



Sexual health programming for vulnerable youth: Improving knowledge, attitudes, and behaviors



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ABSTRACT

Purpose: Among girls in foster care, 48% become pregnant at least once by age 19 (Dworsky & Courtney, 2010). Youth in or at-risk for foster care (YFC) report limited knowledge about, access to, and use of condoms; ambivalent attitudes towards teen parenting; and participation in other risky behaviors. For the current study, we adapted and supplemented an evidence-based sexual health program called SiHLE, using a systematic adaptation framework (ADAPT-ITT, Wingood & DiClemente, 2008), to address the unique and targeted needs of youth living in a temporary shelter due to lack of housing. Youth in this study were either in foster care and awaiting placement, or having serious family problems and were at-risk of entering the foster care system.

Methods: Thirty-six youth participated in SiHLE-YFC during their stay at a temporary shelter. Four 90-minute sessions focused on increasing sexual health knowledge, improving attitudes towards and self-efficacy of condom use, and developing core skills such as problem-solving and communication.

Results: As hypothesized, youth showed high satisfaction with the intervention and significant improvement in sexual health knowledge from pre to post. At one-month follow-up, youth continued to show significant improvement in sexual health knowledge, along with a significant reduction in risky sexual behaviors. Though not significant, there were moderate effect sizes for changes in attitudes towards teen pregnancy and condoms. There were no changes in attitudes towards teen parenting.

Conclusion: Taken together, findings suggest that sexual health education directly targeting the unique needs of YFC may improve sexual health knowledge and behavior, and are discussed in the context of challenges associated with intervention and research with this population.

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1. Introduction

Nearly half of 500,000 youth in foster care are adolescents at risk for poor mental health outcomes (Child Welfare Information Gateway, 2015). Compared to children not in foster care, they are more likely to report histories of trauma, live in poverty, and come from families who experience multiple stressors (Connell, Bergeron, Katz, Saunders, & Tebes, 2007; McGuinness & Schneider, 2007). This may be exacerbated further following placement outside of the home, leading to disruption of family, peer, and community relationships (Boonstra, 2011; Cunningham & Diversi, 2013). These vulnerabilities, in turn, place youth at risk for unhealthy trajectories characterized by sexual risk-taking, STDs, teen pregnancy, mental health problems, substance abuse problems, and juvenile justice involvement. The risk for teen pregnancy, in particular, significantly exceeds the risk of their peers not involved in foster care (Dworsky & Courtney, 2010) with rates reaching up to 50% by the time they age out of the system. Despite these alarming rates,

there are currently no evidence-based sexual health programs specially designed to leverage the strengths or mitigate the unique risks for youth in care.

1.1. Sexual health among youth in foster care

Adolescence has long been recognized as a period of enhanced risk-taking (World Health Organization, 2012). Despite a decrease in early onset of sex and increase in contraceptive use in the past 10 years, approximately 50% of US high school youth have had sexual intercourse, and about 6% of them had their first experience before age 13; this rate rises to 13% for African American youth (Eaton et al., 2012) and to 20% for youth in foster care (James, Montgomery, Leslie, & Zhang, 2009). Significant interest in sexual risk taking among youth in foster care is represented by two decades of epidemiological studies examining national (Carpenter, Clyman, Davidson, & Steiner, 2001; Pecora et al., 2003) and regional data (e.g., Courtney & Dworsky, 2006; Dembo, Schmeidler, & Childs, 2007) in addition to a smaller number of outcome studies (Slonim-Nevo, 2001; Slonim-Nevo, Auslander, Ozawa, & Jung, 1996). Youth in foster care experience disproportionately higher rates of teen pregnancy (Winter, Brandon-Friedman, & Ely, 2016). Studies

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point to older age, history of sexual abuse, and externalizing problems as the most robust predictors of sexual risk-taking (Ramseyer Winter, 2016). Amid persistent controversy regarding whether or not youth with a history of foster care placement engage in more risky sexual behaviors, compelling data point to earlier sexual initiation and more sexual partners as risk factors (e.g., Ahrens, Stansell, & Jennings, 2010; Boonstra, 2011; Carpenter et al., 2001; Gramkowski et al., 2009; James et al., 2009; Ramseyer Winter, 2016). Despite reductions in teen pregnancy nationwide, pregnancy rates among foster care girls also remain high, more than double those of their peers (Courtney, Terao, & Bost, 2004). Nearly half (48%) become pregnant by age 19 and 30% by age 17 (Dworsky & Courtney, 2010) compared to 20% and 13.5% of teens in a national sample (Harris et al., 2009), and repeat pregnancies are also frequent and disproportionate (Dworsky & Courtney, 2010; King, Putnam-Hornstein, Cederbaum, & Needell, 2014; Putnam-Hornstein & King, 2014).

Consequences of teen parenting are well documented, and include social, economic, school and emotional problems for mother, father, and baby. Mothers are less likely to complete high school (Fergusson, Woodward, & Horwood, 2000; Hofferth, Reid, & Mott, 2001), more likely to receive public aid (Sarri & Phillips, 2004), and are at higher risk for depression including post-partum depression (Figueiredo, Pacheco, & Costa, 2007; Patel & Sen, 2012; Schmidt, Wiemann, Rickert, & Smith, 2006). Teen fathers also have lower school attainment and fewer job opportunities, greater psychological difficulties and higher risk for delinquency (Bunting & McAuley, 2004; Stouthamer-Loeber, Loeber, Wei, Farrington, & Wikström, 2002). Babies born to teen parents are more likely to be born premature or low birth weight, abused, end up in state care, have poor cognitive development and more behavioral problems (McFarlane, Parker, & Soeken, 1996; Connelly & Straus, 1992). Boys born to teen parents are more likely to be incarcerated and girls born to teen parents are more likely to become teen mothers compared to children born to adult mothers (Rafferty, Griffin, & Lodise, 2011; Terry-Humen, Manlove, & Moore, 2005). For youth in foster care, negative consequences of teen parenting may be exacerbated by their lack of family support and structure. According to 2011 national statistics, costs associated with teenage pregnancy equaled \$9.4 billion, reflecting increased healthcare, foster care, incarceration of children of teen parents, and lost tax revenue because of low employment among teen mothers (Martin, Hamilton, Osterman, Curtin, & Mathews, 2013).

1.2. Sexual health and pregnancy prevention for youth in foster care

Goesling, Colman, Trenholm, Terzian, and Moore (2014) offer a thorough and systematic review of 31 evidence-based adolescent sexual health programs. Of these, 22 had a statistically significant impact on youth sexual activity, six did not have an impact and three did not measure sexual activity as an outcome. Among other outcomes measured, 14 of 22 had a statistically significant positive impact on contraceptive use and five of five had a statistically significant positive impact on rates of STD and pregnancy or birth outcomes. Although programs use different strategies or target different age groups, genders, ethnic or special risk groups, most sexual health interventions include a set of common elements that are hypothesized to facilitate improvements in attitude or behavior.

Effective sexual health programs actively engage youth; provide developmentally appropriate knowledge; shape attitudes, norms, and self-efficacy; and teach behavioral skills such as goal-setting, problem-solving, and communication (Albarracín et al., 2005; Boustani, Frazier, Becker et al., 2015; Kågesten, Parekh, Tunçalp, Turke, & Blum, 2014; Rotheram-Borus et al., 2009). Some have been designed with close attention to the unique needs of particular groups, such as Assisting in Rehabilitating Kids (St. Lawrence, Crosby, Brasfield, & O'Bannon, 2002) for youth abusing substances; Project IMAGE (Champion & Collins, 2012) for ethnic minority adolescent females with a history of abuse and STDs; Safer Sex (Shrier et al., 2001) for youth who have a history of

STDs; Rikers Health Advocacy Program (Magura, Kang, & Shapiro, 1994) for incarcerated youth; and SiHLE for African-American heterosexual females (DiClemente et al., 2004). Despite well-documented elevated and persistent rates of sexual risk-taking and pregnancy among youth in foster care, their unique needs have been left unaddressed by currently available programs. We propose that the literature points to the following unique needs for youth in foster care: (a) lack of knowledge, access, and use of condoms, (b) ambivalence about teen parenting, and (c) broader vulnerability for high-risk behaviors (Fig. 1).

1.2.1. Lack of knowledge, access, and use of condoms

Foster youth report that sexual health information is available too late (Boustani, Frazier, Hartley, & Meinzer, 2015; Dworsky & DeCoursey, 2009; Kirby & Laris, 2009; Love, McIntosh, Rosst, & Tertzakian, 2005). Perhaps because sexual initiation occurs earlier among foster youth compared to non-foster peers (Hoffman, 2006), they are already sexually active by the time they first receive any information about birth control (Love et al., 2005). Youth have too little information, misinformation, and concerns that condoms might ruin the mood or decrease pleasure (Love et al., 2005). Foster care youth also cite that they either find it challenging to access condoms and general sexual health care, or they are afraid or embarrassed to seek it (Leonard, Dixon, Fantroy, & Laffert, 2013; Freundlich, 2003).

1.2.2. Ambivalence about teen parenting

Furthermore, although many teen pregnancies are unplanned, up to 35% of them are intended (Hacker, Amare, Strunk, & Horst, 2000; Leonard et al., 2013). Vulnerable teens, such as youth in foster care or at-risk for foster care, may perceive that advantages of having a baby to outweigh the costs (Love et al., 2005; Boustani, Frazier, Hartley et al., 2015). Desire for pregnancy is associated with family dysfunction and lack of family connectedness (Boustani, Frazier, Hartley et al., 2015; Hacker et al., 2000) that often characterizes foster care youth. Youth report several reasons for getting pregnant such as wanting to heal childhood wounds or obtain emotional closeness (e.g., with the baby or baby's father; Boustani, Frazier, Hartley et al., 2015; Gordon, 1996; Love et al., 2005; Virginia Teen Pregnancy Prevention). Others report that having a baby may facilitate their exit from the child welfare system and access to independent living (Boustani, Frazier, Hartley et al., 2015; Davies et al., 2003; Stevens-Simon, Kelly, Singer, & Cox, 1996).

1.2.3. Broader vulnerability for high-risk behaviors

Youth in foster care are at disproportionate risk for a trajectory of co-occurring negative outcomes. Epidemiological statistics reveal overall heightened prevalence of mental illness, with mental health disorder rates as much as two and a half times higher than community samples (e.g.: Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Trupin, Tarico, Low, Jemelka, & McClellan, 1993). More recent reports show 28% (Auslander et al., 2002) to 51.1% (James et al., 2009) of youth in care meet clinical cutoffs on standardized measures of externalizing behavior problems, and 25% meet cutoffs for internalizing problems (James et al., 2009); rates more than double those of community samples (<http://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml>) and higher than children living in poverty (Heneghan et al., 2013; Masi & Cooper, 2006; McMillen et al., 2005). Finally, substance abuse and delinquency are widespread (James et al., 2009).

1.3. Current study

We propose that currently available evidence-based sexual health interventions are necessary but not sufficient for vulnerable youth, such as youth in foster care, child welfare involved youth or youth with poor family attachment or at-risk for foster care (we will refer to them as YFC – Youth in or at-risk for foster care) for the following reasons: 1) Programs don't address the ambivalence about teen parenting;

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