

COMMUNICATION ABOUT SEXUAL HEALTH AND DECISION
MAKING WITH ADOLESCENTS IN FOSTER CARE

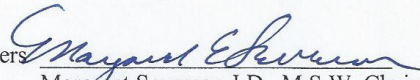
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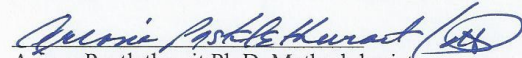
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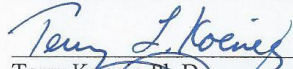
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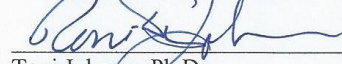
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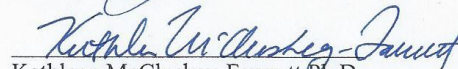
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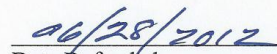

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Dedication

I dedicate this dissertation to my family. My husband, my father, my mother, my siblings, my siblings-in-law, my nieces, my uncles and aunts, all of which had a hand in helping me to defeat my own self-doubt.

We did it.

Abstract

When in foster care, adolescents experience a disruption in the expected avenues through which they would receive sexual health information, such as through parents, school and peers. Adolescents that are placed in foster care come into contact with numerous professionals, and in particular, social workers. These professionals often serve as a gateway to information and resources such as mental and physical health, education, legal assistance, and life skills that are vital to youth in foster care (Bunger, Stiffman, Foster, & Shi, 2009). Social workers are tasked with serving and protecting adolescents in foster care, who are considered one of the United States' most vulnerable populations (Polit, Morrow-White, & Morton, 1987). Consequently, it is important that social workers are equipped with the knowledge and skills necessary as they are in a position of influence to communicate with adolescents about all their special needs including sexual health and decision making.

Adolescents in foster care need increased access to aggressive sexual health education. We know that 93 percent of adolescents residing in foster care are sexually experienced, are less likely to use contraceptives, and commonly experience one or more forced sexual experiences (Becker & Barth, 2000; Child Trends Inc., 2009; James, Montgomery, Leslie, & Zhang, 2009). When social workers support adolescents in foster care, they must draw upon theoretical perspectives that in turn support models and skills designed to discuss issues regarding sexual health in straightforward, comprehensible language or risk giving adolescents the idea that what they are thinking and feeling about sexuality and their own development is disgraceful or morally wrong (Aiello, 1999).

Because of the sexual health concerns facing adolescents residing in foster care, encouraging communication between child welfare workers and these adolescents may result in adolescents becoming more aware of the risks and becoming more aware of available options for promoting safe and healthy sexuality. This study will examine the relationships of child welfare workers' comfort regarding sexual issues, sexual health knowledge, and education level with their capacity to communicate with adolescents residing in foster care about their sexual health and decision making. This study utilized primarily quantitative methods to identify statistically significant models of communication between child welfare workers and adolescents residing in foster care regarding their sexual health and decision making. The comfort level of child welfare workers with sexual health issues was found to be a significant predictor of communication with adolescents residing in foster care in five out of six regression models.

There is a clear relationship in the existing literature between adolescents residing in foster care and engagement in risk behaviors. Included among these identified behaviors are adolescents in foster care engaging in risk related sexual health behaviors. There is a limited amount of literature that focuses exclusively on the sexual health risk behaviors of adolescents residing in foster care. This study uses original data to identify predictors of communication between child welfare workers in the state of Kansas and the adolescents they serve who are residing in foster care regarding their sexual health and decision making. This study makes a contribution to the literature as it is the first to focus attention on certain attributes of child welfare workers in the state of Kansas that serve as predictors for communication with their current adolescent caseload regarding issues of sexual health and decision making. Additionally,

this is the first study conducted in several decades to focus specifically on communication with adolescents residing in foster care regarding their sexual health and decision making.

“There are few things more vital to the welfare of the nation than accurate and dependable knowledge of the best methods of dealing with children, especially with those who are in one way or another handicapped by misfortune...”

-President Theodore Roosevelt 1909 Conference on Children

Chapter 1

Communication with Adolescents in Foster Care Regarding Their Sexual Health and Decision Making

In the United States at any given time there are approximately a half million children residing in foster care (Zetline, Weinberg, & Kimm, 2005). Children are placed in foster care for a multitude of reasons including: physical, mental and sexual abuse, neglect, or due to the inability of their parent or guardian to adequately care for them. Of the approximately 500,000 children residing in foster care nearly half of these are children aged 12 – 17 years (Zetlin, Weinberg, & Kimm, 2005). Adolescents placed in foster care are at high risk for unplanned or unwanted pregnancy as well as for fathering children (Polit, Morrow-White, & Morton, 1987; Risley-Curtiss, 1997). When in foster care, adolescents experience a disruption in the expected avenues through which they would receive sexual health information, such as through parents, school and peers. Adolescents that are placed in foster care come into contact with numerous professionals, and in particular, social workers. These professionals often serve as a gateway to information and resources such as mental and physical health, education, legal assistance, and life skills that are vital to youth in foster care (Bunger, Stiffman, Foster, & Shi, 2009). Adolescents who are placed in foster care and the social workers who serve them are affected by the nature of their worker-client relationship on numerous levels.

Social workers are tasked with serving and protecting adolescents in foster care, who are considered one of the United States' most vulnerable populations (Polit, Morrow-White, & Morton, 1987). Consequently, it is important that social workers are equipped with the knowledge and skills necessary as they are in a position of influence to communicate with

adolescents about all their special needs including sexual health and decision making.

Difficulties in accomplishing these established goals can occur when social workers experience discomfort regarding communication with adolescents in foster care surrounding their sexual health. As a consistent adult figure in the lives of these adolescents, social workers are in a position to communicate with them regarding sexual health and decision making. However, a significant impediment is that social workers may not utilize their knowledge, training, or education to engage in such conversations with adolescents, or they may believe that they are overstepping state or agency policy as well as parental boundaries if they were to engage in discussions with adolescents regarding sexual health and decision making. This dissertation research includes a consideration of social workers' knowledge about and comfort surrounding communication with adolescents in foster care regarding their sexual health and decision making. For the purposes of this dissertation, the use of the title social worker will refer to those social workers who have earned a bachelor of social work degree or masters of social worker degree and are employed as child welfare workers.

This introductory chapter will provide an overview of the history of foster care and child welfare systems in the United States. Additionally, information will be presented that outlines the relationship between child welfare workers and adolescents who reside in foster care. Chapter two describes a proposed conceptual framework regarding communication between social workers and adolescents residing in foster care concerning their sexual health and decision making and how this communication is influenced by aspects of relational, attachment and life span theories. The guidance of this framework informs the study's effort to assess the influence of child welfare workers' sexual health knowledge and comfort pertaining to sexual health issues

on communication with adolescents residing in foster care. The third chapter includes a critical review of the research literature with a focus on the relationship of social work to adolescents in foster care, sexual health of foster youth, the responsibility of the child welfare system to children in foster care, and social work education about sexual health. Chapter four presents the methods used in this dissertation research which examines whether knowledge and comfort surrounding issues of adolescent sexuality are significant predictors of communication between social workers and adolescents residing in foster care. Chapter five presents results of univariate, and bivariate analyses run to identify significant relationships between identified independent variables, control variables and dependent variables. Additionally, multivariate analysis will be conducted in order to identify potential predictors of communication with adolescents residing in foster care regarding sexual health and decision making. The final chapter outlines the implications and limitations of the current research, as well as recommendations for future research in this area of study.

Foster Care in the United States

Child protection is a state level concept with historical roots in the colonial poor laws that were inherited from the English colonies at the close of the nineteenth century (Cohen, 1958; Pumphrey & Pumphrey, 1961). Organized child welfare protections emerged in the late 1800s following the rescue of Mary Ellen Wilson from her guardian's home in Hell's Kitchen, New York (Myers, 2008). Mary Ellen's situation was brought to the attention of law enforcement by a concerned neighbor who had noticed signs of abuse including visible bruising and emaciation (Costin, 1991). Some historians attribute Mary Ellen's case to being the impetus for the child welfare movement in the United States (Costin, 1991; Trammell, 2009; Ventrell, 1998).

Subsequent to the case of Mary Ellen Wilson, the state of New York developed the Society for the Prevention of Cruelty to Children (NYSPCC) (Myers, 2008). The NYSPCC was responsible for establishing state level child welfare laws that are the basis for many current state and federal child welfare laws (Myers, 2008). Philanthropic agencies such as the Children's Aid Society and formal authoritative groups like the Massachusetts State Board of Charities are recognized as some of the earliest child protective entities (Cohen, 1958; Pumphrey & Pumphrey, 1961). In terms of child welfare practices, early organizations focused their attention on child removal (Costin, 1991). Children who were considered to be orphans by authorities were at times placed in adoptive homes or into an involuntary apprenticeship or indentured servitude. The latter allowed for the orphaned children to pay their own way rather than be provided for financially by the state or federal government (Ventrell, 1998).

The Orphan Train

In the mid-19th century, the practice of removing orphaned children from the urbanized cities on the East coast and transporting them to homes in the Western states was called the "orphan train" (Trammell, 2009, p. 4). Between the mid-19th century until 1929, approximately 200,000 children were removed from urbanized East coast cities and sent to homes in Western regions of the United States (Ventrell, 1998). Younger children placed on the orphan trains were at times matched with families who wanted to adopt children. However, older children (aged 12-17 years) identified as making passage on the orphan trains were many times forced into indentured servitude once matched with a family (Trammell, 2009). Doubt was cast on the effectiveness of the orphan trains in the early 1900s when it was found that the authorities responsible for the children transported on the orphan trains were not keeping track of the their

wellbeing after they were placed with families (Trammell, 2009). With doubt arising around the effectiveness of the orphan trains, child advocates began to look at alternative child welfare practices which included a focus on family preservation and permanency in child placement (Ventrell, 1998).

Protection for Children at the Federal and State Level

In 1909, President Theodore Roosevelt hosted a conference at the White House that focused on child welfare issues. This conference led to the development of the United States Children's Bureau (USCB), which then and now focuses on the well-being of children and on their safety while attempting to create permanency in living arrangements for displaced children (Ventrell, 1998). Following the inception of the USCB, in 1921 Congress passed the Sheppard-Towner Act that allowed states to establish their own Children's Bureaus (Ventrell, 1998). After the enactment of state level Children's Bureaus, the Supreme Court set precedence in the 1944 case *Prince vs. Massachusetts*, which allowed states the authority to intervene on the behalf of children in what were previously considered to be private family matters (Ventrell, 1998). Following this ruling, the U.S. government further intervened on behalf of children by adding Aid to Dependent Children to the Social Security Act in 1946 as well as by adopting mandatory reporting laws in 44 states by 1967 (Ventrell, 1998).

Over the following decades significant legislation was passed including the 1974 Child Abuse and Prevention Treatment Act (CAPTA), which provides individual states funding for investigation and prevention of child abuse and neglect (Ventrell, 1998). Despite this, it was not until 2008 that a piece of child welfare legislation passed by Congress, The Fostering Connections to Success and Increasing Adoptions Act, included a small provision that required

child welfare agencies to streamline and concisely maintain the health records of children placed in foster care. The provision requires that a full medical history of each child placed in foster care is taken upon entry into a foster care home or facility (Carpenter, Clyman, Davidson, & Steiner, 2001).

Legislation for the Health and Well-Being of Foster Youth

Extensive research surrounding the health and wellbeing of adolescents in foster care can be found across disciplines. Simms, Dubowitz, and Szilagyi (2000) classify the unique health care needs of children residing in foster care as relating to disorders ranging from chronic health conditions, to extensive mental and developmental delays including severe psychiatric diagnoses. Research conducted in 1995 by the U.S. General Accounting Office (USGAO) reports findings which compound the issues reported by Simms, Dubowitz, and Szilagyi (2000) regarding the condition of youth entering foster care. The USGAO found that despite the youth's condition the majority of children who enter foster care do not receive adequate or preventative medical treatment while in placement (Simms, Dubowitz, & Szilagyi, 2000). Subsequently, a collaboration was formed between the Child Welfare League of America and the American Academy of Pediatrics in order to develop guidelines for the preventative health care of children and adolescents in foster care (Mather, Lager, & Harris, 2007; Simms, Dubowitz, & Szilagyi, 2000).

The Fostering Connections to Success and Increasing Adoptions Act, initiated in 2008, includes Section 205, which explicitly discusses the regulations for the coordination of mental and physical health of children and adolescents in foster care (Geen, 2009). Further, Section 205 presents how children and adolescents in the care of the state or foster care should be subject to

scheduled health screenings and routine preventative care (Geen, 2009). Geen (2009) states that discussions surrounding referrals to routine preventative medical care by child welfare workers should include sexual health screenings for adolescents (e.g., pap smears for females, testicular examinations for males, screenings for pregnancy and sexually transmitted infection (STI), and appropriate contraceptive advice and prescription). The idea of adolescents being provided with comprehensive assessment, referral and necessary treatment while involved with the child welfare system is championed by governing professional boards such as the National Association of Social Workers (NASW) (Bailey, 2003). The child welfare system has evolved and expanded to include federal and state guidelines for the purpose of oversight since the early days of child removal. Throughout this history, one constant resource can be identified among the historical records of the child welfare system, and that is the presence of social workers.

Child Welfare Workers

As the position and responsibilities social workers hold within the child welfare system have evolved, so has the profession of social work. The NASW emerged in 1955 as a formative organization providing oversight, education, and resources for professional social workers (NASW, 2008). In addition to establishing the Code of Ethics, the NASW established standards that all social workers are held to when working with diverse populations (Bailey, 2003). Standards for practice with adolescents provided by the NASW clearly articulate that social work with adolescents must respect “the role of adolescence in individuals’ social, physical, emotional, and sexual growth, including adolescents’ striving for and ambivalence about personal identity, and sexuality” (Bailey, 2003, p. 8).

Social workers serving as child welfare workers. Significant research supports the efficacy of social workers holding the position of child welfare worker (Albers, Reilly, & Rittner, 1993; Dhooper, Royse, & Wolfe, 1990; Jones & Okamura, 2000). It is noteworthy that some research indicates that child welfare workers who hold social work degrees are better equipped for direct practice than are child welfare workers who hold other types of degrees (Dhooper, Royse, & Wolfe, 1990). Additionally, child welfare workers educated at universities that use Title IV-E training funds exhibit higher overall performance in social work practice as well as higher levels of child welfare knowledge and job stability (Jones & Okamura, 2000). Social workers function as the gateways to services for their clients (Bunger, Stiffman, Foster, & Shi, 2009; Stiffman, Pescosolido, & Cabassa, 2004). Further, Stiffman, Pescosolido, and Cabassa (2004) found that most adolescents residing in foster care will not actively seek out assistance for specific needs. Instead, adolescents placed in foster care rely on formal supports such as child welfare workers to accurately assess and refer them to resources that will assist them in their current situation (Stiffman, Pescosolido, & Cabassa, 2004).

Despite the significant research that champions social workers as child welfare workers, additional research with less gratifying results focuses on the relationship between adolescents in foster care and child welfare workers from the perspective of the adolescent. Becker and Barth (2000) conducted research focusing on the development of a specialized sexual health curriculum for adolescents residing in foster care. The authors noted that adolescents placed in foster care are disconnected from the source of their primary sexual health curriculum offered commonly through the adolescents' school or home of origin (Becker & Barth, 2000). Becker and Barth (2000) found that in the four years following their exit from foster care approximately

60 percent of females had given birth to one or more children as compared to 24 percent of their peers. The authors attribute this to adolescents in foster care having little to no access to sexual health education and not fully understanding the consequences of unplanned and unwanted pregnancies (Becker & Barth, 2000). When interviewed by researchers, adolescents in foster care specified that they had not been provided the opportunity or felt comfortable enough to discuss their sexual health and decision making with their foster care provider or any other professional (Becker & Barth, 2000). In addition, adolescents in foster care reported that they had not been provided any type of sexual health education, information, or formal referral for services (Becker & Barth, 2000; James, Montgomery, Leslie, & Zhang, 2009).

In sum, despite the extensive research that shows the efficacy of social workers serving as child welfare workers (Albers, Reilly, & Rittner, 1993; Dhooper, Royse, & Wolfe, 1990; Jones & Okamura, 2000), there is still a significant gap in social work practice in terms of communication with adolescents in foster care regarding their sexual health and decision making.

Child welfare workers' communication regarding sexual health and decision making. There is discussion in the literature about why adolescents are not provided with the opportunity to talk about or receive education and referrals for their sexual health needs. Included in these discussions is the idea that child welfare workers face multiple challenges that contribute to reduced effectiveness with clients (Armour & Schwab, 2007). Low salaries, less than adequate training, marginal supervision, high case loads, and high turnover are common challenges for child welfare workers (Armour & Schwab, 2007). Still, despite the significant number of barriers child welfare workers face in their employment, they should be expected to

adhere to the overall professional standards including those pertaining to adolescent sexual health and development as outlined by the NASW.

Beyond the general job related barriers experienced by child welfare workers, there are additional impediments to communicating with adolescents residing in foster care regarding sexual health and decision making. These include the level of sexual health knowledge individual social workers have, as well as his/her level of comfort in discussing specific topics with adolescent clients. Additionally, child welfare workers who are hesitant to discuss sexual health with adolescents in foster care may be responding to the hands-off approach to this topic that has been modeled by the federal government and many state and local government agencies (Polit, Morrow-White, & Morton, 1987). A few states including Alabama and Texas explicitly disapprove of or do not support child welfare workers communicating directly about sexual health or referring adolescents in foster care for sexual health services (Polit, Morrow-White, & Morton, 1987). Other states, such as California, have expressed full support of child welfare workers engaging in communication with adolescents regarding their sexual health and decision making (Polit, Morrow-White, & Morton, 1987). The majority of states maintain an issue avoidance posture, where no official stance on the issue is articulated (Polit, Morrow-White, & Morton, 1987). Their role in communication with adolescents regarding sexual health and decision making is then often left to the discretion of the child welfare worker.

Social work professionals have the potential to communicate with adolescents in foster care regarding their sexual health and decision making; however, this type of communication may cause discomfort between the worker and the client. Child welfare workers may feel uneasy about discussing topics such as adolescent sexual health and decision making, which at times is

considered taboo (Shulman, 1999). Child welfare workers, like the adolescents they serve, may have been raised to believe that conversations regarding sex are inappropriate under any circumstances, thus creating a shared sense of discomfort (Shulman, 1999). A primary factor in these communication challenges may be that child welfare workers do not feel comfortable or knowledgeable enough to engage in conversations regarding sexual health (Polit, Morrow-White, & Morton, 1987). In addition, child welfare workers may believe or have been told that a discussion about sex with an adolescent in foster care is not appropriate and could cause conflict with the parent or the agency for which they work given the state or federal guidelines that govern that agency (Polit, Morrow-White, & Morton, 1987). With that said, substantial research reports that outcomes for adolescents placed in foster care include engagement in high-risk sexual health behaviors (Carpenter, Clyman, Davidson, & Steiner, 2008; Risley-Curtiss, 1997).

Adolescents in Foster Care

The population of adolescents in foster care, much like the social workers who serve them, is heterogeneous in terms of race, ethnicity, sexuality, socioeconomic status, education level, and religious background. At any given time, there are approximately a half million children in foster care (Zetlin, Weinberg, & Kimm, 2005). Of the approximately half million children in foster care, 250,000 are between the ages of 12-17 years (U.S. Department of Health and Human Services, 2009). Adolescents are placed in foster care for a multitude of reasons, such as being victims of various forms of abuse and neglect or as a result of the basic inability of a parent or guardian to adequately care for the adolescent (Mather, Lager, & Harris, 2007). Since the inception of federally funded foster care programs, hundreds of thousands of adolescents have been placed in care. By the time adolescents are placed in foster care, many

have an extensive history of abuse or neglect by a parent, guardian or relative (Bruskas, 2008; Dowdell, Cavanaugh, Burgess, & Prentky, 2009; Frederico, Jackson, & Black, 2008). Due to problematic histories and subsequent removal from their homes, these adolescents are more likely to be diagnosed with mental illness and behavior disorders, suffer from multifaceted medical and developmental issues, and engage in criminal activities and risky sexual behaviors (Armour & Schwab, 2007; Dowdell, Cavanaugh, Burgess, & Prentky, 2009).

The sexual health of adolescents residing in foster care. A recent survey conducted in 2009 by *The National Campaign* found that 93 percent of adolescents residing in foster care are sexually experienced, compared to 87 percent of their peers (Child Trends Inc., 2009). Clearly noted in this research is the fact that compared to their peers, adolescents in foster care are less likely to use contraceptives and more commonly experience one or more forced sexual experiences (Becker & Barth, 2000; Child Trends Inc., 2009; James, Montgomery, Leslie, & Zhang, 2009; Risley-Curtiss, 1997). In addition, many of the protective factors that assist in the reduction of sexual risk behaviors for adolescents who live at home, such as school engagement, monitoring by and connectedness to a parent or caregiver, religious connection, and expectations for the future, are commonly absent in adolescents residing in foster care (James, Montgomery, Leslie, & Zhang, 2009).

In the mid 1980's Tennessee sought to address the unique issues that adolescents residing in foster care face regarding sexual development, with the development of the Memphis Project. This initiative included the assurance that children ten years of age and older, residing in foster care would attend, with their child welfare worker, a "family life education" (Polit, Morrow-White, & Morton, 1987, p. 21) program. This purpose of this program was to provide formal

sexual health education as well as the opportunity for youth living in foster care to discuss sexual health and development issues with their child welfare workers (Polit, Morrow-White, & Morton, 1987). Although this program was discontinued due to loss of funding, it attests to the fact that adolescents in foster care are at a significantly elevated risk for pregnancy as well as fathering children and the risk of engaging in sexual intercourse increases more than twofold for each year adolescents spend in foster care (Polit, Morrow-White, & Morton, 1987).

This first chapter has provided an overview of the history of foster care and child welfare systems in the United States. Additionally, information that informs the relationship between child welfare workers and adolescents residing in foster has been presented. The subsequent chapter will provide a theoretical foundation which informs the proposed dissertation research.

Chapter 2: Conceptual Framework

Adolescence is a vulnerable time for all children, but particularly those youth residing in foster care. Ninety-three percent of adolescents residing in foster care are sexually experienced, are less likely to use contraceptives, and commonly experience one or more forced sexual experiences (Becker & Barth, 2000; Child Trends Inc., 2009; James, Montgomery, Leslie, & Zhang, 2009); this points to the need for more aggressive sexual health education. When social workers support adolescents in foster care, they must have the skills to discuss issues regarding sexual health in straightforward, comprehensible language or risk giving adolescents the idea that what they are thinking and feeling about sexuality and their own development is disgraceful or morally wrong (Aiello, 1999). Communication regarding sexual health can assist adolescents in developing the ability to engage in reciprocal conversations and incorporate what they have learned in their future behaviors (Romeo & Kelley, 2009). In combination with learned skills and personal experience, social workers can use aspects of theories related to life span development, relational theory and attachment theory, in order to communicate with adolescents regarding their sexual health and decision making.

Life Span Development

Theories of life span development articulate a specific phase of development where adolescents encounter significant physical, emotional and sexual changes and describe how this phase is multi-faceted and at times complex (Corcoran, 2000). When coupled with placement in foster care, the emergence of these changes can be difficult for adolescents. These theories consider sexual growth and development in adolescents as a natural part of the developmental trajectory (Shibusawa & Padgett, 2009). Traditionally, theories of life span development indicate

that noticeable sexual changes occur in children aged seven to eleven years (Sigelman & Rider, 2009). The physical development of adolescents is a pivotal period in life span development, and it includes biological changes such as the rapid maturing of sex organs as well as the maturing of sperm in male and the beginning of menstruation in female adolescents (Sigelman & Rider, 2009). In addition, sexual activity and exploration are recognized as natural parts of adolescent development (Kelly, 2011).

Generally, chronological age is recognized as the most common marker of change in the lives of adolescents (Peterson, 1988). However, adolescence is rife with physical and emotional changes that can only be parceled out by recognizing and understanding specific phases of this developmental period. The most substantial developmental marker identified during adolescence is the onset and journey through puberty (Peterson, 1988). During the phase identified as puberty, adolescents experience significant physiological changes including increased hormones (specifically growth hormones), insulin, and thyroxine, which have influence on an adolescent's growth rate, as well as leptin, which influences an adolescent's body configuration (Neinstein, 2002). The infusion of these hormones during puberty can cause hypersexuality, moodiness, irritability, and conflict in relationships for adolescents (Peterson, 1988). Sexual development is a significant part of the full developmental trajectory of adolescence that requires attention from the adolescent and the significant adults in his/her life (Peterson, 1988). There are times when adolescent development is disrupted from the expected trajectory due to trauma such as removal from their home and placement in foster care; however, it is not halted or discontinued (Shibusawa & Padgett, 2009).

Significant progress in the research into child and adolescent development has been made over the past century, particularly in terms of identifying the differences in children and adolescents socially, physically, and emotionally compared to their adult counterparts.

Historically, adolescent sexuality was viewed from a male perspective, even when dealing with the sexual development of female adolescents (Aiello, 1999). Despite the significant changes in thought regarding adolescent development, one concept has consistently remained: adolescents are sexual beings capable of engaging in sexual behaviors and relationships (Bullough, 2004).

In the late 19th century, Freud opened discussions about sexuality, elucidating the idea that children were sexual beings and introducing concepts such as the Id and the Ego, which were believed to be present in infants at their birth (Freud, 1949). Id impulses, which were commonly mistaken as primitive and destructive in nature, are in fact now viewed as part of a normative pattern of sexual development in adolescents (Goldstein, Miehes, & Ringel, 2009). Formerly, Id impulses were in fact viewed as something that needed to be subdued or hidden in children and adolescents. Thus, forcing what are now known as common facets of adolescent development such as sexual fantasy and exploration to be disregarded or ignored (Crockett, Raffaelli, & Moilanen, 2003).

The suppression of sexual behaviors and desires was championed for centuries in the United States and at one point all forms of sexual behavior besides intercourse between a man and a woman was declared illegal (Hite, 2006). Norms such as the aforementioned one in terms of sexual behavior in adults and adolescents were established early on and continue to permeate the information and education surrounding adolescent sexual health and development even today. This is evidenced by the championing of Abstinence Only education for children and

adolescents in the United States (Crockett, Raffaelli, & Moilanen, 2003). Despite the fact that sexual impulses and behaviors in adolescents are now viewed as common facets of sexual development, the fact remains that there is still inherent discomfort experienced by some professionals in addressing these issues (Hite, 2006).

Critical to the youth's ability to navigate this tumultuous time is the presence of adults who provide stability, helping the adolescent understand the changes taking place within their bodies and providing information about their sexual health. Youth in foster care often do not have these adults in their lives. In the 1950's Erik Erikson, developed the Eight Stages of Man [sic], describing the psychosocial development through the lifecycle which paralleled Freud's description of psychosexual development. Included in Erikson's Eight Stages of Man is the idea that developmental trajectories may go awry, having a potentially negative influence on a developmental course, some of which can be overcome and some that cannot (Erikson, 1950). Erikson (1950) named the stage of development specific to adolescents "Identity versus Role Confusion" (p. 226). In Erikson's seminal work *Childhood and Society* (1950), he articulates how:

...the establishment of a good relationship to the world of skills and tools, and with the advent of sexual maturity, childhood proper comes to an end. Youth begins. But in puberty and adolescence, all sameness and continuities relied on earlier are questioned again, because of the rapidity of body growth which equals that of early childhood and because of the entirely new addition of physical genital maturity (p. 227).

Erikson's findings must be taken in context, as the majority of Erikson's young subjects were male, and his writing on adolescent female development was simply an addendum to the more

significant findings that focused on these adolescent males (Hodgson & Fischer, 1979; Josselson, 1973). Despite the male centered nature of Erikson's research his ideas which surround the effect of trauma on an adolescent's developmental trajectory are still relevant today. In fact, Crockett, Raffaelli, and Moilanen (2003) attribute significant weight to the sociocultural aspects of adolescent's lives in terms of their sexual development. They state that an adolescent's developmental trajectory can easily be disrupted or deviate when the adolescent experiences significant trauma in their lives such as removal from their home of origin and placement in foster care (Crockett, Raffaelli, & Moilanen, 2003). In addition to this, Crockett, Raffaelli, and Moilanen (2003) articulate the importance of adolescents having access to a trusted source for information and guidance in order to redirect an adolescent's disrupted development pathway.

Over the past several decades, theories of life span development and aspects of adolescent development have progressed to a point where an expected developmental trajectory has become significantly clearer. The developmental outcomes of adolescents residing in and aging out of the foster care system continues to be the focus of substantial literature and research (Bruskas, 2008; Risley-Curtiss, 1997; Taussig, 2002). Bruskas (2008) concludes that extensive research demonstrates poor outcomes developmentally, emotionally, educationally, and socially for children and adolescents placed in foster care. She expounds upon the ideas that the removal of adolescents from their homes and placement into foster care has the potential to disrupt expected trajectories of development, and that without assistance, adolescents are forced to struggle through stages of development on their own, limiting their ability to reach optimal levels of development and health (Bruskas, 2008).

While a child welfare worker cannot take the place of a family, Bruskas (2008) insists that the child welfare system must be responsible for providing the assistance and support which adolescents need so that they can “successfully meet major developmental milestones” (p. 72). Although adolescent sexual development is not specifically addressed by Bruskas, she discusses in an all-encompassing manner adolescent development and the use of relational skills by the child welfare system to assist in dispelling the fear, anxiety, and stress felt by adolescents in foster care (2008). The ability of social workers to recognize expected adolescent developmental milestones will assist adolescents with maintaining an expected developmental trajectory. However, when adolescents are removed from their homes and placed into foster care, the ability to recognize developmental milestones must be coupled with an understanding of attachment theory and how it affects the expected adolescent developmental trajectory.

Attachment Theory

Attachment theory developed out of observations of infants who were separated from their mothers (Bowlby, 1951). Early research into attachment, specifically the works of Bowlby (1951) and Ainsworth (1974), emphasized the significance of early interactions between infants and a female primary caretaker (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). These early interactions and subsequent attachment between the child and the primary caregiver set the stage for the child’s ability to form future attachments, or what is referred to as a “secure base” (Hazan & Shaver, 1987, p. 512). Attachment-related behaviors and theories are commonly recognized in three distinct categories across the life span: proximity seeking or the action identified in infants when seeking physical closeness to a caregiver; separation protest or the behavior in infants such as crying identified after a caregiver is removed from physical sight; and

a secure base, which involves infants exhibiting feelings of comfort when they are returned to a caregiver (Hazan & Shaver, 1987; Segrin & Flora, 2005).

Although attachment theories generally focus on the behaviors of infants, more recently the ideas behind developing and maintaining a secure base have been applied to older children and adolescents. Attachment theory evolved into numerous conceptual ideas that have been consistently used in the research and theoretical literature pertaining to children involved with the child welfare system (Washington, 2008). Washington (2008) maintains that “Attachment theory attributes the problems that children continue to experience even after being removed from an abusive situation to the trauma that they endure when experiencing repeated separations from caregivers” (p. 9). Vig, Chinitz, and Shulman (2005) connect aspects of Erikson’s Eight Stages of Man [sic] (1950) to attachment theory when discussing the loss that adolescents feel when they are removed from their homes and cut off from a familiar environment. They surmise that expected adolescent developmental trajectories can be disrupted either temporarily or permanently when foster care placement occurs. This type of significant developmental disruption in adolescence has a tendency to create or compound existing issues regarding attachment. Attachment issues in adolescents commonly manifest in the form of depressive, aggressive, or avoidance behaviors, making it difficult for adolescents to connect with or trust social workers or any other adult who is attempting to provide them with support (Vig, Chinitz, & Shulman, 2005).

Additional literature focuses attention on not only the initial trauma caused by the removal of an adolescent from their primary caregiver and placement into foster care but also on the re-traumatization that can occur while in foster care (Racusin, Maerlender, Sengupta,

Isquith, & Straus, 2005). Often when adolescents are removed from their homes and placed into foster care, it is not their first encounter with the child welfare system. These adolescents may have experienced multiples moves, whether it is between foster homes or between their home of origin and the foster care system (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). Armour and Schwab found that approximately 25 percent of children placed in foster care experienced between 6 and 23 placements in a 12 month period (2007). When adolescents experience multiple placements or repeated disruptions from either their home of origin or a foster home, it is associated with an inability to form positive attachments to adult caregivers as well as negative developmental, social, and emotional outcomes (Herrenkohl, Herrenkohl, & Egolf, 2003; Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005; Vig, Chinitz, & Shulman, 2003; Washington, 2008). This inability to develop trust or form attachments with nurturing adults can lead to an inability to interpret their environment, ask questions about their personal circumstances, or retain vital information surrounding their life situations (Herrenkohl, Herrenkohl, & Egolf, 2003).

Adolescence is a time of significant developmental, as well as social and emotional change beginning with the advent of puberty (Corcoran, 2000). Coupled with the trauma of placement into the foster care system, adolescents need to re-establish their ability to relate to and eventually trust significant adults in their lives (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). Most commonly when adolescents are introduced to the foster care system, they are assigned a child welfare worker. When navigating through the fluid and at times tumultuous movements of the foster care system, the child welfare worker becomes the one constant in the life of the adolescent. The relationship that is formed between the adolescent and the child

welfare worker may be vital to the developmental, social, and emotional outcomes of that adolescent (Beam, Chen, & Greenberger, 2002; Greeson, Usher, & Grinstein-Weiss, 2010; Munson, Smalling, Spencer, Scott, & Tracy, 2010). Consequently, child welfare workers become responsible for assisting adolescents in the re-establishment of trust and the ability to understand their physical as well as their mental environments, in order to move the adolescents forward developmentally, socially, and emotionally. The establishment of a bond between an adolescent and child welfare worker allows for a feeling of comfort when discussing issues that could create anxiety, such as sexual health and decision making.

Relational Theory

Relational theory provides a broader view of the importance of relationship for both healthy growth and development and as a focus of therapeutic intervention (Jordan, 1997; West, 2005). Freedburg (2009), combines this theory with feminism to demonstrate the importance of therapeutic relationships in understanding and explaining the effectiveness of relationships social workers develop with any clients, including adolescents in foster care. Relational theory asserts that the basis of healthy human development is the ability to form associations or connections through relationships (Freedburg, 2009). The main tenants of relational theory include mutuality or a reciprocal exchange of energy and communication between worker and client. Tenants also describe the use of self or the ability of social workers to critically reflect on their personal reservations, and use self-disclosure of experiences or information that aid in the working relationship. A worker's ability to express authenticity or a sense of genuine comfort in the working relationship is another main focus. The worker also needs to fully understand the roles of transference and counter transference that can dictate how the transfer of unresolved feelings

pass from worker to client and vice versa. Finally, a strong understanding of how to develop healthy boundaries which provides a clear separation of personal and professional between the worker and the client. (Freedberg, 2009; Jordan, 1991; Jordan, 2000; Miller, 1999).

These characteristics are the foundation of social work practice where relationship is the essential ingredient to the change process. Relational theory is the embodiment of this, and evolved into the idea that human behaviors and interactions grow and develop over time and are understood only in the context of their environment. The use of these tenants in direct social work practice can lead to a more meaningful relationship between social worker and client (Freedberg, 2009; Jordan, 1991; Jordan, 2000; Miller, 1999). Adolescents are sexual beings, and the course of their development involves significant sexual and physical changes (Bullough, 2004). Adolescents can experience significant trauma, multiple traumas, or re-traumatization during their time in the foster care system (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). This trauma is accentuated by the physical and relational loss of significant adults in their lives such as of parents or guardians. In order to build mutual, trusting, and effective relationships with adolescents residing in foster care, social workers must engage the primary tenets of relational theory.

The tenets of relational theory are made clear in the writings of Shulman (1999), which focus on the discussion of taboo topics with social work clients. By combining the idea of communication around taboo topics and the relationship necessary for child welfare workers to effectively serve adolescents in foster care, Shulman (1999) describes how at times adolescents in foster care struggle to define their situation while displaying an inability to clearly articulate the role they are currently playing in their environment. Adolescents in foster care need to re-

establish trust and develop connections with individuals who can assist them in moving past the trauma of placement in foster care and the feelings of abandonment that many times accompany that placement (Fleming, Catalano, Haggerty, & Abbott, 2010).

One of relational theory's primary concepts, the use of "self" by professional social workers, has been extensively discussed in social work literature. Freedberg (2009) describes the vital areas of a social worker's self as "...personality, culture, appearance, age, ethnicity, gender, and sexual orientation" (p. 35). She illuminates how social workers must be aware of and comfortable with their "self" before they can effectively work with clients. Social workers and adolescents alike bring parts of their selves into the worker-client relationship, creating at times a dynamic that can either strengthen or make ineffective the worker-client relationship. Social workers may also experience the same or similar discomfort when faced with discussing taboo issues such as adolescent sexual health and decision making (Shulman, 1999). Also, social workers are encouraged to develop a trust relationship with adolescents in foster care before broaching a subject such as sexual health, as premature conversations without some basis of trust between the worker and client have the potential to be ineffective (Shulman, 1999).

Adolescents in foster care are disrupted from the avenues by which they might normally expect to receive information on sexual health and decision making. The most common avenues are parents, peers, and schools (Polit, Morrow-White, & Morton, 1987). Although the adolescent is still in school and interacts with peers, these may change with each new placement lacking the continuity needed for healthy development. Therefore, adolescents' relationships with non-parental adults while in foster care are vital to their continued development (Rishel, Cottrell, Cottrell, Stanton, Gibson, & Bougher, 2007). Using relational theory to inform their

practice, social workers are able to discuss topics such as sexual health and decision making with adolescents (Fleming, Catalano, Haggerty, & Abbott, 2010). Freedberg (2009) states that, “An authentic and responsive relational context characterized by mutuality, reciprocity, and intersubjectivity has the potential to enhance clients’ capacity to cope under adverse circumstances and promote adaptation under normative ones” (p. 30). In other words, engaging the main tenants of relational theory in social work practice can assist clients in overcoming adversity while providing them with coping mechanisms and promoting adaptation to their current situation.

In summary, social workers must appreciate the unique relationship between adolescent behavior and development and the context and conditions of each adolescent’s social and cultural perspective (Goldstein, Miehl, & Ringel, 2009). Interest in sexual health and decision making are a natural part of an adolescent’s development (Sigelman & Rider, 2009). Adolescents in foster care may experience trauma related to removal from their familiar environment and placement in an environment foreign to them. The initial trauma is occasionally perpetuated or revisited by the constant transitions that usually occur while they are involved with the foster care system and as they are working through their developmental trajectory (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). The majority of direct social work practice models emphasize the ideals of the client-worker professional relationship (Goldstein, Miehl, & Ringel, 2009). The addition of direct practices that incorporate elements of relational theory, respect adolescent developmental trajectories, and recognize potential issues with attachment are the most beneficial to adolescents in understanding their environment and encouraging them to ask questions about their situations (Shulman, 1999).

Conclusion

Adolescents residing in foster care are sexually experienced, less likely to use contraceptives, and commonly are victim to one or more forced sexual experiences (Becker & Barth, 2000; Child Trends Inc., 2009; James, Montgomery, Leslie, & Zhang, 2009). When social workers are required to support adolescents in foster care, they must have the skills to discuss sexual health in straightforward, comprehensible language. An inability to do this may give adolescents the idea that feelings regarding sexual health and development are disgraceful or morally wrong (Aiello, 1999). Life span theories articulate a specific phase of development when adolescents encounter significant physical, emotional, and sexual changes and challenges. Additionally, these theories provide detailed descriptions of how this phase of development is multi-faceted and potentially complex (Corcoran, 2000). When this complex developmental stage is coupled with placement in foster care, adolescents may experience difficulty understanding the changes they are experiencing. Social workers who communicate with adolescents can assist in establishing reciprocal conversations regarding the adolescent's sexual health and decision making (Romeo & Kelley, 2009).

Chapter 3: Review of the Research

The previous chapters established that in the United States there are approximately a half million children placed in out-of-home care each year (Carpenter, Clyman, Davidson, & Steiner, 2008). This number represents a substantial surge in out-of-home placements for children, which has increased by 95.3 percent since 1986 (Taussig, 2002). Of the 500,000 children placed in foster care in a given year, nearly half of these are ages 12-17 years (Thompson & Auslander, 2011). These adolescents are at high risk for engaging in risk behaviors (Becker & Barth, 2000; Child Trends Inc., 2009; James, Montgomery, Leslie, & Zhang, 2009; Risley-Curtiss, 1997), which result in negative consequences that have substantial short and long term effects. Although these risk behavior do not differ from the risk behaviors of their peers, foster youth who engage in the identified behaviors do so at a younger age and significantly more frequently than their peers (Taussig, 2002). In terms of sexual risk behaviors adolescents in foster care are more sexually experienced than their peers; and less likely to use contraceptives when engaging in sexual activity (Becker & Barth, 2000; Child Trends Inc., 2009; James, Montgomery, Leslie, & Zhang, 2009; Risley-Curtiss, 1997).

This chapter will present empirical research which focuses primarily on individual aspects of the complex issues facing adolescents in foster care and also presents the limited research that focuses on sexual health. The research literature included in this chapter was selected based on the quality and rigor of the research as well as on the usefulness of the research to the specified purposes of this dissertation. Particularly, it examines research literature that has been peer reviewed and published in refereed journals over the past twenty years. An exception

was made for a certain research literature considered seminal in this area and published more than twenty years ago.

Adolescents in Foster Care

As discussed previously adolescence is a tumultuous time, particularly for adolescents in foster care. Over the past several decades, interdisciplinary interest in the foster care system has developed, and a substantial amount of theoretical literature and research has been published on the topic of children in foster care (Beam, Chen, & Greenberger, 2002; Drapeau, Saint-Jacques, Lepine, Begin, & Bernard, 2007; Frederick & Goddard, 2008; Greeson, Usher, & Grinstein-Weiss, 2010; Kienberger, Bilaver, Goerge, Masterson, Catania, 2004; McMillen & Tucker, 1999; Munson, Smalling, Spencer, Scott, & Tracy, 2010; Pryce & Samuels, 2009; Rishel, Cottrell, Cottrell, Stanton, Gibson, & Bougher, 2007; Takayama, Bergman, & Connell, 1994; Taussig & Talmi, 2001; Ward, 2009). Existing research indicates that adolescents who are maltreated and subsequently placed in foster care are at a potentially heightened risk for engaging in risk behaviors such as substance abuse, sexual activity, and criminal behaviors (Dembo, Williams, Schmeidler, Wish, Getreu, & Berry, 1991; Polit, Morrow-White, & Morton, 1987; Widom, 1989). In addition to a heightened risk for engaging in risk behaviors, placement in foster care is commonly associated with negative developmental outcomes (Shin, 2004).

A study conducted by Shin (2004) uses quantitative methods to assess current developmental levels of adolescents residing in foster. Shin (2004) conducted field interviews using standardized questionnaires with a randomized sample of 74 youth aged 16 – 17 who are currently residing in foster care in order to assess their current social, emotional, and education levels. Respondents in the study were asked questions pertaining to their mental health, their

level of reading skill as well as their perceived level of social support while residing in foster care (Shin, 2004). Results obtained from participants were compared to national averages obtained from adolescents who are similarly aged but reside in their homes of origin.

Respondents in this study reported higher levels of depression, anxiety and loss of behavioral and emotional control at home and in public than did their peers who remained in their homes of origin (Shin, 2004). Additionally, participants in this study scored at a lower reading level, were more often placed in special education classes, and reported loss of behavior control frequently in school. A final finding of importance articulated by Shin (2004) illuminates the lack of social support felt by adolescents residing in foster care and how this lack of support is related to engagement in risk behaviors. She reports that the adolescents in her study scored very low on every aspect of the social support measure and reported high levels of engagement in risk behaviors (Shin, 2004). More specifically, adolescents involved in the study reported running away from their foster home on multiple occasions, hitting a person with the intent to harm, carrying a weapon (e.g. gun, knife), being stopped for public intoxication, or being involved in a gang related fight. Finally, 91 percent of the adolescents included in this study suffer from illegal substance use (Shin, 2004). In response to these findings, Shin (2004) postulates that social work practitioners must pay close attention to the level of social support and how it relates to engagement in risk behaviors for the adolescents in foster care they are tasked with serving. These findings are consistent with those presented by Taussig and Talmi (2001).

Foster youth and risk behaviors. In 2001, Taussig and Talmi hypothesized that a number of diverse psychosocial variables (e.g., trauma, attachment to negative peers and mentors, low perception of future opportunities, and limited parental involvement) in

conjunction with placement in foster care and the ethnicity of the adolescents were positively correlated with engagement in risk behaviors. Using the Adolescent Risk Behavior Survey (ARBS) and quantitative methods these researchers found significant correlations between these psychosocial variables, ethnicity, and engagement in risk behaviors among adolescents in foster care.

In line with the research conducted by Taussig and Talmi (2001), additional studies conducted on adolescents in the foster care system focus attention on overall risk behaviors (e.g., substance abuse, sexual activity, and criminal behaviors) that adolescents engage in while in placement (Frederick & Goddard, 2008; Leslie, James, Monn, Kauten, Zhang, & Aarons, 2010; McMillen & Tucker, 1999; Taussig & Talmi, 2001; Ward, 2009). In a longitudinal study of the long term impact on adolescents placed in foster care, Taussig (2002) interviewed 110 youth on two different dates separated by a six year time frame (2002). Participants were deemed eligible for the study if a referral on their behalf was made to the child welfare system, they became dependents of the state, and entered and remained in foster care for a period greater than five months (Taussig, 2002). The participants included in the study had an average age of 15.3 years, were 40 percent male, and represented Caucasian, African American, and Hispanic ethnicity (Taussig, 2002). She emphasizes that adolescents entering foster care come with a host of issues including maltreatment, social and emotional issues, and potential developmental problems that require particular services. In terms of risk behaviors, Taussig notes that youth entering foster care are more likely to engage in risk behaviors than are their nonmaltreated peers (2002). Taussig (2002) also notes that these youth “initiate sexual intercourse at an earlier age, having a

greater number of sexual partners, infrequently or inconsistently using contraceptives, and exchanging sex for money, drugs, or other things” (p. 1181).

Other significant findings articulated by Taussig (2002) include: a positive correlation between the age of the foster youth and increased engagement in risky sexual behaviors; a negative correlation between the existence of consistent parent and teacher support in a youth’s life and engagement in risky sexual behaviors; and that African American adolescents included in this study were not at greater risk of engaging in sexual risk behaviors. This last finding is contrary to earlier findings as cited in Taussig and Talmi (2001) which indicated African American youth were at greater risk. Finally, the results of this study indicated that youth in foster care are engaging in risk behaviors at earlier ages, which leads to substantially more negative long term outcomes. Taussig notes that these findings suggest that interventions focused on reducing risk behaviors in foster youth must be adapted to the developmental process of younger children and put into practice earlier than previous believed.

A second study conducted by Leslie, James, Monn, Kauten, Zhang, and Aarons (2010) focused attention on health risk behaviors of adolescents residing in foster care. Identified among these health risk behaviors are sexual risk behaviors. Using quantitative methods and a subsample (N = 993) of the National Survey of Child and Adolescent Well-Being (NSCAWB) the authors sought to examine health risk behaviors and assess whether certain psychosocial factors (older age, abuse history, association with deviant peers, female gender, limited monitoring by caregiver, and poor school engagement) are related to more substantial rates of health risk behaviors (e.g. sexuality, delinquency, substance use, and depression/suicidal ideations) (Leslie, James, Monn, Kauten, Zhang, & Aarons 2010). The subsample is derived

from the baseline analysis of the NSCAWB which was collected in 1999. All individuals in the sample are age 11 – 15 years and identify as current or former foster children.

Findings of significance include the fact that half of the sample reported engaging in at least one health risk behavior at the time the baseline data was collected. Additionally, over 25 percent of the sample had engaged in sexual intercourse at some point prior to collection of the baseline data. Five percent of the sample reported that they were pregnant, had been pregnant or that they had fathered a child at the time of the interview (Leslie, James, Monn, Kauten, Zhang, & Aarons 2010). Approximately a fourth of the respondents reported being diagnosed with a mental illness, more specifically depression or anxiety, as well as having suicidal ideations. In terms of the psychosocial indicators identified by the authors, they found that foster youth who were younger are more likely than their older peers to engage in health risk behaviors (Leslie, James, Monn, Kauten, Zhang, & Aarons 2010). Additionally, the authors identified a lesser degree of caregiver monitoring and connectedness as well as association with deviant peers as indicators of engagement in health risk behaviors for foster youth (Leslie, James, Monn, Kauten, Zhang, & Aarons 2010).

The findings in the study accentuate those found by Taussig (2002) in that they underscore the idea that adolescents in foster care are engaging in risk behaviors. These risk behaviors often include sexual health risk behaviors. In the study conducted by Leslie, James, Monn, Kauten, Zhang, and Aarons (2010), it would have been beneficial to identify and assess a comparison group or a group of youth who were not in foster care at the time of the study. As the NSCAWB did not limit its sample to youth in foster care, identification of a comparison sample of adolescents ages 11-15 could have been identified. Use of a comparison group would have

allowed the authors to identify areas where youth in foster care either need assistance or excel in terms of the psychosocial indicators identified for the purposes of the study. Additionally, the use of data from 1999 allows for a substantial amount of time to have passed between original data collection and the secondary data analysis conducted a decade later. This passage of time speaks to the cautions of generalizing the findings to current youth residing in foster. Despite this, the findings in this study are still relevant for youth currently residing in foster care and closely align with the findings of a study conducted by James, Montgomery, Leslie, & Zhang, 2009).

The Sexual Health of Foster Youth

There is a limited amount of research that focuses specifically on the sexual risk behaviors of youth residing in foster care. Commonly sexual risk behaviors are included or grouped with other risk behaviors such as delinquency and substance abuse. The following studies identify the sexual risk behaviors of adolescents in foster care as the primary focus of their study. Polit, Morton, and Morrow-White (1989) conducted qualitative research involving interviews with 90 adolescent females residing in foster care and 87 adolescent females residing in their homes of origin. They hypothesized that adolescent females placed in foster care are at heightened risk for early initiation of sexual behaviors (Polit, Morton, & Morrow-White, 1989). The study found that in fact adolescent females placed in foster care were at greater risk of engaging in sexual activity and were less informed regarding birth control methods and overall sexual health (Polit, Morton, & Morrow-White, 1989). Most striking is the finding that adolescents in foster care were in serious need of access to family planning services, such as birth control, but they were found to be significantly less likely to have access to such services (Polit, Morton, & Morrow-White, 1989).

Approximately 10 years later Risley-Curtiss (1997) identified similar issues facing adolescents residing in foster care. Through the use of quantitative methods, Risley-Curtiss sought to bring more attention to and increase the knowledge surrounding the sexual activity of children placed in out-of-home care. Risley-Curtiss (1997) surveyed 846 foster youth aged 8 to 18 years, questioning them about their most recent sexual activity and their use of contraceptives during that sexual encounter. Foster youth as young as eight years were included in the study as this was the earliest age of established sexual activity as cited by Risley-Curtiss (1997). Results of the study concluded that 34 percent of the foster youth surveyed were sexually active; of that 34 percent, the vast majority were female and in a non-Caucasian ethnic classification. She concluded that adolescents in foster care are at a heightened risk for engagement in early sexual activities, and that the majority of the adolescents who reported engaging in sexual activity had been diagnosed with a serious mental illness, had minimal or no medical records, and were not using contraceptives. More specifically, it was found that approximately 25 percent of foster youth in this study had no mention of sexual activity or sexual health in their official medical history (Risley-Curtiss, 1997).

Navigating Adolescence

Beyond poor communication between parent and child, the primary reason for adolescents being removed from their home of origin and subsequently placed in foster care is the neglect and the absence of a caregiver (James, Montgomery, Leslie, & Zhang 2009). James, Montgomery, Leslie, and Zhang (2009) conducted a secondary data analysis in order to examine a potential relationship between a history of placement within the foster care system and sexual risk behavior of adolescents. The study used the baseline data collected in 1996 and Wave 4 data

collected between 2002 – 2004 from the The National Survey on Child and Adolescent Well-being (NSCAW). The NSCAW is a longitudinal study instigated by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). The purpose of the study was to examine a potential relationship between history of placement within the foster care system and sexual risk behavior of adolescents. The authors found that many times the protective factors (e.g., connection to a parent or caregiver, religion, school engagement, and expectations for the future) that are present in adolescents residing in their home of origin are not present for adolescents residing in foster care. A primary concern of the authors is the absence or destructive nature of parent-child communication that occurs in the lives of maltreated youth before and at times after they are placed in foster care.

James, Montgomery, Leslie, and Zhang (2009) expressed continued concern regarding the disconnect between the child welfare system and adolescents in foster care, particularly in regards to sexual health and decision making. These authors emphasize that it is unclear who is responsible within the foster care system for communicating with adolescents regarding their sexual health and decision making (James, Montgomery, Leslie, & Zhang, 2009). They state, “Despite obvious vulnerabilities, relatively few studies have studied risk behaviors among children in the child welfare system, a gap that is particularly glaring in the area of sexual risk” (pg. 990), mirroring the concerns expressed by Risley-Curtiss (1997).

The results reported by James, Montgomery, Leslie, & Zhang, (2009) augment the findings of prior studies that are included in this review. One such finding is that of James, Montgomery, Leslie, and Zhang (2009), which concluded that adolescents with a history of placement in the foster care system initiate sexual activity at an earlier age than do their

counterparts who reside with their families of origin. Most concerning but in line with previous research findings is the idea that adolescents in foster care have extremely limited access to education, resources, referrals, and general information about sexual health and decision making (James, Montgomery, Leslie, & Zhang, 2009). Further, it is postulated that when adolescents in foster care do receive this information, it is often after they would have ideally received it, such as before becoming sexually active (Becker & Barth, 2000; James, Montgomery, Leslie, & Zhang, 2009; Love, McIntosh, Rosst, & Tertzakian, 2005). There are substantially higher rates of teenage pregnancy and teenage fatherhood among adolescents who have histories of placement in foster care, which is not surprising if these adolescents are engaging in sexual activity at earlier ages and without meaningful information regarding sexual health and decision making (James, Montgomery, Leslie, & Zhang, 2009).

In the implications section of her study, Risley-Curtiss (1997) advised that all child welfare staff must possess the appropriate skills and knowledge to communicate with adolescents in foster care regarding sexual health and decision making. She postulated that sexual activity should not be considered an isolated issue that requires a specialist's attention but part of an all-encompassing system of risk behaviors that can be effectively addressed by child welfare workers (Risley-Curtiss, 1997). These implications, discussed in depth in subsequent paragraphs, include clarification of the social worker role and comfort level in terms of providing information, resources, and referrals to adolescents regarding their sexual health and decision making, and the lack of research focused on development and implementation of policies pertaining to adolescents in foster care and their sexual health (James, Montgomery, Leslie, & Zhang, 2009).

Responsibility of the Child Welfare System

The Worker-Client Relationship

As articulated in the previous chapter, adolescents who are placed in foster care have significant feelings of being disconnected from all things that are familiar to them (Herrenkohl, Herrenkohl, & Egolf, 2003). Feelings of disconnect can lead to the adolescents having an inability to develop trusting relationships with adults, interpret their environment, or ask questions about their circumstances, including their sexual health and decision making (Herrenkohl, Herrenkohl, & Egolf, 2003). Boer and Coady (2006) conducted 30 semi-structured interviews over a three month period with twelve worker-client dyads in order to inquire about the quality of the relationship they had with their social worker. The clients included in the study had to reside in foster care at the time of the interviews and both the client and the social worker had to agree to participate in the interviews. Results from the study state that individuals residing in foster care expressed that the relationship they have with their social worker is “characterized by mutual respect, acceptance, trust, warmth, liking, understanding, and collaboration” (Boer & Coady, 2006, pg. 32). Participants in the study conducted by Boer and Coady (2006) expressed key characteristics they felt assisted in the worker-client relationship, which are strikingly similar to the main tenants of relational theory. More specifically, Boer and Coady (2006) articulate the importance of social workers maintaining a non-judgmental perspective when working with clients. Additionally, participants in this study indicated that they found child welfare work to be intrusive, and that the use of respect and a down-to-earth perspective by the worker helps in lessening the intrusiveness of the worker-client relationship (Boer & Coady, 2006).

This sentiment is echoed by the findings of Freake, Barley, and Kent's (2007) study; the researchers stated, "...if young people have positive early experiences of accessing help from professionals they are more likely to continue seeking help when they need it throughout their lives" (p. 640). Freake, Barley, and Kent (2007), conducted a systematic review of the research that included 54 peer-reviewed, quantitative and qualitative studies conducted over the past several decades and which focused the relationship between adolescents and helping professionals. Findings from the review conducted by Freake, Barley, and Kent (2007) include participant statements that champion trust, consistency, a non-judgmental attitude, competence and sympathy in the worker-client relationship. An additional finding of interest in the review is that foster youth appreciated feeling comfortable talking to their child welfare worker about a vast array of issues.

Adolescent Sexual Health in the Child Welfare System

James, Montgomery, Leslie, and Zhang (2009) pointed to a significant need among adolescents residing in foster care to have a clear understanding of who is responsible for communicating about their sexual health and development. The theoretical literature presented in the previous chapter articulated that the social work profession needs to be educated with the information needed in order to build an effective method for communication with adolescents residing in foster care regarding their sexual health and decision making. With this said, there is a lack of empirical research that focuses attention on social workers' communication with adolescents in foster care regarding their sexual health and decision making. One such study by Polit, Morrow-White, and Morton (1987) focuses on the comfort of child welfare workers when discussing sex with adolescents in foster care as well as the knowledge level of these workers

regarding state and federal policies that mandate sex education for foster youth. Researchers used a semi-structured phone interview with 48 child welfare policy specialists nationwide in order to assess child welfare workers' knowledge about current and past policies that dictate sexual health education for adolescents in foster care; they also surveyed by mail 761 foster care caseworkers about their comfort in terms of their responsibility to disseminate sexual health information to adolescents in foster care (Polit, Morrow-White, & Morton, 1987). The authors found that in the mid-1980s, only a few states had policies that specifically directed child welfare workers not to engage in communication with adolescents in foster care regarding sexual health (Polit, Morrow-White, & Morton, 1987). On the other end of the spectrum, nine states had clear policies requiring the inclusion of family planning services for any and all individuals served by the child welfare system, including adolescents in foster care (Polit, Morrow-White, & Morton, 1987). The rest of the states maintained a hands-off approach, expressing a neutral stance that dictated neither for nor against family planning services for adolescents involved with the child welfare system as the best approach (Polit, Morrow-White, & Morton, 1987).

Findings regarding the comfort and ability level of child welfare workers to communicate with adolescents in foster care regarding their sexual health and development raise concerns. The majority of the child welfare workers who participated in the study expressed discomfort with the idea that they would be required to communicate with adolescents regarding sexuality (Polit, Morrow-White, & Morton, 1987). Child welfare representatives voiced uncertainties regarding the potential backlash from the community and their state legislators if they were found to be discussing any topic with adolescents that could be even remotely related to abortion (Polit, Morrow-White, & Morton, 1987). Concern was also expressed regarding a violation of the rights

of families to maintain control over the education of their children regarding moral issues or issues that could cause controversy politically (Polit, Morrow-White, & Morton, 1987). When asked whether they discussed sexual health with adolescents in foster care, one respondent stated that they did not provide information regarding sex unless it came to their attention that the adolescent was currently sexually active. Indeed, Polit, Morrow-White, and Morton interviewed a respondent in an unnamed state who reported, “Some of our social workers won’t say the word S-E-X” (p. 21, 1987).

Social Work and Sexual Health. Beyond the Polit, Morrow-White, and Morton study (1987), an additional study authored by Werley, Ager, Rosen, and Shea (1971) is identified as having contrary results pertaining to social workers' ability to communicate with adolescents regarding their sexual health and decision making. During the late 1960s and early 1970s, the United States experienced a substantial increase in population due to an unprecedented rise in the birthrate. This led local, state, and federal agencies to implement services such as birth control and family planning (Werley, Ager, Rosen, & Shea, 1971). Werley, Ager, Rosen, and Shea (1971) surveyed university students enrolled in medical school, nursing school, and schools of social work as well as faculty members tasked with educating these students regarding their attitudes towards sterilization, abortion, contraception, and population growth. Additionally, researchers asked the students if they could clearly articulate the role they felt they had in disseminating information to clients or patients regarding sterilization, abortion, contraception, and any other topic related to family planning (Werley, Ager, Rosen, & Shea, 1971). This study found that social work students and faculty more often than not expressed comfort with family planning topics such as sterilization, contraceptives, and abortion, even when asked if they would

assist a client in obtaining an illegal abortion (Werley, Ager, Rosen, & Shea, 1971). Social work students also expressed comfort in the following roles regarding family planning services: provision of general information regarding contraceptives, specific contraceptive information, demonstration of contraceptive devices, and assistance in obtaining contraceptives, even in cases where the clients were under the age of 18 (Werley, Ager, Rosen, & Shea, 1971). Additionally, social work students articulated the importance of relaying information to clients about the male and female reproductive system, general information about sexuality, instructions for receiving a sterilization procedure, and issues that may surround an unplanned or unwanted pregnancy (Werley, Ager, Rosen, & Shea, 1971). Overall, the researchers concluded that social work students, followed by medical students, tend to be the most willing to engage in conversations with clients regarding family planning services (Werley, Ager, Rosen, & Shea, 1971). Where the three professions varied significantly was in the provision of family planning services to clients under age 18, with social work students being the most willing to provide services to these individuals (Werley, Ager, Rosen, & Shea, 1971).

Despite what can be considered to be positive results produced from the study conducted by Werley, Ager, Rosen, and Shea, the 1971 date of publication of the study raises some concern. Since its publication, no additional research replicating this study or the study done in 1987 by Polit, Morrow-White, and Morton has been published. Additionally, as noted in the research conducted by James, Montgomery, Leslie, and Zhang (2009), there is a lack of empirical research that focuses on the relationship between social workers and adolescents who reside in foster care and the adolescents' sexual health and decision making. Simply put, if social workers are considered the best fit to serve as child welfare workers and can be armed through

their formal education to develop strong working relationships with clients, why are issues of sexual health and decision making not being addressed with adolescents residing in foster care?

In summary, the findings of these studies suggest adolescents residing in foster care deal with a substantial number of social, emotional, and physical issues before, during, and after their tenure in foster care (Zetlin, Weinberg, & Kimm, 2005). Compounding these issues is the fact that there is an evident lack of communication surrounding the sexual health and decision making of adolescents residing in foster care. Additionally, communication between child welfare workers and adolescents regarding their sexual health and decision making remains a largely uncultivated area in social work research. This is despite the evident correlation between adolescents residing in foster care and increased engagement in sexual risk behaviors; resulting in multiple adverse outcomes for adolescents (i.e. unwanted or unplanned pregnancy, fathering children, Sexually Transmitted Infections (STIs)) that are detrimental to themselves and society in general.

Gaps in Existing Research

The studies included in this review focus on adolescents in foster care, risk behaviors commonly associated with adolescents residing in foster care, the sexuality of adolescents in foster care, the profession of social work and its relationship to human sexuality, and the worker-client relationship. The majority of this research is conducted retrospectively on participants who are no longer in foster care and are age 18 or older, have left foster care, or are merged into a group of foster youth that encompasses newborns to 17 year olds (Drapeau, Saint-Jacques, Lepine, Begin, & Bernard, 2007; Frederick & Goddard, 2008; McMillen & Tucker, 1999; Taussig & Talmi, 2001; Ward, 2009). Despite the substantial body of research literature that

focuses on foster youth's engagement in risk behaviors and the development of resilience, there is a limited amount of research focusing exclusively on the sexual risk behaviors of adolescents residing in foster care, and much of this research is more than 10 years old (James, Montgomery, Leslie, & Zhang, 2009; Polit, Morton, & Morrow-White, 1989; Risley-Curtiss, 1997; Thompson & Auslander, 2011). Of the research that has been conducted on sexual behaviors of adolescents residing in foster care, the findings are similar despite the significant length of time that has passed between the data collection and publication of the studies.

In addition to the outdated nature of the research, the methodology used in the studies and the overall generalizability of the findings leaves something to question. The majority of the studies are qualitative in nature, and although extraordinarily insightful are difficult to generalize to the larger population of foster youth. Additionally, the studies that did employ quantitative methods in an attempt to assess the comfort level of child welfare workers in regards to communicating with adolescents in foster care regarding their sexual health are exploratory in nature. Researchers postulate that examining communication in regards to risky sexual behavior between workers and foster youth could increase knowledge and improve services in terms of the sexual health of foster youth (Carpenter, Clyman, Davidson, & Steiner, 2001; Risley-Curtiss, 1997).

Risk behaviors in foster youth. There is a growing body of interdisciplinary literature that focuses on potential predictors of risk behaviors in foster youth (Frederick & Goddard, 2008; James, Montgomery, Leslie, & Zhang 2009; McMillen & Tucker, 1999; Taussig & Talmi, 2001; Thompson & Auslander, 2011; Ward, 2009). Findings that are consistent across research include the following: foster youth are more likely to engage in risk behaviors (e.g., substance

abuse, sexual activity, and criminal behaviors), foster youth engage in more risk behaviors at great intensity than their peers, and these risk behaviors have significant short and long term negative effects (Taussig, 2002). Despite these findings, researchers have identified contradictory ideas about predictive factors for adolescents engaging in risk behaviors (Taussig, 2002; Thompson & Auslander, 2011). Researchers attribute this to the retrospective nature of their research design as well as the use of participant self-report in their research (Risley-Curtiss, 1997; Taussig, 2002; Thompson & Auslander, 2011). Self-report of participants is often coupled with a records review that allows researchers to identify arrests and pregnancies as indicators of foster youth engaging in risk behaviors; however, this type of records review is identified by some researchers as an unsatisfactory method for identifying and tallying risk behaviors in foster youth (Thompson & Auslander, 2011).

Sexual activity and foster youth. Each year in the United States, approximately 20,000 youth leave foster care through either aging out or reunification with their family (Thompson & Auslander, 2011). Outcomes for youth exiting care are historically reported as poor and include dependence on public assistance, homelessness, lack of health coverage, arrest and imprisonment, lack of education due to dropping out of high school, unemployment, and becoming parents at an early age (Thompson & Auslander, 2011). The existing research that focuses specifically on the sexual activity of foster youth is limited and outdated. Most research combines risk behaviors of foster youth into an overarching category that includes delinquency, mental health issues, substance abuse, and sexual risk behaviors. Research that focuses on risky sexual activity as an isolated behavior and possibly an indicator of the existence of other risk behaviors is limited (Carpenter, Clyman, Davidson, & Steiner, 2001; Risley-Curtiss, 1997). The

majority of research focused on foster youth engaging in sexual risk behaviors is retrospective and relies on the self-report of former foster youth. Risely-Curtiss (1997) found through her research that foster youth as young as eight years old are sexually active. Although the 46 foster youth younger than age 13 who were included in the study is considered too small to provide conclusions regarding sexual risk behaviors, the fact that they were included in the study is enough to identify that sexual behaviors are present in preadolescence youth (Risley-Curtiss, 1997).

Responsibility of the child welfare system. The final section of this review presented research of importance in terms of communication between child welfare workers and foster youth. A striking concern regarding the research reviewed in this section is the time period in which the majority of the research was conducted and published. The research is outdated in that the majority of this research was published in the mid-1970s and mid-1980s with a minimal amount of research published from that point to the present. Despite the outdated nature of the research, the significant amount of time between the studies and the retrospective nature of the research, the concepts covered in the research were and still are of extraordinary relevance to the status of foster youth and social work practice. Research conducted more recently by James, Montgomery, Leslie, and Zhang (2009) focuses on the lack of clarity regarding which professional involved in the child welfare system is best equipped and most comfortable to provide sexual health information to adolescents residing in foster care. Additionally, there is negligible research available to assist those responsible in making educated decisions regarding development of and implementation of policy (James, Montgomery, Leslie & Zhang, 2009). Last, yet most significant, is the fact that adolescents placed in foster care often suffer from

mental illness or have physical health issues; they also lack familial support, have been exposed to emotional, physical, and sexual violence, and have been provided with an unstable educational experience (James, Montgomery, Leslie & Zhang, 2009). All of these factors can lead adolescents in foster care to have a lowered threshold for interpreting their environment, asking questions about their personal circumstances, and retaining vital information about life issues (e.g., sex education) (Herrenkohl, Herrenkohl, & Egolf, 2003; James, Montgomery, Leslie, & Zhang, 2009).

Conclusion

With the substantial surge over the past few decades of children being placed in foster care, the issues discussed in this chapter are of serious concern (Taussig, 2002). Research has identified sexual activity occurring among foster youth at earlier ages than ever before (Risley-Curtiss, 1997). Existing research indicates that foster youth are more likely than their peers to engage in risk behaviors. The risk behaviors (e.g., substance abuse, sexual activity, and criminal behaviors) in which foster youth engage do not differ in nature from the risk behaviors of their peers; however, foster youth engage in these risk behaviors at a more frequent rate and with greater intensity (Taussig, 2002). Additionally, without protective factors in place (i.e., parents and teachers) the negative consequences of engagement in these risk behaviors has a substantial short and long term effect for foster youth (Taussig, 2002). A minimal amount of research focuses specifically on communication between child welfare workers and foster youth about sexual health and decision making. Polit, White, and Morton (1987) conducted a study directed towards the comfort level of current child welfare professionals in discussing issues of sexual health with foster youth. The findings, although outdated, are relevant to the current status of

youth residing in foster care. A substantial number of interdisciplinary researchers have identified negative outcomes for youth aging out of foster care that range from homelessness to dependence on public aid (Thompson & Auslander, 2011). Included in these outcomes for foster youth is an increased chance of becoming a teenage parent (Thompson & Auslander, 2011). Communication about sexual health and decision making with foster youth, if delivered in a timely and developmentally appropriate fashion, can have a significant effect on the future outcomes of these youth (James, Montgomery, Leslie, & Zhang, 2009). An interdisciplinary collaboration is needed to design developmentally appropriate interventions that target sexual risk behaviors at the preadolescent stage (Risley-Curtiss, 1997). This would begin with conducting research with foster youth and the professionals that serve these youth.

Although research has provided some insight into worker-client communication, no known study conducted in the past 20 years has identified predictors of communication about sexual health and decision making between child welfare workers and adolescents residing in foster care. Thus, the present study uses the following questions to address this gap in the research:

- (1) Is there a significant association between the education level of child welfare workers and communication with adolescents residing in foster care regarding issues of sexual health and decision making?
- (2) Is there a significant relationship between child welfare workers' comfort level with sexual topics and communication about issues of sexual health and decision making with adolescents residing in foster care?
- (3) Is there a significant association between child welfare worker knowledge of sexual

health and communication regarding issues of sexual health and decision making with adolescents residing in foster care?

The following hypotheses are proposed:

H₁: Child welfare workers who have earned a Masters of Social Work (MSW) are most skilled at communication with adolescents residing in foster care regarding sexual health and decision making.

H₂: Child welfare workers who maintain a higher comfort level regarding sexuality communicate more often with adolescents residing in foster care regarding sexual health and decision making than child welfare workers with a lower comfort level.

H₃: Child welfare workers with a higher level of knowledge pertaining to sexual health communicate more often with adolescents residing in foster care regarding sexual health and decision making.

With the continually increasing number of adolescents placed in foster care, particularly those aged 12 to 17 years, the proposed study is a step toward filling a significant gap for direct practice in the social work profession. Adolescents residing in foster care are one of the highest risk populations for unplanned and unwanted pregnancies as well as for unplanned and unwanted fathering of children (Polit, Morrow-White, & Morton, 1987). Developing an understanding of the factors that affect the ability of social workers to address the sexual health and decision making of adolescents in foster care will inform social work practice as well as provide strategies to develop effective social policy and programming.

Currently, a gap exists in the theoretical and empirical research on adolescents residing in foster care. This knowledge gap is particularly large relative to empirical research that focuses on

child welfare workers and their direct practices with adolescents in foster care. Furthermore, there is a significant lack of research on the communication between child welfare workers and adolescents regarding their sexual health and development. The profession of social work has an extensive and successful history of serving adolescents as well as the child welfare system. The first step to providing effective sexual health information, resources, and referrals to adolescents residing in foster care is to identify the factors that inhibit social workers from providing this type of assistance. The proposed dissertation research seeks to partially fill this gap by assessing potential predictors for social workers communication with adolescents in foster care regarding their sexual health and decision making.

Chapter 4: Research Methods

Purpose of the Study

The literature review established that adolescents residing in foster care are at greater risk than their peers to engage in sexual risk behaviors. Adolescents in foster care have been cut off from primary avenues such as schools and parents from which they may more readily receive sexual health information. Due to this, adolescents residing in foster care engage in sexual behaviors at an earlier age, have experienced one or more forced sexual encounters, and more frequently engage in sexual activities without the use of contraceptives. Because of the sexual health concerns facing adolescents residing in foster care, encouraging communication between child welfare workers and these adolescents about sexual health may result in the latter becoming more aware of the risks and the available options for promoting safe and healthy sexuality. This study examined the relationships of child welfare workers' comfort regarding sexual issues, sexual health knowledge, and education level with their capacity to communicate with adolescents residing in foster care about their sexual health and decision making. The research protocol was submitted to the University of Kansas' Human Subjects Committee of Lawrence (HSCL) and approved by it on December 12, 2011.

Methods

Sample

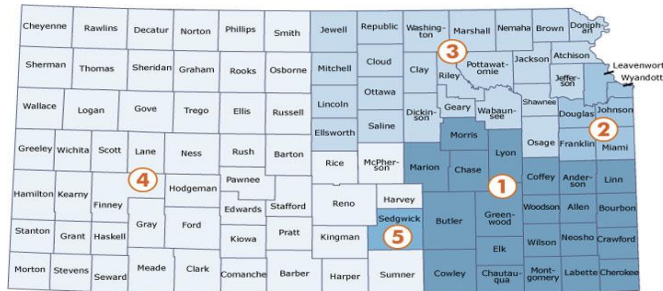
Purposive sampling was used in this study as participants were identified and included due to membership in a certain population (child welfare workers employed in the state of Kansas serving adolescents in foster care). Initial attempts were made to recruit participants at the statewide level in both Kansas and Missouri. However, both state level agencies declined

participation in the study citing time constraints as well as discomfort with the research topic. In 1996, the state of Kansas privatized their child welfare system allowing for individually owned private entities to provide foster care services across the state. Currently five agencies, TFI Family Services Inc., Kansas Children's Service League (KCSL), Kaw Valley Center (KVC), St. Francis Community Services, and United Methodist Youthville (UMY), provide foster care services to adolescents in Kansas. Each individual child welfare agency was contacted by the researcher for permission to survey their child welfare workers. Of the five agencies contacted, four agreed to participate in the study. Although UMY did not agree to participate, KCSL provides services in the same areas as those assigned to UMY. Further, TFI provides services in regions 1 and 3 while KVC provides services in region 2. St. Francis provides services for all of region 4, and KCSL provides services in Sedgwick County (region 5) and Shawnee County. As shown in Graphic 1, all services areas in the state of Kansas are represented in this study. In an effort to mitigate a potentially low response rate, the Boulder County Department of Social Services (BCDSS) was recruited for participation in the study and agreed to do so. During the process of data collection from BCDSS, the sample size of child welfare workers in the state of Kansas increased substantially due to continued recruiting efforts. Consequently, all surveys completed by BCDSS workers were excluded from the final sample.

A final sample of 94 child welfare workers was derived from those employed in these private agencies, contracted with the state of Kansas to serve the foster care population. At the time sampling for this research was completed, all were serving adolescents aged 12 to 17 years.

Table 1

Kansas Department of Health and Human Services Foster Care Service Regions



Recruitment of participants. Upon securing the agency agreement to participate, each individual child welfare agency identified a single person to act as a contact and ultimately as an administrator for the anonymous survey. Letters were drafted for each individual agency to distribute to potential participants. The letter outlined the study and informed potential participants that they would be completing a one-time, anonymous, on-line survey. Recruitment of subjects began in late December 2011, included the privatized child welfare agencies KVC, TFI, KCSL, and St. Francis Community Services, and continued throughout data collection. Continued attempts to recruit additional participants were made throughout data collection due to an initial low response rate.

Participant demographics. Upon completion of the data collection period, a total sample of 95 participants was secured; one participant was excluded as this person reported not carrying an active caseload. Of the final sample of 94 participants, 8.5 percent were male and 91.5 percent were female (Table 2). The majority (87.2 %) of the participants reported their ethnicity as Caucasian while the remaining 12.8 percent reported their ethnicity as African American, Hispanic, mixed ethnicity, and other ethnicity (Table 2). The age of the participants

was reported as a range, with the largest group (39.4 %) reporting their age as 26-35 years (Table 2). Primary religious affiliation was collected with the largest group of participants identifying Protestant (38.3 %), and none (13.8 %). The 26.6 percent of participants who reported in the other religious identification category that provided a write-in option and yielded the following results: Methodist, Lutheran, Christian, Spiritual, Buddhist, Non-Denomination, and Pagan (not identified as Wiccan).

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Table 2

Participant Demographics

Variable	Frequency	Percent
Age		
18 – 25	14	14.9
26 – 35	37	39.4
36 – 45	24	25.5
46 – 55	11	11.7
56 – 65	8	8.5
66+	0	0
Gender		
Male	8	8.5
Female	86	91.5
Intersex	0	0
Ethnicity		
Asian	0	0
African American	4	4.3
Hispanic	3	3.2
Native American/Alaskan	0	0
Caucasian	82	87.2
Other	2	2.1
Mixed	3	3.2
Religion		
Catholic	20	21.3
Protestant	36	38.3
Jewish	0	0
None	13	13.8
Other	25	26.2

Participant education and employment status. Participants were asked to report their highest level of education as well as any degrees they had earned (Table 3). The majority of participants reported having either a Bachelors of Social Work (BSW) degree (40.4 %) or a Masters of Social Work (MSW) degree (30.9 %). Only 6.4 percent of participants reported having some college but no degree issued, while the remaining 18.1 percent reported having a bachelor’s degree in something other than social work (13.8 %) or a master’s degree in something other than social work (4.3 %). Of the 88 participants who reported having earned a

degree, 73 percent reported having a current professional license. Of those carrying professional licenses, 62 of the 64 carry Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), or Licensed Specialist Clinical Social Worker (LSCSW) in the state of Kansas. One participant reported to be an LMSW in both Missouri and Kansas. The amount of time participants have been employed as a child welfare worker was measured in years with the majority (91.5 %) having one or more years on the job. Participants report a median caseload of 11 adolescents and a mode of 12 adolescents per caseload, with the caseloads ranging from one to 65 adolescents per caseload. The majority of participants reported having between 1 – 20 adolescents on their caseload, while two participants reported having a current caseload of 65 adolescents.

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Table 3

Participant Education and Job Status

Variable	Frequency	Percentage
Education		
Some College	6	6.4
Bachelor's Degree in Social Work	38	40.4
Bachelor's Degree other than Social Work	13	13.8
Master's Degree in Social Work	29	30.9
Master's Degree other than Social Work	4	4.3
Other Degree	4	4.3
Licensure		
No License	30	31.9
Licensed Baccalaureate Social Worker	33	35.2
Licensed Master Social Worker	27	28.7
Licensed Specialist Clinical Social Worker	2	2.1
Other License	2	2.1
Time Employed		
11 Months or Less	8	8.5
12 Months – 2 Years	19	20.2
3 – 5 Years	21	22.3
6 – 10 Years	20	21.3
11+ Years	26	27.7
Current Caseload		
1 – 10	45	47.9
11 – 20	34	36.2
21 – 30	14	14.8
31 – 40	0	0
41 – 50	0	0
51 – 60	0	0
61 – 70	1	1.1

Data Collection

For the purpose of this study, a single survey, taking an average of 23 minutes to complete, was designed. The survey was created using Qualtrics software and provided the respondents with the opportunity to complete the online survey anonymously. More specifically, when respondents completed and submitted their survey, no identifying information was collected or saved, thus offering complete anonymity to respondents. Data collection began in conjunction with participant recruitment in December 2011 and continued until February 29, 2012. The person identified as the contact for each child welfare agency was provided with a secure link to a password protected survey, which was in turn provided to eligible participants. All child welfare agencies agreed to allow participants to complete the survey during work time. Participants were able to stop working on the survey, save their progress, and return later to complete the survey. The final survey contained 42 questions (see Appendix 1 for full survey) ranging in design from simple yes or no answers to Likert-style questions. The questions included in the survey asked for information pertaining to child welfare worker demographics, comfort level regarding sexual health, level of knowledge, and communication regarding sexual health and decision making.

Measures. The demographic characteristics were gender, age, ethnicity and religion, and all were used as control variables in the study. Additionally, information pertaining to formal education was collected and was coded as a dichotomous variable to be used in the analysis to assess the relationship between education and communication with adolescents in foster care regarding sexual health and decision making. Demographic variables were treated as categorical variables and numbered: age (1 = 18 – 25, 2 = 26 – 35, 3 = 36 – 45, 4 = 46 – 55, 5 = 56 – 65, and

6 = 66+); gender (1 = Male, 2 = Female, and 3 = Intersex); ethnicity (1 = Asian, 2 = African American, 2 = Hispanic, 4 = Native American/Alaskan , 5 = Caucasian, 6 = Other, and 7 = Mixed Ethnicity); religion (1 = Catholic, 2 = Jewish, 3 = Protestant, 4 = None, and 5 = Other), and formal education (1 = High School Diploma/GED, 2 = Some College, 3 = Bachelor of Social Work, 4 = Bachelors other than Social Work, 5 = Masters of Social Work, 6 = Master's other than Social Work, and 7 = Other Degree). The questions that asked about ethnicity, religion, and formal education provided the opportunity for respondents to enter a text response when they did not identify with any of the categories provided. Several respondents opted to utilize the text response box when reporting their religious affiliation.

Independent and dependent variables. Child welfare workers were surveyed in order to assess their current level of knowledge of sexual health and, comfort level regarding sexual health (independent variables). Child welfare workers also reported the percentage of adolescents on their caseload with whom they had communicated during the prior two months regarding pregnancy prevention, condom use, AIDS prevention, prevention of sexually transmitted infections (STIs), information about the adolescent's intimate partner's sexual history, and the adolescent's sexual history (dependent variables). Existing validated measures were identified and used as indicators of the independent and dependent variables.

Attitudes toward Sexuality Scale (ATSS). Child welfare workers' comfort regarding sexual issues (independent variable) is defined by one measure: Attitudes toward Sexuality Scale (ATSS) (Fisher, 2009). The ATSS measure is designed as a brief tool that evaluates the sexual attitudes of adolescents and adults using nonoffensive language to facilitate use with adolescents (Fisher, 2009). The ATSS utilizes items from Calderwood's Checklist of Attitudes toward

Human Sexuality (1971), adding a slightly modified scoring technique (Fisher, 2009). The measure takes approximately five minutes to complete and has a simple scoring technique which involves reverse coding of negatively worded items. When scoring the ATSS, the number of points is totaled scores ranging from 21 to 105, with lower scores indicating greater conservatism about sexual matters and higher scores indicating greater permissiveness about sexual matters (Fisher, 2009). The alpha coefficient (α) for the internal consistency of the ATSS = .75 with 12- to-20 year olds and .84 with a sample of 31 to 66 year olds (Fisher, 2009). According to Frankfort-Nachmias and Nachmias (2008) an $\alpha \geq .70$ is considered high, as $\alpha = 1$ would indicate zero variable error. The ATSS was validated using a sample of college students aged 18 to 28 years and correlated highly ($r = .83$) with additional sexual health measures such as the Sexual Knowledge and Attitudes Test (SKAT; Lief & Reed, 1972). In the current study sample, $\alpha = .701$.

Mathtech Questionnaires: Sexuality Questionnaires (MQSQ). Child welfare workers' level of knowledge regarding sexual health (independent variable) is defined by the Mathtech Questionnaires: Sexuality Questionnaires (MQSQ) (Kirby, 1984). This measure was developed to reduce unintended pregnancy among adolescents and to measure outcomes pertaining to sexual health education programs. The MQSQ measures knowledge, attitudes, values, skills, and behavior (Kirby, 1984). The original MQSQ contains 34 questions that focus on a range of issues including STIs pregnancy prevention, adult sexuality, and puberty. For the purpose of this research, the 34-item questionnaire focusing on sexual health was reduced to include only the questions that pertain to adolescent sexuality, STIs, pregnancy prevention, and puberty, as the adult sexuality questions are not relevant to the current study. The knowledge questionnaire is a

multiple choice survey with one correct answer per item. Scoring is based on the amount of questions answered correctly. The test-retest reliability for the MQSQ is .89 (Kirby, 1984). Validity of the MQSQ was determined by content experts who developed and implemented the questionnaire (Kirby, 1984). As this measure is considered an index rather than a scale, the alpha coefficient is not applicable. Additionally, due to the structure of the current dissertation research, a test-retest option for this measure was not appropriate. However, the above listed test-retest reliability reported by the author is considered to be strong (Fisher, 2009).

Parent-Adolescent Communication Scale (PACS). Communication, the dependent variable, is defined by a modified version of the Parent-Adolescent Communication Scale (PACS) (Fisher, 2009). The PACS was specifically identified as a reliable tool for measuring effective communication between child welfare workers and adolescents due to the success McDermott-Sales has recorded in measuring effective communication between adolescents and their parents (Fisher, 2009). Currently, there is no known tool that measures effective communication between professionals and adolescents residing in foster care. Contact with Dr. McDermott-Sales, author of the PACS, was initiated to obtain assistance in modifying the measure (J. McDermott-Sales, personal communication, October 22, 2011). Subsequently, the measure was further modified in order for the six items included in the survey to stand alone as individual dependent variables. Additionally, the range of answers to each item was expanded to include ten different choices rather than the previous five. When the six individual items were constructed in Qualtrics, an option to add additional text response was included in order to avoid decreased variability in the dependent variable.

The PACS has an internal consistency score measured by use of a Pearson correlation ($r = .53, p < .001$) (Fisher, 2009). Additionally, the PACS correlates with other constructs focusing on sexual communication between partners. Concurrent validity of the PACS was assessed through correlation frequency of parental communication with adolescents at a baseline, 6 month, and 12 month measure (Fisher, 2009). Additionally, the PACS positively correlated with numerous scales measuring family support, adolescent self-efficacy, and sexual communication with partners (Fisher, 2009). With the current study sample, the alpha coefficient for internal consistency is high ($\alpha = .951$).

Data Analysis

This study used a cross-sectional analysis as the data came from a single survey point. One advantage of using Multiple Regression (MR) is that it allows for the use of multiple independent variables or multiple predictors. Additionally, MR allows for a determination of the degree or scope of the relationship between multiple independent variables and the single dependent variable by calculating the beta weight (β) (Frankfort-Nachmias & Nachmias, 2008).

Data screening. Prior to conducting a MR, regression diagnostics were completed to establish whether the assumptions for the regression are met. The assumptions for MR include linearity, normality, equal variance (homoscedasticity), and that each variable is independent (Frankfort-Nachmias & Nachmias, 2008). After regression diagnostics established that the assumptions were satisfied, bivariate correlation was conducted in order to identify and plot existing relationships between variables (Table 4). Additionally, information regarding regression diagnostics was collected. Regression diagnostics include measures of leverage, distance, and influence for each individual case included in the study (Chatterjee, Hadi, & Price,

2000). Individual cases included in the study which exceed the expected critical values could have a negative effect on the overall data set (Chatterjee, Hadi, & Price, 2000). Cook's Distance (D_i) measures the amount of influence that individual cases have on the overall data set. An appropriate value is $D_i > 0.85$ (Chatterjee, Hadi & Price, 2000); all cases included in the data set met the parameters for influence. DFFITS was also run to measure the influence of individual cases on the overall data set. All of the values produced by the current data set meet the criteria (critical value greater than 1.0) for inclusion according to the DFFITS measure. Mahalanobis Distance, the statistical test used to assess leverage, measures outliers recognized in a data set (Chatterjee, Hadi, & Price, 2000). Mahalanobis Distance was run and the values produced presented no individual cases that could be identified as outliers. No value produced by the analysis exceeded the critical value (15.51). For the purposes of assessing distance, the values produced by the Studentized Residuals are observed. According to an acceptable value for Studentized Residuals < 2 (Chatterjee, Hadi, & Price, 2000); if values exceed this value they should be considered for exclusion from the data set. In terms of the critical value for distance in the current study, all cases met the criteria for inclusion.

Missing data. Less than one percent of the items included in the study had missing data. For the most part, the missing data did not have an effect on the data counts. As there were not a substantial number of missing cases and no apparent pattern to the small amount of data missing, no cases were deleted.

Ratio of cases to variables. In multiple regression, the recommended ratio between cases to variables is 20:1 (Frankfort-Nachmias & Nachmias, 2008). However, a ratio of 5:1 cases to variables is considered to be acceptable (Frankfort-Nachmias & Nachmias, 2008). The current

study yields an approximate ratio of 14:1 cases per variable. This ratio includes two independent variables (comfort and knowledge), one dichotomous variable (highest level of education), and four control variables (age, ethnicity, religion, and gender).

Multicollinearity. Multiple regression is sensitive to high levels of collinearity between independent variables. A satisfactory bivariate correlation is $r < .09$ (Frankfort-Nachmias & Nachmias, 2008). Bivariate correlations between all independent variables were conducted using SPSS 20 software. Out of the 11 bivariate correlations run, $r \leq .09$ for seven of the correlations and $r \leq .19$ for the remaining four correlations. All of the variables included were retained for the purposes of this study.

Table 4

Pearson's Correlation: Independent and Control Variables

Variable	Age	Gender	Ethnicity	Religion	Comfort	Knowledge	Education
Age	-	-	-	-	-	-	-
Gender	.03	-	-	-	-	-	-
Ethnicity	-.06	-.09	-	-	-	-	-
Religion	.09	-.05	.09	-	-	-	-
Comfort	-.19	.03	-.11	.06	-	-	-
Knowledge	.04	.07	-.04	.14	.15	-	-
Education	-.09	.04	.15	.00	.14	-.07	-

Regression tests and procedures

To summarize, for the purposes of this study standard MR was used to assess existing relationships between independent and dependent variables. MR was conducted following univariate analyses (frequencies and measures of central tendency); and bivariate analyses (assessment of relationships between all independent variables and dependent variables). In six separate MR models Five control variables and two independent variables were regressed on six separate dependent variables using standard MR. Additionally, one of the control variables,

highest level of education, was used in six Chi Square (X^2) analyses with the six separate dependent variables. Initially, the dependent variable was believed to be one variable consisting of six separate items. For the purposes of the X^2 analysis only a subset of the sample was used. The subset of the sample represented all child welfare workers who had obtained a BSW or an MSW. This subset was used to assess how communication with adolescents in foster care regarding sexual health and decision making is influenced by level of social work education. However it was decided that the dependent variable (communication) should be divided into six distinct indicators: communication about pregnancy prevention, communication about condom use, communication about AIDS prevention, communication about prevention of STIs, communication about information about the adolescent's intimate partners sexual history, and communication about the adolescent's sexual history. This was primarily due to the fact that although communication is consistent throughout the indicator variables, the topics of communication are diverse enough to represent related but independent areas of sexual health.

In standard MR, all of the independent variables are entered into the regression equation at the same time. Six separate standard multiple regression equations for each indicator of communication were analyzed. An F test was used to determine generalization of any relationships found between variables to the greater population. In addition, the coefficient of determination (R^2) provides the proportion of variance explained by the regression equation (Frankfort-Nachmias & Nachmias, 2008).

Coding variables. Two of the independent variables were recoded into new variables using the Transform and Recode into Different Variables in SPSS 20 software. Comfort, the independent variable measured by use of the ATSS, required that some of the items be reversed

coded; once this was completed, the individual responses from the participants were recoded to reflect a singular value ranging from 21 - 105 for their comfort level. A respondent's total score is calculated by adding the score (1 – 5) of all 21 items included in the Likert Scale. The scores are then categorized in terms of having a: low level of comfort (score between 21 – 49), moderate level of comfort (score between 50 – 77), and a high level of comfort (score between 78 – 105). Additionally, knowledge, the secondary independent variable, consisted of a multiple choice quiz that had to be scored through use of syntax coding in SPSS 20 software. Once the knowledge variable was recoded, respondents were again assigned a singular value for the knowledge level with scores ranging from 0 - 21. Respondent's scores were added and categorized on three different levels: low level of knowledge (score of 1 – 7), moderate level of knowledge (score of 8 – 14) and high level of knowledge (score of 15 – 21). A third variable, highest level of education, was recoded into a dichotomous variable for the purposes of the X^2 using 1 = Bachelor Degree in Social Work and 2 = Master's Degree in Social Work. Highest level of education was again recoded into a dichotomous variable for the regression analyses. For the regression analyses, highest level of education was recoded to reflect 2 = child welfare workers with a degree in social work and 1 = all other child welfare workers.

Chapter 5: Results

This study utilized primarily quantitative methods to examine communication between child welfare workers and adolescents residing in foster care [hereinafter "adolescents"] regarding their sexual health and decision making. Results are presented in detail in the remainder of this chapter.

Univariate Analysis

Frequency distributions as well as descriptive statistics are presented for the five control variables (age, gender, ethnicity, religion, and highest level of education), two independent variables (knowledge level and comfort level), and six dependent variables (communication about pregnancy prevention, condom use, transmission of AIDS, transmission of STDs, adolescent's intimate partner's history, and adolescent's sexual history). Four control variables (age, gender, ethnicity, religion) were defined in Chapter 4 (Table 2). The remaining control variable, the two independent variables, and six dependent variables are defined in the following section.

Control Variable Education

Highest level of education. Child welfare workers reported their highest level of education (1 = High School Diploma/GED, 2 = Some College, 3 = Bachelor of Social Work, 4 = Bachelor Degree other than Social Work, 5 = Masters of Social Work, 6 = Master's Degree other than Social Work, 7 = Other Degree). As previously reported, out of the 94 child welfare workers, 31 percent had earned an MSW. On average the child welfare workers had a minimum of a bachelor's degree. The frequency distribution of those child welfare workers who achieved an MSW are listed in Table 5.

Table 5

Control Variables by: Respondent's Highest Level of Education (Percentages)

	MSW (n=29)	No MSW (n=65)	Total (N = 94)
Age			
18 – 25	10.3	16.9	14.9
26 – 35	58.6	30.8	39.4
36 – 45	13.8	30.8	25.5
46 – 55	10.3	12.3	11.7
56 – 65	6.9	9.2	8.5
Gender			
Male	6.9	9.2	8.5
Female	93.1	90.8	91.5
Ethnicity			
African American	0.0	6.2	4.3
Hispanic	0.0	4.6	3.2
Caucasian	96.5	83.1	87.2
Other Ethnicity	0.0	3.1	2.1
Mixed Ethnicity	3.5	3.1	3.2
Religious Affiliation			
Catholic	17.2	23.1	21.3
Protestant	37.9	38.4	38.3
No Affiliation	24.1	9.2	13.8
Other Affiliation	20.8	29.3	26.6

Table 6

Measures of Central Tendency Control and Independent Variables (N = 94)

	Missing	\bar{x}	SD
Comfort Level	1	72.37	7.53
Knowledge Level	0	14.06	1.29

Independent Variables

Child welfare workers' comfort level regarding issues of sexual health. As previously reported comfort level was measured using the ATSS. The ATSS scores range between 21 and 105 points; a respondent's total score is calculated by adding the score (1 – 5) of all 21 items. Out of the 94 child welfare workers, the majority (53%) reported in the high level of comfort

range; none scored in the low level of comfort range. The average score of child welfare workers on the ATSS was 72.4 (Table 5). The remaining 44 respondents (47%) reported in the moderate level of comfort range (Table 7).

Table 7

Independent Variable Comfort Level (Percentages)

	Moderate (n=44)	High (n=47)	Total (N = 93)
Age			
18 – 25	13.6	14.3	14.0
26 – 35	43.2	36.7	39.8
36 – 45	15.9	34.7	25.5
46 – 55	13.6	10.2	11.7
56 – 65	13.6	4.1	9.0
Gender			
Male	11.4	6.1	8.6
Female	88.6	93.9	91.4
Ethnicity			
African American	4.5	4.1	4.3
Hispanic	0.0	6.1	3.2
Caucasian	88.6	87.8	88.1
Other Ethnicity	2.3	2.0	2.2
Mixed Ethnicity	4.5	0.0	2.2
Religion			
Catholic	15.9	26.5	21.5
Protestant	56.8	22.4	38.7
No Affiliation	6.8	18.4	12.9
Affiliation	20.5	32.7	26.9

Child welfare workers’ knowledge of sexual health issues. The second independent variable, knowledge of sexual health issues, is measured by the MQSQ; 21 multiple choice questions were scored as either correct or incorrect. As with the primary independent variable, comfort level regarding issues of sexual health, no respondents exhibited a low level of sexual health knowledge. Child welfare workers included in this study achieved a mean score of 14.1

(Table 6). Of the 94 respondents, 71 percent exhibited a moderate level of knowledge with the remaining 29 percent having a high level of knowledge (Table 8).

Table 8

Independent Variable Knowledge Level (Percentages)

	Moderate (n=64)	High (n=30)	Total (N = 94)
Age			
18 – 25	17.2	10.0	14.9
26 – 35	42.2	33.3	39.4
36 – 45	21.9	33.3	25.5
46 – 55	9.4	16.7	11.7
56 – 65	9.4	6.7	8.5
Gender			
Male	10.9	3.3	8.5
Female	89.1	96.7	91.5
Ethnicity			
African American	3.1	6.7	4.2
Hispanic	1.6	6.7	3.2
Caucasian	92.1	83.3	87.3
Other Ethnicity	1.6	3.3	2.1
Mixed Ethnicity	1.6	6.7	3.2
Religion			
Catholic	17.2	30.0	21.2
Protestant	45.3	23.3	38.2
No Affiliation	17.2	6.7	13.8
Other Affiliation	20.3	40.0	26.8

Dependent Variables

Communication was measured using PACS. This scale is traditionally used as a 6-item scale which measures communication between parents and adolescents regarding issues of sexual health. As previously reported, the PACS was examined as six independent indicators of communication rather than a single scale. Each indicator was given a 10-point scale which allowed respondents to report the percentage of their current adolescent caseload with whom they had spoken in the two months prior to completing the survey, about specific issues of sexual

health. Additionally, a comment section was provided for all six items so that respondents could expand on their response. The vast majority of respondents reported that they communicated with 10 percent or less of their current adolescent caseload regarding all six of the specific issues of sexual health. This result is in stark contrast to the response provided to the question posed: *When thinking about adolescents residing in foster care, how important is it for the worker to communicate about issues of sexual health?* Of the 94 child welfare workers included in this study, none of the child welfare workers reported that communication with adolescents about issues of sexual health was not important. In fact, thirty-five percent of child welfare workers reported that communicating with adolescents regarding issues of sexual health is very important.

Table 9 presents the percentage of foster care youth with whom child welfare workers communicated about six separate issues related to sexual health and decision making. For all six of the dependent variables communication did not differ significantly by child welfare workers' age, gender, ethnicity, or religion. As previously mentioned, the vast majority of respondents reported that they had discussed issues of sexual health with 10 percent or less of their current adolescent caseload during the prior two months. The first dependent variable to be reported on is: *When thinking about the past two months, with what percentage of your caseload did you discuss methods of pregnancy prevention?* Of the 94 respondents 53 percent reported that they had discussed methods of pregnancy prevention with 10 percent or less of their caseload. In response to: *When thinking about the past two months, with what percentage of your caseload did you discuss condom use?* Eighty-one percent reported that they discussed condom use with 10 percent or less of their caseload.

The third dependent variable reported on is: *When thinking about the past two months, with what percentage of your caseload did you discuss methods of protection from transmission of AIDS?* Seventy two percent reported that they discussed methods of protection from transmission of AIDS with 10 percent or less of their caseload. Of those child welfare workers who reported communication with 11 – 100 percent of their current adolescent caseload all were female. The fourth dependent variable to be reported on is: *When thinking about the past two months, with what percentage of your caseload did you discuss methods of protection from transmission of STDs?* Sixty seven percent reported that they discussed methods of protection from transmission of STDs with 10 percent or less of their caseload. The fifth dependent variable to be reported on is: *When thinking about the past two months, with what percentage of your caseload did you discuss the adolescent's intimate partner's sexual history?* Seventy seven percent reported that they discussed the adolescent's intimate partner's sexual history with 10 percent or less of their caseload. In response to: *When thinking about the past two months, with what percentage of your caseload did you discuss the adolescent's sexual history?* Sixty three percent reported that they discussed the adolescent's sexual history with 10 percent or less of their caseload. Thirty five child welfare workers reported communication with 11 percent or more of the current caseload regarding the adolescent's sexual history.

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Table 9

Child Welfare Workers' Communication with Adolescents Regarding Issues of Sexual Health by Percentage (N=94)

Dependent Variable	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	Total
Pregnancy Prevention	53.2	12.8	5.3	4.3	7.4	2.1	4.3	5.3	3.2	2.1	100.0
Condom Use	80.9	4.3	1.1	2.1	2.1	2.1	1.1	3.2	1.1	2.1	100.0
Transmission of HIV	72.3	7.4	3.2	3.2	1.1	4.3	1.1	2.1	2.1	3.2	100.0
Transmission of STDs	67.0	8.5	3.2	2.1	4.3	3.2	2.1	3.2	3.2	3.2	100.0
Intimate Partner's Sexual History	76.6	9.6	3.2	1.1	2.1	1.1	1.1	2.1	2.1	1.1	100.0
Adolescent's Sexual History	62.8	14.9	6.4	0.0	2.1	3.2	0.0	4.3	2.1	4.3	100.0

Respondent Statements

For the six dependent variables, child welfare workers were also provided the opportunity to comment on their responses. Consistent themes emerged and are presented below. First, five respondents expressed the idea that they believe the adolescents on their caseload are not comfortable talking about issues of sexual health:

“Most of the kids on my caseload are very quiet about their history and who they have been with; very few of them will give me a straight answer.”

“I have never been asked, but would provide information if asked.”

“Clients tend to feel very uncomfortable discussing this in a one on one setting.”

“I don't discuss sex unless the youth or foster parent brings it up as an issue.”

“If the foster child is male, I usually talk to the foster parent and have them talk to the boys so they are more comfortable.”

Second, six respondents reported that communication about sexual health issues with the adolescents on their caseload is the responsibility of other professionals in the adolescent's life:

"This type of information I share with the foster parents, not the adolescent."

"We refer to medical professional for these discussions."

"They get this information elsewhere in our program."

"I don't talk about these issues."

"My kids get this education from the group they are required to attend and their therapist."

"I am on the ongoing [identifying information omitted] team which works with juveniles charged with sexual offenses; so, I spend a lot of time talking with teens about sex; but the real meat of this work is done with their therapist."

Finally, six respondents who reported communication about issues of sexual health with more than 10 percent of their current adolescent caseload also reported the following:

"I was working with a 16-year-old female who had been sexually abused and she was 'sexually acting out' such that she was picking inappropriate partners and she was confused on relationship issues."

"Our discussions mainly focus on methods for safe sex (condoms included) as well as STI's."

"I always address respecting the opposite sex when they are dating, sexual transmitted diseases, appropriate behavior and space, also abstinence."

"This is a conversation that I have with all my kids coming into custody and then again every several months to follow-up."

"Communication happens during monthly contacts; discussion with female clients and their placements regarding medical care, always includes discussion regarding birth control."

"Condoms and abstinence."

Bivariate Analyses

Following the examination of the data for compliance with all assumptions for multivariate analysis described in Chapter 3, further bivariate analyses were performed. Correlation matrices were developed in order to assess associations between independent variables (knowledge level and comfort level) and dependent variables (communication with adolescents residing in foster care regarding: pregnancy prevention [DV1], condom use [DV2], methods for protection against AIDS transmission [DV3], methods for protection against transmission of STDs [DV4], adolescent's intimate partner's sexual history [DV5], and the adolescent's sexual history [DV6]). The following sections outline the findings of a correlation matrices organized by the two independent variables. A subset of the sample was created and the variable representing a child welfare worker's highest level of education was recoded in order to represent those that have a MSW versus those that have a BSW. In order to further analyze the relationship of the dependent variables with this dichotomous variable Chi Square (X^2) test was used. The later part of this section describes the findings of X^2 analyses.

Child welfare workers' knowledge and comfort level. A correlation matrix produced the greatest number of statistically significant tests (Table 10). Five of the six correlations between comfort level and the dependent variables were significant. Child welfare workers' comfort level about issues of sexual health was positively correlated with communication about sexual health related issues. The higher a child welfare worker's comfort level is regarding communication about sexual health issues the more likely they were to discuss pregnancy prevention $r = .31, p < .01$, condom use $r = .30, p < .01$, methods of preventing the transmission of AIDS $r = .25, p < .05$, methods of preventing the transmission of STDs $r = .30, p < .01$, and the

adolescent’s sexual history $r = .30, p < .01$. Child welfare workers’ comfort level was not significantly correlated with communicating with adolescents in foster care about their intimate partner’s sexual history $r = .19, p > .05$. These findings support the hypothesis that the more comfort child welfare workers feel about issues of sexual health, the more likely they are to communicate about these issues with adolescents residing in foster care. The relationships between child welfare workers’ knowledge level and the six dependent communication variables were not significant (Table 10)

Table 10

Pearson Correlation Values for Independent and Dependent Variables

N = 94	1	2	3	4	5	6	7	8
1. Comfort Level								
2. Knowledge Level	.15							
3. Pregnancy Prevention	.31**	.11						
4. Condom Use	.30**	.08	.67**					
5. Transmission of AIDS	.25*	.11	.80**	.83**				
6. Transmission of STDs	.30**	.10	.83**	.80**	.92**			
7. Intimate Partner’s Sexual History	.19	.10	.72**	.69**	.76**	.73**		
8. Adolescent’s Sexual History	.30**	.05	.79**	.69**	.74**	.77**	.83**	

* 0.05 level ** 0.01 level

Chi Square values were obtained for bivariate analyses using a subset of the sample in order to identify any existing significant relationships between child welfare workers’ level of education (MSW vs. BSW) and six communication-related dependent variables. In the results of all six Chi Square tests, 18 cells (88%) had an expected count of zero which can lead to Type I errors (Frankfort-Nachmias & Nachmias, 2008). This is problematic as the minimum expected count is 0.43; subsequently, the six dependent variables were recoded from the 10-category format into six dichotomous variables for the X^2 : 1 = communication with 0 – 10% of current

caseload and 2 = communication with 11 – 100% of current caseload. As previously stated, the majority of respondents reported communication with 10 percent or less of their current adolescent caseload. This imbalance in respondent reporting of communication with their current adolescent caseload caused the excessive amount of cells to be empty thus increasing the probability that a Type I error could occur (Frankfort-Nachmias & Nachmias, 2008). Recoding the dependent variables into a six dichotomous variables eliminated all empty cells from the Chi Square test reducing the probability of a Type I error occurring.

Relationship between child welfare workers' education and communication with current adolescent caseload regarding pregnancy prevention. Those with MSW's were not significantly more likely to communicate with their current adolescent caseload regarding methods of pregnancy prevention than respondents who obtained a BSW $X^2 = .08$, $p = .48$. Approximately half of child welfare workers who had a degree in social work, communicated with 10 percent or less of their current adolescent caseload regarding methods of pregnancy prevention (Table 11).

Relationship between child welfare workers' education and communication with current adolescent caseload regarding condom use. Child welfare workers who obtained an MSW were no more or less likely to communicate with their current adolescent caseload regarding condom use than child welfare workers who obtained a BSW $X^2 = .09$, $p = .51$. A substantial number (78%) of child welfare workers with a degree in social work, communicated with 10 percent or less of their current adolescent caseload regarding condom use (Table 11).

Relationship between child welfare workers' education and communication with current adolescent caseload regarding methods of preventing the transmission of AIDS. No significant relationship existed between a child welfare worker's social work education and communication with their current adolescent caseload regarding methods of preventing the transmission of AIDS $X^2 = .45$, $p = .36$. A total of 73 percent of respondents, regardless of degree status, communicated with 0-10 percent of their current adolescent caseload regarding methods of preventing the transmission of AIDS (Table 11).

Relationship between child welfare workers' education and communication with current adolescent caseload regarding methods of preventing the transmission of STDs. There was not a significant relationship between child welfare workers' degree status and communication with current adolescent caseload regarding STD prevention $X^2 = .06$, $p = .50$. Approximately 67 percent of respondents, regardless of education, communicated with 10 percent or less of their current adolescent caseload regarding methods of preventing the transmission of STDs (Table 11).

Relationship between child welfare workers' education and communication with current caseload regarding the adolescent's intimate partner's sexual history. Child welfare workers who obtained an MSW were not significantly more likely to communicate with their current caseload regarding the adolescent's intimate partner's sexual history than child welfare workers with a BSW $X^2 = 1.56$, $p = .17$. Seventy-nine percent of all child welfare workers, regardless of education reported communicating with 10 percent or less of their current caseload regarding the adolescent's intimate partner's sexual history (Table 11).

Relationship between child welfare workers' education and communication with current caseload regarding the adolescent's sexual history. There was no significant relationship between a child welfare workers' social work degree status and their communication with their current caseload regarding the adolescent's sexual history $X^2 = .86, p = .25$. Only 37 percent of those child welfare workers who obtained degree in social work reported communicating with 11 percent or more of the foster youth on their caseload (Table 11).

Table 11

Communication by Education Level

	MSW (n = 29)	BSW (n = 38)	Total (N = 67)	X ²	p
Pregnancy Prevention					
0 – 10%	51.7	55.3	56.7	.08	.48
11 – 100%	48.3	44.7	43.3		
Condom Use					
0 – 10%	79.3	76.3	77.6	.09	.51
11 – 100%	20.7	23.7	22.4		
AIDS Transmission					
0 – 10%	72.4	76.3	73.1	.45	.35
11 – 100%	27.6	23.7	26.9		
STD Transmission					
0 – 10%	65.5	68.4	67.2	.06	.50
11 – 100%	34.5	31.6	32.8		
Intimate Partner's Sexual History					
0 – 10%	86.2	73.7	79.1	1.56	.17
11 – 100%	13.8	26.3	20.9		
Adolescent Sexual History					
0 – 10%	69.0	57.9	62.7	.86	.25
11 – 100%	31.0	42.1	37.3		

Multivariate Analysis

Six separate multiple regression models were conducted with each of six communication related dependent variables (Table 12). In each model, five control variables (age, gender,

ethnicity, religion, and education), and two independent variables (knowledge level and comfort level), were regressed on a communication variable. For the purposes of the regression analysis only, three of the control variables were dichotomized variables: ethnicity (0 = Non-Caucasian Respondents, 1 = Caucasian Respondents), religion (0 = Catholic, 1 = Protestant, 2 = No Religious Affiliation), and highest level of education (0 = Degree in Social Work, 1 = All other degrees). Results of both regression assumptions and diagnostics which are reported in Chapter 4 led to retention all of the cases in the data set.

Table 12

Regression Models: Child Welfare Workers' Communication with their Adolescent Caseload

	Model 1 Pregnancy Prevention (DV1)	Model 2 Condom Use (DV2)	Model 3 AIDS Transmission (DV3)	Model 4 STD Transmission (DV4)	Model 5 Intimate Partner's History (DV5)	Model 6 Adolescent Sexual History (DV6)
Variable	B	B	B	B	B	B
Constant	-6.35	-5.18	-3.38	-6.21	-0.50	-2.66
Comfort	.11**	.08**	.08**	.10**	.05	.11**
Knowledge	.01	.10	.11	.09	.09	-.08
Age	.08	-.21	.07	.42	-.11	.27
Gender	.80	-.16	.10	.48	-.28	.23
Ethnicity	-.44	1.10	.08	.30	.12	-.33
Religion	-.33	-.37	-.53	-.31	-.73	-.21
Education	-.10	-.16	-.52	-.36	-.41	-.94
Adjusted R ²	.04	.05	.01	.03	-0.01	.05
F	1.54	1.63	1.11	1.44	0.94	1.72

*p < .05. **p < .01.

Regression Results

Predictors of communication regarding pregnancy prevention. In Model 1:

communication with child welfare workers' current adolescent caseload regarding pregnancy prevention, the overall regression model was not statistically significant $F(7, 92) = 1.54, p = .16$.

Only *comfort level* uniquely explained a portion of the variance; specifically, a one point

increase in child welfare workers' *comfort level* was associated with a .11 point increase in the *communication* regarding pregnancy prevention (Table 12).

Predictors of communication regarding condom use. Model 2 was not statistically significant $F(7, 92) = 1.63, p = .14$. Although the overall model was not significant, *comfort level* was a significant predictor of child welfare workers' communicating with their current adolescent caseload regarding condom use. Every one point increase in a child welfare worker's *comfort level* was associated with a .08 increase in *communication* with their current adolescent caseload regarding condom use (Table 12).

Predictors of communication regarding prevention of the transmission of AIDS. Model 3 was not statistically significant $F(7, 92) = 1.11, p = .36$. Predictors in this regression model explained a non-significant amount of variance adjusted $R^2 = .01$ in *communication* with respondent's current adolescent caseload regarding prevention of the transmission of AIDS. Only *comfort level* uniquely explained a portion of the variance; specifically, a one point increase in child welfare workers' *comfort level* was associated with a .08 point increase in the *communication* regarding prevention of the transmission of AIDS (Table 12).

Predictors of communication regarding prevention of the transmission of STDs. Model 4 was not statistically $F(7, 92) = 1.44, p = .20$, as predictors in this regression model explained a non-significant amount of the variance adjusted $R^2 = .03$ in *communication* with child welfare workers' current adolescent caseload regarding prevention of the transmission of STDs. Despite the fact that the overall model was not significant, *comfort level* is a significant predictor of *communication* with respondent's current adolescent caseload regarding prevention of the transmission of STDs. More specifically, for every one point increase in a child welfare

workers' *comfort level* there is a .10 increase in the *communication* with a child welfare workers' current adolescent caseload regarding prevention of the transmission of STDs (Table 12).

Predictors of communication regarding the adolescent's intimate partner's sexual history. Model 5 was not statistically significant $F(7, 92) = .936, p = .48$. Predictors in this regression model explained very little of the variance adjusted $R^2 = -.01$ in *communication* with child welfare workers' current caseload regarding the adolescent's intimate partner's sexual history. Unlike the previous model's findings the independent variable, child welfare workers' *comfort level* was not statistically significant (Table 12).

Predictors of communication regarding the adolescent's sexual history. This model was found not to be statistically significant $F(7, 92) = 1.72, p = .12$. Predictors in this regression model explained a non-significant amount of the variance adjusted $R^2 = .05$ in *communication* with a child welfare worker's current caseload regarding the adolescent's sexual history. The independent variable *comfort level* was a significant predictor of *communication* with child welfare workers' current caseload regarding the adolescent's sexual history. More specifically, for every one point increase in a child welfare workers' *comfort level* there is a .11 increase in *communication* with the child welfare worker's current caseload regarding the adolescent's sexual history (Table 12).

Summary

Statistical significance was not identified in any of the regression models which focused on communication with adolescents regarding pregnancy prevention and the adolescent's sexual history. The comfort level of child welfare workers with sexual health issues was found to be a significant predictor of communication with adolescents in five out of six regression models.

Comfort level was not a significant predictor of communication with adolescents regarding their intimate partner's sexual history. Additionally, the level of comfort a child welfare worker has regarding sexual health issues was positively correlated with five of the six dependent variables, communication about pregnancy prevention, condom use, preventing the transmission of AIDS, preventing the transmission of STDs, and the adolescents sexual history. Child welfare workers' comfort level, along with all other independent and control variables, were not correlated with the fifth dependent variable: communication about the adolescent's intimate partner's sexual history.

Chapter 6: Discussion and Implications

Only a limited amount of literature focuses exclusively on the sexual health risk behaviors of adolescents residing in foster care. This study used original data to identify predictors of communication between child welfare workers in the state of Kansas and the adolescents they serve who are residing in foster care, regarding their sexual health and decision making. Additionally, this study was designed to explore the relationship between a worker's formal education and his/her communication with adolescents regarding their sexual health and decision making. Control variables including age, gender, ethnicity, and religious affiliation of the respondents were incorporated into the analysis in order to assess any relationship these demographic attributes may have in regards to communication between child welfare workers and these adolescents.

Limitations of the Research Methodology

Strengths and weaknesses exist in every methodology. The following paragraphs provide the advantages and limitations of the current research methodology. Survey research, such as the survey described herein, is considered critical when analyzing multiple variables in a concurrent fashion (Rubin & Babbie, 2010). Also, the use of standardized questions can create a more precise measurement through uniform definitions of variables (Rubin & Babbie, 2010). An additional advantage occurs in the use of on-line survey research; this survey format allowed for expedient data collection; access to participants in rural, urban, frontier and suburban regions in the state of Kansas; and required only a brief amount of time for participants to access, complete and submit their surveys. On-line survey research has proven to be cost effective and less time consuming than traditional survey methods (Rubin & Babbie, 2005). On the other hand, a

disadvantage to survey research is that standardized questions do not allow for qualitative contributions from participants. Because quantitative surveys are designed as a prepared list of questions, participants may misinterpret the questions or answers intended by the survey and have no means of gaining assistance in clarification. An additional limitation of the current study relates to the self-report nature of the survey. When utilizing a survey that requires respondent self-report there is the potential for social desirability issues, or the respondents answering questions in the way they believe the researcher would like for them to answer. A final disadvantage is that the survey is designed to measure a single point in time that only identifies participants as child welfare workers at the time of the data collection (Rubin & Babbie, 2010).

Response rate. The survey in this dissertation was purposively created to allow anonymity for respondents. Additionally, this survey was only completed by those respondents who were willing to participate in the research. A single individual at each of the four agencies served as a contact for recruiting potential participants. These individuals communicated with their employees, and once an agreement to participate was received, the participant was provided with an individual link to a password protected survey. Information regarding how many employees agreed to participate and how many declined to do so was not collected. In terms of overall response rate, the sample is considered small to moderate in size. Cohen's *d* was used to assess the effect size of the sample. According to Frankfort-Nachmias and Nachmias (2008) a small effect produces a Cohen's *d* value of 0.2 to 0.3.

Distribution of data. The data was skewed in that there were substantially more Caucasian females than females of any other race or gender represented in the sample. Additionally, the dependent variables used in the analysis did not reflect normal distribution as

established by histograms as the majority of the child welfare workers reported communication with 10 percent or less of the caseload. Due to this generalizability of the current findings to alternative populations of child welfare workers in the United States is limited. More importantly, this phenomenon underscores the need for further research in exploring the subjects of communication that occurs between child welfare workers and adolescents residing in foster care, in order to assess whether the responses are typical or simply unique to this sample of respondents. Despite this, the multivariate analyses chosen for the purposes of this study exhibit robustness in terms of non-normal data and consequently protects against negative effects on the results.

Accuracy of data. Child welfare workers answered questions in a retrospective fashion, recalling conversations they had with adolescents on their caseload over the prior two months. This retrospective reporting could potentially cause issues in terms of validity. Without directly accessing client records and verifying whether or not a child welfare worker documented a conversation about sexual health with an adolescent, there is no way of knowing whether the child welfare workers over or under estimated the percentage of their caseload with whom they communicated about sexual health issues in the two months prior to completing the research survey. Finally, without direct access to the adolescents in foster care, confirmation of the nature and frequency of communication with child welfare workers regarding issues of sexual health cannot be confirmed.

Quantitative Findings

There are major reoccurring themes identified in the analyses that are important to highlight here. Of the variables chosen for inclusion in this study, the child welfare workers'

comfort level with issues of sexual health are significant predictors of communication with adolescents residing in foster care regarding sexual health and decision making. Age, gender, highest level of education and religious affiliation did not significantly influence communication between child welfare workers and adolescents residing in foster care. A single significant correlation between the ethnicity of respondents and communication with adolescents in foster care regarding methods of pregnancy prevention indicates that Caucasian child welfare workers were more likely to have communicated about this topic in the prior two months, and have done so with a more substantial percentage of their adolescent caseload.

Child welfare workers' education level. No significant relationship was identified between those respondents who obtained an MSW vs. a BSW and communication with adolescents residing in foster care regarding sexual health and decision making. Literature presented in previous chapters discussed the championing of social workers as the best fit to serve as child welfare workers (Bailey, 2003). However, the connection between those with social work degrees and communication with adolescents residing in foster care regarding sexual health and decision making has not been previously explored. It may be that, if education about communication techniques surrounding sexual health and development is not addressed in MSW programs, it is not be incorporated into social workers' every day encounters with clients. The inclusion of this measure in the current research serves primarily as an exploratory variable that requires further research in order to evaluate a more specific relationship between a child welfare worker's education and communication with adolescents residing in foster care regarding their sexual health and decision making.

Child welfare workers' comfort level regarding issues of sexuality. The bivariate and multivariate analyses point to the existence of a significant relationship between the comfort level of child welfare workers with issues of sexuality and the percentage of their caseloads with whom they discussed sexual health and decision making. Those respondents who scored higher on the comfort level scale tend to communicate about sexual health and decision making with a larger percentage of their adolescent caseloads than do those respondents who scored lower on the comfort level scale. Correlation matrices produced statistically significant values between comfort level and five of the six dependent variables. A single dependent variable, communication with current caseload regarding the adolescent's intimate partner's sexual history, did not produce significant findings in either the bivariate or multivariate analyses.

These findings are congruent with the literature that explain a strong correlation between the comfort level of social workers regarding issues of sexual health and their willingness to discuss these issues with clients as well as the inverse (Polit, Morrow-White, & Morton, 1987). Chapter 2 identifies a conceptual framework that provides a strong foundation for approaching and subsequently discussing issues such as adolescent sexuality (Freedberg, 2009; Shullman, 1999). An unexpected finding is that child welfare workers reported moderate to high levels of comfort with issues of sexuality. With this said, it is noteworthy that a more substantial number of the child welfare workers did not report having communicated with their current adolescent caseload regarding issues of sexual health and development. Implications for future research in this area will be discussed in subsequent paragraphs of this chapter.

Child welfare workers' level of knowledge pertaining to issues of sexual health.

Results produced by the bivariate and multivariate analyses did not identify a significant

relationship between the sexual health knowledge level of child welfare workers and the percentage of their current adolescent caseload with which they discussed sexual health and decision making. Those respondents who scored higher on the knowledge level scale did not evidence a tendency to communicate with a greater percentage of their current adolescent caseload than those respondents who scored lower on the knowledge level scale.

The inclusion of a child welfare worker's level of knowledge regarding issues of sexual health in this study was a unique approach to assessing communication with adolescents in foster care regarding issues of sexual health and decision making. No existing literature was identified that assessed a connection between the level of sexual health knowledge that a child welfare worker has and a willingness to communicate with adolescents residing in foster care regarding sexual health and decision making. Because this research is considered exploratory in nature, further research is needed to fully assess any relationship that may exist between knowledge and communication.

Implications for Social Work

This study makes a contribution to the literature as it is the first to focus attention on certain attributes of child welfare workers in the state of Kansas that serve as predictors for communication with their adolescent caseloads regarding issues of sexual health and decision making. Additionally, this is the first study conducted in several decades to focus specifically on communication with adolescents residing in foster care regarding their sexual health and decision making. The exploratory nature of this study, taken together with its limitations and its significant findings, points to a need for additional research in this area. Implications for the profession of social work still have many tenants that can be explored. In the subsequent

paragraphs, implications as they pertain to social work policy, practice, education as well as future research will be presented.

Social work policy. In a study conducted in the late 1980s, Polit, Morrow-White, and Morton found that a limited number amount of state legislation specifies policy that encourages or discourages communication between child welfare workers and foster children about issues of sexual health. The majority of states maintain an issue-avoidance policy in that they do not support or prohibit this type of communication, leaving child welfare organizations to create and implement agency level policies (Polit, Morrow-White, & Morton, 1987). In 2008, Congress passed The Fostering Connections to Success and Increasing Adoptions Act, which required child welfare agencies to maintain the health records of children placed in foster care. The provision requires that a full medical history of each child is taken upon placement into a foster care home or facility (Geen, 2009). Additionally, the provision requires that children placed in foster care are assessed and referred for all appropriate services within the first 30 days of placement (Geen, 2009).

It can be argued that a provision which requires assessment and referral to services for all children entering foster care should include and authorize developmentally appropriate communication about sexual health. Risely-Curtiss (1997) identified children, as young as eight years old, being sexually active at the time of their entrance into foster care. Additionally, James, Montgomery, Leslie, and Zhang (2009) report that 93 percent of foster youth are sexually experienced and are less likely than youth not in foster care to protect themselves with contraceptives when engaging in sexual activities. Taken together, these studies indicate that the need for appropriate sexual health education is crucial for all children residing in foster care.

Maintaining an issue-avoidance policy regarding communication with children in foster care regarding issues of sexual health is not a viable option. Change in terms of social policy can be implemented at many different levels. Section 205 of The Fostering Connections to Success and Increasing Adoptions Act specifically states that children should be referred to any and all necessary medical services upon entry into the foster care system (Geen, 2009). This is the only policy that dictates the medical care of children in foster care at the federal level, and it should be expanded to reflect specific and distinct areas of need that should be addressed for each child entering foster care. Included among these policies should be providing developmentally appropriate sexual health education, information, and referral.

A second layer of policy can be dictated at the state level. Foster care systems in the United States are as unique as the states that design them. Some states, like Kansas, have privatized their foster care services; other states, such as Colorado and Missouri, maintain public foster care systems. Despite the differences in organization, state legislatures still have the opportunity to establish and oversee state level policy that will benefit all children residing in foster care. States that maintain an issue-avoidance policy allow for ambiguity in terms of the responsibility for communication about issues of sexual health with children residing in foster care. When policy does not clearly dictate responsibility, child welfare workers are left to question whose responsibility it is to communicate regarding sexual health issues. This construct is elucidated in the respondent statements reported in Chapter 5, where certain respondents reported their belief that the responsibility to communicate with foster youth about sexual health falls on medical professionals, foster parents, therapists, or on anyone but the child welfare worker.

Policies that clearly dictate the responsibility and procedures for communication with children in foster care regarding sexual health would remove the ambiguity caused by an issue-avoidance stance. Additionally, clear policy would allow child welfare workers either to openly discuss issues of sexual health with children in foster care or refer them to professionals designated by policy to engage in communication about sexual health. Whether the actual responsibility of direct communication with foster youth about sexual health falls on the child welfare workers is a question still to be answered. However, the responsibility for communicating with foster youth about issues of sexual health must be delegated without delay.

Application to social work practice. Social workers are regularly serving on the front lines of the child welfare and foster care systems. Some child welfare workers in this current study expressed that they only communicated with the female adolescents on their caseload regarding issues of sexual health. Since females only account for half of the foster youth in the state of Kansas, it begs the question: who is communicating with the male foster youth about their sexual health? There is a need to explore whether the gender and/or ethnicity of a child welfare worker influences the comfort level as well as communication patterns with adolescents residing in foster care regarding sexual health.

A second issue speaks to the responsibility for communicating with adolescents residing in foster care about issues of sexuality. This study produced evidence that very low numbers of child welfare workers had communicated with their current adolescent caseload. Beyond the social worker, who might be engaging in these types of conversations with adolescents? The written responses provided by the child welfare workers provided some ideas about who they assume is communicating about issues of sexual health with adolescents in foster care (i.e.

therapists, foster parents, medical professionals); however, statements made by other child welfare workers made it clear that they did not see this as their responsibility and provided no indication of who they believe to be responsible. Lack of communication between child welfare workers and adolescents residing in foster care could be attributed to feelings of discomfort with the topic of sexuality, and more specifically, the terminology used to communicate with clients regarding sexuality (Abramowitz, 1971).

In the early to mid-1970s, U.S. universities began to include courses in the social work curricula that focused specifically on human sexuality (Valentich & Gripton, 1975). These courses were added as a result of a perceived interest by social work students in topics of sexuality and sex therapies (Benjamin, 1971). Social work students wanted the opportunity to have comprehensive courses provided in their social work curriculum that focused on human sexuality so that they could respond to the rapid changes in society's sexual mores (Abramowitz, 1971; Benjamin, 1971; Valentich & Gripton, 1975). Abramowitz (1971) expressed that sexuality is a substantial part of the larger human condition and that social workers serving as "change agents" (pg. 349) must have education and training in this field.

Strong encouragement has developed for the integration of human sexuality content into the already existing social work curriculum. By the mid-1980s, human sexuality courses were more commonly offered as elective courses in accredited universities across the United States (Polyson, Lash, & Evans, 1986). In social work courses, students are taught to communicate with diverse populations who are affected by a substantial amount of contextual issues (Polyson, Lash, & Evans, 1986). Despite this, the research reported here found that only one of the 94 respondents received formal sexual health education at the college level. The remainder of the

child welfare workers received sexual health education in primary, middle and secondary school as well as from their parents, churches and community centers. Some child welfare workers reported having formal continuing education on issues of sexual health through their local public health centers or in the Peace Corp. Because the social worker is considered a primary contact for adolescents residing in foster care, inclusion of techniques for communicating topics related to sexual health to adolescents should be a part of formal social work education (James, Montgomery, & Zhang, 2009; Polit, Morrow-White, & Morton, 1987).

Future Research

This exploratory research offers an important starting point for future studies that examine the various facets of communication about sexual health and decision making between child welfare workers and adolescents residing in foster care. Purposive sampling was employed for this study as respondents were targeted for participation due to their employment as child welfare workers who serve adolescents residing in foster care in the state of Kansas. Given that there was not a centralized list of child welfare workers employed in Kansas, this sampling strategy produced a smaller than anticipated sample size, rendering the results of the study less generalizable to the greater population of child welfare workers. The current sample of child welfare workers employed in the state of Kansas does resemble the larger population of child welfare workers employed across the United States in terms of gender and ethnicity (Whitaker, Weismiller, & Clark, 2006). Despite this, future research should employ methods that would allow for the collection of a more substantial sample thus producing findings that could be more generalizable to the greater population of child welfare worker in the United States.

Additionally, expanded opportunities to collect more in depth narrative data should be included in future research regarding communication patterns about sexual health between child welfare workers and adolescents residing in foster care. In other words, the one to two line statements provided by the child welfare workers only allowed for a brief explanation as to why they did or did not communicate with their current adolescent caseload. It is possible that if given the opportunity, those child welfare workers who provided statements such as, “I don’t talk about these issues,” might have explained why they do not talk about issues of sexual health with their adolescent caseload. Additionally, the child welfare workers would have the opportunity to further explain the feelings of “discomfort” expressed by themselves and the adolescents on their caseload regarding communication about issues of sexual health.

Questions that explore the perceived importance of communicating about sexual health with adolescents and the frequency with which adolescents are referred to other professionals to discuss their sexual health might provide an indication of: How important child welfare workers view communication with adolescents in foster care regarding issues of sexual health; how often adolescents are referred to other professionals (i.e. doctor, nurse practitioner, county health clinic, therapist, community health educator) to discuss issues of sexual health; the inclusion of questions about the adolescent’s sexual health in the medical history that is collected at the intake for foster care; a child welfare workers’ comfort level in assisting an adolescent in foster care who approached and informed the child welfare worker that they were pregnant or believed they had an STI; and the amount of community resources that are willing to provide sexual health services or education to adolescents in foster care.

This current study sought to explore communication about issues of sexual health between child welfare workers and adolescents residing in foster care. What was found was that there just is not much communication happening. With this said, there are many potential directions for future researchers to take these findings and recommendations in order to expand the information that has been provided through this research.

Conclusion

This research explored communication between child welfare workers and adolescents residing in foster care regarding sexual health and decision making. The objective of the quantitative study was to identify statistically significant predictors of communication between child welfare workers and adolescents residing in foster care regarding issues of sexual health in the state of Kansas. This research also sought to identify a relationship between a child welfare worker's focus and level of education and communication with adolescents residing in foster care. Overall, when child welfare workers scored higher on the ATSS or expressed a higher level of comfort with issues of sexuality, they had a tendency to communicate with a greater number of adolescents on their current caseload. Additionally, it was child welfare workers with undergraduate degrees or with some college but no degree earned who were more likely to discuss issues of sexual health with a more substantial number of their adolescent caseload.

Although the findings of significance in this research are limited, the implications for the social work profession and future research in this field are vast. A significant gap exists in the research that focuses on communicating with adolescents in foster care about issues of sexual health. This is of grave concern as youth in foster care typically experience substantial numbers of negative outcomes in financial, social, physical, and emotional venues. Added to this is a high

rate of unplanned pregnancies and fathering of children for foster youth (Polit, Morrow-White, & Morton, 1987; Risley-Curtiss, 1997). This research begins to close the gap in the existing literature while opening the door for further explorations into communication between child welfare workers and adolescents residing in foster care regarding issues of sexual health.

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APPENDICES

Appendix 1: Dissertation Survey

Approved by the Human Subjects Committee University of Kansas, Lawrence Campus (HSCL). Approval expires one year from 12/12/2011. HSCL #19762 309

Internet Information Statement

The School of Social Welfare at the University of Kansas supports the practice of protection of human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that if you agree to participate, you are free to withdraw your consent to participate at any time without penalty. We are conducting this study to better understand communication about sexual health and decision making with adolescents in foster care. This will entail your completion of an internet based survey questionnaire. The survey is expected to take approximately 15-20 minutes to complete. The content of the survey is unlikely to cause you any discomfort. Although your participation in this research may not benefit you directly, we believe that the information obtained from this study will provide a better understanding of the factors that influence communication regarding sexual health and decision making between child welfare workers and adolescents residing in foster care. Your participation is desired because of your work in the child welfare field, but your participation is strictly voluntary. Your name will not be associated in any way with the research findings. Because of the nature of internet communications, it is possible, that through intent or accident someone other than the intended recipient may see your response. Still, this is highly unlikely. If you would like additional information concerning this study before or after it is completed, please feel free to contact us by phone or mail. Completion of the survey indicates your willingness to participate in this project and that you are at least age eighteen. If you have any additional questions about your rights as a research participant, you may call (785) 864-7429, write:

Human Subjects Committee Lawrence Campus (HSCL)
University of Kansas
2385 Irving Hill Road
Lawrence, Kansas 66045-7563
or email irb@ku.edu

Sincerely,

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1. Your current age:

- 18-25
- 26-35
- 36-45
- 46-55
- 56-65
- 66+

2. How long have you been working in the field of child welfare?

- 11 months or less
- 12 months - 2 years
- 3-5 years
- 6-10 years
- 11+ years

3. Please indicate your gender:

- Male
- Female
- Intersex

4. What is your current job title?

5. Highest Level of Education Achieved:

- High School Diploma/GED
- Some College
- Bachelor of Social Work
- Bachelor Degree other than Social Work
- Master of Social Work
- Master's Degree other than Social Work
- Other Degree _____

6. Do you have a professional license for your academic discipline (i.e. LBSW, LMFT, etc.)? If so please list your title below:

7. Marital Status:

- Single
- Married/Partnered
- Separated
- Divorced
- Widowed

8. Primary Ethnic Identification:

- Asian
- African American
- Hispanic
- Native American/Alaskan
- Caucasian
- Other _____
- Mixed Ethnicity

9. Primary religious identification

- Catholic
- Jewish
- Protestant
- Baptist
- None
- Other: _____

10. Do your religious beliefs guide you in the content and form of communications with adolescents on your case loads?

- Not At All
- Somewhat
- Always

11. How old were you when you were first exposed to sexual health education?

- I have never received formal sex education
- Elementary (K-5)
- Middle School (6-8)
- High School (9-12)
- College
- Beyond College

12. If you have received formal sexual health education, where did that education occur?

- I have never received formal sexual health education
- School
- Physician or other medical personnel
- Parents
- Church
- Community Program (i.e. Boys and Girls Club)

13. When thinking about working with adolescents residing in foster care, how important is it for the worker to discuss sexual health issues?

- Not important
- Somewhat Important
- Neutral
- Important
- Very Important

14. Have you had training and/or education about sexuality since becoming a child welfare worker?

- Yes
- No

15. If you answered yes to the above question, please choose all areas where you received education/training

- Conference
- In-Service
- Coursework
- Supervision
- Other _____

Provide additional comments here:

21. Thinking about your interactions with the adolescents on your caseload during the last 2 months, with what percentage of your adolescent caseload did you discuss the following sexual health issues?

	0-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
How to prevent the transmission of STDs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Provide additional comments here:

22. Thinking about your interactions with the adolescents on your caseload during the last 2 months, with what percentage of your adolescent caseload did you discuss the following sexual health issues?

	0-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
The adolescent's intimate partner's sexual history	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Provide additional comments here:

23. Thinking about your interactions with the adolescents on your caseload during the last 2 months, with what percentage of your adolescent caseload did you discuss the following sexual health issues?

	0-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
The adolescent's sexual history	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Provide additional comments here:

24. Please consider the following statements and indicate whether you strongly disagree, disagree, are neutral, agree or strongly agree.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
24a. Discussing sexuality is essential to an adolescent's health concerns.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24b. I am uncomfortable talking about sexual issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24c. I am more comfortable talking about sexual issues with adolescents than most of the staff I work with.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24d. Most adolescents in foster care are too traumatized to be interested in sexuality.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24e. I make time to discuss sexual concerns with the adolescents I serve.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24f. Whenever an adolescent asks me a sexually related question, I advise them to discuss the matter with a physician.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24g. I feel confident in my ability to address adolescent sexual concerns.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24h. Sexuality is too private an issue for me to discuss with adolescents in foster care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24i. Giving an	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

adolescent permission to talk about sexual concerns is a substantial responsibility.					
24j. Sexuality should be discussed only if initiated by the adolescent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24k. Adolescents expect me to ask about their sexual concerns.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24l. Abortion should be made available whenever someone feels it would be the best decision.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24m. Information about contraception (birth control) should be given to any individual who intends to have intercourse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24n. Parents should be informed if their adolescent under the age of 18 residing in foster care has visited a clinic to obtain a contraceptive device.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24o. Petting (a stimulating caress of any or all parts of the body) is immoral behavior unless the couple is married.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24p. Premarital sexual intercourse for young people is unacceptable to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24q. Sexual intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

for unmarried young people is acceptable without affection existing if both partners agree.					
24r. Homosexual behaviors is an acceptable variation in sexual orientation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24s. A person who catches a sexually transmitted disease is probably getting exactly what he/she deserves.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24t. A person's sexual behavior is his/her own business, and nobody should make value judgments.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24u. Sexual intercourse should only occur between two people who are married to each other.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

25. By the time adolescents graduate from high school in the United States:

- only a few have had sexual intercourse.
- about half have had sexual intercourse.
- about 80% have had sexual intercourse.

26. During their menstrual periods, adolescent females:

- are too weak to participate in sports or exercise.
- have a normal, monthly release of blood from the uterus.
- cannot possibly become pregnant.
- should not shower or bathe.
- all of the above

27. It is harmful for an adolescent to have sexual intercourse when she:

- is pregnant.
- is menstruating.
- has a cold.
- has a sexual partner with syphilis.
- none of the above

28. Some contraceptives:

- can be obtained only with a doctor's prescription.
- are available at family planning clinics.
- can be bought over the counter at drug stores.
- can be obtained by people under 18 years of age without their parents' permission.
- all of the above

29. When unmarried adolescent girls learn they are pregnant, the largest group of them decides:

- to have an abortion.
- to put the child up for adoption.
- to raise the child at home.
- to marry and raise the child with the husband.
- none of the above

30. People having sexual intercourse can best prevent getting a sexually transmitted disease (STD or STI) by using:

- condoms
- contraceptive foam
- the birth control pill
- withdraw method (pulling out)

31. The method of birth control which is least effective is:

- a condom with foam
- the diaphragm with spermicidal jelly
- withdraw method (pulling out)
- the birth control pill
- abstinence (not having intercourse)

32. It is possible for an adolescent to become pregnant:

- the first time she has sexual intercourse.
- if she has sexual intercourse during her menstrual period.
- if she has sexual intercourse standing up.
- if sperm get near the opening of the vagina, even though the male's penis does not enter her body.
- All of the above

33. It is impossible now to cure:

- Syphilis
- Gonorrhea
- Herpes virus #2
- Vaginitis
- All of the above

34. As they enter puberty, adolescents become more interested in sexual activities because:

- their sex hormones are changing.
- the media (TV, movies, magazines, records) push sex for adolescents.
- some of their friends have sex and expect them to have sex also.
- all of the above

35. To use a condom the correct way, an adolescent must:

- leave some space at the tip for the male's semen.
- use a new one every time sexual intercourse occurs.
- hold it on the penis while pulling out of the vagina.
- all of the above

36. The proportion of American adolescent females who become pregnant before turning 20 years of age is:

- 1 out of 3
- 1 out of 11
- 1 out of 43
- 1 out of 90

37. Treatment for venereal disease is best if:

- both partners are treated at the same time.
- only the partner with the symptoms sees a doctor.
- the person takes the medicine only until the symptoms disappear.
- the partners continue having sexual intercourse.
- none of the above

38. Syphilis:

- is one of the most dangerous of the venereal diseases.
- is known to cause blindness, insanity, and death if untreated.
- is first detected as a chancre sore on the genitals.
- all of the above

39. If adolescents have sexual intercourse, the advantage of using condoms is that they:

- help prevent getting or giving venereal disease.
- can be bought in drug stores by either gender.
- do not have dangerous side effects.
- do not require a prescription.
- all of the above

40. The physical changes of puberty:

- happen in a week or two.
- happen to different adolescents at different ages.
- happen quickly for girls and slowly for boys.
- happen quickly for boys and slowly for girls.

41. The birth control pill:

- can be used by any female.
- is a good birth control for women who smoke.
- usually makes menstrual cramping worse.
- must be taken for 21 or 28 days in order to be effective.
- all of the above

42. Gonorrhea:

- is 10 times more common than syphilis.
- is a disease that can be passed from mothers to their children during birth.
- makes many females and males sterile (unable to have babies).
- is often difficult to detect in women.
- all of the above