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“Even if you think you can trust them, don’t trust them”: An exploratory analysis of the lived experiences of sexual health among sexual minority girls in foster care

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Abstract

Girls in foster care are at heightened risk for poor sexual health outcomes compared to their general population counterparts. Sexual minority girls are also at greater risk for poor sexual health compared to their heterosexual counterparts. Yet, little is known about the sexual health of sexual minority girls in foster care. This study aims to provide a preliminary understanding of how sexual minority girls in foster care experience the phenomenon of sexual health. Using a single-case interpretative phenomenological analysis (IPA) design, we interviewed five sexual minority girls in foster care using a single in-depth focus group discussion and analyzed the data using a series of IPA steps. Analysis revealed three major themes about the lived experiences of sexual health among sexual minority girls in foster care: fear of being victimized and distrust within sexual relationships, self-protection from sexual relationship harm, and sexual health communication. Further research is warranted to investigate the sexual health experiences and needs of sexual minority girls in foster care, with particular sensitivity to the potential impact of past sexual victimization and abuse on their sexual health and wellbeing.

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John P. Salerno: Funding acquisition, Conceptualization, Methodology, Investigation, Formal analysis, Writing - original draft, Writing - review & editing. **Olivia N. Kachingwe:** Funding acquisition, Conceptualization, Methodology, Investigation, Writing - original draft. **Jessica N. Fish:** Conceptualization, Writing - original draft, Writing - review & editing. **Eshana Parekh:** Writing - original draft. **Melanie Geddings-Hayes:** Funding acquisition, Resources, Conceptualization, Methodology, Writing - review & editing. **Bradley O. Boekeloo:** Funding acquisition, Supervision, Resources, Conceptualization, Methodology, Writing - review & editing. **Elizabeth M. Aparicio:** Funding acquisition, Supervision, Conceptualization, Methodology, Writing - original draft, Writing - review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Keywords

LGBTQ; Foster care; Sexual health; Sexual minority; Qualitative; Youth

1. Introduction

1.1. Sexual health among girls in foster care

There have been between 396,000–441,000 youth currently in foster care, between 251,000–276,000 youth entering foster care, and between 236,000–276,000 youth exiting foster care on a yearly basis since 2009 in the United States (U.S.) (U.S. Department of Health and Human Services, 2019). In the U.S., girls in foster care are at greater risk for poor sexual health outcomes compared to boys in foster care and girls who are not in foster care. For instance, data from the National Longitudinal Study of Adolescent Health found that girls in foster care are over 3 times as likely to have Trichomonas (sexually transmitted infection), nearly 3 times as likely to have had sex with a casual partner, nearly 12 times as likely to have had sex for money, 3 times as likely to have had vaginal intercourse, 1.5 times as likely to have reported a younger age at first sex, and over 2 times as likely to have reported a greater number of lifetime sexual partners compared to girls not in foster care (Ahrens et al., 2010). Using Midwest Study data (longitudinal cohort study of youth aging out of foster care in Iowa, Wisconsin, and Illinois), researchers have further found that girls in foster care are significantly more likely to report a sexually transmitted infection (STI) diagnosis and inconsistent condom use compared to boys in foster care (Ahrens, McCarty, Simoni, Dworsky, & Courtney, 2013).

History of childhood physical, psychological, and sexual abuse among youth in foster care is associated with risk for poor sexual health outcomes (Winter, Brandon-Friedman, & Ely, 2016). For instance, findings from the National Survey of Child and Adolescent Wellbeing (NSCAW) demonstrate that experiencing acts of physical and psychological abuse from caregivers significantly increases the likelihood of lifetime sexual intercourse among youth in foster care (James, Montgomery, Leslie, & Zhang, 2009). Using Midwest Study data, researchers also found that rates of sexual abuse are significantly greater among youth in foster care (18–27%) compared to the U.S. general population of youth (7%), and that history of physical abuse is significantly more prevalent among youth in care that experience sexual abuse (41%) compared to those who do not (28–30%) (Ahrens, Katon, McCarty, Richardson, & Courtney, 2012). Midwest Study findings further demonstrate that sexual abuse outcomes significantly and disproportionately affect girls (76–84%) in foster care compared to boys (16–24%) in foster care (Ahrens et al., 2012), and that girls in foster care are more likely to experience both physical and sexual abuse compared to boys in foster care (64% vs. 44%) (Ahrens et al., 2013). Girls in foster care with histories of sexual abuse are between 4 and 9 times more likely to engage in transactional sex (e.g., sex for money) compared to girls in foster care without sexual abuse histories (Ahrens et al., 2012), which significantly increases their risk for HIV/STIs (Ahrens et al., 2013). Lastly, Midwest Study findings demonstrate that physical and/or sexual abuse history is linked with greater risk for STIs via delinquent behavior and inconsistent condom use among girls and boys in foster care (Ahrens et al., 2013).

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1.2. Sexual health among sexual minority girls

In the general U.S. population, research consistently elucidates that sexual minority girls demonstrate greater rates of sexual risk behaviors compared to their heterosexual counterparts. For instance, National Youth Risk Behavior Survey (YRBS) data indicate that sexual minority girls are significantly more likely to ever have had sex, have had sexual intercourse for the first time before age 13, have had lifetime sexual intercourse with four or more persons, be currently sexually active, and not have used a condom during last sexual intercourse, compared to heterosexual girls (Kann et al., 2018). These findings are in line with previous research that highlights elevated rates of risky sexual practices among sexual minority girls compared to heterosexual girls (Everett et al., 2019; Goodenow, Szalacha, Robin, & Westheimer, 2008; Poteat, Russell, & Dewaele, 2019; Rasberry et al., 2018; Ybarra, Rosario, Saewyc, & Goodenow, 2016). Elevated sexual health risk behaviors among sexual minority girls have been attributed to increased rates of childhood sexual and physical abuse (Saewyc, Poon, Homma, & Skay, 2008; Scheer, McConocha, Behari, & Pachankis, 2019). This is concerning, given that YRBS data reveal that sexual minority girls are more likely to experience sexual and physical intimate partner violence, and sexual violence and forced sexual intercourse by anyone compared to heterosexual girls (Kann et al., 2018).

1.3. Sexual health among sexual minority youth in foster care

Considering that both girls in foster care and sexual minority girls demonstrate greater risk for poor sexual health outcomes, it is likely that girls in foster care who are also sexual minorities experience unique vulnerabilities for sexual health risks. Local (Los Angeles Foster Youth Survey), state (California Healthy Kids Survey), and national (National Longitudinal Study of Adolescent to Adult Health and NSCAW) survey studies demonstrate that sexual minority youth are overrepresented in the foster care system at approximately 2.5 to 3.5 times the general population rate (Baams, Wilson, & Russell, 2019; Fish, Baams, Wojciak, & Russell, 2019; Wilson & Kastanis, 2015), illustrating the importance of studies detailing the unique sexual health challenges and vulnerabilities of sexual minority youth in foster care. Yet, few studies of sexual health exist with this population (i.e., sexual minority youth specifically in foster care). The majority of studies on sexual minority youth in foster care have historically focused on exploring and improving their experiences in placement (McCormick, Schmidt, & Terrazas, 2017). Only one population-level study has explored direct health outcomes among sexual minority youth in foster care; the study documented that this population experiences greater mental health burden and school victimization compared to heterosexual foster youth and/or stably housed sexual minority youth (Baams et al., 2019). One convenience sample study demonstrated that sexual minority youth in foster care are significantly more likely to experience sexual abuse compared to heterosexual foster youth (Mitchell, Panzarello, Grynkiewicz, & Galupo, 2015). However, the sexual health needs and experiences of sexual minority youth remain largely unexplored, including among sexual minority girls in foster care specifically.

1.4. Current study

Considering the current gaps in the existing scientific literature related to sexual health among sexual minority girls in foster care, the purpose of this analysis is to preliminarily

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explore the lived experiences of sexual health among sexual minority girls in foster care. This is the first known analysis specific to the experiences of sexual minority girls in foster care with regard to their sexual health and provides a vantage point for future work in this area. This analysis also aims to better understand how to address their specific sexual health needs. Our research was guided by the following research question:

What are the lived experiences of sexual health among sexual minority girls in foster care?

2. Methods

2.1. Sampling, recruitment, and eligibility criteria

Data for this study were drawn from a larger community-engaged, formative research project on the sexual health needs of foster youth more broadly, which was developed over a multi-year research-practice partnership between the University of Maryland and Hearts & Homes for Youth (community-based child welfare agency) with shared vision and goals for improving sexual and mental health and well-being among youth in foster care (Aparicio, Kachingwe, Salerno, Geddings-Hayes, & Boekeloo, 2020; Kachingwe et al., 2020). We used a criterion nonprobability convenience sampling strategy to recruit participants in Spring 2018, which began by visiting two group homes for girls in foster care to explore potential participants' interest in the study. We presented information about the research study to girls residing in these homes, including the study purpose, procedures, risks and benefits, and protection of privacy and confidentiality. Group home social workers were asked to obtain informed consent from parents or guardians of youth who expressed interest in participating if they were under 18 years old.

Eligibility criteria for the study included being at least 16 years old and living in a foster care placement. Five cisgender lesbian or bisexual female youth participated in one in-depth focus group. All participants were between the ages of 16–18 ($M = 17$) years. Two identified as African American or Black, three as multiracial, and one as Hispanic or Latina. Four identified as bisexual and one as lesbian, and all identified as cisgender. This research was approved by the University of Maryland institutional review board prior to study commencement.

2.2. Data collection procedures

Five key informant community engagement meetings with foster care social workers and administrators from Hearts & Homes for Youth were conducted to inform the design of the overall study and the development of the focus group interview guides. Prior to beginning the focus group, youth underwent a written and verbal informed consent or assent process that included a description of the study purpose, risks and benefits of participation, and confidentiality and privacy protections. Parents or guardians of youth who were under the age of 18 provided written informed consent prior to youths' participation. Two adult female co-facilitators conducted the focus group; one was a White cisgender, heterosexual female assistant professor and social worker, and the other was a Black cisgender, heterosexual female PhD student in public health. Only the facilitators and participants were present

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during the focus group, and it took place at our community-based child welfare agency partner's headquarters in a private conference room.

During the focus group, we provided youth participants with a comprehensive list of sexual health topics to consider (developed by the research team in collaboration with Hearts & Homes for Youth). Youth were asked whether any topics were missing, and to identify which sexual health areas they believed youth in care were not learning enough about. The list contained neutrally framed (e.g., male or female sexual development), positively framed (e.g., sources of support and belonging, and healthy relationships), and negatively framed (e.g., unhealthy relationships, and HIV/STIs) sexual health topics to choose from. Through this process, youth came to a consensus that *privacy and safety, unhealthy relationships*, and *sexually transmitted diseases* were the areas of greatest importance regarding sexual health among youth in foster care. Next, we comprehensively explored each youth-prioritized sexual health area, including how youth experienced each area of sexual health and how they believed foster youth could be better supported in these areas. Facilitators asked youth to describe what youth in care should be learning about regarding these topics, identify individuals with whom they would feel comfortable discussing these areas, and describe how caregivers and professionals serving them could best support them in these areas of sexual health. At the end of the focus group, youth were asked to provide demographic information.

The focus group lasted approximately 90 min. Participants were compensated with a $15 Visa gift card for their participation. Pizza and soft drinks were also provided for youth participating in the focus group. The focus group interview was audio-recorded and transcribed verbatim by a professional transcription service company. The co-facilitators then checked the transcription against the audio recording to ensure accuracy prior to beginning data analysis.

2.3. Theoretical and analytic approach

This study was guided by a phenomenological approach; Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009). IPA is a well-codified hermeneutic phenomenological method undergirded by both phenomenology (the study of phenomena as experienced or "lived") and hermeneutics (the study of interpretation). IPA focuses upon how a particular group of people (i.e., sexual minority girls in foster care) experience and make meaning of a specific phenomenon of interest (i.e., sexual health). IPA looks beyond basic themes in experience by taking into account the multiple layers of interpretation involved in exploring phenomena as lived and recognizing the important role of the interpretive relationship between the researcher(s) and the participant(s) in co-constructing findings. IPA emphasizes the presence of a double hermeneutic, wherein the data analyst is interpreting the interpretations of participants regarding a particular phenomenon of interest. At the dissemination of findings stage, a triple hermeneutic is involved; those reading the published article or hearing a research presentation are further interpreting the findings using their own lens borne of their prior personal and professional experiences. In order to fully and actively engage in the process of interpretation, analysts must practice reflexivity

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throughout the study design and analysis, identifying and reflecting upon their personal and professional experiences and, later, their related reactions.

2.4. Data analysis

We thoroughly analyzed focus group data to explore the meaning and experience of the central phenomenon of interest (i.e., sexual health) among sexual minority girls in foster care using a 4-step single case IPA approach (Smith et al., 2009). Of note, small samples are typical in IPA as it is an extremely in-depth approach looking not just at themes and descriptions, but the ways in which experience of a particular phenomenon is constructed through participants' language and interpretations. Thus, a single case is appropriate for use with this method (Smith et al., 2009). In step one, we began by listening to the focus group audio-recording while reading the focus group transcript to become re-immersed in the sample participants' experiences. In step two, our team's primary data analyst conducted initial noting: re-reading the transcript and making exploratory notes of important lines and passages, attaching detailed *descriptive, linguistic*, and *conceptual* comments. Descriptive comments focused on the ways in which sexual minority girls in foster care described the phenomenon of interest (i.e., sexual health), linguistic comments highlighted their use of language when discussing sexual health, and conceptual comments noted initial possible connections between coded sections across the transcript. In step three, the lead analyst developed emergent themes by grouping initial notes highlighting similar meanings and experiences of sexual health among female sexual minority youth participants. In the final step, our team worked together to collapse emergent themes into a final set of themes and subthemes characterizing how sexual minority girls in foster care experience the phenomenon of sexual health.

2.5. Study rigor and positionality of the research team

Study rigor and trustworthiness of findings were enhanced through several strategies, including detailed memoing and a significant emphasis on reflexivity through weekly peer debriefing team meetings and reflexive journaling (Smith et al., 2009). The research team (three public health faculty members, two public health doctoral students, and one undergraduate student) met weekly during the analytic process to review coding and discuss emergent findings. The research team practiced reflexivity through regular discussion of reactions to the study as it unfolded, particularly as findings began to emerge. Given that half of the members of the research team identify as gay or queer and the majority of us identify as women, we were able to reflect critically on how emergent findings resonated with our own lived experiences. None of our research team members had been in foster care before, but we have several decades of experience working with foster youth, and several years of experience in sexual health and sexual and gender minority health research. Memos and reflexive journal entries were reviewed as components of an audit trail in order to triangulate emergent findings during the analytic process.

3. Results

Three themes emerged from IPA, which represent facets of how sexual minority girls in foster care experience sexual health: (1) fear of being victimized and distrust within

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sexual relationships, (2) self-protection from sexual relationship harm, and (3) sexual health communication.

3.1. Fear of being victimized and distrust within sexual relationships

Female sexual minority foster youths' experiences of sexual health were largely characterized by distrust and fear of being victimized in different ways and in different contexts within sexual relationships. When discussing potential sexual partners, youth emphasized that you should *"never trust no one*" and that *"even if you think you can trust them, don't trust them… you can't trust them*", highlighting that youth felt a serious need to be extra cautious even with sexual partners whom they believe are generally trustworthy persons. These comments speak to the potential mental health impact of previous victimization by sexual partners who were considered to be trustworthy persons.

Youth used this distrust toward potential sexual partners intentionally, both in online platforms as well as in person, as a defense for their own protection. For example, youth expressed great concern about contracting HIV/STIs from sexual partners, describing how "*you* [can] *have sex with that person then the person get it* [an STI]". Youth asserted their knowledge that "*that's illegal*" (to have unprotected sex with someone knowing you have an STI and not informing them) and that "*you have to tell the person* [that you have an STI] *before you have sex with that person*", emphasizing their stance that it is not acceptable and against the law to have unprotected sex with someone knowing you have an STI that could be transmitted to that person.

Distrust of potential sexual partners was clear in youths' tone of voice and in the context in which they described this hypothetical scenario. One youth shared her perspective that *"this world is crazy, and you never know what who has who and why who how when how they got it"* (i.e., never truly knowing potential sexual partners' sexual health statuses and histories). Another participant added *"-And what their intentions are!"* (i.e., the potential for malicious intention in terms of knowingly transmitting STIs to sexual partners). Youth explained how intentionally spreading STIs is "*putting other people's lives in danger*." Youth discussed the possibility of their potential sexual partners' intentional transmitting of STIs being driven by their own psychological pain: "*…just because you suffering doesn't mean you gotta put somebody else's life in danger*", emphasizing that experiencing mental health distress associated with positive STI status is not an acceptable justification for threatening the sexual health of one's sexual partners.

Youth further took their fear of contracting STIs one step further by highlighting that "*your kid could get born with an STD*" if a male partner fails to disclose their positive STI status and impregnates his female partner. This discussion extends the fear of personal victimization among girls in care by romantic or sexual partners to their future children. This perspective suggests significant life experience and advanced awareness in terms of sexual health risk; understanding that failure to disclose positive HIV/STI status creates the potential for transmission of STIs between romantic partners, and potentially threatens the safety and wellbeing of their future children as well.

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Not necessarily related to contracting STIs, youth more generally described feeling a fear of victimization when meeting potential romantic partners online using dating or social media applications (Kachingwe et al., 2020). Girls in care described meeting romantic partners from the internet as unsafe and implied that girls engaging in this behavior could be victimized:

> "*Like, they just be doing it just to be funny* [being on dating applications] *but they'll be like, they'll usually go to the dating app, and actually talk to the person and just be like, and just be like funny with it. But then*, [I told] *one person…that something's gonna end up happening to you 'cause you keep doing that dumb stuff* [meeting potential sexual partners online]."

Generally, girls in care characterized engaging with dating and social media applications as risky and feared being deceived by potential romantic partners online. Girls in care associated social media and dating applications with "*catfishing*"; the act of using fake or stolen identities online to establish deceptive relationships. They further implied that the internet is an online space that can threaten their sexual health if romantic partners betray them by sharing their sexually explicit photos with others.

3.2. Self-protection from sexual relationship harm

As a result of their fears of being victimized by potential sexual partners, youth stressed the importance of actively protecting themselves from sexual relationship harm through various measures. Youth felt the need to be constantly vigilant with regard to their sexual health. They advised youth to "*be very careful*" and suggested that they "*don't talk to strangers*" and " [not] *let people come into* [their] *personal space*" as ways to establish boundaries that protect against potentially dangerous situations. Youth strongly emphasized the need to be respected at all times as a clear parameter in order to prevent future occurrences of sexual harassment against them:

> "*Like, don't let nobody just say anything to you* [sexually harassing comments] *because then they goin' to feel, like, that they can do that to females and they really can't. Like, you gotta come at a female with respect. No matter what."*

This discussion suggests youths' preference for active vs. passive self-protection in terms of sexual health threat. Youth believe that rather than submitting in the face of experiencing sexual harassment, young women should explicitly demand respect that informs potential perpetrators that their sexually threatening behavior will not be tolerated whatsoever.

Youth further expressed the need to self-protect specifically regarding exposure to STIs, emphasizing that *"you should always protect yourself"* from HIV/STIs, and advising youth to "*wrap it up*" (i.e., use a condom). Youth emphasized the importance of prevention, testing, and treatment for HIV/STIs, stating that "*y'all can go get checked man*" (i.e., get tested for HIV/STIs), and in the event that one does have an STI, "*there's medication for it*" and one should "*seek help immediately before it spreads or gets worse*". Similarly, this discussion demonstrates advanced understanding about sexual health prevention behaviors, emphasizing that these young women in care know that they should use condoms, get tested, and seek treatment when necessary.

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In terms of reporting sexual victimization incidents, girls in care shared that they would seek help from trusted adults, and cited the "*police*", "*school counselors*", and "*CASA workers* [court appointed special advocates]" as potential sources they could seek help from. However, youth followed-up these suggestions with issues they have asking some of these sources for help. One youth explained that "*you can't trust the popo's* [police]… *they like to slam you on the ground for no reason, or pull you over for no reason, tryna taze you for no reason*", emphasizing that law enforcement may be experienced as a source of harm rather than one of safety and wellbeing. Another youth implied that they would not report sexual victimization incidents to their CASA worker because "[they] *don't wanna go to court for that* [sexual victimization] *anymore*". These discussions are concerning, as they suggest the possibility that sexual minority girls in foster care might not report victimization crimes against their sexual health to entities that exist specifically to receive and respond to these kinds of reports. Another youth explained that "*if it's like a serious situation.…like if something happen.…and then like you can't find nobody* [a trusted adult], *but there's people that you don't know but you just gotta go to it, just for help*" (i.e., understanding that sometimes a trusted adult will not be available, and youth may have to reach out to untrusted entities that could help protect them in dangerous situations).

3.3. Sexual health communication

The final facet of how sexual minority girls in foster care experience sexual health is managing sexual health communication, particularly with those who might serve as information sources. Youth described the possibility of communication with various kinds of persons around their sexual health. Youth explained that whether or not they will talk to an adult about sexual health "*depends* [on] *if* [they're] *comfortable*" with that adult. They advised that youth should "*talk to an adult* [about sexual health] *that* [they] *can trust or that* [they] *can put* [their] *faith in*." However, one youth explained that at times it is not easy to talk about sexual health with trusted adults, such as caregivers or staff, particularly when they are too direct or otherwise lack a tactful approach during sensitive discussions about sexual health:

> "*Cause they* [staff and caregivers] *just be, like, so blunt about it* [sexual health], *I be like, hold up, I ain't even know all that, calm down.......I rather they'd be blunt… but I'd rather they just ease into the bluntness.… Like, you can be blunt and not… blow it up at the same time. Cause I feel like when people be blunt, they just blow it up…"*

Thus, youth expressed appreciation for honesty and directness from caregivers and staff about sexual health information and communication, but emphasized that they should approach these conversations with finesse and ease due to the sensitive nature of these topics that could very easily make youth shut down and not want to engage in discussion.

Youth further shared that they would communicate with medical professionals, such as doctors, about some sexual health concerns, including HIV/STIs and unhealthy relationships, but not around other sexual health issues, like privacy and safety. Youth explained that "*privacy and safety is in a different ballpark than STDs and unhealthy relationships… they don't really go hand in hand*". They explained that their doctors "*don't*

need to know if [they're] *sexting or not*", suggesting that educational conversations about sexual health privacy and safety could be unique opportunities for foster care staff and caregivers. Youth also expressed that they would feel comfortable talking with close family members and peers about sexual health, like "*big brothers and sisters", "cousins", or "close friends,"*. Some youth felt that they would prefer to communicate about sexual health with "*somebody who's been through it before…someone who grew up in care and been through that stuff*" (i.e., a former foster youth), because an adult who grew up in foster care "*can tell it better than someone who hasn't been through it.*"

Youth also stressed the critical importance of privacy during sexual health communications and were sensitive to the possibility of sexual health conversations being overheard or shared beyond the individual with whom they were speaking. For example, one youth explained that it would be "*embarrassing*" if others found out they were in an unhealthy relationship as a result of sexual health communications. Another youth alluded to the possibility of a trusted friend or sibling "*saying stuff about you around school*", referring to the possibility of personal sexual health information being shared with school peers.

Generally, youth expressed flexibility regarding who they might discuss their sexual health with but continued to emphasize the importance of establishing comfort with the particular individual with whom they might discuss this topic with. These discussions speak to the importance of establishing strong youth-adult relationships characterized by trust, rapport, and comfort in order to be able to effectively engage in sexual health education discussions.

4. Discussion

Study findings highlight preliminary understanding of how sexual minority girls in foster care experience the phenomenon of sexual health. In this study, sexual minority girls in foster care focused heavily on the potential for negative sexual health outcomes that can result from sexual relationships. Such negative framing of sexual relationships should be further explored, as youths' fears regarding sexual relationships may be related to past experiences of sexual victimization and abuse that can increase sexual health risk in the present and future. Considering that both sexual minority girls (Kann et al., 2018; Saewyc et al., 2008; Scheer et al., 2019) and girls in foster care (Ahrens et al., 2012, 2013) have reported elevated experiences of childhood sexual abuse, it is likely that sexual minority girls in foster care have had these experiences in the past (Mitchell et al., 2015). This is highly concerning, as experiences of sexual victimization and abuse have been linked to increased sexual risk behaviors among both sexual minority girls (Saewyc et al., 2008; Scheer et al., 2019) and girls in foster care (Ahrens et al., 2012, 2013).

Of further concern is that potentially increased rates of sexual risk behaviors among sexual minority girls in foster care could lead to teen pregnancies and repeat pregnancies. Indeed, findings from the National Youth in Transition Database demonstrate that girls in foster care have pregnancy rates over 3 times as high as the general population of girls in the U.S. (Shpiegel & Cascardi, 2015). Further, findings from the Midwest Study indicate that many girls in foster care with one pregnancy will experience a repeat pregnancy, with 46% of girls in foster care with one pregnancy experiencing a repeat pregnancy by age 19 (Dworsky &

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Courtney, 2010). Similarly, elevated rates of teen pregnancy have been found among sexual minority girls, and they have been linked to previous experiences of sexual victimization and abuse (Charlton et al., 2018; Everett et al., 2019; Goldberg, Reese, & Halpern, 2016).

Sexual minority girls in foster care in this study demonstrated advanced understanding of sexual risk prevention practices, such as using condoms, getting tested, and seeking treatment. This was a surprising finding, as girls in our sample form part of national samples that have demonstrated high rates of sexual risk behaviors, STIs, and teen pregnancies. This may be, at least in part, related to mental health burden that impacts youths' abilities to have safe sex. Using NSCAW data, research demonstrates that girls in care suffering from high PTSD symptoms are over 7 times as likely to engage in unprotected sex compared to those not experiencing high PTSD symptoms (Cavanaugh, 2013). Further, Midwest study findings demonstrate that girls in care are significantly more likely to experience depression, PTSD, and relationship anxiety compared to boys in care (Ahrens et al., 2013). A population-based study also found that sexual minority youth in foster care are significantly more likely to experience depression and suicidal ideation compared to heterosexual foster youth (Baams et al., 2019). More research is needed to understand how mental health burden impacts sexual health risk among sexual minority girls in foster care.

Like other youth, sexual minority girls in care prefer to receive sexual health information from adults or youth with whom they have a trusting and supportive relationship and are deemed individuals with whom they feel "*comfortable*." They may therefore seek sexual health support from those who work to earn their trust, protect their privacy and confidentiality, have strong communication skills (including being sensitive and tactful), and can understand their experiences related to being in foster care. Our findings align with previous research, which identified non-judgmental and open communication and relationship-building as strong facilitators of sexual health communication between foster care staff members and foster youth (Serrano, Crouch, Albertson, & Ahrens, 2018). For sexual minority youth specifically, this situation is complicated, because foster care staff members and parents may also lack awareness and have discomforts, biases, misconceptions, and religious beliefs that don't align well with sexual minority identities, and this may impact staff members' abilities to have successful sexual health communications with sexual minority youth in care (Clements & Rosenwald, 2007; Lorthridge, Evans, Heaton, Stevens, & Phillips, 2018; McCormick et al., 2017; McCormick, Schmidt, & Terrazas, 2016; Salazar et al., 2018).

Establishing trustful and supportive relationships with important adults may further be challenging for sexual minority girls in foster care as a result of various potential experiences that may have severed their abilities to trust important adults. For example, one population-based study found that sexual minority youth are significantly more likely to be treated poorly by the child welfare system, experience a greater number of placements, and be placed in a group foster home (vs. a single family foster home or kinship placement) compared to heterosexual youth (Wilson & Kastanis, 2015). Further, multiple research studies suggest that some of the primary reasons sexual minority youth may become involved with the foster care system are biological family and parental rejection of their sexual identities and associated childhood abuse (Choi, Wilson, Shelton, & Gates, 2015;

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Durso & Gates, 2012; Irvine & Canfield, 2016). Unfortunately, sexual minority youth in foster care remain at risk for being rejected, discriminated against, and victimized by foster care-affiliated staff, caregivers, and peers (Freundlich & Avery, 2004; Mallon, 2001; Mallon, Aledort, & Ferrera, 2002; McCormick et al., 2017, 2016). Not surprisingly, sexual minority girls did not reference foster care staff as adults whom they would go to if they needed to report an incident of sexual victimization, and only briefly mentioned them as a potential trusted source to engage in discussions with around sexual health. Similarly, youth also expressed hesitancy about reporting sexual victimization to the police and their CASA workers. Past involvement and negative experiences in the criminal justice system among sexual minority foster youth could be related to lack of trust and comfort with the criminal justice system and its staff (Conron & Wilson, 2019; Irvine & Canfield, 2016; Wilson et al., 2017). Although the current study offers beginning insights into the attributes of people with whom sexual minority girls in foster care may feel comfortable discussing their sexual health, more investigation is needed to understand how to improve the quality of adult-youth relationships, given that sexual minority girls in care may be untrusting of adults who are typically perceived as important trusted sources, such as foster system caregivers and staff.

Considering that sexual minority girls in foster care indicated flexibility regarding potential trusted adult sources of sexual health support, they may benefit from interventions seeking to protect their sexual health via relationship and trust building with important and consistent adults in their lives. Similar to our study findings, sexual health research among African American youth in foster care has found great flexibility in identified sources of support around sexual health, with biological family members (boys and girls) and health care providers (girls) being cited more frequently, and foster system caregivers being cited less frequently (girls) (Diamant-Wilson & Blakey, 2018). Unlike findings in our study, sexual and romantic partners have also been frequently cited as preferred sources of sexual health support (boys and girls) (Diamant-Wilson & Blakey, 2018). Countering the previously cited study, other research has found that biological families have little impact on sexual risk among foster care youth (Maliszewski & Brown, 2014) and sexual minority youth (Johns et al., 2018). Other research has demonstrated that positive peer norms, and communications with regular romantic partners (but not casual partners) are more consistent protective factors for condom use among sexual minority youth (Johns et al., 2018). Lastly, Midwest Study data demonstrate that closeness to foster system caregivers serves as a protective factor against positive STI diagnosis among youth in care (Ahrens et al., 2013). Our finding about comfort and trust being key components necessary for sexual health communications with sexual minority girls in foster care may help in part to explain mixed results regarding preferred sexual health support figures and their impact on sexual health outcomes.

4.1. Implications for future research

Particular to sexual minority youth in care, past research has indicated that they may feel more supported by foster system caretakers and staff when they acknowledge their presence as sexual minorities, demonstrate acceptance and affirmation of their sexual identities, are willing to discuss concerns around their sexual identities, participate in shared bonding activities with them, stand up and advocate for their human rights, make efforts to connect them with affirming peers and organizations, and have open, honest,

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and non-judgmental communication styles (McCormick et al., 2016; Salazar et al., 2018). Such practices might be particularly important to facilitate and encourage sensitive sexual health discussions with sexual minority girls in foster care. Indeed, past research has found that when foster system caregivers are able to affirm foster youths' sexual minority identities, it serves as a pathway that encourages further dialogues about other sensitive and intimate topics (McCormick et al., 2016), such as sexual health. Preliminary intervention research (i.e., RISE) findings support that relationship-building interventions can increase acceptance, affirmation and support of youths' sexual identities, and improve relationship quality, comfort, and communication between sexual minority youth in foster care and their foster system caregivers and staff members, biological families, and other important adults (Lorthridge et al., 2018). Future research studies are needed to examine how affirming practices and behaviors from important adults can be leveraged to support sexual health communications with sexual minority girls in foster care.

Additionally, youth in our sample were characterized by multiple historically oppressed identities, such as female gender, foster-care involvement, and racial and sexual minority identities. Sexual minority youth of color are overrepresented across multiple public systems of care (e.g., juvenile justice, child welfare, foster care) (Conron & Wilson, 2019; Irvine & Canfield, 2016; Wilson et al., 2017), and likely face several structural vulnerabilities that threaten their sexual health and wellbeing (Conron & Wilson, 2019; Grooms, 2020). Thus, future research in this area may benefit from implementing an intersectionality framework (Bowleg, 2012) to account for the complexity of their lived experiences. Implementing intersectionality as a guiding framework would allow for more nuanced examination of multiple marginalized social identities (e.g., race, gender, sexual orientation, systems-involvement), various forms of social inequality and oppression (e.g., class, homelessness, heterosexism, sexism, racism), and their relations to sexual health outcomes among sexual minority girls in care. Intersectional framing may be able to provide novel perspective that reveals how sexual minority youth in care are subordinated by various systems of power and oppression and could help inform the dismantling of such systems to improve their sexual health and overall wellbeing. We encourage researchers to consider intersectionality frameworks in future studies of sexual health among sexual minority girls in foster care.

4.2. Limitations

There are a number of study limitations to be taken into consideration when applying these findings to other youth. We did not definitively learn how participants identified in terms of their sexual orientation until after the focus group discussion concluded, at which point we collected demographic information. Although participants were provided the option to select sexuality and gender as a main sexual health topic (not selected), participants were not asked explicitly to specify how their sexual identities were related to their sexual health (in terms of the topics they chose). Thus, we were unable to conclude how participants believe their sexual minority identities specifically and directly relate to their experiences of sexual health. Despite this, youth freely discussed romantic and sexual relationships with men and women, providing valuable information about the lived experiences of sexual health among sexual minority girls in foster care.

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Due to the sensitive nature of discussing sexual health, we elected to interview youth aged 16 and older, which should be considered when applying findings to others. We encourage future research on the sexual health experiences of younger youth in care. Additionally, although findings were presented to our community-based child welfare agency partners for feedback, study rigor could have been further strengthened by use of member checking with youth themselves, which was not logistically feasible in this study due to the timing of analysis relative to when the data were collected, as well potential changes in youths' foster care placements. Further, although youth appeared comfortable and spoke candidly during the focus group, it is possible that openness to discussing sexual health may have been enhanced by conducting individual interviews. Lastly, youth in this study were living in group foster homes, not in single family foster homes or kinship placements, which could limit the transferability of findings to sexual minority girls in foster care placements other than group homes.

Despite these limitations, the study is a significant contribution to existing literature as the only known study focused on the lived experiences of sexual health among sexual minority girls in foster care. The study's strengths include a rigorous community-engaged approach to study design, analysis, and interpretation of findings; the use of an in-depth analytic approach; significant emphasis on reflexivity through journaling and peer debriefing; advantageous research team positionalities; and the innovation of the topic.

5. Conclusion

Sexual minority girls in foster care characterized their lived experiences of sexual health as being dominated by fear of sexual victimization and distrust of sexual partners. Although these perspectives may protect youth from risky sexual situations, they suggest a powerful impact of past victimization on youths' well-being in the domain of sexual health. More research is needed assessing sexual health among sexual minority foster girls in foster care, how important adults (e.g., foster system caretakers and staff, biological family members) might best address their sexual health needs, and how to help them safely navigate intimate partnerships and protect their sexual health. Learning this information may help inform the development of new interventions, and adaptation of existing interventions (Combs et al., 2019; Lorthridge et al., 2018; Oman, Vesely, Green, Clements-Nolle, & Lu, 2018; Salazar et al., 2019) to improve sexual health and wellbeing among sexual minority girls in care.

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References

Ahrens KR, Katon W, McCarty C, Richardson LP, & Courtney ME (2012). Association between childhood sexual abuse and transactional sex in youth aging out of foster care. Child Abuse & Neglect, 36(1), 75–80. 10.1016/j.chiabu.2011.07.009. [PubMed: 22265906]

Ahrens KR, McCarty C, Simoni J, Dworsky A, & Courtney ME (2013). Psychosocial pathways to sexually transmitted infection risk among youth transitioning out of foster care: Evidence from a longitudinal cohort study. Journal of Adolescent Health, 53(4), 478–485.

Ahrens KR, Richardson LP, Courtney ME, McCarty C, Simoni J, & Katon W (2010). Laboratory-diagnosed sexually transmitted infections in former foster youth compared with peers. Pediatrics, 126(1), e97–e103. [PubMed: 20547646]

Aparicio EM, Kachingwe ON, Salerno JP, Geddings-Hayes M, & Boekeloo BO (2020). Addressing sexual health among youth in foster care: A community-engaged grounded theory model. Sexuality Research and Social Policy Submitted for publication

Baams L, Wilson B, & Russell S (2019). LGBTQ youth in unstable housing and foster care. Pediatrics, 143(3), e20174211. [PubMed: 30745432]

Bowleg L (2012). The problem with the phrase women and minorities: Intersectionality—an important theoretical framework for public health. American Journal of Public Health, 102(7), 1267–1273. [PubMed: 22594719]

Cavanaugh CE (2013). Brief report: The influence of posttraumatic stress on unprotected sex among sexually active adolescent girls and boys involved in the child welfare system of the United States. Journal of Adolescence, 36(5), 835–837. 10.1016/j.adolescence.2013.07.004. [PubMed: 24011099]

Charlton BM, Roberts AL, Rosario M, Katz-Wise SL, Calzo JP, Spiegelman D, & Austin SB (2018). Teen pregnancy risk factors among young women of diverse sexual orientations. Pediatrics, 141(4).

Choi S, Wilson B, Shelton J, & Gates G (2015). Serving our Youth: The needs and experiences of LGBTQ youth experiencing homelessness. *Retrieved from*. https://truecolorsunited.org/wp-content/uploads/2015/05/Serving-Our-Youth-June-2015.pdf.

Clements JA, & Rosenwald M (2007). Foster parents' perspectives on LGB youth in the child welfare system. Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 19(1), 57–69. 10.1300/J041v19n01_04.

Combs KM, Aparicio EM, Prince DM, Grinnell-Davis C, Marra L, & Faulkner M (2019). Evidence-based sexual health programs for youth involved with juvenile justice and child welfare systems: Outcomes across settings. Children and Youth Services Review, 100, 64–69.

Conron K, & Wilson B (2019). LGBTQ Youth of Color Impacted by the Child Welfare and Juvenile Justice Systems: A Research Agenda. The Williams Institute.

Diamant-Wilson R, & Blakey JM (2018). "strap up:" sexual socialization and safer sex practices among african american youth in foster care. Child Abuse & Neglect, 10.1016/j.chiabu.2018.08.007.

Durso LE & Gates GJ (2012). Serving Our Youth: Findings from a National Survey of Services Providers Working with Lesbian, Gay, Bisexual and Transgender Youth Who Are Homeless or At Risk of Becoming Homeless. Retrieved from https://escholarship.org/uc/item/80x75033.

Dworsky A, & Courtney ME (2010). The risk of teenage pregnancy among transitioning foster youth: Implications for extending state care beyond age 18. Children and Youth Services Review, 32(10), 1351–1356.

Everett BG, Turner B, Hughes TL, Veldhuis CB, Paschen-Wolff M, & Phillips G (2019). Sexual orientation disparities in pregnancy risk behaviors and pregnancy among sexually active teenage girls: updates from the youth risk behavior survey. LGBT Health, 6(7), 342–349. [PubMed: 31618165]

Fish JN, Baams L, Wojciak AS, & Russell ST (2019). Are sexual minority youth overrepresented in foster care, child welfare, and out-of-home placement? Findings from nationally representative data. Child Abuse & Neglect, 89, 203–211. 10.1016/j.chiabu.2019.01.005. [PubMed: 30708335]

Freundlich M, & Avery RJ (2004). Gay and lesbian youth in foster care: Meeting their placement and service needs. Journal of Gay & Lesbian Social Services, 17(4), 39–57.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Goldberg SK, Reese BM, & Halpern CT (2016). Teen pregnancy among sexual minority women: Results from the National Longitudinal Study of Adolescent to adult health. Journal of Adolescent Health, 59(4), 429–437.

Goodenow C, Szalacha LA, Robin LE, & Westheimer K (2008). Dimensions of sexual orientation and HIV-related risk among adolescent females: Evidence from a statewide survey. American Journal of Public Health, 98(6), 1051–1058. [PubMed: 18445809]

Grooms J (2020). No home and no acceptance: Exploring the intersectionality of sexual/gender identities (LGBTQ) and race in the foster care system. The Review of Black Political Economy, 10.1177/0034644620911381 In press.

Irvine A, & Canfield A (2016). The overrepresentation of lesbian, gay, bisexual, questioning, gender nonconforming and transgender youth within the child welfare to juvenile justice crossover population. American University Journal of Gender, Social Policy & the Law, 24(2), 2.

James S, Montgomery SB, Leslie LK, & Zhang J (2009). Sexual risk behaviors among youth in the child welfare system. Children and Youth Services Review, 31(9), 990–1000. 10.1016/j.childyouth.2009.04.014. [PubMed: 23606780]

Johns MM, Liddon N, Jayne PE, Beltran O, Steiner RJ, & Morris E (2018). Systematic mapping of relationship-level protective factors and sexual health outcomes among sexual minority youth: The role of peers, parents, partners, and providers. LGBT Health, 5(1), 6–32. 10.1089/lgbt.2017.0053. [PubMed: 29271692]

Kachingwe ON, Salerno JP, Boekeloo BO, Fish JN, Geddings-Hayes M, Allen F, & Aparicio EM (2020). “The Internet is not Private”: The role of social media in sexual health among youth in foster care. Journal of Adolescence. 10.1016/j.adolescence.2020.06.005 In press.

Kann L, McManus T, Harris WA, Shanklin SL, Flint KH, Queen B, … Thornton J (2018). Youth risk behavior surveillance—United States, 2017. MMWR Surveillance Summaries, 67(8), 1.

Lorthridge J, Evans M, Heaton L, Stevens A, & Phillips L (2018). Strengthening family connections and support for youth in foster care who identify as LGBTQ: Findings from the PII-RISE evaluation. Child Welfare, 96(1), 53–78.

Maliszewski G, & Brown C (2014). Familism, substance abuse, and sexual risk among foster care alumni. Children and Youth Services Review, 36, 206–212.

Mallon GP (2001). Sticks and stones can break your bones: Verbal harassment and physical violence in the lives of gay and lesbian youths. Journal of Gay & Lesbian Social Services, 13(1–2), 63–81.

Mallon GP, Aledort N, & Ferrera M (2002). There’s no place like home: Achieving safety, permanency, and well-being for lesbian and gay adolescents in out-of-home care settings. Child Welfare, 81 (2), 407–439. [PubMed: 12014475]

McCormick A, Schmidt K, & Terrazas S (2017). LGBTQ youth in the child welfare system: An overview of research, practice, and policy. Journal of Public Child Welfare, 11(1), 27–39.

McCormick A, Schmidt K, & Terrazas SR (2016). Foster family acceptance: Understanding the role of foster family acceptance in the lives of LGBTQ youth. Children and Youth Services Review, 61, 69–74.

Mitchell RC, Panzarello A, Grynkiewicz A, & Galupo MP (2015). Sexual minority and heterosexual former foster youth: A comparison of abuse experiences and trauma-related beliefs. Retrieved from Journal of Gay & Lesbian Social Services, 27(1), 1–16. http://10.0.4.56/l0538720.2015.988316.

Oman RF, Vesely SK, Green J, Clements-Nolle K, & Lu M (2018). Adolescent pregnancy prevention among youths living in group care homes: A cluster randomized controlled trial. American Journal of Public Health, 108(S1), S38–S44. [PubMed: 29443557]

Poteat VP, Russell ST, & Dewaele A (2019). Sexual health risk behavior disparities among male and female adolescents using identity and behavior indicators of sexual orientation. Archives of Sexual Behavior, 48(4), 1087–1097. [PubMed: 29204816]

Rasberry CN, Lowry R, Johns M, Robin L, Dunville R, Pampati S, … Balaji A (2018). Sexual risk behavior differences among sexual minority high school students—United States, 2015 and 2017. Morbidity and Mortality Weekly Report, 67(36), 1007. [PubMed: 30212446]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Saewyc EM, Poon CS, Homma Y, & Skay CL (2008). Stigma management? The links between enacted stigma and teen pregnancy trends among gay, lesbian, and bisexual students in British Columbia. The Canadian Journal of Human Sexuality, 17(3), 123. [PubMed: 19293941]

Salazar AM, Haggerty KP, Barkan SE, Peterson R, Furlong ME, Kim E, … Colito JM (2019). Supporting LGBTQ+ foster teens: development of a relationship-focused, self-guided curriculum for foster families. Sexuality Research and Social Policy, 1–13. [PubMed: 31890053]

Salazar AM, McCowan KJ, Cole JJ, Skinner ML, Noell BR, Colito JM, … Barkan SE (2018). Developing relationship-building tools for foster families caring for teens who are LGBTQ2S. Child Welfare, 96(2), 75. [PubMed: 29861503]

Scheer JR, McConocha E, Behari K, & Pachankis JE (2019). Sexual violence as a mediator of sexual orientation disparities in alcohol use, suicidality, and sexual-risk behaviour among female youth. Psychology & Sexuality, 1–15. 10.1080/19419899.2019.1690031.

Serrano J, Crouch JM, Albertson K, & Ahrens KR (2018). Stakeholder perceptions of barriers and facilitators to sexual health discussions between foster and kinship caregivers and youth in foster care: A qualitative study. Children and Youth Services Review, 88, 434–440. 10.1016/j.childyouth.2018.03.020.

Shpiegel S, & Cascardi M (2015). Adolescent parents in the first wave of the National Youth in Transition Database. Journal of Public Child Welfare, 9(3), 277–298.

Smith JA, Flowers P, & Larkin M (2009). Interpretative phenomenological analysis: Theory, method and research London: Sage Publications Ltd.

U.S. Department of Health and Human Services, 2019. Trends in Foster Care and Adoption: FY 2009 - FY 2018. Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/trends_fostercare_adoption_09thru18.pdf.

Wilson B, Jordan S, Meyer I, Flores A, Stemple L, & Herman J (2017). Disproportionality and disparities among sexual minority youth in custody. Journal of Youth and Adolescence, 46(7), 1547–1561. 10.1007/s10964-017-0632-5. [PubMed: 28093665]

Wilson B, & Kastanis A (2015). Sexual and gender minority disproportionality and disparities in child welfare: A population-based study. Children and Youth Services Review, 58, 11–17. 10.1016/j.childyouth.2015.08.016.

Winter VR, Brandon-Friedman RA, & Ely GE (2016). Sexual health behaviors and outcomes among current and former foster youth: A review of the literature. Children and Youth Services Review, 64, 1–14. 10.1016/j.childyouth.2016.02.023.

Ybarra ML, Rosario M, Saewyc E, & Goodenow C (2016). Sexual behaviors and partner characteristics by sexual identity among adolescent girls. Journal of Adolescent Health, 58(3), 310–316.