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Meeting the Needs of Sexual and Gender Minority Youth: Formative Research on Potential Digital Health Interventions

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A B S T R A C T

Purpose: Sexual and gender minority youth (SGMY) have unique risk factors and worse health outcomes than their heterosexual and cisgender counterparts. SGMY's significant online activity represents an opportunity for digital interventions. To help meet the sex education and health needs of SGMY and to understand what they consider important, formative research was conducted to guide and inform the development of new digital health interventions.

Methods: Semistructured interviews, in-person focus groups, and online focus groups were conducted with 92 youths (aged 15–19 years) who self-identify as nonheterosexual, noncisgender, questioning, and/or have engaged in same-sex sexual behavior. Data were coded and analyzed using inductive thematic analysis.

Results: Thematic analysis revealed that SGMYs are often driven online by experiences of isolation, stigmatization, and lack of information and are looking for a supportive, validating community and relevant, accurate information. Gender minority youths felt that they faced a larger number of and more extreme incidences of discrimination than sexual minority youths. Most youths described interpersonal discrimination as having substantial negative effects on their mental health.

Conclusions: Any digital intervention for SGMY should focus on mental health and well-being holistically rather than solely on risk behaviors, such as preventing HIV. Interventions should include opportunities for interpersonal connection, foster a sense of belonging, and provide accurate information about sexuality and gender to help facilitate positive identity development. Content and delivery of digital interventions should appeal to diverse sexualities, genders, and other intersecting identities held by SGMY to avoid further alienation.

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IMPLICATIONS AND CONTRIBUTION

To address health disparities experienced by sexual and gender minority youth, sexual health and other digital health interventions must respond to youth's stated needs for resources that represent diverse identities, are comprehensive, that link mental health and sexual health, and are noncrisis oriented.

Research on sexual and gender minority youth (SGMY, nonheterosexual, and/or noncisgender) has been limited and should be bolstered to better understand sexual and gender minority (SGM) health through a life course perspective [1]. Existing research indicates significant disparities for SGMY compared with their heterosexual and cisgender peers in mental, physical, and sexual health outcomes [1–12]. Specifically, SGMYs are at higher risk of contracting sexually transmitted infections (STIs) and unplanned pregnancy than their heterosexual and cisgender peers [1,2,4,8,9,11,12]. Conducting research to inform and develop interventions to prevent, address, or reduce SGMY health disparities is a crucial area to pursue, and intervention research was identified as one of the

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five priority areas by the Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues [1]. A note on language: "SGM" and "LGBTQ" are often used interchangeably; SGM will be used here as it is more inclusive of emerging sexual and gender identities and more reflective of the diversity of identities in this study's sample.

Most of the research on negative health outcomes for SGM youths and adults links the stress of living as a minority in an unsupportive society (minority stress theory) to poor health outcomes [13–15]. Qualitative studies with SGMY have found that psychosocial and emotional well-being in teens and young adults is negatively impacted by lack of parental support, lack of SGM role models, reported and perceived instances of discrimination, internalized negative messages, and insecurity about identity [16–20]. Several studies link discrimination experienced by SGM individuals to lower educational attainment, lower socioeconomic position, decreased access to health care, and increased long-term health risks [3,13,21]. Current inequities and potential implications for future health and well-being make SGMY a vulnerable population in need of focused public health attention.

Digital resources

Emerging data on the ways SGMY engage online suggest that digital approaches are a promising avenue for delivering tailored health interventions. SGMYs are five times more likely to look for information about sexuality or sexual attraction online (62% vs. 12%) and four times more likely to have searched for information about HIV/AIDS and other STIs (19% vs. 5%) compared with their non-SGM peers [22]. SGMYs are also much more likely to have searched online for general health information (81% vs. 46%) [22]. To develop effective digital resources with the maximum potential to reach SGMY, it is necessary to better understand what young people want from digital interventions. The present study consists of formative, exploratory research conducted to assess the issues most important to SGMY and least met by existing resources to guide and inform the development of new, targeted digital health interventions. What experiences of SGMY drive them to seek online resources? What are the implications of SGMY experiences online for new resources?

Methods

Qualitative research was conducted with SGMY aged 15–19 years to inform the design, content, and delivery of digital health resources. The Planned Parenthood Federation of America (PPFA) contracted with the research firm Community Marketing & Insights (CMI) to develop the initial study design. CMI has been conducting research with SGM individuals since 1992. Under PPFA supervision, CMI's senior research director conducted participant recruitment, screening, and data collection and submitted deidentified data to PPFA. This research project was approved by the Chesapeake Institutional Review Board.

Four in-person focus groups, eight online focus groups, and 20 individual phone interviews were conducted with no participant overlap. Online focus groups used the web conferencing platform GoToMeeting (audio only). In-person focus groups took place at professional focus group facilities. Average length of interviews and focus groups were 45 and 90 minutes, respectively.

Recruitment flyers for in-person focus groups were distributed at SGM service organizations in Dallas, Texas, and in Seattle, Washington. Potential participants for the online focus groups and individual interviews were recruited from the existing CMI research panel and through targeted ads placed on Facebook and prominent SGM organization Web sites. CMI's research panel consists of 70,000 SGM community members, recruited through more than 300 events, media outlets, and nonprofit organizations.

Screening questions were completed by 1,400 potential participants; those who met the study criteria were contacted for a telephone interview before being accepted into the study. Eligibility criteria included youth aged between 15 and 19 years who self-identify as any nonheterosexual or noncisgender identity, are questioning, or who have had same-sex sexual experiences. One participant turned 20 between the time of screening and data collection; he was kept in the sample. Participants were excluded if they did not return telephone calls or emails, were unwilling to discuss study topics, or had scheduling conflicts. Informed assent (age: 15–17 years) and consent (18–19 years) was obtained from all participants. Parental permission was not sought, given that youth may not be out to their families, may not receive support from their families around sexual or gender identity, and because youth are able to consent for sexual health services at these ages.

Ninety-two participants were included in the study. Final participant selection was partially in pursuit of demographic diversity. There was attention paid to including a balanced mix of participant experiences to ensure that the conversations did not focus solely on those with extremely negative or extremely positive experiences. Groups were divided by gender identity and age. Two in-person focus groups were conducted in Dallas and two in Seattle with between five and 10 participants per group (n = 30). Eight online focus groups were conducted with between two and seven participants per group (n = 42). Twenty individual telephone interviews were conducted with participants from across the United States. Participants were given $60 (online focus groups) or $75 (interviews and in-person focus groups) incentives via check or gift card in exchange for their participation. See Table 1 for participant demographics.

Data collection

Semistructured interview and focus group guides helped facilitate broad discussion of main concerns for SGMY, available support from friends and family, coming out, and sexual, mental, and physical health habits. Participants were asked about their online behavior and preferences and suggestions for the development of digital resources for SGMY. Data collection was stopped after achieving data saturation. All interviews and focus groups were recorded and transcribed; transcripts did not include personal identifiable information.

Data analysis

Data were analyzed using a general inductive approach to find and clarify patterns and themes from the data [23]. Through

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