressures vary by gender, sexual orientation, and race/ethnicity (e.g., "I think for non-binary people, the expectation is usually... designated female at birth, white, skinny, masculine-presenting... a lot of people who are non-binary feel pressured into fitting into that"; "On Grindr... you'll see people's profiles like 'No fats, No fems, No insert race here'"). (4) Complexity and resilience: LGBTQ contexts as affirming vs. constraining (e.g., "queer spaces have the ability to be some of the most accepting places in terms of body image and appearance... but they also have the potential to be very... constricting").

**Conclusions:** Eating disorder prevention and treatment programs must consider LGBTQ young people's experiences with dominant societal appearance ideals as well as LGBTQ-specific pressures, experiences of stigma, and resilience when adapting programs for this underserved population.

**Sources of Support:** Harvard Strategic Training Initiative for the Prevention of Eating Disorders; Leadership Education in Adolescent Health Training Grant #T71MC00009, MCH, HRSA.

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**HIV RISK FACTORS ASSOCIATED WITH THE PRE-EXPOSURE PROPHYLAXIS CASCADE AMONG YOUNG AND ADULT BLACK MEN WHO HAVE SEX WITH MEN IN BALTIMORE CITY**

Errol L. Fields, MD, PhD, MPH<sup>1</sup>, Christina Fennell, BS<sup>2</sup>, Jessica Wagner, MPH<sup>1</sup>, Christina Schumacher, PhD<sup>1</sup>, Aruna Chandran, MD, MPH<sup>3</sup>, Ashley Price, MS, CHES<sup>4</sup>, Lavisha McClarin, MPH<sup>1</sup>, Jeannie Murray, MS<sup>1</sup>, Renata Arrington-Sanders, MD, MPH, ScM<sup>1</sup>, Maisha Davis, LCSW-C<sup>5</sup>, Kathleen Page, MD<sup>1</sup>, Adena Greenbaum, MD<sup>4</sup>, Patrick Chaulk, MD, MPH<sup>4</sup>, Jacky Jennings, PhD, MPH<sup>1</sup>

<sup>1</sup>Johns Hopkins School Of Medicine; <sup>2</sup>Harvard University TH Chan School of Public Health; <sup>3</sup>Johns Hopkins Bloomberg School of Public Health; <sup>4</sup>Baltimore City Health Department; <sup>5</sup>Chase Brexton

**Purpose:** Young (13-24) black men who have sex with men (YBMSM) and black MSM (BMSM) in general continue to experience HIV disparities. Pre-exposure prophylaxis (PrEP) is a potential tool for reducing these disparities especially when those at greatest risk for acquisition are prioritized for PrEP delivery. PrEP services follow a cascade similar to HIV treatment cascades with gaps at each level of delivery. The study objective was to determine significant differences by age and risk factors associated with HIV acquisition among BMSM who progressed (versus not) along the cascade of PrEP delivery in Baltimore.

**Methods:** HIV risk factor, demographic and PrEP cascade data on BMSM from IMPACT, a CDC-funded initiative focused on increasing PrEP uptake among priority populations, were collected from September 2015 through March 2018 from seven Baltimore-area sites. HIV risk factors included STI diagnosis and number of sex partners in the past 3 months and, in the past 12 months, sex with HIV-positive partner, exchange sex, and receptive anal sex. Age was dichotomized (13-24 and 25+). PrEP cascade categories included: eligible based on risk, referred, accepted, linked, clinically eligible, prescribed, and currently on PrEP. Student t-test with unequal variance and chi-squared test were used to determine significant differences in progression at each level of the cascade by age and risk factor.

**Results:** IMPACT encountered 826 PrEP eligible BMSM. 31% (n=256) were 13-24 (mean=21.2/SD=2.13). Significant differences in HIV risk factors were noted at most steps in the cascade. Among those referred for PrEP (356/826) versus not, there was a significantly lower proportion of those with an STI (48% versus 52%, p=0.002), a greater proportion of those with HIV-positive sex partner(s) (55.3% versus 44.7%, p<0.001) and a higher mean number of sex partners (4.14/SD=8.41 versus 2.56/SD=2.88, p=0.009). Among those who accepted PrEP referral (185/356) versus not, there was a significantly greater proportion of those with an STI (65.3% versus 34.8%, p<0.001), HIV-positive sex partner(s) (61.8 versus 38.2%, p<0.001), and receptive anal sex (53.5% versus 46.5%, p=0.002). Among those linked to PrEP (160/185) versus not, there was significantly greater proportion of those with an STI (90.9% versus 9.1%, p=0.036). Among those found clinically eligible (153/160) versus not and among those prescribed PrEP (137/156) versus not, there was significantly greater proportion of those with an STI (98.6 versus 1.4%, p=0.027 and 95.7% versus 4.3%, p=0.031), and a higher mean number of sex partners (5.14/SD=11.16 versus 1.67/SD=0.58, p=0.002 and 5.32/SD=11.50 versus 2.43/SD=1.81, p=0.033). The only age differences were among those prescribed PrEP versus not where there was a lower proportion of those age 13-24 (81.5% versus 93.9%, p=0.016).

**Conclusions:** At most steps along the cascade, greater proportions of those with HIV risk factors (STI, number of sex partners, HIV-positive sex partner) progressed. These findings suggest higher risk individuals are being identified and/or prioritized in this setting. However, these findings point to two important gaps in the cascade, PrEP prescriptions for YBMSM and PrEP referral for men with STI. These are gaps to be further examined and prioritized to impact HIV disparities in these priority populations.

**Sources of Support:** CDC PS15-1506/1509

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**“THERE IS A POSSIBILITY THAT THINGS CAN GET BETTER”: TRANSGENDER YOUTH’S EXPERIENCES WITH HEALTH CARE SERVICES**

Sanjana Pampati, MPH<sup>1</sup>, Jack Andrzejewski, MPH<sup>1</sup>, Riley J. Steiner, MPH, PhD<sup>2</sup>, Catherine N. Rasberry, PhD<sup>2</sup>, Susan H. Adkins, MD<sup>2</sup>, Catherine A. Lesesne, PhD<sup>3</sup>, Michelle Johns, PhD<sup>2</sup>

<sup>1</sup>*Oak Ridge Institute for Science and Education (ORISE)*; <sup>2</sup>*Centers for Disease Control and Prevention*; <sup>3</sup>*ICF International*

**Purpose:** Transgender youth are at increased risk for a range of adverse health outcomes, but face barriers in both access to and receipt of quality healthcare. Little is known about barriers and facilitators to health care for this population so this study sought to describe transgender youth’s experiences both seeking and receiving healthcare services.

**Methods:** Data came from a qualitative study on protective factors for transgender youth. Thirty-three transgender youth between the ages of 15 and 24 (mean: 22) were recruited from community-based organizations between February and June 2017 in Atlanta, Georgia for individual, in-depth interviews. The sample was diverse by gender identity, and included transfeminine (42.4%), transmasculine (33.3%), and non-binary youth (24.2%). Over half (54.5%) identified as Black or African American. Two coders independently coded interview transcripts for content about healthcare experiences, and content was analyzed using thematic analysis.

**Results:** In terms of healthcare seeking, transgender youth reported multiple barriers, including affordability, availability, and confidentiality. Specifically, high out-of-pocket cost combined with inadequate insurance coverage for gender-transition services were frequently cited as a barrier. The lack of available providers with experience providing care to transgender youth was evident, as participants described traveling significant distances for care. Participants who had not disclosed their gender identity to their parents or who did not have supportive parents mentioned difficulties seeking medical services that required parental notification or consent. For youth who accessed care, pronoun/name usage, communication, and bedside manner affected their level of comfort. Participants spoke favorably of check-in procedures that addressed preferred name, pronoun, and gender. Likewise, consistent use of correct name and pronoun terminology by office staff and providers was appreciated, but youth indicated that these practices were not standard. Youth desired open, non-judgmental communication to ease their own discomfort with healthcare interactions. Participants also described providers and office staff’s discomfort managing transgender patients, as evidenced in their bedside manner. Finally, participants did not always disclose their gender identity, particularly if they were uncomfortable and had privacy concerns.

**Conclusions:** Across seeking and receiving healthcare, transgender youth described some factors relevant to all youth and others that were unique to transgender individuals. These findings underscore that in addition to ensuring healthcare services are youth-friendly, transgender youth need trans-friendly services as well. Front office staff and providers may benefit from trainings on transgender cultural competency so they can better meet the needs of transgender youth in a way that facilitates comfort, including assessing and using correct pronouns and ensuring time alone to discuss potentially sensitive issues, including gender identity.

**Sources of Support:** Funding for this study was provided, in part, by the Centers for Disease Control and Prevention’s Division of Adolescent and School Health to ICF under contract HHS-200-2013-M53944B, task order 200-2014-F-59670.

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**ADDRESSING MENTAL HEALTH AMONG SEXUAL MINORITY ADOLESCENTS AND YOUNG ADULTS: A QUALITATIVE INVESTIGATION**

Lindsay A. Taliaferro, PhD, MPH<sup>1</sup>, Joanna Mishtal, PhD<sup>1</sup>, Meagan Acevedo, MS<sup>1</sup>, Tiernan Middleton, BS<sup>1</sup>, Veenod Chulani, MD, MSED<sup>2</sup>, Marla Eisenberg, ScD, MPH<sup>3</sup>

<sup>1</sup>University of Central Florida; <sup>2</sup>Phoenix Children's Hospital; <sup>3</sup>University of Minnesota

**Purpose:** Lesbian, gay, or bisexual (LGB) young people demonstrate significant mental health disparities, compared to their heterosexual counterparts. However, primary care providers usually receive limited training on addressing mental health issues. We sought to understand the mental health care needs and desires of LGB young people, and how those compare with the perceived capacity of healthcare providers to meet these needs.

**Methods:** Qualitative interviews were conducted with 22 LGB young adults and 24 pediatric/family medicine residents/physicians in-practice mostly from Florida during 2017-2018. LGB young adults were questioned about their experiences being asked and desires to be asked about mental health issues during physical healthcare visits. Clinicians were asked about their comfort addressing mental health with LGB adolescents. Interviews were audio-recorded and transcribed. Two investigators individually coded a transcript from each sample and met to discuss and resolve minor thematic differences to generate preliminary codebooks. Further coding and analysis yielded additional themes for each codebook. All transcripts were coded by two investigators, and data were analyzed for themes and sub-themes using NVivo 11 software and Grounded Theory approach. We triangulated findings from both samples regarding thematic domains.

**Results:** Two primary themes and two sub-themes emerged across the samples. A primary theme involved addressing mental health. All clinicians indicated they felt comfortable addressing mental health with adolescents. However, many young adults reported never being asked about depression, suicidal thoughts, or self-harm by a healthcare provider. Sub-theme one involved the importance of addressing mental health, which was overwhelmingly endorsed across both samples. For example, one young adult stated: "I think so, especially since they're really common among gay youth. Like when I was a kid, I wanted to kill myself because I was gay. I knew other children who felt exactly the same way." Sub-theme two involved practices used (discussion vs. questionnaire) to address mental health issues. Some clinicians explained their clinics' practice of administering depression screening questionnaires. In contrast, several young people expressed a desire for clinicians to speak with them directly, rather than rely on questionnaires: "But if the doctor took the time to really genuinely ask me and not just based off a survey or questionnaire, then I would be more willing [to divulge information]...that's super important, because it can really go a long way." Another primary theme focused on mental health as a topic of training for clinicians. A resident suggested: "Make sure we know the risk of the extra mental health needs, just because of all the stress of having to come out multiple times." Similarly, regarding important topics to teach clinicians, a young LGB person said: "Definitely a good foundation in social and emotional health, and the implications that can have with LGBT people."

**Conclusions:** Although clinicians feel confident addressing mental health needs among adolescents, including sexual minorities, many LGB young adults indicated they were never asked about mental health issues. Clinicians and LGB young people agreed that addressing mental health among this subpopulation is important and should represent a topic of training for healthcare providers.

**Sources of Support:** UCF Department of Internal Medicine

85.

**INTERNAL RESILIENCE STRATEGIES AMONG TRANS AND NON-BINARY ADOLESCENTS**

Kelly Johnson, DrPH, MPH<sup>1</sup>, Colette Auerswald, MD, MS<sup>2</sup>

<sup>1</sup>San Francisco State University; <sup>2</sup>UC Berkeley-UCSF Joint Medical Program

**Purpose:** Transgender adolescents suffer from disproportionately high rates of mental health disorders. Minority stress theory posits that transgender individuals experience unique stressors that can lead to poor mental health outcomes, but that protective factors can buffer the pathways between minority stressors and adverse mental health outcomes. Protective factors include both external resources and individual assets. While some external resources (e.g. family support, access to gender affirming medical services, and school connectedness) have been identified as protective among transgender adolescents, fewer studies have focused on internal resilience strategies. We qualitatively explored the internal resilience strategies identified as protective against minority stress by a diverse sample of trans and non-binary adolescents.

**Methods:** We recruited 28 trans and non-binary adolescents between the ages of 16 to 20 living in New York City and the SF Bay Area. Interviews were conducted in two phases. In Phase one, we conducted “lifeline interviews,” inviting youth to visually depict their life histories along a timeline, displaying significant events in chronological order. At the end of the interview, we asked participants to take photos that corresponded to prompts about internal and external resources (e.g. “Take a photo that represents your personal strengths” or “Take a photo that represents a safe space for you.”) In Phase two, participants returned with their photos, which were used to guide the second interview. All interviews were audio recorded, transcribed verbatim, coded, and analyzed using inductive thematic analysis.

**Results:** Participants described five themes related to internal resilience: 1) Gaining strength through enduring and surviving hardships (e.g. “Going through those tough trials really gave me the strength to carry on with my life and really pursue happiness”); 2) Self-acceptance and self-affirmation (e.g. “I've gone through phases when I severely disliked who I was and being in the body that I was in. So, loving myself was the best support I could've given myself”); 3) Learning how to handle discriminatory situations, either by standing up for oneself (e.g. “I will do me and if they have a problem with it, there's the door”), or by avoiding conflict; 4) Cognitive behavioral techniques, including future orientation, mindfulness, and externalizing/reframing problems (“I have to be conscious of the way that I think about things, because otherwise I easily become really upset about things that there's no evidence for”); and 5) Positive psychology practices, including helping others, practicing gratitude, hope and optimism, and positive thinking (“If I was feeling really overwhelmed or depressed or anything, I would just make a list of things that made me happy”).

**Conclusions:** Trans and non-binary adolescent participants reported the use of multiple individual resilience strategies to manage minority stress in their lives. These resilience strategies can help inform the development of strength-based community, clinical, and school-based interventions serving trans and non-binary adolescents, in order to improve their mental health outcomes.

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86.

### **TRANSGENDER YOUTH'S DISCLOSURE OF GENDER IDENTITY TO PROVIDERS OUTSIDE OF SPECIALIZED GENDER CENTERS**

Gina Sequeira, MD<sup>1</sup>, Elizabeth Miller, MD, PhD<sup>2</sup>, Selma Witchel, MD<sup>2</sup>, Cherie Dhar, MD<sup>2</sup>, Gerald Montano, DO, MS<sup>2</sup>, Kristin Ray, MD, MS<sup>2</sup>

<sup>1</sup>Children's Hospital of Pittsburgh of UPMC; <sup>2</sup>Children's Hospital of Pittsburgh

**Purpose:** Transgender youth face multiple barriers to receiving quality healthcare, resulting in significant health disparities. Understanding the factors influencing gender identity disclosure to providers has the potential to facilitate improved access to care. Assessment tools have been used to identify individual and health systems characteristics associated with an increased likelihood of disclosing sexual minority status to a healthcare provider, but none have investigated these factors in the context of gender identity. The objective of this study was to identify individual and health systems factors that influence transgender youth's choice to disclose their gender identity to providers outside of specialized gender centers.

**Methods:** The study was conducted using a cross-sectional study design with a 67-item survey. Survey items underwent cognitive interviewing with two transgender young adults, content validation with seven content experts, and piloting with transgender youth. Potential participants were identified via review of the electronic health record and recruited during clinic visits at two multidisciplinary, children's hospital gender clinics. Inclusion criteria were ages between 12 and 24 years and self-identification of gender identity as anything other than cisgender. Descriptive statistics and chi-square tests were used to examine factors associated with gender identity disclosure to healthcare providers.

**Results:** Participants (n=70, mean age 17 years) identified with a range of gender identities. Before being seen in gender clinic, 62.9% reported having chosen to disclose their gender identity to a healthcare provider. The vast majority of disclosures (96.1%) were participant initiated rather than provider initiated (19.2%). However, among all participants, 52.9% indicated a preference that their provider initiate the conversation about their gender identity, while only 24.3% said they would rather initiate it themselves. The most common reasons for disclosure were importance to their mental health care (76%), correct use of name and pronouns (74%), and to obtain a referral to a specialized gender clinic (64%). The likelihood of disclosure prior to first gender clinic visit was not significantly associated with self-reported gender expression, current age, age at time of presentation, clinic travel time, degree of parental support, perception of how well they "pass", or receipt of a physical in the last year. Participants indicated that health system factors like forms, using correct names/pronouns and staff training were most important to increasing their comfort with disclosure. 63.6% of patients indicated they learned about the gender clinic from a provider (e.g., therapist, PCP, psychiatrist); choosing to disclose prior to coming to gender clinic was significantly associated with provider referral ( $\chi^2=4.39$ ,  $p<0.05$ ).

**Conclusions:** Over one-third of participants reported they had not chosen to disclose their gender identity to a healthcare provider prior to receiving care at a specialized gender clinic. A majority indicated a preference for provider-initiated conversations about gender identity. Health systems level factors like forms, correct use of names/pronouns and staff training helped increase patient comfort with gender identity disclosure. Mental health and primary care providers play a critical role in facilitating access to gender affirming care for transgender youth.

**Sources of Support:** T32 HD 71834-5

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**USING STANDARDIZED PATIENT ENCOUNTERS TO BUILD INTERDISCIPLINARY PEDIATRIC LEARNERS' GENDER-AFFIRMING CLINICAL SELF-EFFICACY AND SKILLS IN CARING FOR TRANSGENDER YOUTH**

Stanley R. Vance, Jr., MD, Brian Dentoni-Lasofsky, MSN, MSW, RN-BC, PMHNP-BC, Matthew J. Meyers, MD, MPH, Madeline B. Deutsch, MD, MPH, Elizabeth Ozer, PhD, Sara Buckelew, MD, MPH  
*University of California, San Francisco*

**Purpose:** Our previously developed pediatric transgender curriculum, comprised of online modules, demonstrated improvement in learner knowledge and clinical self-efficacy. In order to develop learners' clinical skills in providing gender-affirming care to transgender youth, we expanded the curriculum to include standardized patient encounters (SPEs). This study aims to evaluate the impact of the expanded curriculum

**Methods:** Learners on their adolescent medicine rotation (4th year medical students; pediatric and psychiatry interns; and nurse practitioner trainees) participated in the expanded curriculum's two educational experiences. First, learners viewed six online modules and one clinical vignette video that focus on medical and psychosocial considerations for transgender youth. The second experience involved two, 20-minute formative SPEs featuring transgender teens portrayed by gender expansive, young adult actors. Both SPE cases featured transgender teens presenting to care to discuss initiation of gender-affirming hormones, and learners were instructed to obtain a history and provide counseling. The SPEs were observed remotely by faculty who completed a 20-item checklist that focused on obtaining a gender history and providing counseling on gender-affirming medications. The SPE actors completed a separate 14-item checklist that focused on interpersonal communication. Feedback was provided after each encounter by both the faculty observer and SPE actor. Learners completed assessments pre- and post- online modules, and after conclusion of the SPEs. The first assessment queried learner demographics and transgender clinical exposure. All assessments measured clinical self-efficacy through self-reported confidence in clinically evaluating and counseling transgender youth (0=not at all confident; 10=completely confident). Overall self-efficacy scores were calculated, and Friedman testing was used to compare differences among the scores followed by ad hoc testing via Wilcoxon Signed Rank Tests. For each SPE, total completed checklist items were calculated for the faculty-completed checklist and actor-completed checklist. Change in checklist aggregate scores between the first and second case were compared via Wilcoxon Signed Rank Tests.

**Results:** 34 learners were eligible during the 2017-2018 academic year, and 27 completed all assessments (participation rate of 80%). The majority of learners were pediatric interns (59%) and 4th year medical students (26%). 56% and 44% had female and male gender identities, respectively. The median number of transgender patients to whom learners had previously provided care was 1, and 7% (n=2) had prior experience working in a transgender clinic. Learners' median overall self-efficacy scores improved from pre-module, post-module, and post-SPE assessments from 2.5 to 6.9 to 8.2 ( $p < 0.001$ ). Median faculty checklist score improved between case 1 and case 2 from 11 to 15 ( $p < 0.001$ ) and median SPE actor checklist score improved from 11 to 12 ( $p = 0.003$ ).

**Conclusions:** This study suggests that combined e-learning and standardized patient encounters are effective at enhancing transgender-related clinical self-efficacy and skills in a multidisciplinary cohort of pediatric undergraduate and graduate education learners. These tools can be helpful in allowing learners, who were overall inexperienced with working with transgender youth, to utilize their knowledge and practice skills in a low-stakes, supportive educational environment prior to engaging with a vulnerable patient population.

**Sources of Support:** UCSF Innovations for Educations Grant; MCHB Adolescent/Young Adult Health Research Network

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88.

**THE IMPACT OF SEXUAL IDENTITY DEVELOPMENT ON THE SEXUAL HEALTH OF FORMER FOSTER YOUTH**

Richard A. Brandon-Friedman, PhD, LCSW, LCAC

*Indiana University*

**Purpose:** Former foster youth (FFY) receive less sexual and reproductive health education, experience more negative sexual health outcomes, and engage in more risky sexual behaviors than peers outside the foster care system. Counteracting these adverse experiences requires understanding the contributing processes.

**Methods:** FFY were recruited from service organizations that serve them to complete an online anonymous survey (n = 219; ages 18-24). Measures included: Multidimensional Model of Sexual Health (33 items; z score range: -61.92-25.18;  $\alpha = .92$ ); Measure of Sexual Identity Exploration and Commitment (MoSIEC; 4 dimensions measured with Likert-type scale 0 (very uncharacteristic of me) to 6 (very characteristics of me), Commitment (6 items; range: 7-36;  $\alpha = .85$ ), Exploration (8 items; range: 8-48;  $\alpha = .91$ ), Synthesis/Integration (5 items; range: 5-30;  $\alpha = .87$ ), and Sexual Orientation Identity Uncertainty (3 items; range: 3-17;  $\alpha = .72$ ); Adolescent Patient-Provider Interaction Scale with language modified to encompass six individuals/groups with whom the youth interacted and completed once for each individual/group (8 items; range: child welfare worker, 8-40,  $\alpha = .94$ ; foster parents, 8-40,  $\alpha = .95$ ; professional service provider, 8-40,  $\alpha = .90$ ; member of family of origin, 8-40,  $\alpha = .94$ ; sexual education teacher, 8-40,  $\alpha = .90$ ; and peers, 8-40,  $\alpha = .92$ ); Adverse Childhood Experiences (10 items yes/no; range: 0-10); Childhood Sexual Abuse Severity Scale (4 items yes/no; range 0-4); degree of discussion of sexuality-related topics (11 topics rated from 1 (never) to 4 (often), completed six times, once for each individual/group; range: public child welfare worker, 0-31; foster parents, 0-32; professional service provider, 0-33; member of family of origin, 0-33; formal sexual education teacher, 0-33; and peers, 0-33. Associations of sexual socialization and sexual health were assessed with hierarchical linear models, with tests of mediation by sexual identity development of the relationship between sexual socialization and sexual health using bootstrapped confidence intervals. Analytic controls included time in the foster care system, race/ethnicity, gender identity, sexual orientation identity, and current romantic relationship status, with significance accepted for  $p < 0.05$ .

**Results:** Individuals' gender identity, sexual orientation, adverse childhood experiences, sexual abuse history, and sexuality-related discussions with foster parents and with peers all impacted sexual health. Unexpectedly, sexuality-related discussions with foster parents negatively impacted sexual health. Alternatively, sexuality-related discussions with peers positively impacted sexual health. All four dimensions of sexual identity development significantly contributed to sexual health outcomes, Commitment  $\beta = .428$ ,  $p < .001$ ; Exploration  $\beta = .169$ ,  $p < .05$ ; Synthesis/Integration  $\beta = .350$ ,  $p < .001$ ; Sexual Orientation Identity Uncertainty  $\beta = -.235$ ,  $p < .001$ . Mediation occurred with all four MoSIEC though individuals/groups impacted was dependent on dimension considered, whereas no interaction effects were detected.

**Conclusions:** The sexual health of FFY is negatively affected not only by traumatic childhood experiences but by sexuality-related discussions with foster parents. Importantly, some of these outcomes are mediated by sexual identity development. These results demonstrate the developmental importance of sexual identity and highlight several areas where negative sexual outcomes could be addressed.

**Sources of Support:** Indiana University School of Medicine Section of Adolescent Medicine