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Qualitative evaluation of historical and relational factors influencing pregnancy and sexually transmitted infection risks in foster youth

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ABSTRACT

Purpose: To explore how attitudes, norms, behaviors, responses to early life experiences, and protective factors influence pregnancy and sexually transmitted infection risks from the perspectives of current and former foster youth to inform the development of prevention strategies.
Methods: We conducted semi-structured individual qualitative interviews with a diverse sample of 22 current/former foster youth aged 15–21 years (63% female; average age = 18.6 years). We then used Theoretical Thematic Analysis to systematically analyze the data for key themes related to sexual health in four categories: 1) norms and attitudes, 2) responses to early life experiences, 3) protective factors, and 4) youth-driven intervention ideas.
Results: Participants reported a range of sexual experience levels, varied sexual orientations, and also reported varied life experiences prior to and during foster care. We detected several norms and attitudes that likely contribute to risks of early pregnancies and sexually transmitted infections. These included that one can tell by looking whether a partner is trustworthy or has a sexually transmitted infection, that condoms aren't necessary with long-term or infrequent partners or if birth control is used, and that teen pregnancy is an inevitable event. With respect to responses to early life experiences, youth frequently described difficulties dealing with strong emotions in the context of romantic and/or sexual relationships; many attributed these difficulties to early experiences with biological family members or in foster care. Participants linked emotion regulation difficulties with struggles in trust appraisal, effective communication, and impulsive behaviors. Youth also described a variety of protective factors that they felt helped them prevent sexual risk behaviors or improved their lives in other respects. Finally, participants endorsed factors likely to improve intervention acceptability and efficacy, including an open, non-judgmental group-based environment, involvement of peer mentors, and inclusion of caregiver and caseworker training components.
Conclusions: Trauma-informed, tailored intervention strategies which address key norms and attitudes and provide broad-based assertiveness and emotion regulation skills are likely to be the most effective strategies to reduce risks of teen pregnancies and sexually transmitted infections among teens in foster care. Group-based interventions that involve peer mentors and caregiver and caseworker components may be especially acceptable and effective for teens in foster and/or kinship care.

1. Introduction

Foster youth can face many challenges during adolescence and the transition to adulthood including low economic and educational achievement, involvement with the juvenile and criminal justice systems, and high risk of physical and mental health problems (Ahrens, Garrison, & Courtney, 2014; Courtney, Dworsky, Lee, & Raap, 2009; Courtney et al., 2005, 2007, 2011; Courtney, Terao, & Bost, 2004; Pecora, Williams, Kessler, et al., 2003, 2006). One area of particular importance is reproductive health. Compared with youth in the general population, youth who have been in foster care have 2–14 times the risk of sexually transmitted infections (STIs) including Human Immunodeficiency Virus as well as 2–4 times the risk of teen pregnancy. Nearly half of young women in foster care report having been pregnant by age 19; males who are currently or have been in foster care also report impregnating partners at a higher rate compared with youth who do not have this history (Ahrens, Katon, McCarty, Richardson, & Courtney, 2012; Ahrens, Richardson, et al., 2010; Courtney & Dworsky, 2006; Courtney et al., 2004, 2005, 2007, 2009, 2011; Shields, Wong, Mann, et al., 2004; Surratt & Kurtz, 2012). These outcomes are likely due to

Abbreviations: STI, sexually transmitted infection(s).

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high rates of exposure to adversities early in life (e.g. poverty, abuse and neglect, parental substance abuse, intimate partner violence, and the disruption of relationships with biological caregivers), which in turn lead to increased rates of sexual risk behaviors such as early sexual debut, higher numbers of total and casual partners, and higher rates of reporting sex with an infected partner (Ahrens, Richardson, et al., 2010; Courtney & Dworsky, 2006; Courtney et al., 2004, 2005, 2007, 2009, 2011). The health, psychological, and economic impacts of STIs and early/unwanted pregnancies for this and other populations are well-documented (Office of National AIDS Policy, 2000; Report, 1993; The National Campaign to Prevent Teen and Unplanned Pregnancy, 2010; The National Campaign to Prevent Teen Pregnancy, 2010; The National Campaign to Prevent Teen and Unplanned Pregnancy, 2013; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention).

Studies in other groups of adolescents suggest that interventions informed by a health promotion theory such as Social Cognitive Theory (SCT) are the most effective (DiClemente, Crittenden, Rose, et al., 2008; Kirby & Laris, 2009; McAlister, Perry, & Parcel, 2008; Santelli, DiClemente, Miller, & Kirby, 1999). SCT posits that: 1) knowledge and skills are important but insufficient to engender behavior change; 2) psychological determinants of behavior including an individual's attitudes (beliefs about consequences of risky and protective sexual behaviors), norms (beliefs about what is acceptable to peers), and self-efficacy (confidence in ability to change) are key intermediate factors which significantly influence behavior; and 3) that people learn by observation and practice (McAlister et al., 2008). SCT-based sexual health interventions include hands-on activities to reinforce knowledge skills (e.g. facilitated condom demonstrations) as well as role-playing exercises to help youth recognize stimuli that trigger unsafe sexual behaviors and develop scripts for risky situations. They also focus on behavioral goals that teens and young adults can readily accomplish such as increasing condom and/or birth control use, or improving partner communication skills (DiClemente et al., 2008; Kirby & Laris, 2009; Santelli et al., 1999).

Some interventions based on SCT or similar theories have been shown to increase pregnancy and STI related knowledge, skills, or attitudes among adolescent foster youth (Becker & Barth, 2000; Cronin, Heflin, & Price, 2014; McGuinness, Mason, Tolbert, & DeFontaine, 2002; Slonim-Nevo & Auslander, 1996). However, to date none have demonstrated consistent long-term reductions in sexual risk behaviors for this group. One intervention designed to reduce substance-related and delinquent behaviors that has been shown to reduce teen pregnancies among young women in foster care is Multidimensional Treatment Foster Care (Kerr, Leve, & Chamberlain, 2009). However, this intervention is financially and temporally intensive and targets highly impaired youth, and thus it is not practical to deliver on a wide-scale basis to all foster youth.

The purpose of the present study was to better understand proximal factors influencing pregnancy and STI risks in foster youth, to inform the development of more viably scalable interventions that address the needs of this vulnerable population. We specifically sought to use qualitative methods to explore foster youths' perceptions of norms and attitudes, responses to early life experiences, and protective factors influencing sexual health behaviors and outcomes. We also desired to briefly explore STI and pregnancy prevention/intervention ideas from the perspectives of current and former foster youth. This study represents the second portion of a mixed methodology study designed to elucidate unique factors influencing pregnancy and STI risk among foster youth to inform prevention efforts. In the first study, we used longitudinal data and path analysis techniques to evaluate mediators of relationships between early life abuse and foster care experiences, and sexual risk behaviors in young adulthood. Results suggested that having a history of abuse and having been in a group home were associated with increased externalizing behaviors, which in turn were associated with increased STI risk. Having a close relationship with a foster caregiver and remaining in care past age 18 were protective (Ahrens, McCarty, Simoni, Dworsky, & Courtney, 2013). In the present study, we extend this work by more closely examining foster youths' accounts of their experiences with sexual relationships and their beliefs around factors influencing sexual risk behaviors.

2. Material and methods

2.1. Sampling and recruitment procedures

We partnered with caseworkers from the Department of Social and Health Services and a private agency that provides independent living services to transition-age foster youth from Washington to recruit a sample of 22 youths (62% female) aged 15–21 years who had been in foster or kinship care for at least 6 months as a teen. We employed maximum variation purposive sampling techniques, a technique used in qualitative research to capture a range of perspectives of the population being studied (Sandelowski, 1995). We accomplished this by going to multiple staffing meetings at each agency to explain the study, recruitment criteria, and our goal to interview youths who were diverse in terms of age, race, ethnicity, experiences in foster care, and engagement in sexual and other risk behaviors, to allow us to understand the needs of a wide variety of youth in the foster system.

For youths under 18, we initially obtained written permission from caseworkers (similar to informed parental consent). We also sent a letter to biological parents allowing them to opt their youth out of the study over a 10 day period for minors under 18 who were not legally free (i.e., for whom one or both biological parents still had some legal rights). State or private agency personnel then contacted all youths (over and under 18) to determine if they were interested in participation. Once a potential participant expressed interest in the study, we scheduled an in person meeting at a confidential site of the participant's choosing. A total of 30 youths underwent this procedure, 8 of which no-showed or canceled the meeting (73% response rate).

2.2. Interview procedure

Once the above steps were accomplished, we obtained written informed consent or assent from the youths (depending on whether the youth was over or under 18). Semi-structured in-person interviews were completed by the principal investigator (who has been a foster parent), or one of two research staff. One of these staff members was also a former foster parent whom had worked for over 40 years as a mental health practitioner with foster youth and other high risk youth. All interviewers were white females. Interviews lasted 45–90 min, and no participants terminated the qualitative interview early. Questions were developed a priori, and additional probes were added iteratively during the analysis process (Table 1). Participants were allowed to direct the interview, with investigators suggesting topics after significant lapses in conversation. Interviewers were asked to cover each of the main topics in the script during each interview, but were instructed to prioritize an in-depth, participant-led discussion of a given aspect of a topic over the completion of all of the scripted questions within that topic. Interviews were digitally recorded, transcribed, and reviewed for accuracy. Immediately after each interview, interviewers completed brief assessment forms to describe main themes and suggest new topics to explore probes. Initial probes were primarily open ended (a few yes/no questions were included to cue participants to the next topic which were followed by open ended questions). Following the interview, participants were invited to complete a 20 minute audio computer-assisted self-administered survey to collect basic information on demographics, foster care experiences, and sexual behaviors; 21 out of 22 participants (95%) completed this survey. Participants