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Sexual Identity Development and Sexual Well-being: Differences Between Racial/Ethnic Minority and Non-Racial/Ethnic Minority Former Foster Youth

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Abstract

Little research has examined if there are differences in sexual well-being, negative sexual health outcomes, or levels of sexual identity development between racial/ethnic minority and non-racial/ethnic minority youth in the foster care system. Using a sample of youth formerly in the foster care system (n = 219), this study compared the sexual well-being, sexual identity development, and negative sexual health outcomes of racial/ethnic minority and non-racial/ethnic minority youth and found that racial/ethnic minority and non-racial/ethnic minority youth did not differ in overall levels of sexual well-being and had no significant differences in their levels of sexual identity development. There were differences in incidence of the youth or a partner having an STI/STD. These results indicate that there are few differences in sexual well-being, negative sexual health outcomes, or sexual identity development between racial/ethnic minority and non-racial/ethnic minority youth formerly in the foster care system. All four domains of sexual identity development predicted sexual well-being for non-racial/ethnic minority youth, but sexual orientation identity uncertainty did not predict sexual well-being for racial/ethnic minority youth, emphasizing the importance of sexual identity development. Attention to the sexual development and sexual health of youth in the foster care system continues to be lacking and should be expanded.

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Youth in the foster care system (YFC) are at heightened risk for negative sexual health outcomes and reduced levels of sexual well-being. They experience higher incidence of sexually transmitted infection/sexually transmitted diseases (STI/STDs) and unintended pregnancies, use less birth control and pregnancy prevention techniques, receive less responsive sexual health services and sexual education, engage in more transactional sexual activities, and have higher numbers of sexual partners than peers outside the foster care system (FCS) (Ramseyer Winter et al., 2016; Roberts et al., 2018). Despite the importance of social factors on sexual well-being, little research has examined how demographic factors impact the sexual well-being of YFC. This limits child welfare system (CWS) professionals' and foster caregivers' abilities to address cultural considerations when seeking to enhance YFC's sexual development and sexual well-being. This study sought to address this gap by examining the impact of YFC's racial and ethnic identities on their sexual well-being and negative sexual health outcomes.

1. Literature Review

1.1 Racial/Ethnic minority youths' experiences in the foster care system

Racial/ethnic minority youth (R/EMY) are over-represented in the CWS (Child Welfare Information Gateway, 2016). Most research indicates that these disparities exist throughout interactions with the CWS, starting with service referrals and continuing through neglect/abuse substantiation and then placement into foster care, though there are some variations in findings (Graham et al., 2018; Lovato-Hermann et al., 2016; Woodmass et al., 2017). R/EMY also are more likely to age out of the FCS, are prescribed psychotropic medications at a higher rate, and are more likely to live in congregate care settings when compared to non-R/EMY (Martin &

Connelly, 2015). Further, some research suggests that R/EMY reenter the CWS at higher rates (Semanchin Jones & LaLiberte, 2017). It must also be noted that some other factors may be influencing these disparities; when poverty and neighborhood and familial risk factors are taken into account, disproportionality rates decrease significantly, though they still continue to exist (Boyd, 2014).

While professionals and scholars have often believed that R/EMY have significantly poorer outcomes while in and upon leaving the CWS, recent analyses of outcome data have suggested this is not always the case. When examining utilization of mental health services during foster care, Villagrana (2016) found no differences between Black and White youth and only small differences between these two groups and Latinx youth after leaving the FCS. In a wide-ranging study exploring differences in educational attainment, employment, homelessness, and incarceration, Watt and Kim (2019) found that Black youth were less likely to be employed and more likely to experience incarceration than White youth, but also more likely to enroll in higher education; there were no differences in any outcomes between White and Latinx youth. Based on these findings, the authors stated that there are no clear advantages or disadvantages based on race/ethnicity other than for American Indian/Native American youth, who have clear disadvantages. Further, in their review of several outcomes after leaving care, Barth et al. (2020) found few differences between Black youth and White or “other racial category” (sic) youth. Taken altogether, these findings indicate that while there are some important between the experiences of R/EMY and non-R/EMY within and after leaving the CWS, differences between racial/ethnic groups may be smaller than is often perceived.

1.2 Sexual well-being and negative sexual outcomes

Sexual well-being is a comprehensive concept that moves beyond examining the presence of sexual dysfunction, disease, or violence to incorporate positive physical, interpersonal, and intrapsychic sexual components. Models of sexual well-being vary, but Hensel and Fortenberry (2013) include four domains, the physical, the emotional, the mental/attitudinal, and the social. By incorporating areas such as the ability to pursue sexual pleasure, sexual self-esteem, sexual safety, sexual self-determination, and the ability to engage in sexual communication, sexual well-being is more than just sexual health; it is a full state of wellness related to all aspects of sex and sexuality (Mitchell et al., 2021). For youth, recognition, development, and enactment of their sexual identity and expression of sexual desires may be beneficial to their sexual well-being, physical and mental health, social development, ability to achieve sexual satisfaction, and overall social integration (Balsam et al., 2015; Brandon-Friedman, Wahler, et al., 2020; Harden, 2014). Sexual well-being is also linked to reduced sexual and overall risk behaviors and improved overall health outcomes such as sexual abstinence, increased sexual frequency, use of condoms and other pregnancy prevention techniques, enhanced metal health and social integration, absence of STI/STDs, and reduced anti-social behaviors (Hensel et al., 2016).

1.2 Youth sexual identity development

While “sexual identity” is often conflated with sexual orientation identity, sexual identity is a much broader concept that includes all aspects of individuals’ intrapersonal, interpersonal, and social sexual and romantic beliefs, desires, and actions (Brandon-Friedman, 2019b). Sexual identity affects individuals’ sense of self, ability to engage sexually and romantically with others in a positive manner, avoid undesirable sexual health outcomes, and engage others in social

settings. Understood in this manner, while sexual orientation identity is an important aspect of sexual identity, it is only one component.

Understanding sexual identity development requires attention to myriad influences on sexual development. In broad terms, there are two key areas of influence on sexual identity development, the biological/intrapsychic and the social (for a more detailed discussion of youth sexual development and its importance in social services and social work education, see Brandon-Friedman, 2019b; Giertsen et al., 2021). Biological/intrapsychic influences include sexual maturation and increasing hormonal levels that occur as youth reach puberty and adolescence, both of which increase physiological responses to sexual stimuli and drives toward sexual activities. Socially, as youth age they tend to be exposed to increasing amounts of sexualized content and sexual discourse, leading them to seek out sexual information and possibly pursue sexual activities. While biological/intrapsychic are undoubtedly important, from a social services perspective it is more critical to examine the impact of the social environment, socialization, and other identity-related variables.

1.3 Sexual identity development and sexual well-being

Examining sexual identity development is important as it and the factors that contribute to its development can significantly impact sexual well-being. Worthington et al. (2008) developed a model of sexual identity development that can be useful for individuals of any sexual orientation identity. Their model moves beyond developmental models that focus on a series of steps or phases within sexual identity development by focusing instead on dimensions of sexual identity. Within their model, individuals can occupy different levels of each of the dimensions depending on how their sexual identity has developed. The four dimensions are *Commitment*, which indicates a commitment to a sexual identity without exploration of it;

Exploration, which indicates active exploration of sexual identity; *Synthesis/Integration*, which indicates individuals having synthesized their sexual identity and integrated it into their overall identity; and *Sexual Orientation Identity Uncertainty*, which indicates uncertainty regarding individuals' sexual orientation identities.

Their model was quantified in the Measure of Sexual Identity Exploration and Commitment (MoSIEC; Worthington et al., 2008). Most research using the MoSIEC has explored the relationship between aspects of sexual identity development and sexual health outcomes. In Worthington et al.'s (2008) initial research, they found a relationship between Sexual Identity Synthesis/Integration and two aspects of sexual well-being, sexual assertiveness and sexual self-consciousness, but later research by Muise et al. (2010) found no connection between Sexual Identity Synthesis/Integration and components of sexual health. Sexual Identity Exploration has also been shown to have a positive relationship with aspects of sexual well-being including sexual motivation, sexual assertiveness, sexual consciousness, a more developed sexual schema, and overall levels of sexual health (Muise et al., 2010; Parent et al., 2015; Reid, 2013; Sizemore & Olmstead, 2017; Worthington et al., 2008).

Recent research explored the relationship between MoSIEC subscales and sexual well-being among youth formerly in the FCS, finding that higher levels of Sexual Identity Commitment, Sexual Identity Exploration, and Sexual Identity Synthesis/Integration are predictive of enhanced sexual well-being, whereas Sexual Orientation Identity Uncertainty are predictive of lower levels of sexual well-being (Brandon-Friedman, Wahler, et al., 2020). Within these studies, both positive and undesirable aspects of sexuality were considered, demonstrating the versatility of the measure. Further, it was shown that the MoSIEC could differentiate between sexual minority and non-sexual minority youth, as the impacts of the subscales varied between

the two groups, a finding similar to that of the measure's original authors' analysis of individuals not specifically in the FCS (Brandon-Friedman, Pierce, et al., 2020; Worthington et al., 2008).

1.4 Race and ethnicity and sexual identity development

Studies exploring the intersection of racial/ethnic identity and sexual identity development focus primarily on sexual and/or gender minority individuals or men who have sex with men. This research suggests significant interactions between racial/ethnic identity and sexual orientation identity development, though those findings are not universal (Martos et al., 2015; Moreira et al., 2015; Watson et al., 2020). In general, youth who are racial/ethnic minorities have less developed sexual orientation identities than non-racial/ethnic minority youth, which has been linked to negative sexual outcomes and higher levels of sexual risk behaviors.

The small amount of research on sexual development among R/EMY that do not identify as sexual and/or gender minorities has found negative sexual health disparities between racial/ethnic groups compared to White peers even when the individuals were classified based on patterns of sexual behaviors (Haydon et al., 2012). Possible explanations include that race- or ethnicity-based discrimination and sociocultural conditions affect sexual development (Crooks et al., 2019), that differences in the importance of religiosity/spirituality between racial/ethnic groups affect social messaging about sexuality (Aparicio et al., 2014; Pearce et al., 2019), and that there are racial/ethnic differences in how parents discuss sexuality with youth (Aparicio et al., 2014; Wilson et al., 2010). None of this research examines how sexual identity development differs between racial/ethnic groups nor how sexual identity development impacts sexual health directly, however.

1.5 Sexual well-being and sexual risk outcomes for racial/ethnic minority youth

As with research on sexual well-being among YFC, most of the research on ethnic/racial differences and sexual well-being has focused on negative sexual health outcomes. Kann et al. (2018) found that Black and Latinx youth use less protective sexual health measures, while Murray Horwitz et al. (2018) reported that Black female youth had about half the odds of effective contraceptive use when compared to White female youth. Respress et al. (2018) reported higher rates of STI/STDs among R/EMY than non-R/EMY. On the other hand, in one study R/EMY reported greater rates of testing for STI/STDs than White youth (Cuffe et al., 2016), and some research has found few or no disparities in sexual risk behaviors or use of protective measures during sexual activities based on racial/ethnic identity (Toomey et al., 2017). In a review of the little research looking at positive aspects of sexual well-being, Potki et al. (2017) noted that sexual self-efficacy, sexual self-esteem and sexual satisfaction are lower among Black individuals when compared to other racial/ethnic groups. Taken together, these sometimes contradictory findings indicate that further research is needed to understand how racial/ethnic identities impact sexual well-being.

Research examining possible causal factors for these disparities has generally focused on the social environment. Poverty, single parent-heading household, neighborhood-based disadvantages, overall levels of social support, and parenting styles have been shown to be contributing factors, though they do not fully account for the disparities (Aparicio et al., 2014; Carlson et al., 2014; Decker et al., 2018). Experiencing stigma as a racial/ethnic minority and differing cultural attitudes toward sexuality may also contribute, as significant disparities in the sexual health outcomes between R/EMY and non-R/EMY in samples of sexual and/or gender minority youth have been attributed to the R/EMY youth experiencing a “double multiple

minority" status, variations in cultural beliefs about sexual orientation and gender, and to a lack of attention to race/ethnicity-based discrimination (Perez et al., 2020; Toomey et al., 2017), all of which might also apply to R/EMY in the FCS.

1.6 Sexual well-being and sexual risk for YFC

When comparing YFC to peers not in the FCS, a primary difference is their social milieu. Previous research has indicated that experiencing emotional abuse, sexual abuse, neglect and exposure to parental substance use and neighborhood violence, all of which are risk factors for entering the FCS, can have negative impacts on sexual identity development and sexual well-being (Ahrens et al., 2013; Brandon-Friedman & Fortenberry, 2020; Dragowski et al., 2013). Many YFC have also experienced sexual abuse and traumatic losses, which are risk factors for reduced ability to form coherent sexual identities, lower levels of sexual well-being, and undesired sexual health outcomes (Ahrens et al., 2013; Brandon-Friedman & Fortenberry, 2020).

1.7 Sexual well-being and sexual risk outcomes for R/EMY in the CWS

Comparisons in sexual well-being between racial/ethnic groups within the CWS are very limited. King et al. (2014) found Black and Latinx youth were more likely to give birth while in the foster care system than White youth, while Ahrens et al. (2013) noted differences between Black youth and youth of other races in engagement in transactional sex and in having a diagnosis of an STI/STD for themselves or a partner. Recent work by Diamant-Wilson and Leathers (2020) explored safer sex strategies among African American YFC and found that African American YFC use condoms at the same or higher rate than peers not in the FCS and that the YFC engage in STI/STD testing at higher rates than those outside the FCS. As this research only included African American youth, it was not possible to determine if there were any differences between racial/ethnic groups. With this limited body of work, it is not surprising

that Dworsky (2018) advocated for more research examining differences in sexual and reproductive healthcare needs between YFC from different racial/ethnic groups.

2. Research Hypotheses

Previous research does not fully explore differences in the sexual well-being or negative sexual health outcomes between R/EMY and non-R/EMY in foster care. Further, there has been no attention to differences in the sexual identity development between R/EMY and non-R/EMY. Understanding differences in the experiences between these groups is essential for practitioners to be able to tailor sexual well-being-related interventions for R/EMY. As such, this study sought to examine the impact of racial/ethnic identities on youth formerly in the FCSs' sexual identity development, sexual well-being, and negative sexual health outcomes. The research hypotheses were that among youth formerly in the FCS, R/EMY would have lower levels of overall sexual well-being and higher levels of negative sexual health outcomes than non-R/EMY, that R/EMY would have less developed sexual identities, and that while aspects of sexual identity will impact the sexual well-being of both groups, the impacts will be different.

3. Method

3.1 Recruitment and participants

The data for this analysis came from a larger study exploring aspects of sexual well-being among youth formerly in the FCS (Brandon-Friedman, 2019a). Participants were recruited through various means: direct email to organizations and agencies that serve youth formerly in the FCS asking them to distribute the information to youth; advertising in a magazine aimed at youth formerly in the FCS; posting in Facebook groups for youth formerly in the FCS, groups for current foster families, and groups for professionals serving youth in the FCS; emailing schools of social work and asking them to distribute the recruitment information to students and

staff; and through snowball sampling. Participants were provided a $20 e-gift card as compensation for their time. Email addresses for distribution of the e-gift cards were collected separate from the study data to maintain participant anonymity.

Two hundred and twenty-seven youth formerly in the FCS completed the web-based survey examining how sexual socialization experiences impact their sexual identity development and how that development affects their levels of sexual well-being. Removal of data from eight multivariate outliers left a sample size of 219. Table 1 presents participant demographics. Youth were asked to select their racial/ethnic identity from a provided list or they could write in another identity if they did not identify with any of the listed options. Due to sample size limitations, it was not possible to make comparisons between different minority racial/ethnic groups. For the purposes of this analysis, any youth who selected a racial or ethnic identity other than White was classified as a R/EMY. Those who selected only White were classified as a non-R/EMY. Individuals who selected another racial or ethnic identity and White were classified as R/EMY. A total of 132 participants (60.27%) were classified as R/EMY and the other 87 (39.73%) were classified as non-R/EMY.

3.2 Measures and analysis

3.2.1 Sexual identity development

The Measure of Sexual Identity Exploration and Commitment (MoSIEC; Worthington et al., 2008) was used to evaluate sexual identity development. The measure consists of four sexual identity status, each of which is measured on its own. The four statuses are Commitment (6 items), Exploration (8 items), Syntheses (5 items), and Sexual Orientation Identity Uncertainty (3 items). There is no summary score for the MoSIEC as each status is measured independently.

3.2.2 Sexual well-being

A modified version of a multidimensional model of sexual well-being originally developed by Hensel and Fortenberry (2013) was used to measure sexual well-being. As the measure was initially developed to be used only with adolescent women, several items had to be rephrased to make them applicable to individuals of any sex and one item that specifically referred to the vagina was removed. One subscale, Fertility Control, was removed from the overall measure as that focused on avoidance of pregnancy during the teen years and thus was not applicable to this sample. A further item from the Sexual Anxiety subscale was removed due to a data entry error. The revised measure consisted of 32 items divided into eight subscales. Seven of the subscales, Relationship Quality, Sexual Communication, Sexual Autonomy, Condom Use Efficacy, Sexual Esteem, Sexual Anxiety, and Genital Pain, utilized a four-point Likert-type scale that ranged from Strongly Disagree to Strongly Agree. The final subscale, Sexual Satisfaction, used a seven-point semantic differential scale to measure how satisfied participants were with their current or most recent sexual partner. Participants' overall levels of sexual well-being were calculated by converting the individual's scores on each of the 32 items to *z*-scores and then summing the *z*-scores to account for differences in the measurement levels.

3.2.3 Negative sexual health outcomes

Four prompts were used to measure negative sexual health outcomes, 1) having been diagnosed with an STI/STD, 2) having experienced sexual victimization (as defined by the participant), 3) having engaged in transactional sex (defined as exchanging sexual activities for food, money, or other goods such as clothing, drugs, alcohol, or other needs), and 4) having experienced an unintended pregnancy themselves or of a partner.

3.3 Analysis

Differences between racial/ethnic minority and non-racial/ethnic minority youth were calculated using χ^2 for dichotomous variables and independent measures *t*-tests for continuous variables. Hierarchical regression was used to evaluate the impact of the four statuses of sexual identity development on levels of sexual well-being. Analytic controls used in the regression calculations were: length of time in the foster care system (in years), gender identity (reference group: female), sexual orientation identity (reference group: heterosexual), and relationship status (reference group: single).

4. Results

4.1 Time in foster care

R/EMY reported significantly earlier entry ($\overline{x}$ = 11.34 years old versus 12.41, overall range 0 to 17, $t = 2.12$, $p < .05$) and later exit (17.76 years old versus 16.72, overall range 12 to 23, $t = -3.41$, $p < .001$), and, consequently, longer overall time in the FCS ($\overline{x}$ = 6.42 years versus 4.31, overall range 1 to 20 years, $t = -3.71$, $p < .001$; Table 2) as well as than non-R/EMY.

4.2 Level of sexual well-being and sexual risk behaviors

Reliability on the sexual well-being subscales varied significantly, though Cronbach's α for overall sexual well-being was high (α = .92; Table 2). Contrary to hypotheses, there was no difference in overall levels of sexual well-being between R/EMY and non-R/EMY (*z*-score $\overline{x}$ = 2.02 versus -1.33, $t = -1.39$, $p > .05$; Table 2). The only area of difference was in sexual autonomy, in which R/EMY had higher levels than non-R/EMY ($\overline{x}$ = 10.31 versus 9.70, $t = -2.21$, $p < .05$; Table 2). In terms of negative sexual health outcomes, the only difference was that R/EMY were more likely to have been diagnosed with an STI/STD ($\chi^2 = 3.95$, $p < .05$; Table 3).

4.3 Sexual identity development

As the MoSIEC has four independent subscales, four analyses were run, one for each subscale. All four MoSIEC subscales demonstrated appropriate reliability (α = .72 to .91; Table 3). There were no statistically significant differences between R/EMY and non-R/EMY in levels of sexual identity commitment ($\bar{x}$ = 29.74 versus 30.34, possible range 6 to 36, t = 0.74, p >.05), sexual identity exploration ($\bar{x}$ = 33.92 versus 34.76, possible range 8 to 48, t = 0.58, p >.05), sexual identity synthesis ($\bar{x}$ = 25.26 versus 25.11, possible range 5 to 30, t = -0.23, p > .05), or sexual orientation identity uncertainty ($\bar{x}$ = 5.36 versus 5.46, possible range 3 to 18, t = 0.23, p >.05). This indicates that the sexual identities of the R/EMY and non-R/EMY in this sample had developed similarly.

4.4 Impact of sexual identity development on sexual well-being

4.4.1. Sexual Identity Commitment

The first model was the same for all MoSIEC subscales, so the results are only presented here one. As predicted, there were significant differences in how aspects of individuals' lives and identities impacted their sexual identity commitment. For R/EMY, the first model was significant, (F(4, 127) = 4.049, p < .01; R^2 = 11.3%; Table 4) as was the second model (F(5, 126) = 7.675, p < .001; R^2 = 23.3%; ΔR^2 = 12.0%). Within the first model, gender identity was a significant predictor (β = .200, p < .05), as was sexual orientation identity (β = -.250, p < .01). In this case, identifying as female negatively impacted sexual well-being, as did identifying as a sexual minority. Within the second model, however, none of the predictors from the first model continued to have a statistically significant impact. Sexual Identity Commitment was a significant positive predictor of sexual well-being (β = .396, p < .001), meaning that for R/EMY the higher their level of sexual identity commitment, the better their overall sexual well-being.

For non-R/EMY, the first model was also significant, ($F(4, 82) = 3.149$, $p < .05$; $R^2 =$ 13.3%), with length of time in the foster care system being a significant predictor ($\beta = -.245$, $p <$ .05). The second model was also significant, ($F(5, 81) = 11.969$, $p < .001$; $R^2 = 42.5\%$; $\Delta R^2 =$ 29.2%). The impact of length of time in the foster care system reduced to being not significant ($\beta = -.035$, $p > .05$), but gender identity became a significant predictor ($\beta = .200$, $p < .05$). The Sexual Identity Commitment subscale was a significant predictor ($\beta = .605$, $p < .001$). As with R/EMY, the higher their level of sexual identity commitment, the better their sexual well-being was. Notably, for R/EMY, being female predicted lower levels of sexual well-being, meaning that being female contributed to have lower levels of sexual well-being.

4.4.2 Sexual Identity Exploration

As with Sexual Identity Commitment, there were significant group differences for Sexual Identity Exploration. For R/EMY, the second model was a significant predictor of sexual well-being ($F(5, 126) = 5.028$, $p < .001$; $R^2 = 16.6\%$; $\Delta R^2 = 5.3\%$). In this instance, gender identity and sexual orientation identity continued to be significant predictors ($\beta = .189$, $p < .05$ and $\beta = -.324$, $p < .01$, respectively). Thus, identifying as female or a sexual minority predicted lower levels of sexual well-being. Sexual Identity Exploration was a positive predictor of sexual well-being ($\beta = .246$, $p < .001$). As such, for these youth, the higher their level of sexual identity exploration, the better their sexual well-being was.

For non-R/EMY, the second model was also significant ($F(5, 81) = 4.997$, $p < .001$; $R^2 =$ 23.6%; $\Delta R^2 = 10.3\%$). Length of time in the FCS remained a significant predictor ($\beta = -.237$, $p <$ .05), and the impact of sexual orientation identity increased to a significant level ($\beta = -.225$, $p <$ .05). As with R/EMY, Sexual Identity Exploration was a positive predictor of sexual well-being

(β = .327, $p < .01$). As with the R/EMY, having a higher level of sexual identity exploration predicted higher levels of sexual well-being.

4.4.3 Sexual Identity Synthesis/Integration

For R/EMY, the second model remained predictive of sexual well-being ($F(5, 126) = 6.008$, $p < .001$; $R^2 = 19.3\%$; $\Delta R^2 = 7.9\%$). As happened with the model examining Sexual Identity Commitment, sexual orientation identity remained a significant predictor (β = -.185, $p < .05$), with identifying as a sexual minority predicting lower levels of sexual well-being. Sexual Identity Synthesis/Integration was a positive predictor of sexual well-being (β = .305, $p < .001$). Following the other scales, the higher the level of sexual identity synthesis, the higher the youths' level of sexual well-being was.

The second model was predictive of sexual well-being at a statistically significant level for non-R/EMY ($F(5, 81) = 8.757$, $p < .001$; $R^2 = 35.1$; $\Delta R^2 = 21.8\%$). Sexual Identity Synthesis/Integration was a positive predictor of sexual well-being (β = .496, $p < .001$). As with Sexual Identity Exploration, in the second model none of the other individual predictor variables had a significant impact on sexual well-being. In this instance, for non-R/EMY, being a sexual minority or not did not make a difference in the youth's sexual well-being but having a higher level of sexual identity synthesis did positively impact sexual well-being. Sexual orientation identity not predicting sexual well-being for non-R/EMY but doing so for R/EMY was a notable difference.

4.4.4 Sexual Orientation Identity Uncertainty

As with the other sexual identity development domains, the second model was predictive of sexual well-being for R/EMY ($F(5, 126) = 4.002$, $p < .05$; $R^2 = 13.7\%$; $\Delta R^2 = 2.4\%$). Unlike any other domains, Sexual Orientation Identity Uncertainty was not a significant predictor for

R/EMY (β = -.171, $p > .05$). This indicates that the R/EMYs' level of sexual identity uncertainty did not impact their overall level of sexual well-being.

Similarly, the second model was predictive of sexual well-being for non-R/EMY ($F(5, 81) = 6.265$, $p < .001$; $R^2 = 27.9\%$; $\Delta R^2 = 14.6\%$). As with Sexual Identity Synthesis/Integration, none of the other predictor variables had a significant impact on overall levels of sexual well-being. As opposed the R/EMY, however, Sexual Orientation Identity Uncertainty did predict sexual well-being (β = .410, $p < .001$), with higher levels of uncertainty predicting lower levels of sexual wellbeing. That Sexual Orientation Identity Uncertainty was a significant predictor of sexual well-being for non-R/EMY but not for R/EMY suggests that processes related to sexual orientation identity development impact R/EMY and non-R/EMY in different manners.

5. Discussion

This study sought to examine differences sexual well-being, negative sexual health outcomes, and sexual identity development between R/EMY and non-R/EMY formerly in the FCS. Contrary to the hypotheses, few differences were found between groups. Previous research has identified significant disparities in sexual health outcomes between racial and ethnic groups (Kann et al., 2018; Murray Horwitz et al., 2018), but it must be noted that none of these samples focused on YFC. That which did found more protective sexual health behaviors among Black youth in the FCS (Diamant-Wilson & Leathers, 2020) and that Black YFC are able and willing to implement safer sex methods within intimate relationships (Diamant-Wilson & Williams, 2021). The inclusion of positive components of sexuality within this current study could thus account for the lack of significant differences.

Further, recent research examining changes in attitudes toward risky sexual behaviors as YFC approach emancipation found no differences in the trajectories of White versus Non-White

youth (Martin et al., 2021). This suggests that as YFC age differences based on race/ethnicity become less impactful. The youth within the present study had spent an overall average of 5.58 years in the FCS with 49.3% aging out (data not reported), and within Martin et al.'s study time in the FCS increased positivity toward sexual risk behaviors, which also may have led to a dampening of the differences between the groups. If so, this could indicate a heightened impact of the milieu of the FCS as youth age, emphasizing the importance of addressing environmental influences on the sexual well-being of YFC.

It is important to recognize that R/EMY did have a greater incidence of having been diagnosed with an STI/STD. Having an STI/STD is not only an immediate health concern, but can impact later sexual and overall health in addition to increasing stigmatization (World Health Organization, 2017). R/EMY are already subjected to greater levels of discrimination and harassment, and the additive effect of further layers of stigmatization based on their sexual well-being could have an outsized impact on their overall well-being (Flentje et al., 2020). It is also notable that uncertainty regarding sexual orientation identity had a negative impact on sexual well-being for non-R/EMY but not R/EMY. Many R/EMY sexual minorities struggle with identity conflicts between their racial/ethnic identity and their sexual orientation identity leading to greater mental health concerns (Sarno et al., 2015), but in this case uncertainty regarding sexual orientation identity did not impact sexual well-being in a negative manner for them even as it did for non-R/EMY. This suggests a need for further attention toward the impact of racial/ethnic socialization and the intersections of race/ethnicity and sexual orientation identity.

While few significant differences in sexual well-being and negative sexual health outcomes were found between R/EMY and non-R/EMY youth within this study, differences have been documented in other research and professionals should be attuned to the sexual well-

being needs of R/EMY. Programing such as *¡Cuídate!* (for Latino youth; Villarruel et al., 2006), Horizons (for Black females; DiClemente et al., 2009), Native It's Your Game (for Native and Indigenous youth; Craig Rushing et al., 2018) and training for barbers on how to address sexuality and parenting with Black males (Randolph et al., 2017) have had promising results and agencies serving R/EMY in the FCS should be explore implementing them.

Results from this study further emphasize the importance of the sexual identity process for all youth. Much of the research on sexual identity development continues to focus on sexually-minoritized individuals, but research using mixed samples has demonstrated the significant impact that all aspects of sexual identity development can have on various aspects of sexual health (Brandon-Friedman, Pierce, et al., 2020). Other analyses have indicated that all four of the evaluated sexual identity statuses have an impact on sexual well-being when demographic variables are controlled for (Brandon-Friedman, Wahler, et al., 2020; Muise et al., 2010; Parent et al., 2015). A lack of attention to sexual identity development among non-sexually-minoritized youth limits the knowledge base regarding the importance of sexual identity development and the development of interventions targeting this area of all youths' lives.

As noted previously, social and cultural environments and messaging have outsized impacts on youths' sexual development and sexual behaviors, and YFC report receiving negative messaging about sexuality and as well as modeling of negative relationships patterns (Ahrens et al., 2016; Brandon-Friedman et al., 2017). Such messages can hamper the youths' sexual development and subsequent sexual well-being. Unfortunately, sexuality remains an under-addressed area of YFC's lives, even among social service providers (Giertsen et al., 2021). Research consistently shows that CWS professionals and foster caregivers report feeling unprepared to address sexuality and sexual development with the youth in their care (Albertson

et al., 2020; Harmon-Darrow et al., 2020). Additional barriers include religious beliefs of foster parents, perceived or actual system-based proscriptions against sexual education, and underdeveloped relationships between youth and foster parents and CWS professionals (Brandon-Friedman et al., 2017; Serrano et al., 2018). Additional work needs to be done to educate foster caregivers, CWS professionals, and those responsible for state- and agency-level policies about the importance of sexual development.

Several programs have been developed that focus on training those who work with YFC on how to address youth sexuality. Additional programs focus on the youth themselves, providing the sexual education they are often missing. Examples of these include Making Proud Choices! For Youth in Out-of-Home Care (Taylor et al., 2020) and POWER Through Choices (Covington et al., 2016). Colarossi et al. (2019) recently documented the valuable impact that sexual and reproductive health capacity building can have on creating environments that proactively address youths' sexuality in an open, affirming, and medically accurate manner to increase positive sexual growth within organizations that serve youth in the CWS.

6. Strengths and Limitations

One strength of this manuscript is that it used the youths' self-classification of their race/ethnicity. Research has demonstrated significant differences in how youth self-identify their race/ethnicity versus how others classify them, with the important implications for outcome measures (Schmidt et al., 2015). Letting youth provide their own identification is especially meaningful when exploring something as intimate as sexual identity development and sexual well-being.

This study had several limitations. Recruitment was primarily conducted via internet-based means, likely 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 former foster youth. The youth who engage with such entities have made their identity as a former foster youth a continuing part of their lives, which is not the case for all youth who were previously in the FCS. Those youth only in foster care a short time, those who were adopted, or those who had very negative experiences may be less likely to engage with such entities, thereby having less access to recruitment materials. Finally, this was a cross-sectional study but sexual identity development is a process that unfolds over time.

While there are many strengths to using youths' own racial/ethnic identity to classify them, other people react to and engage with youth based on their perceptions of the youths' identities, which may be different from the youths' own identities. These differences may have impacted the messaging the others directed toward the youth. Additionally, sample size limitations prevented examining differences between subgroups of racial/ethnic minorities, even though there is significant heterogeneity between racial/ethnic groups. Further research exploring the important differences between racial and ethnic minority groups is needed. 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.

7. Summary

This study sought to examine differences in the sexual well-being, sexual identity development, and negative sexual health outcomes between R/EMY and non-R/EMY formerly in the FCS. While research using samples not focused within the FCS has often shown that R/EMY have worse sexual health outcomes than non-R/EMY, there were few differences identified in this study. More recent research has suggested the importance of a larger focus on

social and cultural components that impact youths' sexual well-being, which may be particularly important for YFC as they face disparities in sexual well-being compared to youth not in the FCS. Interventions designed to enhance sexual well-being always must take racial and ethnic factors into account, but these may not be the most impactful factors among YFC. (WORD COUNT: 5,848)

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