

Sexual Health Disparities Among Disenfranchised Youth



- ▶ Youth in Corrections
- ▶ Youth with Developmental Disabilities
- ▶ Youth in Foster Care
- ▶ Homeless Youth
- ▶ LGBTQ Youth
- ▶ Youth with Mental Health Conditions
- ▶ Youth who have Experienced Sexual Abuse



Sexual Health Disparities Among Disenfranchised Youth:

Although sexual development is a life-long process, youth/young adulthood is typically the time of sexual debut and the beginning of sexual exploration. Promoting good sexual health should therefore be a priority during this developmental period.

To that end, in 2009 Oregon published the Oregon Youth Sexual Health Plan (OYSHP), which suggests taking a holistic approach to ensure the sexual health of youth through the reduction of teen pregnancy, sexually transmitted infection (STI), and non-consensual sexual behavior rates. Additionally, Oregon saw the need to offer its youth effective sexuality education and, also in 2009, passed legislation mandating that students in middle and high school be informed about contraception, the prevention of STIs, and healthy relationships.

While all young people need sexual health information and services, there are some youth who would perhaps benefit from greater access to these. Sexual health disparities exist among certain subpopulations of youth; in fact, one of the primary goals outlined in the OYSHP is to eliminate such disparities. Youth populations known to have sexual health disparities include:

- Youth in Corrections
- Youth with Developmental Disabilities
- Youth in Foster Care
- Homeless Youth

- Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth
- Youth with Mental Health Conditions
- Youth who have Experienced Sexual Abuse

The following series of research briefs addresses the sexual health of the above seven subpopulations. Perhaps not surprisingly, it was found that many of these groups experience the same negative health outcomes. On the next page is a table outlining which negative sexual health outcomes have been documented in which youth subpopulations. As can be seen from the Table, three disparities are present in all seven populations: higher rates of pregnancy involvement, sexual abuse, and STIs. Overall, there is a dearth of research on the sexual health outcomes of marginalized youth; therefore it is important to note that a lack of documentation of a disparity does not mean it does not exist.

While the Table clearly illustrates that there is substantial overlap in the disparities experienced by these subpopulations, this does not mean that the same approach can be used with each subpopulation in an attempt to eliminate them. It is important to simultaneously recognize the unique and overlapping circumstances and risk factors that each of these populations experiences in order to eliminate the sexual health disparities documented.

Introduction

by L. Kris Gowen, PhD, EdM



TABLE 1. Summary of sexual health disparities of disenfranchised youth								
Populations ▶ Sexual Health Attributes ▼		Youth in Corrections	Youth with Developmental Disabilities	Youth in Foster Care	Homeless Youth	LGBTQ Youth	Youth with Mental Health Conditions	Youth who have Experienced Sexual Abuse
Lower incidence than general population	Birth Control Use	■						
	Condom Use	■			■	■	■	■
Higher incidence than general population	Multiple Sexual Partners				■	■		
	Pregnancy Involvement	■	■	■	■	■	■	■
	Sexual Abuse	■	■	■	■	■	■	■
	Sexual Activity	■		■	■	■		
	STI Rates	■	■	■	■	■	■	■
	Substance Use During Sex	■				■		
	Survival Sex				■	■		■
	Dating Violence					■		
Earlier than general population	Age of Sexual Debut	■	■	■	■	■		

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The Sexual Health of Adolescents Involved in Corrections

by Celeste Moser, MA

This research brief on the sexual health of youth involved in corrections is part one of a seven-part series on sexual health disparities of marginalized youth.

Introduction

Many adolescents involved in corrections engage in risky sexual behavior, which makes this population vulnerable to sexually transmitted infections (STI), HIV/AIDS, and unintended pregnancies. Studies have shown that detained youth: (1) initiate sexual activity at earlier ages;^{1,2} (2) have more partners;² and (3) use condoms less reliably and consistently than non-detained youth.³

Sexual Activity

In a sample of male and female detainees aged 11 to 18, approximately 89% engaged in sexual activity with the mean age of sexual initiation for vaginal sex being 13.2 years; females (68.1%) were more likely than males (31.9%) to have not used condoms in the month preceding detainment.² In a similar study of detained urban youth aged 10 to 18, more than 90% of the males and 86% of the females were sexually active; 60.8% of males and 26.3% of females had had more than 1 sexual partner in the last 3 months; and females (41.3%) were more likely than males (35%) to have had unprotected sex in the month prior to detainment.⁴



Pregnancy

In a representative sample of adolescents involved with the Dane County, Wisconsin, juvenile justice system, 27% of participants reported that they had been involved with a pregnancy; and, of those, 36% reported that they never use birth control, 44% reported that they inconsistently do, and only 20% reported that they always use birth control.¹

STIs

Teens and young adults in the United States have the highest rates of STIs of any age group, and the most commonly reported STIs are chlamydia and gonorrhea.⁵ In 2009, 0.74% of young men and 3.3% of young women in the United States aged 15 to 19 reported chlamydial infections, and 0.25% of young men and 0.57% of young women reported gonorrheal infections.⁵ However, rates of STIs among detained youth are considerably higher.^{6,7,8} In a recent study, researchers examined the prevalence of chlamydia and gonorrhea in fourteen juvenile detention centers across the United States and found that 15.6% of female detainees and 5.9% of male detainees tested positive for chlamydia; 5.1% of females and 1.3% of males tested positive for gonorrhea; and of the participants who tested positive for gonorrhea 54% of females and 51% of males were co-infected with chlamydia.⁷ Another study of detained youth aged 13 to 18 found that 14% of detained youth tested positive for an STI. Additionally, females were almost three times more likely than males to test positive, and African-American youth were twice as likely as Caucasian youth to test positive.⁶ Katz et al. noted that STI screening is not routinely practiced in jails and juvenile detention facilities.⁸ In Oregon, detained youth do have access to HIV and other communicable disease testing.⁹ However, evidence supports the need for increased national HIV and STI screening and prevention efforts among detainees, especially females.

Factors that can Impact Risky Sexual Behavior

It has been well documented that detained adolescents are disproportionately affected by poor sexual health. Many factors appear to be related to these increased sexual risks: drug use, depressive symptoms, gang involvement, exposure to community violence, and sexual abuse. Research has shown that, among male detainees, marijuana use,^{10,11} but not alcohol use¹¹ is directly associated with risky sexual behavior. However, among detained females, both methamphetamine and alcohol use has been found to be associated with increased likelihood of STI diagnosis. Researchers found that incarcerated female adolescents with a diagnosed STI who reported inconsistent condom use had over twice the odds of methamphetamine use compared with consistent condom users. In addition, those who reported alcohol use had twice the odds of methamphetamine use.¹²

Substance use coupled with psychological distress can have a negative impact on detained adolescents' sexual health. In a community-based sample of adolescents who had an arrest history, participants who had clinically significant levels of depressive symptoms reported significantly greater drug and alcohol use, greater substance use during sex, and a lower rate of condom use when compared to their peers with no depressive symptoms.³

Gang involvement appears to be another predictive factor related to risky sexual behavior among detained adolescents. For example, a sample of male adolescent detainees who reported gang membership, compared to their peers with no gang involvement, were 5.7 times more likely to have had sex; 3.2 times more likely to have impregnated someone; and were almost four times more likely to have been high on alcohol or other drugs during sexual intercourse, have had sex with a partner who was high on alcohol or other drugs,



or have had sex with multiple partners concurrently.¹³ Similarly, Voisin and colleagues found that community violence exposure was significantly associated with drug and sexual risk behavior among detained youths.¹⁴ In addition, researchers found that community violence had a significant, positive, direct relationship to both lifetime gang membership and risky sexual behavior. In a longitudinal study of incarcerated male juvenile offenders in Oregon, 28.3% of participants reported fatherhood before their 20th birthday with gang involvement being the highest predictive value of fatherhood.¹⁵

There is evidence that girls in the juvenile justice system have high rates of past sexual abuse. In a sample of detained female adolescents, 32% reported experiencing sexual abuse. In addition, girls who experienced sexual abuse, compared to those who did not, had more negative mental health, school, substance use, risky sexual behavior, and delinquency outcomes.¹⁶

It is important to note that during the time youth are incarcerated their sexual activity tends to decrease. In a sample of African-American males

aged 12 to 18 who were involved with the juvenile justice system, participants who were living in a facility reported a relatively low level of sexual activity and a decreased number of partners compared to youth who were living at home.¹⁷

Reducing Risk Factors

The literature suggests that youth involved with the juvenile justice system could benefit from sexual education and prevention programs. As noted above, detained youth report earlier sexual debut when compared to non-detained youth;¹⁸ therefore, these young people could benefit from learning about safer sex practices at an earlier age in the classroom, detention center, and/or at home. However, Malow and colleagues point out that many juvenile offenders do not regularly attend school, and are likely to miss sexual education and STI/HIV prevention lessons that are provided in the classroom.¹⁹

Positive gains have been made in HIV/STI risk reduction interventions aimed at detained youth that have used either a comprehensive family-based approach, with the primary focus being on the youths' interactions and relationships within their family as well as their community,¹⁷ or a theater-based approach that uses theatrical performances, games and role-playing exercises.²⁰

A youth's stay at a detention center could provide a valuable opportunity for sexual education and/or health intervention.²¹ Sexuality education curricula for this population could be enhanced by including topics such as intimacy, communication, assertiveness, gender role expectations, and problem solving, in addition to the more common topics of reproductive anatomy, physiology, and contraception.¹

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How Developmental Disabilities Impact the Sexual Health of Young Adults

by Matthew Deschaine, MSW

This research brief on the sexual health of youth with developmental disabilities is part two of a seven-part series on sexual health disparities of marginalized youth.

Introduction

A review of available literature indicates that the romantic functioning, sexual behavior and sexual health outcomes of young adults with developmental disabilities (DD) have been understudied. However, the limited available research underscores a number of significant sexual health disparities, including unplanned pregnancy, sexually transmitted infection (STI) rates, and prevalence of sexual abuse that negatively impact the quality of life for this population. The presence of these disparities indicates that a better understanding of the relationship between the societal, psychosocial and educational barriers to sexual health of young adults with DD is warranted.

Sexually Transmitted Disease and Unplanned Pregnancy

A variety of factors place young adults with DD at greater risk for acquiring an STI, including a lack of knowledge about sexuality and safe sex strate-



gies, difficulty with abstract thinking and medical terminology, and trouble relating health information to their own life experiences. In a nationally representative sample of middle and high school age youth (7th to 12th graders),† the association of low cognitive ability with increased risks of STI among adolescent boys and girls were found to be substantial. These findings indicated that 8% of adolescent male participants with low cognitive ability had been exposed to an STI, as compared to only 3% of males with average intelligence; for adolescent females who were sexually active, 26% of the cognitively impaired reported having an STI, a sharp contrast to 10% of adolescent females with average cognitive ability.¹ The same study found that nearly 40% of cognitively impaired teenage girls had become pregnant—more than double the 18% rate of teenage girls without a mental disability.

With respect to the incidence of unplanned pregnancy, scant data exists on the frequency of pregnancy among adolescents and young adults with developmental disabilities.² A recent study using data from the National Longitudinal Study of Youth suggests that young women with low cognitive functioning are at increased risk for early sexual activity and early pregnancy.³

Sexual Assault and Abuse

One of the most pronounced sexual health disparities for young adults with DD is their heightened vulnerability to sexual assault and abuse.^{4,5,6,7,8} Studies provide evidence that nearly 80% of women with developmental disabilities have been sexually assaulted at some point in their lives.^{9,10} According to a report by the Center for Policy and Partnerships Institute for Child Health Policy, youth with serious physical and/or developmental disabilities are four times more likely to be sexually abused or exploited than those without

disabilities (Shapland, 2000). Statistics gathered from a group of sexual assault treatment centers and disability advocacy groups showed that more than 80 percent of women with DD had been sexually assaulted in their lifetime.¹² Drawing from the same sample, it was also found that of those women with DD who had been sexually assaulted, nearly 80 percent had been assaulted more than once and 50 percent had been assaulted ten or more times. (The study is limited by the use of convenience sampling, where the 162 participants were selected on the basis of their availability, and the accuracy of reporting by agency and advocacy staff.)

It has been suggested that since many offenders are family members or caregivers (including medical providers), victims with DD are less likely to flee from the attack or report the abuse for fear of reprisal, loss of service, or inability to properly communicate the nature of the assault; this may increase the chances that youth with developmental disabilities may be re-victimized.¹³ Young adults with DD are not often taught to question care providers who perform personal procedures inappropriately. Some young adults report feeling that they have no control over their bodies because of their dependency on having these procedures done routinely.¹⁴ One study found that 44 percent of all offenders against people with disabilities made initial contact with their victims through the network of medical, educational and residential services provided to people with disabilities.¹² Other factors that increase the risks of victimization and revictimization include: the presence of multiple caregivers, care provided outside the family home, shared care facilities, a continuing need for intimate care, and sensory impairment.¹⁵

Stigmatization and Sexual Health Education

Young adults with DD comprise a diverse popula-

† The mean age of adolescents with low cognitive abilities was 16.7 years.



tion that includes persons with chronic cognitive, physical, psychological, sensory or speech impairments. Historically, this population has not been afforded the same sexual rights and freedom as those in the general population, despite the same human need for love, affection, and fulfilling interpersonal relationships. Restrictions on sexual activity have been based on the false and often contradictory belief that persons with DD are either asexual or sexually aggressive, in the case of males; promiscuous, in the case of females; or too “childlike” to maintain healthy intimate relationships of their own.^{16,17,18,19}

Research suggests that this tendency to “desexualize” or downplay the sexuality of young adults with developmental disabilities has increased the health risks of this population by limiting their access to sexual health information, reproductive healthcare and counseling.²⁰ In public education settings, students with DD are often systematically excluded from instruction on topics such as contraception, family planning, sexual dysfunction, and the prevention of STI and AIDS/HIV. Moreover, instruction on healthy sexual relationships and the prevention of sexual abuse and exploitation has been largely absent from the health curriculums

designed for students with DD. There is evidence that persons with DD are at times deliberately misinformed about sexuality in order to discourage exploration of sexual and romantic relationships.²¹

With respect to the attitudes of parents and caregivers, sexual health education has often been circumscribed for fear that discussion of sexuality will increase the likelihood of sexual activity, inappropriate sexual behavior or exposure to sexual abuse.^{7,22,23,24} Parental concern about sexual abuse and exploitation is well founded, yet the decision to prioritize safety over sexual education has left young adults uninformed about the relationship between healthy sexuality and their disability,²⁵ which has paradoxically left them more vulnerable to exploitation.

In summary, young adults with developmental disabilities face myriad challenges when it comes to establishing healthy sexual practices and intimate relationships. At the center of these challenges are the issues of stigmatization, social isolation and limited access to population-specific sexual health information. Though a definitive link has yet to be established in the research, the presence of significant sexual health disparities, including elevated

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rates of sexual abuse, STI, and unplanned pregnancy, indicates that current health promotion strategies—as influenced by negative social attitudes—do not provide young adults with DD with the resources to make informed decisions regarding their sexual health and safety. Better instruction in sexual abuse prevention, family planning and contraception is therefore vital to the sexual health and social development of this population as they make the transition to adulthood.

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The Sexual Health and Risk Factors of Youth in Foster Care

by Maya Rowland, MPH

This research brief on the sexual health of youth in foster care is part three of a seven-part series on sexual health disparities of marginalized youth.

Introduction

In 2006, 16,142 children and youth were served by foster care programs in the State of Oregon, 27.4% of whom were youth aged 13 or older.¹ Foster youth have higher rates of risky sexual behaviors and negative sexual health outcomes than youth overall. Youth in foster care are more likely to have had sex and become sexually active at an earlier age than their peers of the same age; 90% of 19-year-olds in foster care have had sex, compared with 78% of their 19-year-old peers,² and 20% reported having consensual sex before the age of 13.³ They are, on average, 7.2 months younger than their peers at first intercourse.⁴ One quarter of foster youth report being tested or treated for an STI, more than four times the national average.⁵ Rates of teen pregnancy are high among youth in care; 26% of female foster youth report being pregnant before the age of 17, and 48.2% become pregnant by age 19,² compared to a 7% pregnancy rate for teens 15-19 years overall.⁶ Over half (51.7%) of pregnant foster youth carry the pregnancy to term.²



Risk Factors Before Entering the Foster Care System

While all youth experience some combination of protective and negative antecedents to their sexual development, it is very likely that youth who are, or have been, in foster care experience more negative antecedents than others. Many of these factors impact a child or young person before they have been placed into care. Compared to youth in the general population, youth in care are statistically more likely to have lived in a community with a high unemployment rate and low educational level, to have experienced a change in their



parents' marital status; and to have mothers who were teen parents themselves. A youth in foster care is also more likely to be a youth of color. Foster youth are more likely to use substances or be diagnosed with a mental health disorder. One quarter of youth in care have experienced sexual abuse.⁷ This is higher than the rates of sexual abuse in the United States overall, which are reported to be 16.8% for girls and 7% for boys.⁸ Several studies have found that experiencing any type of abuse is highly predictive

of negative outcomes. While exact numbers vary, approximately 30% of youth in care have experienced physical and/or sexual abuse and 70% have been neglected by their parents.^{4,9,7} This is in stark contrast to the less than 2% of children and youth in the general population who have experienced abuse or neglect (excluding sexual abuse).¹⁰ According to a study in 2007 by Doug Kirby, all of the above are negative antecedents predictive of risky sexual behavior and negative sexual health outcomes.

Risk Factors Within the System

In addition to the factors that precede entry into care, foster youth experience risk factors while in care that may also lead to negative sexual health outcomes. These include lack of policy or guidance for caregivers, lack of accurate information for youth, and instability. Very few states have any policies regarding the sexual health of youth in foster care.⁴ Care providers, such as social workers or Independent Living Providers, may not feel comfortable providing information about sexual health for fear of retribution, lack of training/knowledge, and/or lack of policy guidelines as to how to approach the topic.⁷ Some provider agencies that do have policies may not allow staff to discuss certain sexuality issues with youth in their care due to their religious or political foundations.

For youth in care, instability is a constant. On average, children and youth are in care for 31 months and have three different placements, although some youth have as few as one placement, and other youth experience many more.¹¹ Due to these placement changes, youth may have multiple social workers, and attend multiple schools in a variety of locations. Short term relationships with foster parents, teachers, and other caregivers may result in few adults feeling comfortable ad-

discussing sexuality with youth. Youth may feel uncomfortable discussing sexual health with adults they have only known a short time. Some youth report that none of their foster parents or other caregivers have ever discussed sexual health with them.¹²

Instability in placements can result in a youth missing the sexuality education offered during school. Timing is a crucial element of an effective sexuality education curriculum; lessons are timed in accordance with the average skill level and experiences of students. For youth in care who may have an earlier sexual debut or experiences with abuse, standard sexuality education curricula may be offered too late to resonate, or may not be reflective of their experiences. Despite this, to date there has been only one sexual health curriculum, "Power Through Choices," developed specifically for the needs of youth in care,⁹ and it is no longer readily available.

Lesbian, Gay, Bi-Sexual, Transgender and Questioning (LGBTQ) youth are overrepresented in the foster youth population. Some youth report being in foster care because of their sexual orientation.¹³ Adults working with foster youth should ensure that materials developed for youth and interactions with youth are inclusive of this population. Please refer to the research brief titled "The Sexual Health of Lesbian, Gay, Bisexual, Transgender, and Questioning Youth," on page 19 of this publication for further information on the needs of LGBTQ youth.

According to a study by Love, et al.,⁷ female youth in care may have different motivations for having sex and becoming pregnant than other youth. The youth stated that they wanted to become pregnant to create a permanent family, to have someone to love, or to demonstrate that they can be better parents than they had themselves. In addition, due to personal experiences with abuse and neglect youth may seek different types of re-

lationships than their peers. Caregivers and adults should note that this population is particularly at risk and in need of trustworthy adults to talk to about their concerns and health needs, and also in need of accurate information offered frequently that addresses their specific needs and circumstances. Improved understanding is needed to inform policies and programs to improve sexual health outcomes for youth in foster care.

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The Sexual Health of Homeless Youth

by Abby Bandurraga, MSW

This research brief on the sexual health of homeless youth is part four of a seven-part series on the sexual health disparities of marginalized youth.

Introduction

It is estimated that between 1.6 and 2.8 million youth between the ages of 13-21 are homeless at any given time in the United States.¹ These youth are often sharing houses with non-family members, sleeping in public or private non-residential spaces, or using emergency shelters and/or sleeping outside in the elements. Pathways into homelessness for youth vary and can include: running away from abusive living situations; being kicked out by their families; or youths' families becoming homeless.² This article reports on the sexual health behaviors of homeless youth and various subgroups of homeless youth.

Homeless youth have fewer personal and social resources than their in-home peers and less access to health care services³ and this is reflected in their health outcomes. Homeless youth experience poorer health outcomes, including increased trauma and higher rates of physical and sexual abuse, as well as substance abuse.¹ Homeless youth are more likely to have earlier onset of sexual activity, to have multiple sex partners, and to have higher incidences of sexual risk



behaviors, including engaging in survival sex and inconsistent condom usage.² Pregnancy and sexually transmitted infection (STI) rates are higher for homeless youth, as they are more likely to have frequent, unprotected sex and to be sexually exploited.¹ Pregnant homeless youth are more likely to face poor pregnancy and parenting outcomes than other adolescents and adult women.⁴

Sexual Behaviors and Outcomes

Several factors influence the sexual health behaviors and outcomes of homeless youth, including: duration of homelessness, gender, and sexual orientation. Chronically homeless youth (those who have been out of home for over 12 months) have greater knowledge about AIDS than youth who have been homeless for less than six months.³ This may be due to the fact that chronically homeless youth have more encounters with street outreach programs and other services that provide HIV/AIDS information. Despite this knowledge, chronically homeless youth engage in more sexual risk taking behaviors and have a lower incidence of safer sex (e.g. using protection and/or avoiding bodily fluids) than youth who have been homeless less than six months.³ These findings suggest a possible benefit to providing accessible sexual health information to newly homeless youth and working to transition them off the streets within six months.

Additional findings indicate that, regardless of how long a youth has been homeless, females are significantly more likely to practice sexual self-care (e.g. seeking help for STIs), to use assertive communication with their sexual partners around condom use, and to practice safe sex than males.³ Despite these sexual health seeking behaviors, homeless young women still experience STI rates that are significantly higher than those of homeless young men (see below) which may be due to the fact that homeless females are more likely to experience sexual victimization and to engage in

survival sex with older partners in order to ensure their safety and protection.⁵

A study of sexual health behaviors in newly homeless youth (those homeless for more than a day and less than six months) also found that predictors of sexual health differed for males and females.⁶ For young men in this study, living out-of-home predicted a greater likelihood of having multiple sex partners than living with family members or in institutional settings. Living out-of-home and engaging in substance use also predicted lower condom use for homeless young women than those who lived with family members or in institutional settings.⁶

Likelihood of engaging in survival sex (sex in exchange for money or other goods to meet subsistence needs) was shown in one study to be predicted by length of time spent on the street. In a study by Greene and colleagues, over 27 percent of a sample of 631 homeless youth reported having engaged in survival sex,⁷ and youth who had been homeless for over a month were significantly more likely to report having had survival sex. Five percent of youth living in shelters and nine percent of youth on the street who had been homeless for less than a month reported having survival sex. Of the youth who had been homeless for more than a month but less than a year, nearly 12 percent of shelter youth and 25 percent of youth on the street reported engaging in survival sex. Finally, of the youth who had been homeless for over a year, 18 percent of youth living in shelters and 37 percent of youth on the street reported having survival sex.

Greene and colleagues also note that gender and ethnicity played a role in risky sexual behaviors. In this study, youth receiving shelter services were more likely to have had survival sex if they were White, male, or had multiple experiences being homeless.⁷ Tyler, et al.,⁵ studied the role of gender in sexually transmitted infection (STI) rates in homeless youth being treated for substance

abuse issues. In this study of 370 homeless 16- to 19-year-old youth in the Midwest, 21 percent reported having contracted an STI. In contrast to the findings by Greene and colleagues, this study found that homeless females were three times more likely to have contracted an STI than homeless males. Additionally, homeless Black youth of both genders were four times more likely than homeless White youth to have contracted an STI.⁵ Finally, these youth reported experiencing homelessness an average of eight times, and the authors found that for every instance of being homeless, a youth's chance of contracting an STI increased by three percent. The STI estimates in this study may be low due to a tendency for all youth to underreport STI status, and due to homeless youths' lack of access to health care.⁵ Other authors have noted that accurately assessing STI numbers in homeless youth and identifying causal relationships is limited by relying on self-reporting. Additionally, it is possible that homeless youth who are less likely to regularly use condoms may be less likely to seek medical help for STIs, and thus may have no diagnosis of STI to report despite their actual STI history.²

LGBT Homeless Youth

Homeless lesbian, gay, bisexual, and transgender (LGBT) youth are more vulnerable to risky sexual health behaviors and negative sexual health outcomes than their heterosexual peers.⁸ The few studies that have examined the differences between LGBT and heterosexual homeless youth and their sexual health behaviors have found that LGBT youth left home more often; were sexually victimized more often; had higher lifetime sexual partners and earlier onset of sexual intercourse; and reported higher rates of unprotected sex.⁹ In addition, lesbian, gay, and bisexual (LGB) youth were more likely to report that they had engaged in survival sex and to have higher HIV risk than their heterosexual peers.⁸ Homeless gay and lesbian youth were more likely to report being diag-

nosed with HIV and to be receiving HIV treatment than either their bisexual or heterosexual counterparts and LGB youth reported higher incidences of all STIs.¹⁰

Interventions

Intervention strategies for helping homeless youth vary widely, with few being rigorously evaluated for their effectiveness in improving outcomes.¹¹ Yet, new and novel interventions are emerging in this field. A recent study¹² that examined associations between internet use and social networking among homeless youth and their impact on sexual health found that using the internet and social media for the purpose of finding a sexual partner or to talk about drugs increased sexual risk taking. However, when social media was used by youth



to discuss love and safe sex, youth reported having greater HIV knowledge and less engagement in exchange/survival sex.¹² Homeless youth who remained connected to family members via the internet and social media sites were less likely to engage in exchange sex and more likely to have been tested for HIV, while those who communicated largely with street peers online had higher rates of participating in exchange sex.¹³ As a surprisingly large number of homeless youth, an estimated 96 percent, frequently access the internet,¹² these findings suggest the potential for developing novel intervention strategies using the internet and so-

cial media to deliver interventions for homeless youth.

Conclusion

Given the prevalence of risky sexual health behaviors among homeless youth and the degree to which predictors of sexual health vary between subpopulations of homeless youth, it is clear that sexual health interventions with homeless youth should be tailored to address duration of homelessness, gender, and sexual orientation. In addition, these interventions need to be evaluated using rigorous methodology in order to establish greater understanding about effective interventions that improve sexual health behaviors and outcomes for homeless youth.

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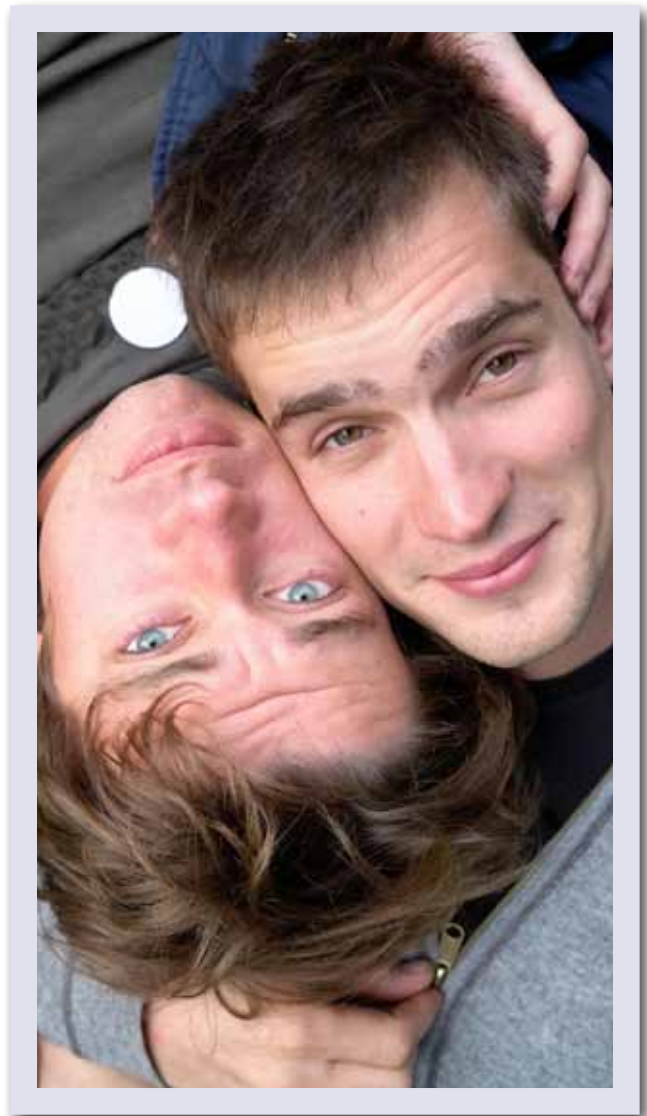
The Sexual Health of Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

by L. Kris Gowen, PhD, EdM

This research brief on the sexual health of lesbian, gay, bisexual, transgender, and questioning youth is part five of a seven-part series on the sexual health disparities of marginalized youth.

Introduction

Although persons of different sexual and gender orientations often get grouped together under the term “LGBTQ” (for lesbian, gay, bisexual, transgender, and questioning), it is important to distinguish between subpopulations based on sexual vs. gender orientation. A person’s sexual orientation is the gender to which a person is emotionally, romantically, and sexually attracted. Gender identity is how a person self-identifies as a particular gender regardless of biological sex characteristics. “Transgender” describes persons who are born a certain sex, but identify with, and consequently wish to live as, a different gender than the sex their anatomy dictates. According to data from the 2009 Oregon Healthy Teens survey, 5% of 11th graders identify as being lesbian, gay, or bisexual, and another 2.3% report being “unsure” of their sexual orientation (i.e., questioning); almost 10% of female and 5% of male 11th graders report





same-sex sexual experiences.¹ The prevalence of transgender or gender non-conforming youth is unknown.

Health disparities among LGBTQ persons have received more public health attention in recent years. The Healthy People 2020 objectives, which set the federal government’s national goals for health, includes a goal to “improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender (LGBT) individuals.”² In 2011, the Institute of Medicine released a consensus report that highlights the health status of persons of different sexual and gender orientations.³ However, both of these initiatives acknowledge the lack of data to inform this topic, especially regarding the health of transgender persons.

What little is known about transgender youth comes from two studies concerning female transgender (i.e., biologically male persons liv-

ing as female) youth, many of whom were living on the street; these studies relied on convenience samples from urban areas, so results should be interpreted with caution. These studies found that the majority (59-67%) of female transgendered young persons have engaged in sex work, and approximately 20% are HIV positive.^{4,5,6} Homelessness, the use of street drugs, and lower perceived social support were associated with a higher likelihood of engaging in sex work.⁵ Approximately one-third of participants report not using condoms consistently during

receptive anal intercourse with casual and commercial partners; less than half consistently use them with a main partner;^{4,5,6} rates of unprotected sex are even higher for ethnic minority transgender women. Rates of alcohol and substance use during sex were also high (40-50%) in this population.

There is better, though still limited, evidence that LGB youth experience sexual health disparities when compared to their heterosexual counterparts. For example, LGB youth are more likely to report being sexually active, and report earlier initiation of sexual intercourse than heterosexual youth.^{7,8,9} LGB youth are also more likely than heterosexual youth to have had sex with higher numbers of sexual partners,^{10,7,8,9} and to have been under the influence of alcohol or other drugs the last time they had sex.^{10,11,9} A 2011 Center for Disease Control and Prevention study used results from nine regions† in the United States to compare the

† CDC included data from youth participants in five states (Delaware, Maine, Massachusetts, Rhode Island, and Vermont) and four large urban school districts (Boston, Massachusetts; Chicago, Illinois; New York City, New York; and San Francisco, California) in its analyses.

sexual health of lesbian/gay youth, bisexual youth, and heterosexual youth (see Table 1). The disparities found in previous research were confirmed. Additionally, the CDC report found great disparities in the amount of dating violence experienced by LGB youth, with approximately 1 in 4 stating that they had been physically hurt by a partner on purpose. Data from the 2007 Oregon Healthy Teens survey also found that LGB youth were significantly more likely to be physically hurt by their partner than heterosexual youth (16% vs. 6%).¹²

Perhaps counter-intuitively, there is evidence that LGB youth are more likely to be involved in a pregnancy than heterosexual youth.^{10,8,9} This may be due to the fact that LGB youth are less likely to use condoms and other forms of birth control than heterosexual youth when engaging in vaginal intercourse.^{13,8,11,9} Sexual orientation is often inconsistent with the sex of sexual partners among youth.^{12,8,11}

Additionally, some disparities have been found in certain subpopulations of LGB youth. Young men who have sex with men (MSM) are disproportionately affected by HIV infection; this is especially true for young men of color. Of all age groups of MSM, HIV/AIDS cases increased most among those aged 13–24. Young black MSM had the most dra-

matic increase in diagnoses—an increase of 93% from 2001-2006.¹⁴ Some research has indicated that bisexual youth and youth who have had sexual experiences with persons of both sexes may be particularly impacted by sexual health disparities such as earlier onset of sexual intercourse, having more sexual partners, higher rates of substance use during last sex, experiencing sexual violence, and being involved in a pregnancy.^{13,8}

While it is important to document the sexual health disparities of LGB youth, it is equally important, if not more so, to determine the reasons underlying these disparities. Previous research has found that LGB youth are more likely to have experienced physical and sexual abuse as children, and that these experiences contribute to the likelihood of poorer sexual health outcomes.^{15,16,9} Discrimination and higher levels of violence and harassment due to one’s sexual orientation, and lack of supportive resources also predict poorer sexual health outcomes,⁹ along with lower self-esteem and higher levels of anxious symptoms.¹⁵ Predictors, however, may vary across ethnicities.^{17,18}

Solutions to improving the sexual health outcomes of LGBTQ students include increased prevalence and support for Gay-Straight Alliances and community support groups,¹⁹ working with families

TABLE 1. Differences in sexual behaviors among gay, lesbian, bisexual, and heterosexual youth¹³			
	US Gay/Lesbian Youth	US Bisexual Youth	US Heterosexual Youth
Had sexual intercourse before age 13	19.8%	14.6%	4.8%
Had sexual intercourse with 4 or more persons	29.9%	28.2%	11.1%
Sex in the past 3 months	53.2%	52.6%	32.0%
Substance use before last sex	35.1%	29.9%	18.7%
Experienced dating violence	27.5%	23.3%	10.2%

of LGBTQ youth to increase their acceptance of their child's sexual and/or gender identity,²⁰ and providing LGBTQ-sensitive sexuality education.^{10,21} Research has found that LGB youth are less likely to receive HIV/AIDS education than heterosexual youth.¹³ Oregon has recently recognized the need to provide LGBTQ inclusive sexuality education; in 2009, legislation was passed that mandated schools provide sexuality education that is "inclusive" of youth of all sexual and gender orientations. While Oregon leads the United States in creating such sexuality education regulations, the impact of this policy has not been studied. The lack of evidence-based sexuality education curriculum that addresses the needs of LGBTQ youth may impede implementation of this law.

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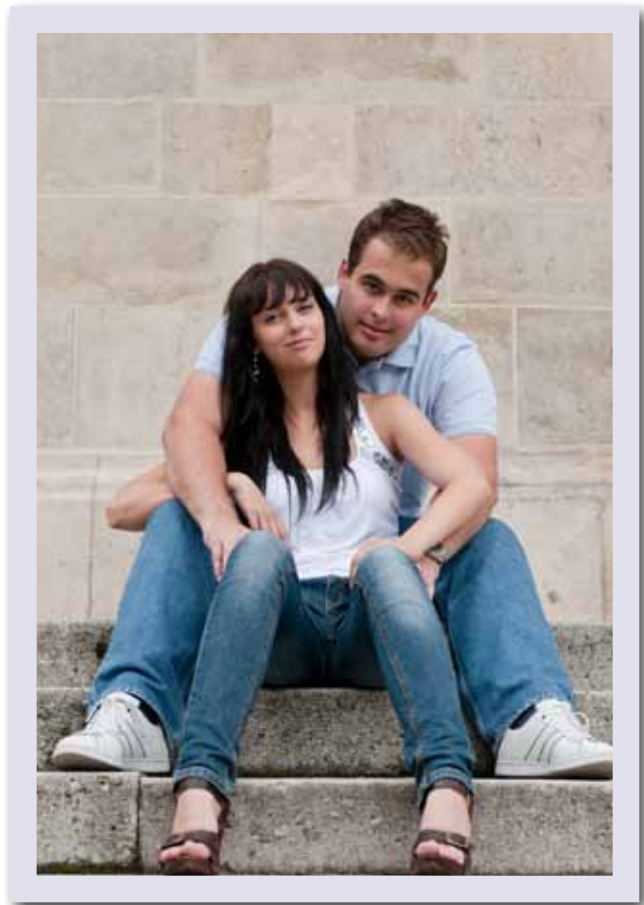
How Mental Health Challenges Impact the Sexual and Relational Health of Young Adults†

by L. Kris Gowen, PhD, EdM

This research brief on the sexual health of youth with mental health conditions is part six of a seven-part series on the sexual health disparities of marginalized youth.

Introduction

Little is known about the sexual and romantic relationships of young adults with serious mental health conditions (SMHC), despite the fact that there is evidence that this population is disproportionately affected by poor sexual health; what little research there is, shows that rates of risky sexual behavior and negative sexual outcomes in young adults with SMHC are especially high. In a representative sample of middle and high school students, depressive symptoms in males were associated with not using a condom during last sex; in females these symptoms were associated with having an STI.¹ Among a group of 21-year-olds, those diagnosed with a serious mental illness were more likely to report having sex without a condom and a lifetime history of STIs when compared to



† Adapted with permission from Gowen, L. K. (2011). *How mental health challenges impact the sexual and relational health of young adults. Focal Point: Youth, Young Adults & Mental Health: Healthy Relationships, 25, 15-18.*

those without mental illness; young adults with a mental health diagnosis *and* a substance use disorder were even more likely to have unprotected sex and history of STIs.² In a community sample of late adolescent women (ages 16-19), higher rates of unwanted pregnancy were associated with higher scores on a measure of bipolar disorder.³ A major limitation to this research is that it is correlational. Therefore, it remains unclear as to whether mental health status causes risky sexual behavior, risky sexual behavior has a negative impact on mental health, or some other factor(s) impacts both.

Factors Influencing The Relationship Between Mental Health And Risky Sexual Behavior

Given the association between SMHC and risky sexual behavior, it is important to understand why these two characteristics might be related. Several factors may play a role in the association between SMHC and risky sexual behavior. It is possible that young persons with SMHC have been exposed to traumatic and/or abusive experiences in early childhood that may affect both mental and sexual health. It is well documented that a history of child abuse—especially sexual abuse—is associated with poorer mental and sexual health in adolescents and adults (see Maniglio, 2009 for a review).⁴

Internal and external stigmatization of mental health conditions may also provide barriers to healthy romantic relationships and associated sexual behaviors. Low self-esteem and high internal stigmatization in young adults with SMHC can lead to expectations of rejection and subsequent loss of confidence to fully participate in a romantic relationship. This perceived undesirability may result in a failure to advocate for safer sex practices, resulting from fear of disapproval or loss of a partner. Internal stigmatization may cause a person to “settle” for a partner that may not respect his or her sexual limits. For example, one study found that 20% of women with a serious mental illness had sex with people they didn’t like.⁵

Some mental health conditions, such as borderline personality disorder (BPD), are associated with impulsivity, poor decision-making, and unstable, intense interpersonal relationships. These symptoms can directly impact sexual behaviors and/or partner choice.^{3,6} For example, impulsivity in sexual decision making could reduce the odds of contraceptive use or safer sex planning. Insecure but intense relationships could cause a person with BPD to rush into a sexual relationship with someone for fear of otherwise losing them.

Issue of Silence

There are few opportunities for youth with mental health conditions to discuss and learn about their sexual health in a supportive environment. This population may lack basic education on pregnancy and STI prevention because parents and health care professionals potentially see these young people as vulnerable and in need of shelter and protection from sexual experience and/or potential heartbreak. Older people may also desexualize young persons with mental health conditions, or perceive them as not able to handle the responsibilities of sexual and romantic relationships. Inconsistent schooling due to health concerns and/or residential placement may cause young adults with SMHC to miss school-based sexuality education classes. However, the evidence points to the fact that young adults with SMHC do engage in all types of intimate relationships, and given the higher rates of negative outcomes they experience, appropriate education about how to maintain good sexual and relational health within this group is imperative. Young adults with SMHC need to be told by supportive adults in their lives (e.g., family members, caregivers, practitioners) that they are worthy of having a partner who cares about them; they are also worth advocating for when it comes to safer sex practices.

Yet even if mental health professionals were open to discussing sexuality with their clients, there is

evidence that they do not receive proper training. A study of staff at a residential treatment setting revealed that while the staff were confronted with many sexual issues at work from adolescent patients (e.g., residents “acting out,” history of sex abuse, lack of knowledge about sex among patients), there was little support for them to help residents address these issues. The vast majority of professionals (90%) reported interest in receiving additional training on sexual issues and how to handle them,⁷ yet a review of the top 20 social work graduate programs reveals that the 13 that do offer a course in Human Sexuality offer it as an elective only.⁸ Proper training of caregivers of young adults with SMHC in relational and sexual health needs to be addressed in order to see improvements in the sexual health outcomes in this population.

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The Sexual Health of Youth who Have Experienced Sexual Abuse

by Maya Rowland, MPH

This research brief on the sexual health of youth who have experienced sexual abuse is part seven of a seven-part series on sexual health disparities of marginalized youth.

Introduction

Young people who have experienced sexual abuse are at risk for both short term and lifelong negative sexual health outcomes. Children or young people can experience sexual abuse at the hands of a family member (incest), or by someone outside of the family (nonfamilial abuse). It is estimated that 16.8% of girls and 7% of boys in the United States experience childhood sexual abuse; these numbers may be low due to underreporting.¹

Health Outcomes

Adolescents who have experienced sexual abuse are more likely than their peers to have been involved in a pregnancy, to have been tested and/or treated for an STI, and to have participated in risky sexual behaviors such as using substances before intercourse, not using contraception, and engaging in sex with multiple partners.²

Many studies of the sexual health outcomes of foster youth have explored the relationship between



sexual abuse and teen pregnancy.^{3,2,4} Consistently, the research has shown that both males and females with a history of sexual abuse have had higher rates of involvement with a pregnancy than those who have not reported abuse. According to one study, males with any abuse history were more likely than females to be involved with a pregnancy; depending on type of abuse history—incest, nonfamilial, or both—22-61% of males and 13-26% of females reported being involved with a pregnancy.² While the experiences of males are frequently ignored in research, it is becoming clear that the relationship between sexual abuse and sexual health is important to examine in males as well as females.

Young people who have experienced abuse are two times more likely to report being tested or treated for an STI than nationally representative samples of young people.² These impacts do not stop with adolescence and may continue throughout the lifetime of an individual who has experienced abuse. Adult victims of abuse were more likely to report having multiple STIs than their nonabused peers.⁵

Coping mechanisms for sexual abuse may put youth at increased risk for pregnancy or STI contraction. Youth experiencing sexual abuse may use or abuse substances in order to deal with their experiences, and may become dependent as a result.⁶ Youth who have experienced incest often run away from home to escape their experience. Running away from home and substance use are risk factors for unintended pregnancies and STI contraction. Additionally, sexual abuse is often associated with other familial issues such as substance abuse, domestic violence or physical abuse.⁷ These added stressors in the youths' homes may exacerbate the experience of abuse, or perhaps leave youth without role models who can help them to develop healthy coping mechanisms.

Sexual Risk Taking

Youth who have experienced abuse may take more sexual risks than their nonabused peers. Because of feelings of powerlessness and boundary violation, youth may find it difficult to communicate about their desire for sexual safety; according to one study, 40% of adolescent females who had



experienced sexual abuse reported never or rarely using a condom, whereas 30% of non-abused young women reported never or rarely using a condom.² Youth who have experienced abuse may run away from home to escape their abusive environment and may subsequently find themselves engaging in survival sex. Females who had experienced sexual abuse were found to have been 2.5 times more likely to have engaged in prostitution than those who had not.⁸

LGBTQ Youth

Sexual minority youth are more likely than heterosexual youth to report a history of abuse. This may be because their LGBTQ status can result in less protection from their families.⁹ More research is needed to better understand and support these populations in order to help them have safer and healthier sexual lives.

Adults working with children and youth of all genders and sexual orientations should be trained to screen for sexual abuse and be prepared to talk to a youth if they suspect that abuse is happening. Young people should hear that abuse is not their fault and learn about resources they can use should they experience abuse or know someone who is. The needs of youth who have experienced sexual abuse are also left out of many sex education curricula. While some curricula, such as FLASH[†], teach youth what abuse may look like and who to talk to about it, few discuss the needs of a young person who has a history of abuse. Sexuality education programs should acknowledge that some youth have experienced abuse, address their specific needs and suggest healthy coping mechanisms and resources for them. Programs and resources available to sexually abused young people should

be inclusive of and sensitive to the needs of all youth, including males and LGBTQ youth.

Conclusion

Sexual abuse can have short- and long-term effects that impact the physical, emotional, and mental health of an individual. More research is needed to identify the mechanism that leads individuals to abuse others and slow this cycle of violence and hurt. In the meantime it is vital that individuals who have experienced abuse are supported by their communities and have access to supportive resources that are equipped to address their needs.

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