African American Female Adolescents' Perspectives Regarding Their Sexual and Reproductive Health Needs While in Foster Care: A Qualitative Descriptive Study

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Abstract

Sexually transmitted infections (STIs) and unintended pregnancy have been a significant issue in the United States and youth of color are significantly affected. Vulnerable youth, such as youth in foster care who have experienced adverse childhood events (ACEs) are at an increased risk for experiencing negative sexual and reproductive health (SRH) outcomes. A gap in knowledge exists regarding the perspectives of female African American Adolescents in foster care about their SRH. This descriptive qualitative study used primary data from 16 adolescents to explore and describe older adolescents with a history of foster care placement perspectives regarding the complex factors that contribute to their SRH disparities. Findings indicated that youth perceived a lack of support, yearned for connection and often learned about SRH independently. History of sexual abuse, reproductive coercion, and perceived judgmental caregivers were some factors that made it challenging for youth to protect themselves against SRH risks. Contrary, open communication with caregivers, abstinence, and the self-desire to be healthy were some health-protective factors identified. This dissertation adds knowledge regarding youth's perspectives on SRH communication. Findings will provide direction on how health-care providers, child welfare workers, policymakers, community leaders, and caregivers can better support the SRH of youth in care.

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Chapter 1

Introduction: Background and Problem Statement

Unintended teenage pregnancy and sexually transmitted infections (STIs) have been affecting ethnic minority populations significantly for many years in the United States (U.S.) (CDC, 2018). Despite the downward trend of unintended pregnancies, in 2017, there were 194, 377 children born to females in the 15 to 19 year old age group and African American teens had the second highest rate, which was 27.5 cases per 1,000 females, 2 times higher than non-Hispanic white teens (13.2 cases per 1,000) (CDC, 2018; Martin, Hamilton, & Osterman, 2018). STIs such as Chlamydia, Gonorrhea, and Syphilis markedly affect African Americans, who in 2017 had the highest rates (CDC, 2018). For Chlamydia, the rate was 5.6 times the rate among Whites (1,175.8 and 211.3 cases per 100,000 population, respectively) (CDC, 2018). In 2017, there were 555,608 reported cases of Gonorrhea in the U.S. and African Americans had the highest rate (548.1 cases per 100,000 population), which was 8.3 times the rate among White individuals with a reported 66.4 cases per 100,000 population (CDC, 2018). For Syphilis, in 2017, there were 30, 644 cases (9.5 cases per 100,000 population), and African Americans had the highest rate (24.2 cases per 100,000 population), which was 4.5 times the rate among Whites (5.4 cases per 100,000 population) (CDC, 2018).

In addition to STIs significantly affecting African Americans, youth in general are also significantly affected. Adolescents had the highest rate of Chlamydia, where two thirds of reported cases (528.8 cases per 100,000) were from individuals between 15- 24 years old (CDC, 2018). In 2017, rates of reported gonorrhea cases continued to be highest among adolescents and young adults, where the highest rates were among females 20–24 years (684.8 cases per 100,000

females) and 15–19 years (557.4 cases per 100,000 females) (CDC, 2018). Syphilis had the highest rate among women aged 20 to 24 years (7.8 cases per 100,000 females) (CDC, 2018).

Given the previously listed statistics, research indicates that adolescents in foster care engage in sexual behaviors that put them at risk for STIs and unintended pregnancy at higher rates, in comparison to adolescents not in foster care. In a Midwest study of youth in foster care, more than 90 percent of adolescents reported having sexual intercourse and about 60 percent of them used contraception (Courtney, Dworsky, Ruth, Havlicek, Perez, & Keller, 2007). Females were also more likely to ever have had sexual intercourse, engage in risky behaviors that placed them at risk for pregnancy, and contract an STI in comparison to female youth not in foster care (Courtney et al., 2007). Female adolescents in foster care are also more likely to receive payment in exchange for sex and also less likely to use birth control in comparison to female adolescent youth not linked to foster care (Courtney et al., 2007).

Female adolescents who are not in foster care obtain information about SRH from sources such as peers, media, school, and their biological parents (Aronowitz, Rennells, & Todd, 2006; Aronowitz, Todd, Agbeshie, & Rennells, 2007; King Jones, 2010). Adolescents who spoke to their biological parents about SRH topics were less likely to engage in risky sexual behaviors (Aronowitz, Todd, Agbeshie, & Rennells, 2007). According to Harris, Sutherland and Hutchinson (2013), adolescents who had both parents present were more likely to use condoms and felt optimistic about their ability to engage in safe sexual health practices. Despite elevated rates of STIs and unintended teenage pregnancy in adolescents in foster care, research among this population is scarce and we do not fully understand how adolescents who are in the foster care system and away from their biological parents obtain information about SRH.

Adolescents in foster care are a unique population with complex issues due to their traumatic history and adverse childhood experiences (ACEs), multiple foster care placements, and high risks for negative SRH health outcomes. Children are removed from their homes and placed into the foster care system due to adverse childhood experiences (ACEs) such as findings of neglect, abandonment, various forms of abuse, and other factors which endangered the health and safety of the child (Virginia Department of Social Services, 2016; Childwelfare.gov, n.d).

Adolescents with a history of ACEs can experience challenges related to behavioral problems (Crosby, Day, Baroni, & Somers, 2015;Thompson & Auslander, 2011) and psychiatric risk factors (Greeson, et al., 2011; Jackson, O'Brien & Pecora, 2011; Thompson & Hasin, 2012; Harpin, Kenyon, Kools, Bearinger & Ireland, 2013; Salazar, Keller, Gowen & Courtney, 2014).Therefore, research and evidenced based interventions should be specifically tailored to them. In a study with about 400 child welfare providers from 12 agencies in Chicago, 59% reported being inadequately prepared to address health care issues directly related to youth in foster care, such as pregnancy prevention (Love, McIntosh, Rosst, & Tertzakian, 2005). Furthermore, there are 42 sexual health intervention programs listed with the U.S. Department of Health and Human Services Office of Adolescent Health; they are not tailored for adolescents in foster care, but designed for adolescents in general (The Office of Adolescent Health, U.S. Department of Health and Human Services, 2016). Limited research evidence regarding the SRH of female African American adolescents in foster care limits their ability to have resources allocated to them. It is important to fill the gaps in knowledge that exists in relation to the perspectives of female African American adolescents in foster care about their SRH.

Purpose of the Study

The purpose of this qualitative descriptive study was to explore and describe the multiple complex factors that contribute to SRH disparities for female African American youth in foster care from their perspectives. A greater understanding of these contributing factors, including how they obtain information about SRH, their trusted source(s) for receiving this information, and what they perceive would be helpful to them were gaps this study intended to fill.

Specific Aims

Specific aims for the study were to:

Aim 1. Identify the perceived SRH needs of African American female adolescents in foster care.

Aim 2. Describe their perceived risks and strengths (developmental assets) that may influence their SRH.

Aim 3. Explore contextual factors, including communication with foster caregivers, that relate to decision making and choices regarding sexual behavior.

Theoretical Underpinnings

In qualitative descriptive studies, because a naturalistic inquiry is often used, theories will often serve as a foundational basis where the researcher will use an existing theory to help understand a phenomenon or use it to help drive the future direction of the study (Sandelowski, 2009). In trying to understand how vulnerable youth who faced adversity can go on to be resilient and have optimal outcomes, various theories were examined. One theory was the resilience theory, which helps us to understand how youth overcome risk exposure and promotes the use of interventions that focuses on a strength-based approach (Zimmerman et al., 2013). Despite various exposures to risks, youth have the potential to be healthy adults (Masten, 2018; Zimmerman et al., 2013). Under resilience theory, youth are able to be resilient when promotive factors such as individual, environmental, and social aspects interrupt their trajectory from risk to

negative outcomes, leading to a positive outcome/alternative (Fergus & Zimmerman 2005), Instead of focusing on the exposure to risks, adversities, or deficits of youth, resilience theory primarily focuses on the youth's strength (Zimmerman et al., 2013). Promotive factors are also further classified as assets or resources, where assets are the adolescents' internal strengths such as efficacy, identity, and preparedness for the future (Zimmerman et al., 2013; Fergus & Zimmerman 2005). Resources are the external factors such as relationships with adults, adult mentors, and opportunities for community involvement (Zimmerman et al., 2013). Under resources, resilience theory addresses the importance of relationships with adults, as they have the opportunity to provide connection, support, and positive guidance for the youth to help them avoid risks (Zimmerman et al., 2013).

Resilience theory serves as a foundation or precursor of the Positive Youth Development theory, which is a strength based theory also and incorporates the internal assets of the youth and external factors to help them avoid risks and have positive outcomes. The Positive Youth Development (PYD) Theory was used to underpin the study. PYD is a strength-based theory that focuses on the strengths of adolescents and seeks to amplify the assets of youth for their positive development (Lerner & Lerner, 2011). PYD theory stemmed from the ecological systems theory and has roots in the realm of positive psychology (Lerner & Lerner, 2011). Additionally, the following theories serve as the basis for PYD: human development theory explains the capacity of youth to change in a direction that fosters individual well-being and the social good, and in what specific conditions and context they are able to change (Benson, Scales, Hamilton, & Sesma, 2006). The theory of context and community influence incorporates Bronfenbrenner's ecological theory, which was developed to illustrate how youth and their environment interact, influencing how the youth will eventually develop (Benson et al., 2006). The third theory of

context and community change involves processes and strategies that can impact contexts and community by engaging adults who can build relationships with children and youth and the context of families, neighborhoods, schools and youth organizations to activate youths' asset-building potential (Benson et al., 2006).

Historically, researchers in the realm of developmental psychology have often focused on the deficits of adolescents and omitted consideration of their assets (Futch Ehrlich, 2016). The failure of researchers to view adolescents through a positive lens serves as a disservice and injustice to youth by framing them in a limited and negative context (Futch Ehrlich, 2016). PYD theory enables youth to be viewed positively, where adolescents are seen as individuals who have the capacity to thrive based on their internal assets with support from external assets, and have potential for positive development (Bruner, Eys, Wilson, & Côté, 2014).

The premise of PYD is that young people are seen as assets because they possess various internal assets that enable them to thrive (Futch Ehrlich, V. 2016). Additionally, when their internal assets and external assets are aligned, the outcome of that youth's positive development is even more possible and successful (Futch Ehrlich, V. 2016). Some internal assets youth may possess include a commitment to learning, which involves their engagement in school, and positive values, which includes being caring, honest, and responsible. External assets include having strong family support, a caring school environment, and other significant adult support and community resources. PYD occurs when a young person is able to have their internal assets complemented with external assets that support their wellbeing and desired positive development (Development, 2018).

Consistent with PYD, the study was conducted with lens for social justice and change. A social justice lens was used in order to bring about social change to address various disparities

that exist which limits the way resources are currently allocated to youth in foster care. The end goal is to bring about change, equity, and human rights (Denzin & Lincoln, 2011).

Operational Definitions

Foster Care

Foster care is a temporary living solution provided for children and youth who cannot live with their biological parents due to adverse findings of neglect, abandonment, various forms of abuse, and other experiences which endangered the health and safety of the child (Virginia Department of Social Services (VDSS), 2016; Childwelfare.gov, n.d; 2006 Code of Virginia § 63.2-100 - Definitions, 2016). Children in foster care often reside in a family foster care arrangement or a treatment foster care setting (therapeutic foster care). Children or youth in family foster care settings live with biological or non-biological caregivers who have been approved by the state to offer care and shelter for them (Childwelfare.gov, n.d.). Treatment foster care parents have specialized training to take care of children and youth who have substantial emotional, behavioral, and social issues or medical needs (Childwelfare.gov, n.d.).

In addition to being classified as family foster care or treatment foster care, there are a variety of placement settings where the children or youth can reside in such as group homes, residential care facilities, emergency shelters, and supervised independent living (Childwelfare.gov, n.d.). The foster care system is in place to allow caregivers to provide a safe, stable, and nurturing environment that will then promote the child's positive development (VDSS, 2016).

The foster care system is home to a substantial number of children and every year the number of children entering foster care continues to increase. Based on reports as of October 2017, the number of children living in foster care every year has been increasing since 2012. For

the fiscal year ending on September 2016, there were 437, 465 children in foster care in the U.S., of which 191, 433 (44%) were White, 101, 825 (23%) were Black or African American (AA), and 91, 352 (21%) were Hispanic children (Adoption & Foster Care Statistics, 2017). Since 13.8% of the U. S. child population is Black or African American, it is noteworthy that this racial group is overrepresented in the foster care population (Federal Interagency Forum on Child and Family Statistics, 2017). Of the total population of children in foster care, 138, 243 (32%) of them were between the ages of 12 to 20 years old (Adoption & Foster Care Statistics, 2017).

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) refers to abuse, neglect, household challenges and other traumatic events or experiences individuals under the age of 18 years old experienced (CDC, 2019). Abuse can be in the form of emotional, physical, and sexual, while neglect can range from emotional to physical neglect (CDC, 2019). Based on social and economic situations, some children are more vulnerable to experience ACEs (CDC, 2019). History of ACEs has lasting effects such as a negative impact on brain development and function, mental health challenges, SRH risks and infectious diseases, chronic disease, and involvement with risky behaviors (CDC, 2019).

Sexual and Reproductive Health (SRH)

Sexual and reproductive health (SRH) is defined as a person's overall physical, emotional, mental, and social wellbeing as it relates to every aspect of sexuality and reproduction (Starrs et al., 2018). For adolescents, SRH encompasses pubertal changes to the body, sexual behavior, sexual orientation, gender identity, and how adolescents protect themselves from unintended pregnancy and sexually transmitted infections (STIs). SRH promotion is an important priority for women as it strives to address issues such as gender equality, empowerment, and

maternal, child, and adolescent health in order to promote positive health outcomes (Starrs et al., 2018).

Relevant Foster Care Personnel

Foster Care Caregivers. This term specifically refers to caregivers youth had while in foster care such as a state appointed foster mother, foster father or both. These individuals are responsible for providing a safe and nurturing environment for the youth.

Foster Care Staff. Foster care staff are individuals who work in various foster care residential facilities such as group homes, institutions or facilities, where numerous youths reside. Staff are responsible for the ongoing care and safety of everyone in the setting and often play a supervisory role.

Social Worker. Social workers support children and families in the foster care system by ensuring that their needs such as nourishment, living conditions, and optimal development are being met. Social workers are also responsible for ensuring adverse reports while in foster care are investigated and that children and family have resources allocated to them (Foster Care Social Worker, n.d.).

Dissertation Overview and Organization

This dissertation represents a synthesis of scholarly work on the SRH of African American female adolescents in foster care. It begins by looking at the state of the science related to the ACEs of African American youth in foster care. To my knowledge, this dissertation is the first to analyze data from interviews using qualitative descriptive methodology to explore the perspectives of female African American adolescents with a history of foster care placement regarding their SRH needs. This dissertation described relationships youth had with

foster care caregivers, how youth learned about SRH, communication about SRH, and how youth protected themselves from SRH risks while in care.

This dissertation is formatted according to the University of Virginia, School of Nursing's manuscript option. The "Manuscript Dissertation Option" includes the following six chapters: Chapter One is the introduction; Chapter Two is the dissertation proposal, which was presented to the committee and revised as requested; Chapter Three is an integrative literature review on the impact of childhood trauma on African American adolescents in foster care, a manuscript to be submitted to the *Child Welfare Journal*, a journal of the Child Welfare League of America; Chapter Four is a manuscript related to the participants' perceptions of limited support during care, their internal assets, sources for SRH information, and perspectives on SRH communication, to be submitted for publication to the *Journal of Adolescent Research*; Chapter Five is a manuscript, which focused on the theme " Protection from SRH Risks" and described how SRH risks were avoided, factors that made it challenging, and protective strategies to avoid risks, to be submitted to the *Children and Youth Services Review*; Chapter Six includes the discussion and conclusions of the dissertation.

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Chapter Two: Revised Dissertation Proposal

Project Summary/Abstract:

Sexually transmitted infections (STIs) and unintended pregnancy have been problems in the United States for many years. Recently, at the National STD Prevention Conference in Washington, D.C, the Center for Disease Control (CDC) issued preliminary findings which indicated that Gonorrhea rose 67% from 2013 to 2017, while Syphilis rose 76% from 2013 to 2017 ("Press Release 2018 STD Prevention Conference | 2018 | Newsroom | NCHHSTP | CDC", 2018). In 2017, there were 1.7 million new cases of chlamydia and 45% of those cases were sexually active females between the ages of 15 and 24 years (CDC, 2018). Interestingly, female African American adolescents in foster care are at an increased risk for unintended pregnancy and high-risk sexually transmitted infectious (STI) behaviors, in comparison to adolescents not in foster care. Approximately 48% of adolescent females in foster care have been pregnant by age 19 in comparison to 27% of adolescent girls in general, and are twice likely to have had sex and not use contraception in comparison to their peers not associated with foster care ("Briefly", 2015). Despite negative outcomes such as elevated rates of STIs and unintended teenage pregnancy related to adolescents in foster care, research among this population is scarce.

Female adolescents who are not in foster care reported learning about sexual and reproductive health (SRH) related topics from peers, media, school, and their biological parents (Aronowitz, Rennells, & Todd, 2006; Aronowitz, Todd, Agbeshie, & Rennells, 2007; King Jones, 2010). Adolescents who spoke to their biological parents about SRH topics were also less likely to engage in risky sexual behaviors (Aronowitz, Todd, Agbeshie, & Rennells, 2007). What we do not fully understand is how do adolescents who are in the foster care system and away from their biological parents obtain information about SRH.

Due to limited research, it is imperative for us to fill the gaps in knowledge that exists in relation to the perceptions of African American/Black adolescent females in foster care about their SRH, the multiple and complex factors that contribute to their SRH disparities, how they obtain information about SRH, their trusted source for receiving this information, and what would be helpful to them. After we obtain more information from these youth in foster care about their SRH, that information can then be used to inform our next steps towards policy development and resources allocation.

Specific Aims

Foster care is a temporary living solution provided by the state for children and youth who cannot live with their biological parents. Children are removed from their homes and placed into the foster care system due to adverse childhood experiences (ACEs) such as findings of neglect, abandonment, various forms of abuse, and other factors which endangered the health and safety of the child (Foster Care (VDSS), 2016). As of September 2016, there were 437, 465 children in foster care in the U.S., of which 191, 433 (44%) were White, 101, 825 (23%) were Black or African American (AA), and 91, 352 (21%) were Hispanic children (Adoption & Foster Care Statistics, 2017). Black children represented the second largest ethnic group in foster care. Of the total population of children in foster care, 138, 243 (32%) of them were between the ages of 12 to 20 years old (Adoption & Foster Care Statistics, 2017).

Many youth in foster care are at greater risk of experiencing negative social and health outcomes in comparison to adolescents without a history of foster care placement. Outcomes include challenges related to behavioral problems, psychiatric risk factors, self-harm, substance abuse, and involvement with the legal system. Adolescents with a history of foster care placement are also at an increased risk for unintended pregnancy, involved with high-risk HIV

behaviors and engage in unprotected sexual behaviors (Thompson & Auslander, 2011 & Gramkowski, Kools, Paul, Boyer, Monasterio et. al., 2009). In terms of STIs, African Americans have gonorrhea rates that are 30 times higher than their White counterparts (CDC, 2015) and African American women are also at highest risk for genital herpes (CDC, 2015).

Despite these negative sexual and reproductive health (SRH) outcomes related to adolescents in foster care, research among this population related to SRH is scarce. It is evident that in comparison to adolescents in general and White youth, African American females in foster care are markedly affected by SRH outcomes negatively. However, elevated rates of STIs and teenage pregnancy are not trending down and there continue to be a limited amount of specifically tailored resources and interventions primarily for adolescents in foster care. Lack of research evidence regarding the SRH of female African American/Black adolescents in foster care limits their ability to have resources allocated to them because evidence-based practices often drive policy development and implementation. As a result, it is imperative for us to fill the gaps in knowledge that exist in relation to the perceptions of female African American/Black adolescents in foster care about their SRH, the multiple and complex factors that contribute to their SRH disparities, how they obtain information about SRH, their preferred means of receiving this information, and what would be helpful to them. After we obtain more information from youth in foster care about their SRH, that information can then be used to inform our next steps towards policy development and resources allocation.

The major objective of this proposed qualitative descriptive study is to explore and describe the multiple factors that contribute to female African American/Black youth in foster care SRH disparities from their perspectives. This study aims to: **1) Identify their perceived SRH needs; 2) Describe their perceived risks and strengths (developmental assets) that may**

influence their SRH; and 3) Explore contextual factors, including communication with foster caregivers, that relate to decision making and choices regarding sexual behavior. In-depth interviews of adolescents with a history of foster care placement will be used to gain adolescents' perceptions regarding their SRH. Data will be analyzed using thematic analysis to understand the subjective experiences of these young women and drive future policy changes and interventions.

Research Strategy

a. Significance

The Context of Foster Care

Children in foster care often reside in a family foster care arrangement or a treatment foster care setting (therapeutic foster care). Children or youth in family foster care settings live with biological or non-biological caregivers who have been approved by the state to offer care and shelter for them (Childwelfare.gov, n.d.). Treatment foster care parents have specialized training to take care of children and youth who have substantial emotional, behavioral, and social issues or medical needs (Childwelfare.gov, n.d.).

In addition to being classified as family foster care or treatment foster care, there are a variety of placement settings where the children or youth can reside in such as group homes, residential care facilities, emergency shelters, and supervised independent living (Childwelfare.gov, n.d.). The foster care system is in place to allow caregivers to provide a safe, stable, and nurturing environment that will then promote the child's positive development (Foster Care, 2016).

The foster care system is home to a substantial number of children and every year the number of children entering foster care continues to increase. During the fiscal year 2016, the

primary reason for children being placed in foster care was due to neglect, which 166, 679 (61%) of children faced, followed by parental drug abuse 92,107 (34%), and caretakers' inability to cope 37, 857 (14%) (Adoption & Foster Care Statistics, 2017). The majority of the children resided in non-biological foster family homes 196, 446 (45%), followed by 139, 017 (32%) living in biological foster family homes (Adoption & Foster Care Statistics, 2017). Additionally, the average age of entry into foster care is about 7.2 years, and the average length of time spent in foster care is 19 months as of September 2016 (Adoption & Foster Care Statistics, 2017). The primary goal of the foster care system is for the placement to be temporary and for the children to be reunified to their original family (Foster Care, 2016).

As of September 2016, 125, 975 (51%) of children were reunified with their parents, and 20,532 (8%) emancipated out of care (Adoption & Foster Care Statistics, 2017). For many youth in the foster care system, one of the biggest challenges that arise is placement stability, where children on average will reside in about three sites before aging out of care (Storer et al., 2014). Reunification or adoption is not always the outcome for many youth in foster care, as a result, the youth will be discharged from care due to emancipation 20, 532 (8%) (Foster Care, 2016). In addition to reunification, adoption, or emancipation, many youth with a history of foster care placement go on to face various negative outcomes.

Many youth in foster care are at greater risk of experiencing negative social and health outcomes in comparison to adolescents without a history of foster care placement. Outcomes include challenges related to behavioral problems (shutting down, isolation, lack of trust, and delinquent behavior) (Crosby, Day, Baroni, & Somers, 2015;Thompson & Auslander, 2011), psychiatric risk factors (increased risk for posttraumatic stress disorder, anxiety, increased levels of mental health distress, suicidal risk, more vulnerable to emotional and sexual abuse, affective

disorder, and at least one clinical psychological diagnosis) (Greeson, et al., 2011; Jackson, O'Brien & Pecora, 2011; Thompson & Hasin, 2012; Harpin, Kenyon, Kools, Bearinger & Ireland, 2013; Salazar, Keller, Gowen & Courtney, 2014), self-harm (suicidal ideation and attempts, more likely to engage in any HIV risk behavior, and more likely to engage in unprotected vaginal sex), substance abuse (consuming and abusing substances such as alcohol and Marijuana) (Pilowsky & Wu, 2007; Harpin et al., 2013; Thompson & Auslander, 2011), and involvement with the legal system (juvenile detention) (Yampolskaya, Armstrong & McNeish, 2011).

Sexual and Reproductive Health Outcomes of Youth in Foster Care

Youth in foster care are at greater risk for engaging in risky sexual behaviors, STIs, fathering a child, and teenage pregnancy. In a study of 320 adolescents in foster care, 70 participants who displayed delinquent behaviors were three times more likely to engage in any HIV risk behavior, and four and a half times more likely to engage in unprotected vaginal sex (Thompson & Auslander, 2011). Thompson and Auslander (2011) also indicated that adolescent females in foster care were more likely to engage in unprotected vaginal sex in comparison to males. In that same study of 320 adolescents, delinquent behaviors were associated with female adolescents being four and a half times more likely to engage in unprotected sex, which places them at risk for pregnancy (Thompson & Hasin, 2012). In one Midwest study of youth in foster care, more than 90 percent of the youth reported having sexual intercourse, most reported having sexual intercourse within the past year, and about 60 percent of the youth reported using contraception (Courtney, Dworsky, Ruth, Havlicek, Perez, & Keller, 2007). In terms of gender, females in the study were more likely to ever had sexual intercourse, engage in risky behaviors that placed them at risk for pregnancy, and contracting an STD in comparison to female youth

not in foster care (Courtney et al., 2007). Female adolescents in foster care are also more likely to receive payment in exchange for sex and also less likely to use birth control in comparison to female adolescent youth not linked to foster care (Courtney et al., 2007).

In terms of pregnancy and fathering a child, regardless of birth control use, adolescents who were sexually active at age 17, had a history of arrest, left foster care before 19 or had difficulty with substance abuse, were at high risk for teenage pregnancy and fathering a child (Oshima, Narendorf & McMillen, 2013). In a study of youth emancipating out of care in Illinois, Iowa, and Wisconsin, almost half of the girls were pregnant by age 19 and most of the care provided by healthcare professionals are often targeted to help parenting teens and their children instead of helping them avoid pregnancy (Love, McIntosh, Rosst, & Tertzakian, 2005; Courtney et al., 2007). The priorities of time and resources being placed on taking care of parenting youth indicates the significant issue of teenage pregnancy among youth in foster care.

In the Midwest study, 261 (71%) percent of the youth with a history of foster care placement reported ever being pregnant in comparison to 34 percent of youth in the general adolescent population, youth in foster care were also more likely to have repeated pregnancies, and the pregnancy was intentional for 30 percent of them (Courtney et al., 2007). In studies conducted in Utah, New York, and Chicago, the results were similar where youth in foster care had higher rates of teenage pregnancy, higher rates of fathering a child, higher rates of STI, and are most likely to engage in risky sexual behaviors (Love et al., 2005).

Sexual and Reproductive Health Disparities Experienced by African American Adolescents in Foster Care

In 2015, youth between the ages of 13 to 24 accounted for approximately 22% of new HIV infections in the United States, which was also more than one in five new diagnoses (CDC,

2016). STIs in addition to teenage pregnancy, are affecting youth at an alarming rate, especially youth of color. Annually, there are about 19 million new cases of STIs (CDC, 2016). Adolescents between the ages of 15 – 24 accounts for half of all the cases and one in four sexually active adolescents have an STI such as Chlamydia or Human Papillomavirus (CDC, 2016). Adolescent females are specifically more vulnerable to certain infections due to increased cervical ectopy (CDC, 2016). In 2014, Black adolescents between the ages of 15 – 24 had the highest rate of Chlamydia (CDC, 2016). Black females between the ages of 15-19 had a rate that was 4.9 times higher (6371.5 cases per 100,000 females) in comparison to white females in the same age group (CDC, 2015). From 2013-2014 there was an 11% decrease in teen birth rates (CDC, 2016), however, Black and Hispanic teens made up 57% of the teen birth rate in America, the highest among all ethnicities (CDC, 2015).

Despite the negative impact of issues such as STIs, teenage pregnancy and sexually risky behaviors among adolescents, especially African American adolescents in foster care, African American youth continue to face disparities because little research is done to help us understand what is causing the youth to be markedly affected in comparison to their White counterparts. In addition to limited research, limited resources or programs are available to specifically serve youth in foster care. In a survey of about 400 child welfare providers from 12 agencies in Chicago, 59% reported being inadequately prepared to address health care issues directly related to foster care youth, such as pregnancy prevention (Love et al., 2005). Providers reported primarily providing care to address pregnant and parenting youth, and less time is spent on pregnancy prevention interventions (Love et al., 2005).

Currently, there are 42 sexual health intervention programs listed with the U.S. Department of Health and Human Services Office of Adolescent Health; however, none are

geared specifically towards adolescents in foster care, but for adolescents in general ("The Office of Adolescent Health, U.S. Department of Health and Human Services", 2016). In addition to the lack of resources available to serve foster youth, there is also a lack of resources and training available for foster parents to handle issues related to SRH. In Virginia, for new foster parents, the Virginia Department of Social Services reports only offering an orientation meeting once to learn what being a foster parent is about and completing a pre-service training (Foster Care, 2016). Most states require 10 to 30 hours of training before an individual becomes licensed to be a foster parent (Foster Care, 2016).

Current federally implemented interventions often focus on promoting the use of contraceptive methods such as long-acting reversible contraceptives (LARC), community involvement (leaders and families), and health clinics (Wiltz, 2015; CDC, 2016). However, many federally funded interventions do not target adolescents in foster care directly, but youth in general. Because adolescents in foster care are a unique population with complex issues due to their traumatic history of ACEs, multiple foster care placement, and high risks for negative health outcomes, research and evidenced based interventions should be specifically tailored to them.

b. Approach

Design

The purpose of the study is to better understand the multiple factors that contribute to female African American/Black youth in foster care SRH disparities from their perspectives. A qualitative descriptive design is appropriate for this study as its primary goal is to richly describe experiences and perspectives of the study participants (Metzger, Norton, Quinn, & Gramling, 2013). In-depth interviews of female African American/Black adolescents with a history of

foster care placement will be used to gain adolescents' perceptions regarding their SRH. Data will be analyzed using thematic analysis to understand the subjective experiences of these young women and drive future policy changes and interventions.

Qualitative descriptive methodology is often used by researchers to describe an observed experience or event while applying their own interpretive take on what was observed in order to provide a rich detailed account and summary of the findings (Sandelowski, 2000). The goal of description is not to merely interpret findings, but to provide detailed and complete descriptions of a participant's experience in a manner that is comprehensible (Sandelowski, 2000). Qualitative description is also less theoretical as it mainly uses naturalistic inquiry, which involves studying an event in its natural state (Sandelowski, 2000). The study will be conducted with lens for social justice and change, which will be used to generate knowledge to address issues of disparities and inequities, the elevated rates of STIs, and teenage pregnancy for youth in foster care.

Rationale for Design

In exploring female African American/Black adolescents' perspectives about their SRH while in foster care, I will explore the participants' experiences and perceptions in order to generate in-depth knowledge and describe those findings. A qualitative descriptive approach with a lens for social justice and change was selected in order to provide the adolescents in foster care with the ability to have their voices heard and their perspectives shared, because adolescents' views are rarely obtained and absent from important interventions and policies (Gulati, Paterson, Medves, & Luce-Kapler, 2011).

Participants, Settings and Sampling Plan

Adolescents who will be a part of the study will be referred to as participants. English speaking female African American or Black adolescents between the ages of 18 to 24 with a history of foster care placement and no cognitive impairment can participate in the study. The PI will speak at events where caregivers or foster youth may be present, use flyers at public locations and online such as Craig's list, and youth centers to recruit participants. Overall, participants will be contacted by flyers and directly, via phone, letter or presentation in a group setting with consent then obtained individually in a private setting. (Script, letter, and flyer available).

Based on their level of development, it is expected that participants who are between the ages of 18 to 24 with a history of foster care placement will be able to give their retrospective input and perceptions related to their sexual and reproductive health (SRH). Specifically, the participants should be cognitively able to give their perspectives about barriers and facilitators to their SRH such as, what they have been through thus far, the challenges, and what interventions they would like to see done for them. Females are the focus of this study since young women are more susceptible to some STIs due to cervical ectopy (CDC, 2015) and their ability to get pregnant. Also, females were selected in order to help empower this group to make positive choices, which can impact themselves and their male peers. By including participants between the ages of 18 to 24, the researcher will not have to worry about the complex issues of assent and parental consent laws in Virginia for foster youth. This age range is now considered to be a distinct phase referred to as emerging adulthood (Sawyer, Azzopardi, Wickremarathne & Patton, 2018). Black or African American female adolescents will be recruited based on this population being markedly affected by STIs and unintended pregnancy compared to their white and male peers.

Approximately 30 participants will be recruited for the study. There are no rigid rules for sample size in qualitative methods; however, a sample of 30 is generally sufficient to reach thematic saturation (Holloway and Galvin, 2017). Recruitment will continue until data saturation has been achieved. Convenience and purposive sampling will be used to recruit participants for the study. Additionally, IRB has approved recruitment from online sources such as Craig's list and social media platforms.

The city of Richmond Virginia has about 29 foster care agencies. Participants will be recruited from the Richmond Metropolitan Statistical Area because that area has the largest population of black foster youth in Virginia and more foster care agencies. As of November 2016, Virginia had 5251 children in foster care, 2040 (39%) were between the ages of 13-18, 3306 (63%) were placed in a non-relative foster home, 540 (10%) in an institution and 243 (4.63%) in a group home (Foster Care (FC) Related Reports, 2016). The city of Richmond, VA has the largest population of Black foster youth in Virginia. As of November 1, 2016, there were 328 children in foster care, 144 (43.9%) females and 280 (85.4%) Black (Foster Care (FC) Related Reports, 2016). Participants for the study will be recruited from various foster care placement sites in Richmond, VA such as: foster care agencies, institutions, group homes, relative, and non-relative foster homes.

The researcher attended various events in the Richmond, VA area that are for adolescent youth and youth in foster care, in order to share information about the study via speech and distribution of the research flyers. The researcher contacted the Richmond, VA Department of Social Services and met with the Director, Mrs. Shunda Giles, and Ms. Vanessa Johnson, Independent Living Services Coordinator, who agreed to collaborate with the study. The Director and her staff will assist by providing possible referrals for study participants, sharing information

about the study at events and inviting the researcher to share information about the study at various meetings or events. In exchange, the researcher will conduct workshops where information related to adolescent health will be shared. The researcher also contacted Dr. Danny Avula, Director, Richmond City Health District; Dr. Em Parente, Program Manager Foster Care and Family Engagement Program; and Honorable Angela Roberts, Retired Judge, Richmond Juvenile and Domestic Relations District Court, who have also agreed to help with the recruitment process by inviting the researcher to share information about the study at various events or meetings, and distribute the study flyers. Each of the named individuals also provided letters of support.

The researcher will also contact and try to set up face to face meetings with representatives from specific foster care sites in order to share information about the study, distribute flyers, and recruit participants. The previously named agencies and representatives will not be providing the researcher with access to foster youth related cases, files, or records. The main purpose of these individuals will be to aid in the recruitment process by inviting the researcher to various events where youth will be gathered to share information about the study and recruit possible participants. The researcher will be collaborating with various foster care agencies to send letters to possible study participants or share information with potential participants about the study (Sample letter available). The researcher will also be collaborating with the Virginia Department Social Services (VDSS) staff who provides transition services for potential study participants.

Data Collection Protocol

This study proposal was submitted to the University of Virginia, followed by the Virginia Department of Social Services. Both Institutional Review Boards approved the study in its

current form. The next step in the data collection process involves consent. There are approvals for both written and verbal consent. Verbal consent will be done for participants who are unable to meet in person for interviews and prefer another interview process such as via telephone, Skype or Facetime. (Verbal/Oral consent script available.)

The study will be described and discussed with possible participants by the researcher. Potential participants will then be given a copy of the consent form to look over and read. Participants will be given an opportunity to ask questions and talk about any issues they may have. Participants will be able to sign the form and if they choose to sign the consent they will be given a copy of the signed consent. If participants are unable to meet face to face for the interview, the researcher will be willing to conduct the interview via interfaces such as telephone, Skype, or Facetime if the participant approves. The participant will consent orally/verbally (script available) and interviews will be audio recorded. No video recording will be done. The Researcher is proposing to accommodate participants who may be unwilling to conduct face-to-face interviews due to effects of their history of Adverse Childhood Experiences (ACEs), such as being shy or social isolation, by conducting interviews via telephone, Skype, or Facetime. Participants will then consent verbally.

After the consenting process, participants will be involved in an interview with the researcher lasting 1 to 1 ½ hours. The interview will be conducted in a semi-public location during daylight hours and will be a friendly conversation between the participant and the researcher. A second interview might be done to ask more questions or for clarification purposes. During the interview, participants will be asked questions about how they learned about changes to their body, sexual health, sexual behavior and how/if their caregiver helped them to obtain the information they needed. A list of possible questions will be attached for the participants to

review. The interview will be audio recorded and participants will not be identified by name. Participants will be asked to identify themselves with a false name. Participants will be informed that they can skip or choose to not answer any question that makes them feel uncomfortable. They can also stop the interview at any time without any effects if they experience any distress/discomfort from the questions being asked.

Interviews will also be digitally recorded and transcribed verbatim. Field notes, reflexivity journaling, and memoing will also be done during the data collection period to capture observed data, thought processes, and notes regarding current or future plans related to the study (Colorafi & Evans 2016; Gulati et al., 2011). Field notes, reflexivity journaling, and memoing are common practices with qualitative descriptive studies and can occur at any point during the research (Colorafi & Evans 2016; Gulati et al., 2011).

Participants will receive a $25 Visa gift card for participating in the interview after the interview has been conducted. The initial gift card payment also covers the possible follow up interview for questions or clarifications regarding the participant's first interview. Participants will not be paid for the second/follow up interview.

Data Analysis

The digitally recorded and verbatim transcription of the interviews will undergo thematic analysis. Thematic analysis is a widely used qualitative analytic method that is used for identifying, analyzing and reporting patterns or themes within data. The data are also minimally organized in order to describe the findings in rich detail (Braun & Clarke, 2006). Thematic analysis is not tied to a pre-existing theoretical framework and can be a realist method, which reports experiences, meanings, and the reality of the participants (Braun & Clarke, 2006). This is consistent with the approach of qualitative description. Themes should be able to capture

important aspects of the data relative to the research question and represents a level of patterned response or meaning within the data (Braun & Clarke, 2006). Braun and Clarke's (2006) six-phase process will be used to conduct the thematic analysis of the data. The phases involve: 1) Becoming familiar with the data by reviewing transcripts and field notes multiple times, 2) Generating initial codes from the data, which involves a process of adding labels to various pieces on the data, 3) Searching for themes, which involves looking for overt and subtle messages from the participant, 4) Reviewing the themes, 5) Defining and naming themes, and 6) Producing the report for dissemination of the findings. For analytic triangulation/peer debriefing, a group of peers not associated with the current study will meet and go over de-identified transcripts. This process will help with the validation and analytic processes of the data.

The researcher will listen to audio recordings, review transcribed interviews, and use field and reflexivity notes to perform data analysis and thick descriptions, using an inductive approach. Thick description refers to the manner in which findings from the study will be presented and involves rich and thorough descriptions of the research setting, participants, and observed transactions and processes (Polit & Beck, 2012). Dedoose, a web-based application software for qualitative data analysis will be used to assist in the analysis of the generated data (Dedoose, 2016).

Data Management

Interviews will be recorded on two audio recorders, to prevent data from being lost due to mechanical malfunction. Interviews and field notes will be transcribed verbatim as soon as possible after the interviews and will be checked for accuracy by reviewing the audio recording with the transcript. Information collected during this study will be kept private. Participant's

name will not be used, and the list linking the code name assigned to the participant's real name will be destroyed after all the data is collected. No one who reads about the study will know who the participant is. The researcher will keep all materials secured and only the research team will have access to the information. All information collected from the participants will be stored on computers that are protected with passwords and stored at the University of Virginia School of Nursing, and will only be available to the researcher and the instructor involved with the study. Information will also be stored on password protected laptops that will also have password protection for the files.

All information collected from the participants will be coded and identifying information such as contact information will be kept separate from these data. Therefore, all information identifying the interviewee, such as name, will be kept separate from information/data gathered during the interview; and all identifying information will be destroyed when interviews are completed. The files with de-identified data will be destroyed five years after the study is finished. If a participant leaves the study, their comments will be removed. Participant's name will not be used in any report or shared with anyone.

Protection of Human Subjects

This study includes human subjects and was submitted to the Institutional Review Board for Social and Behavioral Sciences of the University of Virginia, who approved the study. Additionally, due to the participants being in foster care and the researcher planned to use their resources to help with recruiting, the study was reviewed and approved by the Virginia Department of Social Services IRB, Child Welfare division of the city of Richmond, VA.

a. Risk to Subjects

Human subjects' involvement and characteristics, and design

Adolescents between the ages of 18 – 24 will be invited to participate in the study, where they will be interviewed by the researcher after consent. To minimize participants' burden and promote comfort and privacy, youth will choose the time and place for the interview, as long as the location is semi-public and conducted during daylight hours during the interview. The researcher will ask semi-structured, open-ended questions that will be audio recorded and transcribed. Inclusion criteria will include: African American/Black female adolescents between the ages of 18-24, history of foster care placement, ability to speak English, and have no cognitive impairments/deficits.

Sources of Materials

Protected sources include data from digitally recorded audio, transcribed interview data, and field notes. All protected data collected from the participants will be coded with unique identifiers and identifying information such as the participant's contact information will be kept separate from these data. Information collected during this study will be kept private. Participant's name will not be used, and the list linking the code name assigned to the participant's real name will be destroyed after all the data is collected. No one who reads about the study will know who the participant is. The researcher will keep all materials secured and only the research team will have access to the information. All information collected from the participants will be stored on computers that are protected with passwords and stored at the University of Virginia School of Nursing, and will only be available to the researcher and the instructors involved with the study. Information will also be stored on password protected laptops that will also have password protection for the files. All information collected from the participants will be coded and identifying information such as contact information will be kept separate from these data. Therefore, all information identifying the interviewee, such as name,

will be kept separate from information/data gathered during the interview; and all identifying information will be destroyed when interviews are completed. The files with de-identified data will be destroyed five years after the study is finished. If a participant leaves the study, their comments will be removed. Participant's name will not be used in any report or shared with anyone.

Potential Risk

Participants may feel uncomfortable or distressed when talking about family processes, sexual and reproductive health, and other experiences. Also, there is a potential risk to subjects that they will experience emotional distress during the interview process. During the consent process, the adolescent will be informed that they can withdraw from the study at any time. If participants become upset or exhibit signs of psychological stress in the interview, the researcher will stop the interview and ask the participant if she feels able to continue. If necessary, the researcher will provide a list of local community resources and assist with referrals as needed, with particular attention to psychological or caseworker support individuals. It is also possible that participants can share information about their sexuality or sexual orientation.

The researcher will be sensitive to this information and have contact information available for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) services in the Richmond, VA area if needed.

Protection against Risk. There is a potential risk to subjects that they will experience emotional distress during the interview process. During the consent process, the adolescent will be informed that they can refuse to answer any question, stop the interview, and/or withdraw from the study at any time. To minimize participants' burden and promote comfort and privacy, youth will choose the time and place for the interview, as long as the location is semi-public and

conducted during daylight hours. As a healthcare professional, I will inform all participants that I am obligated as a mandatory reporter by law to report any adverse findings such as various forms of abuse, maltreatment, and neglect that might be reported during the research when the participant was considered a minor under the age of 18.

B. Adequacy of Protection Against Risk

Informed consent

Before obtaining consent, the study will be described and discussed with the participants by the researcher. During the consent process, the adolescent will be informed that the study is completely voluntary and they can withdraw from the study at any time without penalty. Participants will then be given a copy of the consent form to look over and read, and will be given an opportunity to ask questions. Participants will be able to sign the form and if they choose to sign the consent they will be given a copy of the signed consent. If participants are unable to meet face to face for the interview, the researcher will be willing to conduct the interview via interfaces such as telephone, Skype, or Facetime if the participant approves. The participant will consent orally/verbally (script available) and audio recorded.

Protection against Risk

Based on the sensitive nature of this study, participants may experience emotional distress and feel uncomfortable when talking about family processes, sexual and reproductive health, and other past experiences while in foster care. The adolescent will be reminded that they can withdraw from the study at any time. If participants become upset or exhibit signs of psychological stress in the interview, the researcher will stop the interview and ask the participant if she feels able to continue. If necessary, the researcher will provide a list of local community resources and assist with referrals as needed, with particular attention to

psychological or caseworker support individuals. It is also possible that participants can share information about their sexuality or sexual orientation. The researcher will be sensitive to this information and have contact information available for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) services in the Richmond, VA area if needed.

To minimize participants' burden and promote comfort and privacy, youth will choose the time and place for the interview, as long as the location is semi-public and conducted during daylight hours. As a healthcare professional, I will inform all participants that I am obligated as a mandatory reporter by law to report any adverse findings such as various forms of abuse, maltreatment, and neglect that might be reported during the research when the participant was considered a minor under the age of 18.

C. Potential Benefit to subjects and others

There are no direct benefits that can be promised to participants of the study. The adolescents have the opportunity to have their voices heard as they share information regarding their lived experiences and perspectives. By conducting research with adolescents who have a history of foster care placement, they can know that I care about them, their experiences, and value their opinions. Also, hopefully, they can realize that I would like to be able to advocate for them based on the study's findings and generate knowledge that would benefit others linked to the foster care system in the future.

D. Importance of Knowledge to be Gained

Findings from this study have the potential to generate changes to the manner by which future interventions and programs are designed and implemented for adolescents in foster care. Healthcare professionals, political leaders and other members involved with positive youth development can use findings from this study to develop curricula and resources that can help

youth and caregivers linked to the foster care system navigate and handle complex issues such as sexually transmitted infections (STIs) and teenage pregnancy prevention. Also, information from the study can be used to guide communication in general and about specific topics related to sexual and reproductive health among adolescents in foster care and their caregivers.

E. Inclusion of Women

Female adolescents will be included in the study aged 18-24 years of age.

F. Inclusion of Minorities

Given the negative impact of STIs and teenage pregnancy on African American adolescents in foster care, this study focuses on ethnic minority and includes African American adolescents with a history of foster care placement. Also, as of April 2010, the racial composition of Richmond, Virginia was 51% Black (Population estimates, July 1, 2015, 2015). The city also has the highest amount of African American foster children in Virginia.

G. Inclusion of Children

This proposed study involves foster youth/adolescents between the ages of 18-24. Based on their level of development, it is expected that participants who are between the ages of 18 to 24 with a history of foster care placement will be able to give their retrospective input and perceptions about obtaining information related to sexual and reproductive health (SRH). Specifically, the participants should be cognitively able to give their perspective on what they have been through thus far, the challenges, and what interventions they would like to see done for them.

H. Targeted/Planned Enrollment Table

Total Planned Enrollment: 30 Participants

TARGETED/PLANNED ENROLLMENT: Number of Subjects			
Ethnic Category	**Sex/Gender**		
	Females	**Males**	**Total**
Hispanic or Latino	0	0	0
Not Hispanic or Latino	30	0	30
Ethnic Category: Total of All Subjects *	30	0	30
Racial Categories			
American Indian/Alaska Native	0	0	0
Asian	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
Black or African American	30	0	30
White	0	0	0
Racial Categories: Total of All Subjects *	30	0	30

* The “Ethnic Category: Total of All Subjects” must be equal to the “Racial Categories: Total of All

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Chapter Three: The Impact of Childhood Trauma on African American Adolescents in Foster Care: An Integrative Literature Review. (To be submitted to the Child Welfare Journal)

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Introduction

Foster care is a temporary solution for children who were removed from their homes due to issues of neglect, abuse and abandonment. Foster caregivers are responsible for providing a safe, stable and nurturing environment that will promote the child's positive development (Foster Care, 2016). As of September 2016, there were 437, 465 children in foster care in the U.S., of which 101, 825 were Black or African American children (Adoption & Foster Care Statistics, 2017). Many adolescents in foster care, especially African Americans, are at greater risk of experiencing negative health outcomes such as sexually transmitted infections (STIs) and teenage pregnancy in comparison to their White counterparts (Wiltz, 2015).

Despite the traumatic experiences of children in foster care, many interventions, programs, or trainings are not available to help foster caregivers and clinicians effectively address the sensitive needs of youth in foster care to help prevent or handle adverse health outcomes. In a survey of about 400 child welfare providers from 12 agencies in Chicago, 59% reported being inadequately prepared to address health care issues directly related to foster care youth, such as pregnancy prevention (Thiessen Love, McIntosh, Rosst, & Tertzakian, 2005). For new foster parents, the Virginia Department of Social Services reports only offering an orientation meeting once to learn what being a foster parent is about and completing a pre-service training (Foster Care, 2016). Nationwide, six programs have been rated as effective or promising for training caregivers and schools about facilitating healthy relationships with children in foster care (Klain & White, 2013). However, these six programs reach only a fraction of foster parents.

The purpose of this integrative literature review was to explore and synthesize the current literature regarding the impact of adverse childhood trauma on the overall mental health and

wellbeing of Black or African American adolescents in foster care. The goals of this study were to identify the negative outcomes of childhood trauma that distinguish adolescents in foster care from the general youth population, and to determine whether interventions should be tailored towards the unique needs of these adolescents or continue to follow generic adolescent interventions. This integrative literature review will present six themes that were generated from13 selected studies, followed by an in-depth analysis of each theme. The major findings of each included study are presented in Table 1. The generated themes, limitations of both the selected articles and this integrative review will be discussed, followed by future implications of the review.

Methods

Eligibility Criteria

Studies were included in this review if they involved or addressed: (1) Black or African American adolescents in foster care; (2) youth aged 12 – 19 years old; (3) history of trauma (psychological / physical) or mental health illness. Further, only original research conducted during the last twelve years, 2006 to 2018, was included. Studies that did not meet all but had most of the above criteria were reviewed for relevance to support the systematic review objectives. Systematic reviews, commentary publications, non-research-based papers such as dissertation work, and studies not published in English were excluded.

Search Strategy

The following electronic databases were searched to yield articles for the review: Ovid Medline, CINAHL (EBSCOhost), PubMed, and PsychINFO. Keywords such as teens, adolescents, foster care and child welfare, trauma and mental health, helped to identify relevant

studies. The term combination that yielded the most accurate citations was 'foster care and trauma.'

Data Extraction

Data extraction was performed after full review of each journal article in its entirety. Thirteen articles were selected after the inclusion and exclusion criteria were applied and the entire text of the journal was evaluated. After compilation of the 13 articles in the data extraction table, each study's findings were categorized, analyzed and reported based on themes. Themes were generated based on research articles that had at least two similar conclusions/findings. Table 1 is a summary of 13 evidence findings, with data that were extracted based on aims/purpose of the study, design, sample characteristics, and major findings.

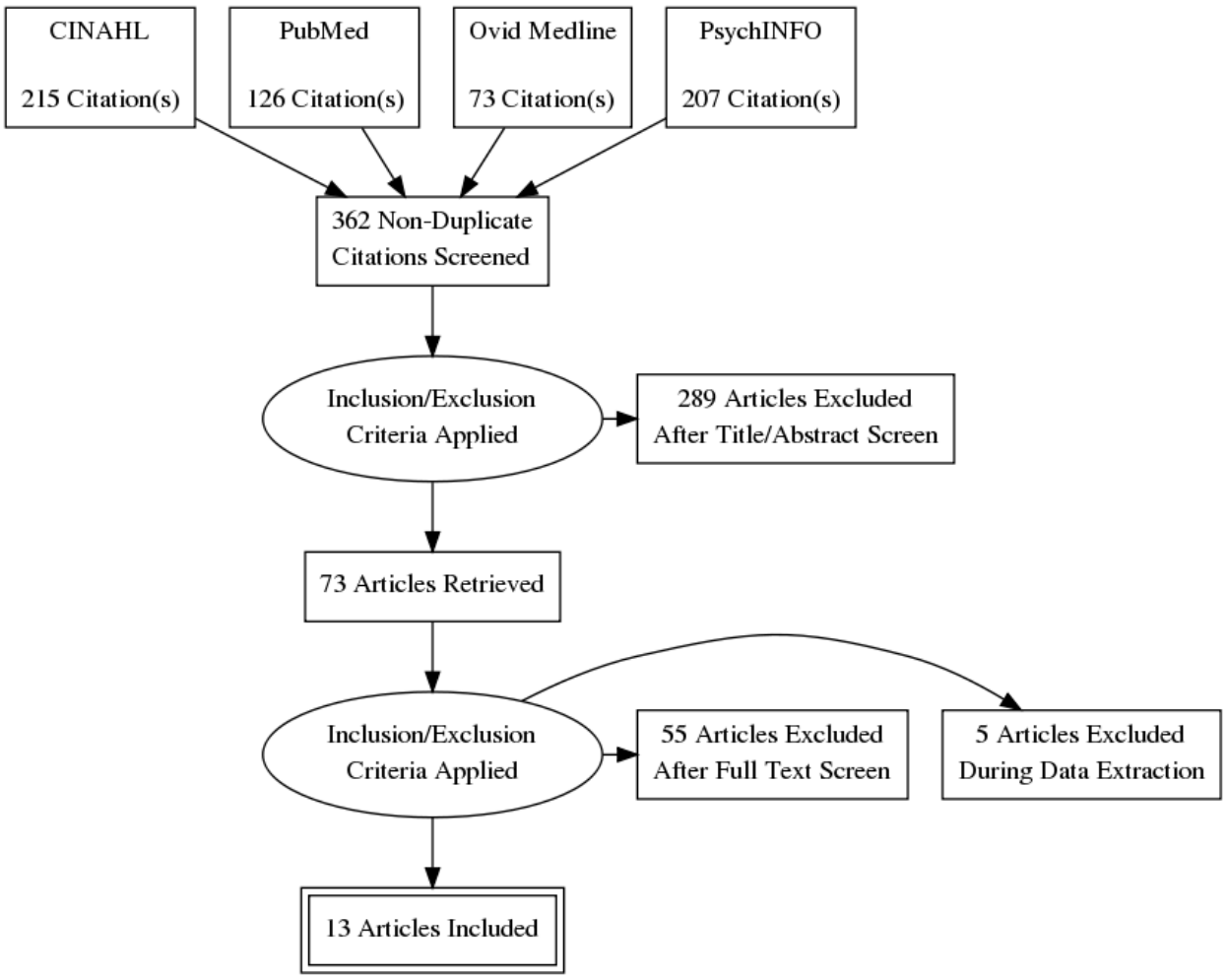
Study Selection

The selection process for obtaining the relevant studies is illustrated in Figure 1 using a PRISMA format (Prisma.thetacollaborative.ca, 2016). The figure illustrates the flow of citations and elimination of articles after inclusion and exclusion criteria were added. Duplicated studies, systematic reviews, and other studies that were not applicable were removed. CINAHL, PubMed, Ovid Medline and PsychINFO yielded 362 non-duplicated studies. After applying the inclusion/exclusion criteria, each title and abstract of the 362 articles were reviewed. Afterwards, 289 articles were excluded yielding 73 applicable studies, based on the following: (1) study participants were 10 years or younger; (2) participants were not linked to foster care or out-of-home living arrangements; (3) participants in study were not African American/Black adolescents.

Full text revision and data extraction were conducted on the 73 articles. 55 articles were eliminated after full text screening, due to inadequate or lack of report regarding incidents of

trauma experienced by research participants. Also, studies that had few or no African American participants, and studies that focused primarily on adults or children under ten years old were eliminated. Five articles were excluded during data extraction; four studies were missed earlier in the elimination process, and a commentary article were excluded. The 13 resulting studies were included in this integrative literature review.

Figure 1. PRISMA of articles found through electronic databases



Results

Study Characteristics

Table 1 depicts sample characteristics for each study. One of the included studies had participants that were under 13 at the onset of the study. However, this study was included because data were collected over a two-year period and some of the participants were adolescents. Four of the selected studies had research participants that were up to 21 years old. One of those studies focused on participants who were 20 to 49 years old. This study was included because the participants were alumni of the foster care system at a younger age. There were two qualitative studies, while the remaining 11 were quantitative and used mainly large data sets to perform data analysis. All of the studies included both male and female African American participants who were linked to foster care.

Results of Individual Studies

The major findings of each of the thirteen studies are presented in Table 1. Six themes were generated:

1. Behavioral Risks or Problems
2. Psychiatric Risk Factors
3. Self-Harm and Substance Abuse
4. Legal System Placement
5. Foster Care Placement as a Facilitator of Continued Trauma
6. Pregnancy and Fathering a Child

Results: Generated Themes

Behavioral Risks or Problems

Youth in foster care are often victims of multiple traumas, and behavioral problems are commonly seen as a result. In a study of 2,251 youth by Greeson et al., (2011), a history of complex trauma such as neglect, loss, bereavement or separation, and having an impaired

caregiver placed youth in foster care at an increased risk for internalized behavior problems. In a qualitative study, 27 teachers and school staff who worked with adolescents in foster care who had a history of trauma reported behavioral issues such as shutting down, isolation, and lack of trust (Crosby, Day, Baroni, & Somers, 2014). The teachers and staff also reported being unprepared when it comes to interacting with the adolescents when they displayed various behaviors (Crosby, Day, Baroni, & Somers, 2014). Another study of 320 adolescents indicated that delinquent behavior was the most commonly identified problematic behavior among adolescents in foster care (Thompson & Auslander, 2011).

Youth in foster care with previously existing behavioral problems often experience no change or an increase in their display of behavioral problems while in foster care. In a study of 49 children in foster care over a two-year period, 18 children had increased behavioral problems, 23 had behavioral problems that were unchanged and only eight had a decrease in behavioral problems (Vanderfaeillie, Van Holen, Vanschoonlandt, Robberechts & Stroobants, 2013).

Additionally, in a study of 56 adolescents, it was shown that in comparison to the general youth population, adolescents in foster care tend to be involved in more risky behaviors such as conflicts at school that hindered their academic achievement, and being sexually active and not using protection (Gramkowski, Kools, Paul, Boyer, Monasterio et. al., 2009). Younger adolescents placed in a relative's care had less risky behaviors, while youth in foster care who had experienced a parental death, history of physical or emotional abuse, or attempted suicide had higher risk behaviors (Gramkowski, Kools, Paul, Boyer, Monasterio et. al., 2009).

Another form of behavioral problem involved sexual risks such as unintended pregnancy at an early age, and HIV from unprotected sex. In a study of 320 adolescents in foster care, 70 participants who displayed delinquent behaviors were three times more likely to engage in any

HIV risk behavior, and four and a half times more likely to engage in unprotected vaginal sex (Thompson & Auslander, 2011). Interestingly, Thompson & Auslander (2011) also indicated that adolescent females in foster care were more likely to engage in unprotected vaginal sex, in comparison to males.

Psychiatric Risk Factors

Histories of complex trauma were associated with psychiatric diagnosis, treatment and even hospitalizations. One study of 423 youth indicated that homeless youth with a history of foster care placement were 70% more likely to report a psychiatric disorder, twice as likely to receive medications and hospitalized for such conditions (Thompson & Hasin, 2012). In a study of 2251 youth, those who experienced trauma prior to entering foster care, were at an increased risk for posttraumatic stress disorder, anxiety, affective disorder and at least one clinical psychological diagnosis, in comparison to youth without such histories (Greeson, et al., 2011; Thompson & Hasin, 2012).

A study of 732 adolescents in foster care, found that youth who experienced sexual trauma had the highest probability of having a posttraumatic stress disorder diagnosis in comparison to other trauma experienced by youth in general and youth in foster care (Salazar, Keller, Gowen & Courtney, 2014). In comparing African American and white youth who were previously in foster care, race and ethnicity did not lead to an increased risk for PTSD, however, females were at an increased risk for a PTSD diagnosis in the year prior to foster care placement (Jackson, O'Brien & Pecora, 2011). Prior to foster care placement, female youth were also significantly more vulnerable to sexual and emotional abuse, and males had higher rates of ADHD and physical/learning disabilities (Jackson, O'Brien & Pecora, 2011). One study of 5516 adolescents indicated that youth in foster care had increased levels of mental health distress,

suicidal risk, and fewer protective factors such as feeling cared for by parents, other adults and school connectedness in comparison to youth who live at home (Harpin, Kenyon, Kools, Bearinger & Ireland, 2013).

Self-Harm

In addition to psychiatric risk factors, as evident in Table 1, youth in foster care with a history of trauma are also at an elevated risk for self-harm such as suicidal ideation and attempts (Pilowsky & Wu, 2007; Harpin, Kenyon, Kools, Bearinger & Ireland, 2013). In a study of 5516 adolescents in out-of-home care, Harpin, Kenyon, Kools, Bearinger & Ireland (2013), found that youth in foster care with a history of sex abuse had higher rates of suicidal thoughts and attempts in comparison to youth living at home. Youth in foster care are also consuming and abusing substances such as alcohol and Marijuana as indicated in a study, which was conducted in the Midwest with 320 adolescents, where 126 reported alcohol ingestion and 114 reported using marijuana frequently (Thompson & Auslander, 2011).

Legal System Placement

Yampolskaya, Armstrong & McNeish (2011) found in their study of 13212 adolescents, that youth in foster care with a traumatic history of chronic maltreatment such as threatened harm (47.6%), physical abuse (28.3%), neglect and sexual abuse (38.5%) were likely to be placed in a juvenile delinquency facility or a detention center. Of all the reported forms of trauma experienced by youth in foster care, sexual abuse was the only one that was associated with first time placement in a detention center (Yampolskaya, Armstrong & McNeish, 2011). Additionally, youth who experienced chronic maltreatment were at 10% increased risk for placement in a detention center and 15% increased risk for placement in the juvenile justice

system with each maltreatment report. African American boys are also more likely to be linked to the juvenile justice system (Yampolskaya, Armstrong & McNeish, 2011).

Foster Care Placement as a Facilitator of Continued Trauma

Youth often enter the foster care system due to reports of various traumas. Surprisingly however, in a qualitative study of 68 participants, it was reported that trauma experienced during their foster care placement was similar to what was experience prior (Riebschleger, Day & Damashek, 2015). Twenty eight percent of the study's participants reported physical abuse or neglect, and emotional abuse (21%) as some of the trauma experienced while in foster care.

Therefore, based on the study's findings, the foster care system that is in place to protect traumatized youth also has the ability to place some of them at risk for continued trauma. Neglect, sexual abuse, physical abuse and emotional abuse were the most commonly reported traumas while in foster care. Being forced to take medications was another significant form of trauma reported by youth in foster care (Riebschleger, Day & Damashek, 2015). In another study of 708 youth, both males and females (212) reported that trauma continued while in foster care and revictimization occurred regardless of the race of the child (Jackson, O'Brien & Pecora, 2011).

Pregnancy and Fathering a Child

Adolescents aging out of the foster care system are at very high risk for early pregnancy or fathering a child. Regardless of birth control use, adolescents who were sexually active at age 17, had a history or arrest, left foster care before 19 or had difficulty with substance abuse, were at high risk for teenage pregnancy and fathering a child (Oshima, Narendorf & McMillen, 2013). Positively, 41% of males in a study of 325 individuals reported condom use. Fathering a child was predicted by substance abuse disorder, failing grades and leaving the foster care system

before age 19 (Oshima, Narendorf & McMillen, 2013). According to a study of 320 adolescents, delinquent behaviors were associated with female adolescents being four and a half times more likely to engage in unprotected sex, which places them at high risk for pregnancy (Thompson & Hasin, 2012).

Table 1
Findings of included studies (N = 13)

Author/Year/Title	Aims/Purpose	Characteristics	Design	Results
Crosby, Day, Baroni, Somers. (2014) School Staff Perspectives	To investigate the needs of teachers and school staff in educating court-involved traumatized students.	n=27school staff 18 Teachers 9 Support 17 White 8 Black 1 Hispanic 1 Multi- cultural	Qualitative study (Exploratory)	School staff identified behaviors such as "shutting down, guardedness, lack of trust in staff and internal distractions as the most challenging behaviors from traumatized students.
Gramkowski, Kools, Paul , Boyer, Monasterio et. al. (2009) Health risk behavior of youth in foster care.	To investigate the health risk behavior of youth in foster care.	n= 56 Aged 11-17 29 Females 27 Males 36% AA 21.4% Latino 8.9% Asian 8.9% Pacific Islander/Hawaii 7% Caucasian 3.6% American Indian	Quantitative (RCT, Descriptive)	In comparison to youth in general, youth in foster care had increased risky behavior. Youth in foster care experiences of a parental death, history of physical or emotional abuse and attempted suicide had higher risk behavior.
Greeson, Briggs, Kisiel, Layne, Ake, Ko, Gerrity, et al. (2011). Complex trauma and mental health.	To examine trauma histories, including complex trauma exposure, posttraumatic stress, and behavioral and emotional problems of youth in foster care.	n=2,251 youth in foster care Ages 0- 21 52.2% Females 38.6% Black 49.1% White 15.7% Hispanic/Latino	Quantitative Quasi – experimental (With history of trauma and those without)	68% of total sample reported history of neglect, 63% loss, bereavement or separation and 59.8% had an impaired caregiver. Youth with complex trauma histories were more at risk for internalizing behavior problems, posttraumatic stress, and having at least one clinical diagnosis than those without these histories.
Harpin, Kenyon Kools, Bearinger & Ireland (2013) Correlates of Emotional Distress	To evaluate mental health distress, along with other risk and protective factors of young	Youth in out-of-home care (n=5516) Youth living at home (n=5500) Aged 0-17	Quantitative (Correlational)	In home youth had higher degrees of parental caring, other adult caring, school connectedness and GPA. For youth in out-of-home care, there were significantly lower GPA and school connectedness.

in Out-of-Home Youth.	people in out-of-home care.	Out-of-home 43.1% youth of color 27.7% white		Youth living in out-of-home care had increased levels of mental health distress. Youth who were sexually abused showed higher rates of suicidal thoughts and attempts compared to the students living at home.
Jackson, O'Brien & Pecora (2011) Posttraumatic Stress Disorder among Foster Care Alumni.	To examine the main effects of race/ethnicity, gender, and foster care context factors.	n=708 Age 20-49 134 AA 574 white	Quantitative (Correlational)	During foster care, males and females reported similar rates of neglect, physical abuse, sexual abuse and re-victimization regardless of race. Females were at increased risk for prior year PTSD diagnosis. Prior to foster care placement, females were significantly more vulnerable to sexual and emotional abuse. Males had higher rates of ADHD and learning disabilities. 31% of participants reported maltreatment while in foster care.
Oshima, Narendorf & McMillen (2013) Pregnancy risk among older youth transitioning out of foster care	To evaluate early pregnancy risk and protective factors known for general population adolescents for their relevance to youth in the foster care system	n=325 Aged 17 to 19 61% Females 59% Youth of color	Quantitative (Correlational)	Females 17-19: Aging out of foster care are at very high risk for early pregnancy, if sexually active at 17 regardless of birth control use (inconsistent / inaccurate use), history of arrest before 17, leaving the foster care system before 19 and substance abuse disorder. Males 17-19: Fathering a child was predicted by substance abuse disorder, failing grades and leaving the foster care system before 19. 98% of males reported condom use.
Pilowsky & Wu (2007) Psychiatric symptoms and substance use.	To evaluate the prevalence of psychiatric symptoms and substance use disorders among adolescents with a history of foster care.	n=19,430 464 adolescents in foster care. Aged 12 – 17 49% females, 35% nonwhite minority	Quantitative (Exploratory Cross sectional)	Adolescents in foster care have higher prevalence of psychiatric symptoms and elevated risk for suicide attempts.
Riebschleger, Day & Damashek (2015). Foster Care Youth Share	To evaluate youth-reported trauma occurring before,	n=68 59% Females 53% AA 38% White	Qualitative (Exploratory)	• 23% trauma frequently experienced before foster care placement included sexual abuse.

Stories of Trauma Before, During, and After Placement	during, and after foster care.	9% Other race		• 23% unsafe/unstable housing. • 23% parental substance abuse. • 16% physical abuse. • 9% physical neglect. • 7% parental mental illness. • 7% parental suicide. Youth reported that trauma during foster care were similar to what was experienced before placement. Most reported trauma during care: • 28% abuse/neglect • 7% sexual abuse • 5% physical abuse • 14 % emotional abuse • 21% disrupted placement and adoptions • 14% family/sibling separations Trauma reported after leaving the foster care system involved: • 19% housing insecurities • 12% homelessness
Salazar, Keller, Gowen & Courtney (2014) Trauma Exposure and PTSD Among Older Adolescents in Foster Care	To evaluate and report the prevalence of exposure to specific types of traumatic events for youth with foster care experience.	N=732 adolescents in foster care Aged 17 and 18 51.5% females 48.5% males 57.3% (African American)AA 31.0% Caucasian 9.8% mixed 1.4% American Indian/Native Alaskan 0.5% Asian/Pacific Islander 8.6% Hispanic	Quantitative (Longitudinal study using logistic regressions)	• 80% experienced trauma • 55% indirect trauma • 50% interpersonal violence • 40.4% trauma involving someone being injured • 30% Being physically attacked • 27% Molested • 26.5% Threatened with a weapon • 26.5% kidnapped Caucasian participants had higher rates of trauma exposure than African-American participants (85% vs. 76.5%) Incidence of rape was linked to the highest probability of PTSD diagnosis. Youth in foster care are highly traumatized and meet the criteria for PTSD more significantly in comparison to other youth.
Thompson & Auslander (2011) Substance Use and Mental Health Problems as Predictors of HIV	To evaluate how substance abuse and mental health problems increased adolescents' possibility of engaging in HIV	320 adolescents, Midwestern Foster care Aged 15 to 18, 54% Females 46% Males 66% AA	Quantitative (Logistic regression)	Alcohol (n=126) and Marijuana (n=114) were most frequently used. Delinquent behavior was the most commonly identified mental health behavior (n= 70) and adolescents who met this criteria were three

Sexual Risk Behaviors	sexual risk behaviors.	34% White		times more like to engage in any HIV risk behavior and 4.5 times more likely to engage in unprotected vaginal sex. 17.8% Unprotected vaginal sex was the most frequently endorsed HIV sexual risk behavior White adolescents in comparison to AA adolescents were more than 1.5 times more likely to engage in any HIV risk behavior and 2x more likely to have unprotected vaginal sex. Females were more likely than males to engage in unprotected vaginal sex.
Thompson & Hasin (2012) Psychiatric Disorders and Treatment Among Newly Homeless Young Adults With Histories of Foster Care	To examine whether a history of foster care was associated with psychiatric disorders, prior psychiatric counseling, prescription of psychiatric medications, and prior psychiatric hospitalization among newly homeless youth.	n=423 youth. (276) without foster care placement and (147) with a history of foster care placement. 8 to 21 years 271 Females 152 Males 242 Black 111Hispanic 28White 42 Other race	Quantitative (Bivariate logistic regression analyses)	Homeless youth with history of foster care were 70% more likely to report a psychiatric disorder, twice likely to receive psychiatric medications and hospitalized for psychiatric problems. History of foster care significantly increased diagnosis of affective, anxiety, or psychotic disorder in 130 (31%) youth with foster care.
Vanderfaeillie, Van Holen, Vanschoonlandt, Robberechts & Stroobants (2013) Children placed in long-term family foster care.	To evaluate the development of problem behavior and associated factors of adolescents in foster care.	N=49 Children in foster care Aged 6 to 12 2004: 77 Foster mothers, 2006: 49 foster mothers	Quantitative (Two-year longitudinal study of a cross sectional sample)	18 children had increased behavioral problems, 23 had unchanged behavioral problems and 8 had a decrease in behavioral problems.
Yampolskaya, Armstrong & McNeish (2011) Children placed in out-of-home care	To evaluate risk factors for juvenile justice involvement among children in out-of-home care.	n=13,212 Aged 7 to 17 52% females 36% AA 56% White 8% Hispanic	Quantitative (Cohort-sequential)	Prevalent forms of reported maltreatment were: • 47.6% Threatened harm • 28.3% Physical abuse • 24% Neglect • 14.5% Sexual abuse Sexual abuse was associated with first time placement in a detention center.

				Youth, who experienced chronic maltreatment, were at 10% increased risk for placement in detention center and 15% increased risk for placement in the juvenile justice facility.

Discussion

The results of this integrative literature review indicate that children enter foster care due to traumatic reasons such as a history of maltreatment, abuse, abandonment, unsafe living environment, and unfit caregivers. Children who were victims of adverse childhood traumas are placed into the foster care system in order to be in a safe and nurturing environment. However, trauma can lead to negative mental and physical health outcomes that follow children throughout their foster care stay. Youth in foster care who were victims of various childhood traumas often struggled with behavioral problems such as isolation and lack of trust in others. These behaviors were also observed in the academic setting. Unfortunately, academic workers reported not being adequately prepared to interact with youth who displayed those behavioral problems. Lack of adequate trauma-informed training for youth-serving individuals placed them and the youth at a disadvantage. Youth workers need to be able to relate to the youth and be knowledgeable on how they can best work with the youth to ensure that they are being supported at school and other institutions, to foster their positive development.

Another form of behavioral problem youth in foster care faced was involvement with risky behaviors such as consuming and abusing alcohol and marijuana, and being sexually active and not using protection. Youth should be exposed to sexual and reproductive health (SRH) guidance that can empower them to learn about their bodies, and make better choices to prevent negative SRH outcomes such as unintended pregnancy and STIs.

Because of adverse childhood trauma experienced by youth in foster care, many of them are faced with various psychiatric risk factors but do not have adequate protective factors in place to help them effectively heal. Youth with a history of childhood trauma should have access to comprehensive mental health services delivered by trained healthcare professionals. Youth-serving individuals and caregivers should be trained to provide nurturing and supportive guidance for youth, who often report lack of supportive relationships.

Another unfortunate finding was the failure of some foster care placements to protect youth from re-exposure to trauma since youth reported experiencing maltreatment such as abuse while in the foster care setting. The fact that some children in foster care are experiencing various forms of abuse, neglect, and maltreatment indicates the need for strict adherence policies, where foster caregivers are actually providing a nurturing environment to promote positive youth development.

Finally, researchers should consider conducting more qualitative studies with both youth in foster care and their caregivers. Qualitative studies have the potential to generate knowledge regarding how adolescents and caregivers in foster care access services or resources to benefit them and promote positive development or the lack of access or disparities faced by them. By having an in-depth perspective of adolescents in foster care and their lived experiences, researchers can potentially tailor interventions that can be implemented to benefit these youth.

Limitations

Of the thirteen studies included in this literature review, only two were qualitative studies. The limited amount of qualitative studies was also evident while conducting database searches for research articles relating to foster care and childhood trauma. While quantitative studies are valuable, qualitative studies are able to capture a more in-depth lived experience of

youth in foster care based on their responses or perspectives. As a result, what many of the quantitative studies added to the literature review was a broader identification and definition of childhood trauma and its effects.

Another limitation of the selected studies was the fact that most of the studies indicated that many youth in foster care often engage in risky sexual behaviors that can put them at risk for unintended pregnancy and HIV. However, none of the studies collected any information related to how a history of trauma affected the way youth in foster care obtained information related to sexual and reproductive health, such as contraception and STD testing.

A final limitation of this integrative review was that the primary author conducted this study independently and there is a possibility for risk of bias related to the article selection and elimination process. The potential to eliminate evidence that does not support the author's objectives or research gap is possible as there was no other researcher to assess the selected articles. This limitation was addressed by having the second and third authors review and verify the study's findings.

Future Implications

Despite the negative health outcomes of adolescents in foster care, limited research and interventions focus on them directly. Currently, there are 37 sexual health intervention programs listed with the U.S. Department of Health and Human Services Office of Adolescent Health, however, none are geared specifically towards adolescents in foster care. Adolescents in foster care should have programs specifically tailored to them due to behavioral problems and difficulties, and history of psychological and physical abuse that about 70% of them experience (Thiessen Love, McIntosh, Rosst, & Tertzakian, 2005). These experiences set adolescents in foster care apart from many other youth in the general population.

A gap in current knowledge is the lack of well-designed and tested interventions to prevent adverse outcomes of youth in foster care, who make up a significant amount of our population and will influence our future. Additionally, interventions to train leaders, educators, and caregivers in managing children and adolescents in foster care, including how to support and nurture them may benefit this vulnerable population. Support services from law enforcement officials, youth or peer groups, such as mentorship programs should be a focus for adolescents in foster care, who can benefit by learning how to form positive relationships and staying away from the justice system.

Conclusion

In conclusion, adolescents in foster care are often exposed to childhood traumas such as various forms of abuse, maltreatment, and neglect. The effects of experienced trauma prior to foster care placement left many youth in foster care with behavioral problems, psychiatric risk factors such as elevated mental health distress, risk for self-harm, substance abuse, involvement with the legal system, and exposed to SRH risks. Psychiatric problems such as PTSD, ADHD, anxiety, and being more vulnerable to sexual and emotional abuse were a major effect of childhood trauma on youth in foster care.

The findings from this literature review indicated that there is a chain of events that adolescents in foster care are involved in. The chain starts with childhood trauma, which then leads to adverse mental and wellbeing outcomes, followed by the lack of adequate resources to help them overcome or adjust to their life as a child in foster care. The last link in the chain is where some adolescents in foster care age out of the system and end up homeless, jobless, inadequately educated and victims of adverse sexual and reproductive health.

Trauma-informed interventions need to be implemented in order to ensure that vulnerable youth with a history of childhood trauma are able to heal, prevent exposure to new traumas, and be empowered to make better health and lifestyle choices that will ensure their positive development. In order to provide suitable trauma-informed interventions, the voices of vulnerable youth should be sought in order to ensure that programs are implemented not based on solely what experts think is best but include the youth's perspectives regarding their needs.

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Chapter Four: "It was only me against the world." Female African American Adolescents' Perspectives on Their Sexual and Reproductive Health Learning and Experiences While in Foster Care: Implications for Positive Youth Development.
(To be submitted to: Journal of Adolescent Research)

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Abstract

Despite evidence that African American adolescent females experience high rates of sexually transmitted infections and unintended pregnancies, little is known about those who are placed in foster care. This study aimed to explore and describe the experiences of female African American/Black youth in foster care related to their sexual and reproductive health (SRH) disparities. The purposive sample was 16 female African American adolescents, ages 18 to 20 years old, with a prior history of foster care placement. Participants were recruited from a metropolitan area in Virginia. This study used a qualitative descriptive design with semi-structured in-depth interviews lasting an average of 1 hour. The transcribed interviews underwent inductive thematic analysis and there were four prominent themes: relationships with caregivers, internal assets, sources for SRH information, and perspectives on SRH communication. Results indicated that youth perceived a lack of support, reported that they relied on their personal strengths to seek information related to SRH, and provided their perspectives on communication about SRH. The findings from this study will provide direction on how caregivers, health-care workers, social services staff, and community members can better support the SRH of young women in foster care.

Introduction

At the forefront of sexual and reproductive health (SRH) is its importance to women as it strives to address issues such as gender equality, empowerment, and maternal, child, and adolescent health in order to promote positive health outcomes (Starrs et al., 2018). SRH is defined as a person's overall physical, emotional, mental, and social wellbeing as it relates to every aspect of sexuality and reproduction (Starrs et al., 2018). For adolescents, SRH encompasses pubertal changes to the body, sexual behavior, sexual orientation, gender identity, and how adolescents protect themselves from unintended pregnancy and sexually transmitted infections (STIs).

The United States (US) has been struggling with alarming rates of STIs and unintended pregnancy for many years (CDC, 2016; CDC, 2018; Martin, Hamilton, & Osterman, 2018). In 2017, the top three reported cases of STIs were Chlamydia, Gonorrhea, and Syphilis respectively (CDC, 2018). In 2017, there were 1.7 million new cases of Chlamydia, the most common notifiable infection in the U.S., which represents 528.8 cases per 100,000 population, a 6.9% increase from 2016 (CDC, 2018). In 2017, reported cases of Chlamydia were highest among Black individuals and 5.6 times the rate among Whites (1,175.8 and 211.3 cases per 100,000 population, respectively) (CDC, 2018). Adolescents and young adults had the highest reported rates, where two thirds of reported cases (528.8 cases per 100,000) were from individuals between the ages of 15- 24 years old (CDC, 2018).

Gonorrhea also had increased rates. In 2017, there were 555,608 reported cases in the U.S., an 18.2% increase since 2016, and 75.2% since 2009 (CDC, 2018). In terms of ethnicity, in 2017, Gonorrhea continued to markedly affect black individuals, who had the highest rate (548.1 cases per 100,000 population) and 8.3 times the rate of White individuals with a reported 66.4

cases per 100,000 population (CDC,2018). Syphilis, has had rates that have increased annually since 2001, with 30, 644 cases reported (9.5 cases per 100,000 population), and Blacks had the highest rate (24.2 cases per 100,000 population), which was 4.5 times the rate of Whites (5.4 cases per 100,000 population) (CDC, 2018). Women between the ages of 20 – 24 years old had the highest rates (7.8 cases per 100, 000 females).

In addition to STIs, teenage pregnancy is affecting youth at an alarming rate, especially in youth of color. In 2017, there was a 7% decrease in the teen birth rate, with 194,377 babies born to women between the ages of 15-19 years old, which represents a birth rate of 18.8 cases per 1,000 women in this age range) (Martin, Hamilton, & Osterman, 2018). Despite the downward trend in teen birth rates, in 2017, Hispanic teens had the highest rate (28.9 cases per 1,000 females), followed by non-Hispanic black teens (27.5 cases per 1,000 females), who both had rates that were more than 2 times higher than non-Hispanic white teens (13.2 cases per 1,000) (Martin, Hamilton, & Osterman, 2018). Negative SRH outcomes are also affecting vulnerable youth with a history of adverse childhood experiences (ACEs) or childhood trauma, such as youth in foster care.

Foster care is a temporary living solution provided by states across America for children and youth who cannot live with their biological parents (Childwelfare.gov, n.d.). Children are placed into foster care due to ACEs such as findings of neglect, abandonment, and various forms of abuse (Virginia Department of Social Services, 2016; Childwelfare.gov, n.d). Placement sites for children in foster care include group homes, resident care facilities, emergency shelters, and independent living programs (Childwelfare.gov, n.d). At the end of 2017, there were 442, 995 children in foster care in the U.S., where 193, 828 (44%) were White, 100, 607 (23%) were Black or African American (AA), and 93, 507 (21%) were Hispanic children (Adoption & Foster

Care Statistics, 2018). The majority of children in foster care were White, followed by Black children, who represented the second largest ethnic group in foster care and are overrepresented relative to the population of Blacks/African Americans (Adoption & Foster Care Statistics, 2017). Reports as of 2014 with combined data from the US Census and the Adoption and Foster Care Analysis and Reporting system (AFCARS) reported that of the total child population, 13.8% were African American/Black and there were 24.3% of African American/Black children in foster care. This indicates a racial disproportionality index (RDI) of 1.8, which means that African American/Black children are represented in foster care 1.8 times their rate in the general population (Child Welfare Information Gateway, 2016).

Female African American adolescents in foster care are at an increased risk for unintended pregnancy and high-risk STI behaviors, in comparison to adolescents not in foster care. Approximately 48% of adolescent females in foster care have been pregnant by age 19 in comparison to 27% of adolescent girls in general and are twice as likely to have had sex and not use contraception in comparison to their peers not in foster care (Dworsky & Courtney, 2010; Ng & Kaye 2013). Despite their poor SRH outcomes such as elevated rates of STIs and unintended teenage pregnancy, research related to SRH among the foster care population is scarce.

Female adolescents who are not in foster care reported learning about SRH-related topics from peers, media, school, and their biological parents (Aronowitz, Rennells, & Todd, 2006; Aronowitz, Todd, Agbeshie, & Rennells, 2007; King Jones, 2010). Adolescents who spoke to their biological parents about SRH topics were less likely to engage in risky sexual behaviors (Aronowitz, Todd, Agbeshie, & Rennells, 2007). From the previously mentioned research, African American youth who communicated with their biological caregivers reported being well informed about their SRH and ultimately made health-protective decisions regarding SRH such

as using contraceptives or delaying the age of sexual debut. It is not fully understood how adolescents with a history of ACEs who have been placed in the foster care system and away from their biological parents learn about SRH.

The purpose of this qualitative descriptive study was to explore and describe the multiple factors that contribute to SRH disparities for female African American/Black youth in foster care from their perspectives. The goal of the study was to understand the multiple and complex factors that contributed to the participants' SRH disparities, how they obtained information about SRH, their trusted source for receiving this information, and what they perceived would be helpful to them. Findings from this study will provide direction on how caregivers, health-care workers, social services staff, and community members can better support the SRH of young women in foster care.

Methods

Design

A qualitative descriptive design was used for this study as its primary goal was to richly describe experiences and perspectives of the study participants (Metzger, Norton, Quinn, & Gramling, 2013). Qualitative description is also less theoretical and minimally interpreted in order to stay close to the data, allowing the researcher to provide complete, detailed, and concrete descriptions of the participants' experiences in a manner that is comprehensible and reflects their own perceptions of their experiences (Sandelowski, 2000; Neergaard, Olesen, Andersen & Sondergaard, 2009; Chen, Rivera, Rotter, Green & Kools, 2016). Qualitative description is also an appropriate pragmatic method when there is limited existing research on a topic and/or population (Neergaard, Olesen, Andersen & Sondergaard, 2009.

The researcher conducted this qualitative descriptive study while maintaining an epistemological interpretivist stance. Under an interpretive stance, there is not one truth, but multiple realities that exist and the participant's experiences are used to generate knowledge regarding their multiple truths. These truths are socially constructed based on the context the in which the participant lives, interacts, and operates in and are historically constructed based on the participant's past experiences and cultural practices (Creswell & Poth, 2018; Kalof & Dan, 2008; Lincoln & Guba, 2000).

This study was underpinned by the Positive Youth Development (PYD) theory, and also includes aspects of the resilience theory. Children enter foster care due to various ACEs. As a result of these experiences, some children are at risk for various negative health and social outcomes, while others thrive despite the risks they face. The resilience theory posits that youth have the potential to thrive and have positive outcomes when individual, environmental, and social aspects are all aligned and work together to promote the youth's positive development (Masten, 2018; Zimmerman et al., 2013; Fergus & Zimmerman 2005). Like PYD theory, the resilience theory encourages adults to focus on the strengths of the child and not on their weaknesses or challenges (Zimmerman et al., 2013). The importance of positive mentoring relationships for the child and community involvement are other important external assets that can promote the child's optimal development (Zimmerman et al., 2013)

The PYD theory is another strength-based theory, which states that youth can thrive if their internal assets are supported by external factors or assets (Development, 2018; Bruner, Eys, Wilson, & Côté, 2014). Some internal assets youth possess include a commitment to learning and positive values, External assets include having strong family support and a caring school environment, in addition to being empowered (Development, 2018). By using the PYD

theoretical framework, adolescents are viewed holistically, where they are seen as whole beings with internal assets, who can help nurses and other youth workers understand how aspects of adolescents' external social context can have an impact on their health.

A qualitative descriptive approach, maintaining an epistemological interpretivism stance with a lens for positive youth development (PYD) and social justice, was selected in order to provide adolescents in foster care with the ability to have their voices heard and their perspectives shared. Adolescents' views are rarely obtained and absent from the design of interventions and policies that directly impact them (Gulati, Paterson, Medves, & Luce-Kapler, 2011). Since we often view vulnerable ethnic minority youth through a deficit lens, this study aimed to view the participants through a positive lens by focusing on their strengths.

Participants, Human Subjects Protection and Settings

Adolescents who identified as female and African American or Black between the ages of 18 to 24 with a history of foster care placement were eligible to participate in the study. This age group was selected for their cognitive ability to reflect back over their experiences during adolescence and while in foster care. Female adolescents were chosen for the study due to them being more susceptible than their male peers or older women to certain STIs, increased cervical ectopy, and their ability to get pregnant (CDC, 2016).

Institutional approval for the study was obtained from the Virginia Department of Social Services (VDSS) and the researcher's institutional review board. This included permission to conduct data collection either in person or by phone per participant preference. Participants were recruited from a metropolitan area in Virginia. Recruitment was conducted by speaking at events where caregivers or foster youth were present, posting flyers at public locations and online, and contacting agencies serving youth with a history of foster placement, relevant gatekeepers who

worked with youth, such as personnel from foster care agencies, independent living programs, community centers, clinics, statewide foster care conference, and the local Department of Social Services.

Data Collection

The study was described and discussed with the participants by the researcher and participants provided informed consent after having an opportunity to ask questions and talk about any issues they had. Six participants were unable to meet face to face for the interview and therefore, participated over the phone. In these cases, consent was provided by listening to an approved oral script read by the researcher, followed by the participant's verbal consent. After the consenting process, participants were interviewed by the researcher for an average time of one hour. Participants were identified using a pseudonym they created.

In-depth interviews of female African American/Black adolescents with a history of foster care placement were used to gain adolescents' perceptions regarding their SRH. A semi-structured interview guide was developed based on relevant literature on adolescent development and SRH. Participants were asked questions related to their foster care background and history, individual strengths, supportive relationships, community involvement, communication with foster caregivers, perspectives about SRH, facilitators, and barriers to sexual health, and ended with their personal feedback on the study. Interviews were digitally audio recorded and professionally transcribed verbatim. Field notes, reflexivity journaling, and memos were completed during the data collection period to capture observed data, thought processes, and notes regarding current or future plans related to the study. Participants received a $25 Visa gift card for participating in the interview.

Data Analysis

Sources for data analyses included audio recordings, verbatim interview transcripts, field notes, and iterative conceptual memos. Dedoose, a web-based qualitative analysis application was used to organize, manage, and store various data related to the study, including memos, generated graphs, and codes. The researcher checked the transcript against the audio files for accuracy. Initially, the audio recordings were reviewed multiple times and notes were taken regarding initial ideas and plans for the study. Transcribed interviews were read at least three times to gain a gestalt of the interview, then analyzed using thematic analysis. Thematic analysis is a widely used qualitative analytic method that is used for identifying, analyzing and reporting patterns or themes within data. The data are also minimally organized in order to describe the findings in rich detail (Braun & Clarke, 2006).

Thematic analysis is not generally tied to a pre-existing theoretical framework and allows the researcher to identify experiences, meanings, and the reality of the participants (Braun & Clarke, 2006). This is consistent with the approach of qualitative description. Coding, while mainly inductive however, was influenced by theoretical underpinnings of positive youth development since this was an important a priori lens used by the researcher to elicit adolescent strengths. Themes captured important aspects of the data relative to the research question and represent a level of patterned response or meaning within the data (Braun & Clarke, 2006).

Braun and Clarke's (2006) six-phase process was used to conduct the thematic analysis of the data. The phases involved: 1) Becoming familiar with the data by listening to the audio files, reading the transcripts and field notes multiple times, making notes of initial thoughts, ideas, and future plans for the study. 2) Generating initial codes from the data and adding labels to various pieces of the data. Open, inductive, line-by-line/micro level coding was done to capture multiple aspects of the participant's perspective. Dedoose was used to assist with data

management, storage, and visualization. The researcher applied multi-level codes (parent, child, grandchild codes) to the transcripts and generated excerpts from salient codes within the software. 3) Searching for themes by looking for overt and subtle messages from the participants, assessing the codes and reviewing relevant field notes on observations during the interview. Codes with similarities were grouped together in order to form broader categories of increasing abstraction or initial themes. Themes were selected if the majority of the participants shared a common or prevalent perspective, or if any participant shared a perspective that was thought-provoking and accurately describes what other participants were experiencing. 4) Reviewing the themes by reviewing the codes, initial themes, and excerpts to decide if the final theme could be merged with another theme or should remain an individual theme. Another step was checking to see if the generated theme made sense and is addressing the research questions. 5) Defining and naming themes by ensuring that the generated themes accurately represented the data, answered the research questions, and provided conceptual meaning. 6) Producing the report for dissemination of the findings.

In order to check that the data were being analyzed fairly by ensuring biases were controlled, reflexivity/journaling allowed the researcher to note thought processes and biases related to the study. Further, analytic triangulation and member checking were used. For analytic triangulation, a group of peers not associated with the current study reviewed coded de-identified transcripts and themes. The researcher also worked with other qualitative researchers to review the data analysis process. Four of the research participants were contacted to review the final themes and overall narratives of the study to determine if the researcher's interpretations of the data accurately fit their perspectives. An expert who has a history of foster care placement and has worked with youth was also consulted to provide feedback on the researcher's analysis of the

data. These processes helped verify the analytic processes used and the conceptualization of the data. Thematic saturation was considered met when data were repetitive across participants, no new information was being provided by additional participants, and the research questions were answered. Thematic saturation started to occur after the 11th interview and this could be attributed to various factors such as the homogenous nature of the participants and the single focus of the interview surrounding SRH. Additional interviews were conducted and analyzed to verify that saturation was met.

Limitations

Data from this study is from a homogenous group of females from one state and may not reflect the views of other youth who were in foster care from other locations. This study also relied on self-reported retrospective information, which may vary from the participants' actual experience. Despite the study's limitations, all youth-serving professionals may consider the findings useful since there are limited qualitative studies about the perspectives of youth in foster care about their SRH. Additionally, the participants in this study were able to provide advice on how individuals who work with vulnerable youth can be supportive in order to promote their positive development and help them avoid succumbing to negative SRH risks.

Findings

Sample Characteristics

Interviews were conducted with 16 female African American adolescents between the ages of 18 and 20 with a prior history of foster care placement. The mean age of the participants was 19 years old. The majority (eleven) of the participants entered foster care between the ages of 11 to 16 (3 entered care between the ages of 6-10 and 2 entered between the ages of 1 to 5 years). The length of time spent in foster care ranged from 2 to 12 years with an average of 6

years. Ten of the participants identified as being straight, 4 bisexual, 1 gay, and 1 lesbian. Three of the participants reported being in a relationship and 3 reported they never had sex. When asked about contraceptive use during sexual intercourse, 8 of the youth reported using contraceptives sometimes, 4 used it all the time, and the other 4 said they never used contraceptives. Two participants reported a history of STIs and 3 reported never being tested for STIs. Eight of the participants had a history of being pregnant, where 6 reported that the pregnancy was unplanned. There was a range of 1-2 children for parents in the study. Six parents in the study had one child, while the other two parents had two children. Ten of the participants were employed, one was a college graduate, 4 had some college and 7 completed high school. Themes for the study included: relationships with caregivers, internal assets, sources for SRH information, and perspectives on SRH communication.

Relationships with Caregivers

The theme of relationships with caregivers refers to any foster caregivers such as foster parents and staff, who were present in the youth's life while they were under 18 and in foster care that they reported having a relationship with. When the participants were asked questions related to relationships with their caregivers or who they considered supportive, the narrative for the majority of the participants was that they did not perceive strong supportive relationships with foster caregivers and felt unable to go to them for information about SRH. At first, almost all of the participants in the study reported that they had no support during care and they supported themselves. Even when the question was rephrased to ask who were responsible for them or who took care of them, many said no one did. As stated by Ivory*, "Nobody. I took care of myself." However, after further probing, the participants reported that staff were present in group

* Pseudonym

homes and foster parents were at home with the youth. However, according to the participants, besides the presence of the caregivers, a sense of relationship was not felt by the youth, and they often had to navigate life in foster care by themselves or with little support.

Challenges with caregivers. Youth reported that some foster mothers were elderly, had health issues and were never home, therefore, they were left alone. Mary* reported that her foster mother was nice, but she had to take care of her sick husband. These factors were felt by youth to hinder a positive relationship when caregivers were unable to fully commit to them. According to India Kelly*, besides the Department of Social Services, she was on her own, as she stated:

> DSS, then really myself, you know, once you've passed from a group home you're basically on your own moving from foster homes and residential and going to juvenile, you're basically on your own.

Lack of trust. Issues with trust was a common reason why youth reported feeling alone in foster care. According to Alex*: "It was hard, just because I felt like people…were not trustworthy. I couldn't trust anybody. It was only me against the world." Alex* also mentions challenges she faced with social workers over time, who were unreliable and how it affected her trust in workers:

> [T]he only person I had the first four to five years into foster care was my social worker but that five year span I had eight social workers. They really told me they would always you know, communicate my best needs when it came to my mental health…And they didn't help me. Like I would tell them how I felt, like those were the times I would voice my opinion when I felt it would make me worse, and you know, they said, okay, we'll do it but they never did anything and I feel like my biggest trust issue is that people say

> they're there and they leave or they say they'll do something and they are there to help you and you watch and observe and they never did do it.

Staff did not take their roles seriously. Youth reported that staff in foster care did not take their jobs seriously, violated confidentiality, and were not interested in trying to help the youth that needed them. For example:

> I wish there were more people in the residentials… that actually did the job because they care and they wanted to make a difference. I feel there's kind of a lot of people that's like - "Well, I got the degree but my job it makes no money so here's the middle ground." And maybe they got the degree but they're just like, the job that they wanted they didn't get it so. – Alex*

One participant also reported that there was no relationship with some of the group home staff and she only interacted or saw the staff when they had to discipline her for bad behavior.

Felt unheard by caregivers. Youth reported having a hard time forming relationships with their caregivers because they felt that caregivers were not actively listening to them. As a result, youth reported a tendency to isolate themselves. Sarah* stated:

> A lot of people listen and don't listen with the intent to understand but listen with the intent to reply, and so it really helps if somebody just listens and is just listening, trying to understand and trying to empathize, you know, just being an ear. Like because so much in foster care we get told - talked at so much and told what we did wrong. There's not a lot of understanding people in foster care, you know, and a lot of us just are tired. Like, you know, sometimes it's nice to just vent and get stuff off our chests, like you know.

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* Pseudonym

Internal Assets

The theme of internal assets references how youth used their personal strengths to navigate a world with little perceived support and strategies they implemented to handle challenges in order to have overall wellbeing. In addition to reported personal weaknesses or challenges and negative coping skills, the youth in the study spoke about their many strengths and strategies for handling various challenges while in foster care.

Individual strengths. In exploring the reported strengths of the youth, it was observed that many of their strengths were exactly what they hoped for in others. Youth wanted caregivers who were listeners, cared for them and uplifted them, to name a few. Participants listed the same or similar characteristics as their strengths in addition to being smart, resilient, social, goal oriented, and determined to succeed. Here are some other examples of reported individual strengths:

> Just being kind-hearted, being open to listen and being open-minded. Like I feel like that's my biggest strength cause like even to this day like being really open-minded about things. – Jordan*

> I would say that I was very goal-oriented, so I wasn't gonna let anything stop me from getting to where I was gonna get. –Treasure*

Children/child as strengths. Some youth reported that being a mom and having a child were both strengths and motivators. Jay* and Nay* mentioned that their pregnancies were unplanned, but they spoke positively of their children and the impact the child/children had on

* Pseudonym

them. Both reported that children served as motivators for them to keep going and be strong. According to Jay*:

> I'd say my kids are my strength cause they kind of like motivate me every time… just go[ing] out there and doing stuff like for them and then me just motivating myself even more. Even if there [are] times when I want to give up half of the time, but then in my mind I'm like, you have children. They want you to be strong for them and then motivate them.

Here is Nay*'s perspectives on how her daughter motivates her to keep going:

> I have celiac disease so some days I'll wake up and I'll just be really depressed and stuff like that and I don't want to get up and go to work … sometimes I will be so sick, so I look at her and she'll just be my motivation...other people get sick or other people be at work and being paid, I can do it too, like mom, I think about other single moms that I see that actually have like more than one kid and live on their own and never really have help, so I actually look at her and when I look at her I think about all that stuff. So, she actually gives me motivation to get up… Christmas time, nobody wants to be broke and have a child, and if she just come out of the room and she don't see no gifts, so like you know, it makes me want to get up and go to work. It makes me want to go to school to show her regardless of what you go through or regardless of how you feel or how sick you get, you never let your sickness, you never let your feelings stop you from being great cause that's what my mom did, just a lot of excuses with me when I was little. A lot of "Oh I can't do this" or "I can't do that" or "Because I have you..." Her excuse why is because of me. –Nay*

Not easily influenced by peers. When asked about peer relationships, most participants reported not having friends. Those who reported having friends stated that they were more like classmates or associates, not a friend to confide in. Most participants also did not talk about being influenced by peers to engage in risky behaviors. Harmony* reported, "I wasn't afraid to say no and I wasn't easily peer pressured... I was an advocate for myself."

Sources for SRH information

Sources of SRH information refers to every reported aspect of how adolescents learned about topics/issues related to SHR such as puberty, contraception, sexual intercourse, getting pregnant and abstinence. Youth reported learning about SRH from sources such as the internet, foster care workers and caregivers, health care professionals, foster care program, and through sexual abuse.

Internet. Some youth in the study mentioned how difficult it was for their biological caregivers to talk to them about topics such as sex and contraceptives when they lived at home because their biological caregiver thought it was inappropriate. As a result, they had to explore on their own before and during foster care. Jordan* stated, "My mom would be mad because like - she just felt like certain things are inappropriate and like, I'm just like, well you didn't tell me, you didn't teach me so how would I know?" Here is another example from Treasure* who said, "She really wasn't trying to open up to me about that kind of stuff, so I Googled it. She wanted me to stay young for a long time which didn't help, so I just Googled it." The majority of the participants reported getting information about SRH from the internet by just searching for what they were looking for.

* Pseudonym

School. Another common avenue for learning about SRH was in school through a sex education/health class. Some youth reported that the classes were not useful because they already knew the information and that the information provided was very "sugar coated"-Jordan*. Others reported learning a lot from the classes in elementary school. Here is a participant's response:

> School. When you get in ninth grade you take a health class and they talk to you about condoms and stuff, about sex, they talk to you about everything all down the line. They talk about everything. So usually in ninth grade, yeah, ninth grade you have to take a health class. -Treasure*

Department of Social Services. Another way the participants received information about SRH was from their local department of social services, who had college-aged students talk to the youth. According to the participants, the group discussion was well received by the youth.

> We had to go to like groups and stuff about like sexual health and stuff like that,…people would come and see us and talk to us about it,… like in foster care … they know a lot of us are sexually active or hypersexual and stuff like that so they try to inform us.-Sarah*

A.C.E s. (Sexual Abuse and Molestation). For some youth, they learned about SRH aspects such as sex and abortion due to being sexually abused in the past. Jordan** reported that she did not learn about her body or SRH "correctly". Jordan* stated:

> A lot of things just happen…I had older siblings so it was just like, they kind of taught me but then after that - I wasn't taught correctly… I didn't like my body growing up because it made me look older and then like being hurt and continuing to be hurt as my body was growing.

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* Pseudonym

Sexual abuse may also cause youth to have a dissociation with sex, as stated by Daisy*, "I was molested and stuff but I wasn't trying to be into sex after that. I wanted to not be in sex for a long time." Mary* reported that she learned about sex by being abused at a young age, then became pregnant and had to have an abortion as a result.

Could talk to obstetrician-gynecologist (OB-GYN) about anything. Youth often reported that they had no relationship with their doctors because they just did their job. However, some youth did mention having supportive relationships with their OB-GYN and went to them for information about SRH, as shared by Mercurel*

> I went to my OB-GYN. Just who she is, personality and there was no judgment and nothing didn't feel no bad vibes, I didn't feel like she was judging me. It didn't feel like I couldn't really talk to her or nothing like that. It felt genuine –Mercurel*

Perspectives on SRH communication

Participants provided information about some of the barriers and facilitators that were present in communication with their caregivers about SRH. This theme represented youths' perspectives on how individuals such as caregivers, healthcare professionals, and other staff can effectively engage in conversations with vulnerable youth, assist, support, and teach them about SRH. The youth in the study provided feedback on what worked for them and what did not.

Establish a relationship. Youth reported entering foster care with their guards up because they did not want to be there and lacked trust with others. As reported by one of the participants, Alex*. Individuals tend to say that they will be there in times of need and they don't show up, which makes them unreliable. This unreliability then leads to a lack of trust between the youth and other individuals. Further, participants reported lack of trust in both the system

* Pseudonym

and in their caregivers as well as a discomfort talking to their caregivers or being in their home. As a result, it was not easy to discuss sensitive SRH topics. Ivory** stated, "It was really awkward. If you don't feel comfortable talking to somebody it's way, it's way more uncomfortable telling them about something like that." Youth reported that caregivers should show the youth that they care and are open to talk about anything.

Relationship takes time. Youth reported that caregivers should try and build genuinely trustworthy relationships with the youth because they have been through a lot and have a hard time forming relationships. Here is an example:

> I build a wall up and it' s always like hard to break it down when you're so use to always being hurt and not use to really having somebody there, so you build a wall and keep your vulnerability in. It always took me to trust someone, at least five or six months, to at least open up about a little thing and then as time goes on like the big stuff will come out after eight months. And so, it takes time for us to realize that you're actually trying to help and you're not just gonna use the information against us, and you're not gonna leave once we tell you the past. Because most people that build up walls like I did, we have attachment issues because of abandonment and stuff like that. So, I know that I didn't want to trust someone because if I trust you I get attached and they're not always gonna be there. -Alex*

Preferred communication style. When discussing sensitive topics related to SRH, it is advised by the participants that the discussion should be paced or occur in steps and the youth should not be bombarded with information or forced to have the discussion.

* Pseudonym

Don't demonstrate anything during SRH discussion. Talking about SRH can be uncomfortable for both youth and their caregivers. Therefore, youth warn not to make the discussion awkward by using unnecessary demonstrations.

> Those parents that want to use like fruit and stuff to demonstrate, it makes it really awkward. Not fruits, just don't demonstrate. You can talk about it but just don't demonstrate, that's like what makes someone feel uncomfortable. – Ivory*

Don't just bluntly ask if they are having sex; ease into discussion. Participants reported feeling negatively judged by their caregivers, who made incorrect assumptions about them regarding their sexual behavior. The youth advised that assumptions about them being sexually active should be avoided. Here is some advice from India Kelly*, "Don't come to them like, "Are you having sex?" Just be like, "Well, I really want to talk to you about …." Nya*, mentions the importance of taking steps during the discussion.

> Take about a step at a time because some kids are not that open to telling you everything, so just take pieces by pieces. Like if you can get a little bit of information from them then just go with that and work your way to know like what is it that they need help with, what is it that they want to know, what is it that they're having a hard time trying to figure, you know. Like stuff like that. So just don't force it. –Nya*

Caregiver Behavior. The participants provided some advice related to how caregivers should behave in order to have the most effective interaction with youth. Participants reported that caregivers should realize that they are working with youth who need to be nurtured. Therefore, caregivers should be patient, genuine, non-judgmental, and non-intimidating to name a few. Below are some subthemes and examples.

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* Pseudonym

Be vulnerable. According to the youth, caregivers such as nurses, staff, and other workers should turn off their professional role sometimes and show their sensitive sides and relate to what the youth is experiencing, if possible. Nay* stated:

> Show [your] vulnerable side. Because like my whole life is a vulnerable side… So, don't be so professional sometimes. Sometimes it's okay to cry with me show that you're sensitive too, you're not just a front. –Nay*

Be loving and nurturing. Youth in foster care were often neglected and abandoned by their mothers. Some participants talked about feeling alone and not having the nurturing and support they yearn for while in care. Here is an example by Alex*:

> When you're dealing with people that are damaged or have a broken past… they're kind of like babies. You know, you have to be open and you have to care and you always have to have patience because I know that some of them are really cautious of who they trust, only because of experience and they're real quick to act out instead of talk about their feelings So it's just, they need people with more patience and actually care and love and support the youth in those situations, and I feel like if that' s what …a lot of us had, [people] would realize a lot quicker that everybody' s not a bad person.- Alex*

Don't be judgmental. Throughout the study, participants talked about feeling judged by various staff, caregivers, and society. As a result, youth encouraged individuals to stop judging them and try to understand them. Here is some advice from Treasure*:

> [A] lot of adolescents or females or girls they don't want to be judged about what they're doing, they just want you to understand where they're coming from or talk to them and be

* Pseudonym

> honest. Don't lie to them … They just want you to be honest and they're scared that somebody's gonna judge them. - Treasure*

Suggested content for SRH discussion. Participants spoke about areas they lacked knowledge in while in care and the kind of information they wished they received related to puberty (menstrual cycle) and topics surrounding contraceptive use. Topics about contraceptive options and pubertal changes/body development can be used to guide future discussions.

Wished step mom provided information about menstruation and contraceptives. Puberty is a topic that caregivers can discuss with youth since all of them will undergo developmental bodily changes. Also, contraceptive methods is a topic that caregivers can talk about. Here is an example from Mary* about what she wished she learned:

> I wish that my step-mom would have told me about my first period. I really got freaked out when I first started… I wish she would have like told me like, you know, this is what's gonna happen at one period of your life as you start growing up and being a lady and stuff like that, and I wish people had told me - to be honest, I didn't know what a condom was until I was what 16, 17, just two years ago, and that's really… embarrassing cause everybody knew what that was except me and I was like, wow. Like I didn't have people in my life that would tell me that but I'm glad that other people do because, you know, they will prevent themselves from having diseases and stuff.

Wished someone said to wait for sex for as long as possible. While it is practical to discuss SRH with youth in order to keep them informed with the most accurate information, some youth are interested in abstinence and caregivers should let youth know that they do have the choice to wait. According to Sarah*:

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* Pseudonym

I wish I would have waited… there was a lot of like peer pressure and stuff like that. Like I wish somebody would have just told me like, you know, you don't have to have sex to be cool. Like, you know, you don't have to have sex to keep someone.

Discussion

This study appears to be one of the first to gain female adolescents with a history of foster care placement's perspectives on their SRH, including how they obtained information related to SRH and how caregivers can better support them. Due to a perceived lack of support, youth are left to find answers to their questions and tools to help them avoid risks on their own. Youth may depend on their individual strengths to learn about issues such as SRH. Characteristics that are found lacking in their caregivers are often what youth will develop as their strengths.

Youth in this study were resilient, smart, adaptable, open-minded, listeners, caring, trust-worthy, and resourceful. These strengths helped them to be investigators and gather information regarding their SRH. Youth turned to the internet as their primary source of information related to SRH. One factor that could potentially explain why youth turned to the internet, was the fact that it was a judgment-free zone, where they could privately gather all the information they needed. Feeling judged was a frequently mentioned issue with the participants. This study had similar findings to King Jones's (2010) study, which reported that youth considered the internet as influencing their SRH and a source for education. Even though youth preferred the internet, they did acknowledge stress related to inaccuracies and complex medical jargons online.

In order to ensure youth are getting accurate information, caregivers should be actively involved in communication about SRH. This study had similar findings to Aronowitz, Rennells, and Todd (2006) and Aronowitz, Todd, Agbeshie, & Rennells (2007), which reported that

African American youth wanted to receive information about SRH from their parents, but parents reported feeling uncomfortable talking to their adolescents about SRH and often lacked accurate information. Youth in this study reported feeling uncomfortable talking with others about sensitive topics due to fear of being perceived negatively by caregivers. It is essential for caregivers to build relationships with youth and initiate conversations regarding SRH.

Youth in this study mentioned various challenges related to their social workers and group home staff. The youth felt like the workers did not value their jobs and were not interested in being supportive of the youth as they should. These perspectives add to current literature, which indicates that many workers within the child welfare system such as social workers are often overworked, underpaid, and unsatisfied with their jobs (Farber & Munson, 2010; Kim & Stoner, 2008). As a result, child welfare workers need to be supported more in their roles by welfare agencies so that they can, in turn, be supportive of the youth they are supposed to serve. Measures should include interventions to ensure that the workload of the workers is manageable, which can allow them the ability to spend more time engaging with youth, offering advice, and being that nurturing role model that the participants sought.

In order to effectively address the needs of youth in foster care, workers should also be trained to understand the various ACEs youth in care faced and their potential outcomes. Workers should then learn how to best work with youth given their history by providing trauma informed care. Some workers may not know how to effectively engage in communication surrounding SRH. Therefore, staff should receive training that will enable them to learn more about SRH, how they can deliver accurate SRH information to youth in care, and where they can find additional resources and support for themselves and the youth.

While society might see teenage pregnancy as all negative, some youth view pregnancy and having a child positively. Also, adolescents can experience teenage pregnancy due to reasons such as uncontrollable environmental or societal factors, lack of personal choice due to sexual abuse and reproductive coercion, the weathering process, and an opportunity to prove their reproductive ability by getting pregnant.

When it comes to teenage pregnancy, evidence tends to indicate the negative effects of childbearing on the adolescent's life and future outcomes (Trussell, 1988). Researchers go on to label teenage pregnancy as a social problem (Winter & Winter, 2012). However, the focus should shift from stigmatizing and viewing the adolescent mother as problematic, but rather examine the external factors that can contribute to early pregnancy. Factors such as poverty, lack of positive role models and caregivers, and limited education can place an adolescent at risk for teenage pregnancy (Furstenberg, 2007), and therefore should be addressed in order to reduce adolescents' risk for unintended pregnancies.

Despite the pregnancy being planned or unplanned, parents in the study viewed having a child positively. Findings from this study about children as strengths or motivators also adds to existing research with other adolescent mothers who reported that there were challenges associated with teenage pregnancy, but having a child had motivating effects related to school, mental wellbeing, and being a good mother (Seamark & Lings, 2004; Chohan & Langa, 2011; Macleod & Weaver, 2003). Some youth in care view having children as an opportunity to have a family they longed for, someone to love and care for, a support for them in the future, and even motivate them to change their lives (Mantovani & Thomas, 2014). Prior studies indicated that some adolescent viewed their pregnancy as an acceptably normal and manageable situation (Olsen, Santarsiero & Spatz, 2002). Some youth doubt their ability to get pregnant and reported

that the ability to conceive served as proof of their body's normal reproductive functioning (Olsen, Santarsiero & Spatz, 2002; Burton, 1990).

Additionally, some youth in foster care might not have choices to avoid pregnancy due to sexual abuse or coercion. In these instances, youth should be empowered to understand the nature of healthy relationships and the ability to make choices regarding reproduction. Another factor to be considered regarding teenage pregnancy is the "weathering hypothesis." The weathering hypothesis proposes that some vulnerable young African American females think that their health will deteriorate as they get older due to various economic and societal factors, and view childbearing as an adaptive/coping mechanism (Geronimus, 1992).

Further studies also support the weathering hypothesis by showing that African Americans start experiencing health deteriorations earlier than their White counterparts due to various factors including chronic stress (Geronimus, Hicken, Keene & Bound, 2006). As a result, some adolescents view early childbearing as a better choice due to their perceptions of aging quickly and having a potentially shorter life span (Meadows, Beckett, Elliott & Petersen, 2013). Some young women are aware of the health status and early mortality rates of community members and may conceive early to give individuals an opportunity to be in their child's life (Burton, 1990). Another factor in the weathering hypothesis is that some young women think that their economic situation may not be ideal and will not improve, and as a result, do not see the need to delay having children until they are older (Meadows, Beckett, Elliott & Petersen, 2013).

Given the mentioned factors surrounding teenage pregnancy or early childbearing, society should not view young mothers as problematic or stigmatize them, but attempt to address various socioeconomic factors affecting them. Addressing problems related to the educational

system, better job opportunities, and equal access to health care to name a few have the potential to change the narrative of vulnerable youth.

As a result, when working with youth who are pregnant or have a child, we should incorporate the positive implications of parenthood rather than exclusively focusing on the negative effects. By focusing on youth's sense of strength and fulfillment, we can work with them to facilitate their and their children's optimal development, health outcomes, and overall wellbeing. It is important to focus on the health promotion of youth in order to help them avoid risks. Despite the participant's reported internal assets and willingness to address SRH issues on their own due to limited support, they still need external assets such as positive relationships with caregivers and resources to help them avoid risks. When youth have healthy relationships and are able to interact with mentors, caregivers, health providers, and other role models they have the opportunity to make better choices and avoid risks (Elkington, Bauermeister, & Zimmerman, 2011; Benson et al., 2006).

Additionally, external resources such as sex education in school, group discussions about SRH similar to what was offered by the DSS are important external factors that can help youth learn about SRH and be more prepared to handle challenges. Youth need to have their internal assets aligned or supported by extremal assets or factors to help promote their healthy positive development and wellbeing (Development, 2018; Futch Ehrlich, V. 2016).

Future Implications for Practice

Youth who experience limited support systems in place are at a disadvantage because they lack important role models, caregivers, and professionals to help guide them as they navigate life and make decisions to promote their overall wellbeing. From this study, we learned that the youth had caregivers around, but youth most often perceived that they did not provide

meaningful support. Youth would like caregivers to be more involved and supportive of them by building trusting relationships with them over time. Vulnerable youth with a history of ACEs know that they are a unique group of individuals and want to be nurtured, listened to, and supported.

Working with vulnerable youth can be challenging, but when we listen to what the youth are saying we see that there are reasons for their behaviors. Issues related to lack of trust and confidentiality with caregivers lead youth to have their walls up. Then, there are caregivers who may lack patience and interest in their roles and so they neglect to form nurturing bonds with the youth. As presented in the study, if we listened to the youth, we will be able to understand them and how to be supportive of them. Also, given their history of ACEs, if caregivers are trained in this area, they will be able to relate to the youth and understand the many challenges some youth face and how to build relationships with them in light of these challenges.

Adolescents are often viewed through a negative lens or as problematic (Damon, 2004). It is easy to avoid vulnerable youth such as those in foster care and judge them. Despite the challenges of working with vulnerable youth, they should be viewed through a positive lens. Everyone working with vulnerable youth should be trained to understand ACEs and implement positive youth development (PYD) based interventions and policies. PYD is important because despite facing various ACEs and ongoing challenges, some youth go on to be productive adults and do not engage in negative or risky health behaviors. From a PYD perspective, adolescents/youth are seen as individuals who have the capacity to thrive based on their potential for positive, successful and healthy development (Bruner, Eys, Wilson, & Côté, 2014). The premise of PYD is that young people are seen as assets because they possess various internal assets that enable them to thrive (Futch Ehrlich, V. 2016). Youth in this study described

numerous personal strengths such as being resilient, smart, goal-oriented, self-advocating, open-minded, adaptable, outgoing, not easily influenced by peers, and caring to name a few. These strengths helped them to be resourceful investigators and gather information regarding their SHR.

The next step is to bring youth to the table and have discussions with them in order to understand how we could best serve them based on their strengths. Policy makers, SRH educators, and personnel from schools, youth-serving agencies, and the Department of Social Services to name a few should work more directly with youth in order to create new policies that ensures caregivers are being trained to deliver trauma informed care, obtain skills regarding SRH communication, and child welfare workers have manageable caseloads. Additionally, researchers should conduct more qualitative studies giving youth an opportunity to share their perspectives on what is needed for their positive development and outcomes.

According to the youth, they would like caregivers to be patient, relatable, genuine, and nurturing to name a few. Their request is simple: be authentic and support them. Stop judging them and listen to them. Caregivers should talk with youth; let them know they are there for them. Also, caregivers should not be afraid or hesitant to talk about SRH, just don't make the conversation awkward by using inappropriate demonstrations, assuming they are sexually active, and bombarding them with information all at once.

This study was conducted due to limited existing knowledge regarding the SRH of adolescents in foster care from their perspectives. Findings from this study provide a deeper understanding of the perceived lack of support experienced by youth in care, their internal strengths, their experiences obtaining knowledge about SRH, and perspectives on SRH communication with caregivers.

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Chapter Five: "I'm not gonna die because of an STD": Female African American Adolescents' Perspectives on How They Protected Themselves from Sexual Risks While in Foster Care.

(To Be Submitted to: Children and Youth Services Review)

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Abstract

Vulnerable youth with a history of adverse childhood experiences (ACEs) are at greater risk for negative sexual and reproductive health (SRH) outcomes. Many of these youth are placed into foster care and lack supportive relationships to help them navigate life. Researchers tend to focus on adolescents' deficits and do not often seek youths' perspectives about their strengths. The purpose of this qualitative descriptive study was to explore and describe how female African American youth with a history of foster care placement protect themselves from SRH risks from their perspectives. This study examined the challenges youth faced as they tried to protect themselves and the protective strategies they used to help reduce SRH risks during foster care. Semi-structured interviews were conducted with 16 Female African American adolescents, ages 18 to 20 years old, with a history of foster care placement. Purposive sampling was done to recruit participants from a metropolitan area in Virginia. The transcribed interviews underwent inductive thematic analysis. This paper focuses on the theme of protection from SRH risks and its subthemes of challenges that made it difficult to avoid sexual risks and protective strategies that facilitated avoidance of sexual risks. Youth reported that yearning for connection, vulnerability to reproductive coercion, and judgmental caregivers were some challenges, while protective strategies included open communication with their caregivers about SRH, abstinence and contraceptive use and their self-desire to be healthy. Findings from this study will add knowledge regarding protective strategies vulnerable youth in foster care can use to safeguard themselves from negative SRH outcomes. Culturally sensitive recommendations regarding Long Acting Reversible Contraceptives (LARCs), screening for reproductive control, and the need for trauma informed interventions will be discussed.

Introduction

The current state of the science related to the sexual and reproductive health (SRH) of adolescent girls in foster care is very limited, yet they represent a unique group of individuals who are at greater risk of experiencing many negative social and health outcomes in comparison to adolescents without a history of foster care placement. Evidence suggests they experience higher rates of behavioral problems (Crosby, Day, Baroni, & Somers, 2015; Thompson & Auslander, 2011), both internalizing and externalizing psychiatric problems (Greeson, et al., 2011; Jackson, O'Brien & Pecora, 2011; Thompson & Hasin, 2012; Harpin, Kenyon, Kools, Bearinger & Ireland, 2013; Salazar, Keller, Gowen & Courtney, 2014), self-harm and substance abuse (Pilowsky & Wu, 2007; Harpin et al., 2013; Thompson & Auslander, 2011), and involvement with the legal system (juvenile detention) (Yampolskaya, Armstrong & McNeish, 2011). Further, youth in foster care are at greater risk for engaging in risky sexual behaviors, which puts them at higher risk for negative SRH outcomes, such as unintended pregnancy and sexually transmitted infections (STIs) (Thompson & Auslander, 2011).

The purpose of this paper is to present findings from a qualitative descriptive study which aimed to explore and describe the challenges female African American adolescents in foster care encountered as they tried to protect themselves from SRH risks and their protective strategies to avoid these risks. Background will be presented on the foster care context, SRH trends for African American adolescents in general, and what we know about African American adolescent SRH in foster care, including the gap in knowledge this study intended to fill.

Background

Foster Care Context

The purpose of the foster care system is to provide an alternative and temporary living solution for children who are unable to live at home with their biological family due to various adverse experiences such as neglect, abuse, and abandonment (Virginia Department of Social Services, 2016; Childwelfare.gov, n.d; 2006 Code of Virginia § 63.2-100 - Definitions, 2016). In the United States, annually, there is a substantial number of children entering foster care and this number increases every year (Adoption & Foster Care Statistics, 2017). As of September 2016, there were 437, 465 children in foster care and 101, 825 (23%) were Black or African American (AA) (Adoption & Foster Care Statistics, 2017). Children enter the foster care system for numerous reasons such as neglect, abandonment, sexual and physical abuse, which may have hindered their healthy development (VDSS, 2016; Childwelfare.gov, n.d.). During the fiscal year 2016, the primary reason for children being placed in foster care was neglect, which 166, 679 (61%) of children faced, followed by parental drug abuse 92,107 (34%), and caretakers' inability to cope 37, 857 (14%) (Adoption & Foster Care Statistics, 2017).

African American Adolescent Sexual and Reproductive Health

African American adolescents acquire sexually transmitted infections (STIs) and experience unintended teenage pregnancy at a much higher rate in comparison to their White counterparts (Wiltz, 2015). In terms of STIs, African Americans have gonorrhea rates that are 30 times higher than their White counterparts (CDC, 2015) and African American women are also at highest risk for genital herpes (CDC, 2015). African American adolescents aged 15 – 24 years had the highest rates of Chlamydia in 2014 (CDC, 2016). In comparison to white females between the ages of 15-19 years old, African American females had rates that were 4.9 times greater (6371.5 cases per 100,000 females (CDC, 2015).

Despite the downward trend of teenage pregnancy since 2011 in America (CDC, 2016), African American and Hispanic teens made up 57% of teen births, which represented the highest rate of all ethnicities (CDC, 2015). In 2016, Hispanic females between the ages of 15 to 19 years old had the highest rates of pregnancy resulting in 31.9 births per 1,000 females, followed by African American/Black adolescents (29.3 births per 1,000 females) (CDC, 2018).

African American Adolescents in Foster Care

Youth in foster care are at greater risk for negative SRH outcomes due to their sexual risk-taking behavior (Gramkowski, Kools, Paul, Boyer, Monasterio et. al., 2009; Thompson & Auslander, 2011). In one Midwest study of youth in foster care, more than 90 percent reported having sexual intercourse, most reported having sexual intercourse within the past year, and about 60 percent of the youth reported using contraception (Courtney, Dworsky, Ruth, Havlicek, Perez, & Keller, 2007). Females in the study were more likely to ever had sexual intercourse, engage in risky behaviors that placed them at risk for pregnancy, and contracting an STI (in comparison to female youth not in foster care) (Courtney et al., 2007). Female adolescents in foster care are also more likely to receive payment in exchange for sex and less likely to use birth control in comparison to female adolescent youth not linked to foster care (Courtney et al., 2007).

While African American adolescents in general experience higher rates of STIs and unintended pregnancies than other adolescents in the general population (Courtney et al., 2007; CDC 2016; CDC, 2018) youth in foster care have even worse negative SRH outcomes in comparison. In the Midwest study referenced above, 261 (71%) percent of the youth with a history of foster care placement reported ever being pregnant in comparison to 34 percent of youth in the general adolescent population, youth in foster care were also more likely to have

repeated pregnancies, and the pregnancy was intentional for 30 percent of them (Courtney et al., 2007). In studies conducted in Utah, New York, and Chicago, the results were similar where youth in foster care had higher rates of teenage pregnancy, higher rates of fathering a child, higher rates of STI, and are most likely to engage in risky sexual behaviors as compared with other adolescents (Love, McIntosh, Rosst, & Tertzakian, 2005).

Despite the negative impact of poor SRH such as STIs, teenage pregnancy and sexually risky behaviors, African American youth in foster care continue to face disparities because we do not fully understand what is contributing to these disparities. In particular, there is limited understanding of the perceptions that adolescents with a history of foster care placement have about their SRH, including the multiple complex factors that contribute to their SRH disparities and how they protect themselves from sexual risks. This lack of research evidence regarding the SRH of adolescents in foster care limits their ability to have resources allocated to them because evidence-based practices often drive policy development and implementation. Evidenced based interventions will empower vulnerable youth to avoid involvement with risky SRH behaviors, and thus protect their health and development.

Methods

Design

In order to capture and report the experiences and perspectives of the adolescents in this study, a qualitative descriptive design was used. Qualitative description is less theoretical and its goal is to go beyond interpretation of the findings, in order to provide detailed and complete descriptions of a participant's experience in a manner that is credible (Sandelowski, 2000; Neergaard, Olesen, Andersen & Sondergaard, 2009; Chen, Rivera, Rotter, Green & Kools, 2016). When working with smaller samples, hard to recruit populations, or the paucity of

research when looking at the perspectives of youth in care regarding their SRH, qualitative description is a pragmatic method that can be implemented (Neergaard, Olesen, Andersen & Sondergaard, 2009)

The epistemological perspective for this study was to maintain an interpretivist stance. Epistemology focuses on what we know and how we know what we know about that reality (Kalof & Dan, 2008). Interpretivism falls under social constructivism and posits that there are multiple truths. The goal of research using this perspective is to rely on the study participants to provide their views on various experiences to reflect these multiple realities and not the researcher's views or perspectives (Creswell & Poth, 2018; Kalof & Dan, 2008; Lincoln & Guba, 2000). Adolescents' perspectives are valuable but often neglected in the development of important interventions that could benefit them (Gulati, Paterson, Medves, & Luce-Kapler, 2011). For this reason, this study uses a qualitative descriptive methodology with a lens for social justice and positive youth development, while holding an interpretivism position.

Theoretical underpinnings for the study included the Positive Youth Development (PYD) theory and the resilience theory. Youth enter foster care for reasons related to ACEs and can be at an increased risk for negative health and social outcomes. However, despite ACEs, some youth are resilient and go on to thrive despite adversity. Resilience theory which serves as a foundation for the PYD theory explains that some youth are able to have better outcomes when their internal assets and external resources/assets (promotive factors) come together in order to provide support and guidance for the youth (Masten, 2018; Zimmerman et al., 2013; Fergus & Zimmerman 2005). Like resilience theory, under PYD, adolescents are seen as individuals who can thrive based on their potential for positive, successful and healthy development (Bruner, Eys, Wilson, & Côté, 2014). PYD is an interdisciplinary theory used by youth development

professionals and programs to promote competent, healthy, and successful youth (Benson, Scales, Hamilton, & Sesma, 2006). The premise of PYD is that young people are seen as assets because they possess various internal assets that enable them to thrive (Futch Ehrlich, V. 2016). The PYD and resilience theories offer a comprehensive and culturally appropriate approach for working with youth in foster care.

Participants and Settings

Adolescents between the ages of 18 to 24 who identified as female and African American with a history of foster care placement were recruited for the study. This age group of emerging adults was selected for their cognitive ability to reflect and share their retrospective experiences regarding SRH while they were under 18 and in foster care. The Virginia Department of Social Services and the University of Virginia institutional review boards provided approval for the study to be conducted in-person and over the phone based on the participant's preference. Purposive sampling was conducted in order to recruit participants from Virginia to participate in the study. An approved flyer was used to advertise the study in public places and online on social media platforms and Craigslist. The researcher also recruited participants by sharing information about the study with staff at agencies and other gatekeepers who worked with vulnerable youth and youth in foster care. Participants who were interviewed received a $25 Visa gift card for their time.

Data Collection

The researcher screened each participant for eligibility and provided information about the study to them. Upon agreement to participate in the study, the participants and researcher decided on a suitable location and time to conduct the interview. Before each interview, the researcher discussed the study and provided the consent form for each participant to read and

sign. If the interview was conducted over the phone, an approved oral script was read by the researcher to the participant, who then provided verbal consent to be in the study. Participants were able to ask questions or discuss their concerns about the study with the researcher. Participants were given a copy of the consent form if requested. After consenting to the study, participants were interviewed by the researcher for an average of one hour, with interviews lasting between 25 to 70 minutes. Participant identity was protected by using a pseudonym of their choosing.

The researcher developed a semi-structured interview guide with input by the research advisors and institutional review boards for feasibility and appropriateness. In order to build rapport, the interview guide started out by asking ice breaker questions. Questions then flowed in a logical manner by asking surface level questions before moving into more specific and sensitive questions related to the participants' SRH. Other sets of questions sought information about foster care history and placement, personal strengths and weaknesses, support systems, communication with caregivers, SRH knowledge, history, and sources for information related to SRH. At the end of the interview, the participants were given the opportunity to freely add their final thoughts or opinions about any matter they chose. Interviews were audio recorded and transcribed verbatim by a professional transcriptionist who adhered to HIPPA rules and policies. Throughout the study, the researcher kept active records such as field notes, reflection journals, and memos to keep track of what was being observed, analytic thought processes, and future plans for the study.

Data Analysis

In order to capture important aspects of the data relative to the female adolescents' perspectives regarding SRH while in foster care, thematic analysis was conducted on the

verbatim transcription of the interviews. Thematic analysis is an analytic method widely used within qualitative research to identify and report patterns or themes within data (Braun & Clarke, 2006). Thematic analysis is not linked to a theoretical framework and inductively focuses on experiences, meanings, and realities based on the participants' perspectives (Braun & Clarke, 2006). Themes should be able to capture important aspects of the data relative to the research questions and aims, and represent a patterned response within the data (Braun & Clarke, 2006). As shown in Appendix A, Braun and Clarke's (2006) six-phase process of thematic analysis was implemented to analyze the participant's responses: 1) Becoming familiar with the data (p.16); 2) Generating initial codes from the data (p.18); 3) Searching for themes (p.19); 4) Reviewing the themes (p.20); 5) Defining and naming themes (p.22); and 6) Producing the report for distribution of the study's results (p.23).

The data analysis process involved reviewing the audio recordings multiple times, recording ideas and ongoing plans for the study. Secondly, the researcher checked the verbatim transcripts against the audio files for accuracy in transcription. The thematic analyses process was initiated after the transcribed interviews were read at least three times each. Dedoose, a secure, online qualitative and mixed methods data analysis program was used to store, organize, and visualize the collected and researcher analyzed data. The researcher initially coded all transcripts by entering codes into Dedoose. Excerpts were created to illustrate salient codes that were prevalent or particularly poignant. Similar codes were iteratively merged into higher order categories until final themes were derived.

The researcher conducted data analysis under the guidance of academic qualitative research experts and a group of peers not associated with the study, but with experience in qualitative methods. After the initial round of thematic analysis, member checking was done by

four of the research participants who were available when contacted via phone for verification purposes to determine the credibility of the researcher's data analysis and interpretations. The researcher also consulted with an expert who was familiar with youth in foster care, trauma informed care, and also had a history of foster care placement for input regarding the data findings and interpretations. During the verification process, the researcher continued to protect the identity of the research participants and only discussed findings and their interpretation over the phone. Data collection stopped after no new responses were being obtained by the interviews to answer the research questions and collected data were repetitive/similar among the participants. At this point, it was determined that thematic saturation was obtained and data collection ended.

Findings

Sample Characteristics

The participants for this study were 16 youth between the ages of 18 and 20, who identified as African American and had a history of placement within the foster care system. All were from the state of Virginia. Eight of the participants were referred to the study by foster care agencies, 5 were referred through information obtained from the VDSS, and 3 were recruited by the researcher through networking events for youth in foster care. Recruiting this population was challenging and gate keepers helped to make this study possible by sharing information about the study with potential participants.

Seven participants were 19 years old, six were 20 years old, and three were 18 years old. The mean age of the participants was 19.19 years old. Participants identified themselves as follows: 10 were straight, 4 bisexual, 1 gay, and 1 lesbian. In terms of education, 7 completed high school, 1 completed college, and 5 had some college education and 10 were employed. The

majority of the participants reported being single (13), 13 reported history of sexual intercourse, 8 used some form of protection sometimes, 4 never used protection, and the remaining 4 reported using protection all the time during sexual intercourse. In terms of pregnancy: 8 of the participants were parents, where 6 reported an unplanned pregnancy and 2 reported that their pregnancy was planned. For participants who were parents, most had 1 child, while 2 of the participants had 2 children. In terms of STIs, 13 participants reported being tested for STIs in the past and 2 reported a history of STIs. In relation to foster care history, 11 participants entered care between the ages of 11 to 16 years, 3 between the ages of 6 to 10, and 2 were placed between the ages of 1 to 5 years old. The time spent in care ranged from 2 to 12 years with a mean time of 6 years in foster care.

In order to understand the participants' perspectives regarding their SRH experience and needs, factors related to SRH decision making were explored. The overarching theme was *protection from SRH risks* and the two sub-themes were *factors that made it challenging to avoid sexual risks* and *protective strategies that facilitated avoidance of sexual risks*.

Protection from SRH Risks

Protection from SRH risks was defined as the strategies youth in foster care used in order to promote SRH and wellbeing by avoiding negative SRH outcomes such as getting a STI, having an unintended pregnancy, or being involved in risky sexual behaviors.

Factors that made it challenging to avoid sexual risks. Findings from interviewing participants suggests that *yearning for connection, vulnerability to reproductive coercion*, and *judgmental caregivers* were some challenges they faced that made it difficult for them to avoid sexual risks.

Yearning for connection. There are many reasons why a youth might engage in risky sexual behaviors. One reason is the influence of being in love or a romantic relationship on the youth's decision to engage in risky behaviors or not. There appears to be a yearning for connection in the form of seeking feelings of love or intimacy during the romantic relationship as mentioned by Ivory* below:

> Love. I wasn't really use to loving anybody or use to being loved, so once I did get that I didn't know how to handle it so I didn't protect myself as well as I would have protected myself with anybody else. –Ivory*

Vulnerability to reproductive coercion. Another reported challenge that was encountered appeared in the form of reproductive coercion, where the participant's partner influenced her decision to not use condoms. Treasure* mentioned that she and her partner had been together for a long time and she never thought of bringing up the use of condoms as this might lead to conflict, or her partner starting to question her fidelity. Here is what Treasure* said:

> He was older, so that had a big part to do with it. He could say like, "Oh, it don't feel good with condoms," and so he was older too... a lot of my decisions he influenced… I didn't want him to feel like I was out doing something else. You know usually how men are…"Oh, we haven't been using condoms since day one then now you want to start using condoms - who else you having sex with?" You know, I just didn't want to get into an argument about that so I just really never brought it up… Like I said, if you got a boyfriend that' s older than you, he will try to influence you to do a lot of stuff that you know you shouldn't be doing, I don't think anything made it hard (to protect herself) but him. – Treasure†

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* Pseudonym
† Pseudonym

Judgmental caregivers. Feeling judged or assuming that they will be judged by caregivers or health care providers often caused the youth to avoid interaction with them and hindered their ability to go to them for help with SRH issues. The majority of participants expressed experiences related to feeling judged, where they perceived that foster parents, staff, health care providers, and social workers would view them negatively and make unfair judgments about them. Participants reported that caregivers tended to assume the worst or that they were usually involved in risky activities. As a result of perceived judgmental behaviors, youth reported that it was a barrier to them obtaining information about SRH or even trusting providers of SRH to care for them. According to Mercurel*:

> I'd say you just got to not judge. Most people, especially I've seen a lot of nurses that judge right off, and they start talking… to other nurses before they come in and then you hear them. I done laid a lot of nurses out just in general because it could be something as in, I'm coming in to get a drug screen and then you're thinking it's a whole other thing. I'm coming for an insurance drug screening and I didn't do nothing. And you're just like, "Oh, this child … must be doing something." cause you see medicine and all that, no, it don't mean nothing like that. You can't be judgmental, like, you can't do that, especially not in those type of careers like that stuff is not even funny, cute, none of that…that really messes somebody up. And then you get to see the doctor and now you're mad, you know, like it's not a good experience.

Here is Treasure*'s perspective on how caregivers being judgmental affects youth.

> Being judged, especially if you've just come, like I came to foster care later, not when I was like younger, so a lot of adolescents or females or girls they don't want to be judged

* Pseudonym

> about what they're doing, they just want you to understand where they're coming from or talk to them and be honest. Don't lie to them because if you get pregnant, you know. They just want you to be honest and they're scared that somebody' s gonna judge them or just maybe what they were going through with their biological family prior to them coming in care and they don't want to really go back to that stuff. A lot of times they just try to deal with everything on their own. That's how they do end up getting pregnant, but for the most part they're just scared to like trust somebody … it scares a lot of girls.

Protective strategies that facilitated avoidance of sexual risks. Youth reported that protective strategies such as *open communication with their caregivers about SRH, abstinence, and contraceptive use and their self-desire to be healthy* helped them to take care of their bodies and avoid SRH risk.

Open communication about SRH with caregiver. Participants frequently mentioned various challenges they had with their caregivers, which left them feeling unsupported and unwilling to discuss sensitive issues concerning their SRH. However, based on their length of time in foster care and changing placements multiple times, some participants reported encountering caregivers who were supportive, trustworthy, genuine, and loving, and this made them more willing to talk openly about their SRH. The youth appreciated this relationship and were prepared to handle their SRH needs. Here is an example by Sarah* who talked about her supportive social worker and foster mother:

> I had a social worker, so even if I had a family that wasn't you know, pro me having sex… I could go to her. She was not biased. You know, she didn't care. She would

* Pseudonym

> rather me be safe than sorry…at the end of the day even if I had a family that didn't like something or wasn't on board with me, wasn't supportive, I could go to her.
>
> [Foster mother] it's always good to have somebody that's not biased and not gonna judge you in your corner. You know you can tell them anything. She really was a mother like, you know.

Youth in the study reported a preference for discussing sensitive SRH issues with a same sex caregiver. When a foster dad or male worker was present, most youth reported feeling uncomfortable discussing SRH and preferred to talk with a female caregiver. However, two participants reported having a foster dad who was very supportive and easy to talk to. Mary reported difficulty trusting males due to being abused by her father and other males when she was younger, but her foster dad helped her to be more open to trusting males again based on the positive way he treated her.

Abstinence. Several youth in the study reported making personal decisions to abstain from sex due to unresolved trauma, being too busy to form relationships, and rules that foster care implemented which kept their time structured. Some youth also reported learning from other people's experiences and deciding that they will wait to have sex in order to work on their personal development and avoid risks. Mercurel* shared her perspective on why she was abstaining from having sex:

> I just wasn't doing a lot and worried about it a lot. I ain't got time to be doing all that, I was grieving over my mother and I wasn't worried about nothing. I was just worried about going to school and doing what I had to do, and I'm trying to get money and all that extra mess.

* Pseudonym

Contraceptive use and self-desire to be healthy. Youth reported that they avoided SRH by valuing themselves, such as making themselves a priority, learning from other people's experiences, and using contraceptive methods to avoid risks such as unintended pregnancy. Youth also reported that they were aware of the negative outcomes associated with STIs and they did not want to be a victim. Ivory stated, "My sister had her baby early and I saw everything she went through and I was like, I'm not gonna do that, not at all." In terms of awareness related to STI outcomes, Ivory explained, "just fear of dying. If I die I want to die like, I'd even settle for a gunshot, but I'm not gonna die because of an STD. I feel like that would be the worst way to die." According to Sarah*, who learned from other people's experiences:

> My mom had me at a young age and I never wanted to have a baby at a young age. And you know, just hearing about people and I've known people that got STDs, like even got exposed for having STDs and stuff like that and I never wanted to be one of those people and you know certain like STDs, you know, you can get that don't show up and can affect like you having kids and stuff like that and I knew I wanted to have kids one day in the future.

Discussion

Youth in the study reported being aware of the risks associated with not protecting themselves from SRH risks, but at times, felt like they lacked agency in sexual decision making, including contraceptive use. The findings from this study support earlier studies where according to Ompad et al. (2006), Langille et al. (2007) and Seth et al. (2010), female adolescents who had partners that were older reported not using condoms and were more likely to engage in risky sexual behaviors. Additionally, based on the participants' reports of their partner's influence on condom use, they may have been experiencing male partner reproductive coercion. Reproductive

coercion refers to behaviors a partner uses in a relationship in order to exercise control and domination in order to influence reproductive health (FVPV 2010; ACOG 2013). Coercive behaviors include trying to get the female pregnant against her wishes, controlling the outcome of a pregnancy, using violence or threats of violence if the female does not engage in sexual intercourse, and forcing the partner to not use condoms during sex (FVPV 2010; ACOG 2013). Also, Black women are more likely to report reliance on their partner's decision making regarding contraceptive use (Holliday et al., 2018).

Love seeking behaviors related to a history of foster care placement and a history of ACEs placed youth at risk for reproductive control (Holliday et al., 2018). Reproductive coercion is also more commonly reported among young women in comparison to older women (Miller et al., 2014), which indicates the need for health care providers to screen for reproductive coercion among adolescents in foster care. Recommending long acting reproductive contraceptives (LARC) to this population may be helpful to protect them from unintended pregnancy in circumstances where they may not feel agency in sexual decision making (Miller et al., 2014; ACOG 2013). In this study, only 4 participants reported using protection all the time and only 2 were using a LARC method. The recommendation for LARC has the potential to benefit the youth by making them less vulnerable to the partner's influence and can help with maintaining personal control over the youth's reproductive health (ACOG, 2013; Miller et al., 2014).

Providers should also be careful when recommending LARCs to females who might be victims of IPV due to risk for harm if their male partner found out about their contraceptive use. It has been shown that some male partners may keep track of their partner's menstrual cycle and bleeding patterns (ACOG, 2013), which can put the woman at risk. Females could benefit from

learning about harm reducing interventions such as a discreet contraceptive methods such as a copper IUD and even learning how to conceal their methods (ACOG, 2013).

LARCs are considered a safe and effective method of contraception (Pritt, Norris & Berlan, 2017), however, some youth might be hesitant to use a LARC due to potential conflicts with their abusive partner who may not approve of contraceptive use, misconceptions regarding their ability to get pregnant in the future, it being a foreign object, potential side effects, and the potential for pain or discomfort (Coates, Gordon & Simpson, 2018; Russo, Miller & Gold, 2013). Therefore, providers should carefully educate youth on LARC and be culturally sensitive to this population based on prior historical trauma related to birth control.

Hesitancy to use LARCs among African American women can stem from historical trauma related to experiences of racial biases and being discouraged to have children by White providers (Higgins, Kramer & Ryder, 2016; Downing, LaVeist & Bullock, 2007). Health care providers have also been shown to be more likely to recommend LARC to low income women of color (Higgins, Kramer & Ryder, 2016; Dehlendorf et al., 2010; Downing, LaVeist & Bullock, 2007). Historically, during the 20th century, poor African American women encountered historical trauma and social injustices related to forced sterilization and eugenics (Stern, 2005; Higgins, 2014). Some youth may be aware of this racial and economic bias and could potentially be hesitant to trust the health care provider's recommendation to use a LARC. It may be beneficial for the provider to not only recommend LARCs but also remind the youth that the choice is ultimately theirs to make as a means to maintain control over their reproductive decisions. Some of the participants reported being neglected, abandoned, and abused by their biological family prior to entering care. As a result, they reported struggling with understanding what love is because they never fully experienced what they thought love should be from their

biological family. As a result, participants expressed how being involved in a romantic relationship and experiencing what they describe as love affected their decision to protect themselves or not from risks. The participants tended to make decisions regarding contraceptive use during sexual intercourse based on the relationship they had with their partners.

Some young women may not be aware of what a healthy consensual relationship is. Nurses and other health care providers can help young women to understand the characteristics of a coercive, unhealthy or abusive relationship and help to raise awareness about the impact of an unhealthy relationship on their SRH (Miller & Silverman, 2010; ACOG, 2013). Nurses and health care providers who raise awareness about reproductive coercion, strategies to reduce the risk of harm from abusive partners have the potential to reduce by 71% among women who were victims of IPV (Miller et al., 2011). These young women are also more likely to identify their relationship as unhealthy and leave the relationship due to personal safety issues (Miller et al., 2011).

During their clinical visits, nurses and health care providers can also provide additional resources such as informative literature about IPV and reproductive coercion, share knowledge about harm reduction strategies, and how to negotiate condom use in a safe manner to the youth (Miller & Silverman, 2010;ACOG, 2013). Nurses and health care professionals can also collaborate with other child welfare staff such as social workers in order to lead youth to violence prevention and victimization resources (Miller & Silverman, 2010). Nurses serve as mandatory reporters and can report findings of IPV to law enforcement agencies (Walten-Moss & Campbell, 2002). Nurses should be aware however, once youth are aware of the role of the nurse as a mandatory reporter, they may believe that reporting will increase their risk for abuse, and therefore, may be less inclined to admit/report experiences of IPV (Campbell, 2001)

Another challenge that made it hard for youth to protect themselves from SRH risks was perceptions of judgmental caregivers, who participants reported assumed the worst about them and often viewed them negatively. Historically, researchers in the realm of developmental psychology have often focused on the deficits of adolescents and omitted consideration of their assets (Futch Ehrlich, 2016). This tendency is also evident in the study as participants reported feeling judged and being viewed negatively. The failure of researchers and society to view adolescents through a positive lens serves as a disservice and injustice to youth by framing them in a unidimensional way (Futch Ehrlich, 2016). Despite a history of ACEs, we know many youth are resilient, lead productive lives, and avoid various risks (Grant & Osanloo, 2014). Therefore, it is important to view youth based on their strengths and potential for positive development (Lerner & Lerner, 2011; Benson, Scales, Hamilton, & Sesma, 2006).

One participant reported feeling judged by nurses during her clinic visit. According to the participant, she knew how health care professionals should behave and was aware of policies such as the Health Insurance Portability and Accountability Act (HIPAA) Laws. Youth reported an awareness of their privacy rights and were dismayed when they felt disrespected by health care professionals. There could be instances when health care professionals might discuss their patient in a public location with another staff without realizing the youth is listening. Breeches of confidentiality and judgmental behaviors may impact the youth's trusting relationship with the provider (Smith & Stepanov, 2014; Reddy, Fleming & Swain, 2002; Gilbert, Rickert & Aalsma, 2014)

Participants' perceptions of a lack of confidentiality during health care visits underscores existing literature regarding the importance of confidentiality to youth. Confidentiality, privacy, and anonymity are very important factors that influence adolescents' information seeking

behaviors and lack of confidentiality can lead to avoidance or delay of preventative health care services (Smith & Stepanov, 2014; Reddy, Fleming & Swain, 2002; Gilbert, Rickert & Aalsma, 2014). This current study demonstrates the negative impact lack of confidentiality has on the health care provider-youth relationship. Similar findings were evident in a study of 1209 adolescents and 709 young adults, where Grilo et al., (2019) found that participants who had private time and were able to engage in confidential conversations with their health care provider, were more likely to talk about sensitive issues, and felt more comfortable talking about their health risks. Given that confidentiality is so important to youth, providers should take care to maintain their patient's confidentiality, especially in a public location.

In addition to feeling like they are treated disrespectfully by health care professionals, there were health care encounters that were perceived as supportive. For example, Sarah, who had a history of sexual abuse, had a hard time during her Ob-Gyn visit due to traumatic flashbacks of sexual abuse. Sarah mentioned how hard it was for her to put her feet up and be examined. Her gynecologist picked up on what was going on and made the visit comfortable for her by acknowledging what she went through and apologized for what happened to her. This simple yet effective gesture made the youth trust the provider more and she was able to get through the appointment. Caregivers can learn from this example and they can best support known and unknown traumatized youth when they come in for care by ensuring examinations are trauma informed. In order to conduct trauma informed care, it is be beneficial to screen youth for experiences related to ACEs such as sexual abuse, intimate partner violence and reproductive coercion (ACOG, 2011,2013). Trauma informed gynecological examinations encourage providers to be empathetic towards youth with a history of trauma, which could make the experience a better one (Bates, Carroll & Potter, 2011). Findings from this study support the

American College of Obstetricians and Gynecologist Committee on Health Care for Underserved Women's recommendations that Ob-Gyns should offer empowering support, counseling, empathetic care, and sensitive examinations when working with victims of sexual abuse (ACOG, 2011; Bates, Carroll & Potter, 2011)

Findings support previous research, which indicated that a history of sexual abuse may lead to women avoiding or delaying examinations, including cervical cancer screenings due to fear, anxiety, distress, memory recall about the incident, and pain (Alcalá, Mitchell & Keim-Malpass, 2017; Leeners et al., 2007; Farley,Golding, & Minkoff, 2002; Hilden, Sidenius, Langhoff-Roos, Wijma & Schei, 2003; Robohm & Buttenheim, 1997). According to Leeners et al., (2007), and as reported by Sarah* in the study, sexual abuse can affect an individual years after the abuse.

Further, when youth in foster care have empathetic social workers or caregivers, this may counter the impact of ACEs that make some vulnerable youth have difficulty trusting others or forming relationships (Crosby, Day, Baroni, & Somers, 2014). When they have caregivers who they perceive are there for them emotionally, are nurturing, present, and can be easily reached, the youth reported positive feelings and would not " trade [such persons] for the world." as stated by Sarah. It is possible that providing empathetic support can lead to mutually positive feelings, as caregivers may feel good knowing they are making an impact on the youth's life.

Another interesting finding from this study was the impact of sexual abuse on sexual behaviors and relationships. There is an existing body of literature which indicates that abstinence messages to youth are not effective as they do not always prevent them from engaging in sexual activities (Bailey & Wolf, 2015; Basch, 2011). However, this study found

* Pseudonym

that there were some youth with a history of abuse who were practicing abstinence as a means to dissociate themselves from sex and romantic relationships. Those youth often reported that they were not interested in talking about sex, having sex, or even being in a relationship. These findings extend our understanding of the variation of responses to sexual abuse and its impact on sex and relationships. Some youth may avoid sexual encounters as a way of maintaining control and to avoid flashbacks about the incident (Bigras, Godbout & Briere, 2015; Bohn & Holz, 1996; Finkelhor, Hotaling, Lewis & Smith, 1990). In cases where abstinence is preferred, it can be beneficial for caregivers to support the youth's decision. However, the youth may also benefit from guidance on how to have and maintain safe and positive romantic relationships.

This study had findings that may contradict earlier studies that show a history of sexual abuse is associated with risky sexual behaviors such as promiscuous behaviors, prostitution, unintended teenage pregnancy, and increased risk for STIs (Johnson, 2001; Felitti et al., 1998; Bensley, Van Eenwyk & Simmons, 2000; Noll, Shenk & Putnam, 2008). For example, some participants who were victims of childhood sexual abuse reported either being single or in a serious relationship with one partner, did not report a history of STIs, and only one person with this history had a child. This suggests that there may be wider variations in responses to childhood sexual abuse. Health care providers and youth workers should be trained to understand the range of responses these vulnerable youth may manifest. Workers should be aware of the varying effects of childhood sexual abuse and know that not every person with this history will have the same narrative, behaviors, or outcome. In terms of positive youth development, workers can empower youth by letting them know that they can heal, have healthy relationships, and avoid SRH risks.

Young women in the study manifested strengths in their ability to find strategies that work for them in order to protect themselves against risks. In order to support them, youth workers and health care providers should receive trauma informed training, and be able to empower young women to make safe choices regarding their romantic relationships, contraceptive use, and SRH care.

Future Implications

This study was conducted with a group of African American young women with a history of foster care placement from a single Metropolitan area in Virginia. Further qualitative research studies should be conducted with youth from various locations to determine their perceptions of their SRH needs and how they protect themselves from risks. This study did not explore issues related to current intimate partner violence (IPV) and reproductive control (RC). Given some of the participants' responses regarding influences on condom use, it would be beneficial for future researchers to explore IPV, RC, and perspectives regarding LARCS more deeply with youth in foster care.

Youth in the study expressed needs related to a yearning for connection, support, and the ability to have open judgment free connection with all levels of caregivers. The voices of vulnerable youth are often left out of intervention design. As a result, anyone working with vulnerable youth should actively work with them by involving them in the planning phases of projects, policies, and other interventions that will directly affect them. Educational interventions for youth in foster care involve educating them about options related to their SRH such as contraceptive use. Despite their vulnerability, youth in foster care embody innate personal assets that can lead them to make health protective choices related to their SRH. Health care providers, caregivers, and youth organization personnel should strive to maximize on the youth's strengths

in order to be more supportive of them and foster their optimal and positive development.

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Appendix A

Braun & Clarke's (2006) six-phase thematic analysis process.

Phases	Description
1. Becoming familiar with the data	Immersing in the data by listening to audio files, reading the transcripts, field notes, and memos numerous times, recording initial thoughts and plans for the study.
2. Generating initial codes	Adding labels to the data by conducting line-by-line, open, inductive coding.
3. Searching for themes	Looking for overt and subtle messages within the data by examining the codes, memos, and any field notes. Codes with similarities were collated in order to form initial themes.
4. Reviewing the themes	Revising the codes, excerpts, memos, and themes to decide if the themes were appropriate or needed to be changed. The researcher also checked constantly to determine whether or not the themes were addressing the research aims.
5. Defining and naming themes	Refining each theme in order to accurately represent the data. Conceptual definitions were generated for each theme.
6. Producing the report	Producing the report for dissemination of the study's results.

Chapter Six: Discussion and Conclusion

This chapter will present the summary of this dissertation's key findings, contributions to the state of the science on SRH of adolescents in foster care, nursing and child welfare implications, limitations and lessons learned, and the implications for future research. Primary data were collected from 16 interviews of young African American women who were formerly in foster care and thematic analysis was used to analyze the data. The end result was three manuscripts to be submitted for publication.

Chapter three is an integrative literature review that was conducted to explore and synthesize the current literature regarding the impact of adverse childhood experiences on the overall mental health and wellbeing of Black or African American adolescents in foster care. The second manuscript, chapter four, explored and described the multiple and complex factors that contribute to the participants' SRH disparities, how they obtain information about SRH, their trusted sources for receiving this information, and what they perceive would be helpful to them. The third manuscript, chapter five, focused on one of the key study themes "Protection from SRH Risks" and its subthemes of challenges that made it difficult to avoid sexual risks, and protective strategies that facilitated avoidance of sexual risks.

Contributions to the State of the Science on SRH of Adolescents in Foster Care

This study appears to be one of the first to gain the perspectives of African American female adolescents with a history of foster care placements on how they obtained information related to SRH and how caregivers can better support them. Participants relied on the internet as their primary source of information related to SRH. This study had similar findings to King Jones' (2010) study, which reported that youth considered the internet as influencing their SRH and a source for education.

This study also had similar findings to Aronowitz, Rennells, & Todd (2006) and Aronowitz, Todd, Agbeshie, & Rennells (2007), which reported that African American youth wanted to receive information about SRH from their parents. Youth in this study reported that they wished both their biological parents and foster parents were more open to sharing accurate information about SRH with them. However, due to their perceptions that foster parents had judgmental behaviors, participants reported feeling uncomfortable talking with their foster parents about sensitive SRH topics due to fear of being perceived negatively.

Youth mentioned various challenges related to their social workers and group home staff and felt that workers did not value their jobs and were unsupportive. It is possible that the participants perceived the staff in this manner due to the work load of the staff and other job-related stressors that may manifest in behaviors that seem unsupportive. These notions are documented in the literature, which indicates that many workers within the child welfare system such as social workers are often overworked, underpaid, and unsatisfied with their jobs (Farber & Munson, 2010; Kim & Stoner, 2008). Child welfare workers need to be supported more in their roles by welfare agencies so that they can, in turn, be supportive of the youth they are supposed to serve.

Findings also indicated that participants who were parents saw children as strengths or motivators for being more successful by going to work when they wanted to stay at home, and helping them to overcome their mental health issues such as depression. These findings add to existing research with other adolescent mothers who reported that despite challenges with teenage pregnancy, having a child had motivating effects related to school, mental wellbeing, and being a good mother (Seamark & Lings, 2004; Chohan & Langa, 2011; Macleod & Weaver, 2003).

This dissertation also adds to existing literature surrounding reproductive coercion as youth reported awareness of the risks associated with not protecting themselves from SRH risks, but some felt like they lacked agency in sexual decision making related to contraceptive use. According to Ompad et al. (2006), Langille et al. (2007) and Seth et al. (2010), female adolescents who had partners that were older reported not using condoms and were more likely to engage in risky sexual behaviors. Based on the participants' responses of their partner's influence on condom use, they may have been experiencing male partner reproductive coercion. Black women are more likely to report reliance on their partner's decision making regarding contraceptive use (Holliday et al., 2018) and this was also similar to study findings.

Findings from this study support the American College of Obstetricians and Gynecologist (Ob-Gyn) Committee on Health Care for Underserved Women's recommendations that Ob-Gyns should offer empowering support, counseling, empathetic care, and sensitive examinations when working with victims of sexual abuse (ACOG, 2011; Bates, Carroll & Potter, 2011). Participants who were victims of sexual abuse reported the psychological distress associated with Ob-Gyn care due to flashbacks of the abuse during examinations. Findings support previous research, which indicated that a history of sexual abuse may lead to women avoiding or delaying examinations, including cervical cancer screenings due to fear, anxiety, distress, memory recall about the incident, and pain (Alcalá, Mitchell & Keim-Malpass, 2017; Leeners et al., 2007; Farley,Golding, & Minkoff, 2002; Hilden, Sidenius, Langhoff-Roos, Wijma & Schei, 2003; Robohm & Buttenheim, 1997). According to Leeners et al., (2007), and as reported by a participant, sexual abuse can affect an individual years after the abuse.

This dissertation provides information related to the impact of sexual abuse on sexual behaviors and relationships as participants reported practicing abstinence and a dissociation from

sexual activity. Findings extend our understanding of the variation of responses to sexual abuse and its impact on sex and relationships. Some youth may avoid sexual encounters as a way of maintaining control and to avoid flashbacks about the sexual abuse incident (Bigras, Godbout & Briere, 2015; Bohn & Holz, 1996; Finkelhor, Hotaling, Lewis & Smith, 1990). This dissertation presents findings that expand on earlier studies that show a history of sexual abuse is associated with risky sexual behaviors such as promiscuous behaviors, prostitution, unintended teenage pregnancy, and increased risk for STIs (Johnson, 2001; Felitti et al., 1998; Bensley, Van Eenwyk & Simmons, 2000; Noll, Shenk & Putnam, 2008).

Nursing and Child Welfare Implications

Nurses have an important role to play in the lives of vulnerable youth, such as those in foster care. Nurses deliver quality health care to their patients and also serve as advocates in order to promote adolescents' healthy development. Some youth in foster care encounter multiple placements and often have challenges forming relationship or having continuity of care with health care providers (Hornor, 2014). Additionally, since the foster care system includes various personnel working with the youth, there needs to be a significant amount of communication and collaboration between nurses and other members of the child welfare team such as case and social workers, foster parents, and even biological family if appropriate (Hornor, 2014). Collaboration can help to ensure that the youth have a health care plan and their needs are being met (Hornor, 2014). Some caregivers may not be prepared to communicate with their foster child about issues surrounding SRH. Nurses, who are also health educators can teach caregivers about SRH and provide resources on where they can get more information as they interact with their youth regarding topics of SRH. Further, to promote youth agency, nurses can

provide SRH education to the youth themselves, as well as direct them to resources that are accurate and appropriate to their development.

Youth in this study perceived lack of support from various caregivers and felt uncomfortable talking about SRH with others. Nurses and child welfare workers should strive to build an open relationship with youth in order for them to feel more supported and willing to communicate about SRH issues. These relationships take time to build trust and are best directed by the youth in terms of pacing, content and focus of communication. Youth reported having their walls up due to being hurt in the past and being unable to rely on others. As a result, caregivers should be patient as they try to build a relationship with the youth, which can take a lengthy time for the youth to "open up", as reported by a participant. Also, youth reported a preference for communication about SRH to occur in a step-by-step method and not all at once, to avoid them feeling bombarded with too much information. Caregivers should methodically share information about SRH, allow youth the opportunity to lead the discussion, and also be vulnerable with the youth by sharing stories/prior experiences with them.

Youth mentioned various challenges related to their social workers and group home staff. Other studies show that many child welfare workers are overworked, underpaid, and unsatisfied with their jobs and thus, adolescent perceptions may be related to these factors (Farber & Munson, 2010; Kim & Stoner, 2008). Therefore, child welfare workers should be frequently evaluated to make sure that they are satisfied with their role requirements, not over worked, or feel unsupported in their role. Workers should have a manageable caseload and be compensated adequately, which may help with job satisfaction and the ability to spend more time building nurturing relationship with youth in care.

Due to the possibility of reproductive coercion, inconsistent contraceptive use and risk for unintended pregnancies and STIs, nurses and other health care providers should directly screen for the possibility of reproductive coercion and intimate partner violence by asking questions related to reproductive coercion and intimate partner violence during their assessment of the youth. The next step should be to implement culturally sensitive trauma informed care/examinations and recommend long acting reproductive contraceptives (LARC) to this population. LARCs may be helpful to protect vulnerable youth from unintended pregnancy in circumstances where they may not feel agency in sexual decision making (Miller et al., 2014; ACOG 2013).

Some youth might be hesitant to use a LARC due fear of conflict from an abusive partner who may not approve of contraceptive use, misconceptions regarding their ability to get pregnant in the future, it being a foreign object, potential side effects, and the potential for pain or discomfort (Coates, Gordon & Simpson, 2018; Russo, Miller & Gold, 2013). Nurses and health care providers should carefully educate youth on LARC based on prior historical trauma related to birth control. Hesitancy to use LARCs among African American women can stem from historical trauma related to experiences of racial biases and being discouraged or prevented from having children by White providers (Higgins, Kramer & Ryder, 2016; Downing, LaVeist & Bullock, 2007).

In addition to LARCs, female adolescents should be empowered to make better choices regarding contraceptive use, identify coercive and abusive relationships, and be equipped with information or resources on where they could go for help if they encounter any adverse situations in their relationship. Findings from this study support the American College of Obstetricians and Gynecologist Committee on Health Care for Underserved Women's recommendations that Ob-

Gyns should offer empowering support, counseling, empathetic care, and sensitive examinations when working with victims of sexual abuse (ACOG, 2011; Bates, Carroll & Potter, 2011).

Confidentiality, privacy, and anonymity are very important to adolescents and lack of these key elements of care can lead to avoidance or delay of preventative health care services (Smith & Stepanov, 2014; Reddy, Fleming & Swain, 2002; Gilbert, Rickert & Aalsma, 2014). As a result, providers should take care to maintain their patient's confidentiality, especially in a public location. Youth reported a need for caregivers to protect their confidentiality, respect them, avoid judgment and be more supportive of them.

When working with youth who are pregnant or have a child, nurses should incorporate the positive implications of parenthood rather than exclusively focusing on the negative effects. Some youth view their children as a motivator and parenthood as a strength. By focusing on youth's sense of strength and fulfillment, we can work with them to facilitate their and their children's optimal development, health outcomes, and overall wellbeing.

Limitations and Lessons Learned

A homogenous group of females from one state provided data for this dissertation study and may not reflect the views of other youth who were in foster care from other regions. The study also relied on self-reported retrospective information, which may vary from the participants' actual experience with the passage of time and cognitive processing. Despite limitations, participants in this study were able to share their perspectives on how individuals who work with vulnerable youth can be more supportive in order to promote their positive development and help them avoid SRH risks.

In terms of lessons learned, recruiting vulnerable populations such as youth in foster care can be very challenging and cannot be done in a short time span. It is important to build genuine

relationships with gatekeepers such as social workers, foster care agencies, independent living program staff, and out-patient youth service workers who can provide guidance related to recruitment strategies. While gatekeepers are important in the recruitment process, they can also be a deterrent due to their relationship with the youth in care. Due to negative experiences between gatekeepers and foster youth, such as lack of trust, gatekeepers may be hesitant to share information about the study with potential participants out of fear that youth may share negative information about their relationship with the researcher.

Lastly, adolescents in foster care have busy schedules that involve various required meetings and sessions while in care. As a result, their time is precious and researchers should value their time and be willing to accommodate their schedule. Some participants prefer to do an interview the moment you contact them and can feel disappointed if they are told that they will be contacted at a later time. Therefore, researchers should always be prepared.

Implications for Future Research

This dissertation study was conducted with African American adolescent women with a history of foster care placement from a single Metropolitan area in Virginia. More qualitative research should be conducted with a more inclusive and diverse range of participants from various locations to determine their perceptions of their SRH needs and how they protect themselves from SRH risks while in foster care. Future studies should also explore issues related to current intimate partner violence (IPV) and reproductive control (RC) among youth in foster care. Given the low rate of LARC use among participants in this dissertation study, it would be beneficial for future researchers to explore perspectives regarding LARCS more deeply with youth in foster care.

This study obtained the perspectives of youth with a history of foster care placement. In order to more fully address the underlying reasons for SRH health disparities in African American adolescents in foster care, perspectives of the foster caregivers such as foster parents, social workers, and staff are needed in order to understand the context of their roles, the challenges they face, and the possible rewards and benefits of their role/jobs. These new findings could potentially provide more knowledge upon which to base interventions for optimal care and support for young people in foster care.

Conclusion

This study was conducted to expand existing knowledge regarding the SRH of adolescents in foster care from their perspectives. Findings from this study provide a deeper understanding of the perceived lack of support experienced by youth in care, their internal strengths, their experiences obtaining knowledge about SRH, and perspectives on SRH communication with caregivers**.** Youth expressed needs related to a yearning for connection, support, and the ability to have open judgment-free relationships with all levels of caregivers. Professionals working with vulnerable youth should actively work with them by involving them in the planning phases of projects, policies, and other interventions that will directly affect them. Educational interventions should involve information about options related to their SRH such as contraceptive use and awareness of RC and IPV. Despite their vulnerability, youth in foster care embody innate personal assets, as well as the potential to develop others that can lead them to make health protective choices related to their SRH. Health care providers, caregivers, and youth serving personnel should strive to maximize on youth strengths in order to be more supportive of them and foster their optimal and positive development.

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