Institute for Clinical Social Work

AFFECT REGULATION—HOMELESS YOUTH ONCE IN THE CHILD WELFARE SYSTEM

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By

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ABSTRACT

This study focuses on the experiences of homeless youth who were formerly part of the child welfare system. Using a mixed-methods design, 12 young adults between the ages of 18 and 26 participated in a semi-structured qualitative interview designed to gather information regarding their experiences prior to, during, and since having exited substitute care. Subjects also completed a 32-question standardized measure of current functioning (Behavior and Symptom Identification Scale—BASIS-32). Subject narratives are evaluated using a content analysis approach. Common themes include: parental mental illness, substance use, and severe neglect prior to entering foster care; emotional and physical abuse, intense feelings of sadness, anger and aggressive behaviors in care; and current struggles with emotions and risk-taking but with the development of survival skills. Underlying these experiences is a pervasive sense of repeated disappointment from relationships and efforts to find idealizable others. A conceptual model for understanding these experiences using concepts from self psychology is proposed and suggests that these subjects lack adequate mirroring and idealizing selfobjects and resort to acting out behaviors to regulate emotions. Narrative data are compared with BASIS-32 scale scores with some different findings noted between the two. This study's potential impact on social work practice and policy is discussed and future research ideas are proposed.

To the youth who participated in this study

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CHAPTER I

INTRODUCTION

Overview of the Problem

Exact figures on the number of homeless young people are difficult to obtain given the transient and nomadic nature of the population. Reliable counts of homeless persons, in general, are complicated in that many do not spend time in shelters but live on the streets and/or move between various friends and family. Rough estimates are that the number of homeless persons in the United States at present is between 600,000 to 2.5 million (CRS Report for Congress, 2005). Though not specified, this number is presumed to encompass homeless persons of all ages. Based on a review of the research explicitly regarding young adults—which can include youth up through their mid-twenties—it is estimated that, nationally, there are nearly 1.6 million homeless young people on the streets on any given day (Robertson & Toro, 1999).

Studies focused specifically on the emotional well-being of homeless young adults have found that this group often has a history of abuse and neglect, which may precipitate and/or exacerbate homelessness (Cauce & Morgan, 1994). Additionally, the literature suggests that this group experiences a significant amount of acute and chronic emotional distress (Clatts, Davis, Sotheran, & Attilasoy, 1998) and reports generally worse levels of overall mental health than their domiciled peers (Commander, Davis, McCabe, & Stanyer, 2002). Furthermore, among homeless young adults, there is an over-

representation of persons having a foster care history (Roman & Wolfe, 1995). Research shows that approximately 30% of homeless young people have had a history of child welfare involvement (Casey Family Programs, 2001; Cauce & Morgan, 1994; Commander, et al., 2002; CRS Report to Congress, 2005; Greene, Ennett, & Ringwalt, 1999; Shelter Partnership, Inc., 1997; Thompson, Safyer, & Pollio, 2001).

Generally, children taken into the custody of the child welfare system have experienced some form of abuse or neglect, resulting in removal from their families. The effects of abusive, neglectful, and other traumatic experiences have been linked to the development of fear, anxiety, depression, post-traumatic stress reactions, suicidal ideation, sexual problems, substance misuse, delinquency, aggression (Cauce & Morgan, 1994), behavioral problems (Kortenkamp & Ehrle, 2002), and difficulties with attachment (Hughes, 1999). Children from abusive and neglectful home environments have often experienced a life of uncertainty, fear, and chaos. In all probability, they have not had sufficient opportunity to experience a sense of comfort and safety from their primary admirable caretaker and have felt a chronic lack of response to their need to be acknowledged, praised, and supported. Once in the custody of the child welfare system, these children are prone to struggles with grief, loss, and ongoing disrupted attachments resulting from early parental illness and separation from their families. Further, there is a chance that their need for connecting with another and experiencing a sense of calm and reflection may not be met in the child welfare system either or it may be repeatedly disrupted. Additionally, children may be maltreated by their substitute caregivers, possibly experience placement instability, and exhibit a range of emotional and behavioral problems as a result. For children who are exposed to repeated disruptions and

lack of responses from a primary other, there is a risk that the foundational structure of their personal selves may ultimately be affected.

For those children who reach adolescence while in substitute care or enter care as teenagers, attention seems to be focused mainly on the development of concrete independent living skills such as money management, education and career goals, household maintenance, etc. in preparation for emancipation (Collins, 2001; Shelter Partnership, 1997). In recent years, there has been slightly more research interest on adolescent wards. However, this interest appears to be focused mostly on the assessment of actual transitional living planning services and programs for wards while in care or concentrate on collecting demographic information regarding young adults post-emancipation through general surveys about the status of their lives since exiting substitute care (Colca & Colca, 1996; Collins, 2001; McMillen & Tucker, 1999; Mech, 1994; Nevada Kids Count Issue Brief, 2000; Shelter Partnership, 1997). Attention to more concrete skill building and obtaining a picture of youth post-emancipation may be due, in part, to the passage of the Foster Care Independence Act of 1999 (Public Law 106-169), which amended Title IV-E of the Social Security Act to provide more funding for tangible services to youth transitioning to independence from foster care (Casey Family Programs, 2001), and the introduction of specific skill building programs and measurement tools designed to help youth with this transition. Notably, much less attention has been directed toward the examination of psychological functioning and emotional well-being of wards—specifically, their ability to manage their affect and behaviors either during care or upon exit.

Although life skills are necessary to build in order to move youth toward independence, it is also important to ensure that youth have had the chance to work

through past trauma and develop the psychological structure required to use these skills and reasonably manage life stressors when they are on their own. A study conducted by the National Alliance to End Homelessness (Roman & Wolfe, 1995) points out the potential ramifications of not tending to past experiences of maltreatment. The researchers suggest that "foster care has an impact on personal risk factors that may eventually result in homelessness and the system often fails to help children deal with problems that resulted from circumstances which caused them to be removed from their homes and fails to help them deal with problems that arise in care" (p. 3).

In an effort to conceptualize the psychological needs of children in substitute care and the impact on youths' ability to move toward independence, concepts from self psychology may prove valuable. According to the major tenants of self psychology theory, children who do not feel admired and guided by their caretakers and/or are not afforded the opportunity to merge with the strength and wisdom of a powerful other who can be idealized, as young adults, struggle to form a cohesive sense of self and have trouble learning to regulate their emotions (Elson, 1986). Without an ability to successfully manage emotions, youth are at risk of engaging in dangerous behaviors and experiencing disrupted relationships and overall instability. There are no known studies or papers addressing the concept of working to strengthen the overall sense of self of youth as part of developing life skills in preparation for exiting from care and transitioning to independence. Further, very few studies have explored, in any combination, the concepts of child maltreatment, substitute care placement, affect regulation, homelessness, and at-risk behaviors. Those that do examine at least some of these factors pay insufficient attention to the potential association between unmet

psychological needs in childhood and while in substitute care and patterns of emotional modulation while homeless.

Some studies on the status of youth post-child welfare involvement, in addition to presenting demographic information, attempt to more closely examine mental health problems, relationships, behaviors, etc. (Brandford & English, 2004; Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Courtney, Tareo, & Bost, 2004; Nevada Kids Count Issue Brief, 2000; Pecora et al, 2005). These studies are still descriptive in nature and look at youths' backgrounds and histories prior to entering substitute care, their experiences while in care, and their current level of functioning in terms of education, finances and employment, involvement with the legal system, social supports, living arrangement, exposure to danger, and physical health. In addition, they use measurement tools to gauge current mental health status, relationships, and behaviors. Prominent findings are that former foster youth experience a great deal of maltreatment prior to entering substitute care, have multiple placements and disrupted relationships while in care, are prone to high rates of mental health problems, engage in risk-taking behaviors, and many are or had been homeless or precariously housed (Brandford & English, 2004; Courtney et al., 2001; Courtney et al., 2004; Pecora et al., 2005). These studies present detailed pictures of the overall experiences of former wards and their current level of functioning but do not focus specifically or provide more in-depth information on the issues of homelessness and patterns of emotional regulation. Furthermore, the focus appears to be on presenting a general overview of a sample of former wards versus exploring their experiences from a theoretical perspective in attempts to make meaning of the experiences.

Given that research has found that homeless youth suffer from a great deal of acute and chronic emotional distress and that there a significant number of former wards among the homeless population, attempting to better understand the development of self-psychological structures of homeless former wards from a theoretical perspective may allow for a more thorough understanding of the possible origins of the current problems of this population. The ultimate aim should be to help wards work through their past experiences of maltreatment and develop healthy, solid self-structures. In so doing, wards could be aided to develop the skills to regulate their emotions while in care and as part of the process of exiting substitute care in any manner, including transitioning to independence, thus possibly reducing their chances of homelessness and risk-taking behaviors after they are discharged from the child welfare system.

Formulation of the Problem

This study was designed to present a profile of the affective regulatory functioning of homeless young adults formerly part of the child welfare system. Its overarching goal was to examine the personal life experiences of a sample of this population with a specific focus on the subjects' relationships and behaviors prior to their involvement with the child welfare system, while in substitute care, and currently, as well as build knowledge related to the experiences, affective functioning, and needs of this population from a theoretical perspective.

Based on the literature from previous studies, it seems clear that these young people have had difficult relationships and have experienced a variety of emotional and behavioral problems—such as drug use, prostitution, gang involvement, and other risk-taking behaviors—which are characteristic of difficulty with self-regulation. Given this,

the basic assumption in this study was that homeless young adults with child welfare backgrounds experience difficulty regulating their emotions and behaviors.

The overall objective of the study was to use concepts from self psychology in an attempt to profile the affective and behavioral experiences of homeless young adults who were formerly involved with the child welfare system to better understand their personal life stories and current level of regulatory functioning. The hope was that this information could be used to re-conceptualize the effects of child maltreatment and placement in substitute care on the development of self-structures, emotional regulation, and future behaviors. The expectation was also that this knowledge could enhance the treatment services for children in substitute care as well as for homeless young adults from abusive/neglectful backgrounds.

CHAPTER II

LITERATURE REVIEW

Introduction

The following literature review is divided into three major parts:

1. Research related to the experiences of homeless young adults
2. Studies around the emancipation/exit of youth from the child welfare system
3. Theoretical literature in the area of self psychology

Given that research on the experiences of homeless young adults focuses on many of the same topics, the first part of this literature review is divided into three subsections to better examine the information. These subsections include: (a) the definitions of homeless young adults, (b) personal histories and background characteristics of homeless young adults and the reasons for homelessness, and (c) the emotional, mental health, and behavioral problems and risks associated with being homeless. Considered for review in the discussion of homeless youth and emancipation/ exit from care were only articles written in the last ten to fifteen years. As self psychology is a theory that has been in existence since 1959 with a peak in popularity in the 1970s, no time limitations were placed on this particularly portion of the literature reviewed.

Experiences of Homeless Young Adults

Definitions of Homeless Young Adults

Many of the studies on homeless youth are not limited to adolescents alone but include young adults up through their mid-twenties. This is because the age span from 17 to 22 is thought to constitute a critical transitional period to adulthood (Mech, 1994). Thus, the developmental characteristics of those in their late teens and early to mid-twenties are assumed to be fairly similar. Much of the research on homeless youth and young adults focuses on those young people between the ages of 12 and 28 (Clatts et al., 1998; Commander et al., 2002; Greene et al., 1999; Lindsey, Kurtz, Jarvis, Williams, & Nackerud, 2000; McCaskill, Toro & Wolfe, 1998; Rew, 2002; Rew, Taylor-Seehafer, & Fitzgerald, 2001; Smart & Walsh, 1993; Tyler, 2006; Tyler & Johnson, 2006).

The term "homeless" has been defined in variety of ways. Most studies consider young people to be homeless if they spent at least one night in a shelter or on the streets, in the subway, abandoned buildings or with strangers, with friends, and had no stable residence (Cauce & Morgan, 1994; Clatts et al., 1998; Greene et al., 1999; McCaskill et al., 1998; Roberston & Toro, 1999; Tyler, 2006). Officially, there is no single federal definition of what it means to be homeless. However, most programs serving the homeless population use the definition provided by the McKinney-Vento Act (P.L. 100-77), which provides federal money for shelters systems:

> An individual who lacks a fixed, regular, and adequate nighttime residence; and a person who has a nighttime residence that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

> (b) an institution that provides a temporary residence for the individuals intended to be institutionalized; or (c) a public or private place not designed, nor ordinarily used as, a regular sleeping accommodation for human beings (CRS Report to Congress, 2005, p. 1).

Personal Histories and Background Characteristics of Homeless Young Adults

According to Kurtz, Jarvis, and Kurtz (1991), there are five major types of young adults who become homeless:

1. Those whose families are homeless
2. Those escaping from sexual or physical abuse
3. Those who were pushed out of their homes due to economic problems and instability
4. The "doubly homeless"—those who are removed from their home of origin due to abuse or neglect and are taken into state custody then leave when placements become intolerable or they age out of the child welfare system
5. Unaccompanied immigrants

Regarding Kurtz's et al. "doubly homeless," more recent studies have found that as many as one-third to two-thirds of homeless young adults had a history of involvement in the child welfare system (Clatts et al., 1998; CRS Report to Congress, 2005; Shelter Partnership, 1997), and these young people experience an average of 3.2 foster care placements during their time in care (Cauce & Morgan, 1994). According to Clatts et al. (1998), some of these young people "discharge themselves from out-of-home care, often for many of the same reasons that youths not in care leave home, including physical and

sexual abuse, conflict over sexual identity, and breakdown of the family as a viable socioeconomic unit" (p. 195).

In general, research has demonstrated that the majority of homeless young adults come from multi-problematic dysfunctional families characterized by violence, substance abuse, and criminal activity; were the victims of maltreatment such as physical or sexual abuse and neglect; and were involved in conflicts over behavioral problems (Cauce & Morgan, 1994; Rew et al., 2001; Robertson & Toro, 1999; Thompson et al., 2001; Tyler, 2006; Tyler & Johnson, 2006). For some young people, disclosure of their sexual orientation resulted in familial rejection and led to homelessness as well (Cochran, Stewart, Ginzler, & Cauce, 2002).

As part of the 1998 National Symposium on Homeless Research, a comprehensive review of recent research on the characteristics of the homeless was presented. Several interesting findings were noted:

- Some studies found the racial and ethnic makeup of their subjects to be reflective of the larger community while a few noted over-representation of ethnic minorities;
- Sexual orientation varied widely across studies but, with some exceptions, compared to the national rate of 10% gay/lesbian;
- Youth consistently reported family conflict (e.g., relational problems resulting from sexual activity, substance use, sexual orientation, school problems, etc.) as the primary reason for their homelessness;
- Neglect and physical and/or sexual abuse were also common experiences. There was evidence that this type of abuse and neglect

may also precipitate separations from family via runaway behavior and removal by authorities;

- Interestingly, many homeless youth never knew their fathers and, in some cases, their mothers, and a significant number had lived with relatives (not parents) for a substantial portion of their lives;
- Stays in psychiatric and criminal justice facilities were not atypical and more than a quarter of youth who had been in foster care, group homes, or juvenile detention became homeless upon release from these facilities;
- Rates of serious mental health disorders, as assessed using standardized instruments with diagnostic criteria, ranged from 19% to 50% and reported suicide attempt rates were consistently higher than for normative groups;
- A wide range of conduct problems were uncovered, though it appeared that some of these problems developed and/or were exacerbated by homelessness;
- A number of youth acknowledged substance use themselves, and by their parents/caretakers, and were found to be at high risk for HIV and AIDS;
- Once on the streets, many homeless youth engage in illegal activities, though some of their behaviors may serve as survival strategies. Some illegal behaviors directly provide for basic needs (e.g., breaking and entering, trading sex for shelter) while others generate income to meet needs (e.g., selling drugs or sex); and

- Finally, studies have revealed high rates of victimization among homeless youth, including physical and sexual assault. In particular, one study found rates of treatment for trauma and sexual assault to be two and one-half to three times higher for homeless youth than non-runaway youth.

All in all, this comprehensive and extensive compilation of the literature suggests that homeless youth share a variety of background characteristics. The similarities include: mental health and behavioral problems; histories of maltreatment; lack of relationships and supports from parents/caretakers; and parents/caretakers who struggled with their own emotional problems, used substances, etc. As a result of these multiple and varied circumstances, these youth are at risk for poor outcomes (Robertson & Toro, 1999).

Emotional Well-Being and Risks Related to Homelessness

Research related specifically to the emotional well-being of homeless young adults centers on the types and prevalence of symptoms displayed by these young people that are representative of the emotional, mental health, and behavioral disorders classified in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-Text Revised* (DSM IV-TR). In a comparative study on the psychopathology of homeless versus housed young adults, McCaskill et al. (1998) found that almost 62% of the homeless young adults exhibited symptoms of one or more emotional and mental disorders such as depression, mania, disruptive behavior disorders, and substance dependency. More specifically, 33% of these homeless young people met the previous DSM IV-R criteria for depression or dysthymia, which supports an earlier study by Smart and Walsh (1993)

who found that one-third of their sample of homeless young adults reported chronic feelings of depression in the three months prior to being interviewed. As previously mentioned, in a review of the literature, Robertson and Toro (1999) reported that there was evidence of high rates of emotional and mental health problems among homeless youth and that the rate of serious disorders, which had been assessed using standardized instruments with diagnostic criteria, were upwards of 50%. Further, low self-esteem, lack of social supports, and long periods of time spent in shelters were related to high levels of depression and increased suicidal ideation (Smart & Walsh, 1993). Many other studies have found relationships between a history of maltreatment and emotional, mental health, and behavioral problems such as depression, anxiety, suicidal ideation, survival sex, and substance use (Greene et al., 1999; McCaskill et al., 1998; Rew et al., 2001; Sherman, 1992).

Moreover, Rew (2002) set out to describe perceptions of connectedness, loneliness, and well-being in homeless youth. Based on survey data, focus groups, and individual interviews, 60% of Rew's sample reported past experiences of sexual abuse, which was significantly related to loneliness and inversely related to connectedness and perceived well-being. In other words, those who had been sexually abused described feelings of isolation, disconnection from others and a lack of overall positive feelings. Other researchers suggest that traumatic childhood sexual abuse can result in feelings of social disconnection and lead to difficulty establishing close and caring relationships with others (Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000).

In addition to feelings of loneliness and detachment from others, there is some indication that early family environments of conflict, abuse, and/or violence can subsequently result in numerous transitions for youth (Tyler, 2006). Using semi-

structured, qualitative interview protocols, Tyler spoke with 40 homeless youth about their family histories of abuse, neglect, and other problems (e.g., substance use, parental criminal activity, etc.). The researcher learned that youth with these background experiences frequently transitioned—including being taken into foster care and having multiple placements—spending time in detention, and moving back and forth between their families' homes and the streets. This phenomenon was explained using a Life Course perspective, which postulates that early family interaction patterns create a blueprint for later living. As such, early family chaos led to later instability.

In a somewhat unique attempt to explore and deepen the understanding of this population, Fall and Berg (1996) wrote a theoretical article examining behavioral characteristics and treatment strategies using an Adlerian approach. Their perspective was that most homeless youth grow up in environments perceived to be threatening and humiliating, characterized by complex interactions of neglect, and where there is a distrust for others, fear of the world, and feelings of worthlessness. Given this, these youth lack the ability to cooperative with, seek, and use any direct supports from others, particularly as they become more overwhelmed with independence. In time, psychological symptoms can develop as a means of evading responsibilities but also as an indirect way to access help.

Examining the emotional well-being and behaviors of homeless youth from yet another perspective, in a qualitative study conducted by Tyler and Johnson (2006), 13 homeless young adults were interviewed about their experiences with the sex trade. Subjects answered questions about when and how they became homeless, their family histories, and their experiences on the streets. The researchers found that more than half of the respondents had direct experience with trading sex for food, shelter, money, or

drugs and, with one exception, all were raised in abusive families where they suffered from multiple forms of child maltreatment (e.g., physical, sexual, and emotional abuse or neglect). The researchers contend that although typically youth have been found to trade sex for resources, some do so because they are coerced, pressured, or manipulated and, as such, their actions are not entirely voluntary.

Life on the streets appears to exacerbate the emotional, mental health, and behavioral problems of homeless young people. Psychological distress may be increased as a result of the uncertainty these young people face concerning finding food and shelter (McCaskill et al., 1998) and avoiding victimization and harmful behaviors. One example of this is a study that examines self-mutilation and homeless youth. Interviews included the gathering of social history information and, along with this, several symptom scales and standardized tools were used to assess functioning. The findings indicate that there is a wide spread prevalence of self-mutilation among this population and that sexual abuse, ever having spent time on the street, deviant subsistence strategies, and meeting diagnostic criteria for depression are positively associated with self-mutilation (Tyler, Whitbeck, Hoyt, & Johnson, 2003). Similarly, studies looking at suicide within the homeless young adult population vary but suggest that between 12% and 42% of these young people attempted suicide (Rew et al., 2001; Smart & Walsh, 1993). Studies looking at self-harm in the form of substance use have found levels of drug and alcohol use averaging around 30% to 60%—depending on the substance—with the most common substances of choice being alcohol, marijuana, opiates, amphetamines, and hallucinogens (Clatts et al., 1998; Commander et al., 2002; Rew et al., 2001; Smart & Walsh, 1993). Strong connections have been found between rates of suicidal ideation and substance use (Rew et al., 2001).

Homeless young adults are prone to using as well as selling drugs, acts of prostitution, and theft for survival. Therefore, they are at increased risk for victimization, pregnancy, and sexually transmitted diseases—including human immunodeficiency virus (HIV) and hepatitis B—as a result of unprotected sex or intravenous drug use (Clatts et al., 1998; Greene et al., 1999; Sherman, 1992; Thompson et al., 2001). Homelessness also puts young people at risk for a number of other health problems such as malnutrition, anemia, respiratory infections, and periodontal disease, among other things (Sherman, 1992).

Not all studies on the emotional and physical well-being and functioning of homeless young adults focus on negative outcomes. An exploratory qualitative study conducted by Lindsey et al. (2000) highlights the strengths and resiliencies of this population, questioning how these youth navigate difficult times and make successful developmental transitions into young adulthood while living in high-risk environments and engaging in dangerous behaviors. Information was collected from 12 youth between the ages of 18 and 25 via semi-structured interviews regarding the nature of the decisive turning points in their lives, personal and contextual factors that contributed to their growth, and how they defined success. They found that personal attributes (e.g., sense of responsibility, caring, maturity, strength, etc.), spirituality, and the ability to change their attitude and learn new behaviors allowed youth to make a successful transition to young adulthood.

Emancipation of Young Adults from the Child Welfare System

Historically, the age of 18 is the legally and culturally identified beginning of adulthood. However, the nation is experiencing a trend toward family responsibility for

young adults into their twenties (Children's Action Alliance, 2005). A nationwide survey determined that most Americans do not believe young adults are ready to live independently until the age of 23, while a third feel that age 25 or higher is a more realistic estimation (Jim Casey Youth Opportunities Initiative, 2003). These beliefs have recently been confirmed by scientific research that contends that the brain does not reach peak maturity until the age of 20 to 25 (The Teen Brain, 2004). In most states, the age of emancipation from substitute care is 18, with some programs allowing youth to remain in care until age 21.

According to the National Clearinghouse on Child Abuse and Neglect Information (2005), during the fiscal year 2003, nationwide, 281,000 children exited foster care: 55% were reunified with parent(s) or primary caretaker(s); 18% were adopted; 15% went to live with a relative or guardian; 8% (approximately 22,480) of young adults were emancipated; and 4% had other outcomes (e.g., transfers to other state agencies, runaways, death). On average, the majority of children (32%) had been in care for less than one year while only 9% were in care for five or more years. Not available was specific information about the length of time in care for youth who are eventually emancipated.

Most of the available research specific to the emancipation of young adults from the child welfare system consists of studies focused on the evaluation of programs designed to prepare young people for independence (Children's Action Alliance, 2005; Colca & Colca, 1996; Collins, 2001; Shelter Partnership, 1997). Other studies are general surveys on outcomes such as education, employment, support networks, medical and developmental conditions, pregnancy and parenting, criminal involvement, substance use,

and living arrangements (Brandford & English, 2004; Collins, 2001; Leathers & Testa, 2006; Mech, 1994; Reilly, 2003).

Recent research in child welfare has focused on the well-being of children in care, family preservation, permanency planning, and early intervention services but less attention has been given to the emancipation of young adults, and a definite need to further examine this group exists (Collins, 2001). According to Collins, this is because adolescents in substitute care generally come from families with multiple problems and often do not have the type of long-term support normally provided by families of origin. Because these young adults do not have this type of supportive safety net, they are vulnerable to homelessness and other problems upon emancipation. Furthermore, the older these young adults become and the longer they remain homeless, the more prone they are to drug dependence, violence, HIV exposure, and emotional stress (Clatts et al., 1998). In addition, children who are abused and neglected tend to have a higher prevalence of involvement with the justice system (Howell, Kelly, Palmer & Magnum, 2004). In Arizona during the 2004 fiscal year, 750 youth were released from the juvenile justice system because they reached the age of majority. Twelve percent of these youth were also exiting foster care at the time of their release (Children's Action Alliance, 2005).

In general, studies on homeless young people across the nation capture some information related to these young adults' histories of involvement with the child welfare system as part of their demographic data. These studies have found that upwards of 30% of the homeless young adults questioned indicate they have been in the custody of the child welfare system at some point in their lives (Clatts et al., 1998; Commander et al., 2002; Greene et al., 1999; Thompson et al., 2001). Thompson et al. found that young

adults who have been under the guardianship of the child welfare system, nationally, have more problems with delinquency while homeless and are less likely than those whose parents were their legal guardians to be reunified with family. However, a different study found that approximately 48% of emancipated wards have some contact with their relatives, yet those young adults discharged from foster care report not feeling very close to these relatives (Mech, 1994). This seems to demonstrate Collins' (2001) notion that emancipated wards do not have very strong familial support systems.

In addition to a lack of support, mental health problems are commonly identified types of special needs among youth emancipated from substitute care. Based on the perceptions of caseworkers in one study, 44% of their young adult clients have significant problems with depression, and in 31% of depressed youth, their mood is reported to be severe enough to impede independent living (Leathers & Testa, 2006). In a similar study where the youths themselves were interviewed, Reilly (2003) suggests that a significant portion of youth exiting foster care face serious difficulty transitioning to independence. Although most are surviving to some degree, an unacceptable number end up homeless or incarcerated, lack the ability to meet their own basic needs, and are at risk of victimization. Moreover, multiple placements while in foster care are found to exacerbate these conditions and are linked to higher rates of pregnancy and violence in dating relationships. Notably, mental health services are deemed critical for this population, both while in care and when youth transition into the community. Per Reilly, "These young adults need to accept their pasts" (p. 744). He notes that many of the young people in his study continued to be victimized by roommates, boyfriends or girlfriends, acquaintances, and others. "Unless these youth can deal with the circumstances that brought them into

care in the first place, they will continue to face difficult hurdles in dealing with life in the community" (p. 744).

The Annie E. Casey Foundation, a private charitable organization dedicated to helping build better futures for disadvantaged children in the United States and a supporter of several independent living programs across the nation, published a summary in 2001 on outcomes of youth exiting foster care. The report acknowledges that "research shows that no group in the United States is more predictably headed for unhappy outcomes than young people who spend their adolescence in foster care . . . homelessness is widespread . . . untreated mental health problems are pervasive" (Nelson, 2001, p. 2). The author of this summary report reminds readers that young people who come from chaotic homes and have been victimized by abuse or neglect will require continued support into early adulthood. Historically, scholars and child welfare officials have paid little attention to the needs of children who grow up in foster care and only a few track former wards into adulthood. From the limited available research obtained for the Casey Study report, it was learned that 56% of young adults accessing federally funded shelters in 1997 had previously been in foster care; 25% disclosed having spent at least one night homeless within 2.5 to 4 years after exiting substitute care; 38% had been diagnosed with emotional disturbances; in Wisconsin, 34% were homeless or lived in four or more places within 12 to 18 months of leaving care and, though 47% received mental health services while in care, only 21% were link to and/or engaged with services at exit; and in Nevada, 24% of former foster youth ages 18 to 21 sold drugs to support themselves while 11% traded sex in exchange for money (Nelson, 2001).

In a related article (Kellam, 2001), also sponsored by the Annie E. Casey Foundation, describing a "bridge" program to independent living in Los Angeles, the

author acknowledges that although the participants gained skills in several areas of independent living, little progress was made in emotional well-being. The program was not effective in increasing self-esteem and, in fact, mental health declined in three of four measures. In a profound statement, the program's creator said, "These kids have more mental health needs than originally anticipated" (p. 22). A supporter and partner of the program mused, "These kids come right out of the county foster care system. Why has this [mental health problems] not been screened and treated before?" (p. 22). As a result of these concerns, it was recommended that mental health services be made a core element of all transitional living programs.

Overall, there are very few studies that begin to explore the emotional and mental health functioning of young adults post-emancipation in more detail than the previously mentioned studies. However, over the last few years, four similar studies, three of which were longitudinal, were undertaken that make some initial attempts to evaluate emotional well-being. The Northwest Foster Care Alumni Study of 2005 examined outcomes—via review of case records, interviews, and standardized assessment scales—for 659 adults ranging in age from 20 and 33 who had been in the foster care system between 1988 and 1998. Key areas of interest included: living arrangement before foster care; parent functioning; parenting style of birth parents, child maltreatment, and reasons for initial placement; mental/physical health problems diagnosed while in care; placement history; education and therapeutic services; foster family relationships, including nurturance and maltreatment; preparedness for leaving care; educational and financial/housing resources post foster care; and mental health diagnoses. To assess current mental health functioning, the Composite International Diagnostic Interview (CIDI)—a World Health Organization-approved psychiatric diagnostic tool—was used. As might be expected,

most children enter substitute care due to some form of maltreatment and parental substance use. More than two-thirds have multiple placements and about one-third to one-half experience some form of maltreatment in care. Since exiting substitute care, over half (54.4%) of the alumni have current mental health problems, as compared to less than one-quarter of the general population. The prevalence of Post Traumatic Stress Disorder (PTSD) is significantly higher among alumni (25.2%) as is depression (20.1%) than among the general United States population (4% for PTSD and 10.2% for depression). The researchers duly note that while several studies of youth between the ages of 17 to 19 who were in foster care found high rates of mental health disorders such as depression and anxiety, their study demonstrates that these disorders persist even in older foster care alumni (Pecora et al., 2005).

In the state of Washington, another study was conducted, which examines the characteristics of youth leaving the child welfare system, how prepared they are for emancipation, and ultimate outcomes. Outcomes included: education; housing; employment; risk behaviors; mental health; and social support structures. This study found that 13% of youth have been homeless at some point since leaving care and 25% are precariously housed (i.e., “couch surfing” with friends). Over two-fifths (42%) have indicators for depression, as determined by a depression scale. More than five times as many youth have been arrested as compared to the general youth population nationwide and only 44% felt prepared for independence. Interestingly, the study revealed that youth who are sexually abused, abandoned, and/or neglected fare far worse on outcomes indicative of success, suggesting a need for more specialized therapeutic services designed to address these issues in an attempt to enhance emancipation outcomes (Brandford & English, 2004).

Another longitudinal study widens the scope of exploration and looks at the experiences of young adults prior to entering substitute care, while in care, and post-emancipation. This study provides descriptive information on the backgrounds and past experiences of former wards of the state, examines their current level of functioning, and uses a standardized measure to assess their mental health and emotional well-being. This study was designed to track the experiences of young adults who left foster care in Wisconsin in 1995 and 1996. The research project was constructed to occur in three phases. To date, the study reports on the results and preliminary analysis of the first two phases of the project. The first looks at the conditions of youth in care as they approach emancipation. The second describes these youths' experiences in the first 12-18 months after leaving care. The third phase will look at these youth three years post-emancipation (Courtney et al., 2001).

The Wisconsin study examines the experiences of youth with relatively lengthy stays in care and looks at the extent to which services provided under the Independent Living Initiative help youth make the transition to independence. The study focuses on a broad range of independent living and well-being variables. Sixty to eighty minute interviews (mostly in-person and in the youths' homes) and the administration of a variety of standardized tests were used to collect data. Participation was voluntary and youth were paid. One hundred and forty one youth were interviewed during the first phase of data collection while 113 were interviewed at phase two. Interview questions focused on the following topics: history of maltreatment and reasons for placement; relations with family of origin and foster family; need for placement; experiences in care; attitude toward care; independent living training and services; social support; educational attainment and aspirations; mental health services received; delinquency and post-

discharge crime; living arrangement; finances and employment; physical health; public assistance; and danger to well-being post-emancipation (i.e., physical victimization, homelessness, criminal justice involvement). Standardized tests included:

1. Multidimensional Scale of Perceived Social Support (MSPSS)
2. Wide Range Achievement Test of Reading (WRAT-R)
3. Mental Health Inventory (MHI)
4. General Health Rating Index (Courtney et al., 2001)

In general, the findings suggest that a significant portion of foster youth have difficulty transitioning to self-sufficiency.

The most significant findings of the study include the following:

- The majority of young adults experienced a history of maltreatment, including physical and sexual abuse as well as neglect, prior to care and while in the system;
- Parental problems included drugs/alcohol use, mental illness, domestic violence, incarceration, and parenting skills deficits;
- Most youth had been in care for approximately 5.5 years and had, on average, 4.6 placements;
- Youth reported feeling lonely, different, and with no roots;
- Many youth felt unprepared for independence;
- In the year prior to emancipation, just less than half of the youth (47%) were in some form of mental health treatment with individual treatment being the most common modality (92%);

- Some youth were taking medication for the emotional/mental health problems (38%), some had been in substance specific treatment (5%), and some had experienced psychiatric hospitalizations (14%);
- The MHI suggested that these foster youth reported significantly more psychological distress than typical for this age group;
- Youth were less likely to receive mental health services once they exited care than while in the child welfare system. Although receipt of mental health care services decreased dramatically over time, there was no evidence that the need for services decreased;
- Problems were noted with delinquency;
- Securing stable housing was problematic. Twelve percent of youth were homeless post-discharge and many lived for different periods of time various other people such as friends, family, etc; and
- The large majority of young adults experienced situations dangerous to their physical well-being (Courtney et al., 2001).

The primary investigator of this study is also in the process of conducting a similar study over three Midwest states. Like the previous one, the Midwest study is longitudinal and is designed to collect data, in three phases, related to youth experiences prior to, during, and after foster care. It presents the results of the first phase of data collection, which examines the histories of 732 youth currently in substitute care, their experiences since being in care, and their current level of emotional, relational, and behavioral functioning. Information was gathered, via interviews, on the following topics: history of maltreatment and reason for placement; experiences in care (adoption plans, placement types, moves, runaway episodes, re-entries); attitude toward foster care;

contact with family; relationship with family and foster parents; social support; independent living services; mental health and medical care and services; education; employment; and delinquency. Additionally, standardized measures or questions from these measures were used to assess various levels of functioning. These measures included:

1. Lifetime Experience Questionnaire (to assess history of abuse/neglect)
2. Medical Outcomes Study Social Support Survey
3. Composite International Diagnostic Interview (CIDI) (to assess psychological functioning)
4. National Longitudinal Study of Adolescent Health (to assess health and delinquency)
5. Wide Range Achievement Test of Reading (WRAT-R) (Courtney et al., 2001)

The first phase of results of the Midwest study resembles those found in the Wisconsin study. The results suggest that youth in foster care come from unstable backgrounds, one-fourth to one-third are the recipients of psychological and psychiatric services while in substitute care, and the likelihood of involvement in violent activity, as either a victim or a perpetrator, is high for the population (Courtney et al., 2004).

In sum, the results of all of these studies suggest that a significant portion of former foster youth have histories of considerable abuse, have been exposed to violent and/or chaotic early environments, have had problematic relationships, experience difficulty with emotional regulation, and engage in risk-taking behaviors. The findings imply that these young adults likely lacked the experience of safe, stable, consistent admirable others early in their lives who could serve as sources of emotional containment and thus help them learn how to manage their own affect.

Beyond these studies, there appears to be very limited information specific to emotional regulation, relationships, and behaviors of young adults prior to exit from care and affect and behavior regulation among homeless former wards post-emancipation. Therefore, additional research in this area seems warranted in effort to determine if there is a possible relationship between these matters.

Contrarily, a study by Schofield (2002) examines elements of positive outcomes for adults with foster care histories. Using a qualitative study design, interviews were held with 40 adults, ages 18 to 30, who grew up in foster families. For Schofield, "Listening to adult narratives can help us make sense of the meanings that experiences of foster family life had in childhood and continue to have in adulthood" (p. 259). Frameworks from attachment and resilience theories were used, in conjunction with the ideas of "belonging," "family membership," and "security" as keys to permanence, to analyze and interpret subject narratives. Based on the study's findings, a new theoretical and dynamic psychosocial model of foster care and successful future outcomes was proposed. Schofield suggests that loving relationships are built on "the experiences of predictable, sensitive care" (p. 262). Children need to feel a sense of value and unconditional love. Further, continuity of relationships offers security and predictability. When caregivers provide these things to children, in essence, helping to contain their anxiety, children eventually internalize these experiences and develop coping skills of their own that can be carried into adulthood. Schofield believes it is these types of experiences that contribute to good outcomes for children in foster care as they enter adulthood. When these experiences are lacking, children struggle with a sense of direction, belonging, and hope and their capacity to cope with future life challenges is damaged.

Homeless Young Adults and Emancipation Literature Conclusions

Overall, there appears to be a variety of research related to the emotional well-being of un-domiciled young adults, in general, focusing on both the reasons for and ultimate results of homelessness. Most of these young people come from dysfunctional families, have been victims of abuse and neglect, and many have been involved with the child welfare system. Furthermore, they are more vulnerable to a variety of emotional, mental health, relational, and behavioral problems due to the precariousness of being homeless coupled with their traumatic family histories. The majority of research in this area offers quantified descriptive and demographic information about the population. There is a paucity of qualitative and/or theoretical studies examining and presenting, in a more in-depth narrative format, the experiences of these young adults.

The numbers of young adults with histories of child welfare involvement have been captured as part of the demographic data in studies on homelessness in general. However, the research related specifically to the emancipation/exit of young people from the child welfare system is somewhat scarcer but becoming more evident in recent years. Though, what is available appears to concentrate mostly on program evaluation or general surveys of outcomes related to education, employment, housing, etc., with the exception of some recent studies in the Northwest, Washington, Wisconsin, and three Midwest states. These particular studies assess affect, relationships, and behaviors as a part of their data collection and provide a descriptive report on the findings. Nevertheless, no further in-depth analysis of the possible relationship between past experiences and present functioning is made, from a theoretical perspective, in effort to lend some explanation for this apparent connection.

There are no known studies focused exclusively on the affect regulation and behaviors of homeless young adults who were once involved with the child welfare. Particularly, there are no studies with these subjects in which the focus is on their histories, experiences while in substitute care, and their emotional, mental health, relational, and behavioral problems from a theoretical perspective.

Theoretical and Conceptual Framework

Concepts from the theoretical perspective of self psychology were used in this study. Self psychology was chosen for several reasons. First, although no research was found analyzing the affective functioning and behaviors of former wards from a theoretical perspective, one academic article was located that suggests that self psychology is a useful way in which to think about the needs of children in the child welfare system and guide clinical interventions and treatment. Goldmeier and Fandetti (1991) call attention to the fact that early theoretical conceptualization regarding the needs of children in the child welfare system has most often been from an ecological perspective. Based on their research and review of relevant literature, they suggest that this approach is useful because of its comprehensiveness in assessing psychosocial difficulties in children and that it could be used as a paradigm for looking holistically at important aspects of the environment, including the reciprocal relationship between social support and personality development. However, they note that some feel the ecological model is incomplete and only serves as a metaphor without considering what is actually occurring in relationships. Further, an ecological model fails to account for how individuals internalize aspects of the external world, unlike other theoretical orientations, in particular psychodynamic theory. The authors acknowledge evidence that

later ecological perspectives attend to how self-esteem is developed and the ways in which values and goals are internalized. Yet, overall, they believe that to best enhance the newer ecological approach, the psychodynamic theory of self psychology may serve as a nice compliment because of its "emphasis on the type of empathic external figures that are needed to promote growth and the internalization of a positive self-concept" (p. 2).

From a self psychological approach, Goldmeier and Fandetti (1991) discuss the ideas, conceptualized by the founder of self psychology theory, Heinz Kohut, of the selfobject transference needs of mirroring and idealization and the emphasis on the use of empathy as a means of gathering information via vicarious introspection. Next, they apply these concepts to therapeutic work with children in substitute care. It is their contention that Kohut's formulations facilitate a deeper understanding of the need for early nurturing relationships, which is crucial in the lives of children in substitute care. They imply that repeated empathic failures on the part of important caretaking others can have an impact on the development of self-admiration and esteem and that without experiencing a sense of vigor, greatness and perfection or feeling a sense of calmness and infallibility, all of which are psychological building blocks created via relationships with caregiving others, the formation of what Kohut refers to as one's self-structure will, in all likelihood, be impaired. To illustrate these selfobject transference needs and early deficits, the authors present case examples of a select few children in substitute care. They describe the children's present functioning and provide an analysis of each child's behaviors and emotional state from a self psychology perspective. They go on to explain how social workers can intervene to meet the child's selfobject transference needs. In general, the authors suggest that "self psychology offers a highly useful framework for understanding the dynamics of the child's relationships with important persons in the

environment" (p. 568). To date, this appears to be the only article that is both self psychology based and child welfare specific. The ideas put forth in this article seem to provide a rationale for, and lend support to, applying self psychological concepts to other areas of child welfare, including the experiences and psychological functioning of former wards.

Though not solely devoted to discussing child welfare, in her work, Elson (1986) makes reference to children who have experienced trauma, abuse, and neglect and who subsequently may have become part of the social welfare system. In a clear and comprehensive manner, Elson summarizes and espouses many of Kohut's self psychological ideals and applies them to work in social services. She cogently articulates how the self is formed and what happens when there are early disruptions. She describes, per Kohut, a metaphorical "bipolar self," which is created through two streams of experience: "that of being mirrored, admired, confirmed and guided; and that of being permitted to merge with the power and wisdom of an idealized selfobject" (p. 4). As basic necessities, selfobjects are "essential to the creation of the self in infancy, to its consolidation in early childhood, and to the sustenance of the self throughout life" (p. 4-5). Infants and children let their needs be known first by their stirrings and bids (e.g., crying, facial expressions, body posture, etc.) then by language and behaviors later (e.g., calling to and/or tugging on caregiver, tantrums, etc.). Caretakers, as empathic selfobjects, ideally read these cues, anticipate, and meet the child's needs, thereby performing a mirroring, confirming, and guiding function and permitting a merger with an idealized strength, calm, and wisdom. These caretakers take pleasure in the child's being, respond joyously to the child's presence, help define feelings, and shape behavior. Meeting even the most basic needs of feeding, changing, holding close and ensuring the

child's comfort enables the child to merge with a caretaker's sense of calmness and competence. If these circumstances occur in sufficient amounts and for adequate durations, and thus the child's emotional and physical needs are fairly routinely sated, these selfobject functions are transmuted into self functions as the child matures. These functions turn into a person's capacity to regulate emotions and feelings of self-worth, monitor anxiety, self-soothe, define and pursue realistic goals, and experience a sense of cohesion and wholeness. It is this basic structure that accounts for one's capacity to respond to the challenges of life and learning. In this way, these earliest memories and experiences come to form one's psychic structure.

Deficits in the formation of the self-structure occur when the original caretaking selfobjects fail to be reasonably in tune with the child and provide such functions. The self is then at risk of injury and fragmentation. Per Elson (1986), the significant failures by and/or unavailability of caretakers is often because of their own deficits in self-structure derived from their early childhood experiences. These, then, deprive their children of appropriate mirroring and guidance and inhibit the opportunity to merge with the competence and strength of an idealized selfobject, which ultimately affects one's ability to regulate emotions and behaviors. The author notes that caretakers with a chaotic history are unable to monitor symptoms of anxiety within themselves, thus cannot help their children develop the self-structure to accomplish this task. Further, caretakers whose rage erupts in punishing behaviors toward their children not only lack the ability to monitor anxiety but cannot modulate their impulses or employ soothing, calming resources to accommodate their children's needs. On the contrary, at such times, these caretakers use their children as selfobjects to sustain their own faltering selves and respond in anger when their children are unable to do so. Elson suggests that these

children, as they become adults, take desperate measures to meet their needs for mirroring and idealizing. They do so through "enactment of behaviors which temporarily calm and soothe them, temporarily stimulate or vitalize them in ways which do not lead to the formulation of reliable self-structure" (p. 31). For young adults, Elson says that Kohut (1971, 1977) views behaviors such as substance use, delinquency, sexual acting out, and suicidal thoughts as the attempts of an enfeebled, chaotic self to overcome a sense of emptiness and have an illusion of wholeness amidst feelings of worthlessness, abandonment, and annihilation. In search of connection and closeness, and without an ability to regulate emotions, feelings of helplessness and rage may lead to senseless outbreaks of violence. Throughout her exposition of self psychology, Elson reminds the reader that the experiences and dynamic relations described are frequently seen in social work settings, including the child welfare system.

Kohut (1971, 1977) conceptualizes the formation of the self and the consequences of empathic failures and traumatic disappointments of selfobjects. Under optimal conditions, the "gleam in the mother's eye" mirrors the child's narcissistic-exhibitionistic enjoyment, which confirms the child's self-esteem and assists in the development of the grandiose self. When the caretaker is responsive to the child's needs for comfort and security, idealization occurs. However, if there are repeated empathic failures on the part of the caretaker, the child may suffer from traumatic disappointment of the idealized selfobject, resulting in an inability to internalize the skills to regulate emotions. Though Kohut speaks mainly about mothers, or other mothering objects, serving these selfobject functions, he notes that if a mother is unable to meet the mirroring needs of the child, a father's, or other fathering object's, presence—provided his personality is not disturbed due to narcissistic fixations—may serve as a compensatory idealizing structure whereby

the child can experience a sense of strength and calm. In essence, “The strength of one constituent is often able to offset the weakness of the other” (Kohut, 1977, p. 186).

If idealizing needs go unmet, for Kohut, there is the possibility that some personalities may become addicts; a disturbance that he thought was the result of inadequate development of the capacity for idealization. Drugs, perversions, and aggressive acts may be sought to calm or reconstitute the threatened self. These substances and actions do not serve as a substitute for the lost objects, or the relationships with them, but as a replacement for a defect in one’s psychological structure (Kohut, 1971).

Goldberg (1995) uses concepts from self psychology to discuss what he calls perverse behaviors. In essence, Goldberg theorizes that perverse sexual behaviors are the result of problems with self-regulation that arise both from repeated disruptions in the conditions for idealizing and a chronic lack of responsiveness to a child’s need for mirroring. He later added other behaviors resulting from problems with self-regulation. These include both substance and process addictions such as drug use, delinquent and criminal activity, gambling or difficulty managing money, and aggressive acts. These are generally considered impulsive behaviors, thus an inability to self-regulate. Goldberg studied an upper middle class population in which these behaviors were once thought to be sporadic and out of the norm; however, they are not uncommon among homeless youth and former wards. Therefore, some of Goldberg’s ideas may be applicable to understanding the at-risk, impulsive behaviors found among the homeless former ward population.

The concepts of the idealized parent imago and mirroring seem quite relevant to the study of affect regulation and behaviors among homeless young adults formerly

involved with the child welfare system. Siegel (1996) concisely describes Kohut's concept of the idealized parent imago. According to Kohut's theory, caretakers are ideally supposed to provide children with an emotionally calm, soothing, idealizable environment through which children eventually learn to regulate their own emotional states. Caretakers initially function as affect regulators for their children. Kohut's theory suggests that, "Psychic structure develops when idealizations are gradually withdrawn from the child's caretakers. These internalizations create new structures that assume the psychological functions previously preformed by the idealized objects" (i.e., caretakers) (p. 71; Kohut, 1971, 1977). Essentially, children who had the experience of an idealizing parent imago, as they grow, are able to internalize the calming, regulatory features of their caretaking others and begin to use them to regulate their own affect and behaviors. Those who did not have the experience of the idealized parent imago have not likely internalized necessary regulatory functions from their caregivers and have difficulty managing their emotions and behaviors.

Per Siegel (1996), Kohut proposes that internalization cannot occur if children suffer the traumatic loss—physical or emotional—of their caretakers. This loss can create different types of disturbances in the realm of the idealized parent imago. Severe, early pre-oedipal trauma often is the result of a caretaker's un-empathic responses. This early lack of attunement to the child's emotional needs denies the child the precursors of tension regulation. These children often "become addicts who turn to the addictive substance to replace the tension-regulating and self-soothing functions of the missing internal structures" (p. 73). Trauma during the later pre-oedipal period, which interferes with the process of drive-controlling and drive-neutralizing, may result in needs becoming sexualized. This need-seeking sexualized behavior is an attempt to soothe and

settle the disrupted self (Kohut, 1971, 1977; Siegel, 1996). If trauma is experienced during the late oedipal and early latency periods when the ego is not yet fully formed, a child will "forever search for external idealizable objects from whom he needs to obtain the approval and leadership, which his insufficiently idealized superego cannot provide" (Kohut, 1971, p. 49; Siegel, 1996, p. 73). In essence, early pre-oedipal trauma (from birth to 18 months) creates a defect in tension regulation, later pre-oedipal trauma (18 to 36 months) leads to the development of sexualized behaviors, and oedipal and latency trauma (3 to 7 years and beyond) creates a superego lacking idealization (Kohut, 1971; Siegel, 1996).

In summary, children have both a need for merger with an idealized, calming other and a need for appropriate responses and recognition, which include an awareness of their state of mind, state of feelings, and state of desire and purpose. Growing up without these needs being met–experiencing massive, repeated, traumatic disruptions in these spheres (multiple and constant narcissistic injuries)–may leave the structure of the self in a non-cohesive state; unregulated (impulsive) behaviors may result. If the mind is chaotic, behavior is chaotic. For those experiencing a non-cohesive self state, one way to manage anxiety and tension is through unregulated behaviors such as addictive behaviors, aggression, impulsive actions, sexual promiscuity, and perversion. A non-cohesive self state may leave one unable to make long-term plans, consider consequences, or make use of external structures. Though rarely applied directly to either the homeless population or to young adults once part of the child welfare system, the major concepts of self psychological theory seem very relevant and fitting.

Operational and Theoretical Definitions

Affect Regulation: The capacity for maintaining cohesion and effectiveness in the face of intense emotions and disruptive experiences. It is held to develop from the effective and attuned back and forth interactions between a child and primary caregiver and contributes to one's capacity for problem-solving, communication, thinking, planning, and goal setting as well as one's sense of self and strength. These early interactions and the capacities that are derived from them constitute the self-structure (Elson, 1986; Goldberg, 1995; Kohut, 1971, 1977).

Behaviors Resulting from Problems with Self-Regulation: At-risk behaviors such as perversion, drug use, delinquent and criminal activity, aggression, etc. (Goldberg, 1995).

Homeless: At least one night un-domiciled, with temporary or shelter housing, and with no fixed, adequate residence (CRS Report to Congress, 2005).

Idealized Parent Imago: The internal representation of the child's experience of merger with the calmness and felt omnipotence of the idealized parenting other (Elson, 1986). The idealizing parent imago is characterized by "a yearning for an omnipotent object to whom one can attach in an effort to feel whole, safe, and firm" (Siegel, 1996, p. 204).

Mirroring Selfobject: The internal representation of the experience of being responded to and confirmed in the child's innate sense of vigor, greatness, and perfection (Elson, 1986).

Non-Cohesive (Damaged or Weakened) Self: The result of faulty, un-empathic interactions between child and the selfobjects of childhood (Elson, 1996).

Selfobject: "The caretaker during childhood that fulfills the function of meeting psychologically essential selfobject needs. Objects that provide the selfobject needs are experienced in terms of their need fulfilling function rather than as entities in their own right" (Siegel, 1996, p.206). The object is not experienced as being separate from the self in terms of the psychological function it provides. A selfobject is something on the outside that is optimally experienced as part of the self. It is an essential element. When it functions properly, it is experienced as part of the self. When not functioning properly, there is distress and weakening of the self.

Selfobject Need: Essential psychological need, originating in childhood, for others to function as part of one's strength and calming (idealized selfobject needs) and to provide attunement and reflection back of an accurate and hopeful sense of self (mirroring needs) (Siegel, 1996).

Ward of the State/Youth Formerly Involved with the Child Welfare System: Any young adult who was placed in the custody of the child welfare system as a minor for some period of time.

Young Adult/Young Person: Persons between the ages of 18 and 26. This age range shares similar developmental features (Mech, 1996).

Research Questions Explored

Based on the literature and dearth of information regarding homeless former wards of the state, the following overarching research question was developed: What are the patterns of affect regulation and behaviors among homeless young adults formerly involved with the child welfare system? Sub-questions included:

1. What are the themes of their relational and behavioral experiences as depicted before they entered the child welfare system, while in substitute care, and at present?
2. How do they score on a standardized measure of affective symptoms and behavioral functioning?
3. Is there coherence or discrepancy between their narrative life stories and their scores on a psychometric measure?

CHAPTER III

METHODOLOGY

Study Design

This study was a mixed methods design. Both qualitative and quantitative data were collected concomitantly using Creswell's (2003) concurrent nested research strategy. In this way, both types of data could be gathered simultaneously in one phase of data collection. Given the transient nature of the population under study, it was presumed that there would not likely be more than one opportunity to acquire information from each subject. Although quantitative measures were also being used, the predominant method of inquiry was a qualitative interview. A nested strategy allowed for one method to guide the study while the other method was embedded within (Creswell, 2003). In this case, the qualitative interview measure guided the study and there were quantitative measures fixed within it along with a standardized measure of behavior. According to Creswell, a primarily qualitative design with embedded quantitative data serves to enrich the description of the subjects.

This study was focused on examining life stories through narrative research inquiry. It was based on a methodology of life story research put forth by Lieblich, Tuval-Mashiach, and Zilber (1998). The authors of this methodology developed a narrative approach to studying life stories that provides guidelines and techniques for reading, analyzing, and interpreting life story material. The authors' theoretical position

is that the mission of psychology is to "explore and understand the inner world of individuals" (p.7). Their belief is that the best way to do this is through verbal accounts and stories of individuals, as one's narrative provides access to and is representative of one's personal identity. They purport that, "Stories are constructed around a core of facts, or life events, yet allow for a wide periphery for freedom of individuality and . . . interpretation of these remembered facts" (p. 8). Lieblich et al. promote a constructivist approach in their claim that individuals build their image based on one's own interpersonal context and that by studying and interpreting self-narratives, researchers can access not only personal identity and meaning but construct a picture of one's social and cultural world. For Lieblich et al., one of the research goals of narrative inquiry is to "illuminate the causes (and meanings) of relevant events, experiences, and conditions" (p. 172).

According to Lieblich et al. (1998), narrative research refers to "any study that uses or analyzes narrative materials" (p. 2). Data can be collected in different ways (e.g., interviews, literary works, field notes, written observations, etc.) and analyzed along a multitude of dimensions including content, structure, style, affect, attitudes, beliefs, motives, etc. The investigator usually has a guiding research question that determines the sample selection and procedure for obtaining narrative life stories, with the goal of reaching interpretive conclusions. The narratives can either be used as the object of the research or the means to study a particular question and to understand personal identities, lifestyles, and social phenomena. Per Lieblich et al., the evaluation of a real life problem or the characteristics or lifestyle of a specific subgroup or particular cohort may be undertaken with a narrative approach.

For the purposes of this study, personal life story narratives were collected and used to try and understand questions related to the past experiences and life problems as well as the current lifestyle of homeless youth who were formerly involved with the child welfare system by examining the content of their stories and making interpretations based on the narrative material. This study aimed to profile the life stories of this homeless young adult population, with a focus on life events such as relationship experiences, behaviors, and the connection to affect and behavior regulation; therefore, a narrative approach to inquiry using a life story methodology seemed most appropriate.

This study was both exploratory and descriptive in nature and utilized concepts from self psychology to examine the data. As there appears to be no known research focused specifically on affect regulation and behaviors in homeless youth who were once involved in the child welfare system, this study served to explore this issue. The study was descriptive in that its purpose was to profile the experiences of homeless youth who were once wards by examining their childhood backgrounds, experiences while they were in substitute care, relationships, and their mental health, emotional, and behavioral problems while homeless. The use of concepts from self psychology expanded the study beyond its exploratory and descriptive aspects and allowed it to have a more theoretical focus, which is something that had not been done in previous research with this population.

Research Questions

The following overarching research question guided the study: What are the patterns of affect regulation and behaviors among homeless young adults formerly involved with the

child welfare system? Sub-questions provided opportunity for more detailed and comprehensive examination of narratives and included:

1. What are the themes of subjects' relational and behavioral experiences as depicted before they entered the child welfare system, while in substitute care, and at present?
2. How do they score on a standardized measure of affective symptoms and behavioral functioning?
3. Is there coherence or discrepancy between their narrative life stories and their scores on a psychometric measure?

Sample Selection

This study used non-probability purposive/judgmental and snowball sampling methods. Purposive/judgmental sampling is useful when studying a sub-set of a population (Rubin & Babbie, 2001). In this study, not all homeless young adults were being considered, only those who were involved with the child welfare system. Thus, homeless youth with a child welfare background were purposefully selected for study. Further, snowball sampling is common with qualitative measures and is appropriate when studying special members of a population who are difficult to locate, such as the homeless (Rubin & Babbie, 2001). It was assumed that once some subjects were gathered, they would be familiar with and able to recruit others to participate in the study as well. Subjects between the ages of 18-26 years of age were sought; the minimum age of 18 years old was selected because young people of this age are considered legal adults and are able to consent to participation in research, and the maximum age of 26 years old was chosen to keep the sample limited to those in their late-teens and early to mid-

twenties because they are thought to be comparable in terms of emotional and developmental characteristics (Mech, 1994).

Three social service agencies in the Chicagoland area that serve young adults up to the ages of 22, 24, and 26 years of age, respectively, were used as the main source of potential subjects. Two of these agencies work specifically with homeless young adults and offer temporary or transitional housing and outreach services or a drop-in center. The third agency is a needle exchange outreach and drop-in program, many of whose clients are homeless or marginally housed young adults. These agencies were selected because they are main sources of service provision for homeless young adults in the Chicagoland area and a variety of subjects could be obtained (i.e., young adults using the shelter and transitional housing services as well as those who chose outreach services or drop-in centers). Two of the programs ask clients directly about their past involvement with the child welfare system as part of their intake process while the third ascertains this information indirectly, usually during the course of establishing a relationship with clients.

Permission was gained to seek subjects from these programs by each agency administrator and information about the study was shared with key staff at all three programs (e.g., directors, shelter and outreach workers). To begin, staff was asked if they currently had any clients who fit the sample criteria and might be interested in participating in a research project. Staff spoke with their current clients who were thought to have child welfare backgrounds and introduced the study. Staff then contacted the researcher to ensure that the clients met the research criteria then scheduled an interview date and time for them. In some cases, where the clients had additional questions, the staff member called and allowed the individual client to speak directly with the

researcher prior to arranging an appointment. A number of clients, after being told about the study, were given the researcher's contact information and called themselves to scheduled an interview. The researcher also spent time at one of the drop-in centers to answer questions and get to know potential subjects in an attempt to begin establishing relationships so that subjects might feel more comfortable if they chose to be part of the project. The researcher maintained frequent contact with staff at all three agencies until the total sample of subjects was gathered and all interviews were completed.

Interviews were held at the location of each subject's choice; all occurred either in a private room at the agency where the subject was receiving temporary housing services, at the researcher's office, or in the apartment where the subject was residing at the time. All subjects signed consent forms, were given a ten dollar grocery store gift card for their participation, and offered snacks and beverages during the interview. For those subjects who traveled to the researcher's office, transportation was reimbursed via a round trip, pre-paid transit card. At the end of each interview, subjects were asked if they knew of anyone else who might be interested in participating in the study and a request was made to pass along the project and contact information to others.

Data Collection and Instrumentation

Subjects were interviewed between April and August 2006. The goal was to secure a sample size of 10 subjects. As this is a difficult population to locate and the study was predominately qualitative with some quantitative elements embedded, this sample size was deemed the most feasible and appropriate. Further, other similar qualitative studies with homeless youth used a comparable sample size (Lindsey et al.,

2000; Tyler & Johnson, 2006). Opportunely, additional subjects became available, thus the final sample size was 12.

A semi-structured interview protocol, containing both closed and open-ended questions (Rubin & Babbie, 2001), was used to obtain the most comprehensive data possible. To gather demographic information such as age, amount of time spent in the child welfare system, number of placements while in substitute care, time since being in care, length of time of homelessness, etc., subjects were asked specific closed-ended questions. In addition to demographic information, subjects were asked to provide their own answers to open-ended questions related to specific areas of inquiry including: their past experiences (e.g., abuse/neglect, exposure to violence, family dynamics, etc.), interpersonal relationships (e.g., connections with others), and behaviors (e.g., substance use, delinquency, risk-taking behaviors—prostitution, gang involvement, etc.) prior to and during their involvement with the child welfare system as well as during the past several weeks. More specific questions were also used to probe for additional details of interest and related to the study's topic. General open-ended questions included the following:

1. "Tell me what you remember about what life was like before you entered the child welfare system? What were the circumstances that brought you into care?"
2. "Think back on all of your time in care as a ward. Tell me what it was like for you—what you remember about how you felt and acted/behaved, your relationships, and so on."
3. "Describe your life at present—how you generally feel, what you do, your relationships, what keeps you here (i.e., without stable housing)."

4. "Thinking back to why you first went into the child welfare system, your experiences while in care, and looking at your current living situation and circumstances, do you think there is a connection?"

The interview was conducted based on Rubin and Babbie's interview guide approach. Rubin and Babbie offer strategies for beginning the interview, physically and verbally attending to the subjects, exploring the research problem, and questioning and probing to obtain more detailed and specific information from broad, open-ended questions.

To increase the study's reliability and validity, interview questions related to childhood backgrounds, relationships, behaviors, and experiences in the child welfare system were derived, when possible and where applicable, from the questions posed in the prior research studies on young adults formerly involved with the child welfare system, which were conducted by Courtney et al. (2001) and Courtney et al. (2004). Questions in the Courtney et al. studies appeared to have face and content validity and examined many of the same areas of subjects' lives that were of interest in this present study. Since the present study was exploratory, replicating, but from a different perspective, questions from other studies with similar samples was thought to be a way of deepening the understanding of the population and promoting theory building. Interviews were chosen over basic surveys, which are read and filled out by subjects, to allow for more in-depth exploration of questions and to avoid the possibility of incomplete information from respondents who may have difficulty reading. All interviews were recorded with permission of the subjects.

To be sure that all interviews would be held in confidence, several measures were taken. When the agencies were initially contacted and introduced to the study, they were asked if they had a private space available where subjects could be interviewed. All

agencies were able to honor this request; interviews were held in staff offices or secure meeting rooms. The researcher's private office, with a sound machine, was also made available to ensure a confidential atmosphere. Those subjects who chose to be interviewed in a home environment were spoken with about privacy prior to meeting. These subjects either made arrangements to be alone or, when others were in the home, requested that they remain in another room throughout the duration of the interview. Subjects were given the opportunity to stop or cease the interview at any time should they become concerned about confidentiality. This did not occur.

Although the researcher—a doctoral level student –conducted all the interviews, efforts were made to establish some additional forms of reliability and validity. One master's level social worker with experience in the child welfare system and one experienced with the homeless young adult population were asked to review the interview instrument for face and content validity. Additionally, after data were gathered and codes were developed for the open-ended questions, a sample of these responses were used for triangulation, to test for inter-rater reliability to determine if the same codes were being applied to the same responses by different raters (Rubin & Babbie, 2001), and in an effort to reduce any possible bias. Two advanced clinicians versed in self psychology theory were provided with two unique interview transcripts each and asked to identify elements within subject narratives that exemplified some of the major tenets of self psychology (e.g., mirroring selfobjects, idealizing parent imago, etc.). Their clinical interpretations of the narratives resembled that of the researcher's. The clinicians noted various comments, made by the subjects, that highlighted their interpretation of the material from a self psychological perspective. All of the comments mentioned by the clinicians were also noted by the researcher as exemplifying concepts from self

psychology. In addition, the clinicians pointed out other narrative remarks that the researcher was able to use to guide analysis of the remainder of the transcripts. Lastly, interview information was examined in conjunction with the overall results of a standardized quantitative measure of functioning to assess for coherence in narrative themes (Creswell, 2003).

While the semi-structured interview was used to obtain personal life story information on subjects' background, experiences, relationships, and behaviors in a narrative format, a brief quantitative measure of the subjects' current emotional and behavioral functioning was administered to enhance the study data, enrich the profile of the subjects, and look for consistencies and discrepancies between narrative reports and scale scores. The Behavior and Symptom Identification Scale (BASIS-32) is a 32-item self-report scale, which can be administered as a structured interview to anyone over the age 14, that examines symptoms as well as one's perception of emotional and behavioral functioning in five major areas:

1. Relation to self/others
2. Daily living/role functioning skills
3. Depression/anxiety
4. Impulsive/addictive behavior
5. Psychosis

The measure asks respondents to rate the degree of difficulty they have experienced in each area in the past week. Respondents rate their degree of difficulty using a 5-point Likert Scale:

0=no difficulty

1=a little difficulty

2=moderate difficulty

3=quite a bit of difficulty

4=extreme difficulty

Examples of each rating are provided with the scale. The BASIS-32 is not diagnosis specific. It was designed to cut across diagnoses, as a wide range of symptoms and problems occur across the diagnostic spectrum. The BASIS-32 provides an overall average score as well as produces subscale scores in the five areas listed above. The instruction manual of the BASIS-32 outlines the procedures for administering the protocol, including providing a recommended introductory statement and suggested methods for asking questions (e.g., "I would like to read to you each of the areas of difficulty and you can tell me how much difficulty you have been experiencing during the past week") and obtaining responses (e.g., giving subjects an index card with the rating scale and asking them to pick the number that is most representative of how much difficulty they have be having) (McLean, n.d.). The BASIS-32 also allows for modification of question wording to ensure that subjects understand what is being asked. The method of administration put forth by the BASIS-32 was used in this study.

The BASIS-32 has generally been used as an outcome measure in a wide variety of both in-patient and out-patient clinical settings. Among other things, it is said to offer insight into the difficulty with symptoms and behaviors experienced by respondents (McLean, n.d.). Therefore, although this measure was not designed specifically for the homeless youth population under study, because it has established reliability and validity, is brief and simple yet provides a profile of the symptoms and behaviors of interest in this study (e.g., relationship and regulatory issues), question wording can be modified to ensure comprehension, the subscales can be evaluated independently, and this study was

examining life experiences and outcomes post-exit from the child welfare system, it seemed quite applicable. According to Rubin and Babbie (2001), using existing scales and measures is a popular way to operationally define variables and increase a study's reliability and validity.

Several studies have demonstrated the reliability and validity of the BASIS-32. According to Eisen, Dill, and Grob (1994), who looked at a sample of 387 subjects ranging in age from 14-89, the internal consistency of the full 32-item scale is .89 and the instrument's subscales range from .63 to .80. Test-retest reliability ranges from .65 to.81 for the five subscales and the instrument is said to have both concurrent and discriminate validity. A study by Eisen, Wilcox, Leff, Schaefer, and Culhane (1999) examined the psychometric soundness of the BASIS-32 when used in an out-patient setting. The researchers found that, using a sample of 407 subjects between the ages of 18 and 65, internal consistency was extremely high, suggesting "The overall mean score provides a good overview of self-reported symptoms and problem difficulty" (p. 14). However, this study found that construct validity was only partially confirmed.

Other measures, such as the Mental Health Inventory (RAND Corporation, retrieved July 6, 2004) and the Composite International Diagnostic Inventory (World Health Organization, 1998) were considered for this study because they were used to assess the mental health status of young adults formerly involved with the child welfare system in a few previous studies (Courtney et al., 2001; Courtney et al., 2004; Pecora et. al., 2005). However, these measures attend more specifically to mood disorders and diagnoses. They do not provide measures of behaviors such as impulsivity, addiction, risk-taking, etc., which may be indicative of affective regulatory problems and are a major aspect of this study.

In addition to the semi-structured interview and the standardized measure of current functioning, field notes were written after each interview. This was not an initially intended part of the study. However, several things occurred related to subjects' statements and interpersonal interactions after the formal process ended that seemed to warrant acknowledgement. Thus, notes related to the overall impression of the interview and subjects' reactions/questions were documented.

Data Analysis

Qualitative Analysis

The semi-structured interviews were recorded and transcribed for data analysis. These written narratives were analyzed using one of Lieblich's et al. (1998) proposed models of life story narrative analysis. Lieblich et al. offer four approaches to analyzing and interpreting narrative material: holistic-content, holistic-form, categorical-content, and categorical-form. For the purposes of this study, the categorical-content model of narrative analysis was used.

The categorical-content model, as put forth by Lieblich et al. (1998), is similar to what is readily known as "content analysis." "Content analysis" focuses on "the content of narratives as manifested in separate parts of the story, irrespective of the context of the complete story" (p. 16). Using this approach, categories are defined based on what is being studied and what themes are recurrent in the narratives. Specific utterances are extracted from the text, coded, and classified into different categories. Categories may be narrow or broad. Narrative material is processed analytically by breaking down themes and these themes are categorized and can be, and are often, subjected to quantitative statistical data analysis as well as qualitative descriptive interpretation. The authors offer

two sub-type approaches to the categorical-content model of analysis and interpretation. One is an objective and quantitative process and the other is a hermeneutic and qualitative perspective. The authors provide a framework for analysis and interpretation but note that the framework is only a guide and is, therefore, flexible and that aspects of both quantitative and qualitative analysis and interpretation may be used simultaneously.

There are four main prototypical steps to Lieblich's et al. (1998) categorical-content model of data analysis and interpretation. The first step is the selection of the subtext. Based on the research question, all relevant sections of the text are marked to form subtexts. These subtext areas are considered the "content universe" (p. 112). A study using a more directive interview approach may lead the subject to focus their life narrative recall on relevant or specific events related to the research question. In this case, all of the obtained text can be used as the "content universe" for data analysis. After selecting the subtext, content categories are defined. In this step, themes that are noted throughout the subtext are categorized and defined. Words, sentences, and/or groups of sentences can be highlighted and used to define and exemplify each category. Categories may be predefined or created after reading the subtext and determining what themes have emerged from the content. Once thematic categories have been devised and defined, the third step is to sort the narrative material into content categories by choosing a "principle sentence." "Principle sentences" are "utterances that express distinct ideas about content universe" (p. 115). Upon sorting the material, the fourth and final step of categorical-content analysis is to analyze the data and draw conclusions from the results. This can be done by counting, tabulating, and ordering the principle sentences, words, etc. in each category and subjecting them to various descriptive statistical computations to obtain quantitative measures. Alternatively, or in conjunction, the contents of each category can

be used descriptively to formulate an overall picture of the "content universe" for the population under study. Per Lieblich et al., the use of numerous quotations in reporting the material as well as suggestions of various alternative explanations helps provide evidence for the interpretations.

For the purposes of this study, a semi-structured, thus somewhat directive interview approach was used to focus the subjects' narrative reports on specific aspects of their lives and experiences. Thus, each subject's entire narrative may be considered the "content universe." Some pre-defined categories were used to structure the interview protocol based on the research question, previous literature, and familiarity with the population, such as experiences of abuse and neglect, relationships, mood, behaviors, etc. During the interview and transcription process, repeated themes were noted for consideration as potential codes. Transcripts were entered into the qualitative database Atlas.ti 5.2. Words, phrases, and paragraphs throughout each transcript were labeled to represent specific themes including, but not limited to: physical, sexual, and emotional abuse; lack of care; abandonment; parental substance use, mental illness, aggression, domestic violence; subject aggression, substance use, arrests, risk-taking and self-harm behaviors; trauma and loss; mood and coping skills; functioning related to school and work; relationship connection and disappointment; absence of father; regulating behaviors, etc. These individual codes were then combined into larger "family" codes and ascribed identifying colors. The "family" codes included: Childhood Abuse/Neglect; Parental Problems; Childhood Trauma; Childhood Mood; Abuse/Neglect during Care; Behaviors during Care; Trauma during Care; Mood during Care; Survival Skills; Current Behaviors; Trauma since Exiting Substitute Care; Current Mood; Relationships; Moments of Normal Development; and Connection Between Past and Present.

Quantitative Analysis

Overarching narrative themes and categories derived from the qualitative interviews were counted in Atlas.ti 5.2 so that the data could be transformed into quantifiable measures (Creswell, 2003; Lieblich et al., 1998, & Rubin & Babbie, 2001). The total number of subjects referring to and the number of times each theme occurred across narratives was tabulated. The patterns, themes, and dynamics that emerged in the various content categories were evaluated descriptively by providing potential interpretations using concepts from self psychology with supporting examples from the narrative data. Reoccurring themes that were noted in the qualitative data analysis were examined in conjunction with quantitative interpretation.

Subject demographic data were entered into the Statistical Package for the Social Sciences (SPSS) computer program where descriptive statistical analysis (e.g., frequency distributions, minimums and maximums, means, etc.) was used. The use of statistical measures in addition to narrative interpretation provided a more thorough means of examining the data in an effort to present a comprehensive picture of the group under study (Rubin & Babbie, 2001).

The analysis of the quantitative data collected from the standardized measure of functioning—BASIS-32—was structured according to the pre-designed scoring system of the instrument itself. The overall score and the subscale scores were calculated by averaging the ratings of each component. The BASIS-32 contains a scoring program for SPSS. The program computes the scores for each subscale and the overall average score (McLean, n.d.). The relationship and impulsivity subscale scores were of primary interest. It was suspected that the subjects in this study would have scores that

demonstrated high impulsivity and problematic relationships. This information was compared to the themes from the qualitative interview protocol to look for similarities and discrepancies in personal life story narrative reports of experiences and quantitative measures of symptoms and functioning.

CHAPTER IV

RESULTS

Subject Demographics

A total of 12 subjects (N=12) participated in this study. Subjects ranged in age from 18 to 26 with a mean of 20.42 years. The majority of subjects were female (75%). More than half (66.7%) were of African American decent, followed by Caucasian (16.7%) then Latino and mixed race (8.3% each). Most subjects identified as heterosexual but 2 of the 12, both males, indicated that they were homosexual. Three-quarters of subjects had some form of tattoo or piercing. Half of the study participants were either involved in a relationship or married. Notably, three were pregnant, one had a young child, and another had recently lost her child to foster care (see Tables 1 and 1a).

Subjects reported an average age of entry into the child welfare system of 5.13 years with a minimum of birth and a maximum of age 16. The mean age subjects exited from substitute care was 14, with a range from age 5 to age 21. On average, participants spent about 8.96 years in substitute care and had 5.58 placements. Interestingly, six of the subjects left the foster care system due to adoption, five were emancipated, and one was returned home. The majority of subjects (66.7%) were involved with the child welfare system in Illinois while two were part of the system in Indiana, one in Minnesota, and one experienced substitute care in Columbia, South America (see Tables 1 and 1a).

At the time of this study, 50% of participants reported being precariously housed (e.g., living with friends, relatives, in a hotel, etc.—in a non-permanent arrangement) while 41.7% were residing in a shelter. One person was currently without housing and living on the streets. The average length of time homeless or precariously housed since exit from substitute care was 1.46 years. Despite the lack of long-term, permanent living arrangements, 8 of the 12 subjects (66.7%) had cell phones (see Tables 1 and 1a).

Table 1

Demographic Information

	Descriptive Statistics		
Characteristics	Minimum	Maximum	Mean
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)			
Age	18	26	20.42
Age at Entry into Substitute Care	0*	16	5.13
Age at Exit from Substitute Care	5	21	14
Total Time in Substitute Care	1.5**	17	8.96
Number of Placements	1	16	5.58
Length of Time Homeless/ Precariously Housed	.5**	5	1.46

*0=birth
**.5 represents one half year

Table 1a

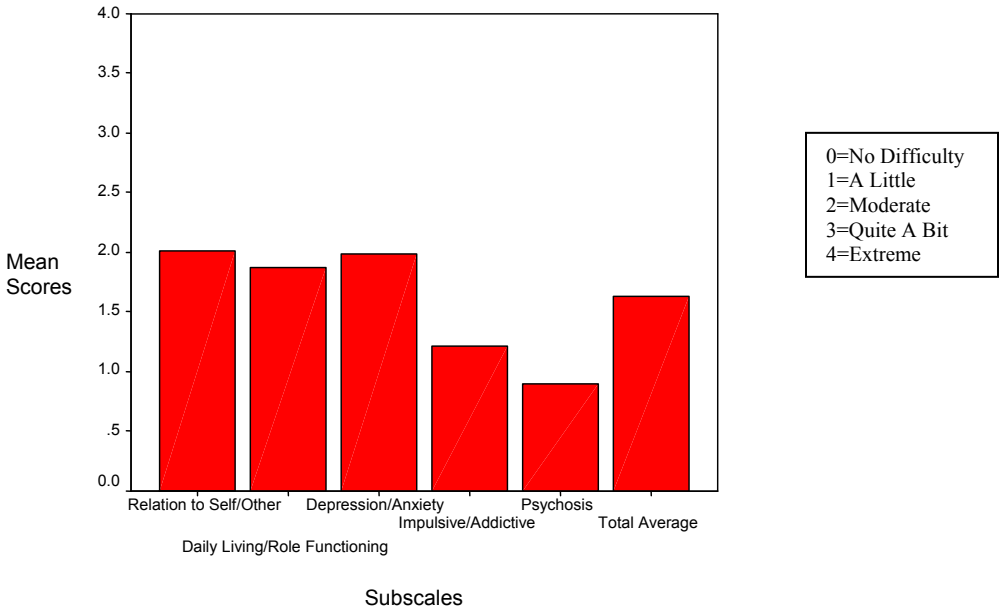
Demographic Information

Characteristics		Frequency	Percentage
	Frequency Distributions		
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)			
Gender	Female	9	75
	Male	3	25
Race	Caucasian	2	16.7
	African American	8	66.7
	Latino	1	8.3
	Mixed	1	8.3
Sexual Orientation	Heterosexual	10	83.3
	Homosexual	2	16.7
Tatoos & Piercings	Yes	9	75
	No	3	25
Parental Status	No Children	7	58.3
	Children	1	8.3
	Expecting	3	25
	Miscarriage	1	8.3
Status at Exit from Care	Emancipated	5	41.7
	Adopted	6	50
	Returned Home	1	8.3
Location of Child Welfare Involvement	Illinois	8	66.7
	Indiana	2	16.7
	Minnesota	1	8.3
	Columbia	1	8.3
Current Living Arrangement	Homeless	1	8.3
	Shelter	5	41.7
	Precarious	6	50
Phone	Yes	8	66.7
	No	4	33.3

Behavior and Symptom Identification Scale (BASIS-32)

Individual scores on the BASIS-32 questionnaire were rated from zero to four, with zero being "no difficulty" and four representing "extreme difficulty." Subjects' overall scores on the 32-item scale averaged 1.63, suggesting little to moderate difficulty with daily functioning. However, with a few exceptions, most of the subscale scores were slightly higher. The subscales examining relationships (Relation to Self/Other) and mood (Depression/Anxiety) had means of 2.01 and 1.98, respectively. Daily living (Daily Living/Role Functioning) produced a mean score of 1.87 followed by impulsivity (Impulsive/Addictive Behavior) at 1.21. Symptoms of psychosis were minimal with a mean of .90 (see Figure 1).

Figure 1. Behavior and Symptom Identification Scale (BASIS-32)



Interview Narratives

Experiences before Substitute Care

Subjects spoke about many aspects of their lives prior to entering the child welfare system. For those who entered care in infancy, much of their memory was, admittedly, based on what they were told from other family members—particularly older siblings who were brought into care at the same time as the subject—or what they learned from caseworkers or their parents while they were in care. Subjects related stories about the problems with which their parents/caretakers struggled, experiences of abuse, neglect, and trauma, and they offered descriptions of their memory about their feelings at the time.

Parental Problems

In relating memories of their experiences before entering substitute care, subjects talked about parents'/caretakers' problems. The two most significant issues were substance use and mental illness. Throughout their narratives, subjects mentioned these problems 20 or more times each; four subjects had parents/caretakers with mental health problems, nine believed their parents/caretakers used drugs, and almost all were described as having multiple problems. Domestic violence was also prominent with 10 mentions by four subjects, followed by prostitution, physical health issues, aggression, and developmental disabilities (see Table 2).

Table 2

Parental Problems

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Mental Illness	4	21
Substance Use	9	20
Domestic Violence	4	10
Prostitution	3	6
Physical Health Issues	2	5
Aggression	4	4
Disability	1	1

Subjects shared the following examples regarding parental mental illness, substance use, physical health problems and associated violence and behaviors:

> My mom, she has a mental illness. She's schizophrenic. She used a lot of hardcore drugs. I don't know exactly what. . . . She thought we were the devil's kids so . . . that's probably why she left us alone so much. She used to set the house on fire all the time, like while we were in it, which is kinda crazy. She's in a home right now.

> I remember her [subject's mother] having bouts of depression throughout my life but it didn't stay all the time. We could usually bring her out of it. It used to scare me because she used to threaten suicide. . . . Dad was a drinker and never around and mom was a double amputee. She had no legs from here [thighs] down. She

lost both legs because of diabetes. Because of that, she couldn't work. It was just all down hill for her. It was crazy growing up.

She [subject's mother] was diagnosed with schizophrenia and borderline and she was depressed. This is how my mom was. She'd be normal and we'd be talking and all of a sudden she'd just go off, like she's talking to somebody else. She'd go off on this tangent and start talking then snap right back like nothing happened. There was one incident . . . somebody must have thrown a brick through the glass window and it shattered on me, on the bed I was in. . . . My mother was just watching me under the glass and she wasn't moving me . . . like in a daze. . . . So, my sister grabbed me and carried me out the door. I think that's why she decided to give us up, because she knew she couldn't do it. She couldn't take care of us in that state.

Our mother was on drugs and she used to get abused by a lot by men. In the course of their drinking they would start arguing and abusing. . . . One day she had got beaten up so bad to the point where she couldn't take care of us anymore.

My mother was doing drugs. She was addicted to cocaine. . . . She used to sell her body when she got out there. She used to have sex to get more drugs. She was arrested also for theft. She broke into one of the family members' houses and stole something. They called the police and she was arrested.

Childhood Abuse and Neglect

Though all subjects experienced some form of maltreatment in childhood, ultimately resulting in removal from their parents/caretakers, neglect was most profound. A sense of abandonment and emotional lack of connection was raised as an issue 15 times and lack of physical care (e.g., food, clothing, utilities, etc.) and supervision was noted 14 times. All 12 subjects indicated experiencing some form of neglect and a number revealed, in addition to neglect, other types of maltreatment, including physical abuse, sexual abuse, and verbal/emotional abuse (see Table 3).

Table 3

Childhood Abuse and Neglect

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Overall Neglect	12	29
Abandonment/Lack of Attention	9	15
Lack of Care/Supervision	9	14
Physical Abuse	4	7
Sexual Abuse	2	2
Verbal/Emotional Abuse	2	2

Speaking about feelings of abandonment and neglect, subjects reported the following:

> My mom wasn't around. She just left me in the hospital [after subject fell ill] . . . left me there. She didn't come for me. She didn't care for me as a mother or anything. She just dropped me off and said "goodbye" or something like that. She

said, “This is the best for you. I hope you have a better life.” I think that’s what she said. Who knows. She just left me there. . . . No mother. No nothing.

We’d be at home for days by ourselves. My two other sisters . . . they knew how to get out there to find some food for us to eat. We could be home for four or five days, weeks at a time, and my mom and dad not be there. They’d run in and run out.

From what I understand, from what family told me, my mom was gone for two or three weeks at a time and then she’d come back for a few days and be gone again. . . . We’d been in places where the power was out because she [subject’s mother] wasn’t paying the bill and there wouldn’t be any food there. Or, we’d have food but the electricity or the gas was off so we’d have to cook on the electric stove or run hot water for those little noodles you’d have in a cup . . . you run hot water and put it in a cup and eat that. I know my brother . . . my brother was arrested for stealing . . . going to the store to get food for us. So, I believe charges were brought against my mother before for child neglect because he was having to steal.

They [subject’s parents] didn’t feed us or bathe us. There was a lot of neglect. So, my brother and sister—my 4-year old and 5-year old brother and sister—fed me peanut butter when I was crying. They left me in a swing for days at a time. . . . The house we were in had rats at that time. It was terrible. It was so dirty. My

mom keeps everything. My dad does too. They're like junkies—they keep garbage. So, our house was always cluttered and not really clean.

Other subjects recounted memories of not only neglect but violence and abuse as well:

She [subject's mother] would leave us—me and my sister—in the house by ourselves . . . at nighttime when she thought we were asleep, she'd leave. We're stuck in the dark because all the lights were off. My sister was just a baby so I had to literally take care of her. . . . Our mother was on drugs and she used to get abused a lot by men. In return, I would get abused by my mother. . . . She'd hit me if I'd, like, spill juice on the table or wet the bed or something like that. She'd start hitting me right out of my sleep until I'd wake up. I'm just a baby. I don't know no better. It was real hectic at that point.

She'd [subject's mother] stay gone most of the time . . . could be weeks at a time. I had to take care of my sisters almost all my life. We had very little food. I had to do things, like help people to their car by carrying bags at the grocery store or cutting grass, to make money. Sometimes I had to steal food. . . . My mom was also abusive to me. She used to hit me . . . she used her hands, fists, belts, whatever.

Mom couldn't get the bills paid all the time. We lived in a trailer that was actually donated to us from a radio station. Mom couldn't get the bills paid because dad was always drinking away all of our money. When he was home, he was always

> yelling, screaming, fighting with everybody. . . . He bruised me so many times. I remember one time in particular he beat the crap out of me with a belt—the belt buckle end. It left welts on me. I also remember social service coming out to the house several times growing up and because I was molested when I was seven years old by a friend of my older brother's that mom used to babysit.

Childhood Trauma

More than half of the subjects talked about serious and repeated loss (7 of 12) and other traumatic experiences (5 of 12) while still in the care of their parents/caretakers, some of which included separations that occurred as subjects were taken into substitute care. For the majority of subjects who spoke about childhood trauma, a great deal of death was mentioned. Overall, comments related to loss and trauma, which often went hand-in-hand, were noted 12 times a piece (see Table 4).

Table 4

Childhood Trauma

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Loss/Separation	7 (6 reporting deaths)	12
Traumatic Event	5	12

Subjects' remarked about loss and separation:

My mom had a baby when I was six and he passed away. When I turned 16—it was right before I turned 17—my dad passed away. That was in August of '02 . . . then in November, my mom passed away, right before my birthday—85 days after my dad. I was forced to leave my family and my home and all my friends and move to Indiana.

We stayed with our grandmother. She had cancer and got sick and was bedridden. My sister and I woke up one morning and tried to wake my grandmother up and she wouldn't wake up. We didn't understand then. . . . A neighbor came by to see us . . . to see my mother and she wasn't there. I opened the door and he came in and saw that my grandmother was dead but we didn't know. He called 911 and left. . . . At the hospital, my grandmother was pronounced dead. My mother was arrested as soon as she walked in for child neglect and she had cocaine on her. She went directly to jail. . . . The next time I saw our mother was at the funeral of our grandmother. She sang. . . . I didn't hear from her again until I was 12.

Three subjects learned of or witnessed the violent beating or death of a family member:

I saw my dad get his head busted to the white meat. . . . He owed some guys some drug money and they wanted their money. I remember we were walking, coming from a wrestling match. . . . We had souvenirs and stuff. . . . We were walking and some guys seen my dad and ran up to him and busted his head . . . and they had brass knuckles. There was blood on the guys' knuckles, on the rings. . . . I

remember me and my sister throwing rocks and biting their legs and scratching and kicking. . . . Finally, my uncle saw my dad lying on the ground and he saw us holding my dad's head in our arms and we were crying and trying to hold his head together until someone came . . . until the paramedics came.

I remember that when I was four, my father got shot in front of me. Me and my dad . . . I think we were walking to the store to get medicine or something. I don't know why he got killed. It could have been . . . there were drugs. It could have been a drug thing . . . . People came up to my dad and shot him. They said something and shot him. I was sitting on the ground with his head in my lap crying. I was bloody because I was touching him.

My dad was murdered. There were a lot of rumors, but one rumor that sticks around was that he was messing with somebody's wife and he came after him.

Other incidents verbalized or implied by the subjects as traumatic were as follows:

We became homeless. . . . We went to see if my mother's sisters would help us out but the doors were just shut to us. I remember . . . it was in the winter time, we slept in the hallway of this project building, which smelled of piss . . . we had to sleep in that because her sisters wouldn't let us in, even to spend the night. I remember my grandmother begging my auntie to let us come in . . . . I can't help but remember that. It stays in my head. So, my mother, she had to give us up.

> [Speaking of molestation and how often it occurred] Everyday. I remember him on top of me but I don't remember exactly what happened. I do remember we went to court . . . . I was five or six and I did it . . . I testified against my own uncle. I don't know what happened after that . . . . I know that he's dead now.

Childhood Mood

Even though several subjects entered substitute care as young children, many of them were able to describe their mood before separation. There were 12 statements predominately describing feelings of sadness and anger (see Table 5).

Table 5

Childhood Mood

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Described Affective State (e.g., sadness, anger, etc.)	7	12

Examples of some of those comments related to subjects' mood were:

> My brother told me I was a cry baby. He said I would just cry all the time.

> I was not very happy when I was little. I was not very . . . I was angry all the time.

> I used to do bad things, like . . . the blocks. I'd see some kid building up their blocks and I'd go over there and just knock it down and watch the kids cry. I don't know why. I was a terror.
>
> ---
>
> I used to be angry about everything. You know, if they'd [peers] pick on me then I'd punch them. I wanted to pick a fight. I wanted to fight somebody.

Experiences during Substitute Care

Contemplating their life during substitute care, subjects provided more examples of negative experiences in their narratives than they did when discussing their childhood with their parents/caretakers. What was not clear was whether they offered more information because: they were older or grew up in care and these life events were more recent in their memory; there was hostility being projected onto their time in care and, thus, they had heightened or exaggerated memories of care and downplayed earlier experiences at home; or if it was because they were victimized, in one sense or another, more by their foster care experience than with their parents/caretakers. Of note was that all but one subject felt their removal from family was necessary, suggesting that their experiences in foster care were acutely negative and not simply projections of anger about having been taken from their families. Topics of reflection in this area focused on experiences of abuse and/or neglect, behaviors, trauma, and mood during substitute care.

Abuse and Neglect during Substitute Care

Similar to their early childhood experiences with parents/caretakers, subjects reported considerable neglect—lack of care/supervision and/or abandonment/lack of

attention (35 statements total)—in foster care. However, unlike their experiences prior to entering substitute care, subjects also disclosed a great deal of verbal/emotional abuse (27 statements by eight subjects), physical abuse (23 statements by six subjects), and sexual abuse (14 statements by four subjects). Virtually all subjects noted multiple forms of maltreatment (see Table 6).

Table 6

Abuse and Neglect during Substitute Care

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Verbal/Emotional Abuse	8	27
Physical Abuse	6	23
Lack of Care/Supervision	6	22
Sexual Abuse	4	14
Abandonment/Lack of Attention	4	13

Sharing memories of neglect, subjects recalled the following:

My auntie [subject's substitute caregiver] started abusing drugs . . . she was smoking crack. I think she'd already been using drugs but it progressed and she became extremely neglectful. . . . My caseworker was doing drugs with her. So, when she would come visit, they would get high together and nothing was being reported. I was like six. She'd leave me home all day by myself . . . with no food. All the money she made went to drugs. We didn't have any food. . . . One time I tried to make rice and almost burnt the house down. There was no food to eat in

the fridge. There was nothing. I couldn't believe it. . . . I would go days without eating unless my older sister would bring food by . . . she would bring me food like tuna sandwiches and stuff. . . . I couldn't go outside. She would not let me go outside. . . . She told me not to go out and I wouldn't because I was afraid of her. I was really afraid of her. . . . I didn't have anyone to help me with my school work and I'd go to school dirty and filthy. The kids made fun of me. I remember being teased and beat up after school because I was so dirty. I was a little kid. I was little. . . . My hair would be nappy and dreaded, but I liked school because I would eat and go and . . . just be away from everything.

When granny's not at work, she's at the boat gambling. We're not having all that we need like clothes, shoes, panties, bras, pads, soap, personal girl stuff . . . . I got third degree burns . . . this whole forearm was covered with fried grease and my grandma was not there. I was so hungry and trying to cook us something to eat because ain't nobody there to fix us nothing to eat. I tried to cook some french fries and ended up knocking the whole pot off the stove. That grease could have started a grease fire and burnt us all up. . . . [After the subject was moved to a foster home] In one foster home, we could never take separate baths. We all had to bathe together. . . . Four little girls in the tub together and you're using the same water and the same soap and the same towels. That's trifling.

She [subject's second foster parent] had 10 foster kids and five real kids. When she took us, we all had to sleep in the basement. It was the worst place I could ever imagine. It was like a dungeon in the basement. There were all these boxes

and we slept down there . . . . We had to cook our own food. It was horrible. At least the other place the lady cooked for us. She was drunk all the time and falling down, but she cooked. We was starving in that house and there were too many kids. We ate oatmeal for like three days.

[Speaking about several foster homes, the subject summed up the experiences] We got food withheld because they were mad at us. One lady had a lock code on the refrigerator. . . . We had foster parents who . . . she had enough room for all of us. But, downstairs in the basement we slept on pallets on the floor. We were lined up, the girls on this wall, the boys on that wall. If we got in trouble, we had to stand up and do squats. We had to do this for three or four hours a day . . . if your legs cramped or hurt, she didn't care and you'd cry. She had a laundry shoot she could look down and you had to have your hands in front of you so she could see your hands going up and down. When the caseworker would come, she would give us nice clothes and we would go upstairs and sit and wait. . . . When she left, we'd have to give the clothes back and we'd go back downstairs. That was the only place we could go in the house.

Abuse—verbal/emotional, physical, and sexual—was also described as being prominent for subjects during their time in substitute care.

Verbal/emotional abuse included:

He [subject's adoptive father] slapped us in the head or would pull our hair or spit in our faces. . . . He was calling me names like "slut" and "whore."

She [subject's aunt] called me lazy. She called me worthless. She called me stupid.

I'd be called a "B," a "slut," a "hoe" for no reason. . . . Sometimes they'd [relative caregivers] say, "You're gonna be just like your mother if you don't do this." That used to hurt me because I didn't want to be like her.

My grandma told me one day, "The day I talk to hoes is tomorrow. Come back and try again." So, she was basically calling us hoes. She didn't care.

She [subject's adoptive mother] kept saying, "You're baby gonna be retarded. You retarded. You're stupid." When I got pregnant, she disowned me.

Physical abuse included maltreatment not only by relative and non-relative caregivers but by other adults and children in the home as well:

She [one of the subject's substitute caregivers] started beating me. She beat me with brooms. Her new boyfriend beat me with a weight belt and I had this brown mark on my body. The worst beating . . . she used to beat me with her fists. She snapped on me and my head was bleeding. She beat me with a fiberglass stick. I still remember the pain. I remember she made me get butt naked to my drawers. I remember running under the table because it hurt so bad.

She [one of the subject's substitute caregivers] started drinking and doing crazy stuff. . . . She had these nails and she scratched me on the face. She scratched me on the arm. . . . I had scratches all over me because this chick went crazy.

[While in a residential treatment center, the subject described the following abuse by staff] I was being choked with hands. I had my head put in a toilet. They wasn't restraining properly. I was wrestling with staff and I got my ankle fractured.

My last foster home I was in, the lady drank a lot. Sometimes when she came home she would whoop the two of us for no reason—myself and her daughter. . . . She was hitting us in the back with a belt buckle. If me and the girl stood next to each other, you could see the strap on my side and the buckle on hers or the other way around from where she would whack us at the same time.

My cousin [subject was living with relative caregivers], she pulled my hair out. She punched me in the face. She hit me like I was a grown woman.

In addition to physical abuse, sexual abuse was noted, as was a general fear of reporting the abuse:

I had been abused in foster homes. I got this [scar on arm]—it's a spoon mark. They put a hot spoon on my arm. There's an iron mark here [on thigh]. These were both done by foster parents. . . . I remember some foster homes I've been in there were like four girls and we'd have a foster parent who was a grandmother

and her grandson was like 18 or 19. We're like 10 or 11. They raped the other people. They molested me. They kept doing it. We got in trouble for telling so it made us scared to tell anymore.

Everyone beat me. I was sexually abused by my cousin. From there it was all hell. I got really beat. Then I got put out.

Living with my grandma, I had experienced some things that I had thought a child should never experience—abuse in the home, molestation in the home, her not believing me because she thought we were too young to know what it was. . . . We were afraid to tell her because we did not know what the outcome would be. I've been raped twice. I had my head thrown through windows and doors.

He [subject's step-grandfather who was a relative caregiver] would act like he was tickling us. He would really grab your breasts, scratch your pooch, grab your butt . . . something that ain't natural. He'd lay on top of us, holding us down while he was tickling us and he was really humping. . . . I was scared to tell because I didn't know what would happen or what he would do.

Behaviors during Substitute Care

Subjects admitted to exhibiting a multitude of behavioral problems while in substitute care, perhaps as a result of their early childhood abuse and neglect, maltreatment in substitute care, or most likely, a combination of these factors. More than half of the subjects, in 14 different statements, said they ran away from placements, while

half made 11 comments about substance use and 18 statements regarding aggressive behaviors. A number of subjects also caused themselves harm, engaged in risk-taking behaviors, including theft, and were arrested. The majority of clients stated that they participated in several of these behaviors simultaneously (see Table 7).

Table 7

Behaviors during Substitute Care

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Aggression	6	18
Runaway	7	14
Substance Use	6	11
Self-Harm	3	9
Risk-Taking	4	5
Arrests	4	5
Theft	3	3

When asked about their behaviors during their time in substitute care, multiple and varied behaviors were described as follows:

> I was balling at 8-years old. I started fighting back. . . . I'd take stuff and throw it. I'd rage. There was so much stuff going on. . . . I was fighting and punching. [In a residential setting] This girl was talking shit . . . she was talking shit and I got mad. I was getting madder and madder. She walked into the room and I started punching her. Then, she ran into the bathroom but I got into the bathroom with her. I locked the door and was beating her ass. They had to bust into the bathroom

and come get me from beating her ass. I was fittin' to kill that damn girl. I had too much rage in me. I used to fight a lot and have to be restrained for whiling out. Somebody would get on my nerves, somebody would make me mad . . . while out and do something crazy. It used to take about eight people to restrain me. It was crazy. I had some much anger in me. It had to come out in some way.

I used to fight everyday at school. . . . I was sitting back on the block smoking and drinking. . . . I was only 13 or 14, getting drunk and getting high. . . . I'd be stealing money and all kinda stuff. . . . I tried overdosing. I tried all type of stuff because I felt like my family really didn't care about us for shit.

I would cut myself, take a lot of pills, runaway from home. . . . One day I cut myself in the bathroom at school. . . . After that, I ended up in a group home.

I ran away altogether about 16 times. I've been arrested several times for runaway and battery. . . . Plus, I smoked marijuana . . . marijuana blunts.

My senior year of high school I was expelled because I was heavily into heroin. Most of the time . . . for a year, I just snorted it. Eventually it led to shooting. I started shooting up.

Trauma during Substitute Care

All but one of the subjects noted having experienced loss, typically related to separation from siblings, lack of contact with relatives, and/or death of loved ones, which

was similar to their experiences prior to entering the child welfare system. In addition, five subjects suffered from other traumatic events. All total, there were 35 comments describing loss and trauma (see Table 8).

Table 8

Trauma during Substitute Care

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Loss/Separation	11	22
Traumatic Event	5	13

Sharing their stories of loss of sibling and other familial connections, including through separation and death, subjects said:

> My older sisters and brother, they moved out as soon as they could. They were much older. So, I was left there [in the relative foster home] by myself. My grandmother died and I was there by myself. I didn't see my mother for like two years because she was in a mental institution. I didn't know where she was. . . . When I was 15, my mother died. She got lung cancer. When she died, it was so unexpected. We found out she was sick and within three months, she was gone.
>
> ---
>
> With my sister, it was sad because when she came to visit, I didn't want her to go and I know she didn't want to go. We would just sit there and hug each other. . . . My mom, I never saw . . . well, I saw her every once in awhile but there were like

times where it would be five years and I wouldn't see her or hear from her, then she'd come out of the blue then I wouldn't hear from her again.

We were separated [subject and sister]. We still visited off and on but it was torturing to me . . . it was heartbreaking every time.

We've been in, I'd say, eight or nine different foster homes. . . . I went for a year without seeing my brother and sister. This happened more than once. . . . It was like a back and forth . . . sometimes we'd live together, sometimes we wouldn't.

I had six different families . . . six different homes before they [child welfare services] finally settled me down with the last family. They kept taking me away. Some of them I didn't understand and some of them I did.

Talking about traumatic experiences, subjects described an incredible array of events related to being witness to and/or victims of violence and being alone during frightening situations. At some point in their narrative recall, they either stated outright that the described event was traumatic or it was presumed to have had a very strong impact on them based on their non-verbal responses (e.g., crying, shaking, covering face with hands, etc.):

[At the subject's relative caregiver's home] I saw people fighting. . . . My auntie and her husband, they would physically fight. My auntie would pull a gun on him sometimes. She never shot him but she would pull a gun on him. She used to do that all the time.

[Subject talking about an altercation with peers over a jacket] I don't know what happened but we started fighting and then the police rolled passed and I walked away. When I walked away, I felt a punch on my shoulder. I turned around then I blacked out. I woke up and they had shot me right here in my shoulder. I couldn't believe it.

One night, one time when I ran away, I ended up getting sexually assaulted by this guy . . . he was an older guy and "mickied" my drink. When I woke up, I was naked and open . . . my body . . . and in pain.

My grandma [subject's relative caregiver] was at work one day . . . my brother got sick and had a fever. My sister didn't know what to do. She left me and him at home. I ended up going in to see about him and he was passed out. All I remember I could do is scream . . . all I could remember was that I got a cold towel and some ice and just rang the towel on his body for him to wake up . . . everybody was gone and I was alone.

[Subject recounting a story of a fire] I grabbed my little sister. We was trying to get out . . . the doors wouldn't unlock. . . . We could hear the fire truck and everybody's outside screaming. They're saying to jump out the window. I still had my little sister in my hands and I pulled up the window to breathe. When I pulled up the window, my little sister pulled my hand away and ran back up the stairs. They was like "jump" and I'm crying because I don't know where my

> sister's at. You can't see nothing. All you can do is feel. So, I jumped out the window. When you're scared you do stuff. I wished I would have grabbed my sister. . . . My little sister . . . when they found her, she was found dead on the stairs, but she wasn't really dead. She wasn't breathing. She was purple. . . . It took like a day and a half . . . she was on a machine but she started breathing on her own and got better. . . . I felt like I should have kept her but she ran back upstairs. . . .

Mood during Substitute Care

Much like their described affective states prior to entering the child welfare system, subjects used words such as anger and sadness—which were again the most intense feelings—in addition to isolation and rejection to illustrate their emotions while in substitute care. Strikingly, there were 80 statements reflective of subjects' mood states. Subjects' emotional well-being was affected such that seven were psychiatrically hospitalized and/or prescribed psychotropic medication and three reported suicidal thoughts and/or attempts. Interestingly, subjects talked about a variety of coping skills to deal with their emotions. However, most of these skills were solitary in nature (see Table 9).

Table 9

Mood during Substitute Care

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Described Affective State (e.g., sadness, anger, fear, isolation, rejection, etc.)	12	80
Coping	9	18
Psychiatric Medication/ Hospitalization	7	13
Suicidal Ideation	3	4

Examples of feeling states included:

I was a down and out depressed person. I hated everything. I really didn't have any will to do anything. I was always tired. I had no motivation, no drive for anything. . . . It's the worst feeling in the world when you're an orphan because there's nobody there and there's not going to be anybody there. It was lonely . . . it was real lonely. I felt suicidal many times. I tried to kill myself.

I felt depressed. I would look out the window a lot and see all of my friends from my classroom playing and stuff. . . . My cousin, she was like my best friend at the time . . . we'd be talking through the window and we'd do this for like an hour, just talking. She didn't always come in. I didn't know whey she didn't want to come in and sit with me. Well, the house was just horrifying . . . I don't blame her for not wanting to come in. So, we would talk through the window . . . I

remember one time I spilled milk on my TV so I couldn't watch TV anymore. I remember it was horrible. So, I just looked out the window. I felt isolated. . . . Then, when my mother died, I changed. I became more depressed. I became suicidal. When she died, I was lost. I had nothing to look forward to anymore. Through all the years my hope was to get back together and have everything okay. So, when she died, I just slipped.

I was sad. I was always sad. And, I used to be so angry. I'd be so mad and frustrated. It's hard. It really do hurt. There were so many times that I'd cry and wonder why I couldn't be with my mother. Why couldn't it be just normal like brother, sister, mother, father? Why couldn't it be like that? But, everything that happened in my life, I just blamed it on her [subject's mother]. I felt like if she would have been there for use, it wouldn't have to be like this.

I'd cry. I was very sensitive. It's not that I was sensitive but my rage was really overpowering and overbearing . . . I felt, at times, I was helpless. I felt like there was nothing to live for. I tried overdosing . . . since I didn't have nothing or nobody . . . I took a whole bunch of pills.

I was pissed off. Depressed. One day, I got really depressed and I did want to kill myself. I took a lot of pills then went to my friend's house . . . . I went to sleep and they called the cops on me. They could tell that I didn't just want to sleep. So, then I went into the psych hospital.

To cope with these emotional states, subjects did several things:

I didn't have anybody to talk to or play with, so I would make up games and stuff like that or I would act what I would see on TV. I would act it out by myself. I didn't have any toys, so I would play with clothes. I would make games out of clothes.

I'd try to pray myself through a lot of situations. Prayer is what got me through everything.

I used to sit in the closet. I liked the dark. I liked sitting in the dark and in the closet. . . . I was sitting in the closet because I was scared a little bit. . . . I could sit there and stare.

I would walk . . . walk all day . . . walk all night.

Experiences after Substitute Care

Since their exit from substitute care, subjects continued to report engaging in some disruptive type behaviors, experiencing trauma, and struggling with their mood. However, their comments were fewer, they seemed to have developed a variety of survival skills, and they recounted moments in their lives that might be construed as "stereotypically normal" despite their numerous complicated experiences.

Current Behaviors

Many of the subjects acknowledged engaging in problematic behaviors at present. For these subjects, typically, their behaviors paralleled their most significant reactions while in substitute care. Substance use and aggression were still the behaviors commented on the most. Though notably, subjects' reports of these behaviors currently were much less. Describing recent behaviors, there were 10 statements about substance use (versus 11 in substitute care) and seven about aggression (versus 18 during substitute care). Remarkable, subjects talked about using drugs more so when they first left substitute care and less so at present. Further, despite a decline in acknowledged acts of physical aggression, subjects shared stories reflective of participating in more emotionally hurtful acts. Risk-taking, self-harm, and legal difficulties (e.g., arrests, theft) were mentioned about half as often as they were when subjects talked about their time in the child welfare system (see Table 10).

Table 10

Current Behaviors

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Substance Use	6	10
Aggression	3	7
Risk-Taking	2	4
Prostitution	3	4
Self-Harm	1	3
Arrests	2	2
Theft	1	1

Subjects described their recent behaviors as follows:

I did coke. I did crack. I did mushrooms. I was really big into ecstasy. . . . I would take all sorts of kinds of pills.

I smoke weed . . . I find it to knock my anger down. When I go off . . . I go off. It will take somebody to come and shoot me up with a tranquilizer or something for me to calm myself down once I get started, especially if I start fighting.

I was always stealing if it was for a high. I've gotten arrested for shoplifting.

I like to hurt people. . . . I can do it . . . I can hurt a person. . . . I like to hurt somebody's feelings. . . . I hurt them so bad . . . they feel like they're so low.

I have cut myself while I was on the street. Sometimes I'll get so mad, I won't even think about safety. I'll pick up a dirty piece of glass from the ground and cut myself. I wasn't thinking about safety. I didn't care. I just wanted to cut myself. It made me feel better.

Trauma since Exiting Substitute Care

Less loss and trauma was reported by subjects since their departure from foster care than either prior to or during their stay in the child welfare system, though multiple subjects (making a total of 16 references) still had these experiences. However, feelings

of loss remained connected to separation from family and the death of loved ones. Other traumatic events tended to stem from subjects' risk-taking behaviors (see Table 11).

Table 11

Trauma since Exiting Substitute Care

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Loss/Separation	7	10
Traumatic Event	5	6

Subjects shared their stories of loss:

I lost my family. I've been abandoned repeatedly by my mother . . . my family betrayed me.

I watched my friend die of a drug overdose. I watched her do it. We were at a party. I used to go to parties with drugs and orgies and all this other crap. She died in front of me.

[Subject's brother] He was murdered. Him and two other guys were trying to rob three other guys . . . then he was shot in the back, the head, the ass. He was laying in the alley bleeding . . . My grandmother passed too. She passed right after my brother. She died in her sleep.

[Speaking specifically of the subject's own child] I gave her up for adoption. I felt like I couldn't take care of her no more. I'm not stable. I can't take care of her. She went to the hospital because she was dehydrated. The reason why she was dehydrated was because we had no food in the place I was staying . . . she wouldn't drink the water. . . . She'd be dehydrated because she wouldn't drink anything. We didn't have koolaid, no sugar, no . . . something for her to drink . . . no juice . . . she won't drink plain water. So, she was dehydrated. I just felt like I didn't do my job as a parent to take care of her.

About trauma, subjects revealed a variety of incidents:

[Subject referring to a drug overdose] I turned blue in the face. My sister started screaming. I could kinda hear things going on around me but I couldn't respond to them. My body was so out of it. They were slapping me, hitting me in the face. The guy next to me is pouring water on me. I could feel the water but I couldn't wake up from it. So, then I eventually stopped breathing. They said my heart was . . . once they got me on the table, my heart stopped. I was in the emergency room. I was, like, dead. I remember seeing this big, bright light. Almost like a big tunnel. I definitely remember that. It was the freakiest thing I've ever seen. I'm like, "I'm about to die."

[subject talking about the events after walking out of a supportive living program] I was really mad and I left and was sitting at the bus stop. Three guys were like, "Hey. How are you doing?" And you know, I like to be flirted with because it makes me feel pretty. They were trying to get me to got with them. . . . They took

me somewhere and then one by one . . . I got raped by all three of them. . . . There was another time . . . I was talking to this guy. I told him that I wanted him to know that I wasn't going to have sex with him. I really just wanted a ride. . . . He took me and turned the corner somewhere down this dirt road . . . he pulled my bra . . . he ripped it and said, "Suck my dick, bitch." He bent me over the front seat. You could tell he was a rapist because I was crying . . . he pulled my pony tail and made me look at him. He was like, "Oh yeah, let me see those tears, bitch." I didn't want to call the cops because he could say that I was a prostitute. I willingly got into the car. I didn't willingly have sex with him but, you know . . . I didn't want to go to jail because I got raped.

One thing I saw that was really bad, I remember . . . I was on skid row. I was looking for it because I knew I was homeless and had nowhere to go . . . I turned down this one block . . . one block. One block full of tents and people just lying on the streets and doing drugs . . . doing heroin right there on the street . . . shooting up. . . . At night they had bon fires and stuff. . . . For the first time in my life I was actually nervous walking down the street. I've never been that scared or nervous or anything. . . . Skid row is the worst thing I have seen. Ever.

Current Mood

Subjects openly described their current affective state via 67 different statements. Though they continued to report feelings of sadness (the most prominent emotion for more than half of the subjects), anger, and fear, there was minimal suicidal ideation and only one mention of psychiatric treatment. This was contrary to their recount of their

mood and experiences while in substitute care. Instead, at present, much of the conversation about mood revolved around present means of coping (see Table 12).

Table 12

Current Mood

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Described Affective State (e.g., sadness, anger, fear, worry, frustration, etc.)	12	67
Coping	10	29
Psychiatric Medication/ Hospitalization	1	1

Of their current emotional state, subjects revealed:

I'm not happy. . . I'm so miserable. . . . I've never gotten over my mother's death. Even to this day. The other day, I was watching a movie. I saw myself in the little girl and I lost it for like an hour. I just went down and my body . . . I couldn't get back up. I stayed down all day. My mother, her death is always with me and I still grieve her. I'm grieving now because I've got time to think about it. Before, I didn't. . . . I get moments when I think about suicide but I can't . . . but then I think about my cats. I can't leave them. Who would take care of them . . . or my dolls. . . . Lately, I've been abusive toward my cats . . . I push them off because I'm so unhappy with my life. . . . I feel myself reacting. . . . It bothers me later but, at the time, it's satisfying because I'm so unhappy with a lot of things, it helps when I get angry . . . but I don't feel satisfied. Then I feel guilty.

I'm snappy. I'm emotional. I have a temper problem and I go off really bad. I think it comes from not being with my mother. I think it all boils down to that. That's why I snap. I've really calmed down over the last two months but I have a real bad temper. I get mad over the little things. Somebody could tap me on my shoulder and I'd just get so mad. I'm talking about so angry.

Everything is difficult. . . . My sisters are both fine. They're doing good because of what the system has done for them and people have helped them. I pretty much want them to suffer like I'm suffering. I sacrificed a lot of shit for them and they turned their backs on me. So, I want them to suffer. That's how I feel.

Ever since I was molested, I've had depression, PTSD—Post Traumatic Stress Disorder. I still have nightmares about it. I have terrible nightmares about it, even after seeking counseling for several years. . . . I cry like nobody's business and I can't help it. I'll cry at the drop of a hat right now. . . . It's just everything I've been through.

I often wonder if I'm going to be a good mom. Am I going to be a mom like I had or am I going to physically always be there for my child? It's a scary thought. My biggest fear is my depression and it affecting my child.

To cope with their emotions, subjects developed a wealth of skills:

I try to write it down . . . write it down. All my thoughts just come on paper. I'm the type of person . . . I don't talk much. I write them on paper. That's how I get all that out. . . . I listen to music while I write. It helps me calm down.

I write lyrics or poems and play basketball or swim.

I just usually talk, especially to my boyfriend. He's very quiet and he listens to me talk. I can talk for hours. I also write and read. It's like an escape. It takes your mind away from everything.

I make these dolls. When I work on them, I go to this zone . . . each of them have lives, names, they've got pasts. I wrote it down on a sheet of paper where they were born, their past, their lives and everything, how they came to be who they are. . . . I make them in my room . . . my miserable room in my miserable life. Making those dolls, I forget my life. . . . My whole life is a fantasy. . . . Sometimes, I dress in drag. I have a drag name. Sometimes I can hear her in my head. I sometimes imagine what she would do if she were here because she's so beautiful. I'd say 60% of my life is fantasy. . . . The more I use my imagination, the stronger it's gotten. Now it's like full throttle.

Survival Skills

In addition to developing means of coping with their emotions, subjects discussed other ways in which they survived, emotionally and physically, since leaving the child

welfare system. With 53 different statements, subjects shared how they used people and systems, engaged in illegal activities, and found work in order to survive and meet their basic needs. Working, the use of others, and theft, were the most frequently mentioned skills (see Table 13).

Table 13

Survival Skills

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Survival Skills (e.g., use of others, illegal activities, employment, social services, etc.)	10	53

Subjects worked a variety of jobs, sometimes resorting to a multitude of means to keep them:

> I've always had jobs. . . . I worked at a pizza place for seven months. . . . I can have a job now with a parking company. I worked there for two years. I do have that job back once I have the baby.
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> I was working at a grocery store. I'd do anything to make money to feed and clothe myself.
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> I worked but it was really hard getting to work and getting my clothes washed when I was homeless. I was a server. It's hard being a server. It's harder when

you're worried about where you're gonna lay your head that night. Being a server with the cash tips helped a little. I would rent hotel rooms. . . . Other times, I'd stay by my boyfriend's house. I'd say, for like a month, I slept in his car every night. His parents would get up and go to work. He'd let me in and let me take a shower and wash my clothes for work.

Subjects were also able to get others, sometimes through manipulation, to provide them with support:

My sister, she's got these sugar daddies who help her with money. . . . We never had a problem because she had so many sugar daddies. We got all the money we needed. We had an apartment. We didn't even pay for the apartment. We didn't pay for anything. We got all of our furniture free. Everything was taken care of.

I would get these guys that I've known for a little bit . . . would go stay at their crib and I would have a cot. I used it to my advantage, that's all it was . . . to survive. I had them posted up everywhere I could . . . just go and stay. . . . Most of the guys . . . "I need this . . . I need some money. . . ." I had one guy who saved me. I'd go over to his house in the middle of the night and stay over there. He'd give me everything I needed and give me money. It was fine. I had no problem with it.

I learned, if you find a male and you really know how to talk to this man, if you use your mouth . . . that's all you really have to do is use your mouth and learn how to talk to people. You can get yourself a crib, a car . . . you can get the world

just talking to people. By them hearing your testimony, people will go for that. They'll give you money, they'll give you anything. . . . The way I talked to them was so cold. I was able to get money, weed, liquor. I was able to get all types of shit without doing nothing. . . . All you need is a role model to show you how you really do get into a person's head. You do it when they're drunk. You get all you can get when they're drunk.

Some subjects also found ways to use the system:

I've been in several shelters. This is my third time back here.

I was at a men's shelter. They did a lottery and I didn't get a spot one night so I left and went to a human services office. They called the shelter here and told them about my situation.

Other subjects resorted to illegal means of survival:

I wasn't proud of it, but I was stealing and selling myself. I had to survive.

I started escorting, which was amazing, because it's like all this money. I had sex as a drag queen and as gay. . . . It was easy money. I went through agencies first then I got my regulars and I quit the agency and had them come to me.

I stole from businesses. I never stole from friends or family. That was my oath. I stole from businesses. I'd steal my makeup, shampoo, food. I'd come out with a backpack full of food. I was a really good thief. . . . From department stores, I'd

> steal clothes. I'd also wash myself in their toilet, literally. You know when there are bathrooms that are more than one, you know you can't really lock the door. I didn't want to do it in the sink. It would be weird. So, I'd take soap in a napkin and clean the bathroom, the toilet, and everything. I'd go back and get another napkin and wash myself in there . . . like a little bird bath in the toilet. It was almost a luxury for me when I found a bathroom that was single and I could lock it. But, it wasn't always a luxury because people would be knocking.

All Encompassing Experiences

For the most part, interviews with subjects revolved around their experiences before, during, and since their placement in the child welfare system. However, their reports were peppered with examples of what might be, and what subjects seemed to define as, more "ordinary" experiences; times not fraught with difficulty. Further, their narratives were permeated with stories about relationships. Though these relationships were repeatedly disappointing, there remained persistence for connection with and idealization of others (see Table 14).

Table 14

All Encompassing Experiences

Themes/Experiences	# Subjects Reporting Experience	# Times Theme Mentioned
Homeless Young Adults Formerly Involved with the Child Welfare System (N=12)		
Moments of Normal Development (e.g., school, social activities, family life, etc.)	12	53
Relational Disappointments (e.g., inconsistencies in relationships, feelings of rejection and isolation, lack of feeling wanted, etc.)	10	166
Absence of Fathers	10	19
Transitional Objects	3	6
Persistence of Idealization (e.g., continued seeking of connections and ideals despite repeated failures, self-idealization, etc.)	12	139
Defenses	11	55
Regulating Behaviors	11	22
Child as Caregiver Commodity	10	38

Moments of Normal Development

Curiously, throughout their life story narratives, subjects periodically referenced moments in time when things were "normal;" when they felt like a "typical" child or young adult and had fewer worries. All 12 subjects mentioned something in this realm for

a total of 53 statements. Subjects mostly spoke of experiences with school, recreational activities, family life, and their home environment (see Table 14).

Conventional experiences for these subjects were described using a number of examples.

About school:

I went to this great school. . . . I got some scholarships and stuff. I played on the football team.

I went to a really nice school. I had good grades. I was on the dance team. I was on the color guard. I played flute for awhile. I did a lot of things.

I went to college. It was a really good experience. I liked college a lot. It was the best time I've had. I was in a frat and had a lot of friends.

About other activities:

I used to love pictures in books. I used to look at the . . . my dad always read the newspaper. I used to look at the pictures in the newspaper.

I used to sing in a lot of different choirs. I love to sing, write, do hair. I love old people and kids, like babies.

I got to learn how to do magic and got to go to Tai Kwon Do . . . I think computer classes too. I did culinary arts classes and got a certificate. We went to basketball camps and amusement parks.

I'm involved in church. They have a dance program. I know sign language. I sing in the choir. I'm involved in a lot there.

About family and home life:

My adoptive parents are pretty wealthy. We grew up in a really nice house. We had like five million cars. I had my own bedroom. I was taken care of . . . I had food, clothing, and a shower.

We were actually living in an upper middle class neighborhood. We were an upper middle class family. We had a house and my mom had cars.

I got a weekly allowance. I got good clothes. I had my own room.

We used to go on family vacations, like down south to visit our people to family, reunions, barbeques, family outings.

Relationships

While subjects spoke at length and in detail about numerous and varied incidents in their lives, their overall narratives were pervaded by an underlying theme focused on relationships and a desired sense of connection and security. In sharing their life stories, it was evident that subjects' experiences of abuse, neglect, and trauma, as well as their behaviors and moods, were all ultimately related to their earlier relationships with important and needed caretaking others. In some instances, subjects themselves became

commodities, or objects, to their caregivers. Deficits in their relationships seemed to result in feelings of disappointment and a continued need to seek an idealizable other.

Relational disappointment.

Remarkably, subjects made 166 statements about feeling disappointed in their relationships. These disappointments were many and repeated. Subjects described a lack of or strained connections with others and feeling isolated from and rejected by family or caregivers. Further, several of their comments reflected a tremendous desire for empathic understanding and a need to be heard (see Table 14).

Subjects' impressions of their relational experiences and disappointments were described in many ways:

> [About her mother] I know she really doesn't particularly like me. I don't think she loves me. I don't think she's ever said that to me. . . . I felt rejected by my mother, yes, and by other family members sometimes. . . . We had other family but I don't think they wanted to be bothered. I don't think that's right. They stood there and watched. We didn't have contact with our family the whole time we were in the system . . . birthdays . . . we didn't have any contact. . . . My mother, I didn't see her until she was trying to get us back. The first day I met her, I didn't know what she looked like. I didn't know her. . . . A mother . . . there are more things that come with that title for me.
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> After the fire, we stayed with my adoptive momma's oldest daughter. She treated me and my sister like crap. She used to tell us, "I wish it was you all that died instead of my brother and my nephews." She used to hurt us . . . like really get to

us. . . . I felt like I was dead in their eyes . . . I felt rejected all the time . . . all the time.

My sister used to take care of me. We don't talk much now. . . . The older I got, the more disconnected we got. She was really mean. She said some harsh things to me. One time she told me . . . after my mother died . . . I had so much I wanted to show her and so much I wanted to do . . . a few weeks after my mother died my sister said, "What would you want to show your mother? You couldn't show her shit." She would say stuff like that and say she hated me all the time.

[Subject talking about having returned to live with mother briefly while in the care of an uncle] I guess they were mad at me for going to stay with my mom for awhile and leaving them. But, that was my mother and I'm a child . . . I was a baby. I needed some type of bond. I guess they didn't like that. So when I came back they decided I was going to live with another relative. At a family reunion, they just left me there. Everything was fine. I'm looking at them getting ready to go. . . . They went out and came back with big black bags. I'm thinking they're giving clothes away. . . . I've got my coat on, my hat on. My uncle stopped me and said, "No, this is where you're staying. . . ." I always wanted to be with my uncle. I always wanted to go back. But, I could never go back. That was the biggest thing that hurt me. . . . My family is not really family to me. I'm an outcast. I know where they are but we don't communicate.

> [Speaking about one particular foster parent] That was the only person that comforted me, that I felt comfortable with . . . the first time I ever felt loved . . . she even introduced us like we was her kids. . . . But, it was only a temporary placement. She didn't want us. She gave us up. I don't understand why. She never had to whoop us. She never had to do anything. We never did anything to make her mad. I was very hurt.

Many of the subjects' comments revealed a desire for an empathic connection and to be heard:

> I want people to know that there's a lot of fucked up shit out there. Everything is not black and white. . . . I want people to be more aware and more open. You don't know that the kid you pass on the corner could be going through some fucked up shit and you just pass him off as a bum. That's what happened to me. People looked at me as a bum. They didn't know what was going on. But, the kid could be full of potential.
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> All I wanted was understanding . . . understanding that I'm scared.
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> No one asked me how I felt about being taken from my mother. They never seen it from my side. That's why they don't understand.
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> People don't understand that kids like us don't know what to look to, don't know what to look for, who to talk to, who to confide in because you're confiding in so many people over the years and you come to find out they ain't your real parents.

> . . . You remember so much from being little and you try to put the pieces together but can never come up with the full story.
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> Having nobody to be there for me to understand my situation, to understand my story . . . it's hard on a child. That's what people don't understand. . . . More love. More support. More guidance . . . that's what you need. . . . You can't be so hard on kids that ain't got no momma or no daddy because nobody knows their situation or understands their story. Nobody will ever, ever, ever understand how that child feels but that child . . . they'd really have to get into your head and dig out your thoughts . . . ain't nobody gonna know what that child is thinking or feeling or nothing, just that child . . . especially if nobody is asking.

Absence of fathers.

Along with feeling rejected, unheard and, in essence, disappointed by their relationships, there was a striking absence of fathers, physically and emotionally. Nearly all subjects either had no memory of their fathers, felt abandoned, and/or lost their fathers to drugs and alcohol, death, or incarceration (see Table 14).

About their memories of their fathers, subject said:

> I don't remember my dad much. I can see his face and I remember situations . . . I remember bits and piece . . . . I didn't really have a relationship with him. When I talk about my mom, I become emotional but with my dad, I get nothing but pictures in my head.
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With my father, I don't remember him in my whole life. I remember him one time. I was like maybe five or six and he was sitting in front with my mother and they was talking. I was running back and forth. It was like this man stayed in my head. I never forgot his face. But, that was my dad.

My mother said my father loved me, but I felt like if he loved me, why all these years didn't he just come to see me. . . . He died last year of an overdose, I think cocaine or heroin. . . . I never really had no feelings . . . I couldn't really cry because I never knew him. I only heard of him. I never seen him in my life. All I knew was his name.

My dad was an alcoholic and never really there. He died when I was 16 and I don't remember a time at all in my life with him either saying, "I love you" or saying that he was proud of me. I remember telling him one time when I was still in elementary school, "Daddy, I love you." He said, "What, are you sick?" So, most of my life I don't even remember calling him dad. I usually called him by his first name because he wasn't a father to me.

My daddy was in jail . . . I used to cry on the phone with him and tell him the shit that was being done to us [in the relative foster home]. . . . He told us all these dreams that when he came home from jail he was gonna be clean, he was gonna get a crib, he was gonna try real hard to find a job . . . and he was gonna get us and take us from this life . . . but he never did.

Transitional objects.

Noteworthy, as seemingly in an attempt to hold onto some sense of connection in the face of so many relational disappointments, some subjects shared memories of specific objects given to them by loved ones and the meaning these objects held (see Table 14):

> I remember she [subject's mother] had got me this teddy bear and I kept it all the way until I was like 14. The head was off and everything but I kept it. She gave me that teddy bear and it was the best . . . to this day the best gift. That was the last time I saw my mom.
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> I always clinged to whatever they [subject's first relative caregivers] gave me. I had a Ninja Turtles pillow and they wrote their number on the back. I clinged to that pillow. If anybody touched it . . . I was very protective of that stuff.
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> One family, I don't know why they took me away from them. They gave me a talking doll. I loved that doll. They never gave it back at the orphanage when I left. I loved that doll. That doll was very important to me. You know, kids form a memory when they're little.
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> There's a video of my adoption . . . I have a video tape. It was at my adoptive parents' house. It got lost because I'm disobedient. I decided to take it from them and became homeless. So, it's somewhere out there.

Persistence of idealization.

In spite of repeated hurt and disappointment, many of the subjects' remarks—139 all total—were demonstrative of attempts to hold onto some idealized image, perhaps in an effort to feel a sense of security and wholeness. In some cases, subjects turned to themselves for idealization. Notably, numerous defenses and regulating behaviors were employed in this endeavor (see Table 14).

Examples of the capacity to continued to seek idealizable others through justification of caretaker actions were revealed in the following responses, keeping in mind that often these same idealized figures were also the ones that subjects admitted caused them pain and sadness:

> Before my mother got sick [subject referring to mental illness], things were fabulous. . . . My mother was extremely . . . she was striking. . . . She was like a hippie, almost, but glamorous . . . she really had it together at times. . . . To me, she was a goddess. She was immortal. . . . I felt safe. I was happy. Even now, it brings up joy in me.

> My mother left us in the house . . . but she always came back. Even though she was on drugs, she never left us for days. It was me, my sister, and my newborn brother . . . but she always came back. . . . There's nothing good about a mother who's on crack but she wasn't the worst mother. She was a bad parent but she made sure she took care of us.

[Referring to a group home] There was one good one but I had a lot of abuse from the staff there. That was the best placement, though. That's pretty messed up. . . . The best times were being around residential staff . . . even the sick ones.

[Subject referring to an older foster child in the home who was abusive] I didn't feel bad. I didn't feel scared of him. He wasn't violent. He was actually, I mean, despite molesting me, he was real protective of me.

Likely due to failed or lack of idealizations, subjects then turned to themselves as models of strength and comfort:

I think I've always had a good head on my shoulders, even after all that happened [subject referring to various life traumas about which were already spoken].

One thing I thank God for is my sense of survival . . . I never got into gangs. I got into drugs but not too long and they didn't destroy me. The potential is still there. I can see it in myself. It drives me. Thank God for that.

I was always a survivor. Even when I was a little premature baby. My momma said that I was so small she could hold me in her hand. They said I wasn't supposed to live. I'm here. She said that was the one thing she knew about me . . . her baby was a fighter. She's a survivor. I'm a fighter. I'm a very strong person. I call myself the warrior princess.

I'm impressed with myself. I am. I'm very impressed with myself and I'm proud of myself too. The things that happened to me should have shut me off right then and there. That's why I call myself a destined child.

Right now, I'm working on a business plan for a transitional living program. Although it's not something you would choose to go through, because of what I went through, it made me a better person. It made me appreciate what I have.

Defenses.

Seemingly, as another means of maintaining a sense of idealization, nearly all subjects, in 55 statements, demonstrated employing—consciously or unconsciously—a variety of defenses, including a lack of memory of potentially emotionally painful experiences and a denial of a need for others (see Table 14):

I don't remember some things. My sister said it's funny how I can remember some things and not other things. Maybe I blocked it out. I don't know.

I don't remember anything about my parents [subject lived with parents until the age of about seven]. I don't remember anything about their relationship or what their faces look like. Sometimes I even think that it's all a dream.

I really can't remember nothing before six . . . six on down. I don't remember living with my mother or father, but she was coming around. I know that. That's all I can remember. I can't remember nothing from my childhood. I wish I could.

I'm not the type of person that . . . I don't sugar coat it. I don't really care about her [subject's mother] because she really hasn't done nothing for me anyway. She didn't ever come to my graduation. She didn't never come to none of my birthdays. So, I don't really give a damn, to tell you the truth. I really don't care.

There's nobody for me . . . I can't count on anybody but myself. It's only me. I don't count on anybody. I don't expect anybody to do anything for me.

Regulating behaviors.

In addition to defenses, through their narratives, all but one subject acknowledged, with 22 comments, engaging in many behaviors that, perhaps, served to help regulate their emotions. The primary behaviors included using substances and other addictions for the purposes of self-soothing, aggression towards self and others, and isolation. Subjects described these behaviors in the following way (see Table 14):

I used to do a lot of drugs. It just . . . I don't think you ever stop being an addict. We just flip it over to something else. That's what I did. I'm addicted to food too. I feel in control when I eat. . . . I also see myself as a sex addict. I go out and I prowl for sex at the gay bars. . . . I feel so guilty after I do it. I think I've been with thousands and thousands of people. I don't know why it gratifies me so much but it does and it makes me happy for awhile. It's the one thing I can be in control of. . . . It's another way I cope with things.

I have a real, real bad temper. I have to work on it but I have a real bad temper. It would get to the point where I'd start hitting the walls or trying to punch the wall

in or I'd start yelling at the top of my voice. Then I'd just start crying because I'm mad to the point where I just slam the door to my room and don't say nothing to nobody. It's how I relieve anger.

Cutting . . . for me it was a way to relieve the stress. I mean, I was carrying pain emotionally and the cutting would get my mind off the emotional pain. It kinda puts a picture to the pain.

In my closet, I would actually hide. There was a big laundry tub. I would take the top off it and get in. I would put the cover over the top and go down on the bottom and have a flashlight and read my book.

Child as caregiver commodity.

As part of their problematic relationships, 10 of 12 subjects, in 38 statements, described memories suggesting that not only were their needs for mirroring and idealizing not met but, on the contrary, they served to meet the needs of caregivers (see Table 14).

About this, subjects said:

I remember a couple of times when my mom . . . she'd make us do stuff we didn't want to do like . . . she'd say go in the store, grab a doll, and then start crying and say you don't know where your momma is. I wanted to just run out of the store with the baby doll. I used to say, "Momma, I don't want to do that." She'd be like, "You said you wanted the doll, so do what I say do." I'd be crying and didn't want to steal out of the store. . . . "Do this, do that. Steal this, steal that. You gotta

do what I say. When I say steal it, you better steal it. . . . ” She should have never did that. That’s the worst thing to ever do to a child—have them steal then put that into their head like it’s okay.

It was my second foster home . . . she [foster mother] was drinking that night. She asked me if I wanted to sleep upstairs with her. So, we go upstairs, lie down, and she started to rub her booty up against my penis. I’m like, “Why is she doing this?” It feeled good but I’m only 14-years old. . . . Later, she comes downstairs with a sheet wrapped around her. She got on top of me and started humping. I was like, “Stop. Stop.” She got off of me and went upstairs. The next morning, it was just a normal day. . . . Another time, she asked me if I’d ever had sex before. I’m like, “No. I haven’t had sex.” She’s like, “You wanna try?” I’m like, “Sure.” So, then she pulled my pants down and I got on top of her. After I came she was . . . I don’t know. She wasn’t angry or nothing but she told me not to tell anyone. The next morning her husband was sitting at the table when I got up. I told him what was going on. Then he got up, went to her room, and closed the door. Then I heard yelling, “He just wants our foster care license revoked . . . tooken away from us . . . he’s a habitual liar, that’s what he is. . . .” I ran away.

I pretty much waited on her hand and foot [subject’s relative caregiver], which I hated doing. I’d get up at 5 am to get ready for school and work my butt off at school and come home to clean house, do laundry for hours, do dishes, put movies in and out of the VCR for her because she wouldn’t do it, watch her

daughter whenever she wanted me to, cook her meals, feed the animals, clean up after the animals. . . .

My auntie was getting money . . . my dad had some kind of money or survivor's benefits or something, so my auntie was spending it on drugs and trips. I remember . . . she had two boys. She took them to Disney World with our money and didn't take us. She left us.

I didn't exist. I was just a paycheck. Just a check. I didn't really exist. . . . My foster mother didn't tell them I ran away because she wouldn't have gotten the money anymore.

Connections between Past and Present

Subjects were asked if, given their multitude of experiences, they noticed any connections between the past events in their lives and their current lifestyle. All subjects acknowledged some links, particularly regarding trust and connecting, and a few spoke of positive lessons learned.

Regarding trust and feelings of connectedness, subjects mused about the following connections between their life experiences:

I see a cycle . . . losing people I care about and getting hurt. Now, I'm not a very trusting person. . . . When I trust you that means that you've gotten past this wall and you've done everything. Those are the people that seem to hurt me. They put their hand right on my heart and twist.

I never really felt like I had anyone I could go to and just talk. If I had the worst day of my life ever, I couldn't do that. So, the fact that I read . . . I read a lot. Now, I'm usually by myself. It's hard for me to participate in things. It's hard for me to open up to people. I don't talk to people a lot. Before I came into the system I didn't have anyone to talk to. While I was there and afterward . . . . So, I'm withdrawn now.

I don't trust people. . . . I just know that those experiences have made a big difference in my life. It's always going to be a part of me . . . something I remember . . . something I'm used to. Nothing's gonna change because that's how I was raised.

About positive things resulting from their experiences, subjects said:

Because I was neglected so much in the system . . . I'm lucky . . . one thing I thank God for is that I've got my sense of survival. I'm articulate and developed an imagination so I was able to stay sane.

I definitely think there's a connection. I don't think I would be as resolved and determined not to do certain things, like drugs. I wouldn't smoke. I'm really serious. I've learned that certain things like cigarettes and alcohol are stairway drugs and they lead to other things. I've never smoked a cigarette or drank alcohol in my life and I never will. I'm actually afraid to take pills. . . I'm nervous . . . I'm scared to take my vitamins.

Field Notes

Recording impressions and experiences after each subject interview was not a task initially built into this study's design, though the methodology allows for this form of data gathering. However, after the first interview, and for most that followed, rather interesting dynamics were observed and, thus, noted for later examination. Virtually all subjects exhibited visible emotional reactions (e.g., tears, sighing, alterations in voice tone and posture, etc.) during their discourse when touching on emotionally laden topics. When tattoos, piercings or other body art was noticed by the researcher and inquiries made regarding the meaning and/or reason for the art form, subjects eagerly shared the symbolism, which was often the loss of an important other. At the conclusion of the interviews, without prompting, two of the pregnant subjects brought out pictures of the sonograms of their developing fetuses and asked to show them to the researcher. One of these subjects also shared some pictures of her mother as well as a political flyer she created. Another subject smiled largely, sighed, and stated that she did not realize how good it would feel to tell her story. She then requested to take a picture, using her cell phone, with the researcher. Further, after talking with two different subjects, a caseworker told the researcher that both young people seemed "changed" after their interviews. The caseworker noted that they appeared "lighter" and were much more open and expressive. One of the young people even offered to share with the caseworker some snacks she received during the interview process, which was apparently very unusual. Per the caseworker, there was a greater sense of connection with these youth.

CHAPTER V

DISCUSSION AND CONCLUSION

Discussion

Data from this study generated several intriguing findings related to the overarching research question: What are the patterns of affect regulation and behaviors of homeless young adults who were formerly involved with the child welfare system? There were also notable emergent themes among the study's sub-questions—the first of which examined subjects' narratives regarding relational and behavioral experiences before, during, and after foster care; the second of which evaluated scores on a standardized measure of affective symptoms and behavioral functioning; and the third that looked for consistency or discrepancy between personal narratives and psychometric scores.

Overall and not surprisingly, the results suggested that young adults who became homeless or precariously housed upon exit from the child welfare system were those that suffered repeated abuse, neglect, and trauma in their early lives, grew up in chaotic family environments, and with parents or caretakers struggling with their own self deficits, including substance use, mental illness, and violence. The early familial experiences of these young adults were consistent with the background characteristics of homeless youth and young persons post-child welfare involvement, as depicted in previous research (Cauce & Morgan, 1994; Courtney et al., 2001; Courtney et al., 2004;

Pecora et al., 2005; Rew et al., 2001; Robertson & Toro, 1999; Thompson et al., 2001; Tyler, 2006; Tyler & Johnson, 2006).

For this sample of youth, once in substitute care, early familial dynamics were not only perpetuated but amplified. Similar to prior research findings, maltreatment in care was not uncommon and youth experienced instability and lack of consistency in relationships due to multiple placement moves and extended periods of time spent in the child welfare system (Courtney et al., 2001; Pecora et al., 2005). In this study, youth experienced an average of 5.58 placement moves and remained in substitute care about 8.96 years. In a similar study, 4.6 was the typical number of placement moves and 5.5 was the average time spent in care (Courtney et al., 2001). Further, youth acknowledged a range of moods, treatment for mental health problems, and engagement in a variety of behaviors, including running away and acts of violence, all of which were consistent with past research findings (Courtney et al., 2001; Courtney et al., 2004; Leathers & Testa, 2006; Nelson, 2001; and Pecora et al. 2005).

Upon reaching the age of majority and formally exiting from substitute care or severing ties with the child welfare system through adoption or other permanency goals, these young adults were not immune to continued victimization; they described experiencing a variety of strong affective states and engaged in risk-taking behaviors. Similarly, recent research found that for young adults post-exit from the child welfare system, mental health problems are routinely identified with reports of feeling lonely, different, and unconnected. Delinquency and incarceration are prevalent and youth are at increased risk of victimization. Homelessness is widespread (Brandford & English, 2004; Courtney et al., 2001; Courtney et al., 2004; Leathers & Testa, 2006; Nelson, 2001; Pecora et al., 2005; Reilly, 2003). Interestingly, although the young adults in this study

still struggled with these issues, they portrayed less severe experiences and behaviors than as were reported while in substitute care and prior. They had developed a wealth of coping and survival skills. Overall, pervading all of the experiences throughout their lives was a sense of repeated disappointments in relationships and ongoing efforts to seek a sense of strength and wholeness through the idealization of others.

Prior to entering the child welfare system, subjects suffered from maltreatment at the hands of their primary caretakers and were raised in generally chaotic environments. Self psychology theory postulates that, for healthy growth and development, a child needs to feel desired, wanted, and valued and have the experience of predictability, dependability, and reliability (Elson, 1986). When a child's basic needs for food, warmth, and soothing are met, feelings of consistency and security are generated and the child feels important. It is the repetition of these idealizing and mirroring selfobject experiences that, if provided to a sufficient degree, lay the foundation for the development of the child's self-structure. With adequate caregiving, a child is able to use these early experiences of nurturance to regulate emotions and feel a sense of cohesion. When a parent or caretaker lacks the capacity to provide these functions for a child, the child's self-structure has the potential to be quite fragile. Thus, the child is at risk of feeling incomplete, unsafe, and being on the verge of fragmentation. Elson notes that chaotic caretakers do not have the ability to regulate their own affective states let alone serve in this capacity for a child. These types of caretakers cannot generally provide the consistent, nurturing environment a child needs to develop the self-structure and skills to effectively manage emotions.

The subjects in this study reported that their parents or caretakers struggled with a number of personal problems, especially substance use and mental health issues. These

problems hamper one's ability to be connected to another, tend to another's needs, and provide a safe and secure environment. Most notably, 100% of subjects spoke of childhood neglect—abandonment, lack of care and attention to basic needs—as the prominent form of maltreatment prior to entering substitute care. Many were left alone at a very young age without adequate provisions. Several suffered severe trauma, including the loss of loved ones through violent death. Others, whose caretakers were physically present, described them as emotionally vacant or unpredictable, caused by substance use, mental health problems, or domestic violence. Given these circumstances, the likelihood of these parents or caretakers having been able to adequately serve a regulatory capacity for these subjects was slim.

For this sample of young adults, their archaic needs for mirroring and idealization were not compensated for while in substitute care. They continued to experience a tremendous amount of neglect in addition to being exposed to more acts of verbal, physical, and sexual violence, not only from caregivers but from other children as well. Subjects acknowledged being fearful and feeling insecure, which seems to be a repetition of their childhood. For many, their environments were described as highly unpredictable, hostile, and unsafe. If this is accurate, in all probability, subjects were still not offered the opportunity to feel valued and to merge with the sense of calmness and strength of an ideal, protective substitute other. It would be extremely difficult to elicit these selfobject functions from a caregiver who is abusive, unavailable, or inconsistent. Further, several subjects shared stories of loss—due to separation from siblings, long absences of parents, death of loved ones, and multiple placement moves—as well as other trauma. There was no indication from subjects that they were aided by their substitute caregivers in dealing

with their feelings. In fact, many subjects described feeling alone and isolated and expressed a desire to be heard and understood.

While in substitute care, subjects recalled feelings of anger, sadness, fear, isolation, and rejection. These emotions were similar to what they felt before being removed from their families but more pronounced. Additionally, suicidal ideation became evident. It seems important that subjects employed methods of coping, such as fantasy and seclusion, which are isolating. There was no evidence that they sought comfort from or connection to others. Based on these findings, subjects likely experienced an increase in negative mood due to continued maltreatment, lack of connections, limited feelings of self-worth, and having no idealized objects from which to find solace and strength.

In a likely attempt to modulate their multiple emotions, subjects engaged in many risky behaviors. They acknowledged acts of aggression, substance use, and running away as their most prominent behaviors. According to Goldberg (1995), these types of risk-taking behaviors are examples of problems with self-regulation. They represent repeated disruptions in the idealizing transference—a lack of opportunity to merge with a calming, soothing other—and a chronic lack of responsiveness to one's need to be mirrored and admired. In essence, with these deficits in the idealizing and mirroring spheres beginning in childhood and further exacerbated while in substitute care, subjects did not likely develop solid self-structures and were unable to learn successful ways to regulate their emotions, instead responding to overwhelming affect with acting out behaviors.

Without knowing its full impact, it seems notable that when examining subject demographic data, half of the sample had been adopted from substitute care prior to becoming homeless. This was striking and unexpected. Based on the literature and the experiences of the researcher, it was presumed that most of the study's subjects would

have reported aging out of the child welfare system. The assumption was that without adequate self-structures and supports, emancipated youth would have difficulty maintaining stability. Systemically within the child welfare system, the assumption seems to be that providing a child with a permanent home—such as through adoption—is of primary importance to development and mitigates future problems. Though stability is a key factor to a child's emotional growth, without the chance to experience a nurturing, consistent relationship, where mirroring and idealizing selfobject needs are met and a solid self-structure is built, a permanent placement alone does not seem sufficient to ensure a healthy future.

This is congruent with the psychosocial model of foster care proposed by Schofield (2002) that was developed based on data from a qualitative study of young adults who grew up in foster care. Schofield found that predictability, sensitive care and feeling a sense of value and unconditional love contribute to successful future outcomes. In this current study, the lack of these features appears to have negatively affected subjects' future stability and overall well-being outcomes. The youth in this study arrived in substitute care with significant deficits in their self-structure, which were rooted in their earlier experiences. However, neither foster care nor adoption seemed to remediate these deficits, perhaps because elaborate defenses developed for survival. Substitute care relationships may have helped sustain youth in some ways but did not appear to be a corrective experience. As such, patterns of behaviors were repeated. Based on the findings from this study, adoption and the idea of permanency seem to be more of a legal status than a cure for a disordered self. Intensive clinical treatment and intervention may be necessary to compensate for the deficits of the self.

All subjects, whether they were emancipated, adopted, or returned home, indicated that they became homeless shortly after reaching the ages of 18 to 21. Prior research suggests that, on average, young adults acknowledged becoming homeless within 2.5 to 4 years after exiting substitute care (Nelson, 2001). Most either left substitute care without adequate financial resources and/or personal supports—and were unable to maintain what they had—or they were forced or chose to leave their adoptive or biological homes due to ongoing conflict and maltreatment. Since becoming homeless, they reported similar experiences in the realms of loss and trauma, mood, and behaviors as those that occurred prior to and during substitute care, though to a much lesser degree. Yet, they talked in detail about ways in which they have learned to survive and cope.

Loss, post-child welfare, was still related to separation from family and death. However, family disconnection was now due to strained relationships—particularly between siblings—and, in some cases, a desire to maintain distance versus forced separations. This may suggest that after a significant time without experiences of closeness and repeated disappointments, subjects were unable or unwilling to engage in this type of intimacy.

Subjects continued to describe their mood with words such as sadness, anger, and fear. They willfully acknowledged difficulty trusting others and recognized how their past experiences with the important others in their lives (i.e., caretakers) had an impact on their character and current state of well-being. Ultimately, these subjects were aware of what proponents of self psychology theory proclaim: traumatic disappointments of idealized selfobjects affect one's self-structure (Elson, 1986; Kohut, 1971, 1977).

Having not developed the self-structure required to learn the skills to sufficiently regulate their emotions, subjects apparently resorted to what they knew and what they

used in the past to cope—risk-taking behaviors. Though in many respects these behaviors decreased, aggression and substance use remained the most frequently reported. For Kohut (1971), these specific types of behaviors reflect an attempt to replace a deficit in one's self-structure—avoiding fragmentation—which is caused by repeated traumatic disappointments of the idealized selfobject.

Despite the described deficits in the subjects' self-structures resulting from previous un-empathic experiences and traumatic losses—literally and figuratively—of primary caretakers, many subjects instituted concrete mechanisms to manage affect and for coping and survival. Writing, talking, music, role play, and physical activity were named as methods by which subjects reportedly attempted to control their feelings. To survive, in addition to engaging in illegal activities (e.g., prostitution, theft), some subjects spoke of manipulating others into meeting their needs. It is possible that resorting to concrete coping skills and using others without guilt or shame evolved from not being responded to empathically by the important others in the subjects' lives. If subjects did not receive adequate empathic responses from caretakers or revel in their strength, it would be difficult to manage emotions internally, as those structures were never fully constructed. Further, it could be hard to experience an empathic connection with someone else if that experience has been unfamiliar or if, as a child, one was used to meet the needs of the caretaker. In this case, it might make it easier to view others as objects and use them to get needs met with no shame. Likely, the subjects that engaged in this behavior were enacting what they had experienced at home or in care.

In their reports of their experiences prior to, during, and since being in the child welfare system, the subjects exuded an overwhelming sense of disappointment in relationships yet a perpetual search for an idealizable other. Through their narratives, they

imparted intense feelings of rejection and lack of value and acknowledged feeling abandoned, isolated, and alone. There was no indication that they ever truly felt they were the "gleam in the mother's eye" (Kohut, 1971, 1977), either at home or in foster care. Even for those young people who spoke of fond memories with their parents or caretakers, often, the reminiscences were tempered by disappointments.

In his writings, Kohut (1977) says that it is the mother or mothering object who serves to provide the mirroring selfobject function for a child—the one who empathically responds to and confirms the child's sense of worth and importance. If the mother is unable to meet this charge, the father or fathering object can compensate for this deficit by functioning as the idealized parental imago with whom the child can merge and feel a sense of omnipotence and calm. In essence, what the child lacks in mirroring has the potential to be overcome if idealization is possible. For the subjects in this study, mothers were the primary caretakers and, for many reasons, seemed unable to adequately provide them with the necessary mirroring functions. Fathers were notably absent, thus hindering any possibility for compensation. Thus, for most of these subjects in early childhood, there were deficits in both the mirroring and idealizing spheres, making it very difficult to feel a sense of wholeness and learn to manage emotions. Interestingly, a few subjects talked about specific pieces of memorabilia—objects—onto which they clung. Perhaps this was a way to fill the void: to feel somewhat more complete, find solace, and experience a sense of connection to a loved and needed other.

In addition to these described failures on the part of caretakers, a number of subjects felt themselves to be commodities. Several were objectified and exploited by those who were supposed to protect and care for them and, as a result, they did not feel

safe. This type of dynamic does not support idealization, as subjects could not likely look to and find strength and solace in someone who treated them as such.

A particularly remarkable finding was that despite the apparent failures of selfobjects, many subjects made efforts to hold onto idealized images and employed several defenses in order to do so. For some, even though they were able to provide details of their histories, they proclaimed they had no memory for certain events and experiences in their lives, such as things about their parents and life before foster care. Many of these absences of memory appeared related to possible disappointments by primary caretakers. For others, they justified or rationalized the maltreatment they received from their caretakers, though they did not condone it. To make some sense of their experiences and try to feel more cohesive, in control, and safe, it is not surprising that subjects would employ these methods of self-preservation.

In furtherance of their efforts to shore up their self-structure, and in the absence of external idealizing figures, subjects turned toward themselves in a self affirming, bolstering way. They talked about their strengths and goals and they shared stories about aspects of their lives that were "normal." In these moments, they seemed to be declaring that although others did not consistently meet their needs for protection, reliability, and nurturance, life was not all bad (i.e., they were not bad). They managed to survive and they looked to themselves to get their needs met.

Although subjects shared their strengths and were making valiant efforts to tend to their own basic and psychological needs, this was a daunting task and they were not always successful. They continued to struggle with affect regulation and acknowledged resorting to certain disruptive and harmful behaviors in an apparent effort to self-soothe. Drugs, sex, food, and aggression towards self and others were the primarily named

methods to manage emotions. As previously stated, for Goldberg (1995), many of these behaviors are considered impulsive and serve to regulate emotions. For the subjects in this study, these behaviors seemed to be an effort to compensate for a lack of an early idealizing parent imago, and thus a deficit in having developed the skills to internally manage emotions more successfully.

Also of note, three quarters of the subjects had tattoos, body piercing, or both. Some consider these behaviors forms of self-harm. From this perspective, physically marking one's body in what is often a painful manner might then be construed as means of emotional regulation. Given that most of the subjects with tattoos reported that their markings symbolized a lost other, permanently connecting this loss with oneself could represent both the ultimate attempt to control emotional pain or an effort to maintain a connection with another by attaching the lost other to oneself permanently and visibly.

Subjects' scores on a standardized measure of current functioning (BASIS-32) and reactions to the interview experience were captivating. On the measure of current functioning, they reported having the most difficulty in the areas of relationships with themselves and others as well as mood, though their scores fell in the moderate range. This differed from their narrative presentations where their stories reflected more disappointing relationships and struggles with mood. Though they could tell their stories, when asked to more directly attach a concrete numeral to these experiences, they ranked them as less troubling than their narratives would have predicted. Perhaps subjects were able to cut off some degree of their feelings when rating their experiences and did not view these areas in their lives as that difficult at present, or a lower rating may have served as a means of self-preservation. In a similar way with their narratives, youth justified having been abused or neglected. Lower ratings of current distress on the

BASIS-32 and rationalization of past maltreatment via narratives may have been the subjects' attempts to maintain an ideal image.

Further, it is conceivable that the experience of disclosing one's narrative was cathartic for some subjects. This was evidenced by a caseworker's report of notable changes within subjects after interviews and by subjects' own verbalization of positive feelings. As the scale was administered at the completion of the interview process, less distressed scores could represent more positive overall feelings at the time subjects were asked to rate their emotions and experiences.

Contrarily, subjects' scale scores may have actually been the more accurate representation of their most recent experiences. In their narrative reports, though problems with relationships and mood still existed, subjects' noted fewer current difficulties at present than while in substitute care or at home. It was predicted that, based on the literature in self psychology regarding behaviors in support of affect regulation and given the experiences of the subjects, the subscale measure of impulsive or addictive behaviors would be ranked among the highest. This was not the case. In their narratives, this had been true for subjects during their time in the child welfare system and directly upon becoming homeless but was not a serious issue at present. The researcher's experience with this population suggested that subjects' would be more dysregulated and thus score higher on this subscale. It may be that the particular subjects who chose to participate in the study were able to do so because they were less impulsive, had more of an ability to regulate their emotions, at least for a period of time, and were somewhat more stable; they had enough self-structure to arrange and keep an appointment. If this is true, it might account for their lower self ratings of impulsivity. Noteworthy is that if these subjects—who experienced repeated maltreatment and still struggled to manage

their emotions—are, in essence, more organized, what might be the self states of those homeless youth who were did not participate.

Regarding the events that followed the interviews, that subjects wanted to share other aspects of their lives (e.g., sonograms, art work) and were interested in and had the capacity to experience a sense of connection (e.g., desired to have picture taken with researcher, reported to be more open with caseworkers) was telling. Perhaps some found relief or a sense of warmth and closeness through being able to share their story in a safe and empathic environment and with someone interested in them. For others, it may have simply been an opportunity to show, and perhaps prove to themselves, that their lives were not fraught with badness but that there was more to them than their past negative experiences and, in some cases, new lives (i.e., pregnancies) were beginning.

Conceptual Model

One of this study's overall objectives was to build knowledge related to the experiences of homeless former wards, particularly focused on affect regulation and relationships, from a theoretical perspective. In the same vein as Schofield's (2002) study where a psychosocial model of long-term foster care was developed using concepts from theoretical perspectives after investigating the experiences of adults who grew up in substitute care, this study's aim was to better conceptualize the experiences of homeless young adults who were once part of the child welfare system. Based on the results of the study, a dynamic model is proposed below, drawing on core theoretical considerations from self psychology. This model has the potential to serve not only as a vehicle for increased understanding of the experiences and psychological needs and make up of youth as they progress through the child welfare system to adulthood, but also to aid in

the promotion of more empathic, supportive, reliable, and consistent relationship building while youth are still in care. These experiences may serve to compensate for early familial relational deficits and promote future healthy emotional growth and self-structure development, including affect regulation, as well as support overall stability for young people as they leave substitute care, in whatever capacity that may be.

In the narratives of the young people in the study, there was clear indication that the entirety of their experiences prior to, during, and post-foster care were inter-related and, in some ways, seemed to move along a continuum of time and development. For these youth, even before beginning their journey in substitute care, there were notable deficits in the realm of mirroring selfobjects and idealized parent imagoes; they lacked the experiences that contribute to one's sense of value, worth, and feelings of admiration as well as predictability, consistency, and reliability from primary caretakers viewed as omnipotent. This was caused by problems with which parents or caretakers struggled (e.g., substance use, mental illness, and domestic violence) and which seemingly hindered and limited their ability to tend to the needs of their children. Without these parental functions, the creation of one's self-structure, as well as the ability to manage emotions in childhood and promote healthy affect regulation and well-being throughout the life course, is affected.

When caretakers become abusive or neglectful, their children are deprived of needed admiration and feelings of security. Further, the children may be viewed by their caretakers as malignant. If so, children may experience powerful feelings—which are seemingly projections from their caretakers—of being inconsequential or hated and despised. The neglectful parental abandoner and abuser has also become a persecutor.

Children may come to see themselves as hateful, destructive, and bad and feel no sense of safety or certainty in their world.

Children with these early experiences enter substitute care with a deficit in their self-structure resulting from deprivation of adequate mirroring and idealization. In addition, they may experience themselves as malevolent. They may be disappointed in their relationships and feel disappointing to others. Relational disappointment, in this case, means that early selfobjects failed to serve their function. As such, in the present, selfobject needs are repeatedly disappointed because they are archaic, and defensive structures, long since created to protect the self from fragmentation, are entrenched in one's self-structure. Thus, one's troubled self-structure is reflected in repeated patterns of relational disappointment.

Substitute care, perhaps with intensive intervention, has the potential to compensate for early experiences and deficits in the self if children are placed in environments where caregivers understand the effects of early relational disappointments and maltreatment on the development of self-structure and emotional regulation. If this does not occur, substitute caregivers cannot be experienced as adequate selfobjects for the children in their charge. They may perpetuate feelings of inadequacy, worthlessness, and insecurity through abusive and neglectful treatment; children may continue to move along the continuum of lacking certain basic needs, not experiencing a sense of safety, and not developing the skills to manage overwhelming emotions. In an attempt to gain some semblance of mastery and control over their emotions and experiences, and without the psychological assistance of primary caregivers, children resort to behaviors such as aggression, drug use, self-harm, and running away, as a means of self-regulation. In the child welfare system, these types of behaviors are not always fully understood from a

psychological standpoint. Instead, they are viewed as disruptive and defiant and may result in frequent placement changes. Repeated moves—in other words, continued selfobject disruptions—perpetuate feelings of inconsequentiality and unease.

There are certain substitute caregivers that do have the capacity to compensate for the early deficits and negative feelings of these children. Yet, perhaps there is a reluctance or inability on the part of the children to connect with anyone out of fear that the other might view them as they view themselves—bad and hateful. For the children that eventually end up homeless upon exit from substitute care, it might be that their self-structure was so damaged early on that they could not use what their caregivers had to offer and, for that matter, could not benefit from concrete life skills services because their psychological make up was not intact. These questions are in need of further exploration.

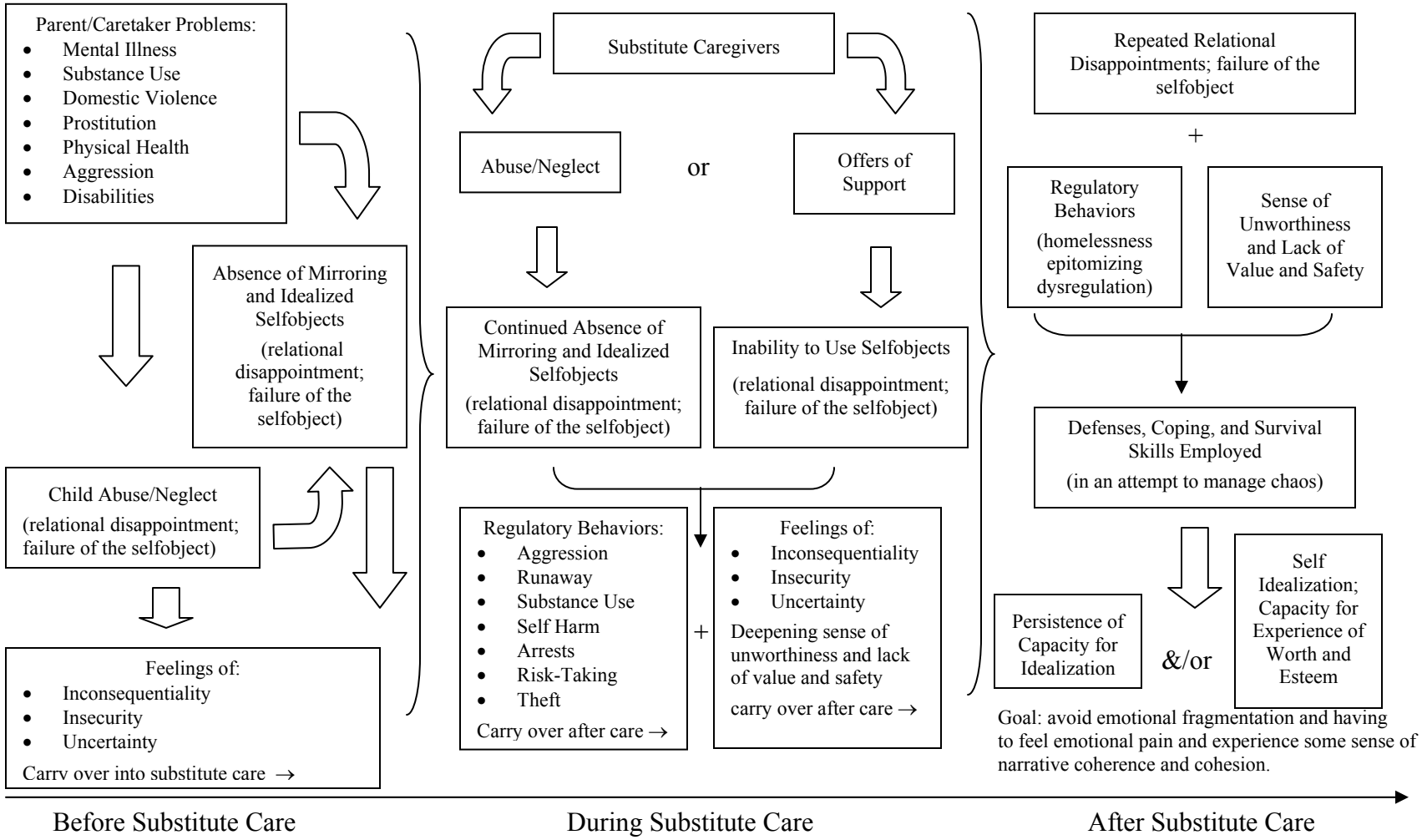
Whether deficits in self-structure were not compensated for by substitute caregivers or children could not use their caregivers in this capacity, feelings of emptiness and lack of value, importance, and strength persist into young adulthood. In an ongoing effort to make sense of their experiences and establish feelings of wholeness and well-being, young adults with this life trajectory employ a variety of defenses to protect themselves from emotional fragmentation. In addition to the use of certain behaviors (e.g., substance use, aggression, self-harm, etc.), other defense mechanisms evolve. These defenses guard against tarnishing a fantasized image of an idealized caregiver imago, which youth need to maintain a sense of narrative cohesion and coherence. They developed the capacity to continue to seek an idealizable object. Further, they began to idealize themselves to serve in the absence of omnipotent others and provide an experience of worth and esteem.

Despite having been maltreated, and perhaps left with feelings of insignificance and apprehension, it is difficult for most people to consistently live in this realm of psychological confusion. As such, young adults with repeated disruptions and disappointments in the selfobject surround may reflect on fond memories of their idealized others and early life events and highlight their own abilities and strengths in spite of negative experiences. In this way, some semblance of personal importance and value as well as feelings of emotional stability and security can be created and used by youth as they enter adulthood on their own.

However, in fact, these young people are homeless. Homelessness is the epitome of instability and a prime example of dysregulation. The lack of external, concrete physical boundaries, control, and security (i.e., housing, financial stability, etc.) associated with homelessness are also symbolic and representative of the internal psychological lives of these young adults (i.e., uncertainty, emotional insecurity, etc.). They appear to exist in a perpetual state of chaos, physically and psychologically. This constant state of dysregulation, at times, functions to stave off connection to emotional pain. It is also a way to be connected to a dysregulated other; connection exists in the form of chaos.

The conceptual framework proposed (see Figure 2) is just one of many possible ways to scrutinize the experiences of homeless young adults who were once involved in the child welfare system from a theoretical perspective. Regardless of the theory used, the important point is that there are many facets to consider when contemplating the underlying needs of children in care, beyond concrete skill building and permanency, and planning for their future success and well-being.

Figure 2: Conceptual Model



Limitations of the Study

In terms of methodology, because this was a primarily qualitative exploratory study with embedded quantitative measures and using a non-random sample, caution must be taken when considering these findings in relation to the larger population of homeless young adults who were once part of the child welfare system. The sample size was limited and there may have been certain qualities about these young adults that drew them to the study that may not be true for those youth who did not participate. Further, using interviews for information gathering, so much data were collected from subjects' narratives that it was impossible to explore every nuance and capture all of the intricacies in their life stories. Adding to this, subjects' life stories were examined mainly from a content analysis approach, which pulls text out of context, and thus, runs the risk of misinterpretation as stand alone data. Moreover, the majority of the data were gathered via self-report. There is always the risk with this type of data collection that memories may not be complete or accurate or that subjects will not fully disclose information for various reasons. In addition, though the quantitative measure of current functioning (BASIS-32) has been found reasonably reliable and valid, it was never used with this particular population. Thus, the accuracy and applicability to this study, though deemed useful, could not be guaranteed.

When considering the use of a theoretical perspective to more closely explore the experiences of these subjects, there were limitations in this area as well. There are multiple theoretical perspectives from which to examine this population. Self psychology is just one of many theoretical lenses from which to consider these subjects and their experiences. There has been much work done on attachment and trauma in relation to children with abusive backgrounds or in substitute care. As such, elements of attachment

theory or aspects of the various trauma-based theories could serve as alternative means of assessing and making meaning of the experiences of this population.

Implications for Social Work Practice and Policy

Most of the information about the well-being of former wards comes from broad descriptive studies designed to present an overview of this population's current functioning and outcomes in the areas of education, employment, housing, legal involvement, and physical and mental health. This study went beyond obtaining information about the general status of former wards. Specifically, it focused on homeless former wards and examined the possible inter-relationship between their childhood histories, experiences in substitute care, relationships, and current patterns of affect regulation and behaviors using concepts from the theoretical perspective of self psychology. Information collected through this study may provide ways to better conceptualize the experiences of homeless young adults who were once a part of the child welfare system and work with youth in substitute care in order to best meet their needs—with the goal of enhancing relationships and improving affect stability—potentially increasing their chances of remaining domiciled post-care. Further, it could have an impact on policy, allotting for more focus on and spending and training in support of creating and maintaining healthy substitute care relationships as part of moving youth toward exiting care.

Conclusion and Implications for Future Research

Although much was discovered about the experiences of homeless young adults who were once involved with the child welfare system and the limited available

information about homeless youth and young adults post-substitute care was enriched, there is still much to learn. Focusing additional research on broadening the scope of and increasing the sample size of the current subject population interviewed may provide additional data or highlight nuances within the data that were not captured in the present study. Alternatively, examining the experiences of this population from other theoretical perspectives could offer additional interpretations for consideration in working with these young people. Additionally, studying the psychological structure and experiences of a group of young adults with more successful outcomes (e.g., financial stability, higher educations, steady employment and housing, etc.) could better illuminate any significant factors that separate more positive from less desired well-being outcomes. Similarly, it would be interesting to see if youth in substitute care who are deemed more emotionally stable perform better in the area of independent living or use concrete skills of daily living more effectively. Finally, as so many subjects became homeless after having been adopted, closer evaluation of adoptive family dynamics and the psychological needs of children in substitute care seems warranted.

A more thorough understanding of the effects of chronic maltreatment and repeated failed relationships on the development of the self may support those in the field of child welfare as they work with substitute caregivers and have implications for social work practice and policy. Armed with this type of knowledge, social workers might have a better chance of ensuring that substitute caregivers are fully aware of and committed to providing for the needs of the children in their charge and that the child welfare system supports this perspective in practice and in policy. Caregivers may come to understand that when children exhibit certain behaviors, their purpose is not to be disruptive but to regulate their overwhelming emotions in the only way in which they have learned.

Knowing these things could help caregivers in general, not just adoptive parents, and the child welfare system as a whole compensate for the early experiences of these children, support healthy relationships, and serve in the capacity of aiding emotional regulation.

APPENDIX A

CONSENT FORM

INSTITUTE FOR CLINICAL SOCIAL WORK
Individual Consent for Participation in Research

I, _____, acting for myself, agree to take part in the research entitled: "Affect and Behavior Regulation Among Homeless Young Adults Formerly Involved with the Child Welfare System." This work will be carried out by Denise Duval, LCSW, under the supervision of Dr. Neil Vincent, Ph.D., LCSW. This work is conducted under the auspices of the Institute for Clinical Social Work, 200 N. Michigan Ave., Suite 407, Chicago, IL 60601, (312) 726-8480.

Purpose
This is a research study that involves talking to young people who, right now, do not have a stable place to live and, in the past, spent some time in the child welfare system (like DCFS – The Department of Children and Family Services) in a foster home, a group home, or possibly living with a relative. The purpose of this study is to find out about each individual's history, in other words, what it was like growing up, what it was like being with DCFS, and what it is like now. The hope is that the information collected from this study can be used to help professionals, who work as part of the child welfare system, better understand these young people and the things that have happened in their lives. The goal is to use this information to find new ways to assist young people, while they are still a part of the child welfare system, and keep them from ending up homeless or without a steady place to stay once they are on their own.

Procedures Used in the Study and the Duration
If you agree to participate in this study, you will be asked to take part in a one-time interview that will not last longer than 90 minutes. The interview will be tape recorded so that the conversation can be written down later and the researcher can look for similar themes in what you said about your life and experiences and what other people said about their lives and experiences, in the past and at present. You will also be asked to answer a brief questionnaire about the things you have been doing, how your mood has been and how other parts of your life, like your relationships with other people, have been going in the past week. All of these questions relate in some way to finding out about your life now.

Benefits
There are no direct benefits to you except that you will be given a $10 gift card to the Jewel grocery store for agreeing to share information about yourself. However, the information gained from your sharing your experiences may help to improve other people's knowledge and understanding of the life experiences of young adults who were once part of the child welfare system and are now without stable housing. What is learned from this study may also affect how the professionals who work in the child welfare system think about the children they are responsible for and it will, hopefully, give them ideas about what these children might need now to give them a chance for a better future.

Costs
There is no cost for participation in this study.

Possible Risks/Side Effects
The potential risks to you for talking about yourself as part of this study are minimal. There is no possibility that you will be physically hurt in anyway and nothing you say will cause you trouble with the police or other authorities, unless you say that you are currently planning to hurt yourself or someone else. For your safety and the safety of others, this information would have to be reported to authorities. Otherwise, the only possible risk to you is that you may feel uncomfortable sharing your private information or talking about some of the things that happened

to you in the past or more recently. Because some of the things talked about might feel very personal, if you start to feel uneasy, you have the right to skip any questions that you do not want to answer. You can also choose to take a break during the interview if you feel uncomfortable and you can end the interview altogether at any time with no consequences. Even if you decide to end the interview, you will still get the gift card. If at some point you decide that you would like to talk more about the things in your life and any feelings that might have been brought up during the interview, the researcher can help you find someone that you can continue to talk with more regularly about these things.

Privacy/Confidentiality

The researcher will make every effort to protect your privacy and confidentiality. Your name will not be written down nor will any other specific information that might identify you. The audiotapes of the interview will be transcribed – written on paper as a word for word conversation – shortly after the interview. The audiotapes of the interview, the transcription/written interview, and the questionnaire will be labeled with a number only. These things will be kept in a locked filing cabinet in the researcher's private office. The audiotapes of the interview will be erased immediately after they are transcribed. The transcription/written interview and questionnaire will be kept for five years after the dissertation is approved then destroyed. No one else will have access to the information. Also, none of your information will be shared with anyone from the shelter or the program staff and it will not affect your relationship with them. Agreeing to participate or choosing not to participate in this study will in no way affect (either improve or limit) your access to any other services.

Subject Assurances

By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the Institute for Clinical Social Work (ICSW) will not be affected in any way, now or in the future, if I refuse to take part or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Denise Duval, LCSW, or Dr. Neil Vincent, Ph.D., LCSW, at (312) 726-8480. If I have any questions about my rights as a research subject, I may call Daniel Rosenfeld, M.A., Chair of the Institutional Review Board, ICSW, 200 N. Michigan Ave., Suite 407, Chicago, IL 60601, (312) 726-8480.

SIGNATURES

I HAVE READ THIS CONSENT FORM AND I AGREE TO TAKE PART IN THIS STUDY AS IT IS EXPLAINED IN THIS CONSENT FORM.

_____ _____

Signature of Participant Date

I CERTIFY THAT I HAVE EXPLAINED THE RESEARCH TO _____ (Name of subject) AND BELIEVE THAT THEY UNDERSTAND AND THAT THEY HAVE AGREED TO PARTICIPATE FREELY. I AGREE TO ANSWER ANY ADDITIONAL QUESTIONS WHEN THEY ARISE DURING THE RESEARCH OR AFTERWARDS.

_____ _____

Signature of Researcher Date

APPENDIX B

SEMI-STRUCTURED INTERVIEW PROTOCOL

Interview Protocol
Demographics

- Age:
- Gender:
- Race:
- Parental status:
- Total time in substitute care:
- Approximate number of placements while in care:
- Time since emancipation:
- Current living arrangement:
- Total time homeless/ marginally housed:
- Length of time of most recent homeless episode:

Experiences Prior to Involvement with the Child Welfare System

"Tell me what you remember about what life was like before you entered the child welfare system? What were the circumstances?"

Possible Exploratory Questions:

"Did any of your caregivers ever say anything that was so hurtful or scary that it made you feel bad about yourself and/or frightened for your safety?"

"Were you ever in a position where you thought you might be at risk of being hurt?"

"Did anyone ever hit you with a fist or an object, kick you, throw things or slap you really hard leaving bruises or causing injury? Were you ever verbally or physically threatened with weapons or injured?"

"Did any adult caregiver ever force you or ask you to do something sexual?"

"Did anyone ever make you go without food or water or abandon you for an extended period of time? Did you ever live in unsafe/unsanitary conditions with caregivers? Did your caregiver have problems with drugs, alcohol, or the law? Did your caregiver have mental health problems or where thought to not be able to/have the skills to parent you?"

"Did you have no one to take care of you (was your caregiver deceased, incarcerated, whereabouts unknown, etc.) or were you considered a delinquent?"

"Who took care of you when you were sick, scared or hurt, sad or had a nightmare? Who was there? What happened?"

"What happened when would get excited about something or did something well? What did your parents/caretakers do?"

"Were you ever encouraged to do something you were interested in? By whom?"

"Was there anyone with whom you felt safe, secure, and loved/admired? Who were you close to?"

"Did you ever feel unwanted, rejected, not valued, or ignored?"

"How would you react when you felt bad, sad, angry, scared, etc.?"

"Pick five words/phrases to describe your past relationship with your parents/caretakers? Why these?"

"Looking back and considering the circumstances at the time, would you say that your placement was necessary or not?"

Experience While in Substitute Care

"Think back on all of your time in care as a ward. Tell me what it was like for you – what you remember about how you felt and acted/behaved, your relationships, etc."

Possible Exploratory Questions:

"Did you ever have, or were you ever told you had, behavior problems or that you did risky things?" (e.g., aggression, impulsivity, runaway episodes, delinquency/detention, etc.)

"Do you remember ever feeling overwhelmingly sad, lonely, anxious, or angry for long periods of time or were you ever suicidal? Did you have eating or sleeping problems? Did you miss your family? How did you feel about yourself? Did anyone, such as a caseworker, foster parent, therapist, psychologist, teacher, etc., ever say that you had mood or emotional problems and/or did you see a counselor or therapist because of it?"

"Were you ever the victim or perpetrator of sexual abuse?"

"Were you ever a witness to domestic violence or any other type of violence? A victim? The perpetrator?"

"Did you ever use drugs or alcohol while in care? Like what? How often?"

"Describe your relationships with friends, family, peers at school, foster parents, etc. How did you get along with others? Is there anyone in particular you remember? Why?"

"Were you ever hospitalized and/or on medication for your behaviors or mood? If hospitalized, approximately how many times? What were the medications for?"

"Did you ever have a counselor or therapist? If so, do you remember why and what you did and talked about? What was that like? Did you have a say in the treatment?"

"Did anyone ever talk with you about how you were feeling, having been separated from your family? Did you ever have the chance to talk about what that was like?"

"Who took care of you when you were sick, scared or hurt, sad or had a nightmare? Who was there? What happened?"

"What happened when would get excited about something or did something well? What did your parents/caretakers do?"

"Were you ever encouraged to do something you were interested in? By whom?"

"Was there anyone with whom you felt safe, secure, and loved/admired? Who were you close to?"

"Pick five words/phrases to describe your past relationship with your parents/caretakers? Why these?"

"Did you ever feel unwanted, rejected, not valued, or ignored?"

"How would you react when you felt bad, sad, angry, scared, etc.?"

"Pick five words/phrases to describe your past relationship with your parents/caretakers? Why these?"

Current Level of Functioning

"Describe your life at present – how you generally feel, what you do, your relationships, what keeps you here, etc."

Possible Exploratory Questions:

"What are the best times for you?"

"What are the worst times for you?"

"What is it that makes you anxious/When do you get anxious? Angry? Overwhelmed? Sad? Happy?"

"Why do these things/situations make you anxious/sad/happy?"

"What do you do? How to do you react?"

"What happens before you do _____ (impulsive behavior)? How do you feel after?"

"Who do you know that handles things the best? The worst? What do they do?"

"Who are the most important people in your life? Why?"

"Now I would like to ask you some questions about how you are feeling and doing currently. Please respond as honestly as possible and let me know if you are not sure about something."

--Administer Basis-32 Self-Report--

Q4: Connection between Past Experiences in Substitute Care and Current Status

"Thinking back to why you first went into the child welfare system, your experiences while in care, and looking at your current living situation and circumstances, do you think there is a connection? Please explain."

APPENDIX C

BASIS-32 SCALE

Instructions to Staff: Please fill in the following information.	**Site Number:**
Patient ID Number:	**Admission/Intake Date:**
Time Point: **1**=Admission/Intake **3**=Discharge/Termination **2**=Mid-Treatment **4**=Post-Treatment Follow Up	**Level of Care:** **1**=Inpatient **3**=Partial/Day **2**=Outpatient **4**=Residential
Program Type: **1**=general adult **2**=child/adolescent **3**=geriatric **4**=affective/mood disorders **5**=psychotic disorders **6**=anxiety disorders/trauma **7**=substance abuse/chemical dependency **8**=dual diagnosis **9**=other	

BASIS-32 (Behavior And Symptom Identification Scale)

Instructions To Respondent: Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below, fill in the box with the answer that best describes how much difficulty you have been having in each area **DURING THE PAST WEEK.**

0 = No Difficulty
1 = A Little Difficulty
2 = Moderate Difficulty
3 = Quite A Bit of Difficulty
4 = Extreme Difficulty

Please answer each item. **Do not leave any blank.** If there is an area that you consider to be inapplicable, indicate that it is ***0=NoDifficulty.***

IN THE PAST WEEK, how much difficulty have you been having In the area of:

1. **Managing day-to-day life.** (For example, getting places on time, handling money, making everyday decisions) ……1☐
2. **Household responsibilities.** (For example, shopping, cooking, laundry, cleaning, other chores) ……..2☐
3. **Work.** (For example, completing tasks, performance level, finding/keeping a job)……..3☐
4. **School.** (For example, academic performance, completing assignments, attendance) ……4☐
5. **Leisure time or recreational activities**……...5☐
6. **Adjusting to major life stresses.** (For example, separation, divorce, moving, new job, new school, a death) …….6☐
7. **Relationships with family members** ……7☐
8. **Getting along with people outside of the family** ……..8☐
9. **Isolation or feelings of loneliness** ……9☐
10. **Being able to feel close to others** ……10☐
11. **Being realistic about yourself or others** ……..11☐
12. **Recognizing and expressing emotions appropriately** ……...12☐
13. **Developing independence, autonomy** ……...13☐
14. **Goals or direction in life** ……..14☐
15. **Lack of self-confidence, feeling bad about yourself** ……..15☐
16. **Apathy, lack of interest in things** ……16☐
17. **Depression, hopelessness** ……...17☐
18. **Suicidal feelings or behavior** ……...18☐
19. **Physical symptoms.** (For example, headaches, aches and pains, sleep disturbance, stomach aches, dizziness)……..19☐
20. **Fear, anxiety, or panic** ……..20☐

0 = No Difficulty
1= A Little Difficulty
2 = Moderate Difficulty
3 =Quite A Bit of Difficulty
4=Extreme Difficulty

IN THE PAST WEEK, how much difficulty have you* been *having in* the *area of:

21. Confusion, concentration, memory ……..21☐
22. Disturbing or unreal thoughts or beliefs ……..22☐
23. Hearing voices, seeing things ……..23☐
24. Manic, bizarre behavior ……....24☐
25. Mood swings, unstable mood ……....25☐
26. Uncontrollable, compulsive behavior (for example, eating disorder, hand-washing, hurting yourself) ……26☐
27. Sexual activity or preoccupation ……....27☐
28. Drinking alcoholic beverages ……....28☐
29. Taking illegal drugs, misusing drugs ……....29☐
30. Controlling tempter, outbursts of anger, violence …….....30☐
31. Impulsive, illegal, or reckless behavior ……31☐
32. Feeling satisfaction with your life …….....32☐

McLean BASIS-32 ITEM CLARIFICATIONS AND ELABORATIONS

1. **Managing day-to-day life:** deciding what to wear, what to eat, using public transportation, self-care including dressing, bathing, etc.

2. **Household responsibilities:** home management, child or elder care (if not done as paid employment), laundry, making bed, organizing clothing and personal possessions.

3. **Work:** paid employment; if unemployed, efforts to find or keep a job, preparing resumes, handling interviews, managing rehab services, career groups or job training programs. Not applicable to those not needing or wanting to work.

4. **School:** high school, vocational or technical training, college or graduate school. Recreational classes (e.g., piano lessons, self-improvement, should be included in #5 (leisure time, recreational activities).

5. **Leisure time:** difficulty structuring free time or finding things to do, boredom. Leisure time activities include hobbies, social clubs, reading, jogging, sports, fitness, etc. Also includes recreational classes; e.g., piano lessons, self-improvement, arts, etc.

6. **Adjusting to major life stresses:** medical illness, job loss, financial or housing difficulties, victim of abuse, violence, or other crime, etc. Does not include the current hospitalization. If person has experienced no major stresses, item is not applicable and should be rated "0." Adjustment to stressors should be considered during the past week. The stressors do not have to have occurred in the past week.

7. **Relationships with family members:** relatives or long-term significant others. If relationships vary with different family members, patients should give their best estimate of family relationships overall.

8. **Getting along with people outside the family:** roommates, friends, neighbors, supervisors, co-workers, teachers, boyfriend, girlfriend.

9. **Isolation, loneliness:** subjective feelings of isolation or loneliness may be independent of actual degree of contact with others.

10. **Being able to feel close to others:** feeling close (trusting, in harmony with, affectionate) to people you especially care about.

11. **Being realistic about yourself or others:** having realistic expectations; e.g., not too high or too low regarding your own behavior or that of others.

12. **Recognizing and expressing emotions appropriately:** showing appropriate affect; recognizing, acknowledging affects such as sadness, anger, affection, etc.

13. **Developing independence, autonomy:** feeling that you can take care of most things (financial, emotional, social) without being uncomfortably dependent on other people; feeling that you are in control of decisions about your life. Age, occupation and other factors may affect autonomy. This question asks about the degree to which lack of independence is problematic for the respondent.

14. **Goals or direction in life:** knowing what you want to be doing in your life; working towards a goal.

McLean BASIS-32®: ITEM CLARIFICATIONS AND ELABORATIONS

15. **Lack of self-confidence, feeling had about yourself:** feeling that you are not a good, likable or worthwhile person; feeling stupid or incapable of accomplishing anything.

16. **Apathy, lack of interest in things:** not caring about anything, not feeling like you want to do things that you usually enjoy.

17. **Depression, hopelessness:** feeling depressed, sad, hopeless about the future, lack of pleasure in life.

18. **Suicidal feelings or behavior:** thinking about, planning, gesturing or attempting suicide by any means.

19. **Physical symptoms:** difficulty should be rated regardless of etiology (e.g., medication side effects).

20. **Fear, anxiety, panic:** nervousness, tension, jitters, agitation, fear of open spaces, heights, darkness, etc.

21. **Confusion, concentration, memory:** difficulty understanding things, thinking clearly, remembering, maintaining focus on a task.

22. **Disturbing or unreal thoughts or beliefs:** paranoid ideation (feeling as if you are being watched, poisoned, or that others can read your mind); delusions, e.g., that your body is rotting, that you can fly, that a TV personality is speaking to you personally, etc.

23. **Hearing voices, seeing things:** auditory or visual hallucinations; hearing messages or commands from a voice in one's head; seeing things that no one else can see.

24. **Manic, bizarre behavior:** racing thoughts, decreased need for sleep, increased talking, spending money, exaggerated sense of well-being; inappropriate behavior including undressing in public, speaking incoherently to strangers; behavior which others would generally consider very unusual or inappropriate.

25. **Mood swings, unstable moods:** feeling happy one minute, sad the next; frequent emotional ups and downs, often unrelated to what is going on in your life at the time.

26. **Uncontrollable, compulsive behavior:** any behavior that one feels compelled to frequently repeat including eating disordered behavior, checking, washing, gambling).

27. **Sexual activity or preoccupation:** any sexual issue experienced as problematic (e.g., impotence, sexual addiction, fetishes, sexual identity confusion, etc.)

28. **Drinking alcoholic beverages:** including difficulty dealing with urges, efforts to find alcohol.

29. **Taking illegal drugs, misusing drugs:** any illegal substance of abuse (cocaine, heroin, crack, marijuana, etc.); misuse or overuse of prescription drugs (sedatives, stimulants, diet pills, anti-anxiety agents, etc.).

30. **Controlling temper, outbursts of anger, violence:** screaming, throwing things, kicking, hitting, etc.

31. **Impulsive, illegal, or reckless behavior:** includes dangerous or illegal behavior, e.g., reckless driving, vandalism, assault, fraud, selling drugs, forging checks, etc.

32. **Feeling satisfaction with your life:** happy with what you are doing, general sense of well-being.

BASIS-3 Rating Scale

0 - No Difficulty

1 - A Little

2 -Moderate

3 - Quite A Bit

4 - Extreme

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