

2016

Nurse Practitioners' Discussion Of Sexual Identity, Attraction And Behavior

Sarah J. McLaughlin
University of Vermont

Follow this and additional works at: <http://scholarworks.uvm.edu/graddis>

 Part of the [Lesbian, Gay, Bisexual, and Transgender Studies Commons](#), [Medical Sciences Commons](#), and the [Nursing Commons](#)

Recommended Citation

McLaughlin, Sarah J., "Nurse Practitioners' Discussion Of Sexual Identity, Attraction And Behavior" (2016). *Graduate College Dissertations and Theses*. Paper 443.

This Thesis is brought to you for free and open access by the Dissertations and Theses at ScholarWorks @ UVM. It has been accepted for inclusion in Graduate College Dissertations and Theses by an authorized administrator of ScholarWorks @ UVM. For more information, please contact donna.omalley@uvm.edu.

NURSE PRACTITIONERS' DISCUSSION OF SEXUAL IDENTITY,
ATTRACTION AND BEHAVIOR

A Thesis Presented

by

Sarah J. McLaughlin

to

The Faculty of the Graduate College

of

The University of Vermont

In Partial Fulfillment of the Requirements
for the Degree of Masters of Science
Specializing in Nursing

January, 2016

Defense Date: November 12, 2015

Thesis Examination Committee:

Ellen Long-Middleton, Ph.D., APRN, Advisor

Alan Rubin, M.D., Chairperson

Carol Buck-Rolland, Ed.D., APRN

Cynthia J. Forehand, Ph.D., Dean of the Graduate College

ABSTRACT

Background: Sexual orientation is comprised of distinct components, including sexual identity, sexual attraction and sexual behavior. Lesbian, gay and bisexual adolescents are at an increased risk of experiencing poor health outcomes compared to non-sexual minority youth. Health care professional organizations recommend that health care providers discuss each component of sexual orientation at every adolescent health supervision visits in order to best assess the adolescent's health risks and needs for intervention and education.

Objective: This survey assessed the frequency with which nurse practitioners (NPs) in the state of Vermont discussed sexual identity, attraction and behavior with adolescents during annual health supervision visits.

Design: A cross sectional study that analyzed descriptive statistics of a small convenience sample of Vermont NPs.

Setting and Participants: Attendees of the Vermont Nurse Practitioner Association 2015 annual conference. Participants in the study were licensed, practicing NPs in the state of Vermont responsible for the health supervision of adolescents.

Results: Participants were overwhelmingly female (93%), with a median age between 40-49 years old, and a median length of years in practice of six to ten years. Sixty-two percent of respondents specialized in family practice. Respondents reported that they always asked adolescents about the sex of sexual partners at 49% of health supervision visits. Respondents always discussed sexual attraction and sexual identity at 31% and 24% of health supervision visits, respectively. Twenty percent of respondents reported rarely or never discussing sexual attraction, and 38% reported rarely or never discussing sexual identity.

Conclusions: The Vermont NPs who participated in this survey were demographically similar to national NP cohorts. Vermont NPs discussed the adolescent's sexual behavior at health supervision visits as frequently as health care providers nationally, and Vermont NPs discussed sexual attraction and sexual identity more frequently than providers nationally. However, Vermont NPs discussed sexual attraction and identity much less frequently than they discussed sexual behavior. Results of this survey illustrate that there is substantial room for improvement regarding the frequency with which Vermont NPs discuss the three components of sexual orientation with adolescents, particularly the components of sexual identity and attraction.

ACKNOWLEDGEMENTS

I would like to acknowledge the journey of all adolescents, but especially lesbian, gay, and bisexual adolescents, as they form their identities and live authentically. It is a process that takes enormous courage, determination and self-awareness.

I would also like to acknowledge lesbian, gay and bisexual youth who navigate adolescence with grace, self-confidence and good health, and who, with their courage and individual talents, contribute so much to the world around them.

Finally, I would like to express my sincere gratitude to all the people who believed in me wholeheartedly, supported me steadfastly, and encouraged me throughout this process.

Thank you.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
LIST OF TABLES	v
CHAPTER 1: INTRODUCTION.....	1
1.1. Overview of the Research Problem.....	1
1.2. Purpose of the Research.....	3
1.3. Conceptual Framework.....	3
1.4. Role of the Nurse Practitioner.....	5
1.5. Significance	5
CHAPTER 2: LITERATURE REVIEW.....	6
2.1. Sexual Orientation and Sexual Minority Youth Defined.....	6
2.2. Incongruence of Adolescent Sexual Identity, Attraction and Behavior	7
2.3. Health Disparities among LGB Adolescents	10
2.3.1. Psychosocial Wellbeing	10
2.3.2. Victimization and Violence	11
2.3.3. Substance Use.....	12
2.3.4. High Risk Sexual Behavior and Sexually Transmitted Infections	13
2.3.5. Obesity and Disordered Weight Control	14
2.4. Recommendations by Professional Organizations.....	15
2.5. Discussion of Sexual Orientation at Health Supervision Visits.....	16
2.5.1. Physicians' Discussion of Sexual Orientation.....	17
2.5.2. Nurse Practitioners' Discussion of Sexual Orientation.....	19
2.5.3. Adolescents' Discussion of Sexual Orientation.....	20
CHAPTER 3: METHODS.....	22
3.1. Sample.....	22
3.2. Recruitment.....	22
3.3. Data Collection and Survey Design	23
3.4. Data Analysis.....	24
CHAPTER 4: RESULTS	25

CHAPTER 5: DISCUSSION.....	30
5.1. Comparison of Demographics	30
5.2. Comparison of Discussion of Sexual Orientation	31
5.3. Implications for Practice	32
5.4. Study Limitations	34
5.5. Future Research.....	35
5.6. Conclusion	36
APPENDIX A:.....	37
APPENDIX B:.....	39
REFERENCES	41

LIST OF TABLES

Table 1. Demographic Characteristics of Vermont Nurse Practitioner Respondents.....	26
Table 2. Vermont Nurse Practitioners' Discussion of Sexual Identity, Attraction & Behavior.....	28

CHAPTER 1: INTRODUCTION

1.1. Overview of the Research Problem

Adolescence is a time during which many youths start to become aware of sexual attractions, initiate sexual experiences and begin to identify with a particular sexual role or group (Institute Of Medicine, 2011). Adolescent sexual orientation and the health care needs of sexual minority youth (youth who have sexual identities or expressions that differ from societal norms) have gained a significant amount of attention in the last decade. There is also a growing body of research showing that lesbian, gay and bisexual¹ (LGB) youth are at significantly greater risk for adverse health outcomes during adolescence (Berlan, Corliss, Field, Goodman, & Austin, 2010; Brewster & Tillman, 2012; Haas et al., 2011; Johns, Zimmerman, & Bauermeister, 2013; Newcomb, Birkett, Corliss, & Mustanski, 2014). Youth Risk Behavior Surveys (YRBS) administered by the Centers for Disease Control and Prevention also highlight a wide range of health disparities experienced by LGB versus heterosexual adolescents. Some of these health disparities include psychosocial wellbeing, self-harm and suicidality, substance use, violence, and sexual risk behaviors (Kann et al., 2011). The Institute of Medicine's (IOM) 2011 report on the health care provision for gay, lesbian, bisexual and transgendered people summarizes the specific health care needs and research gaps of LGB populations.

With the growing awareness of the needs of sexual minority youth, many professional health care organizations have issued policy statements and professional

¹ Transgender adolescents are a population of sexual minority youth who are also at higher risk for health disparities than their heterosexual peers. However, this research will focus primarily on the issue of health disparities and provider-patient discussion of sexual orientation among lesbian, gay and bisexual youth.

guidelines with recommendations that providers routinely include questions about sexual orientation during the sexual history at adolescents' routine health supervision visits (American Academy of Pediatrics, 2013; American Medical Association, 2005; National Association of Pediatric Nurse Practitioners, 2011; Society for Adolescent Health and Medicine, 2013). Healthy People 2020 also identified appropriate and sensitive patient-provider communication about sexual orientation as a focus for the improvement of health care outcomes among LGB populations (United States Department of Health and Human Services, 2011).

Primary care providers responsible for the health supervision of adolescents have the unique opportunity to provide accurate information, education, health interventions and risk reduction in all aspects of health care, including issues involving sexuality and sexual orientation. NPs are ideally suited to help adolescents successfully navigate sexual development based on the NPs educational preparation and clinical expertise in patient centered care, health promotion and education, clinical leadership, and cultural sensitivity. However, this requires that the NP be knowledgeable and adept at initiating discussions about the adolescent's sexuality and sexual orientation in order to best respond to the adolescent's health care needs.

Despite the growing body of literature and the increasing awareness among professional organizations of the specific health care needs of LGB youth, research shows that health care providers do not routinely discuss sexual identity, sexual attractions or sexual behavior with adolescents (Alexander et al., 2014; Henry-Reid et al., 2010; Kitts, 2010; Meckler, Elliott, Kanouse, Beals, & Schuster, 2006). Additionally, research indicates that adolescents themselves do not bring up their sexual identity or

sexual behaviors with health care providers (Chaplic & Allen, 2013; Meckler et al., 2006). These findings suggest a potential gap in the delivery of optimal health care to adolescents and an opportunity for providers to improve care delivery and health outcomes for LGB adolescents.

1.2. Purpose of the Research

The focus of this research is to determine the frequency with which NPs in the state of Vermont incorporate questions about sexual orientation into the routine health supervision of their adolescent patients. This study will answer the question, “Do NPs caring for adolescents 13-17 years old discuss the adolescents’ sexual attraction, sexual behaviors and sexual identity during regular health supervision visits?” The results of the study will be compared to national data and practice implications will be examined.

1.3. Conceptual Framework

The conceptual framework upon which this research is based is Erikson’s stages of psychosocial development. This framework suggests that there is a progression of eight developmental stages through which an individual passes throughout his or her life, based on the integration of biological and sociocultural forces. During each stage, the individual must learn to master a specific “psychosocial crisis” of two conflicting forces. Upon mastery, the individual will carry that stage’s virtue through the remainder of his or her development, hopefully facilitating mastery of subsequent stages and leading to integrated development (Crain, 2011).

The stage of psychosocial development that most concerns this research is the fifth stage, which Erikson labeled Fidelity: Identity vs. Role Confusion. This stage of development, Erikson maintains, is typically experienced during adolescence, and it is the time during which individuals develop their sense of self and personal identity, including the formation of their sexual identity. The general questions, “Who am I” and “What will I be” are explored in a variety of ways during this developmental stage. The individual’s answers to these questions are influenced by the significant changes of puberty, continued neurological development and an increased awareness of societal roles and opportunities. The virtue of fidelity is gained when the individual becomes firmly grounded in his or her true self-identity and develops an awareness of his or her place in society (Crain, 2011).

The discovery of self-identity and sexual identity during this developmental stage are often very fluid as the adolescent experiments with integrating his or her childhood upbringing with who he or she wants to become as an adult. While the adolescent ultimately must explore this stage for him or herself, adults (including health care providers) can and should offer the adolescent support and accurate information. In terms of sexual identity formation during this stage of development, the adolescent should be afforded the opportunity to share his or her progression of sexual development in a safe, respectful space where risk assessment, interventions and education are all provided. Health supervision of this nature not only provides optimal health outcomes for the adolescent, but also facilitates his or her mastery of this developmental stage.

1.4. Role of the Nurse Practitioner

The National Organization of Nurse Practitioner Faculties (NONPF) Nurse Practitioner Core Competencies outline nine areas in which NPs have a responsibility to advance the delivery of high quality care through leadership within the field of health care. Utilizing high quality, critically analyzed evidence to integrate with patient needs and preferences improves patient outcomes in a mutually respectful and collaborative manner. Integrating knowledge and translating research into the context of nursing science in order to develop new, evidence-based approaches to care is also critical to improving health care management for patients. Finally, health care quality and patient outcomes are advanced through communicating these evidence-based innovations to patients, colleagues and all those who are invested in quality care (National Organization of Nurse Practitioner Faculties, 2012).

1.5. Significance

To date, there is little research on the frequency with which health care providers discuss sexual identity, attraction and behavior at adolescent health supervision visits. To the best of the author's knowledge, there is no research specifically summarizing the frequency with which NPs address this topic. The results of this research will provide an assessment of the current practice of Vermont NPs surrounding the discussion of sexual orientation with adolescents during routine health supervision. It is posited that these results will serve to identify gaps in the provision of optimal health care in the adolescent population. With these initial findings, further research and provider education can be instituted to address the health care needs of sexual minority adolescents.

CHAPTER 2: LITERATURE REVIEW

2.1. Sexual Orientation and Sexual Minority Youth Defined

“Sexual orientation” is a term that has historically been used inconsistently in colloquial speech and formal literature to describe an individual’s sexual attraction or sexual behavior. However, in recent literature, the concept of sexual orientation has been used to encompass a multifaceted understanding of sexuality. The Society for Adolescent Health and Medicine (SAHM) states, “Sexual orientation includes multidimensional constructs involving three primary dimensions: sexual attraction, behavior, and identity” (Society for Adolescent Health and Medicine, 2013, p. 507). The American Academy of Child and Adolescent Psychiatry (AACAP), and the Gay and Lesbian Medical Association (GLMA) maintain similar definitions (Adelson, 2012; Gay and Lesbian Medical Association, 2006).

The three primary components of sexual orientation can be explained further. Sexual attraction is defined based on the sex of the individual(s) by whom one is sexually aroused. Similarly, sexual behavior is determined by the sex of the individual(s) with whom one chooses to have sexual contact. Sexual identity is the self-identified label that an individual adopts to describe him or herself. Typical sexual identity labels may include “gay” and “lesbian”, generally used by individuals who are attracted to and have sexual contact with members of the same sex. The sexual identity label “bisexual” is typically used by individuals who are attracted to and have sexual contact with members of either sex. The sexual identity label “heterosexual” or “straight” is typically used by individuals who are attracted to and have sexual contact with members of the opposite

sex (SAHM, 2013). An individual's sexual orientation is an integrated construct of these distinct components, and it should be understood as such for the purposes of this work.

Another frequently used term in the literature is "sexual minority youth". Individuals who may be referred to using this term are young people who self-identify as lesbian, gay or bisexual, or individuals who have had same-sex or both-sex sexual experiences (Berlan et al., 2010; Kann et al., 2011). Kann and colleagues (2011) note that this term may be used in the literature to refer to an adolescent who self-identifies as non-heterosexual, even if he or she has not had a same-sex sexual experience. Similarly, this term may be used to refer to an adolescent who has had a same-sex sexual experience even if he or she does not self-identify as lesbian/gay or bisexual.

2.2. Incongruence of Adolescent Sexual Identity, Attraction and Behavior

An adolescent's understanding of his or her sexual orientation, as described above, suggests an evolving process that may span the course of adolescence as youths become aware of and experiment with their evolving sexual identities. While the dimensions of sexual orientation for an adult are more likely to be formed and settled, the three dimensions of sexual orientation for an adolescent are often in flux and, at times, incongruent (Brewster & Tillman, 2012; Igartua, Thombs, Burgos, & Montoro, 2009; McCabe, Brewster, & Tillman, 2011; Mustanski et al., 2014).

Igartua and colleagues (2009) surveyed 1,951 Canadian high school students 14 years old and older and found several incongruences between the dimensions of sexual orientation. Of youths who reported at least one dimension of non-heterosexuality (i.e. LGB identity, same-sex attraction or same-sex behavior), 62% endorsed only one

dimension of non-heterosexuality, and only 15% endorsed all three. Also of note in this study was that of all the respondents reporting same- or both-sex sexual attraction, only 25% self-identified as LGB. Of the respondents who reported same- or both-sex sexual experiences, 43% self-identified as heterosexual. A review from the 2005-2007 New York City YRBS similarly reported that almost 40% of youth with same-sex partners identified as heterosexual (Pathela & Schillinger, 2010).

Mustanski and colleagues (2014), who surveyed 13-18 year olds about their sexual identity and behaviors, noted an even higher prevalence of adolescents who reported exclusively same-sex behavior yet identified as heterosexual. They found that 64.5% of the surveyed youth identified as heterosexual, while only 21% identified as lesbian or gay.

McCabe and colleagues (2011) studied 2,688 youth age 15-21, and found that most of the respondents had had heterosexual sex (range 57-83%) regardless of sexual attraction or identity. They also noted a significant proportion of adolescents who self-identified as heterosexual and reported exclusively opposite-sex attraction yet had had same-sex sexual experience.

Brewster and Tillman (2012) also reported on the incongruence between the components of adolescent sexual orientation reporting that 50% of adolescent males and 60% of adolescent females who reported some degree of same-sex sexual attraction self-identified as heterosexual.

There are many possible reasons for these incongruences, the most encompassing being the natural course of experimentation during adolescence as youth assess and reassess their sexuality. In particular, for sexual minority youth, the IOM stated, “one of

the major developmental tasks for lesbian and gay youth is the deconstruction of previously internalized heterosexual expectations and the construction of a new set of future expectations of the gay and lesbian life course” (Institute Of Medicine, 2011). This deconstruction and reconstruction may involve a significant amount of experimentation.

It has been suggested that other reasons for the incongruences observed between the components of adolescent sexual orientation may be that sexual attraction typically develops in early adolescence, while sexual experience and sexual identity develop in later adolescence (Mustanski et al., 2014). Also, while an adolescent may be aware of same-sex attraction and self-identify as LGB, he or she may not be ready to engage in sexual behaviors or may not have found a partner with whom he or she wants to engage in sexual behaviors. Finally, sociocultural norms have been found to play a part in an adolescent’s expression of sexual orientation, and they may influence the adolescent’s behaviors or self-identification (Igartua et al., 2009).

Regardless of the causes of the incongruences, it is clear from the literature that sexual attraction, sexual behavior and sexual identity represent distinct dimensions of sexuality, particularly during adolescence. This highlights the importance of addressing each dimension of an adolescent’s sexual orientation separately in order to fully understand his or her experience and to address the range of possible health risks and disparities the adolescent may encounter.

2.3. Health Disparities among LGB Adolescents

It is important to note that LGB youth follow the same physical, mental and emotional developmental pathways as non-sexual minority youth, and that most LGB youth navigate adolescence in good health (GLMA, 2006; IOM, 2011). However, research has highlighted a variety of health disparities for which sexual minority youth may be at increased risk. The cause of this increased risk among sexual minority youth is beyond the scope of this work, but awareness and knowledge of such disparities is critical for providers to understand in order to minimize the impact of these disparities on the health of LGB adolescents.

Additionally, many of the health risks that sexual minority youths encounter (for example, risk for self-harm) may be addressed during the health supervision visit in a context which is independent of the adolescent's sexual orientation. However, exploring the relationship between sexual orientation and health risks may benefit the adolescent in a variety of ways and provide a more holistic and integrated approach to the adolescent's health supervision.

2.3.1. Psychosocial Wellbeing

Psychosocial wellbeing is a topic of particular concern, as it can have a substantial effect on the overall health and development of adolescents. Research has consistently shown that LGB youth, in particular, are at a much greater risk of adverse mental health outcomes such as depression, anxiety and low self-esteem (Johns et al., 2013; Kann et al., 2011; M. P. Marshal et al., 2012; Strutz, Herring, & Halpern, 2015). Results from the 2009 YRBS, which polled a diverse sample of high school students who either identified as LGB or who had had same- or both-sex sexual experience, showed that approximately

40% of lesbian or gay respondents and over half of bisexual respondents had experienced depression in the past year, in comparison to only 25% of non-sexual minority respondents (Kann et al., 2011). In a study of adolescent females, Johns and colleagues (2013) reported that same-sex attraction also increased the respondent's likelihood of depression, anxiety and low self-esteem, highlighting the phenomenon that adolescents do not need to identify as LGB or have had a sexual encounter with a same-sex partner in order to be at increased risk of adverse mental health outcomes.

Associated with poor psychosocial wellbeing is suicidal ideation, attempt and self-harm. A meta-analysis of 19 studies examining suicidality among LGB adolescents reported that 28% of sexual minority youth, versus 12% of heterosexual youth, endorsed a history of at least one construct of suicidality, such as ideation, plan, or attempt (Marshall et al., 2011). These findings were supported by longitudinal data from the Adolescent and Adult Health (Add Health) survey, the Pittsburg Girls Study and by data from the 2009 YRBS (Coker, Austin, & Schuster, 2010; Kann et al., 2011; M. P. Marshall et al., 2012). Some unique risk factors for suicidality and self-harm within the LGB population have been identified. These include LGB victimization and stigmatization, childhood gender non-conformity and lack of parental acceptance of sexuality (Liu & Mustanski, 2012). These unique risk factors, in conjunction with risk factors experienced by adolescents generally, could account for the increased risk of suicide and self-harm in the LGB population.

2.3.2. Victimization and Violence

As discussed above, LGB victimization has been found to have profound impacts on the health outcomes of LGB adolescents. Victimization can take many forms,

including verbal harassment, bullying, personal property damage, engaging in or being injured in a physical fight, or being threatened with a weapon. Intimate partner violence (IPV) and sexual violence must also be considered.

Studies have demonstrated that LGB youth have a high incidence of experiencing victimization, bullying and violence in school and the community (Berlan et al., 2010; Kann et al., 2011; Russell, Everett, Rosario, & Birkett, 2014). This study, using data from the 2009 National School Climate survey, found that 85% of LGB youth ages 13-21 reported being verbally harassed in the past year. Forty percent and 19% reported being physically threatened and physically assaulted in the past year, respectively (McCabe et al., 2011).

LGB individuals were also much more likely than heterosexuals to experience violence within their relationships, with bisexual individuals experiencing the highest risk. Pathela and colleagues (2010) found that one third of bisexual men and women surveyed experienced IPV and/or forced sex in the previous year. Everett and colleagues (2013) reported similar results for bisexual adolescents experiencing IPV, and they also reported that forced sex among sexual minority youth reached 24% within the previous 12 months, as compared to 6% for non-sexual minority youth. Threatened outing, both as a form of abuse and as a barrier to the victim seeking help is a concept unique to sexual minorities who are experiencing IPV (Ard & Makadon, 2011).

2.3.3. Substance Use

Substance use, including drugs, alcohol and tobacco, is another area in which LGB youth may be at high risk. Alcohol and drugs, in particular, can have a significant impact on an adolescent's decision making, and can lead to poor health outcomes as a

result of engaging in high risk behavior while under the influence of a substance. Higher rates of drug use were found among LGB youth for a variety of drugs ranging from marijuana and cocaine, to ecstasy, methamphetamine, injection drugs and inhalants (Brewster & Tillman, 2012; Kann et al., 2011; M. P. Marshal et al., 2008; Newcomb et al., 2014). Alcohol use was also higher among LGB youth compared to heterosexual youth, especially among younger sexual minorities, sexual minority females and bisexual males (Brewster & Tillman, 2012; M. P. Marshal et al., 2008; Talley, Hughes, Aranda, Birkett, & Marshal, 2014). Also, cigarette smoking among LGB youth was increased compared to heterosexual peers, though the extent of the disparity varied based on the component of sexual orientation being measured, and by age and gender (Brewster & Tillman, 2012; Corliss et al., 2014; Kann et al., 2011; M. P. Marshal et al., 2008).

2.3.4. High Risk Sexual Behavior and Sexually Transmitted Infections

Reduced psychosocial wellbeing, increased substance use and increased partner violence can all affect sexual risk taking and have an impact on the transmission of sexually transmitted infections (STIs). As LGB youth experience higher rates of anxiety, depression, substance use and violence, it is understandable that they also experience higher rates of sexual risk taking. For example, all sexual minority youth used a condom less frequently during their last sexual encounter than their heterosexual peers (Everett, 2013; Riskind, Tornello, Younger, & Patterson, 2014). Bisexual and lesbian adolescents reported earlier age of first sexual encounter, more lifetime partners and reported higher instances of having two or more partners in the last three months than heterosexual adolescents (Pathela & Schillinger, 2010; Riskind et al., 2014). Drug and alcohol use

before sex was also much higher among LGB adolescents (Kann et al., 2011; Pathela & Schillinger, 2010; Riskind et al., 2014).

Engaging in high-risk sexual behavior, such as sex without condoms or sex under the influence of drugs and alcohol, may have an impact on sexual health outcomes, especially considering the increased number of lifetime and recent sexual partners LGB adolescents have reported. Strutz and colleagues (2015) found that sexual minority men and women both had a higher lifetime risk of contracting a STI.

Human immunodeficiency virus (HIV) is much more prevalent among men who have sex with men, and this is also true in adolescents (IOM, 2011). Decreased condoms use among bisexual adolescent men also puts their female partners at risk for contracting HIV.

Considering the fluidity of sexuality during adolescents (as mentioned in section 2.2.) and the decreased use of any form of pregnancy prophylaxis by LGB adolescents (Kann et al., 2011), lesbians reported an equal or higher rate of ever being pregnant compared to heterosexual girls (Institute Of Medicine, 2011; Riskind et al., 2014).

2.3.5. Obesity and Disordered Weight Control

Finally, LGB youth have been shown to be at greater risk for obesity and unhealthy weight control. Several studies described the differences between LGB men and women in terms of weight and how they managed their weight. Lesbian's and bisexual women's weight tended to increase during adolescence and trend towards overweight and obesity, while the weight of gay and bisexual men (as compared to heterosexual men) tended to trend down during adolescence (Austin et al., 2009; Laska et al., 2014; Struble, Lindley, Montgomery, Hardin, & Burcin, 2010). Laska and colleagues

(2014) found that lesbian and bisexual women were more likely to engage in binge eating versus heterosexuals women, and that gay men were more likely to engage in unhealthy weight control using laxatives, diet pills or vomiting versus heterosexual men. While LGB youth generally had an increased prevalence of unhealthy weight control compared to heterosexuals, this category of risk was one of the very few in which bisexuals had a lower degree of risk compared to their lesbian and gay peers (Kann et al., 2011).

2.4. Recommendations by Professional Organizations

As research and awareness about the health care needs and disparities of sexual minorities has increased, many professional organizations have published recommendations in support of provider-patient communication about sexual orientation and its integral function as part of quality health supervision.

Position statements from the American Academy of Pediatrics (AAP) and the American Medical Association (AMA) both acknowledge the importance of the provider having knowledge of the patient's sexual orientation in order to provide optimal screening and appropriate patient education (American Academy of Pediatrics, 2013; American Medical Association, 2005). However, they do not place particular emphasis on the provider's responsibility to initiate the discussion, or the content and structure of the discussion.

The AACAP and the SAHM state the importance of provider-initiated questions about sexual orientation with adolescent patients, as well as stating that sexual identity, sexual feelings and sexual behaviors should be addressed independently in such discussions (Adelson, 2012; SAHM, 2013).

The National Association of Pediatric Nurse Practitioners (NAPNAP) provided a detailed position statement on the provision of care of sexual minority adolescents. It states:

To fully address the needs of all youth, pediatric health care providers should explore each adolescents' perception of his or her gender and sexual orientation using LGBTQ [lesbian, gay, bisexual, transgender and questioning] -inclusive questions and gender-neutral language, beginning in early adolescence, and should promote a supportive, LGBTQ-safe health care space for all children and adolescents ... Providers should raise issues of gender identity, sexual orientation, and sexual behavior with all adolescent patients in a sensitive clinical environment and provide the adolescent with frequent opportunities to discuss issues, including sexual orientation, as a part of routine care. (National Association of Pediatric Nurse Practitioners, 2011, pp. 9A-10A)

The NAPNAP position statement recommends that the provider frequently initiate discussions about the multiple dimensions of sexual orientation with adolescent patients in the respectful, non-judgmental environment of regular health supervision.

2.5. Discussion of Sexual Orientation at Health Supervision Visits

Despite the documented risks and health disparities LGB adolescents experience, and the quantity of professional organizations' guidelines encouraging providers to discuss sexual orientation with adolescent patients, literature has suggested that there is significant room for improvement in discussing sexual orientation with adolescents in the clinical setting.

2.5.1. Physicians' Discussion of Sexual Orientation

A survey of 184 attending physicians and residents across a variety of departments at Upstate Medical University in Syracuse, NY, showed that of the 139 participants who had taken an adolescent health history, only 29% reported regularly discussing sexual identity. Sixty-four percent responded that they would regularly ask the adolescent about the sex of sexual partners, and 11% regularly discussed the adolescent's sexual attractions. If, during the health history, an adolescent reported that he or she was not sexually active, 41% of the survey respondents would discontinue further discussion of the adolescent's sexual health. Less than one in five respondents said they would discuss sexual orientation when encountering an adolescent who was depressed or who had suicidal thoughts or attempts (Kitts, 2010).

It is important to acknowledge that many of the physicians responding to this survey were seeing adolescents outside the primary care environment (i.e. the emergency department, psychiatry). However, it is significant that the majority of the respondents reported that they would not regularly ask sexual health questions beyond inquiring about sexual activity during a health history, specifically, respondents did not regularly ask questions about the adolescent's sexual attraction or identity (Kitts, 2010).

Of the specialties surveyed by Kitts and colleagues, physicians in family practice and internal medicine were most likely to have asked adolescents about sexual identity, with 50% and 38%, respectively, reporting regularly discussing sexual identity with adolescents. However, these two specialties were the least likely to have asked adolescents about sexual attraction, with 4% and 7% of family practice and internal medicine respondents, respectively, reporting regularly addressing sexual attraction

during a health history. Among pediatricians, 17% of respondents have been found to regularly asked about sexual identity and 8% of respondents regularly asked about sexual attraction (Kitts, 2010).

Another survey, carried out by Henry-Reid and colleagues (2010) collected responses from 752 members of the AAP regarding the frequency with which physicians addressed a variety of preventive health topics at adolescent health supervision visits. Eighty-three percent of the responding pediatricians reported that they always discuss sexual activity at an adolescent's health supervision visit, but only 18% reported discussing the adolescent's sexual identity. The survey did not ask participants to report on the frequency with which they discussed the adolescents' sexual attractions, nor did it specify if the sex of the sexual partner was addressed as part of the discussion about the adolescent's sexual activity.

A survey of providers in a California health maintenance organization (HMO) found similar results regarding the discussion of sexual orientation with adolescents. This study found that 68% of HMO pediatricians reported asking their adolescent patients about sexual intercourse, while only 18% of respondents reported asking the adolescent about sexual orientation (Halpern-Felsher et al., 2000).

A study by Meckler and colleagues (2006) considered the issue of providers' discussion of adolescent sexual orientation from the perspective of the adolescent. The study surveyed 131 adolescents, ages 14-18, who self-identified as LGB, to determine the prevalence of primary care providers' knowledge of the sexual orientation of these youth. Ninety percent of this sample reported having been to a physician for health supervision within the past two years, but 51% of the adolescents surveyed reported that they had

never had a discussion with a physician about sex or sexual health. While 70% of the adolescents surveyed described themselves as out to most everyone or everyone, only 35% said that their physician knew their sexual orientation. Of the sub-sample of adolescents seeing physicians who had knowledge of the adolescent's sexual orientation, only 21% of these adolescents reported that their physician had raised the topic of their sexual orientation with them (Meckler et al., 2006).

One limitation to the research discussed thus far is that it predominantly summarizes self-reported data on provider-adolescent discussion of sexuality. An observational study by Alexander and colleagues (2014) endeavored to address this limitation by recording provider-adolescent discussions of sexuality during health supervision visits. The intent of the study was to determine the amount of time spent on provider-patient sexuality discussions and the level of adolescent participation. The authors found that only one-third of 253 recorded conversations contained discussions about sexuality, and that the average length of the discussion was less than 40 seconds (Alexander et al., 2014). While the content of the provider-adolescent discussions about sexuality was not reported, the limited length of time spent on the discussion suggests that the content of the discussion was also quite limited, and perhaps it was neither informative nor therapeutic for the adolescent.

2.5.2. Nurse Practitioners' Discussion of Sexual Orientation

No literature was found specifically pertaining to the frequency with which NPs discuss sexual attraction, sexual identity and sexual behaviors at adolescent health supervision visits.

2.5.3. Adolescents' Discussion of Sexual Orientation

While adolescent patients may typically appear reticent during the health supervision visit, especially during the sexual history, the literature supports adolescents' general acceptance of the discussion of sexual orientation and sexuality during routine health supervision.

Adolescents generally felt that sexuality and sexual orientation were important health care topics. Sixty-six percent of LGB adolescents surveyed by Meckler and colleagues (2006) reported that they felt it was very or somewhat important for their health care provider to know their sexual orientation in order to provide optimal care. However, the majority of this sample had not disclosed their sexual orientation to their provider, with the second most common reason for not having disclosed being that their provider had not asked them. The adolescents' number one suggestion to assist providers in facilitating the discussion of sexuality with patients was that the provider should "just ask" (Meckler et al., 2006).

The preference among adolescents that the health care provider should initiate direct discussions about sexuality was echoed in a study by Rosenthal and colleagues (1999) where 77% of adolescents surveyed in a pediatric practice and an adolescent specialty clinic reported that they would prefer that their provider ask them directly about sexuality issues, as opposed to either waiting for the adolescent to bring up the topic or not discussing sexuality at all.

Although the study by Meckler and colleagues (2006) found that 62% of self-identified LGB adolescents stated that they had initiated the discussion of their sexual orientation with their physician, other studies suggest that adolescents are unlikely to

bring up the topic of sexual orientation on their own. In 253 recorded conversations between providers and adolescents, the adolescent brought up the topic of sexuality zero times (Alexander et al., 2014). In another study, only 17% of adolescents brought up the topic of sexuality (Hebert, Beaulieu, Tremblay, & Laflamme, 2013).

Provider initiation of the discussion of adolescents' sexual orientation and the length of the provider's discussion of the topic positively affected the adolescent's participation in the discussion (Alexander et al., 2014; Meckler et al., 2006). Alexander and colleagues (2014) found that it took an average of 104 seconds and approximately 17 different statements about sexuality by the provider before the adolescent offered any personal disclosure about sexuality. Meckler and colleagues (2006) also found that provider-initiated discussions of sexuality greatly increased the adolescents' disclosure of sexual orientation.

CHAPTER 3: METHODS

3.1. Sample

Participants of this research were attendees of the 2015 Vermont Nurse Practitioner's Association (VNPA) annual conference. The primary inclusion criterion for participation was that participants were NPs currently licensed and practicing in the state of Vermont. A second criterion for study participation was that in the NP's current practice, she or he was providing health supervision to adolescents between the ages of 13 and 17 years old. No limits were set on the total number or frequency with which NPs saw adolescents in their practice. Also, no limits were set on the nature of the NP's practice certification; therefore NPs participating in this study had a range of certifications licensing them to provide health supervision to adolescent patients. These inclusion criteria were selected in order to gather the most representative data on the current clinical practices of NPs regarding the discussion of sexual orientation with adolescent patients in the state of Vermont.

3.2. Recruitment

Recruitment for this research was carried out at the VNPA two-day annual conference. The conference was located in Stowe, Vermont, in March 2015. A brief verbal explanation of the research, along with an individualized verbal invitation to fill out a hard copy survey was the main source of recruitment. The principal investigator was the primary agent for carrying out recruitment, with assistance from designated colleagues. The principal investigator interacted with prospective participants at the conference registration table, and provided the individualized verbal invitation just

following each participant's conference registration. One generalized verbal invitation to participate was given by the president of the VNPA during the opening remarks of the conference. Written information outlining the study's purpose, procedure, risks and confidentiality was also available to aid in participant recruitment (Appendix A).

Paper copy surveys were available to conference attendees at the registration table throughout the two-day conference. Recruitment closed at the end of the conference.

The study was approved by the University of Vermont Institutional Review Board under exempt status.

3.3. Data Collection and Survey Design

Data was gathered in the form of a voluntary, anonymous, paper copy survey containing 14 questions (Appendix B). The initial two questions of the survey addressed inclusion criteria, as stated above in section 3.1. Questions three through eight gathered demographic information, including the participant's age and gender, number of years in practice, practice specialty, practice location by county in the state of Vermont, and the number of adolescents seen for health supervision per week. Questions nine through twelve addressed the frequency with which participants discussed sexual identity, sexual attraction and sexual behavior with their adolescent patients using a four point Likert scale. The last two questions inquired about the methods used by participants to facilitate discussions about the adolescent's sexual orientation and the perceived barriers to initiating these discussions. Surveys with missing data were excluded from analysis.

The survey was designed by the principle investigator. It was worded and distributed in such a way as to objectively collect data about NPs' discussion of sexual

orientation with adolescent patients in the state of Vermont, while also minimizing any impression of judgment or implied lack of competence or skill on the part of participants.

3.4. Data Analysis

This survey was a cross sectional study designed to analyze descriptive statistics of a small convenience sample of Vermont NPs. Data from hard copy surveys were transferred to Microsoft Excel and descriptive statistics including the number of participants per response category and percentages were calculated for each survey question.

CHAPTER 4: RESULTS

A total of 69 surveys were collected during the two day VNPA conference in March 2015. Sixty-five percent of the total respondents met the inclusion criteria of currently being a licensed, practicing nurse practitioner in the state of Vermont, and also being responsible for the health supervision of adolescents aged 13-17 years old in their current practice.

The study sample was overwhelmingly female (93.3%) and the majority (71.1%) of NPs responding to the survey saw between one and ten adolescents per week for health supervision. Other demographic characteristics were more evenly distributed. The ages of the respondents were almost equally dispersed across their 30s, 40s, and 50s, with respondents from each decade accounting for between 27-29% of the total sample. Approximately 16% were in their 60s. The median age of respondents was 40-49 year-old. NPs that had been in practice for between zero and five years represented the greatest percentage of respondents at 34%, but the median range of years in practice for the sample fell between six to ten years. Family nurse practitioners represented the majority of respondents (62.2%), with women's health nurse practitioners accounting for 15.5% of the sample and pediatric and adult nurse practitioners each representing 11.1% of respondents. Table 1 summarizes the demographic data of the participants.

Table 1:

Demographic Characteristics of Vermont Nurse Practitioner Respondents

(n = 45 unless specified)					
No./ %			No./ %		
Gender			Practice County (n=43)		
Female	42	93.3	Addison	3	7.0
Male	1	2.2	Bennington	0	0.0
Female/Male	2	4.4	Caledonia	5	11.6
NP's* Age			Chittenden	16	37.2
25-29	0	0	Essex	1	2.3
30-39	12	26.6	Franklin	3	7.0
40-49	13	28.8	Grand Isle	0	0.0
50-59	12	26.6	Lamoille	4	9.3
60-70	7	15.5	Orange	1	2.3
Number of Years in Practice (n=44)			Orleans	0	0.0
0-5	15	34.0	Rutland	5	11.6
6-10	9	20.0	Washington	2	4.7
11-15	10	22.7	Windham	1	2.3
16-20	4	9.0	Windsor	2	4.7
>20	7	15.9	Adolescents Seen Per Week		
Practice Setting			<1 per week	5	11.1
Pediatric	5	11.1	1-10	32	71.1
Family	28	62.2	11-20	5	11.1
Adult	5	11.1	>20	3	6.6
Women	7	15.5			
Other	0	0			
* NP: Nurse Practitioner					

Overall, Vermont NPs responding to the survey reported a high frequency of discussion about sexual orientation with their adolescent patients. Data summarized in Table 2 shows that approximately 98% of respondents reported always or usually taking a sexual history at adolescent health supervision visits. Of the three components of sexual orientation (identity, attraction and behavior), 84% of respondents reported that they always or usually ask adolescents who reported having had sex about the sex of their partners, and almost half (49%) of the NPs surveyed reported that they always ask sexually active adolescents about the sex of their partners. Eighty percent of respondents also reported that they always or usually ask their adolescent patients about the sex of the individuals to whom the adolescent is sexually attracted. Finally, 62% of respondents reported that they always or usually discuss sexual identity with the adolescents at health supervision visits.

NP's discussion of sexual attraction and sexual identity was notably less frequent than their discussion of sexual behavior. NPs reported that they always discuss sexual attraction only 31% of the time during the adolescent's health supervision visit. The majority of respondents (49%) reported usually discussing sexual attraction. However, discussing sexual attraction was the only category to receive a response of never, where 2% reported that they did not ask adolescents about the sex of individuals to whom they were attracted. Discussion of the adolescents' sexual identity was the least frequently discussed component of sexual orientation during the adolescent health supervision visit, with 38% of respondents reporting that they rarely or never discussed sexual identity, and only 24% of respondents reporting that they always discussed this component of sexual orientation.

Table 2:

Vermont Nurse Practitioners' Discussion of Sexual Identity, Attraction & Behavior

(n = 45)									
	Never		Rarely		Usually		Always		
	No. / %		No. / %		No. / %		No. / %		
Take Sexual History	0	0	1	2.2	23	51.1	21	46.6	
Discuss Identity	0	0	17	37.7	17	37.7	11	24.4	
Discuss Attraction	1	2.2	8	17.7	22	48.8	14	31.1	
Discuss Behavior	0	0	7	15.5	16	35.5	22	48.8	

Also of note, but not included in the data tables, was that the majority (68.8%) of NPs engaged the adolescent in organic conversation to facilitate the discussion about sexual orientation, rather than using a validated questionnaire or assessment tool. Of the NPs who used a questionnaire, half used a form that had been developed by their practice, while the other half used standardized forms from Bright Futures or Planned Parenthood.

CHAPTER 5: DISCUSSION

5.1. Comparison of Demographics

The NPs who participated in this study were very similar to the NP population seen across the United States (US). The vast majority (93%) of NPs were female, both in the study sample and in a large US sample, according to data from the American Association of Nurse Practitioners' (AANP) National Nurse Practitioners Practice Site Census of 2013-14 (American Association of Nurse Practitioners, 2015). The average age of NPs across the US was reported at 49 years old, with an average of 10 years in practice (American Association of Nurse Practitioners, 2015). The median age and length of practice for Vermont NPs participating in this study was between 40-49 years old and 6-10 years in practice.

The study results for the distribution of NPs across practice settings were also comparable to National Nurse Practitioners Practice Site Census data for the US population of NPs, with the majority (approximately 62% and 54%, respectively) of NPs from both studies working in family practice. Slightly higher percentages of NPs practicing in pediatrics and women's health setting and slightly fewer adult/gerontology NPs were seen in the VT study sample versus national data. (American Association of Nurse Practitioners, 2015).

The similarity of demographic results seen in this study compared with national data serves to illustrate that although the study was based on a convenience sample of Vermont NPs, the study sample appears to be representative, in the categories measured, of the general population of NPs across the US.

5.2. Comparison of Discussion of Sexual Orientation

A sexual history at an adolescent's health supervision visit should include a discussion about the three distinct components of an adolescent's sexual orientation (Adelson, 2012; NAPNAP, 2011; SAHM, 2013). These components include sexual attraction, sexual behavior and sexual identity. This study reveals that Vermont NPs discussed the sexual behavior component of sexual orientation as frequently as national health care provider cohorts. However, both groups discussed sexual behavior much more frequently than they discussed sexual attraction or sexual identity.

Eighty-four percent of NPs in Vermont reported that they usually or always discussed sexual behavior with adolescents during a health supervision visit, and that they did this in the context of asking the adolescent about the sex of individuals with whom the adolescent had been sexually active. Of surveyed members of the AAP, 83% of pediatricians reported that they always discussed sexual activity (Henry-Reid et al., 2010). Studies by Kitts and colleagues (2010) and Halpern-Felsher and colleagues (2000) reported lower rate of physician-adolescent discussion about sexual behavior, each reporting frequencies of 64%, but even so, sexual behavior was still the most frequently discussed component of sexual orientation across studies. In comparing these studies, it is important to note that with the exception of the study by Kitts and colleagues, the discussion of the adolescent's sexual behavior did not necessarily focus on the sex of sexual contacts, but rather on whether or not the adolescent was sexually active. This is an important distinction to make because asking specific and direct questions about the adolescent's sexual behavior enables the provider to obtain the most accurate information about the adolescent's health risks.

Similar to Vermont NPs, health care providers across the US were less likely to discuss sexual attraction and sexual identity with adolescent patients, though Vermont NPs generally had a higher frequency of discussion of these two components of sexual orientation than national cohorts. Sexual attraction was always discussed by Vermont NPs at 31% of adolescent health supervision visits versus 4% to 8% of providers nationally, depending on the physician speciality (Kitts, 2010). Vermont NPs always discussed sexual identity during the adolescent health supervision visit 24% of the time, while providers nationally discussed this component between 17% and 50% of the time (Henry-Reid et al., 2010; Kitts, 2010). While the study of Vermont NPs shows that they are at or above national levels for discussing sexual orientation with adolescents, this study also illustrates that there is currently substantial room for improvement regarding the frequency with which providers discuss the three components of sexual orientation with adolescents, in particular the components of sexual identity and attraction.

5.3. Implications for Practice

Having distinct discussions about the individual components of sexual orientation is important because it gives the health care providers more detailed information about the adolescent's health care needs. For instance, identifying the sex of the adolescent's sexual partners gives the provider accurate information about risks the adolescent may experience related to STIs, unintended pregnancy and potential for experiencing sexual violence (IOM, 2011; Pathela & Schillinger, 2010; Riskind et al., 2014).

The discussion of sexual identity and sexual attraction is also important for assessing risks. LGB adolescents are at increased risk for poorer psychosocial wellbeing

than their heterosexual peers (Johns et al., 2013; Kann et al., 2011), largely due to the additional psychosocial stress and victimization they experience through associating with a minority group. Discussing sexual attraction and identity, as well as sexual behavior, assists the provider in examining specific mental health risks, such as depression, anxiety, self-harm and suicide, as well as precursors to poor psychosocial wellbeing such as victimization, violence and bullying (Berlan et al., 2010; Russell et al., 2014).

Discussing the multiple aspects of sexual orientation at every health supervision visit ensures that the health care provider has the most current information about the adolescent's sexual development, self-perception and health risks. It also ensures that the provider is attaining this information without making judgments or assumptions based on societal norms or information from past sexual histories. An adolescent's sexual orientation may be fluid throughout this stage of development (IOM, 2011), and one component of sexual orientation may be incongruent with another at any given time (Brewster & Tillman, 2012; McCabe et al., 2011; Mustanski et al., 2014). Incorporating the multiple components of sexual orientation into the health history and health care decision making better equips the provider to initiate appropriate health screening, interventions and education to minimize risks and achieve optimal health outcomes. Moreover, the adolescent is supported in a non-judgmental environment, promoting a sense of acceptance, support and positive wellbeing.

The primary results of this study show that there is a high frequency of discussion about sexual orientation between NPs and their adolescent patients in the state of Vermont, specifically in the area of discussion about the sex of the adolescents' sexual partners. This indicates that Vermont NPs have one piece of the needed information to

provide optimal care to adolescents. However, as described above, NPs in Vermont should direct more attention toward increasing the frequency with which they discuss the adolescents' sexual attractions and sexual identity, thereby gathering the complete information required to provide comprehensive risk assessments and optimal health interventions.

5.4. Study Limitations

There are several potential limitations to this study. First, the survey was self-developed by the principal investigator with limited pre-testing, and it was not a validated survey tool. This could have potentially led to misinterpretation and non-uniformity in respondents' answers.

The nature and the content of the survey also may have contributed to reporting bias. Most NPs know, based on professional guidelines and current research, that taking a thorough, multi-component sexual history is considered the appropriate standard of care for adolescent health supervision, and that it is an important part of the regular adolescent health supervision visit. However, it is possible that NPs who attend conferences, such as the VNPA conference where the survey was administered, would also be more likely to be up to date on current standards of care and more likely to integrate the current standards of care into their practice. Also, while every attempt was made to use objective and non-judgmental wording in the survey, it is possible that reporting bias occurred as a result of respondents over-estimating the frequency with which they discuss sexual orientation with adolescents due to a desire to report the answer that reflected current standards of care.

Similarly, there is a potential that those NPs choosing to participate in the survey were also the NPs who were more likely to routinely take a thorough, multi-component sexual history. Those NPs who do not routinely discuss sexual orientation with adolescents may have opted out of the survey, creating a selection bias showing a disproportionately high frequency of discussion on sexual orientation by NPs.

Finally, there are several limitations to the generalizability of this study. While the study sample was demographically comparable to the population of NPs in the United States as discussed above, the sample was very small and the recruitment process limited. This not only limited the study's generalizability, but also prevented multivariate analyses of the data across demographic and practice categories. Generalizability was also limited by the fact that the sample was taken from a population of NPs in a predominantly rural state.

5.5. Future Research

There is limited research on the frequency with which health care providers discuss the distinct components of sexual orientation at adolescent health supervision visits, and to the best of the author's knowledge, this is the first study to inquire about the frequency with which NPs discuss the components of sexual orientation with adolescents. As such, there is a significant need to continue to generate data on this topic among all health care providers and among specific provider groups in order to evaluate the quality of care adolescents are receiving.

Research on this topic, to date, has been hindered by the inconsistency of terminology and the multiple components of sexual orientation. As research progresses,

it will be important to evaluate and standardize how researchers and, ultimately, providers ask adolescents about sexual orientation in order to collect uniform data and develop validated practice tools which will ensure predictable health outcomes.

Finally, there is also a need to determine whether or not discussing individual components of sexual orientation with adolescents is having a positive effect on their health outcomes. In particular, there is a need to assess whether or not the health disparity gap between LGB adolescents versus heterosexual adolescents is narrowing as a result of more frequent and higher quality discussion about adolescent sexual orientation (Coker et al., 2010).

5.6. Conclusion

Health care professional organizations state that a multi-component evaluation of sexual orientation is a critical aspect of the adolescent health supervision visit due to the large disparity in health outcomes seen between LGB youths and heterosexual youths. Vermont NPs can optimize the health of LGB adolescents by initiating discussions on sexual attraction, sexual behavior and sexual identity at each adolescent health supervision visit. This promotes appropriate risk assessment, health interventions and education, as well as promoting a supportive and non-judgmental environment that respects each adolescent's process of sexual development. Moving forward, Vermont NPs need to pay particular attention to consistently increasing the frequency with which they discuss sexual identity and sexual attraction at adolescent health supervision visits in order to provide optimal health care to this population.

APPENDIX A:

Research Information Sheet

Title of Study: **Nurse Practitioners' Discussion of Sexual Identity, Attraction and Behaviors**

Principal Investigator (PI): Sarah McLaughlin, RN

Faculty Sponsor: Dr. Ellen Long-Middleton, PhD, APRN

Funder: No funding source

Introduction

You are being invited to take part in this research study because you are a licensed, practicing advanced practice registered nurse (APRN) in the state of Vermont. This study is being conducted by Sarah McLaughlin, RN, in conjunction with Dr. Ellen Long-Middleton, PhD, APRN, at the University of Vermont.

Purpose

The primary purpose of this study is to determine the frequency with which APRNs are discussing sexual identity, sexual attraction and sexual behaviors with their adolescent patients at health supervision visits in the state of Vermont. Secondly, this study aims to identify the APRN's perceived barriers to facilitating such discussions with adolescents, as well as to identify which adolescent health questionnaires APRNs most frequently use to initiate these discussions.

Study Procedures

If you take part in the study, you will be asked to complete a one-time, pen and paper survey. This survey is expected to take no longer than five minutes to complete. Questions on the survey include demographic information, frequency and nature of provider-patient discussions about the adolescent's sexuality, barriers to such discussions and the adolescent health questionnaires used to facilitate these discussions.

Some of the survey questions related to adolescent sexuality may be familiar to you and others may not. No judgments about individual practice competency or skill will be made from the results of this survey, and there are no right or wrong answers to the survey questions.

Benefits

As a participant in this research study, there may not be any direct benefit for you; however, information from this study may benefit other people now or in the future.

Risks

No personally identifying information will be collected on this survey in order to protect your privacy.

Costs

There will be no costs to you for participation in this research study.

Compensation

You will not be paid for taking part in this study.

Confidentiality

All information collected about you during the course of this study will be stored without any identifiers (anonymous). No one will be able to match you to your answers.

Voluntary Participation/Withdrawal

Completion of every survey question is not required to remain in the study. Participation is completely voluntary, and you may withdraw from the study at any time during completion of the survey.

Questions

If you have any questions about this study now or in the future, you may contact me, Sarah McLaughlin, at the following phone number (802) 324-9276. If you have questions or concerns about your rights as a research participant, then you may contact the Director of the Research Protections Office at (802) 656-5040.

Participation

Your participation is voluntary, and you may choose to not participate without penalty or discrimination at any time.

Contact Information:

Principal Investigator:
Sarah McLaughlin, RN
(802) 324-9276
Sarah.McLaughlin@uvm.edu

Faculty Sponsor:
Dr. Ellen Long-Middleton, PhD, APRN
(802) 655-3304
Ellen.Long-Middleton@uvm.edu

APPENDIX B:

Survey

Nurse Practitioners' Discussion of Sexual Identity, Attraction & Behavior

*Thank you for your participation in this survey.
Your time and interest is greatly appreciated!*

Are you a licensed, practicing advanced practice registered nurse (APRN) in the state of Vermont?

- Yes No

Do you currently provide health supervision to adolescents ages 13-17?

- Yes No

****If no to either or both questions above, please return the survey with the first two questions answered to the blue box located near registration. If yes to both questions, please continue:**

Gender

- Female
 Male
 Other (Please specify if desired) _____

Age

- 25-29
 30-39
 40-49
 50-59
 60-70

Number of years in practice as an APRN:

- 0-5
 6-10
 11-15
 16-20
 More than 20

Current practice setting:

- Pediatrics
 Family
 Adult
 Women's Health
 Other (Please specify) _____

County where you currently practice:

- | | | |
|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Addison | <input type="checkbox"/> Franklin | <input type="checkbox"/> Rutland |
| <input type="checkbox"/> Bennington | <input type="checkbox"/> Grand Isle | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Caledonia | <input type="checkbox"/> Lamoille | <input type="checkbox"/> Windham |
| <input type="checkbox"/> Chittenden | <input type="checkbox"/> Orange | <input type="checkbox"/> Winsor |
| <input type="checkbox"/> Essex | <input type="checkbox"/> Orleans | <input type="checkbox"/> Other (Please specify) |

Number of adolescents you see for health supervision visits per week:

- Less than 1 per week
- 1-10
- 11-20
- More than 20

At a health supervision visit of an adolescent:

How likely are you to take a sexual history?

Never Rarely Usually Always

How likely are you to discuss the adolescent's sexual identity?

Never Rarely Usually Always

How likely are you to ask about the gender of the individuals that the adolescent is sexually attracted to?

Never Rarely Usually Always

If an adolescent is sexually active, how likely are you to ask about the partner's gender?

Never Rarely Usually Always

What are the main difficulties you associate with asking adolescents about their sexual identity, sexual attractions and sexual behaviors? (Select all that apply)

- Don't feel comfortable asking
- Lack of education/ skills
- Concern about respect for the adolescent's privacy
- Feel that such questions are not developmentally appropriate
- Feel that such questions are not important / Other issues are more important
- Concern about parent/guardian response to such questions
- Concern about legal or ethical issues
- Time constraints
- Other (Please specify) _____

Do you use a standardized questionnaire during adolescent health supervision visits that includes questions about sexual attraction, sexual identity and sexual behaviors?

- No
- Yes, If so, which one? _____

***Please return completed surveys to the blue box located by registration.
Thank you!***

*Please direct questions to Sarah McLaughlin, RN Sarah.McLaughlin@uvm.edu
or Dr. Ellen Long-Middleton, PhD, APRN Ellen.Long-Middleton@uvm.edu*

REFERENCES

- Adelson, S. L. (2012). Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(9), 957-974. doi: 10.1016/j.jaac.2012.07.004
- Alexander, S. C., Fortenberry, J. D., Pollak, K. I., Bravender, T., Davis, J. K., Ostbye, T., . . . Shields, C. G. (2014). Sexuality talk during adolescent health maintenance visits. *JAMA Pediatr*, *168*(2), 163-169. doi: 10.1001/jamapediatrics.2013.4338
- American Academy of Pediatrics. (2013). Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*, *132*(1), 198-203. doi: 10.1542/peds.2013-1282
- American Association of Nurse Practitioners. (2015). *2013-14 National Nurse Practitioner Practice Site Census*. Retrieved from <http://www.aanp.org/images/documents/research/2013-14nationalnpcensusreport.pdf>.
- American Medical Association. (2005). *AMA Policies on LGBT Issues*. Retrieved from <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-advisory-committee/ama-policy-regarding-sexual-orientation.page?>
- Ard, K. L., & Makadon, H. J. (2011). Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. *J Gen Intern Med*, *26*(8), 930-933. doi: 10.1007/s11606-011-1697-6
- Austin, S. B., Ziyadeh, N. J., Corliss, H. L., Haines, J., Rockett, H. R., Wypij, D., & Field, A. E. (2009). Sexual orientation disparities in weight status in adolescence: findings from a prospective study. *Obesity (Silver Spring)*, *17*(9), 1776-1782. doi: 10.1038/oby.2009.72
- Berlan, E. D., Corliss, H. L., Field, A. E., Goodman, E., & Austin, S. B. (2010). Sexual Orientation and Bullying Among Adolescents in the Growing Up Today Study. *J Adolesc Health*, *46*(4), 366-371. doi: 10.1016/j.jadohealth.2009.10.015
- Brewster, K. L., & Tillman, K. H. (2012). Sexual orientation and substance use among adolescents and young adults. *Am J Public Health*, *102*(6), 1168-1176. doi: 10.2105/ajph.2011.300261
- Chaplic, K. C., & Allen, P. J. (2013). Best Practices to Identify Gay, Lesbian, Bisexual, or Questioning Youth In Primary Care. *Pediatric Nursing*, *39*(2), 99-104.

- Coker, T. R., Austin, S. B., & Schuster, M. A. (2010). The health and health care of lesbian, gay, and bisexual adolescents. *Annu Rev Public Health, 31*, 457-477. doi: 10.1146/annurev.publhealth.012809.103636
- Corliss, H. L., Rosario, M., Birkett, M. A., Newcomb, M. E., Buchting, F. O., & Matthews, A. K. (2014). Sexual orientation disparities in adolescent cigarette smoking: intersections with race/ethnicity, gender, and age. *Am J Public Health, 104*(6), 1137-1147. doi: 10.2105/ajph.2013.301819
- Crain, W. (2011). *Theories of Development: Concepts and Applications* (6th ed.). Upper Saddle River, NJ: Prentice Hall.
- Everett, B. G. (2013). Sexual orientation disparities in sexually transmitted infections: examining the intersection between sexual identity and sexual behavior. *Arch Sex Behav, 42*(2), 225-236. doi: 10.1007/s10508-012-9902-1
- Gay and Lesbian Medical Association. (2006). *Guidelines for care of lesbian, gay, bisexual and transgendered patients*. Retrieved from http://glma.org/_data/n_0001/resources/live/GLMA_guidelines_2006_FINAL.pdf.
- Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., . . . Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *J Homosex, 58*(1), 10-51. doi: 10.1080/00918369.2011.534038
- Halpern-Felsher, B. L., Ozer, E. M., Millstein, S. G., Wibbelsman, C. J., Fuster, C. D., Elster, A. B., & Irwin, C. E., Jr. (2000). Preventive services in a health maintenance organization: how well do pediatricians screen and educate adolescent patients? *Arch Pediatr Adolesc Med, 154*(2), 173-179.
- Hebert, N., Beaulieu, E., Tremblay, M. M., & Laflamme, S. (2013). Adolescents' comfort answering questions about sexuality asked by their physicians. *Paediatr Child Health, 18*(3), 129-133.
- Henry-Reid, L. M., O'Connor, K. G., Klein, J. D., Cooper, E., Flynn, P., & Futterman, D. C. (2010). Current pediatrician practices in identifying high-risk behaviors of adolescents. *Pediatrics, 125*(4), e741-747. doi: 10.1542/peds.2009-0271
- Igartua, K., Thombs, B. D., Burgos, G., & Montoro, R. (2009). Concordance and Discrepancy in Sexual Identity, Attraction, and Behavior Among Adolescents. *Journal of Adolescent Health, 45*(6), 602-608. doi: <http://dx.doi.org/10.1016/j.jadohealth.2009.03.019>
- Institute Of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people : building a foundation for better understanding / Committee on Lesbian,*

Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, Board on the Health of Select Populations, Institute of Medicine of the National Academies. Washington, DC: Washington, DC : National Academies Press.

- Johns, M. M., Zimmerman, M., & Bauermeister, J. A. (2013). Sexual attraction, sexual identity, and psychosocial wellbeing in a national sample of young women during emerging adulthood. *J Youth Adolesc*, *42*(1), 82-95. doi: 10.1007/s10964-012-9795-2
- Kann, L., Olsen, E. O., McManus, T., Kinchen, S., Chyen, D., Harris, W. A., & Wechsler, H. (2011). Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12--youth risk behavior surveillance, selected sites, United States, 2001-2009. *MMWR Surveill Summ*, *60*(7), 1-133.
- Kitts, R. L. (2010). Barriers to optimal care between physicians and lesbian, gay, bisexual, transgender, and questioning adolescent patients. *J Homosex*, *57*(6), 730-747. doi: 10.1080/00918369.2010.485872
- Laska, M. N., VanKim, N. A., Erickson, D. J., Lust, K., Eisenberg, M. E., & Rosser, B. R. S. (2014). Disparities in Weight and Weight Behaviors by Sexual Orientation in College Students. *Am J Public Health*, *105*(1), 111-121. doi: 10.2105/AJPH.2014.302094
- Liu, R. T., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. *Am J Prev Med*, *42*(3), 221-228. doi: 10.1016/j.amepre.2011.10.023
- Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H., McGinley, J., . . . Brent, D. A. (2011). Suicidality and Depression Disparities between Sexual Minority and Heterosexual Youth: A Meta-Analytic Review. *J Adolesc Health*, *49*(2), 115-123. doi: 10.1016/j.jadohealth.2011.02.005
- Marshal, M. P., Friedman, M. S., Stall, R., King, K. M., Miles, J., Gold, M. A., . . . Morse, J. Q. (2008). Sexual orientation and adolescent substance use: a meta-analysis and methodological review. *Addiction*, *103*(4), 546-556. doi: 10.1111/j.1360-0443.2008.02149.x
- Marshal, M. P., Sucato, G., Stepp, S. D., Hipwell, A., Smith, H. A., Friedman, M. S., . . . Markovic, N. (2012). Substance use and mental health disparities among sexual minority girls: results from the Pittsburgh girls study. *J Pediatr Adolesc Gynecol*, *25*(1), 15-18. doi: 10.1016/j.jpag.2011.06.011
- McCabe, J., Brewster, K. L., & Tillman, K. H. (2011). Patterns and correlates of same-sex sexual activity among U.S. teenagers and young adults. *Perspect Sex Reprod Health*, *43*(3), 142-150. doi: 10.1363/4314211

- Meckler, G. D., Elliott, M. N., Kanouse, D. E., Beals, K. P., & Schuster, M. A. (2006). Nondisclosure of sexual orientation to a physician among a sample of gay, lesbian, and bisexual youth. *Arch Pediatr Adolesc Med*, *160*(12), 1248-1254. doi: 10.1001/archpedi.160.12.1248
- Mustanski, B. P., Birkett, M. P., Greene, G. J. P., Rosario, M. P., Bostwick, W. P., & Everett, B. G. P. (2014). The Association Between Sexual Orientation Identity and Behavior Across Race/Ethnicity, Sex, and Age in a Probability Sample of High School Students. *Am J Public Health*, *104*(2), 237-244.
- National Association of Pediatric Nurse Practitioners. (2011). Health Risks and Needs of Lesbian, Gay, Bisexual, Transgender, and Questioning Adolescents Position Statement. *Journal of Pediatric Health Care*, *25*(6), A9-A10. doi: <http://dx.doi.org/10.1016/j.pedhc.2011.07.002>
- National Organization of Nurse Practitioner Faculties. (2012). *Nurse Practitioner Core Competencies*. Washington, D.C.: NONPF.
- Newcomb, M. E., Birkett, M., Corliss, H. L., & Mustanski, B. (2014). Sexual orientation, gender, and racial differences in illicit drug use in a sample of US high school students. *Am J Public Health*, *104*(2), 304-310. doi: 10.2105/ajph.2013.301702
- Pathela, P., & Schillinger, J. A. (2010). Sexual behaviors and sexual violence: adolescents with opposite-, same-, or both-sex partners. *Pediatrics*, *126*(5), 879-886. doi: 10.1542/peds.2010-0396
- Riskind, R. G., Tornello, S. L., Younger, B. C., & Patterson, C. J. (2014). Sexual Identity, Partner Gender, and Sexual Health Among Adolescent Girls in the United States. *Am J Public Health*, *104*(10), 1957-1963. doi: 10.2105/AJPH.2014.302037
- Rosenthal, S. L., Lewis, L. M., Succop, P. A., Burklow, K. A., Nelson, P. R., Shedd, K. D., . . . Biro, F. M. (1999). Adolescents' views regarding sexual history taking. *Clin Pediatr (Phila)*, *38*(4), 227-233.
- Russell, S. T., Everett, B. G., Rosario, M., & Birkett, M. (2014). Indicators of victimization and sexual orientation among adolescents: analyses from Youth Risk Behavior Surveys. *Am J Public Health*, *104*(2), 255-261. doi: 10.2105/ajph.2013.301493
- Society for Adolescent Health and Medicine. (2013). Recommendations for promoting the health and well-being of lesbian, gay, bisexual, and transgender adolescents: a position paper of the Society for Adolescent Health and Medicine. *J Adolesc Health*, *52*(4), 506-510. doi: 10.1016/j.jadohealth.2013.01.015

- Struble, C. B., Lindley, L. L., Montgomery, K., Hardin, J., & Burcin, M. (2010). Overweight and obesity in lesbian and bisexual college women. *J Am Coll Health, 59*(1), 51-56. doi: 10.1080/07448481.2010.483703
- Strutz, K. L., Herring, A. H., & Halpern, C. T. (2015). Health disparities among young adult sexual minorities in the U.S. *Am J Prev Med, 48*(1), 76-88. doi: 10.1016/j.amepre.2014.07.038
- Talley, A. E., Hughes, T. L., Aranda, F., Birkett, M., & Marshal, M. P. (2014). Exploring alcohol-use behaviors among heterosexual and sexual minority adolescents: intersections with sex, age, and race/ethnicity. *Am J Public Health, 104*(2), 295-303. doi: 10.2105/ajph.2013.301627
- United States Department of Health and Human Services. (2011). *Healthy People 2020: Lesbian, Gay, Bisexual, and Transgender Health*. . Retrieved from <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25>.