about healthy food, exercise, or lifestyle habits; 9% reported experiencing positive reinforcement about changes to their food habits or weight changes, encouraging their ED behaviors. Additionally, 12% reported unintentional weight loss or gain (e.g., from medication, puberty, or illness) as a trigger for their ED behaviors. Regression analyses showed that for every year younger, patients had 1.30x odds of reporting health education (95%CI 1.02-1.64 [p=0.032]) and 1.25x odds of weight-related teasing (95%CI 1.01-1.56 [p=0.042]) as triggers for their ED behaviors when controlling for amount and time of weight loss. A similar trend was seen with age and physician comments about weight, but this was marginally significant (p=0.059). Patients who were older had 1.45x odds of reporting a preceding unintentional weight change as a trigger for their ED (95%CI 1.11-1.89 [p<0.01]).

Conclusions: Our results suggest that individuals may experience various types of triggers for their ED behaviors, allowing for different targets for the prevention of EDs. Those who are younger may be especially vulnerable to messaging via health education and weight-related teasing. These findings highlight the need to improve public health initiatives to promote body positivity and weight inclusivity in not just social aspects, but also in health education and medical care.

Sources of Support: MCHB T71MC00009 LEAH training grant.

RESEARCH POSTER PRESENTATION I: TRANSGENDER/LGBTQ

42.

"OH MY GOD! HOW DID I MISS THIS?" - BARRIERS TO DISCUSSING PRONOUNS AND GENDER IDENTITY IN PEDIATRIC PRIMARY CARE

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Purpose: Pediatric gender centers have seen a notable increase in demand for gender-affirming care services during the COVID-19 pandemic. This increased need has contributed to delays in youth accessing this time-sensitive care and amplified the importance of primary care providers (PCPs) playing an active role supporting gender diverse youth in the post-pandemic world. To guide interventions to support PCPs in gender-affirming care, we sought to understand how often PCP's see gender diverse youth in primary care and assess PCP comfort facilitating conversations about gender identity in this setting. The objectives of this study were to (1) understand whether PCPs are routinely discussing pronouns and gender identity with adolescents and (2) explore barriers to and the impact of having such discussions in primary care.

Methods: This project integrated data from a needs assessment survey and from semi-structured, qualitative interviews with pediatric PCPs. The 15-item survey was administered to PCPs in a large, hospital-affiliated, pediatric primary care network in the northeastern US to better understand PCPs experiences providing adolescent healthcare. Hour long, semi-structured interviews were conducted with pediatric PCPs in the pacific northwest using an interview guide developed in partnership with two PCP stakeholders. Survey responses were analyzed descriptively. Interviews were transcribed and analyzed by two authors in Dedoose qualitative analysis software via inductive thematic analysis using an iteratively designed codebook that was adjudicated to consensus.

Results: Of the pediatric PCPs surveyed (n=85), the majority were pediatricians (67%) and most had been in practice for more than 5 years (75%). Almost all (92%) PCPs reported caring for at least one gender diverse youth in their practice in the last year. However, PCPs reported discussing pronouns (15%) and gender identity (29%) during annual well visits with adolescent patients much less frequently than discussing mood (98%), motor vehicle safety (77%) and sexuality (61%). Relatedly, gender-affirming care (60%) was the topic most frequently selected by PCPs for additional education. In separate PCP interviews, participants (n=15) indicated that while they felt discussions about pronouns and gender identity were important, they experienced specific structural and interpersonal barriers that prevented these conversations from occurring. These barriers included poor health system infrastructure (like forms and electronic health records), staff concerns, uncertainty around language, lack of awareness and fear. PCPs also discussed that when they asked about pronouns and gender identity, it normalized conversations about gender, helped facilitate family support, created welcoming environments in the health system and allowed for earlier identification of youth in need of support.

Conclusions: Pediatric PCPs recognize the critical role they play in supporting gender-diverse youth and their families, particularly around normalizing conversations about gender identity. However, multiple individual and clinic-level barriers to asking about pronouns and gender identity remain. These results highlight the continued need to provide resources, education and support to PCPs in discussing these topics in the primary care setting to facilitate access to time-sensitive gender-affirming care.

Sources of Support: This project was supported by the Seattle Children's Research Institute Career Development and AHRQ K12HS026393-03 (PI: Sequeira).

43.

THE USE OF DISCRETIONARY POWER OF PARENTS, TEACHERS, PHYSICIANS IN ENACTMENTS OF STRUCTURAL VIOLENCE AGAINST TRANSGENDER AND NONBINARY YOUNG PEOPLE DURING CHILDHOOD AND ADOLESCENCE

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Purpose: Transgender and nonbinary children and adolescents experience complex risks for violence (e.g., physical, sexual, structural) targeting them in all aspects of their social environments (e.g., home, school, healthcare). These risks can be mitigated by affirming parents, teachers, peers, and healthcare professionals. While these risks and mitigating factors for violence are becoming broadly understood, little is known about when these factors develop during childhood and adolescence. This study aimed to explore how violence against transgender and nonbinary young people emerges during their childhood and adolesence and from which areas of their social ecologies.

Methods: Twenty-two transgender and nonbinary young people ages 18-29 participated in two-hour life history interviews describing their experiences of violence and gender development during childhood, adolescence, and young adulthood. Participants were recruited nationally and interviewed via Zoom. Interview transcripts were qualitatively coded using abductive grounded theory to assess for patterns in relation to the study purpose.

Results: A major pattern to emerge from the qualitative analysis revealed the unique and critical role of the discretionary (decision-making) power of adult authority figures in granting or denying access to safety, resources, and affirming healthcare. Participants described gender-rejecting parents using their authority during participants' childhood and adolescence to surveil and/or deny participants' access to privacy, freedom of movement, healthcare, and connections to social networks (e.g., friends, phone, social media, email, the internet). Participants whose healthcare was covered by parents' insurance during young adulthood were especially vulnerable to parent's discretionary violence in denying them gender-affirming healthcare even as adults. Teachers were described as using their authority to excessively discipline participants for their gender identities, resulting in hostile and stressful school environments and loss of educational opportunities. Participants described experiences when physicians would deny the participant's gender and therefore deny gender-affirming healthcare. Physicians were also described using their authority to pathologize the participant's gendered behavior, resulting in involuntary hospitalizations, over-medicating participants, and ignoring or missing signs of abuse and neglect.
Conclusions: These findings contribute to the growing literature demonstrating the clear role of social environments in the health and wellbeing of children and adolescents, specifically transgender and nonbinary young people. During childhood and adolescents, transgender and nonbinary youth are particularly vulnerable to the decisions made by those adults with power over them. Physicians, teachers, parents, and other adult authority figures have a duty to protect vulnerable youth and this duty starts with managing their own decision-making powers. Parents, teachers, and physicians need clear education on how their decisions to affirm or reject transgender and nonbinary young people can have a direct impact on their health and wellbeing.
Sources of Support: University of California President's Dissertation Year Fellowship; SHARE Program at University of California, Berkeley.

44.

EXPANSION AND INTEGRATION OF A NOVEL LGBTQ+ CURRICULUM INTO THE PRE-CLINICAL MEDICAL EDUCATION AT A MIDWESTERN SCHOOL

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Purpose: An estimated 4.5% of the US population identifies as LGBTQ+, and significant health disparities exist due to discrimination. Despite high prevalence, there is limited training in medical schools in LGBTQ+ healthcare. To address this educational gap, a curriculum, which was previously piloted with volunteer students (N=29), was integrated into the second year clinical skills course in order to increase knowledge of LGBTQ+ health issues and improve comfort with taking an inclusive sexual history. This study examines the impact of the now mandatory curriculum on the students' knowledge, attitude, and perspective regarding the LGBTQ+ population.
Methods: The required curriculum included implicit bias testing, one hour lecture, standardized patient encounters with feedback, and a debrief session with faculty. Medical students participating in this experience were recruited for an evaluation of the program via voluntary survey. Data were collected anonymously via surveys pre- and post-curriculum, and participants were assigned a unique identifier to measure the individual effect. Demographic data including year of training, age, race/ethnicity, gender identity, and sexual orientation were collected. Student comfort discussing sexual orientation and gender identity and perceived preparation for taking an inclusive sexual history and providing care for LGBTQ+ patients was assessed via Likert scale (scale 1 [strongly disagree] through 5 [strongly agree]). Additional data were collected on student's perception of the curriculum meeting learning objectives such as learning strategies for creating a safe space and understanding the spectra of gender identity and sexual orientation. Descriptive feedback was also collected on the educational intervention. This data was subsequently analyzed using SPSS version 24. This project was approved by the institutional IRB and was supported by a grant through the University of Oklahoma College of Medicine Academy of Teaching Scholars.
Results: 78 second year medical students completed both pre- and post-surveys. Statistical improvements in student scores post-curriculum were observed with all p-values <0.001 including comfort in: discussing sexual orientation (pre 3.47, post 4.26), discussing gender identity (pre 3.22, post 4.23), and collecting an inclusive sexual history (pre 2.92, post 4.21). Students felt that the learning goals and objectives were met, with mean scores for each objective greater than 4.0. Students reported a high overall satisfaction with the curriculum (mean 4.42, SD 0.57).
Conclusions: This now mandatory curriculum successfully improved student comfort levels in collecting an inclusive sexual history, and there was high student satisfaction with the curriculum.
Sources of Support: This project was supported by a grant through the University of Oklahoma College of Medicine Academy of Teaching Scholars.

45.

BUILDING COMPETENCY IN GENDER INCLUSIVE HEALTHCARE: AN INNOVATIVE VIRTUAL CURRICULUM

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Purpose: The COVID-19 pandemic has challenged the health care and education systems on all fronts: safely providing care for patients, restructuring how care is delivered, and rapidly innovating to deliver stimulating medical education via tele-technology. The pandemic also highlighted multiple health disparities, resulting in an urgent call to action to promote health equity. In response to these challenges, the New York State (NYS) Clinical Education Initiative (CEI) Sexual Health Center of Excellence developed a video-based educational curriculum entitled, "Building Blocks for Trans & Gender Diverse Care." The curriculum aims to guide clinical providers to create a practice space for delivering care that is gender affirming and inclusive.
Methods: The curriculum provides a quick, easy to access, graduated learning experience that engages learners at multiple levels. Content includes foundational concepts and terminology, creating inclusive healthcare spaces and non-stigmatizing encounters. It also offers