

Sources and Usefulness of Information on Sexuality and Sexual Health: A descriptive cross-sectional study of Lesbian, Gay, Bisexual and Questioning Adolescents

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Declaration

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Summary

The development of positive sexual health behaviours in adolescence can lay the foundation for positive sexuality and relationships across the life course. Comprehensive, trusted, age appropriate, relevant sexual education gives adolescents the tools they need to feel more confident in making informed decisions and developing healthier and more satisfying relationships. Information on sexuality and sexual health is primarily delivered through family, schools, community and friends. However, in the context of LGBTQ adolescents these sources of information have been found to be inadequate. There is a lack of evidence on where LGBTQ adolescents access information on sexuality and sexual health.

Aim and Objectives of the Study

While the overall aim of the study was to gain a deeper understanding of the sources and usefulness of information that LGBTQ adolescents (age 13-19) on sexuality and sexual health, there were four specific objectives for this study.

These objectives were to:

- identify sources of information and their usefulness that LGBTQ adolescents of secondary school age (13-19) use in relation to sexuality and sexual health,
- ascertain how useful LGBTQ adolescents find the sources of information in relation to sexuality and sexual health,
- discover which sources of information and their usefulness that LGBTQ adolescents use for different topics, such as Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/Activity and
- identify the impact of demographic variables on the sources of information that are used and are considered useful by LGBTQ adolescents.

Design

A quantitative descriptive cross sectional survey design was selected for this study. An anonymous online survey was used to investigate the experiences of lesbian, gay, bisexual and questioning (LGBTQ) adolescents, aged 13-19, sources of information on sexuality and sexual health. Descriptive statistics were used to describe the profile of the participants and the sources of information used for twenty topics and their usefulness related to sexuality and sexual health under the category headings Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/

Activity. Inferential statistics were used to determine experiences relative to age, gender at birth and living location.

Findings

Key findings from this study indicate that there is no single source of information used by respondents across all topics. The sources of information differ depending on the category of topics. For the Friendship and Sexual Orientation category, the sources most often cited were LGBQ Friends and LGBQ Community for three out of four topics, LGBQ Relationships, Finding LGBQ Friends and Coming Out. The main source of information for Sexual Attraction and Orientation was LGBQ Focussed Internet Search. For the topics in the Readiness for Safer Sex Category, (pregnancy, contraception, sexually transmitted infections, safer sex (condoms)), what it means to consent and how to know I am ready for sex), sources were non LGBQ focussed with families, school and general internet search the primary sources of information with varying usefulness.

For intimate topics in the Sexual Behaviour/ Activity category, primary sources were LGBQ Friends and LGBQ Community, LGBQ focussed internet search and Porn (pornography). Porn was the primary source of information for five topics in this category namely Genital Touching, Masturbation, Oral Sex, Vaginal Sex and Anal Sex. Non-LGBQ Friends were also a primary source of information for vaginal sex.

Conclusion

Findings indicate that different sources were used for different topics. Primary sources of information are a combination of in-person and internet/ media sources. The most used sources were mother/ female guardian, LGBQ and non-LGBQ friends, LGBQ community, school/ teacher, internet searches (LGBQ and non-LGBQ focussed) and porn, all with varying usefulness.

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1 An Overview of the Thesis

1.1 Introduction

The development of positive sexual health behaviours in adolescence can lay the foundation for positive sexuality and relationships across the life course. Having sufficient information on sexuality and sexual health is one factor that can contribute to this (Steinberg 2011), however international research has continually demonstrated that the informational and educational sexual health needs of LGBTQ adolescents are not addressed (Hillier *et al.* 2005, Farrington *et al.* 2014, McCarty- Caplan 2015, Rasberry *et al.* 2017, Nelson *et al.* 2019b, Rabitte 2020, Költő *et al.* 2021, Mata *et al.* 2022). In addition, there is a lack of evidence on where LGBTQ adolescents access information on sexuality and sexual health. This chapter, the first of the thesis provides a brief background to the rationale and aim of the study. A concise overview of the contents of the thesis is also provided.

1.2 Context and Background

Sexual development is central to adolescent development and a person's self-esteem is influenced by the comfort and confidence they possess in relation to their sexuality (National Youth Council of Ireland 2004, Damas *et al.* 2012). A lack of trusted sexual and reproductive health information has implications for individuals' early safe sex behaviour (Pound *et al.* 2017) as well as how they think and feel about intimacy, romance, sexuality and sexual orientation. It is therefore considered important that all adolescents have access to trusted, age-appropriate and comprehensive information on sex and sexuality so that they are enabled to develop comfort and confidence in their sexuality (National Youth Council of Ireland 2004, Department of Health 2015, Carboni and Bhana 2017). For heterosexual adolescents in a heteronormative society this is less challenging than for adolescents questioning their sexual orientation or adolescents who find themselves sexually attracted to the same sex (lesbian/ gay) or both sexes (bisexual).

Over the past few decades there has been a policy drive by successive Irish governments to improve the overall sexual health of the population. Collating and

reporting data on sexual activity, sexual behaviours and sexual health outcomes in the population was an element of this. Findings from these activities suggested that while the rates of unintended pregnancy were reducing, there was an increase in the notifications of sexually transmitted infections (STI) from 3,361 in 1995 to 12,753 in 2013, with the greatest burden of STIs in those under 25 and men who have sex with men (Health Protection Surveillance Centre 2020). The data collected also aided the development of the National Sexual Health Strategy 2015-2020 (Department of Health 2015).

While traditionally the focus of sexual health has been on physical health i.e., the absence of disease and prevention of crisis pregnancy, there is now a more holistic view of sexual health that encompasses emotional, physical and social wellbeing (WHO 2010). This holistic view maintains that optimum sexual health consisting of safe and pleasurable sexual experiences while maintaining a positive approach to sexuality are paramount (WHO 2010), which is reflected in the National Sexual Health Strategy (Department of Health 2015). While sexual health focuses on pleasurable and safer sexual experiences, sexuality is a broader concept and is a facet of human life that incorporates and is expressed in identity, intimacy, romance, sexual behaviours, sexual orientation, sexual health and the attitudes, values and behaviours associated with these (WHO 2010).

This National Sexual Health Strategy (Department of Health 2015) had two main objectives, the first was to develop structures to provide a quality sexual health service to the population (Department of Health 2015). This included building capacity in professionals with responsibility for teaching sex education and in those involved in sexual health promotion through the Foundation Programme in Sexual Health Promotion. This programme which was spearheaded by the Health Service Executive (HSE) which endorses a holistic view of sexuality that focusses on promoting healthy attitudes and values around sexuality and sexual health, as opposed to the traditional medical approach, which is aimed at reducing STIs, unintended pregnancy and sexual violence (Higgins *et al.* 2021).

The second objective of the strategy was to reduce the taboo associated with sex and sexuality in adolescents (Department of Health 2015). Given the evidence that quality sexuality education promotes healthy sexual development and increases an individual's ability to maintain a healthy sexuality throughout life which in turn reduces stigma (Department of Health 2015), early exposure to age appropriate and

comprehensive high quality sexuality education was considered one way of achieving this objective. This was also considered important for the overall development of healthy attitudes in adolescence and to ensure that positive views of sexual health and wellbeing continued throughout their life.

1.3 Rationale for the Study

As stated, the focus of sexual health has traditionally been on physical health within a heterosexual community i.e. the absence of disease and prevention of crisis pregnancy (Donaldson *et al.* 2013, Lindberg *et al.* 2016), while there is now a more holistic focus of sexual health. Early access to high quality sexual education is considered one of the most effective ways to improve sexual health outcomes (Blake *et al.* 2001, Weiss 2007, Power *et al.* 2009, Rose & Friedman 2012, Department of Health 2015). Comprehensive, trusted, age appropriate, relevant sexual education gives adolescents the tools they need to feel more confident in making informed decisions and developing healthier and more satisfying relationships (Braeken & Cardinal 2008, WHO, 2010, Carboni & Bhana 2017). Information on sexuality and sexual health is primarily delivered through family, schools, community and friends. However, in the context of adolescents who do not identify as heterosexual these sources of information have been found to be inadequate (Hillier & Mitchell 2008).

Lesbian, gay, bisexual or questioning (LGBQ) people are at increased risk of health disparities in comparison to people who identify as heterosexual (Saewyc *et al.* 1999, Blake *et al.* 2001, Bailey *et al.* 2004, Hillier *et al.* 2010, Bruce & Harper 2011, Mustanski *et al.* 2011, Rothman *et al.* 2011, Charest *et al.* 2016, Kann *et al.* 2016). Some of the disparities, have been linked to increased risk taking (younger age of sexual debut, higher number of sexual partners, higher use of alcohol and drugs, increased sexual experimentation and decreased condom use) (Blake *et al.* 2001, Mustanski *et al.* 2011). However, research into why young LGBQ adolescents take more risks or have poorer outcomes is sparse (Mustanski *et al.* 2011). It is also argued that young LGBQ people may not have access to adequate sex education or health promotion material other than education that is biased towards heterosexuality (Connolly & Lynch 2016). In addition, for confidentiality reasons or as they fear discrimination, adolescents may conceal their sexual orientation when accessing healthcare and therefore not receive appropriate information, even if it were available

(Rose & Friedman 2012, Arbeit *et al.* 2016, Connolly & Lynch 2016). Establishing positive sexuality and good sexual health practices when adolescents are still sexually inexperienced is considered more effective than trying to change established patterns of risky sexual behaviours in adulthood (Cowan 2002, Flores *et al.* 2011, Masters *et al.* 2013, Nelson *et al.* 2019b, Morales *et al.* 2020). This can be achieved by providing young LGBTQ people with sufficient, trustworthy, age-appropriate relevant information (Flores *et al.* 2011).

Studies with LGBTQ adults suggest that school-based sexuality education is not always applicable to young LGBTQ people due to its heterosexual bias (Blake *et al.* 2001, Buston and Hart 2001, Pingel, *et al.* 2013, Formby and Donovan 2020). Consequently, young LGBTQ people must use alternative information sources, specifically the internet (Kubicek *et al.* 2010, Charest *et al.* 2016, Currin *et al.* 2017). While these studies provide important albeit limited information, they may not be applicable to the younger sector of LGBTQ people (ages 13-19) as they are retrospective accounts of adults, which could be subject to recall bias. They may be influenced by the later stages they have experienced, the significant developmental changes that occur in their lives from 17-19 years when they leave school, commence work or college, have reduced parental influence (Mustanki *et al.* 2011), and have access to additional sources of information.

Developing an understanding of sources of information LGBTQ adolescents use at different ages can assist policy makers and information providers develop suitable health promotion information packages to foster a positive approach to sexual health especially in formative years while adolescent identity is still developing. It may also indirectly reduce the stigma experienced by LGBTQ adolescents (Hillier and Mitchell 2008). The focus of this study is LGBTQ adolescents and while it is expected that some of the LGBTQ population who complete the study may identify as non- binary or transgender, emphasis within this study is on minority sexual orientation groups as opposed to minority gender identity groups. Hence a decision was made from the outset not to conflate sexual orientation and gender identity in selecting the population for the study. However, the gender of participants is collected as a demographic variable.

The ages range of 13 to 19 was chosen for this study as it represents the age when adolescents recognise their sexual orientation and become sexually active (Hillier *et al.* 2010). It is also the age that young people are in second level school education so are

exposed to Relationships and Sexuality Education (RSE). However, to provide information for health promotion, it is important to know what sources of information young LGBQ people use and find helpful. Knowing the sources of information that LGBQ adolescents use and the topics they seek information on can help policy makers, LGBQ advocacy services and educational services plan and deliver relevant, appropriate and LGBQ inclusive information.

1.4 Aim of the Study

This research study aims to gain a deeper understanding of the sources and usefulness of information of LGBQ adolescents aged 13-19, on sexuality and sexual health.

1.5 Objectives of the Study

While the overall aim of the study was to gain a deeper understanding of the sources and usefulness of information that LGBQ adolescents (age 13-19) on sexuality and sexual health, there were four specific objectives for this study.

These objectives were to:

- identify sources of information and their usefulness that LGBQ adolescents of secondary school age (13-19) use in relation to sexuality and sexual health,
- ascertain how useful LGBQ adolescents find the sources of information in relation to sexuality and sexual health,
- discover which sources of information and their usefulness that LGBQ adolescents use for different topics, such as Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/Activity and
- identify the impact of demographic variables on the sources of information that are used and are considered useful by LGBQ adolescents.

1.6 Personal Background to Thesis

As a children's nurse, I have always had a specific interest in adolescent health and this got me involved in the LGBTIreland study as part of the research team in 2014 (Higgins *et al.* 2016). This was a national study of mental health of lesbian, gay,

bisexual and transgender and intersex people (LGBTI)¹ with a special emphasis on adolescents, in Ireland. During this study, I completed qualitative interviews with adolescents about their mental health and experiences in Ireland at that time. Several things occurred to me when completing the interviews. The first was that participants were very clear that traditional sources of information such as school or parents did not provide them with sufficient information about how to navigate their sexual orientation and the LGBTI dating world. Neither did it provide them with information on what to do when they became sexually active. I wondered therefore, where they had sourced their information.

During one interview with an adult male, he focussed on how a lack of information meant he was not prepared for the LGBTI dating scene when he entered it in late adolescence. He discussed how he felt a lack of necessary information contributed to some negative experiences. He considered himself uneducated and naïve and while no adverse events happened, he considered this was more luck than down to any protective measures he had taken himself. These interviews and my involvement in the overall study piqued my interest in this topic. Subsequently, I spoke to key people in BeLonGTo² about my idea for the research. The people I spoke to were enthusiastic about the research and agreed to help me recruit adolescents associated with the BeLonGTo organisation. All these ideas culminated in the development and refining of the ideas for this PhD thesis.

1.7 Format of Thesis

This thesis is organised across **Seven Chapters**. In **Chapter Two** terms are defined and adolescence development is explored, including a discussion on intimacy, romantic and sexual relationships development. These topics are examined to provide context to the literature on adolescent development, sexuality and sexual health. This is followed by **Chapter Three**, which includes an integrative review of the literature on LGBQ adolescents' sources of information for sexuality and sexual health as well as a

¹ The population of my study is lesbian, gay, bisexual and questioning (LGBQ) adolescents. Other terms are used within this thesis to describe the population of a particular study and how it was described by the author of the study.

² BeLonGTo is the national organisation supporting lesbian, gay, bisexual, transgender and intersex (LGBTI+) young people aged 14-23 in Ireland.

review of literature on older LGBQ people and non-LGBQ people sources of information.

Chapter Four outlines the methodological issues that were considered when planning and conducting this research. In this cross-sectional study, data were collected using an online survey and analysed with descriptive and inferential statistics. A background for the methodological underpinnings of the study is presented including a discussion on the rationale for a postpositivism approach to the study. Methods specific to the survey including development, reliability and validity are described. The ethical considerations associated with the research are also discussed. The study was impacted by the COVID-19 pandemic, which disrupted the original study plan, how the study was conducted in relation to recruitment and testing of the survey instrument. The impact of Covid 19 on the study will be discussed in detail in Chapter Four.

Chapters Five and Six present the findings of this study. In **Chapter Five** the descriptive findings from the surveys are presented. These are followed in **Chapter Six** by the inferential findings relative to age, gender at birth and living location.

Chapter Seven discusses the main findings of the study with reference to the existing body of knowledge. This chapter also addresses the limitations and strengths of the study. This chapter also concludes the thesis and presents directions for future research considering the findings. This includes recommendations for policy, practice and future research, and includes a dissemination plan and personal reflection.

2 Sexuality, Sexual Health and Adolescent Development

2.1 Introduction

Adolescence is a distinct and unique time in the life course. It is an important stage of psychological, cognitive, social, cultural and physical development that is affected by changes that have already taken place in childhood and expectations for the future (Petersen *et al.* 1995, Ponton and Judice 2004). Within this stage, adolescents become more aware of themselves as sexual beings and begin sexual exploration and experimentation which has potential for positive or negative outcomes (Ponton and Judice 2004). While this is true for any stage of life, LGBTQ and non-LGBTQ adolescents are experimenting and developing the knowledge to manage their lives independently for the first time away from parents (Ponton and Judice 2004).

Therefore, to provide context for this study, within this chapter, I explore the meaning of some terms used in the study before I go on to provide a brief overview of adolescent development. Given the focus of the thesis specific emphasis is placed on discussing adolescent development in the areas of identity, intimacy, romance and sexual development and some of the factors that influence them. Additionally, the risk factors for adverse sexual outcomes, including rates of pregnancy and sexually transmitted infections and related information are explored.

2.2 Defining terms

This section defines some terms used in this study, namely adolescence, sexuality, sexual health and sexual identity.

2.2.1 Adolescence

The length of time that is adolescence is constantly being debated. Over 50 years ago the World Health Organisation (WHO) (WHO 1965) proposed that the age of adolescence is between 10-20 years, which is similar to the recent United Nations definition who use the ages of 10-19 years as their adolescence benchmark (WHO 2006). Barrett (1996), separates adolescence into different stages; early adolescence (11-13 years), middle adolescence (14-16) and late adolescence (17-19). While it is now widely accepted that adolescence begins at puberty, the exact age it ends is still

subject to debate (Sawyer *et al.* 2018). For this study adolescence is taken as the age period between 13-19 years. Thus, those in early adolescence were not included. The reason being that, in the Republic of Ireland, adolescents aged 13-19 are in second level school so are exposed to Relationships and Sexuality Education (RSE) during their education programme. In addition, for most adolescents, sexual experimentation is expected to begin during middle and late adolescence culminating in sexual intercourse for the majority of adolescents by age 19 (O'Mahoney *et al.* 2021).

2.2.2. Sexuality

Sexuality is a difficult concept to define because it is a complex and elusive phenomenon and interlinked with all aspect of our lives. At its core sexuality has a biological, psychological, cultural, emotional and physical element (Arbeit 2014). Because it is a broad term which has evolved over time, the current most used definition of sexuality is that from the WHO (2006) which states that sexuality is,

“...a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors” (WHO 2006 p5).

This definition highlights that sexuality is inclusive of sexual thoughts, attractions and behaviours and is concerned with identity, relationship with the self, and relationship with others. As suggested sexuality or expression of sexuality is not a fixed and static state, but something that evolves over time, with opposite sex partners and/or same sex partners. How sexuality is viewed and expressed by the person is influenced by their stage of development, beliefs, attitudes and values, which are shaped and influenced by cultural, societal and religious norms (Higgins *et al.* 2006).

2.2.3 Sexual Health

Sexual health is interwoven with sexuality and includes sexual development and reproductive health and is one element of sexuality (Haffner 1998). The biological and physical aspects of sexuality are largely concerned with sexual activity, however sexual health also includes the ability to develop and maintain meaningful interpersonal relationships; appreciate one's own body; interact with all genders in respectful and appropriate ways; and express affection, love and intimacy (Haffner

1998). The way in which sexual health is defined at any timepoint has implications for the values and attitudes that people acquire about sexual activity as this can influence communication patterns, the type of sex education provided, and the way sex and sexuality are treated by society in general. Sexual health has been frequently interpreted as the absence of disease, which is linked to a biomedical interpretation of health. Consequently, the focus of sexual health has been more on the negative aspects of sexual activity such as unintended pregnancy, prevention of sexually transmitted infections and HIV/AIDS (Jones *et al.* 2022).

Today, however, the focus around sexual health has moved to a more social model which recognises the subjective nature of sexual experiences (Green and Tones 2000). While there is no single definition of sexual health but several different interpretations (Green and Tones 2000), for the purposes of this study the definition of sexual health from the WHO (2006) is used.

“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO 2006).

While this definition of sexual health is a broader definition and more positive, as it includes positive aspects of sexual expression, including the enjoyment of sexual activity, it also includes the absence of disease, such as sexually transmitted infections (STI), control of fertility and avoidance of unintended pregnancy.

2.2.4 Sexual Identity

Sexual identity incorporates many elements of personal functioning to include biological sex, gender identity, gender role expression and sexual orientation, sexual preferences, relationship preferences and body image (Lev 2004, Diamond and Savin Williams 2009, Derouin 2019). While biological sex and gender expression are sometimes linked to gender identity, it is important to note that sex and gender are two different constructs. Biological sex refers to anatomy whereas gender identity refers to a person's internal sense of being male, female or something else and may be expressed to others through behaviour, clothing, hairstyles, voice or body characteristics (Gates 2012). Similarly, even though gender and sexual orientation are linked in literature with the acronym LGBTQI+ (lesbian, gay, bisexual, transgender,

questioning/ queer, intersex and other minorities) as members of a minority, gender identity and sexual orientation are also separate constructs (Bosse and Chiodo 2016).

Sexual orientation is a multidimensional concept which refers to a person's sexual attraction toward someone of the same sex, different sex or either sex and is a combination of sexual and emotional attraction, sexual behaviour for an individual based on attraction or behaviour. This is usually categorised into those who are attracted to members of their own sex (gay men or lesbian women), those attracted to members of the other sex (heterosexual) or those attracted to both sexes (bisexual) (Savin Williams 1998, Groß 2008). The population for this study were lesbian, gay, bisexual and questioning (LGBQ) adolescents living in the Republic of Ireland. Hence sexual orientation is the term used in this study and the LGBQ acronym will be used as the focus is on sexuality and sexual health and not gender identity.

2.3 Adolescent Development: An Overview

Adolescence represents a critical time in the development of sexuality (Derouin 2019), which involves a complex interplay of biological, cognitive, psychological, social and psychosexual changes intertwined within the three stages of, early, middle and late adolescence. Understanding adolescent development within a biopsychosocial framework for sexual identity and sexual relationship development is useful. While the next section provides a brief summary of changes using the headings biological, cognitive, psychosocial (social, psychological, psychosexual), it is important to highlight that these divisions are not exclusive as they are all interconnected, each influencing and impacting the other (Petersen *et al.* 1995).

Biological Development: The biological/physical changes in puberty that occur in early adolescence because of hormonal and physical changes in the body bring the capacity for reproduction, the development of secondary sexual characteristics and an interest in sexual activity (Petersen *et al.* 1995, Steinberg 2011, Damas *et al.* 2012, Kar *et al.* 2015, Derouin 2019). In early adolescence, increases in reproductive hormones are responsible for development of sexual sex characteristics, which includes accumulation of body muscle mass, increase in height and changes to breasts in females and penis in males, with individual variations in timing and rate of change (Petersen *et al.* 1995, Derouin 2019). Changes that occur and the time that they happen can influence how an adolescent feels about their appearance but also how attractive they find others to be (Derouin 2019). The more positively adolescents see

themselves, the greater the sense of self-esteem and confidence they have (Petersen *et al.* 1995).

Cognitive Development: Through middle and late adolescence, biological brain development also occurs with development of the frontal lobe and the growth of the myelin sheath around nerve cells enabling faster processing of information (Derouin 2019). However, biological changes in the brain alone do not bring more mature cognitive development or psychosocial capacity so the development of the other domains (social, psychological and psychosexual) are also important in terms of developing self-esteem, social development and decision making (Petersen *et al.* 1995). Thus, cognitive development also takes place in adolescence with Piaget (1972) describing the shift from childhood to adolescence as one from concrete to formal operational thought, with the capacity to use formal logic, think hypothetically, use abstract thinking and reasoning all increasing during adolescence; reaching adult levels by mid adolescence (age 15-17) (Petersen *et al.* 1995). The emergence of formal operational thinking increases adolescent decision-making capabilities concerning sexual issues and allows adolescents to think through the potential benefits of sexual activity before they engage in any behaviour (Derouin 2019). Thus, adolescents are assumed to be able to make more complex decisions, although as adolescence develops through middle and late adolescence, they may find themselves in situations where they lack experience, and this increases their vulnerability (Petersen *et al.* 1995). This may be particularly true for LGBTQ adolescents who have no previous knowledge or experiences of LGBTQ sexual orientation, few role models and consequently struggle to cope with and accept the psychological and social consequences of their sexual feelings, (Petersen *et al.* 1995, Derouin 2019).

Social Cognitive Development: The confidence that comes from biological changes, enhanced physical appearance and the ability to think abstractly allows an adolescent to think more about themselves and their future (Petersen *et al.* 1995). Adolescence represents a critical transition in the life span from childhood to adulthood where a core task to be completed is psychosocial identity development (Granic *et al.* 2020, Branje 2022). Identity is characterised by a person's sense of who they are which is established by their values, characteristics, roles and behaviours (Erikson 1968). As stated, adolescent identity development is triggered by physical changes during puberty, cognitive development but also societal expectations. Choices made by

adolescents in Ireland in mid adolescence around age fifteen for example around subject choice for senior cycle in school, forces them to think about their future occupational opportunities and expectations. Other transitions in an adolescents' life, such initiating intimate and sexual relationships, all go hand in hand with identity development.

Psychosocial Development: There are several theoretical perspectives that inform our understanding of psychosocial adolescent development. Two main theorists in adolescent psychosocial identity development are Erik Erikson (1902-1994) and James Marcia (1937- present), who proposed identity formation cycles that are linked to life stages that people work through called psychosocial crises. According to Erikson (1968), the crisis in the adolescent stage is called "Identity versus Role Confusion" where an adolescent tries to determine where they fit in the world and it is in this context that biological and cognitive development also occurs. Increased cognitive development links with psychosocial development and allows them to question their identity, explore hypothetical risks and benefits of possible behaviours and form identity commitments (Derouin 2019) within several contexts including how they relate to sexuality and sexual behaviour. In other words, healthy psychosocial development is achieved when this stage is navigated and adolescents move on to the next stage (Birch 1998, Dunkel *et al.* 2012, Kim 2012, Seaton and Beaumont 2014). This suggests, however, that the increased decision-making capabilities an adolescent has are used all the time, which is not the case, as time pressure, personal stress or overwhelming peer pressure may negatively influence decision making. Adolescents are more prone to abandoning rational thought processes when under stress or considering unfamiliar and emotional topics, of which sexual behaviour is one (Derouin 2019).

Psychosexual Development: Freud outlined five stages of psychosexual development, with the genital stage commencing at puberty and lasting until death (Lantz and Ray 2022). From the onset of puberty, libido or sexual drive becomes more active, resulting in an individual usually becoming interested in the opposite sex (Kesavelu 2021) and these sexual drives continue to develop in early, mid and later adolescence until later in life.

In the context of development within the LGBTQ adolescent population limited attention has been paid to biological, cognitive, social cognitive, psychosocial and psychosexual

changes that occur in LGBTQ adolescents with theorists assuming heterosexuality with little consideration of the sexual minority community (D'Augelli 1991, Degges- White & Myers 2005). In fact, a major criticism of psychosocial theories is that only domains that an adolescent has control over have been studied and those which can also influence identity development such as gender, sexual orientation, ethnicity and race have not been considered (Adams and Archer 1994, Shorter- Gooden and Washington 1996, Degges- White and Myers 2005, Syed and Azmitia 2008). However, what is known is that identities that have been strongly developed prior to adolescence ending can protect them from difficulties associated with intimate relationship development (Jones *et al.* 2014).

2.3.1 Intimacy and Friendship Development and Adolescence

As the biological changes associated with puberty begin to integrate through middle and late adolescence, emotional and social identities are developed away from their parents and the formation of identity usually involves forming close intimate friendships with same age peers (Derouin 2019). From a developmental perspective, making friends that are dependable, supportive and loyal is an important social resource and is one of the first social developmental tasks that children face outside the family (Hartup and Stevens 1997). However, a key task is to incorporate sexuality successfully into close intimate relationships, which is made possible by the advanced cognitive and psychological abilities that emerge over the course of adolescence (Derouin 2019). Therefore, it is assumed that those that enter adolescence with social or psychological disadvantage are likely to experience the most difficulties in establishing their identity and intimate relationships (Haffner 1998, Jones *et al.* 2014). Thus, much of the research done in intimacy development has also been linked to identity development with little consideration of the LGBTQ population and how they develop intimate relationships in adolescence.

The most important theoretical perspectives on intimacy development are the works of Harry Stack Sullivan (1953). He looked at the social aspects of intimacy development in adolescence (Steinberg 2011). While children develop friendships, it is not until adolescence that intimate relationships based on sharing of information, trust, openness and honesty are developed (Steinberg 2011). Adolescents' close friendships where a strong bond develops, and feelings are shared, are more likely to have a strong foundation of mutual understanding (Bauminger *et al.* 2008). Therefore, it is

possible to have an intimate relationship without the relationship being a sexual one, yet frequently sexual relationships are also intimate ones (Derouin 2019). Sullivan (1953) believed that people achieve healthy development when they can experience both intimacy and sexual desire towards the same person.

Close friendships generally provide adolescents with the security and safety in which disclosure about fears and concerns can be met with support and validation (von Salisch *et al.* 2014). Those that are well accepted by their peers also have a larger reservoir of potential replacements when friendships fail (von Salisch *et al.* 2014). It is in the context of these relationships that adolescents may gather information on same sex and opposite sex relationships (Steele 1999). For LGBQ youth, who are becoming aware of their sexual orientation navigating adolescence without close intimate friends to share experiences with can be challenging. Some LGBQ youths may find community with other LGBQ persons which meets their need for intimacy (Adams and Marshall 1996) but access to this community may not be available to all geographically.

2.3.2 Sexual Orientation Development

Hormonal, physical, cognitive and social development that occur during adolescence all have an impact on sexual orientation development. As adolescents develop physically, cognitively, and emotionally, an understanding of themselves and their social and sexual roles shift. An adolescent will need to come to terms with the external physical changes, such as breast and genital development and the physiological changes that happen such as menstruation or ejaculation (Derouin 2019). Adolescents also become more aware of sexual attraction to the opposite sex, the same sex or both sexes and these sexual attractions may include emotions, physical feelings or both (Auslander *et al.* 2005).

For LGBQ adolescents, there are several staged theoretical models that can provide insights into LGBQ sexual orientation development (Cass 1984, Milton and McDonald 1984, Coleman 1987, Troiden 1989, McCarn and Fassinger 1996, Degges- White and Myers 2005). While there is variation between stages in the models, similarities also exist. In most instances, the initial step is the child/ adolescent questioning if they are not heterosexual, as prior to this heterosexuality is presumed (Damas *et al.* 2012, Chan *et al.* 2017). This is followed by the stages of exploring, forming and adopting a

LGBQ identity. Positive contact with others who accept their sexual orientation and connection with LGBQ people assist this development. Thus, the final stage is marked by the integration of sexual orientation into their broader identity, where the person comes to understand, adopt and express their sexual orientation.

However, development of sexual orientation is not a uniform process and is experienced differently depending on gender, race/ethnicity and social/cultural/religious circumstances. As highlighted, Bishop *et al.* (2020) suggests that the timing of milestones in sexual orientation development is different for males and females. Males may report sexual orientation realisation earlier than females. However, even though males are younger when they report these milestones, they report taking longer to disclose their sexual orientation after first realisations than females (Martos *et al.* 2015). This is also the case in Irish data where Higgins *et al.* (2016) found that the most common age of knowing sexual orientation for lesbian women was in mid adolescence age 16, for bisexuals it was aged 14 and gay males the age was in early adolescence aged 12 years; however, the age of disclosure or telling someone about their sexual orientation was in late adolescence aged 16/17, which was common for all groups.

2.3.3 Romantic Relationships Development and Adolescence

Many adolescents also consider romantic relationships as crucial to identity and intimacy development and an important developmental task that contributes to social functioning (Sullivan 1953, Zani 1993, Feiring 1996). Skills learned in developing friendship intimacy are further developed when a romantic relationship is established and maintained (Erikson 1968, Feiring 1996, Kiecolt- Glaser and Newton 2001). However, romantic relationships differ from intimate friendships as they are typically characterised by attraction, intense emotions and demonstrated by affectionate behaviours progressing to sexual ones (Miller and Benson 1999, Zimmer- Gemback 1999, Moosmann and Roosa 2015). As adolescence progresses, interactions with opposite sex peers become increasingly common and important, social networks expand and change so the pool of people from which LGBQ people can meet potential partners widens (Connolly *et al.* 1999, Zimmer- Gembeck 2002, Shaw *et al.* 2014).

Levinger (1980) proposed an ABCDE model of romantic relationship development which suggested that people become attracted to another, build a relationship through

communication, bonding and interdependence, continuing commitment and progress or deteriorate and end. This is similar to other phase-based theories (Brown *et al.* 1999, Connolly *et al.* 1999, Diamond *et al.* 1999) who follow a linear approach with different stages and increasing levels of commitment moving from infatuation, initiating the relationship, developing affiliation, progressing to intimacy and finally commitment.

Although romantic relationship development is a significant part of adolescent development, relatively little is known about relationship formation and progression among young LGBTQ couples (Macapagal *et al.* 2015) as most of the research has focussed on heterosexual couples. Like their heterosexual counterpart's, LGBTQ adolescents desire traditional romantic relationships (D'Augelli 1991). For LGBTQ adolescents, mixed sex friendships may allow them to explore feelings and attractions for both sexes and provide 'cover' for their sexual orientation (Diamond *et al.* 1999, Feiring 1999). As romantic relationships develop, Diamond *et al.* (1999) suggest that they often facilitate the process of coming to terms with same sex attractions and for many adolescents, can be a definitive confirmation of their sexual orientation. Depending on options, some may date heterosexually and many who are questioning their sexual preferences will do so to assist them to determine or confirm their sexual orientation (Diamond *et al.* 1999). In addition, emerging romantic relationships can buffer against stressors related to their sexual minority status (Diamond *et al.* 1999, Peplau and Fingerhaut 2007, Baurmeister *et al.* 2011).

Where same sex dating relationships are available, LGBTQ adolescents are provided with a crucial sense of normalcy, demonstrating that a lesbian, gay or bisexual orientation does not prevent them from enjoying many of the activities and pleasures of non-LGBTQ adolescents (Diamond *et al.* 1999). The predominant type of relationship in society is heterosexual so LGBTQ adolescents may not have role models in their families, schools, communities or the media to base their relationship development on. In the absence of visible role models for LGBTQ relationships in their lives, LGBTQ adolescents must actively seek out people and relationships to learn from, so they can negotiate their own experiences (Simon and Gagnon 1984). This may differ for gay, lesbian and bisexual people. It may also be the case that engaging in a romantic relationship may hasten the disclosure of one's sexual identity to others, whether intentionally or unintentionally (Diamond *et al.* 1999). A lack of available opportunities to progress romantic relationships may also inhibit development (Santrock 2016). The literature suggests that LGBTQ couples who form same sex couple relationships mostly

met through LGBTQ networks which means being out about their sexual orientation (Macapagal *et al.* 2015).

2.3.4 Sexual Activity Development and Adolescence

While sexual relationship development and sexual activity continue long after adolescence, adolescence is a fundamentally important time (Steinberg 2011). Adolescence embraces that period of self-discovery when adolescents are moving from intimate romantic non-sexual relationships to determining their preferences in sexual behaviour, usually during secondary school years, or in late adolescence from age 15-18. Steinberg (2011) outlines four elements necessary for positive sexual relationship development. These are accepting a changing body, accepting feelings of sexual arousal, understanding that sexual activity is voluntary and practising safe sex. Some previous research has defined sexual behaviour/ activity as penetrative sexual intercourse ignoring the fact that sexual activity can range from kissing and cuddling to oral sex (Steinberg 2011, Li and Davis 2020). Thus, sexual experimentation is common among all groups of adolescents who move from kissing to other more intimate sexual behaviours as they develop from early to late adolescence (Haffner 1998, Li and Davis 2020). However, as stated previously while physical and biological sexual development occurs uniformly for most adolescents during puberty in early to mid-adolescence, social and psychological development can vary significantly (Miller and Benson 1999). Thus, sexual activity initiation varies with some adolescents partaking in sexual activity very early while others are ready at a much later age.

It is expected that most adolescents begin sexual activity by commencing initially with autoerotic behaviour such as masturbation in early adolescence and progressing to sexual intercourse by the end of adolescence (Steinberg 2011). While this is not the same timespan for all, by the age of 20, 84% of Irish adolescents report they had engaged in sexual intercourse (O'Mahoney *et al.* 2021). While this figure is useful as a cumulative percentage of those who have engaged in sexual intercourse at a particular age, it does provide the specific age that people commence having sexual intercourse. Layte and McGee. (2007) found in a sample of Irish 18–24-year-olds that the median age for sexual initiation was 17 years old. Recent Health Behaviours of School Children (HBSC) studies on adolescents aged 15-17 found that in 2010, 2014 and most recently in 2018 that one quarter of boys (25.6%) and nearly one fifth of girls (18.5%) reported already having had sexual intercourse (Young *et al.* 2018). These

figures are comparable to other Irish studies, such as the Growing Up in Ireland study (Nolan and Smyth 2020) and the MyWorld2 study (Dooley *et al.* 2019). It is concerning however, that out of those Irish adolescents who were sexually active, very early sexual activity (<14 years old) was reported by 22.8% of boys and 13.4% of girls (Young *et al.* 2018) with one fifth of the adolescents in the MyWorld2 study reporting having had sex before the legal age of consent (age 17) (Dooley *et al.* 2019). Irish data available on specific sexual activity is from the Growing Up in Ireland study which reports that 40% of 17/18-year-olds had oral sex and 33% had sexual intercourse. The mean ages for sexual activity in Irish adolescents (age 17/18) are older than those of Australia (age 14/16). Power *et al.* (2022) in a study of 6,841 adolescents aged 14-18 in Australia reported the average age for deep kissing was 14.6 years, with oral sex 15.2 years, vaginal sex 15.3 years and anal sex 15.6 years (Power *et al.* 2022). However, there is no Irish data available from LGBTQ adolescents to determine age of first engaging in sexual activity.

There is data available from a longitudinal study in New York with LGBTQ males who have sex with males (n=484), which shows the mean age for mutual masturbation was 14.86 years (median 15), oral sex performed at 15.07 years (median 15), oral sex received at 15.22 years (median 16), insertive anal sex 16.09 years (median 16) and receptive anal sex was 16.39 years (median) (Halkitis *et al.* 2021). Approximately 19% had their first sexual experience before age 13 which was double the national figure of all adolescents found by Lindberg *et al.* (2019) who looked at sexual debut in males aged 13 across the USA. Lindberg *et al.* (2019) reported that the national average was between 3.6% of males aged 15-24 and 7.6% of high school male students who reported having sex before age 13. It is noted that the age of sexual initiation for some sexual activities in this recent study is younger than mean ages from a previous study (mutual masturbation age 15.22/ oral sex age 15.95/ insertive anal sex age 17.33/ receptive anal sex age 17.93) published by Halkitis *et al.* (2011). These studies that describe what sexual acts are performed at different ages are useful to assist with sexual health promotion as other studies ask about age at first sexual intercourse, penetrative sex or other researchers ask about sex but do not define what that means (Halkitis *et al.* 2021).

While international studies are mentioned above, overall, there is much less written about sexual relationships and sexual activity in LGBTQ adolescents in comparison to non-LGBTQ adolescents (McKee *et al.* 2010). Some information is available on the age of first sexual intercourse in males who have sex with males, age 15-17, (Halkitis *et al.*

2011, 2021) but no information was found on the age of sexual debut in lesbian or bisexual women. It is the case, however, that most non-LGBQ adolescents first have intercourse with someone they are in a romantic relationship with (Furman and Shaffer 2003, Auslander *et al.* 2005, O'Mahoney *et al.* 2021). Relationships therefore provide a testing ground not only for the *how* of sexual behaviour but also for the *what* and *when*. Thus, it has been found that they provide context in which adolescents discover what is attractive and arousing, what they like in their partners and what partners tend to like. This information is lacking for LGBQ adolescents.

2.3.5 Factors Influencing Sexuality Development in Adolescence

Many factors influence sexuality development in adolescence. Biopsychosocial adolescent sexual development takes place within social contexts so a range of people can influence identity and sexual development both positively and negatively (Harper *et al.* 2012). Parents, friends and school are the primary influences. The internet and media both mainstream and social media also have a role to play in shaping adolescents' sexual development by transmitting values, opinions and roles. Gender role stereotypes and associated expectations can also influence identity development in preparing for sexuality, sexual behaviour, career, social roles and gender roles (Kroger and Green 1996, Baumeister and Muraven 1996, Furman and Shaffer 2003, Shoveller *et al.* 2004, Jones *et al.* 2014).

2.3.5.1 Parents

Within the context of development in adolescence, adolescent relationships with parents and other family members undergo significant changes. From childhood through early, middle and into late adolescence, rates of parental support and interaction decrease (Furman and Shaffer 2003). These changes in relationships may not reflect a detachment from parents, but instead shows a renegotiation and transformation of a previous parent- child relationships (Furman and Shaffer 2003). In positive sexual development, children learn social and parental values to enable them to make informed decisions about their own sexual activity and parents can influence positive adolescent sexual behaviours by providing accurate information and education about sexuality, fostering responsible decision-making skills, offering adolescents support and guidance to explore and affirm their own values and modelling healthy sexual attitudes and behaviours (Haffner 1998). However, social experience of

homophobia, sexism, racism and classism both constrain and facilitate LGBTQ and non-LGBTQ adolescent sexual development (Arbeit 2014). For LGBTQ adolescents who are in the process of identifying as LGBTQ, this process can be influenced by cultural beliefs and values, societal and family pressures (Derouin 2019).

2.3.5.2 Friends

The first person that a young person discloses their sexual orientation to is usually a same age close friend (D'Augelli and Hershberger 1993, Savin Williams 1998, Galupo & St. John 2001, Rossi 2010) that may be LGBTQ or non-LGBTQ. Being accepted in friendships particularly by heterosexual friends is beneficial as the LGBTQ young person knows that it is then possible to be accepted in a broader social context (Galupo and St. John 2001). Friends are often cited as one of the most influential factors on adolescent sexual development, with little research conducted on how it happens (Ponton and Judice 2004). A large number of studies have however, documented the role that friends play in providing information on sexual activity and sexual health to LGBTQ and non-LGBTQ people (Kubicek *et al.* 2010, Secor-Turner *et al.* 2011, Whitfield *et al.* 2013, Charest *et al.* 2016, Baker *et al.* 2021). Friends as a source of information has benefits as they are considered easy to talk to but they are also a risk as they may provide incomplete or inaccurate information (Ponton and Judice 2004). They can also be a source of support as they may be having the same experiences and can share their views (Ponton and Judice 2004).

2.3.5.3 School

Schools also play an important part in adolescent sexual development. Messages about who one can or cannot be are directly and indirectly communicated in schools, through teaching strategies, teacher expectations, peer norms and separation/streaming of classes (Verhoeven *et al.* 2019). Similarly, communication about expectations outside of school are also conveyed through teachers and schools. Rules and expectations about sexual behaviour are also noted (Verhoeven *et al.* 2019). However, research on the impact of school on sexual development is lacking. Most adolescents receive some instruction within school about sexuality, sexual activity and sexual health (Steinberg 2011). Elements of this include teaching about sexual activity, pregnancy and contraception, safer sex and communication skills to assist in refusing unwanted sex (Shoveller *et al.* 2004, Steinberg 2011). However, school-based sex education is often not applicable to LGBTQ adolescents as it has traditionally focussed

on the prevention of pregnancy and STIs, rather than exploring issues related to sexuality, sexual orientation and sexual relationships and the associated emotional aspects of this (Stonewall 2017, Nolan and Smyth 2020). Thus, adolescents may lack positive education about sex from school but instead have received very specific information on two adverse outcomes associated with sexual activity, crisis pregnancy and sexually transmitted infections.

2.3.5.4 Internet

For LGBTQ adolescents, heteronormativity, marginalization, and negative experiences in public, social, and personal spaces (e.g., school and home) may limit their ability to explore or develop their identities (Pascoe 2011) so could also limit sexual development. Hence, they may increase their engagement with online spaces. The internet has expanded the range of options for LGBTQ adolescents who seek information and who want to meet peers as online interactions with other LGBTQ adolescents provide an unprecedented degree of privacy and anonymity for those who have no access to LGBTQ community resources or those who cannot attend LGBTQ youth groups for risk of disclosing their sexual orientation (Diamond *et al.* 1999, Craig and McInroy 2014). Online communication is not without risks and unless the internet site is specifically for adolescents, adolescents may find themselves communicating with LGBTQ adults who could seek offline meetings to pursue a romantic/sexual relationship openly (Diamond *et al.* 1999).

2.3.5.5 Media

Media (tv/ film/ internet/ porn/ social media) may influence LGBTQ sexual development and behaviours in several ways. Many LGBTQ adolescents do not have role models in their family, peer network or environment so look elsewhere to help them to develop a healthy sexuality and sexual orientation (Fouts and Inch 2005). Historically, this has meant looking to TV, where there were either no portrayals of adolescent LGBTQ people or depictions of gay males between the ages of 20-35 with very limited depictions of people with other sexual orientations and ages (Fouts and Inch 2005, McInroy and Craig 2017). Since the 1980's TV and film depictions of LGBTQ people have increased to where they now play central characters. However, there remains a lack of diversity regarding females or bisexuals (Watson 2008, McInroy and Craig 2017).

The implications for this are that LGBQ adolescents do not become aware of the normal diversity in sexual orientation and may develop stereotypical views about LGBQ people which can affect their own sexual development. There is also a lack of diversity in age, race, ethnicity and socioeconomic status of LGBQ people presented in the media. While traditional media remains an important agent of socialisation for LGBQ people, adolescents relying on fictional media when forming a LGBQ sexual orientation means that real life role models to access LGBQ related materials in their home, school and community have been lacking (McInroy and Craig 2017).

With the advent of newer media and increased use of internet enabled mobile devices from any location at any time, this is changing. More diverse use of media and social media with user generated content means adolescents get to see more people that resemble themselves. The use of video blogs, social media, video sharing sites and messaging apps are being used by adolescents to aid in identity, sexual orientation/sexual health development (McInroy and Craig 2017). Therefore, LGBQ representations for younger people tend to be more openminded. Content on social media sites evolve all the time and is dominated by adolescents which is more attractive to adolescents. Adolescents are coming of age in a rapidly changing media landscape and integration of online technology (internet, social media, photo sharing) is becoming the norm in contemporary society (Craig *et al.* 2015). Thus, how social media affects LGBQ sexual identity development and sexual behaviours is not yet fully determined.

2.3.3.6 Gender Role Stereotypes

Socially, for most adolescents, sexual expression is governed by gender and cultural expectations (Derouin 2019). There are conventions in society and the media that reflect how males and females are expected to behave. Females are expected to adhere to feminine stereotypes of behaviour whereas males are expected to adhere to masculine stereotypes (Petersen *et al.* 1995, Conroy and Dickinson 2018). It is thought that the emergence of dating in adolescence may be one of the most powerful factors that contributes to the consolidation of conventional gender roles, as non-LGBQ adolescents are likely to behave in ways that they think is expected of them to make themselves more attractive to members of the other sex (Furman and Shaffer 2003). This is evident in the ways that males and females are socialised (Ward *et al.* 2022).

Males are socialised into the physical side of relationships and expected to be less intimate. Girls on the other hand learn that they are expected to be more interested in intimacy and romance and less about physical gratification. For most females, sex is therefore expected to occur within a relationship or where feelings are involved, where males are expected to have sex for its own sake (Harrison and Hillier 1999). This presents a double standard in terms of gendered sexual scripts where different experiences are expected (Dempsey *et al.* 2001, Ward *et al.* 2022). Gender roles as they are presented by society may be reinforced by parents, school, friends, internet and media with little consideration for LGBTQ sexual orientation or differing gender identities (Ward *et al.* 2022). However, the same amount of research has not been conducted on social media to determine its impact on gender role stereotypes (Ward *et al.* 2022). Thus, LGBTQ adolescents may experience confusion about how they are expected to behave as role model depiction of LGBTQ adolescents in the media may not align with an adolescent's perception of themselves or reflect their reality.

2.4 Risk Factors for Adverse Sexual Outcomes

There are several risk factors for adverse sexual outcomes presented in this section with information specific to LGBTQ and non LGBTQ adolescents included where available. The age of which an adolescent begins to have sexual intercourse is an important risk factor . Early sexual initiation exposes an adolescent to sexual activity for a longer period and means that they may have more sexual partners, while also exposing them to the risks of crisis pregnancy and sexually transmitted infections for longer. It may also mean that their sexual and psychosocial development may not align, so while they are ready for sexual intercourse physically their cognitive and emotional development may not be in agreement (Kar *et al.* 2015). The level of maturity that someone has can also affect their understanding of risk and so may be less likely to use contraceptives and practice safer sex (Kar *et al.* 2015). Therefore, age at first sexual intercourse, therefore, has been found to be an important indicator of future sexual behaviour and sexual health.

Early sexual initiation in early and middle adolescence before the age of 16 has been associated with adverse sexual health outcomes at the time of first intercourse and also later in life (Young *et al.* 2018, Lindberg *et al.* 2019) including sexual intercourse with high-risk partners (e.g., IV drug users and HIV positive men), multiple sex partners, STI transmission and sexual and physical violence (Lohman and Billings

2008, Young *et al.* 2018). These adverse health outcomes continue later in life (Lindberg *et al.* 2019). Risk factors for early sexual initiation have been identified as having poor family relationships, peer pressure, low education and socio-economic status (Avery and Lazdane 2010). It has been found that among all ethnic groups in the USA rates of sexual activity are higher in economically disadvantaged groups and also among African Americans (Steinberg 2011). Those who engage in sexual activity at a younger age have also been found to have lower levels of academic achievement (Lohman and Billings 2008) whereas a higher level of educational achievement has previously been associated with delayed sexual activity, abstinence, condom and hormonal birth control use, late marriage and pregnancy and smaller family size (Cheedalla *et al.* 2020).

Information is also available from the Growing Up in Ireland (GUI) and Health Behaviours of School Children studies who present information on sexual regret (Moreau *et al.* 2019, O'Mahoney *et al.* 2021). In the GUI study, it was found that age influenced sexual regret with 25% of people who had sex at 17/18 years reporting that they should have waited to have sex until older age. This reduced to 18% of 20-year-olds with more females (9% males/ 28% females) who felt they should have waited longer to have sex. Girls from low affluence families and those with older partners were more likely to regret taking part in sexual activity (Moreau *et al.* 2019). Regret in females has also been found to be associated with less planning, lower autonomy and a less stable relationship with their partner (Layte and McGee 2007). This was not seen in young men. Layte and McGee (2007) also report that women who have sex earlier were 1.8 times more likely than men who have sex earlier to feel that they should have waited longer. This data does not specifically apply to LGBQ adolescents so no direct comparison is available, therefore information on sexual regret in LGBQ adolescents is not available.

It is reported that lesbian and bisexual women and school going males who have sex with both boys and girls are at the same or greater crisis pregnancy risk than their heterosexual peers (Blake *et al.* 2001, Tornello *et al.* 2014, Estes 2017, Hodson *et al.* 2017). In one review from Canada, Blais *et al.* (2015) found that sexual minority people (LGBTQ) were 1.8-3.6 times more likely than their heterosexual peers to have an unplanned pregnancy with Leonardi *et al.* (2019) estimating that the risk of adolescent pregnancy involvement for LGBQ adolescents is between 2 to 10 times higher than heterosexual adolescents. Pregnancy involvement is the term used to reflect that the adolescent was there are conception, without making assumptions about gender (Költő

et al. 2021). It must be noted that crisis pregnancy involvement in LGBQ adolescents is also related to other risks. Thus, lesbian and bisexual females and males who have sex with males and females have been found to be at greater risk of engaging in sexual activity earlier, having unplanned sex with opposite gender partners, having multiple partners, having sex under the influence of alcohol or other drugs and are less likely to use a condom/ contraceptives than heterosexual adolescents but also linked to a lack of LGBQ specific sexual health education (Goodenow *et al.* 2002, Saewyc *et al.* 2008, Kann *et al.* 2016, Tornello *et al.* 2014, Blais *et al.* 2015). Additionally, young women who identify as bisexual have been found to have a higher number of male partners, thus increasing the risk of pregnancy (Tornello *et al.* 2014, Blais *et al.* 2015).

Contraceptive and condom use in Irish adolescents at first sexual intercourse is positive with Nolan and Smyth (2020) reporting that 89% of 17-year-olds used contraceptive at first intercourse. Condom use while also high is less prevalent with Young *et al.* (2018) reporting that 71.6% at age 15 and 96% at age 18 in boys and 77.2% at age 15 to 75% at age 17 in girls (Young *et al.* 2018). There are, however, people in both of these studies who do not use any contraceptives/ condoms (10% in Young *et al.* 2018, 6% in Nolan and Smyth 2020). Data for LGBQ Irish adolescents on condom/ contraceptive use is not available. However, Blais *et al.* (2015) found that Canadian sexual minority youth (LGBTQ) were 1.3 to 3.5 times more likely to engage in condomless sex than their heterosexual peers. While no information is available on Irish LGBQ adolescents condomless sex, rates of STIs would suggest some unsafe sex with 78.3% of new cases of gonorrhoea and 82% of syphilis cases notified in gay and bisexual men who have sex with men (gbMSM). (Health Protection Surveillance Centre 2020)

While not specific to condoms, not using contraceptives for sexual intercourse is associated with three factors, lack of planning, lack of access and lack of knowledge (Layte and McGee 2007, Steinberg 2011). As highlighted in the section on adolescent development, a lack of experience increases vulnerability and this could impact decision making. Using contraceptives/ condoms at first intercourse by adolescents show that they have thought about the sexual encounter in advance and some planning has been made. A lack of access is an especially important barrier among younger adolescents, who may feel uncomfortable discussing their sexual activity with parents or other adults whose help or consent is necessary to obtain contraceptives (Steinberg 2011). Those who are insufficiently educated about sex, contraceptives and pregnancy could leave them misinformed about when and how to use contraception

(Steinberg 2011). This is true for the participants in Palmer *et al.* (2017) and Nolan and Smyth (2020) studies who report that those who used friends as their main source of information were less likely to use contraception at first sex.

While there is less information available for LGBTQ adolescents risk factors for adverse sexual health outcomes than for heterosexual adolescents, there is a more serious dearth of information collected specifically for lesbian and bisexual women. In North America, young bisexual women report poorer sexual health outcomes compared to heterosexual women and lesbian women. These include increased rates of teen pregnancy, higher incidence of sexually transmitted infections, higher rates of riskier sexual practices, greater number of partners, lower rates of condom use, increased rates of sexual assault and intimate partner violence (Flanders *et al.* 2017). A lack of social, medical and educational resources about bisexual sexual health and harmful stereotypes about bisexual people, potentially inhibit young bisexual women's sexual decision making (Arbeit *et al.* 2016) as having the confidence in the ability to refuse a sexual encounter has been a predictor of safer sex practices.

While early sexual initiation, not using condoms and contraceptives and crisis pregnancy pose risks to adolescents' overall health, there seems to be an exclusive reliance on data for these to determine an understanding of the risk factors associated with adverse sexual health outcomes and as such using them to help reduce risky adolescent sexual behaviour (Shoveller *et al.* 2004). However, risk factors cannot be determined unless social context is also considered (Shoveller *et al.* 2004). Most sexual health interventions have emphasised the importance of changing adolescents' attitude to sex through knowledge and information (Shoveller *et al.* 2004). This departs from the traditional framing of all sexual activity among teenagers as problematic and recognises that age alone does not threaten sexual health, any more than older age safeguards it. This is relevant for the information and education that is provided to adolescents. However, providing information that is specific for LGBTQ adolescents' sexual health is necessary as is recognising that there are differences in healthcare information required for LGBTQ and non-LGBTQ adolescents.

2.5 Conclusion

This section considered the definitions of adolescence, sexuality, sexual health, sexual identity in the context of this study. Following that, adolescent development in the areas of identity, intimacy, romance and sexual behaviour were also discussed using a biopsychosocial background to highlight the changes taking place in an adolescent's life, particularly LGBQ adolescents, although there is a lack of information relating to LGBQ adolescents available in these areas. Some factors that influence this development were also presented, namely parents, friends, school, internet, media and gender role stereotypes with LGBQ specific information presented where available. In addition, information outlining risk factors associated with adverse sexual health outcomes were included. These were age of first intercourse, risk factors for this and sexual regret, crisis pregnancy and sexual transmitted infections risks and contraceptive/ condoms use at first and most recent sexual intercourse. Additionally, links between sources of information and adolescent development and adverse sexual health outcomes were indicated where available. The following chapter presents studies available on sources of information for sexuality and sexual health, for LGBQ adolescents, LGBQ adults, non- LGBQ adolescents and some national studies on sources of information.

3 Empirical Studies on Sources and Topics of Information on Sexuality and Sexual Health

3.1 Introduction

Quality sexuality education promotes healthy sexual development and increases an individual's ability to maintain a healthy sexuality throughout life which in turn reduces health disparities. During adolescent development information may be received about sex and sexuality from formal sources, such as school-based education programmes and health practitioners and informal sources, such as parents, friends, partners, internet and television. The focus of this chapter is on the empirical studies completed on the sources of information on sexuality and sexual health used by the LGBQ community and non-LGBQ adolescents, including the topic sources. As no previous qualitative, quantitative synthesis has been previously undertaken, the first part of the chapter includes an integrative review that was completed at the outset of the thesis that synthesised qualitative, quantitative and mixed method peer reviewed studies exploring the sources of information used by LGBQ adolescents (aged 13-19, age cohort which is the focus of this study). The purpose of this was to aid in the development of the survey instrument. This is followed by a discussion of empirical literature on types of information sourced by older LGBT people and non-LGBT adolescents. Section three of the chapter includes a discussion on findings from a scoping review on large cross sectional population studies, located in the grey literature, on sources of information on sexuality and sexual health with as they pertain to adolescents. As the primary aim of the integrative and other reviews was to determine the literature available to aid the development of the survey instrument, much of the literature was reviewed prior to data collection. While the literature was revisited for the discussion aspect of the thesis and a summary of new publications are referred to at the end of this chapter, the integrative and scoping reviews were not updated in this chapter. This decision was based on the need to demonstrate clearly what was available at the time of survey design and what informed the survey.

3.2 Integrative Review of Sources of Information on Sexuality and Sexual Health used by Adolescents (13-19 years) who identify as Lesbian, Gay, Bisexual or Questioning.

3.2.1 Aim of the review

To help inform the design of the survey a review to explore the peer reviewed published research on young (aged 13-19) lesbian, gay, bisexual and questioning (LGBQ) peoples' sources of information on sexuality and sexual health and the specific topics of information accessed from these was needed.

3.2.2 Review Methodology

To achieve this an integrative review methodology using the Preferred Reporting Items for Systematic Reviews (PRISMA) (Moher *et al.* 2009, Page *et al.* 2021) was completed as it allows for the inclusion of different types of studies, qualitative, quantitative and mixed methods (Whittlemore and Knafl 2005, Madden *et al.* 2018). This type of review consists of five components which are search, retrieval, quality review, analysis and presentation of findings (Begley *et al.* 2022). This integrative review was conducted with the same level of rigour as a systematic review using Cochrane Guidelines (Cumpston *et al.* 2019).

3.2.3 Search Strategy

Following assistance from the Subject Librarian to develop search strings, a detailed search of PubMed, CINAHL, Science Direct, PsychInfo, Psych Articles and Web of Science databases was conducted originally in July 2017 and again in June 2019. Key terms relevant to "LGBQ", "adolescents", "sources" "information" "sexuality / "sexual health" linked with 'and' as relevant to each database were used to build a search strategy (Table 3.1). When searching the databases each set of keywords under the components, Participants (P), Exposure (E) and Outcome (O), (P/EO) were searched using Boolean operator 'OR' and these were combined using 'AND' (See Table 3.1 and Table 3.2). Keywords were also determined in consultation with supervisors who had previous experience of conducting studies in the area of sexuality, sexual health and LGBQ health and wellbeing.

Table 3.1. Five key terms used for Search Strategy – Column headings linked by the word “AND” in the final search

Adolescent	LGBQ	Sources	Information	Sexuality/ Sexual Health
Adolescent Adolescence Teenager Teen Youth Young Person Emerging adult Young adult	Lesbians Lesbian women Gay Gay persons Gay men GLBT persons Bisexual Bisexuality Questioning Queer LGB LGBQ LGBT LGBTQ Sexual Minority Homosexual Transgender Same sex attracted Men who have sex with men (MSM)	Sources Location	Information Education Knowledge	Sexuality Sexual Sexual Health Sex Sexual Orientation Sexual Debut Coming Out Sexual activity Sexual identity Intimacy Sexual behaviour

A combination of Medical Subject Headings (MESH) and free searching was utilised. These five key terms were searched individually and then combined using “AND”. To confirm the effectiveness of the key words and databases being used, multiple searches were undertaken restricted to title and abstract only. No time limits were applied to the search to capture the scope of the research that was published on the subject. While the focus of the review was sexual orientation and sexuality but not gender identity, it was still necessary to include the term ‘Transgender’ as a search term to ensure that the search was robust, as transgender adolescents are sometimes included in studies with LGBQ adolescents and they may identify their sexual orientation as LGBQ. English language and peer review limits were applied but no date limit or limit on the types of research methodology were applied. To enhance validity, all searches were saved and replicated a second time with comparable results found (See Appendix 1- Copy of a saved search). Reference lists of all retrieved

sources were hand searched for additional material. The searches were considered successful as the same references appeared consistently.

3.2.3.1 Inclusion and Exclusion criteria

To be included, studies had to be i) published in a peer reviewed journal: ii) primary research about sources/usefulness of information on sexuality and sexual health, iii) in English, iv) contain participants who self- identified as LGBQ or were identified by sexual behaviour such as men who have sex with men (MSM), and v) with extractable data from LGBQ adolescents, aged 13-19. A study eligibility form was developed and consistently applied to reduce selection bias. Editorials, literature /systematic review, position papers, theses, grey literature and commentaries were excluded. The unpublished protocol allowed for studies on all aspects of sexuality, sexual development, identity, sexual orientation, intimacy, romance, sexual debut, sexual behaviour, attraction and coming out, as well as sexual health.

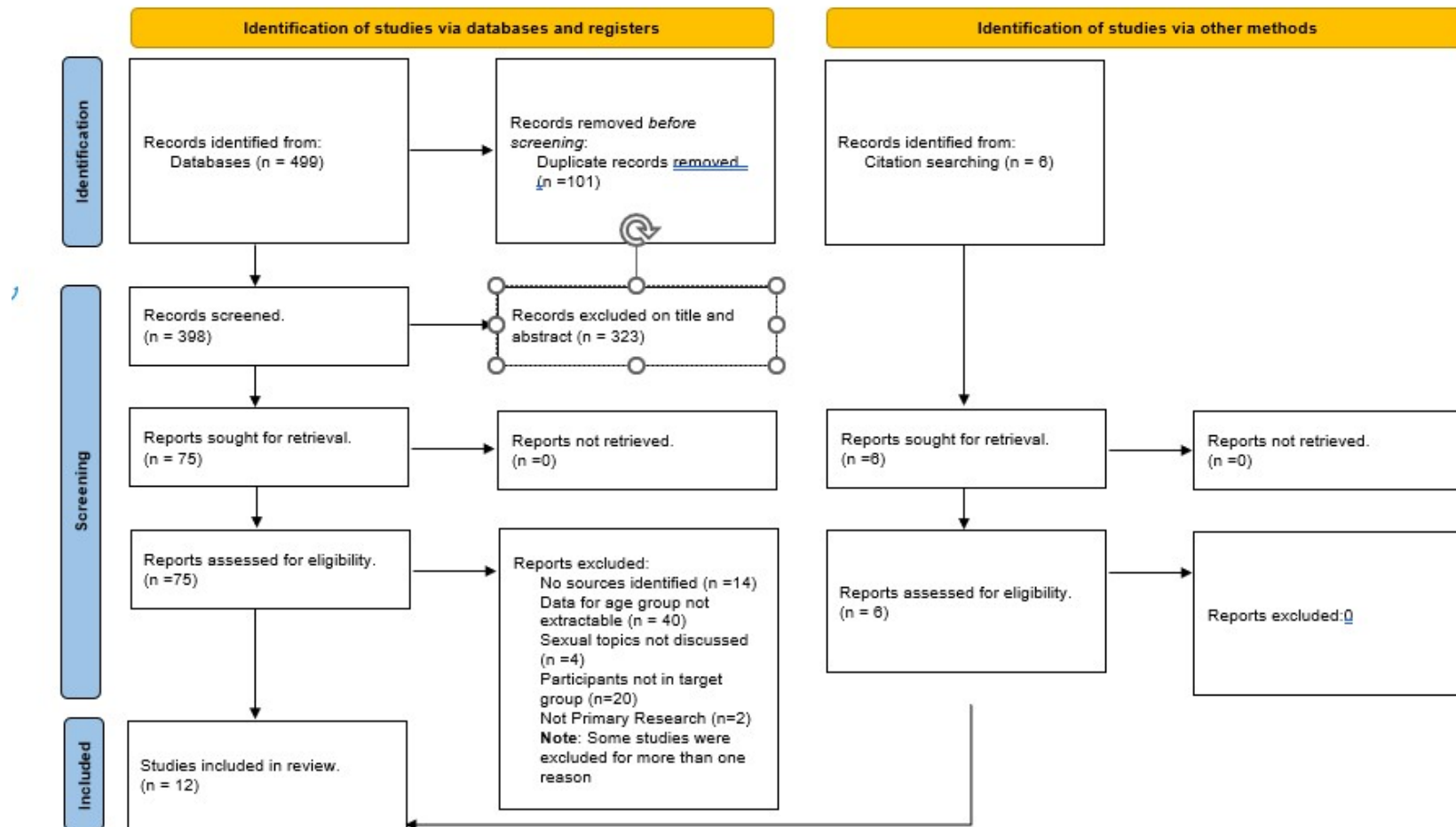
Table 3.2 Inclusion and Exclusion Criteria

	Inclusion Criteria	Exclusion Criteria
Participants	LGBQ Adolescents Aged 13-19	Non-LGBQ Adolescents Data not extractable on LGBQ adolescents aged 13-19
Intervention/ Exposure	Information on sexual health (Friendships and Sexual Orientation. Readiness for Safer Sex, Sexual Behaviour/ Activity)	Studies that did not consider sources of information
Outcomes	Sources used and usefulness of source on sexuality and sexual health	Studies that did not include topics related to sexuality and sexual health

3.2.4 Retrieval /Screening

A total of 499 studies were generated from the initial searches, and six additional studies were found from their reference lists bringing the total to 505. After 101 duplicates were removed the 404 articles remaining were reviewed by title and 323 were excluded as they did not meet the inclusion criteria. The main reasons for exclusion were that the articles related to non-LGBQ adolescents, were non peer reviewed or it was not possible to extract data for 13–19-year-olds. The remaining records (n=81) were screened by abstract and the sixteen (n=16) deemed not eligible were removed. The complete full text of the remaining 75 articles were then retrieved and screened. 63 were excluded leaving only twelve studies (n=12) that met the inclusion criteria (Figure 3.1. PRISMA DIAGRAM (Page *et al.* 2020). The main reasons for exclusion at this stage were articles that were not primary research (n=2), data from age group not extractable (n=40), participants not in the target group (LGBQ) (20), did not ask about sexuality or sexual health (n=4) and did not include sources of information anywhere in the study (n=14). Some studies were excluded for more than one reason. At all levels of screening, title, abstract and full text, two people independently assessed studies, with all three people, myself and my supervisors discussing and agreeing on the final studies for inclusion in the review.

Figure 3.1. PRISMA Diagram for Integrative Review on Sources of Information of Lesbian, Gay, Bisexual and Questioning (LGBQ) Adolescents in relation to sexuality and sexual health (Page et al. 2020)



3.2.5 Quality Review/ Critical Appraisal

The quality of the studies included were assessed independently by the three people (myself and my two supervisors) using Hawker *et al.* (2002) assessment tool, which is suitable to assess studies with differing methodologies. Studies were evaluated across nine domains: abstract and title, introduction and aims, method and data, sampling, data analysis, ethics and bias, results, transferability, generalizability, implications, and usefulness. The quality of each domain was scored using four descriptors, good (40 points), fair (30 points), poor (20 points) and very poor (10 points), with total points of 360 available. All studies were scored separately and mean scores were calculated ranging from 290 to 340 (Table 3.5). Inter-rater agreement scores were calculated on % level of agreement on each domain (Hallgren 2012). Depending on the study, inter-rater agreement ranged from 55% to 70%.

3.2.6 Data Extraction and Synthesis

A pre-designed extraction table was developed, piloted and applied across the studies to record pertinent information based on the aim of the review. In addition to extracting the core data from each paper, extraction also included inference on the sources and topic's use and usefulness (see Table 3.5). To ensure consistency a data extraction form for all studies was initially completed by myself and reviewed by the supervisors.

3.2.7 Data synthesis and analysis

This integrative review included studies of different aims and methodologies (quantitative, qualitative and mixed methods). Therefore, a narrative rather than numerical description was selected as the best way to integrate the results from the different data types (Popay *et al.* 2006, Joanna Briggs Institute Reviewers Manual 2014,). A narrative synthesis was used to group the information together (Popay *et al.* 2006). The qualitative data extracted were analysed using content analysis (Dixon-Woods *et al.* 2004) and quantitative data was coded based on frequency to determine sources and topics. Qualitative and quantitative data were then reviewed to derive a compatible format to further classify and integrate the data.

Within the classification developed the sources and the topics were subdivided into primary and secondary categories based on the frequency and usefulness of the source or topic. Topics and sources that were highlighted in studies as not useful were classified as secondary topics or sources (Figure 3.2). These classifications were continuously refined as the synthesis developed (Popay et al. 2006).

Figure 3.2. Criteria for the conversion of data to compatible format for integrated synthesis

Qualitative studies and qualitative data from mixed methods studies	Compatible format	Quantitative studies and quantitative data from mixed methods studies
A major source emerging when general sources asked	Primary source of information	More than 50% of participants used this as a source of information
A major source discussed as a labelled part of the study's aims		
Cited by at least one participant as a major source even though not labelled as part of the study's aim		
A minor source emerging when general sources asked	Secondary sources of information	Less than 50% of participants used this as a source of information
Cited as a minor source by at least one participant even when labelled as part of the study's aim.		
Cited as not a useful source of information		
A major topic emerging and cited as useful	Primary topics	More than 50% of participants cited it as a major topic
A minor topic emerging and cited as useful	Secondary topics	Less 50% of participants cited it as a major topic.
A topic emerging and not cited as useful.		

3.2.8 Presentation of Findings

The twelve studies included in the final review (Table 3.5) were published between 2008 and 2020. Eleven were conducted in the USA and one in Australia. Eight were quantitative (Hillier & Mitchell 2008, Kingdon *et al.* 2013; Mitchell *et al.* 2014b,

Rasberry *et al.* 2018, Nelson *et al.* 2019b, Nelson *et al.* 2019c, Cafferty *et al.* 2020, Mustanski *et al.* 2020), three were qualitative (Hillier *et al.* 2012, Arrington- Sanders *et al.* 2015, Steinke *et al.* 2017) and one used mixed methods (Arbeit *et al.* 2016). The quantitative studies were published between 2008 and 2020 with the mixed methods and qualitative studies published between 2012 and 2017 (See Table 3.5).

All twelve studies mention ethical approval, eight had a parental consent waiver (Hillier *et al.* 2012, Mitchell *et al.* 2014b, Arrington- Sanders *et al.* 2015, Arbeit *et al.* 2016, Nelson *et al.* 2019b, Nelson *et al.* 2019c, Cafferty *et al.* 2020, Mustanski *et al.* 2020), two studies got parental consent (Kingdon *et al.* 2013, Rasberry *et al.* 2018), one indicated that parental consent was not sought (Steinke *et al.* 2017) and the remaining study did not discuss parental consent (Hillier & Mitchell 2008). The review represents data from 5893 participants in total aged between 13 and 19 years. In terms of gender, four studies had both male and female participants (Hillier & Mitchell 2008, Hillier *et al.* 2012, Steinke *et al.* 2018, Cafferty *et al.* 2020), six had male only (Kingdon *et al.* 2013, Arrington- Sanders *et al.* 2015, Rasberry *et al.* 2018, Nelson *et al.* 2019b, Nelson *et al.* 2019c, Mustanski *et al.* 2020), one had female only participants (Arbeit *et al.* 2016) and the other did not describe gender (Mitchell *et al.* 2014b). Therefore, it was not possible to determine in total, exactly, how many males, females or gender non-conforming participants took part as detail regarding participants gender was not always reported in studies (Table 3.5). Gender identity is not reported in the studies.

The descriptions of participants' sexual orientation varied from study to study. The following descriptions were used, exclusively same sex attracted, attracted to both sexes or unsure (Hillier and Mitchell 2008), being sexual minority (Steinke *et al.* 2017, Rasberry *et al.* 2018), lesbian, gay or bisexual (Hillier *et al.* 2012), bisexual, gay/lesbian/queer, questioning (Mitchell *et al.* 2014b), bisexual and gay (Kingdon *et al.* 2013, Nelson *et al.* 2019c), bisexual females only (Arbeit *et al.* 2016) and males who have sex with males (Kingdon *et al.* 2013, Arrington Sanders *et al.* 2015, Nelson *et al.* 2019b, Mustanski *et al.* 2020). Some studies provide a breakdown in numbers of participants' sexual orientation and others did not, so it was not possible to calculate the overall numbers of people who identified as lesbian, gay, bisexual or questioning (Table 3.5).

While most studies had a variety of participants of different ethnic origin, nine studies reported most participants were white (Hillier and Mitchell 2008, Hillier *et al.* 2012, Mitchell *et al.* 2014b, Arbeit *et al.* 2016, Steinke *et al.* 2017, Nelson *et al.* 2019b,

Nelson *et al.* 2019c, Cafferty *et al.* 2020, Mustanski *et al.* 2020). Education and social class were not documented consistently (Table 3.5).

Of the twelve studies included, one study had sources of information as the aim of the study (Nelson *et al.* 2019b). Three studies looked at school-based sex education (Hillier & Mitchell 2008, Arbeit *et al.* 2016, Rasberry *et al.* 2018) and two examined Internet use exclusively (Hillier *et al.* 2012; Mitchell *et al.* 2014b). Another study explored the sex education/ information young LGBTQ people consider important (Steinke *et al.* 2017). Four studies were topic focussed, with two exploring where young men accessed information on HIV (Kingdon *et al.* 2013, Mustanski *et al.* 2020) and two other studies exploring the topic of sexually explicit material (Arrington-Sanders *et al.* 2015, Nelson *et al.* 2019c). Cafferty *et al.* (2020) researched whether participants discussed sex with healthcare providers.

Sampling methods included convenience or combined convenience and snowball sampling. All studies, except for four (Hillier *et al.* (2012), Arbeit *et al.* (2016), Rasberry *et al.* (2018), Cafferty *et al.* (2020)) used multiple methods to recruit participants. (Table 3.5). Samples were recruited through advertising on Facebook (Mitchell *et al.* 2014b, Arrington- Sanders *et al.* 2015, Arbeit *et al.*, 2016, Nelson *et al.* 2019b, Nelson *et al.* 2019c), internet (Hillier & Mitchell 2008, Mitchell *et al.* 2014b, Arrington- Sanders *et al.* 2015, Steinke *et al.* 2017, Nelson *et al.* 2019b), gay youth organisations/ venues (Hillier & Mitchell 2008, Hillier *et al.* 2012, Kingdon *et al.* 2013, Mitchell *et al.* 2014b, Arrington- Sanders *et al.* 2015, Steinke *et al.* 2017, Cafferty *et al.* 2020), magazines (Hillier & Mitchell 2008), schools (Kingdon *et al.* 2013, Arrington- Sanders *et al.* 2015, Rasberry *et al.* 2018) and health clinics (Arrington- Sanders *et al.* 2015). More recent studies, Nelson *et al.* 2019b, Nelson *et al.* 2019c also used Instagram to recruit participants. Mustanski *et al.* (2020) stated they used social media to recruit but did not provide specific sites.

3.2.8.1 Sources of information

In relation to sources of information, participants identified online (LGBTQ and generic), media (print, film and TV), parents, school, formal education or LGBTQ education classes, health services, community agencies (LGBTQ and non-LGBTQ) and social outlets (bars, clubs etc.) as sources of information. These are listed below in Table 3.3 into Primary and Secondary Sources of Information (Table 3.3). There are four primary

sources, online (generic), online (LGBQ), educational class and parents. These were all secondary sources also with health services, media, social outlets and community centers also listed as secondary sources.

Table 3.3. Categories for Sources of Information for LGBQ Adolescents

Primary Sources	Secondary Sources
<u>Online (generic):</u> Arbeit <i>et al.</i> 2016; Hillier & Mitchell 2008; Hillier <i>et al.</i> 2012; Mitchell <i>et al.</i> 2014; Nelson <i>et al.</i> 2019b <u>Online (LGBQ information) or (LGBQ fora/ chatrooms):</u> Arrington- Sanders <i>et al.</i> 2015; Hillier & Mitchell 2008; Hillier <i>et al.</i> 2012; Kingdon <i>et al.</i> 2013; Nelson <i>et al.</i> 2019c; Steinke <i>et al.</i> 2017	<u>Online (generic):</u> Arrington- Sanders <i>et al.</i> 2015, Nelson <i>et al.</i> 2019b <u>Online (LGBQ Information):</u> Arrington- Sanders <i>et al.</i> 2015
<u>Educational Class:</u> Kingdon <i>et al.</i> 2013 (School and LGBQ education); Mustanski <i>et al.</i> 2020 (School); Nelson <i>et al.</i> 2019b (Formal Sex Education school/ church/ community center); Rasberry <i>et al.</i> 2018 (School)	<u>School (non-LGBQ):</u> Arbeit <i>et al.</i> 2016; Hillier & Michell 2008; Nelson <i>et al.</i> 2019b; Steinke <i>et al.</i> 2017;
<u>Parents:</u> Nelson <i>et al.</i> 2019b	<u>Parents:</u> Cafferty <i>et al.</i> 2020; Mustanski <i>et al.</i> 2020
	<u>Health services (Dr/ Clinic):</u> Arbeit <i>et al.</i> 2016; Kingdon <i>et al.</i> 2013; Nelson <i>et al.</i> 2019b, Steinke <i>et al.</i> 2017; Cafferty <i>et al.</i> 2020
	<u>Media (LGBQ & non-LGBQ specific):</u> Arrington Sanders <i>et al.</i> 2015 (movies/ print material-magazines/ TV); Kingdon <i>et al.</i> 2013 (print media)
	<u>Social outlets (non-LGBQ Bars, clubs):</u> Kingdon <i>et al.</i> 2013
	<u>Community centre/ agencies:</u> Kingdon <i>et al.</i> 2013,

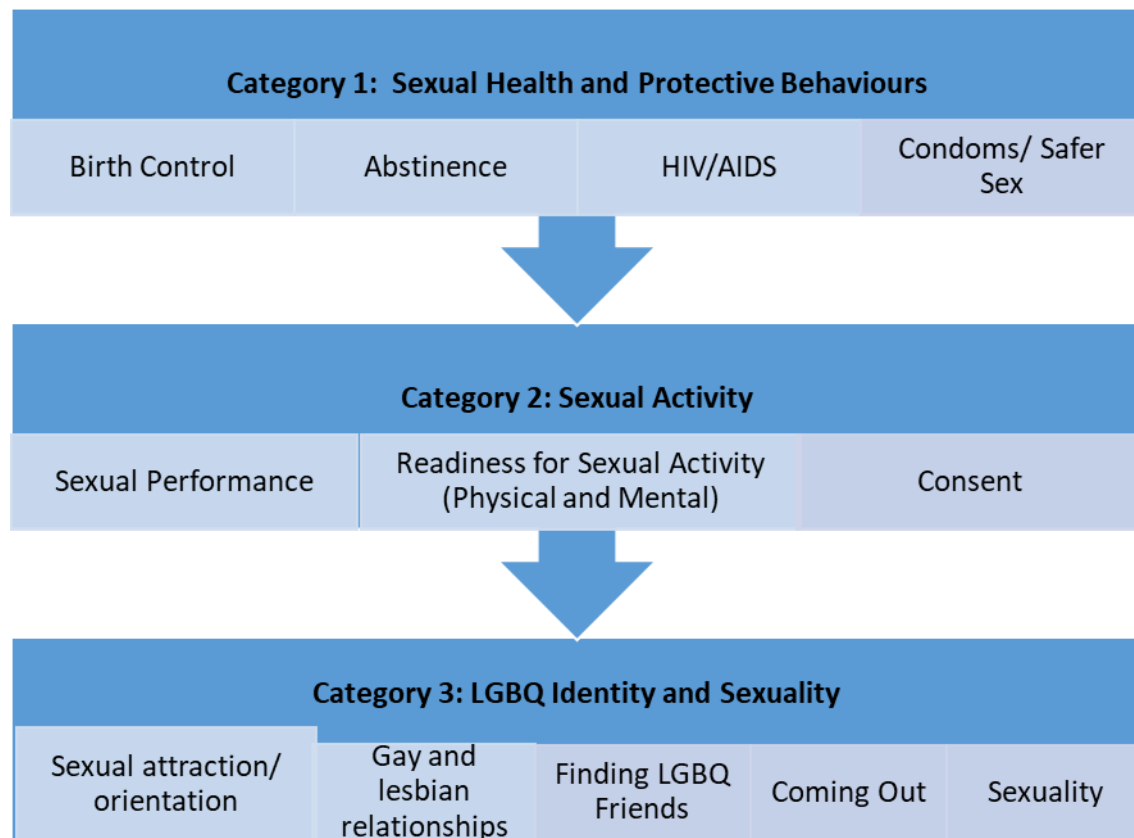
Nine of the studies had online searches as a primary source (a major or useful source), with two studies having online (generic and LGBQ) as a secondary source (a minor or not useful source) (Arrington Sanders *et al.*, 2017, Nelson *et al.* 2019b) (Table 3.3). Internet use was categorised as Online (generic) and those that specifically looked for LGBQ information online or LGBQ fora/ chatrooms . In the studies where the internet was categorised as a primary source, participants in two studies searched both generic and LGBQ sites (Hillier & Mitchell 2008; Hillier *et al.* 2012), four searched LGBQ sites only (Arrington- Sanders *et al.* 2015, Kingdon *et al.* 2013, Nelson *et al.* 2019c, Steinke

et al. 2017), and three searched generic sites only (Arbeit *et al.* 2016; Mitchell *et al.* 2014; Nelson *et al.* 2019b). Of the six studies that cited using LGBTQ online specific sources, three used LGBTQ fora/ chatrooms (Arrington- Sanders *et al.* 2015; Hillier & Mitchell 2008; Hillier *et al.* 2012). Arrington- Sanders *et al.* (2015) study was the only study that cited LGBTQ online as a secondary source, classifying it as both primary and a secondary source. Nelson *et al.* (2019b) on the other hand cited generic online searches as both a primary and secondary source. Health services (Dr./Clinic) were cited as a secondary source for (Kingdon *et al.* 2013, Arbeit *et al.* 2016, Steinke *et al.* 2017, Mustanski *et al.* 2020) but were a primary source for two studies (Rasberry *et al.* 2018, Nelson *et al.* 2019b), social outlets and community centres/ agencies (Kingdon *et al.* 2013) and media (Kingdon *et al.* 2013, Arrington- Sanders *et al.* 2015). However, these findings are limited as two studies had Internet use as the focus of the study so no other source was considered.

3.2.8.2 Sexuality and Sexual Health Topics of Information

Twelve topics emerged from the open coding of the qualitative data and descriptions provided in the quantitative studies. These topics were grouped into three main categories: Sexual Health and Protective behaviours; Sexual Activity; and LGBTQ Identity and Sexuality (Table 3.5, Figure 3.3). Under Category 1 Sexual Health and Protective Behaviours, four topics were classified; Birth control, Abstinence, HIV/AIDS and Condoms/ Safer Sex. For the Category 2 Sexual Activity, there were three topics classified. These were Sexual Performance, Readiness for Sexual Activity (Physical and Mental) and Consent. Finally, five topics were classified under Category 3 LGBTQ Identity and Sexuality. These were Sexual Attraction/ Orientation, Gay and Lesbian relationships, Finding LGBTQ Friends, Coming Out and Sexuality. The categories and classifications that were found in each of the studies are listed in Table 3.5.

Figure 3.3 Sexuality and Sexual Health Categories for Topics of Information



Using the integrated synthesis criteria outlined in Figure 3.2, all topics emerged as primary or useful in some studies. However, in other studies some topics were classified as secondary. In Arrington- Sanders *et al.* (2015) and Mitchell *et al.* (2014b) studies, condoms and safe sex were classified as secondary topics only, whereas in Hillier & Mitchell (2008) study they were classified secondary and a primary topic, depending on the source (Table 3.3). As outlined in Table 3.4 most studies had either a primary topic or secondary topic present under the categories, Sexual Health and Protective Behaviours, Sexual Activity and LGBTQ Sexuality and Identity.

Table 3.4 Categories of Topics Sourced in the Reviewed Studies for LGBQ Adolescents

	Primary topic	Secondary topic
Sexual Health and Protective Behaviours		
Birth Control	Arbeit <i>et al.</i> 2016; Steinke <i>et al.</i> 2017; Nelson <i>et al.</i> 2019b	Mitchell <i>et al.</i> 2014b
Abstinence	Arbeit <i>et al.</i> 2016;	
HIV/AIDS	Arbeit <i>et al.</i> 2016; Kingdon <i>et al.</i> 2013; Steinke <i>et al.</i> 2017; Nelson <i>et al.</i> 2019b; Mustanski <i>et al.</i> 2020	Mitchell <i>et al.</i> 2014b; Rasberry <i>et al.</i> 2018
Condoms/ Safer Sex	Arbeit <i>et al.</i> 2016; Hillier & Mitchell 2008; Hillier <i>et al.</i> 2012; Steinke <i>et al.</i> 2017; Nelson <i>et al.</i> 2019b	Arrington- Sanders <i>et al.</i> 2015; Hillier & Mitchell 2008; Mitchell <i>et al.</i> 2014b; Rasberry <i>et al.</i> 2018
Sexual Activity		
Sexual Performance	Arrington- Sanders <i>et al.</i> 2015; Nelson <i>et al.</i> 2019b	Mustanski <i>et al.</i> 2020
Readiness for Sexual Activity (Physical and Mental)	Arrington- Sanders <i>et al.</i> 2015; Nelson <i>et al.</i> 2019c; Cafferty <i>et al.</i> 2020;	Nelson <i>et al.</i> 2019b
Consent	Nelson <i>et al.</i> 2019b	
LGBQ Identity and Sexuality		
Sexual attraction/ Orientation	Hillier & Mitchell 2008; Mitchell <i>et al.</i> 2014b; Steinke <i>et al.</i> 2017; Nelson <i>et al.</i> 2019c;	Mustanski <i>et al.</i> 2020
Gay and lesbian relationships	Hillier & Mitchell 2008; Hillier <i>et al.</i> 2012;	Hillier & Mitchell 2008; Nelson <i>et al.</i> 2019c;
Finding LGBQ friends	Hillier & Mitchell 2008	
Coming Out	Hillier & Mitchell 2008; Steinke <i>et al.</i> 2017	
Sexuality	Mitchell <i>et al.</i> 2014b; Steinke <i>et al.</i> 2017; Nelson <i>et al.</i> 2019c;	

Table 3.5. Description of Studies

Year/ Author/ Location	Research question Aims/ Objectives	Research Methods	Sample Type LGB/ Number/ Age/ Ethnicity/ Social class	Recruitment, Ethical approval and parental consent Mean Quality Score (Out of 360)	Sources of information and topics sourced
Arbeit <i>et al.</i> (2016) USA (national study)	To assess school-based sources of sexual health information	Mixed methods Online survey and online focus groups Descriptive statistics and thematic analysis	N=40 Age: 14-17 Gender: 40 Females Sexual Orientation: Bisexual Ethnicity: 70% white; 20% Hispanic/Latina; 2.5% Black 2.5% Asian; 5% other Education & Social class: not discussed	Recruitment: Contacted via paid advertisement on Facebook Sampling: Convenience Ethical approval: Yes. Parental consent waiver granted Mean Quality Score: 330	Primary Source of Information: <u>Online Searches (generic)</u> <i>Topics sourced:</i> None described Secondary Sources of Information: <u>School (not LGBTQ)</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: Abstinence and condoms/ safer sex <u>Health Services (Dr/ Clinic)</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: Condoms/ safer sex, HIV/AIDS, birth control
Arrington-Sanders <i>et al.</i> (2015) Maryland USA	To understand the role and function of Sexually explicit material (SEM) on sexual development among Black adolescent males who engage in sex with other males	Qualitative Study Individual face to face semi structured interviews Thematic analysis	N= 47 Age: 15-19 Gender: 47 Males Sexual Orientation: Males who have sex with males Ethnicity: African-American or mixed race Education or social class not discussed	Recruitment: Contacted via Outreach (LGBQ organisation) at youth venues; internet advertisement; clinics (school based/ community based/ STD) and contacted via paid advertisement on Facebook Sampling: Convenience & snowball Ethical approval: Yes. Parental consent waiver granted Mean Quality Score: 340	Primary Source of Information: <u>Online Searches (LGBQ)/ LGBTQ fora (Chatrooms)</u> <i>Primary Topics:</i> Sexual Activity: Sexual performance, Readiness for Sexual Activity (physical and mental) <i>Secondary Topics:</i> Sexual Health and Protective Behaviours: Condoms/ safer sex Secondary Sources of Information: <u>Online Searches (generic)</u> <u>Media (LGBQ and non-LGBQ) - Movies and Print media/ magazines/TV</u> <u>Online Searches (LGBQ)</u> <i>Topics sourced:</i> None described

Year/ Author/ Location	Research question Aims/ Objectives	Research Method	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Cafferty <i>et al.</i> (2020) USA Minnesota	To determine pride attendees' rates of accessing health care via their primary care physician (PCP) and assess if providers are discussing sex and offering screening for STIs.	Quantitative Study Paper Survey Descriptive and inferential statistics	N=336 Age: 13-17 Gender: Males (11.48%) and Female (77.41%) Sexual Orientation: LGBT= 336 Bisexual female (n=139 41.6%) Gay or Lesbian female (n=37 11.01%) Bisexual Male (n=20 5.9%) Gay Male (n=20 5.9%) Ethnicity White 76% Other 24% Education or social class not discussed	Recruitment: Asked to participate as they passed a booth at a Pride festival Sampling: Convenience Ethical Approval – Yes Parental consent waiver granted Mean Quality Score: 290	Primary Sources of Information: <u>Health Services: Dr./ Clinic</u> <u>Primary Topics:</u> Sexual Activity: Sexual Performance, Readiness for Sexual Activity (Physical and Mental) Secondary Source of Information <u>Parents</u> <u>Primary Topics:</u> Sexual Activity: Sexual Performance, Readiness for Sexual Activity (Physical and Mental)

Year/ Author/ Location	Research question Aims/ Objectives	Research Method	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Hillier and Mitchell (2008) Australia	To ask about sex education classes at school and the usefulness of them as sources of information regarding gay and lesbian relationships and safer sex, sexual behaviours and incidence of sexually transmissible infections and pregnancy	Quantitative study Online or printed survey Descriptive statistics.	N= 1749 Age: 14-21 Gender: Males and females (Breakdown not given) Sexual Orientation: 66% exclusively attracted to same sex 29% attracted to both sexes 5% unsure Ethnicity: 22% described as having a culturally and linguistically diverse background. 2% Aboriginal +/- Torres Straight Islanders Education: 37% in school; 34% in university/technical or further education; 12% worked full time; 29% worked part time +/- as well as studied; 4% unemployed Social class not discussed	Recruitment: Advertised nationally in magazines, on the Internet and through youth networks Sampling: Convenience Ethical approval: Yes Parental consent not discussed Mean Quality Score: 320	Primary Sources of Information: <u>Online Searches (generic)</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: Condoms/safe sex LGBQ Identity and Sexuality: Sexual attraction/ orientation, coming out <u>Online (LGBQ Chatrooms)</u> <i>Primary Topics:</i> LGBQ Identity and Sexuality: Gay and lesbian relationship, finding LGBQ friends Secondary Sources of Information: <u>School</u> <i>Secondary Topics:</i> LGBQ Identity and Sexuality: Gay and lesbian relationship Sexual Health and Protective Behaviours: Condoms/safe sex

Year/ Author/ Location	Research question Aims/ Objectives	Research Method	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Hillier <i>et al.</i> (2012) Online – Nationally Northeastern Southeastern Midwestern Southwestern Western regions of USA	To explore the difference in the benefit that Lesbian, Gay & Bisexual (LGB) young people and non-LGB young people derive from the Internet	Qualitative Study Online focus groups Thematic analysis	N= 33 Age: 13-18 Gender: 17 Male, 16 females Sexual orientation: LGB Ethnicity: Most were white, but sample also included a small number of Black/ Hispanic and Asian participants Education or social class not discussed.	Recruitment: Contacted via Gay, Lesbian and Straight Education Network (GLSEN). Sampling: Convenience & snowball Ethical approval: Yes. Parental consent waiver granted Mean Quality Score: 310	Primary Sources of Information: <u>Online Searches (generic) & Online (LGBQ-chatrooms)</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: Condoms/ safer sex LGBQ Identity and Sexuality: Gay and Lesbian relationships Secondary Sources of Information: none described

Year/ Author/ Location	Research question Aims/ Objectives	Research Methods	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Kingdon <i>et al.</i> (2013) New York City, USA	To document and describe where Young Men who have Sex with Men (YMSM) have accessed HIV prevention messages	Quantitative Online Survey Descriptive statistics	N= 36 Age: 13-19 Gender: Males only Sexual Orientation: 22 Gay, 14 Bisexual Ethnicity: 30% Black 30% Latino 5.5 % White 5.5% Asian/ Pacific Islander 28% Mixed/ Other Education not discussed Social Class: Perceived Economic Status over 70% were middle income bracket	Recruitment: Face to face recruitment at schools and LGBQ youth events and paid \$10. Sample: Convenience Ethical approval: Yes Parental consent for Under 18s obtained Mean Quality Score: 310	Primary Sources of Information: <u>Online Searches (LGBQ)</u> <u>Education Classes – (School and LGBQ education class)</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: HIV/AIDS Secondary Sources of Information: <u>Social Outlets: bars/dance clubs non-LGBQ</u> <u>Media – print media</u> <u>Community Centre / agencies</u> <u>Health Services: Dr./ Clinic</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: HIV/AIDS

Year/ Author/ Location	Research question Aims/ Objectives	Research Methods	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Mitchell <i>et al.</i> (2014b) USA	To examine the extent to which youths of different sexual orientation look for sexual health information online, why they look for it, and what if anything they do with it	Quantitative study Online survey Descriptive Statistics	N= 2162 Age: 13- 18 Gender: not described Sexual orientation: Gay/ lesbian/ queer = 1282 Bisexual = 655, Questioning = 225 Education: not discussed Ethnicity: The most common ethnicity was White with Hispanic also represented Social class: 51% had parents who have completed high school 61% had lower than average income	Recruitment: E mail invitations with survey link sent via Gay, Lesbian and Straight Education Network (GLSEN) and Harris Poll Online (HPOL) contact lists and targeted advertising through Facebook. – Internet based invites Sample: Convenience Ethical Approval: Yes Parental consent waiver granted Mean Quality Score: 330	Primary Sources of Information: <u>Online Searches (generic)</u> <i>Primary Topics:</i> LGBQ Identity and Sexuality: sexuality, sexual attraction/ orientation <i>Secondary topics:</i> Sexual Health and Protective Behaviours: HIV/ AIDS, condoms/ safer sex, birth control Secondary Sources of Information: none described

Year/ Author/ Location	Research question Aims/ Objectives	Research Methods	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Mustanski et al. (2020) USA	To report data on HIV testing in a large sample of AMSM aged 13- 18.	Part of SMART Online Survey Descriptive Statistics	N= 699 Age 13-18 Adolescent men who have sex with men (AMSM) Gay 66.4% Bisexual 25% Other 8.6% Ethnicity: African American 17.3% Latino 31.6% White 40.2% Other 10.9% Social Class: Public assistance 33.5% Not on Public Assistance 66.5% Education: not discussed	Recruitment – Social media campaign Sample: Convenience Ethical Approval: Yes Parental consent waiver granted Mean Quality Score: 310	Primary Sources of Information <u>School</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: HIV/AIDS Secondary Sources of Information: <u>Parents</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: HIV/AIDS <u>Health Services: Dr./ Clinic</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: HIV/AIDS <i>Secondary Topics:</i> Sexual Activity: Sexual Performance, <i>Secondary Topic:</i> LGBQ Identity and Sexuality Sexual attraction/ Orientation

Year/ Author/ Location	Research question Aims/ Objectives	Research Methods	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Nelson <i>et al.</i> (2019b) USA Northwest 17% Midwest 20% South 29% West 34%	To ascertain how adolescent males who have sex with males obtain sexual health information.	Quantitative Study Online Survey Descriptive Statistics	N=207 Aged 14-17 Gender: Males Sexual Orientation: Adolescent Males interested in sex with males (AMSM) = Gay or Bisexual Males Ethnicity: Latino 20% Black 15% White 52% Mixed race/ Other 13% Education or social class not discussed	Recruitment: Online advertising and posts on social media (e.g., Instagram (84%) and Facebook (16%)) Sample: Convenience Ethical Approval: Yes Parental consent waiver granted Mean Quality Score: 320	Primary Sources of Information <u>Parents</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: condoms/ safer sex, birth control, consent, HIV/AIDS <i>Secondary Topics:</i> Sexual Activity: Sexual Performance, Readiness for Sexual Activity (Physical and Mental) <u>Formal Sex Education</u> (school/ church/ community center or other) <i>Primary Topics:</i> Sexual Health and Protective Behaviours: condoms/ safer sex, birth control, consent, HIV/AIDS <i>Secondary Topics:</i> Sexual Activity: Sexual Performance, Readiness for Sexual Activity (Physical and Mental) <u>Online Searches (generic)</u> <i>Primary Topics:</i> Sexual Activity: Sexual Performance, Readiness for Sexual Activity (Physical and Mental) Sexual Health and Protective Behaviours: condoms/ safer sex, <i>Secondary Topics:</i> Sexual Activity: Sexual Health and Protective Behaviours: birth control, consent, HIV/AIDS, condoms/ safer sex Secondary Sources of Information: none described

Year/ Author/ Location	Research question Aims/ Objectives	Research Methods	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Nelson <i>et al.</i> (2019c) USA Northeast 16% Midwest 20% South 29% West 35%	To describe Sexually Explicit online media (SEOM) use and perceived influence among adolescent sexual minority males (ASMM)in the USA	Quantitative Online Survey Descriptive Statistics	N= 206 Age 14-17 Gender: Males Gay 66% Bisexual 24% Heterosexual 5% Other 5% Race/ Ethnicity: White 52% Black/ African American 15% Latino 21% Mixed race/ other 13% Education 95% currently in school Social class not discussed	Recruitment: Posts on social media (e.g., Instagram (84%) and Facebook (16%) Sample: Convenience Ethical Approval: Yes Parental consent waiver granted Mean Quality Score: 310	Primary Sources of Information <u>Online (LGBQ)</u> <i>Primary Topics:</i> Sexual Activity: Sexual Performance, Readiness for Sexual Activity (Physical and Mental) LGBQ Identity and Sexuality: Sexual attraction/ orientation: sexuality, sexual attraction/ orientation <i>Secondary Topics:</i> LGBQ Identity and Sexuality: Gay and Lesbian Relationships, sexuality Secondary Sources of Information: none described

Year/ Author/ Location	Research question Aims/ Objectives	Research Methods	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Rasberry <i>et al.</i> (2018) USA	To explore associations between students reports of school- related HIV/ STD classroom-based prevention education and condom use and HIV/ STD testing.	Quantitative Study Survey Descriptive Statistics	N=286 Aged 13-18 Gender: Males Sexual Orientation: Adolescent Sexual Minority Males (ASMM) = Gay or Bisexual Males Education: all in school Social Class: Not discussed Ethnicity: Hispanic 47.2% Black 25.5% White 16.4% Asian 4.2% Other 6.5%	Recruitment: Seven high schools in Urban Florida Sample: Convenience Ethical Approval: Yes Parental permission sought Mean Quality Score: 310	Primary Sources of Information <u>School</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: condoms/ safe sex <i>Secondary Topics:</i> Sexual Health and Protective Behaviours HIV/AIDS Secondary Sources of Information: none described

Year/ Author/ Location	Research question Aims/ Objectives	Research Methods	Sample Type LGB/ Number/ Age	Recruitment Method Ethics Average Quality Score (Out of 360)	Sources of information and topics sourced
Steinke <i>et al.</i> (2017) USA Seattle and Dallas	To determine what sex education/ information young sexual and gender minority youth consider important.	Qualitative Study Online and in person focus groups & individual telephone semi structured interviews Thematic analysis	N=92 Age: 15- 19 Gender: Males and females (Breakdown not given) Sexual Orientation: Gay n=31 Lesbian n=19 Bisexual n= 15 Questioning n=10 Other n=36 Ethnicity: White = 52% African/ American = 16% Mixed race = 12% Asian= 5% American- Native American/ Alaskan native = 1% Education or social class not discussed.	Recruitment: online advertising and printed advertising displayed in LGBQ organisations. Sample: Convenience Ethical approval: Yes Parental permission not sought Mean Quality Score: 310	Primary Sources of Information: <u>Online Searches (LGBQ)</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: condoms/ safer sex LGBQ Identity and Sexuality: sexuality, coming out, sexual attraction/orientation Secondary Sources of Information: <u>School</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: HIV/AIDS <u>Health Services: Dr./ Clinic</u> <i>Primary Topics:</i> Sexual Health and Protective Behaviours: condoms/ safer sex

3.2.9 Discussion of the Integrative Review Findings

In relation to sources of information, participants identified online (LGBQ and generic), media (print, film and TV), parents, school or LGBQ education classes, health services, community agencies (LGBQ and non-LGBQ) and social outlets (bars, clubs etc.) as sources of information. Of these the internet was found to be the most used primary source of information irrespective of whether the study specifically focused on the internet. This is not surprising given the contemporary nature of the studies included (2008-2020) and the part that the Internet plays in adolescent's lives (Lenhart *et al.* 2010). Indeed, previous research studies on LGBQ adults (Magee *et al.* 2012, DeHaan *et al.* 2013, Craig *et al.* 2015, Charest *et al.*, 2016, Currin *et al.* 2017, Flanders *et al.* 2017) and non-LGBQ adolescents (Jones and Biddlecom 2011a, Jones and Biddlecom 2011b) have reported similar findings on the Internet for accessing information on sexuality.

Studies included in this review provided limited detail about where on the internet information was sourced, what devices (smartphones, laptops, tablets) were used to access the internet or how reliable participants found the sites or the information. The studies also lacked specific information on whether the content sourced was fixed content or changing information in the form of blogs, discussion boards or social media. It is surprising, however, that social media, such as Facebook or Instagram was not explicitly identified as a source of information in any of the studies included, as several of the studies used these social media platforms to advertise their studies as a means of recruiting participants (Table 3.5). Thus, it would seem further research into the sites and topics, including the usefulness of the information would be advantageous in the future.

Parents were found to be a primary source in one study (Nelson *et al.* 2019b) and a secondary source of information in two studies (Cafferty *et al.* 2020, Mustanski *et al.* 2020) in this review. This links with previous research that showed LGBQ adolescents are less likely than their heterosexual counterparts to seek information from parents. Challenges of revealing their sexual orientation, of discussing same sex sexual relationships with parents and the inability of parents to relate to the information the young person is seeking may hamper this (Kubicek *et al.* 2010, Rose and Friedman, 2012, DeHaan *et al.* 2013, Currin *et al.* 2017). In addition, adolescents may also fear rejection and victimisation. In Nelson *et al.* (2019b) the topics that parents were a

source of information on were those linked to risk in both LGBQ and non-LGBQ sexual activity, namely condoms/safer sex, birth control, consent and HIV/AIDs so it is not known if the adolescent's sexual orientation was disclosed.

Online peers on the other hand were identified as a source of information in two studies (Hillier *et al.* 2012, Arrington- Sanders *et al.* 2015). This might imply that young LGBQ people are aiming to reduce the risk of rejection and victimisation by connecting to peers online, supporting the work of Hillier *et al.* (2010) and GLSEN (2013), who found that the internet provided an important space for LGBQ people to feel accepted, explore their sexual identity, find others, come out and feel proud. Given that young LGBQ people may find it more difficult to locate LGBQ peers offline (DeHaan *et al.* 2013) due to fears around coming out or being too young to go to nightclubs/ bars, connecting online may be a distinct advantage for a younger age group. It is also not unexpected that social outlets and community centers/ agencies are reported only as secondary sources of information and only in Kingdon *et al.* (2013) study where participants specifically asked about them.

Overall, schools are missing opportunities to provide young LGBQ people with targeted sexuality and sexual health information. Within the studies where school was identified as part of the research aim, school was a secondary source of information (Hillier & Mitchell 2008, Arbeit *et al.* 2016) except for one study (Rasberry *et al.* 2018). This is a disappointing finding as Blake *et al.*'s (2001) study in Massachusetts reported that LGB adolescents who received gay sensitive instruction in school were more likely to have a later sexual debut, fewer partners, less recent sex and less substance abuse during sex than those who did not receive gay sensitive information. Three other studies report school as a primary source of information (Kingdon *et al.* 2013, Nelson *et al.* 2019b, Mustanski *et al.* 2020). All three of these studies reported HIV/AIDS as a primary topic of information in school. Two studies report providing information on condoms/ safer sex (Rasberry *et al.* 2018, Nelson *et al.* 2019b). Nelson *et al.* (2019b) also reported birth control and consent as primary topics. This study identifies locations where adolescents may have accessed HIV information but the usefulness of any of the sources cannot be determined as this was not the core focus of the study. Additionally, as Kingdon *et al.* (2013) and Nelson *et al.* (2019b) grouped school, LGBQ education classes and formal education classes together it was not possible to establish if there was a difference between them as sources. However, other studies report that school-based sex education was not useful or was viewed by the minority as a primary source (and therefore classified in this study as a secondary source)

(Hillier & Mitchell 2008, Mitchell *et al.* 2014b, Arrington- Sanders *et al.* 2015, Arbeit *et al.* 2016, Steinke *et al.* 2017).

Similarly, health services were classed as a secondary source in all studies bar Cafferty *et al.* (2020) which had the role of healthcare providers as the aim of the study. Otherwise, healthcare services were only accessed by a minority of adolescents or they were reported as not useful (Kingdon *et al.* 2013, Arbeit *et al.* 2016, Steinke *et al.* 2017, Nelson *et al.* 2019b). The role of the health professional in the provision of sexual health information is increasingly being emphasised within practice and policy literature (Parker *et al.* 2009, WHO 2010), yet in this review eleven studies did not include them as a primary source of information. The reason for this was not explicit, however LGBQ adults in Rose and Friedman's (2012) study, reported being reluctant to disclose their sexual orientation to health professionals, fearing discrimination or judgement. In addition, they reported that information provided by health professionals was not inclusive, relevant or tailored to their needs and more suited to heterosexual couples even when healthcare providers were aware of their sexual orientation.

Similar to the findings from non-peer reviewed research involving LGBQ adolescents (Hillier *et al.* 2010, GLSEN 2013), the primary topics that emerged in this review related to sexual health and protective behaviours and LGBQ sexual identity and orientation. In relation to sexual health, information was sourced on HIV/AIDS, safer sex/ condoms, abstinence, consent and birth control. While these findings may be related to the fact that the studies focused on these topics, they are also like previous work involving, non-LGBQ adolescents and LGBQ adults. Studies involving LGBQ adults found that they used the internet to find information on HIV or STIs, including information on self-diagnosis, finding a testing site, and information about symptoms transmission or prevention of HIV or STI's (DeHaan *et al.* 2013, Flanders *et al.* 2017).

3.2.10 Limitations of the Integrative Review

Although I searched several databases, adhered to integrative review methods and ensured that two reviewers independently conducted the screening, quality appraisal, data extraction, data analysis and data synthesis, the review has a few limitations in relation to the review methods and the studies included that need consideration. In relation to the review methodology, firstly, due to the limited research in the area, studies with different aims, methods and participant profiles were included making

pooling of data to identify patterns across studies difficult. This could have been because the aims and methodologies of the studies were so diverse. Additionally, excluding non-peer review studies and those not published in English is also a limitation.

3.3. Empirical literature on topics and sources of information used by older LGBQ people and non-LGBQ adolescents

As the integrative review had very strict criteria to help inform the study and the survey design, a more general search was undertaken to identify empirical literature on the type of information sourced by older LGBQ people and non-LGBQ adolescents. Prior to presenting the information on non-LGBQ adolescents, findings from the search for LGBQ people over the age of 19 will be presented.

3.3.1 Search Strategy

The literature reviewed for this aspect was limited to publications in the English language identified through searching electronic databases and manual searches of the references lists of the articles reviewed. A detailed search of PubMed, CINAHL, Science Direct, PsychInfo, Psych Articles and Web of Science databases was conducted throughout this research study finalised in July 2020 when the survey development was complete. Four key terms relevant to “LGBQ”, “sources” “information” “sexuality / “sexual health” as relevant to each database were used to build a search strategy (see Integrative Review for more details as same search strategy was used), except for the term “adolescents”. No age limits were applied to this search.

3.3.2 Findings from Studies of LGBQ people over the age of 19

In total eleven (11) papers were located on sources of information on sexuality and sexual health that included LGBQ people over the age of 19 years (Kubicek *et al.* 2010, Kubicek *et al.* 2011, Magee *et al.* 2012, DeHaan *et al.* 2013, Voisin *et al.* 2013, Craig *et al.* 2015, Charest *et al.* 2016, Rose *et al.* 2016, Currin *et al.* 2017, Flanders *et al.* 2017, Baker *et al.* 2021). All these studies were carried out in North America with nine were from the USA and two from Canada. While all the studies focussed on LGBQ sources of information, Charest *et al.* (2016) compared sources of information for LGBTQ people and heterosexual people. Eight of the studies were qualitative

studies (Kubicek *et al.* 2011, DeHaan *et al.* 2013, Voisin *et al.* 2013, Craig *et al.* 2015, Rose *et al.* 2016, Currin *et al.* 2017, Flanders *et al.* 2017, Baker *et al.* 2021), two used mixed methods (Kubicek *et al.* 2010, Magee *et al.* 2012) and one was quantitative (Charest *et al.* 2016).

Magee *et al.* (2012) and DeHaan *et al.* (2013) present information from the same study with both using the same qualitative interviews but with different findings. In both papers data were analysed using a combination of thematic and content analysis, and quantitative methods were used to estimate the frequencies that topics were mentioned in each theme. Kubicek *et al.* (2010) and Kubicek *et al.* (2011) also present qualitative data from a larger study (Healthy Young Men) which focused on preventing HIV in African American men in Los Angeles. As ten out of the eleven studies collected qualitative data, sample sizes ranged from nineteen (n= 19) to fifty-seven (n= 57) with Charest *et al.* (2016) collecting quantitative data from 171 people.

The overall age range in these studies was aged 16-66 years. For those studies that included participants under the age of 19, it was not possible to extract data for adolescents so they were excluded from the integrative review of LGBTQ adolescents, hence their inclusion here. In nine studies the participants age ranged between 16- 25 years (Kubicek *et al.* 2010, Kubicek *et al.* 2011, Magee *et al.* 2012, DeHaan *et al.* 2013, Voisin *et al.* 2013, Craig *et al.* 2015, Charest *et al.* 2016, Rose *et al.* 2016, Flanders *et al.* 2017). Baker *et al.* (2021) had participants ranging from 19 to 36 years of age and participants in Currin *et al.* (2017) ranged from age 22 to 66. Four studies had male and female participants (Magee *et al.* 2012, DeHaan *et al.* 2013, Craig *et al.* 2015, Charest *et al.* 2016), two had female only participants (Flanders *et al.* 2017, Baker *et al.* 2021) and five had males only participants (Kubicek *et al.* 2010, Kubicek *et al.* 2011, Voisin *et al.* 2013, Rose *et al.* 2016, Currin *et al.* 2017). Reference is made to transgender/non-binary people in some studies (Magee *et al.* 2012, DeHaan *et al.* 2013, Charest *et al.* 2016, Baker *et al.* 2021) but as the authors of the studies present the findings collectively it is hard to know how many participated.

Similar to the studies with LGBTQ adolescents, descriptions of sexual orientation were varied. The descriptions used were LGBT (Magee *et al.* 2012, DeHaan *et al.* 2013),

sexual minority (Craig *et al.* 2015, Baker *et al.* 2021), men who have sex with men (Kubicek *et al.* 2010, Kubicek *et al.* 2011, Rose *et al.* 2016), gay and bisexual men (Currin *et al.* 2017), gay males (Voisin *et al.* 2013), bisexual women (Flanders *et al.* 2017) and LGBTQ+ and heterosexual (Charest *et al.* 2016).

Recruitment of participants was achieved using multiple methods. Ten out of the eleven studies used LGBT community organisations, bars, clubs, coffee shops or other public venues to advertise the study (Kubicek *et al.* 2010, Kubicek *et al.* 2011, Magee *et al.* 2012, DeHaan *et al.* 2013, Craig *et al.* 2015, Charest *et al.* 2016, Currin *et al.* 2017, Rose *et al.* 2016, Flanders *et al.* 2017, Baker *et al.* 2021) with other methods which included social media (Charest *et al.* 2016, Flanders *et al.* 2017, Currin *et al.* 2017, Baker *et al.* 2021). Voisin *et al.* (2013) did not provide recruitment details.

3.3.2.1 Sources of Information

When studies were analysed using the narrative synthesis approach used for the integrative review ten primary and nine secondary topics were uncovered (see Table 3.6). This includes four additional sources used by the older LGBTQ population in comparison to an adolescent LGBTQ cohort. These were peers (LGBTQ friends and non-LGBTQ Friends), sexual partners, clergy and pornography.

Table 3.6. Categories for Sources of Information for LGBTQ people over the age of 19.

Primary Sources	Secondary Sources
<u>Online (generic):</u> Kubicek <i>et al.</i> 2010; Kubicek <i>et al.</i> 2011; Magee <i>et al.</i> 2012; DeHaan <i>et al.</i> 2013; Craig <i>et al.</i> 2015; Charest <i>et al.</i> 2016; Rose <i>et al.</i> 2016; Baker <i>et al.</i> 2021; <u>Online (LGBTQ information) or (LGBTQ for-a-chatrooms):</u> Kubicek <i>et al.</i> 2011; DeHaan <i>et al.</i> (2013);	<u>Online (generic):</u> Currin <i>et al.</i> 2017;
<u>School (non-LGBTQ):</u> Voisin <i>et al.</i> 2013;	<u>School (non-LGBTQ):</u> Kubicek <i>et al.</i> 2010; Charest <i>et al.</i> 2016; Rose <i>et al.</i> 2016; Currin <i>et al.</i> 2017; Flanders <i>et al.</i> 2017; Baker <i>et al.</i> 2021;

<u>Family</u> : Voisin <i>et al.</i> 2013;	<u>Family</u> : Kubicek <i>et al.</i> 2010; Rose <i>et al.</i> 2016; Currin <i>et al.</i> 2017; Baker <i>et al.</i> 2021;
<u>Health Services (Dr./Clinic)</u> : Kubicek <i>et al.</i> 2010; Rose <i>et al.</i> 2016;	<u>Health Services (Dr./Clinic)</u> : Charest <i>et al.</i> 2016; Flanders <i>et al.</i> (2017); Baker <i>et al.</i> 2021;
<u>Media (LGBQ and non-LGBQ)</u> : Voisin <i>et al.</i> 2013; Currin <i>et al.</i> 2017; Baker <i>et al.</i> 2021;	<u>Media (LGBQ and non-LGBQ)</u> : Rose <i>et al.</i> 2016; Flanders <i>et al.</i> 2017;
<u>Peers:(Friends - LGBQ or non-LGBQ)</u> : Kubicek <i>et al.</i> 2010; Charest <i>et al.</i> 2016; Rose <i>et al.</i> (2016);	<u>Peers:(Friends - LGBQ or non-LGBQ)</u> : DeHaan <i>et al.</i> 2013; Currin <i>et al.</i> 2017; Baker <i>et al.</i> 2021;
<u>Sexual Partners</u> : Kubicek <i>et al.</i> 2010;	<u>Sexual Partners</u> : Baker <i>et al.</i> 2021; Charest <i>et al.</i> 2016;
<u>Social outlets (Non-LGBQ Bars, clubs)</u> : Voisin <i>et al.</i> 2013;	
<u>Community centre/ agencies</u> : Voisin <i>et al.</i> 2013;	
	<u>Clergy</u> : Charest <i>et al.</i> 2016; Rose <i>et al.</i> 2016;
	<u>Pornography</u> : Kubicek <i>et al.</i> 2010; Kubicek <i>et al.</i> 2011; Charest <i>et al.</i> 2016;

3.3.2.2 Topics of Information on Sexuality and Sexual Health for LGBQ adults

Using the narrative integrated narrative synthesis criteria (Figure 3.2), ten topics emerged from the narrative analysis of these studies, which were the same as the ones for LGBQ adolescents (Table 3.7). There was, however, sexual attraction/ orientation that emerged as a topic in the integrative review of LGBQ adolescents that did not feature here. Most of the studies were qualitative studies with a focus on internet (Kubicek *et al.* 2011, Magee *et al.* 2012, DeHaan *et al.* 2013, Craig *et al.* 2015), sexual health (Kubicek *et al.* 2010, Flanders *et al.* 2017), HIV prevention (Voisin *et al.* 2013) and sources of information (Rose *et al.* 2016, Currin *et al.* 2017, Baker *et al.* 2021) so sexual attraction/ orientation was not asked in interviews. Consent was a secondary topic in Charest *et al.* (2016) where participants were asked about their confidence in dealing with sexual assault and LGBTQ+ people were found to be less confident than heterosexual peers. Two studies had no primary topic (Craig *et al.* 2015; Flanders *et al.* 2017). Craig *et al.* (2015) study had only one topic, coming out, which

was a secondary topic and Flanders *et al.* (2017) had secondary topics of abstinence and condoms/ safer sex.

Table 3.7. Categories of topics sourced in the reviewed studies for LGBQ people over the age of 19

	Primary topic	Secondary topic
Sexual Health and Protective Behaviours		
Birth Control	Baker <i>et al.</i> 2021	
Abstinence	Kubicek <i>et al.</i> 2010; Currin <i>et al.</i> 2017; Baker <i>et al.</i> 2021;	Flanders <i>et al.</i> 2017
HIV/AIDS	Kubicek <i>et al.</i> 2010; Magee <i>et al.</i> 2012; DeHaan <i>et al.</i> 2013; Voisin <i>et al.</i> 2013; Rose <i>et al.</i> 2016;	
Condoms/ Safer Sex	Kubicek <i>et al.</i> 2010; Kubicek <i>et al.</i> 2011; Magee <i>et al.</i> 2012; DeHaan <i>et al.</i> 2013; Rose <i>et al.</i> 2016; Currin <i>et al.</i> 2017; Baker <i>et al.</i> 2021;	Flanders <i>et al.</i> 2017
Sexual Activity		
Sexual Performance	Kubicek <i>et al.</i> 2010; Magee <i>et al.</i> 2012;	
Readiness for Sexual Activity (Physical and Mental)	Kubicek <i>et al.</i> 2010; Kubicek <i>et al.</i> 2011; DeHaan <i>et al.</i> 2013;	
Consent		Charest <i>et al.</i> 2016
LGBQ Identity and Sexuality		
Sexual attraction/ Orientation	No studies	No studies
Gay and lesbian relationships	Magee <i>et al.</i> 2012; DeHaan <i>et al.</i> 2013	
Finding LGBQ friends	DeHaan <i>et al.</i> 2013	
Coming Out		Craig <i>et al.</i> 2015;
Sexuality	Kubicek <i>et al.</i> 2011;	

3.3.3 Findings from Studies of Non-LGBQ Adolescents

3.3.3.1 Search Strategy

Like the previous search, the literature reviewed for non-LGBQ adolescents was also limited to publications in the English language identified through searching electronic

databases and manual searches of the references lists of the articles reviewed. A detailed search of PubMed, CINAHL, Science Direct, PsychInfo, Psych Articles and Web of Science databases was conducted throughout this research study finalised in July 2020 when the survey development was complete. Four key terms relevant to “sources” “information” “sexuality / “sexual health” and “adolescents” as relevant to each database were used to build a search strategy (see Integrative Review for more details as same search strategy was used). Some studies were identified though the search for the integrative review of the LGBQ adolescent, for example, McKay and Holowaty (1997) and Whitfield *et al.* (2013) were obtained in a search for sources of information on sexuality and sexual health that did not meet the criteria for the target LGBQ group. Non-LGBQ studies for the purpose of this review are studies that do not specify the sexual orientation of the participants or present findings linked to sexual orientation.

3.3.4 Sources of Information for Non LGBQ adolescents

In total eight papers, ranging from 1997-2013, were located that included research about sources of information in adolescents who are non-LGBQ (McKay and Holowaty 1997, Wood *et al.* 2002, Somers and Surmann 2004, Turnbull *et al.* 2010, Jones and Biddlecom 2011a, Jones and Biddlecom 2011b, Secor- Tuner *et al.* 2011, Whitfield *et al.* 2013). There was some homogeneity between the studies, in that all of them had participants that were male and female and the age ranges were similar (age 12-20) and all studies had got parental consent for the adolescent to complete the study. Seven of the studies recruited through schools (McKay and Holowaty 1997, Somers and Surmann 2004, Turnbull *et al.* 2010, Jones and Biddlecom 2011a, Jones and Biddlecom 2011b, Secor- Tuner *et al.* 2011, Whitfield *et al.* 2013), while Wood *et al.* (2002) recruited through a sporting organisation. Six studies were completed in North America, four in the USA (Somers and Surmann 2004, Jones and Biddlecom 2011a, Jones and Biddlecom 2011b, Secor- Tuner *et al.* 2011,) and two in Canada (McKay and Holowaty 1997, Wood *et al.* 2002). Two studies were completed in the United Kingdom (Turnbull *et al.* 2010, Whitfield *et al.* 2013).

Jones and Biddlecom (2011a) and Jones and Biddlecom (2011b) both described the same qualitative study (n=58) with distinct aspects of data presented in each article. The other six studies were quantitative with sample sizes ranging from 100 (Wood *et al.* 2002) to 22,838 participants (Secor-Turner *et al.* 2011). Secor-Turner *et al.* (2011) extracted information from a state-wide study in New York and only used data for

adolescents that were sexually experienced. Sexual orientation of the participants was not described in any of these studies. For this study, these have been designated as non-LGBQ studies. There may have been LGBQ participants included but it is not mentioned and data is not disaggregated for sexual orientation in the findings.

3.3.4.1 Sources of Information

The same six sources of information previously found in this integrative review for LGBQ adolescents and LGBQ adults were found relative to the non-LGBQ adolescent population, with no additional sources emerging. Each of the sources, online (generic), peers (LGBQ and non-LGBQ), school/ teacher, health services (Dr/clinic), family, media (LGBQ and non-LGBQ specific) were both a primary and secondary source.

Whitfield *et al.* (2013) while asking about the most used sources also asked about the most useful sources and found that the most used sources (friends, TV, parents, internet, teachers) differed slightly to those that were considered most useful (best friend, boy/girlfriend, mother/ stepmother, GP (Dr./clinic) and school).

Table 3.8. Categories for Sources of Information for Non-LGBQ Adolescents

Primary Sources	Secondary Sources
<u>Online (generic)</u> : Whitfield <i>et al.</i> 2013.	<u>Online (generic)</u> : Jones and Biddlecom 2011a; Jones and Biddlecom 2011b;
<u>School/ Teacher</u> : McKay and Holowaty 1997; Turnbull <i>et al.</i> 2010; Jones and Biddlecom 2011a; Jones and Biddlecom 2011b; Whitfield <i>et al.</i> 2013;	<u>School/ Teacher</u> : Somers and Surmann 2004; Turnbull <i>et al.</i> 2010;
<u>Family</u> : McKay <i>et al.</i> 1997; Jones and Biddlecom 2011a; Jones and Biddlecom 2011b; Secor-Turner <i>et al.</i> 2011	<u>Family</u> : Somers and Surmann 2004; Turnbull <i>et al.</i> 2010; Secor-Turner <i>et al.</i> 2011;
<u>Health Services (Dr/Clinic)</u> : McKay and Holowaty 1997;	<u>Health Services (Dr/Clinic)</u> : Somers and Surmann 2004; Turnbull <i>et al.</i> 2010; Jones and Biddlecom 2011a; Jones and Biddlecom 2011b;
<u>Media (LGBQ and non-LGBQ)</u> : McKay and Holowaty 1997; Whitfield <i>et al.</i> 2013;	<u>Media (LGBQ and non-LGBQ)</u> : Somers and Surmann 2004; Turnbull <i>et al.</i> 2010;
<u>Peers: (Friends - LGBQ or non-LGBQ)</u> : Secor-Turner <i>et al.</i> 2011; Whitfield <i>et al.</i> 2013;	<u>Peers: (Friends - LGBQ or non-LGBQ)</u> : Somers and Surmann 2004; Turnbull <i>et al.</i> 2010;

3.3.4.2 Topics of Information for Sexuality and Sexual Health for Non-LGBQ Adolescents

Six primary topics emerged from these studies, which were birth control, condoms/ safer sex, sexual performance, consent, relationships and HIV/AIDS (Table 3.8). Unsurprisingly in comparison to LGBQ adolescents and LGBQ adults sexual/ attraction, finding LGBQ friends, coming out and sexuality were not topics sourced by non-LGBQ adolescents. However, consent and abstinence were also not included as topics in these studies. Consent is discussed much more in contemporary studies than older ones so its absence here may be related to the age of the studies. It is surprising however, that abstinence is not a topic in studies, as it is reported as the focus of school-based education in some states in the USA (Currin *et al.* 2017, Currin *et al.* 2020).

A number of the studies had no topics associated with them (Wood *et al.* 2002, Somers and Surmann 2004, Whitfield *et al.* 2013). These studies either asked generic questions about sourcing information on sexuality/sexual health or participants were presented with a list of sources and asked whether they were used on sexuality/sexual health, without including questions on topics.

Table 3.9. Categories of topics sourced in the reviewed studies

	Primary topic	Secondary topic
Sexual Health and Protective Behaviours		
Birth Control	McKay and Holowaty 1997; Turnbull <i>et al.</i> 2010; Jones and Biddlecom 2011a; Jones and Biddlecom 2011b;	
Abstinence	No studies	No studies
HIV/AIDS		McKay and Holowaty 1997;
Condoms/ Safer Sex	McKay and Holowaty 1997; Turnbull <i>et al.</i> 2010; Jones and Biddlecom 2011a; Jones and Biddlecom 2011b;	
Sexual Activity		
Sexual Performance	Secor-Turner <i>et al.</i> 2011	
Readiness for Sexual Activity (Physical and Mental)	No studies	No studies

Consent	McKay and Holowaty 1997;	
Identity and Sexuality		
Sexual attraction/ Orientation	No studies	No studies
Relationships	McKay and Holowaty 1997; Turnbull <i>et al.</i> 2010;	
Finding LGBTQ friends	No studies	No studies
Coming Out	No studies	No studies
Sexuality	No studies	No studies

3.4 Grey literature on Topics and Sources of Information found in National Studies for LGBTQ Adolescents, non-LGBTQ adolescents and Older LGBTQ people

In addition, to peer reviewed empirical literature, a grey literature search was also completed. The focus of the grey literature search was on large cross-sectional studies that included questions on sources of information. The rationale for including these studies was to ensure that all sources and topics used by adolescent/young people were included to allow comparison between LGBTQ adolescents and non-LGBTQ adolescents.

3.4.1 Search Strategy

As an experienced children's nurse with a specialist interest in adolescence, I was familiar with the common sources of grey literature research in adolescent sexuality and sexual health. Therefore, social policy and research publications from the Irish Government, European Union, World Health Organisation and United Nations were reviewed and searches of national and international websites such as the NATSAL-3 (<https://www.natsal.ac.uk/natsal-survey/natsal-3>), Australian Research Centre for Sex, Health and Society in LaTrobe University in Melbourne (<https://www.latrobe.edu.au/arcschs>), Growing Up in Ireland (<https://www.growingup.gov.ie/>) and Health Behaviour of School Children studies (<https://hbcs.org/>) were undertaken to find research that had been undertaken that included research on sources of information on sexuality and sexual health.

3.4.2 Findings

In total nine studies were located. Hillier *et al.* (1998, 2005, 2010) completed 3 studies on LGBT people in Australia aged between 14-21 years, while in the USA, GLSEN (2013) researched LGBT+ adolescents experiences of using the Internet, which included questions on sourcing information on sexual health and sexuality. The other cross-sectional studies were conducted with non-LGBQ young people (Hoff *et al.* 2003, Smith *et al.* 2009, Michell *et al.* 2014a, Clifton *et al.* 2016, Fisher *et al.* 2019). These took place in Australia (Smith *et al.* 2009, Michell *et al.* 2014a, Fisher *et al.* 2019), United Kingdom (Clifton *et al.* 2016) and the USA (Hoff *et al.* 2003).

All these studies used survey methodology to gather data from young people with an age range of 10-24 years. Sample sizes varied from 748 in Hillier *et al.* (1998) to 6,237 in Fisher *et al.* (2019) with all studies including male and female participants. Additionally, transgender and gender diverse participants are described in the studies. While some studies included reference to transgender and gender diverse participants (Hillier *et al.* 1998, Hillier *et al.* 2005, Hillier *et al.* 2010, GLSEN 2013, Mitchell *et al.* 2014a, Fisher *et al.* 2019), only Mitchell *et al.* (2014a) and Fisher *et al.* (2019) report male, female and transgender, gender diverse (TGD) sources of information separately.

In Hillier *et al.* (1998, 2005, 2010) the sexual orientation and gender identity of participants are described together as same sex attracted and gender questioning and they are described as LGBT in GLSEN (2013). Sexual orientation or gender identity are not described in papers by Hoff *et al.* (2003), Smith *et al.* (2009) or Clifton *et al.* (2016). Mitchell *et al.* (2014a) report that 83.2% of participants were heterosexual and in Fisher *et al.* (2019) this figure is 73.7%. However, the findings from Mitchell *et al.* (2014a) and Fisher *et al.* (2019) are presented collectively with no separate data available for LGBQ or heterosexual participants.

Recruitment was through several methods with some studies using more than one method. These methods included random telephone sampling (Hoff *et al.* 2003), email recruitment (GLSEN 2013), school (Smith *et al.* 2009; Mitchell *et al.* 2014a), internet (Hillier *et al.* 1998, Hillier *et al.* 2005, Hillier *et al.* 2010, Fisher *et al.* 2019), postcode selection (Clifton *et al.* 2016) and Facebook (Mitchell *et al.* 2014a, Fisher *et al.* 2019). Apart from GLSEN (2013) which had internet use as its focus, the other studies provided a list of sources and asked participants to pick the ones they had used.

There were no new sources of information found in these studies (Table 3.10). Online (generic), school, family, health services, media, peers (friends), sexual partners and pornography were all primary and secondary sources of information. Gay media and gay community were a primary source of information asked in Hillier *et al.* (1998, 2005, 2010). Youth Worker/ Community Organisation was asked as a source in the three Australian studies (Smith *et al.* 2009, Mitchell *et al.* 2014a, Fisher *et al.* 2019) and was a secondary source in all three studies.

Table 3.10. Categories for Sources of Information for National Studies

Primary Sources	Secondary Sources
<u>Online (generic)</u> : Hillier <i>et al.</i> 1998; Hillier <i>et al.</i> 2005; Hillier <i>et al.</i> 2010; GLSEN 2013; Mitchell <i>et al.</i> 2014a; Fisher <i>et al.</i> 2019;	<u>Online (generic)</u> : Smith <i>et al.</i> 2009; Clifton <i>et al.</i> 2016;
<u>School (non-LGBQ Specific)</u> : Hillier <i>et al.</i> 1998; Hoff <i>et al.</i> 2003; Hillier <i>et al.</i> 2005; Smith <i>et al.</i> 2008; Hillier <i>et al.</i> 2010;	<u>School (non-LGBQ Specific)</u> : Mitchell <i>et al.</i> 2014a; Clifton <i>et al.</i> 2016; Fisher <i>et al.</i> 2019;
<u>Family</u> : Hillier <i>et al.</i> 1998; Hoff <i>et al.</i> 2003; Hillier <i>et al.</i> 2005; Smith <i>et al.</i> 2009; Hillier <i>et al.</i> 2010; Fisher <i>et al.</i> 2019;	<u>Family</u> : Mitchell <i>et al.</i> 2014a; Clifton <i>et al.</i> 2016;
<u>Health Services: (Dr/ Clinic)</u> : Hoff <i>et al.</i> 2003;	<u>Health Services: (Dr/ Clinic)</u> : Smith <i>et al.</i> 2009; Mitchell <i>et al.</i> 2014a; Clifton <i>et al.</i> 2016; Fisher <i>et al.</i> 2019;
<u>Media</u> : Hillier <i>et al.</i> 1998; Hoff <i>et al.</i> 2003; Hillier <i>et al.</i> 2005; Smith <i>et al.</i> 2009; Hillier <i>et al.</i> 2010;	<u>Media</u> : Smith <i>et al.</i> 2009; Clifton <i>et al.</i> 2016
<u>Peers: (Friends - LGBQ or non-LGBQ)</u> Hillier <i>et al.</i> 1998; Hoff <i>et al.</i> 2003; Hillier <i>et al.</i> 2005; Smith <i>et al.</i> 2009; Hillier <i>et al.</i> 2010; GLSEN 2013; Mitchell <i>et al.</i> 2014a; Fisher <i>et al.</i> 2019;	<u>Peers: (Friends - LGBQ or non-LGBQ)</u> : Clifton <i>et al.</i> 2016;
<u>Sexual Partners</u> : Hoff <i>et al.</i> 2003;	<u>Sexual Partners</u> : Clifton <i>et al.</i> 2016;
<u>Pornography</u> : Hillier <i>et al.</i> 1998; Hillier <i>et al.</i> 2005; Hillier <i>et al.</i> 2010;	<u>Pornography</u> : Clifton <i>et al.</i> 2016
<u>Gay Community</u> : Hillier <i>et al.</i> 1998; Hillier <i>et al.</i> 2005; Hillier <i>et al.</i> 2010;	
<u>Gay Media</u> : Hillier <i>et al.</i> 1998; Hillier <i>et al.</i> 2005; Hillier <i>et al.</i> 2010	
	<u>Youth Worker/ Community Organisation</u> : Smith <i>et al.</i> 2009; Mitchell <i>et al.</i> 2014a; Fisher <i>et al.</i> 2019;

3.4.3 Topics of Information for Sexuality and Sexual Health in National Studies

Similar to the non-LGBQ studies presented previously, many of the national cross-sectional studies also lack specific information about topics. As the Table 3.11 outlines there were seven topics that do not emerge from the review of grey literature (abstinence, sexual performance, readiness for sexual activity, consent, findings LGBQ friends, coming out, sexuality). This may be because most of the studies consists of one or two questions on the generic topic of sexuality and sexual health and were part of a larger study on adolescent health, sexual health or experience of school students. Where specific questions on topics were asked they were comparable topics to those already located in previous reviews, namely birth control, HIV/AIDS, condoms/ safe sex, sexual orientation, relationships (See Table 3.11).

Table 3.11. Categories of topics sourced in the reviewed studies for National Studies

	Primary topic	Secondary topic
Sexual Health and Protective Behaviours		
Birth Control	Smith <i>et al.</i> 2009; Mitchell <i>et al.</i> 2014a; Fisher <i>et al.</i> 2019;	
Abstinence	No studies	
HIV/AIDS	GLSEN 2013; Fisher <i>et al.</i> 2019;	
Condoms/ Safer Sex	Smith <i>et al.</i> 2009; Hillier <i>et al.</i> 1998; Hillier <i>et al.</i> 2005; Hillier <i>et al.</i> 2010; GLSEN 2013; Mitchell <i>et al.</i> 2014a;	
Sexual Activity		
Sexual Performance	No studies	
Readiness for Sexual Activity (Physical and Mental)	No studies	
Consent	No studies	
Identity and Sexuality (LGBQ and non-LGBQ)		
Sexual attraction/ Orientation	GLSEN 2013;	
Relationships (LGBQ and non-LGBQ)	Hillier <i>et al.</i> 1998; Hillier <i>et al.</i> 2005; Hillier <i>et al.</i> 2010; Fisher <i>et al.</i> 2019;	
Finding LGBQ friends	No studies	
Coming Out	No studies	
Sexuality	No studies	

3.5 Studies Published on Topics and Sources of Information since the Integrative Review and Survey Development

As the primary aim of the reviews previously presented was to determine the literature available to aid in the development of the survey instrument, this next section summarises studies published since these reviews were completed. Searches were conducted using the same search strategy for the other studies, LGBQ adolescents, LGBQ adults and non-LGBQ adolescents and ten studies were found. This review was completed to help inform the final discussion of the thesis (Chapter 7).

3.5.1 Findings from Studies Published on Topics and Sources of Information since the Integrative Review and Survey Development

Nolan and Smyth (2020) drew data from the Growing Up in Ireland Study³ with reference to sources of information in non-LGBQ Irish adolescents. Waling *et al.* (2020) and Power *et al.* (2022) data came from the National Survey of Australian Secondary Students and Sexual Health. Tabaac *et al.* (2021a, 2021b) looked at media as source of information in LGBQ adults. Roberts *et al.* (2020) and Mata *et al.* (2022) researched information relating to LGBQ adolescents' (aged 14-17) sexuality education experiences and both Rothman *et al.* (2021) and Charest and Kleinplatz (2021) studied LGBQ young people (18-25) sources of information. Similar to the earlier Charest *et al.* (2016) study, Charest and Kleinplatz (2021) studies compared the sources of information used by LGBTQ+ and non-LGBTQ+ young adults. Currin *et al.* (2020) study is also like the previous study by Currin *et al.* (2017) that studied LGBQ men's experience of sex education in Oklahoma. Out of the ten studies, six were conducted in the USA (Currin *et al.* 2020, Roberts *et al.* 2020, Rothman *et al.* 2021, Tabaac *et al.* 2021a, Tabaac *et al.* 2021b, and Mata *et al.* 2022), two in Australia (Waling *et al.* 2020, Power *et al.* 2022), one in Ireland (Nolan and Smyth 2020) and one in Canada (Charest and Kleinplatz 2021).

Seven of the studies were quantitative using surveys for data collection (Currin *et al.* 2020, Nolan and Smyth 2020, Rothman *et al.* 2021, Tabaac *et al.* 2021a, Tabaac *et al.* 2021b, Charest and Kleinplatz 2021, Power *et al.* 2022), two were qualitative (Roberts *et al.* 2020, Waling *et al.* 2020) and one was a mixed methods study (Mata *et al.* 2022).

³ *Growing Up in Ireland* is the national longitudinal study of children and young people running since 2006 gathering data on a wide range of children's issues in Ireland.

Thus, the sample sizes of the studies ranged from twenty-five (n=25) (Roberts *et al.* 2020) to 12,909 participants (Tabaac *et al.* 2021a).

Some studies had only LGBTQ participants (Currin *et al.* 2020, Roberts *et al.* 2020, Mata *et al.* 2022) or only non-LGBTQ (Nolan and Smyth 2020, Rothman *et al.* 2021). For the studies that had LGBTQ participants descriptions are straight and LGBTQ+ (Charest and Kleinplatz 2021), LGBTQ+ (Roberts *et al.* 2020) diverse sexual orientation (completely, mostly heterosexual, bisexual, gay and lesbian) (Tabaac *et al.* 2021a, 2021b), gay and bisexual men (Currin *et al.* 2020), bisexual, pansexual and queer (Bi+) (Mata *et al.* 2022). Waling *et al.* (2020) and Power *et al.* (2022) reported the sample in terms of percentages and report that 59% (Waling *et al.* 2020) and 58.1% (Power *et al.* 2022) were heterosexual in their studies. In more recent studies the descriptions of the samples sexual orientations are more diverse. Both Roberts *et al.* (2020), Mata *et al.* (2022) and Power *et al.* (2022) include bisexual, pansexual and queer in their sample description.

Some studies used gender to describe the participants in their studies. Males were the sole focus of two studies (Currin *et al.* 2020, Mata *et al.* 2022), one had females only (Tabaac *et al.* 2021b) and seven had male and female participants (Nolan and Smyth 2020, Roberts *et al.* 2020, Waling *et al.* 2020, Rothman *et al.* 2021, Tabaac *et al.* 2021a, Charest and Kleinplatz 2021, Power *et al.* 2022). Others used gender and gender identity to provide descriptions of the participants (Waling *et al.* 2020, Charest and Kleinplatz 2021, Power *et al.* 2022). While Charest and Kleinplatz (2021) combined LGBTQ+ participants to present findings, Waling *et al.* (2020) and Power *et al.* (2022) presented separate findings for male, females and TGD (transgender/ gender diverse) participants.

For sexual orientation, Charest and Kleinplatz (2021) compared the findings from both LGBTQ+ and heterosexual participants while other studies mentioned that their sample included LGBTQ participants but separate findings are not presented (Waling *et al.* 2020, Tabaac *et al.* 2021a, Tabaac *et al.* 2021b, Power *et al.* 2022). Findings from Waling *et al.* (2020) are not presented as LGBTQ and non-LGBTQ separate findings but some of the quotes from participants included in the findings are attributed to LGBTQ participants. Power *et al.* (2022) report collective findings with some exceptions. These include comparisons of relevance of school-based education and pornography use for LGBTQ and heterosexual participants. Some comments from open ended questions are also attributed to LGBTQ participants.

3.5.2 Sources of Information

In relation to sources of information, all sources found were the same as LGBTQ adolescents, LGBTQ adults and non-LGBTQ adolescents except for Power *et al.*'s (2022) recent study that directly asked participants about three new additional sources for information on sexual health, which were social media, peer educators trained in sexual health and other well-known adult not related to them. Over twenty per cent of participants report using peer educators and adults well known to them, while over 40% report using social media as a source of information (Table 3.12).

Table 3.12. Categories for Sources of Information for Studies Published on Topics and Sources of Information since the Integrative Review and Survey Development

Primary Sources	Secondary Sources
<u>Online (generic)</u> : Waling <i>et al.</i> 2020; Roberts <i>et al.</i> 2021; Charest and Kleinplatz 2021; Power <i>et al.</i> 2022;	<u>Online (generic)</u> : Nolan and Smyth 2020; <u>Online (LGBTQ information) or (LGBTQ for-a-chatrooms)</u> : Currin <i>et al.</i> 2020; Rothman <i>et al.</i> 2021;
<u>School</u> : Currin <i>et al.</i> 2020; Tabaac <i>et al.</i> 2021b; Power <i>et al.</i> 2022;	<u>School</u> : Nolan and Smyth 2020; Roberts <i>et al.</i> 2021;
<u>Family</u> : Nolan and Smyth 2020; Waling <i>et al.</i> 2020; Roberts <i>et al.</i> 2021; Tabaac <i>et al.</i> 2021b; Power <i>et al.</i> 2022;	<u>Family</u> : Currin <i>et al.</i> 2020; Roberts <i>et al.</i> 2021; Rothman <i>et al.</i> 2021;
<u>Health Services (Dr./Clinic)</u> : Waling <i>et al.</i> 2020	<u>Health Services (Dr./Clinic)</u> : Roberts <i>et al.</i> 2021; Power <i>et al.</i> 2022;
<u>Media (LGBTQ and non-LGBTQ specific)</u> : Tabaac <i>et al.</i> 2021a; Tabaac <i>et al.</i> 2021b; Power <i>et al.</i> 2022;	<u>Media (LGBTQ and non-LGBTQ specific)</u> : Currin <i>et al.</i> 2020;
<u>Peers: (Friends - LGBTQ or non-LGBTQ)</u> Nolan and Smyth 2020; Waling <i>et al.</i> 2020; Tabaac <i>et al.</i> 2021b; Charest and Kleinplatz 2021; Mata <i>et al.</i> 2022; Power <i>et al.</i> 2022; <u>Significant Others/ Partners</u> : Currin <i>et al.</i> 2020; Charest and Kleinplatz 2021	<u>Peers: (Friends - LGBTQ or non-LGBTQ)</u> : Currin <i>et al.</i> 2020; Rothman <i>et al.</i> 2021; <u>Significant Others/ Partners</u> : Power <i>et al.</i> 2022;
<u>Pornography</u> : Waling <i>et al.</i> 2020; Rothman <i>et al.</i> 2021; Charest and Kleinplatz 2021;	<u>Pornography</u> : Power <i>et al.</i> 2022;
<u>Clergy</u> : Tabaac <i>et al.</i> 2021b;	
<u>Social Media</u> : Power <i>et al.</i> 2022;	

	<u>Community centre/ agencies:</u> Tabaac <i>et al.</i> 2021b; Power <i>et al.</i> 2022;
	<u>Peer Educator Trained in Sexual Health:</u> Power <i>et al.</i> 2022;
	<u>Other Well-known Adult not Related:</u> Power <i>et al.</i> 2022;

3.5.3 Topics of Information on studies published since the since the Integrative Review and Survey

Ten topics emerged from these studies. Surprisingly, despite these studies including LGBTQ youths two topics that had previously emerged from the integrative review of the adolescent LGBTQ people did not emerge from this review, these were Coming Out and Finding LGBTQ friends. Two studies out of the ten focussed specifically on LGBTQ adolescents (Roberts *et al.* 2020, Mata *et al.* 2022), but as both were specifically looking at sexual health, they did not ask about these two topics (Table 3.13).

Table 3.13. Categories of topics sourced in the reviewed studies on Topics and Sources of Information since the Integrative Review and Survey Development

	Primary topic	Secondary topic
Sexual Health and Protective Behaviours		
Birth Control	Nolan and Smyth 2020; Tabaac <i>et al.</i> 2021a; Tabaac <i>et al.</i> 2021b; Charest and Kleinplatz 2021; Power <i>et al.</i> 2022;	Roberts <i>et al.</i> 2021; Tabaac <i>et al.</i> 2021a;
Abstinence	Curran <i>et al.</i> 2020; Tabaac <i>et al.</i> 2021b;	Tabaac <i>et al.</i> 2021a;
HIV/AIDS	Tabaac <i>et al.</i> 2021b; Charest and Kleinplatz 2021; Mata <i>et al.</i> 2022;	Roberts <i>et al.</i> 2021; Tabaac <i>et al.</i> 2021a;
Condoms/ Safer Sex	Nolan and Smyth 2020; Tabaac <i>et al.</i> 2021b; Charest and Kleinplatz 2021; Mata <i>et al.</i> 2022; Power <i>et al.</i> 2022;	Roberts <i>et al.</i> 2021; Tabaac <i>et al.</i> 2021a;
Sexual Activity		
Sexual Performance	Waling <i>et al.</i> 2020; Mata <i>et al.</i> 2022;	
Readiness for Sexual Activity (Physical and Mental)	Curran <i>et al.</i> 2020; Nolan and Smyth 2020; Waling <i>et al.</i> 2020; Rothman <i>et al.</i> 2021; Charest and Kleinplatz 2021; Mata <i>et al.</i> 2022;	

Consent	Waling <i>et al.</i> 2020; Tabaac <i>et al.</i> 2021b; Mata <i>et al.</i> 2022; Power <i>et al.</i> 2022;	Roberts <i>et al.</i> 2021; Tabaac <i>et al.</i> 2021a;
LGBQ Identity and Sexuality		
Sexual attraction/ Orientation	Nolan and Smyth 2020; Roberts <i>et al.</i> 2021; Tabaac <i>et al.</i> 2021b; Charest and Kleinplatz 2021;	Roberts <i>et al.</i> 2021;
Relationships (LGBQ/ non-LGBQ)	Waling <i>et al.</i> 2020; Tabaac <i>et al.</i> 2021b;	
Finding LGBQ friends	No Studies	No Studies
Coming Out	No Studies	No Studies
Sexuality	Nolan and Smyth 2020; Waling <i>et al.</i> 2020	

3.6 Summary and Conclusion

In terms of terminology, there is a lack of consistency in terms used to describe how lesbian, gay, bisexual and questioning (LGBQ) populations in the research studies. Some studies use identity labels such as homosexual, heterosexual and bisexual while others use straight, gay, lesbian and bisexual, with some using 'same sex attracted' or described sexual behaviour in male populations who are described as 'men who have sex with men'. Another method used was the use of an umbrella term such as sexual minority youth or an acronym to conflate all groups together such as LGBTIA+⁴ or a combination of those letters. More recent studies include additional sexual orientations (Roberts *et al.* 2020, Mata *et al.* 2022, Power *et al.* 2022) and gender identities (Waling *et al.* 2020, Power *et al.* 2022) to participant descriptions. Similarly, data were not always collected using the same questions. For example, Hoff *et al.* (2003) presented a list of sources and asked if respondents had 'learned a lot' or 'learned some' from sources. Fisher *et al.* (2018) on the other hand asked about sources that respondents 'had ever used'. Despite this, by using the same criteria for all studies to extract the information and classify the sources and topics some comparisons can be made between the studies conducted with LGBQ adolescents, LGBQ adults and non-LGBQ adolescents.

As such, differences were noted between the sources and topics used by LGBQ adolescents and LGBQ adults and non-LGBQ adolescents. More sources were used

⁴ While LGBQ is the acronym used for this study, other terms may be used throughout this review to indicate the terms used by the authors of the studies to describe their population.

by LGBQ adults and non-LGBQ adolescents in comparison to LGBQ adolescents, as the availability of sources increases as LGBQ people get older and they are out to more people. The sources used more by LGBQ adults relative to LGBQ adolescents are peers (LGBQ friends and non-LGBQ friends), sexual partners, pornography, and social outlets (non-LGBQ Bars, clubs). It is interesting to note in the latest study by Power *et al.* (2022) that three additional sources, namely social media, peer educators trained in sexual health and other well-known adult were asked about. The nature of the topics also changes with age, with older LGBT people not searching for information on sexual attraction/orientation, relationships, finding LGBQ friends, and coming out. This may be because less information is required for LGBQ adults to navigate a LGBQ sexual orientation and are out in the LGBQ community.

Friends/peers, as a source of information, were not reported in any of the empirical studies of LGBQ adolescents located for the integrative review. However, Hillier *et al.* (2010) study of LGBQ adolescents aged 14-21, located in the grey literature search, asked about peers as a source of information on heterosexual, gay and lesbian sex. Peers included heterosexual friends, same sex attracted friends and the gay community. Unsurprisingly, for 47% of respondents, heterosexual friends were a source of information on heterosexual sex. Heterosexual friends also provided 17% of respondent's information on gay sex and provided 11% of respondent's information on lesbian sex. Same sex attracted friends were a greater source of information for gay sex (30%) but were an equal source of information on heterosexual and lesbian sex (20%). In the studies with older LGBQ people, respondents reported discussing sex with other LGBQ people (Kubicek *et al.* 2010, Charest *et al.* 2016, Currin *et al.* 2017, Baker *et al.* 2021), which they reported as less stigmatising and embarrassing than asking non-LGBQ people. Charest *et al.* (2016) when comparing LGBTQ+ and heterosexual adults, did not report much difference between heterosexual and LGBTQ+ respondents, with on average 26.6% of both LGBTQ+ and heterosexual groups reporting peers as a source of information and the second most used source. Charest and Kleinplatz (2021) also report very little difference between heterosexual and LGBTQ+ respondents, with the only differences found in heterosexual women sourcing more information on birth control from peers than heterosexual men or LGBTQ+ people. In contrast, LGBTQ+ people received more information on LGBTQ+ issues from friends than heterosexual men or women.

Although studies suggest that most adolescent LGBQ people first disclose their sexual orientation to their friends (Hillier *et al.* 2005, Hillier *et al.* 2010), as noted friends were

not a source for LGBTQ adolescents, although they were a primary source of information for LGBTQ adults and non-LGBTQ adolescents. It may be that once people get older and have disclosed their sexual orientation to friends, they are more comfortable discussing sexual issues with them. Adolescent LGBTQ people may also not have LGBTQ spaces available to them. Voisin *et al.* (2013) report that the younger people in their study found it difficult to enter gay bars/ clubs. The age in which adolescents are legally allowed to enter gay bars and clubs, particularly in the USA, has been highlighted as a difficulty for some people accessing gay communities (Kubicek *et al.* 2011, Currin *et al.* 2017). This can be especially challenging for those who do not have access to other LGBTQ people in the area in which they live. In the absence of peers to consult off-line, online information may be the only suitable option (DeHaan *et al.* 2013).

This review also indicates that the internet is a source of information for all groups (LGBTQ adolescents, LGBTQ adults and non-LGBTQ adolescents). However, several of the studies involving both LGBTQ adolescents (Hillier *et al.* 2012, GLSEN 2013, Mitchell *et al.* 2014b) and LGBTQ adults (Kubicek *et al.* 2010, Kubicek *et al.* 2011, Magee *et al.* 2012, DeHaan *et al.* 2013, Craig *et al.* 2015) had the internet as the focus of their study. Thus, the internet as well as a location to meet people is also recognised as a mainstream mode to access information on all aspects of sexual health and sexuality particularly those who are questioning their sexual orientation (Magee *et al.* 2012, DeHaan *et al.* 2013, Mitchell *et al.* 2014b, Craig *et al.* 2015). Courtesy of the internet, LGBTQ people can educate themselves about intimate issues, meet like-minded people, explore their sexuality and identity and conduct long distance or virtual relationships (Kubicek *et al.* 2010, DeHaan *et al.* 2013).

Motivations for searching online include anonymity, confidentiality, ease of access and convenience in terms of time and location, while avoiding parental supervision or bypassing computer parental controls (Hillier *et al.* 1998, Magee *et al.* 2012, DeHaan *et al.* 2013). While these motivations apply to all people, these are heightened for LGBTQ adolescents as they may wish to explore their sexual orientation in private without disclosing it. Hence, they may be more inclined than heterosexual adolescents to search for sexual health information online (GLSEN 2013, Charest *et al.* 2016). However, finding peers or a LGBTQ youth discussion space online can be problematical (DeHaan *et al.* 2013), with those LGBTQ young adults who do not search online for sexuality information reporting that they are mistrustful of the information available, and fear being caught (Magee *et al.* 2012). In addition, the information accessed may also

not be up to date, accurate and relevant. However, while internet sites facilitate rapid navigation and access to information on sexual practices, they do so with little protection, information or signposting as to whether the content is sexist, explicit, violent or extreme.

Another problem is that sexuality related material on the Internet is linked, intentionally or unintentionally with access to pornography (GLSEN 2013). Online pornography use was the primary subject in two of the studies with LGBQ adolescents (Arrington-Sanders *et al.* 2015; Nelson *et al.* 2019c) and one with non-LGBQ adolescents (Rothman *et al.* 2021). It was also specifically asked as a source in Hillier *et al.* (1998, 2005, 2010), Charest *et al.* (2016), Charest and Kleinplatz (2021) and Power *et al.* (2022). It was found to be a source of information for LGBQ adolescents and LGBQ adults, although less so for LGBQ adults. Pornography, however, is not limited as a source of information for LGBQ+ people as participants in Waling *et al.* (2020) qualitative study and Power *et al.* (2022) studies also report its use as a source of information. Power *et al.* (2022), however, report that more LGBQ+ adolescent participants report use of pornography than their heterosexual counterparts. While no reasons for this are presented as part of the study, it is speculated that traditional sources of information do not meet the needs of LGBQ adolescents.

Some studies involving LGBQ adults report sexual partners as a source of information (Kubicek *et al.* 2010, Charest *et al.* 2016, Baker *et al.* 2021). Sexual partners as a source of information with LGBQ older people provides some interesting information. The young men in Kubicek *et al.* (2010) (aged 18-24) report that in adolescence they experimented with same age peers in sexual behaviours such as mutual masturbation, genital touching and 'grinding'. However, they reported that their first full sexual intercourse was usually with an older gay person. Some reported seeking out older partners, with the difference in age ranged from 2/3 years to 12/13 year, with their first encounter being with men in their thirties as they wished to be with someone experienced. However, the young LGBQ people in Kubicek *et al.* (2010) also stated that the older person controlled the encounter, they did as they were told as they were unable to communicate their sexual needs. Conversely, Baker *et al.* (2021) in their study with lesbian and bisexual women aged 19-36 report that most respondents discussed sexual health, specifically STIs with sexual partners, and that they engage in a mutual exchange of information. More recent studies (Currin *et al.* 2020, Charest and Kleinplatz 2021, Power *et al.* 2022) with LGBQ adults and non-LGBQ adolescents also report sexual partners as a source of information.

Parents were found to be a source of information for LGBQ adolescents and non-LGBQ adolescents but unsurprisingly parents did not feature in the studies on LGBQ adults. A large body of research has been conducted into family members, particularly how parents, communicate with adolescents about sexuality and sexual health (Widman *et al.* 2019). Studies in this review asked about parents together (Wood *et al.* 2002, Hoff *et al.* 2003, Somers and Surman 2004, Turnbull *et al.* 2010, Secor- Turner 2011) or had mothers and fathers listed as separate sources (Smith *et al.* 2009, Mitchell *et al.* 2014a, Clifton *et al.* 2016, Fisher *et al.* 2019, Nolan and Smyth 2020, Power *et al.* 2022). However, most studies, involving LGBQ and non-LGBQ people, find that communication with parents is insufficient and does not meet adolescents' needs, with large portions of adolescents reporting that they did not speak to their parents about sex ever (Clifton *et al.* 2016). However, constructive interactions with parents in sex education have been found to have a positive impact on the subsequent behaviour of adolescents, encouraging later sexual initiation, higher prevalence of protective behaviours and greater confidence in negotiating sexual relationships (Grossman *et al.* 2018, Widman *et al.* 2019, Grossman *et al.* 2021).

Mothers are consistently reported as the most used source of information within families. Fisher and Kauer (2019) in their comparison of sources of information used by Australian non-LGBQ people from 2002 to 2018 report that mothers were consistently used as a source of information by over 50% of the respondents (52.7% in 2002, 53% in 2018), while fathers were used by 31.8% in 2002 reducing to 25.9% in 2018. While mothers are considered a source of information more frequently than fathers, fathers are reported more often in studies as a source of information for non-LGBQ males. Mitchell *et al.* (2014a) in their Australian study (n=2,136) found that fathers were an increased source of information for males (23.2%) in comparison to females (15.6%). This is also the case in the UK, where fathers were reported less as a preferred source of information for both men (2.8%) and women (0.5%) than mothers, with 17.6% of males and 6.9% of females reporting fathers as used source of information (Clifton *et al.* 2016).

Other family members were also reported as a source of information for non-LGBQ adolescents and LGBQ adults but not for LGBQ adolescents. While no studies were found that directly asked LGBQ adults about family members as a source of information, information gained from qualitative interviews discussed extended family members, siblings, cousins and aunts as a source of information especially if the

extended family member was LGBTQ. In surveys with non-LGBTQ adolescents, participants were also asked about family, specifically siblings (brother/sister) (Wood *et al.* 2002, Hoff *et al.* 2003, Somers and Surman 2004, Secor- Turner 2011, Clifton *et al.* 2016), or older brother/ sister (Mitchell *et al.* 2014a, Fisher *et al.* 2019).

Siblings are considered a source of information, particularly older siblings who may be considered sexually experienced (Hoff *et al.* 2003). Mitchell *et al.* (2014a), Fisher. (2019), Fisher and Kauer (2019) and Power *et al.* (2022) all report that older siblings were a source of information in the Australian national non-LGBTQ studies completed between 2008 and 2018. In 2008, 24.2% of respondents reported older siblings as an information source compared to 20.8% in 2018 (Fisher and Kauer 2019) and 18.6% in 2022 (Power *et al.* 2022). Hillier *et al.* (2010) in their national investigation asked LGBTQ young people aged 14-24 about family as a source of information but did not provide a breakdown of family members. In Hillier *et al.* (2010) study, family was described as a source of information for heterosexual sex by 42% of respondents, 18% of respondents on gay sex with 10% reporting family as a source of information on lesbian sex.

Professionals, specifically schools and healthcare professionals were reported as a source of information for all groups, LGBTQ adolescents, LGBTQ adults and non-LGBTQ adolescents in some studies. For LGBTQ adolescents, schools were a primary source of information in Kingdon *et al.* (2013), Rasberry *et al.* (2018) and Mustanski *et al.* (2020) studies and a secondary source in Hillier and Mitchell (2008), Arbeit *et al.* (2016) and Steinke *et al.* (2017). Schools were both a primary and secondary source for participants in Nelson *et al.*'s. (2019b) study. Healthcare professionals on the other hand were a secondary source only for LGBTQ adolescents in Kingdon *et al.* (2013, Arbeit *et al.* (2016), Steinke *et al.* (2017), Nelson *et al.* (2019b) and Cafferty *et al.* 2020 studies.

While sources of information may be different between LGBTQ adolescents, LGBTQ adult and non- LGBTQ adolescents, as mentioned some topics were sourced more by LGBTQ adolescents than the other groups. Topics such as sexual attraction/ orientation, relationships, finding LGBTQ friends, coming out and sexuality are more relevant to LGBTQ adolescents as they are at a time in their lives when they are exploring sexuality and sexual orientation. LGBTQ adults seem to have this period of exploration completed as participants report being comfortable going to gay bars (Kubicek *et al.* 2010, Kubicek *et al.* 2011, Voisin *et al.* 2013, Currin *et al.* 2017), meeting other LGBTQ people

and sexual partners and using them as a source of information. Studies in this review with LGBQ adults mostly recruited participants through LGBQ community spaces so this may have influenced the findings regarding the LGBQ participants in the studies being out in the gay community.

As stated, several studies (Hoff *et al.* 2003, Smith *et al.* 2009, Mitchell *et al.* 2014a, Fisher *et al.* 2019, Power *et al.* 2022) asked participants to choose from a list to determine sources of information, however the usefulness of the sources was not asked in many of the studies. The studies from Australia (Smith 2009, Mitchell *et al.* 2014a, Fisher *et al.* 2019, Power *et al.* 2022) ask participants about their trust in sources or how comfortable they are approaching them but do not explicitly ask about usefulness. Other studies ask about preferred sources (McKay *et al.* 1997; Somers and Surman 2004, Turnbull *et al.* 2010, Rose *et al.* 2016, Baker *et al.* 2021) but were not specific if those sources were currently being used by the participants. For example, Mata *et al.* (2022) ask about the usefulness of a bisexual specific education programme that was not yet in existence.

In terms of usefulness of the sources used, research in this area is lacking, with little or no information if there is a difference in the usefulness of sources used by LGBQ adolescents, LGBQ adults or non-LGBQ adolescents. In the only study that asked about usefulness directly, the participants in Whitfield *et al.* (2013) were presented with a list of sources and asked to identify the sources most approachable and the most useful sources. Findings from this study suggest slightly different sources that are approachable and useful. The most approachable sources were best friend, boy/girlfriend, step/mother and step/ father but the most useful ones were friends, TV, parents and internet. Overall, usefulness of sources are yet undetermined.

The research reviewed for LGBQ adolescents, LGBQ adults and non-LGBQ adolescents indicates that similar sources are used for all three groups. The same topics are sourced by all groups. However, LGBQ adolescents who are going through a period of exploration about their sexuality and sexual orientation seek information on topics that are specific to their needs, such as coming out. What emerges from the literature is that the experiences of LGBQ adolescents sourcing information on sexuality and sexual health is not fully understood, with the focus of studies specific to one source or one topic. Alternatively, studies ask for information that is generic i.e., sexual health with little detail about sources used or topics sourced. Similarly, the usefulness of the sources has not been investigated for LGBQ adolescents. Findings

from the review also suggests that there is a lack of research addressing information seeking practices of LGBQ women aged 13-19, as the only study that deals with women exclusively in this age group is Arbeit *et al.* (2016) who recruited bisexual women. Grouping LGBQ adolescents together for studies can have its advantages but it also has limitations. To tailor information and resources, it is imperative that the specific information needs of each group are understood. Consequently, to further the body of knowledge in this area, further research is needed that includes purposefully recruited participants from all subpopulations of the LGBQ community.

4 Methodology and Methods

4.1 Introduction

This chapter presents the theoretical and philosophical assumptions that underpin this research study and the rationale for selecting this approach. This research is situated in the postpositivism paradigm; a paradigm that provides a philosophical framework for survey research. A survey design using an online platform for data collection was used to gather information from LGBQ adolescents (aged 13-19) on their sources of information on sexuality and sexual health. This design was selected following careful consideration of the methodological issues relevant to this type of research. This chapter also provides a detailed account of and rationale for the methodological choices appropriate for this type of study, such as survey design, testing, sampling, recruitment and data analysis. The impact of Covid-19 on the methodology, including survey testing is also outlined. An explanation is also provided around ethical issues in this study given the vulnerability of the potential respondents.

4.2 Aims and Objectives of the Study

The aim of this study is to obtain an understanding of LGBQ adolescents (age 13-19) information seeking behaviour, information needs and sources of information and their usefulness in relation to sexuality and sexual health. There were four specific objectives of this study.

These objectives were to:

- identify sources of information and their usefulness that LGBQ adolescents of secondary school age (13-19) use in relation to sexuality and sexual health,
- ascertain how useful LGBQ adolescents find the sources of information in relation to sexuality and sexual health,
- discover which sources of information and their usefulness that LGBQ adolescents use for different topics, such as Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/Activity and
- identify the impact of demographic variables on the sources of information that are used and are considered useful by LGBQ adolescents.

4.3 Paradigms

Research in health and social services is approached from different philosophical perspectives. These perspectives are historically influenced and are presented as paradigms or worldviews (Tanlaka *et al.* 2019). All researchers are advised to position their research within a particular paradigm and the choice is dependent on the nature of the study and the research question being asked. The recognition of paradigms and the early use of that word is credited to the work of Thomas Kuhn in the 1960s (Kuhn 1962). While paradigm is the term used by some (Morgan 2007, Lincoln *et al.* 2011, Cohen *et al.* 2018), worldview (Creswell and Plano Clark 2011), ontology and epistemology (Crotty 1998), or research methodologies (Neuman 2011) are all terms that are used interchangeably. Paradigm is the term used in this research. Regardless of the term used, it is generally accepted that a paradigm is a shared set of beliefs and practices underpinning how research is conducted and interpreted (Weaver and Olsen 2006, Morgan 2007, Kaushik and Walsh 2019). This is linked back to ontological and epistemological stances. In this instance the research subscribes to the tenets of postpositivism which is a paradigm commonly used in health and social science research (Bryman 2012).

A paradigm is composed of distinct elements: ontology, epistemology, axiology and methodology (Bryman 2012). These elements relate to the researcher's view of the world, the beliefs they have and the research that is conducted by them. When considered together, ontology, epistemology, axiology and methodology determine the underlying philosophy or paradigm in a study. Ontology refers to the nature of reality (Guba 1990) and understanding of 'what is' or what constitutes reality (Gray 2009). Epistemology considers what constitutes knowledge and how knowledge is acquired through the interaction between the researcher and the subject of the research. Axiology relates to the role of values (Bryman 2012). The personal beliefs or feelings of the researcher constitutes values (Bryman 2012). The ontological, epistemological and axiological underpinnings within paradigms differ. This is reflected in the methodology chosen for this study.

The methodology determines how researchers should go about finding the knowledge that is relevant to the research study. Research is guided by different elements of paradigms and philosophies. Researchers in health and social sciences have traditionally used the opposing and contrasting paradigms of positivism and constructionism (Bryman 2012). These are underpinned by different ontological,

epistemological and axiological assumptions and have been associated with quantitative (positivism) and qualitative (constructionism) methodologies. For this study, the researcher sought to gather knowledge from a wide group of respondents rather than an in-depth examination of sources of information, so constructionism was rejected as a supporting paradigm at a very initial stage for this study. A more detailed examination of positivism was therefore required to consider this as a paradigm option to underpin this research study.

4.3.1 Positivism

Positivism as a research paradigm is historically linked to Auguste Comte's work in the early 19th century. It arose from the philosophy of logical positivism which is based on logic and rules (Weaver and Olsen 2006, Tanlaka *et al.* 2019). Using empirical methods, it was modelled on natural science with the idea of replicating research principles in social science. The ontology of positivism asserts that there is one single reality that exists external to the researcher (Gray 2009). This single reality is investigated through rigorous scientific methods. Thus, this single reality comprises of interacting elements that are available to study. From a positivist viewpoint, objects have meaning prior to and independently of any awareness of them.

The epistemology of positivism is that knowledge is factual (Crotty 1998, Corry *et al.* 2019). Research is used to identify patterns in observations. Facts developed are devoid of subjectivity and objective in nature. The researcher is expected to adhere to strict principles and rules in the pursuit of verified facts (Gray 2009). Therefore, it is mainly the epistemology that influences the methodology and how research is conducted. In positivism, these methods include observation and experiments to produce scientific information that can be exactly replicated using the same precise methods. Data should be measurable using standardised instruments. Therefore, the researcher is considered detached, unbiased and independent from the research. On reviewing this philosophy, it was considered that it was not possible to develop one absolute truth or total objectivity in this study so positivism was out ruled as a paradigm to underpin this study and postpositivism was considered instead as an option to guide the study development.

4.3.2 Postpositivism

Postpositivism started to emerge as a research philosophy after the Second World War (Crotty 1998) to challenge the ontological and epistemological ideas of positivism. The view of postpositivists such as Popper (1902-1994) was that it was not possible to obtain one absolute truth and instead develop information that is probable. In postpositivism it is believed that respondents have multiple perspectives rather than a single reality (Creswell 2013). As such, reality exists but can never be fully appreciated (Guba 1990). Postpositivists consider some of the instruments of science such as self-reports, interviews and surveys as tools to enhance the researchers' abilities to infer but not know with certainty (Tanlaka *et al.* 2019). Postpositivist researchers try to explore and understand relationships between variables as opposed to establishing direct cause and effect relationships between variables (Parahoo 2006). This stance fits more closely with this research study where the experiences of adolescents in sourcing information on sexuality and sexual health were explored using a survey. The survey that has closed and open-ended questions, to consider the subject area from different perspectives and to minimise bias (Clark 1998, Houghton *et al.* 2012). The philosophy of post-positivism therefore underpins this research.

Postpositivist researchers reject absolute objectivity in research and instead suggest that some subjectivity is expected in research studies. Researchers can influence a research study with choices made around how data is collected by the topics they include in survey tools, how questions are ordered and how data is analysed. This is relevant to this study and information relating to the decisions in the study are presented in the Section 4.7 below on the development of the survey. This does not suggest that postpositivist researchers, while accepting some subjectivity is inevitable in decision making, should not strive for research that is impartial and objective. As such, postpositivism provides an alternative to positivism for conducting disciplined research study as methods used still require accuracy, sound reasoning and production of evidence (Creswell 2013, Tanlaka *et al.* 2019).

Postpositivism as a paradigm considers that reality does not exist in a vacuum, variables cannot be controlled and so many constructions of reality are possible. Therefore, there is no one approach to knowledge development but that multiple methods can be used to achieve research objectives (Wildemuth 1993, Houghton *et al.* 2012). It is acknowledged that occurrences that cannot be directly observed, such as experiences, can still be explored by using valid and reliable self-report tools (Tanlaka

et al. 2019). Data is therefore created by those involved in the research such as the researcher and respondents and that research is conducted in a natural setting (Guba 1990). In this instance, the researcher is investigating what is the present reality of sourcing information on sexuality and sexual health for LGBQ adolescents in Ireland.

In addition, the reality and findings are contextually bound by the timing of the study (Weiss 1995). Other factors that might influence the findings are gender, culture and cultural beliefs. These cannot be controlled so the relationship between individual's behaviours, attitudes, external structures and socio-cultural issues are recognised and studied in context at a particular time to find out if they have any meaning. For this study, questions on gender, sexual orientation, age, educational level, living location, living arrangements and ethnicity are all asked to link them to sourcing information on sexuality and sexual health. The optimum way to approach this was a survey design to gain the information required to meet the aims and objectives of the study.

4.4 Research Design

The study design is described as the plan or an approach that links the philosophical or theoretical approach described in the methodology to the research methods to answer the research question (Cohen *et al.* 2018). The research design provides a framework for the collection and analysis of data (Bryman 2012). It identifies what evidence is needed to address the research purpose, objectives and questions. The logic that underpins the connection between data collection and analysis and the conclusions drawn from them is presented using the research design (Cohen *et al.* 2018). As such, the procedures for collecting, analysing, interpreting and reporting data in research studies and sets the 'chain of reasoning' that links together all the elements of the study are determined (Creswell and Plano Clark 2011, Bryman 2012).

In keeping with the aim of the study, a non-experimental cross-sectional study design was used in this study. An online self-administered web-based survey, administered at one time point, was used to ascertain to explore the sources of information and topics sourced on sexuality and sexual health in LGBQ adolescents aged 13-19 in Ireland. This was a non-experimental research design in which a picture of a phenomena was developed by researching it as it occurred naturally. There was no intervention or manipulation of variables, as would be the case in a case control study (Cohen *et al.* 2018), but there was an exploration of the differences between variables which fits with

the postpositivist philosophy of this study (Creswell 2013). A cohort study, while useful to follow the same group of people over a period of time was not appropriate given the and the anonymous nature of the study (Sarantakos 2005).

An anonymous survey was used in this study to ask predetermined questions to an entire group, sample or individuals. Surveys allow a researcher to describe features in a large group, to gain details about the population of interest (Blackstone 2012).

Although principally associated with collecting quantitative data with two or more variables where direct patterns of association are detected (Bryman 2012), the survey also included open-ended questions to get more in-depth information from the respondents which adds to the quality of data collected. The core assumption in mixing qualitative and quantitative information in an exploratory study like this is to enrich and strengthen research results by using different methods of data collection and analysis to study the same phenomenon and to gain a complete understanding of the phenomenon (Maarouf 2019). A fully qualitative approach was not considered to be useful for this study as it did not fit with the aims and objectives. The survey design using closed and open ended questions reflected a practical approach to capture factors that influence young LGBQ peoples' sources of information and topics to be identified from a cross section of young LGBQ people aged 13-19 throughout Ireland. Findings from an integrative review of the literature as discussed in Chapter Three, supported this decision as there were no suitable previous studies identified in this area. More detail on the survey is expounded later in this chapter.

4.5 Data Collection

Data collection is the detailed, methodological gathering of information to meet the objectives, questions or hypothesis of a study (Grove *et al.* 2013). As aforementioned, this study involved the distribution of an online anonymous survey that contained closed and open-ended questions to collect both quantitative and qualitative data.

4.5.1 Online Survey

The survey was delivered online via the platform SurveyMonkey©. An online survey was considered to be the most suitable method to reach the target population. Online surveys have previously been used to success in studies where sensitive and private

information is included in the study, particularly in an LGBQ population (Bull *et al.* 2001, Riggle *et al.* 2005, Masters *et al.* 2013, Craig and McInroy 2014, Ybarra *et al.* 2014, Mustanski 2015, Higgins *et al.* 2016). Sterzing *et al.* (2018) report that LGBQ adolescents are a hard-to-reach research population, as historically they did not take part in studies for fear of being outed. Smartphones and other mobile devices have enabled those who previously had less access to the internet to now complete surveys online and more discreetly. Therefore, Ryan (2013) suggests that online recruitment is considered the most successful, cost-effective and efficient method by which to target and recruit a wide range of adolescents and so was developed for this study. In addition, the online survey platform used in this study ensured the privacy and confidentiality of participants was maintained and effectively reached respondents over a wide geographical region in the Republic of Ireland.

4.6 Population

The population for a study is described as a subset of the target population from which the sample who share similar characteristics are drawn (Parahoo 2006). The population in this study are LGBQ adolescents aged 13-19 living in the Republic of Ireland. The acronym LGBQ was used in this study to specifically describe adolescents who are lesbian, gay, bisexual or questioning their sexuality. In studies with adolescents with a non-heterosexual orientation, broad inclusion criteria are often developed using terms such as those identifying as gay, bisexual, or queer/questioning (LGBQ) or those that experience same sex attraction, or engage in same sex behaviour, to capture all adolescents questioning their sexual orientation.

The focus of the study was sexuality and sexual health, so the focus is on sexual orientation and not gender identity. All adolescents who were sexually attracted to their own gender or their own and another gender were eligible to take part. Similarly, the “Q” was included as it is recognised that adolescents may go through a period of questioning their sexual orientation while in this age group. All gender identities were eligible to take part once they met the inclusion criteria. It is difficult to find consistent language in the literature when acronyms are used for those who identify as lesbian, gay and bisexual. Some studies include sexual orientation and gender identity and use LGBT, LGBTQ, LGBTQIA+ as acronyms. Other acronyms that are used are for sexual orientation only include LGB or LGBQ. The acronym LGBQ is widely used in schools, youth groups and the media in Ireland as this is how youth groups describe the

population they cater for. Therefore, LGBQ was considered an appropriate term to use for this study.

4.6.1 Eligibility criteria

Eligibility criteria in the form of inclusion/ exclusion criteria for study respondents is standard practice for research studies to ensure accuracy and consistency in study findings (Patino and Ferreira 2018). Inclusion criteria are the key features of the target population that are needed to ensure that they have necessary experience to be able to complete the survey to meet the aims and objectives of the study. Inclusion criteria are an important consideration for research with LGBQ adolescents and need to be appropriate for the aims of a study (Mustanski 2015).

For this study, the inclusion criteria were:

- Adolescents who identify as LGBQ (lesbian/ gay/bisexual/ questioning)
- LGBQ Adolescents aged 13-19
- LGBQ Adolescents living in the Republic of Ireland

The exclusion criteria were:

- Adolescents who do not identify as LGBQ
- Adolescents younger than the age of 13 and older than 19
- People who do not live in the Republic of Ireland

4.6.2 Sample, sample size and sampling method

To find the appropriate sample size for this study, several elements were considered as there is no defined number of adolescents between 13-19 in Ireland and no defined number of LGBQ adolescents. Therefore, it was considered that the number of secondary school and Youthreach students in Ireland would be used as a baseline to determine the sample size. In 2016-17, there were 352,257 second level students in Ireland which included secondary, comprehensive and community schools but excluded those doing Post Leaving Cert (PLC) courses (Department of Education and Skills 2017). During this time or in 2016-2017 there were another 6,000 people attending Youthreach, which is an education service for early school leavers who are unemployed aged 15-20. This gave a potential total population of 358,257 second level students for inclusion in the study. Similarly, the exact number of LGBQ adolescents in Ireland is unknown. BeLonGTo report on their website (accessed October 2020) that

over 10% of the world's population are LGBT. Previous research studies in Ireland and Australia have used a guide that 8-11% of the population identify as LGBTQ based on their findings (Dooley and Fitzgerald 2012, Hillier *et al.* 1998, Hillier *et al.* 2005, Hillier *et al.* 2010). The most recent study of LGBTI peoples' mental health in Ireland used an estimate of 10% of the total population to calculate the LGBTI population for their study (Higgins *et al.* 2016). Dooley *et al.* (2019) report that in their study of adolescents' mental health, out of 10,459 12–19-year-olds, 87% identified as heterosexual with the 11% expressing a range of sexual orientations and 2% who wished not to disclose their sexual orientation. While some of these percentage assumptions are based on both sexual orientation and gender identity and this study is focussed solely on sexual orientation, 10% of all secondary school students was therefore considered an acceptable estimate for this population. Thus, the total LGBQ population in Ireland was estimated to be one tenth of 358,257 which was 35,800 for this study.

A non-probability sample consists of any sampling technique for which the probability of a person being selected into the sample is unknown (Meyer and Wilson 2009). A non-probability convenience sample was used to access a group of LGBQ adolescents aged 13-19 for this study. This means that some people of the desired population may not have been included in the sample and other groups may have been overrepresented. The sample was one of convenience in that it was drawn from sources that were most conveniently accessible to the researcher. Statistical advice was sought both pre survey and post survey, to ensure that the sample size was representative of the overall population. A power analysis was calculated using an online tool. Many tools are available to estimate sample size but the online validated tool G*Power was used (Faul *et al.* 2009) (<http://www.gpower.hhu.de>) based on the statistical advice given. The figure 35,800 was used as the population size. For an alpha of=0.05 and a power of 0.80, a sample size of 85 was required to complete bivariate analysis and this was achieved.

As the online anonymous survey was circulated via a link to the survey on social media, the precise population that was reached is not known or how many of those who interacted with the link to the study reached out to their personal contacts. Previous research internationally has found that white educated urban adolescents respond to surveys of this kind (Mustanski 2011, Ryan 2013). However, social media use and mobile phones have changed the way research with adolescents is conducted (McDermott *et al.* 2013, Ryan 2013, Sterzing *et al.* 2018). Nevertheless, DuBois *et al.*

(2012) report that recruiting diverse samples of adolescents online is difficult. Details on the overall sample is presented in the findings.

4.7 Survey Development

This section provides an overview of the survey development, this section details the decision-making process around compiling sections, questions and content, formatting the development of the platform for the delivery of the survey and reliability and validity testing. The integrative review, scoping review and the trawl through the grey literature did not provide a suitable complete survey to replicate to meet the research aim or objectives for this study. Therefore, a decision was made to develop a survey. The survey development process outlined by Rattray and Jones (2007) was followed. The process commenced by reviewing the research questions, exploring the pertinent literature, asking experts and the target population to develop questions. Following this, the questions included in the survey were reviewed by researcher and supervisors to ensure that they adhered to guidelines on the survey development. Suitable response formats were chosen such as closed versus open format questions in how items were constructed. Finally, questions were placed in order in the survey and items that were not relevant were discarded. The generation of items during survey development requires considerable pilot work to refine the wording and content (Rattray and Jones 2007). This was completed over the course of a year by the researcher and supervisors to develop the first draft and was refined again following validity testing.

Review / develop the research questions and explore pertinent literature

The development of survey items was in line with the recommendations of Rattray and Jones (2007), with information coming from several sources including consultation with experts in the field, proposed respondents, and review of the associated literature. Some questions were used from previous studies such as by Hillier *et al.* (2010), Central Statistics Office (2016), Higgins *et al.* (2016) and Pizmony-Levy and BeLonGTo (2019) to collect demographic data from participants. Therefore, the first section to be developed was that of which collected demographic data from participants (see Table 4.2- Description of the Survey).

Following that, an extensive review of literature was conducted and a preliminary list of sources and topics were defined, identified and grouped together (see Table 4.1 List of Sources and Topics Developed from the Literature). Nineteen sources of information

and twenty topics were identified. These sources and topics form the basis of the tables developed in the survey. All possible topics that adolescents could source information on were included and listed. A matrix was formed of sources and topics (Draft 1 of the survey – See Appendix 2). Respondents were asked to tick any sources they had used for the specific topics. As it was not possible to present all the topics on one table, three matrix tables were developed under three separate headings: Sexual attraction/ orientation and relationships; Readiness for safer sex and Sexual activity/ behaviour (Table 4.1). Open questions on whether respondents had used any other sources or sourced information on other topics were also asked following presentation of the lists. This allowed respondents to add to an already existing list but also provided items relevant to this population for further studies on this topic that may not have been evident from the existing literature.

Table 4.1 – List of Sources and Topics developed from the Literature

Sources (19)	Mother/ female guardian, father/ male guardian, siblings, other family members, friends (LGBQ), friends (non LGBQ), LGBQ community, youth group, sexual partners, teacher/ school, health professional (GP/ nurse/ social worker), clergy/ church, sexual health services/ clinics, LGBQ focussed Internet search, General Internet search, LGBQ media, TV/Magazines/Film, porn (pornography), social media (blogs/ discussion/ posts)
Topics (20)	Friendships and Sexual Orientation- sexual attraction/orientation, LGBQ relationships, findings LGBQ friends, coming out. Readiness for Safer Sex - pregnancy, contraception, STI, safer sex (condoms), what does it mean to consent and my rights, how to know I am ready for sex. Sexual Activity/ Behaviour - kissing, cuddling, genital touching, masturbation, oral sex, vaginal sex, anal sex, what to do during sex, how to use safer sex aids, how to use sex toys safely

Additional questions were then asked on the usefulness of the individual sources of information people used for different topics. Questions were linked and respondents were only asked supplemental questions on information they had previously provided. Based on information gathered from the literature and media information, a question on barriers to looking up information was developed. Questions on pregnancy and sexually transmitted infections from Hillier *et al.* (2010) were also asked. A further two questions were developed by the researcher and supervisors on the use of the Internet. Questions on demographic information such as age (Higgins *et al.* 2016),

gender (Pizmony-Levy and BeLonGTo 2019), sex, ethnicity (Central Statistics Office 2016), education, location of main residence and living arrangements were also added.

Development of survey format

For this phase, several different guidelines and recommendations on survey development were used. It was acknowledged that respondents' effort to recall information may decline over the course of a list due to fatigue (Schwarz and Oyserman 2001, Moser and Kalton 2017). Therefore, breaking the topics into three tables while keeping the sources constant was considered to be best practice for the development of this survey. Breaking down tasks into several subtasks can make it easier for respondents to recall information (Schwarz and Oyserman 2001). In line with this recommendation, several separate ways to ask the questions were trialled by the researcher and the supervisory team. The grid/ table was chosen as the most appropriate and efficient way to avoid asking the same question on a potential twenty occasions. These grids/ tables provided a list of sources of information which remained consistent throughout and three sets of topics grouped together under the following headings: Friendship and Sexual orientation, Readiness for Safer Sex and Sexual Activity/ Behaviour. Stated limits were also placed on responses so that only those sources chosen in the first instance carried forward to where respondents were asked if they were useful/ not useful, which may have aided recall also.

During this stage of development, the survey was reviewed for relevance to the aims and objectives of this study. Non-relevant questions were discarded to keep the survey to the point and avoid fatigue for the participant. Questions discarded were in relation to the county of residence and employment. A question about the location of the adolescents' main residence was included based on urban versus rural location instead of a broader question with more options. Linking employment status and sources of information was not an objective and questions related to this were removed. As the questions were developed and refined, they were continually tested and reviewed by the researcher and supervisors to ensure that the questions asked were suitable for adolescents and were formatted appropriately. It was also necessary to refer to the aims and objectives constantly throughout to ensure that the questions were appropriate.

The format of survey questions influences the responses given. Closed ended question or forced choice questions are preferable in surveys (Schwarz and Oyserman 2001, Bryman 2008) as they are more suitable for analysis and are quicker for respondents

to complete (Bryman 2008). Moser and Kalton (2017) recommend lists to be provided with all possible answers. Therefore, tables on sources and topics were provided with all viable options found in the literature. However, it was also possible that some topics and sources were not included so open questions on both were added.

It is also considered best practice to avoid giving options for don't know or other when using closed questions in surveys (Bryman 2008, Moser and Kalton 2017). However, it can be argued that not including these options would force participants to respond to questions and give information that was not relevant to them, or they were not comfortable providing. Therefore, additional open options, such as providing an "other" option in questions were added where appropriate.

As this is an exploratory survey, it was necessary to add some open-ended options to questions and add free text questions to allow respondents to provide additional information that may not have been evident from the literature. While this option can provide rich data and respondents may welcome the opportunity, Polgar and Thomas (1995) highlight that this material can be difficult to analyse and interpret. However, problems with analysis may be outweighed by the benefits of including this option. Free text comments can be especially useful in the early development of a survey, as they can inform future survey development by identifying poorly constructed items or new items for inclusion in subsequent studies (Rattray and Jones 2007). Therefore, open ended questions on additional topics and sources were included in each section asking for additional information to allow respondents to decide on the form, detail and length of their answer (Moser and Kalton 2017) (Appendix 2 Draft 1 of the Survey).

Order of the items on the survey

Moser and Kalton (2017) acknowledge that question order in a survey may affect completion rate. Careful consideration was therefore given to the order in which items were presented. While, controversial or emotive items were avoided at the beginning of the survey (Rattray and Jones 2007), respondents also needed to consider if the survey was relevant to them. Therefore, the survey began by asking respondents about their sexual orientation, followed by sources of information and topics sourced. Forced choice questions (yes/ no) on previous history and demographic data were presented at the end of the survey so if respondents had become weary with the previous questions, they were able to answer these questions more easily.

Face and content validity Phase 1

In August 2019, the Executive Director and Director of Research of BeLonGTo were sent a word copy of the first draft of the survey to achieve face and content validity and to review for inclusiveness of language and suitability of questions for the target population (See Appendix 2 Draft One of Survey). BeLonGTo is a national organisation supporting LGBTI+ young people aged 14-23 and Youthwork Ireland (YWI) supports LGBQ and non- LGBQ people and is the largest youth organisation in Ireland. They provide direct youth work supports and services to young people including groups for members of LGBTI+ community and their allies in local areas.

4.7.1 Description of final pre pilot survey

In total, there were 51 questions presented in 11 sections of the survey (See Appendix 3 – Final Survey Sections). These included 31 questions and a potential 20 supplemental questions, asking whether sources were useful or not, that were presented to respondents depending on the sources of information they ticked. If the source was not picked for a topic, then the supplemental question was not shown to the participant. The format consisted of 42 closed ended questions and 9 open ended questions (see Table 4.2 - Description of Survey).

Table 4.2 Description of the survey

Section of the Survey	Title of Question	Number of Questions	Types of Questions	Additional Questions/ subject of questions	Types of Answer & Logic Applied.
Section 1	1.Survey declaration	1	1 closed ended question	Read declaration yes/no	Tick one box – yes or no Yes- Proceed to Survey No- Proceed to final page
	2. Eligibility	1	1 closed ended question	Confirm aged 13-19 and live in Republic of Ireland	Tick one box – yes or no Yes- Proceed to Survey No- Proceed to final page
	3. Consent	1	1 closed ended question	Consent yes/no	Tick one box – yes or no Yes- Proceed to Survey No- Proceed to final page
Section 2	About your sexual feelings/ attractions (Q 4,5,6)	3	2 closed questions 1 open question	Description of their sexual orientation - Which of these statements best describes your sexual attraction/ orientation? (Adapted from Hillier <i>et al.</i> 2010)	Tick one box - 5 options – allowed to tick one only
				Age of awareness - At approximately what age did you first become aware of your sexual attraction/ orientation? (Adapted from Higgins <i>et al.</i> 2016)	Open ended question – allowed to answer freely
				How do they feel about attraction/ orientation? (Hillier <i>et al.</i> 2010)	Tick one box - 5 options – allowed to tick one only

Section 3	Sources of information on Friendships and Sexual Orientation (Q7 – 13)	2	1. closed ended question (table) Four possible supplementary questions	List of nineteen sources (Table 4.1). Respondents asked to tick those sources they got information from useful/ not useful on four topics sexual attraction, LGBTQ friendships, findings LGBTQ friends, coming out.	Respondents allowed to tick any of the boxes. Only boxes ticked are carried forward into supplementary questions.
				Four supplementary questions on usefulness of information depending on answers in the table- <i>"Thinking about the sources of information on xxx please tick whether you found each source to be useful or not."</i>	Two options – useful or not useful – allowed to tick one only.
			2. open ended questions	One open ended question asking about any other sources that they got information on sexual orientation and relationships- <i>"If you sourced information on sexual orientation and relationships from any other place, please state the source here."</i>	Free text box
				One open ended question asking about any other topics related to sexual orientation and relationships and related sources <i>"Have you looked up information on any other topic related to sexual orientation and relationships that is not listed above? If yes, please tell me and what source of information you used."</i>	Free text box

Section 4	Sources of information on readiness for safer sex (Q14- 22)	2	One closed ended question (table) Six possible supplementary questions	List of nineteen sources given, and Respondents asked to tick those they got information from useful/ not useful on six topics - pregnancy, contraception, STI, safer sex, consent, readiness for sex.	Respondents allowed to tick any of the boxes. Only boxes ticked are carried forward into supplementary questions.
				Six supplementary questions on usefulness of information depending on answers in the table.	Two options – useful or not useful – allowed to tick one only.
			Two open ended questions	One open ended question asking about any other sources that they got information on readiness for safer sex - . <i>“If you sourced information on readiness for safer sex from any other place, please state the source here.”</i>	Free text box
				One open ended question asking about any other topics related to readiness for safer sex and relationships and related sources <i>“Have you looked up information on any other topic related to readiness for safer sex that is not listed above? If yes, please tell me and what source of information you used.”</i>	Free text box

Section 5	Sources of information source on sexual behaviour/ sexual activity (Q 23- 35)	2	One closed ended question (table)	List of nineteen sources given, and Respondents asked to tick those they got information from useful/ not useful on ten topics kissing, cuddling, genital touching, masturbation, oral sex, vaginal sex, anal sex, what to do during sex, how to use safer sex aids, how to use sex toys safely. Ten supplementary questions on usefulness of information depending on answers in the table	Two options – useful or not useful – allowed to tick one only.
			One open ended question	One open ended question asking about any other sources that they got information on sexual behaviour and sexual activity.	
Section 6	Reasons for not sourcing information (Q36)	1	One closed question	List of reasons for not sourcing information with comment option – “If there are reasons why you do not seek information on sexuality and sexual health, please tell me what prevents you. From the list below, please select all that apply.”	Closed – 12 options. Respondents allowed tick as many reasons as they wish or allowed tick other with detail asked for in free text.

Section 7	History (Q 37-39)	3	Three closed ended questions	Have you ever been pregnant? (Hillier <i>et al.</i> 2010)	Tick one box - 3 options – yes/ no prefer not to answer
				Have you ever had a sexually transmitted infection? (Hillier <i>et al.</i> 2010)	Tick one box - 3 options – yes/ no prefer not to answer
				Have you ever received payment or gifts in exchange for sex?	Tick one box- 3 options – yes/ no prefer not to answer
Section 8	Internet use (Q 40-41)	2	One closed ended question One closed ended question with other as an option for additional information	Most common way to access internet,	Tick one box - 5 options
				Most common location for accessing the internet	Tick one box - 6 options - Respondents allowed pick one of five or allowed tick other with detail asked for in free text
Section 9	Demographic data (Q42 -50)	8	Seven closed ended questions One open ended question	Age – what age are you? Adapted from Higgins <i>et al.</i> (2016)	Tick one box One option per year - 13,14,15,16,17,18,19
				Gender identity- what is your gender identity? (Adapted from Pizmony-Levy and BeLonGTo 2019)	Tick one box - 6 options - Respondents allowed pick one of five or allowed tick other with detail asked for in free text
				Gender at birth	Tick one box - 3 options – male/ female/ other (please specify)
				Location	Tick one box - 3 options – city/ large town, village, in the countryside (rural)

				Living arrangements – what type of accommodation do you live in?	Tick one box- 5 options including if none describe where you live, please tell me.
				Education – are you still in education (school/ college)	Tick one box – yes or no Yes- Proceed to Question Survey No- Proceed to final page 2 options Yes – Proceed to Q48 asked about stage of education? No – Proceed to Q49 What age did you leave school/ college?
				What stage of school/ college are you at?	Tick one box – 4 options closed question Logic – brought to question on ethnicity
				One open ended question asking what age they were when they left school	Open Box to allow Respondents to add free text. Logic - Next question on ethnicity
				Ethnicity (Central Statistics Office 2016)	Tick one box – 8 options - Respondents allowed pick one of seven or allowed tick other with detail asked for in free text
Section 10	Comments (Q51)	1	One open ended question		Open box - To allow Respondents to add free text on sourcing information

Section 11	Support Services Information	No Question

4.7.2 Testing the online platform

SurveyMonkey© is an online survey development cloud-based software that was used for the development and distribution of the survey. Online surveys require multiple testing on different electronic hardware devices (e.g., smartphone, tablet, laptop) to ensure that they are compatible with all devices (Sterzing *et al.* 2018). The survey was developed to ensure it was suitable for phones, tablets, laptops and followed standard survey best practice regarding clarity and length. In the early drafts of the survey, all topics and sources were asked in the one matrix question. As all the full tables were not visible on a mobile phone, the tables were changed and spread over three smaller tables to be seen. Logic was applied to some questions to ensure that questions that were not relevant were skipped. In that way only questions relevant to respondents were completed as they progressed through the survey. This was done using the SurveyMonkey© software.

While online surveys are easy to administer and can collect a broad range of data, a limitation of this data collection method is that answers may be interpreted differently by respondents as clarifying answers with the researcher in person is not an option (Sterzing *et al.* 2018). This was addressed by extensive testing of the survey with stakeholders for clarity and user-friendliness and was counteracted by providing clear instructions in the question stem and limiting options in the answers. As the survey was self-administered, no researcher was available to answer questions respondents may have had so particular care was needed to ensure that all questions were clear, relevant and user friendly (Riggle *et al.* 2005). The contact details of the researcher were also provided in the participation information page (Appendix 3) so they could be contacted if difficulties arose. Data errors may also have occurred as some questions may not have been answered by some respondents creating bias in the responses and where this occurred it is acknowledged in the findings.

Settings in SurveyMonkey© can be set to submit the answers either all at once at end of survey or at various stages in the survey. In this survey, data was collected at the end of each page. By doing so it was important to obtain the completion and non-completion rate as it is useful for evaluating the samples representativeness and determining at what points respondents exited the survey. Further settings on SurveyMonkey© software for the survey with the rationale for them are presented in Table 4.3 below.

Settings on the survey also were set to ensure that no one was disqualified by accessing this survey such as by blocking IP addresses and passwords were not needed to access the survey. In line with recommendations by Kosciw *et al.* (2015), cookies were removed to allow multiple responses from the same device. Internet Protocol (IP) address can be used to trace a respondent to an IP provider of a device but may not trace it back to a specific user. Therefore, to ensure anonymity of participants, the researcher removed this function from the survey before it was circulated so that respondents could not be traced back to their machine by the researcher (Riggle *et al.* 2005). This unfortunately does permit the same person to access the survey twice but also allows a shared computer in a café, youth group or school to be used to access the survey if adolescents did not want to complete the survey at home or on their own device (Kosciw *et al.* 2015).

Table 4.3 Survey Settings Selected on SurveyMonkey

Preference	Rationale
Response Editing and Saving Each question is not saved singly but are saved and submitted when a respondent clicks the next/ done button on each page of the survey. Responses editing is on so respondents can return and change answers up to the point that they press done at the end of the survey.	The survey was set up to allow respondents to return to change an answer if something occurs to them later in the survey. However, if respondents exit the survey and go back to it, they get a completely new survey. It records a new response it does not update existing response (limitation). This was to ensure that if respondents did not fully complete the survey, the completed pages would be saved. It also permitted the respondents to exit the survey without completion and return to complete another time. This may prevent exiting survey from dissatisfaction with the survey because they can change at least some of their answers. If turned off it means that respondents cannot go back and change if something occurs to them after they have moved on – it was important that this option is available as respondents progress through the survey as additional topics or sources of information may become relevant that were not evident at the beginning of the survey.

Only one web link will be available for the survey	While Survey Monkey allows for new web links to be created at specified times i.e., every day, week, month or quarter, this was not necessary in this survey. One weblink was consistently used so it could be shared among groups if needed via e mail/ social media.
Custom thank you	A thank you message was written and came up on screen upon completion of the survey.
Multiple Responses	Surveys were allowed be completed more than once from the same device. This was to facilitate those who do not have access to their own device or are not comfortable using it to complete the survey (based on literature). Also, to monitor this means tracking IP addresses and this means respondents may not be 100% anonymous.
Anonymous Responses	Turned on, respondents were anonymous, and no IP addresses are included in results.
Instant results	This was turned off. Respondents were not shown their results after they had submitted. No option was available to go back and change answers once DONE button had been clicked and survey submitted.

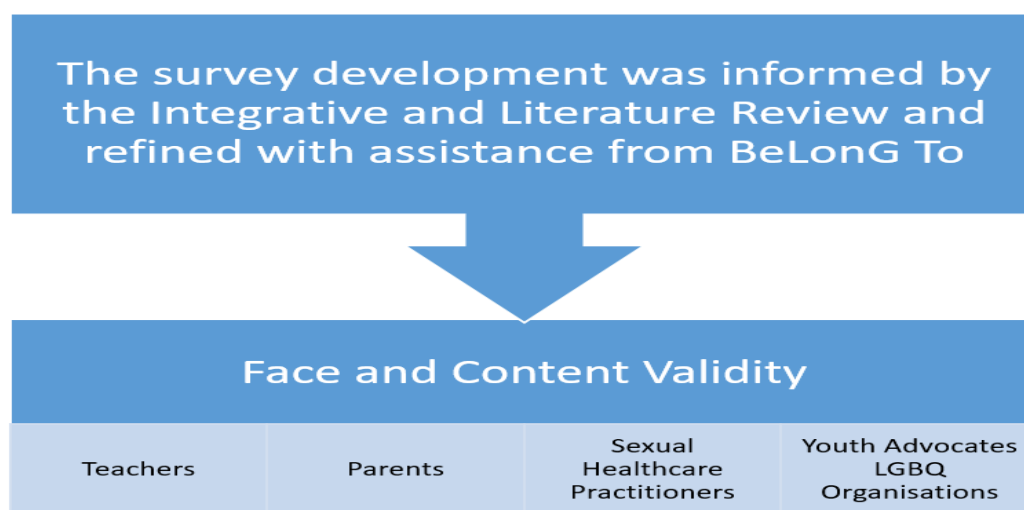
4.8 Public and Patient Involvement (PPI) for Content Validity

The inclusion of the public in doctoral research is considered to strengthen its value and effect (Tomlinson *et al.* 2019). In this instance, the first draft of the survey was reviewed by senior members of BeLonGTo Youth Group. They were asked to consider the language and terminology used and the suitability of the questions being asked. They raised issues about the wording of the questions on gender identity. This question was expanded to include other expressions of gender identity and an additional question on biological sex was inserted (Q44). Also, instead of using the term “same sex relationships and attraction” that the term “same gender relationships and attraction” was recommended for the text of the survey (Q4). A question on sex working was also added on their suggestion (Q39). The survey was amended and

returned to the Ethics Committee for revised approval in December 2019 (See Appendix 3 Letter from Ethics Committee Approving Amendments).

Following the first and second draft survey revision, it was intended, in March 2020, to consult a group of adolescents associated with BeLonGTo to determine face and content validity of the survey. This was to ensure that the language was inclusive, understandable and culturally appropriate for the adolescent LGBTI+ community. However, due to restrictions for Covid19 this was not possible as all face-to-face meetings were suspended for a time and group online meetings were also not taking place at that time. In the absence of any clarity around the duration of these restrictions and as ethical approval did not include access to adolescents via external online platforms, to prevent further delay with the study, a revised content validity strategy was developed using experts in sexual health (6 experts in the public domain) recruited by email, experts in LGBTQ adolescents (6 youth advocates from LGBTQ Organisations) in the public domain recruited by email, parents (accessed through staff in the School of Nursing and Midwifery, Trinity College) and secondary school teachers (accessed through a former teacher that was known to me) (Figure 4.1).

Figure 4.1 Survey Development and Content Validity using PPI



Approval for this method of content validity was received from the Ethics Committee (Appendix 13 Letter of Ethical Approval with Content Validity Amendments). Data for content validity was collected the same way as the data for the main study using an online survey. It differed in that a link to the survey was circulated via email so that the

experts required were targeted directly but could reply anonymously via SurveyMonkey®. Each of the expert groups identified were sent an email with an anonymous survey link and content validity scale for each question on relevance, clarity and user-friendliness and asked to complete it and circulate to colleagues where appropriate.

Guided by the work of Yusoff (2019) and Almanasreh *et al.* (2019), a systematic approach for content validity was developed. Content validity is a subjective measure of how appropriate and relevant items are to a group of reviewers who have expert knowledge of the subject matter. For the online content validity survey, a Content Validity Index (CVI) was developed based on the work of Davis (1992) to disseminate to the expert group. This index used a scale from 1-4 to use to show the relevance (1 not relevant – 4 very relevant), clarity (1 not clear – 4 very clear) and user-friendliness (1 not user-friendly – 4 very user-friendly) of the questions. An introduction was added to the survey explaining the content validity process and an additional question was added after each existing question with a table inserted to determine how relevant, clear and user-friendly the questions were (See Figure 4.2 – Content Validity Question/ Scale). Open ended questions were added to each question/ section to allow the experts reviewing the survey to provide additional comments if required.

Figure 4.2 – Content validity question/ scale

Please rate the information provided above on the 3 specific elements - relevance, clarity and user friendliness. I would ask that you place numbers after each of these items individually to show how relevant, clear and user friendly the information is using the following scales.

1= if it is either not relevant or not clear or not user friendly

2= if it is somewhat relevant or somewhat clear or somewhat user friendly

3= if it is quite relevant or quite clear or quite user friendly

4= if it is highly relevant or very clear or very user friendly

Any other comments may be added in the comment box

	1	2	3	4
Relevance	☐	☐	☐	☐
Clarity	☐	☐	☐	☐
User Friendliness	☐	☐	☐	☐

Any other comments

In total, twenty (20) responses were received from the experts for this survey on content validity. This met the minimum criteria suggested by both Almanasreh *et al.* (2019) (5-10 experts) and Yusoff (2019) (2-6 experts) for overall content validity. No recommendations were made by either author for the number of experts there should be in subcategories. These 20 responses included four LGBQ experts, four experts in sexual health, five teachers, six parents and one who did not identify with which category they were from. This person did not complete the scale but provided comments in the text boxes only. Therefore, the maximum score available on CVI-Index was out of 19 (see Appendix 6 Content Validity Scores).

Table 4.4: Overall CVI-Index for total survey Per group of Experts

	Relevance	Clarity	User Friendliness
Teachers	0.92	0.75	0.79
Sexual Health Experts	0.98	0.95	0.95
Parents	1	0.93	1
LGBQ experts	0.92	0.89	0.925
Overall CVI Index Score	0.93	0.90	0.91

A Content Validity Index (CVI) was calculated for each item/question (I-CVI) using EXCEL spreadsheets for each of the three domains. This was calculated as the number of experts providing a score of 3 or 4 i.e., for relevance those that identified that the item was quite relevant or very relevant, divided by the total number of experts who completed that question (Lynn 1986). This is presented in the form of a decimal i.e., 0.98 indicating that 98% of experts gave a score of 3 or 4 (See Table 4.4 Overall CVI-I per group of experts). Overall scores ranged from 0.90 for clarity to 0.93 for relevance. The overall scores per question for this are available in Appendix 6- (Content Validity Scores). Lynn (1986) and Polit *et al.* (2007) recommend that when there are more than five experts some disagreement is expected. Therefore, in addition to the CV-I a proportion of agreement was calculated across experts in total

and in each subgroup of experts. This allowed decisions to be made to retain or exclude items from the survey with a range of scores available. Questions with a score of less than 1 ($I=CVI$) were reviewed in conjunction with comments made on these questions and some minor changes made to the wording and presentation of the information. In total, changes were made to the information in six sections including the introductory page and final page of support services with minor changes being made to the wording of twelve questions (See Appendix 7 Content Validity Comments). These included changes for the Participant Information to simplify it and additional information was suggested for the Support Information at the end of the survey. Amendments were suggested for another seven questions, but these changes were not made as some of the changes suggested were contradictory of each other and others were not relevant. Rationale for decisions made with each item is presented in Appendix 7 Content Validity Comments .

While CVI-Index has some limitations as a validity instrument, it is still considered to be the most advantageous as it is simple, easily understood and interpreted and allows for scores to be developed per item and for the full survey (Almanasreh *et al.* 2019). Almanasreh *et al.* (2019) also recommends that following the initial content validity process and subsequent changes, the survey should be reviewed again by a smaller content validity panel. With this survey, some changes were suggested to the question on gender and the comments provided by the experts were conflicting (See Appendix 7 Content Validity Comments). The definitive advocacy group for young LGBTQ people the staff of BeLonGTo were contacted to provide advice on the wording and the survey was adapted following their suggestion. However, as there were no major changes to the content of questions and only minor changes to the working of questions and a second review by the full panel of experts was deemed unnecessary (Polit *et al.* 2007). The survey was also reviewed by some colleagues, who were parents of adolescents for suitability before it was distributed, and questions were agreed.

4.9 Reliability

Reliability estimates evaluate the stability of a measure, internal consistency and interrater reliability of instrument scores (Kimberlein and Winterstein 2008, Cohen *et al.* 2018). One of the most common ways to do this is to use Cronbach's alpha, which uses inter-item correlations to determine whether items are measuring the same

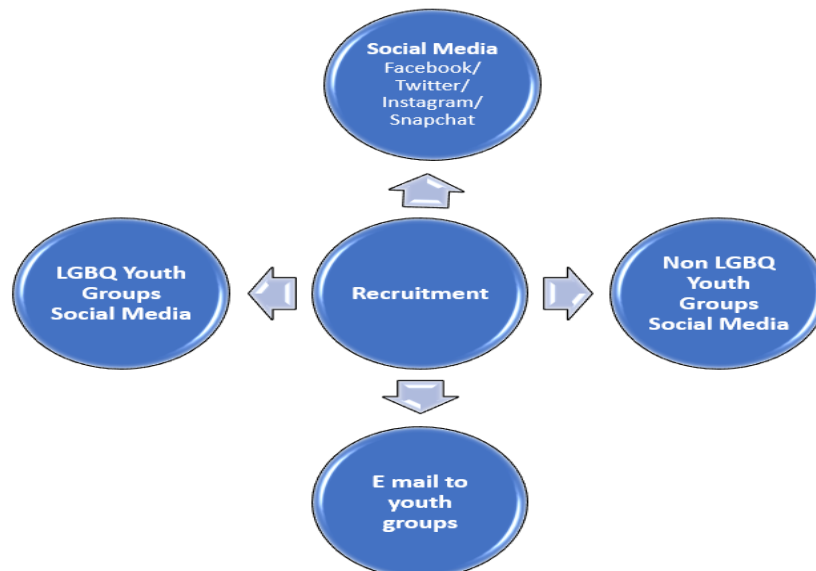
domain such as knowledge. It was not possible to use this as the data collected was subjective so could not be used for statistical tests as there was no measurements or scales present. Pre –post testing and pilot testing an instrument is also recognised as a test for stability of an instrument (Kimberlein and Winterstein 2008, Cohen *et al.* 2018). However, this was not possible with the age group and subject content as once the young person was introduced to a topic in the first survey, they may research it further, so answers to the survey may not be consistent and therefore, pilot testing may not be a reliable measure in this population.

Pilot testing should involve persons/ smaller group from the target population (Riggle *et al.* 2005) with a sufficient sample size to perform systematic appraisal of a survey's performance (Rattray and Jones 2007). In addition to the information presented above, it was considered that pilot testing in this study was not possible as it is an extremely limited population and sending out an online link for a pilot may have diluted the sample size for the data collection for the study as it is usual that data from pilot studies are not included with larger study data especially if survey is modified (Leon *et al.* 2011). In addition, as the link would be distributed anonymously, there was a risk that by sending this out for a pilot even in an older age group that it may be circulated to the target population. This would reduce the number available for the overall study. Therefore, a decision was taken not to perform a pilot study in the target population or those slightly older. As a result of the decision not to do pilot testing or statistical internal consistency, reliability was not tested for this survey. It is expected, however, that data collected from this survey will inform modifications of the survey for use in the future (Leon *et al.* 2011).

4.10 Recruitment Strategies and Data collection

Once the survey was finalised a multi-pronged recruitment strategy using LGBQ and Non LGBQ, youth groups networks and social media was used (Figure 4.3). This allowed the online link to be shared widely. Therefore, the number of people that were informed of the study was maximised.

Figure 4.3 – Recruitment



Respondents to online surveys can be accessed via two routes: closed access and open access. A closed access route involves emailing the survey link to eligible individuals directly and asking them to complete the survey and email it back when complete. Open access, which is the method used in this study, is where a study weblink is sent through email, social media or with a banner posted on a website or social media. The advantage of free/open access is that there is no contact between the researcher and the respondents, allowing for increased anonymity and privacy (Riggle *et al.* 2005).

In this study, recruitment was through LGBQ and Non LGBQ youth groups networks and social media as well as the researchers' and the School of Nursing and Midwifery social media (see Figure 4.3). Originally it was also intended to send the survey link to LGBQ and Non LGBQ youth organisations via paper flyers/ posters to advertise to any adolescents that were attended in person groups and may not be on social media (See Appendix 8- Copy of Recruitment e mail/ Flyer for Recruitment). This was to maximise the number of people that were informed and offered an opportunity to participate in the study. However, as groups were not meeting in person at this time due to COVID19 this was not an option and waiting for online groups to commence would have delayed data collection. Therefore, the sole method of distribution of the survey

was a poster including the link to the study circulated via email and social media. Although schools were used as a method in some studies to access adolescents, they were considered not appropriate to this study as accessing students through schools may have compromised their anonymity should schools require parental consent to disseminate information.

4.10.1 Recruiting through Youth groups – LGBQ and Non LGBQ

To boost recruitment, early in the survey development (2019) both BeLonGTo and Youthwork Ireland Executive Directors were contacted via email and asked if they would assist with distribution of the survey link and advertising on social media and both agreed. This was achieved by sending the SurveyMonkey link via e mail to their national service providers and networks. When the survey was ready, the recruitment picture with the QR Code and link to the study were emailed to the organisations to circulate (See Appendix 8 for copy of recruitment e mail/ Flyer for Recruitment). As partnering with a community partner is considered highly effective with recruitment for surveys (Allison *et al.* 2012, Kosciw *et al.* 2015), all announcements of the survey that were available on social media were also sent through the groups email and networks as well as through national, regional, local organisations that provide services to or to advocate on behalf of LGBT youth. The weblink was also sent by e mail and social media to Foroige which run volunteer led youth groups for all adolescents that are not solely LGBQ specific.

In addition to emails to youth groups and organisations, other youth groups (See Appendix 9 List of Organisations Contacted for Recruitment) that are both LGBQ and non LGBQ focussed and that are active on social media were contacted via direct messaging on social media and email asking them to advertise and disseminate the link to the study via their contact lists and social media platforms.

4.10.2 Recruiting through Social Media – Twitter/ Facebook/ Instagram/ Snapchat

Previous Irish studies (Mayock *et al.* 2009, Higgins *et al.* 2011, Higgins *et al.* 2016, Pizmony-Levy and BeLonGTo 2019) have successfully used a variety of social media strategies to engage local and national LGBQ+ organisations to boost participation in studies. While some studies develop their own social media accounts, others use

existing accounts linked to personal and professional accounts. In this study existing social media accounts belonging to Youthwork Ireland, BeLonGTo, the School of Nursing and Midwifery (TCD) and the researcher were used to advertise the study. As these organisations had an established social media presence and had previously built-up a following, it was considered more prudent to use these instead of developing a study specific one.

The study information was shared on Facebook, Twitter and Instagram regularly for the first two weeks, with networks expanding as smaller youth groups shared and retweeted information about the study. Snapchat is the social media that adolescents in the sample age group are most active on. Following BeLonGTo's advice, paid advertisements were placed on this social media platform as it had proved highly successful for recruitment for the School Climate Study (Pizmony-Levy and BeLonGTo 2019). This proved to be the most successful method of recruitment for this study. After 24 hours of the advertisement running on Snapchat with significant engagement in the survey, an email was received from Snapchat administrators (see Appendix 10 Email from Snapchat Administrators) rejecting the advertisement. Reasons given were that it did not comply with their policy of only targeting over 18's for research studies and that they wished to be supplied with a Privacy Policy for data collected. Thus, while it was possible to continue with recruitment through this method, it did not meet with the aims of the study to collect data from over eighteens only.

A six-week time limit was placed on recruitment initially. Recruitment began on January 6th 2021, with the survey open until February 14th 2021. The deadlines for participation were clearly stated on the participant information sheet on the study. When the survey was live, activity was monitored to determine the number of respondents interacting with the study and two reminders were to be sent. The first reminder was sent at three weeks and the second was due to be sent a week before the survey was closing to remind potential respondents that the survey was going to close in one week.

After the first reminder was posted to Twitter by the researcher and retweeted by BeLonGTo, it was noted by the School of Nursing and Midwifery social media officer that there was some negative reaction to the posting. These negative tweets purported to be on child protection grounds, initially wondering why 13-year-olds were being asked some of the questions with screenshots of portions of the questions shared on Twitter, specific to anal sexual activity and the question "Have you ever had sex in exchange

for money or gifts?” and also posted screenshots of questions on gender identity asking questions “*Like what does this even mean- male or female should be the only options*”. Supervisors, Head of School of Nursing and Midwifery, Director of BeLonGTo and Director of Research in BeLonGTo were all informed and advice sought. The Director of Communications in BeLonGTo was then consulted. She advised that since October 2020 BeLonGTo social media accounts and postings have been targeted online by multiple Twitter accounts who have an anti-Transgender agenda. Their view seemed to be that trans young people should not exist and that children have a sex, not a gender. BeLonGTo have been tracking them and note that it is multiple Twitter accounts from a small number of individuals who predominantly communicate among themselves without gaining much traction from the public, usually citing a child welfare issue. BeLonGTo report that there was no reputational damage or fall in credibility for their organisation because of this activity. However, they advised that as an organisation they would not be engaging with the tweets or would not be removing the tweets, would continue to share the study information for the remainder for the study. It was also reported that some of these tweets previously threatened to maliciously complete research studies that were being run by BelonGTo but this had not occurred. Despite, reassurances on this, responses to the study on that date and after were monitored carefully for signs that there was malicious intent. Particular attention was paid to answers to questions on gender. Following a review of comments that were made on the survey during completion six surveys were removed before data analysis commenced.

The Head of School communicated that they were aware of the situation and was in full agreement with the research study and that it had the support of the school. The Communications Office in the University was also contacted (Appendix 11- email communication to Communications Office) and a response was received that they would be monitoring Twitter for any further communication or information on this. Over the course of twelve hours, the negative activity reduced and was minimal by the following day. However, one of the tweets that had been sent to SurveyMonkey © was picked up by them who replied to the tweet with a link to their Acceptable Use Policy. Two days later, I received an email from SurveyMonkey outlining that while the study met their overall guidelines, that it was not possible to conduct research with Under 18s in the Republic of Ireland on their site and they had shut down the weblink. They suggested that if the study was to continue then the inclusion criteria would need to be changed to include over eighteens only or a statement added that the survey was to be

undertaken only under the active supervision of a parent or legal guardian. At that point, a decision was made to leave the study closed.

Due to the nature of the different types of recruitment, Riggle *et al.* (2005) note that exact response rates in this type of study are difficult to calculate, but every effort was made to ensure that the recruitment for this study was extensive. Riggle *et al.* (2005) described two types of sampling errors in online surveys. The first kind, a coverage error, occurs when an unknown proportion of the target population do not have online access, so they are not sampled. In other words, a sampling error occurs when all those who do not have online access are not reached by recruitment. It is not known if this occurred. It is also a risk that adolescents who do not identify with the labels LGB might have been excluded (McDermott and Roen 2012). To try to avoid this, all the information advertising the study used the term questioning (Q), to show that the survey was also inclusive of this group of adolescents. Those who did not have internet access or did not wish to be seen to complete the survey for confidentiality reasons may also not have been recruited. However, these are unavoidable and using a weblink via open access was the optimal way to recruit a higher number of LGBQ adolescents for the study.

After the survey went live, a record was kept of the number of people that engaged with the surveys weekly and when the study closed (Table 4.5). In addition, details of time respondents spent on the survey was also reviewed continuously throughout. When the survey opened, the participant information stated that the survey could take up to 30 minutes to complete. After the first twenty-five full questionnaire responses were completed, it was noted that the average time for completion was 12 minutes so the information on the front of the survey was changed to 15 minutes reflect this.

Table 4.5: Number of responses at each week after recruitment

	1 week after recruitment began	2 weeks after recruitment began	3 weeks after recruitment began	4 weeks after recruitment began	5 weeks after recruitment began	Total number of responses/ engagements
Number who engaged with study – partial responses	7	14	58	303	Closed	303
Number of complete responses	0	4	25	99	Closed	99

4.11 Data Preparation

Following completion of data collection, to maintain data integrity, data was transferred from SurveyMonkey to IBM SPSS Statistics Version 25 following completion of data collection and cleaned in preparation for full analysis (IBM Corporation 2017). Data cleansing is necessary to maintain the quality in a study. It allows for errors to be systematically searched. A priority in data cleaning was to ensure respondents met the inclusion criteria such as aged 13-19 years. 303 surveys were exported from SurveyMonkey. Answering 'no' to any of the initial three questions in the survey meant the participant was excluded from completing the survey. However, these were still in data transferred from SurveyMonkey. A total of twelve responses were excluded by this route. In addition, six further responses were identified as rogue responses so were excluded, leaving a total final sample of 285 surveys to be reviewed. A code book was prepared in advance of this with information for each question indicating how the information was to be coded and analysed in SPSS and a data analysis plan developed. The preparation of this code book allowed for consistency in codes to be applied throughout. A data analysis plan was developed and tested in advance of data analysis to ensure that it was appropriate for method of data collection (Rattray and Jones 2007).

4.12 Data Analysis

Data was downloaded from Excel to SPSS and coded. Descriptive statistics were generated for each item initially. This allowed for an overall profile of responses to be

developed. It also allowed for a profile of respondents to be developed. Descriptive statistics included mean, median, percentage and range as appropriate. The initial variables generated for sources were the answers to topics (n=20) by each source (n=19) giving a total of 380 variables (See Table 4.6).

Table 4.6 Categories of Topics

Category	Number of Topics	Topics Included
Category 1 – Friendships and Sexual Orientation	4 topics	Sexual Attraction/ Orientation LGBQ Relationships Finding LGBQ friends Coming Out
Category 2 – Readiness for Safer Sex	6 topics	Pregnancy Contraception Sexually Transmitted Infections Safer Sex (condoms) What does it mean to consent to sexual activity and my rights? How to know I am ready for sex
Category 3- Sexual Behaviour/ Sexual Activity	10 topics	Kissing Cuddling Genital Touching Masturbation Oral Sex Vaginal Sex Anal Sex What to do during sex How to use safer sex aids How to use sex toys safely

The 19 sources were merged into 4 Groups. These were:

- 1) **Family Group of Sources** (Mother/ Female Guardian, Father/ Male Guardian, Siblings, Other Family Members).
- 2) **Peer Group of Sources** (Friends (LGBQ), Friends (non LGBQ), LGBQ Community, Youth Group, Sexual Partners).
- 3) **Professional Group of Sources** (Teacher/ School, Healthcare Professionals (GP/ Nurse/ Social Worker), Clergy/ Church, Sexual Health Professionals/ Clinic).
- 4) **Internet/ Media Group of Sources** (LGBQ focussed Internet Search, Non LGBQ focussed Internet Search, LGBQ Media, TV/Magazine/Film, Porn (pornography), Social Media).

In the survey, respondents were presented with three tables of topics categorised as per the table above with the nineteen sources listed in each and asked to indicate what sources, if any, they used for each topic (Appendix 4– Final Survey Sections). Thus, respondents only selected the sources they used. Due to the nature of this type of data, some sources and topics did not have an answer/reply recorded for them. Consequently, it was not possible to differentiate between missing data from a skipped question and non-selected responses. To conduct the first set of descriptive and inferential statistics related to sources and topics, data that was not present was recoded as not a source/topic. Therefore, the used and usefulness variables had two categories which were: yes, they were used /yes, they were useful and no which indicated that they were not used / not useful.

For the inferential statistics, bivariate analysis was carried out at five different levels. The level of significance was set at 0.05 for each level. The levels are outlined below.

Level 1 Individual topics by individual sources: For the first level of analysis the variables individual topic by individual sources were examined as they were collected. To examine differences among groups with variables measured at a nominal level, a Chi squared test of independence was conducted (Grove and Cipher 2020) for each individual topic and each individual source variable to explore the relationships between the variables such as if they were used/not used and useful / not useful and age (In categories 13-15 and 16-19, living location (city or large town and all other location) and gender at birth (Male and Female). All analysis were 2 times 2 tables. Therefore, the Yates Correction for Continuity output was used to correct for overestimation in 2 times 2 tables (Pallant 2007). For Chi squared tests, there is an assumption that the lowest expected frequency is 5 (Pallant 2007). In some cases, the frequency was less than 5 and in those cases the Fisher's Exact Probability Test was used to determine the significance (Field 2013). In addition, in the cases where there was no use of a source for a topic, no statistics can be reported. Therefore, for the 19 sources, 20 topics, for the two variables used / nor used, useful not useful, examined across the three variables, a total of 2280 tests were conducted in this first level of analyses.

Level 2: Category topics by individual sources: For the second level of descriptive and inferential analyses the twenty topics were merged into three categories: 1) Category 1 – Friendships and Sexual Orientation 2) Readiness for Safer Sex and 3)

Sexual Behaviour/ Sexual Activity (Table 6.2). This was done using the case-by-case function in data management in SPSS. This created an output that was scalar i.e. gave a count of the number of topics within a topic category that were used/ useful by each source. Descriptive statistics were then used to describe usefulness as per topic category by individual source (percentage and n).

These variables were then analysed inferentially using the Mann Whitney U test for association with age, living location, gender at birth, and used/not used and useful / not useful as the number of consultations per topic category and per source were not normally distributed (Field 2013). As the variables were not equal in number, the Mann Whitney U test was used to test for the difference between the two independent samples (Field 2013) In this instance, for the 19 sources, three topic categories, for the two variables used / nor used, useful not useful, examined across the three variables, a total of 342 tests were conducted in this second level of analyses.

Level 3: Individual Topics by all sources: In the third level of analysis all sources were merged per individual topic. Descriptive statistics were then used to describe the use and their usefulness per individual topic by all sources (percentage and n). For the inferential analysis, each variable was analysed for associations between the two variables used / nor used, useful /not useful and the three variables age, gender at birth and location using again the Mann-Whitney U test. For all sources combined and for each of the 20 topics, the use and usefulness of each topic was examined in each of the three variables, a total of 120 tests were conducted in this third level of analyses for each variable.

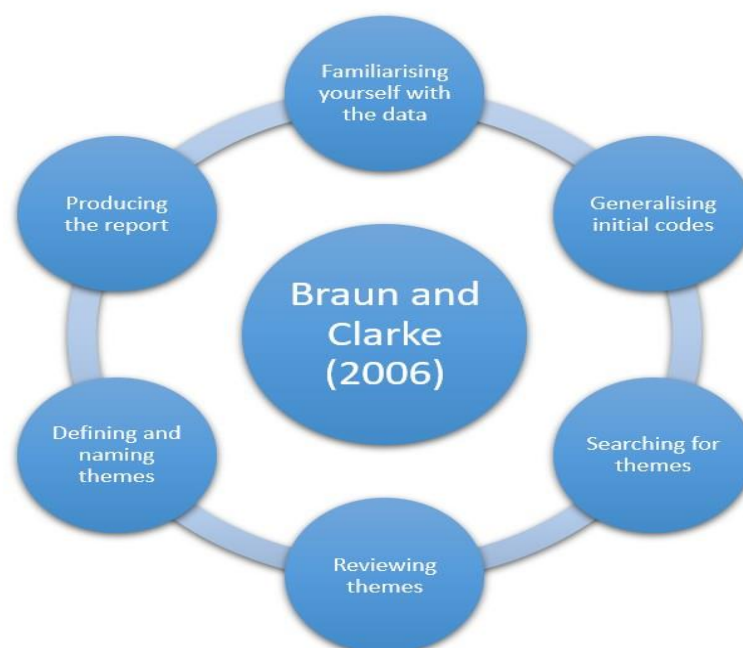
Level 4: Categorised Topics by all sources: In the fourth level of analysis the variable created was categorised topics by all sources merged. Descriptive statistics were then used to describe the use and their usefulness per categorised topics by all source (percentage and n). These variables were analysed using a Mann-Whitney U test for associations between the two variables used / nor used, useful/ not useful in the three variables age, gender at birth and location. Therefore, for all sources combined and for each of the three category topics, the use and usefulness of each topic was examined in each of the three variables, a total of 18 tests were conducted in this forth level of analyses for each variable.

Level 5 All topics by all sources: In the fifth level of analysis the variable created was all topics by all sources merged. These variables were analysed using a Mann-Whitney U test for associations between the two variables used / nor used, useful/ not useful in the three variables age, gender at birth and location. Therefore, for all sources combined (n=1), all topics combined (n=1), the use and usefulness of each topic was examined in each of the three variables, a total of 6 tests were conducted in this fifth level of analyses.

4.12.1 Data Analysis of Open-Ended Comments

While limited information was provided via the comments from the open-ended questions, it was still necessary to analyse the data systematically. Therefore, a modified version of Braun and Clarke (2006) phases of data analysis was used to categorise the data in codes and group them together as themes. In this framework, there are 6 steps. These are familiarising yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report (see Figure 4.4) It was not possible to develop subthemes due to the small number of comments. Therefore, the steps for reviewing, defining and naming themes were combined. The themes identified are presented in Chapter Five.

Figure 4.4. Braun and Clarke Analysis of Open-Ended Comments



4.13 Ethical Considerations

As the population were under eighteen, they are classed as a vulnerable group. This research focused on sexual development and activity, which are considered sensitive and potentially harmful topic to adolescents (Flanagan 2012). Therefore, additional protection and consideration of respondents was required in relation to the research process. The study was planned and conducted whilst adhering to the major ethical principles of respect for the person, beneficence and justice outlined in the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978). Therefore, the next section discusses how ethical approval was obtained, how respect for the person was achieved under the headings: autonomy and consent. In addition, avoiding harm and ensuring privacy are discussed under the heading beneficence. Finally, justice is reviewed and how every effort was made to ensure that all potential respondents were treated fairly, equally and had the benefit of partaking in the study.

4.13.1 Ethical Approval

Ethical approval was applied for after Draft 1 of the Survey was developed from the Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin in June 2019. Using online surveys also have challenges and opportunities in protecting the safety and confidentiality of vulnerable and hard to reach populations (Sterzing *et al.* 2018). Therefore, detailed information for both social media recruitment and online data collection was provided to the Ethics Committee. Documentation provided for the application included a completed ethics form (Appendix 12 Ethical Approval Letter), e mail and social media posters, the wording of online advertisements (Appendix 8), a list of the youth organisations to be contacted (Appendix 9) including how and where the link was to be shared and how many reminders there would be and for how long the link would be live for. Ethical approval was initially received from the Faculty of Health Sciences Ethics Committee in September 2019 (Appendix 12- Ethical Approval Letter One). Approval of amendments were sought and received in December 2019 for Draft 2 of the survey (Appendix 3). A further approval of amendments was received in June 2020 for content validity testing of Draft 2 (Appendix 13).

4.13.2 Respect for the person

Respect for the person is a cornerstone of ethical research (Green and Thorogood 2009). There are two areas to be addressed in relation to respect for the person: autonomy and consent.

4.13.2.1 Autonomy

While all research respondents should be treated as autonomous individuals, those that are younger are entitled to additional protection (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978). When designing the participant information, attention was paid to ensure that the information was freely available, age appropriate, clear and jargon free so that respondents could understand what the study entailed and what was expected of them in their participation. Therefore, respondents were fully informed of what their participation entailed and were free to decide to participate once they had received the email or the information provided with the survey link. As such, the autonomy of the respondents was maintained, and all participation was voluntary. Information on what the study entailed was sent via emails and social media to give prospective respondents an outline of the study but there was no face-to-face contact between researcher and respondents. Autonomy was promoted as respondents self-selected for this survey thus avoided coercion on behalf of the researcher. Advertising was done via e-mails to administrators and the social media accounts of youth groups (Appendix 8). Respondents decided for themselves if they wished to participate. The front page of the survey contained the Participant Information Leaflet (Appendix 4 – Final Survey Sections) and respondents were not allowed to commence the study until they had indicated that they had read the information.

Sterzing *et al.* (2018) acknowledge that issues may present with respondents not fully understanding a study's risks and benefits or their rights. However, for this study, the information at the beginning of the study was presented in small sections with short sentences for ease of reading. The information was also reviewed for clarity by the four groups of people who are familiar with adolescents and their capabilities and minor changes made.

4.13.2.1 Involvement of Parents

For those under eighteen, parental consent is generally needed to protect minors from involvement in research harmful to their wellbeing. Parents are legally responsible for their children's wellbeing and as a rule, both legally and ethically have a right to be informed when their children are asked to take part in research (Taylor 2008). However, there are many examples of previous research of LGBQ adolescents where parental consent for under 18s was waived as getting parental consent would have made them 'out' about their sexual orientation (Rotheram-Borus *et al.* 1995, Hillier *et al.* 1998, Hillier *et al.* 2005, Hillier *et al.* 2010, Mustanski 2011, Young and Rice 2011, Hillier *et al.* 2012, Masters *et al.* 2013, Gowen & Winges- Yanez 2014, Ybarra *et al.* 2014, Arrington- Sanders *et al.* 2015, Arbeit *et al.* 2016, Higgins *et al.* 2016, Ybarra *et al.* 2016, Nelson *et al.* 2019a, Nelson *et al.* 2019b, Mustanski *et al.* 2020).

Many LGBQ adolescents would not take part in research if a consent waiver was not present as it would mean disclosing their sexual orientation (coming out to parents) and may fear being open to potential victimisation as a result (Ybarra *et al.* 2016). If already out they may be uncomfortable discussing sexual health issues with their parents which could inhibit participation (Taylor 2008, Fisher and Mustanski 2014, Mustanski 2015, Fisher *et al.* 2016, Mustanski and Fisher 2016, Flores *et al.* 2018, Macapagal *et al.* 2017, Nelson *et al.* 2019a, Smith and Schwartz 2019). Newcomb *et al.* (2016) report that parents also believe that their permission should not be required in research with LGBQ adolescents. In addition, Bruce and Harper (2011) explain that seeking consent from parents would mean that the sample available would consist of only adolescents who are out to their parents and comfortable discussing their sexual orientation with parents. This could give a skewed sample and limit generalising results to a larger body of LGBQ adolescents (Fisher and Mustanski 2014, Mustanski and Fisher 2016, Macapagal *et al.* 2017).

4.13.2.2 Consent

Informed consent is a prerequisite for participation in research studies and adolescents can provide informed and voluntary consent, when given information in an age-appropriate format (Fisher *et al.* 2016). To enable consent to be informed, respondents

were provided with a briefing on the first page of the survey. This contained information on the online and anonymous nature of the study, the approximate time to complete the survey and that the survey did not collect personal information, so respondents should not include identifying information. They were also informed that some of the sections contained questions about sexual attraction and sexual activity in advance of taking the survey. Furthermore, respondents were informed that a list of support services were available at the end of the survey.

Once the respondents had read the information, they were requested to indicate they had read it and were consenting to participate in the study by ticking a box (Kosciw *et al.* 2015) and this ensured that anonymity was protected.

4.13.2.3 Beneficence

Beneficence requires that measures be taken to ensure the wellbeing of the study respondents is respected and risk is identified and minimised (Mustanski 2011, Ybarra *et al.* 2016, Arrington- Sanders *et al.* 2017, Flores *et al.* 2018). Beneficence was achieved in this study by minimising harm and ensuring privacy and confidentiality. However, it is important to note that there are no direct benefits to respondents taking part in the research except that they may become more aware of sources of information and topics on sexuality and sexual health.

4.13.2.4 Minimising Harm

All research studies aim to minimise harm to respondents of the study (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978). Online surveys are considered minimal risk for harm in research terms and LGBQ adolescents in Macapagal *et al.*'s (2017) study identified online surveys as their preferred method of data collection with LGBQ adolescents. In addition to the protections put in place during the approval process, the adolescents self-selected for the survey so they were not pressured or coerced to participate. Linking with local and national youth groups and LGBQ organisations minimises the risk further. Asking agencies to assist means that having a relationship, no matter how minimal with the research team, the adolescents involved in the study had a link/ route for assistance or support if they needed it.

Ethical approval including a parental waiver for consent, meant that respondents who were at different stages of disclosure were free to partake in the study without risk. However, in the absence of parental consent and awareness of their involvement in the study, strategies were also put in place to protect LGBQ adolescents from harm.

It has also been noted that even when parents are not asked for consent, some adolescents may choose to tell them about their involvement in a study (Ybarra *et al.* 2016). Therefore, it was recommended in the first instance that if people got upset during the study, those that could were advised to speak to their parents or GP. For those who were not comfortable in doing this, there were links provided at the end of the survey to LGBQ and sexual health services on 24-hour helplines and webpages. The researcher also provided a dedicated phone line and link to professional email at the beginning of the study that could be contacted if needed. In addition, a link to some background information on the School of Nursing and Midwifery Trinity Centre for Practice and Healthcare Innovation (TCPHI) website with a photograph of the researcher was provided on the participant information so that potential respondents could find further information on the study and be assured of the veracity of the project.

Asking sensitive questions online may also elicit emotional distress and in the absence of direct contact with the researchers, it was not possible to detect or address these after what may have been challenging questions (Sterzing *et al.* 2018). Therefore, it was ensured that clear participant information was provided in advance of the study, sensitive questions were signposted throughout the survey before respondents reached them with no compulsion to answer them and additional links were provided for both LGBQ and sexual health advice and services at the end of the survey. Kraut *et al.* (2004) also recommends that prior to distributing the survey, it is tested in a face-to-face setting to identify questions that may be distressing. This was not possible, but the LGBQ and sexual health experts contacted for content validity were asked for their views on the appropriateness of the questions. No comments were made, so the content was unchanged.

4.13.2.5 Privacy and Confidentiality

As previously stated, anonymous online surveys are in the 'minimal risk research' category. Minimal risk research is research that at most could cause emotional

discomfort or as risk goes does not exceed that experienced by respondents in their everyday lives (Taylor 2008, Flores et al. 2018). To lower the risk in relation to confidentiality and privacy, only minimal demographic information was requested from participants and all information gathered was downloaded and analysed collectively. Respondents were assured that all data collected was anonymous and would remain anonymous in research reports and publications.

To maintain safety and to ensure compliance with the principles of good research ethics, all data collected was transferred from the survey site to an external site before data analysis began as recommended by Bull *et al.* (2011). To protect the data, additional protection measures were put in place to ensure data was stored safely. This included storing data on a personal computer that was doubly encrypted, fitted with antivirus software and had a firewall applied. All the information gathered was password protected lowering the risk of breach of confidentiality (Riggle *et al.* 2005). An additional protection measure was put in place as the researcher purchased their own account on SurveyMonkey© that was doubly encrypted to ensure that it could not be accessed by others in the workplace and settings were changed to ensure that IP addresses were not recorded and linked to data collected.

General Data Protection Regulations (GDPR) were also complied with for the study. While no direct personal information was collected, there was some sensitive data collected. Therefore, the researcher was conscious of this and limited the number of personal items that could be used to identify an individual. Questions on gender, ethnicity and living location were kept as generic as possible while still collecting valuable data. No personal data was collected but to ensure that the information collected was GDPR compliant, participant information was reviewed by the college Data Protection Office and no issues arose.

4.13.2.6 Justice

The principle of justice states that all respondents must be treated equally and fairly. Additionally, no person or community should not be excluded from the benefits of research (Ybarra *et al.* 2016). Age has been unfairly used to exclude some individuals from research and ethics committees and researchers are duty bound to find ways to include marginalised people in research (Taylor 2008, Költő *et al.* 2021). Researchers have in the past only asked those over 18 years to partake in studies to avoid the pitfall

of ethics (Flores *et al.* 2018). Therefore, equality was ensured by allowing all LGBTQ adolescents under the age of 18 years to be included in the research. LGBTQ adolescents should be invited to take part in sexual health research, as there is a need to understand their experiences and lives. Excluding them may impede the creation of knowledge on their behalf (Flores *et al.* 2018). Justice was supported through efforts to include all adolescents, who would be affected by a lack of sexual health and sexuality information and efforts were made to recruit a diverse sample (Ybarra *et al.* 2016).

The benefits of taking part in the survey is that adolescents may recognise that they have gaps in their sexuality knowledge, and it may encourage them to seek further information (Labott *et al.* 2013, Magappell *et al.* 2017). They may also become more comfortable with their sexual orientation by reflecting positively on information that they have. The benefits of taking part in LGBTQ research were previously reported as a chance to discuss early same-sex sexual experiences, become aware of risky sexual behaviours, developing a sense of empowerment and comfort with one's sexual orientation (Arrington- Sanders *et al.* 2017, Schmitz *et al.* 2019). Taking part in the survey may have also allowed them to feel they have contributed or made a difference without any direct benefit to themselves (Macapagel *et al.* 2017) and allowed them to inform on LGBTQ adolescent information sources. It also means that they are respected as sexual persons and their autonomy is respected. In addition, the research is equitable by ensuring under eighteen's have an opportunity to participate and to have their voice heard without the necessity to out themselves to participate in the study (Flores *et al.* 2018). Thus, it was considered important to ensure justice that all adolescents were free to take part in the study.

Ensuring all populations have the possibility to share and promote the potential benefits of high-quality research to reduce health disparities is important (Arrington-Saunders *et al.* 2017). There is a lack of research on this population relative to other adolescents but while this is improving a lack of data from Ireland, United Kingdom and Europe on sources of information is evident the from the integrative review completed on this topic. This may limit healthcare professionals' ability to address health disparities in this population through primary prevention. Justice is therefore served when vulnerable groups are included and are not exploited or excluded from reaping the potential benefits of research (Mustanski 2011, Mustanski 2015). The goal of

waiving parental consent was therefore not to circumvent the parental authority and their ability to look out for the wellbeing of their children. Instead, it was to conduct scientific research that may improve the health of adolescents in cases where parental permission is not a reasonable requirement to protect participating adolescents (Taylor 2008, Mustanski 2011, Flores *et al.* 2018). This research advances the principle of respect for the person, beneficence and justice and the individuals and groups involved receive the benefits of research and do not bear any burden. Thus, the independence of research was maintained and conflicts of interest were avoided/ made explicit.

4.14 Conclusion

This chapter presents the methodology and methods that were developed for this study which was to determine the sources of information and topics on sexuality and sexual health, that LGBTQ adolescents aged 13-19 in Ireland use to get information. The overall philosophical assumptions and postpositivist approach which supported the research methodology utilised in this study were presented. Details on the research design, survey design were also presented. The research methods were then discussed, presenting information on the population, sample and recruitment for this study. The steps in designing a survey and data collection using the survey were outlined. Due to the impact of Covid19 on the study, validity was established using a Content Validity Index using PPI to ensure the survey was appropriate and steps taken for this were also described. Detail of data analysis is provided with a variety of statistical tests used to provide a comprehensive picture of sources of information and topics used with the usefulness of each source for a topic determined. Qualitative data analysis is also described. The chapter concluded with the ethical considerations for the study presented to ensure the rights of the adolescents were upheld throughout the study.

5 Descriptive Findings

5.1 Introduction

This chapter describes the findings of a web-based questionnaire on LGBQ adolescent's sources of information on sexuality and sexual health. These findings are generated from 284 eligible questionnaire responses from LGBQ adolescents aged 13-19 in the Republic of Ireland. While the overall aim of the study was to obtain an understanding of LGBQ adolescents (age 13-19) information seeking behaviour, information needs and sources of information and their usefulness in relation to sexuality and sexual health, there were four specific objectives for this study.

These objectives were to:

- identify sources of information and their usefulness that LGBQ adolescents of secondary school age (13-19) use in relation to sexuality and sexual health,
- ascertain how useful LGBQ adolescents find the sources of information in relation to sexuality and sexual health,
- discover which sources of information and their usefulness that LGBQ adolescents use for different topics, such as Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/Activity and
- identify the impact of demographic variables on the sources of information that are used and are considered useful by LGBQ adolescents.

This chapter is divided into several sections. The chapter commences with two sections on the response to the questionnaire and sociodemographic profile. Respondents' reported access to the Internet, history of pregnancy, sexually transmitted infections and whether respondents exchanged sex for money or gifts is also included. The core statistical results in relation to the sources of information (objective 1) and usefulness (objective 2) of the sources of information, are divided into three sections, Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/ Sexual Activity. This chapter concludes with responses to the open-ended questions.

Within this chapter, the term ‘minority’ is used to describe results of 20% or less, ‘majority’ is used to describe results over 50% and below 70% and the term ‘vast majority’ is used to describe a percentage of 70% and over.

5.2 Total Number of Responses to Questionnaire

In total 303 people responded to the questionnaire. To progress into the questionnaire from the introductory page, there were three initial questions that had to be answered with a **YES** response (see Table 5.1 below). These questions were

Table 5.1 Compulsory Questions on Introductory Page of the Survey

Q1	<i>Declaration: Before beginning the survey, please confirm that you have read the survey information on the previous page. I confirm I have read the previous page. (Please note this is a compulsory question).</i>
Q2	<i>I confirm that I am aged between 13-19 and I live in the Republic of Ireland. (Please note this is a compulsory question).</i>
Q3	<i>I consent to participate (Please note this is a compulsory question).</i>

Seven people answered **NO** to one or more of these questions which excluded them from completing the remainder of the questionnaire. A review of all answers identified another twelve responses that were excluded based on apparent contradictory responses. These included being too old for inclusion in the survey, indicating that they were male at birth but had also been pregnant, and stating that they were currently aged thirteen but was aged 54 leaving school. In total, two hundred and eighty-four (n=284) responses were included for data analysis. As the number of responses to each of the questions varied, the number of responses per question for data analysis also varied. The number of responses per question is included in the information provided per question.

5.3 Sociodemographic Profile of Population

This section describes the sociodemographic profile of the respondents according to their age, gender, sex at birth, geographical location, living arrangements, education and ethnic or cultural background. The questions used to obtain this information were Questions 42 to 50 (Appendix 4- Final Draft of the Survey Sections). As these questions were placed at the end of the questionnaire there was some attrition. A total

of 93 people (33% of respondents) answered these questions, and this number is used unless otherwise stated in the descriptions below.

5.3.1 Age

As seen in Table 5.3, the number of respondents were very evenly distributed across all age groups, from 13-19 years. There were 11.8% (n=11) at age 13, 16, and 17, with the highest percentage of 18.3% (n=17) at age 19. For the descriptive and bivariate analysis, participants were grouped into 2 age groups, 13-15 and 16-19 to represent middle and late adolescence.

5.3.2 Gender Identity and Gender at Birth

There were 92 responses to the question asking What is your gender identity, the majority of respondents identified as female (including trans) (59.8%, n=55), with 22.8% (n=21) identifying as male (including trans). Another 7.6% (n=7) identified as gender non-binary and 1.1% (n=1) was gender non-conforming. None (0 %) stated that they identified as gender queer. Another 8.7% (n=8) indicated that they did not understand or relate to any of the gender identities listed. Instead, they described themselves using the following descriptions (See Table 5.2).

Table 5.2 – Additional gender identity information provided by respondents.

<i>I am female but think I am trans</i>
<i>I don't label my gender as anything and just use gender neutral pronouns</i>
<i>Prefer not to say</i>
<i>Genderfluid- identify as male, female and non-binary</i>
<i>Female that prefers men's clothes</i>
<i>I am somewhere between female and non- binary</i>
<i>Agender</i>
<i>I am also questioning genderfluid but for convenience I just identify as female</i>

When asked what their gender was at birth, the vast majority (80.6%, n=75) indicated that it was female, with 19.4% (n=18) stating that it was male. This finding differed to the gender that the respondents identified with as there were twenty additional females when asked what gender they identified with and two less males.

5.3.3 Ethnicity

There were 92 responses to this question, of which 77.2% (n=71) indicated they were White Irish. Twelve percent (12%, n=11) were also white but from another background. An equal number of 2.2% (n=2) stated they were Black African and White Irish Traveller respectively. Another 5.4% (n=5) reported being from Other Ethnic or Cultural Background. The descriptions used for this were Mixed, African-Asian, White-European, White Irish – lived abroad and White-Polish. No one selected that they were of Asian background (Table 5.3).

5.3.4 Geographical Location and Living Arrangements

Similar numbers reported that they lived in a city/ large town (31.2, n=29), small town/village (34.4%, n=32) and in the countryside rural (34.4%, n=32). A vast majority of the 92 respondents (88%, n=81) lived in the family home, while 9.8% (n=9) lived away from home in rented or other accommodation. Another 2.2% (n=2) stated that they had other living arrangements. While one did not provide any detail regarding this, one other respondent stated they lived on a farm (Table 5.3).

5.3.5 Education

The vast majority (98.9%, n=92) were attending school/ college. Of the 92 that indicated what stage in school they were at, 43.5% (n=40) were in junior cycle in secondary school, 28.3% (n=26) were in senior cycle in secondary school and 22.8% (n=21) were in university/ third level. A further 5.4% (n=5) reported they were doing technical or further education (i.e., PLC course). One person (1.1%) stated that they were no longer in education and were eighteen years of age when they left school (Table 5.3).

Table 5.3– Sociodemographic Information of the respondents

Question		Values (n)	Percentage
Age (7 groups) n=93 (32.7% of total population)	Aged 13	n=11	11.8%
	Aged 14	n=16	17.2%
	Aged 15	n=15	16.1%
	Aged 16	n=11	11.8%
	Aged 17	n=11	11.8%
	Aged 18	n=12	12.9%
	Aged 19	n=17	18.3%
Gender identity (6 groups) n=92 (32.4% of total population)	Male (including trans)	n=21	22.8%
	Female (including trans)	n=55	59.8%
	Gender non-binary	n=7	7.6%
	Gender non-conforming	n=1	1.1%
	Gender queer	n=0	0%
	Do not understand/ or relate	n=8	8.7%
Gender at birth (2 groups) n=93 (32.7% of total population)	Male	n=18	19.4%
	Female	n=75	80.6%
	Other (please specify)	n=0	0%
What is your ethnic or cultural background? (8 groups) n=92 (32.4% of total population)	White- Irish	n= 71	77.2%
	White Irish Traveller	n= 2	2.2%
	White – any other background	n= 11	12.0%
	Black – African	n= 2	2.2%
	Black- Any other background	n= 1	1.1%
	Asian- Chinese	n= 0	0%
	Asian- Any other Asian Background	n= 0	0%
	Other (write in description)	n= 5	5.4%
Geographical location (3 groups) n= 93(32.7% of total population)	City/ large town	n=29	31.2%
	Small town/ village	n=32	34.4%
	In the countryside (rural)	n=32	34.4%
Living Arrangements (5 groups) n=92 (32.4% of total population)	Family home	n=81	88.0%
	Live away from home (rented or other accommodation)	n=9	9.8%
	None of these/ please tell us	n=2	2.2%
	Direct provision centre	n= 0	0%

	Homeless/ using homeless services	n=0	0%
Are you in education (school/ college)? (2 answers) n=93 (32.7% of total population)	Yes	n= 92	98.9%
	No	n=1	1.1%
What stage of school college are you at? (4 groups) n=92 (32.4% of total population)	I am in junior cycle	n=40	43.5%
	I am in senior cycle	n=26	28.3%
	I am at university/ third level	n=21	22.8%
	I am doing technical or further education i.e., PLC course	n= 5	5.4%
What age were you when you left school/ college?	Open ended answer	n= 1	Age 18

5.4 Sexual Attraction/ Orientation

This section describes the information respondents gave about their sexual attraction/orientation, age of first awareness of sexual attraction and how they feel now about their sexual attraction/ orientation. The questions utilised to elicit the information from respondents were questions 4,5, 6 and 7 in the questionnaire (Appendix 4 – Final Draft of the Survey Sections).

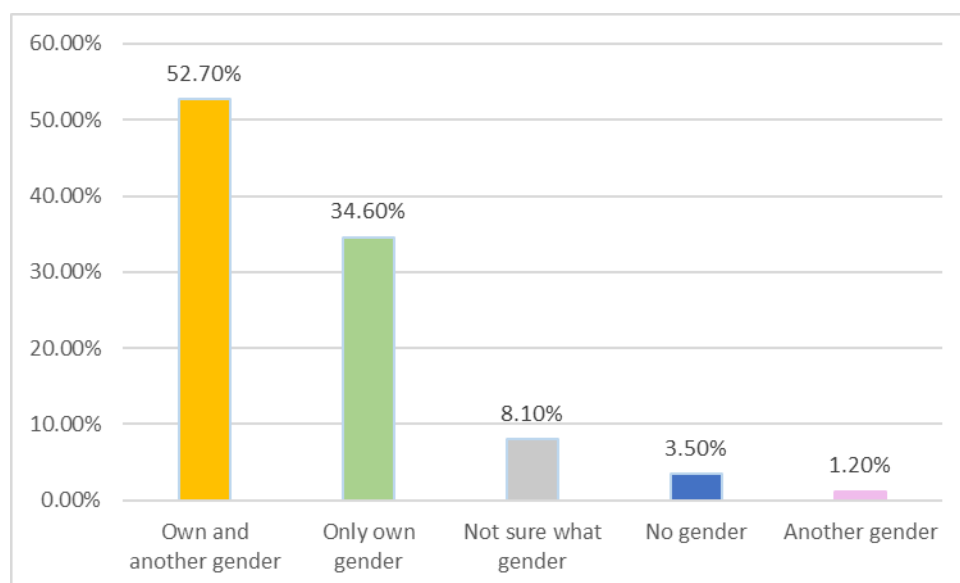
5.4.1 Sexual Attraction/ Orientation

Respondents were asked to select from five statements and an additional ‘Other’ option what best represented their sexual attraction/ orientation (Table 5.4). Of the 260 that answered the question, the majority (52.7%, n=137) reported that they were attracted to their own and another gender, with 34.6% (n=90) reporting they were attracted to their own gender only. A total of 8.1% (n=21) were not sure what gender they were attracted to and 3.5% (n=9) reported they were attracted to no gender. Another 2% (n=3) stated they were attracted to another gender only but did not specify what that gender was (Figure 5.1).

Table 5.4 Sexual Attraction/ Orientation (n=260)

	N=	%
Own and another gender	137	52.7%
Only own gender	90	34.6%
Not sure what gender	21	8.1%
No gender	9	3.5%
Another gender	3	1.2%

Figure 5.1 Sexual Attraction/ Orientation (%)



In addition, at the end of the survey, there was additional comments relating to sexual orientation/ attraction

“I think I’m bi but I have never kissed a boy to know if I could be lesbian, but I still think they’re attractive”

Another comment was on the perceived lack of options when answering the survey on sexuality and sexual orientation.

“For one of the multiple choice question at the beginning on sexuality, there wasn’t an option for my sexuality. I identify as demisexual, meaning in my case that I am unable to experience any attraction towards a person without forming a deep emotional bond. It is on the asexual spectrum, but they are not the same. For me, being demisexual makes it very difficult to know what genders I am attracted to, because I am very rarely attracted to people, so at the moment I simply identify at demisexual panromantic”.

Of the 239 respondents who answered the open question on the age they became aware of their sexual orientation, 195 (81.9%) reported that they were they were between the ages of 10 and 14 years when they became aware of their sexual orientation (Table 5.5). This was an open question where respondents could write down any age. The ages provided by respondents in the answer to this question ranged from 1-19. As the age of one is too young to remember, this answer was excluded from analysis as it was considered erroneous which left 238 responses. Twelve (12) years of age was the most common response (mode) (25.2%, n=60), the mean age of awareness was 12 years, and the median age was 11.5 years.

Table 5.5 Age of First Awareness of Sexual Attraction/ Orientation (n = 238)

Age Range	Frequency (n=)	Percentage (%)
Ages 4-9	22	9.3%
Ages 10- 14	195	81.9%
Ages 15-19	21	8.8%

5.4.2 Feelings about Sexual Attraction/ Orientation

Respondents were asked how they felt 'now' about their sexual attraction/ orientation. Out of the 259 responses given to this question, the most common response was pretty good (31.3%, n=81), 74 (28.6%) respondents reported that they felt 'great' and the same number (n=74, 28.6%) reported that they felt 'OK'. A minority of respondents (8.9%, n=23) reported they felt 'pretty bad' and another seven (2.7%) reported feeling 'really bad'. (Table 5.6).

Table 5.6: How do you feel now about your sexual orientation? (n=259)

	N=	%
Great	74	28.6%
Pretty good	81	31.3%
OK	74	28.6%
Pretty bad	23	8.9%
Really bad	7	2.7%

5.5. Access to the Internet

Two questions were asked in the section looking for information on respondents' use of the Internet. These were the location where respondents accessed the Internet and what device they used primarily to access the Internet.

5.5.1. Location where respondents accessed the Internet

All respondents to this question (n=97, 100%) reported mainly accessing the Internet at home (Table 5.7).

Table 5.7- Location where respondents most often accessed the Internet. (n=97)

At Home	100% (n=97)
At School	0% (n=0)
At College	0% (n=0)
Internet café	0% (n=0)
Library	0% (n=0)
Other	0% (n=0)

5.5.2 Which of the following do you mainly use to access the Internet?

Of those who answered the question on the device most often used to access the Internet (n=97), 89.7% (n=87) stated that they mainly used a smartphone to access the Internet. Another 8.2% (n=8) used a personal computer or laptop and 2.1% (n=2) used a tablet. No other options were chosen for this question (Table 5.8).

Table 5.8- Device most often used to access the Internet (n=97)

Smartphone	89.7% (n=87)
Personal computer/laptop	8.2% (n=8)
Tablet	2.1% (n=2)
Gaming device/ kindle	0% (n=0)
Other	0% (n=0)

5.6 Sexual History

In the section on sexual history, respondents were asked three questions related to previous experience. These were on pregnancy, sexually transmitted infections and whether they ever had sex in exchange for money or gifts. To answer the question, respondents were given a yes, no or prefer not to answer option to respond.

5.6.1 Pregnancy

All the respondents indicated that they had not been pregnant (see Table 5.9).

Table 5.9- Have you ever been pregnant? (n=96)

Yes	0% (n=0)
No	100% (n=96)
Prefer not to answer	0% (n=0)
Total	100.% (n=96)

5.6.2 Sexually Transmitted Infections

Similarly, 96.8% (n=93) reported that they had never had a sexually transmitted infection (STI). 3.2% (n=3) reported that they had an STI previously (Table 5.10). Two of these were female aged 19 and the other was male aged 18.

Table 5.10 - Have you ever had a sexually transmitted infection? (n=96)

Yes	3.2% (n=3)
No	96.8% (n=93)
Prefer not to answer	0% (n=0)

5.6.3. Have you ever had sex in exchange for money or gifts?

Out of the 98 respondents who answered this question, 4.1% (n=4) reported that they had sex in exchange for money or gifts, with 93.9% (n=92) stating that they had not. Another two percent (2% n=2) chose the prefer not to answer option (Table 5.11). From the four who indicated that they had sex in exchange for money or gifts, one provided no demographic information. The other three respondents were two males (both assigned female at birth) and one female. All of the three that provided this information stated they were aged 13-14. This raised issues regarding the safety of these adolescents but as the survey was anonymous and as no additional information was available, it was not possible to identify or follow up on these comments. However, this was discussed with BelongTo team and information on suitable support services was available at the end of the survey that could be accessed by respondents.

Table 5.11- Have you ever had sex in exchange for money or gifts? (n=98)

Yes	4.1% (n=4)
No	93.9% (n=92)
Prefer not to answer	2% (n=2)

5.7 Topics and Sources of Information

As discussed previously in Chapter Two during an integrative review, twenty topics on sexuality and sexual health relevant to LGBTQ adolescents were identified. The twenty topics were grouped together into the following three separate categories: Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/ Sexual Activity. Table 5.12 below shows the number and types of topics that were grouped together.

Table 5.12 Number and Types of Topics in Each Category Table

Category Tables	Number of Topics	Topics Included
Category 1 – Friendships and Sexual Orientation	4 topics	Sexual Attraction/ Orientation LGBQ Relationships Finding LGBQ friends Coming Out
Category 2 – Readiness for Safer Sex	6 topics	Pregnancy Contraception Sexually Transmitted Infections Safer Sex (condoms) What does it mean to consent to sexual activity and my rights? How to know I am ready for sex
Category 3- Sexual Behaviour/ Sexual Activity	10 topics	Kissing Cuddling Genital Touching Masturbation Oral Sex Vaginal Sex Anal Sex What to do during sex How to use safer sex aids How to use sex toys safely

In the same integrative review nineteen sources of information used by LGBTQ adolescents, aged 13-19, to find information on sexuality and sexual health were identified. These were combined into four groups: namely Family group sources (mothers, fathers, siblings, other family members); Peer group sources (friends

(LGBQ), friends (non LGBQ), LGBQ community, youth group, sexual partners); Professional group sources (teacher/ school, healthcare professionals (GP/ nurse/ social worker), clergy/church, sexual health services/clinic) and Internet/media group sources (LGBQ focussed Internet, general Internet, LGBQ media, TV/ magazines/film, pornography (porn), social media- blogs/discussion/ posts).

In the questionnaire, the topics were combined with the sources and respondents were asked to identify the sources of information that they received information from on each topic regardless of usefulness. Combining the nineteen sources with twenty topics provided 380 initial questions to be analysed. Therefore, the results for sources of information are presented in three sections using the three category titles as a guide: i) Friendships and Sexual Orientation- Sources of Information, ii) Readiness for Safer Sex-Sources of Information and iii) Sexual Behaviour/ Sexual Activity- Sources of Information. The same nineteen sources were used consistently in each of the three tables with different topics in each. There was no limit placed on how many sources a respondent could chose for a topic. Therefore, for– Friendships and Sexual Orientation, respondents had 76 options to choose from. For Readiness for Safer Sex, respondents had 114 choices and for Sexual Behaviour/ Sexual Activity there was 190 options available to choose. For each topic, reported sources of information are presented using the most common sources chosen using a table and a figure with percentages.

After selecting a source, respondents were directed to follow up questions where they were asked to rate the usefulness of the sources using the options of useful/ not useful. There was no compulsion to answer questions on usefulness. Therefore, even though respondents ticked a source, not all answered the questions on usefulness. Thus, the information presented is specific to each question and uses numbers (n=) from those who answered the questions. Usefulness of sources for each topic are presented using a figure which shows the difference between the number who reported using the source and those who found it useful. In addition, to ensure clarity all information is presented at the end of the category section with a table on the most common sources (Primary and Secondary sources) and another on the number of people who reported the sources as useful.

5.8 Category One: Friendships and Sexual Orientation Sources of Information

In the category called Friendship and Sexual Orientation, there were four topic headings. These were “*Sexual Attraction/ Orientation*”, “*LGBQ relationships*”, “*Finding LGBQ friends*” and “*Coming Out*”. These topics all related to the stage adolescents were at when negotiating the early stages of sexual orientation, trying to get support and coming out as LGBQ person. 164 respondents completed this category. As it was possible for respondents to select numerous topics and sources for this, there were 76 options for each respondent to select.

5.8.1 Sources of Information on Sexual Attraction/ Orientation

For the topic “*Sexual Attraction/ Orientation*”, the most common sources were within the Internet/ Media group. Respondents reported using four of the six sources listed to access information on “*Sexual attraction/ orientation*”: LGBQ focussed Internet search (57.9%, n=95), General Internet Search (50.6%, n=83), LGBQ Media (51.8%, n=85) and Porn (50.6%, n=83). (Table 5.13)

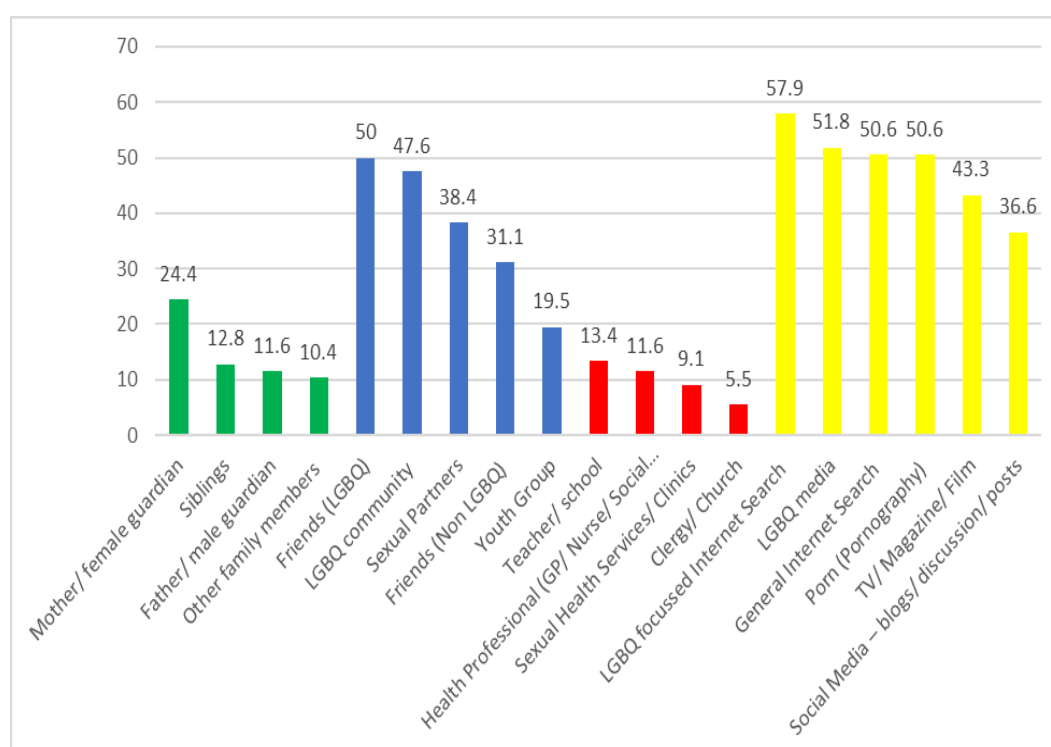
Peers, particularly LGBQ Friends (50%, n=82) and LGBQ community (47.6%, n=78) were reported as secondary sources (the second most common source) of information on “*Sexual Attraction/ Orientation*” (Figure 5.2). Sexual Partners (38.4%, n=63) and non-LGBQ Friends (31.1%, n=51) were also used. A minority of respondents indicated that Youth Group (19.5%, n=32) was a source of information on “*Sexual attraction/ orientation*”.

Family and professional sources were the least used sources of information on “*Sexual Attraction/ Orientation*”. Among family members, mothers/female guardians were the most used source at 24.4% (n=40). A minority reported Other Family Members as a source of information. In addition, professionals were also reported by a minority as a source of information, which was the least used group of sources. Of the professional group, Teachers/school were the most used source. However, it was by a minority of respondents (13.4%, n=22). (Figure 5.2).

Table 5.13 Sources of Information on Sexual Attraction/ Orientation

Family Group Sources	
Mother/ female guardian	24.4% (n=40)
Siblings	12.8% (n=21)
Father/ male guardian	11.6% (n=19)
Other family members	10.4% (n=17)
Peer Group Sources	
Friends (LGBQ)	50% (n=82)
LGBQ community	47.6% (n=78)
Sexual Partners	38.4% (n=63)
Friends (Non LGBQ)	31.1 (n=51)
Youth Group	19.5% (n=32)
Professional Group Sources	
Teacher/ school	13.4% (n=22)
Health Professional (GP/ Nurse/ Social Worker)	11.6% (n=19)
Sexual Health Services/ Clinics	9.1% (n=15)
Clergy/ Church	5.5% (n=9)
Internet/ Media Group Sources	
LGBQ focussed Internet Search	57.9% (n=95)
LGBQ media	51.8 (n=85)
General Internet Search	50.6% (n=83)
Porn (Pornography)	50.6% (n=83)
TV/ Magazine/ Film	43.3% (n=71)
Social Media – blogs/ discussion/ posts	36.6% (n=66)

Figure 5.2 Sources of Information for Sexual Attraction/ Orientation (%)



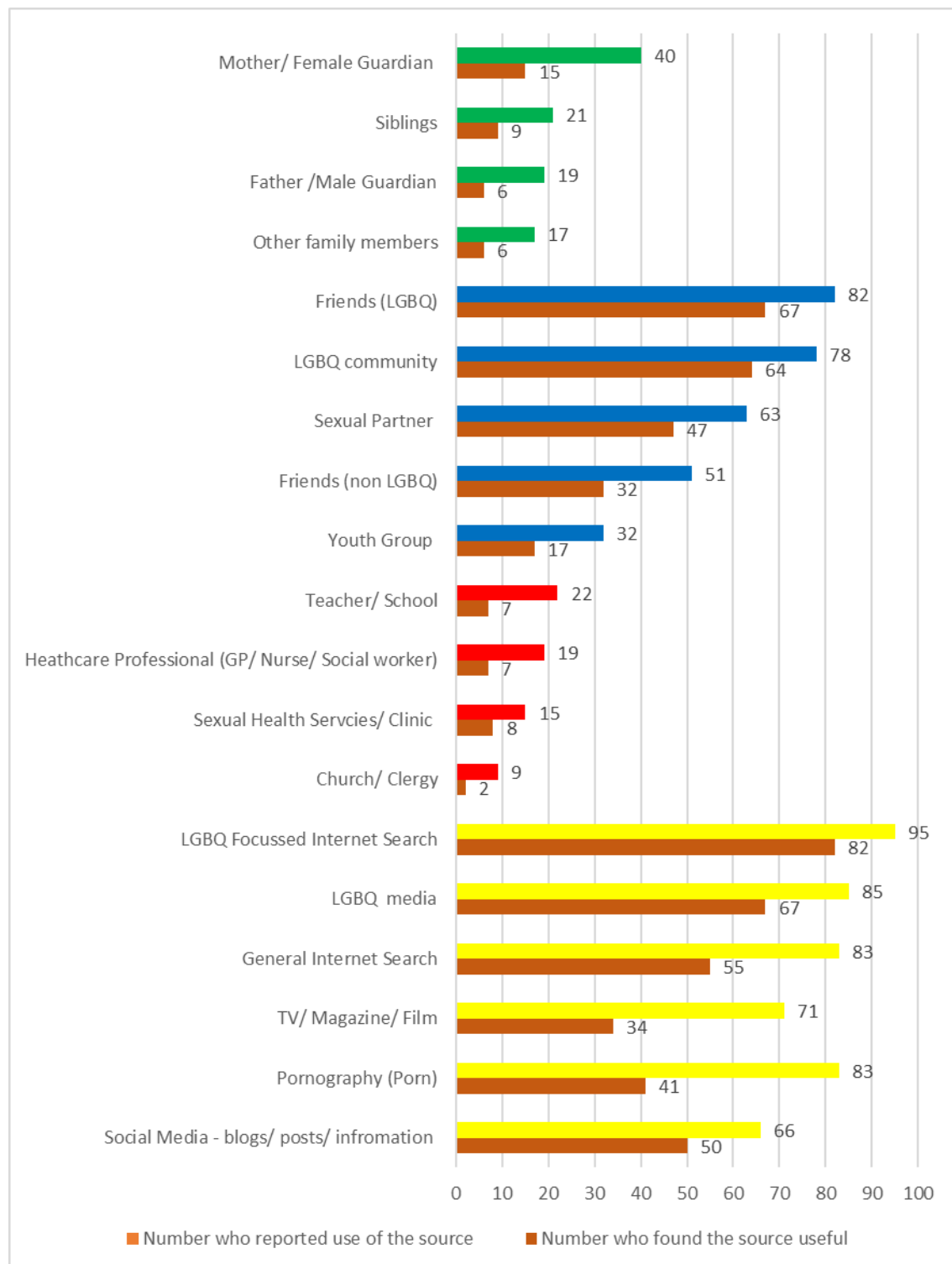
Note: For all tables and figures: Green denotes Family group sources, Blue represents Peer group sources, Red denote Professional group sources and Yellow signifies Internet/ media group sources.

5.8.2 Usefulness of Sources of Information on Sexual Attraction/ Orientation

In terms of usefulness, as well as being the most used source, LGBQ focussed Internet search was also reported as the most useful source (Figure 5.3) with 82 out of 90 (91.1%) respondents indicating that they found it useful. Other sources within the Internet/ Media category were considered much less useful, with less than half of the respondents stating they were useful for information on “*Sexual attraction/ orientation*”. For this topic, one of the most common sources was Porn (pornography) which was a source of information for 50.6% (n=83) of respondents (Table 5.17). However, it was only considered useful by 54.6% (41 out of 75) of those respondents. For other sources, the sources that were reported as being used most often were also reported as being the most useful sources.

Family group sources and professional group sources while the least used sources, were also reported as the to be the least useful. Approximately, 50% who indicated family and professionals as a source also indicated that they were not useful. In the case of mother/ female guardian, siblings, teacher/ school and clergy/church more respondents reported these sources as less useful than useful (Figure 5.3).

Figure 5.3- Usefulness of Sources of Information on Sexual Attraction/ Orientation (n).



***Note figures include only those who indicated the usefulness / non usefulness of the source on the topic of sexual attraction**

5.8.3 Sources of Information on LGBQ Relationships

“*LGBQ relationships*” was the second topic within the category Friendships and Sexual Orientation. LGBQ friends were reported as the primary (most used) source of information on “*LGBQ relationships*” with a majority of 65.2% (n=107) indicating that they used them as a source of information (Table 5.14). The LGBQ community (48.2%, n=79) was also a frequent source of information. Other sources of information within the peer group are reported less frequently (Figure 5.4)

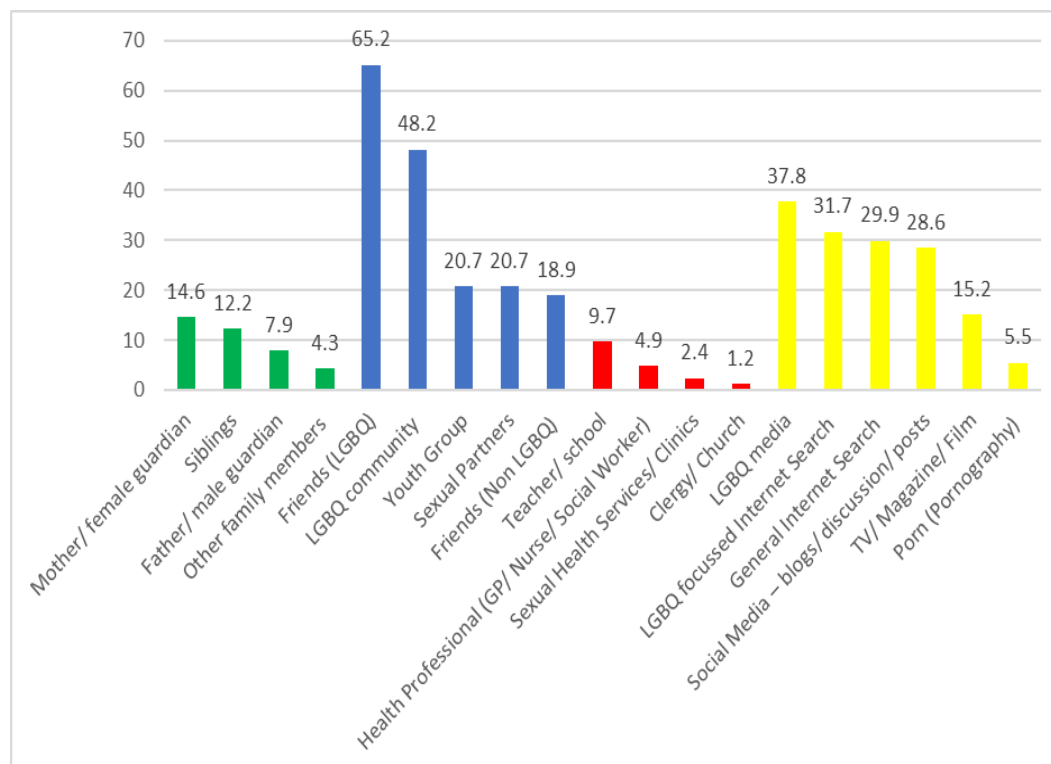
In contrast to the sources of information on “*Sexual attraction/ orientation*”, Internet/ Media sources were reported less as a source of information for “*LGBQ relationships*”. LGBQ media (37.8%) was reported as a source of information most often within this category with the other sources reported less.

Sources in the Family and Professional Group were used by a small minority of respondents as a source of information on “*LGBQ relationships*”. The Mother/ female guardian was the highest source reported within the family group at 14.6% (n=24), with the Teacher/school being the highest in the professional group (Figure 5.4).

Table 5.14- Sources of Information on LGBQ relationships

Family Group Sources	
Mother/ female guardian	14.6% (n=24)
Siblings	12.2% (n=20)
Father/ male guardian	7.9% (n=13)
Other family members	4.3% (n=7)
Peer Group Sources	
Friends (LGBQ)	65.2% (n=107)
LGBQ community	48.2% (n=79)
Youth Group	20.7% (n=34)
Sexual Partners	20.7% (n=34)
Friends (Non LGBQ)	18.9% (n=31)
Professional Group Sources	
Teacher/ school	9.7% (n=16)
Health Professional (GP/ Nurse/ Social Worker)	4.9% (n=8)
Sexual Health Services/ Clinics	2.4% (n=4)
Clergy/ Church	1.2% (n=2)
Internet/ Media Group Sources	
LGBQ media	37.8% (n=62)
LGBQ focussed Internet Search	31.7% (n=52)
General Internet Search	29.9% (n=49)
Social Media – blogs/ discussion/ posts	28.6% (n=47)
TV/ Magazine/ Film	15.2% (n=25)
Porn (Pornography)	5.5% (n=9)

Figure 5.4: Sources of Information for LGBQ Relationships (%)

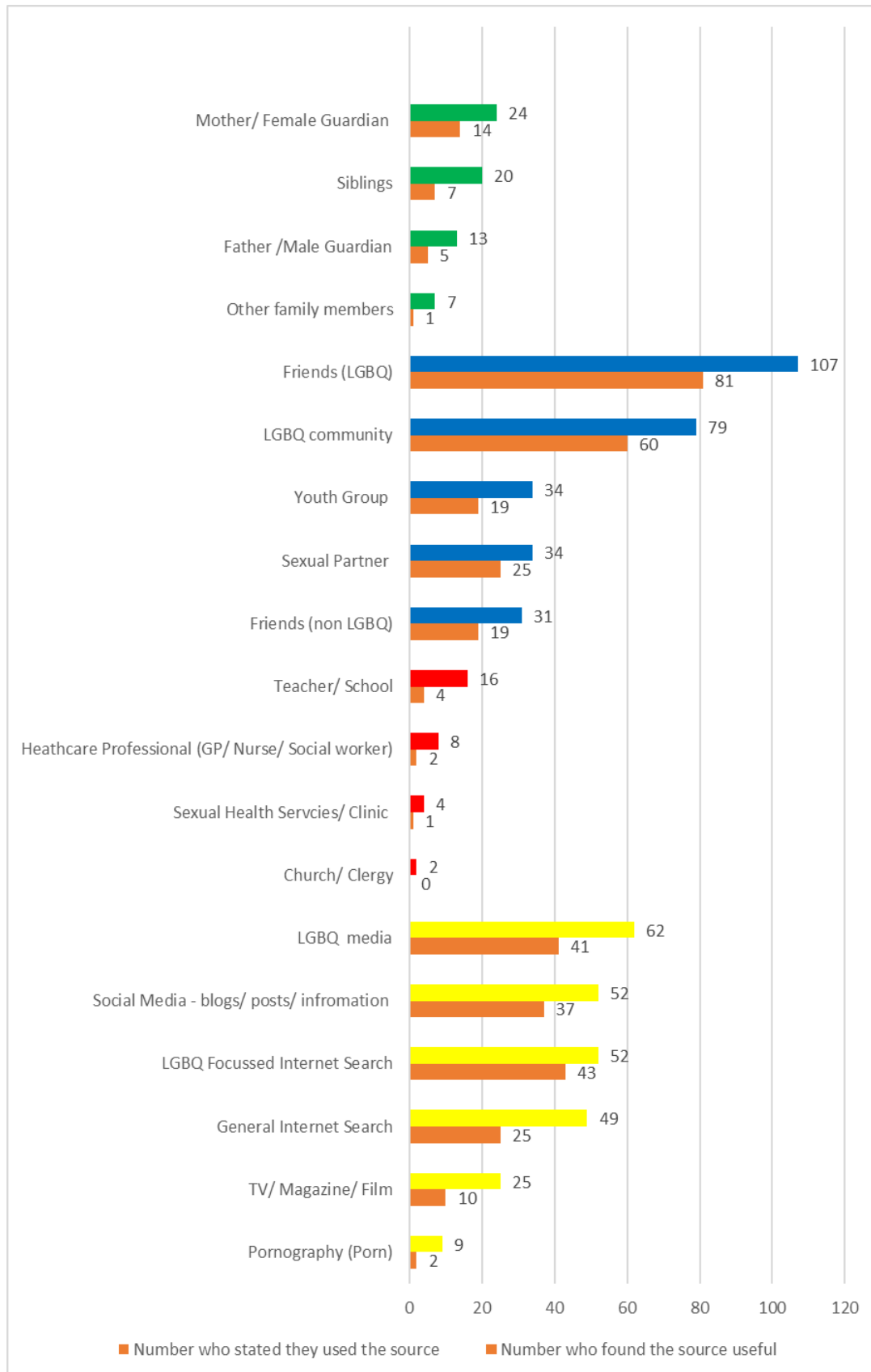


5.8.4 Usefulness of Sources of Information on LGBQ Relationships

In relation to the usefulness of sources of information on “*LGBQ Relationships*”, respondents indicated that as well as being the primary sources, LGBQ friends (81%, n=81 out of 100) and the LGBQ Community (89%, n=60 out of 67) were also the most useful sources (Table 5.17). However, while LGBQ Internet Search was not reported as one of the most used sources for getting information on “*LGBQ relationships*”, 86% (43 out of 50) of those that reported using it as a source also stated it was a useful source (Table 5.17).

Family, Professionals, Non LGBQ Friends, TV/magazine/film and Porn while limited as source of information were also considered not useful by respondents for information on “*LGBQ relationships*” (Figure 5.5).

Figure 5.5- Usefulness of Sources of Information on LGBTQ Relationships



5.8.5 Sources of Information on Finding LGBQ Friends

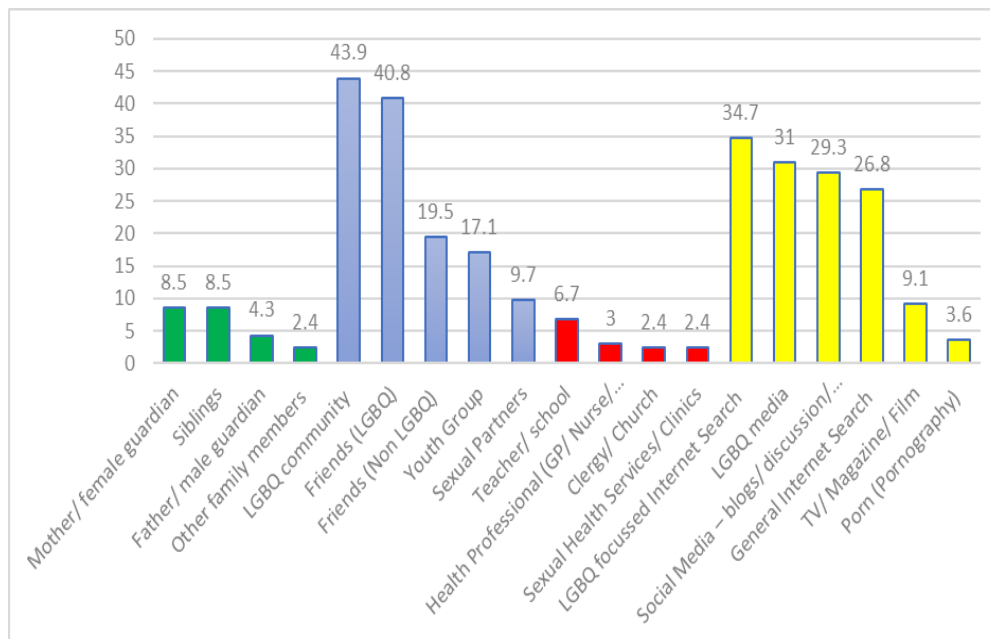
For this topic, the LGBQ community was the primary (most used) source of information (43.9%, n=72), with LGBQ friends (40.8%, n=67) the secondary (second most reported) source. The other secondary (third most reported) source is LGBQ focussed Internet Search (34.7% =57). Other Peer group sources, namely Non LGBQ friends (19.5%, n=32), Youth group (17.1%, n=28) and Sexual Partners (9.7%, n=16) were reported less frequently as a source of information on “Finding *LGBQ friends*” (Table 5.15).

Sources within the Family and Professional group were reported by a minority of respondents, with 8.5% (n=14) reporting Mother/ female guardian and Siblings as a source of information on “*Finding LGBQ friends*”. Teachers were considered a source by 6.7% (n=11). Other sources in these two groups had less respondents that considered them as a source of information. The Internet/ Media category, TV/ magazine/film (9.1%, n=15) and Porn (pornography) (3.6% n=6) were considered by a minority as a source of information (Figure 5.6).

Table 5.15- Sources of Information on Finding LGBQ Friends

Family Group	
Mother/ female guardian	8.5% (n=14)
Siblings	8.5% (n=14)
Father/ male guardian	4.27% (n=7)
Other family members	2.4% (n=4)
Peer Group	
LGBQ community	43.9% (n=72)
Friends (LGBQ)	40.8% (n=67)
Friends (Non LGBQ)	19.5% (n=32)
Youth Group	17.1% (n=28)
Sexual Partners	9.7% (n=16)
Professional Group	
Teacher/ school	6.7% (n=11)
Health Professional (GP/ Nurse/ Social Worker)	3.0% (n=5)
Clergy/ Church	2.4% (n=4)
Sexual Health Services/ Clinics	2.4% (n=4)
Internet/ Media Group	
LGBQ focussed Internet Search	34.7% (n=57)
LGBQ media	31.0% (n=51)
Social Media – blogs/ discussion/ posts	29.3% (n=48)
General Internet Search	26.8% (n=44)
TV/ Magazine/ Film	9.1% (n=15)
Porn (Pornography)	3.6% (n=6)

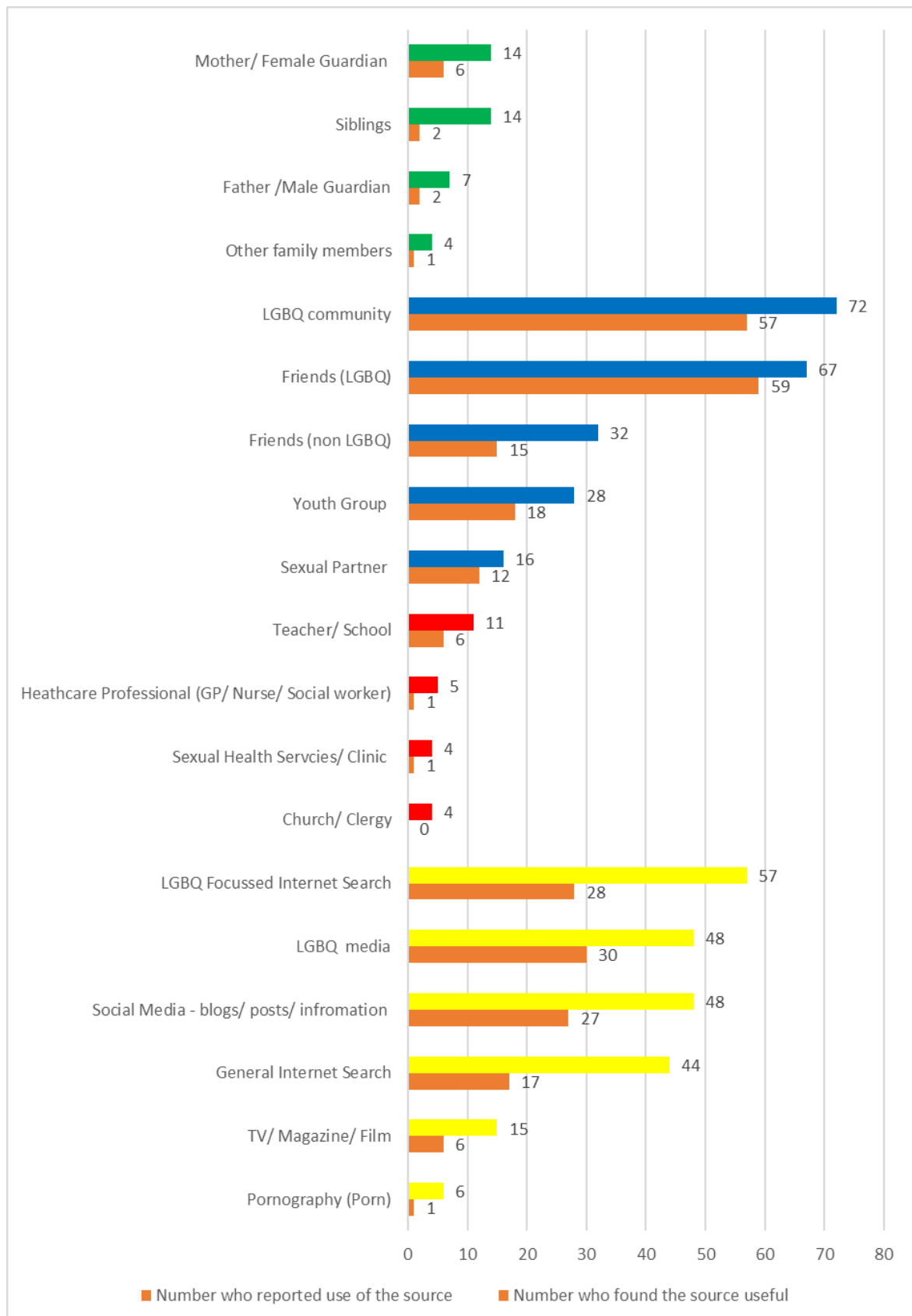
Figure 5.6– Sources of Information on Finding LGBTQ Friends (%)



5.8.6 Usefulness of Sources of Information on Finding LGBTQ Friends:

The most useful source of information for “*Finding LGBTQ Friends*” was LGBTQ Friends. While 67 respondents stated that LGBTQ friends was a source of information, 59 respondents out of 63 (93.6%) that answered the question on usefulness, stated that LGBTQ friends were useful sources of information and 57 people out of 67 (85%) considered the LGBTQ community to also be useful (Table 5.17). LGBTQ Focussed Internet search was considered useful by 28 people out of 51 (55%) and social media was considered useful by 27 people out of 46 (59%). The sources in all of the other groups were considered to be less useful on “*Finding LGBTQ friends*” (Figure 5.7).

Figure 5.7- Usefulness of Sources of Information on Finding LGBTQ Friends (n=)



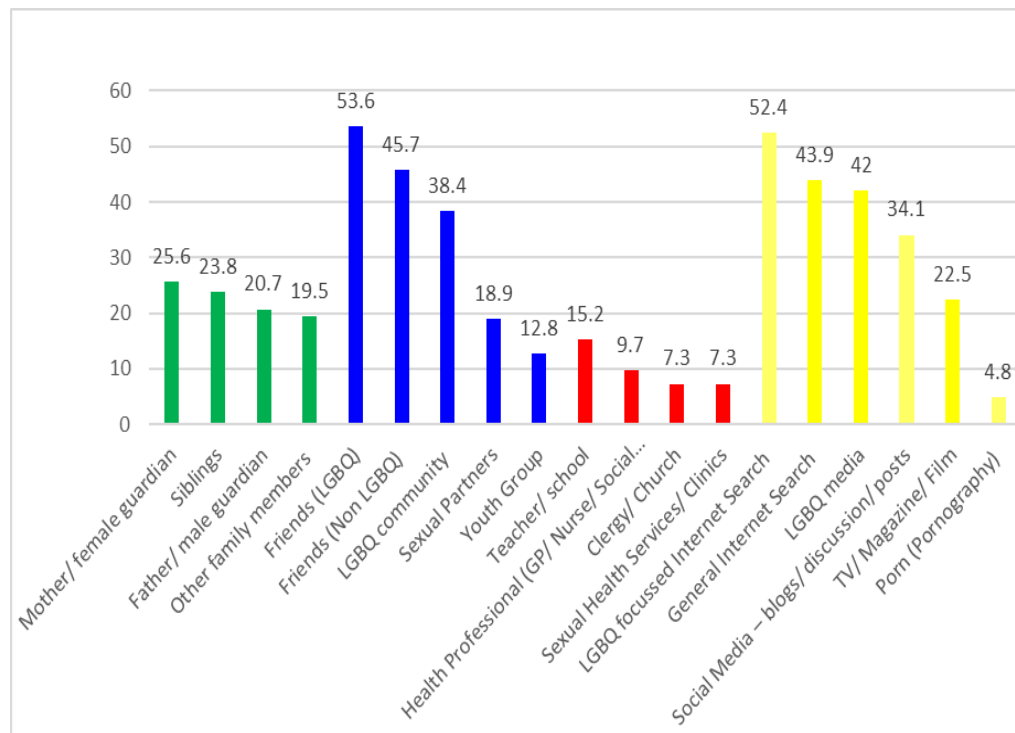
5.8.7 Sources of Information on Coming Out

The primary sources of information (reported most often) on “*Coming Out*” were LGBQ Friends (53.6%, n=88) (Table 5.16). This was followed by LGBQ Focussed Internet Search (52.4%, n=86) and non-LGBQ Friends (45.7%, n=75). In comparison to the previous topics in the category of Friendship and Sexual Orientation (“*Sexual Attraction/ Orientation*”, “*LGBQ Relationships*” and “*Finding LGBQ Friendships*”), the Family Group were reported more frequently as a source of information on the topic “*Coming Out*”. Out of this group, Mother/female guardian were reported as the most used source of information with 25.6% (n=42) reporting them as a source. The Professional Group was reported by less respondents as a source of information than other groups. Teachers were the most reported professional but only by a minority of respondents (15.2%, n=25) (Figure 5.8)

Table 5.16 Sources of Information on Coming Out

Family Group Sources	
Mother/ female guardian	25.6% (n=42)
Siblings	23.8% (n=39)
Father/ male guardian	20.7% (n=34)
Other family members	19.5% (n=32)
Peer Group Sources	
LGBQ Friends	53.6% (n=88)
Non LGBQ Friends	45.7% (n=75)
LGBQ community	38.4% (n=63)
Sexual Partners	18.9% (n=31)
Youth Group	12.8% (n=21)
Professional Group Sources	
Teacher/ school	15.2% (n=25)
Health Professional (GP/ Nurse/ Social Worker)	9.7% (n=16)
Clergy/ Church	7.3% (n=12)
Sexual Health Services/ Clinics	7.3% (n=12)
Internet/ Media Group Sources	
LGBQ focussed Internet Search	52.4% (n=86)
General Internet Search	43.9% (n=72)
LGBQ media	42.0% (n=69)
Social Media – blogs/ discussion/ posts	34.1% (n=56)
TV/ Magazine/ Film	22.5% (n=37)
Porn (Pornography)	4.8% (n=8)

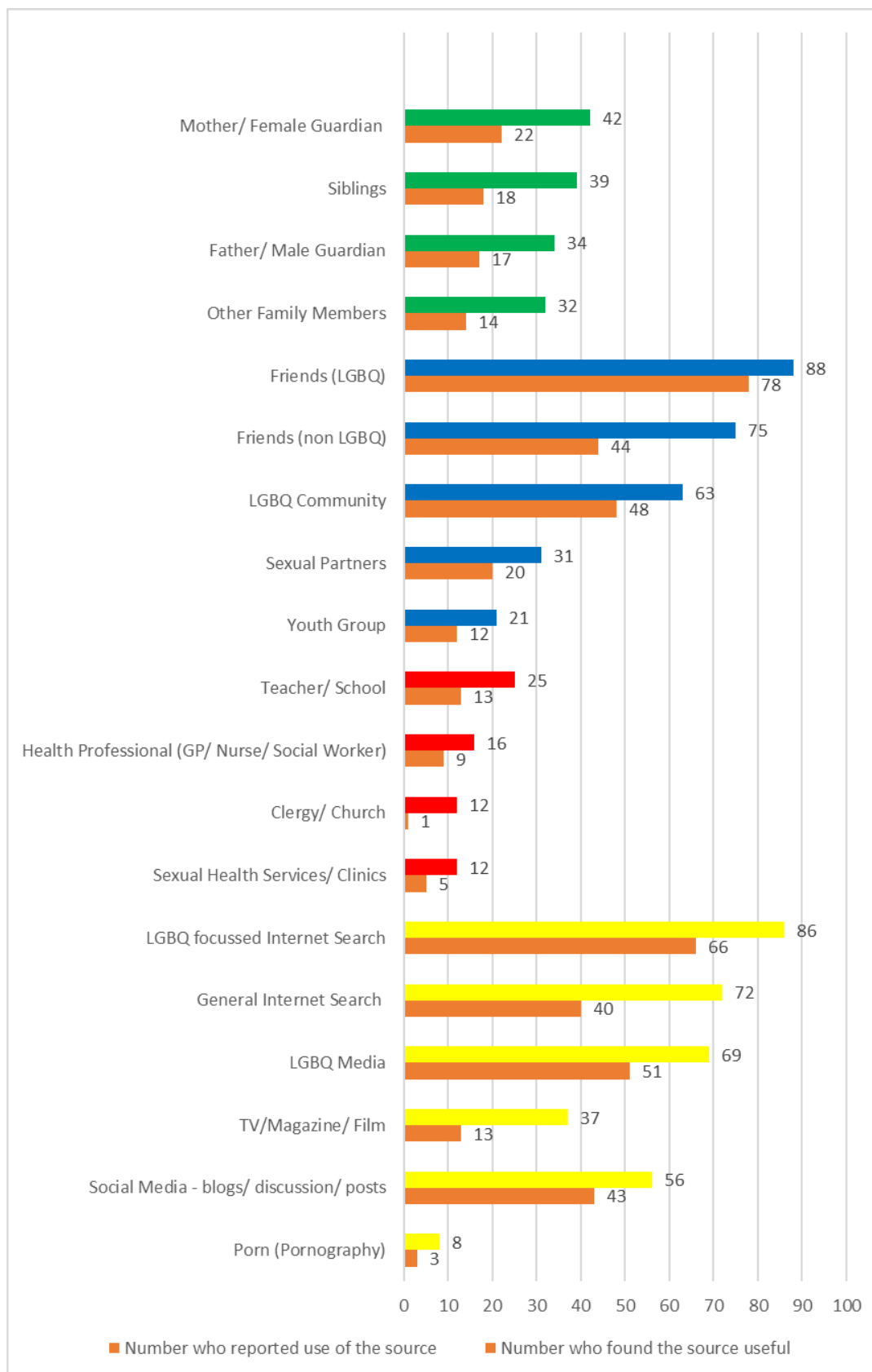
Figure 5.8- Sources of Information on Coming Out (%)



5.8.8 Usefulness of Sources of Information on Coming Out

In terms of usefulness, as well as being the most frequently reported source of information on “*Coming Out*”, LGBQ friends were the most useful with 78 out of 86 (90.7%) respondents stating they were useful (Table 5.17). LGBQ focussed Internet Search was also considered a useful source with 66 out of 78 (84.6%) reporting it useful. Despite Non- LGBQ friends being reported as the third most used source of information, it was considered useful by less respondents than LGBQ Media with 51 people out of 61 (83.6%) indicating that it was a useful source. (Figure 5.9). Non LGBQ friends were only judged useful by 69.8% (44 out of 63) respondents. The other sources were all considered less useful.

Figure 5.9 Usefulness of Sources of Information on Coming Out (n=)



5.8.9 Friendships and Sexual Orientation: Additional Topics and Sources

In response to the open-ended question on sourcing information on topics or using sources not included in the survey, seventeen respondents replied. Four stated 'no' or 'n/a' in their response. Others stated that they sought information on asexuality (three people). Two respondents sought information on homophobia and how to deal with homophobia families and another looked for information on gay shame. Three respondents stated that they sought information on sexual orientation and what it means to be gay and how to know that one is gay. Another stated they took an Internet sexual orientation test while another respondent looked up LGBTQ+ history, rights, vocabulary and gender identity. In addition, two people indicated they looked up information on how gay (one person) and lesbian (one person) sex works. In terms of sources of information respondents indicated that books and fiction novels were also a source of information on Friendships and Sexual Orientation.

5.8.10 Summary of Sources of Information and Usefulness on the Category Friendships and Sexual Orientation

When all the subtopics within the category Friendships and Sexual Orientation are displayed collectively as per Table 5.17 and Table 5.18, the primary sources for these topics were LGBTQ Specific Sources, which were LGBTQ Friends and LGBTQ Community for three of the topics ("*LGBQ Relationships*", "*Finding LGBQ Friends*" and "*Coming Out*") and LGBTQ focussed Internet Search for information on "*Sexual Attraction/ Orientation*" as a topic. Family members and Professionals were reported as a source of information by the minority of respondents for all topics. Outside of these sources, the only different source identified as one of the most common sources was Porn (pornography) which was a source of information for 50.6% (n=83) of respondents on "*Sexual Attraction/ Orientation*". However, it was only considered useful by 54.6% (41 out of 75) of those respondents. With the other sources, the sources of information reported most often also tended to be the most useful ones. All of the sources for the topic of "*Sexual Attraction/ Orientation*" were in the Internet/ Media Group of Sources which are less interpersonal than the other ones. The sources in the other topics were more intimate/personal sources than these.

Table 5.17 Sources of Information for Topics on the Category Friendships and Sexual Orientation (n=164)

Source of Information		Sexual attraction/ orientation	LGBQ Relationships	Finding LGBQ friends	Coming Out
Family	Mother/ female guardian	24.4% (n=40)	14.6% (n=24)	8.5% (n=14)	25.6% (n=42)
	Father/ male guardian	11.6% (n=19)	7.9% (n=13)	4.27% (n=7)	20.7% (n=34)
	Siblings	12.8% (n=21)	12.2% (n=20)	8.5% (n=14)	23.8% (n=39)
	Other family members	10.4% (n=17)	4.3% (n=7)	2.4% (n=4)	19.5% (n=32)
Peer Group	Friends (LGBQ)	50% (n=82)	65.2% (n=107)	40.8% (n=67)	53.6% (n=88)
	Friends (Non LGBQ)	31.1% (n=51)	18.9% (n=31)	19.5% (n=32)	45.7% (n=75)
	LGBQ community	47.6% (n=78)	48.2% (n=79)	43.9% (n=72)	38.4% (n=63)
	Youth Group	19.5% (n=32)	20.7% (n=34)	17.1% (n=28)	12.8% (n=21)
	Sexual Partners	38.4% (n=63)	20.7% (n=34)	9.7% (n=16)	18.9% (n=31)
Professional	Teacher/ school	13.4% (n=22)	9.7% (n=16)	6.7% (n=11)	15.2% (n=25)
	Health Professional (GP/ Nurse/ Social Worker)	11.6% (n=19)	4.9% (n=8)	3.0% (n=5)	9.7% (n=16)
	Clergy/ Church	5.5% (n=9)	1.2% (n=2)	2.4% (n=4)	7.3% (n=12)
	Sexual Health Services/ Clinics	9.1% (n=15)	2.4% (n=4)	2.4% (n=4)	7.3% (n=12)
Internet/ Media	LGBQ focussed Internet Search	57.9% (n=95)	31.7% (n=52)	34.7% (n=57)	52.4% (n=86)
	General Internet Search	50.6% (n=83)	29.9% (n=49)	26.8% (n=44)	43.9% (n=72)
	LGBQ media	51.8 (n=85)	37.8% (n=62)	31.0% (n=51)	42.0% (n=69)
	TV/ Magazine/ Film	43.3% (n=71)	15.2% (n=25)	9.1% (n=15)	22.5% (n=37)
	Porn (Pornography)	50.6% (n=83)	5.5% (n=9)	3.6% (n=6)	4.8% (n=8)
	Social Media – blogs/ discussion/ posts	36.6% (n=66)	28.6% (n=47)	29.3% (n=48)	34.1% (n=56)

Table 5.18 – Sources of Information and Usefulness for Topics on the Category Friendships and Sexual Orientation (n=164)

Source of Information		Sexual attraction/ orientation	Usefulness	LGBQ Relationships	Usefulness	Finding friends	LGBQ Usefulness	Coming Out	Usefulness
Family Group Sources	Mother/ female guardian	24.4% (n=40)	45.4% (15 out of 33)	14.6% (n=24)	63.6% (14 out of 22)	8.5% (n=14)	50% (6 out of 12)	25.6% (n=42)	62.8% (22 out of 35)
	Father/ male guardian	11.6% (n=19)	42.8% (6 out of 14)	7.9% (n=13)	50% (5 out of 10)	4.27% (n=7)	33.3% (2 out of 6)	20.7% (n=34)	56.6% (17 out of 30)
	Siblings	12.8% (n=21)	56.2% (9 out of 16)	12.2% (n=20)	43.7% (7 out of 16)	8.5% (n=14)	16.7% (2 out of 12)	23.8% (n=39)	54.5% (18 out of 33)
	Other family members	10.4% (n=17)	42.8% (6 out of 14)	4.3% (n=7)	20% (1 out of 5)	2.4% (n=4)	33.3% (1 out of 3)	19.5% (n=32)	50% (14 out of 28)
Peer Group Sources	Friends (LGBQ)	50% (n=82)	87% (67 out of 77)	65.2% (n=107)	81% (81 out of 100)	40.8% (n=67)	93.6% (59 out of 63)	53.6% (n=88)	90.7% (78 out of 86)
	Friends (Non LGBQ)	31.1% (n=51)	72.7% (32 out of 44)	18.9% (n=31)	67.8% (19 out of 28)	19.5% (n=32)	51.7% (15 out of 29)	45.7% (n=75)	69.8% (44 out of 63)
	LGBQ community	47.6% (n=78)	88.9% (64 out of 72)	48.2% (n=79)	89.5% (60 out of 67)	43.9% (n=72)	85% (57 out of 67)	38.4% (n=63)	82.7% (48 out of 58)
	Youth Group	19.5% (n=32)	58.6% (17 out of 29)	20.7% (n=34)	63.3% (19 out of 30)	17.1% (n=28)	64.3% (18 out of 28)	12.8% (n=21)	60% (12 out of 20)
	Sexual Partners	38.4% (n=63)	81% (47 out of 58)	20.7% (n=34)	80.6% (25 out of 31)	9.7% (n=16)	80% (12 out of 15)	18.9% (n=31)	68.9% (20 out of 29)

Source of Information		Sexual attraction/ orientation	Usefulness	LGBQ Relationships	Usefulness	Finding LGBQ friends	Usefulness	Coming Out	Usefulness
Professional Group	Teacher/ school	13.4% (n=22)	33.3% (7 out of 21)	9.7% (n=16)	30.8% (4 out of 13)	6.7% (n=11)	66.6% (6 out of 9)	15.2% (n=25)	65% (13 out of 20)
	Health Professional (GP/ Nurse/ Social Worker)	11.6% (n=19)	46.6% (7 out of 15)	4.9% (n=8)	28.6% (2 out of 7)	3.0% (n=5)	25% (1 out of 4)	9.7% (n=16)	45% (9 out of 13)
	Clergy/ Church	5.5% (n=9)	25% (2 out of 8)	1.2% (n=2)	0% (0 out of 1)	2.4% (n=4)	0% (0 out of 3)	7.3% (n=12)	10% (1 out of 10)
	Sexual Health Services/ Clinics	9.1% (n=15)	61.5% (8 out of 13)	2.4% (n=4)	33.3% (1 out of 3)	2.4% (n=4)	33.3% (1 out of 3)	7.3% (n=12)	50% (5 out of 10)
Internet/ Media Group Sources	LGBQ focussed Internet Search	57.9% (n=95)	91.1% (82 out of 90)	31.7% (n=52)	86% (43 out of 50)	34.7% (n=57)	54.9% (28 out of 51)	52.4% (n=86)	84.6% (66 out of 78)
	General Internet Search	50.6% (n=83)	74.3% (55 out of 74)	29.9% (n=49)	61% (25 out of 41)	26.8% (n=44)	42.5% (17 out of 40)	43.9% (n=72)	62.5% (40 out of 64)
	LGBQ media	51.8 (n=85)	87% (67 out of 77)	37.8% (n=62)	73.2% (41 out of 56)	31.0% (n=51)	62.5% (30 out of 48)	42.0% (n=69)	83.6% (51 out of 61)
	TV/ Magazine/ Film	43.3% (n=71)	50.7% (34 out of 67)	15.2% (n=25)	45.4% (10 out of 22)	9.1% (n=15)	46.1% (6 out of 13)	22.5% (n=37)	40.6% (13 out of 32)
	Porn (Pornography)	50.6% (n=83)	54.6% (41 out of 75)	5.5% (n=9)	28.5% (2 out of 7)	3.6% (n=6)	20% (1 out of 5)	4.8% (n=8)	50% (3 out of 6)
	Social Media – blogs/ discussion/ posts	36.6% (n=66)	83.3% (50 out of 60)	28.6% (n=47)	78.7% (37 out of 47)	29.3% (n=48)	58.7% (27 out of 46)	34.1% (n=56)	76.8% (43 out of 56)
Primary		Most common source of information							
Secondary		2 nd most common source of information							
Secondary		3 rd most common source i							

5.9 Category Two: Readiness for Safer Sex

The category Readiness for Safer Sex refers to the information that is needed for a LGBTQ young person to prepare for safer sex and the topics associated with that. The topics within this category are “Pregnancy”, “Contraception (apart from condoms)”, “Sexually Transmitted Infections”, “Safer Sex (condoms)”, “What it means to Consent for Sexual Activity and my Rights” and “How to know I am Ready for Sex”. Respondents were presented with the list of nineteen sources and the six topics and asked to choose the sources of information that they received information from on each topic regardless of usefulness. Each respondent had the option of choosing 114 responses. This table was completed by 116 respondents.

5.9.1 Sources of Information on Pregnancy

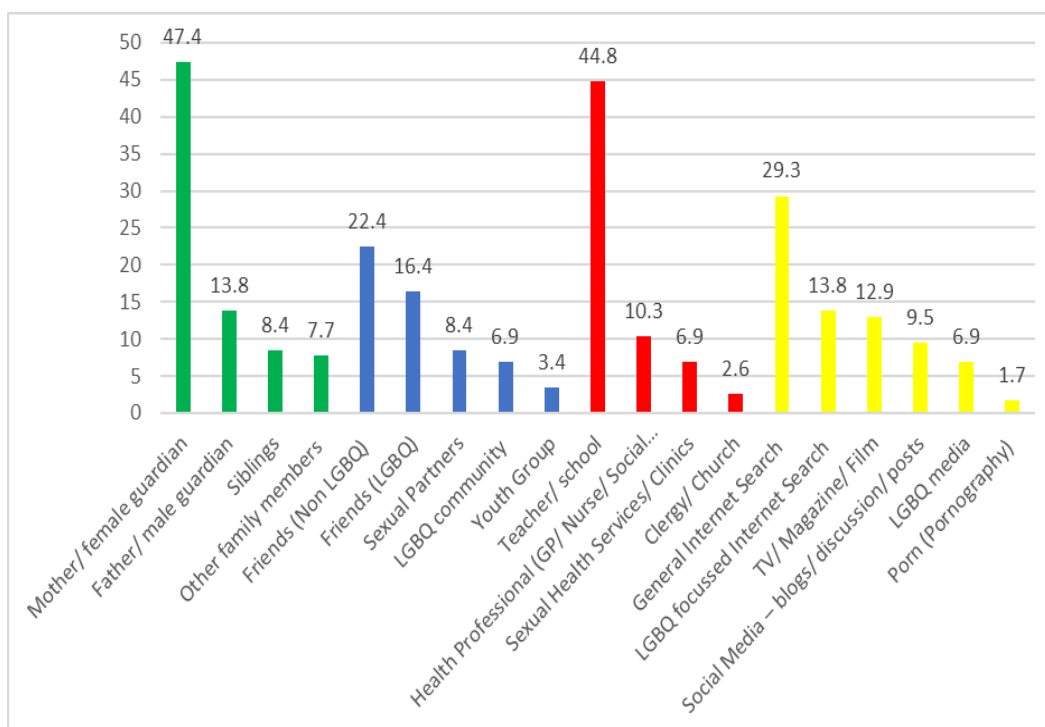
For the topic of “pregnancy”, the three most common sources of information were non-LGBTQ specific sources. Specifically, Mother/ female guardian (47.4%), was the most common source of information reported from the Family group, with Teacher/ school (44.8%) from the Professional Group of sources the second most common source stated (Table 5.19). The other secondary source (third most often) source identified was General Internet Search (29.3%, n=34). Within the Peer group, Non-LGBTQ friends (22.4%, n=26) were the most common source of information identified for the topic of “pregnancy”. All the other sources in all group were identified by a minority of the respondents as a source of information, with Porn (pornography) (1.7%, n=2) the least identified source of information on “pregnancy” (Figure 5.10).

Table 5.19 Sources of Information on Pregnancy

Family Group Sources	
Mother/ female guardian	47.4% (n=55)
Father/ male guardian	13.8% (n=16)
Siblings	8.4% (n=14)
Other family members	7.7% (n=9)
Peer Group Sources	
Friends (Non LGBTQ)	22.4% (n=26)
Friends (LGBTQ)	16.4% (n=19)
Sexual Partners	8.4% (n=14)
LGBTQ community	6.9% (n=8)
Youth Group	3.4% (n=4)

Professional Group Sources	
Teacher/ school	44.8% (n=52)
Health Professional (GP/ Nurse/ Social Worker)	10.3% (n=12)
Sexual Health Services/ Clinics	6.9% (n=8)
Clergy/ Church	2.6% (n=3)
Internet/ Media Sources	
General Internet Search	29.3% (n=34)
LGBQ focussed Internet Search	13.8% (n=16)
TV/ Magazine/ Film	12.9% (n=15)
Social Media – blogs/ discussion/ posts	9.5% (n=11)
LGBQ media	6.9% (n=8)
Porn (Pornography)	1.7% (n=2)

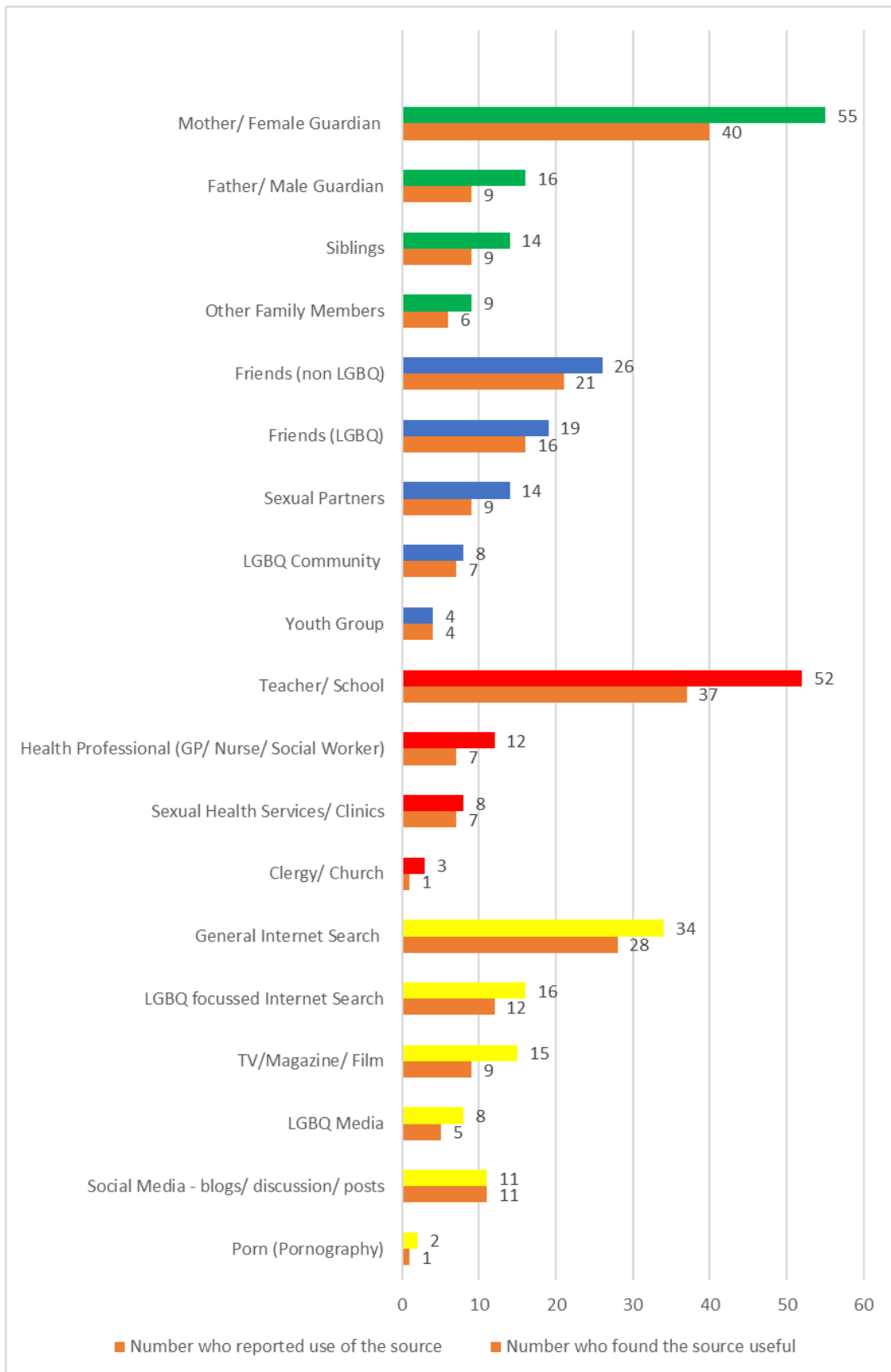
Figure 5.10– Sources of Information on Pregnancy



5.9.2 Usefulness of Sources of Information on Pregnancy

While Mother/female guardian and Teacher/school were the most common source of information on “*pregnancy*”, some respondents indicated that they were not useful. Despite this, the number of respondents who considered them useful was still higher than other sources (Mother/ female guardian 81.6% (40 out of 49); Teacher/ school 82.5% (37 out of 51) (Figure 5.11). Although sources within the peer category were not chosen as often, 21 out of 26 (88.9%) respondents indicated that non-LGBQ Friends were a useful source of information on “*pregnancy*”. Similarly, General Internet Search was indicated by 28 out of 31 (90.3%) as being a useful source of information on “*pregnancy*” (Table 5.26).

Figure 5.11– Usefulness of Sources of Information on Pregnancy



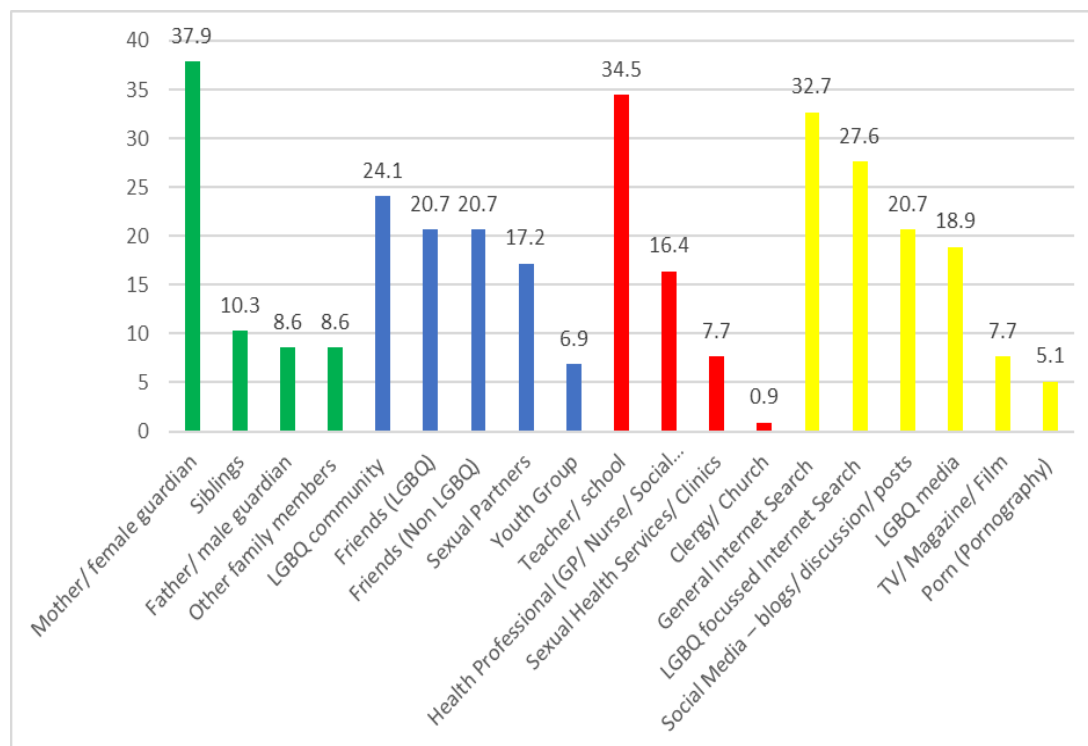
5.9.3 Sources of Information on Contraception (Apart from Condoms)

Like the sources on “*pregnancy*”, Mother/female guardian (37.9%, n=44), Teacher/school (34.5%, n=40) and General Internet Search (32.7%, n=38) were the most reported sources of information on “*Contraception (apart from Condoms)*” (Table 5.20). The other sources that were identified by respondents were within the Peer Group of sources. In this group, LGBTQ Community (24.7%, n=28) was the most reported source, followed by LGBTQ Friends and Non- LGBTQ Friends (who were both reported by 20.7% (n=24) as a source of information). Sexual Partners were identified by 17.2% (n=20) of respondents as a source of information, with the minority (6.9%, n=8) indicating that Youth Group was a source of information on “*Contraception (Apart from Condoms)*” (Figure 5.12). All other sources were identified by the minority of respondents as a source of information for this topic (Table 5.25).

Table 5.20 Sources of Information on Contraception (Apart from Condoms)

Family Group Sources	
Mother/ female guardian	37.9% (n=44)
Siblings	10.3% (n=12)
Father/ male guardian	8.6% (n=10)
Other family members	8.6% (n=10)
Peer Group Sources	
LGBTQ community	24.1% (n=28)
Friends (LGBTQ)	20.7% (n=24)
Friends (Non LGBTQ)	20.7% (n=24)
Sexual Partners	17.2% (n=20)
Youth Group	6.9% (n=8)
Professional Group Sources	
Teacher/ school	34.5% (n=40)
Health Professional (GP/ Nurse/ Social Worker)	16.4% (n=19)
Sexual Health Services/ Clinics	7.7% (n=9)
Clergy/ Church	0.9% (n=1)
Internet/ Media Group Sources	
General Internet Search	32.7% (n=38)
LGBTQ focussed Internet Search	27.6% (n=32)
Social Media – blogs/ discussion/ posts	20.7% (n=24)
LGBTQ media	18.9% (n=22)
TV/ Magazine/ Film	7.7% (n=9)
Porn (Pornography)	5.1% (n=6)

Figure 5.12 Sources of Information on Contraception (Apart from condoms) (%)



5.9.4 Usefulness of Sources of Information on Contraception (Apart from Condoms)

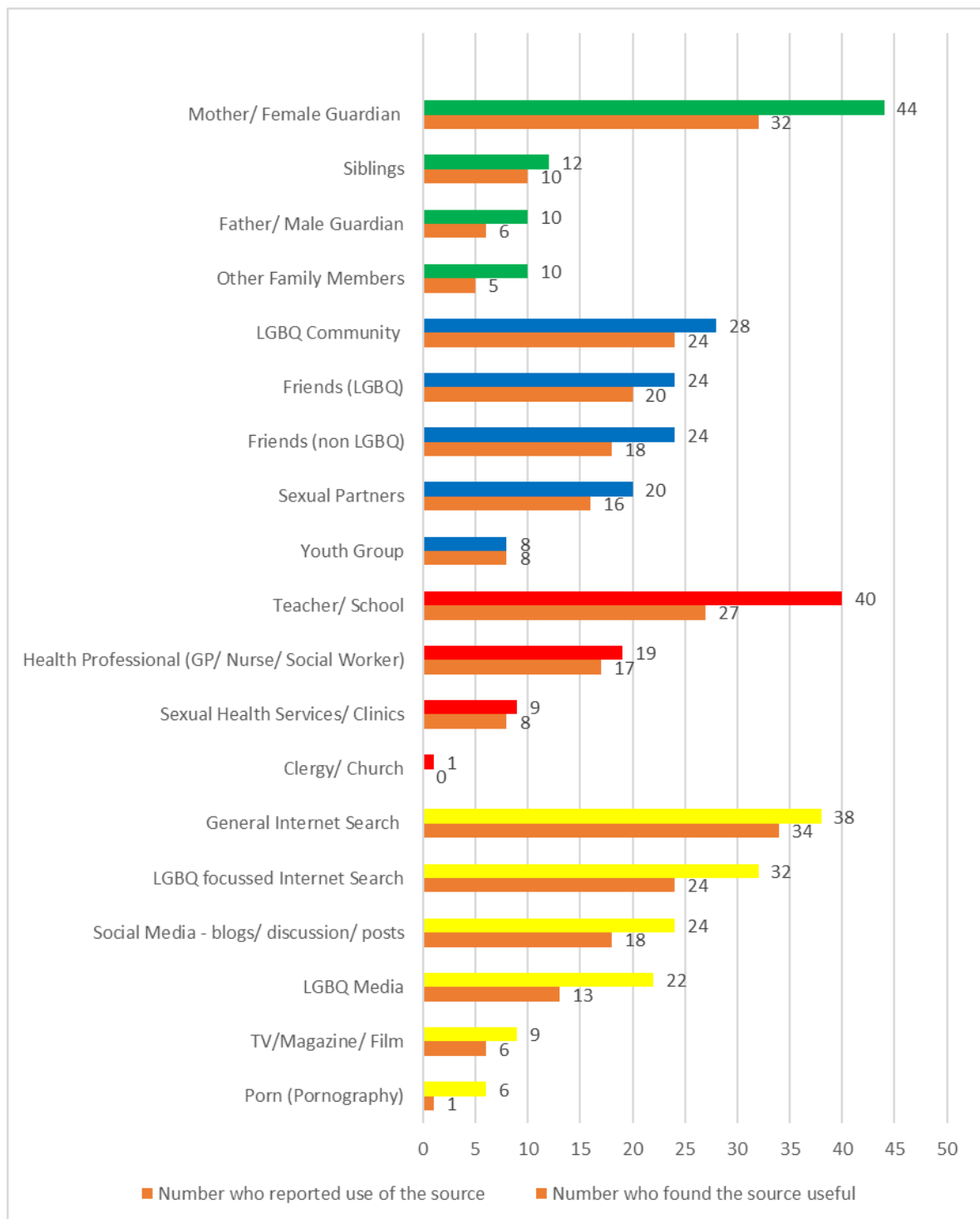
In terms of usefulness of sources on “*Contraception (Apart from Condoms)*”, General Internet Search (89.5%, 34 out of 38) was the most useful source for this topic. LGBQ Focussed Internet Search (24 out of 32) and Social Media (18 out of 24) were also considered useful. LGBQ Media (13 out of 22), TV/Magazine/ Film (6 out of 9) and Porn (pornography) (1 out of 6) were reported as less useful.

Mother/ female guardian was also considered useful, with 32 with 38 (84.2%) respondents reporting them as a useful source. The other sources in the Family Group were reported as useful for the majority of respondents, with Siblings (90.9%, 10 out of 11), Fathers/ male guardian (75%, 6 out of 8) and Other Family Members (55.6%, 5 out of 9) all reported as useful for the topic of “*Contraception (Apart from Condoms)*” (Table 5.26).

The sources within in the Peer Group were also considered useful by most respondents. The LGBQ Community was the most cited source and also the most

useful (85.7%, 24 out of 28). LGBTQ friends (83.3%, 20 out 24) and non-LGBTQ Friends (78.3%, 18 out of 23) as well as Sexual Partners (84.2%, 16 out of 19) were considered useful. All 8 respondents who indicated that Youth Group was a source of information stated that it was useful (Figure 5.13).

Figure 5.13: Usefulness of Sources of Information on Contraception (Apart from Condoms) (n=)



5.9.5 Sources of Information on Sexually Transmitted Infections (STI's)

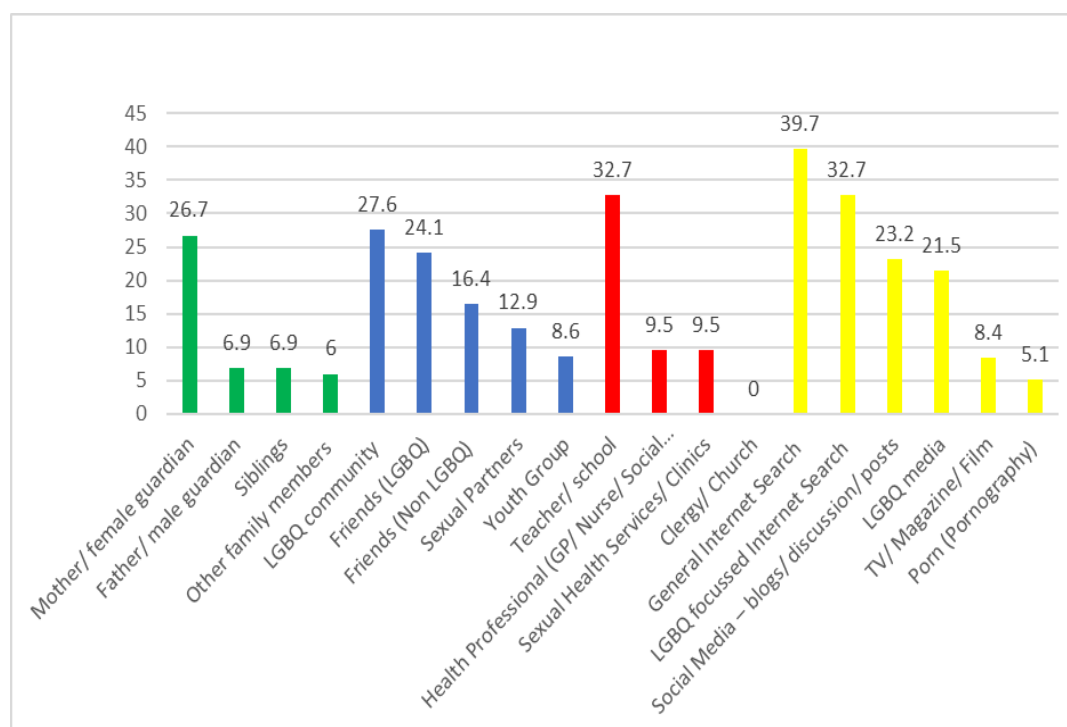
On the topic of “*Sexually Transmitted Infections*” (STI), the primary source of information was a General Internet Search (39.7%, n=46), followed by Teachers/ school (34.5%, n=40), the LGBQ Community (27.6%, n=32) and an LGBQ Focussed Internet Search (32.7%, n=34) (Table 5.21).

In the Family group, the Mother /Female Guardian (26.7%, n=31) was the most common source of information. The other sources in this group were reported by the minority of respondents as a source of information. The sources reported the least as a source of information on “*STI's*” were Porn (pornography) (5.1%, n=6) and Clergy/church (0.9%, n=1) (Figure 5.14).

Table 5.21 Sources of Information on Sexually Transmitted Infections

Family Group Sources	
Mother/ female guardian	26.7% (n=31)
Father/ male guardian	6.9% (n=8)
Siblings	6.9% (n=8)
Other family members	6.0% (n=7)
Peers Group Sources	
LGBQ community	27.6% (n=32)
Friends (LGBQ)	24.1% (n=28)
Friends (Non-LGBQ)	16.4% (n=19)
Sexual Partners	12.9% (n=15)
Youth Group	8.6% (n=10)
Professional Group Sources	
Teacher/ school	34.5% (n=40)
Health Professional (GP/ Nurse/ Social Worker)	16.4% (n=19)
Sexual Health Services/ Clinics	7.7% (n=9)
Clergy/ Church	0.9% (n=1)
Internet/ Media Group Sources	
General Internet Search	39.7% (n=46)
LGBQ focussed Internet Search	32.7% (n=34)
Social Media – blogs/ discussion/ posts	23.2% (n=27)
LGBQ media	21.5% (n=25)
TV/ Magazine/ Film	8.4% (n=14)
Porn (Pornography)	5.1% (n=6)

Figure 5.14 Sources of Information on Sexually Transmitted Infections (%)



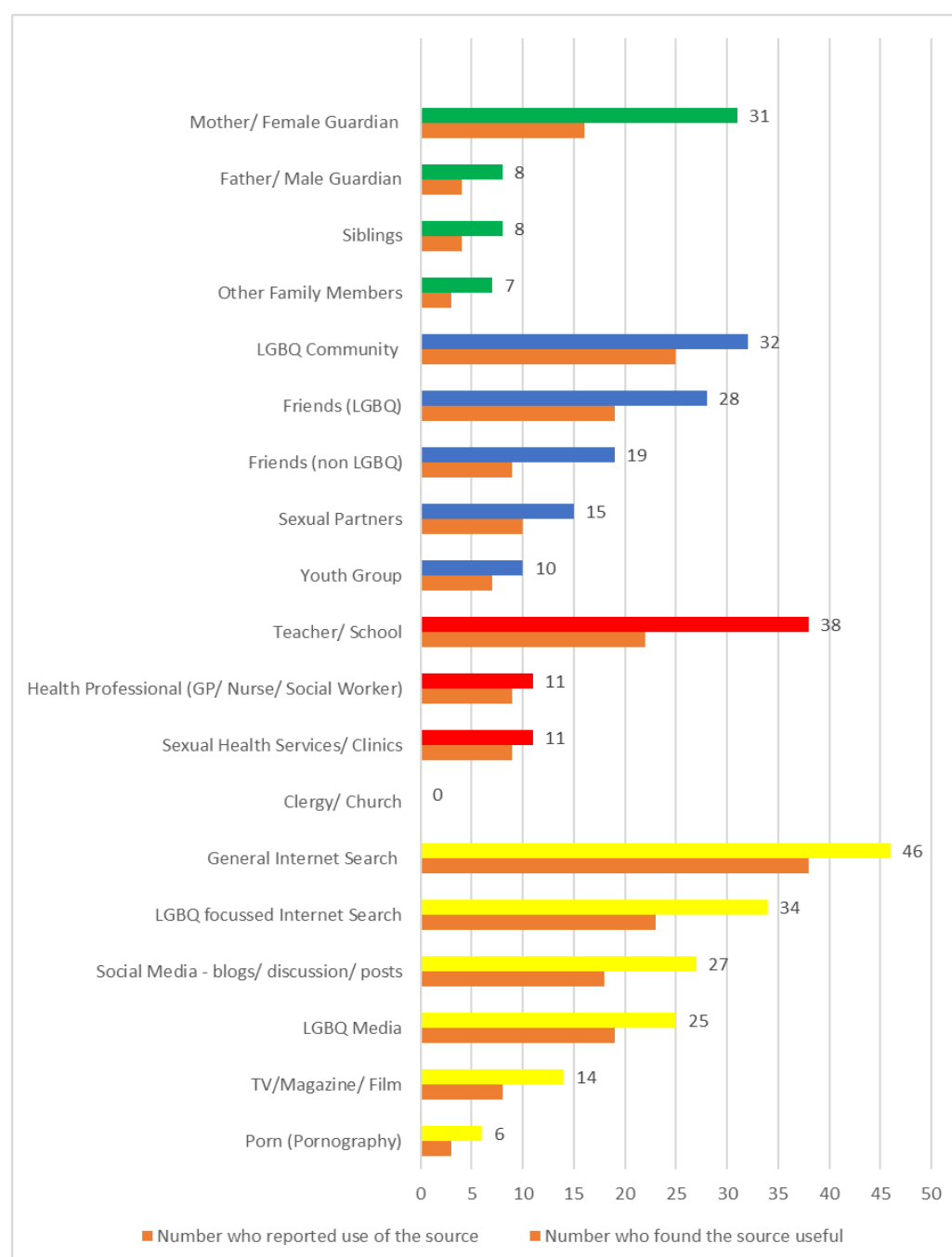
5.9.6 Usefulness of Sources of Information on Sexually Transmitted Infections (STI's)

On the topic of “STI's”, the most useful sources of information were also the ones reported by the most respondents as a source of information. These were a General Internet Search (88.4%, 38 out of 38), the LGBQ Community (86.2%, 25 out of 29), an LGBQ Focussed Internet Search (74.2%, 23 out of 31) and Teachers (57.9%, 22 out of 32) (Table 5.26). Within the Family Group, less than 70% of all respondents who reported a source of information considered it useful (Figure 5.15). These were Mother/ female guardian (64%, 16 out of 25), Fathers/ Male Guardian (66.7%, 4 out of 6) and Siblings (50%, 4 out of 8). Other Family Members (43%, 3 out of 7) were considered the least useful as a sources of informaion on “STI's”.

The Peer Group of Sources were considered more useful than the Family Group of Sources. As stated above, the LGBQ Community (86.2%, 25 out of 29), LGBQ Friends (70.4%, 19 out of 27) were the most useful sources. Non-LGBQ Friends (47.3%, 9 out of 19), Sexual Partners (76.9%, 10 out of 13) and Youth Group (70%, 7 out of 10) were not considered as useful (Figure 5.15).

Health Professionals and Sexual Health Services/ Clinics, while reported by a limited number of respondents as a source of information on “STI’s”, were reported by the vast majority of these respondents as a useful source of information (Health Professionals by 81.8%, 9 out of 11 and Sexual Health services/ clinic by 90%, 9 out of 10).

Figure 5.15: Usefulness of Sources of Information on Sexually Transmitted Infections (n=)



5.9.7 Sources of Information on Safer Sex (Condoms)

For the topic “*Safer Sex (condoms)*”, the most common sources of information (primary and secondary) were Teacher/school (43.9%, n=51) and Mother/ Female Guardian (40.5%, n =47) (Table 5.22). However, the other sources of information in the Family Group (Father/ Male Guardian (11.2%, n= 13), Siblings (8.6%, n=10) and Other Family Members (7.7%, n=9) were reported by the minority of respondents as a source of information. Similarly, in the Professional Group, Sexual Health Services/clinic (10.3%, n=12), Health Professionals (8.6%, n=10) and Clergy/ Church (1.7%, n=2) were described by the minority of respondents as a source of information on “*Safer Sex (condoms)*”.

The Peer group sources all showed similar results with Non-LGBQ Friends (23.2%, n= 27), the LGBQ Community (22.4%, n=26), Sexual Partners (21.5%, n=25) and LGBQ Friends (20.7%, n=24) all comparable in the numbers of respondents who reported them as a source of information (Figure 5.16).

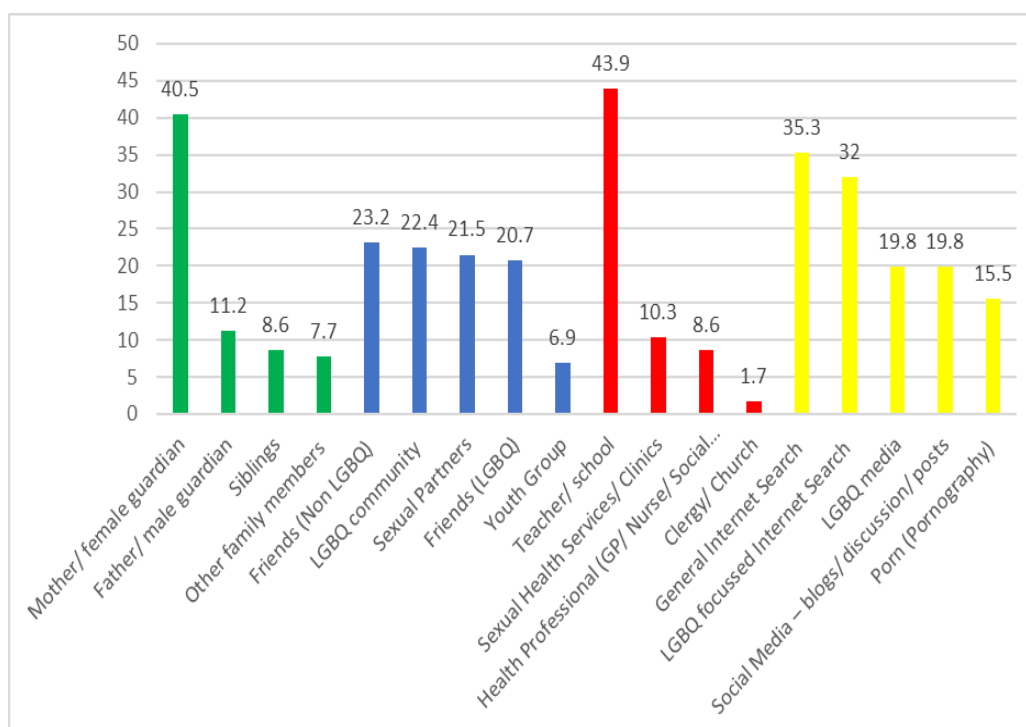
Within the Internet/ Media Group, the most common sources of information on “*Safer Sex (condoms)*” were a General Internet Search (35.3%, n= 41) and LGBQ Focussed Internet Search (32%, n=37). Both LGBQ media and Social Media were reported by 19.8% (n=23) as being a source of information. Porn (Pornography) was reported as a source of information for a minority of respondents (15.5%, n=18)).

Table 5.22 - Safer Sex (Condoms) Sources of Information

Family Group Sources	
Mother/ female guardian	40.5% (n=47)
Father/ male guardian	11.2% (n=13)
Siblings	8.6% (n=10)
Other family members	7.7% (n=9)
Peer Group Sources	
Friends (Non-LGBQ)	23.2% (n=27)
LGBQ community	22.4% (n=26)
Sexual Partners	21.5% (n=25)
Friends (LGBQ)	20.7% (n=24)
Youth Group	6.9% (n=8)
Professional Group Sources	
Teacher/ school	43.9% (n=51)
Sexual Health Services/ Clinics	10.3% (n=12)
Health Professional (GP/ Nurse/ Social Worker)	8.6% (n=10)
Clergy/ Church	1.7% (n=2)

Internet/ Media Group Sources	
General Internet Search	35.3% (n=41)
LGBQ focussed Internet Search	32% (n=37)
LGBQ media	19.8% (n=23)
Social Media – blogs/ discussion/ posts	19.8% (n=23)
Porn (Pornography)	15.5% (n=18)
TV/ Magazine/ Film	13.8% (n=16)

Figure 5.16 – Sources of Information on Safer Sex (Condoms) (n=)

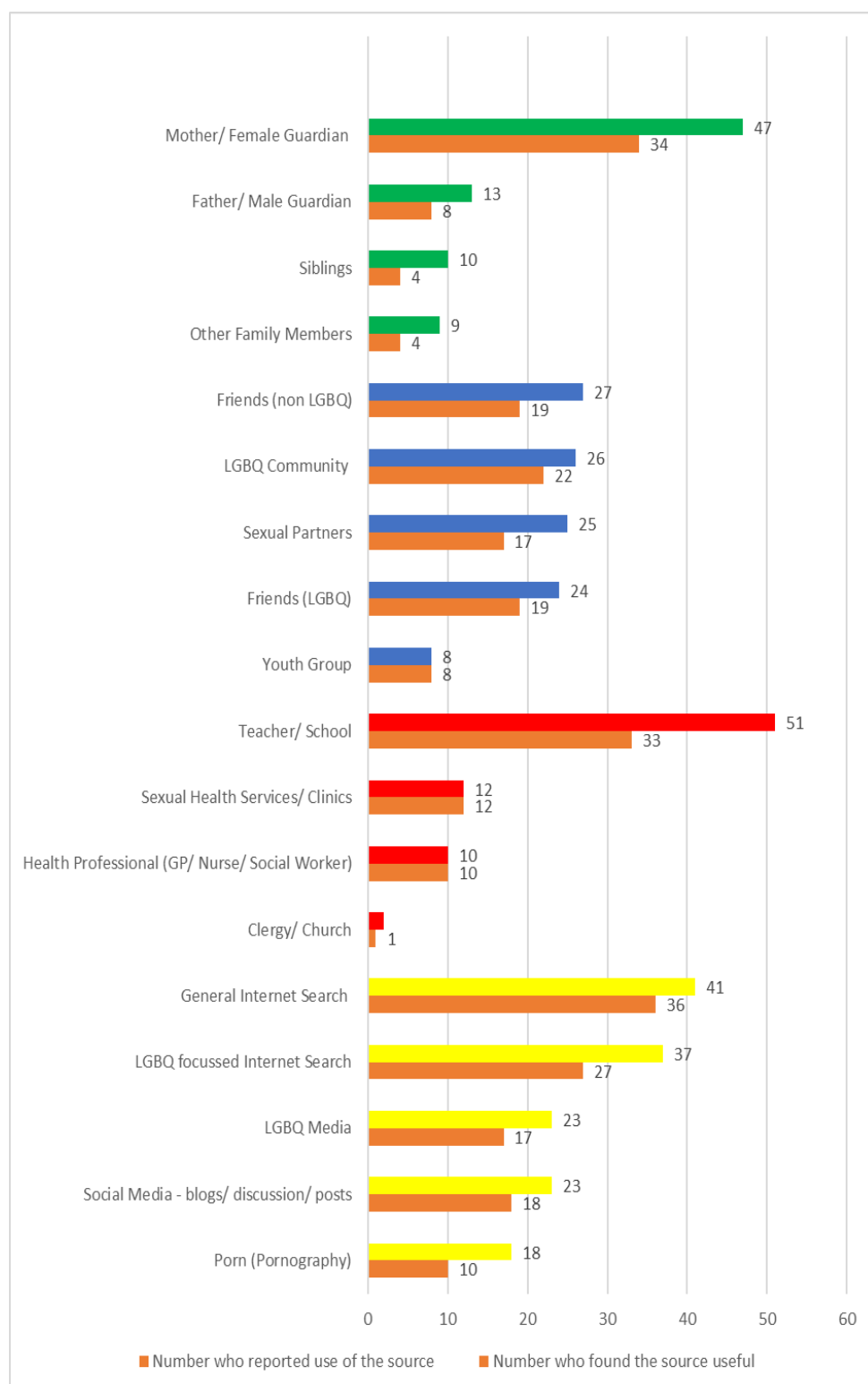


5.9.8 Usefulness of Sources of Information on Safer Sex (Condoms)

In relation to the most common sources used for information on “*Safer Sex (Condoms)*”, Teachers/ School were considered useful by 57.9% (22 out of 32) and Mothers were considered useful by 82.9% (34 out of 41) of respondents. Within the peer group, similar numbers of sources reported sources as useful. These were non-LGBQ Friends (76%, 19 out of 25), LGBQ Community (88% ,22 out of 25), Sexual Partners (73.9%, 17 out of 23) and LGBQ Friends (75%, 18 out of 24). The 8 people who reported Youth Group as a source of information also reported t it as a useful source of information (100%, 8 out of 8). This was also true for Health Professionals (100%, 10 out of 10) and Sexual Health Services/ clinic (100%, 12 out of 12) (Figure 5.17).

Internet Searching, both LGBTQ and General Internet Search was considered useful by the majority of respondents (LGBTQ Internet Search 77.1%, 17 out of 25; General Internet Search 90%, 36 out of 40). In addition, LGBTQ media was considered useful by 81% (17 of 23) of respondents and 81.8% (18 out of 23) identified Social Media as useful sources of information on "*Safer Sex (Condoms)*".

Figure 5.17 –Usefulness of Sources of Information on Safer Sex (Condoms) (n=)



5.9.9 Sources of Information on What it means to Consent for Sexual Activity and My Rights

The primary and secondary sources of information on “*What it Means to Consent for Sexual Activity and my Rights*” were identified by 32.7% (n=38) of respondents as LGBTQ Friends and a General Internet Search (Table 5.23). These were followed by other sources from within the Internet/ Media Group, namely Social Media (31.9%, n=37), LGBTQ focussed Internet Search (29.3%, n=34), LGBTQ Media (21.5%, n=25) (Figure 5.18).

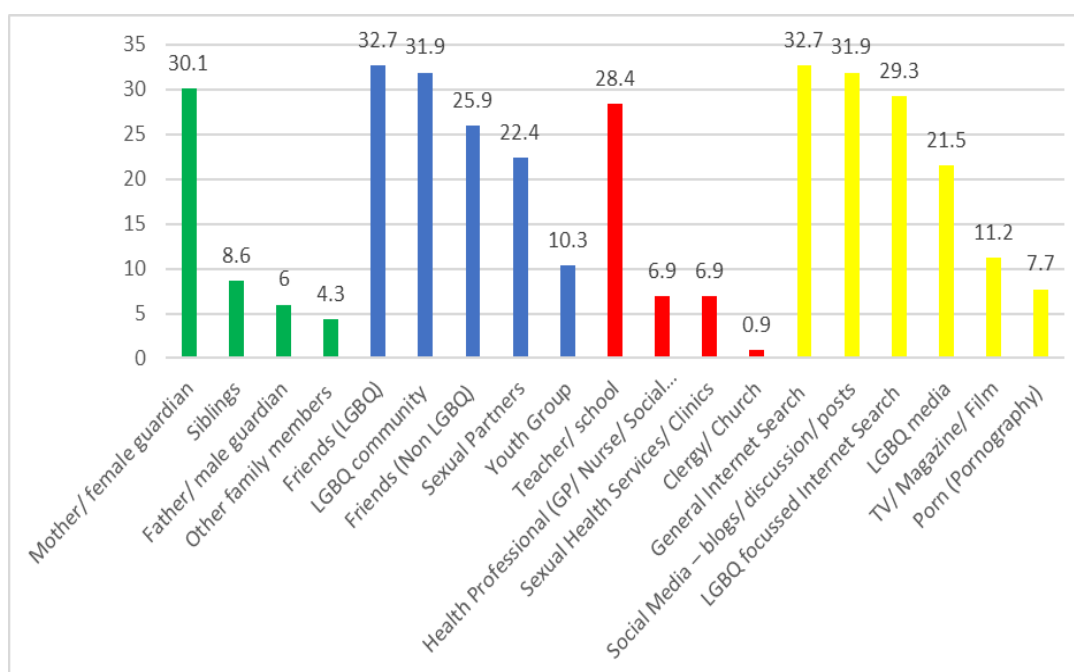
In the Family group of sources, Mother/ female guardian (30.1%, n= 35) was by far the most reported source of information. Other sources in the family group; Father/ Male Guardian (6.0%, n=7), Siblings (8.6%, n=10), Other family members (4.3%, n=5) were identified much less by respondents as a source of information on “*What it means to Consent for Sexual Activity and my Rights*”. The Peer group of sources was a source of information for several respondents, with 32.7% (n= 38) identifying LGBTQ Friends, 31.9% (n=37) picking LGBTQ Community, 25.9% (n=30) identifying Non-LGBTQ Friends and 22.4% (n=26) identifying Sexual Partners as a source of information (Table 5.25). In the Professional Group of sources, the most common source reported was Teachers (28.4%, n= 33). The other sources figured less, with both Health Professionals and Sexual Health Services/ Clinics being identified by 6.9% (n= 8) of respondents as a source of information. The Clergy/ Church (0.9%, n=1) was again identified as the least used source of information on the topic of Consent for Sexual Activity and my Rights.

Table 5.23 – Sources of Information on What it means to consent for sexual activity and my rights

Family Group Sources	
Mother/ female guardian	30.1% (n=35)
Siblings	8.6% (n=10)
Father/ male guardian	6.0% (n=7)
Other family members	4.3% (n=5)
Peer Group Sources	
Friends (LGBTQ)	32.7% (n=38)
LGBTQ community	31.9% (n=37)
Friends (Non LGBTQ)	25.9% (n=30)
Sexual Partners	22.4% (n=26)
Youth Group	10.3% (n=12)

Professional Group Sources	
Teacher/ school	28.4% (n=33)
Health Professional (GP/ Nurse/ Social Worker)	6.9% (n=8)
Sexual Health Services/ Clinics	6.9% (n=8)
Clergy/ Church	0.9% (n=1)
Internet/ Media Group Sources	
General Internet Search	32.7% (n=38)
Social Media – blogs/ discussion/ posts	31.9% (n=37)
LGBQ focussed Internet Search	29.3% (n=34)
LGBQ media	21.5% (n=25)
TV/ Magazine/ Film	11.2% (n=13)
Porn (Pornography)	7.7% (n=9)

Figure 5.18: Sources of Information on What it means to consent for sexual activity and my rights (%)

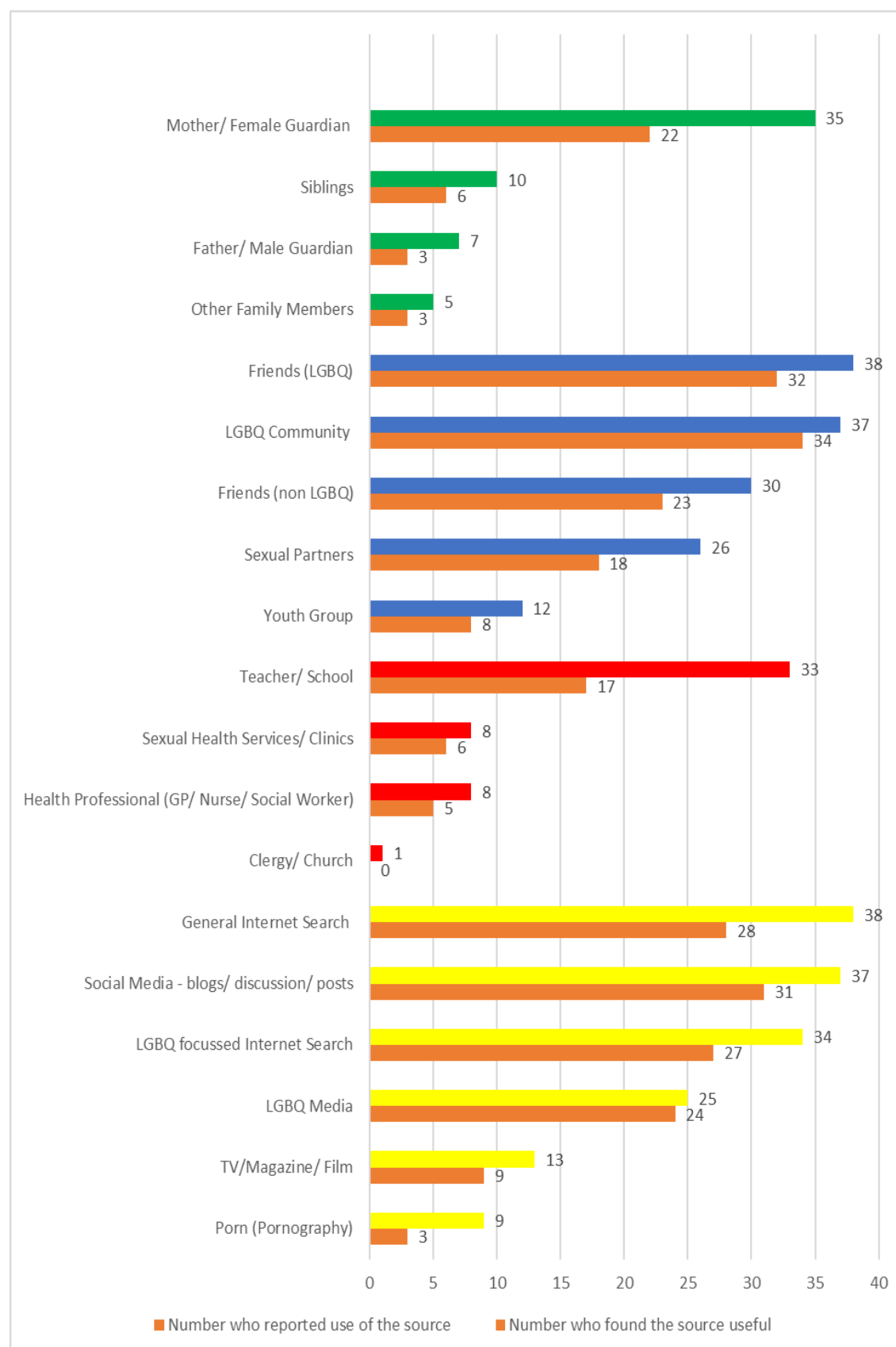


5.9.10 Usefulness of Sources of Information on What it means to consent for sexual activity and my rights

The most useful sources of information on “*What It means to consent for sexual activity and my rights*” were LGBQ Community (97.1%, 34 out of 35), LGBQ Friends (88.9%, 32 out of 36) (Figure 5.19), Social Media (81.8%, 18 out of 22) and Internet searching, both LGBQ Focused Internet Search (90%, 27 out of 30) and General Internet Search (77.8%, 28 out of 36). LGBQ Media was also considered useful by 100% (24 out of 24).

Within the Family group of sources, Mother/ female guardian was a useful source of information with 73.3% (22 out of 30) indicating they found them useful. Teachers/school with 54.8% (17 out of 31) were named as useful by the majority of respondents in the Professional Group of sources. However, both Sexual Health Services/ Clinic (100%, 6 out of 6) and Health Professionals (83.3%, 5 out of 6) had a higher percentage of respondents who stated they were useful. Only 1 respondent indicated that the Clergy/ Church was a source of information on “*What It means to consent for sexual activity and my rights*” and they did not report that as useful (Table 5.26).

Figure 5.19: Usefulness of Sources on What it means to consent for sexual activity and my rights (n=)



5.9.11 Sources of Information on How To Know I am Ready for Sex

In relation to 'How to Know I am Ready for Sex', findings were similar to other topics in the Readiness for Safer Sex category, with the primary source of information being a General Internet Search (31.9%, n=37) followed by LGBQ Friends (31%, n=36) (Table 5.24). Peer group and Internet/ Media were the most common group of sources overall. Within the Peer group, LGBQ Friends followed by Sexual Partners (30.1%, n=35) Non-LGBQ Friends (26.7%, n=31) and LGBQ community (22.4%,n=26) were a source of information (Table 5.25). Within the Internet/ Media group, the most common sources following General Internet Search were LGBQ Focussed Internet Search (26.7%, n=31), LGBQ Media (19.8%, n= 23) and Social Media (18.9%, n=22).

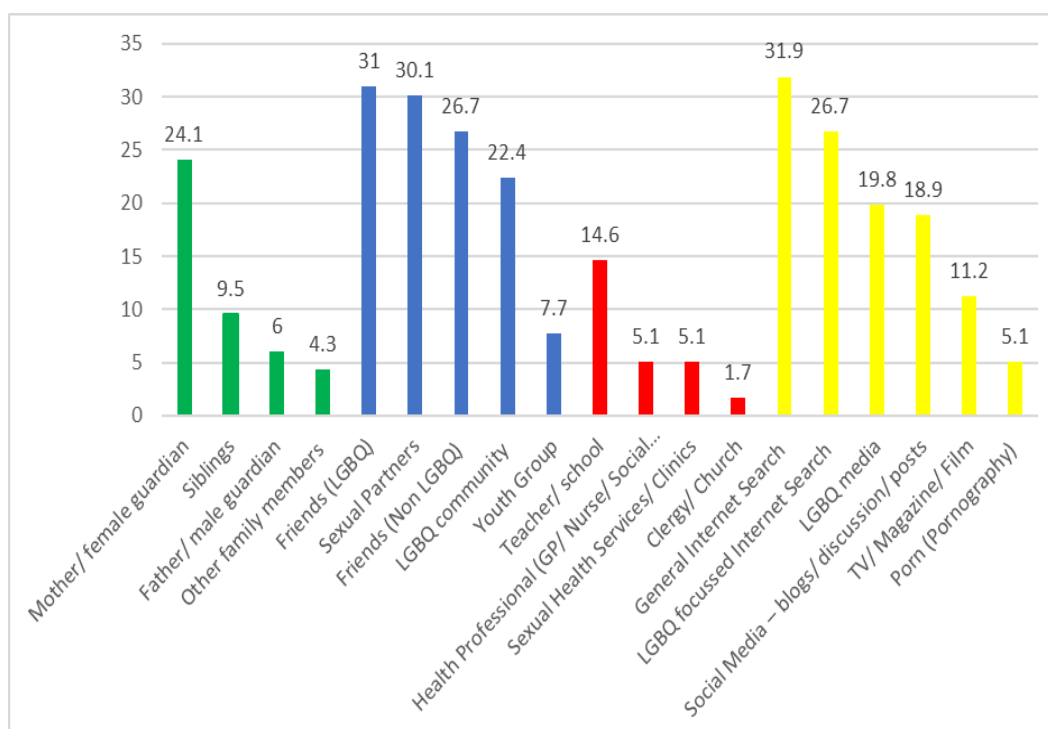
The Family and Professional Groups were reported less often as sources of information on "How To Know I am Ready for Sex". Mother/female guardian (24.1, n=28) was the most common reported source in the Family Group ,with siblings (9.5%, n=11), father/ male guardian (6%, n= 7) and other family members (4.3%, n=5) reported as a source less often than mothers. Wthin the professional group, a minority of respondents reported Teachers/school (14.6%, n=17), Health Professionals (5.1%, n=6) and Sexual Health Services/ Clinic (5.1%, n=6) as a source of information. The Clergy/ Church (1.7%, n=2) was reported by minimal number of respondents as a source of information on "How To Know I am Ready for Sex" (Figure 5.20).

Table 5.24: Sources of Information for How to know I am ready for sex (%)

Family Group Sources	
Mother/ female guardian	24.1% (n=28)
Siblings	9.5% (n=11)
Father/ male guardian	6.0% (n=7)
Other family members	4.3% (n=5)
Peer Group Sources	
Friends (LGBQ)	31.0% (n=36)
Sexual Partners	30.1% (n=35)
Friends (Non LGBQ)	26.7% (n=31)
LGBQ community	22.4% (n=26)
Youth Group	7.7% (n=9)
Professional Group Sources	
Teacher/ school	14.6% (n=17)
Health Professional (GP/ Nurse/ Social Worker)	5.1% (n=6)
Sexual Health Services/ Clinics	5.1% (n=6)
Clergy/ Church	1.7% (n=2)

Internet/ Media Group Sources	
General Internet Search	31.9% (n=37)
LGBQ focussed Internet Search	26.7% (n=31)
LGBQ media	19.8% (n=23)
Social Media – blogs/ discussion/ posts	18.9% (n=22)
TV/ Magazine/ Film	11.2% (n=13)
Porn (Pornography)	5.1% (n=6)

Figure 5.20 – Sources of Information on How to know I am ready for sex (%)

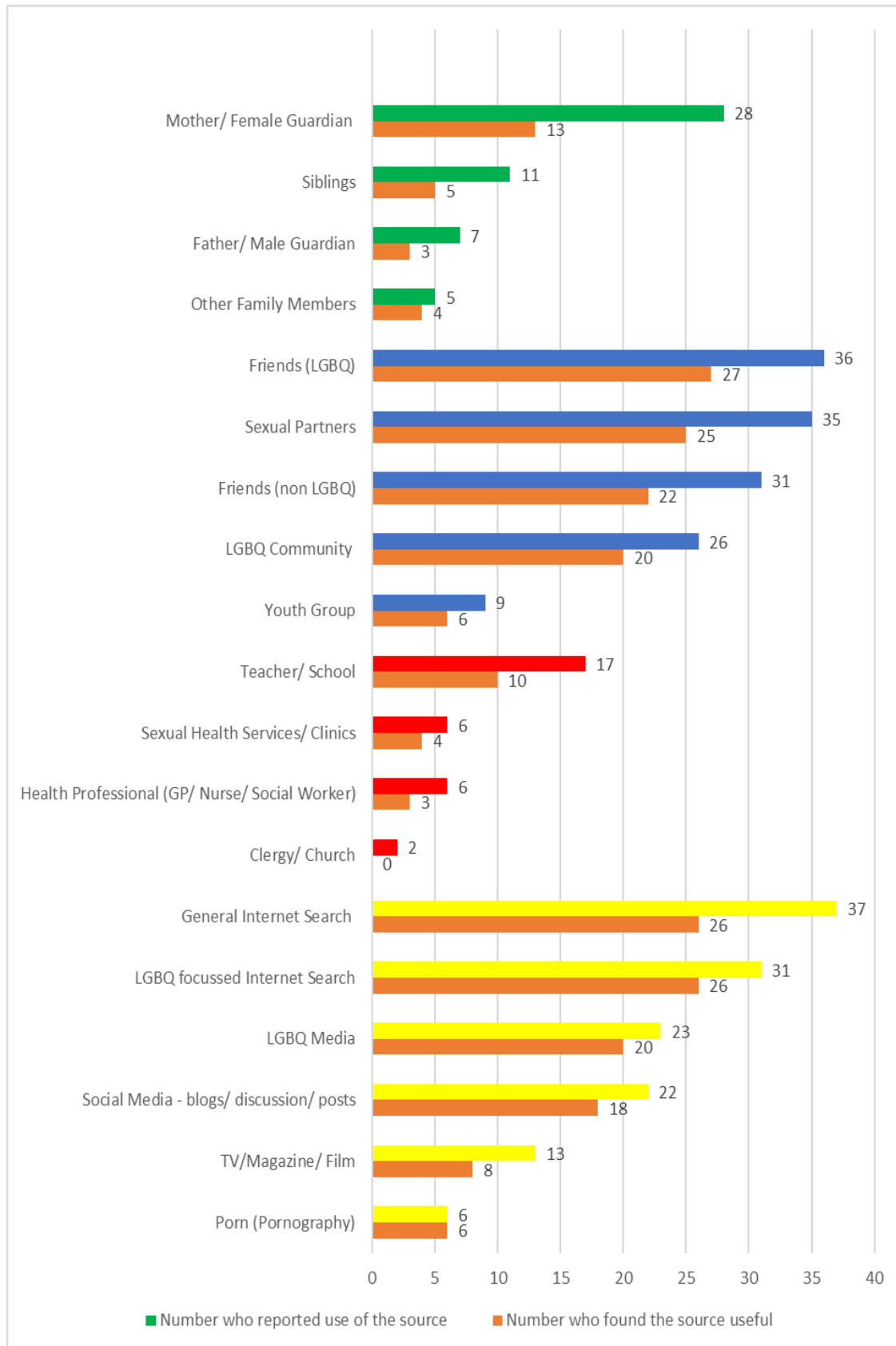


5.9.12 Usefulness of Sources of Information on How to know I am Ready for Sex

Within the Peer Group, LGBQ Friends at 79.4% (27 out of 36) and Sexual Partners at 75.8% (25 out of 35) were considered the most useful source of information on “How to know I am Ready for Sex”. These were followed by non-LGBQ Friends (75.9%, 22 out of 29) and the LGBQ Community (83.3%, 20 out of 24) (Table 5.26). Youth Group (66.7%, 6 out of 9) was the least useful. Mother/ Female Guardian while reported as a popular source of information was not considered as a useful source as only 56.5% (13 out of 28) reported it useful. The Internet/ Media group of sources was the most useful for this topic. General Internet Search (76.5%, 26, out of 34) and LGBQ focussed Internet Search (83.9%, 26 out of 31) were useful. These were followed by LGBQ Media (87%, 20 out of 23), Social Media (85.7%, 18 out of 21) and

TV/Magazine/ Film (66.7%, 8 out of 12). While not identified as a source of information by many, 100% of respondents (6 out of 6) that chose Porn (Pornography) as a source of information on "*How to know I am Ready for Sex*" categorised it as being a useful one (Figure 5.21).

Figure 5.21 Usefulness of Sources of Information on How to know I am ready for sex (n=)



5.9.13 Additional Topics and Sources of Information on Readiness for Safer Sex

In response to the open-ended question on sourcing information for topics on Readiness for Safer Sex, seven people replied. Five stated 'no' on their response and another replied, 'just knew how it worked', while another response stated 'pull out before you cum'. In terms of sources of information, respondents indicated that books and WIKIHOW were sources of information on Readiness for Safer Sex. WIKIHOW is an online WIKI style publication featuring 'how-to' content provided by and modified by users of the Internet site.

5.9.14 Summary of Sources of Information and Usefulness on the Category Readiness for Safer Sex.

When the topics in this category are displayed in Tables 5.25 and Table 5.26, the sources most often identified for *"pregnancy"*, *"contraception"* and *"safer sex (condoms)"* are teachers and mothers. A general Internet search is considered the most common sources for *"Safer Sex (Condoms)"*, *"What it Means to Consent for Sexual Activity and my Rights"* and also *"How to know I am ready for Sex"*. In fact, for most of the topics, in varying order, Teachers, Mother and a General Internet search are the most frequent used sources of information. In addition, for the topics *"What it means to consent for sexual activity and my rights"* and *"How to know I am ready for sex"* LGBTQ friends, LGBTQ community and Sexual Partners are a common source of information. Social media is also a source of information for *"What it means to consent for sexual activity and my rights"* (Table 5.25).

The most common sources are also the most useful sources of information in this category. However, there are a few respondents in all topics that did not find sources they chose for the topic useful. This is particularly true for both mothers/ female guardian, where 80% of respondents found them to be useful for most topics in the category Readiness for Safer Sex. The exception are the topics *"Sexually Transmitted Infections"*, and *"How to know I am ready for sex"* where 64% and 56.5% of respondents found them to be a useful source of information. Teacher/ School were considered useful by between 50-70% of respondents. While limited as a source of information, Healthcare Professionals and Sexual Health Services/clinics were found to be useful by close to 100% of respondents who stated they were a source of information for most topics in this category.

Table 5.25 - Sources of Information for Topics on the Category Readiness for Safer Sex (N=116)

Sources of Information		Pregnancy	Contraception (apart from condoms)	Sexually Transmitted Infections	Safer sex (condoms)	What does it mean to consent for sexual activity and my rights	How to know I am ready for sex
Family Group Sources	Mother/ female guardian	47.4% (n=55)	37.9% (n=44)	26.7% (n=31)	40.5% (n=47)	30.1% (n=35)	24.1% (n=28)
	Father/male guardian	13.8% (n=16)	8.6% (n=10)	6.9% (n=8)	11.2% (n=13)	6.0% (n=7)	6.0% (n=7)
	Siblings	8.4% (n=14)	10.3% (n=12)	6.9% (n=8)	8.6% (n=10)	8.6% (n=10)	9.5% (n=11)
	Other family members	7.7% (n=9)	8.6% (n=10)	6.0% (n=7)	7.7% (n=9)	4.3% (n=5)	4.3% (n=5)
Peer Group Sources	Friends (LGBQ)	16.4% (n=19)	20.7% (n=24)	24.1% (n=28)	20.7% (n=24)	32.7% (n=38)	31.0% (n=36)
	Friends (Non LGBQ)	22.4% (n=26)	20.7% (n=24)	16.4% (n=19)	23.2% (n=27)	25.9% (n=30)	26.7% (n=31)
	LGBQ community	6.9% (n=8)	24.1% (n=28)	27.6% (n=32)	22.4% (n=26)	31.9% (n=37)	22.4% (n=26)
	Youth Group	3.4% (n=4)	6.9% (n=8)	8.6% (n=10)	6.9% (n=8)	10.3% (n=12)	7.7% (n=9)
	Sexual Partners	8.4% (n=14)	17.2% (n=20)	12.9% (n=15)	21.5% (n=25)	22.4% (n=26)	30.1% (n=35)

Professional Group Sources	Teachers/ school	44.8% (n=52)	34.5% (n=40)	32.7% (n=38)	43.9% (n=51)	28.4% (n=33)	14.6% (n=17)
	Health Professional (GP/ Nurse/ Social Worker)	10.3% (n=12)	16.4% (n=19)	9.5% (n=11)	8.6% (n=10)	6.9% (n=8)	5.1% (n=6)
	Clergy/ church	2.6% (n=3)	0.9% (n=1)	0% (n=0)	1.7% (n=2)	0.9% (n=1)	1.7% (n=2)
	Sexual Health clinic	6.9% (n=8)	7.7% (n=9)	9.5% (n=11)	10.3% (n=12)	6.9% (n=8)	5.1% (n=6)
Internet/ Media Group Sources	LGBQ focussed Internet Search	13.8% (n=16)	27.6% (n=32)	32.7% (n=34)	32% (n=37)	29.3% (n=34)	26.7% (n=31)
	General Internet Search	29.3% (n=34)	32.7% (n=38)	39.7% (n=46)	35.3% (n=41)	32.7% (n=38)	31.9% (n=37)
	LGBQ media	6.9% (n=8)	18.9% (n=22)	21.5% (n=25)	19.8% (n=23)	21.5% (n=25)	19.8% (n=23)
	TV/ Magazine/ Film	12.9% (n=15)	7.7% (n=9)	8.4% (n=14)	13.8% (n=16)	11.2% (n=13)	11.2% (n=13)
	Porn (pornography)	1.7% (n=2)	5.1% (n=6)	5.1% (n=6)	15.5% (n=18)	7.7% (n=9)	5.1% (n=6)
	Social Media-blogs/ discussion/ posts	9.5% (n=11)	20.7% (n=24)	23.2% (n=27)	19.8% (n=23)	31.9% (n=37)	18.9% (n=22)
Primary	Most common source of information						
Secondary	2 nd most common source						
Secondary	3 rd most common source						

Table 5.26 - Sources of Information and Their Usefulness for Topics on the Category Readiness for Safer Sex (N=116)

Sources of Information		Pregnancy	Usefulness	Contraception (apart from condoms)	Usefulness	Sexually Transmitted Infections	Usefulness	Safer sex (condoms)	Usefulness	What does it mean to consent for sexual activity and my rights	Usefulness	How to know I am ready for sex	Usefulness
Family Group Sources	Mother/ female guardian	47.4% (n=55)	81.6% (40 out of 49)	37.9% (n=44)	84.2% (32 out of 38)	26.7% (n=31)	64% (16 out of 25)	40.5% (n=47)	82.9% (34 out of 41)	30.1% (n=35)	73.3% (22 out of 30)	24.1% (n=28)	56.5% (13 out of 23)
	Father/ male guardian	13.8% (n=16)	69.2% (9 out of 13)	8.6% (n=10)	75% (6 out of 8)	6.9% (n=8)	66.7% (4 out of 6)	11.2% (n=13)	72.7% (8 out of 11)	6.0% (n=7)	75% (3 out of 4)	6.0% (n=7)	60% (3 out of 5)
	Siblings	8.4% (n=14)	75% (9 out of 12)	10.3% (n=12)	90.9% (10 out of 11)	6.9% (n=8)	50% (4 out of 8)	8.6% (n=10)	50% (4 out of 8)	8.6% (n=10)	75% (6 out of 8)	9.5% (n=11)	45.5% (5 out of 11)
	Other family members	7.7% (n=9)	85.7% (6 out of 7)	8.6% (n=10)	55.6% (5 out of 9)	6.0% (n=7)	42.9% (3 out of 7)	7.7% (n=9)	50% (4 out of 8)	4.3% (n=5)	75% (3 out of 4)	4.3% (n=5)	80% (4 out of 5)
Peer Group Sources	Friends (LGBQ)	16.4% (n=19)	88.9% (16 out of 18)	20.7% (n=24)	83.3% (20 out of 24)	24.1% (n=28)	70.4% (19 out of 27)	20.7% (n=24)	75% (18 out of 24)	32.7% (n=38)	88.9% (32 out of 36)	31.0% (n=36)	79.4% (27 out of 34)
	Friends (Non LGBQ)	22.4% (n=26)	80.8% (21 out of 26)	20.7% (n=24)	78.3% (18 out of 23)	16.4% (n=19)	42.9% (9 out of 21)	23.2% (n=27)	76% (19 out of 25)	25.9% (n=30)	88.5% (23 out of 26)	26.7% (n=31)	75.9% (22 out of 29)
	LGBQ community	6.9% (n=8)	100% (7 out of 7)	24.1% (n=28)	85.7% (24 out of 28)	27.6% (n=32)	86.2% (25 out of 29)	22.4% (n=26)	88% (22 out of 25)	31.9% (n=37)	97.1% (34 out of 35)	22.4% (n=26)	83.3% (20 out of 24)
	Youth Group	3.4% (n=4)	100% (4 out of 4)	6.9% (n=8)	100% (8 out of 8)	8.6% (n=10)	70% (7 out of 11)	6.9% (n=8)	100% (8 out of 8)	10.3% (n=12)	80% (8 out of 10)	7.7% (n=9)	66.7% (6 out of 9)
	Sexual Partners	8.4% (n=14)	75% (9 out of 12)	17.2% (n=20)	84.2% (16 out of 19)	12.9% (n=15)	76.9% (10 out of 13)	21.5% (n=25)	73.9% (17 out of 23)	22.4% (n=26)	78.3% (18 out of 23)	30.1% (n=35)	75.8% (25 out of 33)

Professional Group Sources	Teachers/ school	44.8% (n=52)	72.5% (37 out of 51)	34.5% (n=40)	67.5% (27 out of 40)	32.7% (n=38)	57.9% (22 out of 32)	43.9% (n=51)	67.3% (33 out of 49)	28.4% (n=33)	54.8% (17 out of 31)	14.6% (n=17)	58.8% (10 out of 17)
	Health Professional (GP/ Nurse/Social Worker)	10.3% (n=12)	63.6% (7 out of 11)	16.4% (n=19)	89.5% (17 out of 19)	9.5% (n=11)	81.8% (9 out of 11)	8.6% (n=10)	100% (10 out of 10)	6.9% (n=8)	83.3% (5 out of 6)	5.1% (n=6)	50% (3 out of 6)
	Clergy/Church	2.6% (n=3)	50% (1 out of 2)	0.9% (n=1)	0% (0 out of 0)	0% (n=0)	0% (0 out of 0)	1.7% (n=2)	50% (1 out of 2)	0.9% (n=1)	0% (0 out of 0)	1.7% (n=2)	0% (0 out of 2)
	Sexual Health services/clinic	6.9% (n=8)	100% (7 out of 7)	7.7% (n=9)	80% (8 out of 10)	9.5% (n=11)	90% (9 out of 10)	10.3% (n=12)	100% (12 out of 12)	6.9% (n=8)	100% (6 out of 6)	5.1% (n=6)	66.7% (4 out of 6)
Internet/ Media Group Sources	LGBQ focussed Internet Search	13.8% (n=16)	92.3% (12 out of 13)	27.6% (n=32)	85.7% (24 out of 28)	32.7% (n=34)	74.2% (23 out of 31)	32% (n=37)	77.1% (27 out of 35)	29.3% (n=34)	90% (27 out of 30)	26.7% (n=31)	83.9% (26 out of 31)
	General Internet Search	29.3% (n=34)	90.3% (28 out of 31)	32.7% (n=38)	89.5% (34 out of 38)	39.7% (n=46)	88.4% (38 out of 43)	35.3% (n=41)	90% (36 out of 40)	32.7% (n=38)	77.8% (28 out of 36)	31.9% (n=37)	76.5% (26 out of 34)
	LGBQ media	6.9% (n=8)	71.4% (5 out of 7)	18.9% (n=22)	61.9% (13 out of 21)	21.5% (n=25)	73.1% (19 out of 26)	19.8% (n=23)	81% (17 out of 21)	21.5% (n=25)	100% (24 out of 24)	19.8% (n=23)	87% (20 out of 23)
	TV/ Magazine/ Film	12.9% (n=15)	64.3% (9 out of 14)	7.7% (n=9)	66.7% (6 out of 9)	8.4% (n=14)	57.1% (8 out of 14)	13.8% (n=16)	75% (12 out of 16)	11.2% (n=13)	75% (9 out of 12)	11.2% (n=13)	66.7% (8 out of 12)
	Porn (Pornography)	1.7% (n=2)	50% (1 out of 2)	5.1% (n=6)	20% (1 out of 5)	5.1% (n=6)	60% (3 out of 5)	15.5% (n=18)	58.8% (10 out of 17)	7.7% (n=9)	42.9% (3 out of 7)	5.1% (n=6)	100% (6 out of 6)
	Social Media- blogs/ discussion/ posts	9.5% (n=11)	100% (11 out of 11)	20.7% (n=24)	78.3% (18 out of 23)	23.2% (n=27)	69.2% (18 out of 26)	19.8% (n=23)	81.8% (18 out of 22)	31.9% (n=37)	91.2% (31 out of 34)	18.9% (n=22)	85.7% (18 out of 21)
Primary		Most common source of information											
Secondary		2 nd most common source of information											
Secondary		3 rd most common source of information											

5.10 Category Three: Sexual Activity/ Sexual Behaviour

5.10.1 Introduction

This category refers to topics and sources of information that are needed in relation to Sexual Activity/ Sexual Behaviour. There were ten topics within this category, which were “Kissing”, “Cuddling”, “Genital Touching”, “Masturbation”, “Oral Sex”, “Vaginal Sex”, “Anal Sex”, “What to do during sex”, “How to use safer sex aids” and “How to use sex toys safely”. Respondents were presented with the list of nineteen sources and the ten topics and asked to choose the sources of information that they received information from on each topic regardless of usefulness. There were a possible 190 options for sources to choose on this category. This table was completed by 91 respondents.

5.10.2 Sources of Information on Kissing

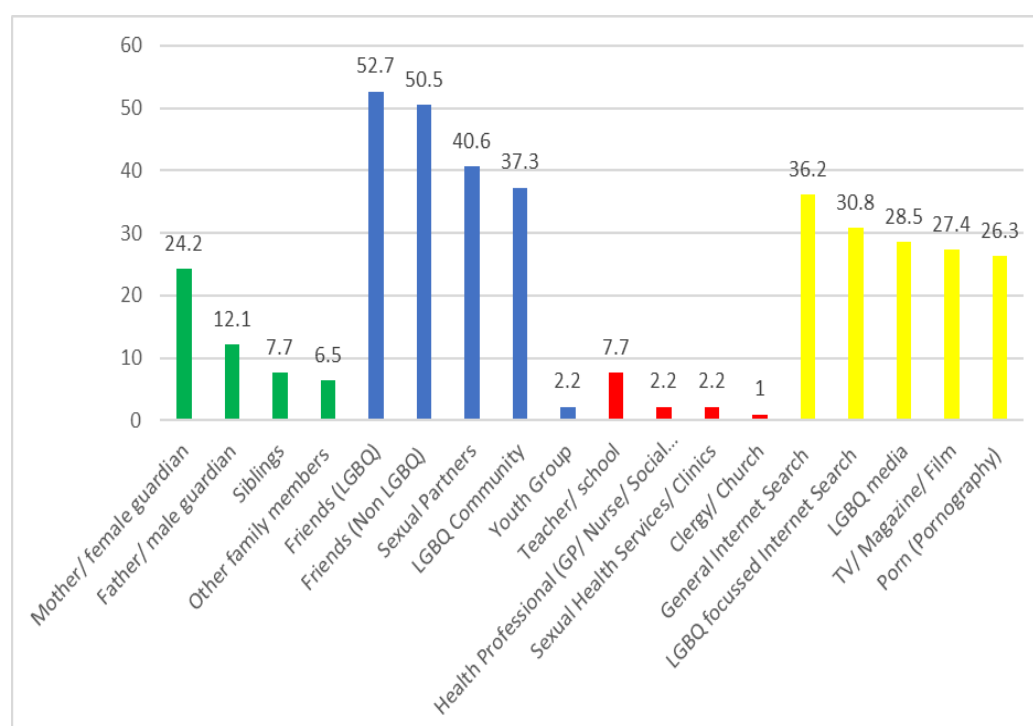
The primary source of information for “Kissing” was LGBTQ Friends (52.7%, n= 48) and non-LGBTQ Friends (50.5%, n= 46) (Table 5.27). Other sources in the peer group, Sexual Partners (40.6%, n=37) and LGBTQ Community (37.3%, n=34), were also cited as a source of information but were less popular. Internet/ Media sources were also identified as a source of information on “Kissing”. The most reported one was General Internet Search (36.2%, n= 33). This was followed by LGBTQ focussed Internet Search (30.8%, n=28), LGBTQ Media (28.5%, n=26), TV/Magazine/Film (27.4%, n=25) and Porn (pornography) (26.3%, n= 24). All the other sources were reported by less respondents (Figure 5.22).

Table 5.27 – Sources of Information on Kissing

Family Group Sources	
Mother/ female guardian	24.2% (n=22)
Siblings	12.1% (n=11)
Father/ male guardian	7.7% (n=7)
Other family members	6.5% (n=6)
Peer Group Sources	
Friends (LGBTQ)	52.7% (n=48)
Friends (Non LGBTQ)	50.5% (n=46)
Sexual Partners	40.6% (n=37)
LGBTQ community	37.3% (n=34)
Youth Group	2.2% (n=2)

Professional Group Sources	
Teacher/ school	7.7% (n=7)
Health Professional (GP/ Nurse/ Social Worker)	2.2% (n=2)
Clergy/ Church	2.2% (n=2)
Sexual Health Services/ Clinics	1% (n=1)
Internet/ Media Group Sources	
General Internet Search	36.2% (n=33)
LGBQ focussed Internet Search	30.8% (n=28)
LGBQ media	28.5% (n=26)
TV/ Magazine/ Film	27.4% (n=25)
Porn (Pornography)	26.3% (n=24)
Social Media – blogs/ discussion/ posts	13.2% (n=12)

Figure 5.22- Sources of Information on Kissing

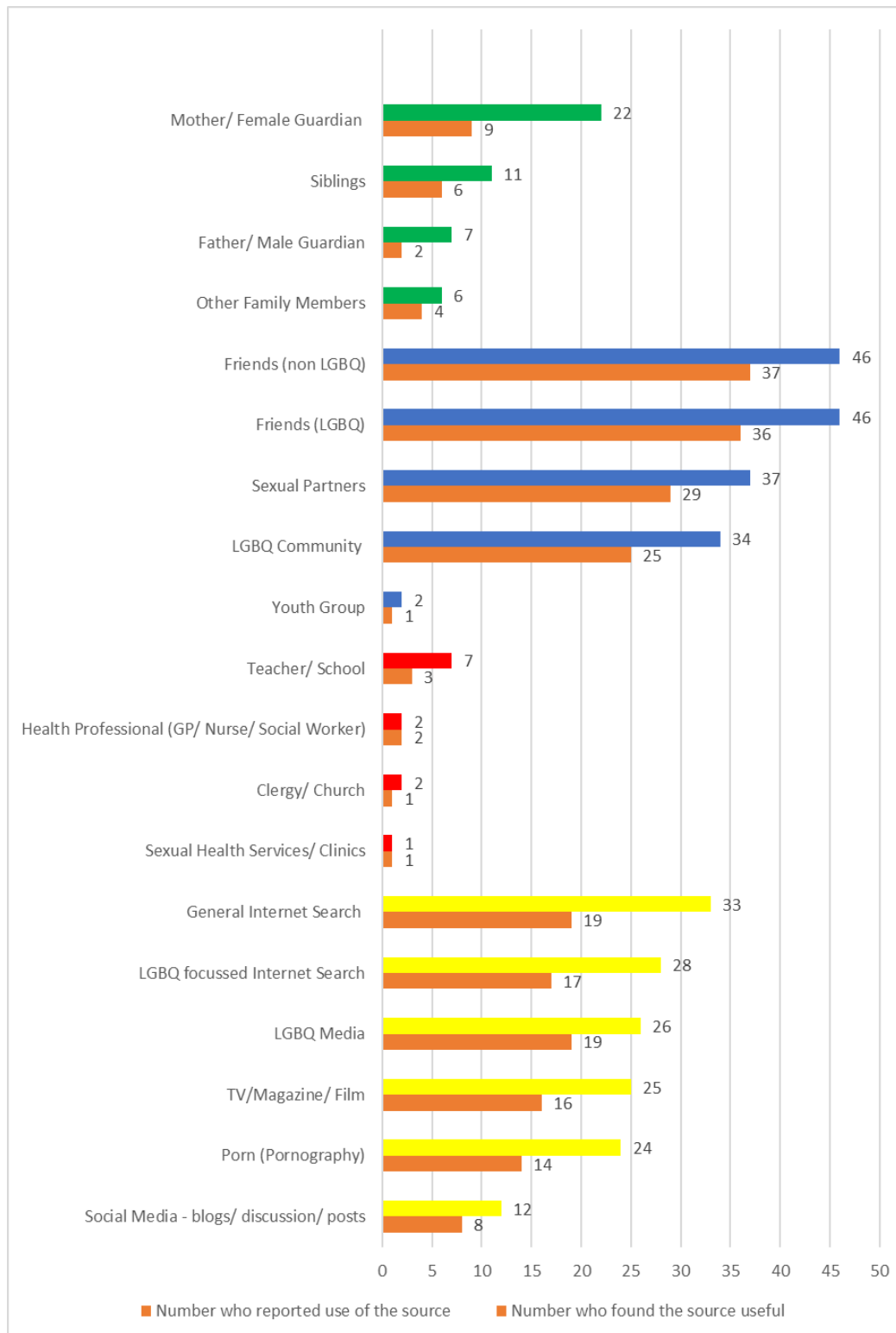


5.10.3 Usefulness of Sources of Information on Kissing

As well as being the sources identified the most, Peer Group sources, such as LGBQ Friends (92.3%, 36 out of 39), Non LGBQ Friends (82.2%, 37 out of 45) and Sexual Partners (87.9%, 29 out of 33) (Table 5.38) were relayed as the most useful sources (Figure 5.23). The Internet/ Media sources were not considered as useful, with 61.3% (19 out of 31) respondents categorising General Internet Search as useful. Similar findings were found for LGBQ Focussed Internet Search (70.8%, 17 out of 24), LGBQ Media (79.2%, 19 out of 24), TV/Magazine/Film (64%, 16 out of 25) and Pornography (58.3%, 14 out of 24). While very limited numbers found Professional or Family Group

as a source of information, these sources were considered useful by the majority, with the exception Teachers/ School (42.9%, 3 out of 7) and Father/ male guardian (33.3%, 2 out of 6).

Figure 5.23- Usefulness of Sources of Information on Kissing



5.10.4 Sources of Information on Cuddling

The primary and secondary sources of information for “*Cuddling*” were all from the Peer Group. These were LGBTQ Friends (47.2%, n= 43) and non-LGBTQ Friends (38.5%, n=35) (Table 5.28). These were followed by Sexual Partners (37.3%, n= 34) and LGBTQ Community (35.1%, n=32).

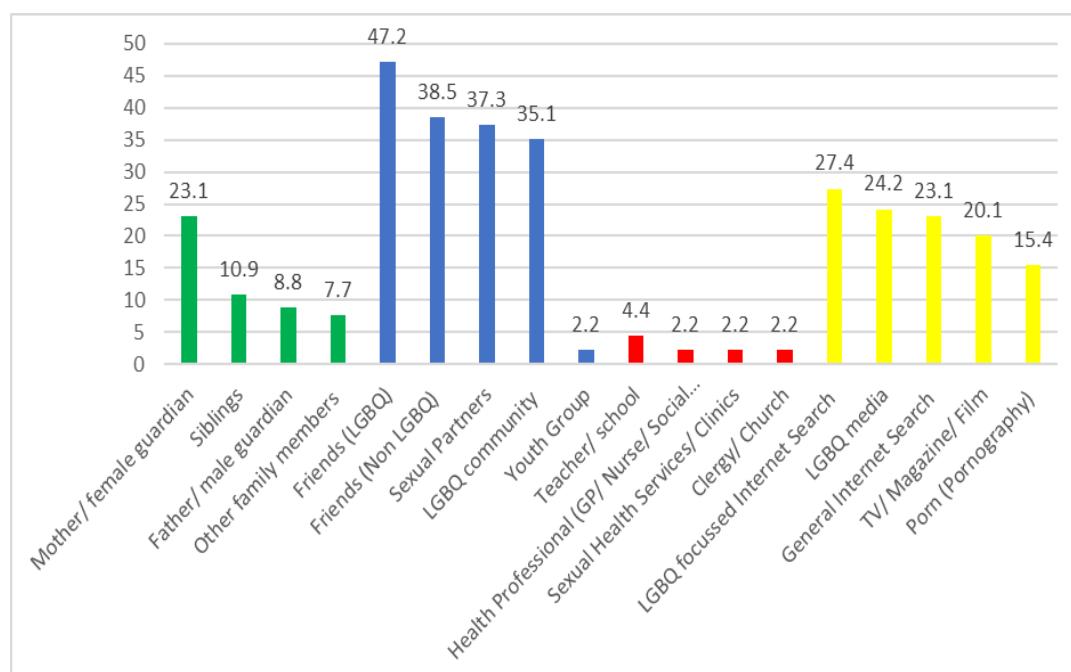
Mother was identified as a source of information by 23.1% (n=20). This was the source identified most often from the Family Group of sources. A minority labelled the other sources in these groups as a source of information.

The Internet/ Media Group sources were also identified as sources by some respondents. This ranged from 27.4% for LGBTQ Focussed Internet Search (n=25) to Social Media 14.3% (n=13) (Figure 5.24).

Table 5.28 Sources of Information on Cuddling

Family Group Sources	
Mother/ female guardian	23.1% (n=20)
Siblings	10.9% (n=10)
Father/ male guardian	8.8% (n=8)
Other family members	7.7% (n=7)
Peer Group Sources	
Friends (LGBTQ)	47.2% (n=43)
Friends (Non-LGBTQ)	38.5% (n=35)
Sexual Partners	37.3% (n=34)
LGBTQ community	35.1% (n=32)
Youth Group	2.2% (n=2)
Professional Group Sources	
Teacher/ school	4.4% (n=4)
Health Professional (GP/ Nurse/ Social Worker)	2.2% (n=2)
Clergy/ Church	2.2% (n=2)
Sexual Health Services/ Clinics	2.2% (n=2)
Internet/ Media Sources	
LGBTQ focussed Internet Search	27.4% (n=25)
LGBTQ media	24.2% (n=22)
General Internet Search	23.1% (n=21)
TV/ Magazine/ Film	20.1% (n=19)
Porn (Pornography)	15.4% (n=14)
Social Media – blogs/ discussion/ posts	14.3% (n=13)

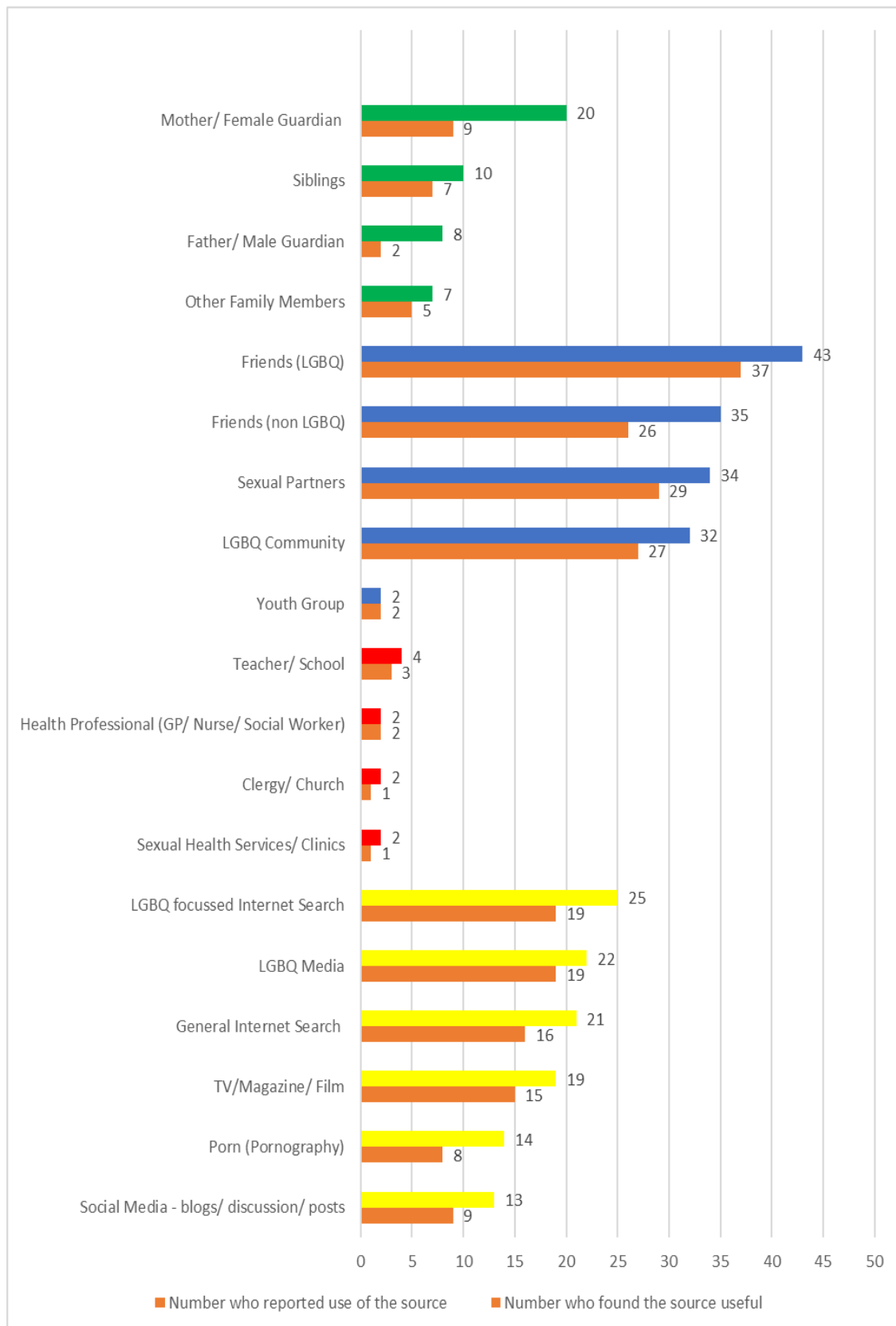
Figure 5.24- Sources of Information on Cuddling (n=)



5.10.5 Usefulness of Sources of Information on Cuddling

The most common sources of information on “*Cuddling*” were also the most useful ones. These were within the Peer Group where 37 respondents out of 38 (97.4%) stated that LGBQ Friends were a useful source of information. Similar findings for non-LGBQ Friends (86.7%, 26 out of 30), Sexual Partners (96.7%, 29 out of 30) and LGBQ Community (90%, 27 out of 30) were also reported as useful (Table 5.38). The sources in the other groups Professional and Family while limited as a source, were found useful by most people. Internet/ Media sources were also considered useful. LGBQ Media (90.5%, 19 out of 21) and LGBQ focussed Internet Searches (95%, 19 out of 20) were the most useful of these (Figure 5.25 Table 5.38).

Figure 5.25: Usefulness of Sources of Information on Cuddling (n=)



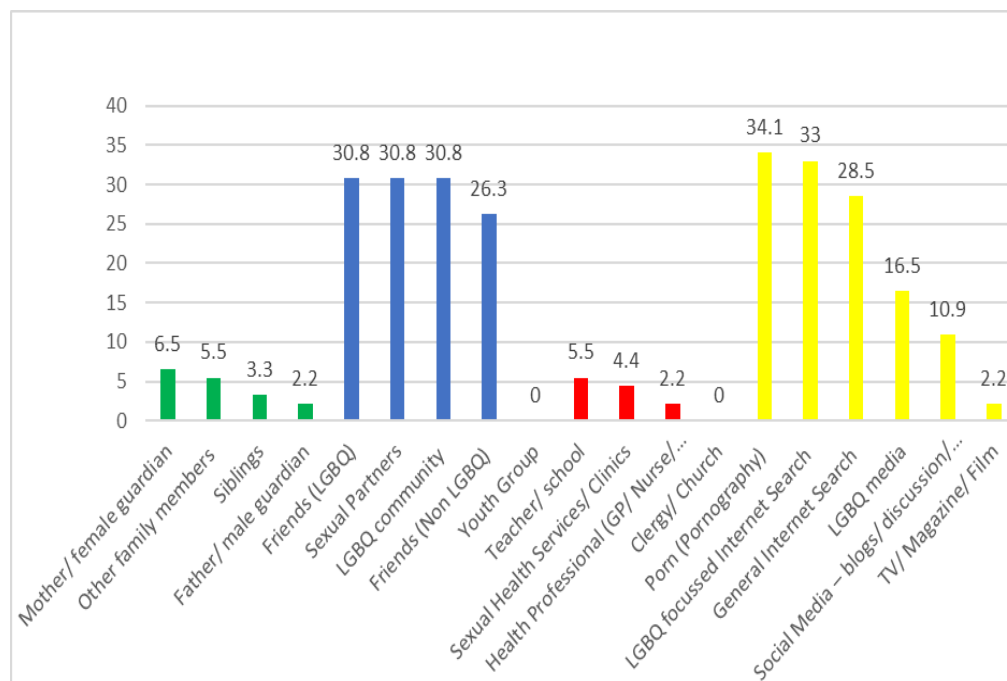
5.10.6 Sources of Information on Genital Touching

In relation to the sources on “*Genital Touching*”, respondents indicated that sources in the Peer group of sources were most useful. Findings were very similar within this with LGBTQ Friends, Sexual Partners and LGBTQ Community all being identified by 30.8% (n= 28) of respondents as a source of information (Table 5.29). Non-LGBTQ Friends were reported by 26.3% (n=24) as a source of information. However, the sources from Internet/ Media group for Porn (pornography) (34.1%, n=31) and LGBTQ focussed Internet Search (33%, n= 30) were considered by more respondents as a source of information for “*genital touching*”. General Internet Search (28.5%, n=26) was also identified as a source (Table 5.37). A very small minority from both the Family Group of Sources and Professional Group of Sources were considered a source of information (Figure 5.26).

Table 5.29: Sources of Information on Genital Touching

Family Group Sources	
Mother/ female guardian	6.5% (n=6)
Other family members	5.5% (n=5)
Siblings	3.3% (n=3)
Father/ male guardian	2.2% (n=2)
Peer Group Sources	
Friends (LGBTQ)	30.8% (n=28)
LGBTQ community	30.8% (n=28)
Sexual Partners	30.8% (n=28)
Friends (Non-LGBTQ)	26.3% (n=24)
Youth Group	0% (n=0)
Professional Group Sources	
Teacher/ school	5.5% (n=5)
Sexual Health Services/ Clinics	4.4% (n=4)
Health Professional (GP/ Nurse/ Social Worker)	2.2% (n=2)
Clergy/ Church	0% (n=0)
Internet/ Media Sources	
Porn (Pornography)	34.1% (n=31)
LGBTQ focussed Internet Search	33% (n=30)
General Internet Search	28.5% (n=26)
LGBTQ media	16.5% (n=15)
Social Media – blogs/ discussion/ posts	10.9% (n=10)
TV/ Magazine/ Film	2.2% (n=2)

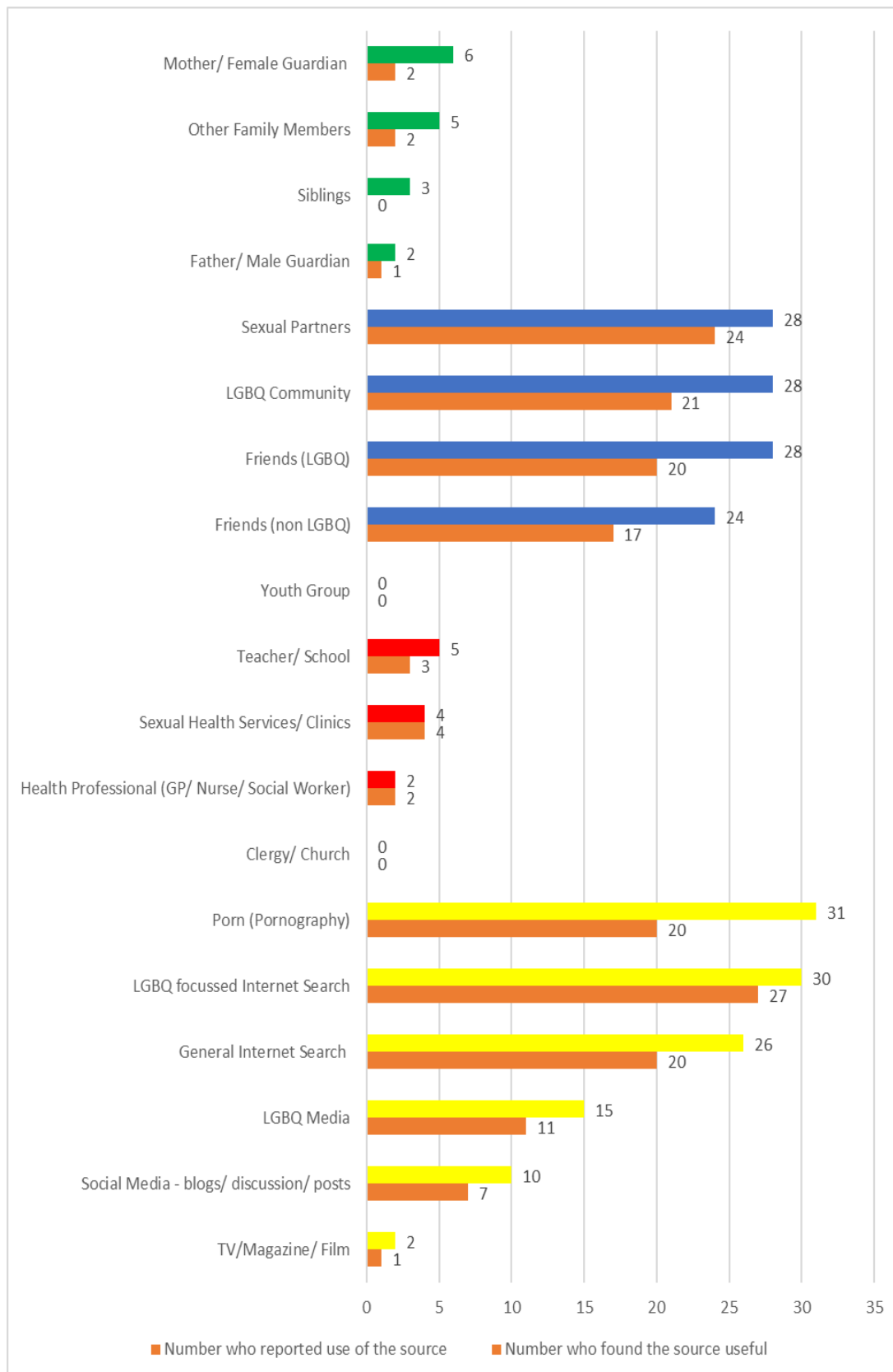
Figure 5.26- Sources of Information on Genital Touching (%)



5.10.7 Usefulness of Sources of Information on Genital Touching

While, Sexual Partners, LGBQ Community and Friends (LGBQ) were all reported as having a similar number of respondents who stated they were a source of information, they also had similar numbers who reported them as useful (Figure 5.27). The most useful of these was Sexual Partners (92.3%, 24 out of 26). LGBQ Community (84%, 21 out of 25) and LGBQ Friends (87%, 20 out of 23) were considered less useful. Family and Professional Group sources were not chosen by many as a source of information but those that chose them considered them as a useful source. The Internet/ Media sources had limited usefulness. While Pornography was the most common source of information identified, only 74.1% (20 out of 27) respondents considered it useful. This is less than LGBQ focussed Internet Search where 100% (27 out of 27) people reported it as useful (Table 5.38)

Figure 5.27 Usefulness of Sources of Information on Genital Touching (n=)



5.10.8 Sources of Information on Masturbation

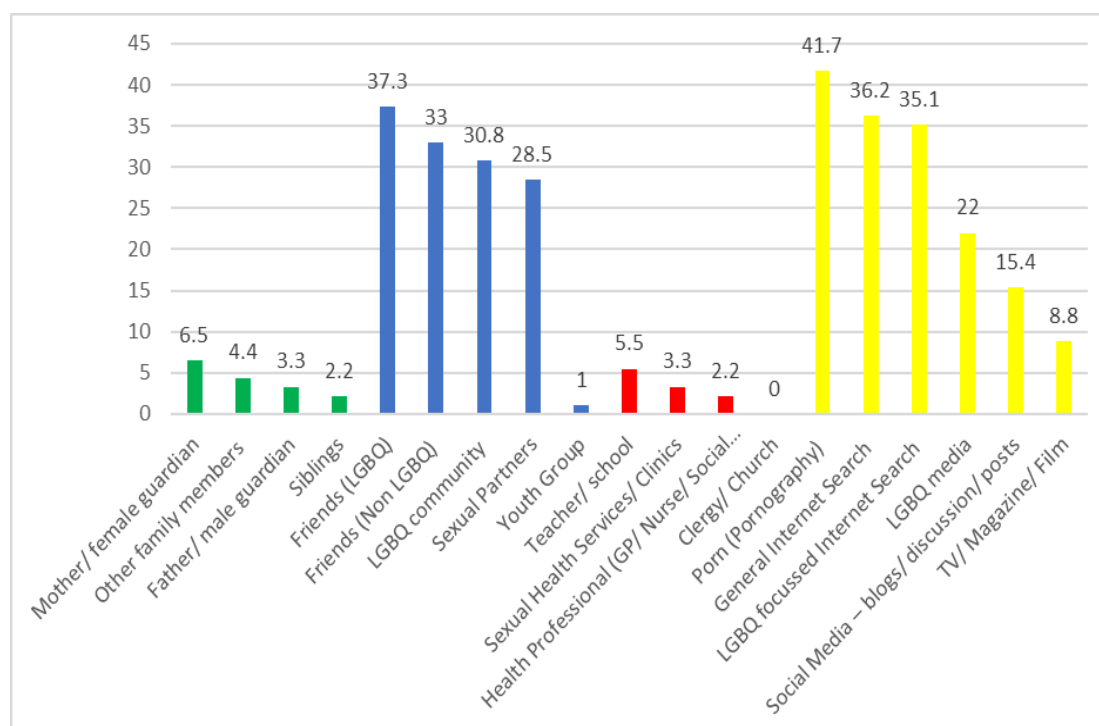
For the topic “*Masturbation*”, the primary source of information identified was Porn (Pornography) (41.7%, n=38) (Table 5.30). The was followed by LGBTQ Friends (37.3%, n=34) and General Internet Search (36.2%, n=33). The sources in both the Peer group and Internet/ Media Group were the ones most identified by respondents as a source of information on “*Masturbation*”. Within the Peer Group, after LGBTQ Friends, Non-LGBTQ Friends (33%, n=30), LGBTQ Community (30.8%, n=28) and Sexual Partners (28.5%, n=26) were the most reported sources of information. The sources in the Family and Professional Groups of sources were considered a source of information by only a small minority of respondents (Figure 5.28).

Sources within the Internet/ Media group were also acknowledged as sources of information. After Porn (pornography), the most common sources chosen were General Internet Search (36.2%, n= 33), LGBTQ Internet Search (35.1%, n= 32) and LGBTQ Media (22%, n= 20). Social Media (15.4%, n=14) and TV/Magazine/ Film (8.8%, n=8) were only considered by the minority of respondents as a source of information.

Table 5.30: Sources of Information on Masturbation

Family Group Sources	
Mother/ female guardian	6.5% (n=6)
Other family members	4.4% (n=4)
Father/ male guardian	3.3% (n=3)
Siblings	2.2% (n=2)
Peer Group Sources	
Friends (LGBTQ)	37.3% (n=34)
Friends (Non LGBTQ)	33% (n=30)
LGBTQ community	30.8% (n=28)
Sexual Partners	28.5% (n=26)
Youth Group	1% (n=1)
Professional Group Sources	
Teacher/ school	5.5% (n=5)
Health Professional (GP/ Nurse/ Social Worker)	2.2% (n=2)
Sexual Health Services/ Clinics	3.3% (n=3)
Clergy/ Church	0% (n=0)
Internet/ Media Group Sources	
Porn (Pornography)	41.7% (n=38)
General Internet Search	36.2% (n=33)
LGBTQ focussed Internet Search	35.1% (n=32)
LGBTQ media	22% (n=20)
Social Media – blogs/ discussion/ posts	15.4% (n=14)
TV/ Magazine/ Film	8.8% (n=8)

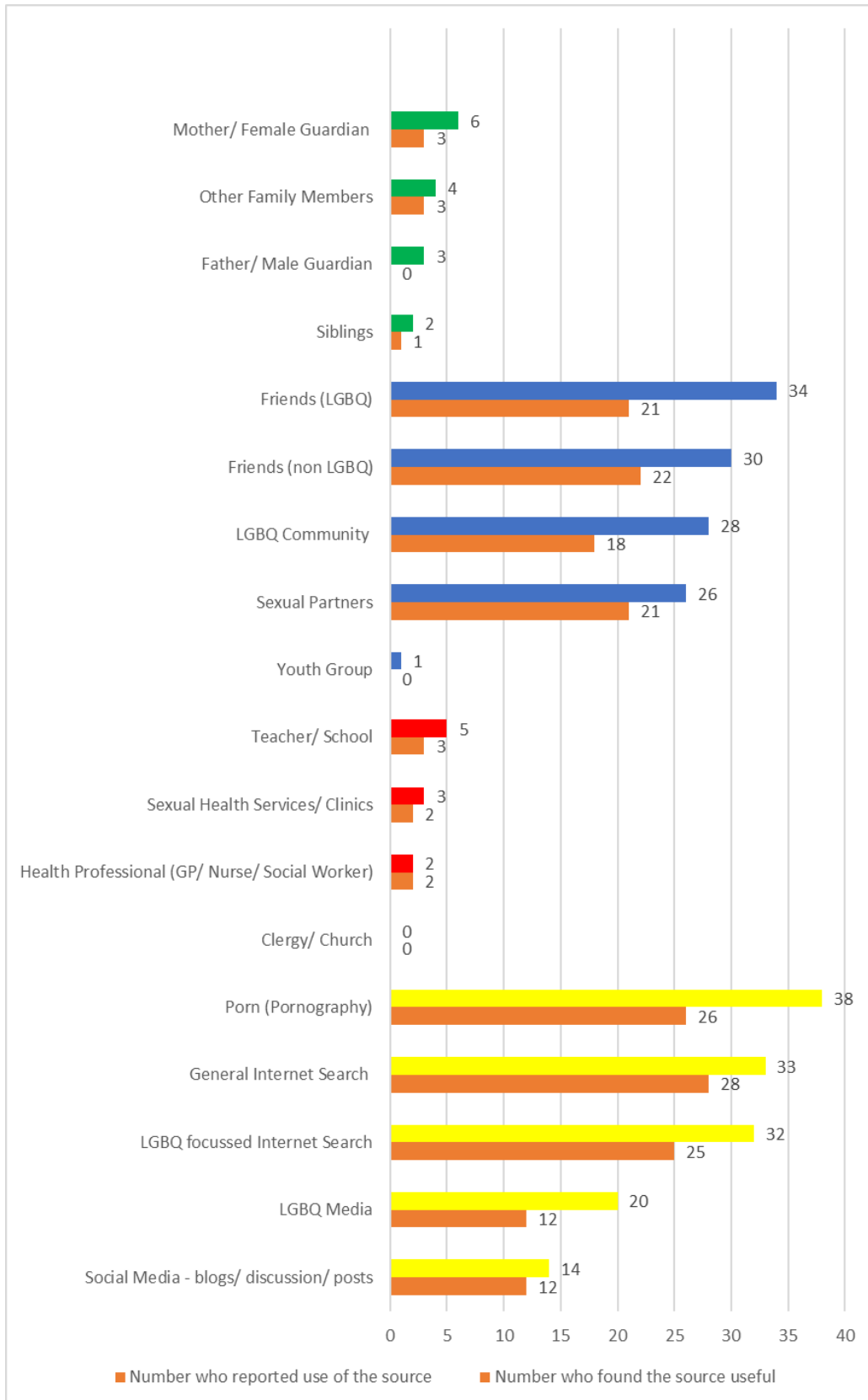
Figure 5.28: Sources of Information on Masturbation (%)



5.10.9 Usefulness of Sources of Information on Masturbation

Usefulness of sources on this topic was limited. Porn (Pornography) while considered a source by 38 respondents, it was only considered useful by 78.8% (26 respondents of 33 who replied to this question). On the other hand, General Internet Search was considered useful by 87.5% (28 out of 32) respondents and LGBQ focussed Internet Search was considered useful for 83.3% (25 out of 30) respondents. These are similar to the Peer Group results that show LGBQ Friends (70%, 21 out of 30), Non-LGBQ Friends (81.5%, 22 out of 27), LGBQ Community (75%, 18 out of 24) and Sexual Partners (95.5%, 21 out of 22) as useful sources of information (Table 5.38). Youth Group as well as sources in the Family and Professional Group were only identified by a very limited number of respondents as a source of information but the majority of these also reported the source as useful (Figure 5.29).

Figure 5.29: Usefulness of Sources on Masturbation



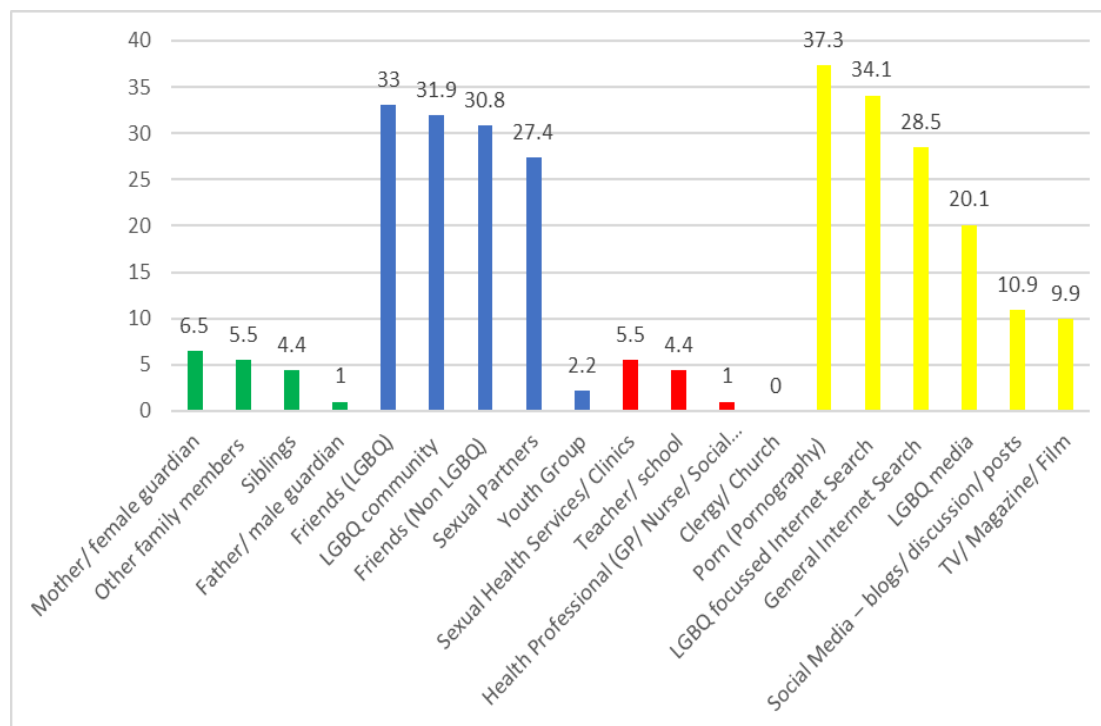
5.10.10 Sources of Information on Oral Sex

For the topic of “*Oral Sex*”, the primary sources of information were the same of those for “*masturbation*”, specifically Porn (pornography) (37.3%, n=34), LGBTQ focussed Internet Search (34.1%, n=31) and LGBTQ Friends (33%, n=30) (Table 5.31). Other sources reported as being used were LGBTQ Community (31.9%, n=29), Non-LGBTQ Friends (30.8%, n=28), General Internet Search (28.5%, n=26) and Sexual Partners (27.4%, n=25). All other sources were reported by a minority of people as a source of information (Figure 5.30)

Table 5.31: Sources of Informaton on Oral Sex

Family Group Sources	
Mother/ female guardian	6.5% (n=6)
Other family members	5.5% (n=5)
Siblings	4.4% (n=4)
Father/ male guardian	1% (n=1)
Peer Group Sources	
Friends (LGBTQ)	33% (n=30)
LGBTQ community	31.9% (n=29)
Friends (Non-LGBTQ)	30.8% (n=28)
Sexual Partners	27.4% (n=25)
Youth Group	2.2% (n=2)
Professional Group Sources	
Sexual Health Services/ Clinics	5.5% (n=5)
Teacher/ school	4.4% (n=4)
Health Professional (GP/ Nurse/ Social Worker)	1% (n=1)
Clergy/ Church	0% (n=0)
Internet/ Media Group Sources	
Porn (Pornography)	37.3% (n=34)
LGBTQ focussed Internet Search	34.1% (n=31)
General Internet Search	28.5% (n=26)
LGBTQ media	20.1% (n=19)
Social Media – blogs/ discussion/ posts	10.9% (n=10)
TV/ Magazine/ Film	9.9% (n=9)

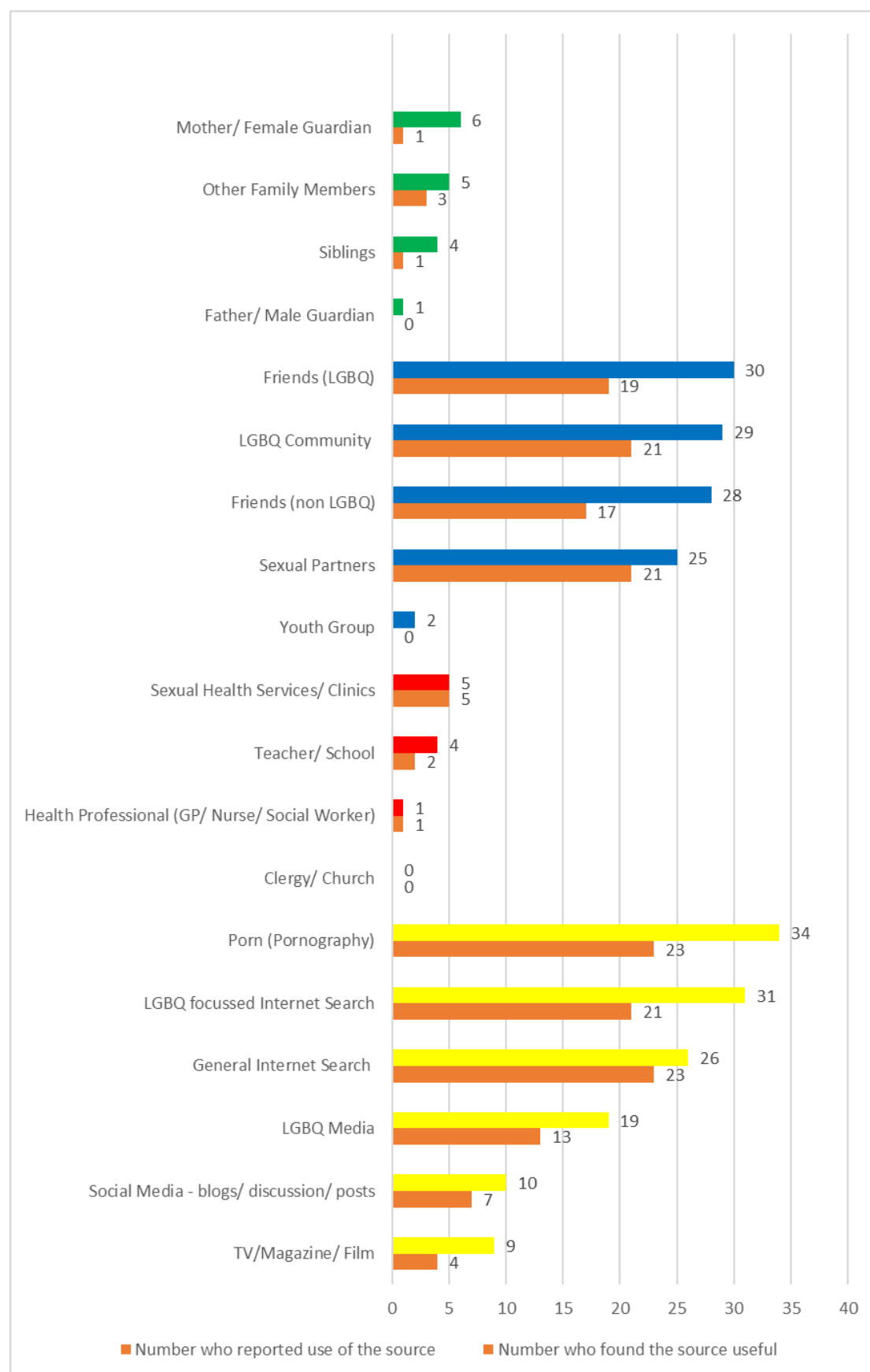
Figure 5.30: Sources of Information on Oral Sex (%)



5.10.11 Usefulness of Sources of Information on Oral Sex

The respondents indicated that General Internet Search (92%, 23 out of 25) was the most useful source of information. Porn (Pornography) was also useful with 76.7% (23 out of 30) reporting it as such (Table 5.38). LGBQ Focussed Internet Search (70%, 21 out of 30), LGBQ Community (84%, 21 out of 25) and Sexual Partners (91.3%, 21 out of 23) were all reported as useful. LGBQ Friends (67.9%, 19 out of 25) and Non LGBQ Friends (68%, 17 out of 25) had similar findings. Mother while reported by 6 respondents as a source of information was only reported by 1 respondent as a useful one (Figure 5.31).

Figure 5.31: Usefulness of Sources of Information on Oral Sex (n=)



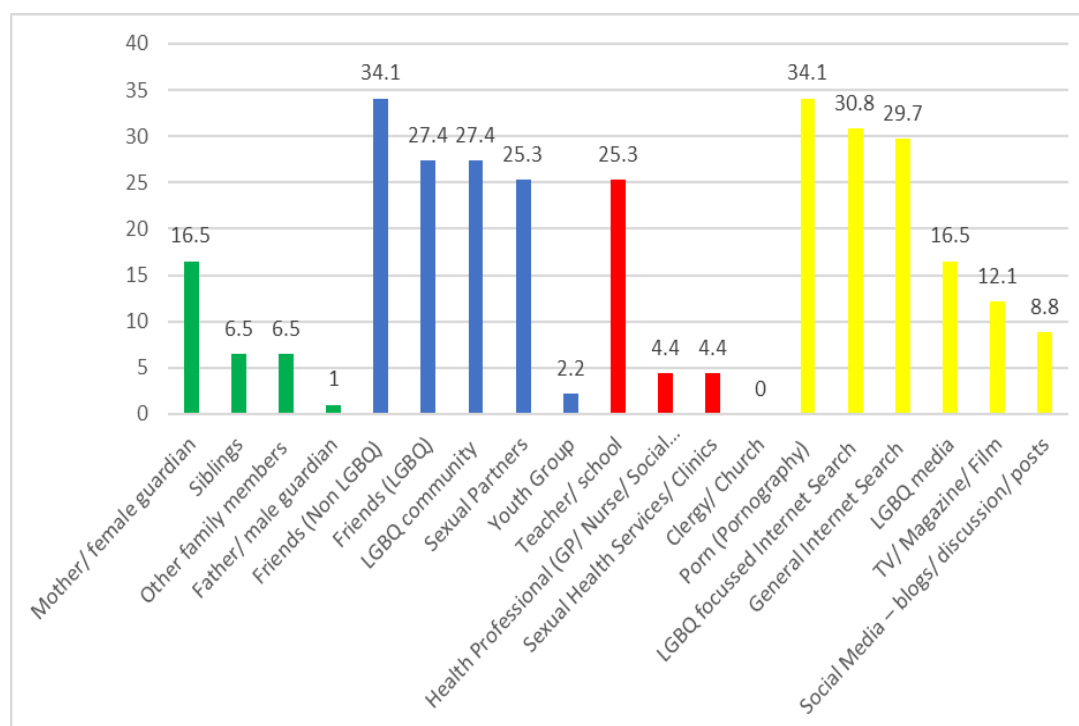
5.10.12 Sources of Information on Vaginal Sex

The primary sources of information on “*Vaginal sex*” were Non- LGBQ Friends and Porn (Pornography) with both being identified by 34.1% (n=31) of respondents as a source of information (Table 5.32). In addition, LGBQ Community and Friends (LGBQ) were both pinpointed by 27.4% (n=25) of respondents as a secondary source of information. Interestingly, both sexual partners and teachers/ school were identified as a source of information by 25.3% (n=23) of respondents. The other sources of information were all identified by the minority of respondents in groups as a source of information (Figure 5.32).

Table 5.32: Sources of Information on Vaginal Sex

Family Group Sources	
Mother/ female guardian	16.5% (n=15)
Siblings	6.5% (n=6)
Other family members	6.5% (n=6)
Father/ male guardian	1% (n=1)
Peer Group Sources	
Friends (Non-LGBQ)	34.1% (n=31)
Friends (LGBQ)	27.4% (n=25)
LGBQ community	27.4% (n= 25)
Sexual Partners	25.3% (n=23)
Youth Group	2.2% (n=2)
Professional Group Sources	
Teacher/ school	25.3% (n=23)
Health Professional (GP/ Nurse/ Social Worker)	4.4% (n=4)
Sexual Health Services/ Clinics	4.4% (n=4)
Clergy/ Church	0% (n=0)
Internet/ Media Sources	
Porn (Pornography)	34.1% (n=31)
LGBQ focussed Internet Search	30.8% (n=28)
General Internet Search	29.7% (n=27)
LGBQ media	16.5% (n=15)
TV/ Magazine/ Film	12.1% (n=11)
Social Media – blogs/ discussion/ posts	8.8% (n=8)

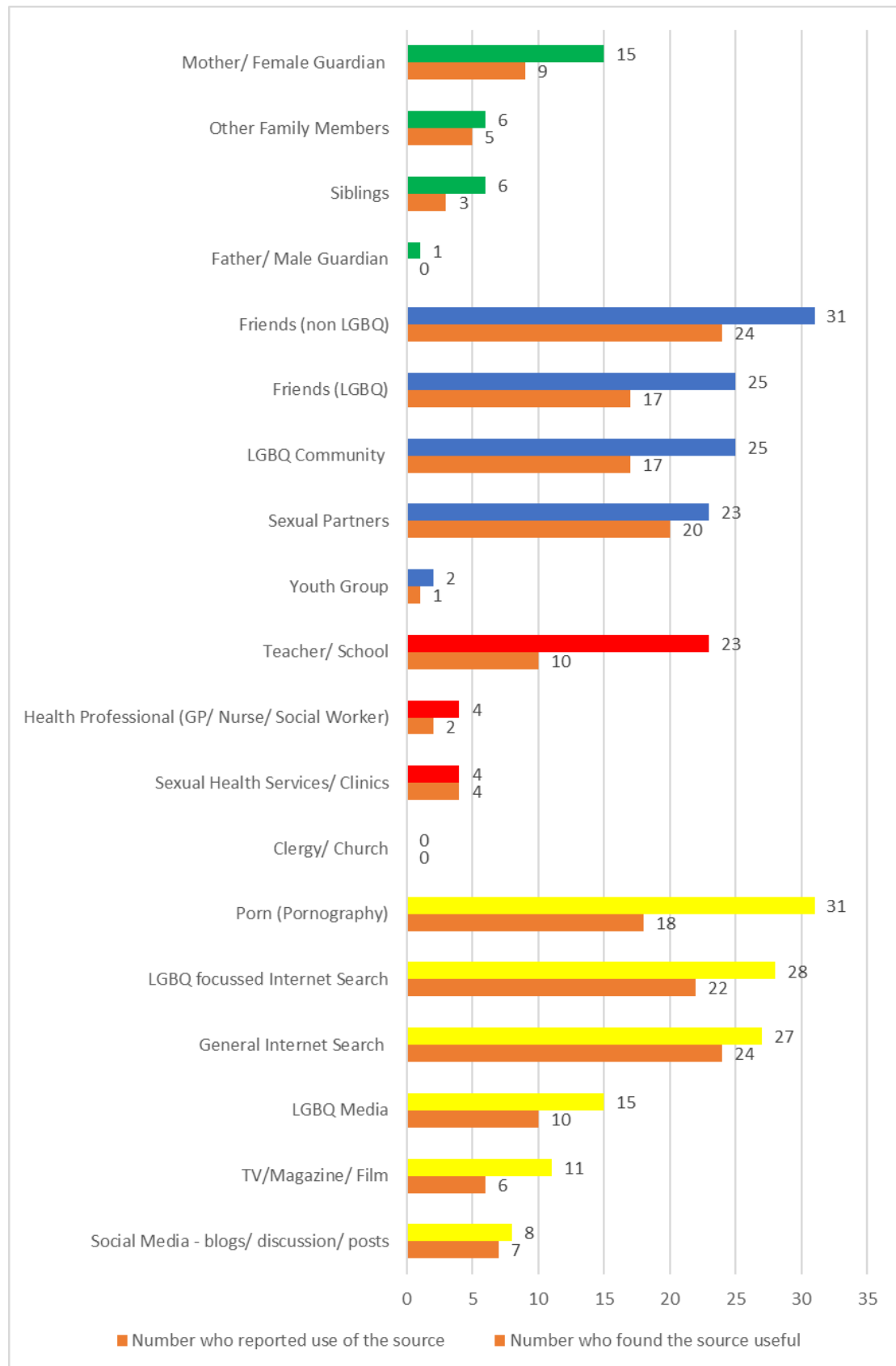
Figure 5.32- Sources of Information on Vaginal Sex (%)



5.10.13 Usefulness of Sources of Information on Vaginal Sex

With the sources being reported as similar for some groups and sources, the usefulness is not the same. Both Non LGBQ Friends and Porn (pornography) while reported by 31 respondents as a source of information, only 24 reported that Non LGBQ Friends and 18 reported that Porn (Pornography) was a useful source in information (Figure 5.33). Both LGBQ Friends and LGBQ Community had similar findings with 77.3% (17 out of 22) of respondents stating that they were a useful source (Table 5.39). Differences were also found with Teachers (47.6%, 10 out of 21) and Sexual Partners 90.9% (20 out of 22) being reported as useful (Table 5.39). For LGBQ Media (76.9%, 10 out of 13) and Mother/ Female Guardian (75%, 9 out of 12) similar results were also found.

Figure 5.33: Usefulness of Sources of Information on Vaginal Sex (n=)



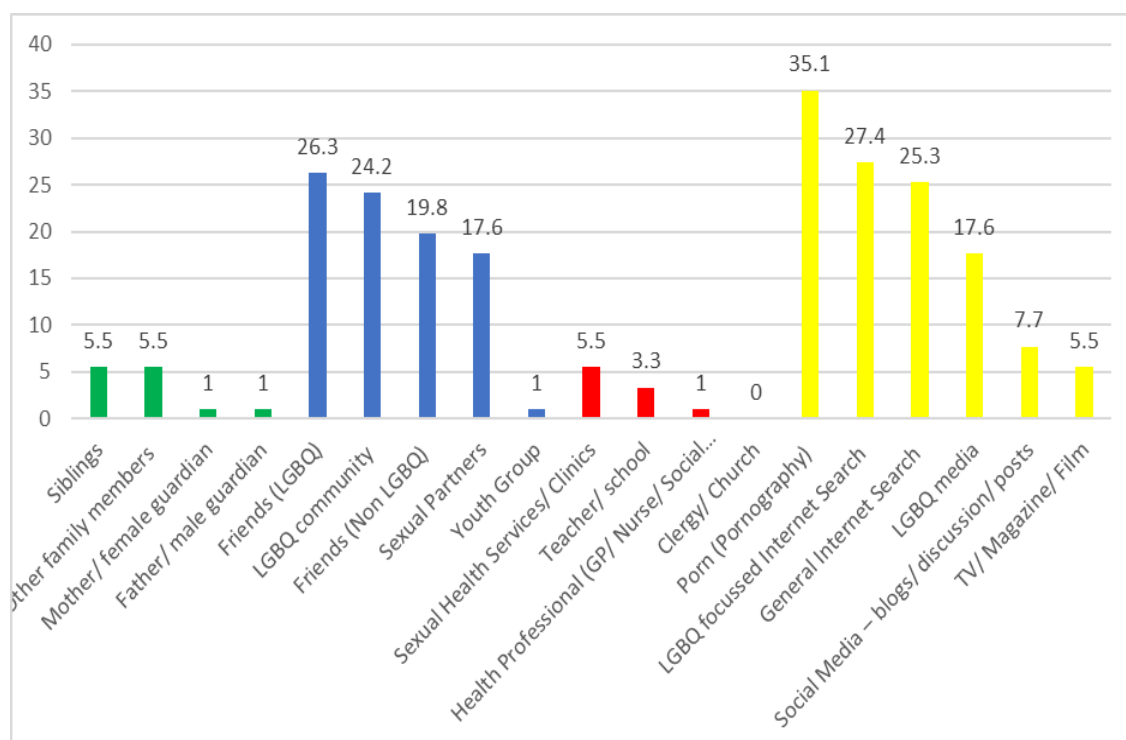
5.10.14 Sources of Information on Anal Sex

The most common sources for information on “Anal Sex” were from the Internet/ Media group of sources (Table 5.33). These were Porn (pornography) (35.1%, n= 32), LGBTQ focussed Internet Search (27.4%, n=25) and General Internet Search (25.3%, n=23). Both Sexual Partners and LGBTQ Media were indicated by 17.6% (n=16) of respondents as a source of information. Other sources in the Peer Group of sources were LGBTQ Friends (26.3%, n=24), LGBTQ Community (24.2%, n=22) and Non LGBTQ Friends (19.8%, n=18). The Family Group were very much in the minority as a source of information and the only source in the Professional Group that was of note was Sexual Health Services/ Clinics which was still in the minority at 5.5% (n=5) (Figure 5.34).

Table 5.33: Sources of Information on Anal Sex

Family Group Sources	
Siblings	5.5% (n=5)
Other family members	5.5% (n=5)
Mother/ female guardian	1% (n=1)
Father/ male guardian	1% (n=1)
Peer Group Sources	
Friends (LGBTQ)	26.3% (n=24)
LGBTQ community	24.2% (n=22)
Friends (Non-LGBTQ)	19.8% (n=18)
Sexual Partners	17.6% (n=16)
Youth Group	1% (n=1)
Professional Group Sources	
Sexual Health Services/ Clinics	5.5% (n=5)
Teacher/ school	3.3% (n=3)
Health Professional (GP/ Nurse/ Social Worker)	1% (n=1)
Clergy/ Church	0% (n=0)
Internet/ Media Group Sources	
Porn (Pornography)	35.1% (n=32)
LGBTQ focussed Internet Search	27.4% (n=25)
General Internet Search	25.3% (n=23)
LGBTQ media	17.6% (n=16)
Social Media – blogs/ discussion/ posts	7.7% (n=7)
TV/ Magazine/ Film	5.5% (n=5)

Figure 5.34: Sources of Information on Anal Sex (%)

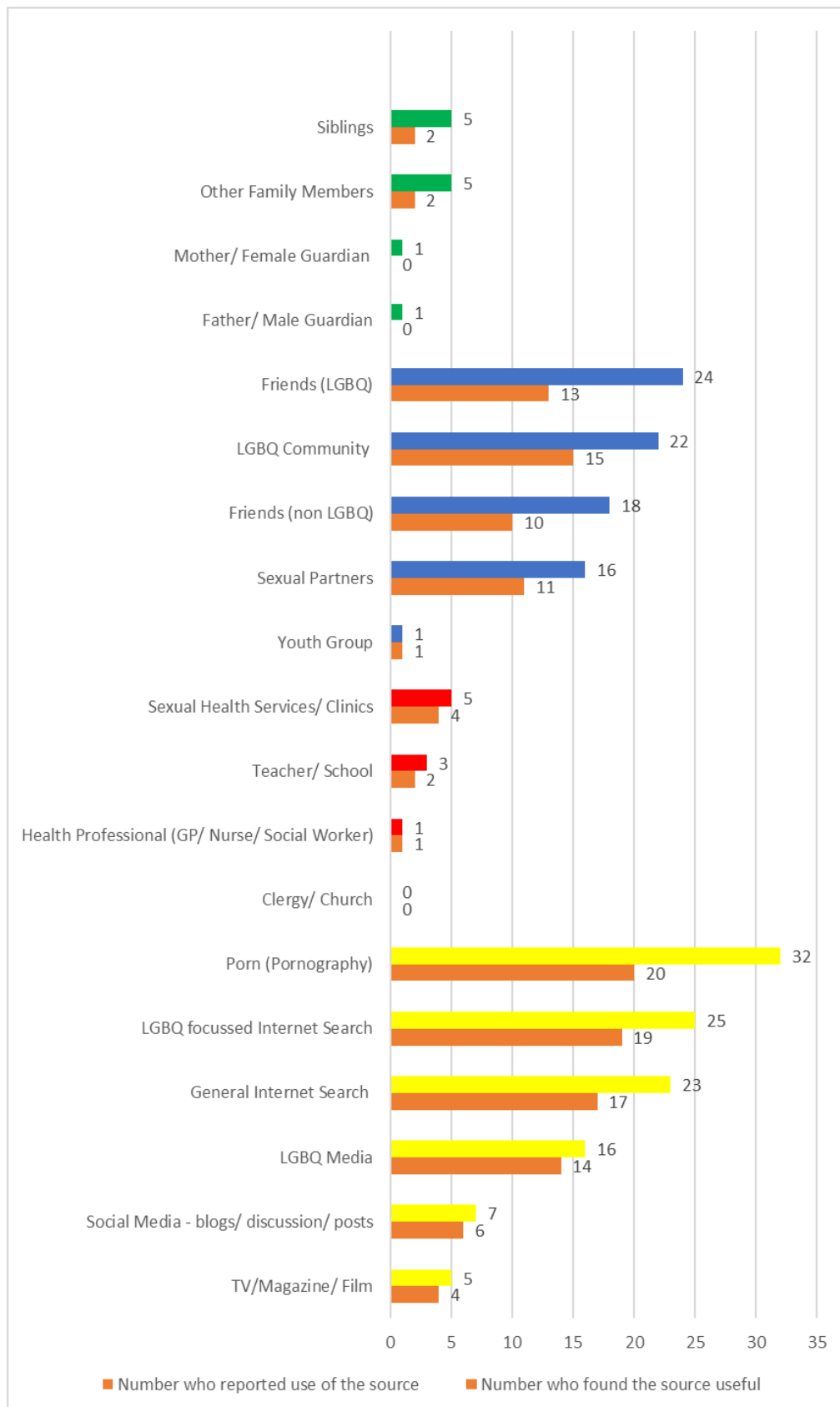


5.10.15 Usefulness of Sources of Information on Anal Sex

Similar to previous topics in the Sexual Activity/ Behaviour category, Porn (pornography) was identified as one of the most used sources of information for “*Anal Sex*”. However, in this instance it was not the most useful with only 71.4% (20 out of 28) indicating that it was useful. There are similar findings for other Peer Group Sources with LGBQ Friends (61.9%, 13 out of 21), LGBQ Community (83.3%, 15 out of 18), Non LGBQ Friends (62.5%, 10 out of 16) and Sexual Partners (73.3%, 11 out of 15) (Figure 5.35).

In the Internet/Media group as well as Porn(pornography), LGBQ focussed Internet Search (82.6%, 19 out of 23), General Internet Search (85%, 17 out of 20), LGBQ Media (93.3%, 14 out of 15) were the most useful sources. Professional and Family Group Sources while being reported as a source by minimal respondents, also had limited usefulness (Table 5.39).

Figure 5.35: Usefulness of Sources on Anal Sex (n=)



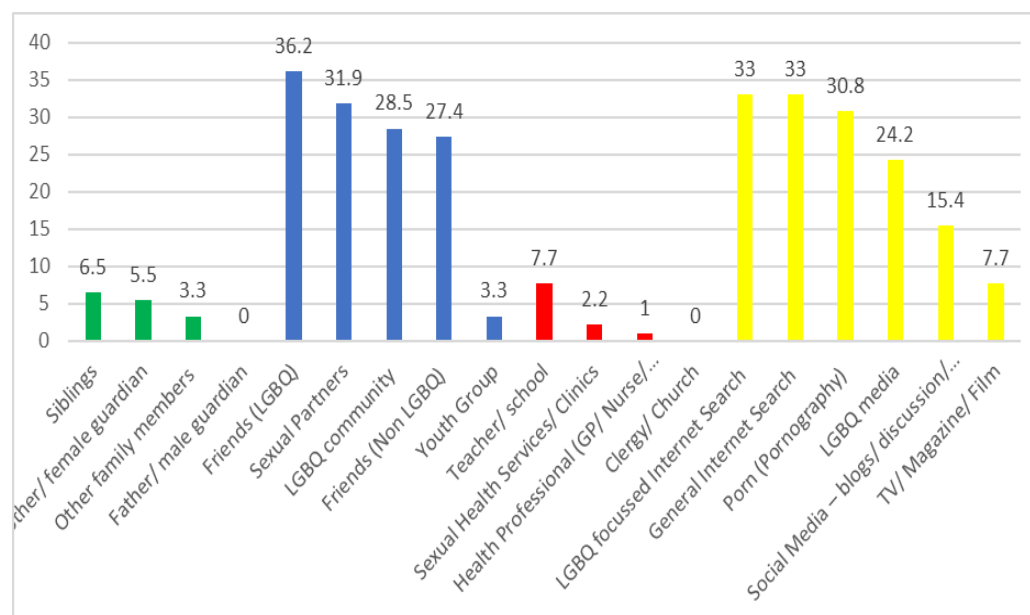
5.10.16 Sources of Information on What to do During Sex

The primary and secondary sources of information on “*What to do during Sex*” were LGBQ Friends (36.2%, n=33), LGBQ focussed Internet Search and General Internet Search who were both reported by 33% (n=30) of respondents as a source of information (Table 5.34). Other Sources that were identified as a source of information were Sexual Partners (31.9%, n=29), LGBQ Community (28.5%, n=26) and non-LGBQ Friends (27.4%, n=25) (Figure 5.36). For this topic, Family and Professionals are not reported as a source of information with the highest of the reports in the Professional Group as Teacher/ School (7.7%, n=7) and in the Family Group as Mother/ Female Guardian (6.5%, n=6).

Table 5.34: Sources of Information on What to do during sex

Family Group Sources	
Siblings	6.5% (n=6)
Mother/ female guardian	5.5% (n=5)
Other family members	3.3% (n=3)
Father/ male guardian	0% (n=0)
Peer Group Sources	
Friends (LGBQ)	36.2% (n=33)
Sexual Partners	31.9% (n=29)
LGBQ community	28.5% (n=26)
Friends (Non-LGBQ)	27.4% (n=25)
Youth Group	3.3% (n=3)
Professional Group Sources	
Teacher/ school	7.7% (n=7)
Sexual Health Services/ Clinics	2.2% (n=2)
Health Professional (GP/ Nurse/ Social Worker)	1% (n=1)
Clergy/ Church	0% (n=0)
Internet/ Media Sources	
LGBQ focussed Internet Search	33% (n=30)
General Internet Search	33% (n=30)
Porn (Pornography)	30.8% (n=28)
LGBQ media	24.2% (n=22)
Social Media – blogs/ discussion/ posts	15.4% (n=14)
TV/ Magazine/ Film	7.7% (n=7)

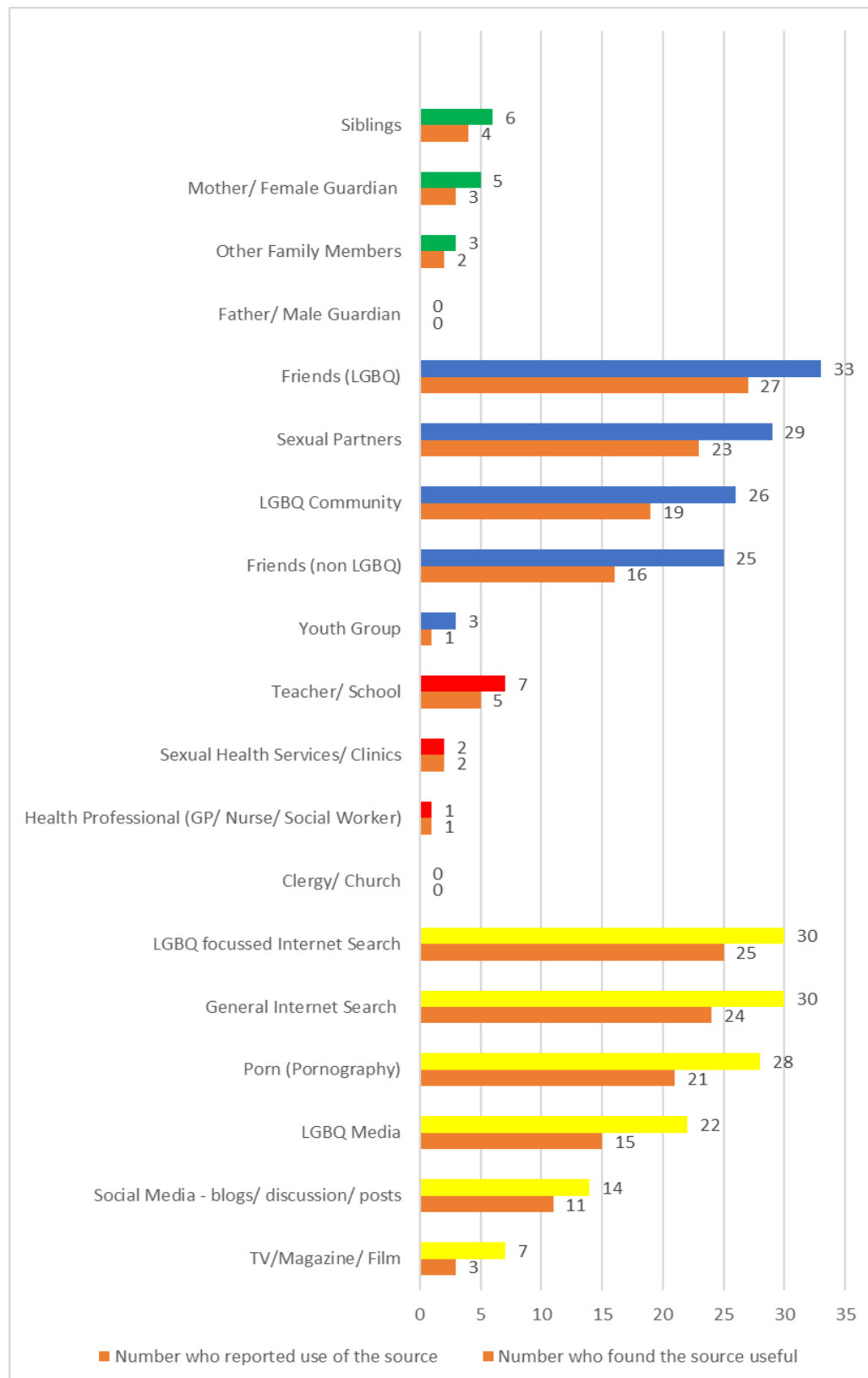
Figure 5.36- Sources of Information on What to do during sex (%)



5.10.17 Usefulness of Sources of Information on What to do During Sex

For this topic, the amount of respondents who reported use of a source and those who found the source useful were similar (Figure 5.37). The source that was most useful was LGBQ Friends (87.1%, 27 out of 31). The sources that was considered the least useful were from the Internet/ Media group and were Non-LGBQ Friends (64%, 16 out of 25), Porn (pornography) (77.8%, 21 out of 27) as well as LGBQ Media (75%, 15 out of 20) (Table 5.39).

Figure 5.37- Sources of Information and Usefulness on What to do During Sex (n=)



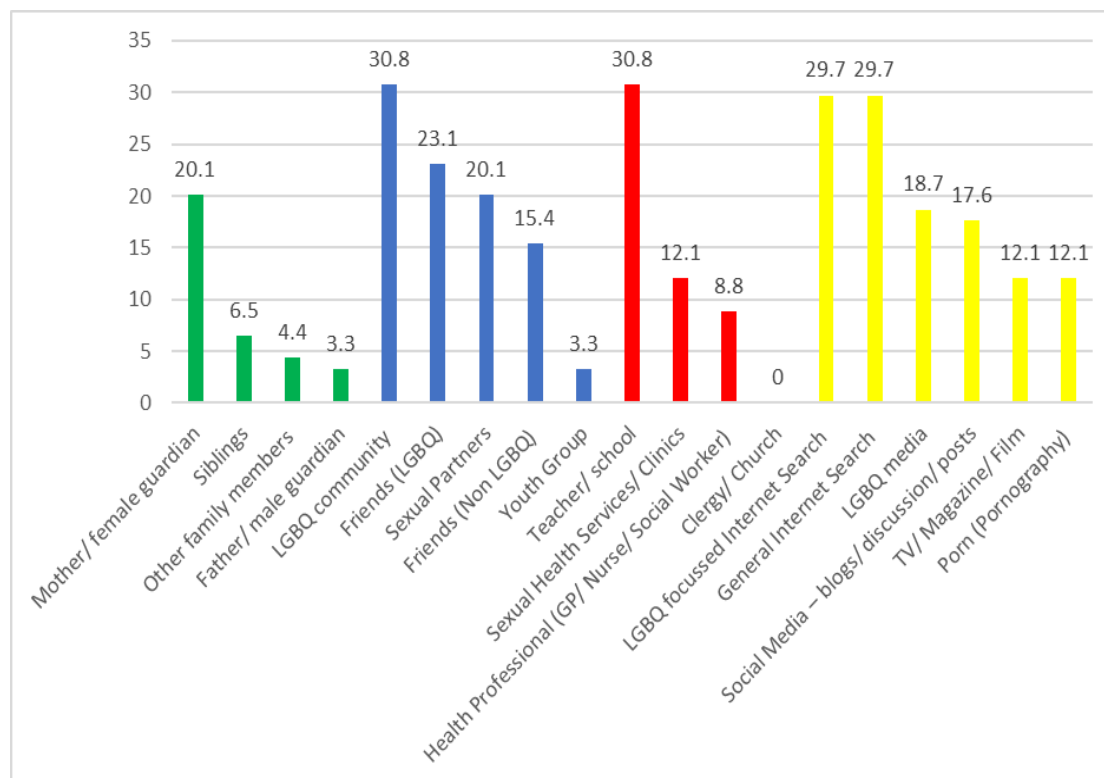
5.10.18 Sources of Information on How to Use Safer Sex Aids

The most common sources of information on “*How to use safer sex aids*” were LGBQ Community and Teachers/ School with 30.8% (n=28) of respondents stating that they were a source of information (Table 5.35). These were followed by Internet Searches (LGBQ and General) where 29.7% (n=27) of respondents had reported these as a source of information. LGBQ Friends were also reported as a source of information by 23.1% (n=21)). Sexual Partners and Mother/ Female Guardian were both chosen by 20.1% (n= 19) of respondents as a source of information. The rest of the sources were chosen by the minority of respondents as a source of information (Figure 5.38).

Table 5.35- Sources of Information of How to use Safer Sex Aids

Family Sources	
Mother/ female guardian	20.1% (n=19)
Siblings	6.5% (n=6)
Other family members	4.4% (n=4)
Father/ male guardian	3.3% (n=3)
Peer Sources	
LGBQ community	30.8% (n=28)
Friends (LGBQ)	23.1% (n=21)
Sexual Partners	20.1% (n=19)
Friends (Non LGBQ)	15.4% (n=14)
Youth Group	3.3% (n=3)
Professional Sources	
Teacher/ school	30.8% (n=28)
Sexual Health Services/ Clinics	12.1% (n=11)
Health Professional (GP/ Nurse/ Social Worker)	8.8% (n=8)
Clergy/ Church	0% (n=0)
Internet/ Media Sources	
LGBQ focussed Internet Search	29.7% (n=27)
General Internet Search	29.7% (n=27)
LGBQ media	18.7% (n=17)
Social Media – blogs/ discussion/ posts	17.6% (n=16)
TV/ Magazine/ Film	12.1% (n=11)
Porn (Pornography)	12.1% (n=11)

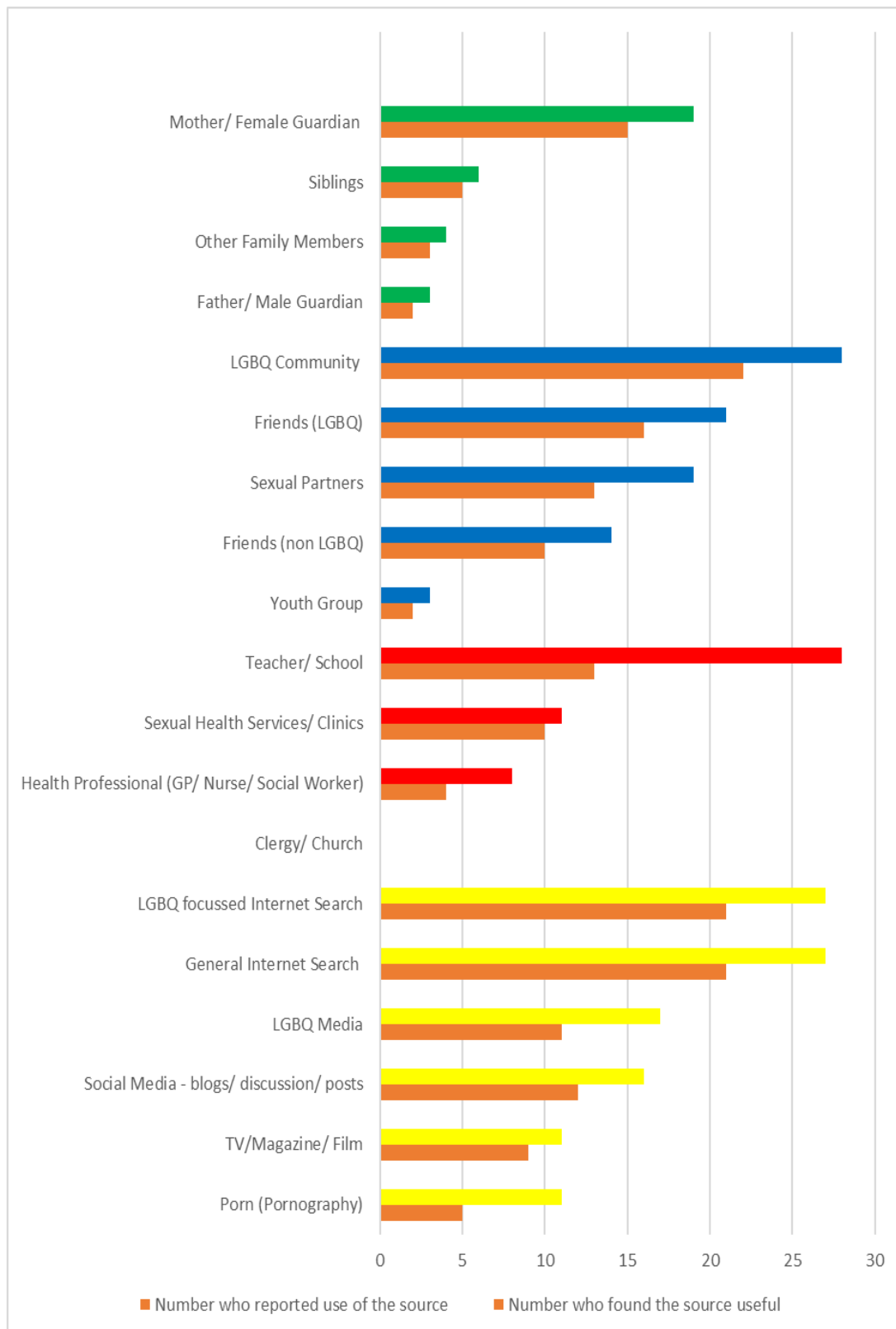
Figure 5.38- Sources of Information on How to use Safer Sex Aids (%)



5.10.19 Usefulness of Sources of Information on How to Use Safer Sex Aids

Similar findings are available on the usefulness of Internet Searches with LGBQ focussed Internet Search (91.3%, 21 out of 23) proving slightly more useful than General Internet Search (87.5%,) with 21 out of 24 respondents indicating that they were useful. The LGBQ Community were also considered useful with 88% (22 out of 25) reporting that they were a useful source. The main difference between those reporting that they used a source and their usefulness was for Teacher/ School where out of the 28 that reported they were a source only 13 considered them useful (Figure 5.39). All the other sources listed had similar numbers between those that reported them as a source and those that found them useful (Table 5.39).

Figure 5.39: Usefulness of Sources of Information on How to Use Safer Sex Aids (n=)



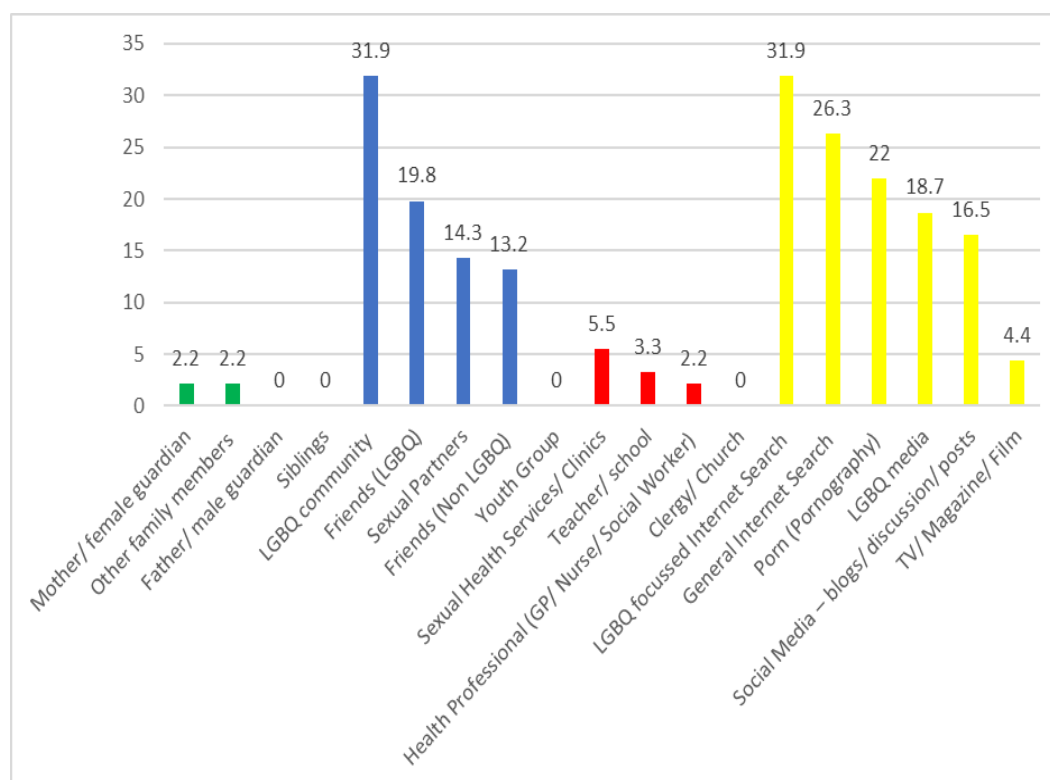
5.10.20 Sources of Information on How to Use Sex Toys Safely

The predominant sources reported for “*How to Use Sex Toys Safely*” were from both the Peer group sources and from the Internet/ Media Group of Sources. The most common sources of information reported for this topic were LGBTQ Community and LGBTQ Focussed Internet Search with 31.9% (n=29) for both sources reporting that they were a source of information (Table 5.36). Other sources reported were General Internet Search (26.3%, n=24) and Porn (pornography) which was reported by 22% (n= 20) of respondents as a source of information. All other sources were reported by the minority of respondents as a source of information (Figure 5.40).

Table 5.36- Sources of Information on How to Use Sex Toys Safely

Family Group Sources	
Mother/ female guardian	2.2% (n=2)
Other family members	2.2% (n=2)
Father/ male guardian	0% (n=0)
Siblings	0% (n=0)
Peer Group Sources	
LGBTQ community	31.9% (n=29)
Friends (LGBTQ)	19.8% (n=18)
Sexual Partners	14.3% (n=13)
Friends (Non-LGBTQ)	13.2% (n=12)
Youth Group	0% (n=0)
Professional Group Sources	
Sexual Health Services/ Clinics	5.5% (n=5)
Teacher/ school	3.3% (n=3)
Health Professional (GP/ Nurse/ Social Worker)	2.2% (n=2)
Clergy/ Church	0% (n=0)
Internet/ Media Group Sources	
LGBTQ focussed Internet Search	31.9% (n=29)
General Internet Search	26.3 % (n=24)
Porn (Pornography)	22% (n=20)
LGBTQ media	18.7% (n=17)
Social Media – blogs/ discussion/ posts	16.5% (n=15)
TV/ Magazine/ Film	4.4% (n=4)

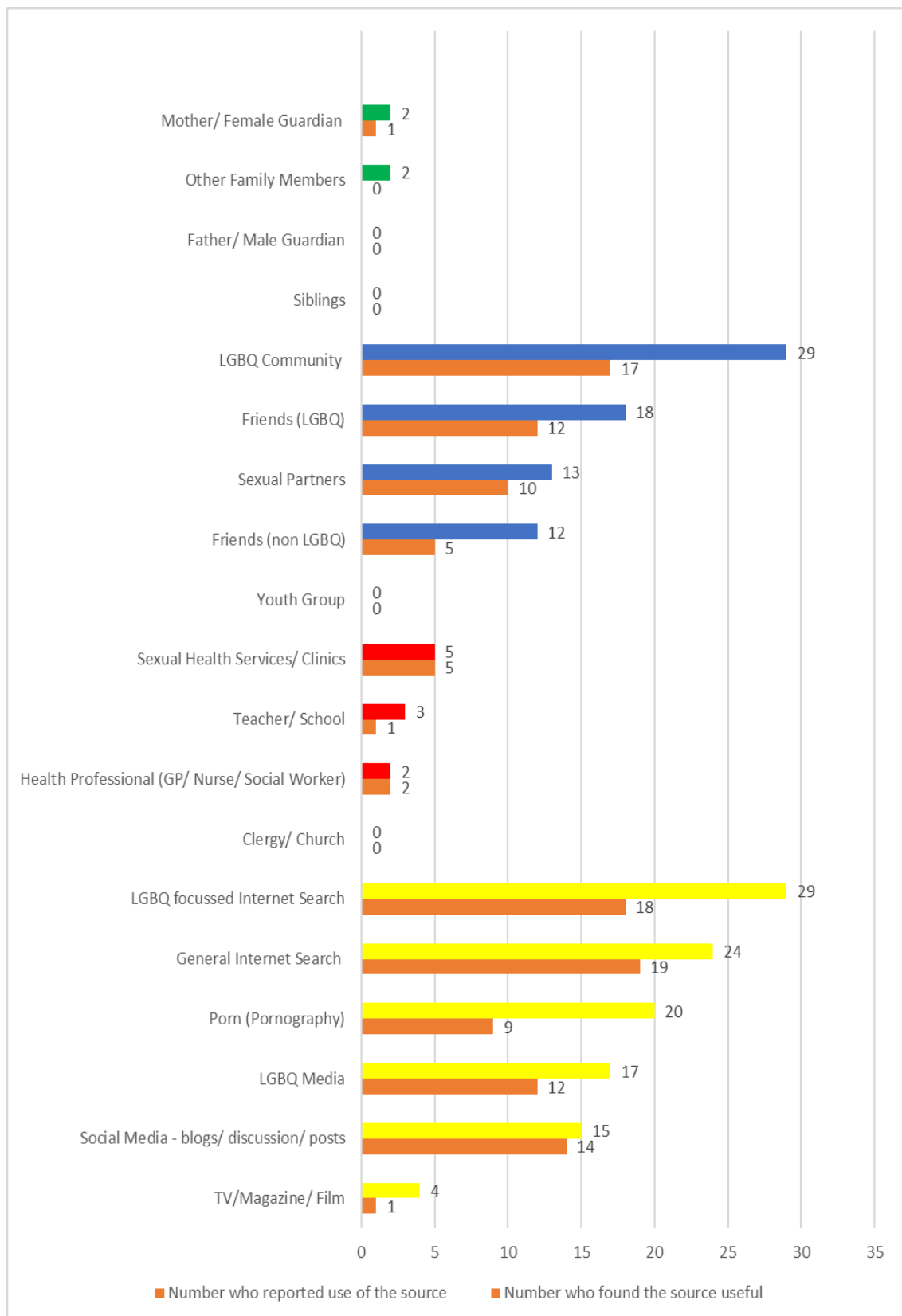
Figure 5.40- Sources of Information on How to use sex toys safely (%)



5.10.21 Usefulness of Sources of Information on How to Use Sex Toys Safely.

While there was a difference in the numbers reported use of LGBQ Community and LGBQ Focussed Internet Searches as a source of information, similar numbers were shown to find LGBQ Community (17 out of 29) and LGBQ Focussed Internet Search (18 out of 29) useful as a source of information (Figure 5.41). General Internet Search was a useful source of information for 82.6% (19 out of 23) respondents. However, only 56.3% (9 out of 16) found Porn (pornography) to be a useful source of information. All the respondents (100%, 14 out of 14) found Social Media – blogs/ discussion/ posts to be useful. However, for Non-LGBQ Friends (41.7%), 5 out of 12 respondents reported that they were a useful source of information (Table 5.39).

Figure 5.41- Usefulness of Sources for How to Use Sex Toys Safely (n=)



5.10.22 Summary Sexual Activity/ Sexual Behaviour – Sources and Usefulness

The predominant sources of information for the topics in this category are from the Peer and Internet/ Media Groups and are LGBTQ specific apart from the topics on “*Vaginal Sex*”. Porn(pornography) was the most cited source of information for five of the ten topics in this category with LGBTQ community the primary source of information for “*How to use safer sex aids*” and “*How to use sex toys safely*”.

5.10.23 Additional Topics and Sources of Information on Sexual Behaviour/ Sexual Activity

Respondents were asked about additional sources and topics that they may have sourced information on for Sexual Behaviour and Sexual Activity. One comment added a source, which was books. There were two responses which mentioned topics. Rape was included by one respondent and douching by another.

Table 5.37 - Sources of Information for Topics on the Category Sexual Behaviour/ Sexual Activity (n=91)

Source of Information		Kissing	Cuddling	Genital Touching	Masturbation	Oral sex	Vaginal sex	Anal Sex	What to do during sex	How to use safer sex aids	How to use sex toys safely
Family Group Sources	Mother/ female guardian	24.2% (n=22)	23.1% (n=20)	6.5% (n=6)	6.5% (n=6)	6.5% (n=6)	16.5% (n=15)	1% (n=1)	5.5% (n=5)	20.1% (n=19)	2.2% (n=2)
	Father/ male guardian	7.7% (n=7)	8.8% (n=8)	2.2% (n=2)	3.3% (n=3)	1% (n=1)	1% (n=1)	1% (n=1)	0% (n=0)	3.3% (n=3)	0% (n=0)
	Siblings	12.1% (n=11)	10.9% (n=10)	3.3% (n=3)	2.2% (n=2)	4.4% (n=4)	6.5% (n=6)	5.5% (n=5)	6.5% (n=6)	6.5% (n=6)	0% (n=0)
	Other family members	6.5% (n=6)	7.7% (n=7)	5.5% (n=5)	4.4% (n=4)	5.5% (n=5)	6.5% (n=6)	5.5% (n=5)	3.3% (n=3)	4.4% (n=4)	2.2% (n=2)
Peer Group Sources	Friends (LGBQ)	52.7% (n=48)	47.2% (n=43)	30.8% (n=28)	37.3% (n=34)	33% (n=30)	27.4% (n=25)	26.3% (n=24)	36.2% (n=33)	23.1% (n=21)	19.8% (n=18)
	Friends (Non LGBQ)	50.5% (n=46)	38.5% (n=35)	26.3% (n=24)	33% (n=30)	30.8% (n=28)	34.1% (n=31)	19.8% (n=18)	27.4% (n=25)	15.4% (n=14)	13.2% (n=12)
	LGBQ community	37.3% (n=34)	35.1% (n=32)	30.8% (n=28)	30.8% (n=28)	31.9% (n=29)	27.4% (n=25)	24.2% (n=22)	28.5% (n=26)	30.8% (n=28)	31.9% (n=29)
	Youth Group	2.2% (n=2)	2.2% (n=2)	0% (n=0)	1% (n=1)	2.2% (n=2)	2.2% (n=2)	1% (n=1)	3.3% (n=3)	3.3% (n=3)	0% (n=0)
	Sexual Partners	40.6% (n=37)	37.3% (n=34)	30.8% (n=28)	28.5% (n=26)	27.4% (n=25)	25.3% (n=23)	17.6% (n=16)	31.9% (n=29)	20.1% (n=19)	14.3% (n=13)

Source of Information		Kissing	Cuddling	Genital Touching	Masturbation	Oral sex	Vaginal sex	Anal Sex	What to do during sex	How to use safer sex aids	How to use sex toys safely
Professional Group	Teacher/ school	7.7% (n=7)	4.4% (n=4)	5.5% (n=5)	5.5% (n=5)	4.4% (n=4)	25.3% (n=23)	3.3% (n=3)	7.7% (n=7)	30.8% (n=20)	3.3% (n=3)
	Health Professional (GP/ Nurse/ Social Worker)	2.2% (n=2)	2.2% (n=2)	2.2% (n=2)	2.2% (n=2)	1% (n=1)	4.4% (n=4)	1% (n=1)	1% (n=1)	8.8% (n=8)	2.2% (n=2)
	Clergy/ Church	2.2% (n=2)	2.2% (n=2)	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)
	Sexual Health Services/ Clinics	1% (n=1)	2.2% (n=2)	4.4% (n=4)	3.3% (n=3)	5.5% (n=5)	4.4% (n=4)	5.5% (n=5)	2.2% (n=2)	12.1% (n=11)	5.5% (n=5)
Internet/ Media Group Sources	LGBQ focussed Internet Search	30.8% (n=28)	27.4% (n=25)	33% (n=30)	35.1% (n=32)	34.1% (n=31)	30.8% (n=28)	27.4% (n=25)	33% (n=30)	29.7% (n=27)	31.9% (n=29)
	General Internet Search	36.2% (n=33)	23.1% (n=21)	28.5% (n=26)	36.2% (n=33)	28.5% (n=26)	29.7% (n=27)	25.3% (n=23)	33% (n=30)	29.7% (n=27)	26.3% (n=24)
	LGBQ media	28.5% (n=26)	24.2% (n=22)	16.5% (n=15)	22% (n=20)	20.1% (n=19)	16.5% (n=15)	17.6% (n=16)	24.2% (n=22)	18.7% (n=17)	18.7% (n=17)
	TV/ Magazine/ Film	27.4% (n=25)	20.1% (n=19)	2.2% (n=2)	8.8% (n=8)	9.9% (n=9)	12.1% (n=11)	5.5% (n=5)	7.7% (n=7)	12.1% (n=11)	4.4% (n=4)
	Porn (Pornography)	26.3% (n=24)	15.4% (n=14)	34.1% (n=31)	41.7% (n=38)	37.3% (n=34)	34.1% (n=31)	35.1% (n=32)	30.8% (n=28)	12.1% (n=11)	22% (n=20)
	Social Media – blogs/ discussion/ posts	13.2% (n=12)	14.3% (n=13)	10.9% (n=10)	15.4% (n=14)	10.9% (n=10)	8.8% (n=8)	7.7% (n=7)	15.4% (n=14)	17.6% (n=16)	16.5% (n=15)
Primary		Most common source of information									
Secondary		2 nd most common source of information									
Secondary		3 rd most common source of information									

Table 5.38: Usefulness of Sources of Information for Topics (1 to 5) on the Category Sexual Behaviour/ Sexual Activity (n=91)

Source of Information		Kissing	Usefulness	Cuddling	Usefulness	Genital Touching	Usefulness	Masturbation	Usefulness	Oral sex	Usefulness
Family Group Sources	Mother/ female guardian	24.2% (n=22)	52.9% (9 out of 17)	23.1% (n=20)	60% (9 out of 15)	6.5% (n=6)	40% (2 out of 5)	6.5% (n=6)	60% (3 out of 5)	6.5% (n=6)	20% (1 out of 5)
	Father/ male guardian	7.7% (n=7)	33.3% (2 out of 6)	8.8% (n=8)	40% (2 out of 5)	2.2% (n=2)	100% (1 out of 1)	3.3% (n=3)	0% (0 out of 1)	1% (n=1)	0% (0 out of 0)
	Siblings	12.1% (n=11)	66.7% (6 out of 9)	10.9% (n=10)	77.8% (7 out of 9)	3.3% (n=3)	0% (0 out of 2)	2.2% (n=2)	100% (1 out of 1)	4.4% (n=4)	33.3% (1 out of 3)
	Other family members	6.5% (n=6)	66.7% (4 out of 6)	7.7% (n=7)	100% (5 out of 5)	5.5% (n=5)	40% (2 out of 5)	4.4% (n=4)	100% (3 out of 3)	5.5% (n=5)	75% (3 out of 4)
Peer Group Sources	Friends (LGBQ)	52.7% (n=48)	92.3% (36 out of 39)	47.2% (n=43)	97.4% (37 out of 38)	30.8% (n=28)	87% (20 out of 23)	37.3% (n=34)	70% (21 out of 30)	33% (n=30)	67.9% (19 out of 25)
	Friends (Non-LGBQ)	50.5% (n=46)	82.2% (37 out of 45)	38.5% (n=35)	86.7% (26 out of 30)	26.3% (n=24)	70.8% (17 out of 24)	33% (n=30)	81.5% (22 out of 27)	30.8% (n=28)	68% (17 out of 25)
	LGBQ community	37.3% (n=34)	80.6% (25 out of 30)	35.1% (n=32)	90% (27 out of 30)	30.8% (n=28)	84% (21 out of 25)	30.8% (n=28)	75% (18 out of 24)	31.9% (n=29)	84% (21 out of 25)
	Youth Group	2.2% (n=2)	50% (1 out of 2)	2.2% (n=2)	100% (2 out of 2)	0% (n=0)	0% (0 out of 0)	1% (n=1)	0% (0 out of 1)	2.2% (n=2)	0% (0 out of 1)
	Sexual Partners	40.6% (n=37)	87.9% (29 out of 33)	37.3% (n=34)	96.7% (29 out of 30)	30.8% (n=28)	92.3% (24 out of 26)	28.5% (n=26)	95.5% (21 out of 22)	27.4% (n=25)	91.3% (21 out of 23)

Source Information	of	Kissing	Usefulness	Cuddling	Usefulness	Genital Touching	Usefulness	Masturbation	Usefulness	Oral sex	Usefulness
Professional Group Sources	Teacher/school	7.7% (n=7)	42.9% (3 out of 7)	4.4% (n=4)	75% (3 out of 4)	5.5% (n=5)	60% (3 out of 5)	5.5% (n=5)	60% (3 out of 5)	4.4% (n=4)	50% (2 out of 4)
	Health Professional (GP/ Nurse/ Social Worker)	2.2% (n=2)	100% (2 out of 2)	2.2% (n=2)	100% (2 out of 2)	2.2% (n=2)	100% (2 out of 2)	2.2% (n=2)	100% (2 out of 2)	1% (n=1)	100% (1 out of 1)
	Clergy/ Church	2.2% (n=2)	50% (1 out of 2)	2.2% (n=2)	50% (1 out of 2)	0% (n=0)	0% (0 out of 0)	0% (n=0)	0% (0 out of 0)	0% (n=0)	0% (0 out of 0)
	Sexual Health Services/ Clinics	1% (n=1)	100% (1 out of 1)	2.2% (n=2)	50% (1 out of 2)	4.4% (n=4)	100% (4 out of 4)	3.3% (n=3)	66.7% (2 out of 3)	5.5% (n=5)	100% (5 out of 5)
Internet / Media Sources	LGBQ focussed Internet Search	30.8% (n=28)	70.8% (17 out of 24)	27.4% (n=25)	95% (19 out of 20)	33% (n=30)	100% (27 out of 27)	35.1% (n=32)	83.3% (25 out of 30)	34.1% (n=31)	70% (21 out of 30)
	General Internet Search	36.2% (n=33)	61.3% (19 out of 31)	23.1% (n=21)	88.9% (16 out of 18)	28.5% (n=26)	87% (20 out of 23)	36.2% (n=33)	87.5% (28 out of 32)	28.5% (n=26)	92% (23 out of 25)
	LGBQ media	28.5% (n=26)	79.2% (19 out of 24)	24.2% (n=22)	90.5% (19 out of 21)	16.5% (n=15)	78.6% (11 out of 14)	22% (n=20)	75% (12 out of 16)	20.1% (n=19)	81.3% (13 out of 16)
	TV/ Magazine/ Film	27.4% (n=25)	64% (16 out of 25)	20.1% (n=19)	78.9% (15 out of 19)	2.2% (n=2)	50% (1 out of 2)	8.8% (n=8)	50% (4 out of 8)	9.9% (n=9)	50% (4 out of 8)
	Porn (Pornography)	26.3% (n=24)	60.9% (14 out of 23)	15.4% (n=14)	61.5% (8 out of 13)	34.1% (n=31)	74.1% (20 out of 27)	41.7% (n=38)	78.8% (26 out of 33)	37.3% (n=34)	76.7% (23 out of 30)
	Social Media – blogs/ discussion/ posts	13.2% (n=12)	80% (8 out of 10)	14.3% (n=13)	75% (9 out of 12)	10.9% (n=10)	87.5% (7 out of 8)	15.4% (n=14)	70% (21 out of 30)	10.9% (n=10)	77.8% (7 out of 9)

Table 5.39 - Sources of Information for Topics (6-10) on the Category Sexual Behaviour/ Sexual Activity (n=91)

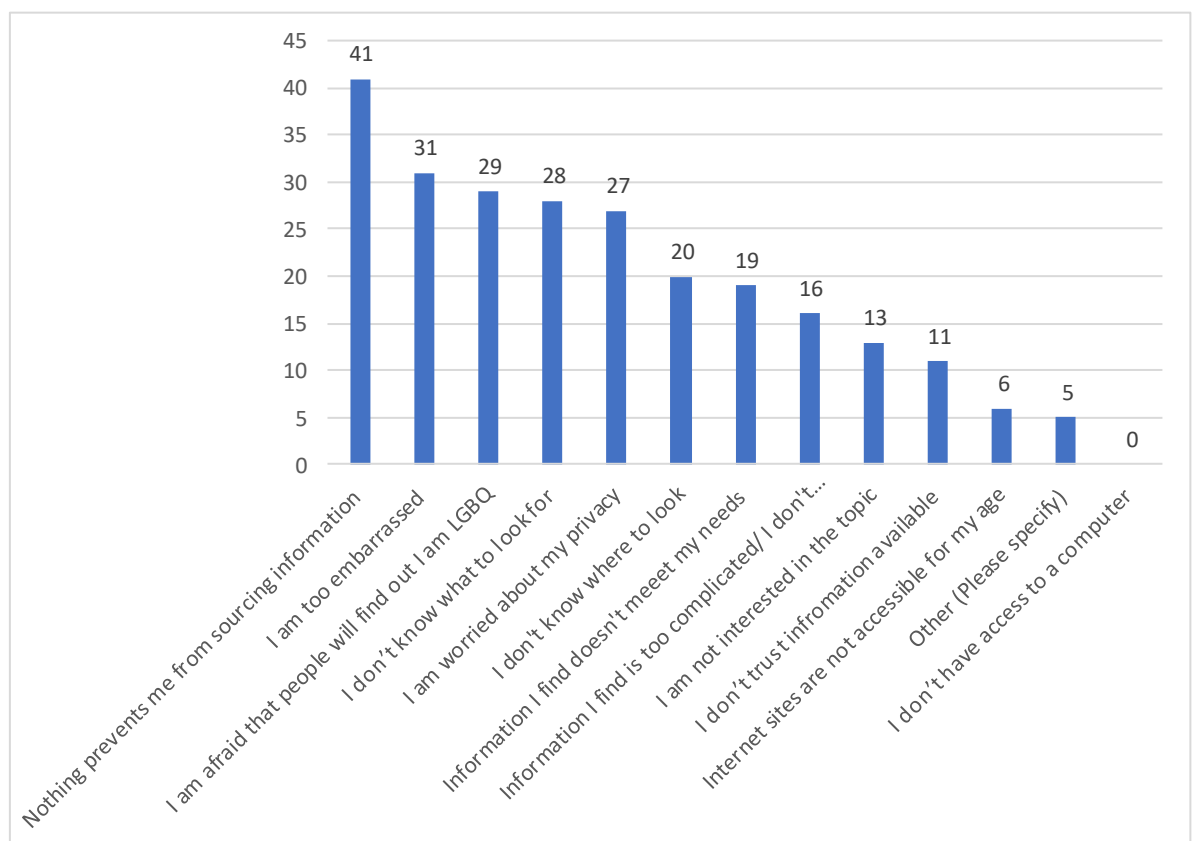
Source of Information		Vaginal sex	Usefulness	Anal Sex	Usefulness	What to do during sex	Usefulness	How to use safer sex aids	Usefulness	How to use sex toys safely	Usefulness
Family Group Sources	Mother/ female guardian	16.5% (n=15)	75% (9 out of 12)	1% (n=1)	0% (0 out of 0)	5.5% (n=5)	60% (3 out of 5)	20.1% (n=19)	88.2% (15 out of 17)	2.2% (n=2)	50% (1 out of 2)
	Father/ male guardian	1% (n=1)	0% (0 out of 0)	1% (n=1)	0% (0 out of 0)	0% (n=0)	0% (0 out of 0)	3.3% (n=3)	100% (2 out of 2)	0% (n=0)	0% (0 out of 0)
	Siblings	6.5% (n=6)	60% (3 out of 5)	5.5% (n=5)	50% (2 out of 4)	6.5% (n=6)	80% (4 out of 5)	6.5% (n=6)	83.3% (5 out of 6)	0% (n=0)	0% (0 out of 0)
	Other family members	6.5% (n=6)	100% (5 out of 5)	5.5% (n=5)	50% (2 out of 4)	3.3% (n=3)	66.7% (2 out of 3)	4.4% (n=4)	75% (3 out of 4)	2.2% (n=2)	0% (0 out of 1)
Peer Group Sources	Friends (LGBQ)	27.4% (n=25)	77.3% (17 out of 22)	26.3% (n=24)	61.9% (13 out of 21)	36.2% (n=33)	87.1% (27 out of 31)	23.1% (n=21)	88.9% (16 out of 18)	19.8% (n=18)	80% (12 out of 15)
	Friends (Non-LGBQ)	34.1% (n=31)	82.8% (24 out of 29)	19.8% (n=18)	62.5% (10 out of 16)	27.4% (n=25)	64% (16 out of 25)	15.4% (n=14)	71.4% (10 out of 14)	13.2% (n=12)	41.7% (5 out of 12)
	LGBQ community	27.4% (n= 25)	77.3% (17 out of 22)	24.2% (n=22)	83.3% (15 out of 18)	28.5% (n=26)	90.5% (19 out of 21)	30.8% (n=28)	88% (22 out of 25)	31.9% (n=29)	70.8% (17 out of 24)
	Youth Group	2.2% (n=2)	100% (1 out of 1)	1% (n=1)	100% (1 out of 1)	3.3% (n=3)	100% (1 out of 1)	3.3% (n=3)	100% (2 out of 2)	0% (n=0)	0% (0 out of 0)
	Sexual Partners	25.3% (n=23)	90.9% (20 out of 22)	17.6% (n=16)	73.3% (11 out of 15)	31.9% (n=29)	88.5% (23 out of 26)	20.1% (n=19)	72.2% (13 out of 18)	14.3% (n=13)	83.3% (10 out of 12)

Source of Information		Vaginal sex	Usefulness	Anal Sex	Usefulness	What to do during sex	Usefulness	How to use safer sex aids	Usefulness	How to use sex toys safely	Usefulness
Professional Group Sources	Teacher/ school	25.3% (n=23)	47.6% (10 out of 21)	3.3% (n=3)	66.7% (2 out of 3)	7.7% (n=7)	83.3% (5 out of 6)	30.8% (n=20)	65% (13 out of 20)	3.3% (n=3)	50% (1 out of 2)
	Health Professional (GP/ Nurse/ Social Worker)	4.4% (n=4)	66.7% (2 out of 3)	1% (n=1)	100% (1 out of 1)	1% (n=1)	100% (1 out of 1)	8.8% (n=8)	66.7% (4 out of 6)	2.2% (n=2)	100% (5 out of 5)
	Clergy/ Church	0% (n=0)	0% (0 out of 0)	0% (n=0)	0% (0 out of 0)	0% (n=0)	0% (0 out of 0)	0% (n=0)	0% (0 out of 0)	0% (n=0)	0% (0 out of 0)
	Sexual Health Services/ Clinics	4.4% (n=4)	100% (4 out of 4)	5.5% (n=5)	80% (4 out of 5)	2.2% (n=2)	100% (2 out of 2)	12.1% (n=11)	100% (10 out of 10)	5.5% (n=5)	100% (5 out of 5)
Internet/ Media Group Sources	LGBQ focussed Internet Search	30.8% (n=28)	84.6% (22 out of 26)	27.4% (n=25)	82.6% (19 out of 23)	33% (n=30)	89.3% (25 out of 28)	29.7% (n=27)	91.3% (21 out of 23)	31.9% (n=29)	75% (18 out of 24)
	General Internet Search	29.7% (n=27)	92.3% (24 out of 26)	25.3% (n=23)	85% (17 out of 20)	33% (n=30)	82.8% (24 out of 29)	29.7% (n=27)	87.5% (21 out of 24)	26.3% (n=24)	82.6% (19 out of 23)
	LGBQ media	16.5% (n=15)	76.9% (10 out of 13)	17.6% (n=16)	93.3% (14 out of 15)	24.2% (n=22)	75% (15 out of 20)	18.7% (n=17)	73.3% (11 out of 15)	18.7% (n=17)	80% (12 out of 15)
	TV/ Magazine/ Film	12.1% (n=11)	54.5% (6 out of 11)	5.5% (n=5)	80% (4 out of 5)	7.7% (n=7)	50% (3 out of 6)	12.1% (n=11)	100% (9 out of 9)	4.4% (n=4)	50% (1 out of 2)
	Porn (Pornography)	34.1% (n=31)	66.7% (18 out of 27)	35.1% (n=32)	71.4% (20 out of 28)	30.8% (n=28)	77.8% (21 out of 27)	12.1% (n=11)	45.5% (5 out of 11)	22% (n=20)	56.3% (9 out of 16)
	Social Media – blogs/ discussion/ posts	8.8% (n=8)	100% (7 out of 7)	7.7% (n=7)	100% (6 out of 6)	15.4% (n=14)	84.6% (11 out of 13)	17.6% (n=16)	85.7% (12 out of 14)	16.5% (n=15)	100% (14 out of 14)

5.11 Reasons for Not Sourcing Information

Questionnaire respondents were asked to indicate the reasons, if any, that prevented them from seeking information on sexuality and sexual health, with the choice available to select as many options as possible that applied to them. A total of 93 respondents answered this question providing 248 responses, including 5 comments from the “Other” option. No respondent (0%) indicated that the reason they did not source information was because they had no access to a computer (Figure 5.42). The option chosen the most was Nothing prevents me from sourcing information (42 respondents). Similar numbers of respondents answered I am too embarrassed (n=31) and I am afraid people will find out I am LGBTQ (n=28), I don’t know what to look for (n=28) and I am worried about my privacy (n=27). The other options were chosen less than these (Figure 5.42).

Figure 5.42 – Reasons for Not Sourcing Information



Even though the respondents had the option to choose multiple options, out of the 93 respondents, 41 respondents chose only one option. This included 27 respondents

who chose the option that stated nothing prevented them from sourcing information as their sole answer. Another 5 respondents chose one response that stated they did not source information as they were afraid that people would find out that they were LGBTQ. Three respondents stated they did not source information as they were not interested in the topic. While 31 respondents stated they did not source information as they were too embarrassed only two had it as their sole answer. Similarly, two more who only chose one answer were worried about their privacy. An additional two stated they did not know what to look for, so this prevented them from sourcing information. Only five provided their own reasons. These included

5.11.1 Reasons for Not Sourcing Information

Too shy to ask people
I'm find it hard admitting it to myself (Bi questioning 14-year-old female)
The information is simply not there or extremely vague or biased. Particularly in secondary and primary schools where LGBTQ sex ed is extremely basic and only lightly touched on
I may get in trouble if anyone finds out
I don't want or need to search for info or porn on specific sexual acts

Fifty- two respondents chose more than one response for their answer. These ranged from 2 to 8 responses as listed below in Table 5.40. Common joint responses were 'I am too embarrassed' and 'I am worried about my privacy' or 'I am afraid that people will find out I am LGBTQ'. Similarly, there were others who chose a combination of 'I don't know what to look for' and 'Information I find doesn't meet my needs' and 'I don't know where to look'.

Number of Responses	Number of respondents who chose this number of responses
1 response	41
2 responses	11
3 responses	15
4 responses	11
5 responses	9
6 responses	2
7 responses	3
8 responses	1

5.12 Open Comments

Twenty responses were provided at the end of the questionnaire when respondents were asked to *“Please feel welcome to add any additional comments you think would be useful about sourcing information on sexuality and sexual health for LGBTQ young people in Ireland”*. Some of these have been included previously in the section on Sexual Orientation/ Attraction.

The content of these responses was reviewed and grouped into three topics (see Section 4.12.1 Data Analysis of Open-Ended Comments). These topics related to Lack of Information on Sexuality and Sexual Health (8 comments), Acceptance and Fear of Judgement (5 comments), and What other Sources of Information and Topics are Needed (4 comments).

5.12.1 Lack of Information on Sexuality and Sexual Health

A lack of information available in comparison to heterosexual or cisgender individuals was highlighted by some comments or that adolescents did not know where to look for information.

“The level at which same sex or cis sexual activity and health information is available in comparison to the level of LGBTQ sexual activity and health information is available is shockingly disproportionate considering that LGBTQ people make up a considerable percentage of the general population”.

“I’ve no idea where to even start when looking for this info. I feel like I’ve been stunted because of my sexuality and am behind my peers. I hope my contribution helped”.

However, most of the comments about a lack of education on sexuality and sexual health referenced school and the lack of inclusivity of non-heterosexual topics in Relationship and Sexuality Education (RSE) within the school curriculum. They also suggested that education on sexuality should start earlier in the curriculum. Examples of these are:

“There isn’t any information in schools, we should learn about gay sex just as we should as normal sex”

“Information should be taught at school, the same way heterosexual sex and relationships are taught to us”

“School, especially primary schools, should give more attention towards sex education (my school didn’t give me or my class any information due to the Covid 19 lockdown) and there should be a bigger focus on LGBTQ+ identities and sex education”

Thus, a lack of information on LGBTQ identities and the timing of the provision of information seems to be the difficulty that adolescents have. However, another indicated that the information provided should not just be about sexual orientations or identities but rather concrete information on sexual health should be provided.

“I also think schools should teach more about LGBT+ sexual health rather than just outlining different sexualities”.

Another respondent highlights that information provided in schools is inadequate but having a family that can supplement information for a lack of school-based education is important. However, as noted, this is not always possible as some adolescents do not live in an inclusive or accepting home environment.

“Schools are not active enough in ensuring that people are educated in regard to sexuality and sexual health. I have complained many times to my primary and secondary schools about the lack of inclusivity in their RSE programmes. However, I have nearly always been told that we would learn about other genders and sexualities when we were older. I always felt really confused as to why my sexuality was seen as ‘inappropriate’ for younger children in the education system. I am very lucky to have a family who is willing to educate me properly, but other people are often not in the same position”.

While another was satisfied with the information given by their parents, they were conflicted because of their religious beliefs around celibacy and what they consider to be conservative views.

“My parents were liberal in giving me information. They fully accept my sexuality. However, I am a Roman Catholic and I believe I am called to chastity. I have never been sexuality active and do not like discussing the topic of sexual activity/orientation/identity with anyone, as my views are very conservative”.

When discussing acceptance, the adolescents discussed how education might foster acceptance, mentioned bullying and how families might influence this. Adolescents described how they had experienced negativity associated with their sexuality/ sexual orientation and as a result felt that adolescents would not ask for information on sexuality and sexual health. Examples of this are:

“A lot of young LGBT people may feel ashamed or embarrassed and be unwilling to ask a guardian/parent or any family member for information regarding sexual health, activity and wellbeing due to social stigma that needs to be replaced with openness and non-judgement”.

Similarly, there was a view that the more people that were open and expressed how it was ‘ok’ to be LGBTQ that stigma and judgment would be reduced.

"I have been judged on my sexuality based on my age, I feel people need to understand that since the Community became more accepted it has become easier for younger people to express and find who they are without feeling pressured by social norms".

"That's its ok to be LGBTQ in any shape or form no matter what stereotypes might say and if enough people come out it will be normalized".

The fact that this person stated that being LGBTQ needed to be normalised indicates that there continues to be some discrimination or bullying regarding LGBQ sexuality. This is confirmed by another response.

"Bullying is obviously a huge issue"

5.12.2 What Other Sources of Information and Topics are Needed

Comments about topics that adolescents would like information on were also included. These included masturbation, consent and sexual health. It was suggested that a lack of sufficient information leads to poor sexual health outcomes with regard to unplanned pregnancy, sexually transmitted infections and the embarrassment associated with that.

"The topics of female masturbation, boundaries/consent and LGBT sexual health and activity have very little reliable information readily available which leads to unwanted pregnancy, STDs, embarrassment and shame."

One comment recommended a podcast with young adults providing information through life experiences. It was also suggested that information on sexual activity and safer sex practices such as condom use, safety regarding sex toys, hygiene and information on transmission of sexually transmitted infections would also be beneficial.

"I would love a podcast or something to listen to about a young adult telling stories of their first time, do's and don'ts of sex, how they knew they were ready for sex, how to use condoms, how to use sex toys safely, explaining how to be hygienic, explaining how STIs work and the many different ways you can get them etc."

Additionally, some comments were made about porn use by teenagers and how what is been viewed is not realistic in the sexual acts performed, the way people are treated within the porn movie and the body types portrayed in the porn that is currently available.

"I think there is a huge problem with porn use among teenagers especially boys who believe the acts they see in porn are real life and can be quite rude and

sexualising towards lesbian and bisexual girls as well as straight girls because of what they've seen. i think it would be good to provide realistic sex ed to young people and let people know that what they see in porn is often violent and unrealistic."

"I think pornography that showcases different body types, people with body hair, transgender people, (non fetishising) gay people, stretch marks, acne etc etc".

5.12.3 Conclusion to Open Ended Comments

From these comments, the adolescents who commented recognise the limitations of information that they have and the potential implications of this for their sexuality and sexual health. They recognise that school does not provide sufficient information and that topics related to LGBQ sexuality need to be introduced in primary school. Similarly, a lack of information around safer sex practices and disparities in sexual health related to this for LGBQ adolescents is acknowledged. This is in addition to recognition of the role that external judgement, bullying and non-acceptance may play in LGBQ adolescents actively seeking the information they need in relation to sexuality and sexual health.

5.13 Sources of Information for Topic and Age, Gender at birth and Living Location

Additional analysis was also completed for males (n=18) and female (n=75) assigned gender at birth for both descriptive and inferential statistics. The living location of respondents was considered for both city (n=29) and all other places (n=64) for sources and topics for descriptive and inferential analysis to determine if those living in cities used different sources than those living outside of cities. Those assigned female and living outside of cities reported accessing more sources than males and those living in cities for all categories of topics.

Further statistical analysis was also conducted on the sources of information used by younger respondents aged 13-15 (n=42) and those older aged 16-19 (n=51) for different topics. This statistical analysis was used to determine if younger respondents used different sources of information on topics to older respondents.

In the Friendship and Sexual Orientation category, for coming out, older participants used the primary source, LGBQ friends, more than younger ones. For Sexual Attraction/ Orientation it was equal between younger and older ones and for LGBQ

relationships and Finding LGBQ friends, younger participants used to primary sources more than the older ones (Figure 5.43).

Figure 5.43 Category One Friendships and Sexual Attraction (Separated by Age)

Friendships and Sexual Orientation (n= 164)	Primary Source of Information	Difference in Age %
Sexual Attraction/ Orientation	LGBQ focussed Internet Search (57.9% n=95)	Aged 13-15 66.7%
		Aged 16-19 66.7%
LGBQ relationships	LGBQ Friends(65.2% n=107)	Aged 13-15 73.8%
		Aged 16-19 58.8%
Finding LGBQ friends	LGBQ Community (43.9% n=72)	Aged 13-15 45.2%
		Aged 16-19 41.2%
Coming Out	LGBQ Friends (53.6% n=88)	Aged 13-15 52.4%
		Aged 16-19 52.9%

For five of the six primary sources in the Category Two Readiness for Safer Sex, older participants report more use of the primary source than the younger ones. The exception is Mother as a source in pregnancy with 13–15-year-olds reporting them more often as a source than older participants (Figure 5.44).

Figure 5.44 Category Two Readiness for Safer Sex Separated by Age

Readiness for Safer Sex (n= 116)	Primary Source of Information	Difference in Age %
Pregnancy	Mother/ female guardian (47.4% n=55)	Age 13-15 40.4%
		Age 16-19 39.2%
Contraception (apart from condoms)	Mother/ female guardian (37.9% n=44)	Age 13-15 23.8%
		Age 16-19 35.3%
Sexually Transmitted Infections	General Internet Search (39.7% n=46)	Age 13-15 33.3%
		Age 16-19 41.2%
Safer Sex (condoms)	Teachers/ School (43.9% n=51)	Age 13-15 26.1%
		Age 16-19 60.8%
What it means to consent for sexual activity and my rights	LGBQ Friends (32.7% n=38)	Age 13-15 16.7%
		Age 16-19 37.2%
	General Internet Search (32.7% n=38)	Age 13-15 28.6%
		Age 16-19 35.3%
How to know I am ready for sex	General Internet Search (31.9% n=37)	Age 13-15 30.9%
		Age 16-19 33.3%

In the Sexual Behaviour/ Sexual Activity, there were five topics in which porn was the primary source. In these five topics, the younger age group used it more than the older age group. For Vaginal Sex, where non-LGBQ Friends were the other primary source, it was used predominantly by the older age group (Figure 5.45).

Figure 5.45 Category Three Sexual Activity and Sexual Behaviour (Separated by age and Source)

Sexual Activity/ Sexual Behaviour (n= 91)	Primary Source of Information	Difference in Age %
Genital Touching	Pornography (34.1% n=31)	Age 13-15 28.6%
		Age 16-19 25.5%
Masturbation	Pornography (41.7% n=38)	Age 13-15 35.7%
		Age 16-19 31.4%
Oral Sex	Pornography (37.3% n=34)	Age 13-15 30.9%
		Age 16-19 29.4%
Vaginal Sex	Pornography (34.1% n=31)	Age 13-15 30.9%
		Age 16-19 25.5%
	Non-LGBQ Friends (34.1% n=31)	Age 13-15 19%
		Age 16-19 39.2%
Anal Sex	Pornography (35.1% n=32)	Age 13-15 30.9%
		Age 16-19 25.5%

In the other topics under Sexual Activity/ Sexual Behaviour category, Kissing, Cuddling and What to do During Sex, LGBTQ friends were the primary source in the older group more than the younger group. This was also the case for How to use safer sex aids (condoms) with LGBTQ community and Teachers also reported by the older age group as more of a primary source than the younger age group. However, for both primary sources for How to use sex toys safely, LGBTQ focussed internet search and LGBTQ community, by the younger age group more than the older one reported that they used this source (Figure 5.46).

Figure 5.46 Category Three Sexual Activity and Sexual Behaviour (Separated by age and Source)

Sexual Activity/ Sexual Behaviour (n= 91)	Primary Source of Information	Difference in Age %
Kissing	LGBTQ Friends (52.7% n= 48)	Age 13-15 42.8%
		Age 16-19 47%
Cuddling	LGBTQ Friends (47.2 n=43)	Age 13-15 38%
		Age 16-19 43.1%
What to do during sex	LGBTQ Friends (36.2% n=33)	Age 13-15 23.8%
		Age 16-19 37.2%
How to use safer sex aids	LGBTQ Community (30.8% n=28)	Age 13-15 23.8%
		Age 16-19 29.4%
	Teacher/ School (30.8% n=28)	Age 13-15 19%
		Age 16-19 21.6%
How to use sex toys safely	LGBTQ focussed Internet Search (31.9% n=29)	Age 13-15 28.6%
		Age 16-19 23.5%
	LGBTQ Community (31.9% n=29)	Age 13-15 30.9%
		Age 16-19 25.5%

5.14 Conclusion

The sources of information differ depending on the category of topics. For Friendship and Sexual Orientation, the sources most often cited were LGBTQ Friends and LGBTQ Community for three out of the four topics, “*LGBTQ Relationships*”, “*Findings LGBTQ Friends*” and “*Coming Out*”. The main source of information for “*Sexual Attraction and Orientation*” was LGBTQ Focussed Internet Search.

For Readiness for Safer Sex category, the main sources of information for all topics and categories are similar. However, there are some differences depending on what the topic is. For topics that are commonly discussed in families and school, such as “*pregnancy*”, “*contraception*”, “*safer sex (condoms)*” and “*what it means to consent for sexual activity*”, the main sources are Mother/ female guardian or Teacher/ School. This is not surprising as these topics are also relevant for adolescents engaging in heterosexual or sexual activity with those of the opposite gender so there is no need for a young person to disclose their sexual orientation or for a Mother or Teacher to know this to provide information for them. For “*Sexually Transmitted Infections*”, “*What it means to consent for sexual activity and my rights*” and “*How to know I am ready for sex*”, General Internet search was the primary source of information. Therefore, all the main sources for this category are non LGBTQ specific sources. The usefulness of mother/ female guardian for this category is between 75% and 80% of respondents. However, the usefulness of Teacher/ School as a source of information for topics in the Readiness to Have Safer Sex is more limited with between 54.8% and 72.5% of respondents indicating they were a useful source of information.

For topics that are more intimate, the sources of information are both LGBTQ friends and LGBTQ community or those Internet/ Media Group of sources. For the category, Sexual Activity/ Sexual Behaviour the sources of information were LGBTQ specific, LGBTQ Friends, LGBTQ Community and LGBTQ focussed Internet Search, apart from sources reported for “*Vaginal Sex*” which was non-LGBTQ Friends. Porn (Pornography) was also the primary source of information for “*Genital Touching*”, “*Masturbation*”, “*Oral Sex*”, “*Vaginal Sex*” and “*Anal Sex*”, with the usefulness of this ranging from 66.7% for “*Vaginal Sex*” to 78.8% for “*Masturbation*”. Females and those living in locations other than cities sourced more information than males and those living in cities. However, some differences were found in age with younger respondents (aged 13-15) reporting more use of some sources than older ones (aged 16-19) on some topics, in particular porn.

The least used and therefore the least useful sources of information were in the Family and Professional groups, with clergy/ church and father/ male guardian consistently being the least used sources for all topics. Siblings, Other Family Members, Healthcare Professionals and Sexual Health Services/ Clinics were also not identified by many participants as a source of information.

6 Chapter 6 - Bivariate Inferential Results

6.1 Introduction

In this section, the result of the inferential analysis is reported relative to three profile variables, namely age, gender at birth and living location at the five levels of analysis. The following section is presented in three sections, each of which will describe the results at the five levels for each variable in order i.e. age, gender at birth and living location. For all analysis the level of significance was >0.05 .

6.2 Bivariate Inferential Results of associations of sources and topics relative to age

6.2.1 Level 1: Individual topics and individual sources and age

For the Friendship and Sexual Orientation category of topics (Category 1) (Table 6.1a) no individual source by individual topic use was found to be significantly relevant to age (age 13-15/ age 16-19). However, two individual sources by individual topic were significant ($p < 0.05$) for usefulness. These were sexual partners as a source of information for “*sexual attraction/ orientation*” ($p = .039$) and LGBQ Friends as a source of information for ‘*LGBQ relationships*’ ($p = .044$). The older cohort were more likely to find Sexual Partners a useful source of information on “*Sexual attraction/ orientation*” and the younger cohort found LGBQ-friends to be a useful source of information on LGBQ relationships.

Several individual sources by individual topic were significantly different relative to age for both used and useful in the Category 2 - Readiness for Safer Sex Topics (Table 6.1b). For the topic of “*contraception*”, these sources were Healthcare Professionals (GP/Nurse/ Social worker) ($p = .009^{\#}$ used/ $p = .010^{\#}$ useful) and Sexual Health Professional/ Clinic ($p = .038$ used/ $p = .015^{\#}$ useful), with the older cohort in these cases more likely to use these sources and to find them useful for these topics. LGBQ friends ($p = .036$ used/ $.009$ useful), non-LGBQ friends ($p = .006^{\#}$ used/ $.004^{\#}$ useful) and Teachers/ School ($p = .002^{\#}$ used/ $.049$ useful) were significant sources that were both used and useful for “*safer sex (condoms)*”, again with the older cohort more likely to

use these sources and to find them useful. Social Media was a used source ($p=.013^{\#}$) in the older cohort for the topic “*safer sex (condoms)*” but was not a useful one. Four sources were both used and useful for “*What it means to consent and my rights*”. These were LGBTQ friends ($p= .049$ used/ $.049$ useful), Non-LGBTQ friends ($p=.009$ used/ $.015^{\#}$ useful), Sexual Health Professional/ Clinic ($p= .031^{\#}$ used/ $.031$ useful) and Youth Group ($p=.015^{\#}$ used/ $.031^{\#}$ useful). Once again, the older cohort more likely to use these sources and also to find them useful for these topics. While Youth Group was also considered significant and more likely to be as a used source ($p=.031^{\#}$) for “*Sexually Transmitted Infection*”, it was not significantly useful ($p=>.05$). The opposite was the case for LGBTQ Friends who were not reported as a significantly used source for “*How to know I am ready for sex*” but were reported as a significantly useful source ($p=.012^{\#}$) for this topic for an older cohort. Non-LGBTQ Friends were on the other hand were significant as a used ($p=.021^{\#}$) and useful ($p=.012^{\#}$) by an older cohort as a source of information on “*How to know I am ready for sex*”.

In the Sexual Activity/ Sexual Behaviour category of topics (Category 3), Sexual Partners were a significant and more likely used source of information for “*what to do during sex*” ($p=.015$) in the older cohort but were not considered a significantly useful source (Table 6.1c).

Table 6.1: Bivariate analysis of the significant results of use and usefulness of individual sources and individual topics relative to age (n= 93) (Chi squared test of independence and continuity correction used unless otherwise indicated).

a) Friendship and Sexual Orientation Topics

Source	Topic	Use yes		χ^2	p	Usefulness yes		χ^2	p
		13-15 (n=42)	16-19 (n=51)			13-15 (n=42)	16-19 (n=51)		
Sexual Partners	Sexual attraction/ orientation					19.0% (8)	41.2% (21)	5.256	.039*
LGBTQ Friends	LGBTQ relationships					64.3% (27)	41.2% (21)	4.925	.044*

b) Readiness for Safer Sex Topics

Source	Topic	Use yes		χ^2	<i>p</i>	Usefulness yes		χ^2	<i>p</i>
		13-15 (n=42)	16-19 (n=51)			13-15 (n=42)	16-19 (n=51)		
Healthcare Professional	Contraception	2.4% (1)	23.5% (12)	8.567	.009* #	2.4% (1)	21.6% (11)	7.545	.010* #
Sexual Health Professional / Clinic	Contraception	2.4% (1)	15.7% (8)	4.665	.038* #	0% (0)	13.7% (7)	6.234	.015* #
Youth Group	Sexually Transmitted Infections	0% (0)	11.8% (6)	5.282	.031* #				
LGBQ friends	Safer Sex (Condoms)	9.5% (4)	27.5% (14)	4.742	.036* #	4.8% (2)	25.5% (13)	7.315	.009* #
Non LGBQ Friends	Safer Sex (Condoms)	9.5% (4)	35.3% (18)	8.470	.006* #	7.1% (3)	31.4% (6)	8.318	.004* #
Teachers	Safer Sex (Condoms)	26.2% (11)	60.8% (31)	11.130	.002* #	16.7% (7)	37.3% (19)	4.847	.049* #
Social Media	Safer Sex (Condoms)	9.5% (4)	33.3% (17)	7.649	.013* #				
LGBQ Friends	What it means to consent & my rights	16.7% (7)	37.3% (19)	4.847	.049* #	16.7% (7)	37.3% (19)	4.847	.049* #
Non-LGBQ Friends	What it means to consent & my rights	7.1% (3)	31.4% (16)	8.318	.009* #	7.1% (3)	27.5% (14)	6.359	.015* #
Youth Group	What it means to consent & my rights	0% (0)	13.7% (7)	6.234	.015* #	0% (0)	11.8% (6)	5.282	.031* #
Sexual Health Professional / Clinic	What it means to consent & my rights	0% (0)	11.8% (6)	5.282	.031* #	0% (0)	11.8% (6)	5.282	.031* #

Non LGBTQ Friends	How to know I am ready for sex	9.5% (4)	29.4 % (15)	5.604	.021* #	7.1% (3)	25.5 % (13)	5.443	.026* #
LGBTQ Friends	How to know I am ready for sex					9.5% (4)	31.4 % (16)	6.513	.012* #

c) Sexual Activity/ Behaviour Topics

Source	Topic	Use yes		χ^2	<i>p</i>	Usefulness yes		χ^2	<i>p</i>
		13-15 (n=42)	16-19 (n=51)			13-15 (n=42)	16-19 (n=51)		
Sexual Partners	What to do during sex	14.3% (6)	39.2% (20)	7.107	.015*				

*Level of Significance =0.05

#Fishers test used

6.2.2 Level 2: Category topics by individual sources and age

In relation to the second level of bivariate analysis relative to age, the findings from the Mann Whitney U test with the topics in each category combined, no significant findings were uncovered from Category 1- Friendship and Sexual Attraction, for either sources used or usefulness of sources. Three sources, LGBTQ friends ($p=.018$ for used/ $p=.003$ useful), Sexual Health Professional/ Clinic ($p=.029$ used/ $p=.028$ useful) and Social Media ($p=.23$ used/ $p=.048$ useful) were found to be significant for the Category 2 topics– Readiness for Safer Sex for both used and useful sources. The older cohort in the case of LGBTQ friends and Social Media were more likely to use sources in this category and find them useful. As the medians and quartiles for Sexual Health Professional/ Clinic were zero, the inferences that can be made from that data is limited. Non-LGBTQ friends ($p=.005$), Teachers/ School ($p=.020$) and Sexual Partners ($p=.022$) were more likely to be significant as a used source in an older cohort for Category 2- Readiness for Safer Sex, but they were not significantly useful. Health Service Professional ($p=.007$) were a useful source for Category 2 – Readiness for Safer Sex but not a used one. The medians and 25% and 75% were zero for this source so determining significance of this relative to age is difficult. Sexual Partner ($p=.022$) were also a useful source in Category 2 Readiness for Safer Sex but not a used one. Interestingly Sexual Partner was found to be very useful for Category 3 Sexual Activity/ Sexual Behaviour topics ($p=.007$) but was not significant as a used

source in this category (Table 6.2), with the older cohort more likely to use and to find this source for this topic category useful. Youth Group ($p=.038$) were also significant as a useful source for Category 3 Sexual Activity/ Behaviour topic but not for sources used. The median for Youth Group was zero with the 25% quartile and 75% quartile also zero so it is difficult to determine the significance of the findings of this source relative to age.

Table 6.2: Level 2 Bivariate analysis of the significant results of use and usefulness of individual sources and topic categories relative to age (n= 93) (Mann Whitney U Tests)(N=93)

Source	Topic	Use				Usefulness			
		Age 13-15	Age 16-19			Age 13-15	Age 16-19		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
LGBQ Friends	<u>Category 2 – Readiness for Safer Sex</u>	.000 (.000-1.000)	1.00 (1.000-3.000)	1346.0	.018*	.000 (.000- .000)	.000 (.000-.300)	1394.0	.003*
Sexual Health Professional / Clinic	<u>Category 2 – Readiness for Safer Sex</u>	.000 (.000-.000)	.000 (.000-.000)	1236.0	.029*	.000 (.000-.000)	.000 (.000-.000)	1237.0	.028*
Social Media	<u>Category 2 – Readiness for Safer Sex</u>	.000 (.000-.250)	.000 (.000-4.00)	1324.5	.023*	.000 (.000-.000)	.000 (.000-2.00)	1283.0	.048*
Non-LGBQ Friends	<u>Category 2 – Readiness for Safer Sex</u>	.000 (.000- 1.000)	1.000 (1.000-3.000)	1393.5	.005*				
Teacher/ School	<u>Category 2– Readiness for Safer Sex</u>	.0000 (.0000-2.250)	2.000 (.000-4.000)	1358.5	.020*				

Sexual Partners	<u>Category 2 – Readiness for Safer Sex</u>	.000 (.000-.250)	.000 (.000-2.000)	1335.5	.022*				
Health Service Professional (GP/ Nurse/ Social Worker)	<u>Category 2 – Readiness for Safer Sex</u>					.000 (.000-.000)	.000 (.000-.000)	1276.0	.007*
Youth Group	<u>Category 3 – Sexual Activity/ Behaviour</u>					.000 (.000-.000)	.000 (.000-.000)	1176.0	.038*
Sex Partner	<u>Category 3 – Sexual Activity/ Behaviour</u>					.000 (.000-.1.000)	.000 (.000-6.000)	1299.0	.043*

*Level of Significance =0.05

6.2.3 Level 3: Individual Topics by all sources relative to age:

When all sources were combined, there was some significant differences in the distributions of topics for either used or usefulness according to age (Table 6.3). These were “*contraception*” ($p=.010$ used/ $p=.001$ useful), “*sexually transmitted infections*” ($p=.035$ used/ $p=.031$ useful), “*safer sex (condoms)*” ($p=.004$ used/ $p=.002$ useful) and “*how to consent and my rights*” ($p=.034$ used/ $p=.021$ useful), with the older cohort more likely to find all sources for this topic both used and useful. All of these topics are in the Readiness for Safer Sex Category of Topics (Category 2).

Table 6.3: Level 3 Bivariate analysis of the significant results of use and usefulness of individual topics by all sources relative to age (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		Age 13-16	Age16-19			Age 13-16	Age 16-19		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
Friendship and Sexual Orientation Topics									
All Sources	Sexual Attraction/ Orientation	5.000 (2.000-7.000)	6.000 (3.000-8.000)	1187.0	.368	4.000 (1.000-6.000)	5.000 (3.000-6.000)	1206.5	.262
All Sources	LGBQ Relationships	3.000 (2.000-4.000)	4.000 (2.000-6.000)	1234.5	.202	2.000 (1.000-3.250)	2.000 (1.000-4.000)	1106.5	.781
All Sources	Finding LGBQ Friends	2.000 (.000-3.250)	2.000 (1.000-4.000)	1199.5	.314	1.000 (.000-3.000)	2.000 (1.000-3.000)	1252.5	.151
All Sources	Coming Out	4.000 (1.000-7.000)	5.000 (2.000-8.000)	1277.5	.109	3.000 (.750-4.000)	3.000 (2.000-5.000)	1273.5	.115
Readiness for Safer Sex Topics									
All Sources	Pregnancy	2.000 (.000-3.000)	2.000 (1.000-4.000)	1174.0	.419	1.000 (.000-3.000)	1.000 (.000-3.000)	1139.5	.588
All Sources	Contraception	1.000 (.000-4.000)	3.000 (1.000- 5.000)	1399.0	.010*	1.000 (.000-2.250)	3.000 (1.000-4.000)	1479.0	.001*
All Sources	Sexually Transmitted Infections	1.500 (.000-4.000)	3.000 (1.000-5.000)	1340.5	.035*	1.000 (.000-3.000)	2.000 (1.000-3.000)	1344.0	.031*
All Sources	Safer Sex (condoms)	2.000 (.000-4.000)	4.000 (2.000-6.000)	1443.5	.004*	1.000 (.000-3.000)	3.000 (1.000-5.000)	1466.5	.002*

All Sources	What it means to Consent and my rights	2.000 (.000-4.250)	3.000 (1.000-5.000)	1342.5	.034*	1.000 (.000-3.000)	3.000 (1.000- 5.000)	1365.0	.021*
All Sources	How to know I am ready for sex	1.000 (.000- 4.000)	3.000 (1.000-4.000)	1309.0	.063	1.000 (.000-3.000)	2.000 (1.000-3.000)	1285.0	.090
Source	Topic	Use				Usefulness			
		Age 13-16	Age16-19			Age 13-16	Age 16-19		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
Sexual Activity / Behaviour Topics									
All Sources	Kissing	3.000 (.000-6.000)	3.000 (.000-6.000)	1090.5	.879	2.000 (.000-4.250)	2.000 (.000-4.000)	1051.0	.875
All Sources	Cuddling	2.000 (.000-5.000)	2.000 (.000-4.000)	1093.0	.863	1.500 (.000-4.000)	2.000 (.000-3.000)	1102.0	.807
All Sources	Genital Touching	1.000 (.000-4.000)	2.000 (.000-4.000)	1172.0	.426	1.000 (.000-3.000)	1.000 (.000-3.000)	1208.0	.276
All Sources	Masturbation	2.000 (.000-5.000)	2.000 (1.000-4.000)	1147.5	.548	1.500 (.000-3.000)	1.000 (.000-4.000)	1136.0	.606
All Sources	Oral Sex	2.000 (.000-4.000)	3.000 (.00-4.0000)	1214.0	.259	1.50 (.0000-3.000)	2.000 (.000-3.000)	1162.0	.466
All Sources	Vaginal Sex	2.000 (.000-4.000)	3.000 (.000-4.000)	1206.5	.286	1.000 (.000-3.000)	2.000 (.000-4.000)	1177.0	.398
All Sources	Anal Sex	1.000 (.000-3.000)	1.000 (.000-4.000)	1140.0	.580	.50 (.000-2.000)	1.000 (.000-2.0000)	1123.0	.670
All Sources	What to do during sex	2.000 (.000-3.250)	3.000 (.000-5.0000)	1306.0	.064	1.000 (.000-3.000)	2.000 (.000-4.000)	1261.0	.133

All Sources	How to use safer sex aids	1.000 (.000-3.000)	3.000 (.000-4.000)	1184.0 .	.369	1.000 (.000- 3.000)	1.000 (.000-4.000)	1080.5	.939
All Sources	How to use sex toys safely	.500 (.000-3.000)	2.000 (.000-3.000)	1223.0	.214	.000 (.000-1.250)	.000 (.000-3.000)	1231.5	.166

*Level of Significance =0.05

6.2.4 Level 4: Categorised Topics by all sources relative to age:

When categorised topics by all sources were examined (Table 6.4), there was a significant difference in the Readiness to Safer Sex Category (Category 2) in both the used ($p=.028$) and usefulness ($p=.009$) distributions. The older cohort were more likely to find all sources in this topic category both used and useful.

In the categories of Friendship and Sexual Orientation (Category 1) and Sexual Activity / Behaviour Category (Category 3), there was no significant differences in the used and usefulness distributions of all sources by individual topics and age.

6.2.5 Level 5: All topics by all sources relative to age

When all sources were combined and all topics were combined as a single variable (Table 6.5), there was no significant difference in their distributions for either used or usefulness across age groups. i.e., the total number of those who used or found useful all topic by all sources was not significantly different across age groups ($p=>0.05$).

Table 6.4: Level 4 Bivariate analysis of the significant results of use and usefulness of categorised topics by all sources relative to age (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		Age 13-15	Age 16-19			Age 13-15	Age 16-19		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
All Sources	<u>Category 1 – Friendships and Sexual Orientation</u>	15.000 (7.750- 20.225)	18.000 (10.000-25.000)	1249.5	.168	11.000 (4.750-16.250)	12.000 (8.000- 16.000)	1196.5	.332
All Sources	<u>Category 2 – Readiness for Safer Sex</u>	10.500 (1.000-23.500)	19.000 (9.000-28.000)	1356.0	.028*	6.500 (1.000-19.000)	14.000 (8.000-21.000)	1409.5	.009*
All Sources	<u>Category 3 Sexual Activity/ Behaviour</u>	19.500 (2.000-35.500)	29.000 (5.000-41.000)	1278.5	.109	14.000 (.750-27.500)	20.000 (3.000-31.000)	1279.5	.107

*Level of Significance =0.05

Table 6.5: Level 5 Bivariate analysis of the significant results of use and usefulness of all topics by all sources relative to age (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		Age 13-15	Age 16-19			Age 13-15	Age 16-19		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
All Sources	All Topics	48.500 (14.250- 80.000)	64.000 (35.000-90.000)	1278.5	.109	33.000 (11.250-61.750)	46.000 (23.000-67.000)	1279.5	.107

6.3 Bivariate Inferential Results of associations of sources and topics relative to gender at birth

6.3.1 Level 1: Individual topics and individual sources and gender at birth

There were two sources relative to gender at birth (male/ female) that were found to be both used and useful with the Level 1 analysis Chi Square test of Independence. These were Father/ male guardian ($p=.006^{\#}$ used/ $p=.012^{\#}$ useful) for “safer sex (condoms)” in the Readiness for Safer Sex Category of topics (Category 2) (Table 6.6b) and Sexual Partners (Table 6.6c) on the topic of “vaginal sex” ($p=.010^{\#}$ used/ $.019^{\#}$ useful) in the Sexual Activity/ Behaviour category of topics. The male cohort reported father/ male guardian as a used and useful source of information on “safer sex (condoms)” with females reporting Sexual Partners as a used and useful source of information on “vaginal sex”. No other source was found to be significant as both a used and useful source relative to gender at birth.

For the Friendship and Sexual Orientation Category (Category 1) (Table 6.6a), no sources were found to be significant for sources used. There were three significantly useful sources, two for “Sexual attraction/orientation” which were TV/Magazine/Film ($p=.037^{\#}$) in a female cohort and Porn (pornography)) ($p=.043$) in a male cohort. Non LGBTQ Friends were considered a useful source of “coming out” ($p=.017$), significant in a male cohort. There were two useful sources relative to gender at birth in the Sexual Activity/ Behaviour category (Category 3, Table 6.6c). These were Mother on the topic of “masturbation” ($p=.006^{\#}$) in the male group and Sexual Partners on “genital touching” ($p=.037^{\#}$) in the female cohort but neither of these were likely to be a used source.

Table 6.6: Level 1 Bivariate analysis of the significant results of use and usefulness of individual sources and individual topics relative to gender at birth (n= 93) (Chi squared test of independence and continuity correction used unless otherwise indicated).

a) Friendship and Sexual Orientation Topics

Source	Topic	Use yes		χ^2	<i>p</i>	Usefulness yes		χ^2	<i>p</i>
		Male (n=18)	Female (n=75)			Male (n=18)	Female (n=75)		
TV/ Magazine/ Film	Sexual Attraction/ Orientation					5.6% (1)	29.3% (22)	4.409	.037 ^{##}
Porn (Pornography)	Sexual Attraction/ Orientation					50.0% (9)	22.7% (17)	5.385	.043 [*]
Non LGBTQ Friends	Coming Out					61.1% (11)	28.0% (21)	7.052	.017 [*]

b) Readiness for Safer Sex Category Topics

Source	Topic	Use yes		χ^2	<i>p</i>	Usefulness yes		χ^2	<i>p</i>
		Male (n=18)	Female (n=75)			Male (n=18)	Female (n=75)		
Father/ male guardian	Safer Sex (Condoms)	27.8% (5)	4.0% (3)	10.439	.006 ^{##}	22.2% (4)	2.7% (2)	9.198	.012 ^{##}

c) Sexual Activity/ Behaviour Topics

Source	Topic	Use yes		χ^2	<i>p</i>	Usefulness yes		χ^2	<i>p</i>
		Male (n=18)	Female (n=75)			Male (n=18)	Female (n=75)		
Mother/ female guardian	Masturbation					16.7% (3)	0% (0)	12.917	.006 ^{##}
Sexual Partners	Genital Touching					5.6% (1)	29.3% (22)	4.409	.037 ^{##}
Sexual Partners	Vaginal Sex	0% (0)	26.7% (20)	6.115	.010 ^{##}	0% (0)	25.3% (19)	5.731	.019 ^{##}

*Level of Significance =0.05

^{##}Fishers test used

6.3.2 Level 2: Category Topics by individual sources and gender at birth:

From the Mann Whitney U tests relative to gender at birth with the topics in each category combined, no Family or Internet/ media source was found to be significant as a used source. Sources in the Family group of sources were also found not to be useful for any of the three categories of topics. Only one source Sexual Partner was both a used ($p=.023$) and useful ($p=.036$) source and this was for Category 3- Sexual Activity/ Sexual Behaviour in a female cohort. TV/ Magazines/ Film ($p=.018$) was found to be useful in a female cohort with Porn (pornography) ($p=.004$) useful in the male cohort both for Category 1- Friendships and Sexual Orientation but neither of these were significant as used sources. Inferences that can be made about Clergy/ church ($p=.004$) were significant as useful sources for Friendships and Sexual Orientation topics but inferences that can be made from this are limited as the medians, 25% and 75% quartiles are zero. Social Media ($p=.046$) was useful for the Category 2 - Readiness for Safer Sex category of topics but again was not significant as a used source. LGBTQ community ($p=.046$) was significant as a used source for females in Category 2 - Readiness for Safer Sex but was not reported as useful. Similarly, Teachers/ School ($p=.023$) were a used source for Category 3- Sexual Activity/ Behaviour but not considered a useful one (Table 6.7).

Table 6.7: Level 2 Bivariate analysis of the significant results of use and usefulness of sources and topic categories relative to gender at birth (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		Male	Female			Male	Female		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
Clergy/ Church	<u>Category 1 – Friendship and Sexual Orientation</u>					.000 (.000-.000)	.000 (.000-.000)	600.0	.004*
TV/ Magazine/ Film	<u>Category 1 – Friendship and Sexual Orientation</u>					.000 (.000-.000)	.000 (.000-.1.000)	879.0	.018*
Porn (Pornograph y)	<u>Category 1 – Friendship and Sexual Orientation</u>					1.000 (.000- 1.000)	.000 (.000-.000)	441.0	.004*
Social Media	<u>Category 2 – Readiness for Safer Sex</u>					.000 (.000-.1.250)	1.000 (.000-2.000)	845.0	.046*
LGBQ Community	<u>Category 2 – Readiness for Safer Sex</u>	.000 (.000-.000)	.000 (.000-4.000)	853.5	.046*				
Teacher/ School	<u>Category 3 – Sexual Activity/ Behaviour</u>	.000 (.000-.000)	.0000 (.000-.1.000)	883.5	.023*				
Sexual Partners	<u>Category 3 – Sexual Activity/ Behaviour</u>	.000 (.000-.000)	.000 (.000-.6.000)	883.5	.023*	.000 (.000-.000)	.000 (.000-5.000)	862.5	.036*

6.3.3 Level 3: Individual topics by all sources relative to gender at birth

When all sources were combined, there was one significant difference in the distribution of topics for usefulness according to gender at birth (Table 6.8). This was Finding Friends ($p=.029$) from Category One – Friendships and Sexual Attraction, with the female cohort more likely to find all sources for topics in this category useful but not a used source. There were no other significant differences for used or useful sources in any of the other topic categories.

6.3.4 Level 4: Categorised Topics by all sources relative to gender at birth

When categorised topics by all sources were examined there was no difference in the distribution for any of the categories of topics for sources used or useful for gender by birth (Table 6.9).

6.3.5 Level 5: All topics by all sources relative to gender at birth

When all sources were combined or all topics were combined as a single variable, there was no significant difference in their distributions for either used or usefulness across age groups. i.e., the total number of those who used or found useful all topic by all sources was not significantly difference ($p=>0.05$) across gender by birth groups (Table 6.10).

Table 6.8: Level 3 Bivariate analysis of the significant results of use and usefulness of individual topics by all sources relative to gender at birth (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		Male	Female			Male	Female		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
Friendship and sexual orientation topics									
All Sources	Sexual Attraction/ Orientation	5.000 (1.750-6.750)	6.000 (3.000-8.000)	768.5	.361	4.000 (1.750-5.000)	5.000 (3.000-6.000)	785.0	.281
All Sources	LGBQ Relationships	2.000 (1.70-5.0000)	3.000 (2.000-5.000)	775.5	.323	2.000 (.000-3.000)	2.000 (1.000-4.000)	823.0	.144
All Sources	Finding LGBQ Friends	1.500 (.000-4.000)	2.000 (1.000-4.000)	762.5	.388	.500 (.000-2.000)	2.000 (.000-3.000)	894.0	.029*
All Sources	Coming Out	4.000 (1.750-6.250)	5.000 (2.000-7.000)	721.5	.650	3.000 (1.750-4.250)	3.000 (1.000-5.000)	629.0	.652
Readiness for safer sex topics									
All Sources	Pregnancy	1.000 (.000-3.250)	2.000 (1.000-4.000)	821.5	.148	1.00 (.000-2.250)	1.000 (.000-3.000)	836.5	.107
All Sources	Contraception	2.000 (.000-4.000)	3.000 (1.000-5.000)	785.0	.249	1.000 (.000-3.000)	2.00 (.000-4.000)	811.5	.176
All Sources	Sexually Transmitted Infections	2.500 (.750-4.000)	3.000 (1.000-5.000)	741.0	.516	1.500 (.000-3.000)	2.000 (.000- 3.000)	694.0	.850
All Sources	Safer Sex (condoms)	3.000 (1.000-5.000)	3.000 (1.000-5.000)	705.0	.423	2.000 (.000-3.250)	2.000 (1.000-4.000)	743.0	.502
All Sources	What it means to Consent and my rights	2.500 (.750-3.500)	2.000 (1.000-5.000)	756.5	.423	1.500 (.000-3.000)	2.000 (1.000-4.000)	804.5	.201
All Sources	How to know I am ready for sex	1.000 (.000-3.000)	3.000 (1.000-4.000)	847.5	.089	1.000 (.000-2.250)	2.000 (.000-3.000)	813.5	.168

Source	Topic	Use				Usefulness			
		Male	Female			Male	Female		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
Sexual Activity / Behaviour topics									
All Sources	Kissing	1.500 (.000-3.250)	3.000 (1.000-6.000)	838.5	.107	1.000 (.000-3.000)	2.000 (.000-4.000)	843.0	.095
All Sources	Cuddling	1.000 (.000-3.200)	3.000 (1.000-5.000)	850.5	.083	1.000 (.000-3.000)	2.000 (.000-4.000)	796.0	.229
All Sources	Genital Touching	1.500 (.000-3.250)	2.000 (.00-4.000)	733.0	.561	1.000 (.000-3.000)	1.000 (.000-3.000)	747.0	.468
All Sources	Masturbation	2.500 (.000-4.000)	2.000 (.000-5.000)	730.0	.587	1.000 (.000-3.250)	1.000 (.000-4.000)	717.0	.675
All Sources	Oral Sex	1.500 (.000-4.000)	2.000 (.000-4.000)	757.5	.412	.500 (.000-3.000)	2.000 (.000-3.000)	780.5	.288
All Sources	Vaginal Sex	1.000 (.000-3.000)	3.000 (.000-4.000)	869.5	.054	.500 (.000-2.250)	2.000 (.000-4.000)	834.0	.110
All Sources	Anal Sex	1.000 (.000-3.000)	1.000 (.000-4.000)	672.0	.976	1.000 (.000-2.000)	1.000 (.000-2.000)	698.0	.812
All Sources	What to do during sex	1.000 (.000-3.000)	2.000 (.000-4.000)	815.0	.163	1.000 (.000-3.000)	2.000 (.000-3.000)	764.0	.375
All Sources	How to use safer sex aids	1.000 (.000-3.000)	2.000 (.000-4.000)	790.0	.250	1.000 (.000-3.000)	1.000 (.000-3.000)	715.5	.683
All Sources	How to use sex toys safely	.000 (.000-2.250)	1.000 (.000-3.000)	798.5	.203	.000 (.000-1.000)	.000 (.000-3.000)	807.5	.150

Table 6.9: Level 4: Bivariate analysis of the significant results of use and usefulness of all topics combined relative to gender at birth (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		Male	Female			Male	Female		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
All Sources	<u>Category 1 – Friendships and Sexual Orientation</u>	13.500 (6.500-21.000)	17.000 (10.000-22.000)	796.0	.360	10.500 (5.7500-15.2500)	12.000 (8.0000-17.0000)	766.5	.373
All Sources	<u>Category 2 – Readiness for Safer Sex</u>	14.000 (4.750-23.000)	17.000 (7.000-29.000)	800.0	.224	7.500 (1.7500-16.0000)	11.000 (5.0000-21.0000)	801.0	.219
All Sources	<u>Category 3 Sexual Activity/ Behaviour</u>	14.500 (.000-32.250)	26.000 (4.000-40.000)	824.0	.186	10.500 (.0000-25.2500)	17.000 (2.0000-31.0000)	800.5	.200

Table 6.10: Level 5 Bivariate analysis of the significant results of use and usefulness of all topics by all sources relative to gender at birth (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		Male	Female			Male	Female		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
All Sources	All Topics	41.500 (21.750- 67.500)	61.0000 (27.000-90.000)	811.0	.186	28.500 (19.500-54.000)	43.000 (18.000-67.000)	800.5	.222

6.4 Bivariate Inferential Results of associations of sources and topics relative to living location

6.4.1 Level 1: Individual topics and individual sources and living location

For the Chi Squared test of independence for living location (City/ Large Town or All other places), no source in the Friendship and Sexual Orientation category (Category One) (Table 6.11a) was found to be both significant for sources used and useful. Two sources were likely to be used on the topic of “*LGBQ relationships*” which were LGBQ friends ($p=.033$) and LGBQ Community ($p=.039$) (Table 6.11a) for those in the cohort All other places. Non-LGBQ friends while not significant as a used source for any topic was significant for usefulness for “*finding LGBQ friends*” ($p=.028^{\#}$) and “*coming out*” ($p=.007^{\#}$) again in the All other places cohort.

Only one source was considered significant as both a used and useful source in the Category 2 - Readiness for Safer Sex Category (Table 6.11b). That was LGBQ Focussed Internet Search for the topic of “*how to know I was ready for sex*” ($p=.009^{\#}$ used/ $p=.005^{\#}$ useful). LGBQ media was also used for this topic ($p=.049^{\#}$) but was not considered statistically useful relative to living location. LGBQ media while not used, was however considered useful for the topic of “*contraception*” ($p=.028^{\#}$) and “*sexually transmitted infections*” ($p=0.002^{\#}$) in the All other places cohort. The other source considered useful relative to living location was LGBQ focussed Internet Search for “*what it means to consent and my rights*” ($p=.016^{\#}$) again in the All other places cohort but was not likely to be a used source.

For Category 3 - Sexual Activity/ Sexual Behaviour topics (Table 6.11c), LGBQ Community was both used ($p=.048$) and useful ($p=.032^{\#}$) for the topic of “*kissing*” in the All other places cohort. No other source was reported significant as a used source of information for this category of topics. There were, however, four sources that were considered useful relative to living location. These were LGBQ focussed Internet Search for “*kissing*” ($p=.018^{\#}$) and LGBQ community ($p=.048^{\#}$), Non LGBQ focussed Internet Search ($p=.018^{\#}$) and LGBQ media for “*cuddling*” ($p=.049^{\#}$). All of these findings were also significant for the All other places cohort.

Table 6.11 Level 1 Bivariate analysis of the significant results of use and usefulness of sources and topics relative to living location (n= 93) (Chi squared test of independence and continuity correction used unless otherwise indicated).

a) Friendship and Sexual Orientation Topics

Source	Topic	Use yes		χ^2	<i>p</i>	Usefulness yes		χ^2	<i>p</i>
		City/ Large Town (n=29)	All other Places (n=64)			City/ Large Town (n=29)	All other Places (n=64)		
LGBQ friends	LGBQ relationships	48.3% (14)	73.4% (47)	5.598	.033*				
LGBQ Community	LGBQ relationships	27.6% (8)	53.1% (34)	5.256	.039*				
Non LGBQ Friends	Finding Friends					0% (0)	15.6% (10)	5.077	.028**
Non LGBQ Friends	Coming Out					10.3% (3)	39.1% (25)	7.821	.007**

b) Readiness for Safer Sex Category Topics

Source	Topic	Use yes		χ^2	<i>p</i>	Usefulness yes		χ^2	<i>p</i>
		City/ Large Town (n=29)	All other Places (n=64)			City/ Large Town (n=29)	All other Places (n=64)		
LGBQ Media	Contraception					0% (0)	15.6% (10)	5.077	.028**
LGBQ Media	Sexually Transmitted Infections					0% (0)	25.0% (16)	8.756	.002**
LGBQ Focussed Internet Search	What it means to consent and my rights					6.9% (2)	29.7% (19)	5.930	.016**
LGBQ Focussed Internet Search	How to know I was Ready for Sex	6.9% (2)	32.8% (21)	7.201	.009**	3.4% (1)	28.1% (18)	7.476	.005**
LGBQ Media	How to know I was Ready for Sex	6.9% (2)	26.6% (17)	4.748	.049**				

c) Sexual Activity/ Behaviour Topics

Source	Topic	Use yes		χ^2	<i>p</i>	Usefulness yes		χ^2	<i>p</i>
		City/ Large Town (n=29)	All other Places (n=64)			City/ Large Town (n=29)	All other Places (n=64)		
LGBQ Community	Kissing	17.2% (5)	40.6% (26)	4.911	.048*	10.3% (3)	32.8% (21)	5.933	.032**
LGBQ Focussed Internet Search	Kissing					3.4% (1)	25.0% (16)	6.205	.018**
LGBQ Community	Cuddling					13.8% (4)	34.4% (22)	4.197	.048**
Non LGBQ Focussed Internet Search	Cuddling					3.4% (1)	23.4% (15)	5.598	.018**
LGBQ Media	Cuddling					6.9% (2)	26.6% (17)	4.748	.049**

*Level of Significance =0.05

**Fishers test used

6.4.2 Level 2: Category topics by individual sources and living location

The second level of bivariate analysis using the Mann Whitney U statistical test for topics combined by category for living location revealed that family members were a significant used source of information for Category 1- Friendships and Sexual Orientation topics but were not useful. The sources more likely to be used were Mother/ female guardian ($p=.012$), Father/male guardian ($p=.012$) and Siblings ($p=.021$) all in the All-other places cohort. Non-LGBQ friends ($p=.018$ used/ $p=.045$ useful) and LGBQ Community ($p=.037$ used/ $p=.028$ useful) were both a used and useful source of information for this category (Category 1- Friendships and Sexual Orientation) again in the All-other places cohort. Healthcare Professionals (GP/ Nurse/ Social Worker) ($p=.036$) were a significant used source in Category 1 but were reported as not significantly useful. Limited inferences can be made about this source relative to living location as the medians and quartiles were all zero.

For Readiness for Safer Sex (Category 2) as a category of topics, LGBQ Focussed Internet Search ($p=.041$) and LGBQ media were a used source of information ($p=.036$)

in the All-other places cohort. However, only LGBQ Media was significant as a useful source ($p=.033$) but the median and quartiles were zero so limited inferences regarding usefulness can be made. No source was significant as either a used or useful source in the Sexual Activity/ Sexual Behaviour (Category 3) category of topics (Table 6.12).

Table 6.12: Level 2 Bivariate analysis of the significant results of use and usefulness of sources and topic categories relative to living location (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		City/ Large Town	All other places			City/ Large Town	All other places		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
Mother	<u>Category 1 – Friendship and Sexual Orientation</u>	.000 (.000-.000)	.000 (.000-1.000)	1193.5	.012*				
Father	<u>Category 1 – Friendship and Sexual Orientation</u>	.000 (.000-.500)	.500 (.000- 1.000)	1197.0	.012*				
Siblings	<u>Category 1 – Friendship and Sexual Orientation</u>	.000 (.000-.000)	.000 (.000-1.000)	1153.0	.021*				
Non-LGBQ Friends	<u>Category 1 – Friendship and Sexual Orientation</u>	.000 (.000-1.000)	1.000 (.000-2.000)	1199.0	.018*	3.000 (1.000-10.000)	4.000 (2.000-9.750)	1147.0	.045*
LGBQ Community	<u>Category 1 – Friendship and Sexual Orientation</u>	1.000 (.000-3.000)	2.000 (.000-4.000)	1171.5	.037*	1.000 (.00-1.5000)	2.000 (.000-3.000)	1184.5	.028*
Healthcare Professionals	<u>Category 1 – Friendship and Sexual Orientation</u>	.000 (.000-.000)	.000 (.000-.000)	1085.0	.036*				
LGBQ Focussed Internet Search	<u>Category 2 – Readiness for Safer Sex</u>	.000 (.000-2.000)	1.000 (.000- 4.000)	1154.5	.041*				
LGBQ Media	<u>Category 2 – Readiness for Safer Sex</u>	.000 (.000-.000)	.000 (.000-.2.750)	1144.5	.036*	.000 (.000-.000)	.000 (.000-.000)	1136.5	.033*

6.4.3 Level 3: Individual topics by all sources relative to living location

When all sources were combined, there were some significant results in the distributions of topics for either used or usefulness relative to living location (Table 6.13). These were “*LGBQ Relationships*” ($p=.032$ used) from Category 1- Friendships and Sexual Orientation in people living in All other places. This was not significant for usefulness. “*Coming out*” ($p=.035$) for those in the All other places cohort was a useful source but was less likely to be used. In addition, “*cuddling*” as a topic from Category 3 – Sexual Activity/ Behaviour was both used ($p=.032$) and useful ($p=.020$) for all sources combined in those living in All other places. In contrast, “*kissing*” was significant as a useful source ($p=.020$) but not for used one for those living outside of cities or large towns (All other places). There were no significant distributions relative to living location for the Category 2 – Readiness for Safer Sex.

Table 6.13: Level 3 Bivariate analysis of the significant results of use and usefulness of individual topics by all sources relative to living location (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		City/ Large Town	All other places			City/ Large Town	All other places		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
Friendship and Sexual Orientation Topics									
All Sources	Sexual Attraction/ Orientation	5.000 (3.000-6.500)	6.000 (3.000-9.000)	1118.5	.112	5.000 (2.000-6.000)	4.000 (3.000-7.000)	1040.5	.347
All Sources	LGBQ Relationships	2.000 (1.000-4.000)	4.000 (2.000-6.000)	1225.5	.013 *	2.000 (1.000-3.000)	2.000 (1.000-4.000)	1083.5	.191
All Sources	Finding LGBQ Friends	1.000 (.000-3.000)	2.000 (1.000-4.000)	1096.5	.156	1.000 (.000-2.000)	1.500 (.000-3.000)	1048.0	.308
All Sources	Coming Out	4.000 (1.000-6.000)	5.000 (3.000-8.000)	1134.5	.085	2.000 (1.000-4.000)	3.500 (2.000- 5.000)	1179.5	.035*
Readiness for Safer Sex Topics									
All Sources	Pregnancy	2.000 (.000-3.000)	2.000 (1.000- 4.000)	1052.0	.296	1.000 (.000-2.000)	1.000 (.000-3.000)	1084.0	.185
All Sources	Contraception	2.000 (.500-4.000)	3.000 (1.000-5.000)	1054.0	.290	2.000 (.0000-3.500)	2.000 (.0000-.00)	977.5	.676
All Sources	Sexually Transmitted Infections	2.000 (1.000-4.000)	3.000 (1.000-5.000)	1021.5	.432	1.000 (.500-2.000)	2.000 (.000-4.000)	1017.5	.447
All Sources	Safer Sex (condoms)	2.000 (1.000-4.500)	3.000 (1.000-5.000)	1002.0	.536	2.000 (1.000-3.500)	3.000 (.000-4.000)	978.5	.671

All Sources	What it means to Consent and my rights	2.000 (1.000-3.500)	3.000 (1.000-5.000)	1068.0	.241	2.000 (.000-3.000)	2.500 (1.000-5.000)	1129.5	.090
All Sources	How to know I am ready for sex	2.000 (.000-3.000)	2.000 (1.000-5.000)	1102.0	.144	1.000 (.000-3.000)	2.000 (1.000-3.750)	1141.5	.070

Source	Topic	Use				Usefulness			
		City/ Large Town	All other places			City/ Large Town	All other places		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
Sexual Activity / Behaviour topics									
All Sources	Kissing	3.000 (.000-4.000)	3.000 (1.000-7.000)	1159.0	.052	1.000 (.000-3.000)	3.000 (.250-5.000)	1202.0	.020*
All Sources	Cuddling	1.000 (.000-4.000)	2.500 (1.000-5.000)	1182.5	.032*	1.000 (.000-3.000)	2.000 (.000-5.000)	1202.5	.020*
All Sources	Genital Touching	1.000 (.000-3.500)	2.000 (.000-4.000)	1022.0	.426	1.000 (.000-2.500)	1.000 (.000-3.000)	1023.0	.417
All Sources	Masturbation	2.000 (.000-4.000)	2.500 (.000-5.000)	1027.0	.404	1.000 (.000-3.000)	1.000 (.000-4.000)	944.5	.888
All Sources	Oral Sex	2.000 (.000-4.000)	3.000 (.000-4.000)	941.5	.909	2.000 (.0000-3.000)	1.500 (.000-3.000)	937.0	.938
All Sources	Vaginal Sex	2.000 (.000-4.000)	2.000 (.000-4.000)	879.0	.679	2.000 (.000-3.500)	1.000 (.000-3.000)	889.5	.742
All Sources	Anal Sex	1.000 (.000-4.000)	2.000 (.000-3.000)	977.5	.670	.000 (.000-2.000)	1.000 (.000-2.000)	1007.5	.484
All Sources	What to do during sex	2.000 (.000-4.000)	2.000 (.000-4.000)	920.5	.949	1.000 (.000-3.500)	2.000 (.000-3.000)	932.0	.973
All Sources	How to use safer sex aids	1.000 (.000-4.000)	2.000 (.000-4.000)	976.0	.682	1.000 (.000-3.000)	1.000 (.000-3.000)	999.0	.541

All Sources	How to use sex toys safely	.000 (.000-3.000)	1.000 (.000-3.000)	1017.5	.432	.000 (.000-3.000)	.000 (.000-2.000)	929.0	.993

6.4.4 Level 4: Categorised topics by all sources relative to living location

When categorised topics by all sources were examined, there was significance in the distribution in the Friendship and Sexual Orientation category (Category 1) for both used ($p=.021$) and useful ($p=.041$) sources. Those that lived in all other places were more likely to find the sources in this category both used and useful (Table 6.14).

In the other two categories – Readiness for Safer Sex (Category 2) and Sexual Activity/ Behaviour (Category 3), there were no significant differences in the used and usefulness distributions of all sources by individual topics and ages.

6.4.5 Level 5: All topics by all sources relative to living location

When all sources were combined and all topics were combined, there was no significant difference in their distributions for either used or usefulness across living location. i.e., the total number of those who used or found useful all topic by all sources was not significantly different across living location ($p=>0.05$) (Table 6.15).

Table 6.14: Level 4 Bivariate analysis of the significant results of use and usefulness of categorised topics by all sources relative to living location (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		City/ Large Town	All other places			City/ Large Town	All other places		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
All Sources	<u>Category 1 – Friendships and Sexual Orientation</u>	13.000 (6.500-18.500)	18.000 (10.250-26.000)	1205.5	.021*	10.000 (5.500- 13.500)	12.0000 (8.250-18.000)	1174.0	.041*
All Sources	<u>Category 2 – Readiness for Safer Sex</u>	10.000 (5.500-222.500)	18.000 (7.000-29.000)	1083.0	.198	9.000 (5.000-16.000)	12.5000 (5.000-22.500)	1070.5	.236
All Sources	<u>Category 3 Sexual Activity/ Behaviour</u>	18.000 (2.000-36.000)	26.000 (3.250- 45.000)	1024.5	.422	13.000 (1.000-28.000)	17.500 (2.250- 33.000)	1016.0	.463

Table 6.15: Level 5 Bivariate analysis of the significant results of use and usefulness of all sources and all topics combined relative to living location (n= 93) (Mann Whitney U Tests)

Source	Topic	Use				Usefulness			
		City/ Large Town	All other places			City/ Large Town	All other places		
		Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>	Median (25% - 75%)	Median (25% - 75%)	<i>u</i>	<i>p</i>
All Sources	All Topics	49.000 (18.000-69.000)	63.000 (27.000-95.000)	1100.5	.152	38.000 (14.500- 55.000)	43.000 (19.250-69.750)	1090.5	.178

6.5 Conclusion

The findings from the inferential statistics relative to three variables (age, gender at birth and living location) supplement the descriptive statistics presented previously for the sources of information that are both used and useful for the individual twenty topics. However, some other additional elements are included here, with the sources and topics combined to provide further information. Overall, it is observed from the findings that females in the older age group of 16-19 that live outside of cities and towns are more likely to use the listed sources and find them useful for both individual and combined categories of topics. These will be further discussed with reference to the literature in the Discussion chapter.

7 Chapter 7 – Discussion, Limitations, Recommendations, and Conclusion

7.1 Introduction

This chapter discusses the study's main findings in relation to literature on LGBTQ adolescents' sources of information on sexuality and sexual health. While the overall study aim was to obtain a deeper understanding of LGBTQ adolescents (age 13-19) information seeking behaviour, sources of information and information needs in relation to sexuality and sexual health, there were four specific objectives for this study.

These objectives were to:

- identify sources of information and their usefulness that LGBTQ adolescents of secondary school age (13-19) use in relation to sexuality and sexual health,
- ascertain how useful LGBTQ adolescents find the sources of information in relation to sexuality and sexual health,
- discover which sources of information and their usefulness that LGBTQ adolescents use for different topics, such as Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/Activity and
- identify the impact of demographic variables on the sources of information that are used and are considered useful by LGBTQ adolescents.

The findings on the sources of information and topics are discussed in the context of their use and usefulness. Both primary and secondary sources are discussed in depth. A primary source is the source most reported per topic, whereas secondary sources are the second and third most chosen ones for a topic. In some instances, the same number of people reported using a source, therefore there are 23 primary sources for 20 topics (Table 5.17, 5.26, 5.37, Chapter 5 Descriptive Findings). Key findings from this study indicate there was no single source of information used by the respondents across all topics. Findings instead indicate that different sources are used for different topics. However, the perceived usefulness of the sources varies with the ones most frequently used not always the most useful.

This chapter commences with a discussion on how the respondents feel about their sexuality. This is followed by an examination of school as a source of information and

the timing of school-based education. Five sources of information, namely family, internet/ media, porn, peers and partners are then discussed. Following this, the sources of information not used as a primary or secondary source are discussed as well as issues around the acceptability of asking LGBTQ adolescents about sexuality and sexual health. Finally, the chapter concludes with a discussion on the limitations and recommendations from the study and some personal reflections on my experience of doing the research.

7.2 Overall Wellness of the Respondents

The majority (60%) of respondents in this study reported that they felt great or really good about their sexual orientation, with an additional 28.4% stating they felt “ok”. However, there was 11.6% who felt ‘pretty bad’ or ‘really bad’ about their sexual orientation. This question was included with permission from Hillier *et al.* (2010), the author of a study of LGBTQ young people in Australia so the findings are directly comparable. Hillier *et al.* asked this question about sexual orientation in three studies (Hillier *et al.* 1998, 2005, 2010) and the numbers who felt good about their sexual orientation increased from 60% in 1998 to 79% in 2010. The number who stating they felt ‘ok’ decreased over time from 30% in 1998, 18% in 2005 to 16% in 2010 ‘felt ok’. A further 10% in 1998 and 4% in 2010 reported feeling bad about their sexual orientation. While it would be expected that the findings to be more in line with the 2010 findings, the figure of 11.6% from my study are similar to the 1998 results from Australia (Hillier *et al.* 1998), which is 25 years ago. In the past 25 years, there has been significant legal changes for LGBTQ people in Ireland which include the right to adopt, the right to have a civil partnership which led to a public vote for same sex marriage. There has also been a positive shift in public attitudes with public awareness events like Pride Month (an annual LGBT Pride Celebration) and Stand-Up Awareness in schools as well as prominent LGBT personalities seen regularly in mainstream media and social media. Therefore, while positive changes have taken place within the Irish legal system and in society, and overall, the findings of my study are positive, some individuals still feel negatively towards their sexual orientation.

While the reasons for the 60% positive wellbeing finding is unclear, protective factors at individual and community levels have been found to be useful to improve positive views of LGBTQ sexual orientation (Költő *et al.* 2021). Hillier *et al.* (2010) and more recently Hill *et al.* (2021) suggest that individual protective factors may be related to

social support from friends, in particular LGBQ friends and family and a recognition by the adolescents that the problems with homophobia they encountered are a societal problem and not with them individually. This may also be the case within the respondents in my study as in recent years there has been a lot of emphasis and discussion in the media on homophobia, minority stress and its impact. Community level protective factors are linked to school policies on antibullying, being a member of a LGBQ community group and visibility of positive LGBQ role models in the media (Higgins *et al.* 2016, Költő *et al.* 2021). However, in contrast to Hillier *et al.* (2010) findings where 4% reported feeling bad, having 10% of respondents in my study reporting feeling bad about their sexual orientation is concerning for several reasons. First there is a relationship between how people feel about their sexuality and instances of self-harm (Hillier *et al.* 2005, 2010). In an Irish context, Higgins *et al.* (2016) and Dooley *et al.* (2019) also report that LGBQ adolescents in comparison to their heterosexual peers were more likely to have lower self-esteem and more dissatisfaction with their lives. Secondly, research also indicates a relationship between self-esteem and experiences of discrimination as well as the likelihood of experiencing depression and anxiety (Meyer 2003, Higgins *et al.* 2016, Goldbach *et al.* 2021).

Negative feelings about sexual orientation are frequently discussed in the literature in relation to stigma and minority stress (Költő *et al.* 2021). While stigmatisation is associated with negative attitudes to LGBQ people leading to homophobia and biphobia, minority stress is the excess stress that those subjected to stigma are chronically exposed to because of their sexual identity (Meyer 2003, Hatzenbuehler and Link 2014) and are disproportionately affected by exclusion from social groups, victimisation and bullying which are core elements of minority stress especially in those aged 12-25 (Alessi *et al.* 2013). Despite positive societal changes towards LGBQ people, poorer mental health outcomes associated with minority stress in LGBQ people in comparison to heterosexual peers has remained consistent over time (Költő *et al.* 2021 Higgins *et al.* 2016). In addition, homophobic abuse is associated with feeling unsafe, excessive drug use as well as self-harm and suicide in LGBQ adolescents (Hill *et al.* 2021). In my study, the responses to the open-ended questions respondents mentioned dealing with bullying and homophobic remarks, which are characteristic of minority stress, so could contribute to the negative views of the respondents towards their sexual orientation.

A shift in how LGBTQ adolescents view themselves can occur from feeling bad about themselves, to later feeling more positive as they age. While Higgins *et al.* (2016) noted dissatisfaction with sexual orientation to be highest in the 14-18 age group, as LGBTQ people aged they reframed their identities in a more positive light. Changes in thinking about sexual orientation have also been found to be assisted by protective factors such as positive attitudes in close personal relationships with family and friends, being affirmed by others, romantic connection and positive changes in community or school attitudes to LGBTQ people (Hill *et al.* 2021, Költő *et al.* 2021). On the other hand, studies in the USA, UK and the Irish National School Climate Studies indicate that homophobic abuse impacts on aspects of schooling including missing class, poor concentration in class and dropping marks or in the worst-case missing school or dropping out of school altogether (Kowciw *et al.* 2015, Stonewall 2017, Pizmony-Levy 2022).

Thus, education and exposure to positive dialogue within schools can influence how LGBTQ adolescents feel about themselves (Hillier *et al.* 2010, Pizmony-Levy, 2022). Affirmative and protective school experience has been associated with higher levels of life satisfaction, with negative school experiences being linked to lower levels of life satisfaction (Hillier *et al.* 2010, Stonewall 2017, Költő *et al.* 2021). However, school has also been found to be the most likely place negative experiences occur (Hillier *et al.* 2010, Stonewall 2017, Pizmony-Levy, 2022). Previous Irish studies have found that school experiences are not always positive for LGBTQ adolescents (Reygan 2009, Higgins *et al.* 2016, O'Donoghue and Guerin 2017, Pizmony-Levy & BeLonGTo 2019, Pizmony-Levy 2022) with 68% of adolescents in the 2019 Irish School Climate study reporting hearing homophobic remarks from other students (Pizmony-Levy & BeLonGTo 2019). While nearly half (48%) of the adolescents reported hearing homophobic remarks from teachers in 2019 study (Pizmony-Levy & BeLonGTo 2019), this worryingly increased to 58% in the 2022 study (Pizmony-Levy 2022). This is despite all the positive work that has been done in recent years in Ireland, with 'Stand Up Awareness'⁵ in secondary schools and the community.

⁵ Belong To's Stand Up Awareness Week is a time for post-primary schools to promote inclusivity for LGBTQIA+ students in school and highlight homophobic, biphobic and transphobic bullying.

7.3 School Based Sex Education

Despite school-based sex education being associated with deferring first sex until an older age, decreasing the likelihood of unsafe sex, and STI diagnosis (Macdowall *et al.* 2013), in my study, information received from school-based sources of information was limited, with teacher/ school, being a primary source of information for only one topic - 'safer sex (condoms)' and a secondary source for 'pregnancy', 'contraception' and 'STI'. The Department of Education and Skills (2017) in Ireland report that all centres providing relationship and sexuality education reported including contraception, teenage pregnancy, healthy relationships, STIs, consent and sexual violence and sexual orientation in the content taught. There is, however, no breakdown in the amount of content or hours provided to each subject. This study suggests that teachers are a primary and secondary source for four of these topics (safer sex (condoms)', 'pregnancy', 'contraception' and 'STI') so it could be assumed that more time was spent on these topics and less on issues such as healthy relationships, consent and sexual violence and sexual orientation when they were being discussed in schools.

While it is positive that these topics are being discussed in school, the focus on these topics suggests that a risk reduction approach to sex education is being emphasised in schools, where avoidance of teenage pregnancy and sexually transmitted infections is the aim. This does not support a positive view of sex education for several reasons. First, a risk reduction approach to sex education does not align with the broad World Health Organisation definition of sexuality that is used earlier in this study, which includes positive aspects of sexuality (WHO 2010). Second, a risk reduction approach may neglect to address sexual rights and pleasure by failing to address factors that contribute to health risks such as sociodemographic factors, issues related to rights and the need for sexual health information and services (Gruskin *et al.* 2019). Elements such as relationships, self-determination, consent, safety, privacy, confidence, communication and ability to negotiate with a partner may also be excluded from the information provided (Gruskin *et al.* 2019). Additionally, a focus on risks and negative outcomes from sex may reduce pregnancy and STIs to subjects of shame and stigma, leading to a situation where many will not seek help from healthcare providers until a negative outcome occurs (Gruskin *et al.* 2019), or delay help seeking because of shame. A risk reduction approach to education has also been found to reinforce gender stereotypes, such as the one that females are solely

responsible for pregnancy prevention in male- female sexual intercourse (Rubinsky and Cooke Jackson 2017).

In addition, studies suggest that adolescents do not like sex education that emphasises risk and the negative aspects of sex and prefer a positive approach to sex education (Pound *et al.* 2017, Kantor and Lindberg 2020), which might explain why teachers/ school were not perceived to be useful sources of information. More importantly positive sex education is linked to open dialogue, the educators' comfort in discussing sexual practices, the inclusion of information that incorporates conversations about sexual health, sexual rights and sexual pleasure, including touching, mutual masturbation, as well as oral, vaginal and anal sex (Power *et al.* 2009, Jarpe-Ratner 2020, Rabitte 2020, Waling *et al.* 2020). This is not a problem unique to LGBTQ adolescents, as the absence of a discussion on wider aspects of sexual pleasure in education, particularly female pleasure, is reported in other studies such as Natsal-3 where 17% of non-LGBTQ women and 20% of non-LGBTQ men wanted to learn more about the pleasurable aspects of sex (Pound *et al.* 2017).

Furthermore, a risk reduction approach to sex education excludes lesbian women from the dominant discourse on sexual health risk (Power *et al.* 2009). For some, lesbian sex may be disassociated from pregnancy, HIV and STIs in sexual health education (Power *et al.* 2009) so their needs are not included in school-based discussions. This may explain why school was not a primary source of information for more topics in this study, such as sexual attraction/ orientation, consent, what to do during sex and how to use safer sex aids, as teachers may not have considered them relevant. This is not surprising from an Irish perspective as no information about female same sex activities has been found in any documents related to school based RSE in Ireland (Department of Education and Skills 2017, National Centre for Curriculum Assessment (NCCA) 2019), so it can be assumed that it is discussed very little if at all, and that heterosexual sexual activities are prioritised in discussions.

Even within the confines of heterosexual sexual activity, studies suggest that the only 'real sex' discussed is penile- vaginal sex with other sexual activities considered alternative and where LGBTQ adolescents are "other" (Gowen and Winges-Yanez 2014, McCarthy-Caplan 2015, Arbeit *et al.* 2016, Rose and Friedman 2017, Formby and Donovan 2020, Grant and Nash 2020, Epps *et al.* 2023). This is supported by Stonewall (2017), in the UK, who outline that while over 60% of LGBTQ adolescents

report learning about contraception, safe sex, consent and violence in school, same sex relationships were not included in class discussions. A heterosexual bias, penile-vagina, sex education focus can also mean that parts of the body related to reproduction are prioritised and other parts that are sexual but not linked with reproduction are not discussed (Kiely 2005, Pound *et al.* 2017, Rabitte 2020). In this context, the sexual health messages linked to touching, mutual masturbation, oral or anal sex are not discussed or when they are discussed they are framed within the risk discourse, in other words the risks associated with these sexual behaviours. This results in the alienation of LGBTQ adolescents within classes and contributes to their disengagement and dissatisfaction with RSE overall (Gowen and Winges- Yanez 2014). For LGBTQ adolescents, framing same sex sexual activities as risky or dangerous (Hillier *et al.* 2010) constructs their identities as risk beings (Rasberry *et al.* 2018, Rabitte 2020). Discussions such as these are less likely to represent positively LGBTQ people and students may feel less connected to the school community or their heterosexual peers as a result (Bodnar and Tornello 2019).

This is true for Irish LGBT youth in schools who often experience mainly heterocentric sex education which is described by the LGBTQ people in comments in this study. This could be another possible reason why teachers/school are reported as a source of information on “*safer sex (condoms)*”, “*pregnancy*” and “*contraception*” but not a useful one. Even when topics such as ‘*safer sex (condoms)*’ are discussed, which may be applicable to LGBTQ adolescents, they may assume that the safer sex as being discussed is only relative to heterosexual sex unless it is explicitly stated that the information is relevant to other sexualities (Power *et al.* 2009, O’Farrell *et al.* 2021, Epps *et al.* 2023). This view is also supported by other Irish researchers in the area (Department of Children and Youth Affairs (DCYA) 2017, National Centre for Curriculum Assessment 2019, Költő *et al.* 2021).

In the context of heterosexual adolescents, the findings from my study contrast with international studies that report school as a predominant used source of information for sexuality for heterosexual adolescents (Hoff *et al.* 2003, Mitchell *et al.* 2014a, Macdowell *et al.* 2013). Nolan and Smyth (2020) in Ireland stated that while 10.8% of 13-year-olds received school-based education and by the age of 17 years, over 90% of heterosexual adolescents received school-based sex education. In my study, older respondents (aged 16-19) reported teachers/ school as both a used and useful source for information much more than the younger cohort (aged 13-15). In the context of my

study, it should also be recognised that the data was collected for this study at a time when adolescents were out of education for long periods during COVID 19 lockdowns, so RSE education may not have been prioritised during this time. As a result, some adolescents who missed human reproduction in 6th class in primary school during this time may not have received any sexuality education until they were in 2nd or 3rd year of secondary school, which may have impacted on the younger cohort.

Overall, respondents in this study report teachers/ school as a used but **not a useful** source for 'safer sex (condoms)', 'pregnancy', 'contraception' and 'STI'. Usefulness of school-based education is also reported by Hillier *et al.* (2010) who reported that while LGBQ adolescents in Australia received school-based information on condoms, birth control and safe sex, 44% found it 'not useful at all' and 40% said it was 'partly useful'. However, perceiving teacher/school as an inadequate source of information is not limited to the LGBQ students in my study, as school-based education nationally and internationally is described as poor for all students, with students often reporting irrelevant content, and teachers that are unprepared and uncomfortable delivering sex education material (Gowen and Winges- Yanez 2014, National Centre for Curriculum Assessment 2019, Waling *et al.* 2020). Therefore, while school may be a preferred source of information for both heterosexual and LGBQ adolescents (Whitfield *et al.* 2013, Mata *et al.* 2022), it would appear from this and other studies that school is not a useful source of information for either heterosexual or LGBQ adolescents and other sources of information are required.

Providing students with school based LGBQ sexuality education not only impacts on sexual health knowledge of students but also helps to alter school culture in a more positive way towards LGBQ people (Stonewall 2017, Jarpe-Ratner 2020, Rabitte 2020). Developing an inclusive curriculum has been found to increase LGBQ visibility in school, promote tolerance and lessen homophobic and biphobic remarks (Stonewall 2017, Pizmony-Levy 2022). An inclusive curriculum is one where LGBQ people and issues are reflected across the curriculum, while not limited to but including sufficient information in RSE classes that incorporates the needs and experiences of LGBQ people (Stonewall 2017, Jarpe-Ratner 2020). It is also one that portrays a variety of relationships and uses gender neutral terms such as partner instead of girl/ boyfriend (Bodnar and Tornello 2019). Respondents in my study suggest a need for more inclusion of LGBQ content in school curricula but specifically in RSE. Consistent inclusion of all sexual orientations in holistic school-based sex education as well as a

broadening of sexuality discussion to include sexual activity for all should be considered. A failure in the provision of information by reliable sources will result in adolescent LGBQ people sourcing information elsewhere, risking the acquisition of inaccurate or unreliable information (Hillier *et al.* 2010, National Centre for Curriculum Assessment 2019, Rabitte 2020). It may also mean that young LGBQ people leave education without the skills and knowledge to develop healthy consensual relationships and protect themselves against potential sexual and reproductive risks (Bodnar and Tornello 2019).

7.4 Timing of School-based Sexuality Education

The age of being aware of sexual orientation has implications for school-based sex education, as it would be expected that the majority of LGBQ adolescents become aware in their primary school years. Findings from this study indicate that over ninety percent (92%) of adolescents are aware of their sexual orientation in early adolescence before the age of 14, with 12 being the mean age of knowing. Higgins *et al.* (2016) in their Irish study also found 12 to be the most common age of realisation with a gap of 1-4 years between being aware and disclosing to another person. The finding on age of awareness is important in the context of schools being a source of information. The gap between awareness and telling is an important developmental time for adolescents described in Chapter 2, as most adolescents experience cognitive, physical and emotional changes associated with puberty at this time. It is also the time that adolescents begin experimenting with dating and sexual relationships. Biological reproduction is taught in 6th class of most primary schools and while it is not expected that same sex activity education will be included in classes at this time, some additional measures can be included through primary school to assist LGBQ adolescents have a more positive school experience in relation to their sexual orientation. The inclusion of sexual identities in schoolbooks and increased visibility of different family types and differing gender roles have been shown to increase tolerance and reduce stigma associated with LGBQ sexual orientation (Hillier *et al.* 2010, Stonewall 2017), as responses in the open comments section in my study showed respondents were not happy being told they would be given information on LGBQ sexual orientations when older.

Despite the junior cycle of secondary school being a critical time for RSE of an Irish adolescent, 17% of schools report they do not teach Relationships and Sex Education

(RSE) as part of their curriculum (Department of Education and Skills 2017). While the amount of sexuality education provided in Irish schools increases from age 13 to 17 years (Nolan and Smyth 2020), there is also a difference in emphasis in schools and between the junior (13-15) and senior cycles (15-18), with contraception and avoidance of teenage pregnancy emphasised more during the senior cycle. This is the case in this study with more older respondents reporting that the teacher/ school was a source of information on “*pregnancy*”, “*contraception*”, “*safer sex (condoms)*” and “*STI*”. While not directly applicable to this study as the majority of my respondents were still in education, this has sex education implications for early school leavers as this content may not be provided prior to them leaving school. In this study, more respondents in the 16-19 age group, in comparison to the younger respondents aged 13-15, reported teachers as a primary source of information for Safer Sex (condoms). These topics were also discussed at senior years in school in Hillier *et al.* (2010) study, but in some instances the information was provided after adolescents had begun having sexual intercourse, which was too late as far as the respondents were concerned. This is supported by studies from the US where sexual education for LGBTQ adolescents was given after sexual activity had begun (Arbeit *et al.* 2016, Hobaica and Kwon 2017, Bodnar and Tornello 2019). Bodnar and Tornello (2019) report that lesbian and bisexual women engage in sex with males earlier than their heterosexual counterparts. They also found that the timing of sexual instruction influenced sexual health outcomes, with those who received instruction before sexual activity began being more likely to report never having been pregnant. In addition, they found that timing of the information was late, with women only receiving information after they had begun sexual activity (Bodnar and Tornello 2019).

While no research data is available in Irish LGBTQ adolescents, the average age in Ireland for sexual intercourse initiation is 17 years in heterosexual population in Ireland (Young *et al.* 2018, O'Mahoney *et al.* 2021). As such it can be expected that adolescents aged 16-19 in the older cohort in this study would be interested in topics that prepare them for sexual activity. This is the case in this study with older respondents (aged 16-19) reported using all the sources of information and finding them more useful than the younger cohort (13-15). This was particularly true for topics in the Category 2 - Readiness for Safer Sex Topics (*'Pregnancy'*, *'Contraception (apart from condoms)'*, *'Sexually Transmitted Infections'*, *'Safer Sex (Condoms)'*, *'What It Means to Consent to Sexual Activity and My Rights'* and *'How to Know I am Ready for Sex'* topics. However, school was the primary source for only one topic *'Safer sex*

(condoms) ' and was accessed more by older respondents than younger ones. More school-based education would be an advantage for LGBTQ adolescents as inclusive school based RSE information delivered at the correct time can help postpone sexual initiation for all adolescents regardless of sexual orientation and a lack of information means that they are unprepared for safer sexual behaviour when they commence sexual activity (Chin *et al.* 2012, Gowen and Winges Yanez 2014, Macdowell *et al.* 2013, Raspberry *et al.* 2018, Epps *et al.* 2023).

7.5 Family as a Source of Information

It is reasonable to expect adolescents to be informed about contraception, pregnancy and condoms from parents, as parents may be personally familiar with these topics and discussions may be prior to any conversations on sexual orientation. In this current study, mothers were a primary source of information for two topics, '*pregnancy*' and '*contraception (apart from condoms)*' and a secondary source for '*safer sex (condoms)*'. Previous studies show that mothers are also a primary source of information for these topics in non-LGBTQ adolescents (Aspy *et al.* 2007, Lefkowitz and Espinosa- Hernandez 2007, Wright and Fullerton 2013). While not a primary or secondary source of information on any topic in this study, fathers were found to be both a used and useful source of information for males relative to '*Safer Sex (condoms)*' in Chi² analysis. This is an important finding as most of the research on parents as a source of information focuses on mother-child relationships. In the studies that include fathers, they are generally identified less as source of information (Flores and Barroso 2017, Bennett *et al.* 2018, Grossman *et al.* 2021), whereas my study suggests that they are a used and useful source for '*Safer sex (condoms)*'.

From an Irish perspective, Nolan and Smyth (2020) report that parents of non-LGBTQ adolescents are the most used source of information for 45% of 13-year-olds and 60% of 17-year-olds. At both ages, however, females were more likely to have spoken about sex/relationships with parents than males. This is also the case in this current study with more females reporting parents as a source of information than males. Nolan and Smyth (2020) found that the onset of puberty was significantly associated with discussions of sex/relationships suggesting that puberty and in particular the onset of menstruation in females was a prompt to discuss sex/relationships with their children as they had a focal point on which to begin discussions (Nolan and Smyth 2020).

The increasing level of communication with parents as non-LGBQ Irish adolescents get older and seen in Nolan and Smyth (2020) is replicated in my study with older respondents reporting parents as a source of information more than the younger respondents. One reason for this is that parents may instigate conversations about sex when they consider that their child is, or, about to become sexually active (Macdowell *et al.* 2013). Therefore, mother as a primary source of information on “*Pregnancy*” and “*Contraception*” in this study corresponds with this. Parents being a source of information for pregnancy is not reported by Nolan and Smyth (2020). They did however find that mothers were a source of information about contraception for 40.4% of 13-year-olds and 71.5% 17-year-olds, whereas fathers were a source of information for contraception for 20.6% of 13-year-olds and 37.9% of 17-year-olds. Similar figures were seen for safer sex, as more mothers than fathers were a source of information for older adolescents than younger ones. Parents were also found to be the most used source of information for contraception at age 13, but other sources were used more at age 17 (Nolan and Smyth 2020). In my study, while additional sources are used by the older cohort, mothers are reported as a more used source in the younger age group for ‘*Sexually transmitted infections*’, ‘*Consent*’, ‘*Masturbation*’, ‘*What to do during sex*’, ‘*Kissing*’ and ‘*Cuddling*’. Fathers relative to age are a source of information for more younger respondents for the topics, ‘*Pregnancy*’, ‘*How to know I am ready for sex*’, ‘*Kissing*’ and ‘*Cuddling*’. In the Category 3 -Sexual Activity/ Behaviour, fathers were reported as a source of information for the young cohort for ‘*Kissing*’, ‘*Cuddling*’ and ‘*How to use Safer Sex Aids*’ but for the other seven topics in that category no respondent in the younger cohort reported the father as a source of information.

A possible reason for a lack of parental-child communication about sex with LGBQ and non-LGBQ adolescents have been found to be related to parents’ age, background and culture, comfort in communication, the timing of the conversation and how parents perceived their own efficacy in communicating about topics related to sex (Jaccard *et al.* 2000, Guilamo-Ramos *et al.* 2012, Guilamo-Ramos *et al.* 2019, Pariera 2016, Flores *et al.* 2019). It may also relate to parents’ upbringing and their own adolescent communication experiences about sex. A possible reason why fathers are not as prominent a source of information as mothers maybe because their own sex education was limited (Bennett *et al.* 2018). It may also be the case that while parents may provide some education it may only be one conversation and not ongoing discussions, with parents inclined to wait for questions rather than be proactive and lead the

communication (National Centre for Curriculum Assessment 2019, Padilla-Walker *et al.* 2020, Mata *et al.* 2022).

The reasons mentioned above do not specifically address different family structures or heterosexual parents discussing sex and sexuality with LGBTQ adolescents. Likewise, experiences may also be different for LGBTQ parents discussing sex with LGBTQ or heterosexual children. This study does not have a breakdown of family structure. Flores *et al.* (2019) noted in their research with LGBTQ males aged 15-20 years that discussions with parents about sexual health were mostly after adolescents came out about their sexual orientation. However, information provided by parents was not inclusive, with heteronormative information being reinforced. Thus, in Flores *et al.* (2019) study, there was no change between information provided by parents before and after parents were told about their child's sexual orientation. Feinstein *et al.* (2018), on the other hand, in their study of gay and bisexual boys found that for 56% of respondents' sexual orientation had a negative impact on their relationships with their parents. In that study 76% reported that being gay/ bisexual influenced conversations about sex and dating with their parents, both before and after coming out. Conversations were considered meagre, vague and uncomfortable and focussed on risk and safety. Uncomfortable conversations were attributed to parents' inexperience and knowledge of gay/bisexual males' sexual health (Feinstein *et al.* 2018, Flores *et al.* 2019). In my study parents are not reported as a primary source of information for any topic in Category 1- Friendship/ Sexual Orientation or Category 3 - Sexual Activity/ Behaviour, suggesting that parents may not be comfortable discussing LGBTQ sexual orientation and sexual activity. However, non-LGBTQ adolescents also report that parents were uncomfortable discussing sex and sexual health with their children (Ashcraft and Murray 2017, Waling *et al.* 2020). So, while it is expected that sexual orientation may be a factor in the provision of limited sexuality education from parents in this study, it may not be the only factor. Thus, further research is suggested into LGBTQ adolescents and parents experience of communication about sexuality and sexual health and the usefulness of the information provided.

7.6 Internet/Media as a Source of Information

In this study, the internet was a primary source of information for four topics. A LGBTQ Focussed Internet search was a primary source of information for 'Sexual Attraction/ Orientation', with a non-LGBTQ focussed internet search being a source for three topics,

'Sexually Transmitted Infections (STI)', *'What it Means to Consent to Sexual Activity and my Rights'* and *'How to know I am Ready for Sex'*. Internet was a secondary source for eight of the ten topics in Category 3 -Sexual Activity/ Behaviour with *'Kissing'* and *'Cuddling'* the only topics in this category that were not searched using the internet. Similar findings of the internet as a source of information were reported in other studies involving LGBQ adolescents aged 13-21 (Hillier and Mitchell 2008, Hillier *et al.* 2010, Hillier *et al.* 2012, Kingdon *et al.* 2013, Mitchell *et al.* 2014b, Arbeit *et al.* 2016, Steinke *et al.* 2017, Mata *et al.* 2022). In these studies, generic internet and LGBQ specific online searches were found to be primary sources for information on safer sex, birth control, gay and lesbian relationships, sexual attraction/ orientation and coming out. In my study, LGBQ internet search was also a secondary source of information on *'Coming Out'*. Respondents reported LGBQ internet searches as a primary source of information and the most useful one for *'Sexual Orientation/ Attraction'*.

Similar findings were reported by Mitchell *et al.* (2014b) and Steinke *et al.* (2017) for LGBQ internet as a used source, however data on the usefulness was not reported in these studies. In my study, as well as being used for the four topics, *'Sexual Attraction/ Orientation'*, *'Sexually Transmitted Infections (STI)'*, *'What it Means to Consent to Sexual Activity and my Rights'* and *'How to know I am Ready for Sex'*, internet searches were found to be a useful source of information for these topics. This is similar to previous studies where internet searches were found to be a useful source of information on sexuality and sexual health in studies with LGBQ and non-LGBQ adolescents but the specific sexuality and sexual health topics they were used for were not discussed (Hillier *et al.* 2010, Jones and Biddlecom 2011a, Jones and Biddlecom 2011b, Kubciek *et al.* 2010, Kubciek *et al.* 2011, Clifton *et al.* 2016), with one exception. Mustanski *et al.* (2011) found that older LGBQ adolescents searched the internet for specific facts about HIV and sexually transmitted infections (STIs), helped them find suitable healthcare providers and learn about safer sex. In my study, non-LGBQ internet searches were also a used and useful source of information for STIs.

The use of internet search as a source of information for so many topics may be related to the absence of education in schools on topics such as consent, sexual orientation and readiness for sex. Internet searches can also be done without person-to-person interaction on topics that LGBQ adolescents may not be comfortable

sourcing on an in-person basis, such as sexual attraction/ orientation, sexually transmitted infections or sexual activity which were all searched in my study. In addition, in my study those living outside cities or large towns used LGBQ focussed internet searches for the combined topics in Category 2 -Readiness for Safer Sex. While the geographic difference is unclear, it may have been due to a lack of other available sources such as parents or school.

In terms of the technology used to search the internet, in my study 90% of adolescents used smartphones to source information. This is over double what Park and Kwon (2018) reported in their study of non-LGBQ adolescents, where 42% used mobile phones to search for health-related information, with the majority using laptops or personal computers. As smartphones are so convenient, it is surprising that the internet was not a primary source of information for more topics, such as '*LGBQ relationships*', '*Finding LGBQ friends*' and '*Coming out*'. This is an important finding that schools and organisations that work with LGBQ adolescents need to be aware of, so that they do not expect adolescents to automatically default to searching the internet. It is also important that alternative/complimentary sources of information are suggested for topics on sexuality and sexual health.

One of the reasons that internet was not a primary source for more topics may that both LGBQ and non-LGBQ adolescents have concerns about privacy, confidentiality and a lack of trustworthy information on the internet (Jones and Biddlecom 2011a, Magee *et al.* 2012, DeHaan *et al.* 2013). Several strategies have been described that adolescents use to determine the veracity of the information provided on the internet which included checking several websites to see if the information provided matched, double checking the information with other sources and ensuring that the website was a medically reliable one. It has also been reported that for some health-related questions, such as relationships, sexuality, sexual behaviour or consent, government, university or scientific or medical based websites are a preferred source (Waling *et al.* 2020). This assumes that all adolescents have the skills to determine the veracity or reliability of information searched.

In this study, respondents also commented in the qualitative comments that they did not know where to start and described searching Google for information on how lesbian sex works and asexuality. The difficulty with using search engines to look for sexuality information on the internet is that some of the links provided through generic

or LGBTQ specific searches can lead to people inadvertently opening porn material which increases the concern that someone may view/ hear material or may be found searching (Hillier *et al.* 2010). In addition, the level of education and age of the person may affect the search terms used. For example, the use of correct medical terms to search may lead to more reliable websites whereas using slang term may lead to less reliable ones and possibly porn sites (Waling *et al.* 2020).

7.7 Pornography (porn) as a Source of Information

Pornography (porn) was the primary source of information for one quarter of all topics in my study, namely those in Category Three- Sexual Activity/Behaviour. These topics were 'Genital touching', 'Masturbation', 'Oral', 'Vaginal' and 'Anal' sex, with approximately 50% reporting it as useful for 'How to use Sex Toys Safely'.

The British National Survey on Sexual Attitudes (Natsal-3) report that only 3% of males and <1% of heterosexual adolescents report using porn as a source of information (Tanton *et al.* 2015). However, in my study porn was used by between 35% and 45% of LGBTQ adolescents as a source for information on sexual activity/ behaviour topics which were 'Genital touching', 'Masturbation', 'Oral', 'Vaginal' and 'Anal sex'.

The use of porn, as a source of information may be related to the absence of information from other sources such as school and parents. Previous research with LGBTQ people reports that 'porn education' is used as a form of education in the absence of reliable information from school or parents (Hillier *et al.* 2010, Arrington - Sanders *et al.* 2015, Nelson *et al.* 2019c, Mustanski *et al.* 2020, Litsou *et al.* 2021). Studies suggest that what LGBTQ adolescents learn from porn is mainly the mechanics of sex, sexual performance, positions and roles, as well as how to perform oral, anal and vaginal sex (Arrington- Sanders *et al.* 2015, Nelson *et al.* 2019c, Litsou *et al.* 2021). Preparing for sex and determining readiness for sex through watching porn was also mentioned in studies, as well the value of porn in helping LGBTQ adolescents relax in advance of sexual activity (Nelson *et al.* 2014, Arrington-Sanders *et al.* 2015). Some of this resonated with the findings of my study as porn was a primary source of information for 'Genital touching', 'Masturbation', 'Oral', 'Vaginal' and 'Anal sex' particularly with those respondents aged 13-15. It was, however, not reported in my study as a primary or secondary source of information for 'How to Know I am Ready for Sex'.

In my study, porn was also reported as secondary source of information for ‘*Sexual Attraction/ Orientation*’. Other researchers also report porn as an information source to help people realise and accept their LGBTQ sexual orientation (Nelson *et al.* 2014, Arrington Sanders *et al.* 2015, Nelson *et al.* 2019b, Litsou *et al.* 2021, Mata *et al.* 2022). However, these studies all focus on women and men who have sex with men with no studies on the use of porn as a source of information for adolescent females who have sex with females. Females in my study, reported porn as a source of information on sexual orientation and sexual activity, with varying usefulness. It was most useful for the topics ‘*Masturbation*’ and ‘*Oral Sex*’. In a study of Canadian young adults (18–25-year-olds), Charest *et al.* (2016) found no difference between LGBTQ+ women and their heterosexual peers in their use of porn as a source of information apart from information on penetration, assumed to be vaginal penetration although this is not specified. In addition to limited discussion in studies on the use of porn for women as a source of information, there is no discussion in any studies on the usefulness of porn as a source of information for women who have sex with women. As such this study provides a contribution to the advancement of knowledge in the use and usefulness of porn on topics related to sexuality and sexual health in LGBTQ adolescent females.

Charest *et al.* (2016) however, found that, in comparison to LGBTQ+ women, LGBTQ+ men were more likely to use porn as a source of information on pleasure, techniques, oral sex, penetration and ejaculation. On Chi² analysis in this study, porn was not significant as a used source for males, it was however a useful source on the topic of “*Sexual attraction/ orientation*”.

While respondents described porn as a useful source of information for some topics, it is important to consider a risk benefit analysis. Porn is associated with having negative effects on the personal lives and sexual experiences of the people who watch it, as it is associated with the provision of unrealistic and inaccurate information (Baker 2016, Dawson *et al.* 2019b, Litsou *et al.* 2021, Mata *et al.* 2022). Unrealistic messages conveyed through porn include presentation of surgically enhanced bodies, speed and duration of sexual activity, people engaging in sexual acts with a lack of facial expressions or communication and exploration of a partner’s body, submissive roles of women as well as a lack of discourse around pleasure (Ashton *et al.* 2018, Listou *et al.* 2021, Mata *et al.* 2022). The objectification of women with men in control during sex in

porn, may communicate a message that women have to be submissive in sexual activity and perform activities that they are not comfortable with (Ashton *et al.* 2018). Some respondents in the qualitative comments in my study were also concerned with the presentation of unrealistic body types and the behaviour of boys towards girls/women as a result of watching porn. Studies on porn have also discussed increased risks of STI's and unwanted pregnancy as condoms may or may not be used in the material being watched (Schrimshaw *et al.* 2016, Wright *et al.* 2020). Additionally, researchers have highlighted the negative impact of porn and porn addiction on the psychological wellbeing of the adolescent (Farre *et al.* 2020, Qadri *et al.* 2023) as well as its association with early or risky sexual behaviour (Pirrone *et al.* 2022) later in life (Sinkovic *et al.* 2013, Perry *et al.* 2019).

In this study, the younger cohort (age 13-15) reported porn as a source of information for some topics more than the older cohort. The topics sourced by this age cohort were “contraception”, “kissing”, “genital touching”, “masturbation”, “oral”, “vaginal” and “anal” sex. No Irish data on the age of first exposure to porn was found, however 48% of adolescents in the senior cycle in the Irish MyWorld2 study reported that they had watched porn (86% males and 24% females) (Dooley *et al.* 2019). Internationally the estimates for age of first exposure to porn is estimated at between 11 and 13 for non-LGBQ males with the estimated age for females being around 16 years (Baker 2016, Zurcher 2017, Davis *et al.* 2018). For this study, similar to international data, porn is also being accessed at young ages (13-15) by Irish LGBQ adolescents, which is worrying for a number of reasons. As porn is very easily accessible via the internet and can be encountered both intentionally and unintentionally (Ashton *et al.* 2018), with the increase in access to digital media from smartphones there is increasing concern that adolescents are engaging with porn at very young ages, and prior to having formal sex education (Baker 2016, Sinkovic *et al.* 2013, Donnelly 2023). In Ireland, 54% of 9-year-olds had access to a smart device in 2017-18 (Smyth 2022) and an additional Irish study of 3,904 children aged 8-12, completed in 2020 found that 93% had their own smart device (Cybersafekids 2022). The impact that viewing porn on a developing child cannot be underestimated and as previously discussed studies have found that earlier exposure to porn is associated with greater sexual risk taking later in life (Sinkovic *et al.* 2013, Perry *et al.* 2019, Donnelly 2023).

Recognition of porn as a problem, in particular the circumstances in which it is made and the addiction elements of it has been highlighted by some governments. The UK

government have over the years led with legislation regarding age of access and controls which prevent children from accessing explicit internet content (Thurman and Obster 2021) which other countries, such as Poland, France, New Zealand and Australia have followed. In 2022, the Irish government announced plans to draft legislation to restrict young peoples' access to porn (McCurry 2022). However, while legislation may provide some protections, laws alone will not reduce access or the negative impacts of access, thus an information campaign for young people and parents as well as a change in the school curriculum is warranted (McCurry 2022). The measures announced by the Irish government in relation to the new Junior cycle RSE curriculum due to commence in September 2023 is to be welcomed, as specific reference is made to discussion on the sharing of sexual imagery online and the influence of porn on young peoples' expectations and norms in relation to sexual expression (National Centre for Curriculum Assessment (NCCA) 2023).

As suggested by respondents in the qualitative comments of my study, the potential harm created when porn is used as a form of sex education can be lessened by openly discussing porn use with adolescents and getting them to think critically about it (Dawson *et al.* 2019a, Litsou *et al.* 2021). Critical thinking while watching porn has been suggested as a protective factor to manage expectations against the negative experiences discussed above and has been linked to prevention of body dissatisfaction among adolescent girls as well as increased confidence in sexual decision making for all (Dawson *et al.* 2019b).

Open discussions on the negative elements of porn are identified as a key issue for education within schools (Baker 2016). Porn, however, is given the least emphasis of all topics in junior and senior cycle RSE education (Department of Education and Skills 2017). Thus, wider discussions on porn use in adolescents may be warranted in school, with consideration given to including critical thinking skills in relation to porn as a core element to RSE for all pupils (Donnelly 2023). Doing this however without addressing broader associated subjects such as consent, healthy relationships, safer sex, body image, gender relations, power dynamics and sexual negotiation skills may be inadequate (Albury 2014, Baker 2016). Therefore, investment in age appropriate incremental RSE programmes that build in hours and content from 1st to 6th year in secondary school to contribute to adolescents being informed, responsible and critical users of porn is important.

A joint effort by parents and schools could be the most effective approach to discussions and critical thinking about porn (Baker 2016). Parental influence is considered a protective factor against potential negative effects of porn use by having them engage in open dialogue and positive discussions about sex. Parents having open and honest dialogue about sexuality and sexual activity throughout childhood and adolescence could reduce the prevalence of adolescents, particularly younger adolescents, accessing porn as a source of information, (Davis *et al.* 2021). Similarly, having honest conversations in school about the influence of porn on young people could reduce its use also. However, in Ireland some objections have been voiced to the inclusion of porn in school based RSE without parental consultation and involvement (Quinn 2023) or that discussion porn in school may introduce it to children who are not yet viewing porn (Baker 2016). In addition, Rothman *et al.* (2017) found that while parents of 16–18-year-olds were not supportive of adolescents watching porn, they were unequipped to have discussions with them about it. Therefore, increased education of parents on how to discuss porn with their children and adolescents as well as increasing engagement with parents by schools is critical (Wright *et al.* 2020, Davis *et al.* 2021).

7.8 Peers as a Source of Information: LGBQ and non-LGBQ friends

In this study unlike other studies the peer group was broken into two distinct groups, namely LGBQ and non-LGBQ friends. Peers (LGBQ friends and non-LGBQ friends) were the primary source of information for six topics. Unsurprisingly, LGBQ friends were a primary source of information on '*LGBQ Relationships*' and a secondary source on '*Finding LGBQ Friends*'. LGBQ friends were also a primary source of information on '*Coming Out*', '*How to consent to sexual activity and my rights*' '*What to do During Sex*', '*Kissing*' and '*Cuddling*'. Non-LGBQ friends were a primary source of information on '*Vaginal Sex*'. Friends have also been found to be a core source of information in studies with LGBQ (Hillier *et al.* 2010, Mata *et al.* 2022) and non-LGBQ adolescents (Hoff *et al.* 2003, Mitchell *et al.* 2014a, Clifton *et al.* 2016, Nolan and Smyth 2020). Differences were found in some studies with older non-LGBQ adolescents using friends more than younger ones (Hoff *et al.* 2003, Nolan and Smyth 2020). This was also the case in my study for all topics where the older group reported using peer sources more than the younger cohort, except for the topic '*LGBQ relationships*' where the younger cohort reported using LGBQ friends. One reason why LGBQ friends may be a source for the younger respondents is that the younger cohort may not have disclosed their sexual orientation to family, so LGBQ friends may be a more private

way to find information on LGBTQ relationships and friends, as they are usually the first ones told of sexual orientation (Savin-Williams 1998, Rossi 2010).

Findings in my study also revealed that females living outside of cities/large towns while not reporting peers as a used source, reported non-LGBTQ friends to be significantly useful. While it is positive that the adolescents in this study use friends as a source of information on LGBTQ topics, it is disquieting that friends are a primary source of information for '*What to do during sex*' and '*Vaginal Sex*', as it would be expected that other sources of information could be more reliable. Waling *et al.* (2020) found that when friends are a source of information for non-LGBTQ adolescents, it is more in terms of sharing information and comparing experiences rather than supplying facts. So, non- LGBTQ friends may only be able to provide information on heterosexual experiences, such as vaginal sex. It is not known if this was the case in this study, so further research in this area would be beneficial.

Additionally, the LGBTQ Community was a primary source of information on '*Finding LGBTQ Friends*', '*How to use Safer Sex Aids*' and '*How to Use Sex Toys Safely*'. Hillier *et al.* (2010) also report that the LGBTQ community was a source of information on relationships and safe sex. In my study the LGBTQ community was both a used and useful source of information for '*Kissing*' and a used source for '*LGBTQ relationships*' for those not living in cities/ large towns. Interestingly, descriptive findings indicated that the LGBTQ community was used equally by the older and younger age cohorts. However, when topics were combined into categories for inferential analysis, in Category One – Sexual Attraction/ Orientation, the LGBTQ community was found to be more useful for older respondents. There was no statistical difference relative to gender for LGBTQ community as a source of information.

7.9 Sexual partners as a Source of Information

None of the studies reviewed for the integrative review on LGBTQ adolescents' sources of information (Chapter Three) asked about adolescent's sexual partners as a source of information. While sexual partners were not a primary source of information in the descriptive data from my study, they were found to be a secondary source of information on '*How to know I am ready for sex*', '*Genital touching*' and '*What to during sex*'. While not a primary or secondary source, the chi² analysis data found sexual partners to be a useful source of information on '*Sexual Attraction/ Orientation*' and

'What to do during sex' for the older age group. When the topics were grouped together by category relative to age, Sexual Partners were also a used source of information for Category 2-Readiness for Safer Sex but were not useful. They were, however, considered useful for Category 3- Sexual Activity/ Behaviour again for the older cohort but also for the female cohort. This is not a surprising finding as the younger cohort of respondents may not have sexual partners. Sexual partners were also found to be significant as a useful source for 'Genital touching' and a used and useful source for 'Vaginal sex' in females. This is the opposite of what Tanton *et al.* (2015) reported from the Natsal-3 study where in comparison to females, non-LGBQ men, aged 16-24 years, were more likely to report their first sexual partner as a source of information on sexual matters. However, the exact nature of the information or the usefulness of sexual partners as a source of information were not reported in Tanton *et al.* (2015) study.

7.10 Sources Used but Not Used as a Primary and Secondary Source of Information

While previous sections discussed primary and secondary sources of information, there were some sources that were not reported as a primary or a secondary source for any topic. These were Siblings, Other Family Members, Youth Group, Healthcare Professionals, Clergy, Sexual Health Professionals, TV/ Magazine/ Film and Social Media. It would have been expected that these would have been used more by LGBQ adolescents in this study as all of these have been reported as used sources by LGBQ and non-LGBQ adolescents in other studies (Hillier *et al.* 2010, Grossman *et al.* 2021). However, while not a primary or secondary source of information in the descriptive analysis, some of these sources were found to be used and useful in the chi² analysis. Relative to age, Healthcare Professionals and Sexual Health Professionals were both significant as used and useful sources for 'Contraception' for the older cohort. Also, while not a primary or secondary source, youth group was a used source relative to age for 'Sexually Transmitted Infections' and a used and useful source for 'What it means to consent to sexual activity and my rights'. These are positive findings as older respondents accessing information from healthcare professionals would be advantageous as they begin to prepare for sexual activity.

Similarly, having youth group as a source of information for an older age group on 'Sexually Transmitted Infections' and 'What it means to consent to sexual activity and

my rights' is also positive as it means there is some discussion of these topics within youth groups. In the UK, Pound *et al.* (2017) report that experts providing RSE outside school to non-LGBQ people reduces discomfort in discussions, allows people to communicate honestly and provide greater confidentiality. National Centre for Curriculum Assessment (2019) also found that youth groups external to schools that provided occasional RSE education were also a useful source of information on RSE in Ireland.

Consent was not associated with school as a source of information which is not surprising as the National Centre for Curriculum Assessment review (NCCA 2019) found that content on consent in schools was unsatisfactory, excessively legal based with less emphasis on sexual communication skills. Consent has been the subject of increased discussion in society since the 'Me Too' movement focussed, in 2018, on sexual harassment and unwanted sexual advances. It is suggested that additional information on negotiating skills be added to RSE discussions in school and evaluated, as the most recent study of content in schools was in 2019 (National Centre for Curriculum Assessment 2019), it is not known if there is more discussion on consent in schools since then.

7.11 Acceptability of Asking LGBQ Adolescents about Sex

Before concluding the discussion, it is important to discuss the issue of targeting by online trolls. In this study as discussed in the methodology Chapter Four, the study was targeted on social media by online trolls who questioned the suitability of the research and the ethics of the study. Being the target of trolls is not only an issue for this study but an issue for future studies where the recruitment is via social media. LGBQ adolescents experience a disparity in sexual health in comparison to their non-LGBQ peers. It is important that research is conducted on LGBQ adolescents as they develop to ascertain the changes that occur around this time, as a lack of research, particularly Irish research means that healthcare professionals may not have the ability to address the disparities (Mustanski 2011, Macapagal *et al.* 2017, Nelson *et al.* 2019b). In addition, waivers of parental consent have become common place in ethical applications (Költő *et al.* 2021) to ensure that the ethical principles of autonomy, justice and non-maleficence are maintained. It is, therefore, concerning as a researcher doing research with LGBQ adolescents and using social media for recruitment that I was targeted personally and professionally on social media during this process alluding that

vulnerable children were being put at risk and that the research was unlawful and unethical. Those involved went to great lengths to go through the survey take screen shots of two questions, one on source of information question on '*anal sex*' and the other on '*Have you ever had sex in exchange for money or gifts?*' that were then taken out of context and posted to Twitter suggesting that I was promoting sexual activity in those under the legal age of consent. Additional screenshots of the questions on gender identity and gender at birth were also taken and commentary provided on these. Throughout the process while I felt fully supported by my supervisors, college and the BelongTo organisation, it was, stressful and embarrassing as I worried about bringing unnecessary negative attention to my supervisors, colleagues, school, college and the BelongTo organisation. The advice given to me by the public relations teams in both TCD and BelongTo was not to respond to any posts and ensure that the survey remained open during this time, which proved to be positive advice. However, it did impact on the duration of the recruitment time.

Behaviour such as this, is however, part of a wider problem in society which is the rise of far-right groups. These groups espouse views which include anti LGBTQ+, anti-immigrant, anti-vaccine and an anti- lockdown to COVID-19 outlook. Public protests orchestrated by these groups are becoming more common across society in Europe (Fanucci 2022). A large increase in the number of far-right anti LGBTQ+ groups operating in Ireland is reported since the Marriage Equality Referendum in 2015, that purport to be anti LGBTQ+ but are specifically anti- trans/ transphobic as was the case with some of those who interacted with the posts surrounding the survey on Twitter (Fanucci 2022). The posts on social media in response to tweet for recruitment in my study asserted that their concerns were about child welfare. Being framed in this manner created enough notice on Twitter to draw negative attention to the study and data collection had to be halted. This may have implications for other researchers in this area and the ability to use social media for recruitment of hidden populations, particularly those under the age of 18. No studies or commentaries were found on this topic during subsequent searches of the literature so further discussion is needed to highlight this for future researchers and youth groups as it is envisioned that this difficulty may arise with future research with LGBT adolescents.

7.12 Summary

These objectives were to:

- identify sources of information and their usefulness that LGBQ adolescents of secondary school age (13-19) use in relation to sexuality and sexual health,
- ascertain how useful LGBQ adolescents find the sources of information in relation to sexuality and sexual health,
- discover which sources of information and their usefulness that LGBQ adolescents use for different topics, such as Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/Activity and
- identify the impact of demographic variables on the sources of information that are used and are considered useful by LGBQ adolescents.

Overall, there was no one primary or secondary source used by respondents for all the topics in the study. The primary sources of information used were mother/ female guardian, LGBQ and non-LGBQ friends, LGBQ community, school/ teacher, Internet searches (LGBQ focussed and non-LGBQ focussed) and pornography (porn) with varying reported usefulness.

In relation to sources of information there was some variation in sources used for different categories of topics; Friendships and Sexual Orientation, Readiness for Safer Sex and Sexual Behaviour/Activity. No discernible pattern was evident between topics and sources. Peers (six topics), internet/ media (4 topics) and porn (5 topics) were the most reported sources of information. The usefulness of sources varied and there were no specific sources that were considered very useful. With regard to demographic information, older respondents, females and those living outside of cities and towns were found to report more sources that were used and useful.

Parents and school-based education played a very limited role in the provision of education in LGBQ adolescents. Where there were sources of information, they were all related to Category Two- Readiness for Safer Sex, and the topics on avoidance of risk in sexual activity, “*pregnancy*”, “*contraception*” and “*safer sex (condoms)*”. Parents and school-based sexuality and sexual health education have been positively associated with better sexual health outcomes for LGBQ and non- LGBQ adolescents (Tanton *et al.* 2015, Hobaica and Kwon 2017, Nolan 2018, Bodnar and Tornello 2019,

Rabitt 2020). This study found that LGBQ adolescents get limited information from these sources.

A common barrier to positive sexual health in LGBQ people is a lack of school-based sexuality and sexual health education or discussion that does not include LGBQ issues and this study found that while topics related to sexual health were discussed in school the information provided was not considered useful by the respondents, as it tended to be framed within a heteronormative perspective. Providing suitable information in school that is inclusive may also serve to reduce stigma and minority stress experienced by LGBQ people. This in turn may help young LGBQ think more positively about their sexual orientation. A rise in negativity in society towards LGBT people was highlighted and the negative attention that the study received on social media was also discussed as well as potential difficulties that may arise with social media recruitment in research studies with LGBQ adolescents in the future.

7.13 Limitations

Several potential limitations need to be considered when reviewing the findings.

- The first of these is the sample size and response rate. It is not possible to determine the overall percentage response rate to the survey as with an online survey, so it is not known how many people the survey reached. However, 284 respondents partially completed the questionnaire with 93 respondents fully completing it. Data collection took place in January 2021, when the country was in lockdown, so youth groups were not meeting in person. Therefore, the option for me to spread the word 'face to face' particularly in minority groups was not available. In addition, due to negative social media data collection finished three weeks earlier than expected, so the response rate was affected by this.
- Similarly, there are no national statistics on the breakdown of LGBQ adolescents in Ireland, so it is not known how well the sample represents the different groups in the LGBQ adolescent population. While there are no national figures to show the size of the overall LGBQ adolescent population, the minimum sample size necessary to represent the population was estimated to be 85 and this was achieved.
- As the study used an online platform to recruit LGBQ adolescents who do not have internet access or do not wish to be seen to complete the survey for

confidentiality reasons may not have been recruited. While this has been noted as a limitation to study recruitment internationally, no methods have been outlined to circumvent this. While social media posts can target specific age groups, there is no guarantee that all potential study respondents in this study were made aware of the study which could bias the results.

- In terms of diversity, while gender identity was not a focus of the study, having a lack of LGBTQ people who identified as non-binary or transgender completing the survey is disappointing as it meant comparing differences in terms of cisgender, non-binary and transgender was not possible. Sources of information for non-binary and transgender adolescents is an area that warrants further research. In addition, the overall demographic profile is predominantly white Irish, which is not representative of racial or ethnic minorities within Ireland. Other marginalised groups, such as early school leavers, travellers and migrants are not well represented so the findings may not be generalisable to these groups.
- In the context of data analysis, while the statistical tests completed are sufficient to draw inferences from for age, gender at birth and living location, given the sample size for some groups it was not possible to complete inferential analysis on ethnicity, gender identity, sexual orientation or early school leavers.
- Due to the large number of bivariate inferential analysis completed in the study, there is a risk that they inflate the overall alpha level resulting in the probability of making Type 1 errors. This is a risk with the type of data included in the study and needs to be contemplated when considering the findings.

7.14 Strengths

Recognising the unique strengths of a study are important (Parahoo 2006). Strengths of this study are indicated as follows.

- This study provides previously unknown information about sources and topics for sexuality and sexual health in LGBTQ adolescents.
- It is the first study of its kind to take place and provides evidence for sources of information used for specific topics which has not been done before to this extent.

- Data were collected from the adolescents themselves to provide a subjective account of their sources of information.
- A survey was devised specifically for this study, which was tested for content and face validated prior to administration.
- Having national youth groups, BeLonGTo and Youthwork Ireland advertise the study through their networks ensured that all adolescents linked to their organisations were informed of the study.
- Sources of information for lesbian and bisexual females aged 13-19 are available for the first time and this may help to advance sexual health promotion in this population.
- This study provides a baseline for future research with LGBQ adolescents on sexuality and sexual health.

7.15 Recommendations

In this section, the recommendations that have emerged from the findings of the study for future LGBTI+ and sexual health policy including school based RSE, practice for healthcare professionals, education and future research will be described.

7.15.1 Recommendations for Policy

The LGBTI+ Strategy (DYCA 2018) identified some key points to enhance the lives of LGBTI+ adolescents in Ireland, while the National Sexual Health Policy 2015-2020 (Department of Health 2015) had some recommendations regarding sexual health and sexual health education in LGBQ adolescents. Some of these have been introduced, such as the introduction of the Human Papilloma Virus vaccine for boys and the Sexual Health Foundation programmes for training professionals and a national safer sex advertisement campaign for men who have sex with men and women ('Johnnys got you covered') but some proposals focussed on education from both policies have not been implemented fully. It is recommended that the following be prioritised. These are:

- An inclusive LGBTI+ education curricula for schools needs to be introduced to all schools.
- The National Sexual Health Policy (Department of Health 2015) identified that some school staff had inappropriate training so the provision of additional training to teachers and other professionals working with adolescents on LGBQ

sexuality and sexual health would be advantageous in primary and secondary school settings.

7.15.2 Recommendations for Practice

Healthcare professionals caring for LGBQ adolescents have not been found to be a source of information on sexuality and sexual health in this study. Opportunities that are presented to open discussions with young LGBQ people on sexual health and sexuality during consultations need to be used to provide reliable information to LGBQ adolescents. Having the requisite skills and competencies to do this is important.

Therefore, it is recommended for healthcare that:

- Education programmes in LGBQ adolescents' sexual health should be enhanced in undergraduate and postgraduate health care practitioners' curricula to discuss how to use consultations to open dialogue on sexuality and sexual health with LGBQ adolescents.
- Inclusivity of children's healthcare services to be enhanced to include display of posters, books, rainbow badges for staff to be further developed, allowing children who are LGBQ to identify allies and recognise that the children and adolescent healthcare environments are a safe space for LGBQ adolescents to talk to staff and ask questions.
- A full suite of age and developmentally appropriate sexuality and sexual health resources for LGBQ adolescents be made available in public spaces in the healthcare environment.

Similarly, some deficits have been found in school-based education that should be addressed to enhance the school experience for LGBQ adolescents. Recommendations for education are:

- Guidance may be required in schools on the delivery of RSE which includes discussing LGBQ issues in an age and developmentally appropriate way from primary school to 6th year in secondary school, supported by inclusive policies and training for teachers.
- Further training in RSE delivery for teachers to improve inclusivity of discussions in school to include more information on LGBQ sexuality and sexual health.

- As openness around sexual orientation in the school curriculum promotes more acceptance of LGBTQ people throughout the school, introducing LGBTQ sexual orientation material and discussions at a younger age needs to be encouraged.
- The advancement of the LGBTI+ weeks to promote inclusivity and antibullying in schools could be encouraged.
- A suite of developmentally appropriate media and social media sources of information on sexuality and sexual health for LGBTQ people that suit all learning styles could be developed and made available to parents/ guardians and students to improve parent- adolescent- school sexual communication so that parents are aware of where further information to enhance LGBTQ sexuality can be accessed outside of school is required.
- This same suite of resources could also be presented to students in school that do not wish to discuss sexuality and sexual health with parents and can be used to enhance the discussion of RSE sources of information in both primary and secondary schools.
- Increased critical discussion in school about porn and its use should be advanced in schools. Consideration could also be given to including, as a core element to RSE for all students from 1st to 6th year, the development critical thinking skills in relation to porn.

7.15.3 Recommendations for Research

Following this study areas for further research have been identified. These were:

- To complete qualitative research on the experiences of LGBTQ adolescents sourcing information and to ascertain what information is needed for them to make informed decisions about sexuality and sexual health.
- To complete a study specifically with non-binary and transgender adolescents on their sources of information on sexuality, sexual health and gender identity.

- More studies with lesbian and bisexual participants would be beneficial. Additionally, future studies using larger samples, to explore the relationship between the nature of the information sought, the sources of information and the usefulness of both the source and topic is a priority.

7.16 Personal Reflections on this Research Study

This research study is one the most difficult and most rewarding tasks that I have ever undertaken. It was a mammoth task, particularly with my other roles as a wife, mother to three children while working fulltime. I was unprepared for the length of time that the integrative review, ethical approval, survey preparation, reliability testing, data collection, data cleaning and descriptive and inferential data analysis took. Apart from the time, the volume of variables and data collected in this study, made it more challenging than anticipated. I learned a lot about statistics and the use of SPSS which were skills I had not developed previously. Likewise completing the integrative review was a learning process and it provided me with additional skills to progress research activities in future. This integrative review provided me with the requisite knowledge to develop a comprehensive survey with 20 topics and 19 sources which I believe enhanced the comprehensiveness of the data collection in this research project. Completing the integrative review, followed by the data collection and analysis in this project was a broad learning curve with regards to both methods and time involved. Therefore, for future research, it may be more practical to take topics and sources as separate elements to gather more detailed information on them and their usefulness in smaller research studies and disseminate the findings.

This study was completed during the Covid 19 pandemic. This had an impact on the development and testing of the survey, as well as recruitment as described in Chapter 4. It also had an overall impact on my preparation and reading, as for long periods of time during the study, it was not possible to access library resources in person and I relied on the online resources that were available.

Additionally, the difficulties encountered in data collection was not something I anticipated. These difficulties gave me some small insight into the abuse that LGBTQ people encounter in their daily lives and demonstrate the severity of vitriolic comments made online which affected me emotionally, personally and professionally. This study is only the beginning of what I now see is a much longer journey to try to fully

understand the sexual health education needs of LGBQ adolescents in Ireland. I owe so much to the adolescents who took their time to complete the survey and make this thesis possible.

7.17 Conclusion

Sources of sexuality and sexual health information can influence the sexual behaviour and activities of LGBQ adolescents. The findings from this cross-sectional study of sources of information in LGBQ Irish adolescents, aged 13-19, found there is no one primary source of information on sexuality and sexual health that LGBQ adolescents used or find useful. Instead, primary sources are a combination of in-person and internet/media sources which are mother/ female guardian, LGBQ and non-LGBQ friends, LGBQ community, school/teacher, Internet searches (LGBQ focussed and non-LGBQ focussed) and pornography (porn) with varying usefulness. This is the first study of sources of information of LGBQ adolescents that asks a variety of sources for twenty different topics and as such advances the knowledge of this subject. This study also found that while individual sources used were similar to those used in other national and international studies, the combined information on sources used and useful specific to individual topics is new. This study, therefore, advances the research that is available on sources of information used by LGBQ adolescents on sexuality and sexual health topics. Specifically, it advances information on the sources of information that adolescent females who identify as lesbian and bisexual use, as this is absent from the research to date. Professionals working with adolescents should be cognisant of the technology that is available to adolescents to source information. The development of a suite of age and developmentally appropriate resources by the National Council for Curriculum and Assessment is timely. Changes to school based LGBTI+ education and sexual health policies, as well as the introduction of inclusive education on sexuality and sexual health to include porn literacy in school would be advantageous.

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Appendices

Appendix 1 – Copy of Saved Search

Search History/Alerts

[Print Search History](#) [Retrieve Searches](#) [Retrieve Alerts](#) [Save Searches / Alerts](#)

☐ Select / deselect all		Search with AND	Search with OR	Delete Searches	Refresh Search Results	
Search ID#	Search Terms	Search Options	Actions			
☐ S15	 (lgbtq or lesbian or gay or homosexual or bisexual or transgender or homosexual or queer or sexual minority) AND (adolescents or teenagers or young adults or teen or youth) AND sources of information	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	 Run	 View Details	 Edit	
☐ S14	 LGBQ AND sources of information AND (adolescents or teenagers or young adults)	Expanders - Apply equivalent subjects Search modes - SmartText Searching	 Run	 View Details	 Edit	
☐ S13	 LGBQ AND sources of information AND (adolescents or teenagers or young adults)	Expanders - Apply equivalent subjects Search modes - SmartText Searching	 Run	 View Details	 Edit	
☐ S12	 S5 AND S7	Search modes - Boolean/Phrase	 Run	 View Details	 Edit	
☐ S11	 S5 AND S6	Search modes - Boolean/Phrase	 Run	 View Details	 Edit	
☐ S10	 S5 AND S6	Search modes - Boolean/Phrase	 Run	 View Details	 Edit	
☐ S9	 S5 AND S6 AND S7	Expanders - Apply equivalent subjects Search modes - SmartText Searching	 Run	 View Details	 Edit	
☐ S8	 S6 AND S6 AND S7	Search modes - Boolean/Phrase	 Run	 View Details	 Edit	
☐ S7	 "coming out"	Search modes - Boolean/Phrase	 Run	 View Details	 Edit	
☐ S6	 "sources of information"	Search modes - Boolean/Phrase	 Run	 View Details	 Edit	

Appendix 2 – Draft One of the Survey

General Questions About you

This section asks some general questions about you and where you live.

Do you currently live in the Republic of Ireland? Please tick one.

Yes

No

This survey is for people living in the Republic of Ireland. If you are not currently living in the Republic of Ireland please **do not complete** this survey.

What is your age? Please tick one.

13	16	18
14	17	19
15		

How do you define your gender at present? (tick one box only)

- Male
- Female
- Transgender – m-f
- Transgender f-m

Which of the following best describes where you currently live? (Tick one box only)

- City/ Large Town
- Small town/ village
- In the countryside (rural)

In what level of school are you at?

I am still in education (school/ college). Please tick one.

- Yes
- No

If yes

Please tick one.

- I am at junior cycle secondary school (before or in Junior Cert Year)
- I am at senior cycle secondary school (after Junior cert and before Leaving Cert)
- I am at university/ third level
- I am doing technical or further education i.e. PLC course

If No –

- What age were you when you left school?

Which of the following now applies? Please tick one.

- I am unemployed
- I am working full time (including apprenticeships)
- I am working part time

What is your ethnic or cultural background? Please tick one.

- White (Irish)
- White (Irish Traveller)
- White (Non-Irish; any other White background)
- Black or Black Irish (African; any other Black background)
- Asian or Asian Irish (Chinese; any other Asian background)
- Other, including mixed background

Where do you currently live? Please tick one.

- I live in a family home
- I live in Direct Provision Centre
- I am homeless/ using homeless services
- I live away from home (rented or other accommodation)
- Other _____ Please state where.

Who do you mostly live with? Please tick one.

- Both parents
- Mother
- Father
- Foster parents
- Another family member
- I live alone
- Other _____ Please state where

About your sexual feelings

The next few questions are related to sexual attraction/ orientation. This describes who you are sexually and emotionally attracted to.

Which of these statements best describes your sexual attraction/orientation at present? (Please tick one box only)

- I am or think I am attracted to only people of my own sex
- I am or think I am attracted to people of both sexes
- I am or think I am attracted to people of the opposite sex
- I am not sure who I am attracted to
- I am not attracted to anyone

At what age did you first become aware about your sexual attraction/ orientation?

I was aged _____

On the whole, how do you feel about your sexual attraction/ orientation? (Tick one box only)

Great 2. Pretty good 3. Ok 4. Pretty bad 5. Really bad

Sources of Information

The next section asks about where you get your information about sexuality and sexual health. The three tables below has columns that lists the different topics of sex education information and to indicate in the table below all sources you accessed on what topics, use yes Y to indicate that it was useful and no X to indicate it was not useful.

Table 1: Sexual Orientation and Relationships

Source of Information	Sexual attraction/ orientation	LGBQ friendships	Finding LGBQ friends	Coming out
Mother/ female guardian				
Father/ male guardian				
Siblings				
Other family members				
Teachers				
Health professional (GP/ Nurse/ social worker)				
Friends (same sex attracted)				
Friends (heterosexual)				
LGBQ community				
LGBT focused Internet search				
General internet search				
Gay Media				
TV/ Magazines/ film				
Pornography				
Youth group				

Table 2: Readiness for Safer Sex

The next section asks about where you get your information about sexuality and sexual health. The tables below has columns that lists the different topics of sex education information and to indicate in the table below all sources you accessed on what topics, use yes Y to indicate that it was useful and no X to indicate it was not useful.

Source of Information	Pregnancy	Contraception	Sexually transmitted infections (e.g. HIV, Chlamydia)	Condoms	Consent	Saying no	How should I be treated?	How to know you are ready for sex?
Mother/female guardian								
Father/ male guardian								
siblings								
Other family members								
teachers								
Health professional (GP/ Nurse/ social worker)								
Friends (same sex attracted)								
Friends (heterosexual)								
LGBQ community								
LGBT focused Internet search								
General internet search								
Gay Media								
TV/ Magazines/ film								

Pornography								
Youth group								

Table 3: Sexual behavior/ how to engage in sexual activity

The next section asks about where you get your information about sexuality and sexual health. The tables below has columns that lists the different topics of sex education information and to indicate in the table below all sources you accessed on what topics, use **yes Y** to indicate that it was useful and **no X** to indicate it was not useful.

Source of Information	Kissing	Cuddling	Genital Touching	Masturbation	Oral Sex	Anal sex	Vaginal Sex	What to do during sex
Mother/ female guardian								
Father/ male guardian								
siblings								
Other family members								
teachers								
Health professional (GP/ Nurse/ social worker)								
Friends (same sex attracted)								
Friends (heterosexual)								
LGBQ community								
LGBT focused Internet search								
General internet search								
Gay Media								

TV/ Magazines/ film								
Pornography								
Youth group								

Thinking about the tables above what stops you from getting the information. Please tick one.

- Personal/ Psychological factors
- I don't know what to look for
- No suitable available sources
- Does not maintain my privacy
- I don't trust the information

Please tell us if you look for information on any other topic not listed above._____

Please tell us if you use any other source not listed above_____

About your Internet Use (Hillier *et al.* 2010)

What is the most common way you use to access the Internet? (Please tick one)

- Smartphone _____
- Tablet
- Personal Computer _____
- Gaming device/ Kindle _____

Where do you most access the Internet? (Please tick one)

- At home
- At school
- At college
- Internet café
- Library
- Other

If other was chosen - Please state where

Have you ever been Pregnant

- Yes
- No

Have you ever had an Sexually transmitted infection

- Yes
- No

This survey is anonymous and contains no personal details. Thank you for participating in the survey, your participation is completely voluntary and you can chose not to complete it if you so wish. We thanks you for your participation. Submission of the survey is taken as consent to participation

-

Appendix 3 – Letter from Ethics Committee Re Amendments to Survey (Draft 2)



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Thelma Begley,
School of
Nursing and
Midwifery,

4th February 2020
Ref: 190610

Title of Study: Information Needs and Sources of Information of Lesbian, Gay, Bisexual and Questioning (LGBQ) Adolescents in relation to sexuality and sexual health.

Dear Thelma,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in January 2020, we are pleased to inform you that the above project (as amended with the following changes) has ethical approval to proceed.

We would advise you to seek review and comments on your DPIA from the DPO if required prior to study commencement.

Please give specific details of the requested amendment(s):

Following consultations with BeLonG To Youth Services who are an advocacy organisation supporting lesbian, gay, bisexual, transgender and intersex young people the survey (Appendix 6) has been amended. This is to ensure that the survey is inclusive and suitable for the population that they cater for (young people aged 13+). Amendments are highlighted in the attached document in red with the rationale for the change also documented.

The following have changed:

Amendments to questions 3, 10, 11, 13, 18, 20, 21,

Additional questions – 4, 16, 24

Deleted questions – 9, 12,

Moved questions – Q17 & 18 moved from end of survey to middle and Q. 25, 26 moved to end of survey. This amendment will not alter any other aspect of the study as approved.

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,


Prof. Jacinta

O'Sullivan
Chairperson
Faculty
Research
Ethics
Committee

Appendix 4 – Final Survey Sections

LGBQ Sources of Information 2020

1. Sources of Information and Information Needs of LGBQ Adolescents on Sexuality and Sexual Health

PARTICIPANT INFORMATION SHEET

Principal Investigator: Thelma Begley, PhD Student, School of Nursing and Midwifery, Trinity College Dublin. E mail: tbegley@tcd.ie

Background: This study is to identify what information young people who identify as lesbian, gay, bisexual or questioning (LGBQ) need and how young LGBQ people of secondary school age (13-19) find information in relation to sexuality and sexual health. This will be done using an anonymous computer based survey that will take approximately 30 minutes to complete.

You are invited to consider taking part in the study if you meet the following criteria: a young person, aged 13-19, living in the Republic of Ireland who thinks they may be lesbian, gay, bisexual or questioning their sexuality. The questionnaire will be available online to June 2020.

The decision to take part in the study is completely voluntary. If you decide to take part you just have to complete the attached survey. Your responses to questions will be completely anonymous so you can be completely honest in your answers. The study will not collect personal information about you i.e. name, address etc. It does however collect some sensitive information such as sexual identity etc. which will be anonymous so you cannot be identified. Please do not insert your name or any other identifiable information anywhere on the survey. Collected results will be presented together in reports.

It is up to you if you decide to take part or not. By submitting the survey you will show that you have given consent to take part. You are free to withdraw your consent and exit the survey at any time.

Please answer all of the questions. However, this survey collects information on sexual attraction, safer sex and sexual activity. Please bear this in mind before, during and after the survey. If any questions make you uncomfortable or you require further information there is a list of support services are provided at the end of the survey.

If you have any questions about the survey, please contact me at tbegley@tcd.ie or 086 8246005

Thanks
Thelma.

* 1. Declaration

Before beginning the survey, we want to be sure you have read the information on the survey on the previous page. If you have not please go back and do so. Once you have read this, please indicate whether or not you want to participate.

☐ Yes

☐ No

* 2. I confirm that I am aged 13-19, live in the Republic of Ireland and consent to participate

☐ Yes

☐ No

This section asks about your sexual attraction/ orientation i.e. who you are sexually and emotionally attracted to.

4. Which of these statements best describes your sexual attraction/ orientation?

- ☐ I am/ think I am only attracted to people of my own gender
- ☐ I am/ think I am attracted to people of another gender
- ☐ I am/ think I am attracted to people of my own and another gender
- ☐ I am not sure what gender I am attracted to
- ☐ I am/ think I am not attracted to any gender

5. At approximately what age did you first become aware of your sexual attraction/ orientation?

I was

6. How do you feel now about your sexual attraction/ orientation?

- ☐ Great
- ☐ Pretty Good
- ☐ OK
- ☐ Pretty Bad
- ☐ Really Bad

7. The next section asks you about sources of information on **sexual orientation and relationships** (you will be asked later if these were useful or not).

Please select the sources of information you used for the **four** topics listed.

Only tick the boxes that are relevant to you.

Sexual Attraction/ Orientation	LGBQ friendships	Finding LGBQ friends	Coming Out
Mother/ female guardian	☐	☐	☐
Father/ male guardian	☐	☐	☐
Siblings	☐	☐	☐
Other family members	☐	☐	☐
Friends (LGBQ)	☐	☐	☐
Friends (non LGBQ)	☐	☐	☐
LGBQ Community	☐	☐	☐
Youth Group	☐	☐	☐
Sexual Partners	☐	☐	☐
Teacher/ School	☐	☐	☐
Health Professional (GP/ Nurse/ Social Worker)	☐	☐	☐
Clergy/ Church	☐	☐	☐
Sexual Health Services/ Clinics	☐	☐	☐
LGBQ focussed internet search			

Sexual Attraction/ Orientation	LGBQ friendships	Finding LGBQ friends	Coming Out
☐	☐	☐	☐
General internet search			
☐	☐	☐	☐
LGBQ media			
☐	☐	☐	☐
TV/Magazines/ Film			
☐	☐	☐	☐
Porn (Pornography)			
☐	☐	☐	☐
Social media - blogs/ discussion/ posts			
☐	☐	☐	☐

8. Other Sources
 If you sourced information on sexual orientation and relationships from any other place, please state the source here.

9. Other Topics
 Have you looked up information on any other topic related to sexual orientation and relationships that is not listed above? If yes, please tell me and what source of information you used.

10. Thinking about the sources of information on Sexual attraction/ orientation, please tick whether you found each source to be useful or not.

	Useful	Not Useful
Mother/ female guardian	☐	☐
Father/ male guardian	☐	☐
Siblings	☐	☐
Other family members	☐	☐
Friends (LGBQ)	☐	☐
Friends (non LGBQ)	☐	☐
LGBQ Community	☐	☐
Youth Group	☐	☐
Sexual Partners	☐	☐
Teacher/ School	☐	☐
Health Professional (GP/ Nurse/ Social Worker)	☐	☐
Clergy/ Church	☐	☐
Sexual Health Services/ Clinics	☐	☐
LGBQ focussed internet search	☐	☐
General internet search	☐	☐
LGBQ media	☐	☐
TV/Magazines/ Film	☐	☐
Porn (Pornography)	☐	☐
Social media - blogs/ discussions/ posts	☐	☐

11. Thinking about the sources of information on LGBQ relationships, please tick whether you found each source to be useful or not.

	Useful	Not Useful
Mother/ female guardian	☐	☐
Father/ male guardian	☐	☐
Siblings	☐	☐
Other family members	☐	☐
Friends (LGBQ)	☐	☐
Friends (non LGBQ)	☐	☐
LGBQ Community	☐	☐
Youth Group	☐	☐
Sexual Partners	☐	☐
Teacher/ School	☐	☐
Health Professional (GP/ Nurse/ Social Worker)	☐	☐
Clergy/ Church	☐	☐
Sexual Health Services/ Clinics	☐	☐
LGBQ focussed internet search	☐	☐
General internet search	☐	☐
LGBQ media	☐	☐
TV/Magazines/ Film	☐	☐
Porn (Pornography)	☐	☐
Social media - blogs/ discussion/ posts	☐	☐

12. Thinking about the sources of information on Finding LGBTQ friends, please tick whether you found each source to be useful or not.

	Useful	Not Useful
Mother/ female guardian	☐	☐
Father/ male guardian	☐	☐
Siblings	☐	☐
Other family members	☐	☐
Friends (LGBQ)	☐	☐
Friends (non LGBQ)	☐	☐
LGBQ Community	☐	☐
Youth Group	☐	☐
Sexual Partners	☐	☐
Teacher/ School	☐	☐
Health Professional (GP/ Nurse/ Social Worker)	☐	☐
Clergy/ Church	☐	☐
Sexual Health Services/ Clinics	☐	☐
LGBQ focussed internet search	☐	☐
General internet search	☐	☐
LGBQ media	☐	☐
TV/ Magazine/ Film	☐	☐
Porn (Pornography)	☐	☐
Social media - blogs/ discussion/ posts	☐	☐

13. Thinking about the sources of information on Coming out, please tick whether you found each source to be useful or not.

	Useful	Not Useful
Mother/ female guardian	☐	☐
Father/ male guardian	☐	☐
Siblings	☐	☐
Other family members	☐	☐
Friends (LGBQ)	☐	☐
Friends (non LGBQ)	☐	☐
LGBQ Community	☐	☐
Youth Group	☐	☐
Sexual Partners	☐	☐
Teacher/ School	☐	☐
Health Professional (GP/ Nurse/ Social Worker)	☐	☐
Clergy/ Church	☐	☐
Sexual Health Services/ Clinics	☐	☐
LGBQ focussed internet search	☐	☐
General internet search	☐	☐
LGBQ media	☐	☐
TV/Magazines/ Film	☐	☐
Porn (Pornography)	☐	☐
Social media - blogs/ discussion/ posts	☐	☐

14. The next section asks you about sources of information on **readiness for safer sex** (you will be asked later if these were useful or not).

Please select the sources of information you used for the **six** topics listed.

Only tick the boxes that are relevant to you.

Pregnancy	Contraception (apart from condoms)	Sexually Transmitted Infections (e.g. Chlamydia, HIV)	Safer Sex (condoms)	What does it mean to consent to sexual activity and my rights	How to know I am ready for sex
Mother/ female guardian	☐	☐	☐	☐	☐
Father/ male guardian	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐
Other family members	☐	☐	☐	☐	☐
Friends (LGBQ)	☐	☐	☐	☐	☐
Friends (non LGBQ)	☐	☐	☐	☐	☐
LGBQ Community	☐	☐	☐	☐	☐
Youth Group	☐	☐	☐	☐	☐
Sexual Partners	☐	☐	☐	☐	☐
Teacher/ School	☐	☐	☐	☐	☐
Health Professional (GPNurse/ Social Worker)	☐	☐	☐	☐	☐
Clergy/ Church	☐	☐	☐	☐	☐
Sexual Health services/ clinics	☐	☐	☐	☐	☐

Pregnancy	Contraception (apart from condoms)	Sexually Transmitted Infections (e.g. Chlamydia, HIV)	Safer Sex (condoms)	What does it mean to consent to sexual activity and my rights	How to know I am ready for sex
☐	☐	☐	☐	☐	☐
LGBQ Focussed Internet Search					
☐	☐	☐	☐	☐	☐
General Internet search					
☐	☐	☐	☐	☐	☐
LGBQ Media					
☐	☐	☐	☐	☐	☐
TV/Magazines/Film					
☐	☐	☐	☐	☐	☐
Porn (Pornography)					
☐	☐	☐	☐	☐	☐
Social Media - blogs/ discussions/ posts					
☐	☐	☐	☐	☐	☐

15. Other Sources
If you sourced information on readiness for safer sex from any other place, please state the source here.

16. Other Topics
Have you looked up information on any other topic related to readiness for safer sex that is not listed above?
If yes, please tell me and what source of information you used.

This section asks a question on you why you have not looked up information.

36. If there are reasons why you don't seek information on sexuality and sexual health, please tell me what prevents you.

From the list below, please select all that apply.

- ☐ Nothing prevents me from sourcing information
- ☐ I am too embarrassed
- ☐ I don't trust the information that is available
- ☐ I am worried about my privacy
- ☐ I am afraid that people would find out that I am LGBTQ
- ☐ I don't have access to a computer
- ☐ Internet sites are not accessible for my age
- ☐ I don't know where to look
- ☐ I don't know what to look for
- ☐ Information I find is too complicated/ I don't understand it
- ☐ Information I find doesn't meet my needs
- ☐ I am not interested in the topic
- ☐ Other (please specify)

The next section asks some questions about sexual activity and sexual history.

37. Have you ever been pregnant?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

38. Have you ever had a sexually transmitted infection?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

39. Have you ever received payment or gifts in exchange for sex?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

The next section asks about Internet use.

40. Which of the following do you mainly use to access the Internet?

- ☐ Smartphone
- ☐ Tablet
- ☐ Personal Computer/ Laptop
- ☐ Gaming device/ Kindle
- ☐ Other (please specify)

41. Where do you mainly access the Internet?

- ☐ At home
- ☐ At school
- ☐ At college
- ☐ Internet cafe
- ☐ Library
- ☐ Other (please say where)

2. General questions about you

This section asks some general questions about you and where you live.

3. What is your age? Please select one.

☐ 13	☐ 17
☐ 14	☐ 18
☐ 15	☐ 19
☐ 16	

4. How would you describe your gender? Select one box only

☐ Male	☐ Gender non-binary
☐ Female	☐ Gender non conforming
☐ Transgender m-f	☐ Gender queer
☐ Transgender f-m	
☐ If you do not understand or relate to any of the descriptions in this list - can you please describe your gender in your own words?	

5. What is the biological sex that was assigned to you when you were born ?

- ☐ Male (boy body parts)
- ☐ Female (girl body parts)
- ☐ Intersex (do not have typical boy or girl body parts)

6. Which of the following describes where you live? Select one box only.

- ☐ City/ Large Town
- ☐ Small town/ Village
- ☐ In the countryside (rural)

8. Are you still in (school/ college). Please select one.

- ☐ Yes
- ☐ No

9. What stage of school are you at? Please select one.

- ☐ I am in Junior Cycle Secondary School (before or in Junior Cert Year)
- ☐ I am in Senior Cycle Secondary School (after Junior Cert and before Leaving Cert)
- ☐ I am at University/ Third Level
- ☐ I am doing technical or further education i.e. PLC course

10. What age were you when you left school?

11. What is your ethnic or cultural background? Please select one.

- ☐ White - Irish
- ☐ White - Irish Traveller
- ☐ White - Any other white Background
- ☐ Black - African
- ☐ Black - Any other black background
- ☐ Asian - Chinese
- ☐ Asian - Any other Asian Background
- ☐ Other (write in description)

51. Please feel welcome to add any additional comments you think would be useful about sourcing information on sexuality and sexual health for LGBTQ young people in Ireland.

Thank you for taking the time to participate in this survey.

If you feel you need to speak with someone about anything that has arisen during this survey that is affecting you, I would advise you in the first instance, where possible, to speak to your parents or your G.P.

Alternatively, information and support is available from the following Support Groups & Services in Ireland. This is not a complete list of support services.

Helplines:

HSE 24/7 Textline 50808

National LGBT Helpline 1890 929 539

LGBTQ Youth Groups or Youth Groups that have a LGBTQ section:

www.belongto.org (LGBTQ youth group)

www.youthworkireland.ie

LGBT Ireland www.lgbt.ie

www.outcomers.org (Dundalk)

www.linc.ie (Cork)

www.gayproject.ie (Cork)

Support Services for Sexual Health Services:

www.sexualwellbeing.ie

GOSHH - Gender, Orientation, Sexual Health, HIV (Limerick) www.goshh.ie

Gay Men's Health Service www.gmhs.ie

Guide Clinic, St. James Hospital www.guidedclinic.ie 01-4162315

Mater STI HIV Clinic 01-8032063

HSE HIV and Sexual Health Helpline Ph: 1800 459 459

Sexual Health Centre, Cork www.sexualhealthcentre.com

Well Woman Centre www.wellwomancentre.ie

Don't forget to press DONE when you are finished.

Thank you for your time and for sharing your valuable information.

Appendix 5 – Ethics Amendment Form – Content Validity

Faculty of Health Sciences Research Ethics Committee Amendment Request Form

Part A – Original Application Details

Application Reference Number	190610
Date of Original Submission	6 th June 2019; Amendment 19 th Dec 2019
Date of Ethical Approval	25 th of September 2019; Amendment 4 th February 2020
Applicant Name	Thelma Begley
Applicant Email	tbegley@tcd.ie
Applicant School / Area	School of Nursing and Midwifery
Applicant Department	School of Nursing and Midwifery
Student Number	15338212
Title of Research Project	Information Needs and Sources of Information of Lesbian, Gay, Bisexual and Questioning (LGBQ) Adolescents in relation to sexuality and sexual health.

Part B – Amendment Request

Please give specific details of the requested amendment(s):

Title of Study: Information Needs and Sources of Information of Lesbian, Gay, Bisexual and Questioning (LGBQ) Adolescents in relation to sexuality and sexual health.

This study has ethical approval from Sept 2019 and amendments to the tool were made and approved by the committee in Jan 2020.

The original content validity was planned through a group of young people through youth group using the same population as the study. Unfortunately, due to COVID 19 I can no longer access a group of the target population planned to ensure the survey is reliable and valid. The LGBQ groups are no longer meeting and I cannot progress with data collection until I ensure this process is complete. I had waited for the past month to see if I could progress using this method but now need to consider an alternative method.

To prevent further delay I am therefore looking to circulate the approved questionnaire with Content Validity amendment (in green) to an expert panel of 15 people for validation including approximately

5 volunteers from each of the following groups

- Secondary school teachers who I will access through a gatekeeper who is a former teacher who can forward the anonymous link to former colleagues
- members of staff with adolescent children , who I will contact using standard protocols for accessing staff for research in a school and
- Experts in the LGBT services and sexual health services whose names are available in the public domain

An introduction is added to the survey explaining the content validity process and the following table will be inserted after each question to determine relevance, clarity and user friendliness and no other changes will be made to any of the questions:

Relevance	Clarity	User Friendliness

By forwarding the link via e mail to the survey that they can reply to anonymously via SurveyMonkey

This amendment will not alter any other aspect of the study as approved.

Part C –Signatures

Lead Investigator:

Name	Thelma Begley
Signature	
Date	20/04/2020

For Student Research Studies:

Supervisor Name	Prof Agnes Higgins
Supervisor Signature	
	20/04/2020
Supervisor Name	Dr. Gabrielle McKee
Supervisor Signature	
	20/04/2020

Appendix 6 – Content Validity Scores

✠

Questions	TW1	TW2	TW19	TW20	TW9	SH M4	SH M16	SH M17	SH M18	P M12	P M13	P M14	P M15	P M11	P M8	LGBQ M10	LGBQ M3	LGBQ M5	LGBQ M6	CVI-SCORE	CVI-INDEX
Info-Sheet	4	3	4	3	4	4	4	4	4	3	3	3	4	4	3	4	3	3	4	17/17	1
Declarations	4	3	4	3	4	4	4	4	4	4	1	4	4	4	3	4	3	3	4	15/16	0.93
Consent	3	3	4	3	3	4	4	4	4	4	4	4	4	4	4	4	3	4	4	17/17	1
Q7	3	3	3	4	4	3	4	4	3	3	3	3	3	3	3	4	3	3	3	7/7	1
Q9	4	4	4	3	4	4	4	4	2	4	4	4	3	4	4	4	4	4	4	17/18	0.94
Q11	2	4	3	4	4	4	3	3	4	4	4	3	4	2	3	4	2	4	4	16/19	0.84
Q13	4	3	4	1	3	3	4	4	4	4	3	4	4	4	4	3	3	4	4	17/18	0.94
Q15	4	3	4	2	4	4	4	4	2	4	2	2	4	4	4	4	4	4	4	14/18	0.77
Q17	4	3	4	1	4	4	4	4	4	4	3	3	4	4	4	4	3	4	4	17/18	0.94
Q19	4	3	2	2	3	4	4	4	4	4	4	3	4	4	2	4	3	2	4	13/17	0.76
Q21	4	3	4	1	4	4	4	4	3	4	4	3	4	4	4	4	4	4	4	16/17	0.94
Q23	4	3	2	1	3	4	4	4	4	4	3	3	4	4	3	4	3	2	4	14/17	0.82
Q25	1	3	4	1	4	4	4	4	2	4	3	3	4	4	4	4	4	4	4	15/18	0.83
Q27	4	3	3	1	3	4	4	3	4	4	4	4	4	4	3	3	3	2	4	16/18	0.88
Q29	3	3	4	1	4	4	4	4	3	4	4	4	4	4	4	4	4	4	4	17/18	0.94
Q31	3	3	3	1	3	3	3	4	4	2	3	3	3	2	4	3	3	3	3	3/6	0.50
Q33	3	3	4	4	4	4	4	4	4	4	4	4	4	4	4	4	3	3	4	17/17	1
Q35	4	3	4	4	4	4	4	4	4	4	3	4	4	4	4	4	2	3	4	15/16	0.93
Q37	4	3	4	2	4	4	3	4	2	4	4	4	3	4	4	4	4	4	4	15/17	0.88
Q39	4	3	4	2	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	17/18	0.94
Q41	4	3	4	3	4	4	2	4	4	4	4	4	4	4	4	4	4	4	4	17/18	0.94
Q43	4	3	4	4	4	4	4	4	4	4	4	3	4	4	4	4	4	4	2	17/18	0.94
Q45	4	3	4	1	4	4	4	4	3	4	4	4	4	4	4	3	4	4	4	17/18	0.94
Q47	4	3	4	2	4	4	4	4	3	4	4	4	4	4	4	4	3	4	4	17/18	0.94
Q49	4	3	4	2	4	4	4	4	4	4	3	4	4	4	4	4	4	4	4	17/18	0.94
Q51	4	3	4	1	4	4	4	4	4	4	4	4	3	4	4	4	4	4	4	17/18	0.94
Q53	4	3	4	2	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	17/18	0.94
Q55	4	3	4	1	4	4	4	4	4	4	4	4	4	4	4	4	1	4	4	16/18	0.88
Q57	4	3	4	1	4	4	4	4	4	4	2	4	4	4	4	4	4	4	4	16/18	0.88
Q59	4	3	4	1	4	4	4	4	2	4	4	3	4	4	4	3	4	4	4	15/17	0.88
Q61	4	3	4	1	4	4	4	4	3	4	4	4	4	4	4	3	1	4	4	15/17	0.88
Proportion Score (out of 31)	27	3	27	7	29	28	27	31	26	29	26	26	29	29	27	27	28	22	28	3	Overall-Index-Score=3
Proportion-Index	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3

Relevance—Content Validity Scores



Question#	TW1#	TW2#	TW19#	T# #20#	TW9#	SH #4#	SH# #16#	SH# #17#	SH# #18#	P# #12#	P# #13#	P# #14#	P# #15#	P# #11#	P# #8#	LGBQ# #10#	LGBQ# #3#	LGBQ #5#	LGBQ# #6#	CVI- SCORE-#	CVI- INDEX#
Info-Sheet#	4#	#	4#	4#	#	4#	4#	4#	4#	4#	3#	3#	4#	4#	3#	4#	3#	4#	4#	17/17#	1#
Declaration#	4#	#	4#	4#	4#	4#	4#	4#	4#	4#	1#	3#	4#	4#	3#	4#	3#	4#	4#	17/18#	0.94#
Consent#	3#	#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	3#	4#	4#	18/18#	1#
Q7#	#	#	4#	4#	#	#	#	#	4#	#	4#	4#	#	3#	3#	3#	#	4#	4#	10/10#	1#
Q9#	4#	4#	4#	4#	4#	4#	4#	4#	3#	4#	4#	4#	3#	4#	4#	4#	4#	4#	4#	19/19#	1#
Q11#	2#	4#	3#	4#	4#	4#	4#	3#	4#	4#	4#	3#	4#	4#	4#	2#	2#	4#	4#	16/19#	0.84#
Q13#	3#	#	4#	4#	3#	4#	4#	4#	4#	4#	4#	4#	4#	4#	3#	4#	3#	4#	4#	18/18#	1#
Q15#	4#	#	4#	4#	4#	4#	4#	4#	4#	4#	3#	3#	4#	4#	4#	4#	4#	4#	4#	18/18#	1#
Q17#	4#	#	4#	3#	4#	4#	4#	4#	4#	4#	3#	3#	4#	4#	4#	4#	3#	4#	4#	18/18#	1#
Q19#	4#	4#	4#	3#	4#	4#	4#	4#	4#	4#	4#	#	4#	4#	4#	4#	3#	4#	4#	17/17#	1#
Q21#	3#	#	4#	3#	4#	4#	4#	4#	4#	4#	4#	#	4#	4#	4#	4#	4#	4#	4#	17/17#	1#
Q23#	4#	#	4#	3#	4#	4#	4#	4#	4#	4#	3#	4#	4#	4#	4#	4#	3#	4#	4#	18/18#	1#
Q25#	3#	#	4#	3#	4#	4#	4#	4#	4#	4#	3#	4#	4#	4#	4#	4#	4#	4#	4#	18/18#	1#
Q27#	3#	#	4#	3#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	3#	4#	4#	18/18#	1#
Q29#	4#	4#	4#	3#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	18/18#	1#
Q31#	4#	#	#	4#	4#	4#	3#	3#	2#	4#	4#	#	#	3#	3#	1#	#	#	4#	11/13#	0.84#
Q33#	4#	#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	2#	4#	4#	4#	#	4#	16/17#	0.94#
Q35#	4#	#	4#	4#	4#	4#	4#	4#	4#	4#	3#	4#	3#	3#	4#	4#	2#	#	4#	16/17#	0.94#
Q37#	4#	#	4#	1#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	16/17#	0.94#
Q39#	4#	4#	4#	2#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	17/18#	0.94#
Q41#	4#	#	4#	3#	4#	4#	2#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	17/18#	0.94#
Q43#	4#	#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	3#	4#	2#	17/18#	0.94#
Q45#	4#	#	4#	3#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	2#	4#	4#	4#	17/18#	0.94#
Q47#	4#	#	4#	2#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	3#	4#	4#	17/18#	0.94#
Q49#	4#	4#	4#	2#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	3#	4#	4#	17/18#	0.94#
Q51#	4#	#	4#	2#	4#	4#	3#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	17/18#	0.94#
Q53#	4#	#	4#	2#	4#	4#	4#	4#	4#	4#	4#	4#	3#	4#	4#	4#	4#	4#	4#	17/18#	0.94#
Q55#	4#	#	4#	3#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	2#	4#	4#	4#	17/18#	0.94#
Q57#	4#	#	4#	1#	4#	4#	4#	4#	4#	4#	2#	4#	4#	4#	4#	4#	3#	4#	4#	16/18#	0.88#
Q59#	4#	4#	4#	2#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	#	4#	4#	4#	16/17#	0.94#
Q61#	4#	#	4#	1#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	4#	#	3#	4#	4#	16/17#	0.94#
Proportion# Score-{out- of:31#}	29#	#	30#	22#	29#	30#	29#	30#	30#	30#	29#	28#	29#	30#	31#	25#	27#	28#	30#	#	Overall- CVI- score- 0.93#

User-friendliness—Content-Validity-Scores-¶

Question¶	¶1¶	¶2¶	¶19¶	¶¶	¶9¶	SH¶	SH¶	SH¶	SH¶	¶¶	¶¶	¶¶	¶¶	¶¶	¶¶	LGBQ¶	LGBQ¶	LGBQ¶	LGBQ¶	CVI-SCORE-¶	CVI-INDEX¶
Info-Sheet¶	3¶	¶	¶	4¶	¶	3¶	3¶	4¶	4¶	4¶	3¶	3¶	4¶	4¶	2¶	4¶	3¶	3¶	4¶	15/16¶	0.94¶
Declaration¶	4¶	¶	3¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	1¶	4¶	4¶	4¶	3¶	4¶	3¶	2¶	4¶	16/18¶	0.89¶
Consent¶	4¶	¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	18/18¶	1¶
Q7¶	4¶	2¶	3¶	4¶	4¶	4¶	4¶	¶	2¶	4¶	4¶	¶	4¶	4¶	3¶	¶	3¶	2¶	¶	12/15¶	0.80¶
Q9¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	4¶	3¶	4¶	4¶	4¶	4¶	4¶	4¶	19/19¶	1¶
Q11¶	4¶	4¶	1¶	3¶	4¶	4¶	4¶	3¶	4¶	4¶	4¶	3¶	4¶	2¶	4¶	3¶	2¶	4¶	4¶	16/19¶	0.84¶
Q13¶	4¶	¶	1¶	4¶	3¶	4¶	3¶	4¶	4¶	4¶	3¶	4¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	17/18¶	0.94¶
Q15¶	4¶	¶	3¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	2¶	3¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	17/18¶	0.94¶
Q17¶	4¶	¶	3¶	4¶	4¶	4¶	3¶	4¶	4¶	4¶	3¶	3¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	18/18¶	1¶
Q19¶	4¶	¶	1¶	3¶	3¶	4¶	4¶	4¶	2¶	4¶	4¶	¶	4¶	4¶	3¶	4¶	3¶	2¶	4¶	14/17¶	0.82¶
Q21¶	4¶	¶	1¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	16/17¶	0.94¶
Q23¶	4¶	¶	1¶	3¶	3¶	3¶	4¶	4¶	2¶	4¶	3¶	3¶	4¶	4¶	4¶	4¶	3¶	2¶	4¶	15/18¶	0.83¶
Q25¶	1¶	¶	1¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	16/18¶	0.89¶
Q27¶	3¶	1¶	3¶	3¶	3¶	4¶	4¶	4¶	2¶	4¶	4¶	4¶	4¶	4¶	4¶	2¶	3¶	2¶	4¶	14/18¶	0.78¶
Q29¶	3¶	¶	1¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	17/18¶	0.94¶
Q31¶	4¶	¶	4¶	4¶	4¶	3¶	4¶	4¶	3¶	3¶	¶	4¶	4¶	4¶	¶	4¶	4¶	4¶	¶	14/14¶	1¶
Q33¶	4¶	¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	18/18¶	1¶
Q35¶	4¶	¶	2¶	4¶	4¶	¶	4¶	4¶	3¶	4¶	3¶	4¶	3¶	4¶	4¶	4¶	2¶	4¶	4¶	15/17¶	0.88¶
Q37¶	4¶	¶	2¶	4¶	4¶	4¶	¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	16/17¶	0.94¶
Q39¶	¶	¶	3¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	17/17¶	1¶
Q41¶	4¶	¶	3¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	18/18¶	1¶
Q43¶	4¶	¶	3¶	4¶	4¶	4¶	4¶	4¶	2¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	3¶	4¶	2¶	16/18¶	0.89¶
Q45¶	4¶	¶	2¶	4¶	4¶	4¶	4¶	4¶	1¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	16/18¶	0.89¶
Q47¶	4¶	¶	2¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	17/18¶	0.94¶
Q49¶	4¶	¶	2¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	17/18¶	0.94¶
Q51¶	4¶	¶	1¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	4¶	4¶	4¶	4¶	17/18¶	0.94¶
Q53¶	4¶	¶	2¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	17/18¶	0.94¶
Q55¶	4¶	¶	1¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	1¶	4¶	4¶	4¶	16/18¶	0.89¶
Q57¶	4¶	¶	1¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	2¶	4¶	4¶	4¶	4¶	4¶	3¶	4¶	4¶	16/18¶	0.89¶
Q59¶	4¶	¶	1¶	4¶	4¶	4¶	4¶	4¶	2¶	4¶	4¶	3¶	4¶	4¶	4¶	¶	4¶	4¶	4¶	15/17¶	0.88¶
Q61¶	4¶	¶	1¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	4¶	¶	3¶	4¶	4¶	16/17¶	0.94¶
Proportion¶ Score-(out- of-31)¶	29¶	3¶	11¶	31¶	30¶	30¶	30¶	29¶	24¶	31¶	27¶	28¶	31¶	30¶	29¶	26¶	29¶	27¶	28¶	¶	Overall- CVI- Score=¶

Appendix 7 – Content Validity Comments

Question	Comments on content validity	Actions taken
Info Sheet	I suggest changing you are invited to consider taking part in the study if you meet the following criteria : a young person, aged 13-19, living in the Republic of Ireland who 'ARE OR' thinks they may be lesbian, gay, bisexual or questioning their sexuality. The questionnaire will be available online to August 2020. #3	This was changed
Info Sheet	there is a lot of text in a single body. It might be more user friendly to break down the text down into short paragraphs or bullet points where relevant. Young people (everyone) read more easily in short chunks rather than one long body of text. #5	Text broken up into sections
Info Sheet	I would consider using ' who might identify as' rather than 'who thinks they might be' #10	This was changed
Info Sheet	The wording could be improved in places and punctuation added. Not sure what' the questionnaire will be available online to August 2020 means #8	This was changed. August 2020 was the closing date for the content validity
Info Sheet	in the last paragraph just remove the 'however' before 'this survey' collects information on...' #12	This was removed
Q1 Declaration		No change
Q2 Declaration 2		No Change

Q3 consent	this is short, clear and to the point. I think all the questions you need to ask need to be reduced to this type of short precise questions. E.g. Q3 needs to be shorter - please confirm if you have read the previous page. Please confirm you wish to participate. (can you block progression if they have not read?) #5	Progression had been blocked – this was made clear in the survey
Q3 consent	is parental consent not a requirement for research with adolescents aged under the age of 16 or 18 year? #15	No
Q4	potentially difficult for young people also navigating gender issues to answer - is the survey specifically for cis-gender identifying LGBTQ young people? #18	No
Q4	The stem of the question should state; The next few questions relate to your sexual attraction/ orientation at present, i.e. Who you are sexually and emotionally attracted to.#20	Changed
Q4	I tried to put 4 in for each answer but it will not allow me to do so #10	Error with the survey
Q4	I was unable to tick 4 once, but I think they are all highly relevant	Error with the survey
Q4	I want to select 4 for each item but it wont allow me to #13	Error with the survey
Q4	no option for non-binary person #11	Not needed here – box for other to comment
Q4	this is very controversial territory. You statements conflate sex and gender which are highly contested concepts in the LGBTI+ community. We speak of same sex/ opposite attraction and gender identity in terms of cis-gender and transgender. In your statements gender is conflated with sex.	Personal opinion - As per BeLonGTo this was the wording suggested
Q4	I suggest ' I am/think I am attracted to people of my own and other genders' #6	Changed
Q4	Just wondering why'I think' has not been added to the last two options? #8	Changed
Q4	Unable to select the same number twice ...4,4,4 #16	Error with the survey

Q5	if answered unsure or not attracted to any gender above then this could/ should be left blank? #15	Yes
Q5	could include a definition of sexual orientation? In case they didn't understand #9	Not needed
Q7	Q13 list is very long	Ok
Q7	Add LGBTQ groups, LGBTQ scene to Q13 #8	Not needed
Q14	Q 15 would be clearer if it read; Please tell us if ever sought or have been given information on any topic on sexuality and sexual health that is not listed above in Q13. In Q 13 the issue of consent and rights should be separate topics #20	
Q14	pornography, chemsex, saunas, cottaging, cinemas (places to have sex), PEP, Prep, Morning after pill, rape, S&M #7	
Q14	info from where ? School, home etc? #13	
Q14	re Q13 I'd consider replacing sexual activity with 'sex' 'safer sex' - can have many implications outside of condom use, particularly for gay/bisexual men - PrEP/ PEP/ Monogamy/ regular testing etc. I'd consider separating 'condoms' and 'safer sex' - along with adding PrEP and PEP #18	
Q14	Glad to see pornography on the list. May be more user friendly to say porn rather than pornography. I can't imagine that pornography is in young people's vernacular. Just a thought. #4	Changed - Both terms are used
Q14	The stem question needs to be rewritten. Red print differentiates this question from the other in the survey. The format and layout of Q 19 is very cumbersome. #20	This was changed and red print removed.
Q14	I found I kept having to scroll back to the top of the page to remind myself what each column was for #10	Ok -

Q23	books/ novels #13	Not added
Q23	again, the introduction paragraph is too long and contains too much. Best to break the information being requested into two tables - who helped you find information about. Beneath this the list of people etc Then who was unhelpful in accessing information about.... #5	This was shortened and changed to reflect suggestions
Q23	Question test is not clear and could be worded better #8	
Q23	suggest changing Gay Media to LGBTQ Media	Changed
Q23	had to read the instructions a few times to grasp what was required... but it was very clear once I understood #9	Ok
Q23	when giving examples of social media it might be worth naming a few platforms like Instagram, YouTube, facebook, Twitter. I think that would be more recognisable for young people. When I spoke to a group of engaged LGBTQ young people last year about my service they 'schooled' me about my 'oldfashioned' website and asked if i had a Youtube channel. It gave me a lot of insight into how they get their information. #4	Not changed
Q23	have them all one colour. Some are highlighted or a different colour and not sure of relevance of this #17	Changed to one colour
Q23	I imagine this research seeks to gather data specifically from cis-gender young people but I fear repeated exclusion of the trans community - particularly when referencing the 'LGBQ' community could be problematic or offputting for LGBTQIA+ young people #18	
Q23	Can you tell us about any other places you get information on sexual orientation and relationships from? What other sources of information on sexual orientation and relationships have you used? #20	Information stem changed
Q23	the table is dizzying in its complexity. Needs to be broken down in simpler parts, less complex, more digestible #5	

Q23	...what sources you used or have been given information on these topics, useful or not' does not read well (also in previous question) #8	
Q23	The stem question needs to be rewritten. Coloured print differentiates this question from the other in the survey #20	
Q23	very long list #3	
Q23	very relevant but quite long for younger participants #9	
Q23	Question is not worded correctly.#20	
Q23	again as per previous entry all one colour not two different shades, easier to read #17	
Q23	As in last 2 questions ...what sources you used or have been given information on these topics, useful or not' does not read well (also in previous question) #8	
Q23	The stem question needs to be rewritten. Coloured print differentiates this question from the other in the survey.#20	
Q23	younger participants may not understand all the terms #9	

Q36	suggest asking about access to the Internet #3	Other as an option
Q36	I don't trust what I am told/ find - poor wording #20	Changed
Q36	Would an 'other' open-ended category be useful here? #15	Added
Q36	Suggest 'in your opinion are there any barriers that prevent you from seeking info.. Please select all boxes that are relevant' #13	Not changed – as question was not just about barriers
Q37, 38, 39	I am not sure why they are told they may not want to answer these questions? #12	Removed
Q37, 38,39	When you say "you may not want to answer them" you don't give them further direction. It might be worth finishing the sentence after history and in a new sentence saying "if you do not wish to answer them move to question 8 #4	Changed
Q37, 38,39	The next few questions asks personal questions in relation to sexual activity and sexual history and you may not want to answer them. The following questions ask about your sexual activity and sexual history. (up to the participant to decide about answering) #20	
Q37	This only applies to biological females #10	
Q37	assume this is not a 'required' question so it can be left blank if respondent prefers? #15	
Q38	Assume this is not a 'required' question so it can be left blank if respondent prefers? #15	yes

Q39	assume this is not a 'required' question so it can be left blank if respondent prefers? #15	yes
Q39	I would consider clarifying - adding "received payment or gifts in exchange for sex" #18	yes
Q39	LGBTQ people may be involved ' in selling' 'buying' or giving sex for money, a place to stay and lots of other ways to survive but may not see themselves a sex workers or prostitutes. Suggest breaking this down for people taking the survey or explaining why you are asking #3	Question changed
Q39	you could add "ever been paid for sex" as some people who are paid for sex but don't strictly consider themselves a sex worker #4	
Q39	OPTION- PREFER not to answer	Added
Q40	personal computer/ laptop #8	Changed
Q40	use of the term most common? Possible reword - which of the following do you use most often to access the Internet? #15	Changed
Q40	? Mobile devices #18	
Q42	sometimes we see patients of even a younger age #16	

Q43	be aware that some trans people do not identify as trans, they identify as their preferred gender. You may have to ask do you have a trans history or was that the gender they assigned you at birth #3.	Changed
Q43	gender fluid #7	
Q43	I would consider adding the "Cis" prefix to male and female and changing the "Transgender - m-f/f-m to Trans male and Trans female. To avoid othering this group #18	
Q44	Male parts/female parts #20	
Q44	I would consider asking "what was the gender you were assigned at birth" - and remove the Boy/Girl body parts parentheses #18	Changed
Q45	do you need to define by population numbers??	Not changed
Q46	again many LGBTQ people who are in face homeless do not see themselves that way, they may be couch surfing, living with relatives and friends #3	As other was an option that was not changed
Q46	In care #7	
Q46	could you include living with other family members and living in foster care #12	
Q47	would school or college cover all - what about in full time education or training - see now that this may be covered in Q53 #15	Ok

Q47	School is very different to college. #20	
Q47	is 'still' necessary in the question? #4	Removed
Q47	Add 'Taking a break' #7	No
Q47	If no where are you now #7	Not added
Q49	If no to Q51, what age were you when you left school? If you answered no to Q51 at what age did you finish in education? #20	
Q49	the question shouldn't be so far away from the question you want me to answer (you asked it 4 questions after) #10	Changed and logic applied
Q50	options are stereotypical #20	Based on CSO
Q50	Should black Irish not be an option also ? Saw it as an option on a form recently #13	
Q51	I think this survey is very interesting, important and worthwhile. The questions are user friendly etc.. However younger students could have a lot of confusion surrounding some term and a few of the questions may not be understood by a 13 year old but would be very relaxant to a 19 year old #9	

Q51	it would be great to include Http://www.hivirelad.ie/what-we-do/power/community-outreach/services/ as an excellent source of support and information. #4	Added
Q51	Very thorough questionnaire and option of person to add comment on questions covers aspects that the person may want to include or comment on. Hope it all goes well #17.	
Q51	fantastic survey - extremely important - best of luck #12	
List of services	Please add Mater Sexual Health Services #18	Added
List of Services	add in helplines HSE 24/7 crisis textline 50808	Added
List of Services	mistakes exist in the helplines section - remove regional helplines and list National LGBT Helpline 1890 929 539 (all constitute the National LGBT Helpline). You should list LGBT+ resource organisations - LINC in Cork www.linc.ie - Gay Project in Cork www.gayproject.ie - Dundalk Outcomers www.outcomers.org - LGBT Ireland www.lgbt.ie #5	This is changed

Appendix 8 – Copy of Recruitment E mail/ Flyer for Recruitment

Dear xxxxxxx,

I am currently completing a PhD study on the Information Needs and Sources of Information of Lesbian, Gay, Bisexual and Questioning (LGBQ) Adolescents in relation to sexuality and sexual health in the Republic of Ireland under the supervision of Professor Agnes Higgins. The purpose of this study is to identify what information young people who identify as LGBQ need and how young LGBQ people of secondary school age (13-19) find information in relation to sexuality and sexual health. This will be done using an anonymous computer-based survey that will take approximately

30 minutes to complete. The survey has received ethical approval from the Faculty of Health Sciences in Trinity College Dublin and has been reviewed by the TCD Data Protection Office to ensure it is GDPR compliant.

In order to progress this research, I am asking youth groups to share the survey on email and where possible on social media and websites. I would appreciate your assistance and the assistance of your organisation in this regard.

Therefore, I would ask that the following text or attached poster, with the survey link, is distributed via e mail and social media on your platforms to reach the intended population of the study.

LGBQ Sources of Info Study on Sexuality and Sexual Health

*Are you Gay, Lesbian, Bisexual or questioning your sexuality?
A young person aged between 13 and 19
And Living in the Republic of Ireland*

Then I want to hear from you.

Tell me where you get your info, what sources are useful, what info do you want and what are the barriers to getting it?

To learn more or complete the survey, visit the link:

<https://www.surveymonkey.com/r/LGBQinformationsources2021>



I would appreciate your consideration of this matter,
Kind regards,
Thelma Begley

LGBQ Adolescents' Sources of Info Study on Sexuality and Sexual Health

Are you Gay, Lesbian, Bisexual or questioning your sexuality?

A young person aged between 13 and 19

And Living in the Republic of Ireland

Then I want to hear from you.

Tell me where you get your info, what sources are useful, what info do you want and what are the barriers to getting it?

To learn more or complete the survey, visit the link:

<https://www.surveymonkey.com/r/LGBQinformationsources2021>



Further information available from Thelma Begley at tbegley@tcd.ie

Appendix 9 – List of Organisations Contacted for Recruitment

Belong To	www.belongto.org	Facebook; Twitter
Gay Switchboard	www.gayswitchboard.ie	
GOSHH - Gender, Orientation, Sexual Health, HIV (Limerick)	www.goshh.ie	Twitter; Facebook; Instagram
Outhouse	www.outhouse.ie	
Gay Men's Health Service	www.gmhs.ie	
Gay Health Network	www.ghn.ie	
Gay Community News	www.theoutmost.com (website of GCN magazine)	Twitter; Facebook
Dublin LGBTQ Pride		Instagram
LINC	www.linc.ie	
My Unique Individuality (LGBT Youth Club)	Carlow	Facebook
Up Cork (LGBT Youth Club)	Cork	Facebook; Twitter
Gay Project	Cork	
Breakout (LGBT Youth Club)	Letterkenny, Donegal	
Belongto Sunday (LGBT Youth Club)	Dublin	Facebook; Twitter
Loving our out Kids (LGBT Youth Club)	Parents group Dublin	Facebook
Over 18's group (LGBT Youth Club)	BeLonGTo	Facebook; Twitter
Tallaght LGBT club (LGBT Youth Club)	Dublin	
The Ladybirds (LGBT Youth Club)	Women club – Dublin	
shOUT (LGBT Youth Club)	Galway	Facebook
Kerry Youth Pride (LGBT Youth Club)	Kerry	Facebook; Twitter
KLGBT (LGBT Youth Club)	Kildare	Facebook
Open Door (LGBT Youth Club)	Kilkenny	
AIM Young Adults and Youth Group (LGBT Youth Club)	Dundalk (2 separate groups)	

SWAG (LGBT Youth Club)	Mayo	
SMILY (LGBT Youth Club)	Sligo	Facebook
OUTstanding (LGBT Youth Club)	Tipperary	Facebook
Chill Out (LGBT Youth Club)	Waterford	Facebook
Athlone Spectrum (LGBT Youth Club)	Westmeath	
Arklow LGBT Support Group (LGBT Youth Club)	Wicklow	Facebook
Bray LGBT youth and friends (LGBT Youth Club)	Wicklow	Facebook
Brod Soc (NUIG society)	Galway	
LIT is Out (LIT society)	Limerick	
LGBT+ Youth Limerick	Limerick	
Rainbow	Ennis	
Letterkenny IT	Donegal	
Tralee IT	Kerry	
UCD	Dublin	
Sligo IT	Sligo	
TCD	Dublin	
UCC	Cork	
DCU	Dublin	
Generic Youth Services (Non LGBTQ Specific)		
Youth Work Ireland	www.youthworkireland.ie	Facebook; Twitter
Youthreach	www.youthreach.ie	Facebook
Foroige	www.foroige.ie	Facebook; Twitter
Spunout	www.spunout.ie	Facebook; Twitter
National Youth Council of Ireland	www.national-youth-council-of-ireland.ie	Facebook
Comhairle na nOg	www.comhairlenanog.ie	Facebook
Social Media Sites		
LGBT Ireland		Facebook; Twitter
Dublin LGBTQ Pride		Facebook; Instagram
Dublin Gay Theatre Festival		Facebook
Dublin Pride Run		Facebook

Mayo Pride		Facebook
LGBTQ+ Youth Work Ireland		Facebook
Cork Pride		Facebook
Yes Equality		Facebook
Kildare Youth Services		Facebook
Marriage Equality Ireland		Facebook
Longford LGBT		Facebook
Limerick LGBT		Facebook
Laois LGBTQ2ia		Facebook
Limerick Pride		Instagram
Gay Ireland		Twitter
Sunrise LGBT (Kildare)		Facebook
Lgbtparents southeast		Twitter
Gay parents		Twitter
Running Amach		Twitter
GayInWaterford		Twitter
Kerryyouthpride		Twitter
Carlow LGBT+ Network		Facebook
Dundalk Pride		Facebook
Dublin lesbian line		Twitter
Rainbow Youth Cavan		Facebook
Outcomers (Dundalk and Drogheda)		Facebook
SMILY	Sligo/ Leitrim	Facebook

Appendix 10 - Email from Snapchat Administrators

Your ads have been rejected



Team Snapchat <ad-api-notifications@snapchat.com>

To Thelma Begley



Tue 26/01/2021 01:04

If there are problems with how this message is displayed, click here to view it in a web browser.

Your ads have been rejected

78c0aba5-e15e-4130-85d5-a9365bc3dfee

Rejection Reason:

Your ad solicits Snapchatters to participate in a clinical trial or research study and does not comply with our policies. All ads for clinical trials or research studies must be targeted to 18+, contain all necessary disclosures, have a privacy policy readily available where personal information is collected, and all personal information must be collected and processed securely. Clinical trials cannot involve taking prescription medications.

Campaign Name:

LGBQ Irish aged 13-19 - Campaign

Ad Set Name:

LGBQ Irish aged 13-19 - Ad Set

Ad Start Date:

1/25/2021

[Fix in Ads Manager](#)

cec00063-0d8f-494d-931d-83e26d9dcdbd2

Rejection Reason:

Your ad solicits Snapchatters to participate in a clinical trial or research study and does not comply with our policies. All ads for clinical trials or research studies must be targeted to 18+, contain all necessary disclosures, have a privacy policy readily available where personal information is collected, and all personal information must be collected and processed securely. Clinical trials cannot involve taking prescription medications.

Campaign Name:

Irish, LGBQ, aged 13-19? - Campaign

Ad Set Name:

Irish, LGBQ, aged 13-19? - Ad Set

Ad Start Date:

1/25/2021

[Fix in Ads Manager](#)

Appendix 11 – Email Communication to Communications Office

From: [REDACTED]
Sent: Tuesday 2 February 2021 10:16
To: Thelma Begley <TBEGLEY@tcd.ie>
Subject: RE: Twitter reaction to research study

Hi Thelma,
Many thanks for explaining this in such detail. I am sorry that this has happened to you. It is not a nice experience. Our team are aware of it, and as I just mentioned to Fintan via email, we will keep an eye on the situation too. Hopefully it will be a storm in a teacup and will fizzle out before it gathers any kind of momentum. It would be great to keep in touch around your research and best of luck with the survey.

Warm wishes
XXXXXXXX

From: Thelma Begley
Sent: Monday 1 February 2021 18:17
To: [REDACTED]
Cc: [REDACTED]
Subject: Twitter reaction to research study

Dear Communications Office and Head of School,

I am staff member in the School of Nursing and Midwifery and a PhD student.

Title of Study: LGBTQ young people aged 13-19 sources of information on sexuality and sexual health.

Research Design – anonymous online survey accessed through a weblink. The survey was developed in conjunction LGBTQ youth organisations (BeLonGTo) to ensure that language was inclusive and appropriate.

Ethics approval was granted by the Faculty of Health Sciences Ethics Committee in June 2020. LGBTQ young people to provide own consent and a waiver for parental assent granted as part of the ethics approval as is usual in surveys with this group.

Study was launched on January 6th 2021 and was circulated via weblink on Twitter (@[REDACTED], @snm_tcd, @BeLonG_To, @ywirl); Facebook – Youthwork Ireland, School of Nursing and Midwifery, TCD.

Today, BeLonGTo received some negative attention to their tweet about the study. I have spoken to BelonGTo Communications director, who informed me that this originated from a group of people who have previously reacted to the work of BeLonGTo and some of it stemming from tweets from last October with discussion that questioned the existence of trans people. These discussion proprot to be based on the welfare of children. The Twitter conversation seems to be among a core group of people with some additional people being included. Belongto have informed me that they are not going to engage with any of the comments or take down the links.

Some of the comments are:

*"For crying out loud, you are normalising, for young teenagers, talking about their sexual experiences, thoughts, feelings etc *online*, encouraging them to disclose possibly traumatic info outside of therapeutic/trusted adult setting. Do you's know nothing about online grooming?"*

I cannot believe this has been approved by an ethics committee and is being run by organisation claiming to work for young people's welfare.

Who is counselling children who respond to say they have been raped or sexually assaulted, once they read and respond to these questions? What follow-up do you give them? Who are @BeLonG_To @TCD_SNM DPOs, given you're processing sensitive info, electronically? @dpcireland #GDPR

Would you be happy if your 13 year old child took a survey with the following questions? Have you ever been PAID FOR SEX? Has PORN taught you how to have ANAL SEX or use SEX TOYS toys? If you aren't happy then either ...

I have attached some screenshots of the discussion to date up to 1 hour ago. I did not ask about rape in the survey. There is a long list of support services and helplines in the survey. In addition, I provided my name and contact details as an option for additional support. To date I have 284 partial survey and 78 fully completed surveys. No body has contacted me for support to date and the qualitative comments at the end of the survey indicated that participants were very positive and grateful for the study. No adverse reactions or comments were reported.

I have not made any response to any of these Twitter comments.

I have discussed with my supervisors and Head of School and feel it is important to inform the Communications Office about this occurrence in case there is an escalation and the University is contacted. I am aware that people in the public domain have been included on a tweet about this.

I will not respond to any queries from outside agencies i.e. press arising from this without your guidance. I would be grateful if you could advise me if there are further actions I need to take.

Kind regards,
Thelma.

Thelma Begley
Assistant Professor in Children's Nursing
School of Nursing and Midwifery
Trinity College Dublin
24 D'Olier St.
Dublin 2

**

Appendix 12 – Letter of Approval from Ethics Committee (Letter One)



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Ms. Thelma Begley
School of Nursing and Midwifery,
Trinity College Dublin,
24 D'Olier St,
Dublin 2.

25th September 2019

Ref: 190610

Title of Study: Information Needs and Sources of Information of Lesbian, Gay, Bisexual and Questioning (LGBQ) Adolescents in relation to sexuality and sexual health.

Dear Thelma,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in June 2019. We are pleased to inform you that the above project has ethical approval to proceed.

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Prof. Brian O'Connell'.

Prof Prof. Brian O'Connell
Chairperson
Faculty Research Ethics Committee

Appendix 13 – Letter of Ethical Approval with CVI Amendments (Letter 3)



Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

Ms. Thelma Begley
School of Nursing and Midwifery,
Trinity College Dublin,
24 D'Olier St,
Dublin 2.

18th May 2020

Ref: 190610

Title of Study: Information Needs and Sources of Information of Lesbian, Gay, Bisexual and Questioning (LGBQ) Adolescents in relation to sexuality and sexual health.

Dear Thelma,

Further to a meeting of the Faculty of Health Sciences Ethics Committee held in May 2020, we are pleased to inform you that the above project (as amended with the following changes) has ethical approval to proceed. We would advise you to seek review and comments on your DPIA from the DPO if required prior to study commencement.

Please give specific details of the requested amendment(s):

This amendment is for the pilot study and due to changes in target population of pilot due to COVID 19

The original content validity for the pilot study was planned through a group of young people through youth groups using the same population as the study. Unfortunately, due to COVID 19 I can no longer access a group of the target population planned to ensure the survey is reliable and valid. The LGBQ groups are no longer meeting and I cannot progress with data collection until I ensure this process is complete. I had waited for the past month to see if I could progress using this method but now need to consider an alternative method.

To prevent further delay I am therefore looking to circulate the approved questionnaire with Content Validity amendment (in purple) to an expert panel of 15 people for validation including approximately

5 volunteers from each of the following groups

- Secondary school teachers who I will access through a gatekeeper who is a former teacher who can forward the anonymous link to former colleagues
- members of staff with adolescent children, who I will contact using standard protocols for accessing staff for research in a school and
- Experts in the LGBT services and sexual health services whose names are available in the public domain. Some of these have previously advised on the survey.



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An introduction is added to the survey explaining the content validity process and the following table will be inserted after each question to determine relevance, clarity and user friendliness and no other changes will be made to any of the questions:

Relevance	Clarity	User Friendliness

By forwarding the link via email to the survey that they can reply to anonymously via SurveyMonkey

Note: font in black and red have previously been approved by FHS Ethics Committee. The amendments are in purple on pages 6 and appendix 6 page 28-4

This amendment will not alter any other aspect of the study as approved.

As a researcher you must ensure that you comply with other relevant regulations, including DATA PROTECTION and HEALTH AND SAFETY.

Yours sincerely,

Prof. Jacintha O'Sullivan
Chairperson
Faculty Research Ethics Committee

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Appendix 14 – GANTT Chart

