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THE PROCESS OF ADOLESCENT IDENTITY DEVELOPMENT

IN THE CONTEXT OF FOSTER CARE

by

Susan McEvilly Kools

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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NURSING

in the

GRADUATE DIVISION

of the

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Susan McEvilly Kools

Abstract

THE PROCESS OF ADOLESCENT IDENTITY DEVELOPMENT
IN THE CONTEXT OF FOSTER CARE

Susan McEvilly Kools

University of California, San Francisco, 1993

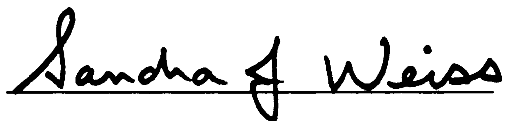
The purpose of this investigation was to generate knowledge regarding the impact of long-term foster care as perceived by adolescents who experience it. Specific objectives included the identification of the impact of foster care on the development of self, interpersonal relationships, and independence, along with factors which contribute to negative versus positive outcomes. The grounded theory approach was utilized to study the subjective experience of foster care within its social context.

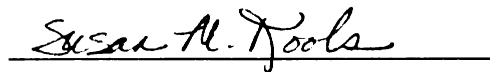
Participants were 17 minority foster youth whose mean age was 17.47. All had experienced long-term foster care (mean 5.7 years), multiple placement transitions (mean 4.1 placements), and living in group home settings. Preplacement histories were characterized by severely detrimental experiences such as child abuse/neglect, parental substance abuse, abandonment, and death of a parent.

The research design combined intensive interviews with the adolescents, naturalistic observations in group home settings, and document analysis of case records. Data were analyzed using the grounded theory method and dimensional analysis.

Growing up in the context of foster care was found to have a primarily negative impact on the process of adolescent identity development. Contextual features of foster care result in two parallel processes. The first is an external process of devaluation of the foster youth's self by others. The institutional structure of the foster care setting and the diminished status and stereotypical view of the foster child are conditions which result in devaluation of self by others. Key components of this process are experiences of depersonalization and stigmatization. Major areas of impact include the development of a stigmatized self-identity, social isolation, and the inability to function independently.

The second process is an internal one of self-protection in response to the devaluation of self by others, detrimental preplacement experiences, and the uncertainty of foster care. The impact of this second process includes the development of a veneer of self-reliance, social detachment, pseudoindependence, and a lack of future orientation. The veneer of self-reliance does not appear to eliminate the stigmatized self-identity that the foster youth manifests but protects the vulnerable self beneath from further harm.





Sandra Weiss, PhD, DNSc, RN   Susan McEvilly Kools

Dedication

To Peter:

his support, unending.

his love, unconditional.

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I am thankful to Ann O'Rielly, MSW, Director of Family & Child Services at the Department of Social Services in San Francisco for her support of my study and for her introduction to Kasey Brenner, MSW, who provided me with access to adolescents in foster care. Their willingness to devote the precious commodity of time in such an overburdened work arena to facilitate this research was greatly appreciated.

I was privileged to have the opportunity to meet and interview the foster youth who so generously participated in this study. Their willingness to so openly share their personal histories, perceptions, and ideas was remarkable. Seeing their faces and hearing their stories has made it impossible to be complacent regarding the serious issues they face on a daily basis as a result of foster care placement.

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CHAPTER 1

THE STUDY PROBLEM

Introduction

Child and adolescent psychiatric nurses have long been interested in human responses to critical life experiences which have the potential for influencing mental health. These experiences are reflective of the interrelationships between the domain concepts of nursing: person, environment, and health. A specific example can be drawn from the client population of adolescents in long-term foster care. Foster care can be defined as a child living in a supervised setting outside of the biological family as mandated by the human services or juvenile justice system. Upon removal from home, the child assumes a new legal status (foster child) whose attributes are defined and governed by these systems (e.g. type of placement, length of stay).

Foster care placements include foster family care, group homes, and various forms of residential treatment. Although length of stay in placement can vary widely from days to years, it is becoming increasingly typical for a child to spend from several years to the duration of childhood within the foster care system. In addition, a trajectory characterized by multiple placement transitions is now commonplace. The effects of this type of environmental transition and the resultant need for adjustment to one's changing social context represent important foci for inquiry

and clinical practice in child and adolescent psychiatric nursing.

The state of the research on the context of foster care to date may be characterized as in its infancy. Researchers have begun to study multiple dimensions of this area (e.g. placement predictor variables, impact of foster care on individual functioning), however, with little integration or synthesis of the findings. Although relevant variables and relationships are beginning to be identified (e.g. relationship between parental visitation and placement outcome), a significant segment of the research has been of questionable quality with multiple threats to validity such as retrospective interpretation and analysis of case records and lack of instrument reliability.

Area for Investigation

A gap in the knowledge base of particular interest from a nursing perspective is the lack of understanding of the subjective experience of foster care as perceived by foster children themselves. An understanding of the client's perception of his or her situation underscores the focus of nursing practice (American Nurses' Association, 1980). In order to elicit knowledge and understanding regarding the social phenomenon of foster care, it is important to appreciate the situation from the viewpoint of those who experience it (Gil & Bogart, 1982).

From the clinical experience of the researcher, a population of specific interest and relevance was made up of

adolescents who have experienced long-term foster care of two years or more. It was presumed that this group possesses a fundamental, albeit natural expertise on the phenomenon of extended foster care because they have been removed from their homes and have lived within the context of foster care for major portions of their lives. They have experienced separations and losses, the formation and frequent dissolution of new relationships, and identity issues related to being foster children. Consequently, it was speculated that much could be learned from this untapped resource. Thus, the central research question for this study was: What is the impact of long-term foster care as perceived by the adolescents who experience it?

The experience of foster care represents a social phenomenon of remarkable complexity. There is little preexisting knowledge regarding this context for care, its meaning to those within it, or the social characteristics and processes involved. It was, therefore, determined to be crucial to investigate and generate theory regarding the perceived impact of the experience of long-term foster care on the lives of adolescents. It is important to understand how the foster child defines his or her unique reality.

Purpose of the Study

The purpose of the study was to generate knowledge that will improve our understanding of the influence of foster care as well as variables which may influence its impact. Specific aims included the following:

1. to identify the impact of foster care on the development of self, significant relationships, and independence (e.g. job skills, ability to care for oneself autonomously) for adolescent foster children.
2. to identify factors which may contribute to negative versus positive outcomes in these areas of impact (e.g. significant people, events, and conditions within the placement history).

Significance of the Problem

Current Trends

A research focus on foster care has become a necessity based on trends which have emerged over the past two decades. According to the most recent statistics (U.S. Congress, 1990a), a disturbing pattern of foster care utilization has developed. Marked increases in the incidence of children entering the system, the length of time spent in care, and the typical number of placements per child have been noteworthy.

Incidence

Due to the decentralization of information involving multiple agencies which provide fragmented services to children in placement, it has been difficult to assess the exact incidence of children in foster care. In fact, only as recently as 1980 were states required to keep inventories containing the most basic demographic information for all children in foster care (Cox & Cox, 1985). Despite this

federal mandate, there has been little demand for state compliance. This has contributed to the dearth of credible information regarding foster children and the services they receive (Finch, Fanshel, & Grundy, 1991; U.S. Congress, 1990a).

In the past decade, social services, juvenile justice, and mental health systems have all contributed to dramatic increases in out-of-home placements (23%, 27%, and 61% increases respectively). The current estimate of children placed by these systems in the U.S. is approximately 500,000. If this trend continues, incidence projections could approach 840,000 by 1995 (U.S. Congress, 1990a).

Factors which have contributed to the rising incidence rates are thought to include a variety of complex and often interrelated problems. First, the actual incidence along with the level of reporting of child abuse and neglect cases has significantly risen. Child abuse and neglect reports have doubled since 1980 with the most recent national statistics from 1989 reflecting 2.5 million cases (U.S. Congress, 1990b). Child abuse and neglect has been described as the principle problem which has led to this rapid growth in the foster care system. Approximately 80% of all children in foster care have experienced some form of abuse or neglect including physical, emotional, and/or sexual (White & Benedict, 1985). This is most often the primary precipitant for removal from home.

Secondly, substance abuse by adults in the U.S. has reached epidemic proportions. More specifically, the burgeoning prevalence of crack cocaine abuse has led to increased violence within affected families. This has contributed to the escalation of abusive episodes toward children and their neglect secondary to the primacy of drug addiction (e.g. family food stamps sold to buy drugs) (U.S. Congress, 1990b).

Another consequence of the drug epidemic has been particularly evident in the numbers of drug and/or HIV exposed infants who require out-of-home placement. In 1988, an estimated 375,000 infants were born drug-exposed in the U.S. Depending on location in the country, between 30 and 60 percent of these infants required foster home placement (U.S. Congress, 1990b). Of this group, many remain in care because their drug-addicted parent(s) are unable to resume caregiving responsibilities. A major contributor to this scenario is the enormous gap that exists between the need for and availability of drug treatment services. As long as this discontinuity persists, the child casualties of the drug war will continue to flood the foster care system.

In conjunction with the growing pervasiveness of drugs, their use and abuse among children and adolescents is more common. Children as young as nine and ten are beginning to be involved in the drug culture. Statistics from juvenile justice report that 95,000 youth are arrested per year for drug or alcohol related offenses (Children's Defense Fund,

1990). Thus, the need for services to treat the problems of juvenile substance abusers has added to the upsurge in out-of-home placements (U.S. Congress, 1990a).

A third factor related to increased incidence is the growing number of families that are touched by the effects of poverty. Currently, there are thought to be 12.6 million children living in poverty. The number of poor children grew by 23 percent between 1979 and 1989 which translates to approximately one out of five impoverished American children (Children's Defense Fund, 1991). Closely related to this problem, the supply of affordable housing as well as federal housing assistance have diminished. These conditions have contributed to the rising numbers of homeless families. In fact, families with children are the fastest growing segment of the homeless population, representing one third of the estimated 2.2 million homeless (Barker & Aptekar, 1990; U.S. Congress, 1990a). As a result, inadequate housing and family homelessness, which are considered to be forms of general child neglect, have become more prevalent precursors to foster care system entry.

Finally, the lack of and/or inadequate funding of services which emphasize placement prevention, early intervention, and family reunification have contributed to this disturbing trend. Children at risk for placement along with their families have multiple and often very severe problems today (Fitzharris, 1989). It is more common for these children to experience serious emotional disturbance,

behavioral problems, the short- and long-term consequences of prenatal drug exposure, and ongoing academic failure. Many of their families are identified as dysfunctional related to mental illness, patterns of family violence, and substance abuse. To address these multiple and complex needs in order to prevent placement, an array of services must exist with coordination between the systems which provide them. As it stands, these services are often fragmented at best with many barriers to access (e.g. long waiting lists, lack of provider reimbursement) (Assembly Office of Research, 1989; Cox & Cox, 1985; U.S. Congress, 1990a).

Aside from the gaps in services that exist, an additional issue is the lack of funding designated for prevention and early intervention services. The Aid to Families with Dependent Children Foster Care program has traditionally been an entitlement program, therefore, when a child is in foster care, treatment expenses are more easily recovered. This has introduced a systematic bias which has favored funding for placement versus other treatment alternatives. Consequently, a percentage of children are removed from their homes when other interventions might be more appropriate and cost-effective. In fiscal terms alone, foster care cost taxpayers $1.5 billion in 1990 (U.S. Congress, 1990b).

Time in Care

As incidence rates for foster care entry have increased, a corresponding increase in system exit has not been

consistently apparent. More foster children remain in care for longer periods of time-- in fact, 40% for more than two years (U.S. Congress, 1990a). The average number of years in foster care is five (Pothier & Kools, 1992).

When foster care reform legislation (Public Law 96-272) was enacted in 1980, one major intention was to reduce the length of time that children languished in temporary out-of-home care. Foster care was not originally envisioned to be a long-term solution for family dysfunction. The concept of permanency was developed in order to offer children needed stability with the ultimate goal of family reunification or finding an alternative permanent placement like adoption (Fein, Maluccio, & Kluger, 1990). Although this initially reduced the amount of time that some children spent in foster care, the direction is once again reversing toward longer stays. This is especially true for older children, minorities, and other difficult to place groups, for example, the medically fragile or seriously emotionally disturbed (Fein et al., 1990; U.S. Congress, 1990a).

The imperative aim to achieve permanency has also produced an unexpected consequence. With the requirement for efforts to develop permanency plans for children in a timely fashion, the chances for disruption of permanent placements have increased. Between 1983 and 1985, the rate of foster care reentry or recidivism nearly doubled from 16 to 30% (Mech, 1988; U.S. Congress, 1990a). Once again, disrupted adoptions and other permanent placements increase in

likelihood with older age at time of placement, history of previous disruption, and emotional/behavioral problems (Berry & Barth, 1990). Examples from the research literature on adoption disruption include rates of 47 to 48% for ages 12 to 17 (Barth & Berry, 1988; Boyne, Denby, Kettenring, & Wheeler, 1984).

In response to both increased incidence and lengthy tenure in placement, agencies that were originally designed to provide emergency shelter care have been forced to become longer term transitional placement services. This is due in part to the inability of long-term or permanent placement resources to keep up with the rapidly increasing demands (Interagency Committee on Abuse & Neglect, 1986).

Number of Placements

In addition to spending an extensive amount of time in placement, a preponderance of multiple placements exists for the foster care population. In several study samples reviewed, evidence of placement instability was as follows: 28 to 55% of the subjects had three or more placements; 10 to 44% had four or more (Byles, 1980; Eisenberg, 1962; Fanshel & Shinn, 1978; Runyan & Gould, 1985a, 1985b). Additional studies have supported this trend. These include Cooper, Peterson, and Meier (1987) and Taber and Proch (1987) which reported the mean numbers of placements to be 3.5 and 9 respectively.

Several researchers have investigated variables related to placement disruption. In a sample of 4288 foster

children, Pardeck (1983) reported a significant positive relationship between behavioral and emotional problems and number of placements. Cooper et al. (1987) confirmed this finding and found other relevant variables to be removal from home at a younger age (e.g. ages one- to three-years-old) and presence of substance abuse within the family of origin.

In separate literature reviews, Barth, Berry, Carson, Goodfield, and Feinberg (1986) and Pardeck (1985) attempted to pull together a profile of factors contributing to this multiple placement trajectory. Placement instability was found to be related both to the nature of the system and the population it serves. Systematic influences leading to foster care instability include lack of clear planning, caseworker overload and turnover, absence of support services to maintain the child in a stable placement, and insufficient placements appropriate to the child's level of need (Cooper et al., 1987; Pardeck, 1985). Population characteristics include a predominance of behavioral, emotional, and attachment impairment problems (Barth et al., 1986; Pardeck, 1985).

Significance to Nursing

Research which addresses itself to the impact of foster care on children has both theoretical significance and practical implications for nursing. On a theoretical level, description of the phenomenon of perceived impact would contribute to the needed development of a foundation of knowledge regarding children in foster care. It is essential

to understand dimensions of impact designated as relevant by the children themselves along with conditions and processes which lead to outcomes such as placement instability and increased emotional disturbance. Likewise, as relationships between dimensions of impact are discerned, the ability not only to describe but to explain and predict impact will be enhanced.

Once the outcomes or consequences of the foster care experience are delineated and understood, clinical practice can be influenced based on empirical findings. In order to improve the quality of nursing care these children receive, their unique needs must be determined. Interventions can be designed to maximize positive outcomes and minimize the negative impact of foster care. For example, clinical practice can more effectively focus on specific dimensions of impact relevant to the individual child (e.g. relationship with family of origin, independent living skills). In addition, nurses can optimize the social environment to foster psychosocial development (e.g. provide support to foster parents to maintain child in stable placement, emphasize continuity of significant relationships like attending same school or regular contact with siblings).

As common care providers for foster children, child and adolescent psychiatric nurses are in a unique position to either improve the functioning of families of origin to reduce the risk of placement or to enhance the placement to

minimize its negative impact. Their interventions, however, must be based on sound theoretical evidence.

Summary

This research was designed with the central purpose of developing knowledge that will contribute to a substantive theory regarding the impact of long-term foster care on adolescents. At this time, little is known about the salient features of impact including the effect of foster care on the development of the self, meaningful relationships with others, and the skills needed for independent living. Likewise, an understanding of variables which influence the nature of outcomes in these areas of impact has been lacking.

Because of the absence of data based on the subjective perceptions of those currently experiencing foster care, a sample of adolescent foster children was identified for study. From a nursing perspective, inquiry which is directed toward discovering a client-centered viewpoint and theory would contribute to the growth of both nursing science and practice. Furthermore, this basic qualitative research has the potential to add to the sorely limited foundation of knowledge on children in foster care in general.

Other criteria which have supported the significance of this problem area are based on current trends in foster care utilization. The rapidly increasing rates of incidence, time in care, and multiple placements point to the burgeoning human cost of this problem. Demographic patterns related to child abuse and neglect, substance abuse, poverty and

homelessness will continue to stress the already severely overburdened foster care system. As of now, the services available to those in foster care have been driven by limited funding sources versus the actual needs of the children.

CHAPTER 2

THE CONTEXT OF FOSTER CARE: WHAT IS KNOWN

In this chapter, the body of literature related to the context of foster care shall be reviewed. First, it is important to gain an historical perspective regarding the development of foster care as a context for the treatment of children who have been removed from their troubled families. Its evolution from a temporary respite from an unhealthy family situation to, often times, a permanent solution to major family dysfunction shall be discussed. The current status of the foster care system shall be presented along with the social policy developments which have outlined directions for its reform.

Second, a critical and integrative review of the research on foster care shall be undertaken with an emphasis on its gaps and limitations. This multifaceted literature review will provide a general background and contextual basis for beginning to understand the impact of foster care on children and youth. Its outcome will suggest where this investigation will contribute to an increased foundation of knowledge regarding this impact.

Historical Development of Foster Care

It is widely believed that the foster care system of today is in the heart of a major crisis. It has been described as overwhelmed, overburdened, and unable to meet the demands for a minimum standard of care for the children it serves (English, 1984; Schor, 1989). To the farthest

extreme, it is more common to hear reports of agency negligence and serious child abuse (even death) occurring within the system that had been designed to protect (Rosenthal, Motz, Edmonson, & Groze, 1991).

With ever-increasing numbers of children and youth entering foster care in an economic environment emphasizing budgetary cutbacks, hopes for major improvements are dim. How did this desperate social situation emerge? It is important to examine the social context of this problem area along with its evolution over time.

The value of children to our society has waxed and waned over time. Solnit (1987) stated, "In the past 400 years our manifest view has moved from that of children as a possession of the parents to that of a "cherished" group within our society" (p. 455). It can be argued that perhaps the pendulum has swung back to a period of devaluation. Societal trends which support this possibility include increased family dissolution, lack of legislative or economic support for critical children's issues (e.g. health, housing, education), and the creation of a class of "throwaway" children (e.g. homeless, impoverished, emotionally disturbed, delinquent).

Tracing back to the roots of American culture, one can find evidence of the existence of society's dependent children. In the 1500 to 1600's, poor and orphaned children were actually sent from England and other European countries to aid in the effort to populate the American colonies

(Bremner, 1970). Colonial communities were devoted to the care of poor and orphaned children due to religious and social obligation. Christian doctrine emphasized this responsibility and societal norms required each individual to become a productive citizen. To ensure this, dependent children were placed with families by the practices of binding out and vendue. Children who were bound out to families would work as indentured servants until adulthood. In the case of vendue, poor children were auctioned off to the lowest bidder in exchange for their keep (Bremner, 1970; Cox & Cox, 1985).

From the turn of the nineteenth century, a period of rapid growth and urbanization began. A huge influx of immigrants from Europe populated American cities. The majority of this group was impoverished which led to the development of an increasingly negative view of the poor and needy. Survival of the fittest or social Darwinism became the prevalent social mentality (Cox & Cox, 1985). Dependent children of this era were sent to live in almshouses or poorhouses. Here, they led a minimal existence alongside the destitute of all categories including the poor, ill, insane, and criminal. Children made up approximately 20% of the almshouse population and had a mortality rate approaching 90% (Cox & Cox, 1985; English, 1984).

With this growing trend, social reformers began to question the practices regarding these children. A proliferation of private orphanages began which launched an

effort to provide separate institutional facilities for children (Bremner, 1970, 1971). Although this was thought to create a more acceptable environment for children, mortality and morbidity rates remained critically high (e.g. in New York City, 50-80% mortality rate). Epidemics, malnutrition, and the psychological impact of institutional living were major issues (English, 1984).

The first opponents to institutional care began to surface. In 1853, the Children's Aid Society was founded by Charles Loring Brace. Through this organization, children were placed with rural families in the west (Bremner, 1970; Cox & Cox, 1985). Likewise, some institutions implemented the practice of boarding out infants to families in an effort to improve their health (English, 1984). These actions may have been the precursors to the development of our current foster care system.

From this period until well into the twentieth century, the debate between proponents of institutional versus foster care ensued. In addition, the burden of responsibility for dependent children shifted from private religious organizations to the state and federal governments (Bremner,1971; Cox & Cox, 1985). In 1909, the White House held its first Conference on the Care of Dependent Children (Bremner, 1971). This gave rise to a landmark attitudinal change which stressed the importance of a family environment to the growth and development of the child.

The transition from institutional to foster family care began to be supported by public policy and legislation. Title V of the Social Security Act (1947) initiated federal funding for foster care through the Aid to Families with Dependent Children Foster Care Program (1961). Emphasis shifted to deinstitutionalization, the provision of living conditions comparable with normative social standards, and the right to treatment versus custodial care (Dore & Kennedy, 1981). Furthermore, the prevention of family dissolution became a consideration.

Current Social Context

Since its inception as a preferred alternative to institutionalization, foster care placements rapidly proliferated to the half a million in existence today. As the foster care system grew in magnitude, it was discovered that children began to get lost within it. A major form of public neglect described as "foster care drift" became evident (Knitzer, 1985). Many children languished in foster care with no clear dispositional or treatment planning. They were often placed in inappropriate settings for their level of need and "drifted" from placement to placement with little stability in their lives. Even the most basic information about these children was unknown, for example, specific number of children in foster care and their location at any given time. The quality of care that they received was also questionable. Foster care as a solution to institutionalization became as great a problem.

Alternatives to out-of-home placement which focused on prevention and early intervention for at-risk children and their families were rare and underfunded. In fact, the Aid to Families with Dependent Children Foster Care Program actually introduced a systematic bias which favored placement over preventive services for troubled families. Foster care was funded as an entitlement while few funds were provided for placement prevention or family reunification (Cox & Cox, 1985). Foster care became a permanent solution to family problems as an unintended side effect.

Recent Policy Developments

While many of these issues currently remain prevalent, landmark federal legislation mandating system reform began with the passage of Public Law 96-272. The Adoption Assistance and Child Welfare Act (1980) attempted to abolish systematic public neglect by making state funding for child welfare services contingent upon existence of the following: placement prevention and family reunification services, foster care inventories and quality assurance systems including mandatory case review, legal protection for children and families involved in foster care, and adoption subsidies for children deemed difficult to place (e.g. older, ethnic minority, emotionally disturbed children) (Cox & Cox, 1985; Knitzer, 1985).

One of the most important outcomes of Public Law 96-272 was the emphasis placed on the concept of permanency. Permanency reflects the continuity within a living situation

that enables a child to develop stable relationships with either nurturing parents (via reunification or adoption) or permanent substitute caregivers (Fein, Maluccio, & Kluger, 1990). It was argued that children were being severely damaged from the instability and resulting uncertainty of out-of-home placement. Without a sense of belonging to any family, foster children were believed to have difficulty in meeting many normal developmental tasks including establishing and maintaining interpersonal relationships and identity development. Research supported that a child's sense of permanency contributes to the feeling of well-being (Maluccio, Fein, Hamilton, Klier, & Ward, 1980). Thus, it became mandated that every child have a plan for a timely permanent placement, be it return home or adoption. Later, long-term foster care was considered to be a viable permanency plan for some children for which other alternatives were undesirable or inappropriate.

Although many states have taken the initiative to develop the services outlined by Public Law 96-272, leadership by the federal government has diminished. Beginning with the Reagan administration (1981-1988), serious attempts were made to repeal this legislation (Knitzer, 1985; Miller, 1987). Despite a lack of success, opposition to system reform remains vividly apparent today.

The past decade of governmental conservatism has advocated less intervention into state control of services and thus, virtually removed accountability for their

provision. In other words, states can receive federal moneys yet are not required to apply them to the priorities specified in Public Law 96-272 (Miller, 1987). Likewise, considerable funds have been diverted from social programs. Examples specific to foster care include budgetary cuts in placement prevention, reunification, and mental health services (Hartley, 1984; Miller, 1987).

The present political and economic climate indicates the potential for continued problems, placing system reform at great risk. In order to ensure and intensify legislative response, the need for research related to all aspects of foster care is crucial. Specific knowledge regarding both problems and effective solutions can lead to improved clinical practice and influence the development of appropriate policy.

Review of the Research Literature

A body of research on children in foster care has begun to develop. Similar to the evolution of other realms of knowledge, investigators have studied many aspects of this problem area. This fragmentary approach has resulted in disconnected and diverse findings which weakens the ability to impact clinical practice and policy. Integration of the multiple dimensions that have been examined is necessary.

One possible way to achieve this objective is to conceptualize foster care as a process: The decision is made to remove the child from the family of origin. The child then has an experience within one or many placement

environment(s). Finally, the child exits the system, returning to his/her original home or to another permanent living situation (e.g. adoption, independent living). Areas of existing research can be organized along the continuum of this process (See Figure 1). The following integrative research review will be categorized into three major groups which represent key points in the process of foster care: decision to place, placement experience, and placement outcomes.

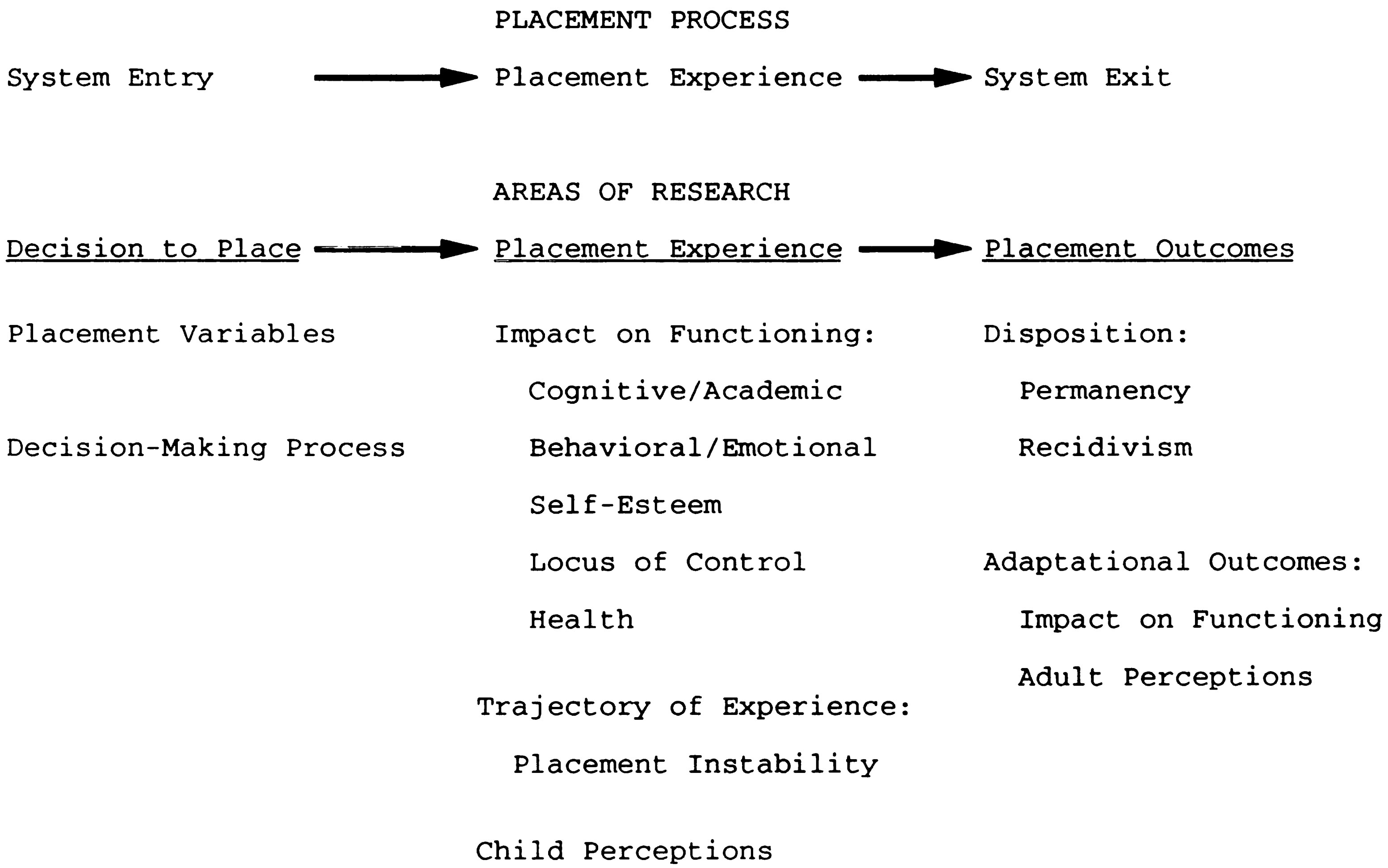
Decision to Place

In order to examine the impact of foster care as proposed in this study, it is important to understand why children enter into care in the first place. Knowledge of precipitating experiences and preexisting problems may influence the nature of impact. It also contributes to the descriptive information that exists on who these children are as a group.

Placement Variables and Decision-Making Process

Although children are removed from their original homes on a daily basis, little research has been undertaken to determine how these decisions are made. With an overrepresentation of poor and minority children in the foster care system, some have proposed that bias exists in the decision-making process (Jenkins, 1974; Jenkins & Diamond, 1985). Others have suggested that decisions are made based on emotion versus policy or protocol (Palmer, 1971).

Figure 1 Integrated Placement Process - Research Continuum



Five studies which focused on the decision-making process and/or placement variables were reviewed. The research was predominantly descriptive in nature. At times, however, authors extended their findings to explanation and prediction. Four studies examined census and/or case record data (Jenkins & Diamond, 1985; Lindsey, 1991; Katz, Hampton, Newberger, Bowles, & Snyder, 1986; Runyan, Gould, Trost, & Loda, 1982). The other utilized case analogs to question child protective workers regarding placement decisions (Meddin, 1984).

Jenkins and Diamond (1985) integrated data sets from the 1980 National Census and the 1980 Office of Civil Rights Survey which provided national data on foster care placement. A random sample of reporting units around the country was taken, providing the researchers with information on over 80,000 placed children. Since minority children were underrepresented in this group, a comparative sample (N=55,000) was drawn from 14 of the nation's largest cities.

In this large-scale evaluation of demographic data, several population variables related to placement incidence were found. Ethnic differences in placement distribution were noteworthy: In the national sample, 61% of children in foster care were white. In contrast, 77% of placed urban children were minorities with black children representing 63% of this group. It was also found that black children were twice as likely to be placed in geographic areas with a low percentage of blacks. Additional variables which were

associated with length of time in care included ethnicity and socioeconomic level. Predictors of time in care were percentage of families living in poverty and percentage of blacks in the population. Ethnic differences disappeared in areas with high poverty levels.

The obvious strength of this study was the huge data set available for analysis. The investigators were able to demonstrate clear ethnic differences within the foster care system. This appropriately leads to concern regarding systematic bias in placement decision-making. The use of specific population variables to predict placement incidence, however, may be premature. Assumptions about ethnic bias may be incorrect. For example, is the evident bias a function of ethnic group or socioeconomic status? To what extent do these variables interact to influence ethnic distribution or time in care? Finally, key variables which could contribute to the variance in the dependent variables were missing (e.g. reason for placement, familial variables).

Lindsey (1991) conducted a secondary analysis on a large data set from the National Study of Social Services to Children and Families from 1978. He selected a stratified sample (N=9597) and used discriminant analysis to determine variables which would predict foster care placement versus supportive services to the biological family without child removal. In all age groups (birth to 18), low income was found to be the variable most predictive of placement in foster care. Economic status was even more significant than

the actual reason for referral. Other demographic variables (e.g. race, ethnicity) were not used in the analysis so that bias secondary to dimensions other than income was impossible to ascertain.

In the studies which examined case reports of abuse/neglect, several variables emerged which influenced the decision to remove a child from home. Runyan et al. (1982) developed a checklist to examine reports from a state central registry (N=7770). They found that children who seemed to have an increased risk for placement following abuse exhibited severe injuries or abandonment and had parents who were substance abusers or perceived harsh physical discipline as acceptable. Other inexplicable variables which may have portrayed systematic bias included geographic area and referral source. Ethnicity and socioeconomic level had no significant influence on placement decision.

Katz et al. (1986) corroborated the trend apparent in the Jenkins and Diamond (1985) and Linsey (1991) studies, demonstrating that children from low income families were more likely to be placed. In their hospital-based sample of reports (N=185), other placement variables included a previous maltreatment report and the mother's involvement in the incident. In contrast to Runyan et al. (1982), these investigators found no significant relationship between the severity of injury and removal from home.

Use of data gathered retrospectively from case reports can be criticized on the basis of accuracy and

interpretation. Researchers had no control over the original assessments made or the quality or completeness of the data collected. Issues regarding the reliability of the findings included both unreported instrument and interrater reliability.

A related study examined the criteria caseworkers in the child protective services used to make placement decisions. Meddin (1984) presented 81 caseworkers with simulated child abuse/neglect cases and asked that they make placement decisions based on several situations. Through open-ended questions and a list of key variables, workers identified criteria which influenced their decisions. The most frequent criteria used to place a child included perceived risk to the child, severity of the incident, functioning and cooperation of the caregiver, and age of the child (e.g. younger were placed). From this, the author inferred that workers were using a consistent set of variables in their decision-making.

Several critical design flaws can be found in this study. The use of case analogs versus real situations upon which to evaluate decisions threatened the construct validity of the findings. Social desirability may have affected subject responses. In addition, vast differences between theory/policy and actual practice may exist. Other weaknesses included inadequate operational definitions of constructs (e.g. risk to child) and simplistic analysis based solely on frequency distributions and correlations.

As a group, these descriptive studies have begun to build a base of knowledge regarding the decision to place a child in foster care. An expansion of the identification and validation of placement variables is necessary. This would increase the knowledge and understanding of potential predictor variables (e.g. personality and family characteristics), thus enabling clinicians to identify children at risk for placement. Interventions could be planned and implemented aimed at its prevention. To improve the external validity or generalizability of study findings, prospective versus retrospective designs must be used. For example, interview protocols or questionnaires administered during or immediately following the placement decision may better reflect the criteria used by caseworkers. Likewise, the development and use of protocols could be explored in controlled studies. Finally, parent and child perceptions of the placement decision have not been addressed. It is crucial to enrich our understanding of placement variables in order to improve the appropriateness of these serious decisions and to reform any existent systematic bias.

Placement Experience

The belief that foster care has an absolute deleterious effect on most children is widely held. Many children fare quite poorly during their tenure as dependents. Is this due to the damaged condition upon which they enter placement or is there some inherent harm inflicted by the foster care experience itself? Systematic research has only begun to

evaluate the effects of placement on developing youngsters. Studies have focused on the impact of foster care on functioning, placement instability, and perceptions of foster children.

Impact on Functioning

Fanshel and Shinn (1978) broke ground in this area of knowledge development when they executed a multidimensional longitudinal study on children in foster care (N=624). Repeated measures using multiple tools were used to determine the influence of foster care on development, psychosocial functioning, school performance, and behavior.

Upon interpretation of the findings, the researchers refuted the assumption that the foster care experience is entirely negative. As a group, the children demonstrated no IQ change and some gain in academic functioning over time. The majority of the children were rated at normal levels of emotional adjustment throughout the study and many appeared to have improved. Furthermore, an absence of visible distress associated with the separation from the family of origin was noted in most of the sample. Caseworkers reported that the children evidenced high levels of acceptance of foster care and "embedment" or feelings of belonging within the placement.

Although consideration of the benefits of foster care must be given, contradictory inferences may be made from their data. Ethnicity, age, and time in care appeared to have an influence on adjustment. For instance, when

categorized by race, white children demonstrated diminished school performance and IQ scores. Older children manifested far more maladaptive behaviors including social detachment, anxiety, and acting out. One quarter of the children who entered care before age five experienced some emotional maladjustment.

Aside from the argument presented on the benefits versus the detriments of foster care, attention must be given to what proved to be the crucial independent variable in this study. It was discovered that parental visitation was a strong predictor variable for both length of time in care and discharge status. Children who had minimal to no visitation spent far more time in placement and were less likely to be discharged. In addition, children with higher levels of visitation had more positive assessments including higher IQ and emotional adjustment. These findings should be underscored as parental visitation has been traditionally unsupported or discouraged within the foster care experience.

Although this study has become a classic in the foster care literature, several threats to the validity of its findings must be noted. Statistical conclusion validity was threatened by a lack of instrument reliability. It was highly probable that cultural bias existed in some of the measures (e.g. IQ tests). Many instruments were developed specifically for this project and were untested. Divergent measures were used over time (e.g. age-appropriate tools used at different levels of development). Secondly, there was no

control over extraneous variables. It was obviously impossible to standardize the foster care experience, thus, competing explanations for covariance could be proposed. Finally, inferences were made with low statistical support.

The presence of potential extraneous variables must be considered as influencing internal validity. Historical events, subject maturation, test familiarity, instrumentation changes throughout the study, and subject attrition were all examples of extraneous variables that could have confounded the effect of foster care on functioning.

Inadequate operational definition of study constructs was apparent, thus affecting construct validity. Definitions were unclear or lacking which introduced the possibility of confounding constructs. Examples included emotional adjustment, attachment, and social functioning. In addition, rater bias was possible. Caseworker, teacher, and parent assessments may have demonstrated bias (e.g. reflecting social desirability or hypothesis-guessing). Likewise, retrospective case record analysis is open to a variety of interpretations.

External validity was threatened to a lesser degree. Study findings were based on a large sample size with diversity in many demographic variables (e.g. ethnic group, age). There was, however, a lack of random selection of study subjects (except in families that had more than three children in foster care). A convenience sample with several exclusion criteria was gathered. This reduced the

representativeness of the sample, however, the researchers were careful not to over generalize from their findings.

Despite the preceding critique, the importance of the Fanshel and Shinn (1978) study cannot be minimized. It served to stimulate an interest in the area of foster care research and several studies on the impact of placement on a variety of areas of functioning have followed.

Cognitive and academic functioning. Two studies looked specifically at cognitive and academic functioning in foster children. Fox and Arcuri (1980) supported the notion introduced by Fanshel and Shinn (1978) that foster care has a beneficial effect in this area. Although the sample (N=163) scored in the low average range for intelligence, aauthors found this to be similar to the general population of poor urban children. This reasoning was used to infer that foster care demonstrated no negative effect. To support this finding, it was noted that most of the subjects were placed at appropriate grade levels.

Study conclusions can be strongly criticized on several counts. Inferences were based on the overinterpretation of data and faulty assumptions (e.g. foster children should be functioning below poor urban children; grade placement is a valid indicator of school performance). Antecedent factors related to academic functioning were poorly addressed. A cross-sectional design measuring intelligence poses threats to all types of validity. Of particular concern regarding statistical conclusion validity are issues of instrument

reliability and validity. The use of IQ as a valid indicator of cognitive functioning has been widely criticized. It is thought to be culturally biased with norms generated for a predominantly white middle class population (Flaugher, 1978; Laosa, 1977). In this study, an IQ test was used to evaluate a poor, mostly black sample. Additionally, inferences of causality with minimal statistical evidence were made. A one-time cross-sectional measure of cognitive and/or academic functioning cannot validly infer either positive or negative changes secondary to the experience of foster care. Despite the aforementioned methodological flaws, the researchers proposed that foster care has ameliorative effects for children from dysfunctional families due to its stable and nurturing qualities. This overgeneralization of study findings threatened external validity.

With a more rigorous longitudinal design, Runyan and Gould (1985b) had contradictory findings. In their data gathered from both foster children (N=114) and a matched comparison group of maltreated children living at home (N=106), they determined that foster care had no apparent positive effect on school performance. Multiple variables measuring school performance were used including attendance records, grades and school failure rates, and IQ. Although attendance rates improved for both groups, they continued to demonstrate poor academic achievement (e.g. school failure rates: foster care = 58%, home care = 34%) and low IQ scores. In the foster care group, the failure to demonstrate

significant positive impact was apparent despite 91% receiving special education services.

Upon evaluation of these children after an average of eight years post-treatment, the findings seemed to provide a more accurate reflection of the impact of foster care than from cross-sectional data. It is more appropriate to make inferences regarding change in a longitudinal design. Another strength of the study was the use of a nonfoster care comparison group of abused youngsters. With this control feature, any differences could more validly be attributed to the intervention of foster care. Case record analysis and subject attrition (foster care = 16%, home care = 35%), however, continued to be identifiable threats to statistical conclusion and internal validity.

Behavioral and emotional functioning. Behavioral and emotional derivatives of the placement experience have been addressed in similar descriptive studies. Eisenberg (1962), Byles (1980), Frank (1980), and Hulsey and White (1989) attempted to evaluate the adequacy of foster care by examining the prevalence of emotional disturbance and behavior problems in their samples. Runyan and Gould (1985b) used the same historical cohort study described earlier to look at the impact of foster care on delinquent behavior. All studies utilized case record review for data collection. Caseworkers were interviewed in the Frank study and Hulsey and White used the Achenbach Child Behavior Checklist.

Eisenberg (1962) reviewed the records of children who were referred for psychiatric treatment while in foster care (N=140). Similar to earlier studies cited, sample characteristics included children with deprived, impoverished backgrounds and a disproportionate number of blacks. Many of the subjects experienced parental abandonment while in care which appeared to be related to referral for emotional disturbance (e.g. adjustment reaction, personality disorder, mental deficiency). Referred behavioral problems tended to be aggressive or antisocial in nature. School problems were commonplace with only 10% of the sample placed at the appropriate grade level. Finally, increasing length of time in care was found to be predictive of psychiatric referral.

Byles (1980) found similarities within a sample of 120 female adolescents in placement. Family circumstances prior to placement were highly disruptive and dysfunctional (e.g. violence, substance abuse, parental mental illness). In this older group, it was found that the adolescent's deviant behavior often contributed to the placement (e.g. running away, substance abuse, suicide attempt). It was noteworthy that behavioral and emotional problems intensified during the placement experience.

In a longitudinal study of children in long-term foster care (N=50), Frank (1980) developed a rating scale to measure emotional impairment and psychosocial problems. All subjects were found to have moderate to severe psychosocial problems upon entry into care. Twelve to sixteen percent received the

worst rating of "psychotic". After five years, there appeared to be significant deterioration in the sample's level of emotional impairment with twice the number found to be psychotic. It was noted that these children were placed in foster care settings for normal children and treatment needs were unidentified and unmet.

The family characteristics of the foster children (N=65) in the Hulsey and White study (1989) were comparable to other samples. They added a matched comparison group of nonfoster children (N=65) from a well-child clinic to control for the effects of family structure and stability on behavior. It was found that foster children had less stable family situations and that this, rather than the experience of foster care, contributed to the higher incidence of behavior problems in this group. While it is important to assess the effects of preplacement variables on behavior, this cross-sectional measurement did not evaluate any positive or negative behavioral change during tenure in foster care. One, therefore, cannot rule out an association between foster care and behavior from this study.

Runyan and Gould (1985a) reported that although foster children (N=114) had more assault charges than their comparative cohort of maltreated children at home (N=106), no significant relationship between placement and delinquent behavior was demonstrated. On the other hand, rehabilitative effects were also unapparent.

Similar methodological issues can be raised about the preceding five studies. The reliability of case record data has previously been questioned in other studies. Due to the retrospective nature of this type of analysis, inaccuracies and misinterpretations of the data are potential risks. Instrument reliability was unreported (e.g. rating scales). Any inferences related to causality are suspect based on internal validity threats (e.g. the possibility of multiple confounding variables such as other historical events and maturation of the subjects over time). It is extremely difficult to separate preexisting problems from those occurring or worsening secondary to the placement experience. Generalizations based on these study findings are tentative based on selection of convenience samples and the lack of control evidenced in several of the studies.

Although the critical review of studies on the impact of foster care on multiple dimensions of functioning has demonstrated inconclusive findings, several important points can be made: Despite the difficulty in separating preplacement problems from those caused or effected by the foster care experience, it is clear that foster children have many dysfunctional characteristics. It was strikingly apparent that these children as a group tend to have severe levels of impairment in all functional areas. Regardless of the onset of these problems, it is also clear that research has failed to identify significant ameliorative effects of foster care. In fact, some of the research was able to show

children's marked deterioration over time in care (Eisenberg, 1962; Byles, 1980; Frank, 1980). Serious questions must be posed regarding the adequacy of foster care in meeting the needs of this population.

Impact on self-esteem. Self-esteem and self-concept were also variables which have been studied in foster care research. From their random sample of children in placement (N=100), Gil and Bogart (1982) found that all subjects scored below normal on a reliable measure of self-esteem. Children in group home settings had the lowest scores. Low self-esteem can be thought of as a characteristic of this sample, but since this was a one-time measurement, it cannot be seen as a valid indicator of a placement effect.

In a pretest/posttest design with placement in a youth home program as the independent variable, Krueger and Hansen (1987) found significant improvement in self-concept scores for their sample (N=46) over a one year period. Male subjects had higher pre- and posttest scores than females. The sample was not compared with standardized norms on the instrument.

An inability to standardize the treatment that the subjects were exposed to represents a threat to statistical conclusion validity. Internal validity was threatened by potential history, maturation, and testing effects. In a pretest/posttest design, extraneous factors can influence outcomes (e.g. normal development, familiarity with the instrument).

Locus of control orientation. Wiehe (1985) examined the impact of foster care on locus of control in foster children (N=56) as compared with a group of nonfoster children (N=56). In a cross-sectional study, both groups completed an Internal-External Locus of Control Scale. It was determined that female foster children differed significantly from male foster children and all nonfoster children with an external locus of control orientation. The researcher interpreted this finding to suggest that foster care and its precipitating factors affected the locus of control orientation in female foster children, leading them to feel little control or responsibility for life events.

It can be argued that results from this study were overinterpreted. With only a cross-sectional measurement of locus of control, an external orientation for female foster children can only be seen as a sample characteristic rather than a placement effect. In order to draw conclusions regarding the causation of sample differences, much more data are necessary. This would most appropriately be achieved using a longitudinal design with better control over confounding variables within the foster care experience.

Impact on health. Another area of inquiry related to placement experience which has been addressed in the research literature is the health status of children in placement. Once again, a preplacement history typically fraught with deprivation most certainly contributes to the health needs and problems of the child in foster care. The current system

of care, however, has been unable to effectively identify and ameliorate the multiple health-related problems of this population (American Academy of Pediatrics, 1987; Schor, 1982).

Five studies examined health status including medical and psychosocial needs (Benedict, White, Stallings, & Cornely, 1989; Frank, 1980; Hochstadt, Jaudes, Zimo, & Schachter, 1987; Klee & Halfon, 1987; Schor, 1982). Many similar findings were manifested across studies. An overriding systematic neglect was apparent including incomplete medical history and records, lack of physical and psychological assessment, and poor case management and health care coordination (Hochstadt et al, 1987; Klee & Halfon, 1987). Even if a child was fortunate to have received an adequate assessment at intake, it was rare to find that an appropriate course of treatment followed.

As a result, it was not surprising to find chronic, pervasive health problems in this group. In their sample of 149 foster children, Hochstadt et al. (1987) found that only 13% had normal physical examinations. Abnormalities in growth and development were prevalent throughout the samples as were vision, hearing, and dental problems. The presence of at least one chronic condition ranged from 40 to 76%. Behavioral and psychological problems were most frequently present and appeared to increase in incidence and frequency with age. Nearly half of the children studied required

mental health consultation and/or referral (Hochstadt et al., 1987; Schor, 1982).

Despite the overwhelming presence of health and mental health deficits, all of the studies demonstrated serious gaps between needs and services. In the Frank (1980) study (N=50), for example, treatment for 85% of the subjects was rated very to most inadequate. In their evaluation of the foster care systems in several California counties, Klee and Halfon (1987) identified many barriers to service delivery. They included a decreasing pool of health care providers willing to take state insured children due to low reimbursement, lack of care coordination, long waiting periods, and limited treatment options (e.g. individual therapy only for mental health problems).

Finally, Benedict et al. (1989) found racial differences in health care utilization among foster children. Although white and black subjects were similar with respect to health status, socioeconomic level, and access to health care, whites had significantly more health visits per year. This was especially true for acute care, dental, and mental health services. This finding may be indicative of the general differences in utilization by race and ethnicity based on health beliefs, practices, and perceptions and level of satisfaction with the health care system (Harwood, 1981).

The consistency of the findings between these five studies increases validity. Two of the studies were well designed with adequate sampling methods (e.g. strategic or

random) resulting in large, representative samples and attention to interrater reliability (75-90%) (Klee & Halfon, 1987; Schor, 1982). The others were less rigorous with threats to statistical conclusion validity (e.g. convenience sampling, questionable reliability of measures), internal validity (e.g. subject attrition), and construct validity (e.g. inadequate operational definitions, bias secondary to experimenter or rater expectancies) (Benedict et al., 1989; Frank, 1980; Hochstadt et al., 1987).

In sum, this area of research raises the critical issue of quality of care. Frank (1980) eloquently stated:

> If lack of appropriate treatment is impeding the development of this group of children, then we are not adequately discharging the social responsibility of caring for them in a way that would promote their arriving at a higher level of maturity as a result of the protective care. We remove them from their families because their needs cannot be met for a variety of reasons in their own homes. It would logically follow that the substitute care should meet their needs more fully. If this is not happening, then the responsibility is not being discharged and the neglect and inadequate care are being continued. Foster care services may thus be largely geographic, that is, a change in address rather than in quality of care (p. 257).

Placement Instability

Key variables related to the placement experience have begun to surface. From the research previously described, length of time in care and biological parental involvement (e.g. visitation) were consistently mentioned as predictors of a child's level of functioning. Another glaring theme was the preponderance of multiple placements in the foster care population. In several studies, evidence of placement

instability was manifested: 28 to 55% of the subjects had three or more placements; 10 to 44% had four or more (Byles, 1980; Cooper et al., 1987; Eisenberg, 1962; Fanshel & Shinn, 1978; Runyan & Gould, 1985a, 1985b). Taber and Proch (1987) actually found that the mean and median number of placements for their adolescent sample (N=51) was nine, with a range from one to 33.

Researchers have investigated variables related to placement disruption. In a secondary analysis of data on 4288 foster children, Pardeck (1982,1983) reported a strong positive relationship between behavioral and emotional problems and number of placements. Cooper et al. (1987) confirmed this finding (N=172) using similar methodology and found other relevant variables to be removal from home at a younger age (e.g. one to three-years-old) and presence of substance abuse within the family of origin. Runyan and Gould (1985a) also discovered an important relationship between multiple placements and subsequent juvenile delinquency, however, the causal direction was unclear. That is, did a child's behavioral problems lead to placement instability or the reverse?

In separate literature reviews, Barth et al. (1986) and Pardeck (1985) attempted to compile a profile of factors contributing to this multiple placement trajectory. Child characteristics common to both reviews included older age, behavioral and emotional problems, and confused self-identity. Other child-related variables were previous

placement disruption, impaired ability to make attachments (Barth et al., 1986), of white race and increased length of time in care (Pardeck, 1985). Common foster parent variables included lack of training and an inability to meet the child's needs. Pardeck (1985) also found that the biological family had traits including alcoholism, abuse/neglect, and family dissolution. Caseworker contributors were frequent turnover and lack of contact/rapport with the child and foster family.

Despite the presence of aforementioned validity threats (e.g. case record analysis, convenience sampling), findings were corroborated across studies. From the diverse research reviewed, common themes have begun to be validated. With continued replication of these findings, a profile of the child at risk for placement disruption could be empirically supported. The potential for influence on practice and policy decisions is of extreme significance.

Intuitively, we know that placement instability of this magnitude cannot be therapeutic for the developing child. There are, however, two serious gaps in this area of research. First, little has been done to analyze the impact of multiple placements on specific areas of functioning. It has been suggested that behavioral and emotional problems intensify with increased placement transitions, but empirical evidence is lacking. Reliable measures for psychosocial constructs like attachment and severity of emotional impairment need to be developed and utilized in longitudinal

research to assess changes over the placement trajectory. Secondly, systematic problems related to instability must be addressed. To what extent are placement transitions a function of flaws within the service delivery system? Examples of this include children placed in settings unsuitable for their needs and placement changes made based on bed availability versus appropriate treatment planning.

Taber and Proch (1987) developed a program which attempted to remedy what they identified as system-related factors leading to placement disruption. With a strong focus on adequate assessment, appropriate placement planning, and consistent case management, they were able to demonstrate a significant reduction of placement transitions. With a median of one year in the program for this "difficult to place" adolescent sample (N=51), mean number of moves decreased from 4.8 to 1.8.

The limitations of this study include a non-random sample and a large range of time for outcome measurement: three to 21 months post-program involvement. It, however, substantiated the need to identify and control system variables. Despite the weak ability to generalize from these outcomes, it was demonstrated that this sample of foster youth experienced improved stability in their placements in response to program interventions.

Child Perceptions of Experience

Very few studies interviewed children currently in foster care to determine their thoughts and feelings

regarding their status as foster children or placement experiences. While several attempts have been made to examine its impact on functioning, perceptions of the actual clients using this service have seldom been elicited.

As a tangential piece of their research, Fanshel and Shinn (1978) gathered some qualitative data related to perceptions from a subgroup of their sample (N=205). Children were queried about the event of separation, reasons for placement, and what it was like to be a foster child. Although the frequency of similar subject responses were unreported, patterns in the interviews were evident. In general, the separation experience was viewed as traumatic and emotionally upsetting. The vast majority of children described feelings of anger and sadness in reaction to this event. Most were unprepared for removal from home and this experience was shocking and frightening. On the other hand, a few older children expressed feelings of relief related to escaping the conflict and turmoil of their home situations. Pervasive themes concerning reason for placement included feelings of rejection or abandonment, child's perceived responsibility (e.g. bad behavior), neglect, family conflict, and parental illness or death. Many children felt responsible for being in foster care, yet currently experienced a loss of control and feelings of helplessness over what would become of them. The stigma of being a foster child was apparent and many wished to return to live with biological parents.

Interview responses were primarily used for illustrative purposes, that is, to highlight results from the quantitative portion of the study. The researchers missed the opportunity to more rigorously analyze these data using qualitative methodology or content analysis. Findings from this large subsample of foster children could thus be more effectively triangulated with other aspects of the study. The potential for contributing to knowledge regarding the impact of foster care on children, especially from their perspective, was very great.

Gil and Bogart (1982) gathered children's impressions of foster care (N=100). They designed a questionnaire which included perception items related to the best place they had ever lived, their understanding of the reason for placement, and quality of the foster care experience. When separated into foster home and group home subsamples, 81% of the foster home children reported liking their current placements as opposed to only 47% of children living in group home settings. Many identified home with their family of origin as the best place to live. Another poignant theme was the utter lack of understanding or confusion regarding the reason for placement and/or plans for their future. Self-blame for rejection by the family was a frequent response. Finally, subjects were able to articulate several recommendations to improve the quality of their care. Common themes included the desire for love and nurturance from caregivers and the need for control over aspects of their lives.

The strengths of this study included interviewing children currently in foster care versus retrospectively and sample representativeness based on random selection. These factors allowed the researchers to generalize their findings to a target population of foster children with similar characteristics. In critique, the reliability of self-report data can be questioned based on issues of social desirability and emotionally-laden topical areas. In addition, the questionnaire was quite simplistic and with minimal extension, could have generated even more rich information from these children (e.g. child perceptions of the impact of foster care on various areas of their lives, such as family or peer relationships).

Bush and Goldman (1982) described the placement permanency status of 370 foster children. They used a set of criteria derived from case record analysis to place each child on a continuum which included unable to return home, adoption, and able to return home. A subset of this sample (N=136) was interviewed to determine their views on their placement status. Eighty-two percent were judged to be unable to return home. For those in this group who wished to be adopted (N=52), the desire for placement stability and the feelings of security and belonging to a family that this would provide were frequently indicated. In contrast, those not interested in adoption (N=59) wanted stability on their own terms which included maintaining ties with biological

families and feeling free to leave their current foster home if they chose to do so.

The strategy that researchers used to assign placement status was somewhat arbitrary, threatening statistical conclusion validity with its potential for unreliable measurement. It was clear, however, that most of their sample had few prospects for family reunification. In view of the current social policy which emphasizes permanency, this study addressed the critical need to consider the child's conception of permanency. This often includes a continued connection with the biological family, even when reunification is contraindicated.

In a British study designed to describe the characteristics and circumstances of children in long-term foster care, Rowe, Cain, Hundleby, and Keane (1984) interviewed 100 children who had been in the same foster home for more than three years (range: 4-18 years). Although this sample seemed to have experienced more stability than those in U.S. studies, prevalent themes were quite similar. A high level of insecurity regarding the stability of the current placement was reported by most of the children. This was despite the majority of the sample being rated as fully or well-integrated into the foster family (a subjective rating by the researchers). Most felt positive toward their foster families yet had ambivalent feelings which expressed a conflict of loyalty between foster and biological families. Finally, the stigma related to being a foster child was a

prominent theme. Foster children were subjected to teasing and intrusive questions which affected their ability to make friends. This group felt different and embarrassed regarding their status and this was often reinforced by foster parents differentiating between their foster and biological children.

Methodological weaknesses of this study centered on the design of the interview guide. The interview was structured with precoded responses. The possibility of inadequate or inaccurate operational definitions of constructs posed a threat to construct validity. Likewise, four versions of the instrument were used for specific ages which could introduce divergence in measurement. Yet even with the questionable ability to generalize between populations of foster children living in different countries with varied social circumstances, the similar nature of their perceptions warrants further attention.

Despite the limitations of the studies outlined above, they set the course for further research in the area of child perceptions of foster care. These preliminary data at the very least describe important perceptions which demand more serious investigation. In past studies, children and adolescents were found to be very responsive to research participation and made contributions of high quality.

Placement Outcomes

The final element of the placement process as conceptualized is system exit. Little research has been undertaken to study actual placement outcomes following

discharge from foster care. A few studies have focused on dispositional or adaptational outcomes.

Disposition

Seven studies examined dispositional outcomes for their samples including the types and stability of the permanent placements (Berry & Barth, 1990; Block, 1981; Fanshel & Shinn, 1978; Fein & Maluccio, 1984; Gurak, Smith, & Goldson, 1982; Lawder, Poulin, & Andrews, 1986; Wulczyn, 1991). In periods ranging from several months to five years, investigators monitored the disposition of their samples. Although a percentage of the children remained in long-term foster care (18-40%), many were discharged to permanent placements. Examples included return to biological parents (53-62%) or relatives (8%), adoption (16-24%), and permanent foster homes (7%) (Fein & Maluccio, 1984; Lawder et al., 1986).

Variables related to an increased likelihood for discharge from foster care included race-white, ongoing kin visitation, and foster care placement secondary to family crisis (Gurak et al., 1982; Lawder et al., 1986). Those children more likely to remain in foster care had multiple behavioral problems and/or a parent who was a teenager, mentally ill, or neglectful (Lawder et al., 1986).

Gurak et al. (1982) proposed a perspective on outcome disposition based on ethnicity. Their large urban sample (N=1235) included a disproportionate number of black children who spent a longer time in care and made slower progress

toward permanency (e.g. home or adoption). Only 20% of the black children exited foster care as compared with 30.2% of the white children. This difference was noted for Hispanic children as well with a 23.5% exit rate.

These ethnic differentials in outcomes could not be explained by group differences in entry level characteristics such as reason for placement or family status. The researchers attributed these findings to systematic racial bias. It was found that minority children in this sample tended to be screened at intake and placed in less effective agencies with poor records for achieving permanent placements.

For the children in the studies who were discharged to a permanent placement, most maintained stable outcomes for the duration of the study periods. Factors related to improved stability in the permanent placement included race-black, placed with siblings or other foster children, foster parents decision to adopt, higher income, and previous placement with a relative (Berry & Barth, 1990; Fein & Maluccio, 1984).

Recidivism rates for the samples ranged from 10 to 28%. Variables associated with return to foster care from the permanent placement were child behavioral problems, adolescent age group (double to triple the rate of younger children), first placement lasting less than 90 days, a history of multiple placements, and parental neglect (Berry & Barth, 1990; Block, 1981; Fanshel & Shinn, 1978; Fein & Maluccio, 1984, Wulczyn, 1991). Wulczyn (1991) underscored

the heightened vulnerability of the child first entering foster care during pre- or early adolescence. One third of this large group (N=2200) became recidivists (N=740) regardless of ethnicity. Divergence in the findings occurred regarding discharge to single versus two parent families. Block (1981) found a positive relationship between recidivism and the two parent family (thought to be due to marital discord). In contrast, Fein and Maluccio (1984) reported increased stability with this family structure.

Once again, case record and data base analyses were primary methods of data collection in the studies. Only one study addressed the reliability of the instrument developed to review records (Lawder et al., 1986). Interrater reliability was moderate (76.3%) and a wide range of variability existed. Another measurement issue was the overemphasis on child-centered problems associated with stability or recidivism. Child behavioral problems were artificially separated from their interrelationship with family dynamics for the purpose of coding. Other major threats to validity included: internal validity- Wulczyn (1991) was the only study to consider system influences on recidivism (e.g. presence/absence of aftercare services); construct validity- recidivism as a construct was operationalized and measured in an inconsistent manner across studies; and external validity- generalizability is restricted in most of the studies secondary to convenience sampling procedures (with the exceptions of Gurak et al.

(1982) who used random sampling and Wulczyn (1991) who studied the complete population available in the data base).

Adaptational Outcomes

Long-term adaptational outcomes have been particularly overlooked as an area of research. Fanshel, Finch, and Grundy (1989b, 1990) conducted a detailed analysis of the case records of 585 discharged foster children from a private program which served "difficult to place" youth. They determined through reviewer ratings that those who had emancipated from care were better adjusted at the time of discharge than those who experienced placement failure (e.g. returned to court or placing agency, runaways). In addition, they did follow-up interviews on a subsample of adults (N=106) with a mean of seven years post-discharge (range one to fifteen years). They found that only 25% were "fairly well-adjusted" and 33% reported low ratings of well-being including experiences of stress, loneliness, and dissatisfaction with life.

The continuity of behavior over the life course in this adult sample was remarkable. The strongest pattern was the positive relationship between childhood juvenile delinquency and adult criminal behavior. Other strong associations included the history of physical abuse and later adult antisocial behavior, especially for males. Finally, abuse, either physical or sexual, which reportedly occurred in foster care resulted in negative adult outcomes in areas such as employment and well-being. This study supported the

commonly held view that earlier traumatic events have a lasting impact into adulthood.

Two additional small scale studies interviewed adults who had been in extended foster care as children to determine how they were functioning and their perceptions regarding their experience (Meier, 1966; Rest & Watson, 1984). Both samples were judged to be functioning adequately in areas of work, educational achievement, family, and social relationships. It was noted, however, that both groups had more problems in areas reflecting one's sense of well-being. Related themes included ambivalence regarding intimate relationships, feelings of inadequacy and insecurity, and the identification of the stigma of being a foster child. One group reported their unresolved issues to be the loss of their biological family (which they idealized), and the self-image of being a "rejected child" (Rest & Watson, 1984). These adult perceptions were also articulated by subjects in the Fanshel et al. (1990) interviews.

These results, though poignant, are tentative at best. Sample representativeness was the key validity threat in all of the studies. Sample sizes were small in two studies (Meier (1966): N=66 and Rest & Watson (1984): N=13) and subjects were difficult to locate in all three studies. For those actually found, only 59 to 67% response rates were achieved in these studies. Selection bias could be argued as study volunteers may have been qualitatively different from

non-participants (e.g. those in prison or psychiatric institutions were not included).

Although it may be difficult to follow-up on those who have had experience within the foster care system, it is important to consider its long-term impact on functioning. Critical research questions can be posited, such as: What are the long-term effects of separation and loss on children and adults who have experienced extended foster care? What are the differences between high and low functioning former foster children? What is the impact of foster care on the development of the self or identity? What are the perceptions of stigma related to being a foster child in the past and how do they effect later functioning? Longitudinal studies must evaluate impact over time, from the immediate period after discharge to later in life. This would enhance the ability to determine periods of potential difficulty and increased vulnerability along with specific needs across the life span.

Summary

Based on the preceding critical review, children in foster care can be acknowledged as a problem area of major complexity and magnitude. An attempt has been made to pull together fragments of information into a meaningful organizational framework derived from the conceptualization of placement as a process. This framework, however, contains many significant gaps. To review, researchers have begun to outline variables which relate to the decision to place a

child in foster care. Unfortunately, the divergent findings have done little to explain an apparent systematic bias (e.g. overrepresentation of ethnic minority foster children). More research is needed to isolate variables which predict placement, thus placing children at risk. With this knowledge, placement prevention efforts could be directed more effectively.

Secondly, the foster care experience itself must be further studied. Although there is sufficient empirical evidence supporting the severe functional impairment suffered by foster children as a group (e.g. poor academic achievement, behavioral and emotional problems), the confounding nature of preplacement contributions has not been well-addressed. Likewise, clear evidence for the ameliorative effects of foster care is lacking. The descriptive base related to the placement experience adequately highlights deficits in the areas of placement stability, quality of care, and health care needs. A greater understanding of the factors or processes which influence this picture is necessary.

Finally, the short- and long-term consequences related to the foster care experience must be delineated. Objective and subjective measures are needed to determine the impact of foster care on overall functioning, development, and well-being. An outstanding gap in knowledge concerns the perceptions of the individuals who actually live or have lived within the context of foster care.

The aim of this study was to address both the foster care experience and its consequences from a subjective vantage point. An interest in the perceived impact of the foster care experience and the status of being a foster child along with factors which influence outcome evolved from the identification of areas which are poorly addressed in the current body of research literature. In order to extend our knowledge of the influence of foster care on key developmental outcomes like identity development, satisfactory relationships, and independence, these shortcomings need to be addressed both descriptively and theoretically.

It is a reality that many children are being reared in foster care today. For a variety of reasons, placement continues to take precedence over prevention or reunification options. Clearly, empirical evidence for both the short- and long-term outcomes is needed to either justify or modify this practice.

CHAPTER 3

METHODOLOGY

From the preceding literature review, a major gap in the knowledge base on foster care has been identified. The need to develop a greater understanding of the subjective experience of foster care and its impact as perceived by foster children and youth is clear. This chapter will outline the research methodology employed in this study to address this gap. It is made up of two major subdivisions. The first supports the selection of a qualitative methodology for this study. This includes a general discussion of the qualitative paradigm, the grounded theory approach, and the analytic framework of dimensional analysis. The second subdivision specifically describes the research design employed in this study. Design features including sampling, data collection and analytical procedures are outlined.

The Qualitative Paradigm

In consideration of the limited extant theory related to the impact of foster care, it was imperative to select an approach for research that was congruent with this existing level of theory development and the corresponding research question posed. In order to assure a paradigmatic fit between research question and methodology, an approach from the qualitative paradigm was selected.

Traditionally, there have been two major paradigms for the development of scientific knowledge. Duffy (1985) outlined the epistemological differences between the

theoretical perspectives and their corresponding research methodologies:

> Positivism, a deductive process of knowledge attainment, seeks to verify facts and causal relationships stated in existing theories. The true experiment is the classical example of positivism. Phenomenology, and inductive processes, generate theory from facts obtained within the natural setting of the phenomenon. The distinct contrast in the philosophy of this methodology from positivism is evident in grounded theory (p. 226).

Although Duffy argued for the priority utilization of qualitative designs at this early stage of nursing science development, others have strongly supported the need for both paradigms (Benoliel, 1984; Haase & Myers, 1988; Leininger, 1986).

Quantitative and qualitative approaches can be viewed as complementary versus competing in the pursuit of knowledge development (Haase & Myers, 1988; Swanson & Chenitz, 1982). The selection of the specific mode for inquiry is dependent upon the study purpose and the extant knowledge base in the area of interest (Artinian, 1988; Murdaugh, 1986). With the insufficient understanding of the perceived experience of foster care, an exploratory study derived from the qualitative paradigm is logically consistent with the purpose of this area for research (e.g. discovery and theory development) and its underlying theoretical structure (e.g. existence of limited substantive theory).

Purpose and Assumptions

The qualitative paradigm is beginning to receive recognition and acceptance as a framework for inquiry regarding complex social phenomena. Its purpose is to gain an understanding of human experience from the point of view of those studied (Benoliel, 1984; Leininger, 1986; Lincoln & Guba, 1985). With the discovery of subjective meaning, theory is generated (Haase & Myers, 1988).

Accordingly, there are major assumptions specific to the qualitative paradigm. First, it is believed that humans create their social worlds. They are active participants in the construction of reality. Reality is both individual and context-dependent. Thus, multiple realities exist and are individually determined though within a social context. Social context and interaction give meaning or substance to one's behavior or experience (Benoliel, 1984; Lincoln & Guba, 1985). Quantitative research has been criticized for "context-stripping" (Duffy, 1985). Because the environment is a crucial component and cannot be separated to understand the meaning of an experience, the qualitative paradigm favors the undertaking of human research in naturalistic settings. Likewise, in order to manage the multiple realities of research participants, the researcher herself must be the primary instrument for data collection. It is improbable that a nonhuman instrument could be designed to account for and adapt to this extensive level of variation (Lincoln & Guba, 1985).

Second, the social world is viewed as dynamic and therefore, unpredictable. Truth is unique to the individual versus universal. It changes with the fluctuation of experiences (Haase & Myers, 1988). The central task of qualitative inquiry, therefore, is to discover "what constitutes reality of the participants in a given situation, to explain how those participants came to view reality in this way" (Lincoln & Guba, 1985, p. 78)

Finally, the roles of the researcher and research participant are seen as interrelated. Their interaction influences the research process and research is considered to be a social act (Benoliel, 1984; Haase & Myers, 1988). The researcher is not seen as neutral, but rather, a participant attempting to discover the subject's view of the study phenomenon (Duffy, 1985). In this process, the researcher and research participant are mutually influential and together shape the data of the investigation (Lincoln & Guba, 1985).

A qualitative approach that is specifically designed to build and validate theory related to complex social phenomena is grounded theory (Strauss, 1987). The grounded theory approach is consistent with the purpose and assumptions inherent in the qualitative paradigm. Additionally, it seeks not only to describe the features of a particular social context (as with some qualitative approaches), but attempts to link them together into patterns and relationships for the purpose of explanation of the social processes involved (Glaser & Strauss, 1965; Stern, 1980). Research which

examines adolescent perceptions of the experience of long-term foster care lends itself to the grounded theory approach and its related methodology.

The Grounded Theory Approach

Theoretical Underpinnings

The grounded theory approach has its theoretical and philosophical roots in symbolic interactionism as inspired by George Herbert Mead, John Dewey, Herbert Blumer, and others. The theory of symbolic interaction explores the meaning of events as perceived by those who experience them as well as the subsequent actions they take related to these perceptions (Manis & Melzer, 1972). Important tenets from this perspective have contributed to grounded theory as conceived by Glaser and Strauss (1965). Society is conceptualized as the symbolic universe which is made up of representations as shared symbols. It is both the medium (e.g. language and symbols) and context (e.g. symbolic universe) for social interaction involving mutual exchange between people. Social interaction provides the individual with the opportunity to engage in self-reflection and evaluation and to view the self as seen by others. Mead described the latter activity as taking the role of the other. The abilities to assume the point of view of others and to anticipate their responses are key components of human interaction (Manis & Melzer, 1972; Perdue, 1986).

According to symbolic interactionism, behavior shapes and is shaped by others in social interactions. Shared

meaning is a key principle involved in social processes and language is the main vehicle for conveying subjective meaning with the expression of concrete and abstract phenomena (Perdue, 1986). Utilizing verbal and nonverbal cues, taking into account prior experiences, humans define and interpret social situations to derive meaning. Once this occurs, alternative actions or responses can be considered. Thus, behavior is seen as determined by the definition of meaning via social interaction (Manis & Melzer, 1972; Perdue, 1986).

Social reality is viewed as being constructed through the use of symbols. The grounded theory approach seeks to develop a theoretical interpretation of this reality from its research findings. A grounded theory has been defined as "... one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon" (Strauss & Corbin, 1990, p. 23).

Major Features of the Research Process

With its dual aims of discovery and theory generation, the grounded theory approach integrates several design features. First, a flexible research design that evolves during the study is employed. Since little is known about the phenomenon before the study is undertaken, a tentative plan for sampling and data collection/analysis is proposed with the understanding that modifications will be made as conceptualizations emerge (Sandelowski, Davis, & Harris,

1989). Strauss (1987) referred to this as "theory-guided data collection" (p. 27).

Second, data collection and analysis are considered to be simultaneous rather than sequential events. The subsequent description of the two activities is artificially separated for the sake of definition but their interrelationship must be underscored. Analysis is conducted during the process of data collection and preliminary findings are used to direct and refine future sampling, observances, and interview themes.

Closely related to the methodological characteristics of emergent design and the inseparable nature of data collection and analysis, theoretical sampling is a third important feature of the grounded theory approach. Theoretical sampling originates from the conception and strategy that sampling needs are best dictated by the evolving theory (Duffy, 1985; Sandelowski et al., 1989; Strauss, 1987). Sampling is directed to find variation and range within subjects or categories. Variations are pursued as they serve to increase the complexity of the developing theory. Every subject will potentially lead the researcher to others for variation and/or validation of conceptualized categories and their components. One must sample in the direction of the greatest theoretical opportunity-- that is, those events or persons whose characteristics are believed to enhance or significantly challenge the emerging theory (Schatzman, 1987). Finally, data collection ceases once "theoretical

saturation" is achieved. Theoretical saturation occurs with the dense description and validation of relevant categories and their relationships. At this point, additional data are most probably redundant and unproductive with no new information or conceptualizations surfacing (Sandelowski et al., 1989; Schatzman, 1987; Stern, 1980).

Data Collection and Management

Sources for empirical data in grounded theory research are multiple and varied, including interviews, field observations, and document review. Most typically, the researcher enters the field or naturalistic setting of the phenomenon to observe and interview. Extensive field notes are recorded on observations, discussions with respondents and others, and document analysis. The purpose of field notes is to keep track of the data, provisional conceptualizations and hypotheses, and future directions for questions and sampling (Strauss, 1987).

Field notes are packaged in preparation for analysis according to the model proposed by Schatzman and Strauss (1973). This model provides a system for recording data made up of observational notes (ON), theoretical notes (TN), and methodological notes (MN). ONs are comprised of objective data received through observing and listening. They are recorded as unit events with little interpretation. TNs provide a place to record preliminary conceptual development, including interpretations, hypotheses, and inferences. Schatzman and Strauss (1973) stated that "TNs represent self-

conscious, controlled attempts to derive meaning from any one or several ONs" (p. 101). Finally, MNs are notations which outline both reflection upon and planned operations for the research process. MNs include critique of the self as researcher, methodological issues that arise, and pertinent instructions and reminders.

As field notes accumulate, a strategy is employed to increase the integration and refinement of previous theoretical thinking. Analytical or theoretical memos are written throughout the research process to monitor researcher hunches, insights, and conceptualizations that are grounded in the data. A memo entails the further development of TNs. In a memo, relationships or comparisons between concepts are made. Complex linkages and patterns are delineated and move the tentative theoretical ideas found in TNs to the more elaborate conceptualizations of the evolving theory. Later, memos can be sorted, refined, and integrated into the theory (Schatzman & Strauss, 1973; Strauss, 1987).

In conjunction with field notes, interview data are also collected in a systematic manner. With permission from respondents, interviews are audiotaped when feasible and transcribed verbatim. Utilizing both the tape and the transcript of the interview, procedures for data analysis can be undertaken. Interview data are coded and analyzed according to a specific framework (described below). As with field notes on observations, theoretical memos are written to

systematically record and develop theoretical conceptualizations.

The Framework for Data Analysis: Dimensional Analysis

The analytical approach selected for this study was dimensional analysis. Dimensional analysis is a variant of grounded theory method conceived by Leonard Schatzman (1990) to improve the articulation and communication of the discovery process in qualitative research. Although dimensional analysis is closely related to the analytic procedures of grounded theory, it has its own epistemology and operations. It is based on the theory of "natural analysis" which Schatzman conceptualized as a normative cognitive process that is used to interpret and understand a problematic experience or phenomenon. This process is learned through early socialization and provides one with a schema to structure and analyze the complexity of a phenomenon.

Through the learning of language and the ability to engage in social interaction, especially communication, human beings develop the attribute of dimensionality. Dimensionality is a theoretical construct which refers to the ability to address the complexity of a phenomenon by noting its attributes, context, processes, and other aspects of importance including its meaning (Schatzman, 1991).

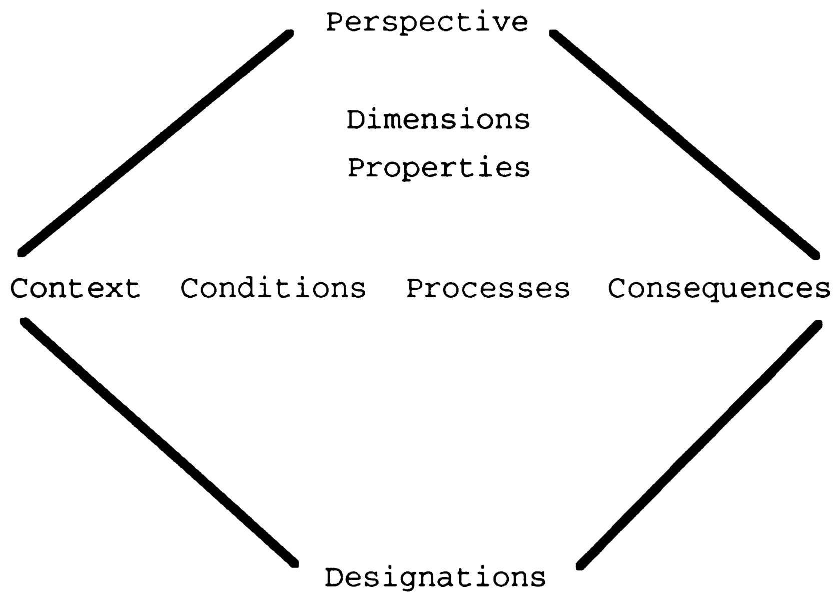
The process of dimensionalizing entails the construction of the multiple components of a phenomenon. In this process, data are dimensionalized into their various attributes

including dimensions and their properties. A dimension is an abstract concept and its properties provide it with quantitative or qualitative parameters for description. When dimensionalizing a given phenomenon, one attempts to address the question of "What all is involved here?" (Schatzman, 1980, 1986, 1991).

As the raw data from an investigation are dimensionalized into their dimensions and properties, the operation of designation simultaneously occurs. Designation is simply the naming or labeling of a concept. This initial substantive coding serves to identify and name the multiple dimensions involved without consideration of their relative importance, relationships, or meaning. In this manner, data are reduced into their component parts for later analysis. The designation of dimensions allows for both specificity and comparisons within the data (Schatzman, 1986). For example, impact of foster care on the self may have the dimensions of self-identity and self-esteem.

Upon deriving a critical mass of dimensions and properties, the explanatory matrix (see Figure 2) is utilized to further differentiate the characteristics of dimensions into context, conditions, process, or consequences. The context indicates the boundaries for inquiry-- that is, the situation or environment in which dimensions are embedded (e.g. characteristics of the group home). Conditions are dimensions selected as salient which facilitate, block, or shape action or interaction. For instance, the condition of

Figure 2 Explanatory Matrix



multiple placement transitions may foster a self-identity which incorporates the sense of failure. Process includes intended or unintended actions or interactions that are impelled by specified conditions (e.g. the development of a cycle of placement failure) and consequences are the outcomes of these specific actions/interactions (Schatzman, 1986, 1990). Example: A consequence of multiple placement failures may be the inability to form and/or sustain close interpersonal relationships.

In using the explanatory matrix, the researcher gives each dimension an equal theoretical opportunity to be elevated to the status of perspective. During the process of data analysis, the researcher must identify the dimension that is most central to the developing theory. This central dimension is referred to as the perspective which then integrates all other salient dimensions. This overarching perspective directs the line of inquiry and logic in the process of theory development. The perspective influences the placement of the other dimensions along the explanatory matrix. The perspective which provides the greatest explanation for the relationship between dimensions is ultimately selected to organize or "choreograph" the data (Schatzman, 1991). It determines whether specific dimensions are salient, relevant, marginal, or irrelevant, thus, shaping the theory (Schatzman, 1986).

Integration or novel reintegration is the final phase of dimensional analysis. The researcher integrates dimensions

and their components according to the central, organizing perspective. In this configuration, relationships between the dimensions are described and explained (Schatzman, 1986). The final product of this phase is a grounded theory "which gives theoretical and explanatory form to a story that would otherwise be regarded, at best, as fine description" (Schatzman, 1991, p. 313).

To summarize, the grounded theory approach stems from the qualitative paradigm which stresses the understanding of a phenomenon both within its social context and from the perspective of those who experience it. Considering the limited substantive knowledge available, the purpose of this approach (e.g. discovery and theory generation) was congruent with the study of adolescent perceptions of foster care. Grounded theory methodology, which emphasizes design flexibility and modification with theory evolution was viewed as especially appropriate for use in this area. Dimensional analysis was selected as an analytical approach to interpret and understand the complex social phenomenon of foster care from the adolescent's perspective.

Research Design

In order to best discover the impact of foster care as perceived by foster children themselves, a research strategy which combined intensive interviews with adolescents in foster care, naturalistic observations in foster care settings, and document analysis of individual case records was undertaken.

Sample

A purposive sample of 17 adolescent foster children was selected. This age group was chosen as most adolescents are at the cognitive level which would enable them to reflect upon and articulate their experiences.

Selection Criteria

Adolescents, ages 12 to 19 with at least two years of experience in foster care were eligible to participate in the study. The federal government's definition of long-term foster care is two years or more. Respondents were chosen in an attempt to reflect a representative group of this population in the San Francisco Bay Area based on length of time in placement and the number and types of foster care settings experienced. Representativeness was determined by examining statistical information on San Francisco County's adolescent foster children supplied by the State of California Department of Social Services Statistical Services Bureau (see Evaluative Criteria, Chapter 6).

It was planned that adolescents would be excluded from the study if their level of emotional disturbance impaired their ability to respond appropriately to interview questions (e.g. psychotic). This, however, did not occur in the selection of this sample with all participants appearing to be well-oriented to reality. One adolescent was excluded from the study with the denial of access to him by the group home supervisor.

Participant Access and Recruitment

Due to the vulnerable nature of this population, access to subjects for this research entailed a lengthy and complex process. In order to identify a pool from which to draw potential participants, the cooperation of the San Francisco Department of Social Services (DSS) was necessary. With permission from the Director of Family and Child Services, whose department oversees service delivery to all foster children, DSS became the "site" for data collection.

Next, permission to conduct this investigation was granted by the Committee on Human Research at the University of California, San Francisco (CHR). The approval number for this study was H1274-07566-01.

With formal approval from DSS and CHR, the investigator was introduced to a DSS social worker who had agreed to assist with the identification of potential subjects. She worked in the department's Independent Living Skills Program which was offered as an option to all adolescent foster children to assist them in preparing to leave care at age 18. In addition, she facilitated a subgroup of these youth who met regularly to discuss issues related to foster care. She approached this group to initially determine their interest in participating in this study.

The social worker generated a list of adolescents who had indicated that they would be interested in the study. Before approaching the adolescents, the next step in this process was to obtain informed consent from their legal

representative, the Presiding Juvenile Justice of San Francisco County. A cover letter describing the study along with a copy of the research proposal, the interview guide, and consent forms for each of the interested adolescents was forwarded to the judge (see Appendix A for consent form). A memo from DSS was also enclosed to indicate their approval of the study.

Once the consent forms were completed and returned by the Presiding Juvenile Justice, the researcher met with the group of adolescents to give a detailed account of the research project and what their participation would entail. Each of the 12 attending members of the group expressed an interest in being interviewed. They were informed that those interested would be contacted by telephone to make arrangements for the time and setting for the interview.

The final and, at times, most difficult point in the process of gaining access to these adolescents was negotiating entree with their specific caregivers. In most cases, this was the supervisor of the group home in which the individual adolescent lived. In a few instances, once the nature of the study was explained, the caregiver welcomed the researcher's contact with the adolescent and expressed an interest in the study. More often then not, however, there was a pervasive concern on the part of caregivers that this research might portray them and their homes/programs in a negative light and, thus, be somehow damaging.

After this initial group of 12 adolescents was interviewed, theoretical sampling was necessary to fully promote the maximum range and variation of relevant concepts and their relationships. This dictated the recruitment of subjects from sources outside of the group. (Rationale for specific sampling decisions shall be discussed in the section on Data Analysis Procedures.) Five additional adolescents were recruited through mental health clinicians in private practice. Since this group was comprised of adolescents who were 18-years-old or older, access was less difficult as they could consent to participate in the study for themselves.

Data Collection Procedures

The adolescent respondents were the primary sources for data collection. In-depth interviews were the main method of gathering data from participants. Data from naturalistic observations and document analysis (e.g. review of individual case records) were utilized as necessary to validate data by permitting corroboration or contradiction of information given by the adolescents. In this manner, triangulation of data sources was thought to enhance the rigor of this qualitative study (Sandelowski, et al., 1989). In addition, multiple sources for data maximized the researcher's ability to achieve the specific aims identified for the study. Each of these data sources shall be described in further detail.

Semi-Structured Interview

Upon receiving consent from the legal representative, a semi-structured interview was scheduled with each adolescent.

Prior to proceeding with the interview, the researcher reviewed the study protocol with the adolescent. The adolescent was told that the purpose of the study was to learn more about foster care from his or her perspective. The interview would focus on the adolescent's history of foster care placements and what it was like to be a foster child. The potential risks were explained including becoming uncomfortable or upset about some of the questions or getting tired. The adolescent was assured that he or she could refuse to answer any of the questions, stop the interview, or withdraw from the study at any time. To maximize confidentiality, study records would be kept as private as possible and no information would be shared with anyone else including family members and caregivers. It was stated that the adolescent would receive no direct benefit from study participation. Written assent was obtained from each of the participants (see Appendix B).

Interviews were conducted in a private, comfortable location. Locations included a quiet area within the individual's group home, a staff office, and a conference room at the University of California, San Francisco. An attempt was always made to meet with the adolescent within the foster care setting, however, this was not always allowed by the group home supervisor. Adolescents were interviewed for approximately one and one-half to two hours. Interviews were recorded via audiotape and tapes were transcribed

verbatim for later data analysis. Tapes and transcriptions bore no identification of the specific respondents.

Based on the previous critique of the research literature (see Chapter 2), the interview guide (see Appendix C) was designed to address a significant gap in knowledge related to the impact of foster care. Selected areas of impact which focused on the self, significant relationships, and living skills were determined to be essential to assess in this adolescent population. Likewise, attention was given to factors within the placement history which may have potentially influenced the nature of the impact of foster care (e.g. type and nature of specific placements). In order to ascertain perceptions about these areas, questions were designed according to three major themes: out-of-home placement history, family of origin information, and perceptions related to being a foster child. Aside from specific demographic information, most questions were open-ended followed by probes to promote explanation and clarification of a subject's responses (Sandelowski, et al., 1989).

During the interview process, it was important to be aware of the unique characteristics of the sample that could potentially influence data collection. Developmental stage was a crucial factor to evaluate when conducting the interview. Flexibility was exercised to account for respondent variation in cognitive development. Questions

were framed to be appropriate to the cognitive level of the individual.

Mental health considerations regarding the population of adolescents in foster care also represented a significant methodological issue for this research. Many of the foster youth in this sample experienced emotional disturbance secondary to earlier experiences, including abuse and/or neglect. This factor along with the inconsistent, unstable patterns of caregiving often received while in foster care contribute to a reluctance to trust adults that is characteristic of this population (Fine, 1985; Pardeck, 1985). In this research, this may have effected the level of self-disclosure demonstrated by these adolescents. In addition, the research experience may, in itself, have been viewed as an additional stressor. It was necessary to spend ample time developing trust and rapport with each respondent and to allow the adolescent to maintain a sense of control over the research process. The interview was designed to flow from nonthreatening to more threatening material over time. The researcher tried to be sensitive to emotionally upsetting issues and to respond with respect and empathy for the adolescent's feelings.

Despite the variability in development and mental health functioning, the sample as a whole demonstrated an enthusiasm regarding the interview along with a capacity for reflection upon and critical analysis of experiences in foster care.

The high level of self-disclosure with regard to, at times, extremely sensitive issues was remarkable.

Naturalistic Observations

Whenever possible, naturalistic observations were undertaken in the group homes where several adolescents were interviewed. The purpose of this strategy was to promote a firsthand understanding of the contexts in which these adolescents were living. In this manner, insight could be gained regarding particular contextual features which were perceived by the respondents as having or contributing to impact. Observations were focused on the physical features of the home, interactions between those within the setting, and informal conversations with the participating adolescent residents and group home staff. Since staff members were considered to be secondary data sources, general information about the setting and its occupants was elicited (e.g. details about the group home including its program, what it was like to live there, and typical activities engaged in by the residents). The maintenance of confidentiality of the adolescent participant was the main priority.

Observations were made in a total of four group homes. Multiple visits were made to these group homes when more than one research subject lived in the setting. Extensive field notes were recorded on observations and conversations with respondents and others in their environments. The model described earlier in this chapter was used to organize the field notes for analysis.

Document Analysis

Document analysis was employed to enhance data validity. Available case records were reviewed by the investigator with particular attention to data which elaborated, clarified, supplemented, or contradicted information from interview data. A case record audit sheet was developed to extract information from the record in a systematic way (see Appendix D). Audit items were derived from the study aims to address foster care's impact on the self, interpersonal relationships, and independence. The audit focused on details related to demographics, family, and placement history which paralleled the themes in the interview guide. It was found that the nature of the data found in the case records had limited applicability for determining impact of foster care but were fruitful for the purpose of verifying adolescent reports of events and history.

Data Analysis Procedures

One of the dilemmas in explicating the process of dimensional analysis is the intrinsic difficulty one has in describing the constant, dynamic interaction the researcher has with the data. Analysis does not usually proceed according to a prescribed process with distinctive phases or stages. Activities often occur simultaneously or in a circuitous fashion. Linearity in the analytic process is only created for the sake of illustration. With this in mind, the process of inquiry for this study will be outlined.

The operations associated with dimensional analysis were employed as a simultaneous process with data collection. Once several interviews and field notes on observations had been completed (for seven participants), it became clear that themes in the data were emerging. Examples of early themes present for all of the respondents included a high magnitude of loss, experiences of stigma related to being a foster child, and the lack of future orientation. It was evident based on multiple interview responses across respondents that both a range and variation of experiences were present, for example, numbers and types of loss and responses to the event of loss. At this point, a decision was made to begin the process of dimensional analysis.

The Process of Dimensional Analysis

The investigator began the initial process of analysis by listening to audiotapes of the interviews while reading the verbatim transcriptions. The question "What *all* is involved here?" provided guidance for this preliminary analysis. Dimensions were identified which represented emerging themes and concepts. Designation entailed the initial naming of these dimensions without regard to meaning, relationship, or relative importance.

After two interviews were coded in this manner, a framework of categories was developed to organize the dimensions. The purpose of this framework was to manage the abundance of dimensions reflected in the interview data. There were two major categories in this organizational

framework. The conceptual base for these categories was derived from the original aims for this study. The first category of the framework identified general dimensions related to the impact of foster care. Critical components of the first study aim were subcategories in this section including dimensions related to the impact of foster care on the self, relationships with others, and the development of independence.

The second major category of the organizational framework tracked the dimensions that were designated as factors which could potentially influence the impact of foster care (second study aim). Subcategories of influential variables included the contextual features of the foster care setting and historical dimensions relevant to the foster care experience. Contextual dimensions included the characteristics of the foster care placement environment that the respondents identified as significant. Historical dimensions which characterized the placement experience included preplacement history and dimensions related to events and experiences during tenure in foster care. It was imperative to fully analyze context and history descriptively as it was unknown which contextual or historical dimensions would ultimately be seen as influencing impact.

Subsequent interviews were coded with the resulting dimensions inserted into the categories of this organizational framework. Field notes were also reviewed for additional evidence to support, elaborate, or contradict

these dimensions. The organizational framework contained a critical mass of dimensions with a high level of redundancy in the data. Further differentiation was now needed in order to organize the dimensions into a logical configuration that would provide them with meaning. The explanatory matrix was utilized as a tool to further differentiate dimensions into context, conditions, processes, and consequences. Dimensions related to the impact of foster care were designated as consequences in the explanatory matrix. Dimensions which were thought to influence the impact of foster care were classified as context, conditions, and their resultant processes.

To arrange the dimensions into a meaningful configuration along the explanatory matrix, an organizing perspective was needed to provide direction for the next level of analysis. Following the selection of the organizing perspective based on the process of identity development (see Chapter 5), a decision was made to conduct additional interviews with older adolescents that had either been recently discharged or were facing impending discharge from foster care after high school graduation. Rationale for this theoretical sampling decision was based on the assumption that these older adolescents would be closer to or already experiencing independent living and would have a more developed sense of identity than younger adolescents. These additional interviews allowed the researcher to clarify and test the conceptual linkages of the developing theory.

After all of the interviews and field notes were analyzed using the explanatory matrix organized according to the organizing perspective, categorical saturation was evident. A great deal of repetition regarding themes and concepts was present in the data across respondents and it was assumed that additional data would most probably be redundant and unproductive. In addition, conceptual linkages were tested and solidified. The configuration of dimensions in the explanatory matrix had been finalized. It was now possible to synthesize the components of a theory regarding the impact of foster care: the process of adolescent identity development in the context of foster care.

CHAPTER 4

PRELIMINARY ANALYSES:

THE DESCRIPTIVE BASE FOR A THEORY OF IMPACT

The purpose of this chapter is to present the salient findings from preliminary analyses as a foundation for a grounded theory of the impact of foster care. Components of these preliminary analyses include the characterization of the study sample and the designation and categorization of initial dimensions. Specifically, dimensions related to the impact of foster care and dimensions thought to contribute to this impact will be reviewed.

Sample Characteristics

The participants in the study were 17 adolescent foster youth. Fourteen were currently living in foster care and three had been recently discharged from care (within the last six months). Nine were female and eight were male. They ranged in age from 15- to 19-years-old with a mean age of 17.47. Eleven participants were African American, two were of mixed ethnicity (but identified themselves as African American), two were Hispanic, and two were Asian/Pacific Islanders.

The mean age at first foster care placement was 10.88 years-old with a range of three- to 16-years-old. Six were placed before the age of 12 and 11 were placed during adolescence. The average length of time in foster care was 5.7 years with a range of two to 11 years. The mean number

of placements experienced was 4.1 with a range of two to eight placements.

All of the adolescents currently in foster care resided in group home settings. In the past, nine of the participants had lived in temporary shelter care at least once. Eleven had previously lived with a foster family with a range of one to three past foster family placements. Six had been formally placed by the Department of Social Services with relatives in the past. Four of these experienced two different relative placements. Ten of the adolescents had lived in additional group home settings prior to their current placement with a range of one to four other group home placements.

Participants often reported multiple reasons that contributed to their foster care placements. Thirteen had a parent or parents who was/were abusing drugs and/or alcohol. Twelve had been physically abused. Eleven suffered general neglect. Eight of the adolescents described personal behavioral or emotional problems that contributed to their removal from home including school refusal, fighting, stealing, depression, and suicide attempts. Seven had lost a parent to death or suicide. Six reported being sexually abused by a family member or adult family friend. Six had been abandoned by their parents. Three had a parent or caregiver who had a mental illness.

Description of Salient Dimensions

From the substantive coding of the interview data, multiple salient dimensions were designated and categorized according to the organizing framework presented in Chapter 3. These specific dimensions, subdimensions, and their properties shall be described.

Dimensions Related to the Impact of Foster Care

The Self

What were the adolescents' perceptions of the impact of foster care on their individual development and views of themselves? From interview responses, the dimension of self was subdimensionalized into two key areas: self-identity and self-esteem.

Self-identity. Self-identity represents one's individuality including one's view of personal abilities, accomplishments, and aspirations. Self-identity, as found in the data, manifested four critical properties: self-awareness, competence, perceived stigma, and future roles and aspirations. Individual respondents demonstrated varying degrees of these properties. First, it was perceived that foster care had an impact on level of self-awareness. Examples ranged from a lack of self-awareness to self-knowledge:

> How did foster care effect what I think about myself? Now that's a good question! I think I'm more confused than when I came in here, that's for sure. Someone's always telling you one thing-- then someone's telling you another. It's enough to drive you crazy!

> Group homes are all right but group homes-- you meet so many different people. And your personality changes.

> Everything is so unexplained. Everything gets so confusing. So then that's the way you later on act in life sometimes. You don't know how to tell people about yourself, what kind of person you are.

> I'm opened up now, so I'm not as boring as I used to be. I used to be all clammed up and didn't want to talk to nobody. I didn't get along too well. I'm cool now; I'll talk about what's going on. I think they might have opened me up too much. Now I'll tell them what I think. Other people want to say something but they don't say it. But when I'm with you I'm gonna tell-- good or bad.

> I am my role model. I am my trend-setter; I am everything. I listen to myself only. Sure I listen to everybody. I take a lot of suggestions. It's good to hear somebody speak their opinion. But then I make my decisions.

A second property of self-identity was level of competence felt by the adolescents. Two examples provided the contrast between feelings of incompetence and competence:

> And, when you come here, they'll do as much as they could to keep you safe from your family and they'll be over-protective, and you wouldn't want that. I mean, sometimes, they get over-over-protective, you know. It makes you depend on them for everything and then you won't know how to do it yourself. And, when I came here I just got depressed. It's not a happy place, it's depressing.

> Being in foster care-- it made me cautious of who's behind my back. I learned a lot of street smarts, especially in the shelter. A lot of juvenile hall kids were there because juvenile hall was right next door to us. And there were girls from there, lots of probation kids. Yep-- living in a shelter makes you streetwise. I think I could handle any situation after that.

The degree to which an adolescent incorporated the perceived stigma of being a foster child into the self-identity was a third property. Variation from internalizing to rejecting the negative views of others was present in the interviews:

> I am ashamed to live in a group home and not live with my family. I'm not like everybody else. I kinda feel ashamed telling people about it.

> Just because we're under 18 and happen to live outside the family because something happened, that doesn't mean we're totally juvenile delinquents. We're not bad!

Even those who outwardly rejected the negative views of others contradicted this stance at other points in the interview. The pain and frustration which stemmed from this perceived stigma was evidenced both verbally and affectively by the respondents. After vehemently denying that the negative way she was perceived by staff in her group home bothered her, one girl revealed this later in the interview:

> I am so determined to get the hell out of here. Here, they see me as a depressed, unreasonable girl. Of course I'm depressed. Of course I'm unreasonable. Who wouldn't be depressed the way they treat you-- like a criminal!

The data consistently demonstrated that the stigma of being a foster child had some degree of negative impact on all of the adolescent participants.

Finally, the foster youth's views of future options and roles was an important attribute of self-identity. Many of the adolescents expressed dreams of attending college and/or having a good job or career but few had any idea as to how to realize these aspirations or roles envisioned for themselves. In addition, role options were seen to be limited by many. Examples of this:

> I promised myself whatever I do in life I will be the best there is, no matter what it is. If it's a janitor, a mechanic, if it's a bank robber, I'm going to be the best there is.

> After you get out of foster care, they help you find a home or you can enlist into the service. The best bet is for some people to enlist into the service. By them enlisting into the service, they will get free benefits and everything. I was thinking about going into the service, but decided not to because I'm not ready for it.

Self-esteem. Self-esteem denotes the way one feels about oneself including the levels of self-satisfaction and confidence that one has. Similar to the dimension of self-identity, self-esteem, with its major property being level of self-esteem (e.g. low versus high), reflected both the negative and positive outcomes of foster care that were perceived by the adolescents. Examples of the negative impact of foster care on self-esteem included:

> When I first came, it affected me because I thought, "Now I'm in a group home and on some kind of special care. I'm gonna feel bad for myself." I used to think I was retarded and needed to go somewhere else and get special help. It took me a long time to judge myself without putting myself down. I still slip back into it a lot.

> It's really hard. I mean, I would tell a lot of people not to come into foster care because it's really hard. Once you lose your family, you lose them forever and then, like, it's still hard growing up without a family and keep on moving around and then later you feel depressed and, you know, you will just hate yourself. And you will be, like, "Oh, my God, what a mess." You know.

> (Interviewer- "How has being a foster child affected the way you feel about yourself?") It makes you feel about this big (presses thumb and forefinger tightly together). Everybody is always putting you down cause you're a foster child.

Perceptions of the positive impact of foster care on self-esteem were far less common. An example:

> My feelings about myself have totally gone up. I have respect for myself. I have respect for others. I don't sell myself short except for when I think I don't know

> how to do something. Then I think I'm so dumb. And if I don't know how to do it, I ask somebody to help me, no problem. I have pride in whatever I do.

One adolescent considered herself to be challenged to feel good about herself in spite of the adversity she encountered in foster care:

> The more they put me down, the more I love myself.

Although a variation between respondents was present in these dimensions related to the impact of foster care on the self, expressions of self-identity and self-esteem were predominantly negative. Evidence of this negative impact was overwhelmingly demonstrated in the prevalence of diminished self-esteem, the limited options for the future foreseen, and the marked tendency to incorporate the negative stereotypes of the foster child into one's self-identity.

Interpersonal Relationships

The study participants reported perceptions of the impact of foster care on interpersonal relationships in two major areas: family relationships and peer relationships or friendships.

Family Relationships

Significant dimensions related to the impact of foster care on family relationships were loss and family contact.

Family loss. This sample, as a whole, experienced multiple losses of family relationships both prior to and during foster care placement. The types of losses included death of a parent or other close family member, parental abandonment or unavailability (e.g. secondary to drug

addiction), separation from siblings, loss of family role, and loss of home and personal belongings. The impact of foster care related to loss was experienced in several ways. First, the pressure by foster caregivers to deal with the loss was seen as frustrating or intrusive. An example from a boy whose parents were both drug addicts and were terminally ill with the AIDS virus:

> They're always wanting me to talk about my parents. They haven't been there for me for so long, it's not like they're even a part of my life. Sure, I'm sorry...I don't know. It's frustrating. They think that every foster kid has a psychological problem. Both my parents have AIDS, I guess that must be my psychological problem. They give you these therapy appointments that are mandatory. They think that you need someone to talk to.

Two other adolescents discussed the pressure to verbalize their feelings regarding their parents' deaths:

> And if your mother happens to die at 12, it's not normal but your body can deal with it; your mind can deal with it. Now, I dealt with it. I have nightmares about my mother now during the month of November-- my mom died a week after Thanksgiving. They tried to say that's a problem that needs to be worked out. People's parents die all the time. It doesn't make you special. I do not need to be treated on because my mother died five years ago.

> (In response to his group home supervisor setting up individual therapy to deal with the loss of his father:) I don't go, because I refuse. I don't like dealing with professionals because they try to tell me what I'm thinking. I don't like people telling me what I think, what I want to do, and what kind of person I am. That's what I don't like.

The second kind of impact related to family loss found in the data was the repetition of these losses in foster care secondary to multiple placement transitions and frequent staff turnover. Caregiver changes and subsequent separation

from familiar caregivers led to a diminished desire and ability to continue to make attachments with adults in these roles. Examples:

> My first foster mom, A., was like my real mom. I lived with her for over six years. It was like I was hers. Then, when she couldn't keep me anymore. So I had to leave. I only saw her once more, then, nothing. Since then, I only live in group homes. It's easier-- you don't have to attach to them.

> Actually, there was one counselor that I was close to, but she doesn't work there anymore. Her name was F. When I first came, she was the only person that I really liked a lot. I still consider her as one of <u>my</u> counselors. But no one since then. None. And, I mean, there's been a lot of them through here.

> There's been so many people working here since I came. I don't trust adults that have authority over me anymore. My mom died and screwed my life up and you're not doing it again!

Another negative impact following foster care placement that was frequently discussed was the loss of sibling relationships. Many of the adolescents were separated from their siblings, even when siblings were also in foster care. Examples:

> My little brother is in foster care, too, but he went somewhere else. He lives in a foster home in X (over one hour from where this respondent lives). It was hard to leave my family but I think it was harder on my little brother because he was much younger. I try to be close and keep in touch with him but it's hard. I hardly ever get to see him.

> First, my sister and me, we were together (in the same group home). And then, from there, we just kind of got depressed and we got separated. Because they thought we needed different places, our own attention and happiness. There was one staff and one would give one attention at once, so me and my sister, we used to get jealous if she gives her attention one on one, and I'm left out. And, I'm, like, that's when we start fighting like cats and dogs. So, they thought we needed attention, so they separated us. It was hard. We were,

> like, "Why? Why? Why?" But, we never got it. But now I understand. But, I still don't know, I'm just guessing.

The loss of family relationships due to foster care placement also resulted in the loss of family role for some of the adolescents. Many of the respondents depicted themselves as parentified children. Their family roles often encompassed high levels of responsibility which included the caretaking of parents and siblings as well as looking after themselves. Two youth (a female and a male) provided examples of this:

> Before I came into foster care, at 12-years-old I was paying the bills, I was taking care of an epileptic and alcoholic mother, I was taking care of a three year younger sister, I was grocery shopping. After my mom died they said, "S., you don't have to be the adult anymore; be a kid." I was 12-years-old and I felt about 19. How do you go back to 12? To me it's like I've never been 12 or 13 or 14 or 15 or 16. I don't feel like I'm 17. They say, "We want you to live your life slow." Well, I've already caught up here. It's not like I can backtrack.

> Before my mom left us, we (respondent and two siblings) always had to take care of her anyways. Like bringing her home and cleaning her up sometimes. After she left, we stayed by ourselves in the house for two, no, almost three years. We started saving money. We worked with our cousin, who owns a record company. We would help him out. He would pay us $5 an hour to help him. And then our cousins that lived around then, we'd help them with their yards and stuff. And then we'd go to Safeway and help people with their groceries and stuff like that. Then, when we got put in a foster home, we were so used to being on our own that we weren't used to anybody telling us what to do anymore. They would say, "Do the dishes." We didn't always do everything right on time, but we got to it. And we made sure that before the day ended we got to it. But then we had people telling us what to do and we weren't used to that at all, so we wouldn't do it.

Finally, the loss of family due to foster care placement was associated with the loss of one's home. Some of the

foster youth reported missing things related to the comfort and familiarity of home. For example:

> I miss my home at my grandmother's. I miss my room I shared with my big sister. It was in kind of an attic and had lots of places where we used to stash things. I miss my cat. And, I miss having my own dresser.

Foster care entry often necessitated leaving a familiar neighborhood and community. One adolescent reminisced about his first foster care placement:

> My social worker decided that it'd be best for me if I got out of the city for awhile. She sent me to a foster home in X (a smaller city in the region). Now, that lady was nice and all but I came from the city. I used to ride around on the Muni (transit system) and get me all over town. I knew where everything was-- you could just ask me and I could tell you how to get there. But X, now that was a trip! Everyone was white or some Mexicans there. It was like they never seen a black person.

Leaving home also involved losing personal possessions that provided links with family, home, and self-identity. Multiple placement transitions perpetuated these losses as the adolescent was continually required to change the home base and as an unintended result, shed personal belongings while in transit. A female respondent described this type of loss when she first was removed from home:

> I didn't want to leave, so I grabbed onto my mother really tight. She was crying so she gave me a picture of her and I took it with me, and I had it in my hand for the whole time. I would not let it go. I would just sit there and just stare. The picture that she gave me, I don't have it anymore. It's like I don't know what happened to it. I think I put it in my photo album and it's in storage somewhere now. I keep a lot of stuff in storage and then I just lose track of it. The teddy bear that my mom sent for me, that's gone, too. I have nothing with me to remind me of home. Where's my momma's picture? I can't find it.

Another girl talked about the repeated loss of belongings that results from multiple placement transitions:

> When you move, you always leave a little something behind that was yours... a little piece of yourself.

Family contact. Members of the study sample varied in the level of contact that they maintained with their families of origin. The variance in contact included none, infrequent, sporadic and unpredictable, and regular, ongoing contact. Many of the foster youth had made choices to either minimize or maximize family contact. More often than not, however, this was controlled by foster caregivers. The adolescents depicted them as the gatekeepers to family access. Group home staff were frequently perceived as discouraging versus supporting home visits:

> Actually it's not fair at all what they do around here. I have two choices when I leave here: I picked living with my aunt, and if she can't take me, then I want to live in a foster home closer to my family, because right now I feel like they're trying to keep me away from my family and draw the line. I can't ever see them without their say so.

> I wanted to go and live with my grandmother but they wouldn't let me. My grandmother, she could have took me from my mother and had me live with my grandmother instead of doing all this. Now, I need their permission to go and visit. And I only get every holiday.

In addition, consequences for misbehavior in the foster care setting were often tied to withholding visiting privileges. Example:

> Me and this other guy, R., we got home late for curfew, maybe by half an hour. So they said we got consequences. Me, cause they said I already got a warning, they took away my pass to go home that weekend. Now that wasn't fair. I don't think they should keep you from your family as punishment. I mean, they could have thought up something else.

In sum, themes of loss and discontinuity were prevalent when considering the impact of foster care on family relationships. A perceived lack of control over how to manage both family-related losses and level of family contact was identified by the adolescents.

Peer Relationships

The impact of foster care on peer relationships was found in the areas of quantity, quality, loss of friendships, and social isolation. Most of the study participants appeared to have few close, enduring relationships within their peer group. The diminutive quantity and, often times, unsatisfactory quality of peer relationships was associated with loss and stigma.

Loss of friendships. Two related phenomena contributed to the repetitive loss of friendships for the foster youth in the study: multiple placement transitions and high resident turnover. Constantly moving within a system that is also continually changing membership leads to the difficulty establishing and maintaining stable, consistent relationships both within and outside of the foster care setting. Several adolescents described their experiences with the loss of friendships secondary to multiple placement transitions:

> (Response to what it is like to live in so many different places:) Pitiful. I've never been in one place for longer than two years. I've lived all over the place. I've moved to Los Angeles and back to the Bay Area so many times that I think I broke a record. Me and my little brother got sent to live with my grandparents in Los Angeles (a formal relative foster care placement). So we had friends in Los Angeles. When we moved back up to the Bay Area, we made more friends here in the Bay Area. We left them and went

> back to Los Angeles, and a lot of the friends in L.A. took a wrong road or something like that. A lot of them remember us but we're not as close to them as we were.
>
> I've changed high schools three times in two years. And you're asking how moving around has effected my friendships?!
>
> When I lived with Ms. B., I had this friend, A. We was kinda on our own most of the time, we stayed out a lot, a lot of things was going on, but we just had each other. Then, they moved me to the city to a group home. Me and A., we did a lot, we did everything together, you know. Last time I seen him was '87 and he was in a foster home himself. I was surprised and shocked to see him. We sat there and talked about the good times that we had and then we had to leave.

Other respondents discussed the loss of friendships made within the context of foster care due to friends leaving or changing placements themselves:

> My best friends came to Group Home A-- they came there about two weeks after I did-- and we became really good friends. If I had any problems they would be the first people I would talk to. If I was really mad or something, instead of going off on somebody, I would sit outside and smoke a cigarette and cry and they would come and talk to me. I didn't want to leave there because these girls I knew were really good friends of mine. I cried because I didn't want to leave, because I knew if I left I would never see them again.
>
> There was this one girl who was the only person I knew I would get along with and not get into an argument with, and her friend got pushed in front of a train. So she told her roommate so her roommate wouldn't think she was mad at her all the time. And her roommate started laughing about it. So she got fed up and pushed her and hit her in the back and kicked her. Her mind just totally exploded and she couldn't do anything else. So they discharged her. Now she's living with her boyfriend in X (a city about 45 minutes away by car). I could see her if I liked to take an outing and go for a drive and see her there, but it's a problem because she has a lot to do everyday.
>
> When R. went AWOL and got discharged, that's when I knew that I lost my only friend there. See, him and me were the only ones that weren't probation kids and we kinda stuck together. But now, he's living back with his

> mother and goes to a different school. I see him once in awhile but not like everyday.

Perceived stigma and social isolation. The dimension of stigma was interwoven throughout the interview data. All of the adolescents experienced the perceived stigma associated with being a foster child in their social interactions. They described the impact of this perceived stigma as social isolation or feeling lonely, isolated, and disconnected from their peers. Examples:

> (In response to "How has being in foster care effected your friendships?") I don't have that many friends. You have to be careful who you pick for your friends. I just don't have time for kids my own age. They'll always be putting you down for living in a group home and then you start to feel all bad about yourself.

> Kids at school, they think that you're in foster care cause you're a bad person. It makes you feel bad about yourself-- completely alone. It's hard to have friends. Sometimes I think that because maybe I live in a group home, they make me feel left out. They ignore you, forget about you. It makes you feel like there is something wrong with you or something.

The stereotypical view of the foster child and its effect on the status of foster child will be more fully discussed as a contextual dimension which contributes to the impact of foster care. Here, it is important to highlight the feelings of stigma experienced by the sample along with the outcome of social isolation as dimensions related to the impact of foster care on peer relationships.

The Development of Independence

The development of independence is widely considered to be an important milestone which typically evolves during the period of adolescence. The impact of foster care on

independence was found in two key areas: independent living skills and future plans.

Independent living skills. In order to live independently, the older adolescent or young adult must be able to procure the basic necessities for survival including food, clothing, shelter, safety, and adequate health. Many of the study participants had participated in a formalized independent living skills training program, a voluntary program offered to adolescents pre-discharge by the Department of Social Services. They reported the positive impact of independent living skills training to be the learning of concrete skills including financial management (e.g. opening a bank account, developing a budget), job skills (e.g. reading the classified ads, interviewing skills, work experience), and the procurement of housing (e.g. locating affordable housing, finding a roommate to share expenses).

Respondents reported receiving limited to no information regarding health and safety. They had little knowledge about caring for one's body, nutrition, or accessing the health care system. Some were given instructions or assistance with applying for state insurance following discharge but were unclear about details regarding coverage, appropriate health care settings to utilize, and the selection of health care providers. An additional limitation of independent living skills training discussed by a few of the female adolescents was the lack of attention given to safety issues (e.g.

measures to maximize personal safety while living in a dangerous neighborhood).

In spite of this preparation for independent living that most of the foster youth felt to be very useful, a major gap was identified. The perceived absence of resources to support independent living was critical. The financial impediment to self-sufficiency was paramount in this group. In addition, many of the adolescents had limited social support and little to no awareness of where to get assistance if needed. This reality led to fear and anxiety regarding future survival as expressed by several of the respondents:

> It's kind of scary to think about leaving (foster care) this summer. I'm scared of staying by my own self in _this_ house. I've only got this little job and no one to help me. Where's the money going to come from? First and last (month's rent). How will I survive? I'm completely alone.

> One thing I think all kids that live with their parents take advantage of after they're 18 and they leave the house, that next week they can call their parents and say, "Hey, I ain't got no laundromat here; Hey, I need this..." When you're 18 and you call your group home and say, "I need money for last month's rent", they'll hang up on you. You have to be prepared. Eighteen-year-olds coming out of group homes have to be more prepared for life or for what they have to learn in life than kids coming out of a home. And if you're not ready, that's just tough shit. You have nobody!

> I don't know how they expect us to live on our own. I heard that San Francisco is the most expensive place. I would like to live on my own but I can't afford the rent (works part-time, minimum wage). I'll probably move with my mom (recovering drug addict) but that's not the best situation. I don't know what will happen to me... but, I'll probably be all right.

Future plans. Most of the adolescents stated that they learned to set goals for themselves while in foster care.

They viewed this as beneficial for the development of independence. Though most of them were able to identify some goal for the future, two key trends in the data suggested an unrealistic chance for goal achievement. First, many of the goals appeared to be based in fantasy versus reality. Examples included being a chiropractor for the San Francisco 49ers and a professional basketball player. It was also typical for a foster youth who had significant academic difficulties (e.g. functioning well below grade level, placed in special education classes) to have a professional goal which required years of rigorous educational preparation (e.g. doctor, lawyer, psychologist). Similarly, the accumulation of material wealth was a common goal for these adolescents who had experienced past deprivation (e.g. mansion in Hawaii, a black BMW, a ranch with lots of land in Montana).

Second, even with goals that could potentially be met, there was a consistent lack of any clear idea, plan, or means for goal attainment. The desire for a college education was a frequent example of this. Most of the adolescents in the sample stated that they wanted or planned to attend college. Only two had any understanding of how to prepare oneself in terms of educational and testing requirements, selecting a school, and the application process. They had more concrete plans to achieve their career aspirations; the first with the help of caregivers and the second, despite a perceived lack of support:

> When I first came here, the school was very hard for me, and now, cause I stay here, I'm going to school every day, I'm bringing my grades up from what they used to be and I've always thought about going to college. Going to a black college, or whatever. And, right now I'm now looking at different black colleges and stuff like that, so just in case I might get myself into black colleges, find a place to stay. They (the group home staff) help me with everything.

> I'm responsible, I'm mature, my life is together. I got accepted to X (a state college). They (the people at work) congratulated me. You know what my group home did? They asked me where was my acceptance letter. They didn't believe me! To them I don't follow through on programs, I don't follow through with my ideas, I get stressed out too easy.

Once again, there was a notable absence of supportive resources to provide information or assist with this endeavor.

Dimensions Which Influence Impact

Contextual Dimensions

The adolescent foster youth in the study focused much of their discussion in the interviews on the contextual features of the foster care setting that they perceived to have an effect on their lives. They were confronted with a myriad of phenomena in their living situations which could have the potential to influence the impact of foster care. These features fit into two major categories: status related to being a foster child and the structure of the foster care setting.

Status of foster child. Status was one of the variables perceived to be most influential by the study participants. It was universally accepted by the respondents that a stereotypical view of the foster child was generally held by

others in the social environment. The major property of status was associated with the value assigned by others to the status of foster child, that is, diminished versus elevated or respected. The adolescents in the study only reported experiencing the diminished status of foster child based on the negative views held by others about them.

The stereotypical view of the status of foster child was encountered both within and outside of the foster care setting. Within the foster care setting, caregivers were often perceived to have views of the foster child which presumed juvenile delinquency or emotional disturbance. These views were exhibited in associated behavioral expectations of the child. If the child, for example, was assumed to be a juvenile delinquent, antisocial or bad behavior was expected and external controls were initiated, with or without the child's demonstration of this behavior. One male respondent provided an example of this:

> When you first come to the group home, they don't trust you at all. They just tell you all these rules and straight up put you on all these restrictions. And they automatically think you be bad. And I'm like, "Hey, I'm in here cause of my father; he beat on me. Man, I didn't do anything wrong!"

If it was assumed that the foster child was emotionally disturbed, the child was expected to express this underlying disturbance via dysfunctional behavior and/or social interactions. As a result, behavior was often interpreted using this clinical perspective and various therapeutic modalities were instituted. One youth recounted his experience in an earlier group home placement:

> I was hyper cause of course I was a kid. I wouldn't mind. They said I was crazy, which I wasn't. They tried to get me to go to therapy, which I had to go to therapy. The therapist thought I was crazy, that there was something wrong with me. They tried to say that I needed to be on medication and stuff like that. I needed to be here, I needed to be there. He need to be watched after every 20 minutes, um,...they thought I was gonna hurt myself, you know, which I didn't do and they was wrong! They just thought wrong.

A related view identified the foster child as a victim of abusive preplacement experiences who was helpless and in need of rescue and/or repair. Example:

> The staff there all felt sorry for me, you know, because of my past. I think they wanted to protect me, to help me. And I said, "Why are you giving me medication to sleep through my nightmares? I'm not working them out. I'm going to be 18-years-old. I'm gonna be freaked out cause I don't have drugs that knock me out. So I can go to a damn doctor and ask him to prescribe me? I mean, I'm not gonna do that. So why give them to me now?"

Similarly, the stereotypical view of the foster child was pervasive in other areas of the foster youth's social world. Social interactions with peers, teachers, people at work, and others were colored by these biased perceptions. Common negative stereotypes about foster children that were directly experienced by those in the sample included bad or delinquent, emotionally disturbed, and sexually promiscuous. Examples:

> When they found out I was a foster kid, at first my teachers would say, "What did you do?" They all think negatively, like we have no goals, and we did something wrong, their parents didn't want them, or something like that. They have no positive thoughts about anybody in group homes or foster care. They treat foster care people a little differently than group home people. You know, they have family, so they're under some kind of supervision. But in the group home, they're bad; they're a menace to society.

> You know how kids love to tease, intimidate people. It was like, "Ha ha, you're a group home boy. You live in a group home. You're a crazy boy-- loony tunes!"

> I really don't care what they think, but then there's the people out there who might think, "Oh, the girls who stay in group homes are-- they're easy" or whatever. And, "they just put out for anyone", something like that.

Another common theme associated with the discovery of one's foster care status by others was the reaction of shock and/or perplexity that the foster child didn't fit with their negative assumptions:

> When they (the people at work) found out I was in foster care, they were like, "Whoa-- you don't seem like _that_ kind of person!" What type of person is that?! (Interviewer- "What did they expect?") They think you're lazy, don't go to school; you're on drugs... alcoholic.

> My friends, like, when I really start getting close to a person, I just tell them (about living in a group home) and they be so shocked. They like, "You do! Are you serious?" They'd say, "Hell, you don't. Stop lying to me." I'm not joking. They always have a idea that you be bad if you live there or whatever. I'm not lying to you. And I tell 'em. I think very few people really know what it's like.

The existence of a stereotypical view of the foster child was widespread throughout the social context for this sample of foster youth. Interview data indicated that all of the adolescents were touched by this dominant view. The assignment of a diminished value to one's status as foster child was perceived consistently across the sample as a dimension which negatively influenced the impact of foster care.

Structure of the foster care setting. The structure of the foster care setting was discussed by all of the study

participants as a variable which contributed to the impact of foster care in some way. Structure included the subdimensions of program type, rules, staffing, residents, and physical space and climate.

Two distinct structures emerged in the data: the institutional structure and the family-like structure. The institutional structure was by far the most predominant setting found in this sample with only four adolescents living in a group home that they characterized as family-like. Three youth in this small subgroup had experienced living in previous foster care placements that could be classified as having an institutional structure.

Institutional structure. The institutional structure had a formalized program which outlined levels of privilege and restriction. An example of this was the point or level system. Residents either earned or lost points based on their behavior or goal accomplishments and this influenced their privilege level. Each privilege level specified activities that the adolescent was forbidden from or free to engage in. The respondents talked about this program in the language of NO:

> Privilege levels go like this: Level 1: no home visits, no candy, you cannot hold your money, no radio, no going to the store without staff. A bunch of other things you can't do. Level 2 was approximately the same thing except you got a 15 minute later bedtime. Level 3 was the same thing. Level 4 you can only use your radio on Saturdays.
>
> No arguments, no violence, no smoking, no home visits, no personal radio or TV, no physical contact, no, no, no...!

> To go up a level, I guess you be good. You don't do anything you aren't supposed to. Cause if you do, you get on restriction. That means you just stay home and stay in your room. You only come out of your room when you take a shower or use the bathroom, eat with people, and that's about it. You cannot talk on the phone. You cannot watch TV. You cannot do anything.

The emphasis was on restrictiveness and consequences despite the label of "privilege" level.

The philosophy of the program may have been formally articulated to emphasize a family-like environment, however, this was not reported to be experienced by the adolescents secondary to excessive restrictiveness:

> It's like an institution. A lot of the rules there aren't even reasonable; they're not fair. They say, "We want to make this more of a family-like situation." You can't do that by saying the very first week that we can't have radios. And we can't go home for four months after we get here. At home, you don't have the knives locked up. Your parents don't tell you when to use the radio-- if you're good.

> The group home is supposed to be like a family-- they tell you that. But it's not like a family. You have stricter rules than at home. It's not a fun place. It's not a place where you want to get away from a family for a night. It's stricter and stricter than your family. It's not a place that you would think that place is going to give you freedom to do whatever you want, to go out and all that. You have no freedom, period.

Program specifics were typically undisclosed to the adolescents. Specific behavioral expectations for gaining or losing privileges were not always clearly communicated or consistently applied. Programmatic and resident labels were concealed. One respondent described getting into trouble for revealing her discovery of these labels to the other residents:

> I found out some stuff that really pissed my house off. They were pissed off at me because I'm the one who told

> the girls that it was a residential treatment center. We had a big blow-up about that. And then I found out some more things about my house. My residential treatment house is for emotionally and mentally disturbed girls. They never tell you this. I want to know. If I live somewhere, I have the right to know what's going on. Don't keep me in the dark. You guys have my life written out on a piece of paper. I want the whole scoop like you guys got the whole scoop.

Program terminology was reflective of an emphasis on restriction. Terms like trial time, probation, emancipation, and AWOL seemed to be derived from a prison framework. This terminology became a part of the adolescents' vocabulary and it was used freely, without apparent awareness of its underpinnings or punitive nature.

Rules were worded in a restrictive manner and were felt to be rigid and fixed. At the same time, rules could also shift or be unfairly or differentially applied by staff. The program itself was subject to change without resident input or knowledge (e.g. group home mergers; changing a family foster home into a group home). This unpredictability led to uncertainty, confusion, stress, and frustration in the residents. Examples of the unpredictability and perceived unfairness of rules:

> The rules. They're not even called for. The staff make them up on a whim. They just go by what they want to do right now. Right now there are no really set rules. It's whatever they think that they want to make are the rules, and we just have to go by it. They're just thinking of it from the head. And you just never know.

> I might say something like, "Don't say that to me again or I'm just gonna have to hit you", they give me restriction. And if some other girl says, "You hit me and I'll have to cut you", and she'll just get a warning. So they give me restriction and they give her a warning. It's not fair at all. It mostly depends on if they like you or not.

> When I first came, the rules were fine, but when they combined together the two houses, they got out of hand. Now, like if we look at guys out the window, like we normally do, they say we can't stand at the windows at all, even if we're just standing there smoking. They'll make you move, close the curtains and yell at you. It's always something else. So I think most of the girls are fed up with it.

> My house is for older teenagers and it's like an independent home for us. At first, we didn't have any rules like serious rules. We had to do stuff but we were mostly all working and not getting into trouble. But then she (the group home supervisor) wanted everything structured like at the other house. It got structured. Now we got point sheets and all this other mess. It got changed and caused us all this extra problem.

Respondents frequently reported feeling a lack of individual consideration in these programs:

> At the other house (a group home run by the same agency), two people messed it up there so she (the group home supervisor) assumed that our house was gonna mess things up too. But we wasn't gonna do that. We explained to her that we're not the other house, you know. But she just treats us all the same.

> Sometimes the staff forgets you're a person. They judge every kid by the same. (Interviewer- "How would you like it to be?") I would have a more individually-based program. So they treat you like an individual.

> One of the things I really don't like is when they don't try to treat each individual as a whole. It makes people mad. If somebody cooks something and one person don't like fried chicken, then everybody don't like it. And it shouldn't be cooked anymore.

The typical program found in the institutional structure appeared to leave little room for the consideration of normal adolescent development. Problems of adolescence tended to be overinterpreted as pathological and behavior was misinterpreted at times to be disturbed, sexual, or aggressive in nature:

> They (the group home staff) think that everything we do must be crazy. Now, if you want to get some emotionally disturbed girls, you take a normal kid from a normal family situation with the teen factor and the boy factor and your hormones are raging, and you've got clothes, you've got school, you've got your parents gettin' on your case-- she be more messed up than we were. It's natural. In teenage years you're pretty much screwed up in the head.
>
> My best friend and I would hop into bed with each other. I had nightmares and we were roommates. We were told we could not do that. They sat us down and said it was not right to sleep in other people's beds. And they got worried because my boyfriend's mother is a lesbian.
>
> One day I was playing a game with my friend-- a stupid little game I played when I was little, before my life got screwed up-- and I found someone who knew that game. It's a little tapping game. There's no physical contact in my group home. You can hug, but there's no hitting, tapping, anything even teasing. And we were playing this game, and it's a tease game is what it is. And one of the counselors came up who had been in eight drug rehabs and had been in group homes all his life, so he was pretty cool, and he saw us playing the game and he knew what we was doing. We were running across the house, it was great! Later that day, we both got put on restriction cause another counselor, who goes straight by the book, said it was inappropriate behavior.

Additionally, some of the rules seemed to be developmentally incongruent for adolescents like needing an escort to the corner store, being unable to spend an overnight with a friend, and unreasonable curfews (e.g. required to be home right after school). The respondents also found it to be difficult to engage in some normal adolescent experiences like dating or getting a driver's license. Examples:

> You can't have a social life. You could, if you wanted your friends to come over and meet your supervisor, if they have an ID, have proof of insurance, name, number, address, height, weight, the color of their eyes, their mother's name, any brothers or sisters, what does their mom work as, where do they work, do they have any sexual intentions towards this girl? I don't bother. I just go out. I can get in trouble for going out with all these

> friends, all the friends I work with. But I don't want to see them interrogated like that, so it's worth it.
>
> I have been saving money to buy an old car. It would help to get to work and around. But foster kids can't have a license or a car. You can't get insurance even if you pay. I guess it's because you're a ward of the state, and the state doesn't want to be responsible for your actions while you're driving.

The staffing patterns of the institutional structure tended to be eight hour shift coverage by multiple staff members. This, along with frequent staff turnover contributed to a lack of continuity in the care that the foster youth experienced. In addition, staff were clearly considered to be distinct from family members. Respondents were emphatic in drawing this contrast:

> I don't think of anybody as family except people who are blood related to me. But then again, I only think of them as if they were camp counselors. I don't think of the house as a family. They're different. I can't relate to them. They get on my nerves. These people are like strangers to me.
>
> The counselors are paid to take care of you. Some might be all right but most of them don't really care. Your family is your family no matter what. They (the staff) can always get another job.

Negative descriptors of the caregivers in the group home were far more common than positive (e.g. provocative, intrusive, nagging, inattentive, unhelpful, lack of empathy, disturbed, disrespectful). Examples:

> And they're supposed to be like our "role models" (the respondent laughs and shakes his head). And some of them have as many problems as the kids. And they like have this attitude. You know, two kids can face off on each other when they're mad but you can't do that with a staff. And some of them try to get you going.
>
> We do the best we can there to give staff our respect. But they just push you to do it right there. They don't ask nicely if you'll do something. They're like, "Get

> up, do this, make sure you get it done, don't even think about goofing around." They just straight up tell you what to do with no respect.
>
> Sometimes the counselors, they bring their attitudes to the group home with them and don't pay attention to what's going on. Like, if you have this really big problem that you need to talk to staff about, like if something's bothering you... the counselor is like, "Oh, could you keep it down a little bit, because I'm using the phone... I'm really busy right now." And you come back to 'em like 20 minutes later and they say, "Well come back in a little bit." It takes them a couple of hours, so they come, <u>finally</u>-- "Oh, what did you want to say?" And by the time that staff come you say, "Oh, I already settled my problems. It's finished now."

As rule enforcers, the staff, like the program itself, were seen as rigid and strict, most often "going straight by the book" in this function. Again, the dichotomy between experiencing both a lack of individuality and the differential application of rules and consequences was present for these adolescents in relation to the staff; that is, the staff were viewed as both inflexible and unfair. Control issues were a prevalent theme with the adolescents living in this structure. They spoke of the power imbalance between staff and residents and their feelings that the staff abused this power at times. This abuse of power took the form of provocation, physical aggression, or exploitation. For example:

> Yesterday, one of the staff was going to change the channel on the TV and I went to turn it back and touched her hand. She says, "You hit me!" And I says, "You'd know it if I hit you!" She wanted me to hit her and kept pushing me...
>
> I was in that group home for two years and there was a lot of funny things going on and we got some funny counselors. I don't know how they got in, just slipped by. You know how counselors watch over kids and the

> counselor let kids get beat up. One time I didn't want to drink some prune juice, so I got beat up for it. The other kids was just beating on me til I said I was gonna drink it. The counselor told them to. He say, "Beat him up. I don't see anything. Just go and beat him up."
>
> The main thing that bothered me when I was there was that I heard that some of the staff was sleeping with some of the girls that were there. They'd (the other residents) say things like, "Such and such counselor told me if I sleep with him, it will make me a better lover." Or, " I'll help you find a place to live and you can come stay with me any time you want." And one night there was this staff named J. who came into my room twice and just stood there over my bed. And I said, "What are you doing?" I threw something at him and he ducked out really fast. I pushed my bed against the door for the rest of the night. I was terrified!

The size of the institutional-type group home had a tendency to be larger (e.g. 10-12 beds). The fellow residents in the institutional structure were not qualitatively different than in its counterpart, the family-like structure, with respect to age, reason for placement, types of problems and level of resident turnover. What did significantly differ were the adolescents' perceptions of fellow residents as clearly distinct from family:

> No, the other kids in the group home are <u>definitely</u> not like your family. There are lots of different kinds of kids, some could even be your friend. Some are just screw-ups who, if given the chance, will live the rest of their life in a group home.

Respondents reported difficulty in establishing and maintaining relationships with other residents due to conflicts and constantly changing alliances. Much more physical aggression and threatening behavior was discussed regarding the residents in this structure. The problems of fellow residents were seen to negatively influence or cause

the adolescent stress. Those on lower privilege levels could hold the adolescent back (e.g. from activities). Likewise, negative peer pressure was seen to be an issue in group living with age-mates. The responses of two foster youth illustrated this:

> When you get in a group home, you start paying attention to everybody else's problems. And for those people who can't handle the peer pressure, they get caught up in the peer pressure. If one kid wants to go rob a liquor store, then he breaks up the house and asks them to help him.

> Every time one person does something, we all get into trouble for it, cause one bad apple messes up the whole tree. A bird goes off course and the rest of the flock goes following after the bird.

The physical space and climate of this structure had both the appearance and feel of an institution to the adolescents. Some adolescents even referred to the setting in which they lived as an institution. Adolescent perceptions of separateness, restrictiveness and control, lack of personal space, environmental chaos, and both active and potential aggression characterized the climate of the institutional structure. Staff space was separate from versus integrated with residents' space. This space was off-limits to the residents. The controlling, restrictive climate of the group home that was perceived by the adolescent was different than the serene, family-like climate that was to be portrayed to the outside world. Adolescents reported being instructed to put on a positive front for potential new residents. Example:

> You have an overnight, a trial time. You stay the night and decide if you like the place and leave and then

> decide if you want to come back. They don't tell you when you go there that there's this long probation time you're going to be on. They tell the girls before the new girl comes in for the overnight to be on their best behavior and don't talk dirty about the counselor, whatever. And usually they tell me not to say anything, cause I always have something to say like, "Do you know when you first get here you can't do this and this?" Cause these kids aren't told.

Generally, there was a lack of privacy for the residents due to having a roommate and/or no personal space within the home. This created an inability to distance oneself from others or to have time alone to reflect. It was difficult, if not impossible to escape from the constant stimulation of the other residents and the behavioral manifestations of their problems or issues. Examples:

> You know, there are times that I just want to be alone to reflect. To think about things that are going on in my life without having to deal with anyone else. In this house, there is absolutely no privacy. Everyone needs a little privacy once in awhile. That's just normal. But here, you always have a roommate or everyone putting their nose in your business. It's never quiet, except for maybe between 1:30AM and 7:30AM when everybody is finally asleep.

> I've been having a roommate and living with everybody else and all their problems. If you're feeling fine and not having a problem that day or anything, and everyone is going around the house screaming, there goes your day. You just want to pull out your hair.

Finally, the prevalence of unpredictability and experiences of chaos and violence between residents and between residents and staff left some respondents feeling frightened, unsafe, and insecure in these settings. Two girls described the climate of their current placements:

> Every week, it's something new to worry about. This person fell down the stairs; this person burned herself; this person hit a staff; so and so is fighting again.

> It's pretty scary here sometimes. You never know what's gonna happen. We get some violent kids here sometimes. Like one time, this girl went after a counselor with a knife. She picked up a knife and said, "I'll kill you!" They called the police right away and they got her. She got discharged because she threatened a staff. You never know the next time...

Another adolescent talked about a previous institutional-style placement:

> Hell. I was so scared. There were girls and boys from age 8 to 18. There was lot of fighting, everyday. There was a lot of violence around and I got into one fight there, and I nearly tore this girl up. I was more scared of getting hurt than trying to be all big and bad.

To summarize, adolescent perceptions of the institutional structure centered on excessive restrictiveness, the lack of individual treatment, unfairness, and unpredictability. The adolescent foster youth strongly rejected the portrayal of this type of group home setting as a family-like environment. Lastly, the institutional structure was viewed by respondents as interfering with the ability to feel and behave like a "normal" adolescent.

Family-like structure. The family-like structure appeared to have a less formal program with an emphasis on having the group home closely imitate a family environment. Some of the group homes that fit into this category had some type of behavioral program based on points or privilege levels for the adolescents to follow, however, its application by the staff seemed less formal and more flexible than in the institutional group homes. Residents had a specific set of expectations for living there and respondents

generally felt them to be reasonable (e.g. school attendance, curfew compliance, being respectful of others in the home). One girl described the differences between her group home and others:

> We have a program here but it's mostly like your own house. We can go out and come back in. It's not as strict as other homes. I know that other homes have to earn passes to be out, and you have to be on different levels. But here you just come and if you're responsible, you can go to your friend's house if you leave the number, or your friends can come over.

Consequences in the form of restrictions were given when expectations were unmet. Being "on restriction" closely approximated "being grounded" (e.g. home directly after school, no outside activities or special privileges), a disciplinary strategy used by many families. Respondents also described getting what they needed in these programs and had the ability to earn extras or special things by doing well. Examples:

> We didn't always get our clothing allowance from DSS but L. (the group home supervisor) would go out of his own pocket to help us out. He made sure that we didn't go without whenever he could.

> Like whatever you want, they'll just give it to you. But they first get your report card, see how you're doing in school, have you been doing good and this and that. So, it's like when you need something you get it right away. And special things. Like graduation dresses. You want to go take pictures, they'll give you money to go take pictures.

The philosophy of the program both articulated and attempted to follow through with this family-like orientation. In addition, two of these group homes incorporated strengthening the adolescent's cultural identity and pride in oneself into the program. These homes were

supervised by strong African American adults (one female and one male), staffed by African American adults, and served predominantly (although not exclusively) African American youth. The foster youth in these homes often referred to these adults as role models.

In addition to the basic behavioral expectations referred to above, rules in the family-like group home seemed to be based on the consideration of others in the home environment (e.g. no smoking or loud music, calling home if you're going to be late). Likewise, privileges were based on trust and the ability to take responsibility for yourself. One participant talked about how the violation of trust was handled in her group home:

> If you do something, you're on punishment and you have to earn your trust back. You have to talk about what you did, say your sorry, convince them that you can be trusted again. Then, if you do it again, that's just it. They won't trust you too much anymore.

Respondents described a level of flexibility in the rules along with individualized treatment. Example:

> They didn't always go by what was said. If you're here, trying to change, they were here to help you. They treated us like people. They didn't treat us like we were in a group home. They treated us like we were part of their family.

The program tended to de-emphasize pathological aspects of behavior by the residents. Respondents appeared to have more developmentally appropriate privileges and their complaints seemed to be more like typical adolescents' (e.g. curfew too early, allowance too meager). Like their

counterparts in the institutional-type settings, the lack of privacy continued to be an unmet developmental need.

Staffing in the family-like group home generally followed the pattern of individual staff members providing 24 hour coverage for several days at a stretch. The adolescents responded to this continuity of care positively and felt that they really got to know their staff. Although staff turnover and quality continued to be an issue in these homes, there was often at least one identified stable and consistently involved and available staff member. Example:

> We've had tons of women coming here. And it's hard to get used to the new person. They usually start out too strict cause they don't know what you can do. But there's always Ms. J. She lives downstairs so even if she's not on, you can get to her if you need her. She's always up here anyways!

Respondents were more likely to view the staff in these homes as family, especially those identified as special. The perception of caregivers as family was exemplified in these responses:

> Ms. J., she's like the mother over our whole house or whatever. If you need someone to talk to, you know, she's there. She's willing to listen to what you have to say; with anything she can help us with, you know, she's there to help us.

> Living here, you're not with your real parents, but you're with someone who takes care of you as your parents.

Positive descriptors for staff included respectful, honest, good listener, helpful, and committed. Staff were described as demonstrating how they felt about residents and were considered to be genuine in their caring:

> I like how she really cares, how she really puts all of herself into each one of us. She shows how she really feels about us. She will talk to me about the things that she feels that are not right, she will talk to me and I like her honesty and things like that. I like how she cares.

Family-like group homes in this sample were typically smaller, housing around six adolescents. Several of them began as foster family homes and transitioned into group homes as the demand for adolescent placements became greater. The respondents stated that the small size of the home allowed for closeness between residents and between residents and staff. Fellow residents were considered to be like family (e.g. siblings, cousins) or good friends. For example:

> Well, I don't exactly see this place here as exactly a group home. I see it more as a family-like place, you know. Cause everybody here we each treat each other like sisters, cousins or whatever. We each watch out for everybody. There's the rules and everything that we have to live by, but this place here, I have to treat it like my home. I see everybody here as my family.

> We're all a bunch of crazy girls. We love to have fun. Some nights we'll just all get together and tell our stories about how we were when we were younger, how we used to do this and how we used to do that. And, we used to just go on and on for hours. And, that's good, cause you know, in some places you probably can't even get to talk to girls or whatever. Cause it's like, well I don't want you knowing my business, or whatever, but here, it's different. We're really open about everything.

Residents were generally felt to be supportive of one another. Even with resident turnover, there seemed to be a stable core group of adolescents that remained in these homes long-term, thus, lending continuity and stability to the family-like atmosphere. Example:

> We're a stable group. There's three of us who have been together for the long time and there's this other guy, M., whose been there longer than us and we get along with him just fine. We talk to him more than the newcomers, you know. We mix in with the newcomers but we're the main group.

The physical space in these homes was similar to an ordinary residence and could not be obviously distinguished as a group home in the neighborhood. The word that was often used to describe the climate of these settings was "homey". Resident rooms and common areas contained personal belongings and the decor was comfortable. One group home displayed photographs of the residents in the living room such as one might find in a nonfoster home. Staff areas were well-integrated with resident areas (e.g. no separate staff office). Finally, it was characteristically reported that violent behavior was not tolerated in this type of setting and there were less frequent episodes of physical aggression described by the respondents. This was, at times, compared with other less favorable placements that the adolescents had experienced in the past:

> This is a good group home. I'm more comfortable here. The girls here are not violent. And we don't get in fights and it's really quiet unless we get rowdy sometimes.

> Here, we don't have loud-mouth girls. Bad girls. Girls with bad attitudes. I have always felt safe.

Feelings related to this predictability and level of safety included comfort and security.

Although only four of the study participants currently lived in foster care settings that could be distinguished as family-like, they were able to illuminate some clear

differences between the institutional and family-like structures. In particular, program execution, as perceived by the adolescents, successfully reflected the underlying philosophy of providing a family-like environment for foster children. It appeared that both individuality and normative adolescent development were acknowledged and respected by caregivers. Despite the presence of similar foster care issues which lead to instability and unpredictability (e.g. staff and resident turnover), the presence of a consistent, supportive caregiver was a significant variable found in the family-like structure.

Historical Dimensions

Other factors which were considered to be possible influences on the impact of foster care focused on the historical dimensions that characterized the individual child's foster care experience. These dimensions included the child's history of events and experiences both prior to and during foster care tenure.

Preplacement history. The first universal experience recounted by the adolescent respondents was the detrimental nature of events prior to foster care entry. As a precondition for foster care placement, all of the adolescents were members of families that were characterized as dysfunctional. Prevalent evidence of family dysfunction experienced within the sample included parental substance abuse (76%), physical child abuse (71%), general neglect

(65%), child sexual abuse (35%), and parental mental illness (18%).

Another major category of preconditions for foster care placement related to the trauma of loss. Many adolescents experienced the death of a parent (41%), parental abandonment (35%), incarceration of a parent or other close family member (29%), and profound instability in their living situation including frequent moves and multiple caregivers (53%).

Many of the adolescents (47%) discussed their personal histories of behavioral and emotional problems. Child-related problems which contributed to removal from home included suicide attempts, behavioral problems (e.g. oppositional behavior, unmanageable by caregivers, truancy, fighting), and emotional disturbance (e.g. depression, eating disorder).

Finally, nearly all of the adolescents endured substandard living conditions which exposed them to the threat of danger, violence, and illegal activities (e.g. the drug trade, crimes against persons and property), and the multiple deleterious effects of poverty (e.g. hunger, inadequate housing, health problems).

Poignant examples to highlight these detrimental preplacement experiences can be drawn from the psychosocial biographies given by three of the study participants:

> Living with my uncle, it was a nightmare for me. My uncle was very abusive... he was horrible. He was just mentally ill. I mean, he was a very sick person. He abused me physically and everything. Once, he tried to kill me with the scissors. I know he was going to kill me sometime. I was like his maid, his slave. He kept

> me home from school. And I didn't get my education. I'm over two years behind in school.
>
> My mother had left us (respondent, age 9, and two younger siblings) because she was using drugs. My father was in a rehab center. He was getting himself together. When my mother left, we were in this house for three years by ourselves and we did real well. We was going to school and everything. And nobody even knew. Then, Mrs. B (a neighbor) found out about it and she made us go stay there. She would see us sitting out at the park 'til almost morning time, just sitting around talking. We never slept. And she would watch.
>
> I lived at home with my parents until I was ten. There was nothing positive about it. It was the most horrifying experience I ever had. It's just the things I had to see that I shouldn't have been seeing. I seen people get shot and stabbed right in front of my face. It's not good for a young person to see. When young people see that, they don't know what to think. I seen people get hit in the head with hammers and beat with hammers. It was bad, it was horrible. I'm surprised I'm not crazy.

There were common attributes which portrayed the nature of these dramatic life experiences including several key dimensions and their properties. First, the multiplicity of events experienced by the foster youth was significant. In this case, it was typical to experience many rather than few. Second, the dimension of temporality highlighted the ongoing nature of these experiences as opposed to incidental, atypical episodes. Finally, the level of severity was consistently high, even life-threatening versus low or minimal.

Tenure in foster care. Beginning with foster care entry, tenure in the context of foster care had several characteristics that could contribute to either negative or positive impact. The child's initial reaction to the removal from home was the first dimension with this potential.

Nearly all of the adolescents described feelings of ambivalence related to this event, however, upon analysis, their experiences could generally be classified as predominantly traumatic or relief-producing. Two adolescents described their negative experiences connected with foster care entry:

> (Respondent age 8 at first placement.) My friend's mother tried to enroll me in school and the police came and they acted like I was some kind of criminal. They handcuffed me-- a little kid! They handcuffed me for no reason. They thought I was gonna beat up on one of them or something. And they handcuffed me and put me in the back of the car. And they took me to shelter.

> (Following the report of physical and sexual abuse made by the respondent's sister to a school counselor.) Then, our counselor said, "Okay, you go home tonight and just pack your bags. Don't show them you have your bags packed. Get a couple few things that you really need, like underclothes and one, two pair of clothes and the next morning you come and you don't go back." So we came next morning. We got out of it. I was so scared and nervous and everything. Then, the whole day, it was, like, police. And they took us to the General (county hospital). There was a small shelter there. We stayed there for a couple hours, and they took our reports again. We had to tell our story over and over again. And have a doctor look at us. And they called all the shelters and found us this one. I was so scared the whole time!

Another girl illustrated a more positive response to her initial placement:

> My uncle slapped the hell out of me. So I packed my stuff and stayed over at a friend's that night. When I came home the next day, I talked to my aunt and the next door neighbor and my aunt said I was to come home or go with the cops. They reported me as a runaway and I wasn't a runaway-- they knew where I was. So I went with the cops by choice. And I basically decided I didn't want to live there anymore. It was such a relief. I needed a break from my family.

Closely related to the initial reaction to out-of-home placement was the level of control that the child perceived

over the event. Events which precipitated placement in this sample were of two types: other-precipitated (71%) and child-precipitated (29%). Other-precipitated events included suspected child abuse/neglect reports made by concerned adults (e.g. neighbor, family friend, teacher) and caregiver's judgment that the child was unmanageable followed by calling the police or social services for removal from home. Child-precipitated events included disclosure of abuse to a peer or authority figure who then reported it to child protective services and suicide attempt followed by psychiatric hospitalization during which reasons for removal from home were identified.

Respondents appeared to perceive less control when removal from home was instigated by others versus self-initiated. Those who precipitated the placement process viewed themselves as different from other residents since they chose to be in foster care. The notion that "I don't <u>need</u> to be here-- I <u>chose</u> to be here" appeared to elevate their perceived status in comparison to other foster children.

Although these two groups of adolescents differed in their perceptions of control over the event of foster care placement, even those who precipitated their own removal from home did so with trepidation regarding the unknown consequences of their actions. Themes of fear and uncertainty were repeatedly found in the data:

> When I came to the shelter, I didn't know about nothing. I was so terrified. I had no idea what would happen to

> me. You were supposed to be there temporarily. I ended up staying there for five months.
>
> When I got here, it was at night and I went right to sleep, but I thought I might not want to be here when I woke up. It was a hard change and I didn't know where I was coming. I heard stories like that they would lock me in my room. And I thought that you would have to be in your room, and when it was time to eat you would have to all come and eat and then the kitchen closes.
>
> I was afraid of what my uncle would do when he found out. He'll really kill us! Would he find us? Would they tell him where we were?

Finally, the prevalence of discontinuity in caregiving found in this sample had the potential for negatively influencing the impact of foster care. With the high incidence of both staff turnover and multiple placements, none of the participants experienced completely continuous, stable caregiving. Despite the reality that only a very few of the respondents were able to identify a consistently available, supportive adult in their lives (either within or outside of foster care), it is important to note that this is a variable that was viewed as contributing to a more positive outcome in the areas of self, interpersonal relationships, and the development of independence. Example:

> My aunt has always been there for me. Especially when I really got fed up with this place. I felt like I wanted to go AWOL so bad. I'd sit there in my room at night and think, "All I really want to do is go AWOL and go visit my family and never come back to this place." So I would wait until the next day and call my aunt, and she would say, "Bite your tongue and hold it and just stay there and see how it goes." So she encouraged me to stay here for a little longer time. And ever since I've been in foster care, I have been on overnights to her house. I'm really getting used to dealing with her now, because she's like the main person that can take care of me now.

Most of the factors identified in the data as having the potential to influence the impact of foster care appeared more likely to accentuate negative outcomes. These included detrimental preplacement experiences, the adolescent's lack of control and uncertainty regarding the future, and unstable and/or continually disrupted caregiving relationships. Though far less prominent in this sample, potentially positive moderators included the perception of greater control over one's life and the presence of a consistent, supportive significant other.

Summary

The purpose of this chapter was to lay out a rich description of the multiple, relevant dimensions that were found in the interview data from this sample of adolescent foster youth. The result of these preliminary analyses was the identification of the many variables which have the potential to contribute to a theory related to the impact of foster care as perceived by the adolescents who actually experience it. The integration and synthesis of key conceptualizations based on these dimensions served as the foundation for a grounded theory.

CHAPTER 5

A GROUNDED THEORY OF IMPACT: THE PROCESS OF ADOLESCENT IDENTITY DEVELOPMENT IN THE CONTEXT OF FOSTER CARE

The next level of analysis required the determination and elucidation of the relationships between salient dimensions derived from preliminary analyses. The selection of a central perspective was made in order to organize the dimensions utilizing the explanatory matrix, the cornerstone of dimensional analysis. The process of adolescent identity development in the context of foster care was selected as an appropriate perspective for organizing the data. Using this perspective to configure the explanatory matrix, conceptualizations advanced from a descriptive level to an abstract, analytic level that enhanced meaning and explanation. The purpose of this chapter is to provide an overview of a grounded theory related to the impact of foster care.

The Central Perspective

Since the main focus for this research was on the impact of foster care, it was helpful to first examine some of the consequences or impact areas that were being described in the data. Despite variation between respondents related to magnitude of impact, three major areas of impact were apparent: stigmatized self-identity, difficulty making and sustaining supportive interpersonal relationships, and lack of future orientation. In asking the question "What central

condition or process contributed to these areas of impact or consequences?", several key dimensions were considered as the central, organizing perspective (e.g. recapitulation of earlier loss experience, contextual structure of placement, the process of becoming independent, and the process of identity development). With each potential perspective, the other dimensions were classified as salient, relevant, marginal, or irrelevant. It should be noted that any dimension can be given consideration as the central perspective. The dimension that is ultimately selected is the one that provides the greatest ability for integration and conceptual development within the theory.

An example of a potential perspective that was tested and rejected was the contextual structure of the foster care setting that the adolescent experienced and its features that contributed to impact on the areas of self, relationships, and independence. Preliminary analyses identified the two major underlying structures found in the group homes represented in this sample: the institutional and the family-like structures. These structures had clear differences. To summarize, common elements of the institutional structure included an excessively restrictive, punitive program, a lack of individual treatment or respect, an unpredictable, chaotic environment, and negative staff issues including a power imbalance between staff and residents, frequent staff turnover, and inappropriate caregivers. The family-like structure, in contrast,

emphasized attempting to make the group home environment closely imitate a home-like atmosphere with stable, nurturing caregivers. Program specifics were less formal, more flexible and individualized, and based on respect for oneself and others.

It was initially hypothesized that the type of structure experienced would influence the kinds of consequences or impact demonstrated by the adolescents. In directing the analysis according to this perspective, it was found that adolescents who lived in settings with an institutional structure manifested a stigmatized self-identity, identified few meaningful relationships, and had little ability to make realistic plans for the future.

Using this perspective to guide examination of the few adolescents who lived in family-like structures, one would suspect that the consequences experienced would be different. Although this group of respondents reported feeling valued by some caregivers and appeared to have a higher level of self-esteem, they still clearly suffered from stigmatizing experiences and demonstrated a lack of future orientation. In light of these findings, the perspective of contextual structure was rejected for its inability to sufficiently explain the trends in the data.

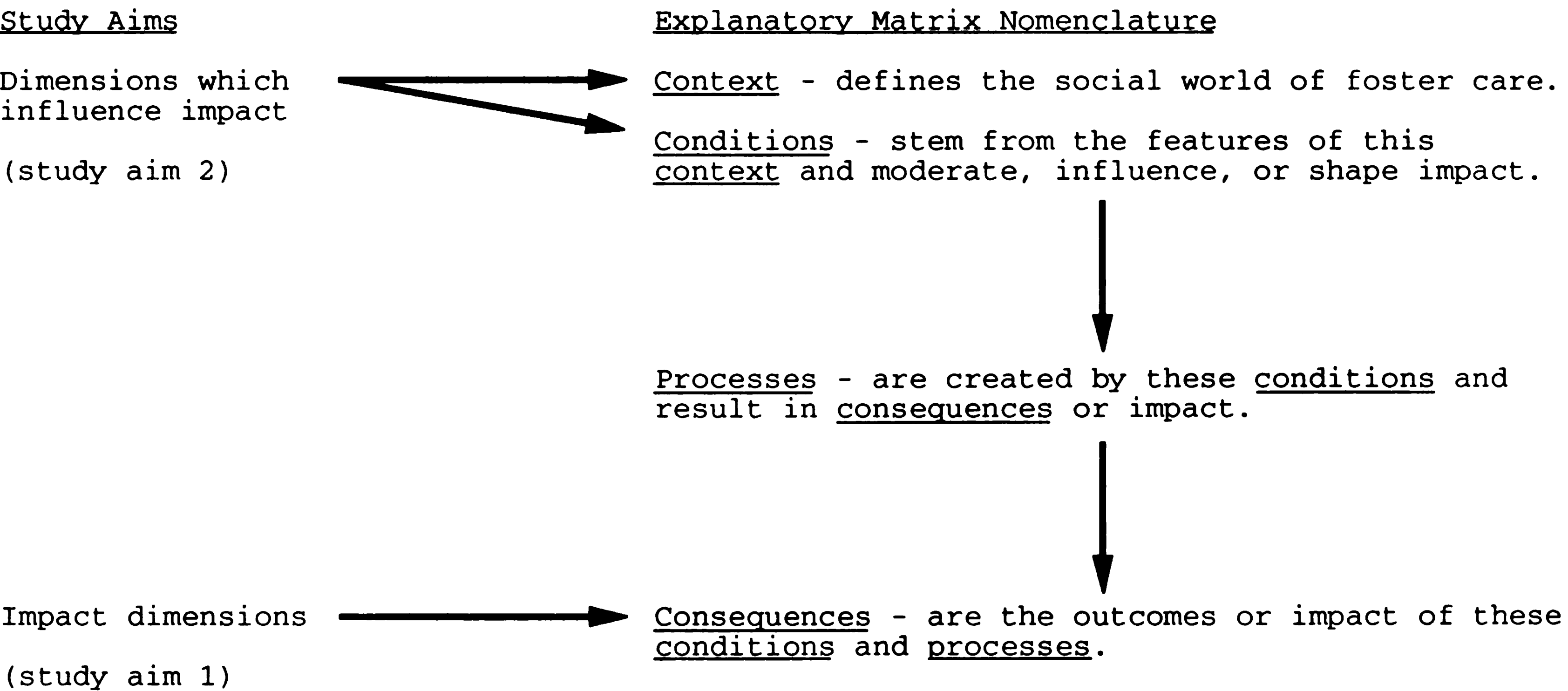
From this consideration of various dimensions as the potential central perspective along with multiple configurations of the explanatory matrix, it was determined that the process of adolescent identity development as seen

within the context of foster care provided the most explanatory power for the range and variation of dimensions expressed in the data. "Becoming a foster child" was an integral component in the development of identity for adolescent foster youth. The incorporation of the status of foster child was a central feature of identity for this group. Identity development thus became the higher order concept around which all of the other dimensions were organized and explained. In this sample of adolescents in foster care, the age-appropriate developmental milestone of identity development subsumed other developmental outcomes like the nature of one's interpersonal relationships and the development of independence.

The Explanatory Matrix

From preliminary analyses, a descriptive list of dimensions was identified. Using the central perspective of adolescent identity development, salient dimensions were selected and arranged along the explanatory matrix as context, conditions, processes, and consequences. To follow the structure and nomenclature of the explanatory matrix, dimensions which influenced the impact of foster care were organized as context, conditions, and their resultant processes. Likewise, dimensions related to the impact of foster care were classified as consequences in the matrix (see Figure 3). In this way, patterns and relationships between dimensions were identified and integrated into a theory related to the impact of foster care.

Figure 3 Integration of Study Aims into the Language of the Explanatory Matrix



The final configuration of the explanatory matrix is illustrated in Figure 4 and Figure 5. The end-product of this explanatory matrix is a theoretical story. Strauss and Corbin (1990) used the procedure of creating a storyline to present an overview of the integrated conceptualizations of a theory. Using this pragmatic device as an organizing schema, the theory can be translated into a clear, narrative version. The process of adolescent identity development in the context of foster care is the pivotal phenomenon of this grounded theory. It shall be presented along with its relationship to other developmental outcomes.

In relating the theoretical story from the explanatory matrix, it is not always possible to proceed in a linear fashion. Conditions, processes, and consequences in the matrix often occur simultaneously. For the purpose of illustration, components of the matrix will be segmented and discussed in the most logical way possible (e.g. flowing from conditions to processes to consequences, as they are related). Headings from the explanatory matrix shall be used to organize this discussion with the understanding that they were originally generated from impact dimensions (study aim 1) and dimensions which influence impact (study aim 2).

The Theoretical Story

From this investigation, a theoretical story emerged which described the experience of "becoming a foster child"

Figure 4 Explanatory Matrix for the Theory of Impact

Organizing Perspective: The Process of Adolescent Identity Development in the Context of Foster Care: Devaluation of Self by Others

Context	Conditions	Processes	Consequences
Detrimental preplacement experiences			Areas of impact:
			Self
Foster care entry			Stigmatized self-identity
New residence	Institutional structure	Devaluation of self by others	Low self-esteem
Conferral of new status	Diminished status of foster child	Depersonalization	Relationships
		Stigmatization	Social isolation
Foster care within the larger social context	Stereotypical view of the foster child		Lack of family connection
			Independence
			Low self-confidence
			Lack of future orientation
			Little belief in self, abilities

Figure 5 Explanatory Matrix for the Theory of Impact

Organizing Perspective: The Process of Adolescent Identity Development in the Context of Foster Care: Protection of Self

Context	Conditions	Processes	Consequences
	Detrimental preplacement experiences		Areas of impact:
			Self
	Devaluation of self by others		Veneer of self-reliance
The uncertainty of foster care	Illusion of a normal existence	Protection of self	Relationships
			Social detachment
	Unpredictability	Strategies:	Independence
		Guard status	Pseudoindependence
		Defensive posture	Lack of future orientation
		Distance self	
		Keep superficial	Fear of future loss and trauma

and the ramifications of this change in status. The context of foster care superimposed the normative process of adolescent identity development and led to outcomes that appeared to be unique to this group. The explanatory matrix will be used as a framework to tell the story of the foster care experience and its impact as perceived by adolescents.

Detrimental Preplacement Experiences

A child enters the context of foster care with a personal psychosocial history which serves as a precondition for foster care entry. A multitude of ongoing, severely detrimental events and experiences set the child apart from others as a candidate for foster care. Parental substance abuse, child abuse and neglect, and other forms of family violence and mental health problems are examples of the family dysfunction that predispose a child to foster care placement. In addition, experiences of loss (e.g. parental death), instability (e.g. multiple caregiver changes) and social deprivation (e.g. poverty) characterize the preplacement biographies of these children.

For foster children, the trajectory of childhood development has already been marred by traumatic episodes and unsatisfactory relationships. The long-standing difficulties that these children have experienced contribute to their heightened vulnerability to future developmental and emotional impairment following foster care placement. In order to ascertain the impact of foster care on children, it

is important to acknowledge that they already enter such care in a compromised state.

Foster Care Entry

With foster care placement, the child enters a new social context for living. The boundaries for this context include the specific foster care residence with its characteristic structural typology and the interface of this setting with the larger social world.

Several characteristics of the foster care context contribute to the impact of the foster care experience on the child's development and functional abilities. Adolescent perceptions of the specific contextual features of the foster care setting along with experiences encountered while in foster care led to the identification of a set of conditions which influence the central process of identity development and other related developmental outcomes (e.g. development of interpersonal relationships and independence). As shown in Figures 4 and 5, salient conditions include the underlying institutional structure of the predominant model of care, the diminished status and stereotypical view of the foster child, the illusion of a normal existence, and the unpredictability of foster care. These conditions occur concurrently and contribute to two major, parallel processes: the devaluation of self by others and the protection of self. Conditions, processes, and the specific consequences that they generate shall be presented in detail.

The New Residence: A New Context for Living

Following removal from home, the child is assigned a new setting in which to live. When the child moves into a foster home or group home, three conditions immediately change. First, the child is placed under the authority of a new caregiver or set of caregivers. Biological parents relinquish control over the child and foster parents or group home staff are now responsible for the supervision and caretaking of the child. With removal from family or relatives, familiar, kin care is replaced with caregiving by strangers in an unfamiliar and formal or institutional residence.

Second, there is a new group identification associated with being in foster care. The foster child is no longer visibly a part of his or her family of origin and the relationship system is sharply and unambiguously altered. In addition to the new caregivers, other children (e.g. foster children or biological children of the foster parents) may live in this new setting. Day to day activities like sharing a room, meals, common living space, and household chores are determined, not by choice or negotiation, but by virtue of the composition of the foster or group home.

Finally, foster care placement precipitates numerous transitions secondary to the child's change in residence. Access to biological family members and identified significant others may be impaired (e.g. out-of-county placement, controlled access to family by staff). A change

in neighborhood and community may lead to the requirement of attending a new school and the loss of friendships. It also requires learning the boundaries of the new context. Is the neighborhood safe? Is the home conveniently located with respect to the child's school or work? The new and formal social environment that the foster child encounters with its unfamiliar rules and guidelines for behavior in unknown surroundings cast the child as a true stranger, unsure of oneself and of how to act.

The Institutional Structure

As the foster child is adjusting to the immediate and obvious changes evoked by the new residence, a major salient condition comes into play and influences the impact of the foster care experience. Some of the most critical contextual features of foster care discussed by the study respondents were related to the underlying structure of the foster care setting. While two distinct structures emerged in the data, the institutional structure represented the predominant model of foster care encountered by the respondents. With descriptive characteristics which emphasized excessive restrictiveness, a lack of individual consideration and respect, a focus on pathology and deviance, and the discontinuity of caregiving, the institutional structure is viewed as a condition which negatively shapes the central process of identity development.

Under these circumstances, when one becomes a foster child, the physical context along with the child's

interpersonal relationships are altered. The foster child now has a new place to live and new people to say who he or she is.

Conferral of a New Status

In conjunction with encountering the prototypical institutional structure found in foster care, the foster child is defined by others in a new way. Foster care placement not only results in the change of a child's primary domicile, but in the change in the child's status as well. The status of "foster child" is conferred on the child by others in authority. Upon receiving this label, the foster child soon learns that it is not a status of which to be proud. Foster child status is neither familiar nor positive. The unfamiliarity is immediate while the negative attributes more gradually emerge with indicators through verbal and nonverbal communication. The status of foster child was seen to be abnormal and bad or damaged by the study participants.

The Diminished Status of "Foster Child"

Based on adolescent perceptions, it was found that many individuals in the new social milieu of foster care appear to manifest a stereotypical view of the foster child. Even though this may not be conscious or intentional, common conceptions of the foster child often automatically include the assumption of delinquency or psychological impairment. The predetermined assumptions and perceptions held by those in the foster care context promote the inferior, diminished

status of foster child which is communicated in both direct and subtle manners.

Foster Care Within the Larger Social Context

Stereotypical View of the Foster Child

Data indicated that biased perceptions associated with the foster child extend beyond the boundaries of the foster care setting. Those in the child's larger social world hold common negative stereotypes of foster children. There appears to be a strong social recognition of what are believed to be the inadequacies of being a foster child.

The dominant culture places a high social value on "belonging" to a family. This legitimate social connection is a part of how one is naturally identified and acknowledged (e.g. a daughter, a brother, one of the Smith kids). If a child is orphaned, this is a status that is understandable, to be empathized with, and seen as not within the child's control. A foster child, on the other hand, *has* a biological family. This status appears to be a social aberration with little understanding, and thus, is suspicious. A common question is "What has the child done to contribute to the circumstances of being placed in foster care?" Likewise, the child is typically viewed as a product of the family, that is, the child is expected to manifest behaviors that are indicative of this past family dysfunction (e.g. drug abusing parents beget drug abusing children).

The lack of public awareness and understanding of foster care is exhibited in several ways which were illustrated in

the interview data. First, the negative stereotypes of delinquent or psychologically impaired are widely held and applied by those in the foster child's social environment. Given these stereotypes, the foster child is expected to behave within the parameters of these labels and is treated accordingly.

Second, the foster child is subject to intense scrutiny by others related to what is considered to be an abnormal status. Questioning focuses on one's differentness and the inadequacy or failure of one's biological parents. Adults and peers frequently ask what are perceived by the child to be intrusive and intensely personal questions about parents, family members, and past experiences.

Finally, the foster child is constantly confronted with the abnormality and inferiority of the foster child status in peer interactions in which he or she is the object of teasing and ridicule. These experiences appear to be especially significant during adolescence when the desire for conformity and sameness with peers is acute. The foster child has frequent, recurrent encounters with peers and adults that exemplify these stereotypical views.

Repetitive experiences of this nature have a significant impact on identity development. The child's self-image mirrors the perceptions of others that are communicated via social interaction. Data suggested that foster caregivers are perceived to do little to dispute these negative social

beliefs and the diminished status of foster child is reinforced both within and outside of the context of care.

The Process of Devaluation of Self by Others

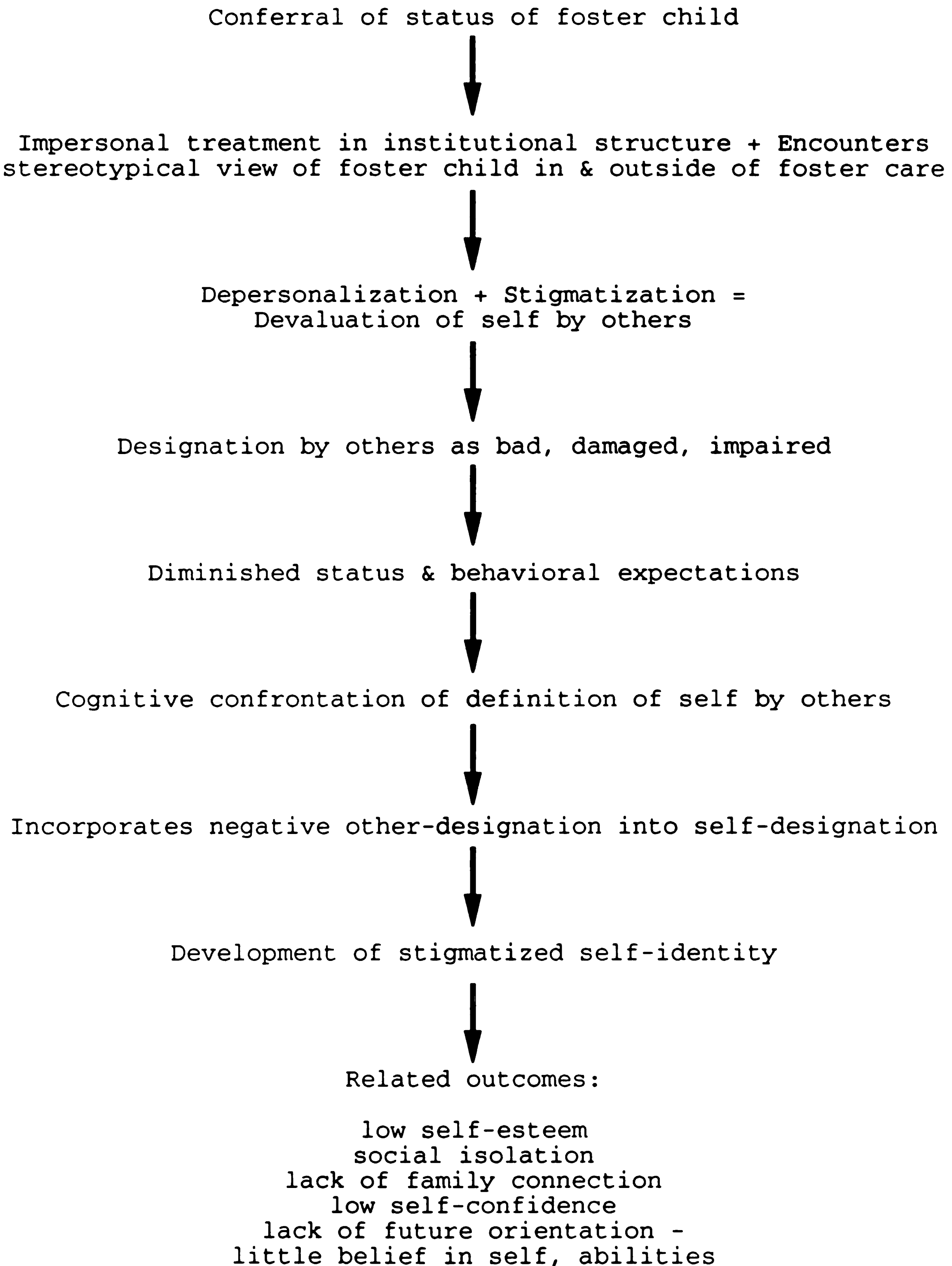
The concomitant conditions of the institutional structure of the foster care setting, the diminished status of foster child, and the stereotypical view of the foster child are closely interrelated. Together, they create a process that is integral to the development of identity in the context of foster care. This process can be conceptualized as "the process of devaluation of self by others".

The devaluation of self by others is defined as the lessening or discounting of one's status by others with beliefs and actions. The process immediately begins when one becomes a foster child and follows several steps which ultimately produce consequences or outcomes (see Figure 6).

With the conferral of the status of foster child, the child must face and endure the stereotypical views held by others both within and outside of the context of foster care. At this point, two major types of devaluation of self by others occur: depersonalization and stigmatization.

Depersonalization represents the devaluation of one's personal identity via impersonal treatment and lack of individual consideration and respect. Living in a setting with an institutional structure, the foster child experiences a punitive style of restrictiveness, a lack of individual treatment and respect, little consideration for one's normal

Figure 6 The Process of Devaluation of Self by Others



development, and inappropriate or unstable caregiving. Interactions of this nature are interpreted by the foster child as depersonalizing or taking away his or her individuality. Personal attributes are stripped away and substituted with the categorical descriptors of foster child status. Foster youth are treated according to this abstract status which describes a type of person without attention to nuances, variability, or individual personhood. The adolescents recounted numerous examples of depersonalization that were an intrinsic part of their daily lives:

> Now they've moved the whole thing (three smaller group homes) into this one gigantic group home in a three-story apartment building. It's like an institution. And now our same staff is called treatment counselors. They weren't treatment counselors before, so what did they go through , what process, to become treatment counselors?! I mean, we just moved down the street! And now they use me as a guinea pig. They try out all these different programs and try and make me fit into it. It's like they go buy a book on how to analyze a 17-year-old kid, the stereotype. And that's how they treat you; not like yourself.

> There was this one counselor named M. She was very mean. She was trying to make everything over-structured. When she was in charge, she would check everybody's rooms and do the score sheets. I never got anything below 100. But once, she was working and put the whole house on restriction because some of the guys got 80's and 70's. It wasn't fair. I missed my junior prom. The dance came and she wouldn't let anyone go. And we had rented tuxes and two limousines. I was confused cause I was on restriction for no reason. But she wouldn't listen. She didn't care.

> Oh and that's another thing: When you do something, they write it in the log. And then everybody knows all about your business. They want you to talk to them about your problems but then they write it all in the log and everybody thinks its their business. Like this time, my aunt never showed up to take me on my pass. I was really upset and I cussed out one of the staff. She was really pissed but later, I apologized and explained to her what was going on with me and we straightened it

> out. Later, she goes off (duty) and the next one comes on and reads the log. At dinnertime, she says in front of everybody, "So P., I heard you're having family problems and you cussed out B. You know it's a rule that you can't cuss out the staff here. You're on restriction; you have to learn not to take all your problems out on everybody else." Then, I had to wait a week for B. to work again so I could get off.

The other form of devaluation of self by others that was universally, emphatically described by the foster youth in the study was stigmatization. Stigmatization is defined as the devaluation of one's personal identity by others via biased assumptions, description or identification in negative, stereotypical terms, and behavioral expectations and treatment according to these biases or labels. When the foster child has an interaction which is colored by negative stereotypes, the experience is characterized as stigmatizing or one that produces stigma-- the mark of social shame. Feelings of inferiority and shame are typical responses to these experiences which are commonplace in the foster child's social world. All of the adolescents who participated in the study described the frequent experiences of stigmatization, their responses, and its perceived effect on their lives. Examples:

> I told a teacher that I'm in a group home, and the kids heard and they go spreading it around that you're in a group home. Then everybody knows about it and they make fun of you. "Did you rob a store? Did you kill somebody? Did you assault and battery? Did you threaten somebody with a gun?" They think you were put in Juvenile Hall or something like that. You want to just stay away from <u>everybody</u>!

> The way they (former foster parents) put me down was that they knew about my mother and her problems. And whenever I acted a little weird when I was there, they

> kept bringing up my mother. They would make cracks like, "You must be taking drugs." I didn't appreciate that much. I would never take drugs. I saw how it tore up my family. But everyone was always treating me like I did.
>
> Other kids sometimes like to think they're better than you, just because you live in a foster home. Some kids, they pick on them because they have problems. Like your family doesn't want you or can't take care of you. But me, I just keep to myself. It really doesn't bother me.

The acts of depersonalization and stigmatization lead to the designation of the foster child by others as bad, damaged, or impaired. These experiences serve to reinforce the diminished status of foster child and to delineate parameters for the child's expected actions and abilities.

The foster child faces a cognitive confrontation of this new status. A prescription is given by others for both a self-definition and a set of behavioral expectations associated with the status of foster child. "I am who others think I am and I will behave accordingly." The child begins to consider this definition of self as transmitted by others. The definition of self by others is either accepted or challenged. In either case, it is extremely influential in the expression of status which is individually determined and has variation.

Impact on the Self

Two major areas of impact on the self appear to result from the devaluation of self by others: a stigmatized self-identity and low self-esteem (see Figure 4)

Development of a stigmatized self-identity. With the constant engagement in the process of devaluation of self by

others, the foster child aligns the self-conception to reflect the perceptions of others. Peer perceptions are of critical importance as the adolescent foster child considers the universal question: "Who am I?". Peer validation of the stigma associated with being a foster child appears to be a particularly powerful influence on adolescent identity development.

Internalization of social feedback from the peer group and other significant persons in the social environment results in the development of a stigmatized self-identity. A stigmatized self-identity incorporates the negative designations and expectations conveyed by others in social interaction. In this sample, common self-designations reflecting the stigmatized self-identity included the bad child, the rejected/damaged child, and the child who doesn't really belong in foster care:

> They said in my file that I wasn't foster home material. (Interviewer- Do you have some thoughts about what that means?) Yeah, I wouldn't be able to cooperate. Cause I'm a troublemaker. You know, getting into fights at school, getting suspended all the time, being sent home, not doing what I'm told, hanging out; you know, a regular teenager. I could be in Juvenile Hall or a drug dealer or something like that.

> I'm not like the other kids at my school. My parents didn't want me. I lived in three foster homes. My foster parents didn't want me. Now, I live in a group home and I'm a loner. Probably for what's happened to me in my life, I'll never fit in.

> I think I'm kind of different from all the other girls here because I chose to stay here. Didn't nobody put me here but myself. The board, the judge or anything, they didn't put me here. This was all on me. Sure, I have my problems. Everybody does. But I'm not that bad.

Low self-esteem. Self-esteem, like self-identity, is vulnerable to social feedback. When the foster child internalizes the negative views that others have of him or her, this devalued status is accepted into the self-perception. A negative evaluation of the self which centers on perceived impairment and limitations has an obvious impact on self-esteem. A common derivative of a stigmatized self-identity is lowered feelings of self-worth.

The research respondents discussed their feelings of shame, self-loathing, and low self-esteem associated with being a foster child. Even those who vehemently denied the personal impact of depersonalization and stigmatization on their feelings about themselves often manifested contradictory affects (e.g. depressed, pained expression, anger) or reversed this stance later in the interviews. Observational data from field notes supported that sadness and hurt appeared to be pervasive undercurrents in these responses which seemed apathetic or nonchalant on the surface.

Living in foster care with the intrinsic process of devaluation has a significant impact on other important areas of development. Considering the self as the core component of development, the development of interpersonal relationships and independence can be viewed as in dynamic interaction with one another. In other words, a condition or process which influences the self also has an impact on social interactions and independent functioning. Thus, the

development of a stigmatized self-identity gives rise to a host of other interrelated consequences as shown in Figure 4.

Impact on Interpersonal Relationships

Two areas of impact relate to interpersonal relationships: social isolation and lack of family connection.

Social isolation. The absence of a positive self-identity appears to have an impact on interpersonal relationships. The abnormality and stigma associated with being a foster child often leaves him or her socially ostracized and disconnected. The foster child may avoid closeness with others to minimize the risk of confrontation of the abnormal or diminished foster child status. The self-definition of abnormality or differentness is validated by stigmatizing social interactions. Others avoid the foster child for this perceived differentness. Thus, both the child and others mutually contribute to the foster child's difficulty establishing and maintaining satisfying interpersonal relationships. The end result is social isolation.

The reality of social isolation for the adolescent foster child is the absence of meaningful peer relationships or friendships. The inner sense of being like one's peers is limited. Feelings of loneliness and exclusion are painful reminders of this limitation. Options for relationships are often confined to other outcasts from the dominant social group or older adolescents and adults. Examples:

> In my new school, there's another girl there that's in a group home, too. She's the only person I know right now. We kinda hang together.
>
> Sometimes I feel like, when I get around people my own age, I'm very mature. Sometimes I feel like I'm much older than 17. Sometimes I feel like I'm 20-something, the way I act. People at school say, "You don't act like you're 17". I say, "I do, I do. I just don't do the things you guys do." There's a serious side of me. I like to just be very serious. So they stay away from me. They used to say, "You act hecka-old". I feel it too! I don't feel like I should be in a 17-year-old person's body. My friends are all older-- mostly over 20.

Very few of the study respondents reported having a current boyfriend or girlfriend. Of these older adolescents, intimate relationships were confined to other foster youth or adults. Aside from the difficult logistics of having a boyfriend or girlfriend while living in a group home (e.g. lack of free time, interrogation of the friend by staff), the need for reconciliation of one's status as foster child seemed to be a prerequisite for risking emotional closeness in this group. For example:

> I never got my childhood, and I kind of feel bad about that. Sometimes I'm around with some people and they complain that you're acting so childish. They just won't understand so I don't tell them. But like, for example, I was acting childish with my boyfriend and he knows a lot about my background. So then I told him that, "Well, sometimes I should get my childhood. I never got my childhood." I don't want him to feel sorry for me but I want him to understand, so we talk about it. And, then, he apologizes and says sorry. Yeah, then he tells me to act childish whenever you want to.

<u>Lack of family connection</u>. The association between identity development and interpersonal relationships is visible in the area of family relationships. The impact of social isolation is also a consequence of the imposed

separation from one's family including biological parents, siblings, and other relatives. Factors inherent in foster care which are perceived to contribute to this include limited access to family (e.g. restricted or controlled home visits) and the lack of support for or facilitation of continued connection between the foster child and family. This continual disruption of the adolescent's family relationships appears to have a significant impact on self-identity. Without a linkage to one's family and past, it seems to be even more difficult for the adolescent to forge an understanding of who he or she is. One adolescent expressed this dilemma:

> I want to go over there and visit some of my family and relatives. I don't want to forget about my culture and stuff so I want to go there. But it's not easy when you are in foster care. It's like you're not part of that anymore. Like they're not your family anymore. I mean, they're still your family but not like they used to be. You know? And, it's easy to forget where you came from, who you are.

Impact on Independence

The development of independence is also negatively effected by the stigmatized self-identity resulting in low self-confidence and lack of future orientation.

Low self-confidence. With a stigmatized self-identity, the focus is on "What I cannot do" versus "What I can do". Data suggested that the foster child has little self-confidence. One's range of abilities and future options are often viewed as limited. The conception of a future occupation or career is an extension of self-identity. As a major component of identity development, the adolescent is

considering what he or she wants to become. Developing a vocational identity is usually a central issue. When incompetence and disability are validated through the social representation of the adolescent as impaired or abnormal, the foster youth's expectations for the future are reduced and aspirations are adjusted accordingly. For example:

> I know I want to become a nurse. That's what I want to do. But I think it's going to be too hard for me. I'm probably not smart enough to pass the course. So I thought of being a nursing assistant.

Lack of future orientation. Having a future orientation can be conceptualized as the ability to both envision and plan for one's future. Despite formalized training to improve independent living skills prior to discharge from foster care, the foster child characteristically maintains a present, "here and now" orientation. Even study participants who were faced with imminent discharge had no, few, or very vague plans for the future. These adolescents exemplified the poor ability to make future plans that characterized this group:

> (This foster youth had just graduated from high school.) I'm planning to go to college. (Interviewer- "What would you like to study?") Something in the computer field. ("Do you know where you could go to school to study computers?") No. ("Has anyone ever helped you figure out which schools would be good for this or how to go about applying?") No. ("Did anyone at your school help you figure out what you needed to do to get ready for college?") No. I was thinking about starting in the spring.

> I will be leaving the group home after graduation in two months. So, it's closer and closer and I'm getting nervous and nervous day by day. (Interviewer- "Do you feel ready to leave?") I feel ready all right, but it's like I have to really make money and get up there and work hard for it. ("Do you have a job?") I'm in a job

> training program and hopefully, I'll become an employee there. But they don't have any openings. ("Do you have any idea where you'll be living?") No, I don't have a place right now. All I know is I just want to have my own keys and I'll know I'm on my own.

The lack of future orientation stems from the constant confrontation with the devaluation of self by others. With the internalization of this viewpoint into the developing self-identity, the foster child may envision limited options for the future and, thus, manifest lowered aspirations.

Without a sense of competence or belief in oneself, the ability to live independently is threatened. Likewise, the lack of social connectedness influences the foster child's ability to envision or achieve independence in the future. Social support and resources are needed to encourage and reinforce the autonomous functioning of any adolescent. These resources are sorely lacking for foster youth who are approaching the reality of independent living.

To summarize, the impact of depersonalization of self by others on the self, interpersonal relationships, and the development of independence is an interwoven process. Of primary importance is the development of a stigmatized self-identity. This negative conception of the self is manifested in the destructive consequences in other fundamental areas of human development: the ability to be satisfactorily affiliated with others and to function autonomously and productively in the social context.

Up until this point, the analytic framework seemed to illustrate a smooth and logical path which moved from a set

of salient conditions in foster care that had impact, their contribution to the process of devaluation of self by others, and the impact of this process including the development of a stigmatized self-identity, social isolation, and low or unattainable future aspirations and options (see Figure 4). What was not explained in this process was the self-presentation of personal strength and independence that many of the respondents portrayed in the interviews. Did these adolescents fit the theoretical story that has been described or were their experiences significantly different? Can one have a stigmatized self-identity and still appear to others as competent and autonomous?

Further analysis led to the discovery of an equally compelling, parallel process which provided explanation for what initially appeared to be divergent findings. This process, its contributing conditions, and its relationship to the central process of adolescent identity development shall be delineated (see Figure 5).

The Process of Protection of Self

When the foster child must endure recurrent assaults on the evolving identity, defenses must be developed to prevent additional harm. "The protection of self" is the process by which one develops these defenses and related strategies to protect oneself from further disappointment, rejection, loss, and/or trauma. This process may actually begin prior to foster care placement with the child's history of major loss or ongoing abusive relationships. Consequently, detrimental

preplacement experiences are conditions which contribute to the protection of self. In any event, the process is accentuated in foster care with experiences such as multiple placement transitions, unstable caregiving, and episodes of further abuse or mistreatment.

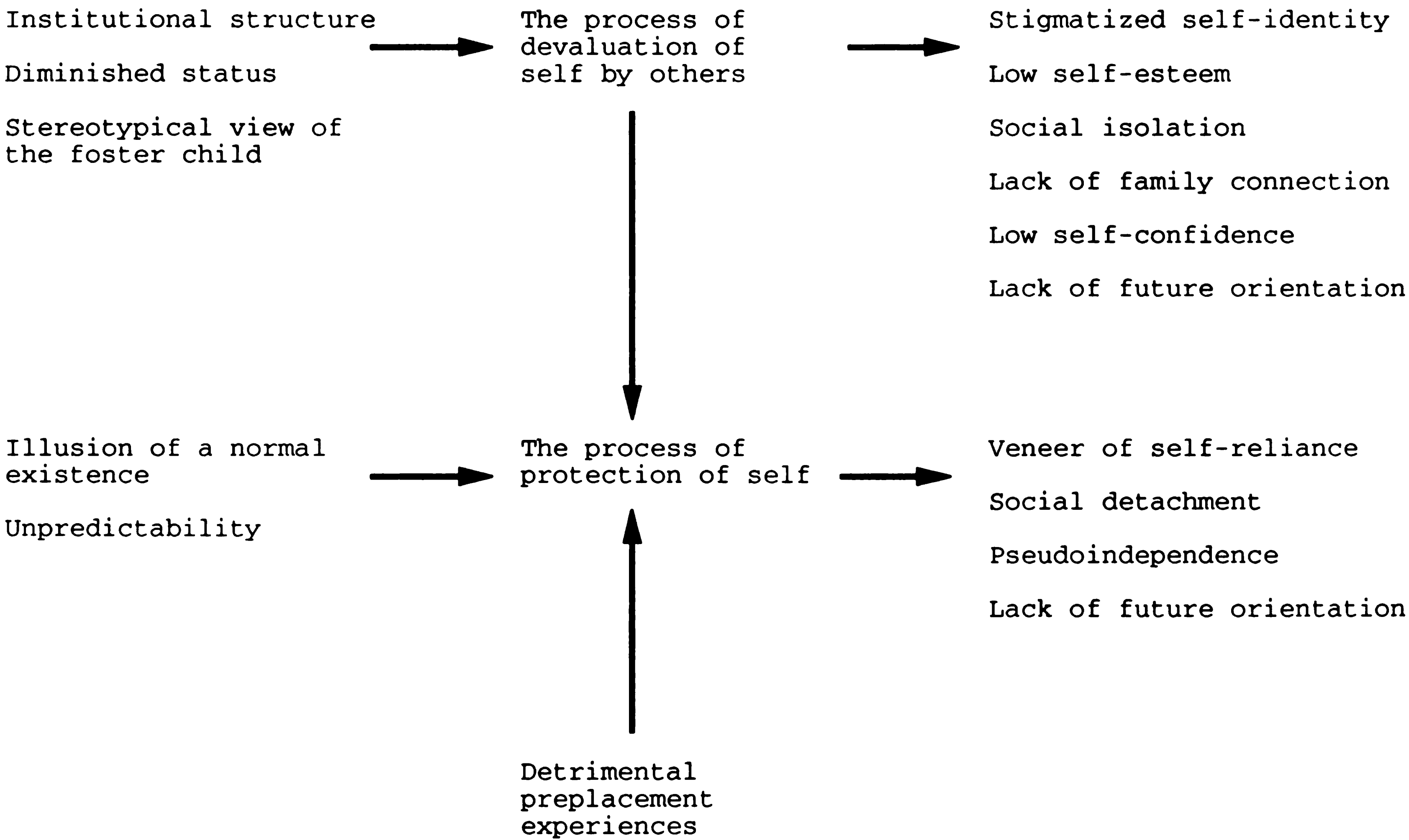
The process of devaluation of self by others is a condition which contributes to the process of protection of self. The foster child must begin to protect himself or herself from the negative impact of continued experiences of depersonalization and stigmatization. In conjunction with conditions encountered in foster care which contribute to the process of devaluation of self by others, other contextual features of foster care serve as conditions which lead to the process of protection of self (see Figure 7). The uncertainty which is inherent in the context of foster care was a prevalent theme in the data. The illusion of a normal existence and the unpredictability of foster care are examples of this uncertainty and are additional conditions which give rise to the process of protection of self.

The Uncertainty of Foster Care

The Illusion of a Normal Existence

Upon foster care entry, several commitments are directly or indirectly made to the child. Promises of a new or alternate family, a permanent home, and stability are often issued. The foster care setting is described as "family-like" and "home-like". Efforts to normalize the experience

Figure 7 The Process of Protection of Self



of living in foster care are made by caregivers. Thus, the illusion of a normal existence is created. Likewise, the ideal of permanence, which is defined as being able to stay in one place with consistent caregiving, is assured.

Study participants viewed the nature of care that they received to be impersonal and excessively restrictive. In conjunction with the frequent perception of the broken commitments for stability in residence and relationships, the foster child is faced with a disparate view of this normal, family-like existence. Many of the adolescent respondents described their disillusionment with the misrepresentation of foster care as family and/or home:

> Next, I lived with the H.'s. They had one son my age and one who just went away to college. It started out cool, W. (foster mother) bought me lots of clothes-- she said I was like the daughter she never had. Then, she turned weird. She blamed me for anything that went wrong in the house. She always took N.'s (her son) side in anything. She always accused me of lying. Anyway, she took me on this long train trip to Chicago to meet her family. She said that she really wanted me to be a part of her family. She blamed me for stirring things up and accused me of things I never did. When we got back to San Francisco, she took me right to DSS and said, "I wanna get rid of her!". We weren't even speaking. Some family!

> When I moved into Group Home C, I was 12. They promised me that this would be my home until I turned 18. I had been in so many other places before. C. was the first place that I really settled down. After I lived there three years, they decided to change it into a program where you only stayed for one year. I couldn't believe that they could do that!

<u>The Unpredictability of Foster Care</u>

The transitory nature of foster care was highlighted in the experiences and interview responses of the adolescents. Foster care, as experienced by this sample, can be described

as a system or context that is in constant flux. Even in the group homes with a stable core group of residents or caregivers, membership of the home continually changed. Both frequent staff and resident turnover were innate features of the living environment.

There is another component to the transience in foster care that must be considered. The foster child may also be moving from setting to setting. In this sample, multiple placement transitions were commonplace. The adolescents experienced an average of four placements. None had lived in only one foster family or group home since foster care entry. Thus, not only are the people within the child's setting changing but the setting itself changes for the child at times.

These multiple and perpetual changes lead to instability and unpredictability in the areas of residence, caregiving, peer and adult relationships, and future options. First, the child's presence in the foster care residence is delimited by the principle of temporality. All foster care placements are essentially time-limited. The language that defines the temporal nature of foster care is often confusing which contributes to uncertainty. A "temporary" placement may, in actuality, extend for a long period of time (e.g. many months) secondary to the difficulty finding a long-term placement for the child. Although the notion of temporary can be prolonged by the system when necessary, time limitations are not equally flexible from the perspective of

the child. When placed in an overtly designated temporary placement, the child generally cannot remain even if he or she has stabilized, made significant attachments, and desires to stay. For example:

> There was this lady and her husband, and the old lady worked with deaf kids. The people were real nice. And one of the kids staying there was deaf in one ear. So he and I had fun and stuff. Everything was fine. I was there for about six months. I had to leave because it was a temporary placement. It was uncomfortable. Places that are temporary are usually the places that you want to stay anyway. That's how the thing is.

The notion of a "permanent" placement is also a misnomer. Even a permanent foster care placement is subject to change. Programs change, foster parents' circumstances or commitment for long-term involvement may change, the child's behavior may precipitate a placement transition, or the child may request to move. One boy discussed overhearing the foster mother that he'd had for two years discussing her plan to "get rid of" him and his brother:

> She wasn't going to tell us but we found out somehow. After graduation (from middle school) was over and we came home, she was going to have some people there waiting for us to take us away. She was talking to her son, and we was walking up the stairs and we heard them talking about the problems with us kids. She was going to keep my little brother. And he (her son) was saying, "We'll have to do something with the other two. I'll call up some people and they'll come right after graduation."

Another girl spoke of losing her permanent placement due to the mental illness of her foster mother:

> Mrs. K., she was this old lady, very religious. Her kids were grown so she wanted to help us. Me and three other kids lived there, sometimes four. Plus her niece. She loved everybody. But then, she had a mental breakdown. She thought everybody was going to kill her.

> She slapped one of the boys. They took her to the hospital. I had to go back to C. (a shelter).

Additionally, the permanent placement is bound by a specific time limitation. The foster child is discharged from care at age 18 or upon high school graduation and the formal commitment for a permanent home is terminated.

A second source of instability is in the area of caregiving. Frequent staff turnover and multiple placement transitions are contributing factors to the discontinuity in caregiving that many foster children experience. Most of the study participants were able to identify at least one past caregiver with whom they felt close. The loss or losses of these significant individuals were described as disappointing and painful. The repeated transitions in caregiving that the foster child commonly experiences often appear to represent the recapitulation of earlier losses or rejections in the foster child's placement and preplacement history.

The adolescents talked about their difficulties in continuing to invest in relationships with adults that may have little future security. The willingness to trust or get close to new caregivers seems to subside with this instability. Even efforts to continually adapt to the styles and expectations of new caregivers are difficult to maintain.

Continuity in interpersonal relationships is also effected by the unpredictability of foster care. Multiple moves may lead to diminished access to and difficulty maintaining relationships with biological parents, siblings,

relatives, and friends. School and neighborhood changes often result in severed ties with the foster child's peer group and community. Personal loss and disconnectedness related to the instability of one's living situation were recurrent themes in the data.

Lastly, the unstable nature of foster care may ultimately impact the foster child's options for the future. Many of the study respondents discussed significant disruptions which had an impact on their plans for the future. Of paramount importance was the frequency with which foster children change schools with placement transitions. Failure to attain the academic and occupational skills necessary to succeed in the work arena limited the options that some of the adolescents identified for themselves. To the furthest extreme, two of the adolescents would fail to graduate from high school secondary to what they perceived to be educational disruption and falling too far behind. Likewise, participation in activities that provide direct or related occupational skills (e.g. job training, leadership skills) may be interrupted or discontinued. Example:

> When I was in the D.'s (foster home), I joined in to a police department. I was in a junior police academy. And I had graduated from the Academy and everything. I made corporal So I was doing real well there. And a promotion was coming up . And then I left. I just started my first year in high school, and then I just disappeared and couldn't go.

Given this trajectory for living, the threat or fear of future loss or trauma is omnipresent. The foster child perceives a lack of control over his or her destiny. To

establish and maintain some sense of control, the foster child institutes measures of self-protection in order to minimize the effects of loss and disruption. These strategies are integral to the process of protection of self which has an ultimate impact on identity development, interpersonal relationships, and independence.

Strategies for Self-Protection

What are the means by which the foster child self-protects? This sample discussed and portrayed a number of behaviors that could be interpreted as self-protective. As shown in Figure 5, four major categories of self-protective behaviors were identified in the data: guarding status, maintaining a defensive posture, distancing self, and keeping relationships superficial.

The preservation of the hidden status of foster child was the first major strategy used by nearly all of the respondents at some time. This ranged from the strict edict to never reveal foster child status to those outside of foster care to the judicious and careful selection of those deemed trustworthy for disclosure. In the first case, adolescents strongly guarded status and associated details about their living situations as their private business, that is, none of anyone else's. This statement characterized many of the adolescents' responses:

> I just go to school-- live my regular life. There has been people that came up to me and asked me am I in a foster home. It's none of their business. I say, "No. I go to school just like you. I'm regular." I do everything that I do and hey, I don't tell nobody.

Several other respondents admitted to creating a fiction to present to others in order to conceal their foster child status and living arrangements. Elaborate stories were used to cover any evidence of living in foster care. An example of this strategy:

> A lot of my friends come here (to the group home). They come in my room upstairs. They just think it's my home. Last year, I even had a birthday party in the garage. It's not a problem. I tell people this is my mother, this is my sister... I had a boyfriend and he never knew this was a group home. Oh, every time a new girl came I just said, "My cousin came from Cleveland and she's staying with us." I used to feel so bad cause I was lying, but I was so deep into lies that I couldn't turn back. And then I'd have to remember what I said.

When the decision is made to disclose foster child status to a peer or adult outside of foster care, it is often done with a great deal of forethought and selectivity. The risks of disclosure, the trustworthiness and loyalty of the selected individual, and the potential changes in the relationship are considered. Example:

> Only one person knows. My best friend. The friend I told I've been with since middle school and I told him so... After awhile, I told him a couple of things and see if he told anybody-- which he didn't. So I trusted him. And then, I told him a little more and a little more. Now he knows the situation I'm in.

The second category of self-protective strategies was the maintenance of a defensive posture with relation to foster care status. Again, there was a range of how this posture was expressed within the sample. From the apathetic "I really don't care who knows" to the defiant exposure of status "I don't give a damn what they think of me; if they don't like it, that's their problem", the defensive posture

appears to minimize the perceived impact of this status and conceals the vulnerability that the foster child has for potentially hurtful interactions with others.

Distancing self from others was a third category of behaviors that study participants used to protect themselves. This included making a conscious decision to keep to oneself, setting up fronts or barriers to avoid involvement with others, and distancing oneself with antisocial or disturbed behavior. Examples:

> I don't have too many friends. I keep to myself. All my friends basically treat me in the same way. If I have problems I don't tell my friends about them. I keep my problems to myself and I solve them in my own mind. That's the way I handle things. I'm not a real personal person. I just like to handle things the way I like to do things. By myself.

> I don't have much time for a social life. I go to school, I work, plus I have a whole bunch of meetings during the week. My days are planned. I do not have free time. I'm always constantly on the go.

> One thing about me a lot of people say is that I'm a different type of person, I'm a unique kind of person. They say they don't know when I'm telling the truth or not. They say they can't tell when I'm angry or anything, cause they say I keep a pretty straight face. They say that when I'm talking to them, they wouldn't even know if I'm lying or not. They just say I can be an actor because if I wanted to act crazy, I could act crazy, cause it's a natural thing. People just don't understand me. They think I'm crazy. I don't do nothing real crazy, but it's things that I be talking about usually happen. I really scare them.

Finally, keeping relationships superficial was a common method used by many of the adolescents to protect themselves from further loss, rejection, and disappointment. This strategy was validated by nearly all of the adolescents. This behavior was manifested in two different ways. Many

adolescents reported making a conscious decision not to get too close to or make attachments with others. Examples:

> Right now, I have no teenage friends. All of my friends are adults. My girlfriend is the same age as I am. Other than that, the youngest friend I have is 20. There comes a point where you stop making friends. You never know how long you'll stay so what's the point? You don't put out any effort at all. Now if people want to be nice to me, that's okay. Even if I know I'm gonna be here for a while, I try not to get too attached to people.

> You get shipped around to different places all the time. I figure anyone can take it. You just got to relax. I say, "Here I am at this new place. I'm just going to hang out here. I'm not getting close because I'm just going to be moving on." I've been to four or five schools. It's not that hard to make new friends. But I just don't attach.

Others admitted to the exploitation of relationships to meet one's needs without investing on a personal level. An illustration:

> I'm not really close to anyone that lives here (the group home). Oh, I'm nice to them, like when I need to borrow something. So I basically just use this place like a motel.

Impact on the Self

The veneer of self-reliance. Despite the range and variation of strategies employed by the sample, their outcome associated with identity development was common to all respondents. The key defense manifested by the foster youth in this sample can be conceptualized as a veneer of self-reliance. The underlying themes which united the strategies were "I can and must take care of myself", "Others can hurt you", and "I don't need anyone".

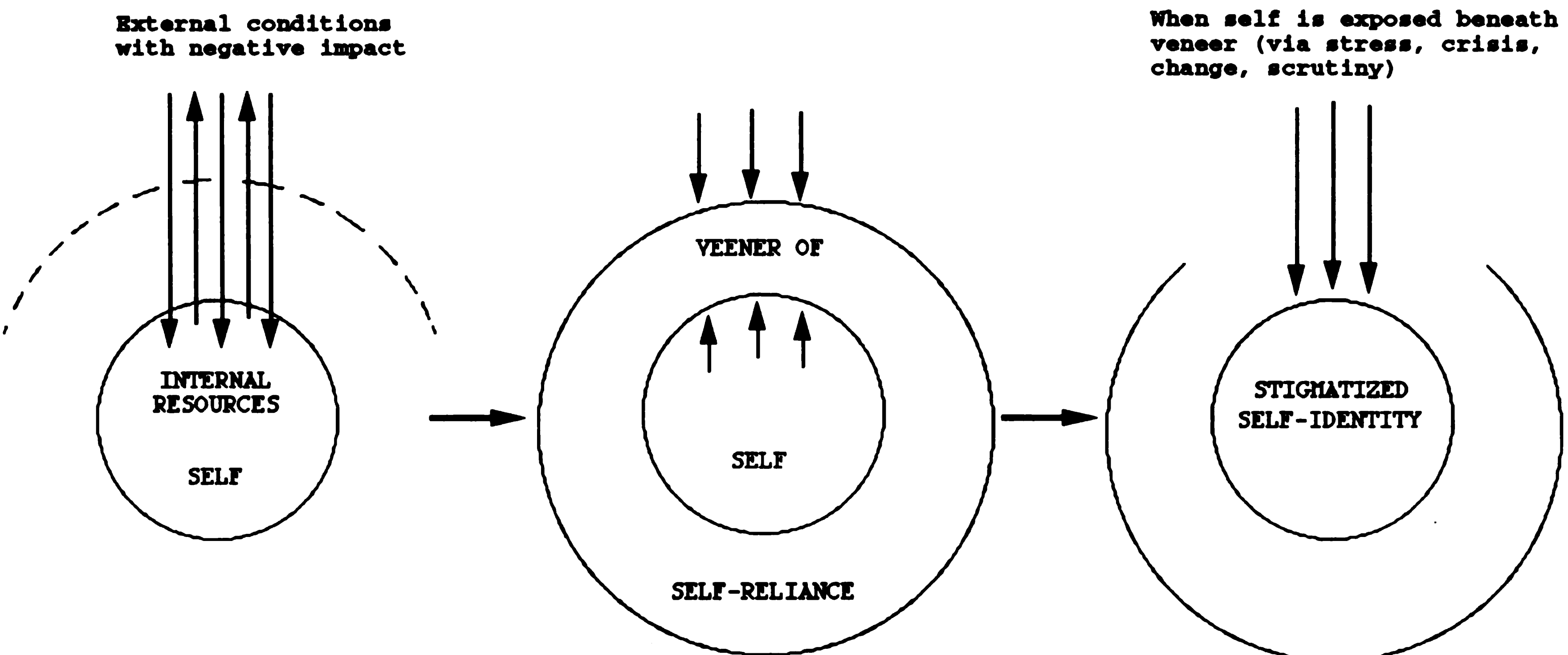
A veneer is defined as a facade or front which covers and protects what is underneath. A veneer of self-reliance

gives the adolescent foster child the appearance of self-confidence, competence, and independence. The veneer of self-reliance is developed using one's internal resources to combat or cope with external conditions which have a real or potential negative impact on the self (see Figure 8).

Contextual features of foster care that lead to the devaluation of self by others (e.g. institutional structure, diminished status, and stereotypical view of the foster child) along with conditions contributing to the uncertainty of foster care (e.g. illusion of normal existence, unpredictability) provide noxious input which influences the developing identity. Using learned self-protective behaviors, the child erects a barrier to confront these deleterious conditions. With the appearance of self-reliance and competence presented to the outside world, the child conceals personal weaknesses and vulnerability and shields the self from further harm.

When the true self beneath the veneer of self-reliance is exposed, the stigmatized self-identity is frequently discovered. Considerable evidence for the existence of this veneer along with the exposure of the stigmatized self-identity that it protects was found in the interview and observational data. In this investigation, all of the adolescents presented themselves to some degree as autonomous, self-sufficient, and competent. During the research process, however, this stance was challenged with scrutiny and stressful interview content. In many instances,

Figure 8 The Veneer of Self-Reliance



the adolescents revealed the negative views of themselves which represented the stigmatized self-identity. Even the respondents who portrayed themselves as fiercely independent with little need for support or assistance from others disclosed or acknowledged views of themselves which reflected abnormality or impairment and feelings of self-doubt and diminished confidence in themselves and their abilities. Toward the end of an interview, one such adolescent disclosed this view:

> My life has been pure hell. Nobody should have to go through what I been through. Sometimes I think I won't make it. Just end up being trash. I might end up in jail or on the streets-- maybe even dead.

The process of protection of self which is used to shield the foster child's vulnerable and already stigmatized identity has an impact on other important areas of development and functioning. Once again, when the self is viewed as the core component of development, any condition or process which has an impact on the self may have an effect on the development of interpersonal relationships and independence. There is obvious overlap between the consequences of the processes of devaluation of self by others and protection of self due to their interrelationship. While the outcomes of the two processes are similar, the impact on interpersonal relationships and independence is secondary to the need for self-protection from further rejection and loss rather than experiences of depersonalization and stigmatization.

Impact on Interpersonal Relationships

Social detachment. The social detachment that results from the foster child's avoidance of hurtful interactions and disappointing relationships leaves the child isolated and disconnected in the social world. Regardless of whether avoidance of attachment with peers is a conscious decision or perhaps, an unconscious defense mechanism used to protect from further loss and stigmatization, detachment from peers was a noteworthy trend in this sample of adolescents.

Total self-reliance has its negative consequences. In protecting the self from the risks involved in potential relationships, the foster child is also inadvertently deprived of the potential benefits of nurturance, support, and resources.

Impact on Independence

Pseudoindependence. The engagement in self-protection is also influential in the development of the ability to be independent. The picture of competence, confidence, and autonomy that the adolescent foster child so often displays with the veneer of self-reliance can be conceptualized as a pseudoindependence. The actual set of independent living, planning, and problem-solving skills that the adolescent possesses may be quite divergent from this facade. This was exemplified in the inability to articulate any specific plans for post-discharge independent living (e.g. housing, financial support) and the absence of tangible preparation (e.g. savings, identifying a roommate). The adolescents

typically had no answer for questions like "Who will you live with?", "What will you do if you can't find a job?", or "Who can you turn to if you run into trouble?"

The lack of supportive linkages in the community and knowledge of potential resources for assistance may make this pseudoindependence difficult to sustain. In this sample, there was compelling evidence that a severe gap in services to support independent living for former foster children existed. One foster youth simply highlighted this:

Once you leave foster care, you're on your own, man!

Lack of future orientation. Just as with the process of devaluation of self by others, a final major consequence of the process of protection of self that nearly all of the study respondents demonstrated was the lack of future orientation. This was especially poignant in the subgroup of adolescents who were rapidly approaching discharge or recently discharged from foster care. Although most of the adolescents were able to identify vague goals for the future, the ability to develop strategies or make concrete plans for goal attainment was clearly absent. Both knowledge and skill deficits were apparent in this group. With little social connection and few resources, the adolescent foster child is reduced to a "here and now", survival-based existence.

The impact of self-protection on future orientation appears to be related to the foster child's fear of future loss and trauma. Having a past history fraught with uncertainty related to detrimental preplacement experiences

and the instability of foster care, the foster child may learn that a predictable future cannot be counted on. It may be safer, therefore, to maintain focus on the present to prevent further harm and disappointment.

Summary

When one becomes a foster child, this change in status is a critical factor in the process of identity development. The diminished status of foster child can actually be conceptualized as one of the major building blocks for the foundation of one's self-identity. The impact of being a foster child is primarily seen in the development of a stigmatized self-identity. This outcome, in turn, has an impact on the foster child's ability to make and sustain interpersonal relationships and to function independently. Related consequences include social isolation, low self-confidence, and the lack of future orientation.

A set of conditions based on the contextual features of foster care contribute to these areas of impact. The institutional structure, the diminished status, and the stereotypical view of the foster child are conditions which result in the process of devaluation of self by others. Key components of this process are the experiences of depersonalization and stigmatization that are commonplace in the lives of foster children.

The process of devaluation of self by others along with detrimental preplacement conditions and conditions which stem from the uncertainty of foster care (e.g. illusion of a

normal existence, unpredictability) contribute to the development of a second important process: the protection of self. The impact of this process includes the development of a veneer of self-reliance, social detachment, pseudoindependence, and a lack of future orientation. The veneer of self-reliance does not eliminate the stigmatized self-identity that the foster child characteristically possesses but serves to protect the vulnerable self beneath from further harm.

From the developmental perspective grounded in the data from this investigation, it is clear that the context of foster care superimposes the normative process of adolescent identity development. This leads to predominantly negative impact in the areas of self, interpersonal relationships, and the development of independence.

CHAPTER 6

DISCUSSION

This final chapter addresses study conclusions and their theoretical significance. Specifically, the meaning of the research findings in relation to the foster care literature and adolescent developmental theory shall be discussed. Evaluative criteria and limitations based on the study sample and research methodology shall be presented. Finally, implications and recommendations derived from the study results will be proposed in the areas of nursing science, practice, education, research, and social policy.

Study Conclusions

Findings from this study have illuminated the subjective experience of foster care as perceived by adolescents. Foster youth repeatedly recounted a story of the deleterious conditions encountered in foster care which led to two primary processes: devaluation of self by others and the concomitant need to protect the self from the feelings associated with this devaluation. The impact of these processes was particularly high in the areas of individual development and psychosocial functioning.

From the perspective of the adolescents, living in the context of foster care appeared to have a major negative impact on the process of adolescent identity development. Outcomes from the processes of devaluation of self by others and protection of self demonstrated almost entirely negative impact on the self, interpersonal relationships, and the

development of independence. The ramifications of these negative effects may have far-reaching implications. Each of these key interrelated areas of impact shall be discussed with an interpretation of its meaning or significance.

Impact on the Self

The internalization of social perceptions based on impairment, deviance, and limitations appears to result in the development of a stigmatized self-identity and related feelings of low self-esteem. Despite the development of a veneer of self-reliance as a protective mechanism, it is an ineffective means for eliminating or counteracting the negative impact on identity. The foster youth's self-designation and behavioral manifestations of society's expectations are, therefore, reflective of this assignment of diminished status.

The significance of maintaining a stigmatized self-identity can be seen in its influence on the view of one's capabilities and place in the social world. A predominantly negative self-conception focuses on one's limitations and inability or limited ability to make a contribution within one's social context. Personal strengths and skills may, in turn, be underestimated and reflected in lowered initiative, ambition, and sense of purpose. Feelings of social ostracism, self-doubt, and low self-worth may inhibit the ability to take on a functional, productive adult role in either relationships or vocation.

As identity is developing, adolescents need opportunities to identify and develop their abilities and to have a positive, optimistic perception of who they are and what they might become. This recognition of individual potential coupled with hope for the chance to realize it are essential ingredients for a positive self-identity. With only hopelessness and despair, foster youth are vulnerable to playing out a script based on society's stereotypical views. The devastating derivatives of a stigmatized self-identity may include increased risk for mental illness, criminal behavior, and poverty-- all of which promote a career in dependency and dysfunction (Children's defense Fund, 1991; Fanshel, Finch, & Grundy, 1989a).

Impact on Interpersonal Relationships

Social isolation and disconnection from potential sources of support are additional consequences which stem from the negative conditions confronted in foster care. Developing a stigmatized self-identity coupled with ongoing experiences of stigmatization leave the foster youth with a serious void in supportive interpersonal relationships.

Persistent social isolation has long-term implications in two major areas. First, foster youth may attempt to fulfill the need for interpersonal connection and support in destructive or unproductive ways. Examples of this include involvement in a gang, substance abuse, and early childbearing. These activities may further contribute to a downward spiral in psychosocial functioning by promoting

exposure to crime, violence, and health problems (e.g. traumatic injuries, drug addiction, sexually transmitted diseases including HIV).

Second, interpersonal disconnectedness may increase the foster youth's risk of failure to live independently. A major disservice has been done to adolescents in foster care by focusing on the requirement for them to survive independently while ignoring their need for attachment and interpersonal connection. By adolescence, foster youth are generally written off as candidates for adoption or placement with a permanent foster family secondary to their age. It is often assumed that they no longer need, desire, or are capable of developing close, interpersonal relationships within the context of a family. And yet, data from this investigation strongly indicated the futility of providing independent living skills training without the presence of social support during the transition to independence.

The insurance of social support for the foster youth transitioning to independent living must be made to improve the chances for success. If the foster child has not been helped to develop positive, enduring relationships with others outside of foster care, necessary supportive linkages with the community will be absent. The lack of appropriate social connections may leave the former foster child vulnerable to dependency on dysfunctional or inappropriate relationships or alternate systems of dependency (e.g. social welfare, mental health, justice).

Impact on Independence

Achievement of the developmental milestone of independence is also to be influenced by the process of adolescent identity development in the context of foster care. In an optimal family context, there is a trajectory of development toward independent adulthood. A principle mechanism of this development is the learning of negotiation and problem-solving skills. The pragmatic testing of skills like assertiveness, compromise, or negotiating for increased responsibility occurs in daily family interactions. The achievement of these skills is incorporated into the self-identity as a sense of confidence and competence.

In contrast, in an institutional structure, many of the skills which underlie independent behavior are de-emphasized or discouraged. Behavioral control of the milieu is often the primary objective, achieved at the expense of individual development. Being good is confined to following rules and causing no disturbance. Qualities like assertiveness, being articulate, inventiveness, and self-reliance are often discouraged rather than reinforced. Independent living requires assertive, negotiative, inventive practices as well as social conformity and compliance. Foster care, at best, produces conformity. The lack of perceived personal strength and competence adds to the development of a stigmatized self-identity.

Outcomes related to the stigmatized self-identity and the veneer of self-reliance developed to protect it include

low self-confidence, pseudoindependence, and a lack of future orientation secondary to both a diminished belief in the self and one's abilities and the fear of future loss and trauma. This negative impact is demonstrated by a primary focus on one's disabilities and limitations, an insufficient set of skills and resources to facilitate autonomous functioning, and uncertainty regarding one's daily survival. This constellation of related consequences contributes to a pessimistic outlook for the future.

The significance of this crippling effect on the development of independence may be manifested in the foster youth's inability to achieve his or her potential or to function as a productive, contributing member of the community in the future. A vulnerability to underachievement, inadequate education, poverty, and dependency are potential long-term outcomes which may have their roots in the experiences of foster care.

In sum, the discovery of the process of adolescent identity development in the context of foster care has generated knowledge that begins to improve our understanding of the impact of foster care as well as variables which appear to influence its impact from the point of view of foster youth.

Theoretical Significance

To understand the theoretical significance of the findings of this study, they must be integrated with the

existing body of knowledge on foster care and adolescent development.

Foster Care Research

This investigation sought to address the gap in the literature related to the perceptions of foster children regarding the impact of their care. Study findings have expanded the limited extant data base which pertains to the subjective experience of foster care. This study demonstrated the value and validity of using adolescent foster children as research participants despite their emotional and behavioral problems. Adolescent respondents were able to contemplate and articulate their thoughts and feelings related to their foster care experiences in an open, analytical, and self-reflective manner.

Traditionally, the specific features of the context of foster care have been inadequately studied. Contributions to knowledge gained from the perceptions of foster youth included a greater level of description and explanation of typical experiences encountered in foster care. Their views related to the context of foster care identified several characteristics of both the group home setting and its interface with the larger social world which lead to deleterious effects. Discussion of the institutional structure as well as the diminished status and stereotypical views of the foster child led to the discovery of the process of devaluation of self by others and its resultant consequences in the areas of identity development,

relationships, and independence. The description of these conditions along with detrimental preplacement experiences and the innate uncertainty of foster care contributed to the conceptualization of the parallel process of protection of self as the manner in which the child shields his or her vulnerability and prevents further harm.

Although several studies have suggested that foster children may deteriorate in levels of functioning over time in care, specific contributors to this increase in psychosocial impairment have not been identified. Study results from this research outlined several contextual features with impact on functioning and offered an explanation for the intensification of the problems that foster youth manifest. The qualitative method enabled adolescents to examine experiences of depersonalization and stigmatization, their responses, and the impact of these situations. This served to increase the specificity regarding the conceptualization of the stigma associated with being a foster child that was present but poorly addressed in the literature. Stigma had been reported but with little exploration, description, or explanation of its occurrence and impact (Meier, 1966; Rest & Watson, 1984; Rowe, Cain, Hundleby, & Keane, 1984).

Finally, the impact of foster care on child development has received minimal attention in the research literature. Adolescents as a significant and growing subgroup of the population of foster children have been particularly

neglected for study. This research has begun to build a base of information which describes this group and identifies their unique needs and developmental issues. Knowledge of the process of identity development in the context of foster care adds to our understanding of the impact of foster care on adolescent development including the development of a stigmatized self-identity, social isolation, and the impaired ability to achieve independence.

Adolescent Developmental Theory

Adolescent developmental theory as it pertains to identity development sets the stage for assessing the conceptual fit of the study findings.

When Erikson (1968) established the theoretical foundation for the understanding of adolescent psychosocial development, its cornerstone was the task of identity development. To successfully achieve a sense of personal identity, the adolescent must accomplish two major objectives. A conception of the self must be developed which incorporates a recognition of one's capabilities and limitations. The adolescent must also answer the question of "Who am I?" with the reconciliation of the past, present, and future into a whole self. This entails coming to terms with past experiences, accepting one's realistic self-definition, and manifesting a future orientation.

Erikson stressed the contextual nature of identity development. The epigenetic model of psychosocial development emphasized the contributions of earlier

experiences and conflicts to subsequent phases of development. Historical events and experiences, therefore, lay the foundation that will either facilitate or jeopardize identity development.

Likewise, the self cannot be separated from the surrounding environment. Identity develops within the environmental context and is, thus, socially-bound. Symbolic interactionism supported this theoretical premise with its declaration that the individual's conception of self emerges from social interaction. Cooley's formulation of the "looking glass self" and Mead's conception of "taking the role of the other" both asserted that the way others are perceived to view the individual has a major effect on identity development (Manis & Melzer, 1972).

Foster youth are most certainly influenced by the negative experiences of their history, both preplacement and during tenure in foster care. Study findings also portrayed the impact of the foster care environment on their identity development. In this social context, the primacy of interactions with others in the determination of one's self conception is underscored. Adolescents are especially sensitive to what others think of them or how they are perceived to be viewed. Their characteristic egocentricity contributes to the belief that they are under constant observance and evaluation by those in the social milieu (Elkind, 1967). Early and persistent experiences of stigmatization in response to foster care status affects

self-definition and identity. Peer validation of this stigma is particularly critical. If peers stigmatize or stereotype the foster youth, these perceptions are likely to be incorporated into the self-identity. This is also true for other persons deemed as important to the adolescent. The development of a stigmatized self-identity as a result of depersonalizing and stigmatizing social feedback was a clear consequence of identity development in the context of foster care.

Marcia (1980) elaborated on Erikson's notion of the identity crisis by creating a taxonomy of identity statuses. The attainment of identity was determined to be based on the presence of personal crisis where one struggles and actively searches for identity with the consideration of role and belief alternatives. According to this theory, it is essential for the adolescent to enter a period of moratorium where experimentation can be engaged in without social, emotional, or economic consequences. Commitments at this stage of identity development are tentative and flexible. With successful resolution of the identity crisis accompanied by a commitment to a vocation and a value system, one is able to reach the identity-achieved status.

Findings from this investigation, however, suggested that foster youth may be at risk for incomplete or impaired identity development. Identity diffusion and foreclosure are two identity status classifications which may more likely fit this group. The identity-diffused adolescent has not

experienced an identity crisis or made a commitment to identity. Identity diffusion is characterized by fluctuation in roles and ideas along with emotional lability and confusion. This status is representative of most early adolescents and is only abnormal if development ceases here. Persistent identity diffusion leaves the adolescent especially vulnerable to social influences and increases the risk for psychological impairment and deviance. Identity foreclosure depicts the individual who has not experienced crisis but has prematurely committed to identity, not based on a personal search or choice. One is socialized into this identity with goals and expectations determined by others or defined by group membership.

The process of identity development in the context of foster care introduces a twist to the trajectory of normative adolescent development. In addition to the negative conditions which contribute to the development of a stigmatized self-identity, this context does not typically provide an essential resource for identity achievement. The concept of moratorium provides a socially sanctioned time period for rehearsing new roles and identities. Support mechanisms in society are usually in place for this rehearsal. Social expectations, family support, and social institutions (e.g. college, working while living at home) provide a context for this activity. The moratorium prolongs the adolescent's normal status within the family and

development has the opportunity to be played out to completion.

Few foster youth, in contrast, have the luxury of a moratorium period. The foster youth is released from the foster care system at age 18 and expected to survive independently far earlier than most nonfoster youth counterparts. Premature launching into independent living frequently occurs before the adolescent is developmentally prepared. There is no socially sanctioned or supported time frame for identity experimentation. Thus, identity development may be interrupted, incomplete, and potentially damaged or foreclosed.

Furthermore, support from the system which has sustained the child in foster care is withdrawn. This can be conceptualized as the institutional foreclosure on identity development. The foster care system eliminates the construction of a family-like existence for the child. The discharged foster youth no longer has either this "pseudofamily" or the safety net of formalized resources to call upon for assistance should the need arise.

The negative impact of foster care described in this research and the institutional foreclosure that is inevitable when the foster youth is discharged from care may lead to the premature establishment of identity. For this reason, identity development will likely be characterized by the assignment of diminished status and stereotypical social expectations. The foster youth incorporates stigma and

related behavioral expectations into a foreclosed, stigmatized self-identity which has an influence on the achievement of subsequent developmental milestones.

The foundation for later intimacy, for example, is established during the adolescent phase of development. To have the ability to make a lasting personal commitment to someone, one must achieve a strong sense of self-identity. As the identity is developing in adolescence, self-definition and concept may be tested out in close interpersonal relationships. A best friend, boyfriend, or girlfriend provides additional social feedback to weigh in the quest for self-identity. A foreclosed, stigmatized identity and the related impact of social isolation may have ramifications for the development of future intimate relationships.

Similarly, arrested identity development serves to limit one's opportunities for the future. The establishment of a vocational identity is effected by an existent self-view centered on incompetence and disability. Future aspirations and options are, thus, circumscribed by a foreclosed, stigmatized self-identity.

Evaluative Criteria

In order to assess the significance and applicability of the findings of this investigation, it is important to demonstrate the process by which the theory and its components were validated. Lincoln and Guba (1985) have developed evaluative criteria upon which to judge naturalistic inquiry. These criteria were used to guide this

study in order to assure testing and verification of the findings.

First, evaluation of the truth value or trustworthiness of the findings is necessary. The qualitative perspective acknowledges the existence of multiple realities or interpretations of the truth. Truth in and about social interaction is subject-oriented rather than researcher defined (Schatzman, 1987). The criterion of credibility is established when the research participants and/or other experts agree with the researcher's conceptualizations. Thus, grounded theory represents faithful descriptions and interpretations of the experiences articulated by the sample involved (Lincoln & Guba, 1985).

The credibility of the findings was assessed using several key resources. During the earlier phase of analysis, several adolescent respondents were called upon to verify developing conceptualizations. At its completion, a synopsis of the findings was presented to the foster care issues group where participants were given the opportunity to give the researcher feedback. Likewise, two adult former foster children were consulted with, using their direct life experiences to validate the emerging theory throughout the process of inquiry. They were particularly valuable in providing critique of the more abstract components of the theory. Experts in the substantive areas of child and adolescent mental health and development were utilized to review raw data, theoretical memos, and the final theory.

Four child psychiatric nurses, one child psychiatrist, one developmental psychologist, and four nurse scientists who focused their research on children and adolescents were available for ongoing consultation.

Another issue related to the credibility of the data which needed to be addressed concerned the validity of research findings drawn from a disturbed population. Were the respondents reliable historians? Did psychological status influence the credibility of their responses? Using triangulation of the data gathered from the document analysis of case records, it was determined that the adolescent reports of events related to foster care placement and psychosocial history were very consistent. Perhaps more importantly from a symbolic interactionist perspective, it is believed that when interaction occurs with mutual understanding, communication is valid. Schatzman (1990) stated:

> With skillful interviewing, taking into account the multiplicity of perspectives and capabilities of the respondents in your study, you get something of relevance. Knowledge and validity is based on many respondents from which you can make generalizations and individual idiosyncrasies melt away (personal communication).

It was, therefore, counterproductive to be overly concerned with respondent perceptions that were divergent from others involved in their care (e.g. social worker, caregiver). Their perceptions were authentic descriptions of experience and valuable regardless of mental health problems.

Second, the criterion of applicability addresses the issue of generalizability. Since qualitative research is context-dependent, generalizability cannot be specified. The grounded theorist's objective is to generate rich, dense description and analysis which make explanation possible. The context and conditions to which the grounded theory applies are made explicit within the theory. The extent to which other contexts or population groups are similar to that which is defined in the theory determines the theory's transferability to other contexts and applicability to other groups (Lincoln & Guba, 1985).

In order to assess the representativeness of the sample, study participants were compared with the larger population of foster youth from which they were drawn. Statistics from the State of California Social Services Statistical Bureau for 1992 were available for this analysis. Comparisons were made using the age group category of 12 to 18 (see Table 1). It should be noted that categories for comparison were not always congruent between the sample and population.

It was found that the sample was representative of minority foster youth in the areas of gender, specific ethnic group (excluding white), range of reasons for out-of-home placement, and number of placements.

The sample differed from the population as a whole in several areas. As a group, study participants were slightly older when entering foster care (mean age- 10.88) with more placements after age 12 (64.7% vs. 12.6%). Members of the

Table 1 Comparison of Study Sample With Population of Foster Youth in San Francisco County

Variable	Study Sample	Foster Youth in SF County
	N = 17	N = 1001
Age		
Mean age in years	17.47	
Range in years	15 - 19	12 - 18
Gender		
Male	47%	45%
Female	53%	55%
Ethnicity		
African American	65%	66%
Asian/Pacific Islander	12%	7%
Hispanic	12%	15%
Mixed - *a*	12%	0%
White	0%	11%
Native American	0%	2%

a - Mixed ethnicity includes African American

Table 1 continued

Variable	Study Sample	Foster Youth in SF County
Age at First Placement		
Mean age	10.88	
Range	3 - 16	
< 12 years old	35.3%	87.3%
12 - 18 years old	64.7%	12.6%
Time in Foster Care		
Mean time in years	5.7	3.2
Range	2 - 11	
Number of Placements		
Mean number	4.1	2.8
Range	2 - 8	
Type of Placement - *b*		
Foster family	6%	71.43%
Group home	94%	28.27%

b - Includes subsample of those recently discharged from foster care

Table 1 continued

Variable	Study Sample	Foster Youth in SF County
Type of Placement		
Previous:		
Emergency shelter	53%	
Foster family	76%	
Group home	65%	
Reason(s) for Placement - *c*		
Sexual abuse	35%	51.11%
Physical abuse	71%	49.28%
Neglect	65%	42.33%
Caretaker abandonment	35%	34.16%
Parental substance abuse	76%	
Parental mental illness	18%	
Death of parent	41%	
Child behavior/emotional problem	47%	33.33%

c - May be > one reason; categories for comparison not always congruent between sample and population

sample spent more time in care than the general population of foster youth (5.7 vs. 3.2 years).

The sample was also distinctive in that all but one were currently residing in or recently discharged from group home settings as opposed to foster family care. Although 76% of the sample experienced living with one or multiple foster families in the past, it is not known whether they were qualitatively different from the 71% of the adolescents in this region who presently live with foster families.

Upon examining these comparative statistics at face value, the sample appeared to average more placement transitions than the population (4.1 vs. 2.8 placements). It was, however, critical to consider that population statistics did not include temporary emergency shelter care as a placement. This was included for the study sample as respondents often spent several months in shelter care. If shelter care is removed from the number of placements experienced by participants, the sample is more representative with a mean of 3.2 placements.

The study sample appeared to represent a particular subgroup of the population of foster youth in this large urban area. Their older age at foster care entry, longer time spent in care, and current or most recent placement in a group home were important distinguishing factors. These sample characteristics outline the parameters of the applicability of research findings to other groups of foster children.

Third, a theory is evaluated according to its consistency. In the grounded theory approach, the criterion of consistency is threatened when there is limited evidence of data categorization and linkages. In this case, it is difficult to determine whether the clusters of data consistently reflect the same category or concept (Atwood & Hinds, 1986). To assure consistency, it is imperative for the grounded theorist to leave a clear and comprehensive theoretical decision trail. The procedures and theoretical process must withstand scrutiny from independent reviewers (Brink, 1987; Burns, 1989; Sandelowski, 1986). To assess the dependability of the method and derived findings, one must be able to follow the process of discovery engaged in by the researcher.

During this study, ongoing discussions regarding theoretical decisions were conducted on a bimonthly basis with a qualitative analysis group. Members of this group included three to five doctoral students also engaged in qualitative research along with a faculty research mentor. This group was involved in a final inquiry audit of the theory development (e.g. audit of the investigator's theoretical decision trail by other researchers). In this way, the researcher's theoretical formulations were found to be consistent and the threat of contradictory findings was reduced.

Finally, the principle of confirmability is evaluated. Are the findings grounded in the data or colored by

investigator or sampling bias (Lincoln & Guba, 1985)? Two potential areas of concern that surfaced during this investigation included cultural bias and sampling bias. The issue of cultural bias arose with the advent of the divergence between the race of the researcher (white) and the final sample composition (all members of racial minorities). In an effort to reduce the possibility of misinterpreting the data from a divergent cultural perspective, conceptualizations were evaluated by nonwhite reviewers from the pool of substantive experts mentioned above. Secondly, the sample may have overrepresented the most accessible and/or verbally articulate subjects. Sandelowski (1986) referred to this threat to sample representativeness as "elite bias" (p. 32). Although assessment from the mental health perspective of the researcher found little difference between the sample and other foster youth encountered in clinical practice, due to the convenient nature of sampling, the issue of sampling bias was not completely addressed.

Other strategies which were used to reduce threats to confirmability are built into grounded theory methodology. To ensure the empirical grounding of the theory, constant comparative analysis and theoretical sampling were used. This involved triangulation across multiple data sets which increased the representativeness of subjects, data, and categories (Sandelowski, 1986; Strauss & Corbin, 1990). Using constant comparisons between respondents, the alternative hypothesis was continually tested which generated

conceptualizations with a high level of detail and specificity (Schatzman, 1987; Strauss & Corbin, 1990). Likewise, confirmation of the grounded theory and its components by research participants and other substantive and methodological experts (including a successful inquiry audit of the researcher's decision trail) enhanced the confirmability of study findings.

In summary, to promote rigorous research using the grounded theory method, the procedures and process must be precisely implemented and explicated. In this study, an attempt to strengthen the principles of credibility, applicability, consistency, and confirmability was made with the systematic application of the analytical procedures outlined in the grounded theory approach. Furthermore, a diverse group of resources provided: 1) expertise in foster care and child and adolescent mental health and development, 2) a congruent cultural perspective, and 3) theoretical and methodological verification.

Limitations

From the evaluation based on the preceding criteria, several potential limitations of the research findings must be recognized. Limitations related to the study sample and the methodological procedures shall be addressed.

Sample

Critique of the study which focuses on the sample centers on two specific areas: sampling procedures and the composition of the sample. First, it can be argued that the

procedure used for sampling limited the sample's representativeness of the population of adolescents in foster care. A convenient sample was drawn primarily, though not exclusively, from a preexisting identified group of foster youth. The issue of selection bias presents itself both with this specific group identification and the voluntary nature of study participation. The self-selection of respondents from a group with an unknown level of representativeness may reduce the applicability of the study findings to other adolescent foster youth.

The extreme difficulty related to the access of this particular population for research participation had a major contribution to these sampling limitations. It is imperative that this vulnerable population be protected from the risk of harm or exploitation in the process of research. A rigorous process for study approval and procuring legal consent to study this group is necessary to ensure their protection. Despite the successful negotiation of all components of this process for this investigation, however, access to the adolescents continued to be limited or blocked by some caregivers. There appeared to be an underlying concern for how study findings would be used (e.g. for the purpose of negative program or caregiver evaluation). The inaccessibility of adolescents from some group homes may have excluded foster youth with different types of experiences and perceptions and, therefore, influenced the nature of the data collected.

The second area of potential limitation is related to the final composition of the study sample. The final sample can be criticized on several points. The small size of the sample may have had an impact on the level of variation demonstrated in the data. Although there were significant repetitive themes in the data for this group, a larger sample may have provided more diversity and conceptual specificity.

Within this sample, there was a heterogeneity of experiences which may have had an effect on the interpretation of the data. The sample experienced a wide range of preplacement conditions. Likewise, experiences during tenure in foster care had a large variability in some cases. Two examples of this included the range of time in care (2 to 11 years) and the number of placements experienced (2 to 8). This diversity of experiences may have had a varying impact on results. While some would consider this a criticism, it can be viewed as a strength which is inherent in the grounded theory method. Sampling for variation is crucial to insure the discovery of as many relevant dimensions as possible and to provide them with conceptual density (e.g. consideration of multiple dimensional attributes).

The factors in which the members of the sample were similar is a limitation regarding the applicability of research findings. This sample can be considered to be representative of adolescents who have experienced living in a group home. As a group, they were characterized as older

adolescents, of ethnic minorities (predominantly African American), from disadvantaged backgrounds (e.g. economic, inner city), who have resided in a large urban area. They had also lived in long-term foster care and experienced multiple placement transitions. Their experiences and perceptions may not be reflective of those who have lived exclusively in foster family care, experienced short-term placement, or maintained relative stability in their living arrangements. The specific characteristics of this sample outline the parameters for the generalizability of this theory of impact to other groups of foster children.

Method

There are several potential methodological limitations for this study. First, the use of the investigator as the instrument for data collection introduced the possibility of bias. The design of the interview guide and the execution of the interview was influenced by the philosophical orientation, professional expertise and experience, and cultural perspective of the researcher. In order to maintain the integrity of the research process, it was necessary for the researcher to work closely with others in order to address this bias and to ensure that conceptualizations were true to the data.

Second, the use of an interview as the primary method for data collection has some inherent properties which influence the type of data gathered. The interview, by its nature, is an interactive process. Its effective use relies

on the development of some level of rapport between researcher and respondent. The issue of the social acceptability of responses is everpresent. In this study, it was clearly apparent that the adolescent respondents wished to present themselves as positive and socially desirable, both to the investigator as an individual and in their responses as they might be communicated to others in the future. Although this certainly influenced the data, the willingness to openly address emotionally-laden interview questions and probes seemed to minimize this validity threat.

An additional feature of the interview process is the lack of control. Although a guide of interview questions was used and the content covered with all respondents was similar, each interview was unique. There was variation in the ordering of questions and the depth to which content areas were addressed based on individual experiences and responsiveness. This lack of consistency is often criticized as negatively influencing the validity of study findings. In grounded theory methodology, however, the emphasis is placed on data collection which is directed by the development of conceptualizations in the evolving theory (Strauss & Corbin, 1990).

The third methodological limitation found in this study was the inconsistent use of secondary data sources. Though an ideal strategy, it was not always possible to interview the adolescents in the foster care setting. Thus, the valuable data based on naturalistic observations were not

consistently available for all of the study participants. Similarly, case records were not available for all of the adolescents (e.g. inaccessible secondary to out-of-county placement, unable to be located). For this reason, this document analysis was solely used to get a general sense that adolescent reports of historical events were accurately represented according to these records.

Finally, both the grounded theory approach and dimensional analysis can be criticized on the grounds that the resultant theory is a manifestation of the particular ideas and interpretations of one investigator. Others may approach the data from another perspective and come up with differing conceptualizations. For the purpose of building a body of knowledge, this activity should be welcomed and encouraged rather than viewed as a threat. Divergent discoveries facilitate dialogue regarding a substantive area and thus, contribute to the growth in understanding of extremely complex phenomena. For this individual study, it was important for the researcher to clearly articulate the process of analysis from which the theory was derived. In this way, it can be judged whether study conclusions are plausible in terms of the central perspective selected and the procedures followed.

Implications and Recommendations

Nursing Science

The focus of child and adolescent psychiatric nursing is on the child's response to actual or potential mental health

problems and their developmental manifestations. These problems include the foci of this study: detrimental life experiences (e.g. child abuse and neglect), environmental transition (e.g. foster care placement), dysfunctional relationships, mental health problems, and developmental change. In order to effectively meet the needs of the foster children and adolescents that nurses serve, it is imperative to have a strong, empirically-derived theoretical foundation upon which to base nursing practice.

This investigation was designed to make a contribution to nursing science by increasing the understanding of the complex social context of foster care and its impact on children and adolescents. In consideration of the limited and fragmented knowledge base that exists regarding this vulnerable population, nursing, in collaboration with other disciplines concerned with foster children, must make its contribution to this body of knowledge through nursing research.

From a nursing perspective, the impact of foster care was studied from the viewpoint of adolescents who actually experienced it. Their unique perceptions along with the researcher's abstraction, integration, and interpretation of the implications of these perceptions must direct and strengthen nursing practice with these clients. In addition, this knowledge must be shared with others who work and live with foster children and youth in order to promote their optimal development and functioning.

Practice

The process of adolescent identity development in the context of foster care has illustrated several areas of negative impact with profound implications for nursing practice. The preliminary findings from this research suggest that changes or modifications in practice should be made. In order to address the factors which contribute to negative outcomes, recommendations for change at the levels of clinical intervention and program development can be made.

Clinical Interventions

Beginning with the detrimental experiences that predispose a child to foster care placement, a commitment to the prevention of out-of-home placement must be made when possible. The early identification and intervention with children and their families who are at risk for this type of family dissolution is necessary. For example, families at risk for or with a history of child abuse and/or neglect or those with substance abuse problems or mental illness could potentially benefit from intensive intervention to prevent family crises and promote child safety.

There are multiple interventions traditionally used by nurses that support family preservation efforts. Parent education and support can be used to develop appropriate parenting and communication skills. Anticipatory guidance may be a strategy to promote the mastery of developmental and situational crises and to reduce family stress. The identification and maximization of family strengths may

enable a family to gain competence and cope with stressors more appropriately and effectively. The identification and mobilization of a social support network for the family can supplement and enhance professional efforts. Finally, and perhaps most critically, the nurse must facilitate the identification and utilization of supportive services of a wide variety (e.g. substance abuse treatment, respite care for children, mental health care, housing assistance) to strengthen families and improve their level of functioning. The necessity of acting as an advocate for the child and family to ensure access to these services is crucial for this vulnerable group.

The implication of addressing the events and experiences that place a child at risk for foster care is the ability to avoid involvement with a system which may expose the child to further deleterious conditions (e.g. diminished status, a depersonalizing institutional structure for living). The findings of this study are that such conditions lead to negative impact on the self, relationships with others, and the development of independence. Once a child is targeted for foster care placement, however, it may be wise for another set of interventions to come into play.

Clinical practice with foster children and adolescents must focus on four key objectives which stem from the findings of this research: reduction of devaluation of the foster child, promotion of normative development and optimal psychosocial functioning, reinforcement of individual

strength and positive self-protection strategies, and connection with resources and supports. These objectives may be met while addressing some of the major areas of impact and their influencing factors which were discovered in this study.

Upon examination of the conditions which lead to the process of devaluation of the self by others and its related consequences, it is clear that interventions must be designed to decrease experiences of depersonalization and stigmatization. In order to accomplish this, it is first necessary to make the prevalent assumptions and biases regarding foster children that underlie practice explicit. The automatic focus on deviance and/or psychological impairment needs reevaluation so that potential strengths and adaptive coping abilities that a child possesses are not inadvertently overlooked or extinguished.

It is also imperative to develop sensitivity and understanding of the behavioral manifestations of the problems commonly experienced by foster children such as extensive personal loss, instability, and abusive, dysfunctional past relationships. Strategies to manage difficult behaviors like aggression and defiance of authority must be therapeutic rather than reactive and punitive. Interventions which may be intrinsically depersonalizing or stigmatizing may contribute to the process of devaluation and ultimately lead to the development of a stigmatized self-identity and its related consequences (e.g. social isolation,

limited view of future options). Practice, therefore, should be assessed for excessive restrictiveness, misinterpretation of behavior, disrespect, and the lack of individual consideration.

To further reduce the devaluation of self that is frequently experienced in foster care, it is important to emphasize and solidify the strengths that the foster child or youth presents. For example, even if the adolescent's behavior is indicative of a veneer of self-reliance which results in "pseudoindependence", it is important to view this behavior as a potential strength which can be developed and maintained with support and assistance. Likewise, assisting the foster youth in discovering and utilizing positive coping skills for self-protection (e.g. the ability to address stigmatization without internalizing the views of others) rather than defensive maneuvers may decrease social isolation and loneliness. Interventions and activities which promote self-esteem and contribute to the development of a positive self-identity are additional strategies to counteract the negative impact of devaluation. It is crucial to focus on the child's abilities versus limitations and to provide success-oriented work, school, and social experiences.

To build a relationship with a foster child or youth, the clinician must also take into consideration the focal issues so prevalent in this group. The impact of loss and discontinuous caregiving often appear to contribute to feelings of insecurity and difficulty making attachments. In

therapeutic work with these children, it should be noted that they may be particularly sensitive to the boundaries of the therapeutic relationship. Issues of trust, commitment, and the structure and value of the relationship may either interfere with or enhance the ability to meet treatment goals, depending on how they are interpreted by the child.

Traditional boundaries may need to be rethought to engage the foster child in a beneficial therapeutic relationship and to prevent the recapitulation of loss. Examples of this include moving beyond the confines of individual therapy to get to know the child in his or her environment and reevaluating the time limitations of involvement with the child (e.g. relationship terminates with the discharge of the foster child from day treatment). Furthermore, clinicians must seriously evaluate practices to prevent the potential contribution to the illusion of a normal existence which is so often promised to the foster child. Commitments to provide a "normal", family-like life and stability in relationships and residence must be made with care. Honesty and clarity regarding what can and cannot be realistically guaranteed to the foster child must be communicated. This may lessen the feelings of self-blame for loss, rejection, and disappointment that may be detrimental to identity development and self-esteem.

In addition to modifying practice within the context of foster care, foster children and youth can be prepared to confront stigmatization in their social world. The

stereotypical view of the foster child should be directly addressed with the child. Anticipatory guidance and problem-solving related to stigmatizing social interactions and the child's response to them may serve to increase coping skills and interrupt the internalization of negative views into the self-identity.

Interventions can also be aimed at reducing social isolation and detachment. Efforts to maximize social connectedness and support include assisting the foster child to develop satisfying relationships with peers, members of the community, and the family of origin, when appropriate. The foster child may need guidance and support to make friends within a positive peer group. Exploration of social interactions with the child within the therapeutic relationship can provide opportunities for self-reflection, feedback, role playing, and learning. Involvement in school and social activities with peers can be encouraged.

Children and adolescents in foster care typically lack strong, positive relationships with appropriate adults outside of the context of foster care. Identifying and facilitating linkages with members of the community can provide the foster child with supportive relationships that have the potential to extend beyond foster care placement. Community-based organizations (e.g. religious, civic, youth-oriented) are resources for both adult role models and activities with peers. The promotion of optimal psychosocial

functioning and social support can be achieved with community involvement.

A final area of social connection that needs exploration with the foster child is the family. Connections with the family of origin should be maintained when indicated to be in the best interest of the child. This may require expanding the definition of the family to identify, mobilize, and assist supportive others (e.g. extended family, kinship network). Contact, visitation, and participation in aspects of the foster child's care should be facilitated. In addition, as the child grows older and approaches the mandatory exit from the foster care system, he or she must be helped to reconcile family relationships. A realistic understanding of the possibilities and the limitations of family relationships may decrease feelings of isolation and disconnectedness.

To further ensure the mobilization of supports and resources for foster children and youth, it is essential that clinical practice be directed by the principles of case management. A knowledge of the complex community service system must be attained and the foster child should be linked with any services that are needed to maximize functioning. These linkages are especially crucial for the adolescent who faces the monumental task of independent living. The nursing perspective which views the client as an integrated person with multiple needs, interacting within a social system prepares the nurse to be an excellent candidate for the role

of care coordination and case management with foster children and youth.

In sum, clinical interventions directed toward the abatement of the negative impact of foster care on the self, relationships and independence are needed to ensure the appropriate and effective treatment of foster children and youth. Failure to attend to their unique needs in a humanistic and individualized manner may lead to even more devastating outcomes. Possible long-term consequences include mental illness, criminality, and the inability to function productively and independently in society-- all of which may lead to a career in dependency and dysfunction.

Program Development

In companion with clinical intervention, program development must be undertaken to address the negative outcomes found in this study. Findings that identified the institutional structure as a predominant model of care received by adolescents and the lack of complete preparation for independent living are two areas that need to be addressed at the programmatic level.

The institutional structure has many innate features that are perceived to promote the devaluation of the foster child. This structure appears to fail at providing the child with a family-like environment despite being based on this philosophical orientation. In its place, the institution-like environment seems to foster the diminished status of the

foster child along with depersonalizing and stigmatizing experiences.

The small subsample of foster youth that were placed in settings which were characterized as family-like provided several clues for program development targeted at eradicating the institutional model of foster care. For adolescents who require group care, structural changes are necessary to modify the negative features which comprise the constellation of the institutional structure.

In order to successfully translate a family-like philosophy into practice, treatment must emphasis a humanistic, individualistic approach. Demonstrating respect for adolescent clients via individual consideration, warmth, and caring may be an effective strategy to teach both self-respect and respect for others. The importance of structure should not be minimized, however, care must be taken to avoid excessive restrictiveness and intervention of a punitive nature. A shift in focus from strict behavioral control to the promotion of individual growth and development may aid in the alignment of the program with philosophy. Likewise, a change in the language used to describe the program can be made to eliminate an underlying emphasis on control and punishment.

Program specifics must be based on sound principles of adolescent development. This knowledge should be woven into privileges, consequences, and responsibilities given to the adolescent. Though it is essential to acknowledge and manage

the behavioral and emotional problems that individuals manifest, stereotypical assumptions and behavioral expectations based on deviance and pathology can be de-emphasized. A focus on strengths and abilities must be made whenever possible as a measure to prevent the development of a stigmatized self-identity. Adolescent participation in both treatment planning and some aspects of program development is not only age-appropriate but may increase the level of responsibility for self, actions, and interactions with others.

Another major component of program development aimed at the reduction of self-devaluation is the area of caregiving. It is vital to direct attention to the quality, style, and continuity of caregiving. Caregiving for foster youth should reflect an authoritative versus authoritarian style of parenting. Limits and structure with flexibility and room for mutual negotiation must be administered in the context of nurturance and caring to communicate expectations for adolescent behavior.

To decrease treatment that is potentially depersonalizing, staff must possess an understanding of and sensitivity toward foster youth. This includes the challenge of biased assumptions, recognition of the ramifications of the status of foster child, and a comprehension of the problems, behavioral manifestations, and dynamics in relationships commonly portrayed by foster youth. Practice based on this knowledge is important. Additionally, a

commitment to providing continuity of care must be made by individual staff members. Personal involvement and responsibility for individual adolescents should be encouraged with the knowledge that the caregiving relationship may be the only stable relationship with an adult that a foster child may have.

With these crucial expectations for caregivers, it is of paramount importance to intensely focus on the recruitment and retention of high quality staff. To attract qualified, high-functioning, mature adults who are willing to make a long-term commitment to the role, it is necessary to make a much greater investment in caregiver support and development. First, financial compensation must be adjusted to be commensurate with the level of responsibility of the position. Similarly, adequate monetary and material resources must be available to assist in the execution of caregiving activities. Professionalization of the role may increase its respectability and social value and positively influence caregiver self-esteem and accountability.

In addition to financial incentives, staff support must be visible in other areas. Ongoing training and supervision, a team approach to treatment planning, and formal and informal mechanisms for communication, consultation, and collaboration are examples of basic resources which are necessary to provide support for caregivers who work with this complex population. Failure to make this valuable

investment in staffing may increase the risk for the discontinuity and poor quality of care.

A final key area which must be addressed in the provision of group care for adolescents can be conceptualized as "normalizing" the context. To reduce the stigmatization experienced when the foster child interacts within the larger social world, it is imperative to erase the evidence of perceived differentness where possible. Integrating the group home into the community can be better achieved through its involvement with youth-oriented organizations and the encouragement of the participation of nonfoster youth in group home activities (e.g. celebration of special occasions, sleep-overs).

Another strategy to normalize the group home as a context for living is to promote continued relationships with residents and staff post-discharge. Encouraging former foster youth to maintain interpersonal connections with caregivers and other residents has the potential to diminish the social isolation of independent living with few resources that is often experienced by these young adults. The program should ideally include a formal transition and follow-up component to facilitate ongoing contact. Specific opportunities to engage this group may be made like regular phone calls from caregivers and invitations to visit for both special and informal occasions. This resource and support has been sorely missing for many former foster youth and

reinforces the artificiality or illusion of the family-like environment.

In order to ensure the maintenance of high quality in group foster care, standards of care based on the preceding discussion must be used in program evaluation. Adolescent perceptions can be extremely valuable in program evaluation and the development of solutions to identified problems. One study participant exemplified the sample's ability to articulate ideas on program development:

> I would take control of the whole situation. First of all there would be more trust. Staff would have to have experience in living in some sort of foster care. It would be mandatory for them not to have a note pad in their hand every time they talk to a resident and write every conversation down. Earn your kids' trust. You're not a police officer. If you want to be a warden go work in the county jail; do not work in my place. Be lenient, and use some of your own judgment. Listen to the kids. Don't _make_ them talk. Treat them with respect. They're not criminals. If they were criminals they'd be in juvenile hall.

With ongoing attention to the care received by foster youth in group home settings, it may be possible to eliminate the deleterious effects of the institutional model of care.

A second and more specific area for program development is the need for the expansion of the preparation for independent living that foster children receive. Independent living skills training must begin much earlier and be interwoven into the daily lives of foster children if they are to be expected to function autonomously upon discharge from care. Behaviors which reflect independence must be reinforced as opposed to inadvertently squelched in an

attempt to control the milieu of the foster care setting. Examples include assertiveness, negotiation, self-reliance, and making choices and decisions. Participation in treatment planning for the present and future can contribute to autonomy.

While current independent living skills programs have provided older adolescents with valuable concrete skills, additional support is needed to increase their chances for successful self-care and survival. Continued education related to financial management, job skills, health, nutrition, and the procurement of safe, affordable housing is needed accompanied by supervised, practical experience (e.g. work experience, budgeting). The gaps identified in the study pointed to additional measures that are necessary to improve skills, foster self-confidence, and develop a realistic, positive orientation toward the future.

Data indicated that foster youth need further guidance and counseling regarding future options. Assistance to develop reality-based aspirations in the areas of education and job or career alternatives is needed. Comprehensive assessment of the youth's strengths and limitations can be made to facilitate appropriate goal-setting. Likewise, the foster youth could receive assistance to develop a specific plan and strategies to ensure goal attainment. Assistance and support must be readily available at every step to put goals within reach and to maximize the potential for achievement.

Finally, the foster youth must be provided with linkages to support and maintain independent functioning. A safety net composed of the necessary resources and supports must be available to divert major crises and prevent a failed attempt at independent living. A transitional or follow-up program for former foster youth can provide a forum to plan, problem-solve, and receive support post-discharge.

The involvement of a consistent adult who has the ability to provide ongoing guidance and attachment may be essential for the foster youth to live independently. The identification of a mentor in the work or educational arena is one example of a resource which may be available to the youth as he or she transitions from foster care to living in the community. Despite the essential need to prepare the adolescent for independent living, the developmental necessity for stable attachment and nurturance should not be overlooked in this group. Without human connection and interdependence to sustain positive gains and enhance feelings of self-worth, the foster youth is at risk for failure at attempts at autonomous functioning.

Education

Findings from this investigation have implications for education in two major areas: professional education and community education.

Professional Education

In order to adequately address the unique needs of foster children and adolescents, nursing education must

respond at both the generalist and specialist levels. Since nurses may interface with foster children in many clinical areas (e.g. pediatrics, school health, mental health), it is necessary to develop a basic understanding and sensitivity for this vulnerable population. To facilitate this, it is of primary importance to explicitly examine the philosophical orientations that students bring to their clinical training. Examining underlying assumptions and biases and providing values clarification opportunities are two activities which may lead to dispelling negative stereotypes and promote a more humanistic, individualistic approach to clients with this background.

In teaching the domain concepts upon which nursing is founded, the foster child presents an excellent and challenging example of the interaction between person, environment, and health. This research on the impact of foster care underscored the need to consider the client within the social context with its multiple influential features before health outcomes can be fully understood. This study also strongly reinforced the value of client perceptions of experience as an integral component of the assessment process.

Study findings have additional implications for educating students in the clinical specialty area of child and adolescent psychiatric and mental health nursing. This research has contributed to the substantive area of foster care along with the knowledge of its impact on child and

adolescent development and psychosocial functioning. An understanding of the theory of adolescent identity development in the context of foster care can be integrated into the theoretical basis for nursing practice with this population. This knowledge has the potential to influence clinician behavior in order to reduce devaluation of the child and enhance identified areas of strength. Furthermore, it can improve interventions based on a better understanding of client problems and their behavioral manifestations.

In addition to education which focuses on enhancing the therapeutic work with foster children, the child and adolescent psychiatric nurse must have a strong knowledge of the variety of community systems that provide services to this group. A skill set which includes care coordination and case management is mandatory in order to effectively serve foster children. Nurses must be prepared to identify and procure the appropriate supports and resources that are needed to address the needs of the whole child.

Finally, supervised clinical experience with children and adolescents in foster care and/or those at risk for out-of-home placement can bring alive the issues faced by these clients for the clinician. Entering the difficult and often disadvantaged social context that these children live within can be a powerful learning experience.

Community Education

The diminished status and the stereotypical view of the foster child must be confronted through community education.

Public awareness of foster care issues is beginning to be increased via the media. These stories frequently focus on the more sensational and horrific examples of abuse and neglect faced by some foster children. While public access to this type of information is essential, it is also necessary to begin to create a more positive image of the children and youth living in foster care. One study participant illustrated the sample's consensus that the negative views of foster children must be dispelled:

> About the kids: They're really not all bad. There's a lot of them out there who really have goals, who are doing very well in school, who are going to graduate in time, and they know what they want to do in their future. They really know what they want to do with their lives and they're staying on the proper track. They forget about what they did, and they're not going backwards.

Another form of community education to reduce stigmatization is to encourage community involvement with children and adolescents in foster care. Individuals and organizations, for example, can provide support, tutoring, recreation, and mentorship. While providing valuable service, these volunteer activities may also increase awareness and promote more realistic and positive perceptions of foster children and youth.

General efforts to expand the public understanding of foster children should be accompanied by specific educational activities targeted for schools. The research findings identified school as one of the most significant contexts in which stigmatization is encountered by foster children and youth. Interventions in the schools must focus on both

teachers and peers. Teacher training is needed to promote an understanding of and sensitivity toward foster children. In particular, the teacher must assist the foster child to integrate into the school environment and its associated peer group while minimizing undo disadvantages (e.g. arriving in the middle of the school term, not functioning at grade level). To reduce social isolation and improve social functioning, attempts to include the foster child in peer activities should be made. Finally, efforts to demystify or normalize the status of foster child may be made by more effectively integrating groups of foster children with nonfoster care groups for activities and developing or extending a peer counseling program to include foster youth participation.

Research

Results from this research on the impact of foster care on adolescents have implications for future research. Study findings have established the beginnings for a substantive theory regarding the process of identity development in the context of foster care. In order to continue to build, validate, and extend this theory, ongoing investigation is necessary.

To maximize the contributions of research in this area, studies should ideally be conceived with several criteria in mind. First, the study of the impact of foster care must be programmatic in nature. A long-term research plan is necessary in a substantive area with a limited and fragmented

knowledge base. Second, collaborative research efforts are essential. Nursing research in this area must be considered as only one facet of knowledge generation. The planning and implementation of research must model the care delivered by a team of professionals interested in foster children and their treatment. Interdisciplinary research is needed to maximize both the gains in and dissemination of new knowledge. Third, it is rational to align future studies with the identified national research priorities to adequately address the major gaps in knowledge that must be filled to better meet the mental health needs of children and adolescents. Clinical research which focuses on assessment, treatment, and prevention of mental health problems in children and adolescents along with interventions, services, and systems of care are priorities endorsed by the National Institute of Mental Health which can be addressed by researchers in child and adolescent psychiatric nursing (McBride, 1992).

This study has stimulated several possibilities for future research. First, a replication of this qualitative investigation on a broader scale with a larger sample would continue theory development and initiate theory testing. Data gathered from comparison groups could expand conceptual variation development. Important groups to consider include adolescents in foster family care and shelter care, those who have experienced short-term care and stability in caregiving and residence, and adult former foster children. In this way, the process of knowledge refinement regarding variables

which have influence and the nature of their impact would continue.

Second, field research which incorporates a strong participant observation component could provide vital gains in knowledge. Intensive interviewing and observation over an extended period of time could be conducted within the context of the foster care setting. If access could be successfully negotiated by the researcher, settings that are reflective of the institutional and family-like structures would be important to include. First hand examination of interactions and relationships within the context and the inclusion of caregivers as a data source are major adjuncts to data based on adolescent perceptions of the foster care experience.

Third, a longitudinal design which incorporates the triangulation of qualitative and quantitative methodology is an ideal research strategy. While maintaining a qualitative focus on perceptions of impact, it is possible to quantitatively measure psychosocial variables that have been identified as significant based on previous studies. Examples might include the assessment of self-esteem, depression, adolescent attachment, and social support.

In this design, a large sample would be utilized to allow the statistical examination of the relationships between variables. It is important to collect data from the sample at several points over time. A possible sampling plan might include administering instruments and conducting interviews to establish a baseline on an early to mid-

adolescent group (e.g. ages 12-15) who have received no formal preparation for independent living or discharge plan. This sample would then be studied during late adolescence (e.g. 16-19) following independent living skills training and with discharge pending plus post-discharge at six months and one year. It would also be of interest to contrast this group with nonfoster youth pre- and post-high school graduation using the psychosocial measures to compare functioning between groups.

With a longitudinal design, the potential for improving our understanding of this population and their needs is great. How did the foster care experience help or harm them? Were they able to successfully achieve independence? Did they feel adequately prepared for independent living? Were they able to begin to set and meet future goals? What were the perceived resources and constraints to autonomous functioning? What were their long-term impressions of the stigma associated with being a foster child? Do these feelings and experiences persist into the future for the former foster child?

Finally, intervention studies must ultimately be undertaken. Once significant contextual variables which promote positive or negative impact are discerned, program design that incorporates changes derived from empirically-based theory must be evaluated. Possible areas of intervention include structural features of the environment, staff training and support, expanded independent living

skills preparation, social support linkages, mental health intervention, and case management. Research which focuses on program evaluation is essential for determining treatment effectiveness and providing an empirical foundation of support for funding.

Social Policy

It is clear that the foster care system which was originally conceived to reform the institutional treatment of children in the early century has itself evolved into a problem of increasing magnitude. It is of the utmost necessity to commit to a vigilance that advocates for strong social policy to reverse the negative trends in this growing area.

A foundational step in this process is to halt the unraveling of human services in this country. It is necessary to emphasize policy which strengthens families and to reinvest in basic services which prevent individual dysfunction and family dissolution. Foster care and residential treatment for children and adolescents are tremendously expensive modalities for care. Making a financial and legislative commitment to the prevention side of the continuum of care would result in long-term cost savings (Children's Defense Fund, 1991). Intensive family preservation, humanistic substance abuse programs, and mental health treatment for families with or at risk for emotional disturbance are just a few of the sorely underrepresented services that could prevent foster care placement.

Additionally, the rebuilding of an infrastructure which ensures a comprehensive array of integrated services for families, children, and youth is needed to promote public health. Community-based services which focus on education, health and mental health care, employment, and child and youth development are necessary to adequately address the biopsychosocial needs of children and their families.

Public policy must also ensure that appropriate contexts for care exist for children and adolescents who require out-of-home placement. Appropriate relatives, members of a child's existing kinship network, and foster families who work effectively with troubled children with multiple, complex needs must be supported and adequately funded as viable alternatives to group care. It is necessary to mandate structural change for group home programs to reduce the negative impact of institutional care. Funding must be channeled to emphasize program and staff development and to establish standards of care and mechanisms for accountability.

Policy which promotes independent living skills preparation must be expanded to begin earlier in a foster child's life and to take into consideration the child's ongoing need for social connection and support. An acknowledgement that intervention beyond technical and economic foci is crucial to maximize the potential for success at post-foster care independent living. Currently, the foster care system can truly claim success only on the

level of protection. Independent living skills training provided in late adolescence represents an ideal and symbolic social gesture while actual preparation for independence may need improvement.

Finally, the continuum of care for foster children and youth must be enlarged to encompass a safety net of supports and resources that extend beyond the current parameters for foster care eligibility. Findings from this research can be used to support the need for continued funding, case management, and transitional services for adolescents following discharge from foster care at age 18 until age 21. It is clearly apparent that few adolescents are sufficiently prepared or developmentally ready to successfully engage in independent living. Adequate housing, economic assistance, continued education or vocational training, and expanded social support are minimum basic requirements needed to promote psychosocial development and functioning for this vulnerable group.

Current social policy and legislation assigns both economic and parental responsibility for foster children and youth to the citizenship of this country. This nation must not foreclose on its investment in their chances for satisfying and productive livelihood.

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APPENDIX A

Legal Representative Consent Form:

Consent for Child to be a Human Research Subject

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Legal Representative Consent Form:
Consent for Child to be a Research Subject

A. PURPOSE AND BACKGROUND

Susan Kools, RN, PhD Candidate from the School of Nursing is conducting a study on the impact of long-term foster care as perceived by adolescents who have experienced it. Because (adolescent's name) is currently living in foster care, he/she has been asked to participate in this study. He/she has expressed an interest in participating after hearing about the study in a group presentation.

B. PROCEDURES

If I decide to permit this adolescent foster child to participate in this study, the following procedures will take place:

1. The adolescent will be contacted by telephone to schedule an interview at his/her convenience.

2. The interview will last approximately one hour and will focus on the following themes:

   a. out-of-home placement history.

   b. information about the child's original family.

   c. perceptions related to being a foster child.

3. The interview will be audiotaped for later verbatim transcription.

4. The adolescent's case records from the Department of Social Services shall be reviewed for the purposes of the study.

C. RISKS/DISCOMFORTS

1. Some of the interview questions may make the adolescent feel uncomfortable or upset. The adolescent will be assured that he/she may decline to answer any question(s) or terminate the interview and/or withdraw from the study at any time.

2. Confidentiality. Study records will be kept as confidential as is possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded and kept in a locked file at all times. Only the investigator will have access to the files and the audiotapes. After the study has been completed and all data have been transcribed from the tapes, the tapes will be destroyed.

3. The adolescent may encounter fatigue during the course of the interview. In this case, the interview will be reduced in length, divided into two sessions, or rescheduled as necessary to reduce fatigue.

D. BENEFITS

There are no direct benefits to the adolescent anticipated. The adolescent may appreciate relating his/her experiences to an interested/concerned adult. He/She may feel positive about helping foster children in the future with his/her participation in the study. The anticipated benefit of these procedures is a better understanding of the impact of foster care as perceived by those who experience it. Knowledge in these areas may help health and social services to provide better services for these children.

E. ALTERNATIVES

The adolescent is free to choose not to participate in this study.

F. COSTS

There will be no costs to the adolescent as a result of taking part in this study.

G. REIMBURSEMENT

The adolescent will be reimbursed $10.00 for his/her time and the inconvenience of study participation. The adolescent will be paid in cash directly following the completion of the interview.

H. QUESTIONS

If I have any questions regarding this study, I may call Susan Kools at (415) 552-1683. I may also call Dr. Sandra Weiss, RN, DNSc, PhD who is the sponsor of this research at (415) 476-3105.

If I have any questions or comments about the adolescent's participation in this study, I should first talk with the investigator. If for some reason, I do not wish to do this, I may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. I may reach the Committee office between 8:00 AM and 5:00 PM, Monday to Friday, by calling (415) 476-1814, or by writing to the Committee on Human Research, Suite 11, Laurel Heights Campus, Box 0616, University of California, San Francisco, CA 94143.

I. CONSENT

I have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. The adolescent is free to be in this study, or to withdraw from it at any point. Refusal to participate or withdrawal from the study will not influence the adolescent's status or the care that he/she receives as a foster child.

__________ ____________________________________

Date Subject's Legal Representative

____

Person Obtaining Consent

H1274-07566-01
1/2/92

APPENDIX B

Adolescent Assent to be a Human Research Subject

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Adolescent Assent to be a Research Subject

A. PURPOSE AND BACKGROUND

Susan Kools, RN, PhD Candidate from the School of Nursing is doing a study on adolescent experiences in foster care. Because I am currently living in foster care, I have been asked to be in this study.

B. PROCEDURES

If I decide to be in this study, here is what will happen:

1. I will be interviewed by Susan Kools to discuss my foster care experience.

2. The interview will last about one hour and will talk about my history of foster care placements and what is has been like to be a foster child.

3. The interview will be tape recorded.

4. My case records will be reviewed at the Department of Social Services.

C. RISKS/DISCOMFORTS

1. Some of the interview questions may make me feel uncomfortable or upset. I may refuse to answer any of the question(s). I may stop the interview. I may withdraw from the study at any time.

2. Confidentiality. Study records will be kept as private as is possible. My name will not be used in any reports about the study. Study information will be kept in a locked file at all times. Only Susan Kools will have access to the files and the tapes. After the study is finished, the tapes will be destroyed.

3. I may get tired during the interview. The interview will be shortened, divided into two sessions, or rescheduled if needed.

D. BENEFITS

There are no direct benefits to me for being in the study. I may appreciate talking about my experiences with an interested/concerned adult. My participation in the study may help other foster children in the future.

E. ALTERNATIVES

I am free to choose not to be in this study.

F. COSTS

There will be no costs to me for being in this study.

G. REIMBURSEMENT

I will be reimbursed $10.00 for my time and the inconvenience of being in the study. I will be paid in cash right after the interview.

H. QUESTIONS

If I have any questions about this study, I may call Susan Kools at (415) 552-1683. I may also call Dr. Sandra Weiss, RN, DNSc, PhD who is the sponsor of this study at (415) 476-3105.

If for some reason, I do not wish to do this, I may contact the Committee on Human Research, which is concerned with protection of volunteers in research projects. I may reach the Committee office between 8:00 AM and 5:00 PM, Monday to Friday, by calling (415) 476-1814, or by writing to the Committee on Human Research, Suite 11, Laurel Heights Campus, Box 0616, University of California, San Francisco, CA 94143.

I. CONSENT

I have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to be in this study, or to withdraw from it at any time. Refusal to participate or withdrawal from the study will not effect the care that I receive as a foster child.

__________ ____
Date Adolescent's Name

____
Person Obtaining Consent

H1274-07566-01

1/2/92

APPENDIX C

Adolescent Perceptions of the Impact of Foster Care: Interview Guide

Adolescent Perceptions of the Impact of Foster Care: Interview Guide

Placement History

- How long have you been in foster care?
- How old were you when you first entered foster care?
- How many different places have you lived since you entered foster care?

Questions about each specific placement:

- Describe the placement (foster home, group home, residential treatment).
- Who lived there with you?
- What were your caregiver(s) (foster parents, the staff) like? What do you remember about these people?
- What were the positive/good things about this placement? ...the caregivers?
- What were the negative/bad things about this placement? ...the caregivers?
- How long did you live there?
- What were the reasons that you left? (include adolescent's perception, foster parents, social worker's)
- Describe how the separation occurred (how, when, where, who was involved).
- How did you feel about leaving?
- How do you think living in that home affected you? ...while you were there? ...after you left?
- What was it like to move to a new place? How did it feel?
- What was it like to live in many different places?

Family of Origin

- Who did you live with before you entered foster care? (original family members, others)
- What were the positive/good things about living with your original family?
- What were the negative/bad things about living with your original family?
- What is your understanding of the reason(s) you entered foster care?
- What were you told by others (e.g. family of origin)?
- What was it like to leave your family of origin? Describe this event. What did you think about? What were you feeling?
- Do you still have contact with your family of origin? If yes, who? How? How often? What is it like when you see them? (evaluation +/-)
- How did living with your family of origin compare with living in foster care?
- Did you ever think of any of your foster parents/caregivers as family? Why or why not?

Being a Foster Child

- If a friend asked you what it was like to be a foster child, what would you tell him/her? What are the positive things? ...negative things?
- How do you think being a foster child will influence your future?
- How has it affected your goals for the future in terms of a job or career?
- Do you want to have a family of your own someday? Tell me what your family would be like.
- Where is the ideal place to live? Where would you prefer to live? Why?
- What has all of this moving around been like for you?
- How has it affected school? ... your friendships? ... your health? ...your happiness?
- How has it affected your feelings about yourself? ...about other people?
- Has it affected any other part of your life?

- Who is/are the important person(s) in your life now? ... in the past? Why?
- In general, what are the positive/good things about foster care? ... the negative/bad things ...?
- What are your suggestions about how foster care could be improved?

APPENDIX D

Case Record Audit Sheet

Case Record Audit Sheet

Demographic Information

Respondent Number

Age

Gender

Race/Ethnicity:

Asian
African American
White
Hispanic
Native American
Mixed
Other
Unknown/unspecified

Family Status:

Intact, both natural parents
Intact, adoptive
Biological parent & stepparent
Unmarried couple
Single parent (divorced, separated, never married, death)
Parents deceased
Parents' location unknown
Relative

Placement History

Current Placement

Type of Placement

Length of Stay

Identified Reason for Placement

Initial Placement

Age at First Placement

Identified Reason for Initial Placement

Type of Placement

Length of Stay

Identified Reason for Placement Transition

Each Additional Placement (including return home):

Type of Placement

Length of Stay

Identified Reason for Placement Transition

Total Time in Placement

Total Number of Placements

Possible Reasons for Placement

Conditions in Family History - Parent Contributors to Placement

Inability to control child
Inability of parent to care for self
Neglect
Physical abuse
Sexual abuse
Emotional abuse
Substance abuse
Prostitution
Relinquishment
Abandonment
Parental mental illness
Incarceration
Suicide

Child Behaviors

Aggressive behavior
Stealing
Substance abuse
Destruction of property
Suicidal threats/attempts
Self-destructive behavior
Pregnancy
Runaway
Sexual acting out
Truancy
Problems relating to peers

Child Physical/Psychological Condition

Withdrawal
Fearfulness
Phobias
Hyperactivity
Depression
Psychosis
Bizarre behavior
Compulsive
Obsessive thoughts
Excessive lying
Passive/aggressiveness
Tenuous hold on reality
Impulsive behavior
Delayed social development
Enuresis/encopresis
Extreme dependency needs
Eating disorder
Physical health problems- acute
Physical health problems- chronic
Cognitive deficits, learning disability

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