**Abstract**

This study uses original data to identify predictors of communication between child welfare workers in a Midwestern state and the adolescents they serve who are residing in foster care regarding their sexual health and decision making. Quantitative analysis was used 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 around discussing sexual health issues with adolescents residing in foster care was found to be a significant predictor in five out of six regression models.

Adolescents placed in foster care are at high risk for unplanned or unwanted pregnancy (Polit, Morrow-White, & Morton, 1987; Risley-Curtiss, 1997). When in foster care, adolescents experience a disruption in the expected avenues through which they would ordinarily receive sexual health information, such as from parents, school personnel, and peers. When placed in foster care, these adolescents come into contact with numerous professionals, and in particular, with social workers. These professionals serve as the gateway to information and resources, such as those related to 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. Difficulties in accomplishing this 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.

**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 provide adequate care (Mather, Lager, & Harris, 2007). By the time adolescents are placed in foster care, many have amassed an extensive history of abuse or neglect by a parent, guardian or relative (Bruskas, 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 (Dowdell, Cavanaugh, Burgess, & Prentky, 2009).

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. Despite this, there is a limited amount of research that focuses specifically on the sexual risk behaviors of youth residing in foster care. One such study conducted by Polit, Morton, and Morrow-White (1989) involved 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 residing 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 are the findings that the adolescents in foster care were

in serious need of access to family planning services, such as birth control, but they were significantly less likely to have access to these services (Polit, Morton, & Morrow-White, 1989).

A decade later Risley-Curtiss (1997) identified similar issues facing adolescents residing in foster care. Risley-Curtiss (1997) 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 old were included in the study 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 of a non-Caucasian ethnic classification. Further, Risley-Curtiss found that these adolescents 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. Indeed, 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).

A related study by James, Montgomery, Leslie, and Zhang (2009) involved a secondary data analysis which sought to examine a potential relationship between a history of placement within the foster care system and sexual risk behavior of adolescents. Using baseline data collected in 1996 and Wave 4 data collected between 2002 – 2004 from The National Survey on Child and Adolescent Well-being (NSCAW), the authors examined the 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. James, Montgomery, Leslie, and Zhang (2009) expressed concern regarding an apparent disconnect between the larger child welfare system and adolescents in foster care, particularly in regard to sexual health and decision making. These authors remark on the lack of clarity about who in the foster care system is responsible for communicating with adolescents about their sexual health and decision making (James, Montgomery, Leslie, & Zhang, 2009). Mirroring the concerns expressed by Risley-Curtiss (1997) the authors remark, "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).

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 insisted that sexual activity should not be considered an isolated issue requiring a specialist's attention but instead, sexual activity should be seen as part of an all-encompassing system of risk behaviors that can be effectively addressed by child welfare workers (Risley-Curtiss, 1997). The implications outlined by Risley-Curtiss (1997) 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.

**Social Worker Communication with Foster Youth**

Adolescents who are placed in foster care have substantial feelings of being disconnected from all things that are familiar to them (Herrenkohl, Herrenkohl, & Egolf, 2003). James, Montgomery, Leslie, and Zhang (2009) pointed to a significant need to have a clear understanding of who is responsible for communicating about these adolescents' sexual health and development. However, there is a lack of empirical research that focuses attention on social

workers' communication with adolescents in foster care regarding the adolescents' sexual health and decision making. One such national 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 on the knowledge level of these workers about 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 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 with having the responsibility to disseminate sexual health information to adolescents in foster care (Polit, Morrow-White, & Morton, 1987). The authors found that in the mid-1980s, that most states either allowed for or did not prohibit discussion around sexual health with adolescents in foster care (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 remainder 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 (Polit, Morrow-White, & Morton, 1987).

Findings regarding the comfort and ability levels 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, particularly around moral issues or issues that could arouse political controversy (Polit, Morrow-White, & Morton, 1987). When asked whether respondents 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 unidentified state who reported, “Some of our social workers won’t say the word S-E-X” (p. 21, 1987).

**Study Objectives**

The sexual health concerns facing adolescents residing in foster care suggest that encouraging communication between child welfare workers and these adolescents about sexual health may help adolescents become more aware of sexual risks and the available options for promoting safe and healthy sexuality. Although research provides some insight into worker-client communications, no known study has identified predictors of communication about sexual health and decision making between child welfare workers and adolescents residing in foster care. Thus, this study sought to examine the relationships of child welfare workers’ comfort with discussing sexual issues, the sexual health knowledge, and their education level with their capacity to communicate with adolescents residing in foster care about the adolescents’ sexual health and decision making. 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:

$H_1$: 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.

$H_2$: 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.

$H_3$: 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.

## Sample and Methods

This study examined communication that occurred during the two months prior to data collection between child welfare workers in one Midwestern state and the adolescents on their caseloads, focusing specifically on the content related to six specific topics focused on sexual health and development. Purposive sampling was used in this study as participants were

identified and included due to membership in a certain population. Initial attempts were made to recruit participants at the statewide level in two Midwestern states. However, both state level agencies declined participation in the study citing time constraints as well as discomfort with the research topic. In 1996, one of the identified states privatized their child welfare system allowing for individually owned private entities to provide foster care services across the state. Currently five agencies provide foster care services to adolescents in this state. 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. 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. A final sample of 94 child welfare workers was derived from those employed in privatized agencies that contracted with the state to serve the foster care population. Participants were surveyed through the use of a single survey which took an average of 23 minutes to complete and provided respondents the opportunity to complete the online survey anonymously. At the time sampling for this research was completed, all of the child welfare worker participants were serving adolescents in foster care who were 12 to 17 years old. Participant demographics are presented in Table 1.

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Table 1

*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 |
| 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 |

**Analysis**

Standard multiple regression was used to assess existing relationships between control, independent, and dependent variables. The child welfare workers were surveyed about their current knowledge of sexual health [IV1] and their comfort level in talking about sexual health [IV2]. The child welfare workers were asked to identify the percentage of adolescents on their caseloads with whom they had communicated during the prior two months regarding: pregnancy prevention [DV1], condom use [DV2], methods used for protection against AIDS transmission [DV3], methods used for protection against transmission of STDs [DV4], the adolescents' intimate partner's sexual history [DV5], and the adolescent's sexual history [DV6]. 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 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).

**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 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).

**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.

Multiple regression 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 multiple regression models five control variables and two independent variables were regressed on six separate dependent variables using standard multiple regression. Additionally, correlation matrices were developed in order to assess associations between independent variables (knowledge level and comfort level) and the six dependent variables. Finally, 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 Master of Social Work (MSW) degree and those that have a Bachelor of Social Work (BSW) degree. In order to further analyze the relationship of the dependent variables with this dichotomous variable Chi Square ($X^2$) test was used.

**Results**

When asked the 21 questions included in the ATSS, the majority of participants (53%) reported a high level of comfort around issues of sexual health; no participants scored in the low

level of comfort range. The remaining 44 respondents (47%) reported in the moderate level of comfort range. As with the primary independent variable, comfort level regarding issues of sexual health, no respondents exhibited a low level of sexual health knowledge. Of the child welfare workers included in this study 71 percent exhibited a moderate level of knowledge about sexual health with the remaining 29 percent having a high level of knowledge.

Communication was measured using six indicators, derived from the PACS, which measured communication between parents and adolescents regarding issues of sexual health. Each indicator was given a 10-point scale which allowed respondents to retrospectively report the percentage of their adolescent caseload with whom they had spoken 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, all reported that communication with adolescents about issues of sexual health was important. In fact, 35 percent of child welfare workers reported that communicating with adolescents regarding issues of sexual health is very important. Table 2 provides 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.

Table 2

*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 |

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 indicated 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."*

Four 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:

> *"We refer to medical professional for these discussions."*

> *"They get this information elsewhere in our program."*

> *"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, five respondents who reported having communication about issues of sexual health with more than 10 percent of their current adolescent caseload also added:

> *"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."*

A correlation matrix produced the greatest number of statistically significant findings (Table 3). Five of the six correlations between comfort level and the dependent variables were significant. 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. The relationships between child welfare workers' knowledge level and the six dependent communication variables were not significant.

Table 3

*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 Udfse | .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 (Table 4). Obtained values show that there was no difference by degree: pregnancy prevention ($X^2$= .08, p = .48), condom use ($X^2$ = .09, p = .51), methods of preventing the transmission of AIDS ($X^2$ = .45, p = .36), STD prevention ($X^2$ = .06, p = .50), the adolescent's intimate partner's sexual history ($X^2$ = 1.56, p = .17), and the adolescent's sexual history ($X^2$ = .86, p = .25).

Table 4

*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 | | |

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. Despite this, the comfort level of child welfare workers around issues of sexual health 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 (Table 5).

Table 5

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

| Variable | Model 1 Pregnancy Prevention (DV1) B | Model 2 Condom Use (DV2) B | Model 3 AIDS Transmission (DV3) B | Model 4 STD Transmission (DV4) B | Model 5 Intimate Partner's History (DV5) B | Model 6 Adolescent Sexual History (DV6) 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

**Discussion**

This study is the first known to focus attention on certain attributes of child welfare workers 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 years which focused 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 limited significant findings, points to a need for additional research in this area. A primary limitation of the study pertains to the survey which was purposively created to allow anonymity for respondents. The survey was only completed by

those respondents who were willing to participate in the research. 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. Due to this generalizability of the current findings to alternative populations of child welfare workers in the United States is limited. 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.

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. 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). 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 Social Work Practice**

Polit, Morrow-White, and Morton (1987) found that a limited 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.

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 the Midwestern state studied here, have privatized their foster care services; other states, 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. 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.

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 this Midwestern state, 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).

**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. The study sample of child welfare workers employed in this Midwestern state, although small, 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.

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