ADOLESCENTS IN FOSTER CARE: THEIR KNOWLEDGE ABOUT AIDS/HIV AND ITS IMPACT ON THEIR SEXUAL AND DRUG PRACTICES

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JANIECE DIANE HARRISON

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ABSTRACT

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ADOLESCENTS IN FOSTER CARE: THEIR KNOWLEDGE ABOUT AIDS/HIV AND ITS IMPACT ON THEIR SEXUAL AND DRUG PRACTICES

Advisor: Professor Hattie Mitchell

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The overall objective of this study was to assess the knowledge of adolescents in foster care in relation to AIDS/HIV and to determine if their knowledge impacted on their sexual and drug practices. The researcher examined the following factors that influence adolescent high risk behaviors: (a) parents, (b) peers, (c) school, (d) religion, and (e) the media. A cross-sectional research design was used. A self-administered questionnaire was given to foster care adolescents who reside in group homes in Metropolitan Atlanta. Two hypotheses were tested. (1) There was no relationship between the adolescents' knowledge about AIDS/HIV and their sexual practices, and (2) There was no relationship between the adolescents' knowledge about AIDS/HIV and their drug

practices. Both hypotheses were rejected. The results of the study indicated a significant relationship between the adolescents' knowledge of AIDS/HIV and their sexual practices and the adolescents' knowledge of AIDS/HIV and their drug practices.

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CHAPTER 1

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) is a disease that destroys the body's immune system. This destruction makes the body unable to fight off common organisms, as in the common cold. AIDS is not only a disease that destroys the body's immune system, but leaves it powerless against infection. It has also intensified homophobia in our society (Rice & Kelly, 1988).

AIDS was first seen in this country during the late 1970s although not diagnosed until 1981. Primary victims were gay men living in New York and California. These previously healthy men were diagnosed with Kaposi's sarcoma (KS), a rare skin cancer and/or Pneumocystis carinii pneumonia (PCP), an opportunistic infection. This new phenomenon was labeled Gay-Related Immune Deficiency (GRID) and later renamed AIDS (Buckingham & Rheem, 1987).

AIDS was once thought to be a disease confined to gay males. The AIDS virus has been diagnosed in over 83,000 men, women, and children in all races and

socio-economic groups in the United States. Approximately 47,000 people have died from AIDS/HIV or AIDS Related Complex (ARC) (Centers for Disease Control, 1989).

The virus that causes AIDS, the third Human T-Lymphocyte virus, (HTLV-III/LAV), was simultaneously isolated in America and France in 1984 and 1985. The HTLV-III/LAV virus was renamed the Human Immunodeficiency Virus (HIV), now an internationally accepted term (Buckingham & Rheem, 1987).

According to reports from the Centers for Disease Control (CDC), exposure to AIDS can be manifested in three ways. There are persons who are HIV antibody positive who have no symptoms; those with physical symptoms (ARC), but do not have AIDS; and those with AIDS. Incubation of the virus may be a few months to 10 years. There is an 80% mortality rate within two years of diagnosis. Persons with AIDS (PWAs), most often become emaciated and demented during the final stages of their illness. Usually, there is prolonged disability and frequent hospitalizations.

Sexual activity and drug use are two high risk behaviors most associated with contraction of AIDS/HIV.

These behaviors are prevalent in the adolescent population (Koop, 1986) and likely to be more so in teens in Foster Care. Adolescents in Foster Care lack the stability and support found in some intact families. Adolescents in Foster Care represent neglected and maltreated youth who tend to have low self-esteem and the need for acceptance (Sturkie & Flanzer, 1987). These factors may result in the high risk behaviors (sex and drugs), making this population vulnerable for infection of AIDS/HIV.

Statement of the Problem

Adolescents represent 1% of reported AIDS/HIV cases (CDC, 1988). Based on current knowledge of adolescent behavior and development, this age group has been targeted as a "bridging" group to those currently infected (Hein, 1986).

Koop (1986), "Adolescents and pre-adolescents are those whose behaviors we wish to especially influence because of their vulnerability when they are exploring their own sexuality (heterosexual or homosexual) and perhaps experimenting with drugs."

In a forum discussion on "Save The Children: Building An AIDS Program for D.C.'s Out-of-Home Youth," November, 1988, it was reported that a group of teens living in foster homes shared their knowledge about the threat of AIDS and their attitudes about effective education about sex and drugs (two high risk behaviors). They discussed the needs for services which they can relate to and are staffed by people who listen and accept them for who they are.

While interest in the adolescent is not new, the scientific study of the effects of knowledge about AIDS/HIV on sexual and drug practices of adolescents in Foster Care is a relatively new phenomenon. The growth in interest and study of this issue is due, in large part, to the lack of relevant scientific knowledge about AIDS/HIV within this population. Teenagers often consider themselves immortal and may be putting themselves at risk.

This vignette supports Koop's statements about adolescent vulnerability:

> ...Bill, 18, the youngest of five brothers and gay, "Yes, I'm worried about getting it, but if I get it, I'll have to live with it."

He denied practicing safe sex and asserted that nuclear war would annihilate the population long before he could die from AIDS (Cates, 1987, p.159).

Georgia leads the nation in sexually transmitted diseases. The Centers for Disease Control (CDC) have reported that pubescents and adolescents account for 55% of the gonorrhea and 40% of all syphilis cases.

AIDS is claiming the lives of many children. As of December 1988, 325 cases have been reported in persons aged 13 to 19. Most of the babies born with AIDS are Black. Most of the children with AIDS are Black. Most of the women with AIDS are Black. The startling fact is, Blacks are three times more likely to get AIDS than whites (Howard University, 1988).

Other studies indicate that Black adolescents (many of whom are in Foster Care) may be at a higher risk than their white counterparts (DiClemente, Boyer & Morales, 1988). The lack of knowledge relative to the cause, transmission and precautionary measures are associated with high risk for infection.

It was the intent of this study to examine the relationship between the Foster Care adolescents' knowledge about AIDS/HIV and their sexual and drug

practices. Specific research questions were:

1. What is the relationship between the Foster Care adolescents' knowledge about AIDS/HIV and their sexual practices?

2. What is the relationship between the Foster Care adolescents' knowledge about AIDS/HIV and their drug practices?

Significance of the Study

This researcher became interested in the problem after having worked with adolescent mothers and adolescents in Foster Care. Adolescents are the preferred population of this researcher in relation to the provision of services.

Adolescents represent the only population whose mortality rate has increased in the last two decades (U.S. Census, 1986). Many teens are uninsured or underinsured and are not receiving comprehensive health care.

Adolescents between the ages of 13 and 19 comprise approximately 10% of the American population, accounting for approximately 25 million individuals (U.S. Census, 1986).

The Centers for Disease Control have reported that most persons infected with AIDS/HIV are between the ages of 20 and 29. Given the incubation period described as being from a few months to 10 years, one can assume that some of these persons were infected during adolescence.

This researcher hopes that the data obtained from this study may be utilized to increase the longevity and quality of life of adolescents in Foster Care. The results may encourage child welfare agencies, educators and others concerned about the health of this population to develop or modify prevention strategies.

The data presented in this study proposes to bring before professional clinical social workers some understanding of the knowledge, opinions, drug and sexual practices of adolescents in Foster Care, so that strategies, interventions, and educational programs can be more effective in enabling teenagers to modify their high risk behaviors to prevent the transmission of AIDS/HIV.

Virginia Anderson (1989), Child Welfare League of America's (CWLA) pediatrician, cogently explains the challenge and focus of our concern:

There need not be one more person infected, ever...We have known how to prevent the spread of HIV infection since 1983, but there has been no national declaration that, in order to prevent the spread, we must discuss developmentally appropriate sexual activity, sexual identity, and human sexuality, comprehensively...Since 1983, thousands of children when entered and existed in the child welfare system, have not yet received sufficient information in appropriate ways to prevent their becoming infected with the virus. We will soon discover, if we already haven't that young adults we knew as children, are infected, ill, dying, or dead. Whether they became infected while in our Foster Care or after leaving it, we must ask ourselves, are we doing everything possible to help every child within our sphere of influence to avoid becoming affected? (Foundation for Children with AIDS, 1989, p. 3)

CHAPTER II

REVIEW OF THE LITERATURE

There is a dearth of professional literature addressing adolescents and AIDS/HIV. Factors influencing sexual activity and drug use have been reviewed. These include: a) parents; b) peers; c) schools; d) religion; and e) the media.

Parental Influence

A recent Louis Harris Poll cited in Wattleton (1987), conducted for Planned Parenthood, confirmed that sexuality education still begins at home. The teens overwhelmingly cited parents as their most important source of information on sexuality, pregnancy, and contraception. The researcher also found that parent-child communication needs improvement.

Moore, Peterson & Furstenberg (1986) also support the need for better parent-child communication. Their study revealed that parents with traditional values discuss sex with their daughters to postpone sexual involvement. However, discussions with sons are not

held until parents believe that the sons are already sexually active.

Unlike Harris, Hogan & Kitagawa (1985) reported a strong relationship between parental control of daughters' dating experiences and the daughters' sexual activity. Parents knew who their daughters were dating, where they went on dates, and their expected arrival from the date. Sixty-seven percent of the daughters reporting low parental control were sexually active compared to 44% of those reporting high parental control.

The amount of parental discipline varies from none to rigid. Sexual permissiveness and intercourse experience has been found to be highest among adolescents viewing their parents as having no rules, lowest among those reporting some discipline, and intermediate among teens who viewed their parents as very strict (Miller, Mccoy, Olson & Wallace, 1986).

The teens in the cited studies were members of intact families. Subjects of this researcher's study were adolescents in Foster Care, specifically residential settings. The "sex education" that many of them received from parents was in the form of sexual

abuse. These "lessons" have been known to result in suicide, pregnancy, promiscuity, and some teens have left their homes.

Hersch (1988) points out how risky running away has become since the AIDS epidemic:

> Physically and sexually abused adolescents account for 36% of the runaway population. The irony is that many youths flee dysfunctional families and stressful environments and find that prostitution is a means to an end. Sex more than anything puts runaway kids at risk for AIDS (p.32).

This risk became a reality for Wendy Blakenship, a 19-year old prostitute with AIDS. "On the streets they call me Turnpike because that's the way I run. You pay before you get on, and the longer you ride, the more it costs." As a child, Wendy was sexually molested by her stepfather and forced to leave home by her mother (Blais, 1987).

Jim Kennedy, the Medical Director of Covenant House (a shelter in New York City), finds that young girls are being infected with Human Immunodeficiency Virus (HIV) just by having sex with new boyfriends, the guys who take them in when their families throw them out.

Last summer he tested four girls who fit this description. Three tested HIV positive. One of the three was pregnant (Hersch, 1988).

The difficulty in parent-child communication about sex is that many parents are embarrassed and do not know how to broach the topic. Their inability to discuss sex with children who are young may cause additional problems for the kids as teens.

Dr. Calderone addressed this point in an interview with Jaworski (1987): "If the parent is closed and fearful about sex or rejecting of sex, the child feels it and this impression colors later attitudes."

Parents appear to be more traditional about sex than they were during their teens. The number of teens who are sexually active may be equal to that of prior decades, although the age of sexual initiation seems to be decreasing. This early initiation can be attributed to the biological changes of puberty which are starting earlier. Menarche, the onset of menstruation, has declined steadily from 15 years in 1900 to 12.5 years today. In 1950, 50% of all 19-year-olds were married and 50% of those marriages were preceded by pregnancy (Kotulak, 1987).

Peer Influence

One function of the peer group is to defend the adolescent from his own uncertainty through the security of his membership in a group. It also provides a chance for him to achieve status of his own merits - not those of his family - in terms of the values held by his age mates. It gives him an opportunity for further developing his self-image, especially as regards the behavior that differentiates him or her from members of the opposite sex (Cole & Hall, 1965).

In a group discussion with teens, ages 15 to 18 in a local high school, this researcher asked them to state their reasons for having sex. One male responded, "When you go to a party and you see this fine babe, you take her to the bedroom. Then when you hang out with the fellas and they ask, 'Did you get that?' you can tell 'em 'yeh'."

The same question was asked of adolescent girls, ages 13 to 18. The responses included: "Because everybody else is doing it"; "It feels good"; "I thought that I really loved the guy" and "Because I wanted to."

The latter response came from an 18-year-old. Many girls may "want to", but many want to be accepted. There is an enormous amount of pressure on girls to have sex. "If you loved me, you would do it" has been heard through the years. Sol Gordon, author and sex educator, has a book titled, You Would if You Loved Me (1978).

A Planned Parenthood survey, conducted by Syntex Laboratories, of 1,000 young men were asked if it was alright to lie to a girl, saying that you loved her in order to have sex; 70% said yes (Brown, 1981). Male teens also feel that sex is important to affirm their masculinity and that contraception is the girl's responsibility (Vadis & Hale, 1977).

These attitudes of young males are not surprising, given the double standard. Boys are expected to act out their sexuality. Girls, on the other hand, are expected to wait until they are older or married (Gordon, Scales & Everly, 1979).

These statistics reflect the statements of Gordon, Scales and Everly: By age 15, 16% of boys and 5% of girls in the United States have had heterosexual intercourse at least once. By age 17, these rates

almost triple for boys and increase 5 times for girls. By age 19, three-quarters of all boys and almost two-thirds of all girls have been sexually active (U.S. Dept. of Education, 1987).

The lesbian or gay teen often cannot conform to the norms of peers. She or he must deny her or his sexual feelings or be singled out as different. Heterosexual youth often show little tolerance for this type of difference, especially males (Hunter & Schaecher, 1987; Price, 1982). The New York City Board of Education recently established the Harvey Milk High School for homosexual teens who experienced difficulty in regular public schools.

In spite of the heterosexuals' intolerance, more and more homosexuals are "coming out" in adolescence. Coming out refers to the process of admitting to oneself and others that one is homosexual. Although several theories exist, no one is certain what makes a person homosexual or heterosexual.

Lesbian and gay youth are represented in the Foster Care system. During the 1970s, a number of gay adolescents who had run away from home or had been thrown out by parents after learning of the child's

homosexuality, have been occasionally placed with gay male couples. Of course, the foster parents have been carefully screened to eliminate the inappropriately motivated (Harry, 1988).

Los Angeles has group homes for adolescent homosexuals. Most of the boys and girls were street children picked up in Hollywood. Group and individual therapy is provided, and efforts are made to teach the teenagers that they can lead happy productive lives, regardless of their sexual orientation (Linedecker, 1981).

Gay youth are likely to be more susceptible to AIDS/HIV than their lesbian or heterosexual counterparts. This statement can be validated by the fact that the gay subculture appears to be more important to the males than the females (Sullivan & Schneider, 1987). Reportedly, lesbians are most often monogamous. Gay men engage in rimming, fisting, and other sex practices that tear the mucous membranes of the anus, which may allow transmittal of the virus. They are more likely to participate in group sex (Schafer, 1977) and anonymous sex (Lee, 1977). These practices place them at higher risks and the gay

adolescents need to be aware of the consequences.

The peer group is the most influential factor during adolescence as teens withdraw from parental influence in search of their own identity.

Some prevention strategies have begun to utilize the peer group in the wars on drugs, sex, and AIDS.

This strategy is about to occur in Atlanta. The Youth Outreach Committee at AID Atlanta is moving ahead to begin a peer AIDS education program (AID Atlanta Newsletter, Feb. 1989).

School Influence

The issue of sex education in schools has been controversial through the years. Dr. Prince A. Morrow encouraged support for formal sex education programs as early as 1900 (Brown, 1981). At that time, conferences were organized to plan worldwide attacks on venereal disease.

These "plans of attack" are underway throughout the United States in schools and communities. Approximately one-half of all sexually transmitted disease (STD) patients are less than 25 years old (Yarber, 1987). The CDC reports that, nationwide,

persons, ages 10 to 24, accounted for 62.5% of gonorrhea cases and 40% of syphilis cases in 1985.

Syphilis cases continue to rise, making AIDS/HIV infection a reality for some. Syphilis does not cause AIDS, but people with AIDS are more likely to transmit the virus if they also have syphilis (NASW News, Feb. 1989).

A very few school systems across the nation have sex education and AIDS prevention instruction for grades K-12.

This extensive curriculum has been mandated by the State of Georgia for all public schools statewide. The curriculum must be taught from the values of the local community, emphasizing the practice of abstinence as a means of pregnancy and disease prevention (Senate Bill 352).

In addition, the Bill was amended to make clear that neither contraceptive distribution nor abortion-related services could be performed on school grounds or by school personnel.

Georgia currently ranks eighth in the nation in reported cases of AIDS/HIV; Atlanta ranks eleventh among cities (CDC, 1989). Georgia is rated fifth in the

country in adolescent pregnancies (DHR, Vital Statistics, 1988).

Adolescent females at risk for pregnancy should be forewarned that the AIDS virus can be passed on to the unborn child.

According to the Fulton County Health Department, the infant mortality rate among teenagers in 1986 totaled 16.6% per 1,000 live births. Blacks accounted for 20.2% per live births and whites accounted for 9.8% per live births.

The health care needs of adolescents are unmet for various reasons. One approach to meeting their needs, in addition to a sex education and AIDS prevention curriculum, is that of the school-based clinic (SBC).

School-based clinics offer comprehensive health care, including physicals, immunizations, counseling, screenings for pregnancy and sexually transmitted diseases. Staff at these clinics usually consist of a physician, nurse, and social worker.

Most of the school-based clinics are on or near the grounds of junior and senior high schools. The cost for services are free or minimum. Because they are accessible, convenient, affordable, and comprehensive,

SBCs are used by students. By making referrals and providing follow-up after student visits, the clinic staff facilitate access to the whole health care system, increasing use of available resources and at the same time training young people to be knowledgeable consumers within the system (Lovick, 1988).

Religious Influence

Religion has been an influential factor in the lives of most human beings regardless of age or race. Its relevancy can be seen in baptisms, bar mitzvahs, weddings, funerals, and other rites of passage.

Religion as an influence for youth is on the decline. The University of Michigan conducted a survey in 1950 and repeated the survey in 1980 attempting to determine the major influences on children. Here, as cited in Kunjufu (1984), are their findings:

1950	1980
home	home
school	peers
church	television
peers	school
television	church

This decline may be a contributing factor in sex before marriage or sex before adulthood.

One study in which all of the respondents were "born again", supports the facts of sex before marriage and adulthood. The survey's overall results indicate that teens in evangelical churches are only 10 to 15% behind the general population in regard to sexual activity. Of the 1438 respondents, 43% had sex before the age of 18. Thirty-five percent of the 17-year-olds and 26% of the 16-year-olds had had sex ("Sex and Teens," 1988).

Since most denominations have formal services, it is the opinion of this researcher that these services could provide guidance and information relevant to sexuality to youth in the congregation. This is not to suggest that everyone in the clergy is comfortable or capable of discussing sex and surrounding issues.

Media Influence

Teenagers watch television more than any other age groups ("Teens Tune Out," 1988). Dr. Bruce R. Hare in his 1988 article in the National Urban League report highlights television as another major contributor to

the impoverished attitudes of our children. It is, he says, "the most massive programming and socializing instrument ever created."

Teens report that TV is equally or more encouraging about sexual intercourse than their friends, and high television use has been correlated with dissatisfaction about virginity among high school and college students. In fact, students who think that TV accurately portrays sex are more likely to be dissatisfied with their own first experiences (Haffner & Kelly, 1987).

Although TV does not accurately portray sex, AIDS is having a significant effect on this broadcast medium. Television industry officials have stated that less casual sex and more monogamous relationships will be depicted (Center for Pop. Options, 1987).

True to their word, some of the prime time serials have shown their characters openly discussing sexuality and birth control.

NBC has offered several programs relevant to AIDS. The network with its "An Early Frost" specifically dealt with a young gay male coming to terms with the disease.

More recently, the NBC-TV program, "Midnight Caller", changed the conclusion of an episode in which a bisexual man with the AIDS virus continued to have sex with a large number of men and women. The infected man was rescued by the main character and urged to seek counseling. The show emphasized that the AIDS carrier's actions were not representative of homosexuals and bisexuals (NASW News, February 1989).

The music industry is also responsible for the messages that young people receive. These messages are becoming more and more sexually explicit. "I Want Your Sex," "Do Me Baby," and "Wild Thing," are a few of the recordings on the radio today.

Tipper Gore, wife of Tennessee Senator, Al Gore, has written a book titled, Raising PG Kids in an X-Rated Society (1987). Mrs. Gore has been influential in getting the music industry to place labels on recordings stating that the lyrics are sexually explicit.

Drugs and AIDS/HIV

The use of drugs, intravenous drugs specifically, is the second of the two high risk behaviors associated

with AIDS/HIV.

Adolescents tend to experiment with drugs (Koop, 1986) and teen drug use has received a lot of attention in recent years.

For the purpose of this study, this researcher has briefly discussed findings relevant to cigarettes, alcohol, marijuana, and cocaine. The latter is the only drug directly associated with intravenous drug use.

Johnston, O'Malley & Bachman (1988) have researched drug use among American high school students since 1975-1987. They discovered that the daily cigarette smoking rate decreased between 1977 and 1981 (from 29% to 20%); it has only dropped very little in the six years since (by another 1.6%). This is despite a decline in most other substances.

One of these substances is alcohol. Alcohol is the most widely used and abused drug (Lang, 1985). Despite the fact that it is illegal for adolescents to purchase alcohol, 92% of high school seniors have drunk alcoholic beverages (Johnston et al. 1988). Estimates of the problem drinking, defined in terms of drunkenness and negative consequences, average around

30% for high school students. These drinking problems, which are worse for boys, have been associated with approval and modeling of drinking by both parents and peers (1985). Daily use was reported by 7.2% of the males versus 2.5% of the females (1988). Many teens believe that alcohol is a sexual stimulant. Alcohol can make a male impotent temporarily and decrease his sexual desire (Calderone & Johnson, 1981).

Another drug believed to arouse one sexually is marijuana. Marijuana comes from the Indian hemp plant and different parts of the plant yield various strengths of intoxicants. The use of marijuana reduces the number and quality of sperm and damages their ability to move around, possibly effecting fertility (Snyder, 1985). The drug may harm the fetus of a pregnant teen.

Marijuana use reached its peak with American high school students in the late 1970s. In 1987, one in every thirty seniors (3.3%) reported daily or near daily use. This is a decrease in the 6% level first observed in 1975 (Johnston et al. 1988). In 1987, the annual and daily prevalence of marijuana use declined and remains at 15-16% below their all time highs.

There have been significant changes in the attitudes and beliefs that teens hold relative to marijuana (1988).

Cocaine, a white crystalline alkaloid powder derived from the coca plant, is one of the most used drugs today. It can be administered intravenously. The injection of the drug gives its users an intense "rush" in two minutes or less (Johnson, 1986).

The use of cocaine by high school students, in terms of monthly and annual use, decreased significantly in 1987. Annual use decreased from 12.7% in 1986 to 10.3% in 1987 and monthly use decreased from 6.2% to 4.3% over the same period (Johnston, et al. 1988).

In addition to the decline in cocaine use is the decline of crack, a cocaine derivative. The annual crack prevalence measured in 1986 was 4.1%, which is almost equal to the 4% yielded by the 1987 question on annual prevalence. This further suggests that crack use leveled out in 1987 and did not continue to increase in high school population (1988).

Cocaine tends to increase sexual desire and activity. With its continued use, the ability to

perform and enjoy is reduced as exhaustion, nervousness, and serious irrationality set in. In the female, cocaine can cause dryness and irritability (Calderone & Johnson, 1981).

Although most intravenous drug users are age 25 to 45, more than 20,000 teenagers have used drugs intravenously. Most older intravenous drug users have a history of involvement with illegal drugs that began in their teens (U.S. Dept. of Education, 1987).

Adolescents' Knowledge About AIDS/HIV

Assessment of adolescents' knowledge about AIDS/HIV began less than five years ago, several years after the disease had been described.

One of the earliest studies was conducted in Baltimore, Maryland by Price, Desmond & Kukulka (1985). At that time, students had a low level of knowledge and concern about AIDS. More than half of the respondents, all of whom were 8th and 11th graders, indicated that they were not worried about contracting AIDS.

At approximately the same time, students enrolled in Family Life Education classes in San Francisco took part in a study relating to their knowledge and

attitude about AIDS. This study indicated that minority populations (Black, Hispanics, and Asians) were less knowledgeable than whites in regards to the cause, transmission, and precautionary measures to be taken during sexual intercourse to decrease the likelihood of infection. Further, the San Francisco teens fared the same or better than teens in previous studies (DiClemente, Zorn & Temoshok, 1986).

More recently, James (1988) replicated the Baltimore study with students in Atlanta. The researcher found that students showed increased knowledge of AIDS, as compared to all previously conducted surveys that have assessed students' knowledge.

Overview of Major Theoretical Orientations

In order for the reader to have a clearer understanding of the adolescents' high risk behaviors, this researcher included information relevant to theories of cognition, development, and social learning.

Cognition refers to the ability to learn and think. Piaget, the most noted of cognitive theorists, proposed that all people go through various stages of thought processes (Zastrow & Kirst-Ashman, 1987).

Two of these stages or periods occur in adolescence: (1) the period of concrete operations extending from approximately age 7 to 12. At this point, the child's thoughts are on things that can be seen, heard, smelled, and touched. (2) The period of formal operations, ages 12 to 16, the adolescent is expected to reason and assess probabilities. Many do not. These formal operations are confounded by the adolescent's egocentrism complemented by the development of the "personal fable" in Elkind, Inhelder, and Piaget's studies (cited in the NASW Encyclopedia, 1987). This concept involves viewing one's thoughts and feelings as unique experiences. This view has been linked to the teen's failure to use birth control and risk-taking behavior.

Erik Erikson developed a theory of psychosocial development comprising eight stages beginning with infancy continuing through old age (Zastrow & Kirst-Ashman, 1987).

Erikson places adolescents in Stage 5: Identity Versus Role Confusion. At this stage, the adolescent attempts to "find himself" through exploration and experimentation.

Behavioral theorists state that people learn or acquire their behaviors from observation, reinforcement, and stimulus response (Bandura, 1969). It is likely that the patterns of any individual's sexual expression are probably a product of that person's learning as reported in Gochros' study (cited in Brown, 1981).

On the basis of social learning theory, researchers have proposed that adolescent drinking can be explained in part by parental models of drinking behavior (Barnes, Farrell & Carris, 1986).

DEFINITION OF TERMS

All terms are defined in the context of this study.

1. Adolescents - Persons between puberty and adulthood, ages 13 to 18.
2. AIDS/HIV - Acquired Immune Deficiency Syndrome/ Human Immunodeficiency Virus. AIDS is a viral disease that destroys the body's immune system. There is an 80% mortality rate within two years of diagnosis. HIV is the virus that causes AIDS and is transmitted through blood and semen.
3. Drug Practices - The acts of smoking cigarettes (tobacco and marijuana), consuming alcoholic beverages (beer, wine, and liquor), an ingestion of cocaine by smoking, snorting, or injecting with a needle.
4. Foster Care - Substitute parental care provided to adolescents by county and private agencies. The adolescents reside in group home settings, residential or cottages and supervised by adults known as houseparents.
5. Knowledge - Factual or non-factual information about sex and drugs that the adolescents

acquired from parents, peers, religion, school, and the media.

6. Sex practices - Acts of anal, oral, and vaginal intercourse where the persons do or do not protect themselves from AIDS, pregnancy, or sexually transmitted diseases.

Statement of the Hypotheses

Two hypotheses were tested in this study:

1) There is no relationship between the adolescents' knowledge about AIDS and their sexual practices.
2) There is no relationship between the adolescents' knowledge about AIDS and their drug practices.

CHAPTER III

METHODOLOGY

Research Design

The research design for the purpose of this study was the cross-sectional survey. The cross-sectional survey attempts to show a relationship between two or more variables.

R X O The Cross-Sectional Survey

'R' represents the sample of the population.

'X' represents the independent variable: Knowledge about AIDS/HIV.

'O' represents the dependent variables: Sex and Drug Practices.

Research Setting

The research setting consisted of 5 group homes specifically designed for adolescents in Foster Care. The homes are located in Metropolitan Atlanta.

The group homes provide the adolescents with food, shelter, clothing, medical and dental care, and monetary allowances.

The residents receive individual and group counseling on a weekly basis. Visits by residents with their families are coordinated by agency staff.

Sampling

The sampling technique for this study was a non-probability convenient method. A non-probability sample is one in which the probability of selection is not known. A convenient sample is one in which the most readily available subjects are chosen for the study. The sample consisted of adolescents in Foster Care who are 13 to 18 years old. The researcher received written permission from the agency directors to administer the instrument to the adolescents.

Data Collection Procedure/Instrumentation

The respondents for the study were given a 41-item self-administered questionnaire. They were asked 14 questions about AIDS/HIV, 19 questions relevant to their sexual practices and attitudes, and 8 questions regarding their drug use and attitudes.

The instrument was valid and reliable in that the questions were derived from standardized

questionnaires. The sexual questions were extracted from Sorensen's, Adolescent Sexuality in Contemporary America (1973). The questions relating to drugs were taken from Student Drug Use in America: 1975-1981, produced by the Department of Health and Human Services, 1981. Some of the questions were modified for better reading comprehension.

Data Analysis

For purposes of data analysis, the Pearson r was used. The Pearson r is a parametric statistic used for measuring the strength of a relationship between two variables. The coefficient is symbolized by the Greek letter r and varies between -1.00 and +1.00, with 0.00 signifying no relationship or zero percent accuracy in prediction; +1.00 predicts a positive or 100 percent accuracy that there is a relationship between two variables and -1.00 means a 100 percent accuracy in predicting a negative relationship between two variables (Bailey, 1987). Chi square was used to test the null hypotheses.

CHAPTER IV

PRESENTATION OF RESULTS

This study utilized two null hypotheses. The first null hypothesis was: There is no relationship between the adolescents' knowledge about AIDS and their sexual practices. This hypothesis was tested using a chi square analysis. $x^2 = .73193$, d.f. = 1, $p < .0009$, which reveals a statistically significant relationship between the adolescents' knowledge about AIDS and their sexual practices. Therefore, the null hypothesis was rejected.

The second null hypothesis was: There is no relationship between the adolescents' knowledge about AIDS and their drug practices. It was also tested using a chi square analysis. $x^2 = .93750$, d.f. = 1, $p < .0001$. Again, these statistics show a significant relationship between the adolescents' knowledge about AIDS and their drug practices. The null hypothesis was rejected.

A 41-item questionnaire was administered to a total of 33 adolescents in Foster Care. Of the 33 respondents, 21 were female and 11 were male. One

respondent did not identify his or her sex. The adolescents ranged in age from 13 to 18 with an average age of 15.5 years. Fifteen were Black, 14 white, 1 Hispanic, 2 stated "other", and one respondent did not answer this question. Demographics are shown in Table 1.

TABLE 1

DEMOGRAPHIC DATA OF FOSTER CARE ADOLESCENTS

AGE	FREQUENCY	PERCENT
13	3	9.1
14	6	18.2
15	6	18.2
16	10	30.3
17	7	21.2
18	1	3.0
TOTAL	33	100.0

SEX	FREQUENCY	PERCENT
MALE	11	34.4
FEMALE	21	65.6
TOTAL	32	100.0

RACE	FREQUENCY	PERCENT
BLACK	15	46.9
WHITE	14	43.8
HISPANIC	1	3.1
OTHER	2	6.3
TOTAL	32	100.0

Questions 1 - 14 were designed to assess the adolescents' knowledge about AIDS. Sixty-one percent, n = 20, strongly agreed that they could not get AIDS from kissing someone on the lips, sharing a drinking glass, or by sitting on the toilet seat. In response to the same question, one respondent strongly disagreed, one did not know, and 11 agreed. Table 2 shows the results from questions 5, 9, 11, and 14.

TABLE 2

FOSTER CARE ADOLESCENTS' KNOWLEDGE ABOUT AIDS

QUESTION	VALUE	FREQUENCY	PERCENT
5. I CANNOT GET AIDS	1	1	3.0
FROM KISSING SOMEONE ON	2	0	0.0
THE LIPS, SHARING A	3	1	3.0
DRINKING GLASS, OR BY	4	11	33.0
SITTING ON THE TOILET	5	20	60.6
SEAT. TOTAL		33	100.0
9. AIDS STANDS FOR	1	0	0.0
ACQUIRED IMMUNE DEFICIENCY	2	2	6.1
SYNDROME.	3	8	24.2
	4	9	27.3
	5	14	42.4
TOTAL		33	100.0

(table continues)

11. AIDS IS TRANSMITTED	1	2	6.1
ONLY THROUGH SEX, BLOOD,	2	4	12.1
AND DIRTY NEEDLES.	3	2	6.1
	4	10	30.3
	5	15	45.3
TOTAL		33	100.0

QUESTION	VALUE	FREQUENCY	PERCENT
14. THE SAME ACTIVITY	1	2	6.1
THAT CAUSES PREGNANCY AND	2	0	0.0
SEXUALLY TRANSMITTED	3	5	15.2
DISEASES CAUSES AIDS.	4	9	27.3
	5	17	51.5
TOTAL		33	100.0

VALUE

1 = STRONGLY DISAGREE

2 = DISAGREE

3 = DON'T KNOW

4 = AGREE

5 = STRONGLY AGREE

Sexual activity is a high risk behavior that is prevalent in the adolescent population. Seventy-nine percent, n = 26, stated that they had engaged in sexual activity. Forty-two percent, n = 14, reported that the first time they had sex, they protected themselves from pregnancy and AIDS. Questions 15, 18, and 19 with their results are listed in Table 3.

TABLE 3

SEXUAL PRACTICES OF FOSTER CARE ADOLESCENTS

QUESTION	YES	PERCENT	NO	PERCENT
15. HAVE YOU EVER HAD SEX?	26	86.7	4	13.3

18. THE FIRST TIME THAT WE HAD SEX:	FREQUENCY	PERCENT
1. MY PARTNER AND I PROTECTED OURSELVES FROM PREGNANCY AND AIDS.	14	53.8
2. MY PARTNER AND I DID NOT PROTECT OURSELVES FROM PREGNANCY AND AIDS.	12	46.2
TOTAL	26	100.0

19. IF YOU ARE SEXUALLY ACTIVE, HOW OFTEN DO YOU HAVE SEX?	FREQUENCY	PERCENT
1. ONCE A WEEK	4	26.7
2. TWICE A WEEK	2	13.3
3. ONCE A MONTH	6	40.0
4. TWICE A MONTH	1	6.7
5. MORE THAN TWICE A MONTH	2	13.3
TOTAL	14	100.0

Attitudinal statements about sex were included in the questionnaire. Table 4 has the nine statements that were used. The mean and standard deviation for each has been calculated.

TABLE 4

MEAN AND STANDARD DEVIATION OF

SEXUAL ATTITUDES OF FOSTER CARE ADOLESCENTS

QUESTION	MEAN	STD. DEV.
26. IT IS NOT HEALTHY FOR SOMEONE MY AGE TO GO A LONG TIME WITHOUT SEX.	2.152	1.503
27. SOMETIMES I FEEL GUILTY ABOUT MY SEXUAL BEHAVIOR.	2.438	1.343
28. TEENAGERS ARE UNDER A LOT OF PRESSURE TO HAVE SEX.	3.424	1.347
29. LIVING IN THE GROUP HOME DOES NOT INTERFERE WITH MY SEX LIFE.	2.839	1.508
30. THE ONLY REASON THAT TEENAGERS HAVE SEX IS FOR PHYSICAL ENJOYMENT.	3.242	1.480
31. MY PARENTS HAVE TAUGHT ME ABOUT SEX.	3.182	1.530
32. AS FAR AS SEX IS CONCERNED, WHAT MY FRIENDS DO HAS NO EFFECT ON WHAT I DO.	3.848	1.439
33. I BELIEVE THAT IT IS WRONG TO HAVE SEX IF I AM NOT MARRIED.	2.273	1.153

(table continues)

	MEAN	STD. DEV.
34. SOMETIMES I GET SEXUALLY EXCITED BY THE MUSIC THAT I HEAR.	2.030	1.510

1.00 = STRONGLY DISAGREE

2.00 = DISAGREE

3.00 = AGREE

4.00 = STRONGLY AGREE

Assessment of the drug practices and attitudes about drugs were made. The statistics were almost identical for those reporting smoking cigarettes 1 - 2 times as those reporting having smoked five times or more. Table 5 lists the frequency and percentages of the practices and mean and standard deviation for the attitudes.

Half of the respondents reported having drunk beer, wine, or liquor more than five times. Similarly, forty-two percent, n = 14, stated that they have never tried marijuana and 33%, n = 11, reported having smoked marijuana over five time.

In response to question 38, "I have used cocaine or crack," 79%, n = 26, reported never using the drug and 15%, n = 5, said that they have used cocaine or crack 1 - 2 times (Table 5).

TABLE 5

DRUG PRACTICES AND ATTITUDES OF FOSTER CARE ADOLESCENTS

QUESTION		FREQUENCY	PERCENT
35. HAVE SMOKED CIGARETTES:			
LESS FREQUENT (0-2 TIMES)		15	48.4
MORE FREQUENTLY (3+)		16	51.6
	TOTAL	31	100.0

36. HAVE DRUNK BEER, WINE, OR LIQUOR:	VALUE	FREQUENCY	PERCENT
	1	5	16.1
	2	7	22.6
	3	3	9.7
	4	16	51.6
TOTAL		31	100.0

37. HAVE SMOKED MARIJUANA:	VALUE	FREQUENCY	PERCENT
	1	14	45.2
	2	4	12.9
	3	2	6.5
	4	11	35.5
TOTAL		31	100.0

(table continues)

38. HAVE USED COCAINE OR CRACK:	VALUE	FREQUENCY	PERCENT
	1	26	83.9
	2	5	16.1
	3	0	0.0
	4	0	0.0
	TOTAL	31	100.0

1 = NEVER

2 = 1 - 2 TIMES

3 = 3 - 5 TIMES

4 = MORE THAN 5 TIMES

	MEAN	STD. DEV.
39. ALCOHOL INCREASES SEXUAL PLEASURE.	2.613	1.174
40. ON ONE OR MORE OCCASIONS, UNDER THE INFLUENCE OF ALCOHOL, I HAVE HAD SEX WITH SOMEONE I WOULD NOT OTHERWISE HAVE HAD SEX WITH.	2.129	1.522

(table continues)

	MEAN	STD. DEV.
41. ON ONE OR MORE OCCASIONS, UNDER THE INFLUENCE OF DRUGS, I HAVE HAD SEX WITH SOMEONE I WOULD NOT OTHERWISE HAVE HAD SEX WITH.	1.871	1.335
42. TEENAGERS ARE AT RISK FOR AIDS BECAUSE OF THEIR DRUG PRACTICES.	3.226	1.383

1.00 = STRONGLY DISGREE

2.00 = DISAGREE

3.00 = AGREE

4.00 = STRONGLY DISAGREE

CHAPTER V

SUMMARY AND CONCLUSIONS

In general, as the empirical research data regarding Adolescents In Foster Care: Their Knowledge About AIDS/HIV And Its Impact On Their Sexual And Drug Practices, the findings indicated an appreciable difference in their responses than found in previous studies (DiClemente et al. 1985; Price et al. 1985) on adolescents' perceptions and misperceptions, knowledge, and attitudes about AIDS. A more detailed analysis might reveal that the particularly intense AIDS education programs in various high schools and media coverage about AIDS, which has taken place since the 1985 studies, likely had an impact on the responses of the Foster Care adolescents.

However, there should be caution against over-extrapolating the findings. Perhaps the greatest reservations regarding the findings of this study concerns the validity of the responses. A question which always arises in the study of sensitive behaviors like AIDS, drugs, and sexual practices is whether honest reporting can be secured. This researcher has

no objective validation of the present measures, but strongly suggests that the self-report questions produce largely valid data.

The researcher's summary and conclusions are based on those identified cautions.

Limitations of the Study

The results of this study allows enough consistency to render the study valid. Because of the specific foster care agencies chosen for collection of data, our results may be limited in terms of desired quantity, disallowing the researcher to randomly select participants. The researcher can state only that the results can be applied to the sample group of Foster Care adolescents.

Suggested Research Directions

Further explication through research would be useful to define more fully which of the dimensions of the questionnaire and which of the in-service training dimensions impact on adolescent knowledge and perception or misperceptions about AIDS.

Generalizations could lead to theory-building regarding in-service training for Social Work practitioners and consequently facilitate linkage to agency programs like Foster Care for the proper structuring of in-service training and continuing education about AIDS.

CHAPTER VI

IMPLICATION FOR SOCIAL WORK PRACTICE

A search of the social work literature revealed that issues related to AIDS/HIV in adolescents in Foster Care have not been a research priority.

Social workers, child welfare workers, particularly, can make invaluable contributions in the area of research. Workers have been instrumental in identifying critical AIDS/HIV issues and must maintain these efforts.

This study sought to determine the knowledge adolescents in Foster Care have about AIDS/HIV and its impact on their sexual and drug practices. The findings indicated that over half of the respondents were knowledgeable about the cause, transmission, and precautionary measures relevant to AIDS/HIV.

Social workers must also be knowledgeable about AIDS/HIV and related issues. This knowledge will assist in the development of prevention strategies as well as the reduction of myths and fears about AIDS/HIV.

Findings from the study also revealed that almost all of the respondents have engaged in sexual intercourse and that the onset of sexual activity begins in the pre-teens, if not earlier.

In order to provide services to this population, social workers must be knowledgeable about the psychological tasks of adolescence. This knowledge will allow workers to assess high-risk behaviors and develop intervention strategies.

Social workers need to understand clearly the impact of AIDS/HIV on the adolescents in Foster Care. The profession must make a stronger commitment to this population in dire need of our support and services. For example, in November 1988, it was reported that a group of teens living in foster homes shared their concèrns about the need for services which they could relate to and identified a desire to have a staff of people who could <u>listen</u> and accept them for who they are.

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APPENDICES

ATLANTA UNIVERSITY
SCHOOL OF SOCIAL WORK
223 James P. Brawley Drive, S. W.
ATLANTA, GEORGIA 30314-4391
(404) 653-8548

January 5, 1989

Mr. Robert Weaver
Executive Director
Families First
P. O. Box 7948, Station "C"
Atlanta, GA. 30357-0948

Dear Mr. Weaver:

For my research as a master's candidate in the School of Social Work at Atlanta University, I have chosen to explore how AIDS has impacted the knowledge and attitudes of adolescents in foster care.

Adolescents tend to experiment with sex and drugs, the two most recognized methods of transmission of the AIDS' virus. According to the Centers for Disease Control (CDC), the age group with the most reported AIDS cases ranges from 20 to 29. Given the incubation period of a few months to 10 years, some of these persons probably contracted the virus during adolescence.

With your permission, I would like to include in my sample, residents from the agency's 4 group homes. My study will be an exploratory one utilizing the descriptive survey method. Confidentiality and anonymity are assured as no names will be used - residents or Families First.

It is my sincere hope that the data obtained from this study will be valuable and enlightening to child welfare workers, group home parents, teachers, researchers and other professionals involved with this population.

I look forward to talking with you. Any comments and assistance that you can lend will be appreciated. I will contact you by Tuesday of next week. Hopefully, you will have time to consider my request.

Thank you,

Janiece D. Harrison

Janiece D. Harrison

FAMILIES FIRST℠

Serving Children and Families since 1890

February 22, 1989

Robert M. Weaver, ACSW
Executive Director

Ms. Janiece D. Harrison
Atlanta University
School of Social Work
223 James P. Brawley Drive, S.W.
Atlanta, Georgia 30314-4391

Dear Ms. Harrison:

We are pleased to grant approval for you to include subjects who are clients at Families First in your proposed research study.

Our understanding is that you will study how AIDS has impacted the knowledge and attitudes of adolescents in foster care. You will use a descriptive survey method and neither subjects nor Agency name will be used. Your subjects will be chosen from our four Group Homes.

Best wishes for your study. We look forward to receiving a copy.

Very Sincerely,

Rosemary Funderburg

Rosemary Funderburg
Associate Director for Program

Robert Weaver

Robert Weaver
Executive Director

RF/gs

Agency Affiliations
United Way of Metropolitan Atlanta
Child Welfare League of America
Family Service America

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1105 West Peachtree Street, N.E.
P.O. Box 7948, Station "C"
Atlanta, Georgia 30357-0948
(404) 873-6916

ATLANTA UNIVERSITY
SCHOOL OF SOCIAL WORK
223 James P. Brawley Drive, S. W.
ATLANTA, GEORGIA 30314-4391
(404) 653-8548

January 30, 1989

Ralph J. DiClemente, PhD.
Department of Epidemiology and International Health
HSW 1699
School of Medicine
University of California
San Francisco, CA. 94143

Dear Dr. DiClemente:

For my research as a master's candidate in the School of Social Work at Atlanta University, I have chosen to explore how AIDS has impacted the knowledge and attitudes of adolescents in foster care.

With your permission, I would like to obtain and utilize the AIDS Information Survey. My sample is to include adolescents residing in private and state operated group homes in Fulton County, Georgia. Some of these teens have received AIDS information from various professionals and some have not.

Georgia presently ranks eighth in the nation in reported AIDS cases. The State has mandated sex education and AIDS prevention education for its public schools effective July 1989.

I look forward to hearing from you. Any comments and assistance that you can lend will be appreciated.

Thank you,

Janiece D. Harrison

Janiece D. Harrison

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Department of Epidemiology
and International Health

SAN FRANCISCO, CALIFORNIA 94143-0560

2 March 1989

Janiece D. Harrison
Atlanta University
School of Social Work
223 James P. Bawley Drive, S.W.
Atlanta, GA 30314-4391

Dear Ms. Harrison:

I apologize for the protracted delay in responding to your request for material. Unfortunately, I've been traveling a great deal out of the country.

Enclosed please find a copy of the information you requested. I hope you will find this questionnaire useful. There are three subscale: general information, casual contact and perceived risk. The reliability coefficients for each are 0.72, 0.75 and 0.55, respectively. Fortunately, I have reprints available which describe the development of the summary scores for each scale. The references would provide this information are: J Applied Soc Psychology, 1987, Vol. 17 (3) and the Am J Public Health, 1988, January, Pgs. 55-57. I will be standardizing these measures over the next few months. As that work proceeds I'll certainly keep you in mind. If you have the opportunity, please keep me informed as your work progresses.

I certainly endorse your use of my scale with the only proviso that you reference the source in any publication. Your work is quite timely and important. I hope that all goes well and perhaps you will forward a copy to me when possible.

If I can be of any further assistance, please do not hesitate to contact me directly at (415) 925-0664.

Good Luck,

Ralph J. DiClemente, PhD

Encl: manuscripts requested

ATLANTA UNIVERSITY
SCHOOL OF SOCIAL WORK
223 James P. Brawley Drive, S. W.
ATLANTA, GEORGIA 30314-4391
(404) 653-8548

Dear Participant:

I am trying to find out what types of AIDS prevention programs are needed for teenagers.

Your participation in this study is voluntary. The attached questionnaire has statements about **AIDS, SEX AND DRUGS.** This is not a test.

In order for you to be comfortable and open in your responses, **DO NOT** write your name on the questionnaire. This guarantees that no one will know who you are.

Thank you,

Janiece D. Harrison

Janiece D. Harrison

AN AIDS, SEX AND DRUGS QUESTIONNAIRE

PLEASE CIRCLE YOUR ANSWER. SD=STRONGLY DISAGREE; D=DISAGREE; DK=DON'T KNOW; A=AGREE and SA=STRONGLY AGREE.

1.	Getting AIDS is not a serious problem because I can go to the doctor and get cured.	**SD D DK A SA**
2.	Teenagers cannot get AIDS.	**SD D DK A SA**
3.	I can protect myself from getting AIDS.	**SD D DK A SA**
4.	Anybody can get AIDS.	**SD D DK A SA**
5.	I cannot get AIDS from kissing someone on the lips, sharing a drinking glass or by sitting on the toilet seat.	**SD D DK A SA**
6.	The risks of teenagers getting AIDS are the same risks for adults getting AIDS.	**SD D DK A SA**
7.	I can be infected with the AIDS virus and not know it.	**SD D DK A SA**
8.	Condoms can protect me from getting AIDS.	**SD D DK A SA**
9.	AIDS stands for Acquired Immune Deficiency Syndrome.	**SD D DK A SA**
10.	Teenagers need AIDS prevention education.	**SD D DK A SA**
11.	AIDS is transmitted only through sex, blood and dirty needles.	**SD D DK A SA**
12.	It is safe to go to school or to work with someone who has AIDS.	**SD D DK A SA**
13.	I can tell by looking at someone that he/she has AIDS.	**SD D DK A SA**
14.	The same activity that causes pregnancy and sexually transmitted diseases causes AIDS.	**SD D DK A SA**

SECTION II. SEXUAL PRACTICES AND ATTITUDES

1. Have you ever had sex?

If you answered "NO", go to PART B.

2. I was ___ years old when I first had sex.

3. The first time that I had sex, my partner was: (PLEASE CIRCLE ONE).

   1. A boy/girl younger than me.
   2. A boy/girl the same age as me.
   3. A boy/girl older than me.
   4. A grown man/woman.

4. The first time that we had sex: (PLEASE CIRCLE ONE.)

   1. My partner and I protected ourselves from pregnancy and AIDS.

   2. My partner and I did not protect ourselves from pregnancy and AIDS.

5. If you are sexually active, how often do you have sex? (PLEASE CIRCLE ONE.)

   1. Once a week.
   2. Twice a week.
   3. Once a month.
   4. Twice a month.
   5. More than twice a month.

6. When did you last have sex? (PLEASE CIRCLE ONE.)

   1. Yesterday.
   2. Last week.
   3. Last month.
   4. Over a month ago.

7. Where did you last have sex?

   1. In a car.
   2. In the group home.
   3. In my parent's home.
   4. At a friend's home.
   5. At a motel.
   6. Other _____.

8. Have you ever had a sexually transmitted disease (STD)?

   1. Never.
   2. 1-2 times.
   3. 3-5 times.
   4. More than 5 times.

9. Do you prefer to have sex with:

    1. Someone of the same sex.
    2. Someone of the opposite sex

10. The number of people that I have had sex with this month? (PLEASE CIRCLE ONE.)

    1. 0
    2. 1-2
    3. 3-5
    4. More than 5

PART B

1.	It is not healthy for someone my age to go a long time without sex.	**SD D DK A SA**
2.	Sometimes I feel guilty about my sexual behavior.	**SD D DK A SA**
3.	Teenagers are under a lot of pressure to have sex.	**SD D DK A SA**
4.	Living in the group home does not interfere with my sex life.	**SD D DK A SA**
5.	The only reason that teenagers have sex is for physical enjoyment.	**SD D DK A SA**
6.	My parents have taught me about sex.	**SD D DK A SA**
7.	As far as sex is concerned, what my friends do has no effect on what I do.	**SD D DK A SA**
8.	I believe that it is wrong to have sex if I am not married.	**SD D DK A SA**
9.	Sometimes I get sexually excited by the music that I hear.	**SD D DK A SA**

SECTION III. DRUG PRACTICES AND ATTITUDES

For questions 1-4, please circle your answers.

1. I have smoked cigarettes:

    1. Never.
    2. 1-2 times.
    3. 3-5 times.
    4. More than 5 times.

2. I have drunk beer, wine or liquor:

    1. Never.
    2. 1-2 times.
    3. 3-5 times.
    4. More than 5 times.

3. I have smoked marijuana:

    1. Never.
    2. 1-2 times.
    3. 3-5 times.
    4. More than 5 times.

4. I have used cocaine or crack:

    1. Never.
    2. 1-2 times.
    3. 3-5 times.
    4. More than 5 times.

For questions 5-10, please circle SD=STRONGLY DISAGREE; D=DISAGREE; DK=DON'T KNOW; A=AGREE and SA=STRONGLY AGREE.

5. Alcohol increases sexual pleasure. **SD D DK A SA**

6. On one or more occasions, under the influence of alcohol, I have had sex with someone I would not otherwise have had sex with. **SD D DK A SA**

7. On one or more occasions, under the influence of drugs, I have had sex with someone I would not otherwise have had sex with. **SD D DK A SA**

8. Teenagers are at risk for AIDS because of their drug practices. **SD D DK A SA**

AN AIDS, SEX AND DRUGS QUESTIONNAIRE

Please complete the following background information.

My age is: (Please circle one.)

1. 13
2. 14
3. 15
4. 16
5. 17
6. 18
7. 19

My sex is: (Please circle one.)

1. Male
2. Female

My race is: (Please circle one.)

1. Black
2. White
3. Hispanic
4. Other _____

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.