Salud sexual de la población adolescente del sistema de protección

Tesis doctoral presentada por
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En aras de la claridad de la prosa, y de acuerdo con la normativa vigente de la Real Academia de la Lengua Española, vamos a utilizar siempre que sea posible las formas colectivas de sustantivos y pronombres. Así, a lo largo de esta tesis doctoral haremos uso del masculino para referirnos tanto a personas del género masculino como del femenino, ya que es la forma gramaticalmente correcta de incluir a ambos sexos. El femenino, por tanto, se usará para referirnos expresamente a personas de este género.

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ÍNDICE

WIDE SUMMARY

THEORETICAL FRAMEWORK

Sexual health, defined by the World Health Organization, as a state of physical, emotional, mental and social well-being related to sexuality, is not limited to the absence of disease or dysfunction. It requires a positive and respectful approach to it, as well as the opportunity to have enjoyable and safe sexual experiences, free from coercion, discrimination, and violence. Therefore, in order to achieve and maintain adequate sexual health, sexual rights of all people must be respected, protected and guaranteed. Societies that prioritise sexual health of their citizens are characterised by maintaining political commitment to this issue, developing public policies that promote healthy sexual development, and enacting laws that protect citizens from exploitation and guarantying the free experience of sexuality. But, it is also important to recognise the impact that culture, sexual preference, religious differences, age, disability and socio-economic status, among other factors, can have on sexual development and, therefore, on the sexual health of each individual. Sexually healthy people who express their sexuality in a positive way, in line with their values, enjoy sexual relationships with others, avoid coercive sexual practices, and feel comfortable with their bodies and sexual orientation. According to this proposal, sexual health is manifested through the free and responsible expression of sexual capacities, which is particularly important for the overall health of the individual throughout the life cycle (Carrillo Romero, 2022; OMS, 2006).

From birth, the exploration and discovery of one's own body and pleasurable sensations (Fernández et al., 2004). Sexual responsiveness is present within hours of birth: baby boys are able to have erections and baby girls are able to have vaginal lubrications (Masters et al., 1982), as well as enjoy sensual experiences such as sucking on fingers or toes. Childhood is characterised by the interest in a variety of sexual play experiences (Reynolds et al., 2003), while pre-adolescence brings with it the first experiences of sexual attraction and the perception of social segregation along gender lines, distinguishing males and females as separate groups (DeLamater & Friedrich, 2002). Subsequently, adolescence brings a series of much more powerful biological,

psychological, social and cultural changes that make it a key period in an individual's sexual development. The onset of puberty, which brings increased production of sex hormones, maturation of the secondary sex organs and increased sexual urges and desires, leads to the adoption of sexual values by adolescents and the onset of sexual behaviour. It is also at this stage that adolescents begin to define their sexual identity and managing physical and emotional intimacy in relationships with others (Moore & Rosenthal, 2006). However, the process of reaching sexual maturity continues into adulthood, when a clearer preference for the desired sexual lifestyle develops and certain interpersonal skills are honed that facilitate the establishment of intimate relationships (DeLamater & Friedrich, 2002). In a recent goverment survey, 68.6 % of Spaniards said they had an affective and sexual relationship with someone with whom they shared a life project, while 17 % had no sexual or affective relationship with anyone (CIS, 2023). Furthermore, heterosexual monogamy is still the most common sexual lifestyle among the Spanish adult population (CIS, 2023; Ministerio de Sanidad, 2009), although 47.6 % now favour having two or more affective-sexual relationships at the same time (CIS, 2023). The frequency with which they have sex is weekly for more than half of the couples, although, as it is still considered a taboo issue, 41 % do not talk about their performance in bed with their partner (Sanghvi, 2021). Sexual satisfaction is also an important part of sexual health, especially for people in this age group, with 69.4 % of respondents believing that satisfactory sexual relations are essential to maintaining a romantic relationship (CIS, 2023). Finally, in old age, a stage characterised by age-related changes in the functioning of the sexual organs, the individual is confronted with a series of negative prejudices about his or her sexuality, which may lead to a decrease in the frequency of sexual intercourse and sexual satisfaction (Ballester-Arnal et al., 2019; DeLamater & Friedrich, 2002).

Regardless of an individual's stage of development, sexual health is an integral part of every person and influences our thoughts, feelings, actions, and interactions, and therefore our physical and mental health, and must receive appropriate attention (Carrillo Romero, 2022; Langfeldt & Porter, 1986). However, as it is a multidimensional construct, value judgements about it need to consider the different aspects it

ecompasses. Sexual knowledge, skills, attitudes, and behaviours could be seen as the backbone of this multidimensionality.

Firstly, lack of knowledge about sexuality and poor access to information are linked to a wide range of risky sexual behaviours, the spread of sexually transmitted infections (STIs) and increased discrimination and intolerance towards sexual diversity, among other things (Blanco Monsalve & Orejarena Regueros, 2014). Similarly, the beliefs, values, and perceptions that an individual has about sexuality and sexual relationships can also have a direct impact on their sexual behaviour and the way they approach and express their own sexuality. For example, people with negative attitudes towards sexuality may feel uncomfortable buying or using contraceptives, which may reduce the likelihood of effective use; whereas those who tend to have positive attitudes towards sexuality show greater acceptance of sexual diversity and a lack of prejudice, leading to more effective communication with their sexual partner(s) and greater sexual satisfaction (Sánchez-Fuentes et al., 2014). In particular, sexism and LGTBphobic attitudes are considered to be the most harmful prejudices related to sexuality, as they have the greatest impact on people's sexual health (Alonso-Martínez et al., 2022). Sexist attitudes are understood as a predisposition to perpetuate inequalities, stereotypes and roles that are perceived as female and male behaviours (including traditional sexual double standards), and are associated with cultures of violence, rape and murder (Álvarez-Muelas et al., 2022). Hostile sexism evaluates overtly discriminatory attitudes and behaviours based on the perceived inferiority of women, and benevolent sexism explores attitudes that, even when expressed in a positive affective tone, stereotype and confine women to traditional roles. Nowadays, these beliefs are present through the idealisation of the male role as caregiver and protector of women (benevolent sexism) and are more common in boys. In contrast, hostile sexism, which consists of the expression of overtly negative beliefs about women, is less common (Fernández-García et al., 2022). Whereas LGTBphobic attitudes, such as transphobia, homophobia, or biphobia, may manifest themselves in overt hostility towards LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual and +) people, or indirectly undermine these sexual identities and orientations, even by feigning positive attitudes towards them (Timmins et al., 2020). However, all of them, in whatever form, are associated with

the heteropatriarchal regime that privileges male heterosexuality as the hegemonic sexual identity and sexual orientation (Westwood, 2022).

Furthermore, because we are social creatures, a person's ability to interact effectively with their partner during sexual activity also plays an essential role in their sexual development. These skills are not limited to a person's ability to engage in and/or perform specific sexual techniques, but also include the ability to communicate openly and effectively with one's partner, to respond to one's partner's needs and desires, and to express and negotiate one's own needs and desires so that one's sexual rights and needs are not violated. In this sense, sexual assertiveness, considered as an individual's ability to openly communicate their sexual thoughts, feelings, preferences, needs or opinions to their sexual partner (Erchull & Liss, 2014; Koolaee et al., 2014; Loshek & Terrell, 2015; Santos-Iglesias et al., 2014), is one of the main skills to achieve a healthy sexual life, as it is undoubtedly linked to an increased sexual satisfaction and the prevention of experiences of sexual victimisation (Jangi et al., 2023; Mirshamshiri et al., 2015). These and other sexual experiences and behaviours can, of course, influence an individual's sexual development. However, although scientific research and social interest has always focused on the study of unprotected sexual practices (Amare et al., 2019), the use of the internet as a means of communication has led to the emergence of other risky sexual behaviours such as sexting (primary sexting as the sending of one's own sexually explicit images, Choi et al., 2016; Marume et al., 2018; Wolak et al., 2012; Ybarra & Mitchell, 2014; secondary sexting as the dissemination of sexual content to third parties, such as sending, receiving and forwarding sexually suggestive and/or explicit photos, videos and text messages, Mitchell et al., 2012; Villacampa, 2017). Sharing of sexual content via an electronic device has become a common phenomenon, especially among teenagers and young adults (Del Rey et al., 2019; Van Ouytsel et al., 2015). Among its consequences, not only is it associated with other risky sexual behaviours such as unprotected sex or cyberpornography, but it also seems to affect the psychological well-being of individuals (e.g., onset of depressive symptoms and even suicidal ideation, among others) (Gewirtz-Meydan et al., 2018; Morelli et al., 2017). Despite this, it appears that sexual victimisation, or engaging in any sexual behaviour through coercion, manipulation or the use of force, remains the sexual behaviour with

the most serious short and long-term consequences for the well-being of the victim (development of post-traumatic stress disorder, anxiety, depression and/or substance abuse disorder, problems with sexual desire and functioning, etc.) (Jina & Thomas, 2013; Tharp et al., 2012).

The influence of each of these dimensions of sexual health on an individual's development will differ according to the individual's stage of life. In this sense, although adolescence has long been regarded as simply a transitional stage between childhood and adulthood, it is now understood as a key period of life in which complex changes take place that are often crucial to future well-being, especially in relation to sexuality (Liang, et al., 2019). In addition to the biological changes brought about by the onset of puberty, adolescents are preparing to take on adult roles by developing certain interpersonal skills that will enable them to enter romantic and sexual relationships, and to engage in decision-making processes about their sexual orientation and identity. All these physical and psychological changes are normative adolescent developments influenced by social and cultural factors. It is therefore not correct to define adolescent sexuality as problematic, as has often been studied, but it is essential to be aware of how this development takes place and the challenges adolescents face (Moore & Rosenthal, 2006).

Related to this, the age of sexual initiation has been falling in recent years, with adolescents having their first sexual experience at an increasingly younger age. A comparative study of risky sexual behaviour between two cohorts in Spain found that the age of first intercourse decreased over time, from 15.1 years in 2006 to 14.7 years in 2012 (Espada et al., 2015). This trend is confirmed by a more recent Spanish study, which reports that the average age of first sexual intercourse has fallen to 14 (García Vázquez et al., 2019). Similarly, the Youth Risk Behavior Surveillance (YRBS) in the United States of America (USA) also reported that 20.4 % of students surveyed had already initiated sexual relations between the ages of 14 and 15 (CDC, 2018). These results could be understood as an indicator of sexual freedom following the huge cultural and social changes that sexuality has experienced as a result of the 21st century sexual revolution in first world countries and could be associated with risky sexual practices without appropriate sex education (Chisamya et al., 2012; Sigusch, 2004). Similarly, although

men continue to be more precocious due to the way masculinity is understood in more macho societies (Gonçalves et al., 2015; Roman Lay et al., 2021), the gender gap has narrowed exponentially in recent decades, with young girls being as sexually active as their male peers (CDC, 2020). However, this analysis does not apply to what happens in other contexts. According to data from the Global School-Based Health Survey (GSHS) in eight African countries, the proportion of adolescents who had ever had sex at age 11 or younger (11.8 %) was higher than at age 12 (5.5 %), 13 (3.9 %) and 14 (6.1 %) (Peltzer, 2010). In the African context and in other developing countries, this early sexual initiation is not new. Historically, due to cultural and religious beliefs and norms, adolescent girls, in particular, have been forced into marriage at a very young age and are prohibited from engaging in premarital sex altogether (Reis et al., 2023), resulting in early sexual initiation.

On the other hand, non-coital sexual activities (kissing, autoerotic practices, etc.) still precede sexual practices involving greater intimacy (vaginal intercourse, etc.) (Boislard et al., 2016; Kotiuga et al., 2022; Lindberg, Scott et al., 2021), although young people now seem to engage in a wider variety of sexual behaviours (Lindberg, Firestein et al., 2021). This may be due to the release of negative attitudes towards less traditional sexual practices experienced by younger people (Manning et al., 2006). Several studies of Canadian and Portuguese populations report that there is now a significant proportion of young people for whom oral sex precedes intercourse, especially among women (Kotiuga et al., 2022; Santarato et al., 2022). While masturbation and vaginal intercourse with penetration are the most common sexual practices among adolescent boys, adolescent girls are also more likely to engage in other sexual practices such as oral sex and anal sex. According to data collected by the Centers for Disease Control and Prevention (CDC) in 2020, 74 % and 47.5 % of USA adolescent boys engaged in masturbation or vaginal intercourse, respectively, while the prevalence of these sexual practices among adolescent girls declined significantly. Masturbation was practised by 47.6 % of female participants and vaginal intercourse by 42.4 %. The opposite was true for the prevalence of oral sex. While 42.4 % of adolescent boys engaged in oral sex, the prevalence among adolescent girls was 59.8 %. This can be seen as a problem if we consider that adolescents do not equate coital sexual practices with oral sex, and

therefore do not recognise the risk of STIs associated with this practice, which contributes to the rejection of condom use and leads to a well-founded increase in concern about the risk of transmission (Moore & Rosenthal, 2006).

HIV-positive adolescents continue to represent a high percentage of all those diagnosed each year, not only in developing countries but also in regions of developed countries. In this regard, the number of adolescents estimated to be HIV-positive is over 2 million, with sub-Saharan African adolescents having the highest prevalence (United Nations, 2023a). However, young men and women aged 15-24 accounted for half of all STI cases detected in the USA in 2008 (Satterwhite et al., 2008), as well as 61 % of all chlamydia cases reported in Europe in 2015 (European Centre for Disease Prevention and Control, 2017). Therefore, STIs in adolescents are arguably a major global problem, especially when we consider the serious consequences for their physical and mental health (OMS, 2018). In addition to damage to the immune system, it has been linked to infertility, nervous system problems, other diseases such as cervical cancer (Shannon & Klausner, 2018) and significant psychological and emotional repercussions (anxiety, depression, etc.) (Singh & Singh, 2021). However, the risks to adolescents who become pregnant at this age are not insignificant (increased risk of eclampsia, puerperal endometritis, systemic infections and postpartum depression, among others). In many parts of the world, including developing countries, teenage pregnancy is common (OMS, 2018). Worldwide, about 16 million adolescent women give birth each year, accounting for about 11 % of all births, and 95 % of these occur in low- and middle-income countries. An estimated 21 million teenage pregnancies occur each year among adolescents aged 15-19 in developing countries (Darroch et al., 2016; OMS, 2018). High rates of child marriage, scarcity and inaccessibility of sexual and reproductive health services, negative community attitudes towards adolescent contraceptive use, low levels of adolescent knowledge about sexuality and widespread sexual violence are some of the reasons for the high prevalence of adolescent pregnancy in these countries (Kassa et al., 2018; OMS, 2018). However, this is not just a problem for young women in developing countries. In the USA, the teenage pregnancy rate was 6 % in 2021 (Elflein, 2023; Rascoe, 2023), while in the UK, the Western European country with the highest teenage pregnancy rate, the prevalence was 13.1 conceptions per 1000 women aged 15-17 in

2020 (Office for National Statistics, 2022). However, teenage pregnancy rates have fallen in these countries in recent decades as governments have implemented policies to prevent teenage pregnancy (e.g., making affective-sex education compulsory, intervention on economic and employment inequalities etc.) (Cook & Cameron, 2017; Office for National Statistics, 2022; Rascoe, 2023).

In this regard, the greater variety of contraceptive methods now available to adolescents may also have contributed to these encouraging results by increasing their use (Moore & Rosenthal, 2006; Todd & Black, 2020). In the USA, 87 % of sexually active adolescents reported using a method of contraception during their last sexual intercourse (Kaiser Family Foundation, 2014). Lindberg, Firestein et al. (2021), in their study of three cohorts of USA adolescents, reported that the proportion of young women who had used a contraceptive method at last intercourse increased from 86 % in the 2006-2010 cohort to 91 % in the 2015-2019 cohort. This prevalence also increased in men, but to a lesser extent. While 93 % of adolescent men in the 2006-2010 cohort had used a contraceptive method at their last sexual intercourse, this rose to 94 % in the 2015-2019 cohort. However, other studies show less flattering data, such as one conducted by Kantorová et al. (2021) with young women from almost 200 different countries around the world, in which only 10.2 % of respondents aged 15-19 years used any method of contraception. In this study, the highest proportions of users were adolescent girls from Latin America and the Caribbean (25.3 %) and North America and Europe (23.5 %) (Kantorová et al., 2021). However, although condoms are currently the most widely used method of contraception among adolescents (CDC, 2020; Kaiser Family Foundation, 2014; Lindberg, Firestein et al., 2021; Trussell, 2011), most do not use them consistently and therefore do not enjoy full sexual protection. Situational factors during sexual encounters, such as high arousal, alcohol or drug use, partner rejection and/or lack of knowledge about the exchange of sexual fluids, may lead them to deny the need for consistent condom use. Having a steady partner, even if they have only been together for a few months, has also been associated with a greater tendency to engage in risky sexual activities, specifically low condom use. This may come from a desire to show trust in the other person (Moore & Rosenthal, 2006). In this context, the practice of "withdrawal" has become one of the most common methods among

adolescents (the third most common contraceptive method among adolescents according to a recent USA study; Lindberg, Firestein et al., 2021), despite the fact that it does not prevent unwanted pregnancies or STIs. The same is true for the contraceptive pill, the second most widely used contraceptive method among adolescents in many countries (CDC, 2020; Kaiser Family Foundation, 2014; Lindberg, Firestein et al., 2021). By the same token, users of this contraceptive method forgo condoms and expose themselves to STIs because they are unaware that preventing pregnancy does not mean having safe sex (Moore & Rosenthal, 2006).

The lack of cognitive maturity in early adolescence, which leads them to make a biased assessments of the future consequences of their actions, seems to be behind this increased sexual risk-taking (Moore & Rosenthal, 2006). But, of course, this is not the only factor. Sexuality education is a key protective factor not only in preventing of STIs, unwanted pregnancies and other risky sexual behaviours, but also in promoting adolescents' mental and emotional health (Hall et al., 2016). In a survey of young people (aged 15-24) in Asia and the Pacific, fewer than one in three considered that they had received "very good" or "fairly good" sexual education at school (UNESCO et al., 2021). However, in countries where secondary education is more formalised, the percentage of children or adolescents who have received sexuality education appears to be increasing, although this does not necessarily imply that the quality and coverage of sexuality education is desirable. For example, the National Survey on Sexuality and Contraception among Young Spaniards found that 72 % of respondents had received specific and formal education on sexuality (SEC, 2019). However, 68.5 % of them felt that the education they had received was not sufficient (SEC, 2019), and only 42 % of adolescents confirmed that they had received education on STI prevention and contraception (CDC, 2020). Moreover, it seems that the wealth of information available to teenagers today, thanks to the Internet, is not always to their advantage. Their knowledge of sexuality remains limited or, worse still, misguided. Their sexual attitudes are less liberal and tolerant than would be desirable (Altekar et al. 2021; CDC, 2020). In Europe, Brunelli et al. (2022) found that only 48.2 % of Italian students in their sample had adequate general knowledge about sexuality. In particular, only 22.6 % of examinees showed adequate knowledge of STIs, while 28.3 % of students wrongly

thought that contraceptive pills protect against STIs. Furthermore, large numbers of girls in many countries have knowledge gaps and misconceptions about menstruation that cause fear and anxiety, preventing them from being prepared for their first menstruation (Chandra-Mouli & Patel, 2020), especially in developing countries (Woog et al., 2015).

Values, beliefs and opinions about sexuality are strongly influenced by culture and society. While Altekar et al. (2021) reported that Indian adolescents in their study had mostly undefined attitudes towards sexuality, other studies with Indonesian and African populations reported negative attitudes in almost half of the respondents (Brillian et al., 2021; Mesele et al., 2023). However, contrary to what one might think, sexist attitudes among adolescents are still very much present also in supposedly less heteropatriarchal countries, perpetuating stereotypical gender roles among the youngest (UNESCO, 2018). In Spain, for example, adolescent boys hold more sexist attitudes than girls, believing that boys should be the economic providers in a relationship and girls should be responsible for childcare. They also believe that women have less sexual desire than men and that men have the right to have sex without mutual consent, and even that gender-based violence is sometimes acceptable in certain situations where the man is "provoked" by the woman (Ramiro-Sánchez et al., 2018).

Since the advent of widespread mobile communication, online sexual behaviours, such as sexting, have become common among teenagers (Ehrenreich et al., 2019; Houck et al., 2014; Madigan et al., 2018; Mitchell et al., 2012). According to a recent meta-analysis, 15 % of young people have ever sent a sexually explicit text message and 27 % have received one, with evidence that prevalence is increasing (Madigan et al., 2018). This is a lower rate than that reported by Gil-Llario et al. (2020) in their study of Spanish adolescents (24.4 %), in which they also found gender differences in favour of boys. Thus, given the range of risks (increased involvement in experiences of sexual victimisation, sex without condoms or with multiple partners, etc.) and psychosocial consequences (feelings of shame and humiliation, symptoms of anxiety, depression) associated with it, we could give it a critical consideration in adolescent sexual health, especially in developed countries (Doyle et al., 2021; Gassó et al., 2019; Houck et al., 2014; Reyns et al., 2013; Rice et al., 2018; Titchen et al., 2019). However, even more

worrying and with even more serious consequences is the fact that, for a substantial minority of young people, first sexual intercourse is not voluntary (Salmon et al. 2022; Warner & Warner, 2019). Around 1 in 5 women and 1 in 13 men report having been sexually abused as a child between the ages of 0 and 17, and 120 million girls and young women under the age of 20 have experienced some form of forced sexual contact (OMS, 2022). Sexual abuse/assault by an acquaintance is the most common form of sexual abuse/assault among adolescents, although prevalence rates fluctuate widely depending on the source of information consulted. A recent study of Brazilian adolescents found that 4.1 % of respondents had experienced forced sex, with 3.6 % of males and 4.5 % of females (Feitosa et al., 2021). A much lower prevalence than that reported in other studies of European population. In a study of Spanish adolescents, the prevalence was 8.7 % (Pereda, Guilera et al., 2014), while in a study of a sample of Portuguese adolescents, the prevalence was as high as 10 % (Sani et al., 2021). Moreover, the seriousness of this public health problem is compounded by the fact that a history of sexual victimisation can double or even triple a person's risk of future victimisation (Walker et al., 2019). Thus, people who are sexually abused/assaulted at a very young age are at greater risk of being re-victimised, with consequences for those affected, who tend to show not only poor physical and emotional well-being and quality of life, but also an increased risk of suicidal ideation (Classen et al., 2005; Finkelhor et al., 2007; Koola et al., 2018; Salmon et al. 2022). Regardless, problems with sexual assertiveness have been linked to experiences of sexual victimisation and may be a significant risk factor for sexual victimisation (Fernández-Antelo et al., 2020; Tomaszewska et al., 2022). In a recent study of Spanish adolescents, Fernandez-Fuertes et al. (2020) found that 31.34 % of young men and 19.02 % of young women did not refuse to be touched when they did not want it. In addition, 26.11 % of men and 22.61% of women had sex even when they did not feel like it, and almost half of the participants never indicated when they would like to be touched (46.64 % of men and 43.71 % of women) (Fernandez-Fuertes et al., 2020).

All in all, this shows that adolescence is a time of many challenges in an individual's sexual development. However, the impact on the child is largely modulated by the child's family and community environment, given their role as primary sexual educators

and as providers of emotional stability (Achen et al., 2021; Alimoradi et al., 2017). As a result, adolescents in the child welfare system may face even more difficult challenges to their sexual development. These children have faced multiple negative experiences that may have forced them to leave home to ensure their physical and/or emotional well-being (Browne, 2009; Collin-Vézina et al., 2011). This is the case for children and adolescents in residential care. According to the latest government report, in 2021 there will be more than 16,000 minors in residential care centres or homes in Spain (Ministerio de Derechos Sociales y Agenda 2030, 2022), of which 1,484 were in the Eastern of the country (Generalitat Valenciana, 2021). These are worrying figures, according to many organisations defending the rights of the youngest children, because, although residential care is a child protection measure implemented when a child cannot live with their family of origin due to situations of risk or lack of protection, there are also studies that suggest that residential care can have negative effects on the emotional and social development of children and adolescents, especially if it is prolonged. It is therefore important to stress that this is a temporary measure and that foster care should always be promoted as the preferred alternative (UNICEF, 2022).

Inconsistent, harsh or unavailable parenting, a history of trauma or sexual abuse, a poor environment in which to grow up, among other risk factors, as well as the absence of protective factors (e.g., the absence of positive family relationships) (Connell et al., 2007; McGuinness & Schneider, 2007; Tarren-Sweeney, 2008), can disrupt their biopsychosocial development (American Academy of Pediatrics, 2012). It is therefore important to have a detailed knowledge of child's life background before and during their involvement in the child welfare system in order to draw coherent conclusions about this group and, in particular, about their sexual development. For example, simply belonging to a sexual minority may directly promote more liberal sexual attitudes, and the use of psychoactive substances may be associated with greater involvement in risky sexual behaviour. Whereas, indirectly, for example, identifying with the female gender in a sexist society may mean that this group suffers more acutely from the social consequences of sexism. But, in addition, in the case of children and adolescents in the child welfare system, who have a greater number of non-normative experiences (Pereda, Abad et al., 2014), it is also necessary to collect specific information about these

events prior to entry into the child welfare system and more recent experiences (e.g., protection measures, relationship with their biological family, frequency of visits, etc.). Minors involved in the child welfare system are a very heterogeneous group that can present very different realities (Equipo de Incidencia Política y Estudios UNICEF Comité Español, 2017), so that the interpretation and generalisation of any research result requires a thorough knowledge of the characteristics of the sample group. However, the lack of tools for collecting and transmitting information in a structured and systematic way information on the essential aspects of these minors is a major limitation, which is recognised by professionals, and which can hinder the analysis of their sexual development. These forms are often developed ad hoc for a particular research and sample (López López, et al., 2010) and do not focus on exploring specific aspects of this sample group (e.g. their background in the child welfare system or biological family background) that may be of great importance in the process of assessing and analysing their psychosexual development.

Living in a residential care facility is associated with an increased likelihood of early sexual intercourse, especially for men (James et al., 2009; Zhan et al., 2017). A recent research of high school students in residential care in Connecticut (USA) found that 19.1 % versus 11.9% had had their first sexual intercourse before the age of 14 (Zhan et al., 2017). This association, although less strong, was confirmed by Kobulsky et al. (2022) in their recent study of adolescents (mean age 14 years) in the child welfare system in Los Angeles (USA), where 39.8 % of respondents had ever had sex (and 32 % oral sex and 24.4 % anal sex), compared with 19.4 % in the out-of-care population (and 16.8 % oral sex and 9.8 % anal sex). Nugent et al. (2020) also reported that more than half of respondents who had ever been in residential care facilities in the USA (59 % of men and 55 % of women) had had sex before the age of 15, compared with 28 % of men and 25 % of women who had never been in residential care. Moreover, by the age of 18, the figures were 9 out of 10 for young people who had ever been in residential care, compared with 7 out of 10 for young people who had never been in residential care (Nugent et al., 2020).

What is really worrying, however, is that this increase in sexual activity and at an increasingly younger age does not seem to be associated with increased condom use

among these adolescents (Kobulsky et al., 2022; Lambert et al., 2013). In a recent study of people in the child welfare system in Los Angeles (USA), 27.8 % of respondents reported having had sex without a condom in the previous three months, compared with 9.2 % of people outside the child welfare system (Kobulsky et al., 2022). Slightly more worrying data was found by Zhan et al. (2017) in their study of adolescents in the child welfare system in Connecticut (USA), where 39.7 % did not use a condom at last intercourse and 13.7 % did not use any method. Similarly, in the CalYOUTH study in the USA, 76 % of respondents reported having sex without a condom at least once in the past year and 58 % reported not using a condom the last time they had sex (Courtney et al., 2014). In line with this, Cheung et al. (2015) in their study of young people in the child welfare system in Texas (USA), reported that almost half of the sample did not normally use any contraception and only a quarter used condoms. Social learning, among other causes, could be one of the reasons for this lack of consistency in use.

These adolescents may have internalised beliefs and expectations about sexual activity, contraceptive use and family formation that lead them to experience teenage pregnancy and childbearing at higher rates than their peers in the general population (Font et al., 2019). According to Garwood et al. (2015), the child welfare system population is 66 % more likely to become pregnant than those not involved in the child welfare system. In a recent study of adolescents in the USA child welfare system, 43 % of young women and 27.5 % of young men reported one or more pregnancies during their adolescence. These rates rose to 49 % and 33 %, respectively, when pregnancies in women under the age of 21 were included. In the same study, the average age at first pregnancy was 17.5 years and more than a quarter of the sample who had been pregnant reported repeat pregnancies (Combs et al., 2018). However, it is important to note that not all pregnancies in these adolescents are unwanted. When asked about their reasons for wanting to have children at their age (in retrospective studies) they report a desire for love and attention, to rewrite their childhood and to give the love they did not receive in their own childhood (Aparicio et al., 2015; Shannon & Broussard, 2011). Furthermore, although an increased risk of adolescent pregnancy does not necessarily mean an increased risk of adolescent birth, in most cases it does. According to several studies, about two thirds of adolescent pregnancies end in birth, while 18-24

% end in miscarriage and 12-15 % in abortion (Combs et al., 2018; Courtney et al., 2018; Kost et al. 2017; Nugent et al., 2020; Perper et al., 2010). In this regard, the incidence of births to adolescents in the child welfare system does not appear to have declined, although the rate for adolescents in the general population has fallen (King et al., 2014). It is therefore important to be borne in mind that for these girls who give birth at such a young age, their vulnerability due to their personal circumstances is compounded by the effects of being a mother at such a young age (e.g., low educational attainment and the resulting economic disparities, etc.) (Dworsky & DeCoursey, 2009; Font et al., 2019; Melby et al., 2018).

These results may also be explained by their favourable attitudes towards early pregnancy and teenage parenthood, as well as their more reluctant attitudes towards condom use (Oman et al., 2018). In this sense, sexist attitudes are also more common among these adolescents than among minors outside the child welfare system (Carbonell et al., 2021; Steinlin et al., 2017), possibly due to the assimilation of heteropatriarchal family models that lead them to adopt gender stereotyped behaviours (Maas et al., 2010). These beliefs are present through the idealisation of the male role as caregiver and protector of women (benevolent sexism) and are more prevalent among boys (Carbonell et al., 2021; Martínez-Pecino & Durán, 2019; Rey Anacona et al., 2017).

Online sexual behaviours, namely sending sexual images online under pressure, using the internet or an app to find a sexual partner, and having sex with someone they know via the internet or an app, have been shown to be more prevalent among these adolescents, compared to the rates reported by their peers in the general population. A recent study reported that 30 % of adolescents in the child welfare system in Los Angeles (USA) had used the internet or dating apps to find someone to have sex with and 29.3 % had had sex, which contrasts with data for adolescents not in the child welfare system (6.5 % had used the internet or dating apps to find someone to have sex with and only 4.4 % had gone on to have sex). Similarly, of the 24.7 % of adolescents in the child welfare system who had ever sent sexually explicit images, 22.9 % had done so because of pressure, compared with 11.3 % of young people in the general population who had ever sent such content and only 3.2 % who had done so because of pressure (Kobulsky

et al., 2022). This upward trend in risk behaviours among this group has been linked to their greater experiences of sexual abuse and child and adolescent maltreatment, which are more prevalent among this population (Kobulsky et al., 2022; Noll et al., 2022).

Sexual victimisation is a truly alarming problem in this population, especially if we compare its prevalence with that reported by adolescents in the general population and consider the serious and long-lasting consequences it has on the individual development (physical, emotional and behavioural problems) (Dworsky, 2018). A recent study reported that 41.1 % of adolescents in the child welfare system in some regions of Spain had experienced some form of sexual victimisation in their lifetime (Indias et al., 2019). Similar prevalence to another Canadian study (38.3 %; Wekerle et al., 2017), but lower than a German study (62 %; Allroggen et al., 2017). However, these data are alarming when compared with results from studies recruiting adolescents from the general population, which report much lower prevalence (8.7%, Pereda et al., 2014 in Spain; 10%, Sani et al., 2021 in Portugal; 15.1%, Méndez-López & Pereda, 2019 in Mexico). Of course, the events of their difficult childhood would be behind these high rates, but also the affective and material deprivation that makes them a much more vulnerable group. However, there is no clear evidence of a link between lack of sexual assertiveness and an increased vulnerability to sexual abuse/assault in this group. In this sense, studies on sexual assertiveness in this group are scarce and, moreover, report somewhat contradictory data. While in some USA research identifies a lack of sexual assertiveness in relationships as a problem young people face, particularly females and especially when negotiating condom use (Constantine et al., 2009); there are other studies in the same context that take a more positive approach, reporting that adolescents involved in the child welfare system have high levels of sexual assertiveness despite facing significant difficulties (Bay-Cheng & Fava, 2014; Johnson et al., 2018). However, regardless of whether they consider sexual assertiveness to be more or less prevalent in adolescents in this group, there is sufficient evidence to support the need for and benefits of sexual assertiveness training for these adolescents (Bay-Cheng & Fava, 2014).

Like adolescents in the general population, those in the child welfare system appear to have little or inaccurate information about sexuality in general (Combs et al., 2019). In particular, research in several American states has found that their knowledge of

anatomy and contraceptive methods is low (Combs et al., 2019; Oman et al., 2018), and that they are misinformed about HIV and safe sex practices (Boustani et al., 2017). This could be due to the frequent changes of residence and the problems of educational uprooting they face, which predispose them to receive little or no sexuality education (Ramseyer Winter, 2017). Moreover, sex education for adolescents in the child welfare system, when it comes, is often too late for them because the age of first sexual experience is earlier than average (Boustani et al., 2015). In addition, sexuality education programmes have rarely been developed and/or adapted to meet the needs of these adolescents. This is important because intervention strategies that have been shown to be effective with adolescents in the general population may not be effective, or may be less effective, with young people in residential care due to their particular characteristics. It is possible that the prevalence of mental health problems and educational deficits, the absence of family or social support networks, and the high rates of exposure to abuse or other trauma among young people in residential care may compromise their effectiveness or contribute to these practices having a detrimental effect on them, for example by contributing to re-traumatisation (Dworsky, 2018). In this regard, although there are exceptions such as the POWER Through Choices (PTC) 2010 programme (Oklahoma Institute for Child Advocacy & University of Oklahoma National Resource Center for Youth Services, 2010) and "Making Proud Choices!" (Finley et al., 2014) which have been adapted to take into account of the different characteristics of this group, these programmes do not comprehensively address all aspects of healthy sexual development. The POWER Through Choices (PTC) 2010 programme (Oklahoma Institute for Child Advocacy & University of Oklahoma National Resource Center for Youth Services, 2010) was specifically designed to empower young people in the child welfare system to make healthy and positive choices about their sexual behaviour, acquire knowledge and skills about contraception, develop and practice effective communication skills, and learn how to identify and access available resources. The "Making Proud Choices!" program is also tailored to this population and appears to help increase their knowledge of behaviours that put them at risk of pregnancy and STIs and empower them to make healthy choices (Finley et al., 2014).

In addition to the sex education problems that these adolescents seem to have, many of them may also face a lack of role models to act as sex educators. Residential care professionals face many challenges in addressing issues related to the sexual development of young people in their care. Both a lack of consistency with one's own sexual values and beliefs and difficulties in establishing a relationship of trust with the child could lead the professional to avoid taking on such a responsibility (Harmon-Darrow et al., 2020). Institutional conditions often conflict with their role as caregivers, preventing them from being closer and forcing them to stick to their professional duties (Lindahl & Bruhn, 2018). In addition, practitioners sometimes report unclear and inconsistent policies and even question whether discussing the issue with minors could lead to them being accused of abuse (Albertson et al., 2018; Constantine et al., 2009). These professionals also express doubts about what knowledge to provide to these young people, and how and when to do so. Sometimes, as mentioned above, they claim not to have received the necessary information about the child's life background to identify which aspects of the child's or adolescent's sexual health are most relevant to the child or adolescent based on their life experiences (Albertson et al., 2018; Harmon-Darrow et al., 2020). Furthermore, practitioner's comfort level with these issues, which is partly shaped by their values, is essential in considering the ease with which they will be able to engage in effective and meaningful conversations with them. In this sense, they identify education and training as the main strategy for improving the effectiveness of their interventions with the children and adolescent they serve. Professionals confessed that they did not feel they had the skills and resources to provide the conceptual and emotional support that young people need, and that they felt more comfortable and confident working with young people on sexual and reproductive health after receiving a comprehensive update on the topic. Thus, providing more and better sexual and reproductive health training for protection workers is therefore not only a demand, but also a need that would have numerous individual and social benefits (Harmon-Darrow et al., 2020).

In short, children and adolescents in the child welfare system are considered to be a particularly vulnerable group (Euser et al., 2014; Indias et al., 2019). In the case of children and adolescents in residential care, while they are waiting to see if their family

context improves or if there is a foster family that adequately meets their needs (DGIA, 2017), their past may be full of negative experiences that may contribute to their victimisation and disrupt their healthy psychosexual development from a very early age. It is therefore necessary to consider them as a group requiring urgent and special attention.

EMPIRICAL STUDY

This thesis aims to respond to the needs of a priority group for the growth of society: children and adolescents. As stated in the Estrategia Española de Ciencia, Tecnología e Innovación 2021-2027 (EECTI) (Ministerio de Ciencia e Innovación, 2020), specific measures to support young people and combat child poverty are necessary lines of action in the European Union's Cohesion Policy. Specifically, this proposal promotes the generation of knowledge on the conditions of minors in the child welfare system. An institutionalised group facing inequality, multiculturalism, marginalisation and stigmatisation, all of which are areas of intervention for the EECTI (Ministerio de Ciencia e Innovación, 2020). Furthermore, the overall objective of this doctoral thesis reinforces the common interest of both programmes, the EECTI and the Horizon Europe Programme (2021-2027) (Ministerio de Ciencia e Innovación, 2020), in addressing health as a global challenge, in this case sexual health.

The general objective of this work is to examine the sexual health of adolescents in residential care in the Eastern of Spain, focusing on the experiences that have the greatest impact on their sexual development and their contribution to the well-being of the individual, after developing a tool to collect socio-demographic information on this group. This descriptive study is structured around four research articles that address the different specific objectives.

The first of these (included in the Appendix 1), in response to the first specific objective, presents the construction process and properties of an instrument for collecting socio-demographic data on children and adolescents in the child welfare system. In this sense, the following hypotheses are proposed: (1) The developed instrument, according to the analysis of its properties and the feedback from

professionals, will prove to be a useful and effective tool to collect socio-demographic information on children and adolescents in the child welfare system.

The second specific objective (included in the Appendix 2), addressed in the following article, aims to describe the sexual health of adolescents in residential care in the Eastern of Spain, by exploring their sexual knowledge, attitudes and behaviours, and analysing differences by gender and/or age. The hypotheses to be tested in relation to this objective are: (2) Adolescents in residential care will have little knowledge about sexuality, poor sexual attitudes, will experience first sexual practices at an early age, with masturbation being the most common, and will habitually engage in risky sexual behaviours (sexual practices without condoms); (3) The gender of adolescents in residential care will not influence their level of sexual knowledge or contraceptive prevalence, although it will influence their sexual attitudes, age of sexual initiation and sexual behaviours, with boys having more negative attitudes, initiating sex earlier and engaging in more sexual practices; (4) The age of the adolescent in residential care will positively influence their level of knowledge about sexuality, their involvement in sexual practices and their use of contraceptives, but not their sexual attitudes or age of sexual initiation.

The third article (included in the Appendix 3) explores the prevalence of lifetime sexual victimisation in this sample group, analysing the main characteristics of the different types of sexual victimisation, possible differences according to the sex and age of the victim, and contrasting self-reported information with that reported by professionals. In this sense, the hypotheses to be tested are: (5) Adolescents in residential care will have a high prevalence of sexual victimisation; (6) Sexual victimisation by a known adult will be most common among adolescents in residential care; (7) The degree of agreement between the rate of sexual victimisation self-reported by adolescents in residential care and that reported by professionals in the home or residence will be low; (8) Girls will be more vulnerable to sexual victimisation, but the age of the adolescent will not be an implicated variable; (9) The sexual offender is usually a young person known to the victim (close relative); (10) Most victims have experienced more than one type of sexual victimisation and on more than one occasion (revictimisation); (11) The younger the age of the victim at the time of the first

experience of sexual victimisation and the closer the relationship with the perpetrator/offender, the greater the likelihood of sexual revictimisation (more episodes of sexual abuse/assault and/or multiple types of sexual victimisation); (12) Emotional problems will be the most common sequelae for adolescents in residential care who have experienced sexual victimisation.

Finally, the fourth article (included in the Appendix 4) focuses on examining the last specific objective, the mediating role of facets of emotional regulation in the relationship between sexual victimisation and psychological well-being. On the other hand, we also propose to trace the modulating role that gender and the condition of unaccompanied child/adolescent migrant status may play in this model. To this end, we propose to test the following hypotheses: (13) All facets of emotional regulation will have a mediating effect on the relationship between sexual victimisation and psychological well-being among adolescents in residential care, in a negative sense; (14) High levels of sexual victimisation will be associated with a lack of emotional awareness, acceptance of emotional responses and emotional clarity, poor access to emotional regulation strategies, and difficulties in controlling impulses and maintaining goal-directed behaviours when feeling uncomfortable; (15) Lack of emotional awareness, acceptance of emotional responses and emotional clarity, poor access to emotional regulation strategies, and difficulties in controlling impulses and maintaining in goal-directed behaviours when experiencing distress is felt will show a significant negative association with psychological well-being; (16) Both gender and unaccompanied child/adolescent migrant status will be presented as variables that modulate the mediation exerted by facets of emotional regulation on the relationship between sexual victimisation and psychological well-being. Specifically, being male and being an unaccompanied child/adolescent migrant will act as a modulating variable driving the association between sexual victimisation and lack of emotional awareness and clarity, poorer acceptance of emotional responses and access to emotional regulation strategies, more difficulty in persisting with goals when feeling uncomfortable and in controlling impulses, all of which lead to poorer psychological well-being.

In this sense, in order to respond to these objectives and contrast the hypotheses they contain, 346 adolescents between 11 and 19 years of age, recruited in 47 homes or

residences in the Eastern of Spain, were assessed using validated instruments. The originally estimated rate (N = 342) was achieved. For this estimation, G*Power software was used to analyse intra-age differences by sex that were significant at the $\alpha = 0.01$ level, with a minimum statistical power of 0.8 and with a mean effect size.

Preparation of this study began in 2019. Firstly, contact was made with the Dirección General de Infancia y Adolescencia (DGIA), which, depending on the Vicepresidencia y Conselleria de Igualdad y Políticas Inclusivas of the Generalitat Valenciana, is the body responsible for implementing measures for the protection of minors and which has custody and/or guardianship of minors. Following the presentation of the project, a collaboration agreement was drawn up between the Vicepresidencia y Conselleria de Igualdad y Políticas Inclusivas (Generalitat Valenciana) and the Universitat de València (Estudi General) as a framework for the study of childhood and adolescence in the child welfare system, which was signed in September of the same year. At the same time, approval was requested from the Ethics Committee for Experimental Research of the Universitat de València (Estudi General), which was granted in February 2020. The ethical principles of the 1964 Declaration of Helsinki have also been respected. Confinement due to Covid-19 halted the preparation of the work which resumed in June 2020.

At that time, the directors of the different entities involved in the study were contacted to present the project and to obtain their permission to enter the residential care facilities. Once this approval was obtained, an initial contact was made with the participants to explain the objectives and to obtain informed consent from those who agreed to participate in the study. A battery of instruments was then used to collect both socio-demographic data and the different variables identified in the scientific literature as being associated with healthy sexual development, using the interview format. Later, in March 2022, once the database was complete, the process of analysing the data and writing the articles corresponding to each of the objectives of the doctoral thesis began.

DISCUSSION AND CONCLUSIONS

Adolescence is a time of physical, emotional, and social transition when sexual and reproductive health and rights issues shape future well-being. Adolescents around the world face challenges in their sexual behaviour and choices, but these are often not comparable to the challenges faced by children and adolescents who are exposed to high-risk situations from birth. This is the case for minors in the child welfare system. Thus, this doctoral thesis, through the 4 articles that comprise it, has explored the sexual health of adolescents in residential care in the Eastern of Spain, focusing on the experiences that have the greatest impact on their psychological well-being and on the mechanisms that could mediate this impact; after previously constructing a tool that allows us to better understand the group in question.

The study of the psychosexual development of individuals and the variables that influence it requires a thorough knowledge of their life history, before and during their involvement with the child welfare system (Morales et al., 2018). To this end, we propose the development of an instrument that will allow us to collect information on the main socio-demographic characteristics of children and adolescents in this context. The findings in response to this first objective confirm that the CAWSys (Child and Adolescent Welfare System Form), developed using the Delphi method -an approach that allows a research question to be answered through the consensus reached by a panel of experts-, is a useful and effective instrument for collecting socio-demographic information on children and adolescents in the child welfare system, thus fully confirming the *first hypothesis*.

This form consists of 66 items, divided into 6 dimensions that structure the instrument: (1) Nine of its items make up the 'General Information' dimension, which collects basic data on the child's sex, date of birth, nationality, sexual orientation, disability, physical or mental health problems and psychoactive substance use. The inclusion of this dimension is considered essential in order to obtain information from the child or adolescent that can explain the patterns of responses in the other dimensions. (2) The “School/Work Situation” dimension also consists of nine items and elicits information about the child's current education and/or employment situation, as

well as on the child's academic background and school attitude and integration at school. As the school/work environment is the setting in which children and adolescents spend most of their time and form most of their interpersonal relationships, analysis of this area of the individual can provide crucial information. (3) Information about their background in the child welfare system (previous child welfare measures, age of entry, reason, and legal status) and their current situation in the child welfare system is collected through nine items of the "Child Welfare System History " dimension. Their inclusion is fully justified by the life history of the target group. (4) The "Family Visitation History" dimension, which consists of nine items, aims to assess the child's visitation arrangements with relatives (place, frequency, duration, control, persons attending, compliance and evaluation of the child). This information on the child's encounters with family members can be useful in assessing the evolution of the child's situation in the child welfare system. (5) The "Biological Family Information" dimension consists of twenty-three items asking about the socio-demographic characteristics of the child's or adolescent's biological parents that may influence their development (e.g., physical and mental health, substance abuse, history in the child welfare system and judicial background, etc.), their family relationship, as well as other aspects related to their socio-economic situation and community environment. (6) Finally, seven items make up the dimension "Experiences of Sexual Abuse" and inquire about the child's experiences of sexual abuse (suspicion, confirmation, frequency, characteristics of the aggressor and consequences), based on the information contained in the child welfare system file and held by the residential care facility. Early knowledge of these facts is crucial for assessing their sexual health, as well as for developing of effective intervention protocols, hence the experts' agreement to include this dimension in the tool. With regard to the procedure to be followed for its completion, this form is intended to be filled in by the professionals of the child welfare system who know the minor well and have access to his or her report.

The rigorous construction process, which involved the participation of experts from different areas and a previous application in a real environment, has ensured that the items are sufficiently robust to obtain good results. Around 80 % of the items were answered correctly by all participants. Nevertheless, the items related to the child's

school situation, the time spent in the child welfare system and the child's social and family context show the worst results. As these data are more difficult for professionals to access, in many cases they do not have the information directly and need do some prior research. In addition, thanks to the consensus reached by the expert panel, this tool addresses all aspects of children and adolescents in the child welfare system on which information needs to be collected for a comprehensive assessment of them.

In this sense, the results obtained allow us to conclude that, by developing CAWSys, we have contributed to improving the process of collecting essential information on the socio-demographic characteristics of children and adolescents in the child welfare system. This is essential not only for drawing accurate and generalisable conclusions about the affective and sexual development of the group, but also for developing effective intervention strategies tailored to the sample group. In addition, this form is intended to promote better communication between the various professionals who attend to them and the production of more accurate statistics on the characteristics of this group, avoiding the disparity of data depending on the source consulted.

Once we had an adequate and efficient instrument for collecting information from the study population, we set ourselves the second objective of this thesis. In this sense, adolescents in residential care in the Eastern of Spain confirm a low level of knowledge, an early start to sexual practices and a low use of contraceptive methods, together with worryingly sexist attitudes. These findings, which are discussed in detail below, allow us to confirm the *second hypothesis*.

In terms of knowledge, these adolescents in particular report little information on general aspects of sexuality and contraceptive methods, especially when these results are compared with those of studies of children and adolescents in the general population (Claramunt Busó, 2011). This conclusion has also been reached by other studies with a child welfare system population (Boustani et al., 2017; Oman et al., 2018), which echo the low level of knowledge of young people in the child welfare system compared to the results of research with young people in the general population. In this sense, Combs et al. (2019) conclude that adolescents in the USA child welfare system generally have little or inaccurate information about sexuality. In particular, research in several USA states has found that their knowledge of female anatomy, fertility and

contraception is low (Combs et al., 2019; Oman et al., 2018), and that they have misinformation about HIV and safe sex practices (Boustani et al., 2017). This could be explained not only by the fact that this group receives less sex education, given their often-unstable location and poorer access to sexual and reproductive health services (Finigan-Carr et al., 2018; Ramseyer Winter, 2017), but also because, given their earlier sexual activity, information about sexuality, when it comes, is often too late (Boustani et al., 2015). In the case of knowledge about STIs, in line with the findings of the study of the community population by Claramunt Busó (2011), this is the aspect in which the adolescents in our sample obtain the highest scores (although they are still low). This could be because STIs are also part of the compulsory school curriculum and therefore their learning is reinforced in the classroom, even if it remains insufficient (Bączek et al., 2020).

In the case of sexual attitudes, adolescents in residential care in this sample express unfavorable beliefs about sexuality, especially when compared with those expressed by young people in the general population (Claramunt Busó, 2011). However, it is worth noting the results that suggest a high internalisation of sexist attitudes among these adolescents. In particular, the expression of benevolent sexist manifestations is most common among these young people, as it is among young people outside this context (Fernández-García et al., 2022). Adolescents in the child welfare system have lived in potentially problematic homes where sexist stereotypes are common (Grusec and Hastings, 2014; Maas et al., 2010), which may explain these findings. However, social advances in equality that criminalise certain more overt manifestations of sexism have also contributed to covert expressions among these young people (Cross & Overall, 2018).

Regarding sexual behaviour, the majority of adolescents in residential care in our study (90%) have already initiated sexual activity, almost half (50 %) have had their first sexual practice at 12 years old of age or earlier and masturbation has been presented as the most frequent sexual practice. These results are consistent with those reported in other research with adolescents with similar characteristics (Wilson et al., 2014), but are much worse than those found in studies of young people from the general population (James et al., 2009). Some experts justify these findings by the relationship between

experiencing traumatic events (e.g., childhood sexual abuse, gender-based violence, etc.) and/or having mental health and substance abuse problems, and earlier onset of sexual activity (Lambert et al., 2013; Oshri et al., 2012). In addition, despite the high levels of sexual activity found in this group, they report low rates of contraceptive use. Less than half of the sample reported using condoms regularly and an even smaller percentage reported using any other method of contraceptive (oral contraceptive pill, patch and hormonal injection or female condom). Similar results were reported by Cheung et al. (2015) and Lambert et al. (2013) in their studies of youth in the child welfare system. In contrast, contraceptive prevalence is higher among young people in the general population (Ott et al., 2014). Special mention should be made of the fact that "withdrawal" is the second most frequently used method among the adolescents in our sample. Dissatisfaction with hormonal methods or a desire to express confidence in the partner seem to underpin this high prevalence (Whittaker et al., 2010). In contrast, the female condom is rarely used compared to male condom, which is also common among young people in the general population, and seems to be due to its high cost, difficult accessibility and lack of awareness among potential users (Ott et al., 2014).

As part of this second objective, we also set out to explore the existence of certain characteristics of the sample that might lead us to consider a subgroup of these adolescents as particularly vulnerable to developing poorer sexual health. In relation to gender, girls report having more knowledge about sexuality and less sexist attitudes, although their sexual debut occurs at a similar age to their male peers, but they make more exceptional use of male condoms. These results, discussed in more detail below, did not allow us to fully validate the *third of our hypotheses*.

As reported in other studies with populations similar to ours (e.g., Combs et al., 2019), girls in our sample report significantly more knowledge about sexuality than boys. This could be justified by their increased access to sexual and reproductive health services, as this is a venue for receiving information about sexuality (Finigan-Carr et al., 2018). However, this gender inequality has not been found among adolescents in the general population. Claramunt Busó (2011), in a study of adolescents from the general population, found no statistically significant differences by gender. Similar results have been obtained with regard to sexual attitudes, as it seems that it is the adolescent girls

who present a more liberal disposition towards sexuality, less homophobic/heterophobic attitudes and less sexist attitudes. This suggests that boys may be more strongly influenced by patriarchal family contexts, that are more prevalent among adolescents in the child welfare system, leading them to accept traditional gender stereotypes and sexual discrimination (Baber & Tucker, 2006). In contrast, gender was not found to be an influential variable either in the age at which sexual relations began or in the prevalence of the different sexual practices assessed, with the exception of masturbation. In this population, girls continue to report fewer autoerotic practices than boys, despite efforts to encourage the female population to take responsibility for their own pleasure by encouraging self-exploration and female sexual self-stimulation. Genital anatomical differences, hormonal differences and, of course, strong social and cultural influences may underlie these results (Robbins et al., 2011). However, the absence of gender differences in the prevalence of the remaining sexual practices assessed and in the age of sexual initiation may reflect slow but effective progress in demystifying information about female sexuality (CDC, 2020). In terms of contraceptive method use, as in other studies conducted with adolescents in the child welfare system (Lambert et al., 2013; Oman et al., 2018; Risley-Curtiss, 1997), boys in our sample are more likely to use condoms and reversal methods regularly, while girls tend to use oral contraceptives and long-acting contraceptives. This may reflect the lack of sexual assertiveness often displayed by girls, especially in relation to condom use (Ballester-Arnal & Gil-Llario, 2021; Constantine et al., 2009), and evidence of the greater vulnerability of the female sex to STIs (Ross et al., 2021).

After analysing the possible differences in terms of gender, we thought it would be useful to check whether the age variable could help to clarify the results obtained in terms of the group's knowledge, attitudes and sexual behaviour. In this sense, as adolescents get older, they become more knowledgeable about contraceptive methods, use them more regularly, engage in a wider range of sexual practices, and express more hostile sexist attitudes. We can therefore conclude that the *fourth hypothesis* is partially fulfilled.

Information about contraceptive methods held by adolescents in residential care in our sample appears to increase with age. These results are consistent with findings from

studies of adolescents in the general population (Clark et al., 2002). Both the increased interest in safer sex with age and the fact that visits to sexual and reproductive health services increase with age may explain these results. In contrast, age does not appear to be an influential variable in the sexual attitudes of the adolescents in our sample, with the exception of hostile sexist attitudes. The lower level of hostile sexist attitudes among younger respondents could be explained by the greater influence they have received from more liberal social and cultural models that adhere to a less patriarchal ideology (Roets et al., 2012). This is consistent with the findings of other studies of child welfare system populations (Carbonell et al., 2021), but not with studies of community samples (Fernández-García et al., 2022). On the other hand, the variety of sexual activities increases with age, although older adolescents report a later onset of sexual activity. Similarly, the use of male condoms and long-acting contraceptives is positively and significantly associated with age. These results could be explained by the cognitive gains that come with maturity, leading young people to engage in less risky behaviors (Baker et al., 2011; Ballester-Arnal et al., 2017), and by the greater access to sexual and reproductive health resources that comes with age. Pergamit & Johnson (2009) found similar results in their study of young people in emancipatory households.

In light of these findings, we must consider that sexual health is a very important part of any individual's development, but even more so for adolescents in residential care. It is therefore an aspect of children's development that should not be left unexplored if we really want to identify their main needs and limitations and ensure that they have the same opportunities as all their peers to achieve holistic well-being. The above results may be particularly useful for the development of tailored intervention strategies for children and adolescents, professionals, but also society at large. This description of the sexual development of this group can help to demystify beliefs about these minors and encourage society to get involved in improving their quality of life.

Having analysed the basic aspects of adolescent' sexual health in the child welfare system, we focused on exploring one of the events that seems to have the greatest impact on their psychosexual development, sexual victimization. In relation to this third specific objective, although the *fifth hypothesis* is confirmed, the *sixth hypothesis* is not. It is confirmed that adolescents in residential care in the Eastern of Spain have a

significant prevalence of sexual victimisation, but the most frequent sexual abuse/assault is not perpetrated by a known adult.

The adolescents in our study report a high prevalence of sexual victimisation (35.3 %), similar to that reported in studies with participants with similar sample characteristics to ours (Indias et al., 2019; Segura et al., 2015; Wekerle et al., 2017), and much higher than that found in research with adolescents from a community sample (Méndez-López & Pereda, 2019; Pereda, Guilera et al., 2014; Sani et al., 2021). While Indias et al. (2019), in their study of adolescents from 24 residential care facilities in two Spanish regions, found that 41.1 % of their sample had been victims of some form of sexual victimisation in their lifetime; other studies of adolescents in residential care in north-Eastern regions of Spain reported a prevalence of 29.5 % (Segura et al., 2015). In this sense, it is true that adolescents involved in the child welfare system are more likely to have witnessed situations of abuse and/or maltreatment in their immediate environment and have not grown up with their basic physical and emotional needs met (Indias et al., 2019). This not only predisposes them to becoming involved in toxic relationships because of their difficulties in establishing secure attachments, but also increases the likelihood that they will have low sexual assertiveness and lack the necessary skills to refuse unwanted sex (Hanson, 2016; Indias et al., 2019; Thompson et al., 2017). However, there are experts who believe that structural problems in residential care facilities are the real cause of this high prevalence (Euser et al., 2014). They argue that these are settings where large numbers of children and adolescents with frequent behavioural problems live, which increases the risk of peer sexual abuse/assault, the most frequent type of sexual victimisation in our sample. However, in this research, sexual abuse/assault perpetrated by a known adult is the type in which the victim is most often re-victimised, the type in which objects are most often introduced into the victim's body, the type that occurs when the victim is younger and the type that is most often reported to the police and/or judicial authorities. This makes sense given that, in most cases, this type of sexual abuse/assault is perpetrated by a close family member who has more frequent contact with the victim and is more likely to be able to justify encounters with the victim alone (Aydin et al., 2015). Furthermore,

given that the family is the first socialising agent, it is logical that it is sexual abuse/assault that occurs at an earlier age of the victim (Amador Moncada et al., 2018).

Taking into account the sensitivity of the issue, it is also considered relevant to contrast the information reported by the adolescents themselves with the data reported by the professionals in the home or residence. In this regard, the adolescents in our sample report a prevalence rate of sexual victimisation that is more than twice as high as that reported by professionals. In other words, the degree of agreement found between the information provided by the two sources is moderate to low, which partially confirms our *seventh hypothesis*. While 74 of the cases of sexual victimisation reported by adolescents are not known to professionals, 17 of the cases reported by professionals are not reported by adolescents. This high number of cases of which professionals are unaware could be due to the lack of an adequate and trusting caregiver-victim relationship, resulting in the child's reluctance to disclose these experiences to the professional (Euser et al., 2014). Likewise, cases reported by the professional but not by the adolescent could be due to immature cognitive and/or emotional development at the time of the sexual abuse/assault. If the event took place at a very young age, the child may not be aware of the events, but they may be recorded in his or her file because a professional reported it (London et al., 2005). It may also be that the adolescent preferred to respond negatively because of the discomfort and feelings of shame and guilt associated with confirming that he/she was a victim of sexual abuse/assault (Classen et al., 2005; Feiring & Taska, 2005; Herrera, 2006; Negriff et al., 2017).

In relation to the victim profile, adolescent girls in our sample experience a significantly higher number of sexual victimisation experiences. This is consistent with findings from both research with adolescents in residential care and research with young people sampled in the community (Allroggen et al., 2017; Euser et al., 2013; Indias et al., 2019; Méndez-López & Pereda, 2019; Pereda, Guilera et al., 2014). This may be due to male gender stereotypes limiting disclosures of sexual abuse/assault in boys, leading to a higher false negative rate in this sub-sample (Esnard and Dumas, 2013; Wekerle et al., 2017). In contrast, in our sample we found no effect of age on the rate of sexual victimisation, indicating the young age at which adolescents in this group are exposed

to traumatic events. Like us, other research with adolescents in residential care has rarely concluded the existence of significant differences between the age groups (Euser et al., 2013; Segura et al., 2015). In view of the above, the *eighth hypothesis* is validated, as is the *ninth hypothesis* concerning the characteristics of the abuser/aggressor. In this regard, the findings report that the abuser/aggressor is usually a young man known to the victim. So, although there are few studies interested in examining the profile of the perpetrator, some of them reveal that in more than 70 % of the cases the abuser/aggressor is male (Allroggen et al., 2017; Euser et al., 2013). These abuser/aggressor characteristics are the same in studies of adolescents from a community sample (Auderset et al., 2021). This makes sense, given that it is easier for caregivers and related persons to have contact with children without being suspected or mistrusted by children/adolescents (or other adults) (Aydin et al., 2015).

Regarding the *tenth* and *eleventh hypotheses*, sexual revictimisation is also common in this group and is positively and significantly related to the early age at which the victim experiences the first episode of sexual abuse/assault and to the closeness of the victim-offender bond, which confirms both hypotheses. Specifically, in line with the literature on this group (Indias et al., 2019), our study confirms the tendency of these adolescents to suffer multiple episodes of negative sexual experiences and different types of sexual victimisation (by a known or unknown adult, by a peer or by sexual exposure). However, it is also found that there is a positive and significant relationship between both variables, such that those victims who experience a greater number of episodes of sexual victimisation are also involved in more types of sexual victimisation. For all these reasons, the age of the victim at the time of the first episode of sexual abuse/assault and the closeness of the relationship between victim and abuser/aggressor have been analyzed to test whether they could be risk factors for this increased revictimisation. In this sense, both variables show positive associations with both the number of episodes of sexual abuse/assault and the number of types of sexual victimisation suffered. Therefore, the earlier the negative experience and the closer the relationship with the abuser/aggressor, the greater the likelihood that the adolescent will suffer sexual revictimisation. A victim's early age of exposure to sexual abuse/assault may exacerbate the psychological impact of sexual abuse/assault, thereby increasing the likelihood of

re-victimisation (Casey & Nurius, 2005). Similarly, if the victimisation is caused by a close member of the child's family, there is an early maladaptive attachment which leads to emotional regulation problems and increased vulnerability (Gawryszewski et al., 2012). Furthermore, emotional disturbances are the most prevalent consequences of the sexual victimisation among the adolescents in our sample. This confirms the *twelfth hypothesis* raised and is in line with the findings of most research using samples with similar characteristics to ours (Finkelhor et al., 2009; Kendall-Tackett, 2009).

These conclusions are especially useful for planning and implementing primary prevention measures and for preventing future experiences of sexual victimisation or revictimisation. However, in addition, knowing more about the characteristics of the victimising event and the characteristics of the victim and the abuser/aggressor can help to identify these events and alleged victims at an early stage in order to mitigate the serious consequences of their experience, particularly in terms of their mental health.

In the light of the findings resulting from the analysis of the third aim of this thesis, the urgency of addressing the high rates of sexual victimisation among adolescents in residential care and the strong association between these rates and the mental and interpersonal health problems experienced by victims has become even more apparent. This led to the fourth objective of this thesis, the results of which partially confirmed the *thirteenth hypothesis* (as not all facets of emotional regulation moderate the relationship between sexual victimisation and emotional well-being). In this sense, findings have shown that the relationship between sexual victimisation and psychological well-being is mediated by a lack of emotional awareness, acceptance of emotional responses and emotional clarity, as well as poor access to emotional regulation strategies. These findings are consistent with those reported in other studies (McLaughlin et al., 2020; Weissman et al., 2019). They further state that experiences of sexual victimisation lead these adolescents to exhibit problems with understanding emotions, emotional avoidance or disconnection, and the adoption of maladaptive emotional regulation strategies, which increase the individual's stress and anxiety and reduce psychological well-being (Gruhn & Compas, 2020).

Examining the relationship between these variables independently and in more detail, we can conclude that both the *fourteenth* and *fifteenth hypotheses* are partially

confirmed, as sexual victimisation and emotional well-being are not significantly related to all facets of emotional regulation. Lack of acceptance of emotional responses and emotional clarity, limited access to emotional regulation strategies, and difficulties in persisting with a goal when feeling uncomfortable are positively and significantly related to sexual victimisation. In this sense, previous studies confirm that survivors of these negative experiences not only pay less attention to their emotional states and relapse into emotional inhibition, but also use maladaptive strategies such as rumination that prevent them from persisting in their goal (McLaughlin et al., 2020; Walsh et al., 2011). Victims of sexual abuse/assault have difficulty identifying and labelling emotions and develop feelings of generalised helplessness, which results in less effective attempts to reduce these emotions (Jenness et al., 2021). On the other hand, lack of emotional awareness, lack of acceptance of emotional responses, lack of emotional clarity and poor access to emotional regulation strategies show a significant negative relationship with emotional well-being. According to Miragoli et al. (2020), the victim's failed attempts to identify emotions, repeated efforts to suppress them, and the use of maladaptive strategies (self-medication, drug use, etc.) interfere with the individual's cognitive processing and emotional growth. Deficits in recognising and describing emotions, as well as a lack of interest in experiencing them, interfere with the processing of all experiences, leading to problems of self-acceptance and self-exploration in the victim. In this regard, it should also be noted that emotional avoidance leads to experiential avoidance, with behaviours such as dissociation, self-harm, etc., which have a negative impact on psychological well-being (Miragoli et al., 2020).

Likewise, with regard to the influence of gender and unaccompanied child/adolescent migrant status on the relationship between sexual victimisation and psychological well-being, we cannot consider the *sixteenth hypothesis* to be confirmed. Gender is not a significant moderating variable in the proposed mediation model (mediating role of the multiple facets of emotional regulation in the relationship between sexual victimisation and psychological well-being) and unaccompanied child/adolescent migrant status only moderates the association between sexual victimisation and access to emotional regulation strategies. Specifically, not being an unaccompanied child/adolescent migrant acts as a modulating variable driving the

association between sexual victimisation and having lower emotional regulation strategies, as opposed to victims who are unaccompanied child/adolescent migrants. This could be explained by the fact that, although unaccompanied child/adolescent migrants have very different experiences from other adolescents in the child welfare system, they feel lucky to be able to continue their search for a future, which seems to make them to be more resilient and to develop certain appropriate coping strategies (Ní Raghallaigh & Gilligan, 2010).

The identification of the key variables involved in the relationship between sexual victimisation and psychological well-being allows for the development of much more effective interventions to alleviate the consequences for victims. But, not only this, the detection of key predictors of poorer psychological well-being will make it easier to identify those adolescents in residential care who may be at risk of maladaptive development. This means that those young people with low emotional awareness, low acceptance of emotional responses and emotional clarity, and poor emotional regulation strategies should receive priority attention in order to avoid major emotional maladjustment. Similarly, the conclusions regarding the most frequent emotional regulation problems in victims of sexual abuse/assault will help to identify and facilitate the disclosure of victimised minors, as well as the reporting process, thus avoiding re-victimisation as a result of having to recount the event several times. Thus, practitioners and experts should pay particular attention to problems of acceptance of emotional responses, emotional clarity, limited access to emotional regulation strategies, and difficulties in persisting with a goal presented by adolescents who they already suspect may have been sexually victimised. These behaviours can be strong indicators of victimisation and their early detection can speed up action. Ultimately, these findings will help to prevent victimised children from reaching such high levels of emotional distress, leading to better home or residential environments and reduced mental health costs resulting from these unfortunate experiences. Likewise, while the strategies developed by the unaccompanied child/adolescent migrants can help to work with the others to acquire skills and tools for emotion management, it should also be a priority to focus on empowering other facets of emotion regulation with the unaccompanied child/adolescent migrants.

In short, this thesis concludes that adolescents in residential care are a particularly vulnerable group with needs that differ from those of other adolescents in the general population. Thus, providing them with the adequate knowledge to demystify misinformation, the skills to enjoy consensual sexual exchanges and the attitudes to manage their psychosexual development in a positive way are essential aspects if we want them to enjoy a healthy experience of sexuality. In this sense, research such as this is key to designing affective-sexual education initiatives that focus on the distinctive characteristics of this group and work to reverse the negative consequences derived from the frequent experiences of sexual victimisation. The results of this research should also be interpreted as a call to government agencies to develop effective public policies that will positively influence the dynamics of the child welfare system and the mental health systems and give visibility to a particularly underserved group.

However, this work is not without its limitations. In the first place, the evaluation of such a vulnerable group as children and adolescents in the child welfare system, especially when it is still a very sensitive issue for a large part of society, has not only made the process to take too long, but has also led to the loss of part of the sample. Numerous permits and authorisations are required to initiate research with this group. These range from obtaining the appropriate permits from the public administration that has parental authority and/or guardianship, to obtaining permission to enter the homes and residences from the coordinators of each foundation/organisation responsible for managing the different resources and the board of directors of the home/residence itself. However, in cases where the parent/guardian has the legal guardianship of the minor, they must also consent to the child or adolescent's participation in the study, and they often have certain reservations. Finally, of course, it requires the agreement of the participant themselves, who is sometimes difficult to motivate to get him involved. Therefore, in this research, of the 60 homes/residences contacted, 47 eventually participated, but not all children and adolescents from these centres did so, as there were a large number of minors from these homes/residences who could not participate because their legal guardians did not authorise it and others who did not agree to do so. However, despite all these drawbacks, to which we must add those due to the

limitations of Covid-19, we have been able to achieve the sample size required to obtain valid and reliable results.

In terms of sample size, although the representativeness and the internal validity of the sample were satisfactory, the gender and age distribution could not be fully equitable. Boys aged 14 - 16 were over-represented, but it is important to note that the gender and age distribution found is typical of adolescents in residential care.

On the other hand, given that not only the information provided by the minors was needed, but also the collaboration of the professionals who take care of them in the homes and residences, we must be aware of the limitations that this has entailed. Despite their remarkable commitment, given their workload and the discomfort that the subject of this research could sometimes cause them, some of the CAWSys questions had a higher than desired non-response rate (up to 26.3 %), which should be taken into account when interpretating the results. In addition, only one professional reported information on each adolescent, so it was not possible to verify the accuracy of the data provided.

In addition, although one of the major strengths of the research is that the information is obtained directly from the population being studied, as the children and adolescents in the child welfare system themselves were interviewed (except in the case of CAWSys), this can also be a limitation. Self-report instruments require a certain capacity for introspection, which in many cases is not yet sufficiently consolidated in adolescents. This is further complicated when asked about past events that have had a significant impact on the respondent (del Valle & Zamora, 2021). Despite this, according to Finkelhor et al. (2005), from the age of 11, children are considered to have sufficient metacognition to respond to a self-report measure, confirming the reliability of the data obtained. However, another drawback related to the use of self-report measures is the social desirability bias that may influence participants' responses. Although this is a common limitation in social science studies, it is true that it may be more common in this group, given their tendency to want to please others, especially authority figures whose attention and approval are sought. In addition, the sensitivity of the issues raised (sexist attitudes, sexual victimisation, etc.) favours responses that are more in line with what is socially desirable. In favour of the study, it is worth mentioning that all the

adolescents who voluntarily decided to take part in this research were especially insisted upon and completely guaranteed the anonymity of the information they provided.

Methodological choices may have had some influence on the results obtained. In this sense, inferential analyses with observational data have been used to answer the last objective of this thesis. However, although it should be reported, such an approach has proposed multiple hypotheses that could be met and has reported the findings as associations, ensuring the reliability of the findings and the reported conclusions.

This study looked at the knowledge, attitudes and sexual behaviour of this population. However, sexual skills are also an important aspect to consider when assessing an individual's sexual affective development and have not been explored here. In this sense, sexual assertiveness, understood as the ability to communicate appropriately with one's sexual partner about the sexual relationship, is directly related to achieving a healthy sexual life. However, in this group, the published literature on this aspect is limited and contradictory. Therefore, this would be a future line of research whose approach I consider to be the main one. Likewise, in terms of population characteristics, unaccompanied migrant children/adolescents currently make up more than a quarter of this population. These minors have grown up in culturally very different countries, educated in family and social values and beliefs that are generally less liberal and tolerant, and with more heteropatriarchal tendencies than those of more developed countries. Added to this, the hardship of travelling alone at a young age and the difficult adjustment they face on arrival, which sometimes affects their mental health. Thus, given that all of this could affect their psychosexual development, this condition of some minors in the child welfare system should be more fully explored in other future studies. The same applies to children and adolescents in foster care. They may have been influenced by values and beliefs more similar to those of children in the general population and may have developed a more secure attachment bond, which may be influencing their sexual development. However, given the frequent early negative experiences that have also shaped their past, we cannot conclude that their sexual health is similar to that of the rest of their peers in a community sample. It is therefore considered appropriate to continue this research project by exploring the sexual development of children living in foster care.

I. PRESENTACIÓN

La primera parte de esta tesis doctoral, la **fundamentación teórica**, ofrece un marco argumental que recoge la importancia científica y social de explorar la salud sexual de los niños y adolescentes en el sistema de protección. Esta comprende cuatro apartados a través de los cuales se justifica el abordaje de este tema en esta tesis doctoral. El primero de ellos recoge la definición del concepto de salud sexual, indicando el enfoque desde el que se estudia actualmente y explorando las implicaciones que se derivan de ella a nivel personal y social. También expone cómo evoluciona la misma a lo largo del ciclo vital, ensalzando la importancia de esta área del individuo en cualquier etapa del desarrollo. En el segundo apartado se presenta una síntesis de los diferentes aspectos a considerar a la hora de realizar un análisis completo de la salud sexual de cualquier individuo, y, especialmente, de los adolescentes. Por su parte, el tercer apartado, tras ofrecer una contextualización del desarrollo global que experimenta el adolescente, destacando el lugar principal que ocupa la sexualidad en esta etapa, ahonda en los resultados de los estudios científicos publicados hasta el momento sobre los diferentes aspectos que definen su salud sexual. Finalmente, el cuarto apartado, presenta a la población diana de esta tesis doctoral, los adolescentes del sistema de protección, describe su principal contexto de desarrollo y reporta las evidencias empíricas más recientes de los aspectos de su desarrollo psicosexual.

En la segunda parte, el **estudio empírico**, se recogen los objetivos e hipótesis de esta tesis doctoral, así como los aspectos principales vinculados a la metodología empleada en el desarrollo de la presente investigación. Asimismo, teniendo en cuenta que se trata de una tesis doctoral por compendio de artículos, no sólo se concretó qué objetivo se explora en cada una de las publicaciones, sino que también se ofrece la información principal sobre su título y revista en la que fue publicado o está en proceso de serlo, así como un breve y conciso resumen de lo que se expone en el mismo.

La tercera parte recoge la **discusión** y las **conclusiones**. En el primer apartado, se discuten los resultados obtenidos a partir de los hallazgos recogidos en la literatura científica previa, exponiendo en qué medida se ha cumplido cada una de las hipótesis planteadas al inicio de la investigación. Por otro lado, en el segundo apartado, se exponen las conclusiones que se derivan de los resultados obtenidos, reportando la contribución que el presente estudio hace a la investigación sobre este colectivo, a la

población objeto de estudio, en sí misma, y a la sociedad en general. También recoge las principales limitaciones y las líneas futuras de investigación.

En el cuarto apartado, **referencias bibliográficas**, se ofrece un listado de toda la bibliografía consultada. Y, por último, en los **anexos**, se incluye la relación de publicaciones que componen esta tesis doctoral, junto al permiso del editor para incluir dicho trabajo en la misma cuando este no ha sido publicado en abierto.

II. FUNDAMENTACIÓN TEÓRICA

Capítulo 1

Concepto de salud sexual y su expresión a lo largo del ciclo vital

La salud sexual, de acuerdo con la definición que ofrece la Organización Mundial de la Salud (OMS), es el estado de bienestar físico, emocional, mental y social en relación con la sexualidad. Según esta propuesta, la salud sexual se manifiesta a través de la expresión libre y responsable de las capacidades sexuales, lo que favorece el bienestar personal y social. Por tanto, no se trata simplemente de la ausencia de enfermedad o disfunciones. La salud sexual requiere un enfoque positivo y respetuoso de la sexualidad y las relaciones sexuales, así como la posibilidad de tener experiencias sexuales placenteras y seguras, libres de coerción, discriminación y violencia. Por tanto, para alcanzar y mantener una adecuada salud sexual, los derechos sexuales de todas las personas deben ser respetados, protegidos y garantizados. Además, debe reconocerse el impacto que la cultura, la preferencia sexual, las diferencias religiosas, la edad, la discapacidad y el nivel socioeconómico, entre otros factores, pueden tener en el desarrollo sexual y, por ende, en la salud sexual de cualquier individuo (Carrillo Romero, 2022; OMS, 2006).

Las personas sexualmente sanas y que expresan su sexualidad de forma positiva, lo hacen de acuerdo con sus valores, disfrutan cuando se relacionan sexualmente con otras, evitando prácticas sexuales opresivas, al tiempo que saben gozar de la sexualidad individual también, se sienten a gusto con su cuerpo y con su orientación sexual, expresan apropiadamente el afecto y comparten su intimidad responsablemente (Carrillo Romero, 2022). Las sociedades que protegen y dan prioridad a la salud sexual de sus ciudadanos se caracterizan por mantener un compromiso político con este tema (el estado reconoce la importancia de esta área del individuo), elaborar políticas públicas para promover el desarrollo sexual saludable, aprobar leyes que protegen a los ciudadanos de la explotación y que aseguran la vivencia libre de la sexualidad, contar con una infraestructura de profesionales especializados en la resolución de inquietudes de índole sexual y, sobre todo, se caracterizan por disponer de una cultura de apertura hacia el bienestar sexual que le asigna a este la prioridad que le corresponde (Carrillo Romero, 2022; López de la Llave, 2012).

Sin embargo, a pesar de que se ha demostrado que la salud sexual es fundamental para el bienestar general de cualquier individuo (Glasier et al., 2006; Lee et al. 2016), raramente se le presta la atención que merece. Ejemplo de ello es que los sanitarios

(médicos, enfermeros, etc.) escasamente se interesan por la salud sexual de sus pacientes, a pesar de la importancia de indagar sobre ello antes de emitir cualquier diagnóstico clínico (Alexander et al., 2014). Alrededor del 50% de los países del mundo no tienen políticas nacionales que aborden la educación sexual integral y el 20% no cuenta con servicios de salud sexual y reproductiva accesibles (Boyer et al., 2016; OMS, 2018). Todo ello, sin tener en cuenta las barreras adicionales que experimentan ciertos colectivos en el acceso a la salud sexual. Este es el caso, por ejemplo, de las personas LGTBIQ+ o de las personas con cualquier discapacidad ya sea física o intelectual (Gil-Llario et al., 2018; Stephenson et al., 2017). En este sentido, la falta de atención a la salud sexual y reproductiva puede conllevar consecuencias negativas tanto para el desarrollo físico como mental del individuo, incluyendo el aumento del riesgo de sufrir infecciones de transmisión sexual (ITS), trastornos sexuales (p.ej. disfunción eréctil, trastornos parafílicos, disforia de género) y/o trastornos mentales (p.ej. depresión, ansiedad y estrés) (Janighorban et al., 2022; United Nations, 2023b). Pero también tiene un importante impacto negativo a nivel comunitario, en la economía y en el desarrollo social del país (OMS, 2006).

En este sentido, dado que el desarrollo sexual es inherente a todo ser humano y se va dando de forma progresiva y continuada, las repercusiones de la desatención de esta área de la vida tienen un impacto importante en todos los individuos, independientemente de la etapa evolutiva en la que se encuentren. Este proceso comienza en el nacimiento, con la exploración y descubrimiento del propio cuerpo y de las sensaciones placenteras que se pueden experimentar (Fernández et al., 2004). La capacidad de respuesta sexual está presente pocas horas después de nacer, pudiendo los bebés varones tener erecciones y las niñas lubricaciones vaginales (Masters et al., 1982), así como disfrutar de experiencias sensuales como chuparse los dedos de las manos o de los pies. Asimismo, como forma natural de expresión sexual, los infantes de ambos sexos muestran interés por los genitales del sexo opuesto y se involucran en una variedad de experiencias de juego sexual, que se vuelven cada vez más encubiertas a medida que el menor crece y toma consciencia de las normas culturales (Reynolds et al., 2003).

Durante la preadolescencia, los niños perciben la división social de acuerdo con el sexo, distinguiendo a hombres y mujeres como grupos separados, y comienzan a vivenciar sus primeras experiencias de atracción sexual que motivarán el desarrollo de las habilidades para mantener relaciones íntimas (DeLamater & Friedrich, 2002). Posteriormente, en la adolescencia, el aumento sustancial de los niveles de hormonas sexuales y la maduración de los genitales y las características sexuales secundarias, conducen a una oleada de interés sexual, aunque la edad de inicio de las relaciones sexuales vendrá modulada también por ciertos factores sociales y culturales (p. ej. creencias religiosas, contexto sociocultural, etc.). Asimismo, durante esta etapa, los adolescentes comienzan a definir su identidad sexual y se enfrentan al manejo de la intimidad física y emocional en las relaciones con los demás.

El proceso de alcanzar la madurez sexual continúa en la edad adulta. En esta etapa, los individuos deben tomar las principales decisiones respecto a su estilo de vida sexual, así como perfeccionar sus habilidades de comunicación haciéndolas más efectiva si desean mantener relaciones íntimas interpersonales (DeLamater & Friedrich, 2002). En una encuesta estatal realizada recientemente, el 68,6% de los españoles encuestados aseguró mantener una relación afectiva y sexual con una persona con la que compartía un proyecto de vida, mientras el 17% no mantenía ningún tipo de relación ni sexual ni afectiva con nadie (CIS, 2023). Además, el estilo de vida sexual más común en la población adulta española sigue siendo el monógamo heterosexual (CIS, 2023; Ministerio de Sanidad, 2009), aunque actualmente el 47,6% se muestra a favor de tener dos o más relaciones afectivo-sexuales a la vez (CIS, 2023). La frecuencia con la que mantienen relaciones sexuales es semanal en más de la mitad de las parejas, aunque, dado que sigue considerándose un tema tabú, el 41% no hablan sobre su desempeño en la cama con su pareja (Sanghvi, 2021). Asimismo, especialmente entre los individuos de esta edad, la satisfacción sexual constituye un componente importante de la salud sexual, de manera que el 69,4% de los evaluados considera esencial para mantener una relación sentimental que las relaciones sexuales sean satisfactorias (CIS, 2023).

En la mediana edad y en la vejez, la biología, una variable altamente influyente en la niñez y la adolescencia, vuelve a tener un peso significativo en la salud sexual (DeLamater & Friedrich, 2002). En las mujeres, el cese de la menstruación se asocia con

una disminución en la producción de estrógenos, lo que conlleva ciertos cambios en el funcionamiento de los órganos sexuales que pueden provocar cierta incomodidad en algunas prácticas sexuales (Faubion et al., 2017). Asimismo, en el hombre también disminuye gradualmente la producción de andrógenos, lo que puede acarrear problemas para alcanzar la erección y/o un aumento del periodo refractario (Araujo et al., 2011). Todos estos cambios biológicos, junto a las actitudes sociales negativas hacia la sexualidad de los más mayores, predisponen a una disminución de la frecuencia de las relaciones sexuales con la edad (Smith, 1994), aunque esto no debería impedir el disfrute de una actividad sexual satisfactoria (Ballester-Arnal et al., 2019; DeLamater & Friedrich, 2002).

En definitiva, la sexualidad es una parte integral de todas las personas independientemente de la etapa evolutiva en la que se encuentren. Es una necesidad básica y un aspecto del ser humano que no puede separarse de otros aspectos de la vida. La sexualidad no es sinónimo de relaciones sexuales ni se trata de la suma de toda nuestra vida erótica. Esto puede formar parte de nuestra sexualidad, pero esta va más allá. Es el disfrute de la intimidad, la forma con la que interactuamos con el resto, etc. La sexualidad influye en nuestros pensamientos, sentimientos, acciones e interacciones y, por tanto, en nuestra salud física y mental (Carrillo Romero, 2022; Langfeldt & Porter, 1986).

Capítulo 2

Componentes de la salud sexual

Como se ha recogido en el capítulo anterior, la salud sexual es un constructo complejo que abarca múltiples aspectos de la sexualidad, los cuales están relacionados entre ellos e interactúan para garantizar una vida sexual saludable y satisfactoria. Es por ello que, a la hora de emitir juicios de valor sobre la salud sexual de los individuos, es necesario contemplar los diferentes aspectos que se ven implicados en esta, los cuales vendrán dados por los modelos normativos de salud sexual derivados de la experiencia de la comunidad objetivo. En este sentido, tomando como base la definición de salud sexual y las teorías e investigaciones realizadas hasta el momento, ofrecemos una breve descripción de los componentes que se han mostrado esenciales de la sexualidad humana y que, por tanto, debemos tener en cuenta cuando valoramos el desarrollo sexual, sobre todo, de los adolescentes.

1. CONOCIMIENTOS SOBRE SEXUALIDAD

La OMS (2021), en su definición de bienestar sexual, especifica que el acceso a la información y el conocimiento sobre sexualidad son constituyentes importantes de un desarrollo sexual saludable. Es más, la falta de conocimiento se ha relacionado con múltiples comportamientos sexuales de riesgo (p.ej. prácticas sexuales opresoras, menor uso del preservativo, etc.), con la propagación de ITS y con una mayor discriminación e intolerancia a la diversidad sexual, entre otros (Blanco Monsalve & Orejarena Regueros, 2014). Osadolor et al. (2022) aclararon que, si bien disponer de conocimientos sobre sexualidad no evita que los adolescentes participen en actividades sexuales, sí que les dota de la información necesaria para protegerse contra las actividades sexuales de riesgo que podrían perjudicarles y contribuir a una mala salud sexual.

Por lo general, cuando hablamos de "*conocimientos sobre salud sexual*" hacemos referencia a toda aquella información que se posee sobre anatomía y fisiología sexual (p. ej. información sobre la menstruación, la erección, la eyaculación, el orgasmo, etc.), salud reproductiva y anticoncepción (p. ej. ventajas y desventajas de los diferentes métodos anticonceptivos), prevención de ITS, derechos sexuales y reproductivos (p.ej. conocer los servicios de salud sexual y reproductiva a los que se puede acceder), identidades y orientaciones sexuales, y prácticas sexuales autoeróticas y de intercambio sexual seguras (Warner et al., 2018; Weinstein et al., 2008), principalmente.

2. ACTITUDES HACIA LA SEXUALIDAD

Las creencias, valores y percepciones que un individuo tiene hacia la sexualidad y las relaciones sexuales pueden incidir de forma directa en su comportamiento sexual y en la forma en que aborda y expresa su propia sexualidad. Por ejemplo, aquellas personas con actitudes negativas hacia la sexualidad pueden sentirse incómodas al comprar o usar métodos anticonceptivos, lo que puede hacer que disminuya la probabilidad de su uso efectivo; al igual que aquellas personas que tienden a presentar actitudes positivas hacia la sexualidad muestran mayor aceptación de la diversidad sexual y ausencia de prejuicios, lo que les lleva a una comunicación más efectiva con su/s pareja/s sexual/es y a experimentar una mayor satisfacción sexual (Sánchez-Fuentes et al., 2014). Factores como la edad, el género, la orientación sexual y/o las creencias religiosas parecen influir en las actitudes que se desarrollan hacia la sexualidad (Herbenick et al., 2010).

Actualmente, el *sexismo*, la *homofobia* y la *transfobia* son considerados los prejuicios más dañinos asociados a la sexualidad, en tanto que tienen una mayor repercusión en la salud sexual de los individuos (Alonso-Martínez et al., 2022). Las *actitudes sexistas* se entienden como una predisposición a perpetuar desigualdades, estereotipos y roles que se perciben como conductas propias de mujeres y hombres (incluido el tradicional doble rasero sexual), y se asocian con culturas de violencia, violación y asesinato (Álvarez-Muelas et al., 2022). El sexismo moderno tiene formas de discriminación tanto directas como más sutiles (Tipler & Ruscher, 2019) y, aunque prevalecen estas últimas (Fernández-García et al., 2022), cualquiera de sus formas se asocia con el régimen heteropatriarcal, que privilegia la heterosexualidad masculina como identidad y orientación sexual hegemónica. Esto contribuye a la perpetuación de los prejuicios contra las mujeres y las personas LGBTQIA+ (comunidades lesbianas, gays, bisexuales, transgénero, queer, intersexuales, asexuales y +; Charest & Kleinplatz, 2022; Silvestrini, 2020). Al igual que el sexismo, las *actitudes LGTBfóbicas*, como la *transfobia*, la *homofobia* o la *bifobia*, se han categorizado en manifiestas y sutiles. El manifiesto se caracteriza por una abierta hostilidad hacia las personas LGBTQIA+, mientras el sutil busca socavar indirectamente estas identidades y orientaciones sexuales, incluso fingiendo actitudes positivas hacia ellas (Timmins et al., 2020). Estas culturas dominantes reprimen y niegan la salud sexual a las personas pertenecientes a minorías

sexuales, generalmente estereotipándolas negativamente, excluyéndolas e invisibilizándolas (Westwood, 2022).

3. HABILIDADES SEXUALES

Dado que somos seres sociales, el desarrollo de una sexualidad saludable se ve influenciado también por múltiples factores contextuales y socioculturales, entre los que destacan las relaciones que el individuo establece con su/s pareja/s sexual/es. En este sentido, la capacidad de una persona para interactuar de forma efectiva con su pareja durante las actividades sexuales juega un rol esencial. Estas habilidades no se limitan a las destrezas del individuo para involucrarse y/o realizar técnicas sexuales específicas, sino que también incluyen la capacidad para comunicarse de forma abierta y efectiva con la pareja, responder a las necesidades y deseos de la misma, así como expresar y negociar los propios para que sus derechos y necesidades sexuales no se vean vulnerados.

En este sentido, la *asertividad sexual* se considera una de las habilidades principales para lograr una vida sexual saludable, por su indudable vinculación con la satisfacción sexual y la victimización sexual (Jangi et al., 2023; Mirshamshiri et al., 2015). Sayyadi et al. (2019) encontró que aquellas mujeres con alta asertividad sexual no sólo experimentan mayor actividad sexual, sino también más orgasmos, mayor deseo sexual y sentimientos manifiestamente positivos hacia su pareja. El término asertividad sexual incluye los aspectos cognitivos, conductuales y emocionales de hablar y comunicarse con una pareja abiertamente sobre los pensamientos, sentimientos, preferencias, necesidades u opiniones sexuales (Erchull & Liss, 2014; Koolaee et al., 2014; Loshek & Terrell, 2015; Santos-Iglesias et al., 2014). A pesar de las implicaciones positivas que se ha demostrado que se derivan del cultivo de esta habilidad (Jangi et al., 2023; Sayyadi et al., 2019; Widman et al., 2018), en sociedades más colectivistas el desarrollo de la misma no es percibido de forma tan positiva, ya que sus normas culturales anteponen las necesidades, los pensamientos y los sentimientos comunitarios, frente a los individuales (Alvarado et al., 2020). No obstante, independientemente de las diferencias culturales, se ha reportado que las mujeres son menos asertivas sexualmente que los hombres debido a las limitaciones impuestas por las normas culturales y las expectativas sociales heteropatriarcales (Bourdeau et al., 2008). Esto es de especial relevancia si

tenemos en cuenta que la asertividad sexual actúa como factor de protección frente a la victimización sexual (Fuertes Martín et al., 2013; Walker et al., 2011) y que las mujeres presentan las tasas más altas de abuso/agresión sexual (Hust et al., 2019; Krahé et al., 2015).

4. COMPORTAMIENTOS SEXUALES

La investigación ha demostrado que los comportamientos sexuales pueden afectar la salud sexual de las personas de diversas maneras. Por ejemplo, el uso consistente y correcto de preservativo durante las relaciones sexuales puede reducir el riesgo de ITS y de embarazo no deseado (CDC, 2022). En este sentido, comúnmente hablamos de *comportamientos sexuales de riesgo* para referirnos a aquellas prácticas sexuales (vaginales, orales o anales) sin protección, de las que los jóvenes, concretamente los varones, presentan tasas más altas (Amare et al., 2019). Sin embargo, no hemos de olvidar otros comportamientos sexuales como el intercambio de contenido sexual a través de Internet o el mantenimiento de relaciones sexuales no deseadas o forzadas.

Por un lado, la comunicación móvil electrónica, como la mensajería instantánea, ha alterado la forma de relacionarnos, dando lugar a la aparición de otros comportamientos sexuales de riesgo, sobre todo entre los más jóvenes (Del Rey et al., 2019). El *sexting*, definido como el intercambio de contenido de naturaleza sexual a través de un dispositivo electrónico (Van Ouytsel et al., 2015), es uno de ellos. Las delimitaciones conceptuales van desde las más restrictivas que identifican exclusivamente el sexting como el envío de las propias imágenes sexualmente explícitas (sexting primario; Choi et al., 2016; Marume et al., 2018; Wolak et al., 2012; Ybarra & Mitchell, 2014) hasta las más amplias que incluyen otras conductas que encubren la difusión de contenido sexual a terceros, como el envío, recepción y reenvío de fotos, videos y mensajes de texto sexualmente sugerentes y/o explícitos (sexting secundario; Mitchell et al., 2012; Villacampa, 2017). Sin embargo, independientemente de la definición que consideremos, los estudios reportan que es un fenómeno común, sobre todo entre los adolescentes (Gil-Llario et al., 2020; Houck et al., 2014), y que además las personas que lo practican se ven inmersas más frecuentemente en otros comportamientos sexuales de riesgo, como realizar ciberpornografía, tener relaciones sexuales sin protección, tener múltiples parejas y/o consumir sustancias psicoactivas

antes del sexo (Morelli et al., 2017; Rice et al., 2012; Temple et al., 2012). Asimismo, aunque no todos en la comunidad científica lo consideran una conducta de riesgo, otros estudios han encontrado que el sexting puede afectar a la salud física y psicológica de los implicados (Gewirtz-Meydan et al., 2018), llevándolos a experimentar síntomas de depresión e incluso ideación suicida (Del Rey et al., 2019; Jasso Medrano et al., 2018), además del aumento de otras conductas de riesgo relacionadas, como acabamos de comentar.

Por otro lado, la *victimización sexual*, entendida como cualquier comportamiento sexual realizado bajo coacción, manipulación o uso de la violencia, es un problema global con consecuencias inmediatas y a largo plazo para el bienestar físico, sexual, social y mental del individuo (OMS, 2019). Schapansky et al. (2021) encontraron que el 64% de la población belga encuestada había experimentado algún tipo de victimización sexual a lo largo de su vida, y el 44% lo había sufrido en los últimos 12 meses. Sin embargo, la disparidad entre los datos reportados por los diferentes estudios no permite sacar conclusiones determinantes (Krahé et al., 2015), aunque sí coinciden en que las mujeres y los jóvenes tienen un riesgo más alto de victimización sexual (Auderset et al., 2021; Buysse et al., 2013) y en que las consecuencias a nivel individual, interpersonal y social pueden ser graves y duraderas, no sólo por lo que respecta a la salud mental de la víctima (desarrollo de trastorno por estrés postraumático, ansiedad, depresión y/o trastorno por abuso de sustancias; Jina & Thomas, 2013), sino también respecto a su desarrollo sexual, al acarrear problemas en el deseo y funcionamiento sexual del implicado e incrementar las probabilidades de que se conviertan en abusadores/agresores sexuales (Tharp et al., 2012).

Capítulo 3

La salud sexual de los adolescentes

Las cuestiones, los conflictos y las crisis relacionadas con la sexualidad pueden comenzar antes de la adolescencia y extenderse ciertamente después de esta etapa vital. Sin embargo, no hay duda de que, para la mayoría de las personas, la adolescencia es un período clave en el que se produce un aumento exponencial de los impulsos sexuales, la asunción de valores sexuales y la iniciación de conductas sexuales (Moore & Rosenthal, 2006). Aunque durante mucho tiempo, la adolescencia ha sido considerada simplemente una etapa de tránsito entre la infancia y la adultez, hoy en día se entiende que constituye un periodo clave de la vida donde se producen complejos cambios que resultan muchas veces determinantes para garantizar el bienestar futuro, especialmente en relación con la sexualidad (Liang, et al., 2019).

Todas las teorías del desarrollo adolescente dan a la sexualidad un lugar central en la transición de la infancia a la adultez. Sin embargo, si queremos comprender el significado que la sexualidad tiene durante este periodo, debemos considerar cómo encaja en los aspectos biológicos, psicológicos, sociales y culturales del desarrollo adolescente. A nivel biológico, la sexualidad es la característica central, marcada por el inicio de la pubertad, que señala el aumento de la producción de hormonas sexuales, la maduración de los órganos reproductores y el repunte del deseo sexual. Con la pubertad, los cambios a nivel psicológico tienen que ver con la preparación para asumir roles adultos, incluyendo las relaciones sexuales y la procreación, así como el desarrollo de habilidades interpersonales que ayudarán a la gestión de las primeras relaciones afectivas. Hay un cambio de una orientación primaria dirigida a la familia a una confianza ciega en los pares como principales referentes, así como una madurez en cuanto a la toma de decisiones acerca de la identidad sexual. Esto ocurre en un contexto de habilidades cognitivas ampliadas que le permiten al adolescente evaluar puntos de vista alternativos. A un nivel más amplio, la sociedad da forma a la sexualidad de los adolescentes al establecer ciertas normas y valores relacionadas con la sexualidad y con las expectativas ligadas al género (Moore & Rosenthal, 2006). Esto nos lleva a pensar que el desarrollo sexual de las personas está enormemente influenciado por una cultura socialmente aprendida a nivel familiar, social y comunitario (Achen et al., 2021). De manera que, en aquellos países que prevalecen creencias y actitudes más conservadoras hacia la sexualidad, los adolescentes parecen presentar un menor y peor acceso a los

recursos de salud sexual y reproductiva y/o actitudes más negativas hacia la diversidad sexual y de género, entre otros (Alimoradi et al., 2017). Es por ello que, las diferencias culturales existentes respecto a las normas sexuales que prevalecen en cada contexto deben considerarse como el eje vertebrador del análisis que en este apartado se ofrece.

Los cambios tanto físicos como psicológicos relacionados con la sexualidad son eventos normativos en el desarrollo de los adolescentes y tienen potenciales consecuencias tanto positivas como negativas. Así, no es correcto definir la sexualidad en la etapa de la adolescencia como un hecho problemático, a pesar de que frecuentemente ha sido estudiada como tal. La actividad sexual consentida y segura, desde el punto de vista de la salud mental y física, puede contribuir positivamente al desarrollo de los adolescentes en la medida en que puede dotarles de una mayor independencia, competencia social y autoestima. Esto no quiere decir tampoco que todo el comportamiento sexual adolescente sea adaptativo y saludable. Claramente pueden darse actividades sexuales demasiado pronto y en contextos inapropiados (Moore & Rosenthal, 2006).

La edad de inicio de la pubertad ha disminuido significativamente en todo el mundo en las últimas décadas. Varios estudios atribuyen esta disminución a factores ambientales y de estilo de vida, como la nutrición y el estrés (Alotaibi, 2019; Herman-Giddens et al., 2012), sobre todo en los países desarrollados, y concluyen que esto podría conllevar una mayor exposición a comportamientos sexuales de riesgo en los adolescentes (Downing & Bellis, 2009). En este sentido, se ha observado una asociación entre la madurez puberal temprana y la *iniciación sexual* precoz (Pedersen et al., 2003). Un estudio comparativo de conductas sexuales de riesgo entre dos cohortes en España encontró que la edad de la primera relación sexual disminuyó con el tiempo, pasando de los 15,1 años en 2006 a los 14,7 años en 2012 (Espada et al., 2015). Una tendencia que queda confirmada en un estudio español más reciente, en el que se informa que la edad promedio de la primera relación sexual se ha reducido a los 14 años (García Vázquez et al., 2019). El Observatorio de Conductas de Riesgo en Jóvenes (Youth Risk Behavior Surveillance [YRBS]) en los Estados Unidos de América (EUA) también reportó que el 20,4% de los estudiantes encuestados ya habían iniciado relaciones sexuales entre los 14 y los 15 años (CDC, 2018). Estos resultados podrían entenderse como un

indicador de libertad sexual tras la tremenda transformación cultural y social que la sexualidad ha sufrido fruto de la revolución sexual del siglo XXI en los países del primer mundo, y puede estar asociada con la realización de prácticas sexuales de riesgo si no se recibe una educación sexual apropiada (Chisamya et al., 2012; Sigusch, 2004). Sin embargo, este análisis no es aplicable a lo que ocurre en otros contextos. Según los datos obtenidos en la Encuesta mundial de salud basada en la escuela (GSHS) de ocho países africanos, la tasa de adolescentes que habían tenido relaciones sexuales a los 11 años o menos (11,8%) fue mayor en comparación con la tasa a los 12 (5,5%), 13 (3,9%) y 14 (6,1%) años (Peltzer, 2010). En el contexto africano, y de otros países en vías de desarrollo, esta precocidad en el inicio sexual no es algo novedoso. Históricamente, debido a las creencias y estándares culturales y religiosos, sobre todo las niñas y adolescentes, se han visto obligadas a contraer matrimonio a una edad muy temprana, teniendo totalmente prohibido mantener relaciones sexuales prematrimoniales (Reis et al., 2023), lo que deriva en un inicio sexual precoz. Respecto a las diferencias de género en la edad de inicio de las relaciones sexuales, aunque los hombres siguen presentando mayor precocidad para involucrarse en prácticas sexuales que las mujeres, por el modo en que es entendida la masculinidad en las sociedades más machistas (Gonçalves et al., 2015; Roman Lay et al., 2021), en las últimas décadas la brecha entre los sexos se ha reducido exponencialmente en los países desarrollados. Así, estudios recientes en este contexto no identifican diferencias sustanciales de género y sugieren que las niñas jóvenes son tan activas sexualmente como sus pares varones (CDC, 2020) por la influencia, en parte, del movimiento feminista e iniciativas demandantes de igualdad de género de los últimos años (Chisamya et al., 2012).

Respecto a la secuencia de *comportamientos sexuales* adolescentes, aunque generalmente las actividades sexuales no coitales (besos, caricias, prácticas autoeróticas, etc.) siguen precediendo a las prácticas sexuales más íntimas (coito vaginal, etc.) (Boislard et al., 2016; Kotiuga et al., 2022; Lindberg, Scott et al., 2021), esta secuencia es cada vez menos clara (Lindberg, Firestein et al., 2021) y los jóvenes se involucran en una variedad más amplia de comportamientos sexuales al liberarse de las actitudes negativas que recaían sobre las prácticas sexuales menos tradicionales (Manning et al., 2006). Entre los varones adolescentes, la masturbación y las relaciones

sexuales vaginales con penetración son las prácticas sexuales más frecuentes, mientras que, en las mujeres adolescentes, además de la masturbación y el coito vaginal, son muy comunes otras prácticas sexuales como el sexo oral y el sexo anal. Según los datos recogidos por el Centro para el Control y Prevención de Enfermedades (Centers for Disease Control and Prevention [CDC]) en 2020, el 74% y el 47,5% de los varones adolescentes estadounidenses se masturbaban o tenían relaciones sexuales coitales vaginales, respectivamente, mientras las cifras de la prevalencia de estas prácticas sexuales en las mujeres adolescentes disminuían sustancialmente (47,6% y 42,4%, respectivamente), contrariamente a lo que ocurría con la prevalencia del sexo oral (el 42,4% de los hombres adolescentes, frente al 59,8% de las mujeres adolescentes lo practican). Estos datos destacan las diferencias, a favor del género masculino, que han sido encontradas también por otras recientes investigaciones con adolescentes canadienses, respecto al número de menores que practican la masturbación en solitario o visionando material pornográfico (Kotiuga et al., 2022). Asimismo, los datos reportados por el CDC también van en la línea de lo concluido en varios estudios con población canadiense y portuguesa que afirman que actualmente existe una proporción significativa de jóvenes para quienes la práctica del sexo oral precede al coito, sobre todo en el caso de las mujeres (Kotiuga et al., 2022; Santarato et al., 2022). Esto puede concebirse como un problema si tenemos en cuenta que los adolescentes no equiparan las prácticas sexuales coitales con el sexo oral, de manera que no reconocen el riesgo de transmisión de enfermedades asociado a esta práctica, lo que contribuye a rechazar el uso del preservativo, convirtiendo el sexo oral en una potencial fuente de propagación de una variedad importante de ITS (Moore & Rosenthal, 2006).

El aumento de la actividad sexual entre los adolescentes, sumado a otros múltiples factores (algunos de ellos comentados en líneas anteriores), ha suscitado el crecimiento de las preocupaciones sobre el mayor riesgo de *ITS* y de *embarazos no deseados* entre los adolescentes. En este sentido, el número de adolescentes que se estima que sean seropositivas es de más de 2 millones, siendo los jóvenes subsaharianos quienes presentan una prevalencia más alta (United Nations, 2023a). Asimismo, los jóvenes de ambos sexos de entre 15 y 24 años representaron la mitad de los casos de ITS detectados en EUA en 2008 (Satterwhite et al., 2008), así como el 61% de todos los casos de

clamidiasis registrados en Europa en 2015 (European Centre for Disease Prevention and Control, 2017). Por lo que las ITS en los adolescentes podríamos decir que constituyen un importante problema, más si tenemos en cuenta las graves consecuencias que estas tienen para su salud (OMS, 2018). A nivel físico, dependiendo de la ITS y la fase en la que se encuentre, además de perjudicar al sistema inmune, esta puede causar infertilidad, afectar al sistema nervioso o derivar en otras enfermedades como cáncer de cuello de útero (Shannon & Klausner, 2018); mientras que a nivel psicológico la carga también es muy importante y se vincula principalmente con afecto negativo, ansiedad y depresión en el diagnosticado (Singh & Singh, 2021). No obstante, no son menos los peligros a los que se exponen las adolescentes que se quedan embarazadas a esta edad (aumenta el riesgo de eclampsia, endometritis puerperal, infecciones sistémicas y depresión postparto, entre otros). En muchos lugares del mundo, los embarazos en la adolescencia son habituales (OMS, 2018). A nivel mundial, alrededor de 16 millones de mujeres adolescentes dan a luz cada año, lo que representa alrededor del 11% de todos los nacimientos, ocurriendo el 95% de estos en países de bajos y medianos ingresos. Se estima que cada año se producen 21 millones de embarazos entre adolescentes de 15 a 19 años en países en vías de desarrollo (Darroch et al., 2016; OMS, 2018). Según un reciente metaanálisis, la elevada tasa de matrimonios infantiles, la escasez e inaccesibilidad a los servicios de salud sexual y reproductiva, la actitud desfavorable de la comunidad hacia el uso de anticonceptivos por parte de los adolescentes, el escaso conocimiento de estos sobre sexualidad y la violencia sexual generalizada en los países en desarrollo son algunas de las razones de la alta prevalencia de embarazo entre estos adolescentes (Kassa et al., 2018; OMS, 2018). Sin embargo, este no es un problema exclusivo de las jóvenes de países en vías de desarrollo. En EUA, en 2021, la tasa de embarazo adolescente fue del 6% (Elflein, 2023; Rascoe, 2023), mientras en el Reino Unido, el país de Europa Occidental con las tasas de embarazos adolescentes más altas, se alcanzó la prevalencia en 2020 de 13,1 concepciones por cada 1000 mujeres de entre 15 y 17 años (Office for National Statistics, 2022). Sin embargo, bien es cierto que, en contra de lo que sucede en algunos países en vías de desarrollo, en los países desarrollados la tasa de embarazos adolescentes ha ido disminuyendo en las últimas décadas, influida, posiblemente, por la implementación de estrategias de prevención de los embarazos adolescentes por parte de los gobiernos (p. ej. la implantación de la

educación afectivo-sexual como obligatoria, la intervención sobre desigualdades económicas y laborales, etc.; Cook & Cameron, 2017; Office for National Statistics, 2022; Rascoe, 2023).

Detrás de estos esperanzadores hallazgos, podría estar también la amplia gama de *métodos anticonceptivos* que actualmente los adolescentes tienen a su disposición y que ha contribuido a la evolución positiva de la aceptación y el uso de los mismos por parte de los adolescentes de muchos países (Moore & Rosenthal, 2006; Todd & Black, 2020). En EUA, el 87% de los adolescentes sexualmente activos informaron haber usado algún tipo de método anticonceptivo durante su última relación sexual (Kaiser Family Foundation, 2014). Un dato similar al reportado por Lindberg, Firestein et al. (2021) en su estudio con tres cohortes de adolescentes estadounidenses, en el que la proporción de mujeres jóvenes que habían usado un método anticonceptivo en su última relación sexual pasó del 86% en la cohorte de 2006-2010 al 91% en la de 2015-2019; y en los hombres del 93% al 94%. Sin embargo, hay otros estudios que reportan datos menos halagüeños, como el realizado por Kantorová et al. (2021) con mujeres jóvenes de casi 200 países diferentes del mundo, en el que tan sólo el 10,2% de las encuestadas entre 15 y 19 años usaba algún método anticonceptivo, perteneciendo las proporciones más altas de usuarias a las adolescentes de América Latina y el Caribe (25,3%) y de América del Norte y Europa (23,5%.). Sin embargo, cabe tener en cuenta que estas cifras, además de variar en función del país, también lo hacen en función del tipo de anticonceptivo por el que se pregunta. Diversos estudios con población culturalmente muy variada concluyen que actualmente el preservativo es el método anticonceptivo más usado entre los adolescentes (CDC, 2020; Kaiser Family Foundation, 2014; Lindberg, Firestein et al., 2021; Trussell, 2011). Según los datos recogidos en la Youth Risk Behavior Survey, el 89,7% de los estudiantes estadounidenses entrevistados había usado el preservativo en su última relación sexual (Szucs et al., 2020). Sin embargo, este aumento en las tasas de uso del preservativo parece deberse, en gran medida, a que la mayoría de los jóvenes dicen usarlo “a veces”, es decir, no disfrutan de una protección consistente. En este sentido, factores situacionales que se dan en los encuentros sexuales (alta excitación, consumo de alcohol o drogas, renuncia de la pareja, falta de conocimiento sobre el intercambio de fluidos sexuales) llevan a los adolescentes a rechazar la necesidad de

utilizar el preservativo de forma sistemática (Moore & Rosenthal, 2006). Asimismo, a esto se suma que la píldora anticonceptiva es el segundo método anticonceptivo más usado entre los adolescentes en muchos países (CDC, 2020; Kaiser Family Foundation, 2014; Lindberg, Firestein et al., 2021) y, dado que no contemplan que la prevención del embarazo no implica la realización de sexo seguro, los usuarios de este método anticonceptivo prescinden del uso del preservativo y se exponen a contagios por ITS (Moore & Rosenthal, 2006). Lo mismo sucede con la práctica de la "marcha atrás", el tercer método anticonceptivo más común entre los adolescentes según un reciente estudio estadounidense (Lindberg, Firestein et al., 2021). Este método no previene ni los embarazos no deseados ni las ITS. Por otro lado, parece que los adolescentes también hacen una distinción entre parejas ocasionales y estables, teóricamente entendidas estas últimas como aquellas que implican mayor nivel de compromiso y formalidad y que se prolongan más de dos años. En las relaciones estables los adolescentes se involucran en más comportamientos sexuales de riesgo y, teniendo en cuenta que, debe transcurrir un lapso muy corto de tiempo (en ocasiones, menos de 6 meses) para que muchos adolescentes consideren una relación "estable", esto es realmente preocupante. Añadido a todo lo anterior, hay que tener en cuenta que puede que no todos los adolescentes que se implican en prácticas sexuales conozcan los métodos anticonceptivos que tienen a su alcance, sepan usarlos y tengan acceso a ellos, así como que cuenten con los conocimientos necesarios para saber de su importancia y tengan las habilidades apropiadas para adquirirlos y negociar su uso (Moore & Rosenthal, 2006).

Asimismo, los comportamientos sexuales en línea, como el *sexting*, se han vuelto comunes entre los adolescentes desde el advenimiento de la comunicación móvil generalizada (Ehrenreich et al., 2019; Houck et al., 2014; Madigan et al., 2018; Mitchell et al., 2012). Un reciente metaanálisis encontró que el 15% de los jóvenes envió un mensaje de texto con contenido sexual alguna vez y el 27% lo recibió, habiendo evidencia de una prevalencia creciente (Madigan et al., 2018). Una tasa menor a la reportada por Gil-Llario et al. (2020) en su estudio con adolescentes españoles (24,4%) en el que además encontraron diferencias de género a favor de los hombres. El sexting, como ya comentamos en el capítulo anterior, se ha asociado con una variedad de resultados psicosociales que implican riesgo, por lo que es una consideración crítica en

la salud sexual de los adolescentes (Doyle et al., 2021; Gassó et al., 2019; Houck et al., 2014; Reyns et al., 2013; Rice et al., 2018; Titchen et al., 2019). Una revisión sistemática reciente encontró que el sexteo se asoció con la victimización sexual, los problemas de relación con los compañeros, los sentimientos de vergüenza y humillación, y los comportamientos sexuales de riesgo (p. ej. tener relaciones sexuales sin condón o con múltiples parejas) entre los jóvenes (Doyle et al., 2021).

La falta de madurez cognitiva, que se evidencia con la creencia característica de los adolescentes de que nada malo o indeseable puede sucederles ("fabula personal") y con sus limitaciones para pensar en las consecuencias futuras de sus actos, parece estar detrás de esa mayor asunción de riesgos sexuales (Moore & Rosenthal, 2006). Sin embargo, por supuesto, este no es el único factor implicado. Múltiples estudios se han hecho eco de la relación negativa entre formación y conductas sexuales de riesgo, y han concluido que la *educación sexual* actúa como un factor de protección clave no solo para la prevención de ITS, embarazos no deseados y otros comportamientos sexuales de riesgo, sino también para la promoción de la salud mental y emocional de los adolescentes (Hall et al., 2016). En una encuesta con jóvenes (de 15 a 24 años) de Asia y del Pacífico, menos de uno de cada tres consideró que había recibido en la escuela una educación en sexualidad «muy buena» o «bastante buena» (UNESCO et al., 2021). En el caso de los países en los que la educación secundaria está más reglada, el porcentaje de adolescentes que han recibido educación sexual se ve incrementado, aunque esto no tiene por qué implicar que la calidad y el alcance de la misma sea el deseable. Por ejemplo, la Encuesta nacional sobre sexualidad y anticoncepción entre los jóvenes españoles encontró que el 72% de los encuestados había recibido formación específica y reglada en temas de sexualidad (SEC, 2019). Sin embargo, el 68,5% de ellos consideraba que la formación recibida no era suficiente (SEC, 2019), y sólo el 42% de los adolescentes confirmó haber recibido educación sobre la prevención de ITS y la anticoncepción (CDC, 2020).

Hoy en día, los adolescentes tienen a su alcance gran cantidad de información, a través, por ejemplo, de Internet, redes sociales, etc. En este sentido, Internet fue el principal medio de educación sexual en el estudio realizado por el SEC (2019), aunque esto no siempre se traduce en conocimiento adecuado y preciso. En general, estudios

recientes reportan que los adolescentes presentan *conocimientos* limitados, o lo que es peor, erróneos, sobre sexualidad y reproducción, así como actitudes negativas hacia la sexualidad (Altekar et al. 2021; CDC, 2020). En Europa, Brunelli et al. (2022) en su investigación con estudiantes italianos hallaron que sólo el 48,2% tenía conocimientos generales adecuados sobre sexualidad. Concretamente, únicamente el 22,6% de los evaluados mostró un conocimiento adecuado sobre ITS, mientras el 28,3% de los estudiantes pensaba erróneamente que las píldoras anticonceptivas protegen contra las ITS. Sin embargo, en países en vías de desarrollo, estos datos empeoran. En el estudio de Brillian et al. (2021) el 79,2% de los adolescentes indonesios encuestados presentaba bajos niveles de conocimiento sexual. Asimismo, un gran número de niñas de muchos países tienen lagunas de conocimientos e ideas erróneas sobre la menstruación que les provocan miedo y ansiedad, y ello les impide estar preparadas para su primera menstruación (Chandra-Mouli & Patel, 2020). Especialmente en África y Asia, no sólo hay una notable falta de servicios de salud sexual y reproductiva, escasamente accesibles para las adolescentes, sino que también se observa un grave desconocimiento entre ellas sobre dónde pueden conseguir diferentes métodos anticonceptivos modernos y cómo usarlos (Woog et al., 2015).

Paralelamente, una adecuada formación sobre sexualidad no se constriñe a la enseñanza de conceptos y transmisión de información, sino que también implica la adopción de valores y posicionamientos favorables a la diversidad sexual y de género, así como la adopción de habilidades de comunicación efectivas. En este sentido, las *actitudes sexuales* parecen verse ampliamente influidas por la cultura, de manera que se han encontrado resultados dispares en función del país de origen de los adolescentes. Mientras Altekar et al. (2021) reportó que los adolescentes indios de su estudio presentaban mayormente actitudes poco definidas hacia la sexualidad, otros estudios llevados a cabo con población indonesias y africanas informaban de actitudes negativas en casi la mitad de los encuestados (Brillian et al., 2021; Mesele et al., 2023), sobre todo en el caso de los chicos (Brillian et al., 2021; Claramunt Busó et al., 2011; Martínez-Pecino & Durán, 2019) y por lo que se refiere a las actitudes sexistas y estereotipos de género (Brillian et al., 2021; UNESCO, 2018). Sin embargo, en países donde teóricamente hay un menor predominio de las normas culturales y las expectativas sociales

heteropatriarcales, estas actitudes son el presente también. En España, por ejemplo, los adolescentes varones mantienen más actitudes sexistas que las mujeres, creyendo que ellos deben ser los proveedores financieros en una relación y las mujeres las responsables del cuidado de los niños, que ellas tienen menos deseo sexual que los hombres y que estos últimos tienen derecho a tener relaciones sexuales sin consentimiento mutuo, e incluso que, en ocasiones, la violencia de género es aceptable en ciertas situaciones en las que el hombre es "provocado" por la mujer (Ramiro-Sánchez et al., 2018).

Estas actitudes, más presentes entre los jóvenes de lo deseable, se asocian de forma significativa con más problemas de *asertividad sexual* (dificultades para comunicar los límites y exigir respeto por los derechos sexuales en las relaciones íntimas) y con una mayor exposición a experiencias de victimización sexual (Fernández-Antelo et al., 2020; Tomaszewska et al., 2022). En un reciente estudio con adolescentes españoles, Fernández-Fuertes et al. (2020) encontraron que el 31,34% de los hombres jóvenes encuestados y el 19,02% de las mujeres jóvenes no rechazaban las caricias a pesar de no desearlas, mientras que el 26,11% de los varones y 22,61% de las mujeres mantenían relaciones sexuales aunque no les apeteciera, y casi la mitad de los participantes nunca indicaban cuándo les gustaría que les tocaran (46,64% de los hombres y 43,71% de las mujeres).

Sin embargo, todavía más preocupante es que para una minoría sustancial de jóvenes el primer encuentro sexual no sea voluntario, con las consecuencias que las experiencias de *victimización sexual* tienen en la salud física y mental de los afectados (mayor riesgo de sufrir trastornos mentales, implicarse en abuso de sustancias, etc.; Salmon et al. 2022; Warner & Warner, 2019). Una de cada 5 mujeres y 1 de cada 13 hombres declaran haber sufrido abusos sexuales cuando eran niños de 0 a 17 años, ascendiendo a 120 millones el número de niñas y jóvenes menores de 20 años que ha sufrido alguna forma de contacto sexual forzado (OMS, 2022). Un reciente estudio con adolescentes brasileños encontró que el 4,1% de los encuestados habían experimentado relaciones sexuales forzadas, correspondiendo al 3,6% la tasa de hombres y al 4,5% la tasa de mujeres (Feitosa et al., 2021). Una prevalencia mucho menor a la reportada por otros estudios con población europea (8,7% en adolescentes españoles, Pereda, Guilera

et al., 2014; 10% en adolescentes portugueses, Sani et al., 2021). Sin embargo, hay mayor disparidad respecto a las características del perpetrador, aunque comúnmente el abuso/agresión es perpetrado por un adulto conocido o por un igual (generalmente la pareja). En este sentido, este último tipo de victimización resulta alarmante en la medida en que es un excelente indicador de la dinámica de poder de género que opera actualmente en el mundo sexual de los jóvenes. Asimismo, además de lo comentado, la gravedad de este problema de salud pública se ve exacerbada si tenemos en cuenta que las vivencias de victimización sexual previa pueden duplicar o incluso triplicar el riesgo de victimización futura de un individuo (Walker et al., 2019). Así, aquellos individuos que sufren abuso/agresión sexual a una edad muy temprana van a ver aumentado su riesgo de sufrir revictimización con las secuelas que esto tiene para los implicados, quienes tienden a presentar no sólo un pésimo bienestar físico y emocional y peor calidad de vida, sino también mayor riesgo de ideación suicida (Classen et al., 2005; Finkelhor et al., 2007; Koola et al., 2018; Salmon et al. 2022).

En definitiva, la salud sexual de los adolescentes está determinada por múltiples factores, incluyendo los biológicos, psicológicos, sociales y culturales. Así, como hemos visto, la edad a la que se inicia la pubertad y/o la presencia de ITS, se asocian directamente con la salud sexual que desarrolla el individuo, al igual que su autoestima y/o sus niveles de ansiedad, entre otros. No obstante, independientemente de lo anterior, los individuos pasan por un proceso de socialización sexual a través del cual aprenden acerca de los deseos, sentimientos, roles, expresiones y prácticas sexuales de su cultura y de su contexto específico de interacción social (Achen et al., 2021). En este sentido, una serie de estudios han destacado la influencia de la estructura y las relaciones familiares, los compañeros, las creencias religiosas, el nivel socioeconómico y los cambios sociales en la comunidad, como factores especialmente determinantes de la salud sexual del individuo. Con ello, mantener una comunicación materna/paterna deficitaria y/o criarse en un entorno de mayor pobreza, se ha asociado con una peor salud sexual (Alimoradi et al., 2017).

Capítulo 4

La salud sexual de los adolescentes inmersos en el sistema de protección

Los niños y adolescentes inmersos en el sistema de protección son considerados un grupo especialmente vulnerable (Euser et al., 2014; Indias et al., 2019). Este es el caso de los menores que se encuentran en acogimiento residencial, bien porque es la medida más adecuada a la vista de sus circunstancias particulares, bien porque están pendientes de considerar si mejora su contexto familiar o si existe una familia de acogida que cubra adecuadamente sus necesidades (DGIA, 2017).

Según el informe estatal más reciente, en 2021, más de 16.000 menores de edad vivían en centros u hogares de acogimiento residencia en España (Ministerio de Derechos Sociales y Agenda 2030, 2022), de los cuales 1.484 se encontraban en la Comunidad Valenciana (Generalitat Valenciana, 2021). Unos datos preocupantes, según muchas organizaciones que luchan por los derechos de los más jóvenes, ya que, aunque el acogimiento residencial es una medida de protección a la infancia que se implementa cuando la persona menor de edad no puede vivir con su familia de origen debido a situaciones de riesgo o desprotección, también hay estudios que consideran que el acogimiento residencial puede tener efectos negativos en el desarrollo emocional y social de los niños, especialmente si se prolonga en el tiempo. De ahí la importancia de subrayar que se trata de una medida temporal y que debe promoverse en todo momento el acogimiento familiar como alternativa preferente (UNICEF, 2022).

La mayoría de estos niños y adolescentes, antes de llegar a un centro de acogimiento residencial, han sufrido múltiples formas directas y/o indirectas de victimización que pueden haber contribuido a forjar su salida del hogar, para garantizar su bienestar físico y/o emocional (Browne, 2009; Collin-Vézina et al., 2011). En este sentido, es común que estos menores reporten historias de trauma o abuso sexual, hayan vivido en la pobreza, hayan tenido una crianza inconsistente, dura o no disponible, y provengan, en definitiva, de familias que experimentan múltiples factores de estrés (Connell et al., 2007; McGuinness & Schneider, 2007; Tarren-Sweeney, 2008). Además, a esto cabe sumar la ausencia de factores de protección que suelen presentar (p.ej. ausencia de relaciones familiares positivas) así como la frecuencia con la que cambian de ubicación desde que salen de su hogar hasta que encuentran un núcleo de convivencia más o menos estable, lo que incrementa exponencialmente su vulnerabilidad (King et al., 2019; McGuire et al., 2018). Estas experiencias negativas pueden perturbar el desarrollo biopsicosocial

saludable del menor desde una edad muy temprana (American Academy of Pediatrics, 2012), por tanto, va a ser esencial conocer en detalle la historia de vida del niño o adolescente antes y durante su inclusión en el sistema de protección, previamente a la toma de decisiones y extracción de conclusiones respecto a este colectivo (Martin Pluma & Wic Galván, 2016).

Las características sociodemográficas de los individuos determinan directa e indirectamente su desarrollo, y, por ende, su desarrollo psicosexual. Por ejemplo, el simple hecho de pertenecer a una minoría sexual puede fomentar directamente actitudes sexuales más liberales, y el consumo de sustancias psicoactivas podría estar relacionado con una mayor implicación en comportamientos sexuales de riesgo. Mientras que, indirectamente, por ejemplo, identificarse con el género femenino en una sociedad machista puede conllevar que este grupo sufra, de forma más acentuada, las consecuencias sociales del sexismo. Pero, además, en el caso de los niños y adolescentes del sistema de protección, que reúnen un mayor número de vivencias no normativas (Pereda, Abad et al., 2014), se precisa también la recogida de información específica sobre estos eventos previos a la entrada en el sistema de protección y aquellas experiencias más recientes (p. ej. medidas de protección, relación con su familia biológica, frecuencia de las visitas, etc.). Los menores inmersos en el sistema de protección son un colectivo muy heterogéneo que puede presentar realidades muy diferentes y haberse enfrentado a experiencias vitales realmente específicas, ante las que su forma de responder puede haber sido muy variada (Equipo de Incidencia Política y Estudios UNICEF Comité Español, 2017), por lo que la interpretación y generalización de cualquier resultado de investigación va a requerir el conocimiento profundo de las características del grupo muestral. En este sentido, la eficacia de las estrategias de intervención pasa por que estas se adapten al perfil del participante y tengan en cuenta sus necesidades específicas (Pluma & Galván, 2016; Tyndall et al., 2022). Hogben et al. (2015) concluyeron que las intervenciones eran más potentes en aquellas áreas que habían venido definidas por las características de la población diana.

Los profesionales del sistema de protección, sin embargo, manifiestan problemas para elaborar planes de intervención individualizados eficaces a la llegada del menor al hogar o residencia. Dicen carecer de información suficiente sobre el menor, dados los

problemas de coordinación interprofesional existentes entre todos los profesionales que les atienden (Albertson et al., 2018; Harmon-Darrow et al., 2020), y reportan la falta de herramientas que les permitan recoger y transmitir de forma estructurada y sistemática información sobre los aspectos esenciales del menor (Equipo de Incidencia Política y Estudios UNICEF Comité Español, 2017). Esto también queda confirmado tras la profunda revisión bibliográfica que se ha realizado, en la que no se han encontrado instrumentos publicados diseñados para recoger datos sociodemográficos que hayan demostrado ser válidos y efectivos en la población infanto-juvenil, y menos aún en menores con experiencias tan específicas como las que involucran alas de los niños y adolescentes del sistema de protección. Estos formularios a menudo se desarrollan ad hoc para una investigación y una muestra en particular (López López, et al., 2010) y no se enfocan en explorar aspectos específicos de este grupo muestral (por ejemplo, su historia en el sistema de protección o los antecedentes de la familia biológica) que pueden ser de gran importancia en el proceso de valoración y análisis de su desarrollo psicosexual, dada su mayor predisposición a asumir riesgos sexuales y enfrentarse a ITS o embarazos no deseados, entre otros problemas (Ramseyer Winter et al., 2016; Svoboda et al., 2012).

Una investigación reciente con estudiantes de secundaria de Connecticut (EUA) encontró que vivir en hogares de acogimiento residencial se asocia con una mayor probabilidad de informar que “alguna vez ha tenido relaciones sexuales” (61,8% frente a 39,6% de los adolescentes externos al sistema) y de mantener *relaciones sexuales a una edad temprana* (el 19,1% frente al 11,9% había tenido su primera relación sexual antes de los 14 años; Zhan et al., 2017). Esta asociación, aunque de forma menos contundente, fue confirmada por Kobulsky et al. (2022) en su reciente estudio con adolescentes (edad promedio de 14 años) del sistema de protección de Los Ángeles (EUA), en el que el 39,8% de los encuestados habían tenido sexo alguna vez (y el 32% sexo oral y el 24,4% sexo anal), mientras en la población externa al sistema de protección el porcentaje era del 19,4% (y del 16,8% sexo oral y del 9,8% sexo anal). Nugent et al. (2020) también reportaron que más de la mitad de los encuestados que alguna vez habían estado en hogares de acogimiento residencial estadounidenses (59% hombres y 55% mujeres) había tenido relaciones antes de los 15 años, frente al 28% de los hombres

y al 25% de las mujeres que nunca habían estado en el sistema de protección. Es más, a los 18 años las cifras aumentaban a 9 de cada 10 entre los jóvenes que alguna vez han estado en el sistema de protección, en comparación con 7 de cada 10 de los jóvenes que nunca había estado en este contexto (Nugent et al., 2020). El estudio CalYOUTH realizado con una amplia muestra de jóvenes del sistema de protección de Carolina (EUA) también encontró que el 86% de los participantes habían tenido relaciones sexuales antes de los 19 años, experimentando su primer encuentro sexual a la edad promedio de 15 años (Courtney et al., 2014); lo que contrasta con lo reportado por el estudio Ad Health con jóvenes externos al sistema de protección en el que el 79% había tenido relaciones sexuales a los 19 años, siendo la edad promedio de su primera relación sexual los 16 años (Harris et al., 2009). A pesar de que estas últimas diferencias no son abismales, tiempo atrás estos datos ya reflejaban tasas más altas de relaciones sexuales entre los adolescentes inmersos en el sistema de protección y a una edad más temprana. Respecto al género, aunque no en todos los estudios se demuestra su influencia de forma significativa (Nugent et al., 2020), en varias investigaciones con adolescentes estadounidenses, los chicos parecen iniciarse en las relaciones sexuales a una edad más tempranas que las chicas de este grupo poblacional (James et al., 2009; Zhan et al., 2017).

Sin embargo, lo realmente preocupante es que esta mayor actividad sexual y mayor precocidad en su iniciación parece ir de la mano de un menor *uso del preservativo* también en estos adolescentes (Kobulsky et al., 2022; Lambert et al., 2013). En un reciente estudio con población del sistema de protección de Los Ángeles (EUA), el 27,8% de los encuestados informó haber tenido sexo sin preservativo en los últimos tres meses, frente al 9,2% de la población externa a este contexto (Kobulsky et al., 2022). Datos algo más preocupantes encontraron Zhan et al. (2017) en su estudio con adolescentes del sistema de protección de Connecticut (EUA), ya que el 39,7% no usó el preservativo en la última relación sexual, mientras el 13,7% no utilizó ningún método. En cambio, en el estudio CalYOUTH, en contexto estadounidense también el 76% de los entrevistados aseguró haber tenido relaciones sexuales sin condón al menos una vez durante el último año y el 58% no haberlo usado la última vez que había tenido relaciones sexuales (Courtney et al., 2014). En esta línea fueron los resultados

reportados por Cheung et al. (2015) en su estudio con jóvenes en el sistema de protección de Texas (EUA), en el que casi la mitad de la muestra no usaba ningún anticonceptivo normalmente y sólo una cuarta parte usaba preservativo.

El aprendizaje social, entre otras causas, parece estar detrás de esta falta de constancia en el uso del preservativo. Estos adolescentes pueden haber internalizado creencias y expectativas sobre la actividad sexual, el uso de anticonceptivos y la formación de una familia que les conducen a un embarazo y parto temprano (Font et al., 2019). Así, se ha documentado un riesgo elevado de *embarazo y parto* en esta etapa entre los adolescentes involucrados en el sistema de protección (Brännström et al. 2015; Noll & Shenk 2013; Putnam-Hornstein & King, 2014; Zhan et al., 2017). Según Garwood et al. (2015) la población del sistema de protección tiene un 66% más de probabilidad de embarazo en comparación con aquellos no involucrados en el mismo. En un estudio reciente con adolescentes del sistema de protección estadounidense, el 43% de las mujeres jóvenes y el 27,5% de los hombres jóvenes reportó uno o más embarazos durante su adolescencia. Tasas que aumentaron al 49% y 33%, respectivamente, cuando se incluyeron los embarazos de mujeres menores de 21 años. En este mismo estudio, la edad media del primer embarazo fue de 17,5 años y más de una cuarta parte de la muestra que tuvo un embarazo informó de embarazos repetidos (Combs et al., 2018). En el estudio estadounidense CalYOUTH, aproximadamente un tercio de las mujeres encuestadas se habían quedado embarazadas antes de los 18 años, y esta tasa aumentaba a casi la mitad de la muestra a los 19 años (Courtney et al., 2014; Dworsky & Courtney, 2010). Sin embargo, en los hombres, esta tasa bajaba exponencialmente, informando el 20% de haber dejado embarazada a su pareja antes de los 19 años (Courtney et al., 2018), aunque esta prevalencia podría estar infraestimada al no ser conocedores muchos de ellos del embarazo de su pareja sexual (Combs et al., 2018). En el estudio CalYOUTH, para ambos géneros, las tasas informadas fueron más de 2 veces superiores a las tasas en una muestra estadounidense de jóvenes de edad y composición racial similares (Courtney et al., 2007). Sin embargo, es importante tener en cuenta que no todos los embarazos en estos adolescentes son no deseados, y que cuando se les pregunta sobre los motivos para buscar tener descendencia a su edad (como parte de estudios retrospectivos) informan de su deseo de tener amor y atención, de reescribir

su infancia y de dar el amor que no recibieron en su propia infancia (Aparicio et al., 2015; Shannon & Broussard, 2011). Además, aunque un mayor riesgo de embarazo adolescente no tiene por qué implicar un mayor riesgo de parto adolescente, en la mayoría de los casos sí que es así. Según varios estudios, alrededor de dos tercios de los embarazos adolescentes culminan con el nacimiento del bebé, mientras del 18 al 24% resultan en aborto espontáneo y entre el 12 y el 15% en aborto (Combs et al., 2018; Courtney et al., 2018; Kost et al. 2017; Nugent et al., 2020; Perper et al., 2010). Otros estudios, con contexto estadounidense también, no informan de tasas tan altas de maternidad/paternidad antes de los 18 años en esta población (alrededor del 18%; Font et al., 2019; King, 2017). Sin embargo, la incidencia de nacimientos en adolescentes del sistema de protección no parece haberse reducido, a pesar de las disminuciones en los nacimientos en adolescentes de la población general (King et al., 2014). Asimismo, debe tenerse en cuenta la dificultad de la experiencia y las importantes repercusiones que la maternidad adolescente tiene en el desarrollo de diferentes aspectos de la vida del individuo. Normalmente, las jóvenes que dan a luz durante esta etapa son particularmente vulnerables a desarrollar un bajo nivel educativo y las consiguientes disparidades económicas, dado que se ven obligadas a dejar sus estudios y se enfrentan a limitaciones importantes para encontrar empleo y emanciparse (Dworsky & DeCoursey, 2009; Font et al., 2019; Melby et al., 2018).

La participación en el sistema de protección también se ha asociado con una mayor probabilidad de implicarse en *comportamientos sexuales en línea*, concretamente con el envío de imágenes sexuales electrónicas por presión, el uso de Internet o una aplicación para encontrar una pareja sexual y la práctica de relaciones sexuales con alguien conocido a través de Internet o de una aplicación. Un reciente estudio informó que el 30% de los adolescentes del sistema de protección de Los Ángeles (EUA) había usado internet o aplicaciones de contacto para encontrar a alguien con quien tener sexo y el 29,3% había llegado a tener sexo con esa persona, lo que contrasta con los datos de los adolescentes no inmersos en el sistema de protección (6,5% había usado Internet o aplicaciones de contacto para encontrar a alguien con quien tener sexo y sólo el 4,4% llegó a tener dicho encuentro sexual). Asimismo, del 24,7% de los adolescentes del sistema de protección que alguna vez había enviado imágenes de contenido sexual, el

22,9% lo hizo por presión, mientras en la población comunitaria el porcentaje de jóvenes que había enviado este tipo de contenido alguna vez fue del 11,3%, motivados sólo el 3,2% por la presión (Kobulsky et al., 2022). Estas tasas tan altas de comportamientos sexuales en línea entre los adolescentes inmersos en el sistema de protección, frente a las reportadas por quienes no se encuentran en este contexto, podrían venir explicadas por la mayor prevalencia de maltrato y abuso sexual que han experimentado estos jóvenes en su infancia y/o adolescencia y la relación causal encontrada entre ambas circunstancias (Kobulsky et al., 2022; Noll et al., 2022).

La *victimización sexual* ha demostrado ser uno de los problemas más frecuentes entre los niños y adolescentes del sistema de protección y una de las vivencias que mayor impacto y más duradero tiene en el desarrollo del individuo (problemas físicos, emocionales y de comportamiento; Dworsky, 2018). Un estudio reciente, informó que el 41,1% de los adolescentes del sistema de protección de algunas regiones de España, habían sido víctimas de alguna forma de victimización sexual a lo largo de su vida (Indias et al., 2019). Una prevalencia similar a la reportada por otro estudio de Canadá (38,3%; Wekerle et al., 2017), pero menor a la encontrada en una investigación alemana (62%; Allroggen et al., 2017). En cualquier caso, estos datos resultan alarmantes, sobre todo si los comparamos con los hallados en estudios con muestras de adolescentes de la población general expuestos en el capítulo anterior. En este sentido, los datos no sólo muestran la dura infancia que han tenido estos menores de edad, sino también que las carencias afectivas y materiales que presentan les predisponen a convertirse en víctimas de abuso/agresión sexual con mayor facilidad.

Asimismo, dada la relación existente entre la falta de *asertividad sexual* y la participación en relaciones sexuales no deseadas (Fernández-Antelo et al., 2020; Tomaszewska et al., 2022), podría este colectivo caracterizarse por un déficit intrínseco en esta habilidad y actuar esta como causante o mediadora de la mayor prevalencia de menores victimizados en el sistema de protección. Sin embargo, las investigaciones que han abordado este tema en este colectivo son muy escasas y ofrecen datos contradictorios. Mientras en algunas investigaciones estadounidenses los jóvenes mencionan la falta de asertividad sexual en las relaciones de pareja como un problema al que se enfrentan, sobre todo las mujeres y principalmente durante la negociación del

uso del preservativo (Constantine et al., 2009); hay otros estudios en este mismo contexto que, desde un enfoque más positivo, reportan que los adolescentes inmersos en el sistema de protección presentan niveles altos de asertividad sexual a pesar de haberse enfrentado a dificultades significativas, mostrando que la victimización sexual y la asertividad pueden coexistir (Bay-Cheng & Fava, 2014; Johnson et al., 2018). Sin embargo, a pesar de esto último, tanto el entrenamiento de la habilidad de asertividad como el abordaje de las actitudes sexuales se recogen como aspectos clave a incluir en las estrategias de intervención si queremos reducir el riesgo de embarazo adolescente o ITS entre estos jóvenes (Bay-Cheng & Fava, 2014).

En relación a las *actitudes sexuales*, Oman et al. (2018), en su investigación con una muestra de jóvenes que vivían en centros de atención residencial en diferentes estados de América, encontraron que, aunque las actitudes hacia el uso de métodos anticonceptivos eran positivas, no lo eran tanto como las de los jóvenes que no pertenecían a este contexto, y, además, los adolescentes en el sistema de protección tenían actitudes mucho más positivas hacia el embarazo temprano y la maternidad/paternidad adolescente. Asimismo, algunos estudios europeos han encontrado una alta interiorización de *actitudes sexistas* entre los adolescentes en acogimiento residencial (Carbonell et al., 2021; Steinlin et al., 2017), posiblemente debido a la asimilación de modelos familiares heteropatriarcales que los llevan a adoptar comportamientos de género estereotipados (Maas et al., 2010). Estas creencias están presentes a través de la idealización del rol masculino como cuidador y protector de las mujeres (sexismo benevolente) y son más frecuentes entre los chicos (Carbonell et al., 2021; Martínez-Pecino & Durán, 2019; Rey Anacona et al., 2017).

Estas actitudes negativas o inadecuadas están directamente relacionadas con la falta de *conocimientos sobre sexualidad*. Combs et al. (2019) concluyeron que los adolescentes inmersos en el sistema de protección estadounidense tienen muy poca información sobre sexualidad en general o la que tienen es errónea. Concretamente, algunas investigaciones desarrolladas en diferentes estados americanos detallan que sus conocimientos sobre la anatomía y la fertilidad femenina y sobre los métodos anticonceptivos son bajos (Combs et al., 2019; Oman et al., 2018) y que tienen información errónea sobre el VIH y las prácticas sexuales seguras (Boustani et al., 2017).

Esto podría estar causado por los frecuentes cambios de hogar y los problemas de desestructuración educativa a los que se enfrentan, que les predisponen a recibir una baja o nula educación sexual (Ramseyer Winter, 2017). Bien es cierto que, entre los adolescentes de población general, los niveles de educación afectivo-sexual tampoco son muy elevados (Goldfarb & Lieberman, 2021; Hall, et al., 2016), como hemos expuesto en el apartado anterior, pero, en ellos, esas carencias se ven compensadas por otros aspectos como los vínculos de apego seguro y otros factores de protección de los que los adolescentes del sistema de protección carecen. Además, normalmente, la educación sexual en los adolescentes del sistema de protección, cuando llega, lo hace demasiado tarde para ellos, debido a que la edad de las primeras experiencias sexuales es más temprana que la media (Boustani et al., 2015), y su acceso a información y servicios de salud sexual y reproductiva se ve frecuentemente bloqueado (Finigan-Carr et al., 2018).

Existen también otras barreras que contribuyen a que los adolescentes del sistema de protección no reciban educación sexual (Dworsky, 2018). Por un lado, los programas de educación sexual escasamente han sido desarrollados y adaptados para satisfacer las necesidades distintivas y únicas de los adolescentes en situación de acogimiento. Esto es importante porque las intervenciones cognitivo-conductuales y basadas en habilidades que han demostrado ser eficaces con los adolescentes de la población general, pueden no serlo o serlo menos con los jóvenes en hogares de acogimiento residencial. Más concretamente, la prevalencia de problemas de salud mental y déficits educativos, la ausencia de familia o redes sociales de apoyo y las altas tasas de exposición a abusos u otros traumas entre los jóvenes en acogida pueden comprometer su eficacia o ayudar a que estas prácticas tengan un impacto nocivo en ellos, por ejemplo, contribuyendo a la retraumatización (Dworsky, 2018). A pesar de ello, existen excepciones, como el programa POWER Through Choices (PTC) 2010 (Oklahoma Institute for Child Advocacy & University of Oklahoma National Resource Center for Youth Services, 2010), que fue diseñado específicamente para empoderar a los jóvenes en el sistema de protección para que tomen decisiones saludables y positivas en relación con su comportamiento sexual, adquieran conocimientos y habilidades en materia de anticoncepción, desarrollen y practiquen habilidades de comunicación eficaces y

aprendan a localizar y acceder a los recursos disponibles. Asimismo, otros programas, como “Making Proud Choices!”, han sido adaptados a esta población. Este programa de salud sexual interactivo y basado en evidencia, aunque no fue diseñado específicamente para este colectivo, contribuye al aumento de los conocimientos de estos sobre los comportamientos que les ponen en riesgo de embarazo e ITS, y les capacita para tomar decisiones saludables (Finley et al., 2014). Asimismo, cabe comentar que, a pesar de que la eficacia de estas herramientas ha sido probada, no realizan un abordaje exhaustivo de todos los aspectos implicados en un desarrollo sexual saludable.

Por otro lado, los profesionales del sistema de protección juegan un papel fundamental no sólo en el apoyo a los jóvenes de este contexto como adultos de referencia, sino también como la principal fuente de conocimiento y estabilidad. Sin embargo, los profesionales enfrentan numerosos desafíos cuando se trata de abordar las cuestiones vinculadas al desarrollo sexual de los jóvenes bajo su cuidado, empezando por la relación inconsistente profesional-joven que en ocasiones se da y que puede condicionar la confianza que el menor establece con su adulto de referencia. Es fundamental para este desafío que los trabajadores perciban su responsabilidad de educar a los adolescentes en el cuidado de la salud sexual y reproductiva (Harmon-Darrow et al., 2020), algo especialmente complicado en un contexto que ya está lleno de conflictos de roles, ya que en muchas ocasiones las condiciones institucionales chocan con su rol de cuidador impidiéndoles mostrarse más cercanos y obligándoles a ceñirse a sus obligaciones profesionales (Lindahl & Bruhn, 2018). Además, en ocasiones los profesionales de este ámbito informan de la poca claridad e inconsistencia de las acciones políticas, de manera que incluso se preguntan si hablar de este tema con los menores de edad podría llevarlos a ser acusados de abuso (Albertson et al., 2018; Constantine et al., 2009). Estos profesionales expresan también tener dudas sobre qué conocimientos proporcionar a estos jóvenes, y cómo y cuándo hacerlo, ya que, en ocasiones, como comentábamos anteriormente, dicen no haber recibido la información necesaria sobre la historia de vida del menor como para identificar qué aspectos de la salud sexual del niño o adolescentes son más relevantes para este según sus vivencias y experiencias vitales (Albertson et al., 2018; Harmon-Darrow et al., 2020). Asimismo, la comodidad del profesional frente a estos temas, que viene marcada en parte por sus

valores, es esencial a la hora de considerar la facilidad con la que establecerá conversaciones efectivas y significativas con ellos. En este sentido, la educación y la capacitación fue la principal estrategia identificada por los profesionales en el estudio de Harmon-Darrow et al. (2020) para mejorar la efectividad de sus intervenciones. Los profesionales confesaron que no se perciben con las capacidades y recursos necesarios como para brindar los apoyos conceptuales y emocionales requeridos por los jóvenes, y que se sentían más cómodos y confiados trabajando el tema de la salud sexual y reproductiva con estos jóvenes después de recibir información integral actualizada sobre el tema. Así, ofrecer más y mejor formación en salud sexual y reproductiva a los trabajadores del sistema de protección no es sólo una demanda sino también una necesidad de la que se derivarían numerosos beneficios individuales y sociales (Harmon-Darrow et al., 2020).

III. ESTUDIO EMPÍRICO

Capítulo 5

Hipótesis, objetivos y procedimiento

La presente tesis doctoral responde a las necesidades que exhibe un colectivo prioritario para el crecimiento de la sociedad, los niños y adolescentes. Tal y como se indica en la Estrategia Española de Ciencia, Tecnología e Innovación 2021-2027 (EECTI) (Ministerio de Ciencia e Innovación, 2020), aquellas medidas específicas de apoyo a los jóvenes y la lucha contra la pobreza infantil son líneas de actuación necesarias en la Política de Cohesión de la Unión Europea. En concreto, esta propuesta favorece la generación de conocimiento sobre las condiciones de los menores que se encuentran en el sistema de protección, un contexto, el institucionalizado, que se enfrenta a la desigualdad, la multiculturalidad, la marginalización y la estigmatización, todos ellos ámbitos de intervención de la EECTI englobados en la línea estratégica de Seguridad para la Sociedad. Asimismo, el objetivo general de esta tesis doctoral refuerza el interés común de ambos programas, tanto la EECTI como el Programa Horizonte Europa (2021-2027) (Ministerio de Ciencia en Innovación, 2023), en el abordaje de la salud como desafío mundial, en este caso de la salud sexual.

A partir de la revisión de la literatura científica sobre el objeto de estudio que se ha realizado en el punto anterior, planteamos las siguientes hipótesis de partida:

HIPÓTESIS 1: El instrumento elaborado se mostrará una herramienta útil y eficaz, según el análisis de sus propiedades y el feedback de los profesionales, para recoger información sociodemográfica de los niños y adolescentes del sistema de protección.

HIPÓTESIS 2: Los adolescentes en acogimiento residencial tendrán pobres conocimientos sobre sexualidad, actitudes sexuales poco favorables, experimentarán las primeras prácticas sexuales a una edad temprana, siendo la masturbación la más prevalente, y se involucrarán comúnmente en comportamientos sexuales de riesgo (prácticas sexuales sin preservativo).

HIPÓTESIS 3: El género de los adolescentes en acogimiento residencial no influirá en su nivel de conocimientos sexuales ni en la tasa de uso de los métodos anticonceptivos, aunque sí lo hará respecto a las actitudes sexuales, a la edad de iniciación sexual y a los comportamientos sexuales en los que se

involucran, siendo los hombres quienes presentan actitudes más negativas, una iniciación sexual más temprana y se involucran en más prácticas sexuales.

HIPÓTESIS 4: La edad del adolescente en acogimiento residencial sí que influirá positivamente en su nivel de conocimientos sobre sexualidad, en su implicación en prácticas sexuales y en el uso que hacen de métodos anticonceptivos, aunque no en sus actitudes sexuales ni en su edad de iniciación en prácticas sexuales.

HIPÓTESIS 5: Los adolescentes en acogimiento residencial presentarán una prevalencia elevada de victimización sexual.

HIPÓTESIS 6: La victimización sexual por parte de un adulto conocido será la más frecuente entre los adolescentes en acogimiento residencial.

HIPÓTESIS 7: El grado de acuerdo entre la tasa de victimización sexual de los adolescentes en acogimiento residencial reportada por ellos mismos y la reportada por los profesionales del hogar o residencia será baja.

HIPÓTESIS 8: Las chicas presentarán mayor vulnerabilidad a sufrir victimización sexual, pero la edad del adolescente no será una variable implicada.

HIPÓTESIS 9: El abusador/agresor sexual será frecuentemente un hombre joven conocido para la víctima (familiar cercano).

HIPÓTESIS 10: La mayoría de las víctimas han sufrido más de un tipo de victimización sexual y en más de una ocasión (revictimización).

HIPÓTESIS 11: Cuanto menor sea la edad de la víctima en el momento de la primera experiencia de victimización sexual y más cercana la relación con el abusador/agresor, mayor será la probabilidad de sufrir revictimización sexual (más episodios de abuso/agresión sexual y/o diversos tipos de victimización sexual).

HIPÓTESIS 12: Los problemas emocionales serán las secuelas más comunes entre los adolescentes en acogimiento residencial que han sufrido victimización sexual.

HIPÓTESIS 13: Todas las facetas de la regulación emocional tendrán un efecto mediador en la relación entre victimización sexual y bienestar psicológico en los adolescentes en acogimiento residencial, en dirección negativa.

HIPÓTESIS 14: Una elevada victimización sexual se asociará con la falta de conciencia emocional, de aceptación de las respuestas emocionales y de claridad emocional, con un pobre acceso a estrategias de regulación emocional, y con dificultades para el control de los impulsos y para persistir en los comportamientos dirigidos a objetivos cuando se siente malestar.

HIPÓTESIS 15: La falta de conciencia emocional, de aceptación de las respuestas emocionales y de claridad emocional, un acceso pobre a estrategias de regulación emocional, y las dificultades para el control de los impulsos y para persistir en los comportamientos dirigidos a objetivos cuando se siente malestar, mostrarán una asociación negativa y significativa con el bienestar psicológico.

HIPÓTESIS 16: Tanto el género como la condición de ser niño, niña o adolescente migrante no acompañado (NNAMNA) se presentarán como variables que modulan la mediación ejercida por las facetas de la regulación emocional sobre la relación entre victimización sexual y bienestar psicológico. Concretamente, pertenecer al sexo masculino y ser migrante no acompañado actuará como variable moduladora impulsando la asociación entre victimización sexual y falta de conciencia y claridad emocional, peor aceptación de las respuestas emocionales y acceso a estrategias de regulación emocional, más dificultades para persistir en objetivos cuando se siente malestar y para el control de los impulsos, todo lo cual redunda en un peor bienestar psicológico.

Esta tesis tiene como objetivo general examinar la salud sexual de los adolescentes que se encuentran en hogares o residencias de acogida en la Comunidad Valenciana mediante la realización de un estudio descriptivo que permita identificar las variables asociadas a un desarrollo sexual no saludable especialmente en las víctimas de abuso/agresión sexual, con el fin último de contribuir a la mejora de su bienestar.

Los objetivos específicos, que se corresponden con los artículos publicados recogidos en anexos son los siguientes:

OBJETIVO ESPECÍFICO 1: Desarrollar un instrumento para la recogida de datos sociodemográficos de los niños y adolescentes del sistema de protección, describiendo su proceso de construcción y sus propiedades.

OBJETIVO ESPECÍFICO 2: Describir la salud sexual de los adolescentes en acogimiento residencial en la Comunidad Valenciana a través de la exploración de sus conocimientos, actitudes y comportamientos sexuales, y analizar posibles diferencias en función del género y/o la edad del evaluado.

OBJETIVO ESPECÍFICO 3: Explorar la prevalencia de victimización sexual a lo largo de la vida de los adolescentes en acogimiento residencial en la Comunidad Valenciana, describiendo las principales características de los diferentes tipos de victimización sexual y las posibles diferencias en función del género y la edad de la víctima, así como contrastando la información autoinformada con la reportada por los profesionales.

OBJETIVO ESPECÍFICO 4: Examinar el papel mediador de las múltiples facetas de la regulación emocional en la relación entre victimización sexual y bienestar psicológico de los adolescentes que se encuentran en acogimiento residencial en la Comunidad Valenciana, explorando, asimismo, el papel modulador de las variables género y la condición de ser NNAMNA en el modelo de mediación.

Para la consecución de los objetivos se ha desarrollado un estudio cuantitativo que nos ha permitido obtener información objetiva y exhaustiva de la muestra a través de instrumentos de evaluación validados.

El diseño de la investigación ha sido transversal. La población diana de este estudio la conforman los niños y adolescentes con edades de entre 11 y 19 años que se encuentran con una medida de acogimiento residencial en la Comunidad Valenciana. El tamaño muestral ha sido de 346 participantes reclutados de 47 hogares o residencias, por lo que se cumplió con la tasa inicialmente estimada (N estimada = 342) mediante el software G*Power para el análisis de diferencias entre géneros dentro de una misma

edad, significativas a nivel $\alpha = 0,01$, con una potencia estadística mínima de 0,8 y con un tamaño del efecto medio.

La preparación de este estudio se inició en 2019. En primer lugar, se contactó con la Dirección General de Infancia y Adolescencia (DGIA) que, desde la Vicepresidencia y Conselleria de Igualdad y Políticas Inclusivas de la Generalitat Valenciana, es el órgano competente para ejecutar las medidas de protección de menores y que tiene su guarda y/o tutela. Tras presentar el proyecto se elaboró un convenio de colaboración entre la Vicepresidencia y Conselleria de Igualdad y Políticas Inclusivas (Generalitat Valenciana) y la Universitat de València (Estudi General) como marco para el estudio de los niños y adolescentes que están en el sistema de protección, convenio que se firmó en septiembre de ese mismo año. Al mismo tiempo se solicitó el permiso de la Comisión de Ética de Investigación Experimental de la Universitat de València (Estudi General), el cual fue concedido en febrero de 2020. También se han cumplido con los principios éticos de la Declaración de Helsinki de 1964. El confinamiento debido al Covid-19 detuvo la preparación del trabajo que se reanudó en junio de 2020.

En ese momento se contactó con los directores de las diferentes entidades participantes en el estudio, para presentarles el proyecto y solicitarles su autorización para entrar en los recursos de acogimiento residencial. Una vez obtenidos estos permisos se realizó un primer contacto con los participantes en el que se les explicaron los objetivos y se recogieron los consentimientos informados de quienes accedían a participar en el estudio. A continuación, se aplicó una batería de instrumentos que recoge tanto datos sociodemográficos como de las diferentes variables que la literatura científica ha identificado como implicadas en el desarrollo sexual saludable, mediante el formato de entrevista.

En marzo de 2022, una vez completada la base de datos, se inició el proceso de análisis de datos y redacción de los artículos correspondientes a cada uno de los objetivos de la tesis doctoral.

Capítulo 6

Publicaciones

1. ESTUDIO 1

OBJETIVO 1: Desarrollar un instrumento para la recogida de datos sociodemográficos de los niños y adolescentes del sistema de protección, describiendo su proceso de construcción y sus propiedades.

TÍTULO DEL ARTÍCULO: Construction of a Form for Users of the Child Welfare System Based on the Delphi Method

PUBLICADO EN LA REVISTA: Children (FI: 2,4; Q2)

RESUMEN DEL ARTÍCULO

En el proceso de exploración de la salud sexual de los adolescentes en el sistema de protección y de las variables que pueden estar influyéndola, contar con información básica de su historia vital antes y durante su inclusión en el sistema de protección es esencial. Sin embargo, no se ha encontrado una herramienta clara y exhaustiva, elaborada teniendo en cuenta la compleja casuística de este colectivo, que nos permitiera recoger la información esencial de estos niños y adolescentes. Así, en este artículo se expone el proceso de construcción y las propiedades de un formulario para la recogida, de forma estructurada y destallada, de las principales características personales y sociales del menor de edad, el cual ha sido elaborado basándonos en las aportaciones que, a partir de su experiencia, facilitó un panel de profesionales. Se incluye la descripción de las dimensiones y de la estructura de la herramienta, con el fin de ofrecer el máximo de información de un instrumento validado por expertos como base para conocer en qué medida las vivencias previas y actuales pueden estar influyendo en su desarrollo psicosexual. Asimismo, se muestra el riguroso proceso de elaboración seguido, a través del método Delphi -aproximación que permite responder a una pregunta de investigación a través del consenso alcanzado por un panel de expertos-, junto al feedback recibido por los expertos en cada uno de los pasos del proceso, como prueba de su validez de contenido, de su usabilidad y de su relevancia para los expertos.

Una copia completa de la publicación de este trabajo se incluye en el Anexo 1.

2. ESTUDIO 2

OBJETIVO 2: Describir la salud sexual de los adolescentes en acogimiento residencial en la Comunidad Valenciana a través de la exploración de sus conocimientos, actitudes y comportamientos sexuales, y analizar posibles diferencias en función del género y/o la edad del evaluado.

TÍTULO DEL ARTÍCULO: Sexual Health among Youth in Residential Care in Spain: Knowledge, Attitudes and Behaviors

PUBLICADO EN LA REVISTA: International Journal of Environmental Research and Public Health (FI: 4,614; Q2)

RESUMEN DEL ARTÍCULO

Este artículo pone el foco en la descripción de la salud sexual de los adolescentes en acogimiento residencial en la Comunidad Valenciana. Para ello, se exploran los conocimientos, actitudes y comportamientos sexuales de estos adolescentes. Respecto a los conocimientos, se ha querido tener en cuenta tanto los conocimientos generales sobre sexualidad como los específicos sobre ITS y métodos anticonceptivos. Con relación a las actitudes, se ha puesto el foco en las actitudes sexistas, sin dejar de lado la tendencia general de las actitudes hacia la sexualidad que presenta este colectivo. Y, en relación con sus comportamientos sexuales, no sólo se ha querido atender a las prácticas sexuales que realizan estos adolescentes sino también a la edad con la que las practicaron por primera vez, analizando aquellas más comunes, y a la frecuencia de uso de los diferentes métodos anticonceptivos. Asimismo, secundariamente, se busca analizar si el género y la edad de los adolescentes son variables influyentes en el nivel de conocimientos, actitudes y comportamientos sexuales que poseen y experimentan, de manera que se ha querido indagar sobre la existencia de diferencias entre hombres y mujeres y entre los participantes en función estén en la adolescencia temprana, media o tardía.

Una copia completa de este trabajo publicado se incluye en el Anexo 2.

3. ESTUDIO 3

OBJETIVO 3: Explorar la prevalencia de victimización sexual a lo largo de la vida de los adolescentes en acogimiento residencial en la Comunidad Valenciana, describiendo las principales características de los diferentes tipos de victimización sexual y las posibles diferencias en función del género y la edad de la víctima, así como contrastando la información autoinformada con la reportada por los profesionales.

TÍTULO DEL ARTÍCULO: Sexual Victimization of Adolescents in Residential Care: Self-Reported and Other-Reported Prevalence

PUBLICADO EN LA REVISTA: The Journal of Sex Research (FI: 3,6; Q1)

RESUMEN DEL ARTÍCULO

Principalmente, el propósito de esta publicación es determinar la incidencia de las experiencias de victimización sexual a lo largo de la vida entre los adolescentes en acogimiento residencial. Se pretende prestar atención a los diferentes tipos de victimización sexual (adulto conocido, adulto desconocido, igual y experiencias de exhibicionismo), reportando las tasas de prevalencia de cada una de ellas, así como sus principales características (rasgos del abusador/agresor, de la víctima y del suceso). También se ha querido determinar el grado de acuerdo entre la información proporcionada por otros informantes, concretamente por los profesionales del hogar o residencia en el que se encuentran los menores, y la reportada por los propios participantes respecto a sus experiencias de victimización. Secundariamente, se ha creído conveniente identificar los grupos de adolescentes en acogimiento residencial especialmente vulnerables a sufrir victimización sexual, teniendo en cuenta el género y la edad de la víctima; así como el perfil del abusador/agresor sexual más común. Asimismo, la victimización sexual en una etapa temprana es una de las experiencias con mayor impacto y más duradero en el desarrollo vital del menor, por lo que se ha querido examinar también en qué medida el tipo de relación víctima-agresor y la edad de la víctima en el primer episodio de victimización sexual son variables vinculadas a la revictimización sexual en estos adolescentes, y en qué medida experimentar múltiples episodios de abuso/agresión sexual y/o diversos tipos de violencia sexual es frecuente

en este colectivo. También se ha indagado en las consecuencias más comunes que se derivan de estas vivencias.

Una copia completa de la publicación de este trabajo se incluye en el Anexo 3, junto al permiso de la editora para incluir dicha copia en el mismo.

4. ESTUDIO 4

OBJETIVO 4: Examinar el papel mediador de las múltiples facetas de la regulación emocional en la relación entre victimización sexual y bienestar psicológico de los adolescentes que se encuentran en acogimiento residencial en la Comunidad Valenciana, explorando, asimismo, el papel modulador de las variables género y la condición de ser NNAMNA en el modelo de mediación.

TÍTULO DEL ARTÍCULO: Does Emotion Regulation in Adolescents in Residential Care Mitigate the Association Between Sexual Victimization and Poor Psychological Well-being?

EN PROCESO DE PUBLICACIÓN EN LA REVISTA: Children and Youth Services Review (FI: 3,3; Q1)

RESUMEN DEL ARTÍCULO

Siendo conscientes de los datos de prevalencia de victimización sexual en este colectivo y de su impacto en el desarrollo vital, el principal cometido de este artículo es explorar en qué medida las múltiples facetas de la regulación emocional median la relación entre victimización sexual y bienestar psicológico en adolescentes que se encuentran en acogimiento residencial. Tanto la falta de conciencia emocional, de aceptación de las respuestas emocionales y de claridad emocional, como el pobre acceso a estrategias de regulación emocional, y las dificultades en el control de los impulsos y en persistir en los comportamientos dirigidos a objetivos cuando se siente malestar, se han probado como posibles variables mediadoras. En este sentido, también se ha analizado la relación de cada una de estas covariables con la victimización sexual y con el bienestar psicológico, por separado. Asimismo, en segundo lugar, se ha querido explorar en qué medida el género y ser NNAMNA, variables con marcada influencia en este colectivo y cuya repercusión en los resultados de victimización sexual y en el bienestar psicológico ha sido probada, actuaban modulando las covariables del modelo de mediación planteado.

Una copia de la última versión de este trabajo enviado a la revista referida, en la que está bajo revisión, se incluye en el Anexo 4.

IV. DISCUSIÓN Y CONCLUSIONES

Capítulo 7

Discusión

La presente tesis doctoral, a través de los 4 artículos que le dan forma, se ha centrado en explorar la salud sexual de los adolescentes en acogimiento residencial de la Comunidad Valenciana, poniendo el foco en las vivencias que mayor impacto tienen en su bienestar psicológico y en los mecanismos que podrían estar mediando este impacto; tras construir, previamente, una herramienta que permita conocer mejor al colectivo en cuestión mediante la recogida de información sobre sus principales características sociodemográficas.

El estudio del desarrollo psicosexual del individuo y de las variables que lo influencian pasa por poseer un conocimiento profundo de su historia vital, antes y durante su inclusión en el sistema de protección (Morales et al., 2018). Con este cometido surge el primer objetivo de esta tesis doctoral, *desarrollar un instrumento para la recogida de datos sociodemográficos de los niños y adolescentes del sistema de protección, describiendo su proceso de construcción y sus propiedades*, que ha sido abordado en el artículo 1.

Mediante el método Delphi se ha construido el CAWSys (Child and Adolescent Welfare System Form), un formulario que consta de 66 ítems (59 de respuesta cerrada y 7 de respuesta abierta) que se agrupan en 6 dimensiones que estructuran el instrumento, y cuyo propósito principal es recoger información sociodemográfica del menor de forma estructurada y concisa. (1) Nueve de sus ítems configuran la dimensión "Información General" en la que se recogen datos básicos del menor en relación con su género, fecha de nacimiento, nacionalidad, orientación sexual, discapacidad, problemas de salud física o mental y consumo de sustancias psicoactivas. La inclusión de esta dimensión se considera esencial para obtener información del niño o adolescente que permita explicar patrones de respuesta en el resto de las dimensiones. (2) La dimensión "Situación Escolar/Laboral" consta de nueve ítems también y extrae información sobre los estudios que el menor está cursando en el momento de la evaluación y/o su situación laboral, así como sobre los antecedentes académicos y su actitud e integración escolar. Dado que el entorno escolar/laboral es un escenario en el que los niños y adolescentes pasan gran parte de su tiempo y establecen la mayoría de sus vínculos interpersonales, analizar esta área del individuo puede aportar información fundamental. (3) La información sobre sus antecedentes en el sistema de protección (medidas de protección

pasadas, edad de ingreso, motivo y estatus legal) y su situación actual en el mismo se recogen a través de nueve ítems de la dimensión "Historial del Sistema de Protección". Su inclusión está fuertemente justificada por la historia de vida del colectivo al que va dirigido el formulario. (4) Con la dimensión "Historial de Vistas Familiares", que incluye nueve ítems, se pretende indagar en el régimen de visitas que el menor establece con sus familiares (lugar, frecuencia, duración, control, personas que asisten, cumplimiento y valoración del menor). Esta información sobre los encuentros del menor con sus familiares puede ser de utilidad para valorar la evolución de la situación del evaluado en el sistema de protección. (5) La dimensión "Información de la Familia Biológica", a través de veintitrés ítems, indaga sobre las características sociodemográficas de los padres biológicos del niño o adolescente que puedan influir en su desarrollo (p. ej. salud física y mental, abuso de sustancias, antecedentes en el sistema de protección y antecedentes judiciales, etc.), y su relación familiar, así como otros aspectos relacionados con su nivel socioeconómico y su entorno comunitario. (6) Y, por último, siete ítems configuran la dimensión "Experiencias de Abuso Sexual" e indagan sobre las vivencias de abuso sexual del menor (sospechas, confirmación, frecuencia, características del agresor y consecuencias), partiendo de la información que aparece en su expediente del sistema de protección y que el recurso de acogimiento posee. El conocimiento temprano de estos hechos es determinante para la valoración de su salud sexual, así como para elaborar protocolos de intervención eficaces, de ahí el acuerdo de los expertos sobre incluir esta dimensión en la herramienta. Por lo que respecta al procedimiento a seguir para su cumplimentación, este formulario está destinado a ser rellenado por los profesionales del sistema de protección que conocen bien al menor y tienen acceso a su expediente.

Su riguroso proceso de construcción, en el que han participado expertos de diferentes áreas y que ha contado con una aplicación previa en un entorno real (estudio piloto), ha constado de varias fases guiadas con el método Delphi, lo que le ha aportado la suficiente solidez al proceso como para presentarlo como un instrumento útil y eficaz. El análisis del comportamiento de los ítems informa de que casi el 80% han sido respondidos correctamente por todos los participantes, quienes valoran positivamente el formato de respuesta (recogida de información rápida y concisa con los ítems de

respuesta cerrada, y de información más detallada y subjetiva con los ítems de formato abierto). Los ítems relacionados con la situación académica del menor, el tiempo que este lleva en el sistema de protección y su contexto social y familiar, son los que muestran un peor desempeño. Debido a que son datos de más difícil acceso para los profesionales, en muchas ocasiones estos no poseen directamente la información y deben hacer cierta labor previa de investigación. Esto es algo que habrá que tener en cuenta a la hora de cumplimentar el CAWSys. Por otro lado, se ha encontrado que el formulario aborda correctamente todos los aspectos de los que se precisa recoger información relativos a los niños y adolescentes del sistema de protección, gracias al consenso al que ha llegado el panel de expertos (validez de contenido). Los participantes del estudio piloto corroboran su utilidad para el cometido para el que ha sido elaborado.

En este sentido, considerando los hallazgos reportados en el artículo 1 podemos confirmar la *primera hipótesis*, dado que se el CAWSys se presenta como una herramienta útil y eficaz para la recogida de información sociodemográfica de los niños y adolescentes del sistema de protección.

Una vez contábamos con un instrumento adecuado y eficiente para la recogida de información de la población objeto de estudio, nos planteamos el segundo objetivo de esta tesis doctoral, *describir la salud sexual de los adolescentes en acogimiento residencial en la Comunidad Valenciana a través de la exploración de sus conocimientos, actitudes y comportamientos sexuales, y analizar posibles diferencias en función del género y/o la edad del evaluado*. Este objetivo ha sido abordado en el artículo 2.

Respecto a los conocimientos, los adolescentes en acogimiento residencial obtienen puntuaciones escasamente por encima de la puntuación mediana del rango de puntuaciones, tanto por lo que respecta a los conocimientos generales sobre sexualidad, como los conocimientos específicos sobre métodos anticonceptivos y sobre ITS (puntuando ligeramente más alto en este último aspecto). Así, podríamos interpretar que estos adolescentes “aprueban” ajustadamente. Sin embargo, cuando comparamos estos resultados con los reportados por un estudio con adolescentes de población general que fueron evaluados con el mismo instrumento (Claramunt Busó, 2011), podemos concluir que los adolescentes en acogimiento residencial tienen pobres conocimientos sobre sexualidad en general, incluyendo ITS y métodos anticonceptivos.

A esta conclusión también llegaron otros estudios con población similar (Boustani et al., 2017; Oman et al., 2018), que se hicieron eco de los escasos conocimientos que los jóvenes inmersos en el sistema de protección presentan, en comparación con los resultados obtenidos por las investigaciones con jóvenes de población general. Esto podría venir explicado no solo porque este grupo recibe menos educación sexual, dada su habitual ubicación inestable y su peor acceso a los servicios de salud sexual y reproductiva (Finigan-Carr et al., 2018; Ramseyer Winter, 2017), sino también porque, dada su actividad sexual más temprana, la información sobre sexualidad, cuando llega, normalmente lo hace demasiado tarde (Boustani et al., 2015). Asimismo, coincidiendo con lo concluido por Claramunt Busó (2011) en su estudio con población comunitaria, los jóvenes de nuestro estudio presentaron más conocimientos sobre ITS que sobre métodos anticonceptivos y aspectos generales de la sexualidad (p.ej. anatomía y fisiología, respuesta sexual, prácticas sexuales, etc.). Esto podría deberse a que las ITS también forman parte del currículo escolar obligatorio y, por tanto, su aprendizaje se refuerza en el aula, aunque la información proporcionada no llega a ser suficientemente significativa para ellos como para usarla en su beneficio (Bączek et al., 2020).

En el caso de las actitudes sexuales, los adolescentes en acogimiento residencial evaluados también reportan, en general, creencias poco favorables hacia la sexualidad, sobre todo en comparación con las informadas por los jóvenes de la población general (Claramunt Busó, 2011). Sin embargo, destacan los resultados que presuponen una alta interiorización de actitudes sexistas entre estos adolescentes, de manera muy superior a la informada por los jóvenes de población general. Hay que señalar que la expresión de manifestaciones sexistas benévolas es la más prevalente entre estos jóvenes, al igual que sucede entre el resto de los jóvenes externos a este contexto (Fernández-García et al., 2022). La fuerte influencia que ejercen los valores y experiencias familiares sobre el desarrollo de las actitudes, podrían estar explicando estos resultados. Los adolescentes inmersos en el sistema de protección han vivido en hogares potencialmente problemáticos en los que los estereotipos sexistas suelen estar muy presentes (Grusec & Hastings, 2014; Maas et al., 2010). Sin embargo, los avances sociales en materia de igualdad que penalizan ciertas manifestaciones más evidentes del sexismo han

contribuido a que se adopten expresiones encubiertas también entre estos jóvenes (Cross & Overall, 2018).

Asimismo, respecto a los comportamientos sexuales, la gran mayoría de los adolescentes en acogimiento residencial que participaron en nuestro estudio (90%) ya se ha iniciado en la actividad sexual en el momento de la evaluación, casi el 50% ha tenido su primera practica sexual a los 12 años o antes y la masturbación se ha presentado como la práctica sexual más frecuente. Estos resultados, van en la línea de lo reportado por otras investigaciones con adolescentes con características semejantes (Wilson et al., 2014), pero son mucho peores que los encontrados en estudios con jóvenes de población general (James et al., 2009). Algunos expertos han hallado cierta relación entre el hecho de haber experimentado eventos traumáticos (p.ej. abuso sexual infantil, violencia de género, etc.) y/o presentar problemas de salud mental y de abuso de sustancias, y la iniciación más temprana en actividades sexuales (Lambert et al., 2013; Oshri et al., 2012). Así, dado que estos problemas son más prevalentes entre los adolescentes en acogimiento residencial, como sucede en nuestra muestra (más del 30% presenta problemas de salud mental y/o abuso de sustancias, por ejemplo), esto podría explicar su tendencia a iniciar prácticas sexuales a una edad más temprana. Asimismo, a pesar de la alta actividad sexual encontrada en este colectivo, reportan un bajo uso de métodos anticonceptivos. Menos de la mitad de la muestra confiesa usar regularmente el preservativo y un porcentaje aún menor dice usar cualquier otro método anticonceptivo (píldora anticonceptiva oral, parche e inyección de hormonas o barrera de látex). Resultados similares fueron reportados por Cheung et al. (2015) y Lambert et al. (2013) en sus estudios con jóvenes del sistema de protección. Por el contrario, la prevalencia de uso de métodos anticonceptivos es mayor en jóvenes de la población general (Ott et al., 2014). Mención especial merece el hecho de que la "marcha atrás" se posiciona como el segundo método más usado generalmente entre los adolescentes de nuestra muestra, a pesar de su más que demostrada falta de eficacia frente a la protección de ITS y de embarazos no deseados. La insatisfacción con los métodos hormonales o el deseo de manifestar confianza a la pareja, parecen sustentar esta elevada prevalencia (Whittaker et al., 2010). Por el contrario, la barrera de látex es muy poco usada, en comparación con el preservativo, algo también común entre los

jóvenes de población general y que parece deberse a su elevado coste, difícil accesibilidad y ausencia de conocimientos sobre la misma por parte de las posibles usuarias (Ott et al., 2014).

Este análisis de los conocimientos, actitudes y comportamientos sexuales de la muestra nos permite confirmar la *segunda hipótesis*. Como planteamos, los menores que están en acogimiento residencial tienden a presentar bajos conocimientos sobre sexualidad y actitudes sexuales menos favorables, mostrando una disposición menos liberal hacia la sexualidad y una mayor tendencia a manifestar actitudes sexistas. Además, la edad de iniciación sexual es mucho más temprana y hacen un uso poco regular del preservativo. La masturbación es la práctica sexual más común entre ellos, tal y como hipotetizamos.

Como parte de este segundo objetivo, también nos propusimos explorar la existencia de ciertas características muestrales que puedan llevarnos a considerar a un subgrupo de estos adolescentes particularmente vulnerable a desarrollar una peor salud sexual, es decir, un nivel más bajo de conocimientos sobre sexualidad, actitudes sexuales menos favorables y comportamientos sexuales más arriesgados. Por un lado, se ha probado la existencia de posibles diferencias de género respecto a los conocimientos, actitudes y comportamientos sexuales. En este sentido, tal y como informaron otros estudios con este grupo poblacional (p. ej. Combs et al., 2019), las chicas de nuestra muestra reportan más conocimientos sobre sexualidad que los chicos, siendo estas diferencias estadísticamente significativas y posiblemente debidas a su mayor acceso a servicios de salud sexual y reproductiva, en tanto que es un lugar de obtención de información sobre sexualidad (Finigan-Carr et al., 2018). Sin embargo, esta inequidad de género parece algo propio de los adolescentes del sistema de protección, ya que Claramunt Busó (2011) en un estudio realizado con adolescentes de la población general no encontró diferencias estadísticamente significativas en función del género. Resultados similares han sido obtenidos respecto a las actitudes sexuales, ya que parecen ser las adolescentes las que presentan una disposición más liberal hacia la sexualidad, actitudes menos homófobas/heterófobas y menos sexistas. Esto apunta a que, posiblemente, los varones se ven influenciados más fuertemente por los contextos familiares patriarcales, que suelen ser más frecuentes entre los menores de edad

inmersos en el sistema de protección, lo que les lleva a mantener y aceptar los estereotipos de género tradicionales y la discriminación sexual (Baber & Tucker, 2006). Contrariamente a estos resultados, el género no se muestra una variable influyente ni en la edad de inicio sexual ni en la prevalencia de las diferentes prácticas sexuales evaluadas, con la excepción de la masturbación. A pesar de los esfuerzos realizados por alentar a la población femenina a que se responsabilice de su propio placer, fomentando la autoexploración y la autoestimulación sexual femenina, los resultados indican que, en esta población las chicas continúan masturbándose considerablemente menos que los chicos. Las diferencias anatómicas de los genitales, las hormonales y, por supuesto, la potente influencia social y cultural, podrían estar en la base de estos resultados (Robbins et al., 2011). No obstante, la ausencia de diferencias de género en la prevalencia del resto de las prácticas sexuales evaluadas y en la edad de iniciación sexual podría ser un reflejo de los lentos pero eficaces avances en la desmitificación de la información sobre la sexualidad femenina (CDC, 2020). En el caso del uso de los métodos anticonceptivos, al igual que en otros estudios llevados a cabo con adolescentes del sistema de protección (Lambert et al., 2013; Oman et al., 2018; Risley-Curtiss, 1997), los chicos de nuestra muestra parecen realizar un uso más regular del preservativo y de la marcha atrás, mientras que las chicas presentan un mayor uso de píldoras anticonceptivas orales y anticonceptivos de acción prolongada. Estas diferencias fueron significativas y pueden entenderse como un reflejo de la falta de asertividad sexual que a menudo exhiben las chicas, sobre todo respecto al uso del preservativo (Ballester-Arnal & Gil-Llario, 2021; Constantine et al., 2009). Además, estos resultados subrayan la mayor vulnerabilidad del sexo femenino a contraer ITS al hacer un menor uso del preservativo como método anticonceptivo (Ross et al., 2021).

En definitiva, todos los resultados expuestos nos llevan concluir que la *tercera hipótesis* no se confirma en su totalidad, ya que las chicas sí presentan actitudes más favorables hacia la sexualidad que los chicos, pero también existen diferencias respecto al nivel de conocimientos a favor de las chicas, en contra de lo hipotetizado. Además, no se han encontrado diferencias de género en la edad de inicio sexual, a diferencia de lo que planteamos, únicamente se han encontrado discrepancias respecto a las tasas de

masturbación (no en el resto de las prácticas sexuales evaluadas), y también respecto a la prevalencia de uso de los diferentes métodos anticonceptivos.

Una vez analizadas las posibles diferencias en relación con el género, consideramos la idoneidad de comprobar si la variable edad podría contribuir a esclarecer los resultados obtenidos en cuanto a los conocimientos, actitudes y comportamientos sexuales del colectivo. En el caso de los conocimientos, y concretamente por lo que respecta a los conocimientos sobre métodos anticonceptivos, estos parecen crecer a medida que aumenta la edad de los adolescentes que se encuentran en acogimiento residencial. Estos resultados coinciden con lo concluido en estudios efectuados con adolescentes de la población general (Clark et al., 2002), y podrían venir explicados por un aumento del interés por las prácticas sexuales seguras con la edad, o simplemente por el hecho de que las visitas a los servicios de salud sexual y reproductiva son más asiduas a medida que se hacen mayores, sobre todo, en las adolescentes. Por el contrario, la edad no se muestra una variable influyente en las actitudes de los adolescentes en acogimiento residencial de nuestra muestra, a excepción de las actitudes sexistas hostiles. Esta disminución de las actitudes sexistas hostiles a medida que baja la edad de los evaluados podría estar explicada por la mayor influencia que los más jóvenes han recibido de los modelos sociales y culturales más liberales, fieles a una ideología menos patriarcal (Roets et al., 2012). Esto coincide con lo concluido por otros estudios con población del sistema de protección (Carbonell et al., 2021), pero no con estudios con muestra comunitaria (Fernández-García et al., 2022). Por último, hemos podido comprobar en nuestra muestra que con la edad aumenta la práctica de diferentes actividades sexuales, aunque los adolescentes más mayores informan de un inicio sexual más tardío. Asimismo, el uso del preservativo y de los métodos anticonceptivos de acción prolongada se relaciona de forma positiva y significativa con la edad. Estos hallazgos, al igual que el aumento de los conocimientos sobre métodos anticonceptivos, podrían explicarse por los logros cognitivos alcanzados con la madurez que llevan al joven a implicarse en menos comportamientos de riesgo (Baker et al., 2011; Ballester-Arnal et al., 2017), y por el mayor acceso a recursos de salud sexual y reproductiva que se logra con la edad. Estos resultados van en la línea de lo encontrado por Pergamit & Johnson (2009) en su estudio con jóvenes en hogares de emancipación.

En resumen, podríamos concluir que la *cuarta hipótesis* se cumple parcialmente ya que la edad sí que se muestra una variable influyente en el nivel de conocimientos, la implicación en prácticas sexuales y en el uso de algunos métodos anticonceptivos, y lo hizo en menor medida en las actitudes sexuales, influyendo únicamente de forma significativa en las actitudes sexistas hostiles.

Una vez analizados los aspectos básicos de la salud sexual de los adolescentes en acogimiento residencial, y estudiados los subgrupos muestrales que presentan una mayor vulnerabilidad, nos centramos en uno de los sucesos que mayor impacto parece tener en su desarrollo psicosexual, la victimización sexual. Así, el tercer objetivo de esta tesis doctoral, abordado en el artículo 3, es *explorar la prevalencia de victimización sexual a lo largo de la vida de los adolescentes en acogimiento residencial en la Comunidad Valenciana, describiendo las principales características de los diferentes tipos de victimización sexual y las posibles diferencias en función del género y la edad del evaluado, así como contrastando la información autoinformada con la reportada por los profesionales.*

Los adolescentes de nuestro estudio informan de una alta prevalencia de victimización sexual (35,3%), similar a la reportada por estudios con participantes de características muestrales semejantes (Indias et al., 2019; Segura et al., 2015; Wekerle et al., 2017), y mucho mayor a la encontrada en investigaciones cuya población objeto de estudio son los adolescentes de una muestra comunitaria (Méndez-López & Pereda, 2019; Pereda, Guilera et al., 2014; Sani et al., 2021). En este sentido, bien es cierto que los adolescentes inmersos en el sistema de protección son, de forma más frecuente, testigos de situaciones de abuso y/o maltrato en su entorno cercano y no han crecido con sus necesidades físicas y emocionales básicas satisfechas (Indias et al., 2019). Esto no sólo les predispone a que se involucren en relaciones afectivas toxicas, por sus problemas para establecer vínculos seguros, sino que también incrementa las posibilidades de que exhiban una baja asertividad sexual y carezcan de las habilidades necesarias para rechazar relaciones sexuales no deseadas (Hanson, 2016; Thompson et al., 2017). Sin embargo, hay expertos que encuentran en los problemas estructurales de los centros de acogimiento residencial la causa real de esa alta prevalencia (Euser et al., 2014). Argumentan que se trata de entornos en los que vive un gran número de niños y

adolescentes con frecuentes problemas de conducta, lo que aumenta el riesgo de sufrir abuso/agresión sexual por parte de un igual, el tipo de victimización sexual más frecuente también en nuestra muestra. Sin embargo, en nuestro estudio encontramos que el abuso/agresión sexual cometido por un adulto conocido es aquel en el que la víctima es revictimizada en más ocasiones, en el que más frecuentemente se le introducen objetos en su cuerpo, el que ocurre cuando esta es más joven y el que es más denunciado a las autoridades policiales y/o judiciales. Esto tiene sentido si tenemos en cuenta que, en la mayoría de los casos, este tipo de abuso/agresión sexual es cometido por un familiar cercano que va a tener contacto con la víctima de forma más recurrente y que es más probable que pueda justificar encuentros a solas con ella (Aydin et al., 2015), lo que haría aumentar las probabilidades de revictimización. Además, dado que la familia es el primer agente socializador, es lógico que sea el abuso/agresión sexual que se da a una edad más temprana de la víctima (Amador Moncada et al., 2018).

El análisis global de la prevalencia de victimización sexual en los adolescentes en acogimiento residencial confirma la *quinta hipótesis*, ya que un porcentaje elevado de nuestra muestra ha sufrido victimización sexual. Sin embargo, la *sexta hipótesis* debe ser rechazada, ya que el tipo de victimización sexual que presenta una tasa más alta de prevalencia es el perpetrado por los iguales, y no el realizado por un adulto conocido como hipotetizamos primeramente.

Teniendo en cuenta la sensibilidad del tema abordado, como parte de este objetivo se considera relevante contrastar la información reportada por los propios adolescentes con los datos comunicados por otros informantes, concretamente por los profesionales del hogar o residencia. En este sentido, podemos concluir que los adolescentes de nuestra muestra informan de una tasa de prevalencia de victimización sexual de más del doble respecto a la reportada por los profesionales. Es decir, el grado de concordancia encontrado entre la información proporcionada por las dos fuentes es entre moderado y bajo, ya que 74 de los casos de victimización sexual denunciados por los adolescentes no son conocidos por los profesionales y 17 de los casos denunciados por los profesionales no son declarados por los adolescentes. Según Euser et al. (2014) este alto número de casos de los que los profesionales no son conocedores podría atribuirse a la ausencia de un vínculo adecuado y de confianza entre el cuidador del hogar o residencia

y el menor, que lleva a este último a no estar dispuesto a revelarle estas vivencias al profesional, más aún si el abuso/agresión sexual ha tenido lugar en el hogar o en la residencia. Asimismo, en cuanto a los casos comunicados por el profesional pero no por el adolescente, un desarrollo cognitivo y/o emocional inmaduro podría ser la causa, ya que si el suceso tuvo lugar a una edad muy temprana y fue denunciado por el profesional que lo detectó (profesional de salud, escolar, etc.) habrá quedado constancia en su expediente pero el menor no tiene consciencia de los hechos o ha preferido olvidarlos dada su dureza (London et al., 2005). Asimismo, también puede ser que el adolescente haya preferido responder negativamente a las preguntas del evaluador sobre las experiencias de victimización sexual, debido al malestar que implica reafirmar que sufrió abuso/agresión sexual y al sentimiento de vergüenza y culpa que implica relevar la vivencia de este tipo de sucesos (Classen et al., 2005; Feiring & Taska, 2005; Herrera, 2006; Negriff et al., 2017).

En este sentido, los resultados obtenidos de la comparativa de la información reportada por diferentes informantes respecto a la tasa de victimización sexual confirman parcialmente la *séptima hipótesis* originalmente planteada, al no llegar el valor del grado de concordancia a 0,5, considerándose, por tanto, medio-bajo.

En relación con el perfil de la víctima, el género se muestra una variable influyente, ya que las adolescentes experimentan un número marcadamente mayor de experiencias de victimización sexual. Algunos estudios coinciden en que estas significativas diferencias en las tasas de prevalencia de victimización sexual de chicos y chicas se deben a los estereotipos de género masculino que limitan las revelaciones de abuso/agresión sexual en los chicos (Esnard & Dumas, 2013; Wekerle et al., 2017). Según estos autores, no es que haya una diferencia tan marcada entre la tasa de casos de victimización sexual en chicos y la tasa de casos de victimización sexual en chicas, sino que los chicos albergan un porcentaje mayor de falsos negativos. Contrariamente, no se han encontrado efectos de la edad en la tasa de victimización sexual en nuestra muestra de adolescentes en acogimiento residencial, lo que evidencia que los adolescentes más jóvenes han estado expuestos al mismo grado de victimización que aquellos que son más mayores y que supuestamente podrían haberse enfrentado a más experiencias negativas (Indias et al., 2019). Esto puede ser interpretado como una muestra de la

temprana edad a la que los adolescentes de este colectivo se enfrentan a eventos traumáticos.

Así, los resultados relativos a las variables del perfil de las víctimas que influyen en la prevalencia de la victimización sexual permiten validar la *octava hipótesis* inicialmente planteada, ya que mientras las chicas son comúnmente más victimizadas, la edad no parece interferir.

En cuanto a las características del abusador/agresor, los análisis reportan que generalmente es un varón joven conocido por la víctima. Esto coincide con lo hallado en otros estudios con población similar (Allroggen et al., 2017; Euser et al., 2014), y podría venir explicado porque las personas conocidas y emparentadas pueden tener contacto con los menores de forma más fácil y sin que estos (u otros adultos) sospechen o desconfíen de ellas (Aydin et al., 2015). Concretamente, si indagamos sobre el tipo de vínculo víctima-agresor, encontramos que, mientras los adolescentes comunican que la victimización sexual ha sido perpetrada en mayor medida por un compañero de la escuela o del hogar, los profesionales señalan que mayoritariamente son familiares cercanos. Es decir, en ambos casos confirman que se trata de una persona de confianza para la víctima.

Estos resultados nos llevan a confirmar la *novena hipótesis*. Independientemente del informante, en la mayoría de las ocasiones la victimización sexual es perpetrada por un hombre joven conocido por la víctima, aunque no hay un elevado acuerdo entre informantes respecto al vínculo víctima-agresor más frecuente.

Teniendo en cuenta las características del colectivo estudiado y dada su mayor implicación en experiencias sexuales negativas, se ha considerado interesante explorar la tendencia que estos adolescentes presentan a sufrir múltiples episodios y varios tipos de victimización sexual (por un adulto conocido o desconocido, por un igual o por exposición sexual). En nuestro estudio, congruentemente con lo expuesto en la literatura sobre este colectivo (ver Indias et al., 2019), esta tendencia también se confirma. Pero, además, se ha encontrado que existe una relación positiva y significativa entre ambas variables, de manera que aquellas víctimas que se enfrentan a un mayor número de episodios de victimización sexual también se ven involucradas en más tipos

de victimización sexual. Por todo esto, se ha analizado la edad de la víctima en el momento del primer episodio de abuso/agresión sexual y la cercanía del vínculo víctima-agresor con el propósito de explorar posibles factores de riesgo del propio hecho victimizante que puedan estar en la base de esa tendencia a presentar una mayor revictimización. En este sentido, ambas variables muestran asociaciones positivas tanto con el número de episodios de abuso/agresión sexual como con el número de tipos de victimización sexual sufridos. Por tanto, esto nos lleva a concluir que cuanto más tempranamente se produce la experiencia negativa y más estrecha es la relación con el abusador/agresor, mayor es la probabilidad de que el adolescente sufra revictimización sexual (más episodios de abuso/agresión sexual y/o diversos tipos de violencia sexual). La temprana edad a la que la víctima se expone al primer episodio de abuso/agresión sexual puede aumentar su vulnerabilidad al agravar el impacto psicológico de este, incrementando así las posibilidades de volver a ser victimizados (Casey & Nurius, 2005). Algo similar ocurre cuando la victimización es causada por un miembro cercano al menor, ya que conlleva un desajuste temprano del apego que deriva, no sólo en problemas de interacción, sino también en problemas de regulación emocional y autoestima, lo que coloca a la víctima en una situación de mayor vulnerabilidad (Gawryszewski et al., 2012).

A la luz de estas conclusiones, tanto la *décima* como la *undécima hipótesis* quedan totalmente confirmadas. No sólo es común la revictimización sexual entre los adolescentes de acogimiento residencial, sino que además la temprana edad a la que la víctima experimenta el primer episodio de abuso/agresión sexual y la cercanía del vínculo víctima-agresor, parecen estar a la base de dicha tendencia.

Otro aspecto fundamental para tener en cuenta a la hora de desarrollar intervenciones adaptadas a las necesidades de las víctimas es conocer las consecuencias que se derivan de las experiencias de victimización sexual en este colectivo. En nuestro estudio, en consonancia con los hallazgos de la mayoría de las investigaciones realizadas hasta la fecha con adolescentes del sistema de protección (Finkelhor et al., 2009; Kendall-Tackett, 2009), los problemas de control emocional son los más comunes (presentes en casi la mitad de las víctimas), seguidos de los problemas de interacción sexual y social.

Estas conclusiones respecto a las consecuencias que se derivan de las experiencias de victimización sexual en los adolescentes en acogimiento residencial permiten confirmar la *duodécima hipótesis,* al ser los trastornos emocionales las consecuencias más comunes también en nuestra muestra.

A la vista de los hallazgos fruto del análisis del tercer objetivo de esta tesis doctoral, se evidenció, más si cabe, la urgencia de atender las altas tasas de victimización sexual en los adolescentes en acogimiento residencial y el potente vínculo de estas con los problemas de salud mental e interpersonal que presentan las víctimas. Como consecuencia de esto y dada la importancia de conocer más sobre esta relación a la hora de elaborar intervenciones eficaces, se ha planteado el cuarto objetivo de esta tesis doctoral, *examinar el papel mediador de las múltiples facetas de la regulación emocional en la relación entre victimización sexual y bienestar psicológico de los adolescentes que se encuentran en acogimiento residencial en la Comunidad Valenciana, explorando el papel modulador de las covariables género y ser NNAMNA en el modelo de mediación*. Este fue el objetivo abordado en el artículo 4 de esta tesis doctoral.

En base a lo concluido por Gawryszewski et al. (2012), quienes expusieron que el menor victimizado presenta problemas de regulación emocional debido al desajuste temprano del apego que se deriva de las experiencias de victimización sexual perpetradas por una persona cercana, en nuestro estudio hemos encontrado que una mayor victimización sexual se asocia con un bienestar psicológico más pobre en adolescentes en acogimiento residencial a través de los mecanismos de falta de claridad emocional percibida, ausencia de aceptación de respuestas emocionales y acceso limitado a estrategias de regulación emocional. Estos hallazgos son coherentes con lo declarado en otros estudios (McLaughlin et al., 2020; Weissman et al., 2019), y presuponen que las experiencias de victimización sexual impulsan a estos adolescentes a presentar problemas de comprensión de las emociones, evitación o desconexión emocional y adopción de estrategias de regulación emocional desadaptativas, lo que, al mismo tiempo, aumenta el estrés y la ansiedad del individuo, y esto se traduce en un menor bienestar psicológico (Gruhn & Compas, 2020).

Estos hallazgos confirman parcialmente la *decimotercera hipótesis*, ya que, aunque varias de las facetas de la regulación emocional (la falta de claridad emocional y de

aceptación de respuestas emocionales y el acceso limitado a estrategias de regulación emocional) se presentaron como variables mediadoras en la relación entre victimización sexual y bienestar emocional, no todas lo hacen. La falta de conciencia emociona y las dificultades para el control de los impulsos y para persistir en los comportamientos dirigidos a objetivos cuando se siente malestar, no han demostrado tener efecto mediador en dicha relación.

Examinando la relación entre estas variables por separado y con mayor detalle, la asociación entre una mayor victimización sexual y una baja claridad emocional percibida se ve respaldada por investigaciones previas que exponen que la falta de atención a los estados emocionales que caracteriza a los supervivientes de estas experiencias negativas contribuye a los problemas que estos presentan para identificar y etiquetar emociones (Walsh et al., 2011). Una mayor victimización sexual también se asocia con dificultades para persistir en un objetivo cuando se siente malestar. En este sentido, algunas investigaciones coinciden en que las víctimas de abuso/agresión sexual son más propensas a permanecer alerta y emplear estrategias como la rumiación, lo que les obstaculiza para persistir en su objetivo (McLaughlin et al., 2020). Esto podría explicar los problemas académicos y laborales que, en ocasiones, presentan estos adolescentes (Miragoli et al., 2020). Los resultados de nuestra investigación también sugieren que los participantes más victimizados presentan una baja aceptación de las respuestas emocionales, lo que es coherente con lo reportado por un conjunto de investigaciones que sugieren que la incapacidad de estos individuos para afrontar ciertos aspectos de su experiencia traumática les conduce a la inhibición emocional (Walsh et al., 2011). Asimismo, una mayor victimización sexual también parece contribuir a tener más problemas para acceder a estrategias de regulación emocional adecuadas. Esto es congruente con lo reportado por algunos estudios que encontraron que una mayor victimización contribuye a aumentar los sentimientos de indefensión generalizada de la víctima, lo que se traduce en intentos menos eficaces de reducir dichas emociones. Además, esto coincide con la mayor tendencia de los adolescentes del sistema de protección a presentar estrategias desadaptativas, al haberlas aprendido de modelos inadecuados (Jenness et al., 2021).

Dado que no todas las facetas de la regulación emocional han demostrado una asociación significativa con la victimización sexual, la *decimocuarta hipótesis* se confirma parcialmente. La falta de conciencia emocional y las dificultades para el control de los impulsos no se relacionan de forma significativa con estas experiencias negativas. Sin embargo, la falta de aceptación de las repuestas emocionales y de claridad emocional, el acceso limitado a estrategias de regulación emocional y las dificultades para persistir en un objetivo cuando se siente malestar sí lo hacen, de forma positiva y significativa.

Por otro lado, los desajustes en el bienestar psicológico pueden considerarse el resultado de los intentos de la víctima por regular sus emociones. Concretamente, en nuestro estudio, la falta de conciencia y de claridad emocional repercute negativamente en el bienestar psicológico, ya que los déficits en el reconocimiento y la descripción de las emociones interfieren en el procesamiento cognitivo de todas las experiencias, lo que conllevará problemas de autoaceptación y autoexploración en el individuo. Asimismo, nuestros hallazgos muestran que una mayor falta de aceptación emocional también contribuye a un menor bienestar psicológico en estos adolescentes. Esto podría venir explicado por el bajo interés de las víctimas por experimentar emociones y sus repetidos esfuerzos por reprimirlas que contribuyen a la acumulación de emociones no resueltas y conducen a un cierto agotamiento de los recursos cognitivos, lo cual limita el crecimiento emocional. En este sentido, también cabe tener en cuenta que la evitación emocional conlleva evitación experiencial, con comportamientos como la disociación, la autolesión, etc., que tienen un impacto negativo en el bienestar psicológico (Miragoli et al., 2020). Por último, también se ha encontrado una asociación entre el aumento de los problemas para acceder a estrategias adecuadas de regulación emocional y un peor bienestar psicológico. Esto sugiere que el uso de estrategias desadaptativas, como la automedicación o el consumo de drogas conduce a cierta desconexión social y pérdida de la red de apoyo, lo que repercute negativamente en el desarrollo psicológico del individuo (Gruhn & Compas, 2020; Snow et al., 2022).

Estos hallazgos relativos a la relación entre las diferentes facetas de la regulación emocional y el bienestar psicológico validan parcialmente la *hipótesis decimoquinta*. La falta de conciencia emocional, de aceptación de las respuestas emocionales y de claridad emocional y el pobre acceso a estrategias de regulación emocional manifiestan

una relación negativa y significativa con el bienestar emocional. Sin embargo, las dificultades en el control de los impulsos y para persistir en los comportamientos dirigidos a objetivos cuando se siente malestar no mostraron una relación significativa con el bienestar psicológico.

En estudios previos, el género y ser NNAMNA han demostrado su influencia sobre las experiencias de victimización sexual y el bienestar psicológico (El-Awad et al., 2017; Kaur et al., 2022; Nickerson et al., 2011; Zalar et al., 2018), algo que también recoge el enfoque de la perspectiva del curso de la vida (George, 2020). Sin embargo, cuando se ha probado su efecto moderador en el modelo de mediación planteado (rol mediador de las múltiples facetas de la regulación emocional en la relación entre victimización sexual y bienestar psicológico), mientras el género no resulta ser una variable moderadora significativa sobre ninguna de las facetas de la regulación emocional, el hecho de ser NNAMNA sí que modera el impacto que la victimización sexual tiene sobre el acceso limitado a estrategias de regulación emocional. Concretamente, no ser NNAMNA actúa como una variable moduladora que impulsa la asociación entre la victimización sexual y tener estrategias de regulación emocional más bajas, a diferencia de las víctimas que son NNAMNA. Esto podría explicarse porque los NNAMNA tienen experiencias muy diferentes a las de otros adolescentes del sistema de protección, en parte debido al difícil viaje que han hecho sin familia a una edad muy temprana y a los esfuerzos que deben hacer para integrarse en una cultura diferente sin el apoyo de su red social. Por complicado que sea el presente, se sienten afortunados de poder seguir en busca de un futuro mejor tal y como desean sus familiares, lo que parece llevarlos a ser más resilientes y a desarrollar y utilizar más frecuentemente determinadas estrategias de afrontamiento como agentes activos (Ní Raghallaigh & Gilligan, 2010).

Teniendo en cuenta los resultados de los análisis del efecto modulador del género y de la condición de ser NNAMNA sobre el modelo de mediación planteado, la *decimosexta hipótesis* no se valida. Mientras el género no demuestra ser una variable moduladora en dicho modelo, el hecho de ser NNAMNA sí que lo es, pero únicamente en la mediación de la variable "acceso limitado a estrategias de regulación emocional", y en la dirección opuesta a lo hipotetizado, ya que no ser NNAMNA impulsa la asociación

entre la victimización sexual y tener menor acceso a estrategias de regulación emocional.

EN RESUMEN…

La hipótesis relativa al primer objetivo se confirma en su totalidad. Gracias al riguroso proceso seguido en la construcción del CAWSys, este se ha presentado como una herramienta útil y eficaz para la recogida de datos sociodemográficos de los niños y adolescentes del sistema de protección, lo que nos permitirá conocer más sobre su historia de vida y sobre los posibles aspectos relacionados con su salud sexual.

En general, las hipótesis relacionadas con el perfil de salud sexual de los adolescentes en acogimiento residencial se confirman parcialmente. Los conocimientos, actitudes y comportamientos sexuales de este grupo permiten inferir una mayor vulnerabilidad a experimentar bajos niveles de salud sexual. Además, las variables sociodemográficas analizadas -género y edad- demuestran su influencia específica en el nivel de conocimientos, la tendencia de las actitudes sexuales y la implicación en comportamientos sexuales de riesgo, aunque no siempre en la dirección que propone la escasa literatura existente. Esto podría deberse a los avances en materia de igualdad de género y en la desmitificación de la información sobre la sexualidad femenina.

Las hipótesis relativas al análisis de la prevalencia de la victimización sexual en los adolescentes en acogimiento residencial y de las diferentes características del suceso, de la víctima y del abusador/agresor, se confirman prácticamente en su totalidad. La tasa de victimización sexual de nuestra muestra es similar a la establecida en estudios con muestras semejantes, encontrando diferencias reportables en función del informante. Asimismo, las características tanto de la víctima como del abusador/agresor coinciden con lo que comúnmente se reporta en la literatura, aunque el tipo de victimización sexual más común es el ejercido por un igual. Esto podría deberse a las características tan específicas de esta muestra (más tiempo en el sistema de protección) y al tipo de medida de protección que tienen asignada. La revictimización también fue común entre estos adolescentes, mostrándose la edad del abuso/agresión sexual y la cercanía del vínculo víctima-agresor como variables explicativas de la misma. En el caso

de las consecuencias de la victimización sexual, las más prevalentes en este colectivo coinciden con las que comúnmente reporta la literatura.

Por último, las hipótesis relativas al cuarto objetivo no se confirman completamente. No todas las covariables analizadas ejercen un rol mediador en la relación entre victimización sexual y bienestar emocional. Asimismo, ni la victimización sexual ni el bienestar emocional están relacionadas con todas las facetas de regulación emocional, tal y como se había hipotetizado. Además, de las variables inicialmente consideradas como moderadoras en este modelo de mediación, únicamente la condición de ser NNANMA ejerce este rol en la mediación de la variable acceso limitado a estrategias de regulación emocional.

Capítulo 8

Conclusiones, limitaciones y perspectivas futuras

1. CONCLUSIONES

La adolescencia constituye un periodo de transición física, emocional y social en el que las cuestiones relativas a la salud y los derechos sexuales y reproductivos tienen un impacto tan importante que determinan el bienestar futuro. Aunque los adolescentes de todo el mundo enfrentan desafíos en cuanto a sus comportamientos y decisiones sexuales, en muchas ocasiones estos no son comparables con los retos y las dificultades que enfrentan los niños y adolescentes expuestos a situaciones de especial riesgo desde sus primeros años de vida. Este es el caso de los menores de edad en el sistema de protección. Por ello, en esta tesis doctoral hemos pretendido ahondar en la descripción de las principales características de la salud sexual de los niños y adolescentes que se encuentran en acogimiento residencial en la Comunidad Valenciana, contribuyendo, así, a una de las líneas de actuación enmarcadas en el Plan de Acción de Juventud 2022-2024.

En primer lugar, mediante la elaboración del CAWSys, hemos contribuido a la mejora del proceso de recopilación de información esencial sobre las características sociodemográficas de los menores en el sistema de protección. Este se presenta como un instrumento útil y eficaz para obtener información sobre la historia de vida del niño o adolescente antes y después de su entrada en el sistema de protección, teniendo en cuenta su casuística. El conocimiento detallado del colectivo es esencial, no únicamente a la hora de sacar conclusiones precisas y generalizables sobre el desarrollo afectivo-sexual del mismo, y encontrar posibles factores explicativos asociados a las respuestas del individuo, sino también para elaborar estrategias de intervención eficientes y ajustadas al grupo muestral. Además, este formulario pretende promover también la mejora de la comunicación entre los diferentes profesionales que los atienden para ayudar a la elaboración de los planes de intervención individualizados, así como contribuir a la preparación de estadísticas más precisas sobre las características de este colectivo, evitando la disparidad de los datos reportados según la fuente consultada y permitiendo la comparabilidad de las cifras entre áreas geográficas.

Siendo conocedores de las experiencias vitales que han marcado la infancia y la adolescencia de estos menores y de su realidad actual, la salud sexual se convierte en un componente muy significativo de su desarrollo, que no debe dejarse sin explorar si

realmente queremos detectar sus principales necesidades y limitaciones y permitir que tengan las mismas posibilidades que cualquiera de sus pares de alcanzar el bienestar integral. A la luz de los resultados de la presente investigación, el bajo nivel de conocimiento sobre métodos de protección, el inicio temprano de prácticas sexuales y el uso escaso de métodos anticonceptivos, junto con actitudes preocupantemente sexistas, colocan a este colectivo en una situación de gran vulnerabilidad. Esto aumenta el riesgo de embarazos no deseados, infecciones de transmisión sexual, participación en otros comportamientos sexuales de riesgo (p. ej. conductas de sexting), e incluso violencia en el noviazgo y abuso o agresión sexual, especialmente entre las chicas y entre los más jóvenes. Aunque las chicas presentan más conocimientos sobre sexualidad, su temprano inicio sexual junto a su infrecuente uso del preservativo en las prácticas sexuales y la posibilidad de sufrir las consecuencias de las elevadas tasas de actitudes sexistas que presentan sus pares varones, las convierte en un subgrupo prioritario para la atención y el acceso a los recursos de salud afectivo sexual. Algo similar sucede con los más jóvenes, quienes, aunque presentan actitudes más liberales y menos sexistas que los más mayores, muestran un nivel más bajo de conocimientos sexuales y se implican en más actividades sexuales de forma temprana sin hacer un uso regular del preservativo.

Sin restar importancia a estos resultados, los antecedentes especialmente críticos de victimización sexual que presentan los adolescentes en acogimiento residencial, aunque no siempre estén registrados en sus expedientes, son una de las conclusiones de esta investigación que comprende consecuencias y tiene implicaciones más remarcables. Además, en este grupo, en el que son tan comunes las experiencias de abuso/agresión sexual desde edades tempranas por parte de las figuras cercanas, nuestros hallazgos confirman que estas vivencias constituyen un factor de riesgo para la revictimización sexual posterior. Sin embargo, esto no debe significar que otros tipos de victimización sexual, como la perpetrada por el grupo de iguales, deban pasar desapercibidas, sobre todo teniendo en cuenta el entorno en el que crecen estos jóvenes. Asimismo, de nuevo, el análisis del perfil de la víctima pone el foco en las adolescentes, independientemente de su edad, como potencialmente vulnerables a sufrir victimización, mientras que respecto al perfil más común del abusador/agresor

sexual se señala a los varones jóvenes conocidos por la víctima. Estas conclusiones son especialmente útiles a la hora de planificar e implementar acciones de prevención primaria y evitar futuras experiencias de victimización o revictimización sexual, así como para detectar tempranamente estos sucesos y paliar las graves consecuencias que se derivan de su vivencia, sobre todo respecto a su salud mental.

Teniendo en cuenta estos hallazgos que sitúan al bienestar psicológico como el principal aspecto del funcionamiento del individuo que se ve afectado por estas frecuentes experiencias negativas, explorar las variables involucradas en esta relación (victimización sexual vs. bienestar psicológico) tiene implicaciones importantes a nivel individual y colectivo. Concretamente, la identificación de la falta de claridad emocional y de aceptación de respuestas emocionales, así como del acceso limitado a estrategias de regulación emocional, como las facetas de la regulación emocional que median la relación entre la victimización sexual y el bienestar psicológico va a permitir elaborar intervenciones mucho más eficaces para aliviar las consecuencias que experimentan las víctimas. Pero no sólo esto, la detección de las variables predictoras clave de un peor bienestar psicológico va a permitir identificar más fácilmente a aquellos adolescentes en acogimiento residencial que pueden estar en riesgo de presentar un desarrollo desadaptativo. Es decir, aquellos jóvenes con baja conciencia emocional, pobre aceptación de las respuestas emocionales y de claridad emocional y escasas estrategias de regulación emocional deberán recibir atención prioritaria para evitar desajustes emocionales mayores. Al igual, las conclusiones respecto a los problemas de regulación emocional más frecuentes en las víctimas de abuso/agresión sexual van a contribuir a identificar menores victimizados y facilitar su revelación, así como el proceso de denuncia, evitando la revictimización fruto de tener que contar el suceso en múltiples ocasiones. Así, los profesionales y expertos deberán prestar especial atención a los problemas de aceptación de las repuestas emocionales, de claridad emocional, de acceso limitado a estrategias de regulación emocional y a las dificultades para persistir en un objetivo que presenten los adolescentes de los que ya sospechan que pueden haber sido victimizados sexualmente. Estos comportamientos pueden ser potentes indicadores de victimización y su detección temprana puede agilizar la actuación. En definitiva, estos hallazgos contribuyen a evitar que los menores victimizados alcancen

niveles tan elevados de malestar emocional, lo que derivará en un mejor ambiente en el hogar o residencia y ayudará a reducir el gasto en salud mental fruto de estas desafortunadas vivencias. Asimismo, a la luz de las conclusiones de esta investigación, aunque las medidas a considerar no tendrán que atender diferencialmente al individuo en función de su género, sí se tendrá que considerar que los NNAMNA pueden contar con más estrategias útiles de regulación emocional, lo que podría ayudar a trabajar con el resto esa adquisición de habilidades y herramientas de gestión, priorizando que con los NNAMNA se ponga el foco en empoderar otras facetas de la regulación emocional.

En general, este estudio nos ha permitido constatar que los adolescentes en acogimiento residencial son un grupo especialmente vulnerable que, debido a los hechos que marcaron su infancia y adolescencia, tienen necesidades muy diferentes a las de los demás adolescentes de la población general. Así, dotarles de los conocimientos necesarios para desmitificar la información falsa, las habilidades que les ayuden a disfrutar de los intercambios sexuales consentidos y las actitudes que les permitan orientar su desarrollo psicosexual de manera positiva, son aspectos esenciales si queremos que disfruten de una vivencia saludable de la sexualidad. En este sentido, investigaciones como la que aquí se presenta son claves a la hora de diseñar iniciativas de educación afectivo-sexual que se centren en las características distintivas de este colectivo y trabajen para revertir las consecuencias negativas derivadas de las frecuentes experiencias de victimización sexual. Los resultados de esta investigación también deberían interpretarse como un llamamiento a las agencias gubernamentales para que desarrollen políticas públicas y planes de acción útiles y efectivos, que tan escasos y necesarios son en este momento. Es decir, animar al estado a que invierta en la mejora de las condiciones de vida de estos menores, fin último de nuestra investigación, teniendo en cuenta las conclusiones aquí ofrecidas y considerando que esto revertirá positivamente en la dinámica del sistema de protección y del sistema de salud mental. Todo ello, sin pasar desapercibida la contribución de esta investigación a la desmitificación de ciertas creencias sociales sobre este colectivo y a la visibilización de una población especialmente olvidada a nivel social.

CONCLUSIONS

Adolescence is a period of physical, emotional and social transition in which issues regarding both, sexual and reproductive health, and rights, have such an important impact that they determine individual's future well-being. Although adolescents around the world face challenges in terms of their sexual behaviors and decisions, these are often not comparable to the challenges and difficulties faced by children, and adolescents are, therefore, exposed to particularly risky situations from their earliest years of their life-cycle. This is the case of minors in the child welfare system. Therefore, in this doctoral thesis we have tried to deepen in the description of the main characteristics of the sexual health of children and adolescents in residential care in the Eastern of Spain, thus contributing to one of the lines of action framed in the *Plan de Acción de Juventud 2022-2024*.

First, through the development of the CAWSys, we have contributed to the improvement of the process of collecting essential information on the socio-demographic characteristics of minors in the child welfare system. It is presented as a useful and effective tool to obtain information on the child or adolescent's vital antecedents before and after entering the child welfare system, taking into account their casuistry. Detailed knowledge of this group is essential, not only in order to draw accurate and generalizable conclusions about the affective-sexual development of the group, and to find possible explanatory factors associated with individual responses, but also, in order to develop effective intervention strategies adapted to the sample. In addition, this form is also intended to promote better communication between the different professionals who care for them to help in the development of individualized intervention plans, as well as, contributing to the preparation of more accurate statistics on the defining features of this group, avoiding disparity in the data reported depending on the source consulted and allowing comparability of figures between geographical areas.

Being aware of the life experiences that have marked the childhood and adolescence of these minors and their current reality, sexual health becomes a very significant component of their development, which should not be left unexplored if we really want to detect their main needs and limitations and allow them to have the same possibilities

as any of their peers to achieve an integral wellbeing. In light of the results of the present investigation, the low level of knowledge about protection methods, the early initiation of sexual practices and the scarce use of contraceptive methods, together with worryingly sexist attitudes, place this group in a situation of a great vulnerability. This increases the risk of unwanted pregnancies, sexually transmitted infections, engagement in other risky sexual behaviors (e.g., sexting behaviors), and even dating violence and sexual abuse or assault, which is especially observed towards girls, and also, among the very young ones. Girls have more knowledge about sexuality, but show early sexual debut, low condom use in sexual practices, and the possibility of suffering the consequences of high rates of sexist attitudes displayed by their male peers. It makes them a priority subgroup for attention and access to affective-sexual health resources. Something similar occurs with younger people, who, although they present more liberal, and, less sexist attitudes than older people, they show a lower level of sexual knowledge and they do engage on more sexual activities at an early age, without using condoms regularly.

Without detracting from these findings, the particularly critical background of sexual victimization among adolescents in residential care, although not always recorded in their records, is one of the findings of this research that has most notable consequences and implications. Furthermore, in this group, in which experiences of sexual abuse/assault from an early age by close figures are so common, our findings confirm that these experiences constitute a risk factor for later sexual revictimization. However, this should not mean that other types of sexual victimization, such as that perpetrated by the peer group, should go unnoticed, especially given the environment in which these youngsters grow up. Likewise, once again, the analysis of the victim profile focuses on adolescent girls, regardless of their age, as potentially vulnerable to victimization, while the most common profile of the sexual abuser/offender is young males known to the victim. These conclusions are especially useful when planning and implementing primary prevention actions to avoid future experiences of sexual victimization or revictimization, as well as, to detect these events early on in time and tackling the serious consequences emerging, especially on what their mental health concerns.

Given these findings that place individual's psychological well-being as the main aspect that is affected by these frequent negative experiences, exploring the variables involved in this relationship (i.e. sexual victimization vs. psychological well-being) has important implications at individual and collective levels. Specifically, the identification of lack of emotional clarity and acceptance of emotional responses, as well as, the limited access to emotional regulation strategies that the adolescents seem to have. Furthermore, the facets of emotional regulation that mediate the relationship between sexual victimization and psychological well-being will enable the development of much more effective interventions to alleviate the consequences experienced by victims. But not only that, the detection of key predictors of poorer psychological well-being will facilitate the identification of those adolescents in residential care who may be at risk of maladaptive development. That is, in order to avoid a major emotional imbalance, the attention and care provided to those children with low emotional awareness, poor acceptance of emotional responses and emotional clarity, and poor emotional regulation strategies, should be prioritized. Likewise, the findings on the most frequent emotional regulation problems in the victims of sexual abuse/assault will contribute to identify the victimized minors and facilitate their disclosure, as well as, the reporting process, avoiding re-victimization as a consequence of having to retell the event on multiple occasions. Thus, practitioners and experts should pay particular attention to problems with acceptance of emotional responses, emotional clarity, limited access to emotional regulation strategies, and difficulties in persisting with a goal exhibited by adolescents whom they already suspect may have been sexually victimized. These behaviors can be powerful indicators of victimization, and early detection can prompt direct action. Ultimately, these findings contribute to preventing victimized children from reaching such high levels of emotional distress, which will result in a better living environment and it will also help reducing mental health costs, which results from these unfortunate experiences. Likewise, in light of the conclusions of this research, although the measures to be considered will not have to differentially address the individual according to gender, it will have to be considered that NNAMNAs may have more useful strategies for emotional regulation, which could help to work with the rest of the adolescents, in the acquisition of management skills, and coping mechanism, placing them in a situation of greater risk.

In general, this study has allowed us to confirm that adolescents in residential care are a particularly vulnerable group who, due to the events that had an impact on their childhood and adolescence, have very different needs from those of other adolescents in the general population. Thus, actions such as providing them with the necessary knowledge to demystify false information, teaching skills that will help them enjoy consensual sexual relationships and the attitudes that will allow them to guide their psychosexual development in a positive way, are essential aspects, if we want them to enjoy a healthy experience of their sexuality. In this sense, research such as the one presented here, is key when designing affective-sexual education initiatives that focus on the distinctive characteristics of this group, and, work to reverse the negative consequences derived from the frequent experiences of sexual victimization. The results of this research should also be interpreted as a call to government agencies in order to develop useful and effective public policies and action plans, which are scarce and necessary nowadays. In other words, the ultimate goal of our research would be to encourage the government to invest in improving the living conditions of these minors, taking into account the conclusions offered here and considering that this will have a positive impact on the dynamics of both, the child welfare system, and the mental health system. All of this should be taken into account without overlooking the contribution of this research to demystify certain social beliefs about this group of adolescents which will raise awareness towards a sector of the Spanish population that is especially forgotten at a social level.

2. LIMITACIONES Y PERSPECTIVAS FUTURAS

Los hallazgos de la presente investigación ayudan a conocer mejor a los niños y adolescentes del sistema de protección, ahondando en su desarrollo afectivo sexual, y hacen una contribución sustancial a la mejora del bienestar de estos menores concretamente, y de la comunidad en general. Sin embargo, esta investigación no está exenta de limitaciones.

A las dificultades que conlleva realizar estudios con personas menores de edad, se le suman, en este caso, los múltiples requisitos que hay que cumplir para entrevistar a esta población debido a sus condiciones de extrema protección. En primer lugar, la guarda o tutela de estos niños y adolescentes pertenece a la administración pública, quien tiene que dar en primer lugar su permiso. En los casos cuya tutela pertenece a la administración pública, puede que los agentes gubernamentales estén muy implicados en la mejora de las condiciones de vida de estos menores y la visión que la sociedad tiene de ellos, y demanden o faciliten la realización de este tipo de estudios. Sin embargo, en los casos que la tutela la tiene el padre/madre/tutor del menor, estos también deberán autorizar la participación del niño o adolescente en el estudio, y es frecuente que muestren ciertas reservas. Además, indistintamente de quién tenga su tutela, los coordinadores de cada fundación/organización encargada de gestionar los diferentes recursos de acogimiento residencial y la junta directiva del propio hogar/residencia, también deben mostrarse favorables a facilitar el acceso de los investigadores a su recurso. Por último, se requiere, como es obvio, el permiso del propio participante, quien en ocasiones es difícil de motivar para lograr su implicación. En definitiva, se requieren numerosos permisos y autorizaciones para iniciar una investigación con este colectivo, y más cuando se trata de un tema que, desgraciadamente, sigue siendo muy delicado para una buena parte de la sociedad, lo que nos ha llevado no sólo a que el proceso se demore demasiado en el tiempo, sino a que perdamos algo de muestra. En nuestra investigación, de los 60 hogares/residencias con las que se contactó, finalmente participaron 47, pero no en su totalidad, ya que hubo un elevado número de menores de esos centros que no pudieron participar porque su tutor legal no lo autorizó y otros que, no accedieron a hacerlo. A pesar de todos estos inconvenientes, a los que debemos unir los derivados del confinamiento

debido al covid-19 que nos obligó a extender en el tiempo la recogida de la muestra, hemos sido capaces de alcanzar el tamaño muestral necesario para obtener resultados válidos y fiables.

Por otro lado, se precisaba no sólo la información ofrecida por los participantes, sino también la colaboración de los profesionales que se ocupan de ellos en los hogares y residencias, con el fin de obtener la información relativa a cada menor que se recoge en el CAWSys. Ha sido destacable su implicación a pesar de la sobrecarga laboral que a menudo presentan estos profesionales colaborando en el estudio incluso a pesar de la incomodidad que en ocasiones les podía suscitas el tema de esta investigación. Las numerosas aclaraciones, de diversa índole (formal, pero sobre todo actitudinal), han supuesto un trabajo adicional que, en la mayoría de los casos ha dado sus frutos, aunque, desgraciadamente, no en todos. La consecuencia de esto ha sido la ausencia de más datos de los deseados en algunas de las preguntas de dicho formulario (hasta un 26,3%), lo que debe tenerse en cuenta en la interpretación de los resultados. También queremos destacar que, sólo un profesional reportaba información de cada adolescente, por lo que no nos fue posible verificar la veracidad de los datos aportados.

Con relación al tamaño muestral, aunque la representatividad de la muestra y la validez interna se mostraron satisfactorias, la distribución por género y edad no pudo ser completamente equitativa. Los chicos de entre 14 y 16 años estuvieron mayoritariamente representados, pero es importante destacar que la distribución hallada es la típica en cuanto a género y edad de los adolescentes que están en acogimiento residencial.

Por otro lado, una de las mayores fortalezas de esta investigación es que la información se obtiene directamente de la población objeto de estudio, ya que son los propios niños y adolescentes del sistema de protección los que han sido entrevistados y han aportado de primera mano información sobre sus conocimientos, actitudes, habilidades y comportamientos. Sin embargo, esta también puede ser considerada una limitación. Los instrumentos de autoinforme requieren de cierta capacidad de introspección que, en muchos casos, aún no está suficientemente consolidada en los adolescentes. Esto se complica más cuando se pregunta por eventos pasados de importante impacto para la persona entrevistada (del Valle & Zamora, 2021). A pesar de

ello, según Finkelhor et al. (2005) a partir de los 11 años se considera que los niños tienen metacognición suficiente para responder a un autoinforme, lo que confirma la fiabilidad de los datos obtenidos. Otro inconveniente relacionado con el uso de autoinformes es el sesgo de deseabilidad social que podría estar afectando a las respuestas de los participantes. Aunque esta es una limitación común en los estudios de ciencias sociales, bien es cierto que en este colectivo puede darse con mayor frecuencia dada su tendencia a querer agradar a los demás, máxime cuando se trata de figuras de autoridad, buscando su atención y aprobación. Además, la sensibilidad de los temas abordados (actitudes sexistas, victimización sexual, etc.) favorece respuestas más acordes con lo deseable socialmente. En favor del estudio cabe decir que se insistió especialmente y se les garantizó por completo, el carácter anónimo de la información aportada a todos los adolescentes que decidieron participar de forma voluntaria en esta investigación.

La toma de decisiones de tipo metodológico también puede haber tenido alguna influencia en los resultados obtenidos. En este sentido, con el propósito de responder al último objetivo de esta tesis doctoral, se han empleado análisis inferenciales con datos observacionales. Sin embargo, aunque debe informarse de ello, en dicho planteamiento se han propuesto múltiples hipótesis que podrían cumplirse y los hallazgos han sido comunicados como asociaciones, lo que asegura la fiabilidad de los hallazgos y de las conclusiones reportadas.

En este trabajo, se abordaron los conocimientos, las actitudes y los comportamientos sexuales de este grupo poblacional. Sin embargo, las habilidades sexuales son un aspecto también importante para tener en cuenta a la hora de valorar el desarrollo afectivo sexual del individuo, y no han sido exploradas aquí. En este sentido, concretamente la asertividad sexual, entendida como la capacidad de comunicarse adecuadamente con la pareja sexual sobre la relación sexual, se relaciona directamente con el logro de una vida sexual saludable. Sin embargo, en este colectivo la literatura publicada sobre este aspecto es limitada y contradictoria. Por ello, esta sería una futura línea de investigación cuyo abordaje considero principal.

En cuando a las características de la población, actualmente los NNAMNA constituyen más de una cuarta parte de esta población. Estos menores han crecido en

países culturalmente muy diferentes, educándose en valores y creencias familiares y sociales generalmente menos liberales y con tendencias más heteropatriarcales a las de los países más desarrollados. Además, a esto se le suma la dureza del viaje que han realizado solos a una temprana edad, así como la difícil adaptación a la que deben enfrentarse a su llegada. Todo ello podría condicionar su desarrollo psicosexual, por lo que esta condición de algunos menores del sistema de protección debería ser atendida más extensamente en otros estudios futuros.

Por último, afortunadamente, no todos los niños y adolescentes del sistema de protección se encuentran institucionalizados. Los menores que viven con familias de acogida pueden haber recibido la influencia de valores y creencias más similares a las del resto de menores de la población general y haber desarrollado un vínculo de apego más seguro, lo que puede estar influyendo en su desarrollo sexual. Sin embargo, tampoco podemos inferir que estos menores presenten una salud sexual similar a la del resto de sus pares. Su infancia ha estado marcada por la separación de su principal figura de referencia y la falta de ese vínculo seguro desde el nacimiento, así como por otras experiencias negativas que, en mayor o menor medida, han contribuido a su desarrollo. Por ello, dado que no podemos considerar que los resultados de esta investigación son generalizables plenamente a todos los niños y adolescentes del sistema de protección ni que los menores en acogimiento familiar tienen una sexualidad como la del resto de sus pares de población general, se considera oportuno continuar el proyecto de investigación expuesto con la exploración del desarrollo sexual de los niños y adolescentes en acogimiento familiar.

V. REFERENCIAS BIBLIOGRÁFICAS

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VI. ANEXOS

Anexo 1

Estudio 1

Construction of a Form for Users of the Child Welfare System Based on the Delphi Method

children

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Article

Construction of a Form for Users of the Child Welfare System Based on the Delphi Method

Olga Fernández-García, María Dolores Gil-Llario and Rafael Ballester-Arnal

MDPI

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children

MDPI

Article

Construction of a Form for Users of the Child Welfare System Based on the Delphi Method

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Abstract: Professionals in charge of designing individualized plans for children and adolescents in the child welfare system often lack the necessary information, either because it has not been systematically collected or because there are doubts about the reliability of the data obtained. The lack of consensual and validated instruments that gather the necessary information has led to the development of a rigorous and effective form, based on the Delphi methodology, aimed at obtaining an exhaustive knowledge of the characteristics of children and adolescents under the child welfare system. Once a consensus of different specialists approved the hetero-informed form, it was completed by 41 professionals working in residential care facilities for 307 children and adolescents. It consists of 66 items grouped into six dimensions: general information, school/work situation, child welfare system history, family visitation history, biological family information, and experiences of sexual abuse. During its construction and validation, a panel of experts analyzed its format and content during the different phases. Most of the items showed good performance, and professionals highlighted their ease of use and relevance. The method used ensured the content validity of this form. This instrument has proven to be a useful and effective tool for collecting sociodemographic information on children and adolescents in the child welfare system, which may improve their conditions.

Keywords: form; child welfare system; children and adolescents; sociodemographic; sexual abuse; delphi method; instrument; construction

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1. Introduction

The inclusion of a minor in the child welfare system is the measure adopted to address a situation of neglect of children or adolescents, intending to provide them with a protective and safe environment that guarantees the complete fulfillment of their rights and the opportunity for complete development [1]. However, according to the latest Statistical Data Bulletin on Child Welfare System, despite existing problems of data homogeneity [2], the number of children and adolescents growing up under the child welfare system in Spain already surpasses 50,000 for the first time [3]. Generally, these minors have experienced several violations of their human rights (right to survival, education, or freedom from any form of violence) and repeated situations of fear and stress that have forced them to develop dissociative mechanisms to survive. This makes it common for them to have established destructive affective models and faces a permanent conflict of belonging during their immersion in the child welfare system [4,5]. For this reason, protection measures must be designed with minors and their needs at the focus, and each minor should be provided with individualized plans that include the specialized resources necessary to meet their differential characteristics [6].

Therefore, it is essential that children and adolescents in foster or residential care be recognized as a group of special vulnerability, with special needs, and that their curricular

adaptation and training itineraries are assessed [2]. However, on many occasions, the professional team responsible for developing the individualized intervention plan for the child or adolescent when they first arrive at a residential care facility, as a temporary measure, lacks sufficient information about their situation. Generally, coordination between the different actors and agents involved in the child welfare system is not adequate [2], which means that the professional receives a simple e-mail with general data on the child's current situation and their evolution in the last facility in which they were attended, or, in the best of cases, they are given an extensive report full of annotations that the social services prepared to assess their situation at a particular time and from which it is difficult to extract concise and useful information. Having to change foster care or residential homes frequently [5,7], as well as a large number of external resources (school resources and external therapists, extracurricular activities, etc.) with which the professional must coordinate [2], makes it difficult to properly transmit information on essential aspects of the child or adolescent.

Additionally, as a result of the in-depth literature review that has been carried out, it is concluded that there is a lack of published instruments designed to collect sociodemographic data that have proven to be valid and effective in the child and adolescent population, and even less so in minors with such specific experiences as those involved in the child welfare system. These forms are often developed ad hoc for a particular research and sample (see [8]). They do not focus on exploring specific aspects of this group (e.g., their history in the child welfare system) that may be of great importance when preparing interventions or explaining other aspects of their psychophysical development.

Given the above, the need for a brief and concise instrument to collect these fundamental aspects while being simple to complete and explore after completion is evident. Furthermore, this would allow data collection on this group to be standardized, achieving more precise statistical reports and making the basic information on minors easily accessible to the different professionals in the child welfare system who work with them. For this purpose, the present study describes the development process and the characteristics of a sociodemographic data form for children and adolescents in the child welfare system, the Child and Adolescent Welfare System Form (CAWSys).

2. Materials and Methods

2.1. Participants

The participants in this study were 41 professionals working in residential care facilities located in the Eastern of Spain, and who completed the CAWSys of 307 children and adolescents. Specifically, they provided services to children and adolescents who were housed in residential care facilities for general care (70.73%), preparation for emancipation (14.63%), severe behavioral problems (7.32%), or were migrants without known relatives (7.32%). Almost 74% were women, while only 26% were men. Most of them were psychologists (56.1%), while in 21.95% of cases, the form was completed by the director, 12.19% by a social educator, and 9.76% by a social worker. The approach followed was that the professional from the residential care facility who knew the child and their situation best and who had access to the welfare case record to check the necessary information should participate.

In this sense, they reported information on 307 children and adolescents living in residential care facilities. Among 66.1% were male adolescents, while 33.9% were female adolescents, and the mean age was 15.63 (SD = 1.67). Almost half of the sample (48.5%) were between 14 and 16 years old, followed by 39.2% between 17 and 19 years old, and only 12.2% were between 11 and 13 years old. Although the majority of the participants (57.9%) were born in Spain, there were 29.7% who were born in Morrocco, and the remaining nationalities were underrepresented (Eastern European: 4.7%; West African: 3.3%; South/Central American: 2.7%; Pakistani: 1.2%; and Portuguese: 0.6%). Likewise, 27.7% were migrant adolescents without relatives.

2.2. Procedure

The Delphi method [9] was used to construct the CAWSys (Figure 1). This method is a well-established approach to answering a research question through the identification of a consensus view across subject experts [9,10]. It is ideal for issues where scientific evidence is absent and it is essential to have information for judgment, as was our case. In this study, gathering the opinions and beliefs of experts from different areas (child welfare system, childhood and adolescence, methodology and research, etc.) was not only useful but also necessary to develop an effective instrument [11]. Also considering the discrepancies and different points of view of experts, while seeking consensus, has allowed us to create a tool that considers the wide variety of existing realities. Moreover, at the methodological level, compared to other techniques, the anonymity of panelists in the survey rounds, the controlled feedback, and the iterative discussions that characterize the Delphi method bring a certain validity to the process of constructing the instrument [12].

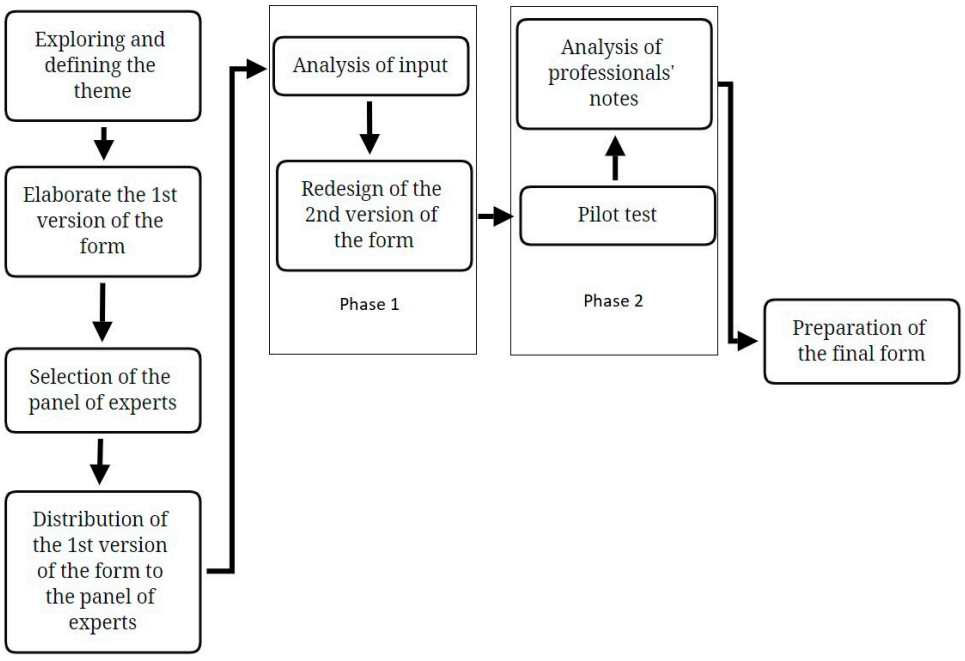

Figure 1. Procedure for the application of the Delphi method.

Exploring and defining the theme. First, an exhaustive literature review of sociodemographic data collection studies and instruments published so far was conducted, and several reports produced by the child welfare system were analyzed, examining their content (areas assessed), format (response format and the number of items), among others. This review was carried out by members of the research team in charge of developing CAWSys, who are experts in the characteristics of the child welfare system, instrument development, and sexual health. As a result of this analysis, six dimensions were considered for inclusion: general information, school/work situation, child welfare system history, family visitation history, biological family information, and experiences of sexual abuse. The first dimension (general information) was included with the aim of obtaining essential information about the child or adolescent, the content of which would allow explaining response patterns in the rest of the dimensions. Secondly, the school/work environment is a setting in which children and adolescents spend a large portion of their time and establish most of their interpersonal bonds, so analyzing their behavior and attitude in this environment can provide essential information. This encouraged the inclusion of items in the school/work situation. Likewise, the inclusion of items on their child welfare system history was strongly justified, as it was one of the main reasons for constructing the form. On the other hand, the experts considered that the importance of the child's

encounters with their relatives (family visitation history) should not be overlooked in their evolution in the child welfare system, as well as the need to explore possible background information of the father and mother that could explain behaviors and attitudes of the child or adolescent (biological family information). Finally, the need to collect information on past victimization experiences of the child or adolescent (experiences of sexual abuse) was considered, given that early knowledge of these events by professionals will determine the individualized intervention protocol.

Elaboration of the first version of the form, selection of the panel of experts and distribution of the first version of the form to the panel of experts. Based on this research and the defined dimensions, a preliminary set of items was formulated and shared with an advisory board (or panel) of experts in child and adolescent, in child welfare system (specifically, in the analysis and report writing of children and adolescents in the child welfare system), and in data analysis methodology. The objective was to evaluate the degree of relevance of each item in the construct, thereby increasing the instrument's content validity by revising the proposed items and suggesting new ones.

Phase 1: *Analysis of input and redesign of the second version of the form*. As a result of this analysis, six items were reformulated to improve their wording and comprehension, and six new items were included to collect information on aspects that had not been considered. The resulting document was reviewed again by the group of experts, who ratified its structure.

Phase 2: Pilot test and analysis of professionals' notes. After this final stage, the instrument consisted of 67 items with different response formats (dichotomous, multiple-choice, open-ended, among others), and a psychologist reviewed this provisional version of the CAWSys from a residential care facility who completed the form for five individuals aged between 15 and 18 years, to determine whether the items were correctly understood and if they provided new information. This step allowed further revisions of the items, improving the wording, integrating more inclusive language in one of them, and modifying the response options in five others.

Preparation of the final form. Once these improvements had been made, the instrument was definitively established.

In a subsequent phase, the directors of the residential care facilities were contacted to present them with the project and request their collaboration. Next, a member of the group of experts from the research team went to the residential care facilities to train the professional(s) who were going to conduct a CAWSys for each of the children and adolescents in the residential care facility, once the prescriptive consent had been given. Likewise, the pertinent permissions were obtained beforehand from the Directorate General of Childhood and Adolescence within the collaboration agreement signed between the Department of Equality and Inclusive Policies and the SALUSEX research group and the permission granted by the Ethics Committee of the University of Valencia (Spain).

2.3. Data Analysis

Descriptive statistics were used for the descriptive analysis of the sample group and the items. All statistical analyses were performed with the IBM SPSS Statistics 23 program.

3. Results

3.1. CAWSys Description

The instrument consists of 66 items, 59 closed-ended responses (dichotomous and multiple-choice), and 7 open-ended responses, grouped into 6 dimensions that give meaning to the instrument's structure:

- General information: This dimension includes nine items that collect basic information about the minor concerning sex assigned at birth, sexual orientation, date of birth, nationality, disability, physical or mental health problems, and psychoactive substance use. Regarding the response format, two items are open-ended (A.3. and A.4.), five are

dichotomous (A.1., A.5., A.6., A.7. and A.8.), and two have multiple response options (A.2. and A.9.);

- School/work situation: Consisting of nine items with multiple response options that collect information about the studies being pursued at the time of the evaluation, if they have started working, academic history, attitude, and school integration;
- Child welfare system history: The nine items that constitute this dimension collect information on the age of entry into the child welfare system, the reason for this entry, their current legal status, and current and past protection measures. Regarding the response format, three of the items require an open-ended numerical response (C.1., C.4. and C.6.1), two have a dichotomous response format (C.2. and C.5.), while the rest present multiple response options (C.3., C.6., C.6.2 and C.6.3);
- Family visitation history: This dimension consists of nine items that inquire about the established visitation regime (place, frequency, duration, control, and persons attending), whether it is complied with, and the child's or adolescent's assessment of these visits. Four of the items are dichotomous (D.1., D.2., D.3., and D.6.), and the remaining ones have multiple response options (D.4., D.5., D.7., D.8. and D.9.);
- Biological family information: This dimension aims to inquire about the characteristics of the biological parents of the child or adolescent that may influence or have influenced them and their situation, as well as their relationship with them and their possible siblings. Likewise, some items also include the family's economic condition, the community environment in which the child or adolescent grew up, and intrafamily relationships. Thus, of the 23 items that make up this dimension, all of them with multiple response options, 9 are duplicated by asking on the one hand about aspects concerning the father and, on the other, about those of the mother;
- Experiences of sexual abuse: Consisting of seven items, the aim is to inquire about the information available to the residential care facility regarding the possible experiences of sexual abuse experienced by the participant (suspicions, confirmation, frequency, characteristics of the perpetrator, and consequences). Two of the items are open-ended (F.4. and F.6.), while the rest are dichotomous (F.1., F.2., F.3., F.5., and F.7.).

The form should be completed by the professionals of the residential care facilities, based on the reports of the child or adolescent in the child welfare system, and it takes approximately 10 min to complete, depending on the participant's characteristics.

The final version of the CAWSys is attached in Supplementary Materials.

3.2. CAWSys Construction and Item Properties

During the CAWSys construction process, the Delphi method was implemented in two phases. In the first phase, the experts were provided with an initial list of 61 items distributed in six dimensions (see Table 1). After conducting the necessary assessments, they proposed the inclusion of four items exploring the degree of physical and psychological disability of the parents (items E.2.4/E.3.4 and E.2.5/E.3.5) and one item examining the presence of filio-parental violence (item E.1.) in the dimension "Biological family information". It was also proposed to introduce another item in the dimension "Experiences of sexual abuse" that would consider therapeutic support for those children and adolescents who had suffered sexual abuse (item F.7). Likewise, items A.3. ("Date of birth" instead of "Age", since it provides more detailed information), A.6. ("Disability" instead of "Disability/functional diversity", since disability is referred to when the social-service department has granted a degree of disability) and A.9. ("Consumption of psychoactive substances" instead of "Consumption of toxic-dependent substances", so that sporadic consumption could also be included) of the "General information" dimension were reformulated. On the other hand, the term "minor" was replaced by "minor person" in item C.2. ("Current legal status of the minor person") of the dimension "Child welfare system history", in the statement of item D.9. ("Assessment of visits by the minor person in general") of the dimension "Family visitation history" and in an alternative of item E.4. ("Siblings") of the dimension "Biological family information".

Table 1. Evolution of the composition of CAWSys in its building process.

Dimensions	Items	First Version	Second Version [1]	3rd Version [2]	Final Version
General information	N	9	9	9	9
	Reformulated	NA	3 (items A.3., A.6., A.9.)	0	NA
School/work situation	N	9	9	9	9
	Reformulated	NA	0	1 (item B.1.)	NA
Child welfare system history	N	9	9	9	9
	Reformulated	NA	1 (item C.2.)	2 (items C.6., C.6.3)	NA
Family visitation history	N	9	9	9	9
	Reformulated	NA	1 (item D.9.)	0	NA
Biological family information	N	19	24	24	24
	Added	NA	5 (items E.1., E.2.4, E.2.5, E.3.4, E.3.5)	0	NA
	Reformulated	NA	1 (item E.4.)	3 (items E.1., E.2.9, E.3.9)	NA
	Deleted	NA	NA	NA	1 (item E.7.)
Experiences of sexual abuse	N	6	7	7	7
	Added	NA	1 (item F.7.)	0	NA
	Reformulated	NA	0	1 (item F.1.)	NA
Total of the form	N	61	67	67	66
	Added	NA	6	0	NA
	Reformulated	NA	6	7	NA

Note: NA = Not Applicable, [1] After review by the panel of experts, [2] After the pilot test.

In the second phase, the redesigned form was distributed to a residential care facility for completion by its professionals, who made a qualitative assessment of its items by making annotations in the margin to determine argumentative proposals to improve the wording. Firstly, the wording of one of the alternatives in item C.6. ("Current protection measure") of the dimension "Child welfare system history" was corrected, as it referred to a typology of the residential care facility and did not conform to the new nomenclature. On the other hand, professionals suggested the inclusion of 5 new alternatives in item B.1. ("School/work situation") of that same dimension, to specify the academic situation of the child and avoid losing information; in item C.6.3 ("Final aim of the intervention") of the "Child welfare system history" dimension, they also suggested introducing two more precise possible intervention objectives related to the situation of children and adolescents with behavioral problems or who had been in the child welfare system for a short time, in item E.2.9 and E.3.9 ("Employment status") of the dimension "Biological family information" they detected the need to include an alternative that contemplated the parents' "Compensation" situation and in item E.1. ("Filio-parental violence") of the dimension "Biological family information" and F.1. ("Suspected sexual abuse") of the dimension "Experiences of sexual abuse" the alternative "N/A" was added.

On the other hand, analyzing the percentage of missing responses (unanswered items) (Table 2), it can be stated that, in general, most of the items that constitute CAWSys seem to work adequately, except for some that were not answered by all the participants. This is the case of eight items of the "School/work situation" dimension (items B.2. to B.9.), which address their attitude and integration in school and their academic record and which were left unanswered approximately 9% of the time. To a lesser extent, items C.4. ("Years in the child welfare system"), C.6.1 ("Months enjoying the measure"), and C.6.3 ("Final aim of the intervention") of the dimension "Child welfare system history" were left blank approximately 5% of the time. Likewise, parent items E.3.7 ("Victim of maltreatment"), E.5. ("Economic situation"), E.6.1 ("Conflicting social dynamics"), E.6.2 ("Presence of a support network"), and E.7. ("Separation/divorce") were also unanswered by 15, 7, 9, 6 and 20% of the total sample, respectively. In this line, items D.2. to D.9., whose content refers to the established visitation regime, and F.2. to F.7., whose content refers to the characteristics of the alleged sexual abuse experienced, were only to be answered if the item directly preceding them, i.e., items D.1. and F.1., respectively, were answered affirmatively. As a result, the referred items show lower response rates.

Table 2. CAWSys form items and the number and percentage of professionals' responses to each item in relation to the total number of children and adolescents they assessed.

Dimensions	Items CAWSys	N (%)
General information	A.1. Sex assigned at birth:	307 (100%)
	A.2. Sexual orientation:	307 (100%)
	A.3. Date of birth: [1]	307 (100%)
	A.4. Nationality: [1]	307 (100%)
	A.5. Unaccompanied migrant child:	307 (100%)
	A.6. Disability:	307 (100%)
	A.7. Physical health problems:	307 (100%)
	A.8. Mental health problems	307 (100%)
	A.9. Consumption of psychoactive substances:	307 (100%)
School/work situation	B.1. Current school/work situation	307 (100%)
	B.2. Has any school adaptation?	280 (91.2%)
	B.3. Integration in the school:	279 (90.8%)
	B.4. Behavior in the classroom:	288 (90.8%)
	B.5. Has been expelled from the school?	280 (91.2%)
	B.6. Attitude and motivation towards learning:	281 (91.6%)
	B.7. School habits/skills:	279 (90.9%)
	B.8. Has repeated a grade?	281 (90.26%)
	B.9. Truancy:	279 (90.8%)
Child welfare system history	C.1. Age of entry into the child welfare system: [1]	307 (100%)
	C.2. Current legal status of the minor person:	307 (100%)
	C.3. Event giving rise to the placement:	307 (100%)
	C.4. Years in the child welfare system: [1]	290 (94.46%)
	C.5. Past protection measures:	307 (100%)
	C.6. Current protection measure:	307 (100%)
	C.6.1. Months enjoying the measure: [1]	292 (95.11%)
	C.6.2. Degree of adaptation/satisfaction with the measure:	307 (100%)
	C.6.3. Final aim of the intervention:	291 (95.1%)
Family visitation history	D.1. Are there established visits?	307 (100%)
	D.2. Are they occurring?	185 (100%)
	D.3. Place of the visits:	185 (100%)
	D.4. Frequency of the visits:	185 (100%)
	D.5. Duration of the visits:	185 (100%)
	D.6. Control of the visits:	185 (100%)
	D.7. Persons with whom the child/adolescent is seen:[1]	185 (100%)
	D.8. Compliance with visits:	185 (100%)
	D.9. Assessment of visits by the child/adolescent (in general):	185 (100%)
Biological family information	E.1. Filio-parental violence:	307 (100%)
	E.2.1/E.3.1 Background in the child welfare system:	M 307 (100%)/F 307 (100%)
	E.2.2/E.3.2 Physical health problems:	M 307 (100%)/F 307 (100%)
	E.2.3/E.3.3 Mental health problems:	M 307 (100%)/F 307 (100%)
	E.2.4/E.3.4 Recognised degree of physical disability:	M 307 (100%)/F 307 (100%)
	E.2.5/E.3.5 Recognised degree of mental disability:	M 307 (100%)/F 307 (100%)
	E.2.6/E.3.6 Substance abuse:	M 307 (100%)/F 307 (100%)
	E.2.7/E.3.7 Victim of maltreatment:	M 307 (100%)/F 264 (85.7%)
	E.2.8/E.3.8 Criminal record:	M 307 (100%)/F 307 (100%)
	E.2.9/E.3.9 Employment status:	M 307 (100%)/F 307 (100%)
	E.4. Siblings:	307 (100%)
	E.5. Economic situation:	286 (93.2%)
	E.6.1 Conflicting social dynamics:	278 (90.5%)
	E.6.2 Presence of a support network:	289 (94.2%)
	E.7. Separation/divorce:	245 (80.1%)
Experiences of sexual abuse	F.1. Suspected sexual abuse:	307 (100%)
	F.2. Confirmation of suspected sexual abuse:	52 (100%)
	F.3. Alleged perpetrator:	52 (100%)
	F.4. Occasions on which it has occurred (approx.): [1]	52 (100%)
	F.5. Sex of alleged perpetrator:	52 (100%)
	F.6. Short and/or long-term consequences: [1]	52 (100%)
	F.7. Have you received subsequent therapeutic support?	52 (100%)

Note: M = Mother; F = Father; [1] open-ended items.

3.3. Content Validity, Usability, and Relevance of the CAWSys

Content validity was ensured by the consensus reached by the panel of experts. While in the first phase of the process only 62% of the experts reached a consensus, in the second phase 89% of the experts reached a consensus, which is an appropriate percentage to affirm the existence of content validity of the form.

In terms of ease of use, the professionals who participated in the completion of the instrument rated the number and content of the items, as well as the time required to complete them. More than 90% of the experts agreed that 95% of the items could be answered by the tutor or psychologist of the residential care facility, provided that they have access to the child's or adolescent's reports. Likewise, 98% of the respondents stated that the items were straightforward to answer due to their format (most of them with multiple response options) and the average time required to complete the form (approximately 10 min).

Regarding the relevance of the CAWSys, 94% of the professionals who participated stated that the CAWSys allowed them to have an overall perspective of the characteristics of the child or adolescent and that it would have been beneficial for them when developing their individualized plan upon arrival at the residential care facility. In 92.2% of the cases, they assured that they would use it to transfer the primary information about the minor. However, 56% suggested that the information on the form was advised to be supported by effective communication between professionals to expand and clarify this information.

4. Discussion and Conclusions

CAWSys was developed following a rigorous construction process in which multiple experts from different areas have participated and which has been tested in a real setting (pilot test) before the final format was achieved. This gives sufficient solidity to the construction process, presenting it as a useful and effective instrument for collecting sociodemographic data on children and adolescents in the child welfare system.

Overall, the items performed correctly, since almost 80% were answered correctly by all the participants and the evaluation of the response format was positive. However, the items related to the minor's academic situation, time in the child welfare system, and those asking about specific aspects of their social and familiar context were not completed by all the professionals. Those who did not complete them alleged that they did not possess such information at the time they filled the forms and that they had to carry out further research (such as asking school personnel, the staff of the residential care facility where the minor had previously resided, and so on) to answer them, which made it difficult for them to respond. In this sense, when using the CAWSys it should be considered that these were the worst performers, as well as excluding the item that asks about parental separation or divorce as it was the item that obtained the worst results. Regarding the response format, the fact that the instrument includes both open-response items, which allow the collection of more detailed information, and closed-response items (dichotomous or multiple-choice), which can be used to obtain more precise data that fits a previously established pattern, thereby reducing the time spent in completing them, appears to be a significant strength of the instrument presented. This allows more subjective data to be collected on relevant and distinctive aspects of each child or adolescent without obtaining highly disparate responses that may limit the subsequent comparison and elaboration of statistics.

In addition, the instrument was found to cover all relevant aspects of the purpose for which it was developed. In other words, according to the panel of experts, all the areas in which it collects information are indispensable and no aspect of particular relevance has been left out. Likewise, the professionals who completed them considered that it was helpful in their task and could be beneficial for managing and transmitting the information.

Regarding the methodology used in the process of constructing this form, the use of the Delphi method, being a flexible technique, helped to encourage, to a greater extent, the reflection and creativity of the experts, a key factor in the elaboration of a much more complete tool. However, above all, it stands out because it made it possible to construct an instrument that considers both the phenomenon and the evaluation context and is mainly

oriented towards practical contribution, thanks to the verifiability, comprehensibility, and holism of this method. However, the methodology used also has some limitations in terms of the quality of the evidence reported, as the decisions taken in the process of constructing this instrument have been based mainly on the consensus of the panel of experts and this should be considered. In this regard, it would be advisable for future studies to investigate the validity and efficacy properties of CAWSys, as well as its usefulness in other similar contexts (e.g., judicial system) and in other countries.

Consequently, it can be concluded that the form developed and tested in this study contributes to the transmission of basic information about the child or adolescent of the child welfare system among the professionals working with them. In other words, it contributes to the improvement of interprofessional communication, which would help in the preparation of much more individualized and specialized intervention plans, and on a larger scale, in the compilation of more accurate statistics on the characteristics of this group, avoiding the disparity of the data reported depending on the source consulted. Furthermore, although the main implication of this study is to contribute to the improvement of the work of child welfare professionals, researchers around the world could use this form in their studies to ensure the collection of information on the main socio-demographic aspects of these children, which will help them to make sense of the other variables assessed in their research. This would also help to ensure comparability of data across countries. This is unusual so far and could contribute to improving social policies in countries with the worst statistics, considering the plans implemented in those with better data, with the final aim of optimizing the conditions of these children and adolescents.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/children10061026/s1, Child and Adolescent Welfare System Form (CAWSys).

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Experimental Research Ethics Committee of the University of Valencia (approved 6 February 2020) [UV-INV_ETICA-1240597].

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study and from their legal guardians. Written informed consent has been obtained from the patients to publish this paper.

Data Availability Statement: The data presented in this study are available on request from the corresponding author upon reasonable request.

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Anexo 2

Estudio 2

Sexual Health among Youth in Residential Care in Spain: Knowledge, Attitudes and Behaviors

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Article

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Sexual Health among Youth in Residential Care in Spain: Knowledge, Attitudes and Behaviors

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Abstract: Adolescents in the child welfare system often face multiple maladaptive experiences that predispose them to worse sexual health outcomes. This study aims to (1) describe the sexual health of adolescents in Spanish residential care by exploring their sexual knowledge, attitudes toward sexuality, and sexual behaviors and (2) to find out whether there are certain characteristics that make a subgroup particularly vulnerable to engaging in risky sexual behaviors. A total of 346 adolescents recruited from 47 Spanish residential care facilities (34.1% girls, 65.9% boys) aged between 11 and 19 years old completed some self-report instruments. Descriptive analyses and tests to prove gender and age differences were conducted. Their knowledge of sexuality was lower than observed in the general adolescent population, their attitudes more negative, and their tendency to engage in risky sexual behaviors higher. Girls made very infrequent use of condoms, while boys had more sexist attitudes and made habitual use of withdrawal. Although more than 20% of them had experienced sexual exchange activities before the age of 13 until 17, they did not use condoms systematically. The low level of knowledge, the early initiation of sexual exchange activities, and the scarce use of protection methods, together with sexist attitudes, place this group in a situation of great vulnerability, increasing the risk of unwanted pregnancies, sexually transmitted infections, and even teen dating violence.

Keywords: sexual health; sexual knowledge; attitudes toward sexuality; sexual behaviors; sexism; condom use; adolescents; child welfare system; residential care; Spain

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1. Introduction

Individual, family, and social experiences have a major impact on all areas of the individual and their sexual health outcomes [1]. Adolescents in the child welfare system who have had to be separated from their family and immediate environment to ensure their physical and emotional well-being are more likely to report histories of trauma or sexual abuse, living in poverty, having inconsistent, harsh, or unavailable parenting, and coming from families who experience multiple stressors [2–4]. For this reason, this vulnerable group of adolescents is at greater risk of experiencing unhealthy trajectories by sexual risk-taking, STDs, and teen pregnancy, among others, compared to adolescents not in the child welfare system [5,6].

In particular, these youths often lack a solid base of knowledge that would enable them to make adequate sexual health decisions [7]. Oman et al. [8], in their research with a sample of young people living in residential care facilities in different states in America, reported that their participants presented low knowledge about female anatomy and fertility and methods of protection. However, their knowledge was slightly higher on condom use and pregnancy risk, especially among girls [9]. Other studies claim that these young people have very little information about sexuality in general and condom use in particular or that

the information they do have is erroneous [10]. Similar results were reported by Boustani et al. [11] regarding the HIV knowledge and safe sexual practices of a group of youth in residential care. It is believed that this lack of knowledge could be due, in part, to the frequent changes in residential care facilities and the problems of educational disruption experienced by these boys and girls. These situations make it difficult for them to receive information from the main educational contexts: their homes and their schools [7].

Lack of knowledge is directly related to the development of erroneous and negative attitudes about sexuality and the different aspects related to it. Oman et al. [8] stated that the attitudes of their study participants toward the use of contraceptive methods were positive; however, they reported that most of their sample agreed that condoms reduced pleasure, which calls into question their main conclusion. Furthermore, comparing their results with those obtained in studies of community samples, they added that adolescents in residential care, especially boys, have poorer attitudes than other adolescent groups, and that directed them toward sexual risk-taking. While half of the adolescents in the community sample indicated that they would be upset if they got pregnant or got someone pregnant, only a quarter of the youth in residential care would be upset. This positive or ambivalent attitude toward adolescent motherhood and parenthood, which is common in this group [11], would be behind the disproportionately high rate of early pregnancies. The desire for pregnancy is associated with family dysfunction, as it is perceived as a healing mechanism of childhood wounds or to make up for emotional shortcomings with their possible current baby or partner [12]. Likewise, as children learn and internalize observed family models, another consequence of growing up in potentially conflictual homes is the adoption of stereotypical gender roles and behaviors [13]. In this regard, some studies have found a high internalization of sexist attitudes among adolescents in residential care [14,15]. These beliefs are present through the idealization of the male role as caregiver and protector of women (benevolent sexism) and are more common in boys [14,16,17]. As in the youth in the community sample [18], hostile sexism, consisting of the expression of overtly negative beliefs toward females, is less common in these adolescents. However, age positively influences the expression of sexist attitudes in community adolescents [18,19], but this relationship has not always been found in adolescents in the child welfare system [14,20].

Thus, given the lack of appropriate knowledge and attitudes of these young people, it is not surprising that many of them have a higher likelihood of engaging in risky sexual behavior [21]. This vulnerable group of adolescents reports being sexually active at a younger age than adolescents of community samples [22,23]. Different studies with adolescents in residential care facilities in the Americas [24,25] postulate that, regardless of the participant's gender, a remarkable percentage of their sample have had their first sexual activities at age 14 or earlier. The most frequent sexual activity appears to be vaginal intercourse together with oral sex, which is performed at an earlier age compared to anal sex [25]. The data from these studies contrast with those conducted with adolescents in the community sample. James et al. [23] found that while 6% of US high school youth have had their first sexual intercourse experience before age 13, this rate rises to 20% for youth in the child welfare system.

Early sexual activity has been associated with a propensity to engage in additional risky behaviors, such as lower contraceptive use [26]. The lack of neuro-development of high-order cognitive skills that characterize individuals in early adolescence [27] leads to those who engage in sexual activities at a younger age being more likely to make poor decisions without thinking through the consequences of, for example, having unprotected sex [28]. Studies with youth in the child welfare system, in addition to reporting extremely low rates of contraceptive use in these adolescents [29], all agree on the significant influence of gender in the use of contraceptive methods, being in favor of boys, especially with respect to condom use [8,25,30]. Age seems to lead to greater use of contraceptive methods too. Research conducted with emancipation or out-of-care adolescents over the age limit reported higher rates of contraceptive use that approached those of their peers in the community sample [31,32]. This would confirm the hypothesis that a lack of cognitive mat-

uration directly influences risk-taking and, thus, contraceptive use. However, residential care youth also cite finding it difficult to access condoms and general sexual health care [33], which would explain the differences found between adolescents in the child welfare system and their peers in a community sample.

The lack of information on the sexual health of adolescents in the child welfare system in Spain and the need to provide these adolescents with interventions that would truly ensure their healthy sexual development led us to propose the following research. The first aim of this study is to describe the sexual health of adolescents in residential care in Eastern Spain by exploring their sexual knowledge, attitudes, and behaviors. The second objective is to find out whether there are certain characteristics of the sample (gender and age) that make a subgroup of these adolescents particularly vulnerable to developing poorer sexual health. As a consequence of these two objectives, the present study is not only to shed light on their sexual information and their sexual behavior but also allows to detect their main strengths and weaknesses in sexual education in order to develop educational interventions fully adapted to the needs of this high-risk population in Spain.

2. Materials and Methods

2.1. Data Collection

This cross-sectional study was conducted between June 2020 and May 2021, and 47 residential care facilities in Eastern Spain were recruited. A total of 346 adolescents in the child welfare system completed the Child and Adolescent Protection System Form, the Sexual Knowledge and Attitudes Questionnaire, the Contraception Methods Knowledge Questionnaire, the Sexuality and Health Knowledge Questionnaire, the Ambivalent Sexism Inventory, and the AIDS Prevention Questionnaire.

The inclusion criteria established for the selection of the sample were: (1) being 11 years of age or older (Finkelhor et al. [34] suggest that youth can respond to surveys with reliable information after age 10) and (2) living in a residential care facility at the time of the interview. The exclusion criteria were: (1) poor understanding of the Spanish language and (2) insufficient cognitive ability to understand and respond to the measurement instruments (information reported by residential care facilities professionals).

Procedure

Permission was obtained from the Directorate General for Childhood and Adolescence (DGCA) of the Valencian Region, the administrative agency responsible for implementing steps to protect minors and who have guardianship over them. Subsequently, the coordinators and directors of the residential care facilities were contacted to explain to them the project and to request authorization from them to enter the centers. These homes and residences offer comprehensive and educational care to children and adolescents in care and/or guardianship to those who are deprived of a suitable family environment. Once this first contact had been established, the center's staff explained the proposal to the boys and girls of the residential care facility, and appointments were arranged with the minors who wished to participate on a voluntary basis. No financial assistance or compensation was offered to participants.

At the same time, three professionals from the research team with extensive experience in the evaluation and treatment of minors were trained in the application of this battery of instruments to avoid or reduce as much as possible the interviewer bias in the evaluation of the participants and ensure the maximum reliability and validity of the data collected. The application of the standardized instruments was carried out in person, individually, and in a comfortable environment of maximum privacy. Only the participant and one of the evaluators were present while the assessment was being completed. All participants were informed of the confidentiality of their responses before beginning to complete the battery, as well as their right to leave the study at any time. All residential care facilities and adolescents who chose to participate gave their prior authorization to do so. CAPSys had to be completed by a professional from the residential care facility (director, psychologist,

educator, etc.), who knew the adolescent well and had been previously instructed to ensure full understanding of the items on the form. Participants always had the support of the expert who was available to resolve their doubts.

2.2. Measures Tool

2.2.1. Child and Adolescent Protection System Form (CAPSys [35])

This instrument, validated in Spanish [35], consists of 67 items grouped into six dimensions: "*General information*" (9 items), "*School/work situation*" (9 items), "*Protection system history*" (9 items), "*Family visitation history*" (9 items), "*Biological family information*" (24 items), and "*Experiences of sexual abuse/maltreatment*" (7 items). For this study, only "*General information*", which explores basic information about the adolescent (e.g., gender, date of birth, nationality, etc.), was used. It is an instrument designed to be completed by a professional from the residential care facility who knows the child well and has access to his or her record. The internal consistency of this instrument in this study ranged between 0.61 and 0.78.

2.2.2. Sexual Knowledge and Attitudes Questionnaire (CAS [36])

The CAS consists of 34 dichotomous response items (agree/disagree) divided into two subscales: "*Sexual Knowledge*" (17 items; e.g., "Masturbation does not generate physical disorders") and "*Sexual Attitudes*" (17 items; e.g., "Homosexuals are sick and vicious people"). This questionnaire was validated in Spanish [36]. Each subscale has a score range from 0 to 17. The internal consistency was acceptable for both subscales (α = 0.66 and α = 0.62, respectively) in this study.

2.2.3. Contraception Methods Knowledge Questionnaire (ANTI [36])

This Spanish-validated self-reported instrument, consisting of 9 items, assesses knowledge about different contraception methods (e.g., "Withdrawal and natural methods are the best and most effective contraceptive methods"). The total score is obtained by adding the scores obtained in each of the items (0, disagree; 1, agree), and the range is between 0 and 9. The reliability analysis in this study was found as an α of 0.60.

2.2.4. Sexuality and Health Knowledge Questionnaire (SYS [36])

The SYS is a Spanish-validated self-reported instrument to assess the level of knowledge about sexually transmitted diseases, and more specifically, HIV and its transmission (e.g., "A person carrying AIDS can transmit the infection even without having symptoms"). It includes 9 items, and the total score is obtained by adding all the items, where each item can be scored as 1 (agree) and 0 (disagree), and the score range is between 0 and 9. The reliability analysis in this study report an acceptable internal consistency (α = 0.62).

2.2.5. Ambivalent Sexism Inventory (ASI [37,38])

The ASI, validated in Spanish [38], assesses ambivalent sexist beliefs about women. It comprises two subscales of 10 items, each measuring "*Hostile sexism*" and "*Benevolent sexism*". Hostile sexism evaluates openly discriminatory attitudes and behaviors based on the supposed inferiority of women (e.g., "Boys should exert control over who their girlfriends interact with"). Benevolent sexism explores attitudes that even when expressed in a positive affective tone, stereotype and limit women to traditional roles (e.g., "Boys should take care of girls"). The sum of all of the scale items gives the total scale score for "*Ambivalent Sexism*" as the convergence of apparently positive (benevolent sexism) and negative (hostile sexism) attitudes towards women. All items are statements to which participants respond on a scale from 0 ("strongly disagree") to 5 ("strongly agree"). Each subscale score ranges from 10 to 60, and the total scale score ranges from 20 to 120. The internal consistency was α = 0.91 for the total scale, α = 0.87 for the hostile sexism subscale, and α = 0.86 for the benevolent sexism subscale in this study.

2.2.6. AIDS Prevention Questionnaire (CPS [39])

The CPS is a Spanish-validated [39] self-administered measure that includes 44 different response format questions. The main components are information and knowledge about HIV (12 items), attitudes and perceived self-efficacy (14 items), condom use intentions (6 items), safe sexual behavior (7 items), and, finally, stigma and discrimination towards people living with HIV (5 items). For this study, only the "Safe sexual behavior" component was used to explore sexual practices and the frequency of use of some contraceptive methods. The reliability analysis found a good internal consistency for this component in the study ($\alpha = 0.67$).

2.3. Statistical Analysis

A descriptive analysis was conducted, including means (M) and standard deviations (SDs) for numerical variables (General knowledge, Contraception methods knowledge, sexually transmitted infections (STIs) knowledge, General attitudes, Sexism, and Age of first time of sexual practices), and frequencies (%), and the number of subjects (n) for categorical variables (Sexual practices, Contraception methods use, and Age groups of first time of sexual practices).

The distribution of each of the dependent variables was examined for normality assumptions and compared by gender as well as by age. These two variables have been shown to be determinants in samples of community adolescents. Numerical dependent variables were related to age using Pearson correlation (r) and independent sample t-test to compare gender groups. Effect sizes (ESs) of the raw mean differences were obtained using the standardized mean difference, d [40]. For categorical dependent variables, analysis of variance (ANOVA), chi-squared, or independent sample t-test was performed. Further, odds ratios (OR) or standardized mean difference (d) were added to report the power of the association whenever possible. Age groups were also created to examine the trends according to age ranges following the stages of adolescence (early, middle, and late).

Enough evidence to reject the null hypothesis was considered if $p < 0.05$. Following Cohen's classification, the magnitude of the standardized d value can be interpreted as 0.25, 0.5, and 0.8 for small, median, and large effects on the outcomes of interest. ESs were calculated using an effect size calculator [41]. OR was considered statistically significant when its 95% confidence interval (CI) did not include the value 1. Data analyses were conducted using SPSS 26.

2.4. Ethic Considerations

The study complied with the ethical principles of the 1964 Declaration of Helsinki and was approved by the Experimental Research Ethics Committee of the University of Valencia (Spain).

3. Results

3.1. Sociodemographic Characteristics

Of the total participants, 34.1% ($n = 118$) were females compared to 65.9% ($n = 228$) who were males. The study sample was between 11 and 19 years of age (M = 15.73; SD = 1.76). Almost half of the adolescents (48.5%, $n = 167$) were between 14 and 16 years old, followed by 39.2% ($n = 135$) between 17 and 19 years old and only 12.2% ($n = 42$) who were between 11 and 13 years old. Regarding their sexual orientation, almost 85% identified themselves as heterosexuals, while 7.1% as bisexuals, 2.1% as homosexuals, and 0.3% as pansexual. Around 6% of the sample defined themselves as being in the process of exploring their sexual identity. Although the majority of the participants (57.9%) were born in Spain, there were 29.7% who were born in Morrocco, and the remaining nationalities were underrepresented (Eastern European: 4.7%; West African: 3.3%; South/Central American: 2.7%; Pakistani: 1.2%; and Portuguese: 0.6%). Among the adolescents 29.9% presented mental health problems ($n = 100$), and 33.3% had substance use problems ($n = 115$).

3.2. Sexual Knowledge

The total sample had a mean score close to the median of the range on the three scales assessing knowledge (Table 1). However, participants had more knowledge about STIs than contraception methods. The results also showed significant gender differences in knowledge about general sexuality (t = 5.47, $p < 0.001$), STIs (t = 3.89, $p < 0.001$), and contraception methods (t = 3.25, $p = 0.001$), favoring women. General sexual knowledge had a large ES for females (d = 0.62, 95% CI [0.39, 0.85]), contraception methods knowledge had a modest ES (d = 0.37, 95% CI [0.14, 0.59]), and STIs knowledge a medium ES (d = 0.45, 95% CI [0.22, 0.67]). Regarding age, a correlation was statistically significant with contraception methods knowledge (r = 0.2; $p < 0.001$). Participants between 14 and 16 years of age seemed to be the most knowledgeable about sexuality in general and STIs.

Table 1. Sexual knowledge and attitudes in Spanish residential care adolescents and differences between age and gender groups.

		Range	Total M (SD)	Age			R	Gender			
				11–13 M (SD)	14–16 M (SD)	17–19 M (SD)		Male M (SD)	Female M (SD)	*t*-Test [a]	d (CI) [a]
Knowledge	General	0–17	9.9 (3.2)	8.56 (2.68)	10.16 (3.1)	10.02 (3.4)	0.1	9.24 (2.95)	11.16 (3.31)	5.47 ***	0.62 (0.39, 0.85)
	Contraception methods	0–9	5.16 (1.7)	4.44 (1.48)	5.14 (1.59)	5.44 (1.81)	0.2 ***	4.95 (1.72)	5.57 (1.59)	3.25 **	0.37 (0.14, 0.59)
	STIs	0–9	5.61 (1.93)	4.43 (1.91)	5.88 (1.77)	5.66 (2.01)	0.1	5.32 (1.95)	6.17 (1.77)	3.89 ***	0.45 (0.22, 0.67)
Attitudes	General	0–17	13.36 (2.82)	13.02 (2.63)	13.6 (2.63)	13.19 (3.07)	−0.03	12.81 (2.9)	14.41 (2.34)	5.47 ***	0.59 (0.36, 0.81)
	Ambivalent sexism	20–120	61.46 (21.86)	61.12 (12.09)	59.23 (20.24)	63.79 (24.02)	0.09	67.73 (49.63)	49.63 (19.24)	−7.88 ***	−0.77 (−1.01, −0.54)
	Hostile sexism	10–60	29.81 (11.67)	28.49 (9.73)	28.66 (11.23)	31.37 (12.51)	0.14 *	32.74 (11.58)	24.24 (9.66)	−6.8 ***	−0.85 (1.08, −0.62)
	Benevolent sexism	10–60	31.65 (12.12)	32.63 (11.37)	30.56 (11.42)	32.43 (13.04)	0.04	34.96 (11.27)	25.39 (11.19)	−7.44 ***	−0.89 (−1.13, −0.66

Note: M = Mean; SD = Standard Deviation; r = Pearson correlation; d = standardized mean difference; CI = Confidence Interval. [a] Positive scores greater than 0 means favoring females. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

3.3. Sexual Attitudes

In the different attitudinal aspects evaluated, the influence of gender was significant. Women scored significantly higher on attitudes toward sexuality in general than men (t = 5.47, $p < 0.001$), and significantly lower on sexism which includes ambivalent, hostile, and benevolent (t = −7.88, $p < 0.001$; t = −6.8, $p < 0.001$; t = −7.44, $p < 0.001$; respectively). Ambivalent, hostile, and benevolent sexism had a large effect size for men (d = −0.77, 95% CI [−1.01, −0.54]; d = −0.85, 95% CI [1.08, −0.62]; d = −0.89 95% CI [−1.13, −0.66]; respectively). Regarding age, the correlations were not significant with any attitudinal aspects evaluated, except with hostile sexism (r = 0.14; $p = 0.012$). For the remaining variables, adolescents aged 14 and 16 years scored slightly higher on positive attitudes towards sexuality in general, younger adolescents scored slightly higher on benevolent sexist attitudes, and older adolescents scored slightly higher on ambivalent sexist attitudes. Table 1 shows these results.

3.4. Sexual Behaviors

Among 90% of adolescents in the sample had engaged in any of the sexual activities that they were asked about. More than 80% of the total sample had masturbated and almost 60% had masturbated as a couple. More than 70% had performed vaginal penetration and almost 50% had performed oral sex. The percentage of adolescents who had engaged in anal penetration was lower (18.8%) (Table 2).

The prevalence of sexual practices was not influenced by gender, with the exception of masturbation ($\chi^2 = 51.44$, $p < 0.001$), in which men had a significantly higher prevalence. No statistically significant differences were found between men and women with respect to the age at which they first engaged in each sexual practice. Regarding age, there were statistically significant differences in the mean age of adolescents who engaged in the assessed sexual practices compared to those who had not. The age of the participant at the time of assessment correlated positively and statistically significantly with the age of the first time of performance of each sexual practice (Table 2).

Table 2. Sexual practices experienced and the age of the first time in Spanish residential care adolescents and differences between age and gender groups.

			Total	Age						Gender			
			M (SD)/ % (*n*)	11–13 M (SD)/ % (*n*)	14–16 M (SD)/ % (*n*)	17–19 M (SD)/ % (*n*)	M (SD) [b]	r/*t*-Test	d (CI) [a]	Male M (SD)/ % (*n*)	Female M (SD)/ % (*n*)	χ^2/ *t*-Test [c]	OR (CI)/ d (CI) [a]
Behavior	Sexual Practices	Masturbation	80.8 (274)	56.1 (23)	80.7 (134)	88.6 (117)	15.95 (1.63)	−4.76 **	−0.72 (−0.99, −0.44)	92 (206)	59.8 (70)	51.44 ***	7.68 (4.19, 14.1)
		Age first time	12.25 (2.31)	10.52 (1.72)	11.79 (2.31)	13.13 (2.07)	NA	0.37 ***	NA	12.27 (2.15)	12.21 (2.71)	−0.19	−0.03 (−0.31, 0.25)
		Mutual masturbation	59.6 (201)	29.3 (12)	63 (104)	64.9 (85)	15.97 (1.57)	−3.09 **	−0.36 (−0.58, −0.14)	56.3 (125)	66.7 (78)	3.42	0.64 (0.4, 1.03)
		Age first time	13.76 (2.01)	10.91 (1.97)	13.2 (1.48)	14.88 (1.89)	NA	0.61 ***	NA	13.98 (2.02)	13.43 (1.93)	−1.84	−0.28 (−0.57, 0.02)
		Oral sex	48.4 (163)	24.4 (10)	47.6 (78)	56.8 (75)	16.1 (1.56)	−3.92 ***	−0.85 (−0.9, −0.6)	47.7 (106)	50.4 (59)	0.22	0.89 (0.57, 1.41)
		Age first time	14.11 (1.98)	11.1 (1.45)	13.53 (1.57)	15.2 (1.69)	NA	0.68 ***	NA	14.28 (2.04)	13.86 (1.86)	−1.24	−0.21 (−0.55, 0.12)
		Vaginal intercourse	71.4 (242)	24.4 (10)	73.9 (122)	82.7 (110)	16.12 (1.47)	−6.23 ***	−0.42 (−0.64, −0.21)	73.7 (165)	67.5 (79)	1.42	1.35 (0.83, 2.19)
		Age first time	13.79 (1.93)	10.67 (1.32)	13.28 (1.61)	14.65 (1.79)	NA	0.49 ***	NA	13.94 (1.99)	13.51 (1.75)	−1.54	−0.22 (−0.51, 0.06)
		Anal sex	18.8 (63)	7.5 (3)	17.1 (28)	24.2 (32)	16.19 (1.44)	−2.67 **	−0.32 (−0.59, −0.05)	19.5 (43)	17.1 (20)	0.28	1.17 (0.65, 2.1)
		Age first time	14.16 (1.8)	11 (1)	13.6 (1.5)	15.04 (1.51)	NA	0.59 ***	NA	14.06 (1.86)	14.35 (1.73)	0.55	0.15 (−0.43, 0.74)

Note: Conditional percentage of the dependent variable knowing the category of the independent variable information. Age first time was used as numerical variable. M = Mean; SD = Standard Deviation; % = frequencies; *n* = number of subjects; r = Pearson correlation; χ^2 = chi-squared; d = standardized mean difference; OR = Odds Ratios; CI = Confidence Interval; NA = Not Applicable. [a] The 95% confidence interval does not include the null value (OR = 1; d = 0); [b] Mean age of the group of participants who have engaged in this sexual practice; [c] Positive *t*-test scores greater than 0 means favoring females. ** $p < 0.01$, *** $p < 0.001$.

In addition, almost half (46.4%) of them had their first sexual activity before the age of 13, while 50.7% had it between the ages of 13 and 15 years and 2.9% after the age of 15 years. As shown in Table 3, masturbation was the earliest onset sexual practice, with 44% of our sample first engaging in it at 12 years of age or younger. Anal sex and oral sex were the sexual practices with the latest onset (25.4% and 23.8% performed for the first time at 16 years of age or older, respectively).

Table 3. Prevalence of Spanish adolescents in residential care who have engaged in sexual activity at 12 years of age or younger, between 13 and 15 years of age, and at 16 years of age or older and gender differences.

			Total			Gender						
						Male			Female			
		Sexual Practices/Age of First Time	12 Years Old or Younger % (*n*)	Between 13 and 15 Years Old % (*n*)	16 Years Old or Older % (*n*)	12 Years Old or Younger % (*n*)	Between 13 and 15 Years Old % (*n*)	16 Years Old or Older % (*n*)	12 Years Old or Younger % (*n*)	Between 13 and 15 Years Old % (*n*)	16 Years Old or Older % (*n*)	χ^2
Behavior	Sexual Practices	Any sexual activity	46.4 (127)	50.7 (139)	2.9 (8)	47 (86)	51.4 (94)	1.6 (3)	45.1 (41)	49.5 (45)	5.5 (5)	3.19
		Masturbation	44 (109)	51.8 (128)	4 (10)	41.8 (28)	50.7 (34)	7.5 (5)	45 (81)	52.2 (94)	2.8 (5)	2.78
		Mutual masturbation	21.2 (39)	59.3 (109)	19.5 (36)	25.7 (19)	64.9 (48)	9.5 (7)	18.2 (20)	55.5 (61)	26.4 (29)	8.29
		Oral sex	19.6 (28)	56 (77)	23.8 (35)	19.6 (11)	64.3 (36)	16.1 (9)	19.5 (17)	50.6 (44)	29.9 (26)	3.8
		Vaginal intercourse	19.6 (42)	63.7 (137)	16.4 (36)	24.3 (18)	64.9 (48)	10.8 (8)	17 (24)	63.1 (89)	19.9 (28)	3.72
		Anal sex	17.5 (9)	56.8 (29)	25.4 (13)	11.8 (2)	58.8 (10)	29.4 (5)	20.6 (7)	55.9 (19)	23.5 (8)	0.67

Note: Conditional percentage of the dependent variable knowing the category of the independent variable information. % = frequencies; *n* = number of subjects; χ^2 = chi-squared.

Table 3 also shows the frequency of men and women having sexual activities at 12 or younger, between 13 and 15, or at 16 or older.

As shown in Table 4, 42% of the sample used male condoms regularly, and 35% of them never used male condoms. The remaining contraceptive methods had a lower prevalence of use, with withdrawal being the next most prevalent (11.2%) after the male condom. The frequency of use of most contraceptive methods was influenced by gender (male condom, $\chi^2 = 9.65$, $p = 0.008$; withdrawal, $\chi^2 = 6.99$, $p = 0.03$; oral contraceptive pills, $\chi^2 = 14.49$, $p = 0.001$; hormone patches and injections, $\chi^2 = 17.34$, $p < 0.001$), with the exception of female condom use. Male condom use and withdrawal were in favor of men (43.5% and 13.9% for boys vs. 39.1% and 6.1% for girls, respectively), while oral contraceptive pills and hormone patches and injections favored women (4.2% and 2.3% for boys vs. 15.7% and 13.9% for girls, respectively). The differences with respect to the mean age of participants who used male condoms never, sometimes, and usually were statistically significant (F = 25.74, $p < 0.001$) as well as for hormone patches and injections use (F = 3.14, $p = 0.045$).

Table 4. Contraceptive methods use in Spanish residential care adolescents and differences between age and gender groups.

			Total	Age					Gender		
			% (*n*)	11–13 % (*n*)	14–16 % (*n*)	17–19 % (*n*)	M (SD) [b]	F-Value	d (CI) [a, c]	Male % (*n*)	Female % (*n*)	χ^2
Behavior	Contraception Methods Use	Male Condom						25.74 ***				9.65 **
		Never	35 (116)	82.5 (33)	32.7 (51)	23.3 (31)	14.87 (1.93)			29.6 (64)	45.2 (52)	
		Sometimes	23 (76)	2.5 (1)	28.2 (44)	23.3 (31)	16.07 (1.37)		−0.69 (−0.99, −0.39)	26.9 (58)	15.7 (18)	
		Usually	42 (139)	15 (6)	39.1 (61)	53.4 (71)	16.3 (1.52)		−0.83 (−1.09, −0.57)	43.5 (94)	39.1 (45)	
		Withdrawal						2.04				6.99 *
		Never	64.7 (214)	90 (36)	60.3 (94)	63.2 (84)	15.62 (1.93)			65.3 (141)	63.5 (73)	
		Sometimes	24.2 (80)	10 (4)	26.3 (41)	24.8 (33)	15.9 (146)		−0.15 (−0.41, 0.11)	20.8 (45)	30.4 (35)	
		Usually	11.2 (37)	0 (0)	13.5 (21)	12 (16)	16.19 (1.22)		−0.31 (−0.66, 0.04)	13.9 (30)	6.1 (7)	
		Oral contraceptive pills [d]						2.11				14.49 **
		Never	78.9 (261)	92.5 (37)	78.2 (122)	75.2 (100)	15.64 (1.8)			83.8 (181)	69.6 (80)	
		Sometimes	13 (43)	7.5 (3)	12.2 (19)	15.8 (21)	16.09 (1.69)		−0.25 (−0.58, 0.07)	12 (26)	14.8 (17)	
		Usually	8.2 (27)	0 (0)	9.6 (15)	9 (12)	16.19 (1.42)		−0.31 (−0.71,0.09)	4.2 (9)	15.7 (18)	
		Female condom [d]						0.09				0.28
		Never	96.7 (320)	100 (40)	95.9 (149)	97 (129)	15.74 (1.78)			96.3 (208)	97.4 (112)	
		Sometimes	3.3 (11)	0 (0)	4.5 (7)	3 (4)	15.91 (1.04)		−0.096 (−0.69, 0.51)	3.7 (8)	2.6 (3)	
		Usually	0 (0)	0 (0)	0 (0)	0 (0)	15.75 (1.76)		−0.006 (−1.97, 1.96)	0 (0)	0 (0)	
		Hormone patches and injections [d]						3.14 *				17.34 ***
		Never	86.4 (286)	100 (40)	86.5 (135)	82 (109)	15.65 (1.82)			90.7 (196)	78.3 (90)	
		Sometimes	7.3 (24)	0 (0)	7.1 (11)	9.8 (13)	16.33 (1.17)		−0.38 (−0.79, 0.04)	6.9 (15)	7.8 (9)	
		Usually	6.3 (21)	0 (0)	6.4 (10)	8.3 (11)	16.38 (1.32)		−0.41 (−0.85, 0.04)	2.3 (5)	13.9 (16)	

Note: Conditional percentage of the dependent variable knowing the category of the independent variable information. M = Mean; SD = Standard Deviation; % = frequencies; *n* = number of subjects; χ^2 = chi-squared; d = standardized mean difference; CI = Confidence Interval. [a] The 95% confidence interval does not include the null value (d = 0); [b] Mean age of the group of participants who have marked that alternative; [c] Standardized mean differences have "Never" as a comparative category; [d] The information on the frequency of use of this contraceptive method reported by the men in the sample refers to its use by their partners. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

4. Discussion

The development of successful sexual health involves multiple domains, including the acquisition of positive skills and understandings [42]. There is absolute agreement in the literature on the importance of possessing certain knowledge about sexual development and sexuality that demystifies many of society's strongly held beliefs [43], helps develop a positive and respectful attitude towards one's own and others' sexuality [44], and aids in the understanding that sexual behavior is, in and of itself, positive as long as the risks associated with certain sexual decisions are known and avoided [45]. This study aimed to explore the knowledge, attitudes, and behaviors of adolescents living in residential care facilities in Eastern Spain.

Contrasting the sexual knowledge of adolescents in our sample compared to the sexual knowledge of adolescents in a community sample from the same country who were assessed with the same instrument [36], we can conclude that adolescents in residential care in Eastern Spain have poor knowledge about sexuality in general, including STIs and contraceptive methods. This could be due not only to the fact that this group receives much less sexual education because of their habitual mobility of facilities and worse access to sexual health services [33] but also because, given their earlier sexual activity, information about sexuality comes too late [12]. Other research on youth in the child welfare system also reported similar results [8,11]. In addition, our findings agreed with those of Claramunt [36], who reported that young people have more knowledge about STIs than about contraceptive methods or general aspects of sexuality (sexual practices, sexual response, etc.). This could be because STIs are also part of the compulsory school curriculum and, therefore, their learning is reinforced in the classroom. However, despite the over information that may be available to adolescents about STIs, there is an increase in them, probably favored by the lack of effective campaigns and educational programs against STIs.

Gender differences in sexuality have long been a research target. In our study, as in other literature with adolescents in the child welfare system in other countries (e.g., Combs et al. [9]), girls had more knowledge about sexuality. These results could be explained by girls' more frequent access to sexual health services, a place to obtain information about human sexuality. However, Claramunt [36], in their research with adolescents from a community sample of the same country, did not find these results since, although girls scored slightly higher, they did not find significant differences compared to

boys. As for the influence of age, although our results could not be compared with other research conducted with adolescents in the child welfare system, it certainly appears that as age increases, so does their knowledge of contraceptive methods. This may be due to an increased interest in safer sex practices with age or simply because visits to sexual and reproductive health services are becoming more frequent with age, especially among girls. Studies with adolescents from a community sample [46] obtain similar results, although they report that the sexuality knowledge of this population remains disturbingly low even in older participants with higher scores.

The adolescents in our sample also seem to have less positive attitudes towards sexuality, if we compare our results with those obtained by Claramunt [36]. In this regard, previous research with adolescents in the child welfare system reported somewhat contradictory information [8], although in any case, they agreed that it should be an aspect on which to intervene, especially considering that beliefs and attitudes are strongly influenced by family values and experiences, which tend to be particularly negative in these adolescents. This would also justify the findings, which indicate that adolescents in residential care in Eastern Spain show a high internalization of sexist attitudes, much higher than that of young people in the community population [18]. These results support that adolescents who live or have lived in potentially problematic homes are more likely to follow gender roles and develop stereotypical behaviors [13,47]. The findings of our study also confirm that in both males and females' benevolent sexist manifestations are more frequent than hostile ones [14] as well as in community adolescents [18]. These results reflect the tendency of developed societies to present more covert manifestations of sexism due in part to numerous advances in equality that have occurred in recent decades and that punish the most obvious expressions of sexism [48].

In relation to the latter, these social movements also seem to be bringing about a paradigm shift with respect to the expression of attitudes towards the sexuality of the different sexes. Although traditionally, boys were the ones who showed more positive attitudes towards sexuality [49], currently, both in the community sample [16,36] and in the child welfare system [14], girls seem to present more liberal attitudes towards sexuality and less homo/heterophobic and sexist attitudes. The higher prevalence of sexist attitudes in boys confirms the maintenance of traditional gender roles in adolescents in the child welfare system as a consequence of the influence of patriarchal family contexts [50]. By contrast, age was not shown to be a variable influencing adolescent attitudes, with the exception of hostile sexist attitudes. This is consistent with what has been found in studies with youth in the child welfare system [14], although not in a community sample [18]. The positive relationship between hostile sexism and age could be explained by the greater influence that older adolescents have received from social and cultural models faithful to an even more conservative patriarchal ideology [51].

All of the above is reflected, to some extent, in the sexual behavior of our sample. The vast majority of adolescents in residential care in Eastern Spain interviewed had engaged in sexual activity, with masturbation being the most frequent sexual practice. However, what is most worrying is that they started to engage in sexual exchange activities at a very early age, with almost a quarter of adolescents having their first sexual activity before the age of 13. Other studies with adolescents in the child welfare system have reported similar results [24] and highlighted that their participants engaged in sexual practices much earlier than adolescents in community samples [23]. Being a victim of childhood sexual abuse, suffering intimate partner violence, or presenting mental health and substance abuse problems, has been related to an earlier age of sexual debut [25,52]. Given that these problems are highly prevalent in this population, as well as in our sample (more than 30% had mental health and/or substance abuse problems), this could explain the earlier sexual initiation in adolescents in the child welfare system versus peers in the community sample. However, gender was not shown to be an influential variable either in the age of sexual initiation or in the prevalence of the different sexual practices evaluated, with the exception of masturbation, where boys reported engaging more in this self-pleasure practice. In this

sense, it seems that despite the efforts made to encourage the female population to take responsibility for their own body and pleasure, promoting self-exploration and sexual self-stimulation, the results show that the adolescent girls in our sample continue to masturbate considerably less than boys. Genital anatomical, hormonal differences, and, of course, the strong influence of society and culture explain these results [53]. Nevertheless, the absence of differences with respect to the other sexual practices evaluated does reflect some progress in demystifying information about female sexuality. With respect to age, those who report having engaged in sexual practices have a higher mean age than those who have never engaged in these sexual activities. Likewise, older adolescents in our sample also reported later sexual onset.

Despite the high sexual activity of this sample, contraceptive use was low among these adolescents. Less than half of the sample regularly used the male condom, and an even smaller percentage used other contraceptive methods (oral contraceptive pills, hormone patches and injections, or female condoms). Similar results were reported by Cheung et al. [29] in their study of youth in the child welfare system in Texas, with nearly half of their sample using no contraception and one-quarter using condoms. Lambert et al. [25], in their study with adolescents in the child welfare system, also found similar results, although, in our sample, girls presented a slightly higher male condom use prevalence and slightly lower oral contraceptive pills use. Among adolescents in a community sample, although the priority of use of the different methods appears to be similar, the prevalence of use is much greater [54]. It is of concern that withdrawal was cited as the second most used contraceptive method among adolescents in our sample, as it is considered a "non-method," which does not protect against STIs or unwanted pregnancies. The main reason for engaging in this practice appears to be dissatisfaction with hormonal methods or the desire to express confidence in the partner [55]. It is also worth noting the low use of female condoms compared to male condoms, as in the community sample, due in part to their high cost, lower accessibility, and lack of knowledge regarding their existence [54]. As in other studies of adolescents in the child welfare system [8,25,30], boys appear to make greater regular use of male and female condoms and withdrawal, whereas girls make greater use of oral contraceptive pills and longer-acting contraceptives compared with boys. This shows, once again, the greater vulnerability of girls to contracting STIs [56], but it is also a reflection of the lack of sexual assertiveness they often exhibit, which increases their risk of teen dating violence [57]. Age was also shown to be a significant variable in the use of male condoms and longer-acting contraceptives, with the use of these contraceptive methods becoming more common with the increasing age of the participants. These findings are supported by reports from other studies with youth living in emancipation households [32] and could be explained by cognitive advances with age that influence lower risk-taking [27,28] and greater access to sexual health resources with age.

To our knowledge, this is the first study conducted with adolescents in Spanish residential care focused on exploring their sexual health by analyzing their sexual knowledge, attitudes, and behaviors. However, it is not without limitations. Although the representativeness of the sample and the internal validity have been satisfactory, in order to generalize our results, the number of residential care participants should be increased to increase the external validity and, therefore, its generalization to other contexts. Moreover, the distribution of the sample by gender and age was not completely equal, as there was a higher percentage of boys between 14 and 16 years of age. However, this has been taken into account when analyzing and interpreting the results, and the sample represented the typical gender and age distribution of youth in residential care. Likewise, it should be noted that although all the measurement tools obtained a Cronbach's Alpha of 0.6 or above in the reliability analysis, some professionals consider this value to be acceptable but not good, so precautions should be taken in this regard. Finally, the existence of a social desirability bias in the participants' answers should not be ignored since we are dealing with particularly sensitive topics such as sexist attitudes. To control this, the anonymity of the adolescents who volunteered for the study was guaranteed.

5. Conclusions

Sexual health is a significant component of overall health, and evidence suggests that for adolescents in the child welfare system, it is even more so, given their life histories marked by experiences of abuse, maltreatment, or neglect. Therefore, this is a critical area that cannot be left unattended if we really want these boys and girls to have healthy development and achieve integral well-being. However, it seems that in this group, on many occasions, no one is assuming the role of a sex educator, which typically corresponds to parents. On the one hand, it is not clear who should assume this responsibility, and on the other hand, resource professionals are not always properly trained and have appropriate educational strategies to implement. Thus, this study should be considered an appeal to the main caregivers of this sample group as well as to those responsible for their training.

This research allows us to conclude that the low level of knowledge about protection methods, the early initiation of sexual exchange activities, and the scarce use of protection methods, together with sexist attitudes, place this group in a situation of great vulnerability. This increases the risk of unwanted pregnancies, sexually transmitted infections, and even dating violence. Child welfare policymakers must also be aware of this reality in order to take action and implement appropriate steps in the area of sex education, not only aimed at adolescents but also at the professionals who care for them and who sometimes do not know how to attend to and manage the needs of the younger people in this area of development. Ensuring greater access to sexual health services at an early age and having spaces in which to share doubts and concerns about this topic can be effective measures, provided they are supported by experts that adolescents can trust.

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Anexo 3

Estudio 3

Sexual Victimization of Adolescents in Residential Care: Self-Reported and Other-Reported Prevalence

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Sexual Victimization of Adolescents in Residential Care: Self-Reported and Other-Reported Prevalence

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ABSTRACT

Adolescents in the child welfare system have been exposed to multiple forms of victimization, most notably sexual victimization, many times underreported and misreported. The main aim of this study was to explore the lifetime prevalence of sexual victimization among adolescents in residential care in Eastern Spain, contrasting self-reported information compared to the information reported by the professionals. Sexual abuse/assault characteristics and effects of gender and age were analyzed. Additionally, the association between sexual revictimization and the relationship with the aggressor as well as the age of the first episode of sexual abuse/assault was analyzed. The sample comprised 346 adolescents (34.1% females, 65.9% males) aged between 11 and 19 years old. The prevalence of sexual victimization reported by adolescents was 35.3%, more than double compared to the information reported by professionals (16.9%). Females experienced significantly more sexual victimization than males (OR = 0.23, 95% CI [0.14, 0.37]). The age of the victim at the first episode of sexual abuse/assault and the relationship with the aggressor were explanatory variables of revictimization. Research such as this is crucial to ascertain that these adolescents have very different needs that will influence the design of affective-sexual education initiatives, which are essential to ensure healthy sexual development.

Introduction

Children and adolescents in the child welfare system are considered a particularly vulnerable group (Euser et al., 2014; Indias et al., 2019). This is the case for boys and girls who are in residential care, either because it is the most appropriate measure in view of their particular circumstances or because it is pending consideration of whether their home context improves or whether there is a foster care family that adequately meets their needs (Dirección General de Infancia y Adolescencia [DGIA], 2017). Most of them, prior to being cared for in residential care, have suffered multiple direct and/or indirect forms of victimization that may have contributed to forging their exit from their home (Browne, 2009; Collin-Vézina et al., 2011). These negative experiences can disrupt the child's healthy biopsychosocial development from a very early age (American Academy of Pediatrics, 2012).

Sexual victimization, any sexual behavior under coercion, manipulation or use of violence, has been shown to be one of the most frequent problems among adolescents and young adults in residential care. Indias et al. (2019) recruited adolescents from 24 residential care facilities in two Spanish regions and they reported that 41.1% of their sample had been victims of some form of sexual victimization in their lifetime, with higher prevalence than other regions in north-Eastern Spain (29.5%; Segura et al., 2015), but lower than in other European studies (62%; Allroggen et al., 2017 in Germany) and similar to other developed countries (38.3%; Wekerle et al., 2017 in Canada). In any case, these data are alarming when compared to results from studies that have recruited adolescents from the general community, which report much lower prevalence (8.7%, Pereda et al., 2014 in Spain; 10%, Sani et al., 2021 in Portugal; 15.1%, Méndez-López & Pereda, 2019 in Mexico). These data not only highlight the harsh childhoods that children and adolescents living in residential care facilities have, but it may also hint at the greater likelihood that they will experience negative outcomes in multiple areas of their lives (Fergusson et al., 2013; Wekerle et al., 2017) compared to adolescents living in their family homes.

When the prevalence of sexual victimization, in particular of vulnerable groups, is analyzed the source of the information must be taken into account. Thus, it has been found that when data are self-reported by adolescents in residential care facilities, a much higher prevalence is disclosed than when the information comes from government reports (Euser et al., 2013; Gilbert et al., 2009). This could be due to the fact that, in most cases, government records only include officially reported cases and, as a result, the actual frequency of sexual violence is likely to be underestimated (Allroggen et al., 2017; Euser et al., 2013), especially considering that although many children and adolescents disclose their sexual victimization experiences to others, they don't make official reports (Herrera, 2006). Lower prevalence is also reported when the information is provided by residential professionals (Deutsches Jugendinstitut, 2011), although they do not only rely on officially reported cases. It should be noted that retrospectively self-reported information, while certainly reporting

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data that are more in line with reality, also includes considerable false negative rates (between 40 and 50%; Hardt & Rutter, 2004; Scott et al., 2010) and presents some limitations (such as it requires the victim to recall the traumatic event and recognize it as an experience of sexual victimization; Paine & Hansen, 2002). Therefore, the combination of information reported by two or more sources is the most adequate method to capture a more complete spectrum of sexual victimization cases (Negriff et al., 2017; Smith et al., 2008).

The studies about the most prevalent type of sexual victimization among adolescents are inconclusive. Many studies report that the most common sexual abuse/assault is the one committed by peers among young people (Allroggen et al., 2017; Euser et al., 2013; Indias et al., 2019). However, others (e.g., Segura et al., 2015) have reported sexual abuse/assault by a known adult as the most frequent. These inconsistencies have also been found in studies with adolescents in community samples (Méndez-López & Pereda, 2019; Pereda et al., 2014). In addition, there have been limited studies interested in examining the profile of the perpetrator as a means to better understand the variables that may be influencing the high rate of sexual victimization among adolescents in residential care facilities. In more than 70% of the cases the aggressor is male and is approximately the same age as the victim (Allroggen et al., 2017; Euser et al., 2013). These characteristics of the perpetrator are the same for those studies with adolescents from a community sample (UBS Optimus Foundation, 2012).

Both research with adolescents in residential care facilities and research including community-sampled youth, report female participants having higher rates of reporting sexual victimization experiences than male participants (Allroggen et al., 2017; Euser et al., 2013; Indias et al., 2019; MacMillan et al., 2013; Méndez-López & Pereda, 2019; Pereda et al., 2014). Some studies attribute these gender differences to the internalization of social gender norms and male stereotypes by boys, which leads them to suffer greater stigmatization when they are victims and to feel guilty for not having been able to stop the aggressor (Esnard & Dumas, 2013; Wekerle et al., 2017). In relation to the age of the participants at the time of assessment, although research has rarely concluded the existence of significant differences between the different age groups (Euser et al., 2013; Segura et al., 2015), older adolescents do seem to report a slightly higher percentage of lifetime sexual victimization compared to younger adolescents in residential care (Indias et al., 2019; Segura et al., 2015). These results are also similar among young people in community samples (Finkelhor et al., 2014; Méndez-López & Pereda, 2019; Pereda et al., 2014). The most commonly found justification is that older adolescents have had a longer period of time to experience these victimizations (Finkelhor, Ormrod et al., 2009) and their advanced metacognitive development allows them to more easily retrieve past memories and repeat these experiences (Ensink et al., 2016; Finkelhor, Ormrod et al., 2009).

There is a lack of studies focusing on age and frequency of victimization among children and adolescents living in residential care. However, among the few published studies, it has been found that victims are frequently victimized in more than one context and this makes them more likely to suffer multiple episodes of sexual abuse/assault (Finkelhor, Omrod et al., 2005; Turner et al., 2016). The multiple negative consequences of experiencing sexual victimization have been studied to a greater extent. Thus, the most common internalizing problems include depression, anxiety and post-traumatic stress disorder, and the most frequent externalizing problems include disruptive behavior at home and with peers and substance abuse (Finkelhor, Turner et al., 2009; Kendall-Tackett, 2009). This information is crucial to provide tailored and efficacious interventions among children and adolescents living in residential care to ensure adequate biopsychosocial development. In this way, government agencies will also be able to develop useful and effective action plans, which are as scarce as they are necessary at this time.

Finally, historically, Eastern Spain, given its wealth and advantageous location, is overpopulated compared to other parts of Spain (the fifth most populated region in part of Spain; National Institute of Statistics, 2021). This part of Spain has had a significant growth of suburban areas (e.g., highest rural population growth of all Spanish regions in 2019, 34,000 people in a year; Regional Observatory of Valencia, 2019) where people have poorly paid jobs, contributing to a greater number of dysfunctional families and, to that extent, to higher levels of neglect in the care of children, sometimes leading to child abuse (Mora Castro et al., 2018). This, together with the growing number of cases of sexual victimization of children and adolescents in residential care that are coming to light, makes the study of this controversial issue in this region of Spain especially relevant not only for academics and experts, but also for the general population and the government, which is becoming concerned about the characteristics of the adolescents in its care and aims to prevent this type of event from continuing to occur. In this regard, in recent years, a significant investment of resources has been made in the implementation of measures aimed at improving the care received by children and adolescents in the child welfare system. For all these reasons, we cannot rely on published data from regions with similar sociodemographic characteristics this context has had and continues to have its own characteristics.

Objectives of This Study

The first aim of our study was to assess the lifetime prevalence of sexual victimization of adolescents in residential care in Eastern Spain, and to describe the main characteristics of the different types of sexual victimization. To strengthen our evidence, we have obtained and contrasted information provided by both professionals and adolescents themselves. Having both sources of information allowed us to assess the degree of agreement between professionals and adolescents about the prevalence of sexual victimization. The second objective was to identify special vulnerable groups among adolescents in residential care facilities, analyzing differences in the prevalence of sexual victimization as a function of gender and age of the adolescent at the time he/she/they has been assessed,

since previous research has reported that both are important variables to explore in this group. The third and final aim was to examine whether the type of relationship with the aggressor and the age of the first episode of sexual abuse/assault could be variables related to the sexual revictimization of adolescents (greater number of episodes of sexual abuse/assault and/or more types of sexual victimization).

Method

Participants

The sample comprised 346 adolescents recruited from the child welfare system in Eastern Spain. All of them were teenagers who were in residential care because they had been deprived of their main rights and were in a situation of risk or lack of protection that endangered their physical and/or emotional well-being. In addition, although priority was given to the selection of centres located in urban areas with a medium population density, the representativeness of the population in rural areas was taken into account given their differential characteristics. Thus, in the final sample, around 16.19% of the participants were from cities with a population density >500,000, around 60.69% were from cities with a population density between 10,000 and 500,000, and around 23.12% were from cities with <10,000 inhabitants (considered rural areas).

In the sample, 34.1% (n = 118) were female adolescents, while 65.9% (n = 228) were male adolescents. All participants in the study were between 11 and 19 years of age (M = 15.73; SD = 1.76). Almost half of the sample (48.5%, *n* = 167) were between 14 and 16 years old, followed by 39.2% (*n* = 135) between 17 and 19 years old and only 12.2% (*n* = 42) who were between 11 and 13 years old. The majority of adolescents (57.9%) were born in Spain, 29.7% in Morocco and the remaining nationalities were underrepresented (Eastern European: 4.7%; West African: 3.3%; South/Central American: 2.7%; Pakistani: 1.2%; and Portuguese: 0.6%). The majority were between 7th and 10th grade, (49.7%, *n* = 172), followed by those doing associate degrees[1] (29.1%, n = 101); 7.3% (*n* = 25) were between 1st and 6th grade, 0.6% (*n* = 2) in 11th or 12th grade and 1.8% (*n* = 6) in unregulated courses. The rest worked (2.1%, *n* = 7) or did none of the above (9.4%, n = 33). Regarding health problems, while only 11% (*n* = 37) reported physical health problems, the percentage of adolescents with mental health problems amounted to 29.9% (*n* = 100).

The inclusion criteria established for the selection of the sample were: (1) being 11 years of age or older and, and (2) living in a residential care facility at the time of the interview. Finkelhor, Omrod et al. (2005) suggested that youth can respond to surveys on child maltreatment with reliable information after age 10.

[1]An associate degree is the first level of non-vocational degree you can pursue following a high school diploma. Typically designed to be completed in two years or less, associate degree programs include introductory courses through which students can start to learn about a particular field or academic discipline.

Measures

Child and Adolescent Protection System Form (CAPSys; Fernández-García et al., in press)

This instrument consists of 67 items, 58 closed-ended responses (dichotomous and multiple-choice), and 9 open-ended responses, grouped into six dimensions: *General information* (9 items), *School/work situation* (9 items), *Protection system history* (9 items), *Family visitation history* (9 items), *Biological family information* (24 items), and *Experiences of sexual abuse/maltreatment* (7 items). For this study, information related to the dimensions "*General information*" (basic information about the adolescent in terms of gender, date of birth, nationality, physical or mental health problems, etc.), "*School/work situation*" (information about the participant's occupation) and "*Experiences of sexual abuse/maltreatment*" (information available to the residential care facilities professionals about the participant's possible experiences of sexual abuse) was used. It is an instrument designed to be completed by a professional from the residential care facility who knows the child well and has access to his/her/their record. The internal consistency of the CAPSys dimensions, measured as Cronbach´s alphas (r), was r = 0.61, r = 0.74 and r = 0.78, respectively.

The Juvenile Victimization Questionnaire (JVQ; Finkelhor, Hamby et al., 2005)

The JVQ evaluates, in a self-reported format, 36 different types of victimization against children and youth grouped into six modules: conventional crime (nine items), caregiver victimization (four items), victimization by peers and siblings (six items), sexual victimization (six items), witnessing and indirect victimization (nine items), and electronic victimization (two items). For each item the presence or absence of this victimization experience was scored as 1 or 0, respectively. In the current study, only the sexual victimization module was used, which inquired about 4 specific lifetime experiences of this type of victimization (sexual abuse/assault by a known adult, sexual abuse/assault by an unknown adult, sexual abuse/assault by a peer, and flashing/sexual exposure). Evidence of the validity of the Spanish adaptation of the JVQ has shown adequate psychometric properties (Pereda et al., 2016). The reliability for the sexual victimization module was r = 0.62 in our study.

Procedure

First, permission was obtained from the Directorate General for Childhood and Adolescence (DGCA) of the Valencian Region, the administrative agency responsible for implementing steps to protect minors and who has guardianship over them. Subsequently, the coordinators and directors of the residential care facilities were contacted to explain the project and to request authorization from them to enter the centers. Once this first contact had been established, the center's staff explained the proposal to the youth of the residential care facility and appointments were arranged with the minors who wished to participate on a voluntary basis. No financial assistance or compensation was offered to participants.

Three professionals from the research team with extensive experience in the evaluation and treatment of minors were trained in the application of this battery of instruments, with the aim of avoiding or reducing as much as possible the interviewer bias in the evaluation of the participants and ensuring the maximum reliability and validity of the data collected. The application of the standardized instruments was carried out in person, individually and in a comfortable environment of maximum privacy. Only the participant and one of the evaluators were present while the assessment was being completed. Adolescents had the option to complete the instruments as a semi-structured interview with the professional or autonomously, depending on the participant's comfort as well as their level of comprehension, reading, and writing skills. All participants were informed of the confidentiality of their responses before beginning to complete the battery as well as their right to leave the study at any time. CAPSys had to be completed by a professional from the center (director, psychologist, educator, etc.) who knew the adolescent well, and who had been previously instructed to ensure full understanding of the items on the form. A single professional was in charge of reporting information on the adolescent. The professional extracted the information mainly from the participant's child welfare system report, which includes all of the adolescent's data since entering in the child welfare system. Likewise, in specific questions, the professional was expected to convey their general knowledge about the adolescent's behavior in the center or respond with the information that the boy or girl had transmitted directly to him or her on the subject. The expert (the senior author) was always available to resolve any doubts.

For this cross-sectional study, 60 residential care facilities in Eastern Spain were contacted, of which 47 were finally recruited. These homes and residences offer comprehensive and educational care to children and adolescents in care and/or guardianship who are deprived of a suitable family environment. The study complied with the ethical principles of the 1964 Declaration of Helsinki and was approved by the Experimental Research Ethics Committee of the University of Valencia (Spain).

Data Analysis

Descriptive analyses were conducted, including means and SDs for numerical variables, and percentages for categorical variables. For the JVQ sexual victimization module and each specific submodule we computed prevalence rates for lifetime, including odds ratios (OR), to compare across age, and beta coefficient (β) was used to compare gender groups. Variables related to sexual revictimization were explored by using logistic regressions and reporting ORs. OR was considered statistically significant when its 95% confidence interval (CI) did not include the value 1, and the β when its 95% CI did not include the value 0. Finally, to explore the variables related to sexual revictimization, the AC statistic for categorical variables and Pearson correlations for numerical variables were calculated to analyze the degree of agreement between the responses of both informants. The AC statistic, degree of agreement, can be interpreted as 0.25, 0.5, and 0.75 for small, median, and large level of concurrence, respectively (Gwet, 2002). SPSS v.24 was used for all data analysis and Excel to calculate degree of agreement.

Results

Self-Reported Sexual Victimization

In our sample, 35.3% of the adolescents (58.8% of female adolescents and 24.4% of male adolescents, *OR* = 0.23, 95% *CI* [0.14, 0.37]) reported at least one experience of sexual victimization during their lives. Sexual abuse/assault by a peer was the most common form of sexual victimization reported (21%). Differences between male and female participants were statistically significant for all types of sexual victimization reported, with boys reporting less sexual victimization than girls (Table 1). There were no statistically significant differences on any of the types of sexual victimization explored by age groups (Table 1). However, the percentage prevalence of sexual victimizations overall and for the sexual abuse/assault by a known adult was higher among older adolescents (17–19 years old) (37.9% and 16.7%, respectively), while adolescents between 14–16 years old reported a higher percentage of sexual abuse/assault by an unknown adult (8.8%). The percentage of sexual abuse/assault by a peer and flashing/sexual exposure was higher among younger adolescents (26.8% and 24.4%, respectively). Table 1 presents prevalence of different types of sexual victimization and differences between age and gender groups.

Considering the different types of sexual victimization (Table 2), sexual abuse/assault by a known adult was the one in which victims experienced more episodes (M (SD) = 7.92 (9.65)), and they were younger when this occurred (M (SD) = 10.18 (3.72)). Regardless of the type of victimization, the percentage of male offenders was higher, although the age of the perpetrator changed slightly depending on the type of sexual

Table 1. Prevalence of different types of sexual victimization in Spanish residential care adolescents reported by themselves, and differences between age and gender groups.

		Age group (%)				Gender (%)		
	Victimized *n* (%)	11–13	14–16	17–19	β (CI)[a]	M	F	OR (CI)[a]
Sexual victimization	122 (35.3)	34.1	35.6	37.9	0.007 (−0.02, 0.04)	24.4	58.8	**0.23** (0.14, 0.37)
S1. Sexual abuse/assault by a known adult	53 (15.9)	10	16.3	16.7	0.005 (−0.02, 0.03)	8.3	29.9	**0.21** (0.11, 0.39)
S2. Sexual abuse/assault by an unknown adult	25 (7.5)	4.9	8.8	6.1	−0.002 (−0.02, 0.01)	5.1	11.9	**0.39** (0.17, 0.90)
S3. Sexual abuse/assault by a peer	70 (21)	26.8	21.3	18.3	−0.02 (−0.04, 0.008)	15.3	31.4	**0.39** (0.23, 0.68)
S4. Flashing/sexual exposure	52 (15.5)	24.4	15.6	12.9	−0.02 (−0.4, 0.008)	9.7	26.3	**0.3** (0.16, 0.55)

Conditional percentage of the dependent variable knowing the category of the independent variable information.
[a]The 95% confidence interval does not include the null value (OR = 1; β = 0).

Table 2. Characteristics of each type of sexual victimization as self-reported by adolescents in residential care.

	Sexual victimization	S1. Sexual abuse/assault by a known adult	S2. Sexual abuse/assault by an unknown adult	S3. Sexual abuse/ assault by a peer	S4. Flashing/ sexual exposure
Average n° of times [M (SD)]	8.86 (11.49)	7.92 (9.65)	3.08 (5.79)	4.23 (5.79)	6.24 (8.27)
Average age of the adolescent [M (SD)][a]	11.39 (3.89)	10.18 (3.72)	11.83 (4.17)	12.81 (3.15)	12.04 (3.18)
Sex of perpetrator (%)					
Male	72.1	79.2	88	68.6	69.2
Female	25.4	18.9	12	30	26.9
Both	2.5	1.9	-	1.4	3.8
Average age of perpetrator [M (SD)][a]	26.62 (14.54)	36.26 (13.12)	31.46 (12.54)	14.7 (2.68)	22.31 (12.55)
Introduced any object (%)	39.1	40.4	28	32.9	25
Reported (%)	28.1	42.3	32	14.3	11.5
Talked about what happened (%)	26.9	44.2	28	12.9	9.6

[a]The age of the adolescent and the perpetrator refer to when the victimized experience occurred.

victimization reported. Introduction of objects during the sexual abuse/assault was more frequent when the perpetrator was a known adult (40.4%). The victim usually reported to the police or the court or talked about what happened more often when the perpetrator was a known adult (42.3% and 44.2%, respectively). Sexual abuse/assault by a known adult was usually perpetrated by a family member (38.5%), while sexual abuse/assault by a peer was usually perpetrated by a classmate or a roommate (37.1%; Figure 1).

Almost half (45.08%) of the victims had suffered more than one form of sexual victimization (28.69% suffered two forms; 13.93% three forms; and 2.46% four forms of sexual victimization). All types of sexual victimization were shown to be predictive of increased sexual victimization in general (S1, *OR* = 8.39, 95% *CI* [5.1, 13.79]; S2, *OR* = 6.51, 95% *CI* [3.75, 11.3]; S3, *OR* = 7.43, 95% *CI* [4.76, 11.58]; S4, *OR* = 11.07, 95% *CI* [6.26, 19.59]). Having suffered more than one type of sexual victimization also showed significant positive correlations with the number of times the individual was victimized ($r = 0.38$, $p < .001$). Having suffered sexual abuse/assault by a family member was significantly positively associated with greater exposure to other types of abuse ($r = 0.24$, $p = .01$) and to happen more often ($r = 0.29$, $p = .002$) than other types of abuse. First time victimization age also exhibited significant positive correlations with greater revictimization (n° of types of sexual victimization, $r = 0.38$, $p < .001$; n° of times, $r = -0.39$, $p < .001$)).

Other-Reported Sexual Victimization

Professionals reported that 16.9% of the participants were suspected of having suffered sexual victimization, and 51% of those cases were confirmed. There were statistically significant gender differences in the prevalence of sexual victimization reported by professionals (*OR* = 0.25, 95% *CI*

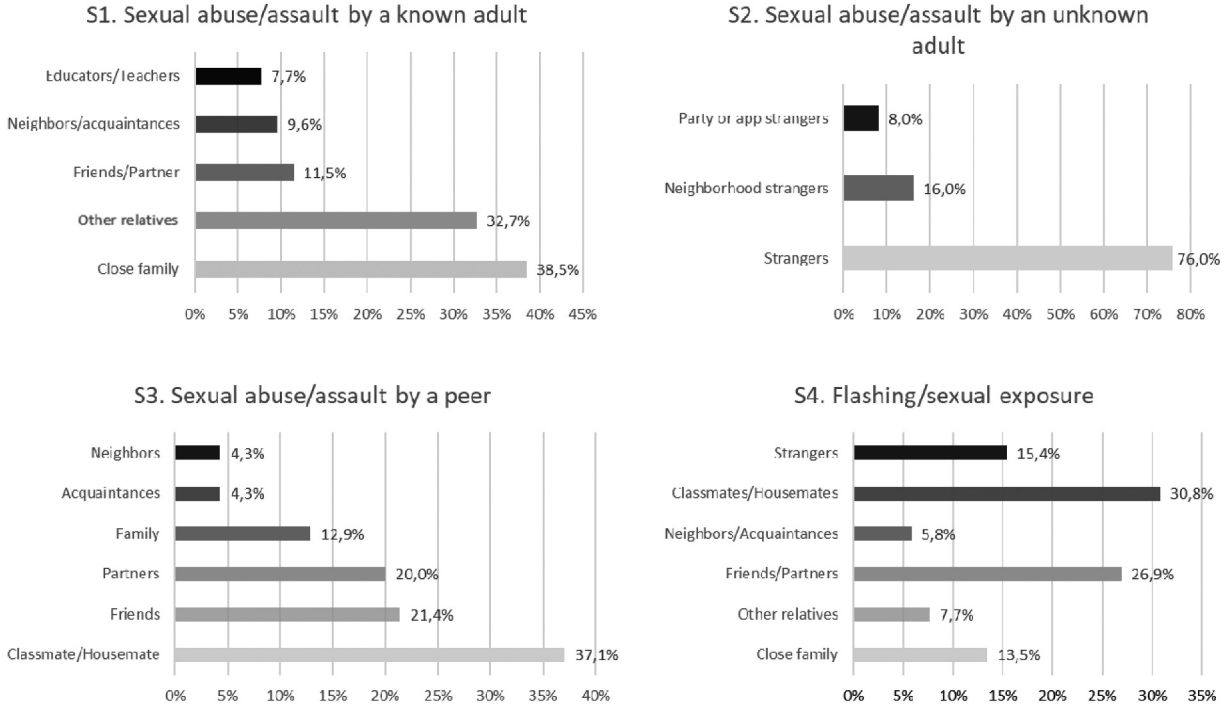

Figure 1. Perpetrator-victim linkage ("Who is the perpetrator") based on type of sexual victimization as self-reported by adolescents in residential care. Note: "*Stranger*" was understood as someone you have never seen and with whom you have never established contact of any kind prior to the sexual victimization event; "*Friend*" as a person with whom you have close ties of mutual affection that lead you to feel trust and real sincerity towards him or her; and "*Acquaintance*" as a person whom you know either because you have certain information about him or her or because you recognize his or her face, identifying that it is not the first time you have seen him or her, but with whom you do not have a strong bond of affection that brings you trust and security.

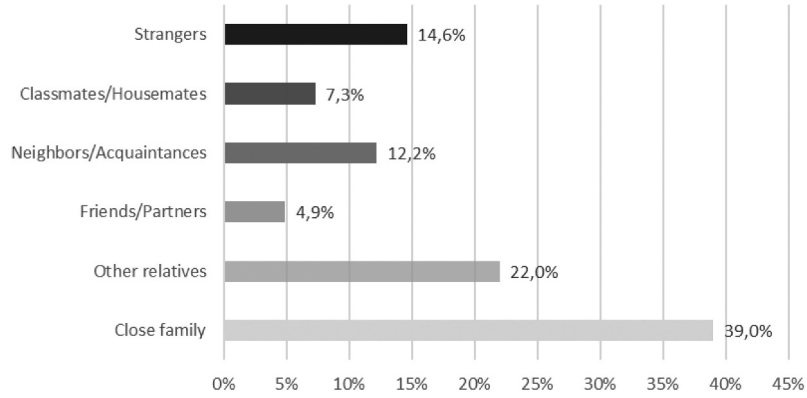

Figure 2. Perpetrator-victim linkage in the experiences of sexual victimization ("Who is the perpetrator") as reported by residential care professionals. Note: "*Stranger*" was understood as someone you have never seen and with whom you have never established contact of any kind prior to the sexual victimization event; "*Friend*" as a person with whom you have close ties of mutual affection that lead you to feel trust and real sincerity towards him or her; and "*Acquaintance*" as a person whom you know either because you have certain information about him or her or because you recognize his or her face, identifying that it is not the first time you have seen him or her, but with whom you do not have a strong bond of affection that brings you trust and security.

[0.14, 0.45]), with male adolescents having the lowest percentages (male, 10%; female, 30.9% of the total of the sample). However, no statistically significant differences were found according to age (β = −0.007, 95% CI [−0.03, 0.16]; 11–13 years old, 20.5%; 14–16 years old, 18.2%; 17–19 years old, 14.8%). Professionals reported the perpetrators being mostly male adolescents (93.2%) known to the victim (91.5%) (mainly close family members, 39%; Figure 2). More than half of professionals (51.6%) reported emotional disorders as the sequelae of adolescents who had suffered sexual abuse and professionals declared that 75.6% of these adolescents had received therapeutic support. Table 3 presents the information about the prevalence of sexual victimization and its characteristics reported by professionals.

Comparative Self-Reported Vs Other-Reported Information

The degree of agreement between adolescents and professionals about the information reported was 0.39 (see Table 4). Regarding prevalence, 74 adolescents reported having suffered sexual victimization without awareness among the professionals. However, professionals reported that 17 adolescents had suffered some type of sexual victimization while the adolescents denied it.

Table 3. Prevalence and characteristics of sexual victimization experiences in adolescents in the Spanish residential care as reported by professionals.

	M (SD)/%
Suspected sexual victimization	16.9
Confirmation of sexual victimization[a]	51
Average n° of times	7.04 (7.98)
Relationship with the perpetrator	
Known	91.5
Unknown	8.5
Sex of perpetrator	
Male	93.2
Female	6.8
Short- and long-term consequences	
Emotional disorders	51.6
Sexual disorders	12.9
Social interaction problems	12.9
Self-injurious behaviors	9.7
Urination and bowel and bladder control problems	6.5
None	6.5
Therapeutic support	75.6

[a]Percentage of confirmed cases out of the total number of suspected cases.

Table 4. Degree of agreement between information reported by adolescents and professionals regarding the prevalence of sexual victimization experiences and their characteristics.

	Degree of agreement
Prevalence of sexual victimization	0.39
Number of times	0.29[a]
Relationship with the perpetrator (Known/Unknown)	0.90
Who is the perpetrator (close family, other relatives, etc.)	0.70
Sex of perpetrator	0.93

[a]Degree of agreement of the variable *number of times* (quantitative variable) was calculated by performing a Pearson correlation.

Discussion

Using information reported by adolescents and professionals in residential care facilities, this study has shown the extent of lifetime sexual victimization of adolescents in residential care in Eastern Spain. Collecting information from two different sources in this group of adolescents in Spain was a methodological innovation itself, since in the current scientific literature there is no evidence of prevalence of lifetime sexual victimization among this high-risk group reported by different informants having been collected in the same study.

If we first examine the self-reported prevalence rate, the adolescents in our study reported a high prevalence of sexual victimization (35.3%), similar to that reported by studies with similar sample characteristics (Indias et al., 2019; Segura et al., 2015; Wekerle et al., 2017). Youth immersed in the child welfare system have often witnessed, directly and/or indirectly, situations of abuse and/or neglect in their immediate environment and have not grown up with their basic physical and emotional needs met (Indias et al., 2019). This, among other things, not only increases the likelihood that they will become involved in toxic affective relationships given their problems in

establishing secure attachments, but also predisposes them to exhibit low sexual assertiveness and lack the necessary skills to refuse unwanted sexual relations (Hanson, 2016; Thompson et al., 2017). Euser et al. (2013) considered that a structural problem of residential care facilities could be behind this high prevalence. They argued that in these settings live large groups of children with frequent behavioral problems, which could increase the risk of sexual abuse/assault by peers, the most frequent type of victimization. Several studies focused on this high-risk population group (Allroggen et al., 2017; Euser et al., 2013; Indias et al., 2019) as our study did (specifically abuse/assault perpetrated by classmates or housemates). However, this was not the type of sexual abuse/assault in which victims were exposed to the most episodes. Sexual abuse/assault committed by a known adult was one in which the victims had the experience on more occasions, had objects introduced into their body more frequently and occurred when the victim was younger. It is also the one that was most frequently reported to the police or officers of the court and, therefore, had to be recounted. This could be due to the fact that, in a majority of cases, this type of abuse/assault is committed by a close relative, so that the victim-offender contact is recurrent and makes it easier for the latter to find and justify times in which he/she stays alone with the victim (Aydin et al., 2015). Likewise, given that the family is the first socializing agent, it is also logical that this is the abuse/assault that occurs at an earlier age of the victim (Amador Moncada et al., 2018). Sexual abuse committed by a close relative seems to cause the greatest maladjustment in the victims, due in part to the trauma that occurs at such young ages when the person who should provide security and meet all the child's needs is the main source of discomfort (Swanson & Mallinckrodt, 2001).

In this study we took into account that, although the victims themselves are the most accurate and precise source of information (Paine & Hansen, 2002; Save the Children, 2004), they may report a significant percentage of false negatives (Scott et al., 2010). The feeling of shame and guilt involved in disclosing this type of experience (Feiring & Taska, 2005; Herrera, 2006), the hardship of having to relive the traumatic experience, and the immature cognitive and emotional development of the child at the time of the event (problems in becoming aware of the experience; London et al., 2005), could be behind the lack of self-disclosure of positive cases (Negriff et al., 2017). Therefore, collecting information on the prevalence of sexual victimization of this group through other informants like residential care professionals was crucial. In this regard, adolescents reported a prevalence rate of sexual victimization more than double that of professionals. This is a difference that Euser et al. (2013) attributed to the lack of bonding between the residential care facility caregiver and the child, leading to the latter's unwillingness to disclose these experiences to the professional. This reluctance is increased in those cases in which the adolescent has suffered sexual abuse/assault in the residence itself. The degree of agreement found between the information provided by the two sources was moderate to low; since 74 of the cases of sexual victimization reported by the adolescents were not known to the professionals and 17 of the cases reported by the professionals were not declared by the adolescents. Regarding cases reported by professionals but not reported by adolescents, London et al. (2005) attributed causality to the immature cognitive and emotional development of the child at the time of the event. Those cases of sexual abuse at an extremely young age detected and reported by health professionals, school professionals, etc. may be in the adolescents´ written records but the adolescent may have no memory of the event. Likewise, it should also be taken into account that there may be cases in which the adolescent, due to the harshness and discomfort involved in reaffirming that he/she suffered sexual abuse, has preferred to answer negatively when asked by the investigator (Classen et al., 2005). Regardless, these data on the degree of agreement justify combining information reported by more than one source as the most advisable method to collect data as close to reality as possible (Negriff et al., 2017; Shaffer et al., 2008), especially if we take into account that, in our study, professionals acknowledged that only half of the cases about which they had suspicions had been confirmed (legally).

As for the victim profile, there was a higher degree of agreement between the information provided by both groups of informants. They agreed that female adolescents experience a markedly higher number of episodes of sexual abuse/assault (regardless of the type of sexual victimization), while the age of the adolescents at the time of assessment was not shown to be influential. In relation to gender, some studies attribute these notable differences to male gender stereotypes that may be limiting disclosures of sexual abuse/assault in boys (Esnard & Dumas, 2013; Wekerle et al., 2017). Thus, they argue that it is not that there is such a marked difference between the rate of sexual victimization cases in men and women, but that men have a higher percentage of false negatives. Not finding the age effects among residential care adolescents reflects that younger adolescents have been exposed to the same degree of victimization that is expected for older youths (Indias et al., 2019).

Regarding information on the characteristics of the aggressor, the degree of agreement among informants was also high. They agreed that the perpetrator was usually a man known to the victim. This profile is consistent with that found in studies of similar populations (Allroggen et al., 2017; Euser et al., 2013). This may be attributed to people who are known and related having easier access to children, and to children not suspecting such people and trusting them more easily (Aydin et al., 2015). However, if we inquire into the victim-aggressor link, while adolescents revealed that most of the time they were schoolmates or housemates, professionals pointed out that they were close family. Also, these data should be interpreted cautiously since the proportion of responses from professionals to these questions on the profile of the perpetrator was limited.

Finally, there is recent research focusing on the detection of the main consequences derived from experiences of sexual victimization, an essential aspect to have knowledge about in order to develop interventions tailored to the needs of the victims. In our study, consistent with most research to date working with this population (Finkelhor, Turner et al., 2009; Kendall-Tackett, 2009), professionals reported emotional control problems in almost half of the sample, followed by sexual and social interaction problems.

Nevertheless, there is now specific concern about the multiple episodes and types of sexual victimization faced by victims of child sexual abuse/assault, especially for adolescents in residential care (Classen et al., 2005; Indias et al., 2019). The findings of our study also confirmed this tendency to experience more than one type of sexual victimization among victims of sexual abuse/assault. However, few studies have focused on the risk factors of the victimizing event itself that could explain this tendency to experience more than one type of sexual victimization and a greater number of episodes when the adolescent has suffered sexual abuse/assault in childhood. The results of our analyses have allowed us to demonstrate that those victims who face a greater number of episodes are also involved in more types of sexual victimization (by a known or unknown adult, by a peer or by sexual exposure). In addition, the age of the victim at the time of the first episode of sexual abuse/assault and the type of relationship with the aggressor, especially when it was a close family member, is also positively associated with the previously mentioned variables (number of episodes of sexual abuse/assault and types of sexual victimization). Thus, this leads us to confirm that the earlier the negative experience occurs and the closer the relationship with the aggressor, there is a greater probability that the adolescent will suffer sexual revictimization (more episodes of sexual abuse/assault and/or diverse types of sexual victimization). The age at which initial sexual assaults occur may increase adolescents' vulnerability by exacerbating the psychological impact of a victimization experience, thereby increasing his or her chances of being revictimized (Casey & Nurius, 2005). In this sense, something similar occurs when sexual abuse/assault is caused by a family member, since the early attachment mismatch entails not only interaction problems but also problems of emotional regulation and self-esteem, which places the victim in a situation of greater vulnerability (Gawryszewski et al., 2012).

Strengths and Limitations

One of the most relevant contributions of this study are the prevalence figures of sexual victimization duly contrasted by several informants and the large sample size, considering that is a sensitive issue among a population difficult to access. Among other strengths of this research is also its methodological approach, compiling information from different informants and contrasting the information reported by the victims themselves and by the professionals who work with them on a daily basis in the same study. In addition, an innovation of this study was the complete analysis of the profile of the aggressor, which is unusual in these studies and may contribute to improving the early detection of cases.

The current study was not without limitations. It was not easy to obtain the collaboration and motivated participation of the residential care facilities' professionals, and they did not always get involved in the study. This is a limitation that should be taken into account when interpreting the results, since we had more missing data than desired in some of the questions answered by the professionals (up to 26.3%). It is also important to keep in mind the limitations of self-report instruments to assess sexual victimization (Acierno et al., 2003), due to the introspection capacity required to provide information on this issue (del Valle & Zamora, 2021), although from the age of 11 children are considered to have sufficient metacognition to provide a self-report (Finkelhor, Omrod et al., 2005). It should also be noted that, with respect to the information provided by the professional, there was only one professional/expert reporting information for each adolescent, so it was not possible to verify the veracity of the data provided by the professional. Lastly, it should be noted that, although all the measurement tools obtained a Cronbach's Alpha of 0.6 or above in the reliability analysis, some professionals consider this value to be acceptable but not good (Nunnally & Bernstein, 1994).

Conclusions

Adolescents in residential care constitute a with population with critical sexual victimization history, although this is not always registered in their records. In this group, in which experiences of sexual abuse/assault from a young age by caregiving figures are so common, our findings confirm that these experiences constitute a risk factor for subsequent sexual revictimization. However, this should not mean that other types of sexual victimization, such as those perpetrated by the peer group, should go unnoticed.

This study has allowed us to confirm that adolescents in residential care are a particularly vulnerable group who, due to the events that marked their childhood, have very different needs from those of other adolescents in the community. Thus, providing them with the necessary knowledge to demystify false information, the skills to allow them to enjoy consensual sexual exchanges and the attitudes that allow them to guide their psychosexual development in a positive way, are essential aspects if we want them to enjoy a healthy experience of sexuality. In this sense, research such as the one presented here is key when designing affective-sexual education initiatives that focus on the distinctive characteristics of this group and work to reverse the negative consequences derived from experiences of sexual victimization. The results of this research should also enable government agencies to develop useful and effective action plans, which are so scarce and needed right now. In addition, the results presented can be interpreted as a wake-up call to those geographic areas with similar sociodemographic and historical characteristics on the importance of continuing research on this issue.

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Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Marcas:

Asunto: Re: [External] Sexual Victimization of Adolescents in Residential Care: Self-Reported and Other-Reported Prevalence

Para: Olga Fernández García <Olga.Fernandez-Garcia@uv.es>

De: "Graham, Cynthia" <cygraham@indiana.edu>

Fecha: Thu, 8 Jun 2023 23:52:36 +0000

Estructura del mensaje y adjuntos:

1 TEXT/PLAIN 21225 bytes, "", ""
2 TEXT/HTML 23461 bytes, "", "" **Adjunto mostrado debajo**

Dear Olga:
yes, this would be just fine. And congratulations on getting your thesis completed!
best wishes,
Cynthia

> On 8 Jun 2023, at 18:45, Olga Fernández García <Olga.Fernandez-Garcia@uv.es> wrote:
>
> This message was sent from a non-IU address. Please exercise caution when clicking links or opening attachments from external sources.
> ---
>
> Dear Ph.D. Graham,
>
> I am contacting you because last April a research article entitled "Sexual Victimization of Adolescents in Residential Care: Self-Reported and Other-Reported Prevalence" was published in your high-quality journal, "The Journal of Sex Research".
>
> This article is part of a doctoral thesis by compendium of articles and, in this context, a copy of the article must be included in the appendix of the thesis. I am therefore writing to you to request authorisation to include a copy of it in my thesis, bearing in mind that its access and use is entirely restricted to teaching purposes only, i.e. the assessment of the suitability of the doctoral student. These circumstances will, of course, be stated in the doctoral thesis.
>
> I look forward to hearing from you in due course, and thank you in advance for your cooperation.
>
> Kind regards,
> Olga Fernández García,
> Ph.D. Student.

Anexo 4

Estudio 4

Does Emotion Regulation in Adolescents in Residential Care Mitigate the Association Between Sexual Victimization and Poor Psychological Well-being?

Does Emotion Regulation in Adolescents in Residential Care Mitigate the Association Between Sexual Victimization and Poor Psychological Well-being?

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Abstract

Background: Childhood sexual abuse/assault has been linked to mental health problems that affect an individual's psychological well-being. This study explores the facets of emotional regulation as mediating mechanisms in the relationship between sexual victimization and psychological well-being in adolescents in residential care in Eastern Spain. Furthermore, it examines the role of sex assigned at birth and being unaccompanied asylum seeker children as possible moderators of the mediation model.

Methods: A total of 346 adolescents (34.1% girls, 65.9% boys) aged between 11 and 19 years old completed a battery of instruments. Parallel multiple mediation paths were tested to determine whether sexual victimization is associated to psychological well-being across emotional regulation dimensions. Moderated mediation models with sex assigned at birth and the condition of unaccompanied asylum seeker children were tested too.

Results: This study demonstrates that high sexual victimization is associated with poor psychological well-being in adolescents in residential care through the lack of emotional clarity, non-acceptance of emotional responses, and limited access to emotional regulation strategies (β=-0.6,95%CI=-1.26,-0.09; β=−0.38, 95%CI=-0.9,0.002; β=-0.39, 95%CI=-0.93,-0.03, respectively). In addition, the latter indirect effect pathway was significantly moderated by the condition of being unaccompanied asylum seeker children (β=1.46, 95%CI=0.28,2.84). Sex assigned at birth was not shown to be a significant moderator.

Conclusions: Identifying which mechanisms of emotional regulation mediate the relationship between sexual victimization and psychological well-being in adolescents in residential care may contribute not only to reducing the psychological distress of these adolescents but also to improving the effectiveness and efficacy of the child welfare system.

Keywords: sexual victimization; psychological well-being; emotional regulation; adolescents; child welfare system; parallel multiple mediation

1. INTRODUCTION

Adolescents in the child welfare system that were removed from their families to ensure their physical and emotional well-being, often undergo numerous victimization experiences from an early age (Collin-Vézina et al., 2011). Specifically, this population reports extremely high rates of sexual victimization, which are linked to negative behavioral, emotional, and cognitive developmental outcomes (Casanueva et al., 2012; Indias et al., 2019).

Psychological well-being, according to Ryff's approach, is a dynamic construct and refers to optimal psychological functioning and positive individual development (McLellan et al., 2012; Ryff, 1989). This approach is framed within the eudaimonic philosophical stance, which states that it is important for individuals to have a sense of meaning and fulfilment in life (Deci & Ryan, 2008). Taking this stance, Ryff (1989) proposed a theoretical model of psychological well-being which comprises six different aspects of positive functioning, namely autonomy (as the sense of self-determination and freedom from norms), environmental mastery (as the belief of one's ability to manage life events), personal growth (as one's openness to new experiences and growth), purpose in life (as the sense of purpose and meaningfulness in life), positive relations with others (as the extent of having satisfying relationships with others) and self-acceptance (as one's attitude towards oneself). Although Ryff's model was originally developed to reflect adults' positive functioning (Ryff, 1989), there is sufficient empirical evidence that this theoretical model benefits research in adolescents' psychological well-being as well (Gao & McLellan, 2018). In adolescents, it is associated with the ability to evaluate oneself according to personal standards, having positive attitudes toward oneself, perceiving quality family and friendship relationships, and having the perception of pursuing meaningful goals (Reis et al., 2018). Psychological well-being is quantified by an individual's positive and negative experiences, so it is not surprising that, despite the efforts of child welfare professionals to ensure the healthy psychological development of these adolescents, several studies report lower levels of psychological well-being among adolescents in residential care compared to their peers in community samples (Crous, 2017; Greeno et al., 2019).

The individual's ability to regulate his or her emotions in the face of adverse events is a key process in the development of positive psychological functioning, especially among

adolescents that are transitioning into adulthood with all the different changes that this life stage requires (Park et al., 2020). Emotional regulation is considered a multidimensional construct consisting of cognitive and behavioral processes to manage emotional responses and involves: (a) awareness and understanding of emotions, (b) acceptance of emotions, (c) ability to control impulsive behaviors and engage in goal-directed behaviors when experiencing negative emotions, and (d) ability to use emotional regulation strategies appropriate to the situation (Gratz & Roemer, 2004). The skills necessary for emotional regulation are often acquired, in part, through interaction with primary caregivers. Thus, those adolescents who have experienced victimization and live in residential care facilities have not only had fewer opportunities to develop coping skills, but often the strategies learned are maladaptive or caregivers minimize or punish their emotional displays. This puts them at a disadvantage when it comes to identifying, regulating, and expressing emotions effectively (Finkelstein-Fox et al., 2022).

A history of childhood sexual abuse/assault has been consistently linked to a variety of mental health and interpersonal problems that affect an individual's psychological well-being (Breckenridge et al., 2019; Burgić Radmanović, 2020; Burns et al., 2010; Hébert et al., 2021). This association has also been documented in the literature on adolescents in the child welfare system (Auslander et al., 2015; Matta Oshima et al., 2014; Papalia et al., 2021). Auslander et al. (2015), in their study with adolescents in the U.S. child welfare system, demonstrated that victims of sexual abuse experienced negative psychological outcomes of significant severity, even leading to suicide (Matta Oshima et al., 2014). Therefore, identifying the mechanisms through which such a relationship is established is crucial to understanding what interferes with the psychological recovery of sexual victimization survivors and developing early interventions for this high-risk population.

In this sense, some studies justify that sexual abuse/assault may interrupt typical psychological and biological developmental processes, creating vulnerabilities in self-regulatory functioning across physiological, affective, and behavioral domains (Papalia et al., 2018; Papalia et al., 2021). These vulnerabilities can affect their psychological well-being and can increase risk for various mental health disorders via mechanisms such as impaired risk detection and response, emotion dysregulation and risk-taking behavior (Atmaca & Geçöz, 2016; Krahé & Berger, 2017; Papalia et al., 2021).

However, we should not forget that the possible mediation of the variables involved in this association may also be moderated by certain sociodemographic characteristics. The sex asigned at birth could be one of them. According to the literature, the prevalence of sexual victimization varies substantially by sex assigned at birth (Fernández-García et al., 2023; Indias et al., 2019) as do mental health indicators, especially those related to emotional regulation (Kaur et al., 2022; Zalar et al., 2018). Matta Oshima et al. (2014) found that girls immersed in the child welfare system who had experienced sexual abuse made significantly greater use of mental health services than men, possibly due to differences related to skills and behaviors developed because of having experienced sexual victimization. However, in general, non-acceptance of emotional response and avoidance of negative emotions is significantly higher among boys, possibly due to stereotypical gender roles adopted in our society, which identify men's emotional expression as a sign of weakness and grant women the development of more emotional regulation strategies (Kaur et al., 2022).

In addition, it is well known that emotions have an important cultural component. Unaccompanied asylum seeker children (UASC) are young people under the age of 18 who arrive to other country without any responsible adult to care for them and who are applying for asylum in their own right (Generalitat Valenciana, n. d. a). Because of the traumatic experiences they have had before or during their flight and the difficulties involved in the acculturation process, they are at particularly high risk of mental health problems. This coexists with their difficulties with emotional regulation, especially anger management and goal setting and striving to achieve them (El-Awad et al., 2017). Nickerson et al. (2011) concluded that impaired emotion regulation might act as a mechanism empowering the connection between migrate' victimization experiences and mental health outcomes. It is, the experience of extreme emotional distress in connection with trauma events, like sexual abuse/assault, might force the migrate to use dysfunctional emotion regulation strategies and limit their access to functional strategies, which may thus empower the association between sexual victimization experiences and psychological problems (El-Awad et al., 2017; Nickerson et al., 2011). These results alert us that being UASC is possible moderating covariate that should be taken into account in the analysis of the mediating effect of facets of emotional regulation on the relationship between experiences of sexual victimization and psychological well-being.

1.1. The study context

Spanish legislation establishes that the administrative agency must promote, on a preventive basis, whatever actions are necessary to guarantee the comprehensive and integral development of minors in their family nucleus (art. 89 Law 26/2018). However, when this cannot be guaranteed, the Law 26/2018 on Rights and Guarantees for Children and Adolescents establishes that the public administration will assume the care of the child through foster care and, if it is not possible or convenient for the child's interest, through residential care (art. 110 Law 26/2018). Residential care is a protective measure whereby a protected person is provided with a place of residence and cohabitation and care oriented towards their holistic and community development (art. 137 Law 26/2018). That is, these homes or residences offer comprehensive and educational care to children and adolescents in care and/or guardianship who are deprived of a suitable family environment. Although the avoidance of institutionalization of children aged 0-6 years is encouraged, all homes or residences are intended for persons up to 18 years of age (except for emancipation homes) whose custody is the responsibility of the regional administrative social service agency, with the ratio of children per center being 8 children/adolescents in the case of homes and up to 30 children/adolescents (maximum) in the case of residences. Depending on the functional characteristics, we can distinguish between reception centers (intended for immediate care or first reception, when they have just separated from their guardians), specific centers for minors with behavioral problems (intended for the care of boys and girls with special needs), general care centers, and homes for preparation for emancipation and adult life (for adolescents and young people between 16 and 23 years of age who would otherwise be expelled from the system) (Dirección General de Infancia y Adolescencia, 2017).

1.2. Objectives of this study

Although some of the literature has focused on the study of inadequate emotional regulation as a risk factor for internalizing and externalizing problems (McLaughlin et al., 2020; Weissman et al., 2019), there are few studies that inquire about which factors of emotional regulation are actually acting as mediators in this relationship. Knowing the mechanisms of action is something really relevant, according to the meta-analysis of Compas et al. (2017), to gain efficacy and effectiveness in interventions. Likewise,

published investigations focus on the study of mental health pathologies from a deficit approach and not from a positivist approach of promoting psychological well-being, which may mean that those young people who do not meet the diagnostic standards for certain psychopathologies do not benefit from scientific advances.

Also, following the life course perspective approach, our study assumes that lives unfold over time and that events and conditions at earlier phases of the life course have persisting effects at later phases. According to this theory posits that inequality widens across the life course, with the advantaged becoming even more advantaged over time and the disadvantaged becoming more disadvantaged. Therefore, research aimed at mitigating cumulative disadvantage is considered of relevance. This involves research with adolescents in residential care, a highly vulnerable group to unfavorable life development, whose early experiences place them at a disadvantage and motivate scientific interest in reversing this undesirable predisposition. In this sense, the life course perspective assumes that certain aspects (time, place, history, and interpersonal relationships) affect the life trajectory according to the individual's condition. Thus, it insists on and justifies the need to document the ways in which life course trajectories differ across population subgroups, including those based on sex assigned at birth, and other circumstances related to race/ethnicity (George, 2020).

In this sense, under the life course perspective approach, the present study aims to explore the mediating role of multiple facets of emotional regulation in the relationship between sexual victimization and psychological well-being in adolescents in residential care in Eastern Spain, as well as to examine the modulating role of the covariates of the mediation model (sex assigned at birth and being UASC) that are shown to be significant.

Given the results obtained so far and considering what is planted by the life course perspective, the starting hypothesis is that all the facets of emotional regulation (awareness of emotions, acceptance of emotions, emotional clarity, control impulsive behaviors, goal-directed behaviors when experiencing negative emotions and emotional regulation strategies) mediate the relationship between sexual victimization and psychological well-being in adolescents in residential care. Specifically, greater sexual victimization is expected to be associated with greater lack of emotional awareness and clarity, less acceptance of emotional responses, more difficulties in persisting in goal-

directed behaviors when feeling distress and in controlling impulses, and less access to emotional regulation strategies, all resulting in worse well-being.

Considering the discrepancies in the existing studies regarding the modulation role of sex assigned at birth in the mediation model relationship between sexual victimization experiences and psychological wellbeing, it is difficult to set a hypothesis. However, we can suppose that male acts as a modulating variable driving the association between sexual victimization and greater lack of emotional awareness and clarity, less acceptance of emotional responses and access to emotional regulation strategies, more difficulties in persisting in goal-directed behaviors when feeling distress and in controlling impulses, all resulting in worse well-being. As for, being UASC modulating role, it is expected that being UASC acts as a modulating variable driving the association between sexual victimization and having worse understanding of emotions and acceptance of emotional responses, difficulties in control of impulses and in persisting in goal-directed behavior when feeling discomfort, higher lack of emotional clarity and lower emotional regulation strategies, all resulting in worse well-being.

2. METHODS

2.1.Participants and procedure

This cross-sectional study was conducted between June 2020 and May 2021. Recruitment occurred through the administrative agency responsible for the welfare of adolescents in the Valencian region, which put us in contact with the directors of the residential care facilities. After explaining the project to them and obtaining their authorization to enter the home or residence, the center's staff explained the proposal to the youth of the residential care facility and appointments were arranged with the minors who wished to participate. A total of 346 adolescents were recruited from 47 residential care facilities in Eastern Spain (hosting a total of 509 children and adolescents), obtaining a response rate of 68%. Those adolescents who wished to participate voluntarily and gave their consent were interviewed by an expert from our team specifically trained for this purpose. The application of the standardized instruments was carried out in person, individually, and in a comfortable environment of maximum privacy. Only the participant and one of the evaluators were present while the assessment was being completed. All participants were informed of the

confidentiality of their responses before beginning to complete the instruments, as well as of their right to leave the study at any time. Inclusion criteria were (1) being 11 years of age or older and, (2) living in a residential care facility at the time of the interview. The study complied with the ethical principles of the 1964 Declaration of Helsinki and was approved by the Experimental Research Ethics Committee of the University of XXX (XXX).

2.2.Measures

Child and Adolescent Welfare System Form (CAWSys; Fernández-García et al., in press).

This instrument consists of 67 items grouped into six sections: "*General information"*, "*School/work situation"*, "*Child welfare system history"*, "*Family visitation history"*, "*Biological family information"*, and "*Experiences of sexual abuse/maltreatment".* For this study, information related to the dimensions "*General information*" (basic information about the adolescent in terms of sex assigned at birth, date of birth, nationality, the condition of being UASC and sexual orientation) and "*Child welfare system history*" (information on age of entry into the child welfare system, reason for entry, months in the system, current legal status, and current protection measures) was used. It is an instrument designed to be completed by a professional from the residential care facility who knows the child well and has access to their welfare case record.

The Juvenile Victimization Questionnaire (JVQ; Finkelhor et al., 2005; Pereda et al., 2016).

The JVQ evaluates, in a self-reported format, 36 different types of victimization against children and youth into six modules: conventional crime, caregiver victimization, victimization by peers and siblings, sexual victimization, witnessing and indirect victimization, and electronic victimization. In the current study, only the sexual victimization module was used, which inquire about 4 specific lifetime experiences of this type of victimization: sexual abuse/assault by a known adult *("At any time in your life, did a grown-up you know touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up you know force you to have sex?"*), sexual abuse/assault by an unknown adult ("*At any time in your life, did a grown-up you did not know touch your private parts when they shouldn't have, make you touch their private parts or force you to have sex?"*), sexual abuse/assault by a peer

(*"Now think about other kids, like from school, a boyfriend or girlfriend, or even a brother or sister. At any time in your life, did another child or teen make you do sexual things?"*), and flashing/sexual exposure (*"At any time in your life, did anyone make you look at their private parts by using force or surprise, or by "flashing" you?"*). For each item, the presence or absence of this victimization experience was scored as 1 or 0, respectively, so the total score for this module ranged between 0 and 4. The internal consistency for the sexual victimization module was r = 0.62 in this study.

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004; Gómez-Simón et al., 2014).

It is a 36-item self-report questionnaire measuring clinically relevant aspects of emotional regulation. It is divided into six subscales: *"Awareness"* (6 items), *"Impulse"* (6 items), *"Non-acceptance"* (6 items), *"Goals"* (5 items), *"Clarity"* (5 items), and *"Strategies"* (8 items). The items are scored on a 5-point Likert scale (1: almost never, 5: almost always). Subscales and total scores are obtained by the sum of the corresponding items and higher scores indicate more difficulties in emotional regulation. The reliability analysis found α ranging between 0.70 and 0.88 in this study.

Brief Scale of Psychological Well-Being for Adolescents (BSPWB-A; Ryff, 2013; Viejo et al., 2018).

The scale contains 20 items evaluated on a Likert scale of six points (1 = completely disagree to 6 = completely agree) and was designed to assess multiple dimensions of psychological well-being. The total score (sum of all items) was used in this study, ranging from 20 to 100, with higher scores indicating greater well-being. The internal consistency was r = 0.81 for the total scale score in this study.

2.3.Data Analysis

SPSS version 26 was used for statistical analysis. Significance level was set at p-value ≤ 0.05 with a confidence interval of 95%. Descriptive statistics were used to examine participant characteristics. The Shapiro–Wilk test, as well as skewness and kurtosis statistics were used to assess normality of variables. The assumptions of linearity, homoscedasticity, normality of estimation error, and collinearity were tested. The total percentage of participants who had suffered any type of sexual victimization in their lifetime was also calculated by recoding the total score of the sexual victimization

module (1, 2, 3 or 4 score like a 1; 0=no lifetime sexual victimization, 1=some lifetime sexual victimization). Pearson correlations assessed relationships between age and sexual victimization, psychological well-being and emotional regulation dimensions. Independent t-tests assessed differences in sexual victimization, psychological well-being and emotional regulation dimensions by sex assigned at birth (male vs. female) and the condition of being UASC (non-UASC vs. UASC). All relations with psychological well-being were explored too using Pearson correlation (r) for numerical variables and chi-square (X^2) or independent t-test (t) for categorical variables. A parallel multiple mediation model with pathways in a causal system based on associations was tested to determine whether sexual victimization predicted psychological well-being across emotional regulation dimensions (path a = association between independent variable -sexual victimization- and mediating variables -emotional regulation dimensions-; path b = association between dependent variable -psychological well-being- and mediating variables -emotional regulation dimensions-). Sex assigned at birth and the condition of being UASC were assigned like covariates and possible moderators in path a, so moderated mediation models were also tested. We based this decision about covariates on previous research indicating the impact of each one of these variables on dependent variable (El-Awad et al., 2017; Kaur et al., 2022; Nickerson et al., 2011; Zalar et al., 2018;), as well as on the life course perspective approach (George, 2020). PROCESS v3.1 macro model 4 was used for parallel mediation and model 7 for moderated parallel mediation analyses (Hayes, 2019). Mediation was tested by computing bias-corrected (BC) bootstrapped 95% confidence intervals (CI) using 5,000 data resamples.

3. RESULTS

3.1.Participant characteristics

Participants were between 11 and 19 years old (M = 15.73; SD=1.76), were predominantly male (65.9%) and identified themselves as heterosexual (84.4%). Although the majority were born in Spain (57.9%), 31.3% were UASC. Regarding their background in the child welfare system, the majority of the participants (72.3%) joined the child welfare system after the age of 11 (M = 12.33; SD=4.21) and have been in the system for between one and two year (40.3%; M = 39.58 months; SD=45.02). Although

a relatively high percentage of them, given their young age, have been in the child welfare system for more than 10 years (9.2%). Likewise, in 76.2% of them, it was the declaration of a situation of helplessness (situation arising from the failure or impossibility/inadequate exercise of the duties of protection of minors resulting in the deprivation of the latter of necessary moral or material assistance; Generalitat Valenciana, n. d. b) that triggered their immersion in the child welfare system. As for the placement stability, on average the participants had been in this residential care facility for one and a half years (M = 18.29 months; SD=22.33).

About 35% of the sample had suffered some type of lifetime sexual victimization (sexual abuse/assault by a known adult, sexual abuse/assault by an unknown adult, sexual abuse/assault by a peer, and flashing/sexual exposure) and the means obtained in the components of emotional regulation and psychological well-being are shown in Table 1. Some demographic characteristics were associated with independent and dependent variables. Younger age was associated with more difficulties in the control of impulses and being persistent with a goal when they are excited emotionally, with lower access to efficacy strategies for emotionally regulation and with less psychological well-being ($r = -0.24$, $p < 0.001$; $r = -0.21$, $p<0.001$; $r = -0.17$, $p = 0.002$; $r = 0.15$, $p = 0.008$, respectively). Women showed less acceptance of emotional responses, more lack of emotional clarity, less access to efficacy strategies of emotional regulation, more sexual victimization, and less psychological well-being ($t = 2.41$, $p = 0.017$; $t = 2.72$, $p = 0.007$; $t = 2.84$, $p = 0.005$; $t = 5.5$, $p < 0.001$; $t = -2.81$, $p = 0.005$, respectively). Finally, non-UASC showed more difficulties in the control of impulses, being persistent with a goal when they are excited emotionally and more sexual victimization ($t = 3.76$, $p < 0.001$; $t = 3.79$, $p < 0.001$; $t = 4.38$, $p < 0.001$, respectively). The relationship of all variables with psychological well-being (dependent variable) were tested too (Table 2).

Table 1. Demographic and clinical characteristics of the sample

	% (*n*) / M (SD)
Sex assigned at birth	
Female	34.1 (118)
Male	65.9 (228)
Age (years)	15.73 (1.76)
Nationality[a]	
Spanish	57.9 (195)
Morrocco	29.7 (100)
Eastern European	4.7 (16)
West African	3.3 (11)
South/Central American	2.7 (9)
Pakistani	1.2 (4)
Portuguese	0.6 (2)
Unaccompanied Asylum Seeker Children	
Yes	31.3 (105)
No	68.7 (230)
Sexual orientation	
Heterosexual	84.4 (287)
Homosexual	2.1 (7)
Bisexual	7.1 (24)
Pansexual	0.3 (1)
I am not sure	6.2 (21)
Sexual Victimization	0.59 (0.93)
Emotional Regulation	
Awareness	17.53 (5.39)
Impulse	17.31 (6.99)
Non-acceptance	15.95 (7.39)
Goals	16.56 (5.57)
Clarity	12.79 (4.59)
Strategies	17.24 (6.29)
Psychological Well-Being	82.73 (15.19)

Note: [a]Underrepresented nationalities were grouped according

to the continental area in which they are located

Table 2. Relationship of all variables to psychological well-being

		Psychological Well-Being
Sex assigned at birth (M±DS)	Female	84.61±12.97
	Male	79.15±18.26
	t-test	-2.81**
Age (years)	r	0.15**
Nationality (M±DS)	Spanish	82.41±16.4
	Morrocco	82.13±11
	Eastern European	87.87±12.55
	West African	93.3±15.35
	South/Central American	78.57±25.24
	Pakistani	89.33±10.02
	Portuguese	92±12.73
	X^2	1.46
Unaccompanied Asylum Seeker Children (M±DS)	Yes	83.61±11.43
	No	82.75±16.47
	t-test	-0.53
Sexual orientation	Heterosexual	83.46±14.82
	Homosexual	81.67±15.55
	Bisexual	72.04±16.83
	Pansexual	100
	I am not sure	87.16±15.07
	X^2	3.95**
Sexual Victimization	r	-0.2***
Emotional Regulation (r)	Awareness	-0.48***
	Impulse	-0.35***
	Non-acceptance	-0.30***
	Goals	-0.29***
	Clarity	-0.53***
	Strategies	-0.43***

**p<0.01; ***p<0.001

3.2.Mediating effect of perceived emotional regulation components on sexual victimization and psychological well-being

Mediation analysis examined whether perceived emotional regulation components mediated the relationship between sexual victimization and psychological well-being (Fig. 1). The direct effect of sexual victimization on psychological well-being was not significant (β = -1.04, 95% CI = −2.58, 0.51). The total effect between sexual victimization and psychological well-being for emotional regulation components was significant (β = -2.87, 95% CI = -4.75, -0.99).

There were significant pathways between sexual victimization and some emotional regulation components. Higher sexual victimization was significantly associated with more lack of acceptance of emotional responses and with difficulties in persisting in goal-directed behavior when feeling discomfort (β = 1.59, 95% CI = 0.67, 2.52; β = 0.93, 95% CI = 0.24, 1.63, respectively). Sexual victimization and lack of emotional clarity were significantly associated too (β = 0.79, 95% CI = 0.22, 1.37), the higher sexual victimization, the higher lack of emotional clarity, boys having statistically significantly higher sexual victimization than girls. And the pathway between sexual victimization and limited access to emotional regulation strategies was positive and significantly associated (β = 0.92, 95% CI = 0.13, 1.71).

Pathways between some perceived emotional regulation components and psychological well-being were statistically significant. Greater lack of emotional awareness, acceptance of emotional responses, emotional clarity, and limited access to emotional regulation strategies were statistically significantly related to worse psychological well-being (β = -0.84, 95% CI = -1.14, -0.53; β = -0.24, 95% CI = -0.47, -0.01; β = -0.75, 95% CI = -1.14, -0.37; β = -0.42, 95% CI = -0.75, -0.08, respectively). None of the results of path b were significantly different by sex assigned at birth and the condition of UASC.

This pattern of results suggests that some perceived lack of emotional regulation components mediate the relationship between sexual victimization and psychological well-being (total indirect effect β = -1.83, 95% CI = -3.25, -0.53). There is a significant indirect effect of sexual victimization on psychological well-being through perceived lack of emotional clarity, non-acceptance of emotional responses, and limited access to

emotional regulation strategies (β = -0.6, 95% CI = -1.26, -0.09; β = −0.38, 95% CI = -0.9, 0.002; β = -0.39, 95% CI = -0.93, -0.03, respectively). The higher sexual victimization, the more perceived lack of emotional clarity, the worse acceptance of emotional responses, and the higher limited access to emotional regulation strategies all result in worse well-being. The latter indirect effect was significantly moderated by UASC (conditional indirect effect of sexual victimization on psychological well-being through limited access to emotional regulation strategies β = -0.82, 95% CI = -1.61, -0.23, index of moderate mediation β = 1.46, 95% CI = 0.28, 2.84). Sex assigned at birth was not shown to be a significant moderating variable in any pathways. The results of moderated mediation analysis are included in Table 3. Indirect effect of sexual victimization on psychological well-being through perceived lack of emotional awareness, difficulties in impulse control perceived, and difficulties in persisting in goal-directed behavior when feeling discomfort were not significant.

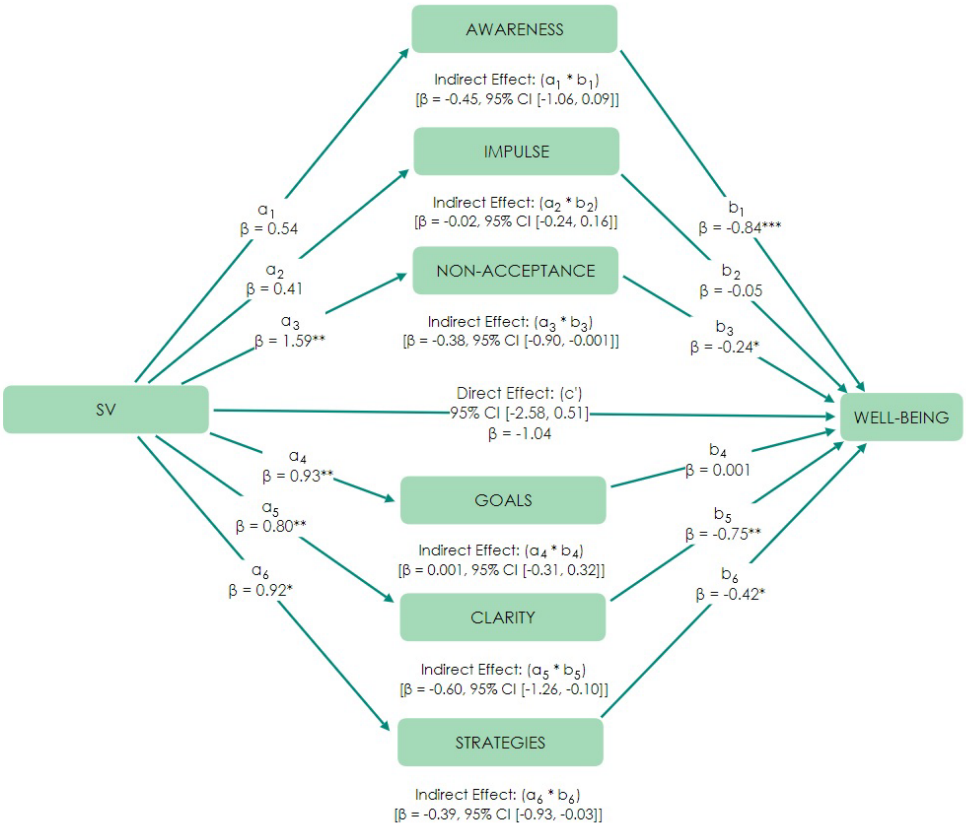

Fig 1. Pathways and beta-coefficients of the parallel multiple mediation model of emotional regulation components on sexual victimization (SV) and psychological well-being in adolescents in Spanish residential care

Table 3. Results of moderated mediation analysis

Mediators	Awareness	Impulse	Non-acceptance	Goals	Clarity	Strategies
Conditional Indirect Effects			Effect (CI)[a]			
Sex assigned at birth						
Women	-0.61 (-1.46, 0.19)	-0.006 (-0.2, 0.22)	-0.44 (-1.07, 0.007)	0.006 (-0.33, 0.42)	-0.71 (-1.58, 0.05)	-0.56 (-1.22, -0.04)
Men	-0.28 (-1.09, 0.42)	-0.02 (-0.33, 0.24)	-0.32 (-0.94, 0.09)	0.005 (-0.32, 0.33)	-0.52 (-1.58, 0.05)	-0.24 (-0.98, 0.26)
UASC						
Yes	-0.48 (-1.85, 0.68)	0.002 (-0.26, 0.27)	0.18 (-0.31, 0.93)	0.01 (-0.29, 0.5)	0.16 (-0.55, 0.91)	0.63 (-0.33, 1.68)
No	-0.44 (-1.15, 0.15)	-0.01 (-0.24, 0.2)	-0.49 (-1.13, -0.02)	0.02 (-0.29, 0.38)	-0.49 (-1.18, -0.05)	-0.82 (-1.61, -0.13)
Index of moderated mediation[b]			Index (CI)[a]			
Sex assigned at birth	0.34 (-0.77, 1.43)	-0.02 (-0.38, 0.29)	0.11 (-0.45, 0.75)	-0.0007 (-0.25, 0.19)	0.18 (-0.95, 1.23	0.31 (-0.49, 1.15)
UASC	-0.04 (-1.48, 1.33)	0.01 (-0.33, 0.37)	0.67 (-0.004, 1.81)	-0.006 (-0.3, 0.36)	0.65 (-0.11, 1.77)	1.46 (0.28, 2.84)

Note: [a]The 95% confidence interval does not include the null value (β = 0).

[b]The index of moderated mediation is the difference between two effects (UASC, non-UASC; Women, Men).

4. DISCUSSION

To our knowledge, this is the first study to demonstrate that high sexual victimization is associated with poorer psychological well-being in adolescents in residential care through the mechanisms of perceived lack of emotional clarity, non-acceptance of emotional responses, and limited access to emotional regulation strategies. Findings from this study are consistent with and contribute to the research on sexual victimization, emotional regulation, and psychological well-being (e.g., McLaughlin et al., 2020; Weissman et al., 2019), partially fulfilling our main hypothesis. In this sense, experiences of sexual victimization predispose these adolescents to present problems of understanding emotions, emotional avoidance or disconnection, and the adoption of maladaptive emotional regulation strategies. These results, at the same time, increase the individual's stress and distress, which translates into lower psychological well-being (Gruhn & Compas, 2020).

Of note, in the specific case of the mediation of the variable "limited access to emotional regulation strategies", the fact of not being UASC moderated the impact that sexual victimization has on this component of emotional regulation, contrary to what was postulated in our third hypothesis. UASCs have very different experiences than other adolescents in the child welfare system, in part because of the difficult journey they have made without family at a very young age and the efforts they must make to integrate into a different culture without the support of their social network. This appears to lead them to become more resilient and to develop and make more frequent use of certain coping strategies as active agents (Ní Raghallaigh & Gilligan, 2010). Thus, this may explain why not being UASC acts as a modulating variable driving the association between sexual victimization and having lower emotional regulation strategies, unlike those who are UASC. Our second hypothesis was not fulfilled, because sex assigned at birth did not prove to be a significant moderating variable in any facet of emotional regulation.

Looking at the relationship between the variables in more detail, the association between high sexual victimization and low perceived emotional clarity is supported by

previous research showing that the lack of attention to emotional states that characterizes survivors of sexual victimization contributes to the problems these adolescents have in identifying and labeling emotions (Walsh et al., 2011). A high sexual victimization was also associated with difficulties in persisting on a goal when excited. Some research agrees that victims of sexual abuse/assault are more likely to remain alert and employ strategies such as rumination, making it difficult for them to be persistent with their goal (McLaughlin et al., 2020). This could explain the academic and occupational problems that these young people sometimes present (Miragoli et al., 2020). Our research also suggests that sexually victimized adolescents exhibit greater emotional nonacceptance. This is consistent with a body of research that suggests that these individuals' inability to confront certain aspects of their traumatic experience leads to emotional inhibition (Walsh et al., 2011). A high sexual victimization also contributes to more problems in accessing emotion regulation strategies. It is consistent with other studies reflecting that increased victimization contributes to increased feelings of generalized helplessness in the victim, resulting in less effective attempts to reduce such emotions. In addition, these adolescents are prone to present maladaptive strategies since they have been learned from inappropriate models (Jenness et al., 2021).

Mismatches in psychological well-being can be seen as a result of the individual's attempts to regulate emotion. Our findings show that lack of emotional awareness and clarity negatively impacts psychological well-being, as deficits in emotion recognition and description interfere with cognitive processing of all experiences, which will lead to problems with self-acceptance and self-exploration. A greater lack of emotional acceptance also contributes to poorer psychological well-being, as the unwillingness to experience emotions (and repeated efforts to suppress them) contribute to the accumulation of unresolved emotions that lead to some depletion of cognitive resources, limiting personal growth. In addition, emotional avoidance leads to experiential avoidance, with behaviors such as dissociation, self-injury, etc. having a negative impact on psychological well-being (Miragoli et al., 2020). The association between increased problems in accessing appropriate adaptive emotional regulation strategies and poorer psychological well-being suggests that the use of maladaptive strategies, such as self-medication or drug use, leads to some social disconnection and loss of support network, which negatively impacts psychological development (Gruhn & Compas, 2020; Snow et al., 2022).

Notwithstanding the above, this study has some limitations due to the use of inferential analysis with observational data (Rohrer, 2018). However, multiple plausible assumptions have been used and the findings have been reported as associations.

5. CONCLUSIONS

The present findings have important implications for alleviating some of the consequences of sexual victimization experiences and ensuring the psychological well-being of adolescents in residential care. But, in addition to the individual benefits, developing evidence of the mechanisms mediating the relationship between sexual victimization and impaired psychological well-being in these adolescents may contribute to improving the efficiency and effectiveness of the child welfare system.

This study helps professionals not only to offer interventions focused on key mediating mechanisms, but also to identify more easily those adolescents in residential care who may be at risk of maladaptive development through the detection of these key predictor variables. This will contribute to the well-being of adolescents in all areas of their lives to not reach such high levels of psychological distress, and also to improve interpersonal dynamics in residential care facilities and reduce mental health spending.

Therefore, this research is a sincere appeal to professionals in residential care facilities, but also to child welfare policy makers, who must take into account information on the characteristics of these young people and on the factors that cause the maladaptive psychological development in order to implement appropriate social plans and policies.

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