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Gender Differences in Sexual Well-Being and Sexual Identity Development among Youth Formerly in the Foster Care System in the United States

Richard A. Brandon-Friedman [1,2,*] and Tayon R. Swafford [1]

[1] School of Social Work, Indiana University, Indianapolis, IN 46202, USA
[2] School of Medicine, Indiana University, Indianapolis, IN 46202, USA
* Correspondence: rifriedm@iupui.edu

Abstract: Little research has heretofore examined differences in the sexual well-being and sexual health outcomes between female and male youth in the foster care system. This cross-sectional study examined these differences and as well as how sexual identity development impacts sexual well-being using a sample of 217 youth formerly in the foster care system. It found that females have lower levels of overall sexual well-being, lower scores on several components of sexual well-being, and more negative sexual health outcomes than males. The four domains of sexual identity development explored all predicted overall sexual well-being for both females and males, with a pronounced negative impact of being a gay male. These results support the importance of sexual identity development and indicate that the sexual health needs of females within the foster care system are not being addressed as well as those of their male counterparts. To address these discrepancies professionals and caregivers working with youth in the foster care system need to be attuned to the specific needs of female youth and work to address these needs in a manner that considers their gender.

Keywords: sexual well-being; sexual identity; sexual health; gender; child welfare; foster care

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1. Introduction

Adolescence is a period when youth begin to solidify the beliefs, norms, and values that will become core components of their identities. While this process can be difficult for many youth, trauma experiences such as involvement with the child welfare system (CWS) or being placed into the foster care system (FCS) can inhibit the development of coherent identities, which can contribute to later difficulties with physical, social, and emotional functioning [1]. Identity theory suggests that while individuals can be perceived as having a global identity of sorts, every person is really a collection of smaller identities that are continually in flux [2]. At a given time, any specific identity may become more or less salient depending on the individual's experiences or needs.

One identity that often becomes particularly salient during adolescence is youths' sexual identity. While the phrase "sexual identity" is often conflated with "sexual orientation," sexual identity is a larger concept that incorporates all aspects of individuals' lives related to sex and sexuality [3]. This can include their sexual desires, beliefs, actions (both individually and with others), and norms, as well as their sexual health and well-being. For many, sexual identity also includes related areas such as romantic desires, values, and actions, though these can be separate for some individuals. It can also incorporate aspects of gender due to interactions between gender, sex, and sexuality. Thus, while for many their sexual orientation is an important component of their sexual identity, it is only one piece.

The importance of understanding youths' sexual identity development extends beyond just sexuality. Aspects of sexual identity development can influence all areas of youths' lives, including their physical health, interpersonal relationships and interaction patterns,

emotional well-being, and, of course, their sexual well-being [4–7]. Yet youths' sexual identity development often receives little attention, especially when the youth are forced to focus on areas such as having their basic needs met.

While there has been some movement toward recognizing the importance of sexual identity development and an emphasis on helping youth within the CWS as they explore and develop their sexual identities, a better understanding of how aspects of youths' lives impact their sexual identity development and sexual health and well-being is needed. More specifically, despite the complexity of interactions between gender and sexuality, there is a dearth of research that has examined differences in the sexual well-being and sexual health outcomes between female and male youth. In fact, as discussed more below, no research was identified that looked at gender-based differences in multiple aspects of sexual well-being among youth within the United States using a single sample.

To begin to address this gap, this study examined differences in sexual identity development, sexual well-being, and sexual health outcomes between female and male youth who were formerly in the FCS. Recognizing the complexity of gender and gender labels, the terms "male" and "female" are used throughout this article as these were the term options selected by the participants. Understanding differences in the impact of sexual identity development and in sexual well-being between these groups will allow for more targeted interventions to assist youth within the CWS with their sexual identity development, which can then positively impact other areas of the youths' lives.

2. Literature Review

During adolescence, physiological changes such as sexual maturation and hormone level changes combine with an increase in exposure to sexuality-related discourse to initiate a more in-depth exploration of sexuality and a more intense focus on sexual identity development [4,8]. This process incorporates sexual messaging that can be varied based on how others view and interact with the youth, which can include considerations of gender, race, ethnicity, and sexual orientation. Further influences can include social positionality, religiosity/spirituality, social views/beliefs, and personal experience [4,8]. Additionally, the role of the individual and the quality of the relationship between the youth and the individual who is providing information about sexuality can affect what is discussed, how it is discussed, and the comfort level of the discussion, whether the person providing the information is a family member or a professional [9–11]. These messages impact how youth conceptualize and perceive their sexual selves, impacting their sexual identity development and influencing their sexual behaviors.

2.1. Sexual Well-Being

Sexual well-being is a broad concept that goes far beyond a lack of disease through incorporation of positive areas of sexuality such as abilities to communicate sexual needs, to achieve sexual pleasure, and to have sexual autonomy, in addition to having a well-developed sexual self-conception and/or sexual identity [12,13]. As part of the process of an individual coming to understand their sexuality, sexual identity development is thus a key component of sexual well-being. In fact, more advanced levels of sexual identity development have been linked with advancements in youths' sexual health and overall physical, mental, and social well-being [3,4,14–16].

2.2. Sexual Well-Being and Sexual Risk for Male versus Female Youth

Research examining gender-based differences in sexual health and well-being have had varied results. Research has generally indicated that males have more interest in sexual activity than females, though these differences are small, and that females experience more sexual pain and experience higher incidence of sexual violence than males [17]. Data from 2017 indicated that even though there were no differences in the percentages of youth who were currently sexually active, significantly more males have had sex during high school and have had more than four sexual partners than females [18]. At the same time,

males reported greater use of a condom during their last partnered sexual interaction than females, a finding later repeated in Scull and colleagues [19]. In terms of risky sexual behaviors, males have greater intentions to engage in such behaviors [19], but males and females have been found to have a similar risk profile and association between experiencing sexual abuse and such behaviors [20].

Only one direct comparison between genders on aspects of sexual well-being among youth within the United States was able to be located. In that study, males reported being more open with their partners about their levels of sexual pleasure whereas females reported being more open with their partners about sexual satisfaction [21]. Further, males reported higher comfort telling their partners if they are experiencing pain during sexual intercourse. When adults in the United States were sampled, there were no differences in sexual pleasure experiences between males and females [22].

Looking internationally, among Mexican adolescents no differences in sexual satisfaction were found between genders though males reported greater usage of condoms and females reported more unwanted sexual advances [23]. For Ugandan youth, Kemigisha and colleagues [24] utilized self-esteem, body image, and views of gender equity as proxy components of sexual well-being, finding that females had lower levels of the first two but higher levels of belief in gender equity. An important limitation of this previous research is that it has all used relatively limited conceptions of sexual well-being.

2.3. Sexual Well-Being and Sexual Risk for Youth in the FCS

Most of the research that addresses sexual well-being and sexual risk for youth with involvement in the FCS highlights and prioritizes negative health outcomes. Ramseyer Winter and colleagues [25] explained that youth in the FCS tend to have more partners, are more likely to engage in transactional sex, and tend to contract STDs/STIs more frequently than their non-FCS peers. Additionally, Ramseyer Winter and colleagues [25] and Agnihotri and colleagues [26] noted that youth in the FCS are less likely to receive and/or be responsive to interventions designed to help them make safer choices regarding sex and sexual health services. Further, by virtue of their involvement in the CWS, youth in the FCS have all experienced trauma and many have experienced significant abuse. Experiencing sexual abuse and/or trauma are risk factors for engagement in risky sexual behaviors, being diagnosed with an STD/STI, and for having difficulties developing sexual positive beliefs, values, and norms as well as a coherent sexual identity [27–29]. In terms of early parenthood, female youth placed in out-of-home care have a higher likelihood of motherhood before age 18 than youth of a similar SES status but not in out-of-home care, but they are less likely to become pregnant while in out-of-home care than the other youth of the same age who are not in out-of-home care [30].

2.4. Sexual Well-Being and Sexual Risk Outcomes for Male versus Female Youth in the FCS

Research examining differences in sexual health outcomes, sexual behaviors, and aspects of sexual well-being between male and female youth in the FCS is limited as most studies only examine one gender. In one direct comparison study between males and females with a history of foster care placement, Combs and colleagues [31] found that females were more likely to report a pregnancy than males were to report having caused one, but that there were no gender differences in rates of repeat pregnancies or in ages of first pregnancy. Interestingly, the percentages of youth who reported a birth were not statistically different between genders. In contrast, Taussig and Roberts [32] and Zhan and colleagues [33] reported that females had a higher level of pregnancy than males reporting having caused one.

Diamant-Wilson and Leathers [34] examined safer sex strategies among African American youth in the FCS and found that females reported receiving more support messaging regarding sexual well-being from service providers, whereas males reported more messaging from foster parents. Additionally, they found that males received condoms more often.

There were no differences in the amount of messaging regarding STIs/HIV provided to male and female youth.

2.5. Sexual Identity Development

Departing from earlier stage-based models of sexual identity development that focused almost exclusively on sexual minority individuals, Worthington and colleagues [35] developed a model of sexual identity development that can be used with all individuals regardless of their sexual orientation identity. This model replaced the idea of stages with dimensions that represented aspects of sexual identity development. Each of the dimensions is considered independently and individuals can occupy different places on each of the dimensions. The four statuses within the model are *Commitment*, which represents commitment to a sexual identity without having previously explored that identity (generally based in an acceptance of others' sexual proscriptions); *Exploration*, which represents active exploration of an individual's sexual identity; *Synthesis/Integration*, which represents the solidification of a sexual identity after exploration as well as its integration into an individual's more global identity; and *Sexual Orientation Identity Uncertainty*, which measures the degree to which an individual is uncertain of their sexual orientation identity.

Worthington and colleagues [35] operationalized their model with the Measure of Sexual Identity Exploration and Commitment (MoSIEC). The MoSIEC has been used in several studies examining the relationships between sexual identity development and aspects of sexual well-being. Worthington and colleagues' initial research indicated a positive relationship between Sexual Identity Synthesis/Integration and sexual self-consciousness and sexual assertiveness. In contrast, Muise and colleagues [6] did not identify a relationship between Sexual Identity Synthesis/Integration and any aspects of sexual health. Sexual Identity Exploration has been studied the most, with research indicating positive relationships between levels of sexual identity exploration and sexual assertiveness, sexual self-consciousness, sexual motivation, a more developed sexual schema, and overall levels of sexual health [6,35–38]. Sexual Identity Exploration has also been linked with higher overall levels of sexual well-being [4]. The Sexual Orientation Identity Uncertainty subscale has been shown to reliably differentiate between individuals with minoritized sexual identities and those who do not identify as a sexual minority [35,39].

3. Research Hypotheses

To date, researchers have not examined the differences in the sexual well-being and sexual health outcomes between female and male youth formerly involved with the FCS. Further, there has been no exploration of differences in sexual identity development between these groups. This study begins to address this gap through an exploration of differences in sexual well-being and identity development between males and females, as well as examining the impact of their sexual identity development on their sexual well-being.

The three hypotheses for this study were: (1) Males and females would not differ in their overall levels of sexual well-being or sexual health outcomes with the exception of females having greater incidence of unintended pregnancy and higher levels of sexual victimization; (2) due to their earlier sexual maturation, females would score higher on levels of Sexual Identity Commitment and Sexual Identity Synthesis/Integration, and lower on levels of Sexual Identity Exploration and Sexual Orientation Identity Uncertainty; and (3) the impact of the four sexual identity dimensions will differ between females and males.

4. Method

4.1. Recruitment and Participants

This analysis used a subset of data from a larger study [3] that explored the impact of aspects of YFCs' lives on their sexual well-being. Youth formerly in the FCS were recruited using a variety of methods including emails to organizations that serve youth formerly in the FCS; posts in social media groups that are focused on youth formerly in the FCS, on

current caregivers of YFC, and on social service providers who work with youth formerly in the FCS; paid advertising in a magazine for youth formerly in the FCS; emailing schools of social work and asking them to distribute study materials to their students and staff; and via snowball sampling. As compensation for their time, all participants were sent a $20 e-gift-card. The e-mail addresses used for distributing the e-gift cards were collected independently from the study data to maintain anonymity. All study procedures were reviewed by the authors' Institutional Review Board and approved and all participants provided informed consent for participation.

A total of 227 youth formerly in the FCS completed the larger study. Data from eight youth were identified as multivariate outliers and thus were removed, leaving a sample of 219. Youth were asked to select their gender identity from a provided list or they could write in another identity if they did not identify with any of the options listed. Of the 219 youth, two indicated that they identified as gender-diverse or that they were not cisgender. As this was a gender-based analysis and there was no way to know how others perceived or reacted to the gender-diverse youths' gender, it was unfortunately necessary to remove them from the analysis. A further two-step analysis was used to determine if any participants identified with a gender other than that which is considered to correspond with their sex assigned at birth but not as gender-diverse, but none were identified.

The decision to remove youth who identified as gender-diverse was difficult as the experiences of gender-diverse youth are very understudied. With only two youth identifying as gender-diverse, however, it was not possible to conduct any analysis. This left a sample for this analysis of 217. Of these, 129 participants (59.45%) identified as female and the other 88 (40.55%) identified as male. Full participant demographics are shown in Table 1.

Table 1. Demographics of Study Participants [a].

	n	**%**		***n***	**%**
Race [b]			Gender [b]		
African American/Black	68	31.34	Female	129	59.45
American Indian/Native Alaskan	7	3.23	Male	88	40.55
Asian	11	5.07	Prefer to Not Say	0	0.00
Biracial/Mixed	31	14.29			
Native Hawaiian or Pacific Islander	3	1.38	Sexual Orientation Identity [b]		
White	114	52.53	Asexual	2	0.92
Unlisted Identity	9	4.15	Bisexual	24	11.06
Prefer to Not Say	0	0.00	Gay	15	6.91
			Heterosexual/Straight	169	77.88
Ethnicity			Lesbian	8	3.69
Hispanic/Latino	39	17.97	Pansexual	3	1.38
Not Hispanic/Latino	171	78.80	Queer	1	0.46
Prefer to Not Say	7	3.23	Unlisted Identity	0	0.00
			Prefer to Not Say	0	0.00
Sex Assigned at Birth					
Female	128	58.99			
Male	89	41.01			

[a] $n = 217$; [b] Totals may be greater than 217 as participants could select more than one option in several categories.

4.2. Measures and Analysis

4.2.1. Sexual Identity Development

Worthington and colleagues' [35] Measure of Sexual Identity Exploration and Commitment (MoSIEC) was used to evaluate sexual identity development. The MoSIEC contains four sexual identity statuses, each of which is independent. As such, there is no composite score for the measure. The four subscales are: Commitment (6 items), Exploration (8 items), Syntheses (5 items), and Sexual Orientation Identity Uncertainty (3 items).

4.2.2. Sexual Well-Being

Hensel and Fortenberry's [13] multidimensional model of sexual well-being was originally developed to measure aspects of sexual well-being for cisgender adolescent women. As this study included youth assigned male at birth, several items were rephrased to make them applicable to individuals regardless of their sex assigned at birth. Further, one item was removed as it referred specifically to the vagina. The original Fertility Control subscale was excluded because it was intended to measure desire to avoid teen pregnancy whereas all the youth in this sample were over age 18. An error in data entry necessitated the removal of a single item from the Sexual Anxiety subscale.

The revised measured consisted of 32 items divided into eight subscales. Seven scales utilized a four-point Likert-type scale ranging from Strongly Disagree to Strongly Agree, Condom Use Efficacy, Genital Pain, Relationship Quality, Sexual Anxiety, Sexual Autonomy, Sexual Communication, and Sexual Esteem. The Sexual Satisfaction subscale measured how satisfied participants were with their current or most recent sexual partner using a seven-point semantic differential scale. To determine the youths' overall levels of sexual well-being, each individual's scores on the 32 items were converted to *z*-scores and the *z*-scores were then summated for an overall total score.

4.2.3. Sexual Health Outcomes

Sexual health outcomes were measured using four independent prompts. These were: (1) having been diagnosed with an STI/STD; (2) having engaged in transactional sex (defined within this study as exchanging sexual activities for food, money, or other goods, which could include a place to sleep, clothing, drugs, alcohol, or other needs); (3) having experienced sexual victimization (as defined by the participant); and (4) having experienced an unintended pregnancy of themselves or a sexual partner.

4.3. Analyses

Chi-squares were utilized to measure differences between males and females for dichotomous variables and independent measures *t*-tests were used for continuous variables. The impact of the four statuses of sexual identity development on levels of sexual well-being were calculated using hierarchical regression. Length of time in the foster care system (in years), racial identity (reference group: White), sexual orientation identity (reference group: heterosexual), and relationship status (reference group: single) were used as analytic controls for regression analyses.

5. Results

5.1. Time in Foster Care

There were no statistically significant differences between females and males on age entering care, age leaving care, or overall time in care (Table 2).

Table 2. Mean Differences Between Male and Female Youth.

	Female [a]		Male [b]			Female [a]		Male [b]	
	$\bar{x}$	SD	$\bar{x}$	SD		$\bar{x}$	SD	$\bar{x}$	SD
Time in Foster Care					MMSW Subscale [c]				
Age Entering Care	11.66	4.25	11.86	3.30	Relationship Quality (α = 0.89)	19.85	3.96	21.13 **	3.13
Age Exiting Care	17.41	2.15	17.22	2.24	Sexual Communication (α = 0.84)	9.94	2.01	10.41	1.77
Time in Foster Care System	5.75	4.77	5.35	3.92	Sexual Autonomy (α = 0.66)	10.16	2.03	9.90	2.01
					Condom Use Efficacy (α = 0.88)	12.73	3.04	13.82 **	2.14
MoSIEC Subscale [c]					Sexual Esteem (α = 0.53)	9.64	1.91	10.11 *	1.43
Commitment (α = 0.85)	29.09	6.33	31.34 **	4.93	Sexual Anxiety (α = 0.67)	12.07	2.92	12.55	2.42
Exploration (α = 0.91)	33.46	10.09	35.63	10.79	Genital Pain (α = 0.89)	14.25	2.47	14.44	2.55
Synthesis (α = 0.87)	24.42	4.74	26.42 *	3.57	Sexual Satisfaction (α = 0.94)	28.65	6.33	31.00 *	4.24
Sexual Orientation Uncertainty (α = 0.72)	5.89	3.28	4.61 **	2.34	Overall Sexual Well-being d (α = 0.92)	−2.09	19.30	4.76 **	13.98

[a] $n = 129$; [b] $n = 88$; [c] α levels indicate values for the overall sample ($n = 217$ unless otherwise specified); [d] z-scores; * $p < 0.05$; ** $p < 0.01$.

5.2. Level of Sexual Well-Being and Negative Sexual Health Outcomes

Cronbach's alpha for the overall sexual well-being scale was 0.92, though the reliability on the individual scales varied significantly (Table 2). Contrary to our hypotheses, there was a difference in overall levels of sexual well-being between females and males (z-score $\bar{x} = -2.09$ versus 4.76, $t = -3.03$, $p < 0.01$; Table 2), with females having lower overall levels. There were several areas of difference: Relationship Quality ($\bar{x} = 19.85$ versus 21.13, $t = -2.64$, $p < 0.001$), Condom Use Efficacy ($\bar{x} = 12.73$ versus 13.82, $t = -3.10$, $p < 0.01$), Sexual Esteem ($\bar{x} = 9.64$ versus 10.11, $t = -2.10$, $p < 0.05$), and Sexual Satisfaction ($\bar{x} = 28.65$ versus 31.00, $t = -3.27$, $p < 0.01$), with females scoring lower on all of them. In accordance with Hypothesis One, females experienced more unintended pregnancies ($\chi^2 = 7.44$, $p < 0.05$; Table 3), however in contradiction to our hypothesis of no differences, females were diagnosed with an STI/STD more often ($\chi^2 = 9.00$, $p < 0.05$) and had engaged in transactional sex more often ($\chi^2 = 7.49$, $p < 0.05$). Further, and contrary to Hypothesis One, there were no differences in sexual victimization between females and males.

Table 3. Chi-square Comparisons Between Female and Male Youth.

	Female [a]	Male [b]	
	% Yes	% Yes	χ^2
Sexual Outcomes			
Experienced unintended pregnancy	11.98	2.76	7.44 *
Diagnosed with an STI/STD	10.59	1.84	9.00 *
Experienced sexual victimization	20.74	10.14	2.92
Engaged in transactional sex	8.76	2.30	7.49 *

[a] $n = 129$; [b] $n = 88$; * $p < 0.05$.

5.3. Sexual Identity Development

The analyses for the impact of sexual identity development were run independently for each of the four MoSIEC subscales. All the subscales demonstrated appropriate reliability (α = 0.72 to 0.91; Table 2). Contradicting Hypothesis Two, females had lower levels of sexual identity commitment ($\bar{x} = 29.09$ versus 33.34, possible range 6 to 36, $t = -2.93$, $p < 0.01$), lower levels of sexual identity synthesis ($\bar{x} = 24.42$ versus 26.42, possible range 8 to 48, $t = -3.55$, $p < 0.001$), and higher levels of sexual orientation identity uncertainty ($\bar{x} = 5.89$ versus 4.61, possible range 3 to 18, $t = 3.35$, $p < 0.001$).

5.4. Impact of Sexual Identity Development on Sexual Well-Being

5.4.1. Sexual Identity Commitment

All of the four sexual identity statuses impacted overall sexual well-being. The results for the first model are only presented once as the model was the same for all analyses. For females, the first model was not significant, $F(4, 124) = 1.581$, $p > 0.05$; $R^2 = 4.9\%$ (Table 4), but the second model was, $F(5, 123) = 8.60$, $p < 0.001$; $R^2 = 21.1\%$. Within the first model, there were no significant predictors. Within the second model, only Sexual Identity Commitment was a significant positive predictor of sexual well-being ($\beta = 0.500$, $p < 0.001$).

Table 4. (a) Results of Hierarchical Multiple Regression for MoSIEC Subscales on Sexual Well-being. (b) Results of Hierarchical Multiple Regression for MoSIEC Commitment Subscale [a].

(**a**)

	Commitment Female [a]		**Commitment Male [b]**		**Exploration Female [a]**		**Exploration Male [b]**	
	Model 1	**Model 2**	**Model 1**	**Model 2**	**Model 1**	**Model 2**	**Model 1**	**Model 2**
	β	**β**	**β**	**β**	**β**	**β**	**β**	**β**
Length of Time in Foster System [c]	−0.126	0.002	−0.025	0.112	−0.126	−0.076	−0.025	0.043
Race/Ethnicity [d]	0.106	0.075	0.084	0.118	0.106	0.099	0.084	0.079
Relationship Status [e]	−0.017	−0.031	0.211 *	0.098	−0.017	0.013	0.211 *	0.256 *
Sexual Orientation Identity [f]	−0.136	−0.014	−0.437 ***	−3.54 ***	−0.136	−0.168	−0.437 ***	−0.564 ***
MoSIEC Subscale		0.500 ***		0.427 ***		0.304 ***		0.282 **
F	1.581	8.600 ***	5.796 ***	8.994 ***	1.581	3.918 **	5.796 ***	6.484 ***
R^2	0.049	0.259	0.218	0.354	0.049	0.137	0.218	0.283
ΔR^2	0.049	0.211 ***	0.218 ***	0.136 ***	0.049	0.089 ***	0.218 ***	0.065 **

(**b**)

	Synthesis Female [a]		**Synthesis Male [b]**		**Sex Orient Female [a]**		**Sex Orient Uncert Male [b]**	
	Model 1	**Model 2**	**Model 1**	**Model 2**	**Model 1**	**Model 2**	**Model 1**	**Model 2**
	β	**β**	**β**	**β**	**β**	**β**	**β**	**β**
Length of Time in Foster System [c]	−0.126	−0.094	−0.025	0.058	−0.126	−0.128	−0.025	0.000
Race/Ethnicity [d]	0.106	0.094	0.084	0.047	0.106	0.080	0.084	0.126
Relationship Status [e]	−0.017	−0.032	0.211 *	−0.002	−0.017	−0.020	0.211 *	0.138
Sexual Orientation Identity [f]	−0.136	−0.069	−0.437 ***	−0.393 ***	−0.136	−0.034	−0.437 ***	−0.354 **
MoSIEC Subscale		0.367 ***		0.489 ***		−0.300 **		−0.317 **
F	1.581	5.279 ***	5.796 ***	10.964 ***	1.581	3.607 **	5.796 ***	7.232 ***
R^2	0.049	0.177	0.218	0.401	0.049	0.128	0.218	0.306
ΔR^2	0.049	0.128 ***	0.218 ***	0.182 ***	0.049	0.079 **	0.218 ***	0.08 8 **

Notes: [a] $n = 129$; [b] $n = 88$; [c] in years; [d] Reference Group: Non-Racial/Ethnic Minority; [e] Reference Group: Single; [f] Reference Group: Non-Sexual Minority; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Alternatively, for males the first model was significant, $F(4, 83) = 5.796$, $p < 0.001$; $R^2 = 21.8\%$ (Table 4), with relationship status and sexual orientation identity being significant predictors ($\beta = 0.211$, $p < 0.05$ and $\beta = -0.437$, $p < 0.001$). In this case, being

in a relationship was a positive predictor, while identifying as a sexual minority was a negative predictor. The second model was also significant, ($F(5, 82) = 8.994$, $p < 0.001$; $R^2 = 35.4\%$; $\Delta R^2 = 13.6\%$). The impact of relationship status was no longer significant ($\beta = 0.098$, $p > 0.05$), but sexual orientation identity remained a significant negative predictor ($\beta = -3.54$, $p < 0.001$). The MoSIEC subscale was a significant positive predictor ($\beta = 0.427$, $p < 0.001$).

5.4.2. Sexual Identity Exploration

For females, the second model predicted sexual well-being at a statistically significant level ($F(5, 123) = 3.918$, $p < 0.01$; $R^2 = 13.7\%$; $\Delta R^2 = 8.9\%$). As with Sexual Identity Commitment, there were no significant predictors except for the MoSIEC subscale ($\beta = 0.304$, $p < 0.001$). Sexual identity exploration was a positive predictor of sexual well-being, meaning that the higher the levels of sexual identity exploration, the higher the youths' overall sexual well-being.

Among males, the second model was also significant ($F(5, 82) = 6.484$, $p < 0.001$; $R^2 = 28.3\%$; $\Delta R^2 = 6.5\%$). Relationship status and sexual orientation identity remained significant predictors ($\beta = 0.256$, $p < 0.05$ and $\beta = -0.564$, $p < 0.001$, respectively). As with females, Sexual Identity Exploration was a positive predictor of sexual well-being ($\beta = 0.282$, $p < 0.01$).

5.4.3. Sexual Identity Synthesis

Similar to the Sexual Identity Commitment and Sexual Identity Exploration models, the second model remained predictive of sexual well-being for females (F (5, 123) = 5.279, $p < 0.001$; $R^2 = 17.7\%$; $\Delta R^2 = 12.8\%$). None of the other variables were significant predictors except the MoSIEC subscale, with Sexual Identity Synthesis being a positive predictor of sexual well-being ($\beta = 0.367$, $p < 0.001$).

The second model predicted sexual well-being at a statistically significant level for males ($F(5, 82) = 10.964$, $p < 0.001$; $R^2 = 40.1$; $\Delta R^2 = 18.2\%$). As with Sexual Identity Commitment, only sexual orientation identity and the MoSIEC subscale had a significant impact on sexual well-being ($\beta = -0.393$, $p < 0.001$ and $\beta = 0.489$, $p < 0.001$, respectively). This subscale's impact was also positive in direction.

5.4.4. Sexual Orientation Identity Uncertainty

As with the other sexual identity development domains, the second model was predictive of sexual well-being for females (F (5, 123) = 3.607, $p < 0.01$; $R^2 = 12.8\%$; $\Delta R^2 = 7.9\%$), with only the Sexual Orientation Identity Uncertainty subscale being a significant predictor ($\beta = -0.300$, $p < 0.01$). Different from the other models, Sexual Orientation Identity Uncertainty was a negative predictor of sexual well-being, meaning the more uncertain the youth were about their sexual orientation identity, the lower their levels of sexual health were.

Similarly, the second model was predictive of sexual well-being for males ($F(5, 82) = 7.232$, $p < 0.001$; $R^2 = 30.6\%$; $\Delta R^2 = 8.8\%$). As with all subscales except Sexual Identity Exploration, only sexual orientation identity and the Sexual Orientation Identity Uncertainty subscale had significant impacts on overall levels of sexual well-being ($\beta = -0.354$, $p < 0.01$ and $\beta = -0.317$, $p < 0.01$, respectively). This scale was also a negative predictor, indicating Sexual Orientation Identity Uncertainty impacted sexual well-being in a negative manner for both males and females.

6. Discussion

Little prior research examined differences in the sexual well-being or sexual identity development between females and males. This study began to address this gap using a sample of youth who were formerly in the FCS. Contrary to hypotheses, females had significantly lower levels of overall sexual well-being and had higher incidence of several negative sexual health outcomes than males. Further, females had lower levels of sexual identity commitment and sexual identity integration/synthesis while also having higher

levels of sexual orientation identity uncertainty. The impact of various aspects of sexual identity development on sexual well-being were similar between females and males, with sexual identity commitment, sexual identity synthesis/integration, and sexual identity exploration positively impacting sexual well-being, while sexual orientation uncertainty negatively impacted sexual well-being. Of all the demographic variables considered, only sexual orientation identity had a continuing impact on sexual well-being throughout the models, and that was only for males and was negative in direction.

Respress and colleagues [40] incorporated Bronfenbrenner's ecological systems lens to show how the environments in which adolescents are reared influences their readiness, willingness, and ability to guide the formation of healthy attitudes and behaviors regarding sex. Even though Respress and colleagues' population centered African American and Latino/a adolescents, an important idea was illuminated that greatly benefited this study: engagement with the CWS, system benefits and constraints, interactions with professionals, and the household composition and dynamics of a respective foster family can have a strong impact on the development of youths' sexual identity, sexual health, and sexual well-being.

This can be especially important for the many youth in the CWS who have been exposed to abusive and neglectful environments and who have often observed unhealthy relationship patterns. These patterns can negatively influence how youth conceptualize their relationships and hamper their abilities to identify concerning relationships within their lives [41,42]. Given that females are more likely to be victims within unhealthy relationships, this concerning modeling could contribute to the unexpectedly lower levels of sexual well-being and higher incidence of negative sexual health outcomes among the females within this sample. This interpretation is further enforced given that females rated their relationship quality to be lower. While it might also be reasonable to project that the higher levels of sexual victimization that female youth experience compared to males [43] could be a contributing factor, within this sample there was not a significant difference in experiencing sexual victimization. This suggests that this specific form of victimization may not have been a significant factor for this sample. This lack of difference in sexual victimization rates could be attributable to the sample being youth in the FCS as sexual victimization is a common reason for entry into the FCS and thus the percentage of males who experienced sexual victimization could be higher than in samples from the general population.

That the females in this sample felt less sexual esteem is concerning given the importance of being able to advocate for oneself in sexual situations. Fortunately, there were no differences in feelings of sexual autonomy or sexual communication ability. Unfortunately, with there being no comparison group outside the CWS, it is not clear if this meant the females in this sample felt more empowered than might be expected or if the males may have felt less empowered. The lower scores on condom use efficacy among females reinforce previous research that indicated that females in the CWS use condoms less than males [31,34], which is concerning. It is important to note, however, that the sample included several female youth who identified as lesbians or another sexual minority so condoms may not have applicable to their most recent sexual interaction. Even so, caregivers and providers working with female youth within the CWS need to heavily focus on messaging about the importance of using condoms or other protective barriers when engaging with others sexually. This needs to include discussions of safer sex practices during any sexual contact, regardless of whether it involves vaginal penetration.

This research further reinforces the importance of a focus on sexual identity development with youth. All of the measured aspects of sexual identity development had a significant impact on the youths' sexual health, indicating that caregivers and professionals need to be attuned to assisting youth in the FCS with the sexual identity development process. Active sexual identity exploration had a positive impact on sexual well-being, suggesting that those who work with youth should not avoid discussing sexuality. Instead, as advocated for by Hyde and colleagues [11], Lee and colleagues [44], and Brandon-

Friedman [3], among others, professionals should encourage an active exploration of it within safe and appropriate boundaries (note that this exploration does not need to be only physical, but rather can be introspective, educational, and/or emotional/romantic, to name a few non-physical types of exploration). That both solidified aspects of sexual identity (commitment and synthesis/integration) positively impacted sexual well-being demonstrates the importance of helping youth to achieve stability in their sexual identity.

Discussions of sexual orientation identity within publicly funded systems has become an area of political and procedural contention in many places, but sexual minority youth continue to be overrepresented in the CWS and to face discrimination and harassment within it from peers, professionals, and caregivers [45,46]. Further, it is legal in some states to restrict services to LGBTQ+ youth and to prevent LGBTQ+ caregivers from being foster caregivers within the CWS, further alienating LGBTQ+ individuals and stifling discussion of sexual orientation identity [46]. That within this study sexual orientation identity uncertainty negatively impacted sexual well-being further emphasizes the need not only for discussions around sexual orientation identity, but active and direct support for LGBTQ+ and questioning youth in the CWS as they explore their sexual orientation identity. This is especially true for males, as while the sexual orientation identity uncertainty scale was inversely related to sexual well-being for both genders, identifying as a sexual minority negatively impacted sexual well-being within all models for males.

Even though youth in FCS may face additional barriers pertaining to the development of healthy sexual identities and positive sexual well-being, research has shown that the conditions can and must be created for CWS professionals to make sexual health development a possibility. Nixon and colleagues [47] emphasized the need for agency policies and procedures that not only permit the discussion of sex, sexuality, and healthy relationships with youth within the CWS, but require it. They went so far as to suggest that these discussions be documented in the youths' files to ensure that the conversations is are held. Similarly, Harmon-Darrow and colleagues [10] noted that professionals within the FCS who see themselves as caregivers and therefore responsible for discussions of areas such as sexuality are able and willing to have these important conversations as long as they feel such conversations are permissible. Hyde and colleagues [11] provided further guidance, emphasizing the need for professionals to not only recognize the complexities and nuances of sexual health for YFC, but to explore how these youths' difficulties in recognizing, expressing, and processing emotions may contribute to difficulties navigating social environments where they might be pressured into having sex. To have these conversations, however, child welfare professionals and caregivers need training on how to determine who is best situated to facilitate these conversations and what methods should be used when discussing sex, sexual activity, and sexual values.

Fortunately, several curricula have been developed to assist professionals within the CWS with having these discussions. Covington and colleagues [48] evaluated POWER through Choices (PTC), which is a sex education group curriculum that was specifically designed for youth who reside outside of their primary home(s) such as those who are in the FCS, in congregate care communities, or who live within the juvenile justice system facilities. Covington and colleagues found that participants who were 17 years of age and above who completed the program showed lower rates of sexual activity, unprotected sex, and unintended pregnancy of themselves or a partner compared to the control group. Taylor and colleagues [49] evaluated the effectiveness of Making Proud Choices! For Youth in Out-of-Home Care (MPCOOH) for transition-age foster youth in extended foster care arrangements. The results showed a significant improvement in sexual and reproductive health knowledge, familiarity with birth control, and stronger attitudes toward sexual health and self-efficacy, after completing the program.

Foster caregivers also need encouragement to discuss sex and sexuality and training on how to do so. Brasileiro and colleagues [50] found that almost half of caregivers within the FCS felt unprepared to discuss relationships and sexual health with youth within their custody and almost three-quarters desired more training in these areas. This is despite

both caregivers and professionals within the FCS recognizing that this is a critical role for caregivers [51]. In order to meet the sexual well-being and sexual identity development needs of youth in the FCS, foster care agencies, whether public or private, need to not only provide this education to caregivers and professionals within the FCS but make it a requirement.

7. Limitations

This study had several limitations. Recruitment was primarily conducted via internet-based means, limiting participation by youth who do not have a digital presence. Further, much of the recruitment occurred through agencies, media, and social groups targeted toward youth formerly in the FCS. The youth who engage with such entities have made their identity as a youth formerly in the FCS a continuing part of their lives, which is not the case for all youth who were previously in the FCS. Those only in foster care a short time, those who were adopted, or those who had negative experiences within the FCS may be less likely to engage with such entities, thereby having less access to recruitment materials. Additionally, this was a cross-sectional study but sexual identity development is a process that unfolds over time. Finally, recruitment materials emphasized that the survey asked questions about sexuality and sexual health, which may have prevented youth who do not feel comfortable with such questions from participating.

8. Conclusions

The time between adolescence and transitional adulthood is critical for helping youth and young adults develop their own beliefs, norms, and values pertaining to safety, stability, well-being, and permanency. Critical components of this are youths' sexuality and sexual identity. This study focused on the development of sexual identity, sexual health, and sexual well-being for youth who were formerly involved in the FCS, as each of those are components of how youth will develop as sexual beings and each have important impacts on the rest of youths' well-being. It was one of the first to compare aspects of sexual health and sexual well-being between male and female youth using a single sample, providing a unique insight into gender-based differences.

All youth within the CWS deserve a more direct focus on assisting them with their sexual development. This study demonstrated that gender-based differences exist in sexual health and sexual identity development between females and males in the FCS. Females appear to have additional needs beyond those of males, suggesting particular attention be paid to working with them. Sexually-minoritized youth, and particularly sexually-minoritized male youth, also need prominent attention as indicated both here and in similar research [39]. The CWS needs to reaffirm its focus on all aspects of youths' well-being, which includes looking at places such as sexuality that may be less comfortable for some.

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