In the System for Too Long:
Former Foster Youth and the Structural Ambivalence Towards Mental Health

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Dedication

This dissertation is dedicated to the memory of "Victoria" one of the participants in the study that passed away shortly after interviews were concluded.

Abstract

A growing research literature documents that young people who "age out" of foster care (after turning 18 or in some states 21) frequently encounter challenging obstacles during their transition into adulthood, and in particular are susceptible to poor mental health and substance abuse problems throughout their early twenties. Drawing from an 8-month longitudinal study of 26 young people transitioning out of care, the dissertation reports on the conflicted relationship that some former foster youth have with service providers, mental health programs and ideas of seeking help more generally, during their transition out of care. The dissertation argues that many former foster youth endorse conventional health beliefs about the efficacy of mental health treatments, but are nonetheless ambivalent about re-integrating themselves with what they perceive as an inconsistent and untrustworthy system of social services and public supports. This sense of what I describe as "structural ambivalence " reflects the inconsistent and contradictory forms of support that many foster youth received while wards of the state, and underpins many of their decisions as young adults to avoid and resist prolonged engagement with social services. Structural ambivalence has implications for meso-level theories of health seeking behavior, and in particular recent frameworks that emphasize the role that social networks and culture play in shaping the dynamic engagement that young consumers have with mental health treatments. This conceptual framework also highlights the contradictory logics of welfare and public health institutions more broadly in the US, and the troubling situation that former foster youth find themselves in while navigating these public systems during their uncertain transition to adulthood.

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Brendon's Story

     Having bounced in and out of fifteen foster care placements for nearly a decade of his life, Brendon was clearly eager to be finally leaving the foster care system. He started our conversation that summer day by describing his excitement of having found a two-bedroom apartment only a few blocks away from the park where we met. Though the finer details of the move were still unclear, Brendon was convinced that he and his roommate, whom het worked with at a supermarket, would be living in their very own place by that upcoming weekend. Hinting at the fact that foster care can feel overly regimented, Brendon pointed out that there would be no curfews at the apartment. Life on his own would mean not needing to ask for permission to go somewhere or stay out late. Apartment life would also mean independence, privacy and not needing to have the bedroom door open when a female visited, he said.

     I first interviewed Brendon a week before he was to move out of his last foster care placement, a foster home he had lived in for two years with an elderly woman he affectionately referred to as 'Aunt Lilly,' though they were not related. Because Brendon had described Aunt Lilly as the most important person in his life, I was hoping to get a chance to meet her during our interview. But Brendon had called a few hours before and changed the location of our meeting to the north side of town where he had been visiting his 'biological mom' for the weekend.

     It was fine, I said over the phone, though I was ambivalent about going to his mother's apartment to do an interview. From our previous conversations I knew Brendon had a strained relationship with his mother, and that the State had removed him out of her care for reasons I had presumed were related to child neglect or abuse. Perhaps sensing my discomfort with the changed location, Brendon clarified on the phone that we wouldn't be able to do the actual interview in his mother's one-bedroom apartment. There wasn't space in the home for us to talk—"cuz there's too many people livin' here"—he explained in a deep and raspy voice that I would continually find surprising for an eighteen year old. But we could meet in the park across the street from

the apartment complex, he continued. There were benches to sit at and the park would be safe at this time of the day, he felt inclined to point out.

With a bit of apprehension I had driven to the assuredly 'safe park' and waited a while for Brendon to appear out of the small, rundown apartment complex across the street that I hoped corresponded to the address that he had given me. There was no physical address on the street side of the building and the intercom system by the front door appeared clearly broken with a hair of wires emanating from its speakers. I had been comforted by the broken intercom; the fact that I would have to wait for Brendan to walk out of the building meant in part that I could avoid a chance encounter with his mother, from whom I preferred to keep some distance.

After fifteen minutes of waiting and watching a group of young men playing basketball at the other end of the park, I was relieved to finally see Brendon emerge out of the dark hallway that led from the entrance of the apartment. He wore a baggy pair of jeans matched by a white, sleeveless t-shirt that highlighted his impressive muscular build. As he walked down the front steps and into the bright sunlight, he held a serious frown in his face, squinting as he looked toward the sun and then the basketball game. If I hadn't met Brendon at a support group for older foster youth and known of his rather friendly nature, his demeanor would have been a bit intimidating. When he crossed the street and saw me he instantly broke into a reassuring wide smile.

We found picnic table far away from the basketball game and after reviewing the formalities of the research project, we began talking about Brendon's upcoming plans for life after foster care. He discussed moving into his first apartment, hopefully, in the next week and continuing his job at a nearby supermarket bagging groceries through the summer, or at least until he could find a "better job" near the community college where he was starting in the Fall. Despite this semblance of a plan, Brendon was still unsure of what he was actually doing or where he was headed in the months to come. He was enrolled in school in part because his case manager had told him he could get some "assistance from the state" if he took enough classes, but he was far from convinced that college was really right for him given his "academic deficiencies." Like many foster youth who move around from placement to placement, Brendon had missed a

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considerable amount of school over the years. And even though he had just graduated from high school he honestly assessed that his reading and writing were "really at the fifth grade level."

"I'm worried about taking a college course, you know at the college-level," he stated frankly. "I think that it's just going to be harder for me."

Nonetheless, Brendon's high school football coach had told him that he had the ability to play "college ball," which in part had been his motivation to enroll in the community college. Indeed, he discussed that if could get his "academics up," maybe he could eventually transfer to a school up north where the coach had some connections to the football program. Maybe he could play "college ball" and maybe doing so would help him get through school. And maybe this could lead to a good job and he hoped a better life.

Brendon, like many of the foster youth I interviewed, wasn't clear on the exact details of what was coming next, but like all of them he was excited about having movement in his life, in whatever direction, "out of the system."

"It's like I've been in the system for so long," he explained. "Doing what people say, when they say. And I'm just ready to be able to go out on my own," he said assuredly. "Make my own mistakes. Play my own game."

In some ways this sense of excitement about being out on "one's own" is perhaps not unlike what many young adults experience when they leave home for the first time around Brendon's age bound for college or working life. For many young adults, leaving home symbolizes one's growing independence, self-sufficiency and, importantly, the ability to make one's own life choices. And in today's modern context, it's not uncommon for a young person to be both excited and unclear about the future, particularly during one's late teens or early twenties. But Brendon's narrative of leaving foster care also touched upon the institutionalized dimensions of growing up under the care of the state. Although he had been living with Aunt Lily the last couple of years— a traditional, private foster home in the community—his exit from foster care nonetheless sounded like a long awaited release and freedom, especially from what he felt were the tight controls that dictated his day-to-day life. There were the rules and structure that he

always had to follow at different placements, but almost more constraining for Brendon had been this feeling of constantly being watched and under surveillance. There were the countless social workers, case managers, therapists, court judges, foster parents and many others that comprised a constellation of adults who were always prying into his life. It was clear that Brendon was tired of this attention and desperate to leave the system whether he felt he was prepared to be on his own or not.

"Maybe I'm not ready," Brendon said, acknowledging some self-doubt. "But I can't live in the system. I'm ready to get out, no matter what that means, you know? I can't live in the system no more."

Once "out" of the system, Brendon hoped to prove —to himself but also the social workers of his past—that he could make it. Likely reflecting the stigma he felt as someone from a "broken home," Brendon, like many of the foster youth I interviewed, saw his upcoming exit from care as an opportunity to make a break from his troubled past.

"I think it's all about your environment, it's all what you've grown up around" Brendon explained. "All my family is in gangs so I would have grown up around gang banging, guns and violence," he said a moment later, imagining a life in which his foster care placement never took place. "I would have been a thug."

Brendon avoided eye contact as he elaborated this point, looking above my head and giving the impression he was gazing at the basketball game at the other end of the park.

"You grow up around violence, more likely you'll be violent. And that's what I was like when I was young, violent, that's how I know," he said, noticeably raising his voice, almost as though he was getting angry." I probably would have been in jail probably plenty of times by now. I probably would have dropped out of high school. Hell, I probably would have had kids by now," he said a moment later.

These weren't just abstractions of how Brendon thought about his neighborhood, but rather the lived realities he saw of his older brothers and cousins who had stayed behind while he was in foster care. Many of the young men in his family had either been in prison or were currently incarcerated. All seemed connected in one way or the other

with "hustling" as a way of surviving, he described. Some younger than him already had children and seemed trapped in a familiar cycle of poverty and violence.

"I don't wanna be out here hustling every day just to trying to put food on the table," Brendon said sharply. "Or to keep money in my pocket, or trying to get the new Air Force ones." he continued, referring to the brand of basketball shoes desired by many in his neighborhood. "I wanna do everything the legal way."

But if Brendon was adamant about the life that he did not want to live, he was less clear on what a different and 'legal' life would look like. He vaguely described wanting to go to school and getting a good job one day, but he had little knowledge of what these careers might be, or the specific schooling they might require. His case manager had helped him register at a local community college,[1] but he couldn't remember which classes he had enrolled for the upcoming semester or describe the types of degrees or specialties his school offered. And even his ambitions to play college ball in "the school up north" sounded vague and elusive. Nonetheless, Brendon was adamant that he could be successful almost by the fact that he had a drive to make things work.

"I've got a lot of motivation, you know. I'm willing to do what I gotta do, you know. I'm not the brightest, but I'm not gonna be out here 'not making something' out of my life."

I asked Brendon what 'making it' looked like for him, pushing him to clarify his definition of being successful, but his answers remained vague if nonetheless sincere.

"I just know I don't want my kids to go through what I had to go through," Brendon said bluntly about children that he did not yet have. "I just want them to have it better than me."

If Brendon was far from clear about his future, he was at the same time well aware of some of the obstacles that lay ahead of him in the next couple of months. When I first met Brendon at a support group for foster youth, I asked him if he could help me understand some of the challenges that youth like him face leaving the system.

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[1] Before the summer Brendon's case manager from the county had taken him to a local community college and helped him enroll in two classes for the upcoming semester. Brendon was clearly proud to be one of only three people within his extended family to be pursuing post-secondary education—an aspiration made possible by a special fellowship offered by the state to former foster youth.

Immediately he brought up the issue of "family help" (or, more precisely, the general lack of it) that most former foster youth experience when they age out of care and are "out on their own."

"Like me, I got nobody watchin' my back, you know," he stated. "I want to be on my own, you know, but I don't really know anyone who's going to be there if I need it, for like help or something. You're on your own, so it's harder for some of us coming up out of the system and not really have the family to go back to."

His comments highlighted for me the distinct disadvantage foster youth face aging out of care, particularly in respect to the family support that most young adults normatively rely on today throughout their twenties. Indeed, while most young people experience a gradual transition into adulthood, benefiting from the intermittent financial and emotional support provided by their parents, for foster youth the same transitional experience is much more abrupt and often isolating. Even though Aunt Lily had been an important source of support for Brendon, and one of the few reliable adults he had interacted with in his life, he seemed aware that this relationship would change fundamentally after he moved out, and that he would be largely by himself.[2]

Sitting in the park that summer day, Brendon once again emphasized this point by discussing the difference between himself and his soon-to-be roommate, Jeff. Unlike Brendon, Jeff had the comforting reassurance that he could always move back in with his parents if plans with their new apartment fell through.

"Jeff doesn't get it, you know, he has parents he can go back to if this doesn't work, so he's not as serious about this as me. I ain't got nobody if this apartment doesn't work out. I'm more mature about it in a way because I gotta be. I have to do everything on my own, you know, because that's the way it is. But that's harder, too, because it's all on me, and if we lose the apartment for something stupid, it's gonna cost me more."

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[2] According to Brendon, if he needed to do laundry in the next few weeks and didn't have enough money to go to the laundromat, he figured he could probably visit Aunt Lily once or twice. But these interactions would become less frequent over time, he knew. Indeed, as we sat in the park that day discussing his plans for the upcoming move, Brendon revealed that "somebody new," another foster youth, was already slated to move into his bedroom the next week. "We got a good relationship even though she's kinda kicking me out too, you know. But I kinda wanna be out too, so I think that's okay."

As he considered the lack of support in his life, Brendan also mentioned that he was worried about dealing with the stress that would likely come with this isolated transition into adulthood. He was worried about the uncertainties of finding a job closer to school, improving his academics, dealing with the females in his life, and coming up with some sort of plan for the long term future.

"The biggest thing is that, is that I'm just not good with stress," he lamented. "There's going to be a lot of it when I'm on my own, I know. And to be honest, I've always had struggles handling stress."

Perhaps reflecting the fair amount of counseling that he had experienced in care, Brendon talked about some of the emotional struggles that he was anticipating for himself in the context of all these different stressors. Indeed, revealing an almost keen sense of emotional insight, or what some psychologist describe as emotional intelligences, he reflected on the various problems and "triggers" he would have to confront in the weeks ahead.

"I have problems managing my anger sometimes. I'd get angry as a kid all the time, you know, I was always angry. I have this anger inside of me sometimes. It started when I saw my dad killed when I was little," Brendon said, casually referring to the trauma of witnessing his father murdered.

"And it just comes out," Brendon continued a moment later. "If I didn't care about you [when I was younger], you know, if you didn't respect me, or if I didn't respect you, I would just—you know—hit you," he said clenching his fist.

Through years of counseling and some experiences with medication, which he had often resented at the time, Brendon learned to eventually rein in his anger as well as deal with some of the trauma from his past. Though he disagrees with how foster youth are sometimes "forced into therapy," and from his perspective "put on meds" indiscriminately, he nonetheless implied that these interventions had benefited his life in some ways.

"I wouldn't say that they've helped me all the way, but they did help me some," he explained. "I was locked up [in a residential treatment center] for a year for anger management, and we had these groups we had to do every morning, and sometimes they

were okay. I mean talking can help, I think, but if you're talking just for the sake of talking, that's nonsense."

Clearly resentful of the fact that his placement in a residential treatment center felt coercive if not punitive—in that he had been "locked up for anger management"—Brendon appeared uneasy attributing the positive changes in his life solely to the mental health interventions he had experienced.

"Some maybe helped but I think a lot of it had to do with my state of mind and my maturity level. I mean, my maturity has gone up. And so I think that's the biggest thing...I just need to remember to manage my triggers...you know, think before you act, you know when females start stressing you, or something comes up, I just can't lose it."

In listening to Brendon talk about his complicated relationship with therapy, social workers and even medication, it was difficult not to see some parallels with the broader ambivalence he seemed to feel toward the institution of foster care itself. Similar to how he felt conflicted about being forced into therapy, Brendon was clearly resentful of the abrupt way he had been taken out of his family's home. The foster care system had "robbed" him of "a normal childhood," he stated at one point. Nonetheless, it was also clear that Brendon felt that he had benefited in some substantial ways from the state's intrusion into his life. Like the indirect benefits of going to groups and being on medication, his life might have been perhaps even more difficult had he been left in his mother's care. Evidence of what his life could have looked like was all around him, he said. Now that Brendon was going to be on his own, he had no interest in continuing to seek help for his anger problems, nor did he want any prolonged contact with the system. Nonetheless, he readily acknowledged that these interventions had had a positive influence on his life.

It was in this context of Brendon's continuing ambivalence and impending social isolation that I could make some sense of his decision that weekend to visit his mother's apartment on the eve of his emancipation. Sitting a few yards away from the very apartment that he had been removed from ten years before, Brendon explained that he wanted to reconnect with his family now that he was leaving state care, even though he knew these would be complicated relationships to navigate.

"I know that if things don't work out I can always come back here with my mom," Brendon stated, almost contradicting his previous statements that nobody's 'got his back.' "That's what's happened with all of us, my sister and brothers, they all went back home. I don't really want that to happen because I have some bad memories here, but I know can come back here."

Brendon told me that he wasn't expecting anything from his mother and that he was taking things slow with her. Yet it was telling that the apartment Brendon had chosen was much closer to her neighborhood than to his work or the school he was planning to attend in the neighboring town. Even if the feelings of mistrust still pervaded Brendon's relationship with his mother, he was nonetheless excited about being back in contact with his older brothers and cousins.

As our first interview drew to a close, I wondered whether Brendon's desire to pursue these relationships would be problematic and contradictory with the very same ambitions for success that he had described for himself. It seemed clear that Brendon was hoping to reconnect with a family and community that he longed for. But these reunions also meant he was coming back to the exact environment and community that he claimed he wanted to escape. Clearly Brendon was hoping to strike a delicate balance between reconciling a sense of connection with home and also being successful in overcoming the lived realities he saw around himself. But unclear to me was how one could actually negotiate this while being back in the old neighborhood.

"I wouldn't say I'm coming back to it," he responded when I pushed him on this point. "Cause even though it's around me, I'm over it. It's not a life for me. It's not the life I want to live."

"But aren't you still coming back to this neighborhood, this same life that you say you want to avoid?" I asked.

"Yeah, I'm coming back to it, but…" he paused for a moment. "But I'm coming back to it with a more mature state of mind."

Which makes all the difference, he seemed to imply.

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Introduction

Each year nearly twenty thousand youth in the United States leave the foster care system, like Brendon, by virtue of their coming of age as independent adults (Children's Bureau 2010; Courtney & Heuring 2005). At age 18, or 21 in some states, these individuals literally "age out" of their protected status as minors in the child welfare system, and as a consequence abruptly exit their tenure as recipients of public-subsidized care. As Brendon's story demonstrates, former foster youth confront some of the same challenges that many coming-of-age adults experience. During a relatively short phase of life that sociologists associate with the transition to adulthood, most young people navigate new adult roles, experiment with new freedoms and struggle to define and purse long-term life plans (Hartmann & Swartz 2006; Shannon 2000; Setterson, Furstenbert & Rumbaut 2005). Brendon's story also highlights, however, the precarious social context in which many former foster youth navigate this already stressful and often critical phase of adulthood. With little in the way of resources and social connections, most former foster youth confront the challenges of housing, education, employment and long-term planning with few sources of support and guidance. A number of these young adults also struggle with significant emotional and mental health problems that can often times complicate their transition to adulthood (Osgood, Foster, Flanagan & Ruth 2009). For many foster youth like Brendon, aging out of care is indeed a long awaited and exciting freedom from the system, but simultaneously it is also an abrupt exit from state support and an entrance into a precarious and often isolated adulthood.

Sadly, a growing body of literature on former foster youth confirms a grim outlook for many of these young adults. Longitudinal studies that track cohorts of youth

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who have aged out of care document a high frequency of homelessness, incarceration, withdrawal from school, early parenthood and under-employment among this young adult population (Barth 1990; Cook 1991; Courtney et al. 1998; Courtney et al 2010; Needell et al. 2002). Many of these negative outcomes often occur within the first two years of youth leaving care and invariably not only disrupt their smooth transition to adulthood but also have enduring impacts on their life-long trajectories (Courtney et al. 2010; Jones 2011; Shin 2005). Over their lifetime former foster youth are more likely to remain in poverty, experience a psychiatric hospitalization and report diminished mental and physical well being, compared to the general population (Courtney 2009b; Jayakody, Danziger & Kessler 1998; Osgood, Foster, Flanagan & Ruth 2009). It is telling that a recent survey of emergency shelters in Minnesota estimated that nearly 40% of the adult homeless population in the state are individuals who were at one time in the foster care system, many of whom aged out of care (Wilder 2009). As one prominent child welfare scholar recently described, few groups in society are more deserving of the label "high-risk" as foster youth preparing to age out of the system (Courtney 2009b).

It should be stressed, however, that most youth in foster care entered the system under already challenging social circumstances, which underpin the overall social disadvantages they later face as adults. Broadly speaking, foster care refers to an out-of home placement[3] for children whose parents were unable to provide safe and sufficient care. While youth can be placed in foster care for a variety of life circumstances (such as a parent becoming ill, incarcerated, or otherwise incapacitated), the vast majority of

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[3] As will be discussed in chapter two, out-of-home placements include non-relative foster homes, relative foster homes (also known as "kinship care"), group homes, institutions, and pre-adoptive homes.

foster youth enter the system due to a 'substantiated' concern by the state of severe

parental abuse or neglect in the family home (US Dept of Human Services 2007). Given

this dynamic, most foster youth were removed from troubled and dysfunctional family

settings characterized by high levels of domestic violence, chemical dependency and

mental illness that all contribute to the risks of child endangerment[4] (Danielson & Lee

2009; Leslie et a. 2004; Stahmer et al. 2005). It should be emphasized, however, that

while child abuse and neglect stem in part from poor parental choices, as well as at times

the mental illness of a parent, social and economic factors also contribute substantially to

the phenomenon of child maltreatment more broadly.[5] A growing body of literature has

shown that chronic stressors associated with under-employment, poverty, neighborhood

violence and lack of care resources all dramatically exacerbate parents engaging in poor

childcare practices, the use of coercive disciplinary methods and the "learned

helplessness" associated with child neglect (Barth and Blythe 1983; Belsky, Schlomer &

Elis 2012). As indicated by a recent congressional report on the prevalence of child

abuse and use of foster care in the US, a growing number of youth are disproportionately

removed from single female-headed households with earnings below $16,500 a year that

are located within poor urban neighborhoods (National Incidence Study 2010).

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[4] Studies based on the National Survey of Child and Adolescent Well-being (NSCAW) find that 70% of
children enter foster care with a history of child abuse and/or neglect, and 40% have exposure to domestic
violence (Stahmer et al. 2005). Studies also document that biological parents of foster youth have high
rates of mental illness, substance abuse, and cognitive impairment, all of which raise the risk of emotional
health problems in their children (Leslie et a. 2004).

[5] While not always described as a causal factor to child maltreatment, there is widespread agreement that
stress, and in particular chronic stress related to economic deprivation, strongly contributes to incidents of
child maltreatment (Barth and Blythe 1983).

Because of the salient relationship between child poverty and child maltreatment, foster care has been described as a last resort, residual,[6] intervention for families already failed by the state and its social policies (Lindsey 2003: 16). Indeed, most families entangled with the child welfare system represent some of the most marginalized and "socially abandoned"[7] sectors of society, often facing a multitude of economic, social and health challenges in their lives (Danielson & Lee 2009; Roberts 2007). Some scholars have also suggested that "structural racism" contributes to the intervention disproportionately impacting families of color (Robert 2002; 2007), given that youth of color in care often double their representation in the population in most states (Wulczyn & Lery 2007). Undoubtedly, the high concentration of child welfare cases within poor urban communities (US Dept of Human Services 2007) stems in large part from structural inequalities that are highly racialized in the US, such as the high level of under-employment, economic deprivation and anomic isolation existing in many *urban underclass* neighborhoods (Wilson 1984).[8] Indeed, within the broader context of

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[6] A *residual system* refers to Titmus' (1958) taxonomy of different policies/logics that can orient welfare state services. Residual welfare, as often exemplified in the US, pertains to policies that target groups/individuals not already absorbed by existing informal institutions—the "residual" of traditional sources of supports. This restrictive welfare logic is based on an assumption that individuals in society can, and should, access their own resources of support during periods of crisis, whether through family, the market or some other informal institution. Residual interventions are in stark contrast to more encompassing forms of state welfare that cover large swaths of the population (what Titmus called *institutional* welfare).

[7] Ethnographers have recently implicated the concepts of "social abandonment" (Biehel 2009) and "structural violence" (Farmer 2009) to describe the economic conditions, and social policy gaps, that contribute to increased incidents of neglect, violence, and preventable health conditions prevalent within marginalized sectors of society.

[8] It is telling that according to national estimates African American youth raised in single-headed households within a poor urban neighborhood are 64 times more likely to experience some form of maltreatment, and possibly be removed from their homes, as compared to white adolescents living in two-headed households (NIS 2010). While child maltreatment occurs across all groups and social strata, the high racial disparity within the foster care system speaks to the ongoing racialization and feminization of poverty that has grown in many urban communities during the last thirty years. Particularly as single-

growing inequality in the US, the dearth of well-paying jobs in now de-industrialized

urban areas, and the mass incarceration of poor minority groups, it is not surprising that

the number of youth coming into the attention of child welfare services, and specifically

child protection services, has steadily increased during the last four decades (NIS 2010).

Nor is it surprising that a majority of the parents entangled with the child welfare system

are poor, minority, and female (US Dept of Human Services 2011).

   To have been in the system for so long as to literally age out, however, is a rather

unique and relatively rare *foster care experience* unto itself. Because the modern child

welfare system is guided by a "family preservation" mandate to rehabilitate the home

environment when possible and to eventually re-unify parents with their children,[9] the

majority of youth in out-of-home placements experience foster care as only a temporary

intervention. As illustrated by Figure 1, below, which depicts the exit trajectories of one

large cohort of youth removed from their homes in 2000, approximately 65% to 70% of

foster youth return to either their parents' or their extended families' care (such as an

older sibling). After the state has deemed a household rehabilitated enough to ensure a

child's safety and well being, the majority of foster youth return back to their families in

one fashion or another within two years of their initial removal from home. If family re-

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headed families have become more prevalent in these urban communities, the risk of an out-of-home
placement has increased dramatically (Lindsey 2003). Roberts (2002) cites that during the 1990s one in ten
African American youth in Harlem, New York City were in the foster care system (Katz 2000). During
this time in Chicago it was estimated that 70% of foster youth were African American even though as racial
group they represented less than 30% of the youth in city (US Dept of Human Services 2007).
[9] As will be discussed in chapter two, since the 1980s several child welfare reforms and laws have
mandated that case managers actively engage with parents to improve the conditions of their homes, so that
their children can be safely returned to their care. To this end, family courts often require parents to
complete counseling, parenting classes, anger management and drug addiction treatment in order to regain
custody of their children.

unification efforts fail after two years, parental rights are often terminated by a family

court and the foster youth becomes an official ward of the court.

Figure 1 Monthly Status of Californian Youth who entered Foster Care in 2000,(n=11,802)
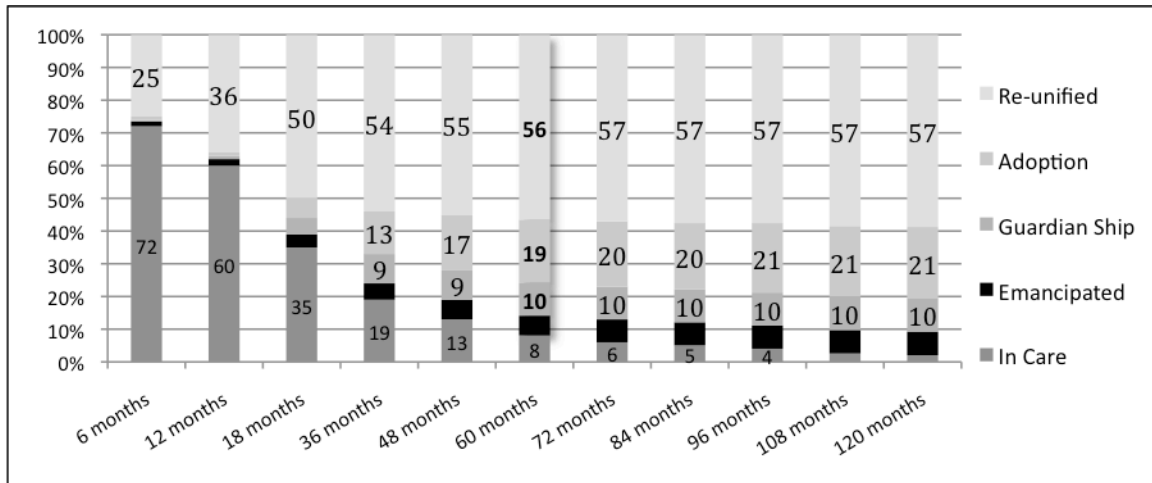
Source: Data tabulated from the California Child Welfare Indicators Project
(http://cssr.berkeley.edu/ucb_childwelfare/)

Following this procedure, the court will often place the foster youth on public adoption,

which accounts for approximately 20% of youth who leave the system before turning 18.

These trends suggest that youth who "age out" of care not only represent a small

minority of the overall foster care population but often (as an indirect result of this) come

from the most problematic family settings that the system confronts. Resembling what

some sociologists might characterize as the "selection effects" of long term foster care,

the same family dynamics that perpetuate youth remaining in foster care for an extended

period of time—such as severe levels of family dysfunction and violence—contribute to

the general lack of connections and resources that many of these youth experience when

they age out of care.[10] As Brendon's story demonstrates, his mother's neglect had been too severe for reunification to be an option, and extended relatives such as aunts, uncles, or grandparents either were not present or were unwilling or unable to provide alternative kinship care. Moreover, foster youth who were passed over in public adoptions are more likely to be disconnected from their siblings, exhibit emotional and behavioral problems, and have cognitive deficits that all can hamper their ability to navigate independence successfully (Courtney 2009b).

Despite these daunting challenges, most young people aging out of care are excited about leaving foster care. Many have literally grown up in the "system," and have had prolonged experiences with not only child welfare but also other public institutions (such as family court, juvenile corrections and the children's mental health system). Some like Brendon were removed from their parents at a young age and have resided within the child welfare system through a single, long stint in care for a decade or longer. For others, their time in foster care was more sporadic and intermittent, entering and exiting the system several times during periods of family crises. Because foster care can be a rather unstable experience itself, with youth often moving back and forth between foster homes and group homes, it is not surprising that long term foster youth are eager to finally exit the uncertainty associated with their time in the system. Even with the clear challenges ahead of them, many youth, as was the case of Brendon, express optimism about being finally free from the system and having a chance "to play [their] own game."

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[10] Some researchers also emphasize that the racialized aspects of the child welfare system engender a salient disparity in adoption rates—wherein poor children of color are more susceptible to remain and eventually age out of care than white youth (Roberts 2007).

Purpose of the dissertation

The goal of this dissertation is not to re-substantiate the obvious claims that young people aging out of foster care are a vulnerable population, or that they are deserving of extended resources and services after care. Such claims are easily supported by numerous research findings of the past 60 years that highlight the above-mentioned outcomes and vulnerabilities. Rather, the purpose of this qualitative study is to explore the more subjective experience of aging out of the foster care system with a specific focus on the troubled relationship that many former foster youth have with state-sponsored social services and mental health programs. Despite recent reforms to expand new services and programs for this group of young adults, a growing number of studies find that many foster youth are reluctant to access mental health providers in the community, seek general support, or continue with treatments after they age out of care (Courtney, Dworsky & Cusick 2005; Delman & Jones 2012; Mares 2012; McMillian & Raghavan 2009; Moses 2011; Munson et al. 2012; Webster & Harrison 2008). Given these trends, this dissertation investigates the process by which some former foster youth come to understand their "needs," and in turn the sources of support available to them, in the context of their transition out of care. Particularly because "untreated mental health problems" have been speculated to be the underlying problem of most poor transitional outcomes in this population (Osgood et al 2009), the dissertation hopes to illuminate the institutional factors that perpetuate a salient reluctance among some youth to seek assistance from state-sponsored care. Though broader in scope than a study solely on mental health services, the dissertation investigates the nuanced ways that some former foster youth make sense of the services they received while in care, often related to

mental health, and how these experiences have anchored their attitudes moving forward

as adults in the community.

Unpacking the Problems of "Mental Health"

A large literature in child welfare documents high rates of emotional disturbances,

behavioral problems and mental illness among long term foster youth (Clausen et al.

1998; Garland et al. 1995; Havlicek, Garcia & Smith 2013; Landsverk, Hough, & Ellis-

MacLeod 1996; Shin 2005; Pecoria, Kessler, Williams, O'Brien 2005). One study

recently suggested that youth in foster care have a higher prevalence of Post-Traumatic

Stress Disorder (PTSD) than veterans returning from active combat (Pecoria et al. 2005).

Due to this presumed level of need, foster youth are typically exposed to high levels of

mental health treatment during their time in care (Halfon, Mendonca, & Berkowitz 1995;

Havlicek, Garcia & Smith 2013; Leslie et al. 2005; Zito et al. 2008). Described by some

as the "gateway to mental health services," entrance and prolonged experience in foster

care is associated with a tripling of odds that a youth receives mental health treatment

(Leslie et al. 2005). Some studies estimate that between 60% to 90% of long term foster

youth have been provided treatment by the time they age out of care (McMillan et al.

2003; Shin 2005, Pecoria et al. 2005), with their rates of use for such services typically

much higher than comparable populations (dosReis, et al. 2005; Halfon, Mendonca, &

Berkowitz 1995; Harman, Childs, and Kelleher 2000; Takayama, Bergman & Connell

1994).[11] As one example of this, Halfon and colleagues (1992) estimated that while

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[11] Compared to similar populations that also use Medicaid-paid services (public insurance for the poor that nearly all foster youth qualify for when entering care), foster youth access mental health services at rates 10 to 15 times higher than their peers (dosReis, Zito, Safer, Gardner, Puccia, Owens 2005; Halfon, Mendonca, & Berkowitz 1995; Harman, Childs, and Kelleher 2000; Takayama, Bergman & Connell 1994).

foster youth comprise only 4% of Medicaid enrollees in California, they account for nearly 40% of all Medicaid expenditures related to mental health services. More recent investigations have similarly found that foster youth are prescribed psychotropic medications at dramatically higher rates than the general population (dosReis et al. 2005; Zito et al. 2008).

These dramatic utilization patterns are in stark contrast to the precipitous decline in the use of mental health services exhibited by my most youth aging out of care, almost immediately after they transition into the community (Courtney, Dworsky & Cusick 2005; McMillian & Raghavan 2009). Several longitudinal studies have documented that when these presumably high-need youth age out of the system and transition into the community, most immediately withdraw from mental health services altogether. In one startling example, McMillian and Raghavan (2009) reported a 90% decline in service use among one cohort of foster youth exiting care over the course of two years. A variety of institutional factors perpetuate this dynamic (such as foster youths' diminished access to public insurance after they age out of care and the dearth of public mental health programs they confront in the community), but studies also suggest that many foster youth are themselves resistant to ideas of seeking care for reasons that are not always clear (Delman & Jones 2012; Moses 2008, 2011; Munson et al. 2012; Webster & Harrison 2008). Despite several reforms in the last twenty years to extend new state entitlements and support services to this population during their transitional years, many youth exiting state care still exhibit a salient reluctance to access community resources and professional services once they are on their own (Courtney et. al 2010; Shin 2005).

Some qualitative research in this area has suggested that this reluctance stems in part from a resistance among foster youth to self-label themselves with a mental health diagnosis (Moses 2009), their antagonistic attitudes towards medication (Moses 2011; Muson 2010), a fear of stigma (Moses 2009), and inconsistent health-seeking beliefs about mental health (Munson 2010). However, little work has explored how such youth make sense of their explicit "needs" and the resources available to them in the context of their ambivalent relationship with the system and their transition out of it. Though researchers have called attention to the role that "contextual factors" play in shaping health-seeking attitudes and decisions (Munson 2010), the varied meanings that foster youth associate with "context," and what context actually means to former foster youth, have been largely underdeveloped in the literature.

Given this, the dissertation provides a case study of 30 former foster youth aging out of care and the complicated challenges they face navigating the few social supports available to them as vulnerable adults. Drawing primarily form longitudinal interviews that were conducted before and after youth transitioned out of care, the case study explores how former foster youth made sense of their changing needs, life circumstances and access to mental health resources during the first critical months of their transition. The case study also draws from ethnographic observations and expert interviews from two transitional programs serving former foster youth in the community, and in doing so hopes to contribute to a more contextualized understanding of why some foster youth develop an antagonism toward mental health as well as broader supports offered by the state during their transition out of care.

Toward these ends, the dissertation will ask the following sets of questions:

1) Upon exiting the system, to what extent do former foster youth consider "mental health" and "poor mental functioning" significant issues in their lives?[12] Do they self-identify as individuals in need or who could benefit from mental health or social service interventions? Do these perceived needs change or remain static during the course of their transition?

2) How do former foster youth perceive the term "mental health" more generally? What does this term mean to former foster youth? More specifically, what does it mean to be associated with a mental health diagnosis for a former foster youth, and what does "receiving help" signify in terms of their sense of identity as young adults who were former wards of the state?

3) How do former foster youth reflect upon their time as past recipients of public care, and how do these attitudes inform their relationships with service providers today in the community? Do factors associated with race and gender affect how some youth perceive their time in and relationship with the system?

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[12] According to conventional health-seeking models of patient behavior, that informs much of this area of foster care research, accessing care is predicated on a person first exhibiting mental health "symptoms" but also recognizing the significance of these symptoms as signs of a broader mental health problem (Kasper 2009). From a largely rational-choice perspective many foster youth are unmotivated to seek care in part because they lack the "mental health literacy," or adequate *explanatory model* (Kleinman, Eisenberg & Good 1978) for understanding the medical significance of their mental health needs and/or the options available to them for effective treatment. As is explored in chapter five, this first question directly assesses this presumption by directly exploring the interpretative frameworks that former foster youth use to describe their past and present experiences with mental health issues and problems, particular as they confront the often difficult and stressful of transitioning out of care.

A primary goal of this dissertation, then, is to shed light on the complex (and I argue highly troubled) relationship that many former foster youth have with the system of services available to them, and how these attitudes reveal some of the broader tension and ambivalence that this population experiences as former recipients of state care. In addition, this dissertation contributes to a range of discussions related to the struggles of former foster youth and more broadly the modern difficulties of navigating a young adulthood marked by a dearth of resources, unclear choices and anomic-like conditions of isolation.

Definition of terms
This dissertation intentionally uses a broad understanding of the terms *mental health* and *mental health services*. While some medical sociologists have argued against conceptualizing overly-generic constructs like "mental health" in sociological research (Timmermans & Haas 2008), in part because they may presumably "obscure the ontological reality of specific conditions and their symptoms" (Timmermans & Haas 2008: 663) during the course of the study I discovered that foster youth had varied and often times expansive understandings of clinical terms that were not always consistent with their technical nosological definitions used in psychiatry. Terms like Clinical Depression, ADHD, Bipolar and PTSD could be ubiquitous terms used by some participants but often inconsistently, even during the same interview. The diagnosis ADHD, for instance, could mean different things to different foster youth at different times, as indicated by the range of emotions and behaviors that youth associated with the

term (from hyperactivity, to sadness and anger). Similarly, several male youth in the

study described having anger problems, or problems managing anger, that initially

appeared informal and disconnected from the topic of mental health. However, upon

further probing [13] I discovered that several of these youth had been diagnosed and treated

for Intermittent Explosive Disorder—a controversial conduct disorder gaining popularity

among institutionalized youth of color. Though most remembered hearing the term

applied to them, these individuals generally exhibited a lack of familiarity with the

specificity of the diagnosis and preferred instead to self-identify with anger managements

problems more broadly.

For these reasons, this dissertation uses the term *mental health* loosely to reflect

the expansive ways that participants used diagnostic terms themselves, and also how they

more broadly talked about their emotional well-being and experiences with therapists.

Though a few were unclear about what I meant by mental health, most recognized it as a

term associated with therapists, social workers and often medication. Indeed, nearly all

understood the word to signify emotional and behavioral problems that cause some

functional impairment in their lives and in which some people seek help with a counselor

or therapist. As I elaborate on the sampling methods used in the study, discussed in

Chapter Three, not all participants in the case study were formally diagnosed with a

mental disorder or illness, but all were familiar with mental health services during their

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[13] As will be discussed in chapter five, participants were inconsistent in how they talked about their mental health status—at times contradicting themselves on whether they had ever received a mental health service while in care. In follow-up interviews or in follow-up questions, I would at times attempt to clarify whether participants had ever been diagnosed by specifically listing common diagnoses associated with this population (ADHD, Clinical Depression, Bipolar, Oppositional Defiant Disorder and Intermittent Explosive Disorder). During these times, several respondents who preferred describing themselves as having anger problems identified several of these diagnoses as having been applied to them at some point while they were in care.

time in care. As such, I argue that the term *mental health* has a unique social connotation among former foster youth that deserves further attention by researchers, despite its lacking clinical specificity. Because mental health services can be provided by a range of professionals in the US (counselors, therapists, social workers, behavioral therapists, clinical psychologists and psychiatrists) and can encompass a growing list of life conditions, it is perhaps not surprising that foster youth had expansive understandings of clinical terms. Indeed, as I discovered youth often used the topic of mental health to discuss a variety of different issues related to the stress in their lives, their sources of support, medication, their anxieties as young adults and their feelings about the system.

It should be noted that the project did not start with such a broad and expansive definition of mental health. During the prospectus stage of the dissertation I was more narrowly interested in how youth former foster care specifically reflected upon the particular labels/diagnoses applied to them during their time in care. The social phenomenon of labeling seemed like a pertinent topic to explore in a qualitative study given the ongoing concerns in the literature about foster youth being unnecessarily medicalized (Epstein 1996; Finn & Checkoway 1998; Kutchins & Kirk 1998; Pfohl 1977; Specht & Courtney 1995).[14] As I began shifting through the large collection of data I had

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[14] My interests in labeling and mental health also stemmed from my own professional experiences as a case manager in the child welfare for several years. From my institutionalized perspective, I tended to view, and still do, the diagnostic terms and labels that we used to describe the personal problems of foster youth as essentially valid.   Many of the youth I worked with had experienced traumatic events in their lives, and likely as result, occasionally exhibited problematic and disruptive behaviors that were associated with various diagnoses (Bipolar, ADHD, PTSD etc). But bracketing the issue of whether these problems were real or contrived, it was undoubtedly clear that the language of mental health—the categories of problematic behavior—was primarily our way as professionals for framing these issues and not of foster youth themselves.   After years working within this context, I developed a strong interest, and a basic curiosity, into whether the language of mental health held any substantial value for the youth themselves, particularly when they left these environments.

gathered, however, the project began to expand beyond the scope of specific diagnoses,

and even mental health itself. Indeed, the analysis stage of the project revealed that while

many youth were rather open, and candid about their emotional disturbances in the

interviews, and in turn willing to discuss their views regarding the merits of mental health

interventions, it had been nonetheless difficult to keep the conversations focused on

topics related to accessing care. While for me, as the researcher, I had been interested in

exploring mental health as a distinct social concept—to limit the discussion to easily

reducible and researchable topics of labels and stigma —it was clear that most

participants understood these issues in much more expansive ways.

In short, most respondent could not compartmentalize their complex feelings

about mental health to a set of specific topics, and particularly could not talk about

mental health without discussing their experiences with the "system" of foster care

itself.[15] Moreover, many youth could not discuss the ideas related to their emotional

health outside of the context of their current difficulties; how many struggled in their new

socially isolated state as young adults During this difficult stage of data analysis, I

decided to modify the original parameters of the study. I let the project de-center itself

from the topic of mental health, so that I could interrogate more broadly the *ambivalent*

space that many respondents conveyed about their status as former foster youth, and what

this *perpetual inbetween-ness* might say about modern conditions of vulnerable and

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[15] Like Brendon, some foster youth saw little value in, nor knew much, about formal psychiatric categories, but could nonetheless talk about mental health as "a part of foster care" that had both positively and negatively affected his life. Others were better versed in the lexicon of diagnoses and their corresponding medications, but similarly seemed more comfortable using the topic of mental health to talk broadly about their life circumstances rather than discussing their attitudes about seeing a therapist.

isolated adults accessing care.   In this way the dissertation moved away from being about

mental health directly (as an analysis of how participants make solely sense of diagnostic

terms and the stigma of their emotional disturbances) to being a project that uses mental

health as an example of the conflicted tensions that former foster youth face. In short it

became clear that foster youths' ambivalence with the state, and their precarious

relationships with various institutions, were constitutive to their very understanding of

mental health, and in turn their reluctance to use such state-sponsored services.

Structure of the dissertation
Because foster care is not an issue often studied by sociologists, the dissertation begins

with an institutional overview of the child welfare system in terms of its organizational

structure and functional relationship with the broader American welfare apparatus. While

not an exhaustive description of foster care, chapter two also introduces the reader to the

key social and cultural factors that I argue have shaped American efforts to rescue and

save vulnerable children during the last two centuries. Summarizing essentially the

social history of foster care in the US the chapter discusses the different moral panics

(Cohen 1987) surrounding children, poverty and the medicalization of child abuse, that

have driven the evolution of American child welfare interventions.   Overall the chapter

describes the relevant cultural, social and institutional forces that I argue strongly shape

the care, but also the structural ambivalence, that many foster youth experience while

wards of the state today.

Subsequent chapters of the dissertation focus on the empirical aspects of the

project itself, starting first with chapter three that summarizes a critical literature review

of recent research on former foster youth and their complicated relationship with mental health services. This literature review summarizes three distinct bodies of research that have highlighted: a) the unique vulnerability of foster youth to both have mental health problems but also be overly-medicalized; b) the dramatic decline in the use of mental health services typically exhibited by most former foster youth during their transition out of care and into adulthood; and c) the documented barriers s foster youth experience accessing care in the community, including their own negative attitudes toward mental health and mental health services more broadly. Chapter three concludes by introducing the conceptual framework I developed from the literature review for organizing my analysis and the specific set of empirical questions that guided my case study.

Chapter four is the formal summary of methods and analytical strategies I pursued in my case study of former foster youth transitioning out of care. Towards this end the methods chapter first highlights the rationale, and appropriateness, of a multi-method, qualitative approach for interrogating the subjective experiences and worldviews of former foster. Next, I review the sampling, methodological decisions and overall research design that organized the case study. In this section I also detail the holistic and iterative-driven orientation I took to analyzing and coding the large quantity of data I had collected during the course of the project. Chapter four lastly overviews some of the unavoidable limitations that come with this type of interpretive analysis, as well as the ethical complications that I encountered conducting research on a vulnerable population.

The remainder of the dissertation is organized around the central empirical findings that emerged during my interviews in respects to mental health and the

ambivalent attitudes that most participants had about re-engaging with services. Chapter five specifically summarizes the complicated relationship that many foster youth in my sample reported with mental health services, and in particular their troubled histories with labels, medication and unresponsive counselors in foster care. Interestingly, while many respondents spoke strongly about their resentment towards to what they perceive as the coerciveness of mental health services provided in foster care, most nonetheless acknowledged the value that some of these interventions have had on their lives. The chapter reveals an irony that while some foster youth could see themselves as potentially benefiting from more counseling and sometimes medication, particularly as they struggled with the challenges of being on their own, many were actively reluctant to use such services because that might re-entangle them back into the "system." Resembling what I describe as a type of "modified self-labeling"[16] most former foster youth I interviewed could self-identify with having emotional problems, but often with an explicit qualification that they were reluctant to endorse labels that in their minds could justify their re-institutionalization.

This finding speaks to the central argument of the dissertation, that rather than being primarily an issue of stigma, or lacking familiarity with mental heath services, the reluctance to seek health services among former foster youth—or more broadly, to accept help from the state—stems from their conflicted institutional experiences as recipients of public care. This fear is less about the risks of being literally psychiatrically committed or hospitalized, though it was in some cases, as it was about conflicted status as foster

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[16] As elaborated in chapter five, my concept of modified self labeling takes inspiration both Peggy Thotis self-labeling theory (1985) and Link and Phelan's modified labeling theory (1999)

youth. To elaborate this point chapter six focuses on the subjective experiences that participants associated "the system"—a cynical phrase used ubiquitously by nearly all respondents to describe foster care and social welfare programs more broadly. Speaking to what I describe as the *structural ambivalence* of being recipients of public care, most youth characterized their experience in "the system" as one marked by tensions, contradictions and unpredictability. These sources of conflict specifically referred to the way many youth experienced their entrance into the child welfare system (the coercive nature of being removed from their families), the stigma they felt imposed on them as youth rescued from broken homes, and the contradictory interactions many experienced with caring adults that would intermittently enter and leave their lives (the ironies of professionalized care work). While sometimes unavoidable, these institutional sources of conflict perpetuated an uneasy sense of *structural ambivalence* that many youth associated with the system and that nearly all were eager to avoid and never come into contact with again.

The concluding seventh chapter of the dissertation summarizes these points by arguing that the structural ambivalence inherent of the foster care system illustrates some of the continuing challenges of providing care, and in particular mental health care, to socially vulnerable adults. In many ways, the youth in the study illustrate the new modern depths of isolation that some young adults can face when they have little social and economic resources to cultivate a sense of grounding and cohesion. Whether any mental health intervention can really address the gulf of needs that such youth have for support and social connection is explored.

In terms of policy recommendations the chapter will suggest that new initiatives and reforms within the mental health field, particularly those related to principles of "recovery" and "harm-reduction," hold much potential to alleviate some of the contradictory sentiments that many former foster youth hold toward the system. Because these new approaches emphasize more generalized notions of "well-being" over the "disease classification" systems of traditional treatment, there is a potential that re-orientated interventions will cultivate a greater sense of agency and control among mental health consumers, even those from vulnerable backgrounds. My analysis suggests that the more that mental health providers can disassociated themselves from the labels and diagnoses associated with the system, the more that former foster youth will gravitate towards these resources in the community.

On a broader, though more pessimistic note, however, the concluding chapter will also suggest that the ambivalence of the foster care experience also speaks to some contradictory ideas about independence and young adulthood in the modern era. Indeed, participants in the study highlight the contradictory tensions of needing structure, but also wanting to break free from it, as one transitions into a less defined adulthood. Resonant with what Bachmann (1997) calls liquid modernity, foster youth confront a modern culture of young adulthood in which the prospects for the future are simultaneously exciting but ever-less clear to define and plan in terms of career paths, employment opportunities and life choices. While some see the de-structuring of young adulthood as the emergence of a more flexible and self-reflexive adulthood (see Arnett 2000) others warn that young people from marginalized background are now more vulnerable to

prolong periods of "anomic frustration" in this context[17]. For foster youth this anomic

condition is less a potential risk of adulthood but often their starting point for it. Mental

health problems as well as chemical dependency are likely to become even more

ubiquitous in the near future in the absence of new institutions that could provide some

structure and connection to such adults.

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[17] Indeed privileged young adults may excel in this new "sink or swim" context of modern adulthood, but those already lacking resources and social connections are more likely to struggle with their unclear ambitions and plans, if not become even more disconnected.

Chapter 2: A Social History of Foster Care

Introduction

This chapter provides a brief introduction to the institution of foster care and the broader child welfare system encompassing it. The first part of the chapter outlines the conventional organization of most foster care systems as found in most state in the US, and the institutional relationships that exist between child welfare programs and the broader American welfare system.

The second section overviews the social history of foster care itself, identifying some of the key social and cultural tensions that have shaped governmental efforts to "save" abused and neglected children. While not an exhaustive overview, the chapter touches upon the "system in crisis" discourse that has somewhat defined child welfare's dialectic evolution; a dynamic of prevailing tensions between efforts to "protect children" and "save families" that continue to shape policies of the child welfare system. As calls to improve the systemic failures of child welfare policies continually arise, the system has over time incorporated different institutional solutions to address the entrenched, and evolving, needs of children and poor families.

The chapter concludes by reviewing the "current crisis" of foster care as related to the problematic aging foster youth and their transition out of the system. As future chapters explore, the social and cultural underpinnings of this current crisis—and its connection to previous crises—provide a broader context for understanding the problematic relationship that many foster youth report having with the system itself.

A System in Perpetual Crisis

One of the most ubiquitous ways to describe foster care is that the system is in

crisis. From policy reports describing the financial strains of the system (Chamberlain,

Moreland & Reid 1992), to media accounts of youth dying under state care (Ingrassia &

McCormick 1994; Roche 2000), to autobiographical descriptions of youth who grew up

"going in and out" of foster care (Cameron 2002; Toth 1997), the assertion that the child

welfare system is "broken," "failing kids" or "a disaster" is often heard from a variety of

voices. While such concerns are serious and deserve attention, from a historical

perspective it is also clear that the foster care system has always been in a perpetual state

of crisis, and likely will always be. This is due, in part, because as a *residual* aspect of

the American welfare system,[18] child welfare has long been be a minimalist intervention

targeting poor and marginalized groups of children (Lindsey 1994; Titmus 1958). As a

consequence child welfare is often underfunded and over burdened particularly given its

elusive, if not impossible, mandate to ensure the safety and well being of all children in

the US. In this way the crisis of foster care is perhaps endemic to a system in which the

political ambivalence towards serving a marginalized group, will always have to be

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[18]As previously discussed, a *residual system* refers to Titmus' (1958) taxonomy of different policies/logics that can orient welfare state services. Residual welfare, as often exemplified in the US, pertains to policies that target groups/individuals not already absorbed by existing informal institutions—the "residual" of traditional sources of support (Titmus 1958; Katz 1988; Esping-Anderson 1990). This restrictive welfare logic is based on an assumption that individuals in society can, and should, access their own resources of support during a period of crisis, whether through family, the market or some other community institution. Underpinning this orientation is an implicit belief that over-intervention by the state will undermine and erode informal community institutions. Means-tested income supplemental program in the US, for instance, consistently provided families incomes significantly below the levels attainable through full employment in the lowest wage work (see Soss, Fording & Schram 2011). In general, residual systems favor limited and targeted intervention and are in stark contrast to more encompassing forms of state welfare that cover large swaths of the population (what Titmus called *institutional* welfare).

challenged by occasional calls of "crisis" to reform its inadequate funding and revamp its neglected infrastructure.

From another perspective, the crisis of the child welfare system also stems from the constructed and dialectic meaning of child abuse itself in the United States. Modern child welfare interventions, such as placing an abused child in a foster home sought to resemble a normal family setting, are predicated on evolving conceptions of what constitutes a proper childhood and in turn a severe deviation from it requiring state intervention. Indeed, the institution of foster care is constantly being *reformed* and during its relatively short history has re-invented itself several times through periods of moral crises and public outcry about the proper treatment of children. As cultural understandings of children, poverty and maltreatment have shifted, so have the calls to intervene into the lives of poor families and save abused and neglected youth.

In this chapter I describe how foster care, but more broadly the American child welfare system, has evolved through different historical stages; as a system that initially addressed the needs of parentless youth (orphans), to later become a set of institutions that confronted the rise of industrial-era street youth, and more recently has morphed into a set of governmental programs and policies to confront the disturbing social problem of abused and neglected children. Throughout these stages the system has had to confront a series of economic but also cultural "crises"—or what some may call moral panics (Cohen 1972)—regarding children that in turn have motivated broad institutional changes to how social welfare is practiced in the US. Consequently I argue that child welfare plays an integral part in the American welfare apparatus, but as a specific poverty

program it still embodies a continuing set of tensions about its goals and intentions—particularly around saving children or saving families. In many ways the current system of child welfare, with its contradictory mix of policies and programs, is the result of continuing controversies about poor families but also broader anxieties about changes in modern society.

While this dissertation addresses only the narrow issue of youth exiting the foster care system, the broader tensions of how the system evolved provide an important institutional and cultural context to understanding the structural ambivalence that many foster youth experience as wards of the state. In short, to understand how youth like Brendon, introduced in chapter one, can feel conflicted about their experiences in foster care, requires an appreciation of the broader historical and social forces that have shaped the intervention itself.

Section 1: A Systems Overview

Before reviewing the conflicted history of foster care in the US, it is useful to first consider the institutional organization of the child welfare system as it exists today. While its official mandate is to protect children from harm and promote their well being (Adoption and Safe Families Act of 1997; ASFA 1997) the US child welfare system has always been interconnected to issues of child poverty and America's broader social safety net apparatus (CDF 2010; Pelton & Milner 1994). As will be discussed later, in the early 20th century the emerging welfare system in the US was essentially a collection of programs and private charities concerned primarily with the "welfare of dependent and destitute children" (Katz 1988; 35). As these programs gradually became more

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formalized and assumed as state responsibilities, particularly after the passage of the

Social Security Act of 1935 (SSA 1935), child welfare gradually evolved into a variety of

different public assistance and social service initiatives. Consequently, the child welfare

system has always been primarily a child *poverty* program, albeit one that has been

mostly concerned with the *consequences* of child poverty than its *root causes.*

Like the broader American welfare apparatus, child welfare is highly

decentralized, consisting of a constellation of private programs and government services

that include *child protective services*, *family preservation-unification programs*, *family*

and *juvenile courts*, a variety of *foster care placements* and *adoption services* (see below

Table 1 for more detail). Similar to most poverty efforts in the US, child welfare is also

dependent on a "diverse blend" of private-public collaborations between private

stakeholders in the community (private families, non-profit agencies and, more recently,

for-profit corporations) and varying governmental entities (agencies and policies enacted

by municipalities, county, state and federal governments).   This "blend" of private and

public agencies can be quite diverse as states and regional government in the US have

wide latitude in structuring their own child welfare efforts—contributing to the often

noted "localism" of American welfare systems (Katz 1988). Consequently, the "reality"

of child welfare varies considerably throughout the United States and even within states

and counties themselves. Indeed, traveling across California and Minnesota where the

fieldwork of this dissertation was conducted, I was struck by the stark differences in the

structure and organization of child welfare programs that I encountered even though most

shared similar program names and functions.[19]

Despite the diversity of child welfare programs across the country, the federal

government has nonetheless played a substantial role influencing, or at least harmonizing,

the institutional aspects of these interventions. During welfare expansion in the 1930s,

and later again in the 1970s, passage of federal laws and mandates provided a basic

structure, and importantly matching funds, to evolve child welfare systems across the

country along similar paths. Consequently, while it is somewhat problematic to describe

a typical foster care experience in the US it is nonetheless instructive to review the basic

structure by which most child welfare systems are organized.

A minor's first point of contact with most child welfare systems is through a 24-

hour report hotline that each city or county is mandated to maintain for investigating

allegations of child endangerment, often called Child Protective Services (CPS). While

on occasion children make contact with CPS themselves, the majority of the 3.3 million

reports that CPS offices receive on average each year come from "mandated reporters"

such as healthcare providers, educators, police officers and social workers that are

required by law to report suspicions of child maltreatment (CDC 2010). Most CPS

offices investigate only a small minority of the reported allegations they receive, finding

evidence of "substantiated" maltreatment in 1 out of 5 cases on average (Danielson &

Lee 2009). Though regions differ in how they investigate and categorize child

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[19] Even within the same state some group homes seemed analogous to a "locked down" juvenile corrections facility, whereas in other areas they resembled a mental health program. Still in other areas, group homes seemed little more than an emergency shelter for youth.

maltreatment—ranging from parental absence and neglect to physical and sexual abuse—
most substantiated cases are related to some form of parental neglect.[20]

When CPS determines that some form of child maltreatment has occurred in the
home in question, most investigations will next rely on a standardized assessment to
determine the risk of such abuse/neglect continuing and the potential of harm that these
incidents may have on the children present (DePanfilis & Salus 2003). These
assessments often focus on the presence of particular risk factors in the home —such as
reports of substance abuse and domestic violence—known to be highly associated with
child endangerment (Belsky 1984). Severe CPS cases in which youth are deemed to be
in "imminent danger" will almost always result in their immediate removal from the
home. In most situations, however, a substantiated report will lead to little more than
continued monitoring by CPS for a probationary period of time—often described by
social workers as "family having an open CPS case." However, family/youth courts will
often mandate that families involved with CPS also work with a social service agency to
ameliorate the home environment and address the particular "family problems" that lead
to the initial investigation. Often encapsulated under the term of "family maintenance,"
or "family preservation," these mandated services can include some form of required in-
home counseling, substance abuse treatment, parenting education or other interventions

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[20] The distinction between child neglect and abuse hinges on whether child maltreatment is rooted in the
inaction of a parent or their deliberate *action* (Keeping Children and Families Safe Act of 2003). Neglect
often refers to a "failure to act" in a responsible parental manner, or the abandonment of childcare
altogether. In contrast, child abuse refers to a pattern of behavior or action that impedes on a child's well
being. It is often in reference to extreme forms of punishment by a parent (physical and/or emotional) or
sexual misconduct. Today each state defines their own standards for child abuse and neglect, based on a
minimum standard set by the Child Abuse Prevention and Treatment Act (CAPTA) of 1974.
Approximately, two-thirds of all substantiated cases of child maltreatment are associated with neglect
(Children's Bureau 2010).

designed to mitigate the need for an out-of-home placement.   By federal law, the state

must offer families these preventative services—to rehabilitate the home environment in

an attempt to "keep the family preserved"—unless in extreme situations (Adoption

Assistance and Child Welfare Act 1980; AACWA 1980).

Table 1:Components of the Child Welfare System in the US

Components	Programs and Services	Goals/Activities	Composition
Child Protective Services	Reporting Hotlines

County CPS workers | Document allegations of abuse, neglect and child endangerment

Investigate of allegation

Coordinate Services | County or State Office

(i.e Departments of Children Services) |
| *Family Preservation and Maintenance Programs* | In-home Counseling for family and youth

Out-patient/In-patient Chemical Dependence Treatment

Reintegration support for youth transitioning back home | Rehabilitative/Therapeutic

Support family efforts to improve home environment to maintain youth at home

Referral for additional public supports (food stamps, housing etc.)

Support transition back from foster care | Mostly private and non-profit agencies contracted out by a county or state administration |
| *Juvenile or Family Courts* | Dependency Hearings | Mandate specific "steps" for family unification

Termination of Parental Rights | County or State Court System |
| *Foster Care Placements* | Family Foster Care Kinship Care Foster Care Agencies Group Homes Residential Facilities | Provide safe housing, food, clothing and care for youth | Mostly private and non-profit

May include private or public mental health, behavioral or corrections placements |

If the initial assessment of maltreatment is deemed severe enough, or later if parents are viewed as unwilling to comply with and/or make little progress with family preservation efforts, CPS can seek a "dependency petition" by either a juvenile or family court to forcibly remove the child from the home. At what is essentially a custody hearing between the state and the parents, the court adjudicates whether a youth will officially enter foster care.[21] It is important to note that at even at this stage at which a youth becomes designated as "a ward of the court," the out-of-home placement is still seen as a temporary status by the state. Indeed, family courts often assume that parents will successfully pursue efforts with the prescribed social services to rehabilitate their home environments, resulting in an eventual "unification" of the family. As is discussed below, the majority of youth in the foster care system in fact return home within a year of their removal.

When children are removed from their homes by the state, federal laws require that they be placed in the most family-like and "least restrictive" setting possible. Ideally this means placing a youth in a state accredited family home in the community preferably in a neighborhood near where the youth had previously resided. Recent reforms in several states have also encouraged child welfare workers to give priority in placing youth with relatives in semi-formal arrangement resembling foster care (known as kinship foster

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[21] In rare occasions in which the risks to a child's well being is severe the police, or CPS worker, will immediately remove a child from their home, though an eventual court proceeding will have to be administered at some point. At these hearings the court will often dictate the specific terms under which parent must meet to regain custody of their children (such as completing substance abuse treatment and/or achieving sobriety for a period of time).

care) or with foster parents who share some cultural/ethnic similarity with the child.[22]

Depending on the "needs" of specific children, however, foster youth can be placed in

more structured environments, ranging from therapeutic foster agencies (FFAs),[23] to

congregate-style group homes and even to rehabilitative residential facilities. As

described in Table 2, foster placements can vary considerably in terms of their level of

care (less or more therapeutic), structure (less or more supervision/regimentation) and

setting (from familial to highly institutional).[24]

All foster placements are licensed, or accredited by either the county or state, and

receive a monthly stipend for the boarding of each foster youth under its care. While

rates vary by state, and by the type of placement, on average foster homes receive

between $500-$700 per child, with more institutionalized settings receiving substantially

more (CWIGA 2009). To pay for most foster placements states receive matching funds

from the federal government under Title-IVB of the Social Security Act (SSA 1935), an

amendment to the original New Deal Era legislation that established the American

welfare state.[25]

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[22] While federal laws have contradicted themselves in the issue of race and ethnicity, (see Multiethnic Placement Act of 1994) child welfare workers often attempt to place youth in homes of the same race and cultural background.

[23] Occasionally foster homes are organized or contracted out through a foster family agency (FFAs) that may provide foster parents additional support such as access to behavioral, mental health and case management services. Sometimes termed "therapeutic foster homes," these placements are primarily intended for youth who exhibit behavioral and emotional problems, and would otherwise be placed in a more regimented residential facility.

[24] Typically the need of a youth dictates their type of placement, with more severe cases resulting in more restrictive settings. However, a county's resources and it availability of foster homes do play a role in the types of placements that a youth will experience as well.

[25] Currently, federal reimbursement for foster care is limited to youth whose biological parents would have qualified for the now defunct Aide to Families with Dependent Children (AFDC) program. Consequently, youth whose biological parents would have not qualified for AFDC "welfare" during its last year of

Regardless of the type of placement a foster youth experiences, the state goal of all child welfare cases is for the foster youth to achieve some form of permanency by either returning to their rehabilitated parents or alternatively, being adopting permanently into a new home. Since the passage of 1980 Adoption Assistance and Child Welfare Act (AACW 1980) child welfare workers are mandated to ironically pursue both goals of family reunification and eventual adoption simultaneously (known as "concurrent planning"). This means that social workers are required to actively work with parents to improve their home environments, while at the same prepare youth for the alternative reality that will be adopted into a new family. Indeed, more recent reforms of ASFA 1997 established a 24-month "time clock" for parents to complete their rehabilitative activities and unify with their children, after which time states are required by federal law to follow through with their plans to terminate parental rights and place the child in the public adoption market. Functioning as a type of coercive incentive to speed up rehabilitative efforts on the part of parent (Roberts 2002), the 24-month time frame and concurrent planning were enacted out of a concern that some foster youth linger in the system for too many years waiting for their parents.

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operation in 1996 (their current incomes put them above the unadjusted welfare standards of 1996) are not subsidized by the federal government as foster youth. Non-AFDC foster youth are typically supported solely by the state or county and at significantly lower amounts (in California for instance, non-AFDC foster youth are reimbursed at an average of $285 a month) (Child Welfare Information Gateway 2011). Nonetheless, while Title IVB has become more limited to only a number of foster youth, it's funding has nonetheless expanded in scope during the post-welfare era as new services beyond foster placements have been included as Title-IVB programs.

Table 2: Types of Child Welfare Placements

Type of Placements	Description	Youth Characteristics
Foster Family Home *Kinship Foster Care*	Family residence in the community that is licensed to house between 1-6 foster youth at a time (depending on size of home). Relatives' home can also become a foster home pending accreditation	Children typically with little or no special needs or disabilities
Foster Family Agency *Therapeutic Foster Home*	Non-profit agencies licensed to recruit, train and support a network of family foster homes in the community. Agency will typically coordinate care and provide case management for mental health and behavioral needs (i.e. access to a psychiatrist).	Children typically with some modest levels of emotional and behavioral needs who would otherwise placed in a more residential form of group home. However, less severe children are sometimes placed in FFAs or therapeutic homes due to a low number of "regular" foster homes.
Group Home	Congregate style living arrangement for between 6-100 youth. Most group homes tend to be more structured and/or treatment focused.	Children who exhibit more serious emotional and behavioral issues. Youth may have "graduated" to a more structured placement after struggling with less institutional settings.
Residential Treatment Facility	Secure residential placement with focus on treatment and behavioral modification. Typically staff by professional care workers on a 24 - hour basis. Use of physical and chemical restraints are common in some regions.	Children with severe mental health and behavioral needs. Cost of placement is typically offset with use of public health insurance because of treatment being provided (access to therapists, psychiatrists and behavioral analysts).

Despite the somewhat "strong arm" approach underpinning these recent reforms (Roberts 2002), the resulting policies have likely contributed to the substantial reductions in foster care populations observed in many states during the last decade. Both because states are now adopting children out of the system quicker, but also are reunifying families on a

more consistent basis, the number of youth in long term care has decreased

approximately by 15%-20% the last 15 years —with some states like Illinois and

California decreasing their foster care populations effectively by half (Child Welfare

Information Gateway 2011). Indeed, approximately half of all youth removed from their

homes today will return to their parents within 24 months. Of the remaining youth who

remain in care approximately 10%-15% will be adopted out by the state to private

families in the public adoption market (Child Welfare Information Gateway 2011).

According to the Adoption and Foster Care Analysis and Reporting System (2011),

approximately 250,000 to 300,000 young people enter the child welfare system every

fiscal year, contributing to the approximately 800,000 children experiencing some form

of foster care placement during that time. The total foster care population at any one

point in time, however, is around 450,000 to 500,000, because approximately 200,000 to

250,000 foster youth return home during any 12-month time period. In short, the foster

care population is constantly fluctuating, and while many youth will enter and exit the

system several times, it is intentionally designed to be a temporary, transitory, and more

recently quick, status for young people to enter and exit.

Table 3: US Foster Care Entry Rates by Year

	2007	2008	2009	2010	2011
Total Youth in foster care on Sept 30th (end of fiscal year)	488,285	463,799	421,350	406,412	400,540
Youth entered foster care during fiscal year	293,276	280,384	255,161	255,402	252,320
Youth exited foster care during the fiscal year	294,989	288,762	278,157	257,481	245,260
Youth waiting to be adopted	133,682	125,741	114,450	109,456	104,236

Source: Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2011 data

To illustrate these trends, below I present trajectory outcomes on one cohort of Californian foster youth who were initially removed from their homes in 2000, and subsequently reported on every six months thereafter in terms of their placement status (tabulated data provided by the *California Child Welfare Project*). Stratifying exit trajectories by months, across 10 years, Figure 1 highlights how most foster youth (approximately 85%), "exit" the system in some fashion within 5 years of their entrance, either by reunifying with their parents (56%), experiencing an adoption (19%), or achieving guardianship with a relative or older sibling (10%).

Figure 2 Exit Trajectories of Californian Youth who entered Foster Care in 2000
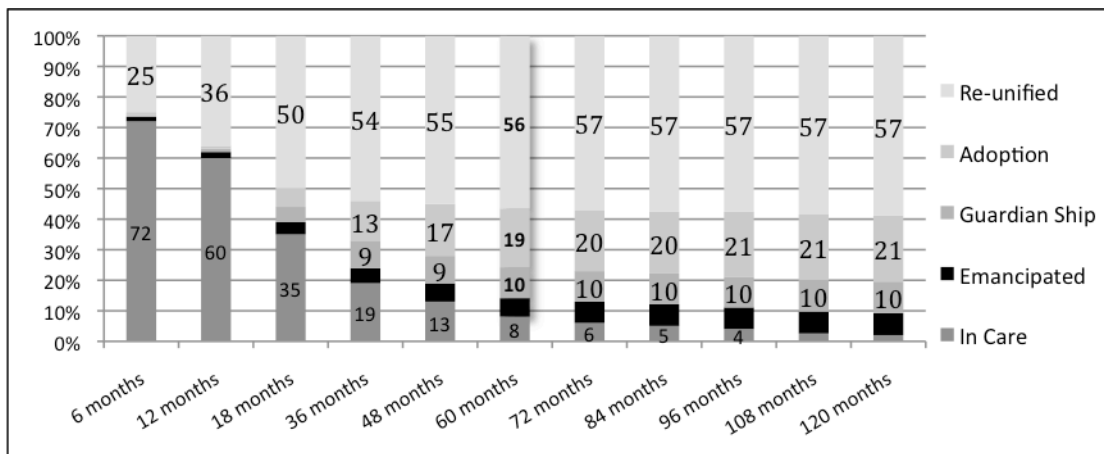
Source: California Child Welfare Project 2012 (http://cssr.berkeley.edu/ucb_childwelfare/)

As the above figure shows, a quarter of the youth in this cohort returned home within six months of their initial removal from their families, with the number of family reunifications doubling during the subsequent 18 months. Even though some youth likely exited but returned to the system, most of the change in placement status occurred

during the first 36 months of being in care. This data also demonstrates how the majority

of public adoptions were formalized between the 36th and 60th month of a youth being in

care.   In contrast the remaining 8% of youth who remain in the child welfare system for

five or more years (comprising what are designated long term foster youth) were more

likely to exit the system by being emancipated at the age of 18.

While long term foster youth are still eligible for adoption or guardianship it is

typically an unlikely possibility as the above data reveals, particularly given their

relatively older age. Long term foster youth, as discussed in the last chapter, are more

likely to have been older when they first entered the system, but they are also more likely

to exhibit behavioral problems and/or have had multiple entries and re-entries into the

foster care system (returned to their parents and then removed again) (Courtney 2009b).[26]

Indeed most of these individuals will only "age out" of the system when turning 18, or 21

in some states, when their legal status as adults disqualifies them for most supports and

services associated with child welfare. As is discussed in more detail in chapter 3, these

transitional youth have gained substantial attention in the literature given the often dire

social outcomes that many experience after they leave state care.

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It is important to note that while this child welfare system as described above is

almost synonymous today with child abuse and neglect, the system itself somewhat

predates modern society's concern with child maltreatment. Indeed, child abuse became

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[26] As discussed in the previous chapter, there is a type of pervasive "selection effect" underpinning recent efforts to reduce the number of foster youth, wherein youth with the most problems are the least likely to get adopted and leave the system.

largely culturally acceptable to address only after it was "discovered" by medical

scientists in the late 1950s. The state's power to remove children from their families for

their own safety is a relatively recent development. At the same time, it could be argued

that aspects of the child welfare system date back to the era orphanages if not earlier.

Human societies, and American society in particular, has always had to confront the

challenges of destitute children in form or the other. Though social reformers, social

workers and, social advocates have likely always confronted some dimension of child

'maltreatment' in their work, it is also true that the prevailing logic of "child welfare"

has shifted several times in history. As discussed below, children have often been targets

of prevailing hysterias about the consequences of social change, and as the US has gone

through periods of urbanization, rapid industrialization and contentious demographic

change, so too have justifications for a child welfare system.

Section 2: The Birth of the Orphanage[27]
In his well known social history of childhood, Philippe Ariès' (1962) argues that the

"preciousness" that many today associate with children, and childhood more broadly is

largely a Western if not *bourgeois* discursive phenomenon. Accordingly, throughout

much of human history childhood was rarely considered "a distinct life stage," between

infancy and adulthood, or at least one that deserved special attention let alone

governmental protection. While the young have often been viewed as having limited

capacities and of need of some parental care, Ariès argues that the labor-intensive nature

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[27] This section title takes inspiration from Foucault's (1977) <u>Birth of the Clinic</u>, as the early institutionalization of child welfare shares some similarity with the rise of modern therapeutic approaches toward mental illness.

of most pre-modern, agrarian societies perpetuated the notion that the young were essentially "small adults" after the age of five (Ariès 1962).

While some historians have critiqued Ariès's "constructed childhood" thesis as overgeneralizing social trends (see Hendrick 1992), his cultural perspective is nonetheless useful to consider in the context of America's evolving child welfare system. Indeed, ideas of child "neglect" and "abuse" have largely been non-existent throughout much of US history (Pfohl 1977). What would today be considered as harsh and cruel punishment of children, particularly by parents, was not only accepted but likely normative in many families less than a hundred year ago. As Viviana Zelizer (1985) has similarly pointed out, it wasn't until the late 19th century that laws and social institutions existed to protect, and essentially embrace, the vulnerabilities of children (such as child labor laws, educational reforms and child rearing campaigns). In short, there was little demand, or even awareness, for social institutions to protect or rescue children from maltreatment before the 20th century.

Nonetheless, a child welfare tradition, albeit in a different form, has long existed since the country's founding. Because young people under the age of 15 were often viewed as *dependents* of their adult parents, particularly for survival, most colonial communities provided some social effort to assist parentless youth who had lost family to one of the many deadly ailments during age of pre-modern medicine. Consistent with the same communitarian tradition by which townships and parishes collected local funds to administer poor relief to its "deserving members," (Katz 1988) *orphans* were often viewed as dependents of the broader community itself, and their caring a communal

responsibility. Local authorities often drew upon a European statute known as *parens patriae*,[28] to act as the "communal parent" for parentless children, organizing and partly subsidizing their care in the home of an adult relative, neighbor or nearby family farm. Orphans were also commonly apprenticed out to workshops, or *binded out* to either "work in the fields" or provide service work for a local family.[29] Because most communal efforts during this time centered around religious practices and institutions, churches were often the first child welfare agencies in the US organizing and providing housing for most orphaned children (Katz 1988).

But while such communal arrangements defined child welfare endeavors for much of America's early history, such efforts would become strained, and seen as inadequate, as the country experienced rapid urbanization during the 19th century. Various historians have cited that as Americans migrated into urban areas and often entered into low-wage industrial work, a significant portion of families struggled to stay intact, particularly during the destructive economic cycles of early-industrial capitalism (Empey 1972; Katz, Doucet & Stern 1982; Platt 1977). Gradually this contributed to a new urban phenomenon of *voluntarily orphaned*—or simply *abandoned youth*— living on the streets of most American cities by the middle of the 19th century (Empey 1972). As

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[28] The term *parens patriae* is Latin for "parent of the nation," and refers to the rights of the state to assume parental responsibilities for individuals incapacitated by age or mental defect. In the context of child welfare, it is often in reference to a court action against parents who are unable to act in the best interest of their children. The concept derives originally from Queen Elizabeth's English Poor Laws that were imported to the US during the 16th centuries.

[29] The parochial nature of these arrangements and the uneven economic development of the United States, suggest that early child welfare efforts varied considerably across communities. In some areas, townships could occasionally provide the parenting party a small community stipend for the care of an orphan. In northern areas the community stipend was derived in inverse proportion to the assumed labor value that a young person would bring to a farm. Given the opportunity to exploit an orphan in these economic exchanges some placements resembled forms of indentured servitude.

the practice of binding out children to families became less practical and more difficult to facilitate in this urban context, abandoned street children became one of the most visible and salient manifestations of urban poverty by the 1830s, giving rise to an early youth reform movement (Platt 1977).

Indeed, in the context of America's relatively quick urbanization and emerging industrialization, "the growing tide" of abandoned orphans living on the streets became a rallying cry for moral crusaders anxious about the potential break down of America's social order (Empey 1972; Platt 1977). Citing the deviant acts of many of the young delinquents (i.e. begging, pick pocketing and drinking in public), early social reformers cultivated a range of "environmental theories of crime" to explain the high rates of children living on city streets (Conrad & Schneider 1980). In characterizing the young as hapless, moral victims to the perversities of the urban environment, the "abandoned orphan crisis" gradually solidified into a new awareness of children's unique moral vulnerabilities and particularly their susceptibility to delinquency (Empey 1972).

This view that children needed to be protected for their own good would in part motivate the gradual rise of a juvenile court system in the US orientated toward a differential legal treatment of young offenders (Platt 1977). But by the 1830s these sentiments were already giving way to new "urban policing" strategies to remove abandoned children from city streets and place them into more reforming, morally conducive, environments (Platt 1969). Because the existing reforming system of *almshouses, workhouses* and *debtor's prisons* were now seen as inadequate to this new view of children, and in particular their need to be protected from perverse adult

influences (Foucault 1973),[30]a variety of reformers called for the creation of new child-specific institutions to re-orient the abandoned street youth. Often called "houses of refugees" in the US, these orphanage-like institutions emerged quickly in most US cities by the middle of the 19th century, emphasizing strict obedience, discipline and religious moral training.[31] While the specific doctrine advocated varied, most reformatories were designed to explicitly inoculate the young from the negative influences of urban poverty (Gowan 2010).[32] As an administrator from one Boston's largest orphanages described, the goal of his institution was "not only to remove the young people from the sordid environment of the congested city life, but (also) train their heart, hand and head for service to God and humanity" (Crenson 1998: 134).

It is interesting to note that the emergence of these institutions in the US and Europe coincided with the broader growth of asylums for the mentally ill during the same time period. What Foucault (1973) describes as the era of *the great confinement,* was somewhat analogous to this effort to isolate wayward children from the broader society.

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[30] While these institutions were originally designed for able-bodied adult paupers by the early 19th century they also commonly housed orphans, the mentally ill, and other "undesirables" at significant numbers (Foucault 1973).

[31] Orphanages had an initially been a European Catholic tradition imported to the US as early as 1759, but in the context of the rising tide of delinquents, enjoyed a substantial resurgence in the 1850s.

[32] Moral treatments more broadly signify a shift in the way poverty was constructed within 19th century discourses about the poor and their need of reformation. While earlier Catholic orientations towards poverty were encapsulated within a tradition of charity giving, the growing influence of Protestantism in the United States and its orientations toward the virtues of "hard work" cast many of the poor and destitute as morally idle by the 19th century. In this context early social reformers in the US increasingly viewed poverty as a moral issue requiring an explicit moral re-orientation and treatment. Katz (1986) argues that America's fundamentally Protestant work ethic has strongly informed an enduring cultural distinction between the deserving and undeserving poor that has since defined American interventions toward poverty. Gowan (2010) has suggested that during the 1850s moral discourses underpinning poverty interventions, and its associated knowledge systems, were institutionalizing a new form of "sin talk" that still pervade contemporary efforts to combat homelessness and poverty in the US.

Orphanages predicated on a similar "protective penology" that assumed that children were not only vulnerable to social influences, but that they needed to be isolated and contained within a curative community (Platt 1977, Conrad & Schneider 1980). Rothman (1977) and Crenson (1998) similarly suggest that both the asylum and orphanage systems were underpinned by the same cultural anxiety[33] about the immorality of industrial society and the need to isolate vulnerable individuals from it. In this way the orphaned child symbolized not only the moral failings of society but also the potential to reform it, through "strict disciplining" and "proper moral rearing."

The Child Saving Movement and the Rise of the Family

While orphanages had been seen as the solution to the inadequacy of almshouses during the early part of the 1800s, by the end of the century they would themselves be viewed as problematic institutions needing reform. Like the previous crisis, worsening economic conditions precipitated a new child-saving movement during the height of the Gilded Age. At the conclusion of America's Civil War many urban areas again witnessed a growth in the number of destitute children living on streets and alleyways. The combined effects of new immigration from Europe, the aftermath of the Civil War and the turbulent economic conditions of industrial capitalism, all resulted in an expanding population of destitute children that once again strained the fledgling orphanage system (Zelizer 1985). In New York City some estimates suggested that in a city of approximately two million

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[33] Indeed Ariès' (1962) depiction of orphanages suggests that these reforming institutions actually increased the level of anxiety surrounding children by institutionally an expectation that young needed to be closely watched and under constant supervision.

inhabitants, as many as thirty thousand children were living on the streets by the second half of the century (Fry 1974).

Overwhelmed and underfunded, many orphanages by the 1870s were becoming less known as houses of relief, but more for their depilated living conditions and harsh treatment of the young (Crenson 1998). Moreover, the institution quickly became outdated in the context of emerging ideas about children and family life, resulting in a variety of voices calling for more humanitarian treatment of children overall.

Sociologists have suggested that some of the criticisms towards orphanages during this time reflected a gradual pessimism that would grow for the next century regarding the rehabilitative functions of moral institutions for treating problems like mental illness to pauperism (Foucault 1973; Gowan 2010; Rothman 1977). While a full "de-institutionalization" of mental asylums would not emerge until the second half of the 20th century[34], already by the late 19th century numerous penal specialists and superintendents were championing reforms *within* their institutions to make moral interventions less custodial and "prisonlike" (Conrad & Schneider 1980). This included experiments with "cottage systems" and the organization of "resident families" within institutions, as well as efforts to send patients out to rural parts of the country to enjoy the benefits of a "simpler, more natural life" (Platt 1977). Criticisms toward orphanages during this time similarly pointed to the institution's "dehumanizing" and overly regimented structure. Indeed, penal reformers feared that while orphanages were

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[34] Despite growing disillusionment with rehabilitative institutions and their inability to effectively cure most mental illnesses, the de-institutionalization of mental health—the closing of most psychiatric hospital and asylums—did not occur until the mid 20th century because effective management for most mental disorders were still in their infancy until the development of modern psychiatric medication and treatments.

necessary, they nonetheless "overly- institutionalized" the young in what was essentially an unnatural family environment (Crenson 1998).

Efforts to find an alternative to orphanages emerged as early as 1854 when Charles Loring Brace founded the first "home-finding" organization—called *The Children's Aide Society*—that focused on relocating orphans out of cities and into family homes in rural parts of the country. Commonly known for its "orphan trains" that shipped thousands of "rescued" youth out to the Midwest every year, the organization facilitated care arrangements with "receiving families" in states like Minnesota and Illinois that resembled an early version of foster care. In some ways the system called upon an earlier method of binding children to work in farms, but the intervention also incorporated a network of hired "case workers" who would occasionally visit and supervise the care provided by host families. Despite occasional criticisms that this early home-finding effort often displaced children, the program was initially praised for providing a viable, more natural, alternative to orphanages, that at the same time celebrated the virtues of family life in rural America.[35]

Indeed, criticism toward orphanages as an unnatural institution also reflected changing, and more romanticized conceptions of family life itself. Vivana Zelizer (1985)

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[35]The Children's Aide Society founded by Brace in 1854, transported an estimated 300,000 youth to live and work in family farms during its 75 years of operation (Lindsey 1996). In ideal circumstance Brace coordinated transportation to family farms where youth worked in much the same fashion as previous orphans did a hundred years prior. Indeed this solution to the crowded orphanages system harkened back to an earlier time in which colonial communities binded orphans out to nearby families. But even this "traditional solution" would soon come to be seen as being inadequate from evolving perspectives toward the proper rearing of children. Facing criticisms that Brace did not provide enough supervision to ensure that children were being placed with good families, were not being exploited and that these family environments were intact over time, forced Brace to develop an early from of case management system. While the orphan train would eventually be abandoned, it did provide the basic framework of case management techniques and technologies from which modern social work practices would emerge.

has argued that the late 19th century progressive movement, and in particular its associated disillusionment with industrial capitalism, cultivated what she calls a gradual *sacralization* of families in the West and specifically in the United States. According to Zelizer, by the early 20th century middle class parents in particular were increasingly approaching childhood, and childcare, as "priceless" and non-commodified aspects of their lives, almost as a way of countering the ever encroaching influences of the free market (Zelizer 1985).   In short, the continued industrialization, but also now the commercialization, of the West gave rise to what was essentially a more privatized, and decommodifed understanding of the "nuclear family" (Berk 1985), one that celebrated "children as priceless" bastions of non-economic and non-rationalized ideals.   Some have similarly suggested that middle class ambivalence toward industrial capitalism cultivated a "cult of domesticity" surrounding childcare, which perpetuated a growing distinction between the private and public spheres (Stacey 1996). In short, as men's roles became more defined within the parameters of productive-paid work, women's care of "vulnerable" children became more sanctified and interconnected with notions of domesticity.

In the context of child welfare efforts of the 19th century, the centrality of family within the construction of an innocent and dependent childhood cast a negative light on the custodial care provided by orphanages. Indeed, the orphanage's inherent institutional nature where children were essentially warehoused in large numbers contrasted sharply with sentiments that connected childcare to the family home. While the orphanage resembled an efficient and economical way of providing care to many children at once,

its "rationalized form" contradicted the very virtues of motherly nurturance endorsed by most middle class parents (Crenson 1998). Worse still, orphanages commonly required children to work in nearby industries to subsidize their own care—further violating the sacred distinction between children and paid laborers (Zelizer 1985).

But more broadly this growing interdependence between middle class ideas of femininity and child vulnerability would also motivate a distinctly feminine child saving movement at the turn of the century. Made up of mostly upper middle class women, this *second* child saving movement consisted of a number of charities, societies and settlement houses broadly concerned with the plight of children in the community (Conrad & Schneider 1980).[36] While partly a social advocacy movement, most organizations also intervened directly with families, by administering aid and giving "childrearing advice," to parents who were seen as at-risk for abandoning their children to orphanages or the streets. Some organizations similarly founded various settlement houses in Chicago, New York and Boston that provided free childcare, education and residence to families in need.

Most notable to a discussion about foster care, child saving organizations also pursued several "home finding" efforts for youth already living on the streets or who had been rescued from orphanages. Improving upon the orphan train model advocated earlier by Charles Brace, several groups experimented with their own renditions of "urban"

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[36] Conrad and Schneider (1980) have argued that child-saving campaigns resembled a type "calling" for a some women who saw their duties as mothers beyond their family home but also in the community. Indeed, the fact that such child-saving activities gained significant traction and legitimacy during this time, speaks to how these organizing efforts were likely seen by the broader public as natural extensions of the female roles as "caretakers" and experts in child welfare. These female-headed organizations often established milk depots, child-rearing clinics, and adoption centers for abandoned youth.

based foster care by the 1880s.[37] While the definitions of foster care varied considerably during this time,[38] several charities facilitated arrangements with often lower class mother to "take in" additional children from the neighborhood in exchange for a monthly stipend. Often times these payments were meager in proportion to the actual cost of housing additional children, in part because of the underlying assumption that an ideal foster mother would provide care out of a moral and motherly imperative, and not an economic one. Ironically, this financial arrangement not only reified the non-economic and gendered nature of taking care of children—a sentiment that still structures foster care funding today (Swartz 2004)—but it also contributed to a growing schism between professional charities and the lowered class mothers hired to provide childcare. Indeed, skepticism among helping organizations that many foster parents were primarily motivated by financial gain, reinforced the notion that lower class parents, even those receiving subsidies for care, needed constant monitoring and surveillance by a professional "case worker."

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[37] The indentured servitude like conditions by which some family foster farms operated underpinned concerns that Brace's alternative to orphanages neither nurtured nor protected children but exploited them as laborers. Moreover, Brace's organization initially lacked the infrastructure capacity to supervise the care that orphans received, or did not receive, in far away locations. In response to such criticisms the organization gradually developed new systems of surveillance and record keeping techniques, to vet appropriate families and supervise the quality of care provided. These techniques would become a precursor to modern case management practices in social work as well as lead to more organized arrangements with foster families in the Midwest. As fostering efforts became more formalized, other charities began experimenting with fostering children to local families instead of distanced ones thousands of miles away from the city.

[38] During the late part of the 19th century, and early parts of the 20th, the term "foster parent" denoted various situations in which an adult "took in" other people's children into their homes temporarily and permanently, informally and formally. Foster care could also describe children who earned their keep by working, children whose board was paid by agencies, and children placed in "free homes." Adopted children were also called foster children in the early part of the 20th century.

In many ways the charity worker of this era would become the precursor of the modern social worker, with her activities with families and children resembling an early form of case management that the field would eventually claim as an area of "professional expertise" (Poppel & Reid 1999). From a more cynical perspective, Platt (1967) has argued that professionalized child savers of this time also functioned as "agents of social control" on behalf of a class-based, bourgeois, effort, to regulate marginalized groups. Indeed, case managers often promoted, if not forced upon recipients of their charity, a particularly "middle class" understanding of children; one that associated the young as precious entities in need of intense, middle-class forms of nurturing. It was not uncommon for early foster organizations, for example, to make charitable contributions to families "conditional" on parents adhering to specific childrearing practices[39] (the hallmarks of what was considered "scientific charity"). More recent feminist critiques of charity workers have similarly suggested that child saving campaigns of this time ironically perpetuated "patriarchal systems" of dominance between men and women (Martin 1990). Whether early social workers perpetuated either class or gendered forms of oppression, or perhaps both, it is nonetheless clear that the paternalistic nature of the welfare system is not exclusive to the contemporary period. While some have characterized modern welfare practices as only recently incorporating a unique mix of punitive and rehabilitative functions (see for example Wacquant 2009), in some respects the emphasis on surveillance, discipline and reform have long been

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[39] Most child saving organizations facilitated childrearing clinics that explicitly defined—usually in a quasi-scientific language— the appropriate ways of interacting with the young.

hallmarks of "helping professions" and their work with the poor (Soss, Fording & Schram 2011).

But while the child saving groups may have represented some of the very first, paternalistic social service organizations in the country, it is also clear that they contributed to a broader political movement that increasingly pursued the state to extend protections to children and other vulnerable groups. In this way, the child saving movement shared some similar ideological roots to other progressive movements and social activism of the early 20th century. Efforts to expand public education and ban child labor, for instance, coincided with broader initiatives to improve the working conditions of the poor and mitigate some of the negative societal consequence of industrial capitalism (Zelizer 1985). Indeed, child saving activists gradually advocated for a great role of the state in "decommodifying" children, especially through public sponsored pension programs that would precipitate America's contemporary welfare state (Katz 1988). Such an evolution, however, would not emerge without considerable controversy among social workers themselves about the ramifications of extending state scope into the domestic sphere. A debate of whether the state could support poor children, without at the same time undermining the sanctity of families, would come to the forefront of discussions about child abuse and social welfare at the turn of the 20th century.

The Discovery of Child Abuse and Social Welfare
It is important to note that child- saving movements of the late 19th century focused primarily on issues of improper child rearing, neglect and abandonment, but not child

abuse itself, particularly within the domestic realm of families (Pfohl 1977). As

previously discussed, harsh punishment inflicted onto children by their parents, such as

whipping and birching, was commonplace if not normative well into the early parts of the

20th century.[40]

The first organization that explicitly pursued efforts to "protect" children from

excessive cruelty and violence was ironically the New York Society for the Prevention of

Cruelty to *Animals* (SPCA/SPCC).[41] The landmark case of Mary Ellen in 1874, an eight

year old orphan who had suffered extreme mistreatment by her foster parents, represented

the first legal effort in the US to rescue a child from an abusive situation. Lacking a legal

precedence to remove a minor from their legal guardians, SPCC brought the case to the

New York Supreme Court in 1874, arguing that as a member of the animal kingdom

Mary Ellen should be protected under pre-existing laws that protected animals from

similar acts of "human cruelty." This successful, if somewhat novel application of

habeas corpus provided the first legal justification for removing children from their

homes and was soon followed by other SPCC "child rescue missions" throughout the

next decade. By the turn of century these efforts gradually led to a variety of child

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[40] The cult of the family perpetuated the notion that parents had total sovereignty over the treatment, or maltreatment, of their children. As Pholf (1977) notes, even during the height of the child saving movement the dictum of "spare the rod and spoil the child" captured the prevailing attitude towards children.

[41] Ironically the SPCA had been initially founded to confront cases of animal cruelty, a prevailing concern among its upper-class members, but after being lambasted by the media for its apparent indifference towards "the misery of the human species" the organization was gradually pressured to pursue rescue efforts of maltreated children as well as animals (Conrad & Schneider 1983). After the Mary Ellen case the society altered its name to the New York Society for the Prevention of Cruelty to *Children* (SPCC), which is one of the country's longest running child welfare advocacy organization.

welfare legislations that extended some modest protection for young people against abuse.[42]

While these new child abuse laws were rarely evoked, they nonetheless had important ramifications for the judicial system and its increasing involvement in adjudicating parent-child interactions. Since the middle of the 19th century the US had witnessed a gradual growth of new court systems that focused exclusively on juvenile offenders and by the early 20th century many of these courts were embracing preventative intereventions juvenile delinquency.[43] Consequently, the legislative protections rendered by the Mary Ellen case provided juvenile courts some impetus to preemptively remove would-be young offenders from homes deemed problematic and conducive to future deviant acts (Conrad and Schneider 1980). Though such rulings to remove children from their home were relatively uncommon, they nonetheless established a dramatic precedent for the American judicial system to practice guardianship over a minor, not as a criminal but as a *ward of the state*. In effect, such court actions extended the state's scope of *parens patriae* by consolidating a new public jurisdiction over appropriate parenting and precedence for juvenile courts to rule "in the best interest of the child."

Though such judicial actions did much to solidify child welfare's scope, they nonetheless generated substantial ambivalence among many child-saving reformers themselves (Stadum 1999). As discussed above, the emergence of physical child abuse

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[43] As previously discussed these court systems reflected a growing belief that children were more the victims of their environment than offenders, and hence required differential treatment by the justice. Reflecting progressivism's dual affinities for "science" and "the family," by the 20th century many juvenile courts were embracing quasi-medical and psychiatric approaches to "treating" and "preventing" delinquency, particularly within the context of poor and dysfunctional families (Platt 1977).

as a legitimate social problem reflected in part the sacralization of childhood (Zelizer 1985), that was itself constructed directly in relation to the sanctity of the family. As such, the prerogative to save children by removing them from their natural homes clashed with the more family centric beliefs espoused by most child saving advocates. Indeed, Mary Ellen herself, like most of the youth rescued by SPCC, had been removed from her non-biological foster guardians and not her natural parents, as the organization mainly focused on stopping child cruelty perpetrated by employers, foster parents and other non-familed adults (Pfohl 1977). The notion that courts had now the legal precedence to remove children from their biological, natural parents was seen as paramount to attacking the institution of family itself.[44] Worse still child saving reformers feared that new mandates to act "in the best interest of the child" might lead to a wholesale removal of countless children residing in "poor homes in society," possibly precipitating a resurgence of the very orphanage system that many reformers decried as inhumane for children (Crenson 1998). While early caseworkers concerned themselves with the child rearing practices of the lower classes, their focus was ultimately to bolster families and not separate them. As the founder of the first adoption agency in the US, once stated " a poor home is often better than a good institution" (Crenson: 104).[45]

The seminal *1909 White House Conference on the Care of Dependent Children* hosted by Theodore Roosevelt was in part an effort to find appeasement within social

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[44] Most social workers at this time saw their mission to better the treatment of children in the home—using at the times the threat to remove children from the home as leverage against parents—but the goal was not to forcibly remove substantial numbers of youth from their families. Indeed the sentimentality surrounding families meant that reformers were often interested in keeping families together whenever possible

[45] Cited in Crenson (1998) as Henry Dwight Chapin, "Family vs. Institution," *Survey* 55 (January 15, 1926): 485-488.

welfare advocates between the countervailing notions of rescuing children and supporting families.[46] At the conclusion of the conference, the two hundred attendees of social workers, judges, child saving reformers and developmental psychologists (at the time an emerging discipline) offered nine proposals that defined the parameters of a future, public run, foster care system. Most importantly the conference solidified the status of foster care as the "ideal" and "most family like" placement for destitute children particularly given its contrast to the unnatural custodial care provided by orphanages. On the other hand the conference was also unequivocal that the state should intervene to prevent these out-of-home placements whenever possible—that while foster care is an ideal placement, it should nonetheless be an intervention of last resort by the state. Underpinning this position was the view that although child maltreatment or abandonment was often associated with economic deprivation, poverty should not itself be the sole justification for removing a child from their family. Instead, the reformers of the conference called upon the state to increase supports, and in particular public pension programs for mothers, as a way of bolstering poor families against the "social ills" of child abandonment and neglect.

While the conference had no legal authority to put these proposals into effect, its conclusions were nonetheless influential in orientating the child welfare system and the social work field more broadly to embrace more generalist interventions (Poppel & Reid 1999). Indeed, after the White House conference, mothers' pension legislations passed

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[46] Because the new field of social work was still struggling to define itself as a profession—for instance whether social work should prioritize "generalist" or "specialized forms" of interventions—the conference also provided an opportunity to solidify the goals of the helping-professions more broadly. Though the conference had no legal jurisdiction to mandate changes in judicial action or social policy, the gathering was seen as providing a general coherence to child welfare norms and practices.

easily in many states, and by 1921 forty states were using public funds to subsidize poor

families with some form of public assistance (Stadum 1999). While some programs

provided pitifully low supports for women with children and were often inconsistently

and haphazardly administered (Skocpol 1989),[47] they nonetheless solidified a new role of

the state in the administration of relief programs. Indeed, mothers' pension programs

represented a shift from a private charity giving enterprise, or a municipal form of poor

relief, to a formal entitlement state program (Leff 1973). In the wake of the economic

calamity of the 1930s and the Great Depression, mother pension programs would provide

the basic blueprint (Katz 1988) for what would eventually become Aide to Families with

Children (AFC)—the quintessential "welfare" program of the 20th century.

To be sure, the eventual passage of the Social Security Act of 1935 (SSA) and the

emergence of America's formal welfare state reflected a confluence of social and

economic s factors not all related to child welfare concerns. Welfare scholars have

generally described the evolution of public assistance programs in the US through the

lens of class conflict, labor movements and acts of appeasement by the state following

periods of social unrest.[48] Nonetheless, one could argue that the passage of New Deal

welfare policy reflected as well as solidifed government's growing role in funding and

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[47] These pension or aid programs often stipulated strict moralist condition upon female recipients—as for
instance that single women not have unmarried male visitors at the home—calling upon again the
surveillance duties of middle class case managers (Skocpol 1989).

[48] Welfare theorists, particularly those informed by Marxist frameworks, have often discussed the
emergence of welfare regimes through the lenses of class conflict (in particular the disputes between labor
and capital) in which the state, in the face of acute civil strife and disorder, will initiate and extend social
supports in attempts to appease and placate constituents. For example, Piven and Cloward (1971) suggest
that welfare expansion in the 1930s was the government's response to widespread fear of growing social
disorder in the face economic calamity. They have generalized that when "mass unemployment leads to
outbreaks of turmoil, relief programs are initiated to control and absorb the unemployed." Other theories
have contrasted the rather a top down model of welfare expansion (where the state or elites initiate welfare
as a form of social control or mediating intervention) to emphasize the role that social movements play in
mobilizing the state to counteract the inequities of the market (Korpi 1989).

facilitating child welfare efforts. As Katz (1988) similarly argues, the basic structure of state sponsored "welfare" was initially conceived out of child saving efforts to improve the welfare of destitute children. Though the Social Security Act also unified social insurance programs (such as those related to unemployment, disability and aging) under the auspice of state "welfare," at its core the legislation addressed concerns first raised and discussed in reference to the child saving movement. Indeed, the pursuit of mothers' pension programs, and their later expansion into AFC, reflected a gradual acknowledgement within the child saving movement itself that the needs of poor children were beyond the scope of individual charities, if not local municipalities, but instead required the full investment and infrastructure of the state (Crenson 1998; Leff 1973). With Title IV of the Social Security Act establishing revenue sources for state governments to provide services for children under care, child welfare became solidified as an official financial and regulatory responsibility of the federal government.

Indeed the implementation of the welfare regime in the late 1930s would have the intended effect of reducing the number of children living in absolute poverty in the following decades, making the abandoned orphan or street child a rare observation in modern America. As Crenson (1999), argues, despite the temporary increase in the need of orphanages during the Great Depression, the "welfare state" finally and effectively ended the reign of orphanages in the US by "replacing the institution with a monthly check" (p. 197). As others have suggested, the redistributive policies by the state, coupled with broad upward social mobility in the country overall, lead to a gradual stagnation of youth being placed in foster care between the 1930s and 1960s (Lindsey

1996). Even though the Social Security Act expanded the bureaucratic infrastructures associated with child welfare and the institution of social work, the number of poor children needing such services would somewhat stagnate during the 1940s and 1950s.

Saving the Medicalized Child and the Modern Family

During the last half of the 20th century child welfare would experience dramatic change and rapid mobilization. This was reflected both in the increasing numbers of children entering care, but more fundamentally in the "new types" of youth coming under the purview of the system. While conceived as a system primarily for orphans, and later abandoned street youth, foster care by the 1960s and 1970s would consist mostly of children forcibly removed from their homes by the state due to reports of parental abuse and maltreatment. Despite previous attempts by progressive reformers to temper the state's/child welfare's potentially coercive reach into families, in the 1960s a new understanding of child abuse, particularly as a medical condition, would trump efforts to preserve the sanctity of families. The foster care population would also became much more diverse during this time as social welfare programs expanded and became more intertwined with the problems of race and poverty in the US. Indeed, underpinning the massive mobilization of child welfare in the end of the 20th century was not only the moral panic of child abuse, but also the fundamental restructuring of America's economy and the substantial impacts it would have on poor and working class families.

Much of the culture change surrounding modern child welfare practices hinged first on a new social awareness of child abuse and its prevalence in modern family life. Despite the legal ramifications of the Mary Ellen case in 1874, as late as in the 1960s

child abuse perpetrated by *parents,* particularly within the confines of an intact family, had remained largely ignored as a public issue. While new institutions had emerged to confront the problems of abandoned children in the country, there was little societal concern about the physical maltreatment of children who lived with their biological parents. Pfohl (1977) argues that the high cultural status of parents, combined with the cult of domesticity, had kept incidents of child maltreatment largely hidden as a social problem even as social work institutions extended their scope throughout the early parts of the 20th century. In this sense it is somewhat ironic that it would take advances in pediatric radiology and "x-ray" technology to render abusive parents visible to societal scrutiny. In a seminal article titled "The Battered Child Syndrome" a team of pediatric radiologist published the landmark finding that a high proportion of young children who visited hospital emergency rooms suffered from bone trauma likely afflicted by their caregivers (Kempe, Silverman, Steele, Droegemueller & Silver 1962). Characterizing the otherwise hidden bruises of children as manifested symptoms of "an underling Battered Child Syndrome," Kempe and colleagues were first to document the antecedents and consequences of child maltreatment in the language of medical science (Pfohl 1977). Indeed, the new "syndrome" identified both the symptoms of physical abuse but also its etiological roots within the psychological pathologies of parents—effectively *medicalizing* both the abused and the abuser (Pfohl 1977).

Within a few years of its "discovery" by the medical establishment, child abuse became a prevailing social epidemic faced by local and state governments across the country throughout the 1960s. In some ways, the medically codified designation of child

abuse and its consequence provided labels, if not a whole vocabulary of legitimacy, that

social workers were quick to incorporate in their work with poor families. Though social

workers had likely long observed forms of child maltreatment in their work, the new

scientific documentation of child abuse provided the profession a new, culturally

palatable language to talk about the tabooed topic. Followed by sensationalistic media

depictions of the battered child syndrome, a number of states witnessed a rapid increase

in the number of reported "incidents of violence" against children. In Florida, for

example, the implementation of new child abuse reporting laws and media "awareness"

campaigns saw the number reported cases of child maltreatment dramatically increased

from 17 in one year to 19,120 the next (Nagi 1977).   More broadly the number of abuse

allegation that authorities received each year grew across the country from an estimated

10,000 in 1962 to nearly 60,000 in 1974 (Lindsey 1996), to 1.1 million in 1980 (Reid

1995), eventually reaching 3.3 million allegations a year in the early 2000s (CDC 2011).

In some respects the cultural awakening to the concept of child abuse reflected, if

not cultivated, a new "hysteria" that children in America were in perpetual danger of

becoming victimized by strangers and family members alike. Indeed, some have

suggested that the moral panic surrounding child abuse in the 1970s, and later 1980s,

reflected deep cultural anxieties about the broad social changes occurring within gender

roles, and family structures, at the same time[49] (Showalter 1998; Hacking 2000).

Moreover, the momentum of the child abuse epidemic galvanized political support for

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[49] Child maltreatment, as it would be discovered, often occurred in single-headed homes and in particular minority households. Fear of abuse also focused on "day care centers" an emerging institution used by families busied by work and career.

new government institutions to protect and stop child maltreatment in its various forms.[50]

As a hallmark of medicalization, the social problem of child abuse not only became

legitimized in a language of science but it also called forth new surveillance and control

efforts by the state (Conrad 2010). Within 10 years of the original JAMA article that

identified the abuse syndrome, every state had statues in placed known as "mandatory

reporting" laws that required specific professions to notify the authorities of any

suspected case of child maltreatment that they encountered in their work—including

teachers, doctors, and even individuals working in photography (Pfohl 1977). The

passage of The Child Abuse Prevention and Treatment Act of 1974 (CAPTA 1974)

solidified these laws at the federal level as well as established new funding revenues for

preventative and social services related to child maltreatment.

　　Not surprisingly, during this time the number of allegation but also "substantiated

investigations" [51] of child abuse increased dramatically leading to the ballooning of the

foster care population in the US. Though most youth associated with these investigation

were ultimately not removed from their homes, the backlog of CPS investigations that

occurred in many communities lead to foster care being occasionally used as stop-gate

measure in situations in which youth would be placed in care while their abuse

allegations were investigated (Lindsey 1996). Some have suggested that such

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[50] Heighten public attention given to the issue of children and abuse, however, also meant that the cultural category of abuse would itself gradually expand to encompass new forms of sexual, emotional and psychological victimization. Similarly, domestic violence and its connection to child maltreatment would also become more publically acknowledged, as the battered child soon gave way to battered women's shelters in many cities in the 1970s and 1980s.

[51] Substantiated reports refer to situations when an investigation by authorities yielded positive evidence of abuse and neglect.

procedures occasionally obscured the CPS mandate to protect children, and instead

promoted a more class based bias to place young people in supposedly "better"

environments [52](Roberts 2002). By1965 the number of children in out of home

placements had reached over a quarter million, peaking in the 1970s to over 300,000

(Lindsey 1996). In the 1980s foster care populations would temporarily decline but

eventually vacillate between 500,000 to 800,000 as economic conditions worsened in

some communities (Children's Bureau 1990).

Beyond its growing size the foster care population would also become more

racialized between the 1960s and 1990s as the presence of children of color—particularly

African Americans and Native Americans—gradually grew to disproportionate levels.

This racialization reflected in part new amendments to the Social Security Act starting in

1962 that had allowed states to use AFC federal funds to directly subsidize foster care for

children whose family qualified for the entitlement program (changing its name to Aide

to Families *and* Dependent Children; AFDC). As social movements mobilized to expand

AFDC to new groups in the mid 1960s, welfare in general not only became racialized

(Quadagno 1994) but so did the ability to use foster care as a social intervention.

Aspolitical concerns about the disintegration of the black family (Moynihan 1968) foster

care became mobilized for a disproportionate number of families of color struggling in

poverty throughout the 1970s and beyond. Indeed, even though surveillance efforts by

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[52] An enduring criticism of the foster care system is that social workers are at time overzealous removing children from minority parents. Particularly within a context where the parents may exhibit a different socio-economic status of their caseworkers, there is a tendency to confuse the mandate to protect children, with the desire to improve a child's overall upbringing. As Roberts (2002) argues, while such sentiments are understandable, they are often anchored in our own cultural bias about what constitutes a proper childhood. More importantly, the state has no legal grounds to remove children from families beyond reasons related to personal safety.

the state had been bolstered by the concerns over child endangerment, the majority of children being removed from their homes would increasingly become related to child neglect issues.

Moreover, the 1970s and 1980s would be marked by sharp deindustrialization and dramatic re-orientation of the American economy, that would substantially contribute to the racialization of child poverty and in turn the foster care system (Pelton & Milner 1994). Broad economic shifts in the 1970s related to the Post-Fordism economy and the subsequent decline of well-paying manufactory jobs that required little education, substantially increased the number of children living under the poverty line (Moller, Huber, Stepnens, Bradley & Nielsen 1996), and hence their danger of being neglected and abused (Drake & Pandy 1996; Plotnick 2000).   Groups historically disadvantaged from educational opportunities saw their social wages decline throughout the last two decades of the 20th century as labor markets increasingly favored the highly skilled and educated (Stigliz 2012).   Well-paying, low-skill unionized employment steadily declined in many US regions, resulting in a dramatic growth, and tightening of the low-wage service, labor market.   Many cities also experienced an exodus of middle class capital to the outward suburbs, contributing to an ever-increasing concentration of poverty that Williams has associated with new racialized underclass (1984). Somewhat linked to the stagnated wages, and limited opportunities for social mobility within the inner city, America's infamous Drug War increased dramatically throughout the decade leading to a mass incarceration of young men of color (Wacquant 2009). In the context of increasing urban poverty, a proliferation of drug use and high incarceration of men of color, the rise

of reported child abuse cases and subsequent foster care placements reached "astronomical levels" in the 1970s and throughout the 1980s (Lindsey 1996). Indeed, despite the growth of the welfare state of the previous decade, structural and economic conditions resulted in a growing child poverty rate that many child welfare scholars have cited as the "driving engine" of growing rates of child maltreatment in the 1980s (Pelton & Milner 1994).

Combined these factors meant that by the late 1970s and early 1980s the growing influx of children being placed in foster care would itself become the new crisis of child welfare and source of moral panic. With many more foster youth needing homes than was available, the system experienced a resurgence of congregate style group homes and large residential treatments centers. This increased use of orphanage-like settings resurfaced past anxieties that children were once again being "warehoused" and "institutionalized." [53] Similarly, many advocates became concerned that many foster youth drifted from home to home, never experiencing permanence and stability in their lives. Some policy researchers warned that the expansion of federal support for foster care in the 1960s had actually created a financial incentive for states to put youth too quickly into care, and likewise had little incentive to return youth back to their families (Shotton 1990). These and other concerns culminated into widespread critiques by the end of the 1970s that child welfare system was itself destroying family life in some communities, particularly among already marginalized groups. In 1978 Congress,

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[53] The sheer number of youth entering foster care, even for temporary basis, outpaced the ability for communities to recruit and authorize an adequate supply of willing and qualified foster homes. Though new funding schemes and programs were introduced to support and train networks of foster parents and foster homes, the late 1970s and early 80s witnessed a resurgence of congregate style group homes and residential treatments centers

responded to the dramatic calls by Native American tribal advocacy groups—which at one time equated child welfare as a form of "cultural genocide"— by passing the Indian Child Welfare Act (ICWA 1978) to reduce the disproportionate number of native children being removed from their homes and placed in non-native foster homes.[54]

But broadly the high number of children being housed by the state resurfaced a more fundament tension between the need to protect children and the cultural value that society placed on families. What some have described as child welfare's "swinging policy pendulum" between "child safety" and "family preservation" would again structure a set of countervailing reforms and legal mandates in the 1980s and 1990s (Gainsborough 2010; Lindsey 1994). On the side of family centric policies, the 1980s would witness several reforms and programs aimed at bolstering and supporting families engaged with the child welfare system. This consisted of federal reforms (such as the Adoption and Child Welfare Act of 1980) that established new mandates for child welfare workers "to make reasonable efforts" to reunify foster youth with their biological families, and when possible avoid out-of-home placements for families amenable to rehabilitative efforts. Along these lines, several new "Family Preservation" programs, and social service models, emerged throughout the 1980s and 1990s that focused on helping parents improve their child caring skills and regain the custody of their children. The passage of the 1993 Family Preservation and Support Act, and the increased funding

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[54] This federal law specifies that tribal councils, or tribal nations, hold jurisdiction over child protection cases for children removed from their homes and identified as Native American. The respective tribe will in most cases determine a youth's placement and the steps necessary that Native parents will need to complete to regain custody of their children. In 2013 aspects of this law was challenged in the Supreme Court case *Adoptive Couple vs. Baby Girl*. In the controversial ruling the court found in a 5 to 4 ruling that the law could not be applied to situations in which a mother willingly puts up her children for adoption without prior consultation with a tribe.

that these programs received as a result, reflected in some respects a rare consensus between "pro-family" conservatives and "anti- poverty" liberals in the early 1990s that centered on the need to extend supports to vulnerable families.

Despite these family-centric policies, however, the political culture underpinning the child welfare system during this time nonetheless prioritized a fundamental "child safety" prerogative above all other concerns. As several child welfare scholars have pointed out, initiatives to support and bolster families during the 1980s, and primarily poor families, were often undercut by a perpetuate distrust in the broader public of parents that intentionally harmed their children. Indeed, increased funding for family-centric programs backfired to some extent whenever stories surfaced that children were being kept in homes known to have histories with abuse (Gainsborough 2010). In particular, media accounts of parents continuing to harm their children while receiving services, at times even to point of killing them, periodically galvanized a public antagonistic toward family programs and reunification efforts seen as putting abused children in danger. Some have also suggested that the increasing stigma associated with poor parents during the 1980s— as encapsulated in the caricature of the *welfare queen* promulgated by conservative pundits at the time—contributed to a more antagonistic child welfare culture that was increasingly more punitive with single parents of color.[55]

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[55] Roberts (2002) argues that the stigma of poor parents during the 1980s and beyond has worked to undermine and de-stabilize a "balanced" child welfare system that addresses both the needs of children but also families —particularly single-headed households. As perhaps best encapsulated by Charles Murray's (1986) *Losing Ground*, several conservative voices argued that the urban underclass was itself a by-produce of an over-expanded welfare system that eroded the incentives to work and/or get married. As Roberts (2002) and others have pointed out, these conservative narratives about a dependency culture in the inner city served not only to stigmatize women on welfare, and in particular reinforce a racialized caricature of the "welfare queen"—but they also perpetuated a "strong arm" approach to the activities pursued by child welfare agencies. Indeed, the welfare queen supposedly was not only at fault for her own predicament, but

As a consequence, family programs were generally underfunded when compared to the almost limit-less federal resources allocated to out-of-home placements. Even when family interventions were implemented most were often limited in scope and duration. Moreover, despite the stated goal of assisting families, some family intervention became little more than new surveillance programs by the state (Roberts 2002). The late 1980s and middle 1990s would also see a rise of lawsuits against child welfare agencies that had been too family-friendly in its support of abusive parents, and by the 1997 new reforms would be implemented to soften the mandate that social worker "make reasonable efforts" to reunify families with children in the foster care system (Gainsborough 2010). These laws in particular would speed up the process by which parents' rights were terminated and foster youth placed for adoption.

Despite the contradictions in child welfare policies of the 1980s, during the economic upturn of the mid 1990s the rate of children entering foster care nonetheless stagnated as the total number of youth under state care began to decline. Though efforts to reunify foster youth with their parents had gained some momentum in the early 1990s, and in turn might have been influential in turning the tide of youth entering the system, it is likely that the improved economy and its impact on overall child poverty were likely the key drivers of this trend (Plotnick 2000). Interestingly, speculation that foster care rates might again balloon after the passage of welfare reform in 1996—a sentiment shared by both conservative and liberal groups—motivated Congress to take up efforts to

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her inability to parent properly only contributed to her neighborhood's dysfunction and chaos. Within this context, Roberts (2002) argues child welfare agencies, and federal policies in general became more punitive, rather than rehabilitative in form. Similarly, Loic Wacqunet (2009) argues that the resurgence of moral behaviorism within welfare policies during this time reflect a penalization of poverty, as penal and welfare institution merged together to punish the marginalized poor.

revamp the child welfare system almost immediately after welfare reform in 1996. Embracing elements of market-oriented strategies, the Adoption and Foster Care Safety Act of 1997 (ASFA 1997) introduced new incentives for states to increase their "performances" on key measures of safety, permanency and child well being. Most notably the reform incentivized states to increase their adoption of children out of foster care, awarding public agencies additional financial reimbursements for increasing the speed and efficiency of adoption procedures.[56] By the early 2000s, the declines in the foster care population that had started in the 1990s became more dramatic as these reforms, and in particular the adoption incentives, began to go into effect.   Indeed, during the last 15 years, most states have reported substantial reductions in their foster care populations, with Illinois and Californian effectively reducing the number of youth in these systems by half (Courtney 2009b). As concerns that children were warehoused in foster care for too long began to dissipate, however, the system would begin to hear new concerns about a new crisis regarding former foster youth by the 21st century.

Conclusion: The New Crisis of Young Adulthood

The above historical review of foster care reveals how child saving institutions have evolved considerably, if not dialectically, during the last two hundred years.   As the US has witnessed dramatic social, cultural and economic change, so has its child saving and child welfare institutions. The term *dialect* is perhaps appropriate to describe the evolution of child welfare given that the system seems to be in a perpetual state of crisis

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[56] The reform also encouraged states to experiment with new managed care models of structuring their child welfare systems—awarding states like Florida, Michigan and Kansas special block grants to employ a competitive bidding between child welfare providers.

and reform. In many ways the emerging problems of child welfare are frequently constructed as stemming from the inadequacies and failures of past interventions. This type of social change is of course not exclusive to child welfare, but is worth highlighting given the recursive ways the debate about the goal and function of the system have shifted from saving children and/or saving families several times during the last several decades (Gainsborough 2010).

Moreover, an appreciation of the role that conflict has played in the evolution of child welfare reminds us of the constructed, and constantly changing, nature of child maltreatment itself. The crisis of child welfare reflects society's changing standards in respects to how children should be treated, and in turn our understanding of children's special needs and unique vulnerabilities. As discussed above these changes are often connected to broader anxieties related to cultural, social and often economic developments.

While the system of foster care continues to be in a state of crisis in various ways, it is telling that in the last twenty years the discourse about its endemic problems have shifted somewhat toward the predicament of young adults who were former foster youth. The problematic outcomes that many young people face aging out of care, and during their often problematic transition into adulthood, has been the focus of both much child welfare policy and research in the last fifteen years (Courtney 2009b). During the last two decades a number of studies and policy reports have repeatedly found that former foster youth have relatively high likelihoods of experiencing homelessness, incarceration, early pregnancy, chemical addiction and diminished mental well being (Fansehl, et al.

1990; Cook 1992; Courntey 2001; Courtney 2005, Courtney et al. 2005; Lawerence, Carlson and Egelande 2005). Former foster youth are also more likely than their similar aged peers to remain in poverty for extended periods of time, struggle with education and job attainment and have problematic relationships with intimate partners (Barth 1990; Cook et al. 1991; Cook 1992; Courntey 2001).

While there is considerable debate as to what extent these outcomes are the result of the system's fragmented form of care, or in contrast whether youth who enter care have prior propensities toward these outcomes given their SES origins (Berzin 2008), the consensus among many child welfare scholars and advocates is that the system fails to adequately support these young adults (Courtney & Heuring 2003). Not surprisingly, the last ten years has witnessed a dramatic growth of new services and programs for transitioning youth aging out of foster care, such as new housing services, education subsidies, mental health programs and insurance extensions[57].

As will be discussed in the future chapters and in my critical review of this literature, this crisis, while real and deserving of attention, likely reflects a broader ambivalence in society about the uncertainties of modern young adulthood itself, and the difficulties many young people face, both in and out of foster care, navigating the current economic environment. Similarly, changing definitions of an "emerging adulthood" (Arnett 2000) wherein the first years of adulthood are now viewed as a stage "extended

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[57] The most notable of these reforms was the Foster Care Independence Act (FCIA) of 1999 that mandated that foster youth aged 16 or older be provided a series of sessions related to "life skills" and "transition planning" at least 24 months before their emancipation. Along with other policy reforms, FCIA provided substantial funding and resources for new programs that offer transitional and supportive services for recently discharged youth, resulting in a dramatic growth and evolution of transitional housing, educational and mental health programs around the country. Similarly, several localities have made efforts to extend medical and education benefits to this population (such as free tuition in some state universities in Minnesota) with some states even attempting to extend the age of emancipation itself to 21 or older.

adolescence" have likely contributed to increased awareness that former foster youth are "deserving" of additional support and resources. Indeed, the fact that many foster youth experience difficulties after leaving care have been known since the 1920s (Van Senden Theis 1924), yet, only recently have such findings become so prominent in foster care reform. Similarly, renewed discussions about the abandoned foster adult likely also stem from the precarious condition of the welfare system itself. As budget crises have lead to ongoing reforms and sometime dismantling of America's safety net institutions, social workers and advocates have increasingly sought to extend social supports to one of the few remaining deserving adult groups in the US—the formerly abused child. That is to say, efforts to extend state supports to former foster likely encapsulates a broader anxiety about the new forms of social abandonment becoming realized in the US.

One variation of the discourse about the problematic, adult foster youth and the need to extend services pertains specifically to their mental health needs. As will be discussed in the next chapter an expanding social work literature has pointed to pernicious dynamic wherein former foster youth have a high need for mental health services, but also exhibit a salient reluctance to access such resources (McMillan et al. 2009). Because the transition to young adulthood is often associated with heightened levels of stress and mental heath disorder (Kessler 2008), there is growing concern among many child welfare researchers that former foster youth experience a vacuum of services during a critical phase of their life course. Indeed, findings consistently show that mental health service use declines at ages when the prevalence rate of mental health disorders is peaking.

In the context of current anxieties about the general precariousness of young adulthood, and the changing nature of social welfare programs for adults, social workers and child welfare advocates have increasingly called attention to the struggles that former foster youth experience transitioning into productive adulthood. One rendition of this current crisis discourse focuses on the mental health needs of recently aged foster youth.

Chapter 3: Literature Review

Introduction

As the quintessential "at-risk" population, foster youth are the focus of much research that detail their increased susceptibility to a variety of negative life events, including psychiatric hospitalization, incarceration, underemployment, victimization of crimes and diminished well being (Barth 1990; Cook 1991; Courtney & Dworsky 2006; Needell, Cuccaro-Alamin, Brookhart, Jackman, & Shlonsky 2002). More recently this research has focused on the "transitional challenges" that many former foster youth experience almost immediately after aging out of care—such as becoming homeless or leaving school— and the continuing difficulties that many contend with throughout their twenties negotiating new adult roles, identities and responsibilities (Courtney, Dworsky, Lee, Raap, Cusick, Keller, & Bost 2010; Jones 2011; Shin 2005). Such findings are not particularly surprising given the limited resources that many foster youth have at their disposal at the time in which they age out of care.[58] In addition, some foster youth have significant mental health needs that negatively affect their ability to maintain steady employment, secure housing or be successful with higher education (Jayakody, Danziger & Kessler 1998). Some scholars have as a consequence dubbed the process of aging out of a care as a type of "double transition" that foster youth go through as they enter a precarious adulthood while simultaneously exiting state supports (Courtney 2009b).

As stated previously the goal of this dissertation is not to re-substantiate the obvious claims that former foster youth are a vulnerable population, or that they are

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[58] As discussed in the last two chapters, most young people that have had experiences in foster care were in care for relatively short periods of time (typically six months or less) and eventually were reunified with their families. In contrast, long term foster youth who have been in care for multiple years, often to the point of aging out, typically have little to no connections with family members or social networks of support.

deserving of extended resources and services after care. Such claims are easily supported by a large body of research that highlight the above-mentioned outcomes and vulnerabilities. Rather the purpose of this qualitative study is to explore the more subjective experience of aging out of the foster care system with a specific focus on the troubled relationship that many former foster youth have with state-sponsored social services and mental health programs. While several policy initiatives in the last twenty years have attempted to extend new supports and services to this population during their transitional years, many youth exiting state care still exhibit a salient reluctance to access community resources and professional services once they are on their own (Courtney et al. 2010; Shin 2005). In particular the child welfare literature points to a precipitous decline in the use of mental health services by former foster youth, almost immediately after they leave care (Courtney, Dworsky & Cusick 2005; McMillian & Raghavan 2009). A variety of institutional factors perpetuate this dynamic (such as the diminished access to insurance and the dearth of public mental health programs that many youth experience in the community) but studies also suggest that many foster youth are themselves resistant to ideas of seeking care for reasons that are not always clear (Delman & Jones 2012; Moses 2008, 2011; Munson, Jaccard, Smalling, Kim, Werner & Scott 2012; Webster & Harrison 2008). Given this trend, this dissertation investigates the subjective ways that former foster youth understand their "needs" and in turn the sources of supports available to them, in the context of their transition out of care.

In this chapter I review the literature and empirical questions that initially motivated this study in three parts. The first part of this review discusses a growing

literature that documents a very high use of mental health services among youth in foster care, but the lack of consensus among researchers about the significance of such trends. The second section reviews the precipitous decline in mental health services that typically occurs when youth exit the system, and the pressing policy problem this represents given recent conceptualizations of young adulthood. In the third section of the review, I summarize the few qualitative studies that have interrogated more directly the reasons why some foster youth are reluctant to access services and supports in the community. Because most of these studies are informed by conventional models of "health-seeking behavior," in this section I also overview how health researchers and sociologist have typically understood the decision to seek mental health care and how the case of former foster youth somewhat complicates these models and raises new theoretical questions.

Finally this chapter concludes by describing a new conceptual framework for understanding the reluctance of former foster youth to re-engage the "system" of services available to them particularly during a time when they are aging out of the purview of the system itself.

Mental Health and Foster Care: Greater Needs or Overuse?

When considering the topic of mental health and foster care it should be emphasized that the modern child welfare system was intentionally designed to serve abused and neglected children, many of whom have experienced significant trauma in their lives. While not all youth in care are as a result "severely emotionally disturbed" (a disability designation often used in child welfare) most were removed from troubled homes and

disordered environments where the prevalence of mental health problems and substance

abuse disorders are assumed to be much higher than in the general population.[59] Not

surprisingly, numerous studies during the past 30 years have documented a high

prevalence of emotional and behavioral disturbances among youth in foster care

(Clausen, Landsverk, Ganger, Chadwick, & Litrownik 1998; Garland, Landsverk,

Hough, & Ellis-MacLeod 1996; Halfon, Mendonca, & Berkowitz 1995; Havlicek, Garcia

& Smith 2013). While precise estimates are difficult to model for this population, several

studies suggest that between 50% to 80% of youth in long term foster care exhibit a

mental disorder, an emotional disturbance or a developmental disability (Landsverk,

Garland, and Leslie 2002; Taussig 2002). More recently, studies using clinical and

diagnostic measures have found that foster youth report greater symptoms associated

with depression, mood disorders and attention deficit disorder than the general population

(Havlicek et al. 2013; Shin 2005; Pecoria, Kessler, Williams, O'Brien 2005). One, well-

publicized, study recently suggested that former foster youth have a higher prevalence of

Post-Traumatic Disorder (PTSD) than veterans who experienced active combat (Pecoria

et al. 2005).

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[59] The association between lower SES status and increased mental problems is well documented, (Williams, Jackson & Anderson 1997) and would suggest that a welfare program that primarily works with poor and often marginalized families, would result in clients with substantial mental health needs. Moreover, child welfare researchers often argue that foster youth have a high exposure to genetic, familial factors and adverse childhood experiences that predispose them toward poor mental and emotional health (Garland, Landsverk, Hough, & Ellis-MacLeod 1996). Studies based on the National Survey of Child and Adolescent Well-being (NSCAW) find that 70% of children enter foster care with a history of child abuse and/or neglect, and 40% have exposure to domestic violence (Stahmer, Leslie, Hurlburt, Barth, Webb, Landsvertk & Zhang 2005). Studies also document that biological parents of foster youth have high rates of mental illness, substance abuse and cognitive impairment, all of which raise the risk of emotional health problems in their children (Leslie, Hurlburt, Barth & Slymen 2004).

Given the high prevalence of emotional difficulties among youth in foster care, it is perhaps not surprising that foster youth have also been identified as "heavy consumers" of public mental health programs (Havlicek et al. 2013). Estimates range that between 60% to 90% of all foster youth have been treated for at least one mental health condition while in care (McMillan et al 2003; Shin 2005, Pecoria et al. 2005). Studies based on state Medicaid expenditures—the billing records of government subsidized healthcare which nearly every foster youth are eligible for once in the system—suggest that 25% to 50% of youth in care receive some form of mental health treatment each year (Leslie 2004; 2005). Though child welfare advocates occasionally cite "gaps" and "service disparities" in the types of mental health treatments available to all foster youth (Garcia et al. 2013; Landsverk et al. 2009) this literature has generally found that youth in care receive mental health treatments at much higher rates than similar populations. One often cited study by Halfon and colleagues in the 1990s (Halfon, Berkowitz, & Klee, 1992) found that the rate of Medicaid billing for mental health was nearly 10 times greater for foster youth than for non-foster youth enrollees of public insurance programs.[60] More recent Medicaid studies in California, Washington and Pennsylvania corroborate that children in foster care consistently account for large, disproportionate shares of state expenditures on mental health, at rates that are 5 to 15 times higher than the general Medicaid population (dosReis, Zito, Safer, Gardner, Puccia, Owens 2005; Halfon, Mendonca, & Berkowitz 1995; Harman, Childs, and Kelleher 2000; Takayama, Bergman & Connell 1994). These studies also highlight that expenditures related to psychotherapy

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[60] While foster youth comprised only 4% of Medicaid enrollees in California in 1990, their use of services constituted a total 43% of all Medicaid expenditures related to mental health in the state that year

and medication (as opposed to billings for physical healthcare) constitute large portions of Medicaid billings for foster youth.

Cohort studies of older foster youth transitioning out of care, which draw from more precise individual-level data over time, have similarly documented a high use of mental health services by youth in the child welfare system, particularly during their final years in care before they "age out." In McMillen and colleague's (2003) longitudinal study of older foster youth in Missouri, 83% of the sample reported receiving some form of mental health treatment during their last year in foster care. This is similar to the 80% rate reported by the Casey Alumni Northwest Study (Pecoria, Kessler, Williams, & O'Brien 2005). In slight contrast, the ongoing Midwest Study reported that only about half of the sample had a recent history of receiving mental health services (Courtney et al. 2005); though this was still a substantially higher rate than what is found in community samples of similarly aged youth.

Because of the presumed greater mental health needs within the foster care population, the child welfare literature has generally portrayed these high treatment patterns positively and as an indication of the increased improvements made to children's mental health programs in recent years. In a special edition of the journal *Child Welfare* dedicated specifically to the issue of mental health policy (Feb 2009) contributors cited the above trends as "promising signs" of how modern child welfare systems were better addressing the needs of abused children compared to the past (Landsverk et al. 2009). Interestingly, despite the high percentage of youth receiving services in foster care today, many of the contributors emphasized recent findings that of continuing "unmet mental

health needs" among some in this population, particularly among very young foster

youth.[61]   Such sentiments resonate with what could be characterized as an emerging

"public health framework" gaining popularity in child welfare research that points to

relative differences in treatment rates across groups as evidence of "mental health

disparities" in foster care (see review by Garcia, Palinkas, Snowden & Landsverk 2013).

While the association between foster youth exhibiting symptoms and receiving treatment

has been generally found to be strong (Burns, Phillips, Wagner, Barth, Kolko, Campbell

& Landsverk 2004), this new area of research nonetheless highlights the relative "service

gaps" that exist between different child welfare populations, particularly across white and

non-white foster youth (Garcia 2013; Hurburt 2001; Zwllich 2000). In Leslie and

colleagues' (2004) analysis of older foster youth in the NSCAWB, for example, the

researchers found that African American youth in the national sample were a third less

likely to be receiving services than white foster youth; even though the broader study

found that 75% of all youth in the sample who had "exhibited need" had received a

mental health intervention.[62] This finding is similar to other studies that highlight how

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[61] The National Study of Child and Adolescent Well Being (NSCAWB) is one of the few nationally
representative surveys in child welfare that randomly samples directly from child protective agencies. In
one recent analysis of the NSCAWB, it was found that only a third of incoming foster youth receive a
mental health screen during their first year in care, while at least 70% report experiences of severe abuse in
their past (Landsverk et al 2009). Other analyses also find that a substantial amount of "unmet needs" in
the NSCABW, (Burns et. a 2004) though this seems to be particularly prevalent among young children in
the system who are more likely to return home in the first year of being in care. Other analyses of the
NSCAWB that focus on older, long term, foster youth reveal that nearly 75% of all youth identified with
"needs" had received at least form of mental health treatment in their past (Leslie et al. 2004).

[62] In this study Leslie and colleagues (2004) based their analyses on the Children's Behavior Check List
(CBCL) a common measure of emotional and behavioral problems used in child welfare settings
(Achenbach 1991). While not a formal diagnostic assessment, most studies treat CBCL scores of 64 or
higher as indicating substantial need of treatment. In their analysis of 400 foster youth, drawn from a
subsample of the NSCAWB, the researchers found that 75% of all youth with scores of 64 or higher had
received mental treatment in the past year. In their logistic model of mental health service use, however,

minority foster youth, and especially girls, are underserved relative to white males in the system (Garcia 2013; Hurburt 2001; Zwllich 2000), even though as a general group foster youth are much more likely to receive mental health treatment than youth in the community (Leslie et al. 2005).

Overall these and other studies speak to some inconsistency in the literature about the meaning and significance of the high use of mental health treatments in foster care. While the evidence suggests that some youth are perhaps not provided adequate access to mental health screenings or the appropriate types of treatment (particularly among minority groups) the literature is also clear that some youth experience an over-utilization of such services, particularly in respects to psychotropic medication. One study by the Texas Department of Health Services (2008), for example, found that nearly two-thirds of all foster youth 13 and older in the state were on psychotropic medication. This finding is consistent with a series of Medicaid studies done in the last twenty years that estimate medication billings for foster youth to be 3 to 11 times higher than other Medicaid-insured groups (dosReis, Zito, Safer, Gardner, Puccia, Owens 2005; Halfon, Mendonca, & Berkowitz 1995; Harman, Childs, and Kelleher 2000). More recently, Zito and colleagues (2005) found that foster youth in Texas, when compared to other youth in the state also on Medicaid, were four times more likely to be on *multiple* psychotropic medications simultaneously, and that nearly half (43%) of all medicated foster youth in the state were on three *different prescription classes of psychotropic medications* (Zito et

the researchers found that controlling for CBCL scores above 64 (exponentiated OR of 5.66) and other relevant factors (age, placement type and history of abuse) resulted in an odd-ratio of .36 for being African American (with whites being the reference category). The researchers also highlighted how African Americans were substantially less likely to receive services at lower threshold levels of the CBCL.

al 2008). The physician-researchers also found that 75% of all foster youth prescriptions were for "off-label" purposes (treatments for children not endorsed by the Food and Drug Administration) and often had little clinical correspondence with the diagnostic designations on file for individual youth. These and other recent findings have lead some to characterize foster care as a "gateway institution" for mental health treatment (Leslie et al. 2005) and even motivated a number of recent congressional hearings on the issue of over-medicating youth in the foster care system (US Congress 2011).

Both sociologists and critical child welfare scholars have pointed to a variety of institutional and cultural factors that likely contribute to these trends. At the bureaucratic level some have suggested that the "high staff turn-over" among psychiatrists that work in child welfare creates an environment where the over-medication of foster youth is likely to occur (Zito et al. 2008, Munson et al. 2010). Long term foster youth are likely to encounter several psychiatrists and therapists during their tenure in care, many of many of whom will be reluctant to discontinue medication of previous physicians due to the unknown side effects that doing so would have on baseline behaviors. Accordingly, as new symptoms and problematic behaviors arise among aging foster youth, psychiatrists are more prone to simply add to a youth's existing regiment of medication—contributing to their "med cocktail"— than discontinue past prescriptions (Zito et al.2008). This dynamic could in part explain why older youth in foster care have a much higher probability of being on multiple, and often inconsistent regiments of medications than younger youth (Leslie 2005). Some have also suggested that new *managed care models of reimbursement* underpinning many public mental health programs have lead to an

increased use of psychopharmacology for youth, given the institutional emphasis on

efficient symptom-targeted mental health interventions over prolonged, talking-based

treatments (Munson 2013). In this new financial context it is perhaps not surprising that

the proliferation of medications for childhood disorders, and especially the use of

SSRIs,[63] have dramatically increased during a time when the public appeal and marketing

for "efficient chemical interventions" have gradually grown in the last two decades

(Conrad 2008; Healy 2004; Rose 1998).

Though conventional perspectives in child welfare have acknowledged that some

of these "service quality issues" reflect an under funded and uncoordinated mental health

system (Landsverk et al. 2009), others have speculated that these trends also speak to a

more pernicious dynamic within the culture of social work itself. For example,

Fedorvacicus and colleagues (2008) have argued that the overutilization of mental health

services in foster care stems, in part, from an over-rationalized "bureaucratic logic"

within welfare agencies that conflates the need to help abused children with efforts to

provide more mental health services. In their qualitative study of child welfare managers,

family court judges and therapists, Fedorvacicus and colleagues (2008) discovered an

underlying "street bureaucrat logic" in foster care, which views providing *more treatment*

as equivalent to providing *better services*. Accordingly, the high number and regular

frequency of mental health treatments conveys an "institutional signal" to public

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[63] SSRIs (Selective Serotonin Re-uptake Inhibitors) refer to a class of compounds often used as antidepressants in the treatment of depression and other mental health disorders. SSRIs work by blocking the transmission of specific neurotransmitters (in this case serotonin) within the synaptic spaces of neurons, thereby altering the neuro-signals in the brain and theoretically one's emotions and cognitions. Since the 1990s SSRIs have been becoming increasingly popular in the treatment of depression, as well as in use with childhood disorders. Rose (1998) argues that the effectiveness, marketing and appeal of SSRIs have resulted in a new "neuro-chemical understanding of the self" in society wherein individuals reflect upon themselves, and their emotions, as entities to be augmented, and optimized, by a chemical intervention.

stakeholders that the child welfare system is functioning smoothly, particularly in respects to its mandate to help abused children. Ensuring for example that foster youth experience a set number of therapy sessions, or are being treated for a set number of issues, provide "measurable metrics of success" for what are otherwise morally difficult situations for social workers to define and work in. Interestingly in the study several social workers acknowledged that this reductive logic contributed to a "danger of "over-labeling some youth with unnecessary needs," though ultimately many felt all foster youth could be more "helped and than hurt" by unnecessary treatments.

What could be characterized as well intentioned medicalization was similarly observed in Swartz' (2005) ethnography of one foster care agency in Southern California, where a casualness toward "labeling mental health needs" seemed institutionalized and embedded within daily social work practice. In their interactions with foster parents and other public stakeholder, Swartz for example found that case managers often relied upon medical terms and diagnoses to convey their own legitimacy as child welfare experts, even at the expense of exaggerating the pathology exhibited by a foster youth. Particularly in situations when "difficult" foster parents challenged the authority of the foster care agency, Swartz noticed that case managers often emphasized the clinical and dysfunctional dimensions of youth's behaviors, almost as a way of bolstering the agency's jurisdictional legitimacy over family issues. Not surprisingly case managers, who were often younger as well as less experienced with children than foster parents themselves, exercised their symbolic power most effectively when they could re-narrative the needs of youth vis-à-vis their own educated clinical expertise. While Swartz did not

find social workers intentionally mis-labeling youth, or falsifying diagnoses, her institutional ethnography highlights the long-held observation by sociologist that mental health diagnoses are in their nature "sticky social constructs" (Goffman 1969) that once applied to an individual tend to "anchor" most of their social interactions, particularly within an institution.

These and other similar findings also dovetail broader critiques within the social work field itself about what some view as an overreliance on "the medical framework" to legitimize social service interventions and the unintended consequences this has had for individualizing societal problems (Hays 1996; Specht & Courtney 1995).[64] These critiques reflect longstanding tensions within the field of social work between generalist and clinical orientations (Poppel & Reid 1999), but within the context of foster care they also highlight the broader role that medicalization has played in establishing legitimacy and funding for the child welfare system itself. As was discussed in chapter 2, the impetus for much growth of the modern child welfare system in the 20th century was largely dependent on the effective "medicalization of child abuse" in the early 1960s when the "battered child syndrome" was first documented by pediatric radiologists (Pfohl 1977). In the ensuing moral crisis concerning child abuse in America, child welfare bureaucracies expanded dramatically in scope and jurisdiction in the 1960s and 70s, but also gradually grew more financially dependent on revenue from medical insurance programs throughout the 1980s and 90s (Courtney 1998; Urban Institute 2004). From a critical perspective it is perhaps not surprising that concerns over unmet mental health

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[64] Indeed, in their provocative rebuke against social work's increasingly clinical orientation, Specht and Courtney (1995) argue that concerns about mental health in particular have *individualized,* and hence obscured, the very social conditions that motivated the field's inception.

needs have only increased during this time, particularly given the growth of public

insurance programs for children, mental health services and new childhood diagnoses.

But whether or not these trends reflect foster youth experiencing an over-use of

mental health services, or perhaps not enough, is a nuanced question not easily reduced to

one single perspective. Given the high prevalence of emotional and behavior problems in

the foster care population—and the reality of most fragmented and uncoordinated mental

health programs in the US—it is undeniable that many disturbed youth could benefit

from more concerted efforts to improve and increase access to services[65]. At the same

time, it is also clear that social services in the US are shaped by an institutional

prerogative to continually identify increasing "medical needs" among its clients. Foster

youth more than any other group are likely most vulnerable to well-meaning, though no

the less intentional, forms of medicalization. In this way foster youth, and particularly

those that have grown up in the system, represent a unique population of under served,

over-served, youth who simultaneously suffer and benefit from the growth of the

"medicalization industrial complex" (Conrad 2009).

What is far clearer, however, is that when foster youth "age out" many not only

transition out of the system, but also out of their previous status as "heavy consumers" of

mental health services. As will be discussed in the next section, former foster youth

typically exhibit a dramatic decline in accessing such services in the community almost

immediately after leaving care. Because this drop in service use occurs during what is

characterized as a critical phase of young adulthood, there has been growing concern that

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[65] As discussed earlier most conventional perspectives in child welfare have cited many of the above
overutilization problems more as "service quality issues," that could be resolved with increased funding
and better coordination.

disruptions in treatment happen precisely when needs are at their greatest. Indeed some

child welfare researchers argue that one of the most important factors underpinning many

of the poor transitional outcomes associated with foster youth—homelessness,

incarceration, unemployment, abusive relationships— is the high prevalence of untreated

mental health and substance abuse problems among this population (Courtney and

Heuring 2006).

The Troubling Decline during Troubled Times

In contrast to the high use of mental health services characteristic of foster youth *while in*

care, several studies point to a dramatic and precipitous decline in such service use after

youth leave care. In McMillen and Raghavan's (2008) two-year longitudinal study of

youth aging out of care, the researcher's found that service rates declined by 89% during

the 24 months of the study period. Surprisingly 60% of the reduction occurred within the

first two months of when youth left care. Indeed, the researchers found that "time of exit

from foster care" was the strongest predictor of when participants specifically stopped

accessing services, even when accounting for other factors like their access to insurance

and/or status of mental health.[66]

Similarly, the ongoing Midwest Study by Courtney and colleagues has also

documented that many former foster youth abruptly disengage from mental health

services after leaving care. In a series of published studies, Courtney and colleagues

reported that the number of youth accessing mental health resources decreased almost by

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[66] The staggered sampling design of the study provided multiple (9) observations of the youth over the 24 months, allowing the researchers to estimate the precise effect that leaving care had on the propensity to disengage from services in their multivariate logistic regression.

half in their first year as emancipated adults, and declined subsequently another third in the following years (Courtney et al. 2005, 2007, 2009a, 2011). Youth in the study also stopped using psychiatric medication by approximately the same rate during this time. Overall these findings are consistent with broader research based on Medicaid billings on "transitional age youth" exiting a variety of public systems (including the criminal justice, mental health and child welfare systems). Analyzing over a decade of Medicaid data on a national sample of transitional youth, Pottick and colleagues (2009) found that billings for mental health services declined 53% in the first year that youth transitioned out of care and continued to precipitously decline in subsequent years, particularly for outpatient therapy sessions. Interestingly, the researchers found that some individuals eventually "rebounded" in their utilization patterns during their late twenties, ironically when many became involved with the criminal justice system.[67] Nonetheless, for most individuals the period young adulthood was a time of few contacts with mental health service providers; utilization patterns that seem generalizable to many young adults (McMillen & Raghavan 2009).

From a clinical perspective the consequences of abruptly stopping a mental health treatment at age 18 or 21 can vary considerably, depending to a largely on the severity of an individual's mental health condition but also importantly on their regiment of medication (Howland 2010). Patients suddenly stopping a psychiatric medication, as opposed to gradually reducing a dosage over time, can lead to severe withdrawal

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[67] In this study Pottick and colleagues (2009) linked Mediciad and administrative data By their late twenties some individuals had almost returned back to their previous "high utilization patterns," though at this later stage the start of mental health treatments often coincided with their entrance into the criminal justice system.

symptoms, increased emotional distress and, in extreme situations, even induce a psychiatric relapse (Baldessarini, Tondo, Ghiani & Lepri 2010; Freedman, 2010). On the other hand, many mental health treatments—such as cognitive therapy sessions—can be intermittent in nature, where it is quite normative for patients to abruptly exit but eventually return to care several times throughout their "illness career" (Pescosolido, Gardner, & Lubell 1998, Aneshensel 2013). Nonetheless clinical perspectives within child welfare have long characterized "aging out" foster youth as particularly "vulnerable" when they disengage from treatment (see review by Munson and McMillen 2012). The clinical literature suggests that while many foster youth may crave their independence when they age out of care and are "finally free from the system," most harbor significant emotional problems that hamper their abilities to successfully navigate the challenges of young adulthood, particularly without "therapeutic support." From these and other similar perspectives in child welfare, many aging foster youth stop accessing mental health services precisely when mental health needs may be at their greatest (Courtney 2009b).

Such concerns have recently received more attention in part because of an "evolving awareness" in the child welfare literature of the transitional challenges associated young adulthood more generally (Courtney 2009b). According to recent epidemiological estimates 75% of all mental health disturbances in the general population occur before the age of 24 (Kessler & Wang 2008) and a growing body of research depicts the "transition to adulthood" as a specific time when emotional problems increase due to heightened levels of stress (Linda 1993). During this relatively short phase of the

life course, typically between 18 and 25, young people navigate a variety of

consequential and stressful decisions related to education, employment, partnerships and

family. Because many of these decisions are often made under uncertain and changing

circumstances, it is assumed that the heightened stress associated with these transitions

exacerbate mental health problems and one's propensity toward psychopathology.[68]

Similarly, sociologists working within life course perspectives have suggested that

marginalized youth often lack support and help from family members to effectively cope

with "the vicissitudes of life" during this time and are as a result more prone to increased

mental health difficulties (Shanahan 2000, Setterson, Furstenbert & Rumbaut 2005).[69]

Because many foster youth are disconnected from family members, or at least have

problematic relationships with their parents of origins, it is assumed that most are in a

distinct disadvantage in respects to the extended parental supports that many young

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[68] Most theories of psychopathology describe life stressors, and the inability to handle such stress, as the underlying cause of most mental health difficulties. For example the stress-diathesis model of depression (Abramson, Metalsky & Alloy 1989; Beck 1976) suggests that stressful life circumstances—such as those associated with precarious employment, feelings of isolation and exposure to uncertainties –can result in "depression reactions to stress" that in the absences of treatment or support will crystallize into clinical depression over time. Sociologists have contributed to this stress paradigm by arguing that exposure and reaction to stress reflect a socially structured process; meaning that some groups are exposed to more toxic combinations of stress, and have less resources to cope with such stress, than others (see Perlin's 1980 description of the stress process model). More recently, behavioral geneticists have reported evidence that a person's response to stress is moderated by both their genes but also their history of abuse (Caspi et al. 2003), suggesting that young people exiting foster care, often with extensive histories of abuse, have a heightened "genetic risk" for depression.

[69] One example often discussed in this literature revolves the precarious circumstances under which some marginalized youth enter "early parenthood," and the lacking resources and supports they have available to confront the role strain of being a young parent. Young women in particular often experience significantly more stress, and are as a consequence more vulnerable to depression, because they often face more severe labor market disadvantages as parents then men.

people today experience (Courtney 2009b; Osgood, Foster, Flanagan & Ruth 2009).[70]

Given these developments child welfare scholars have suggested that like most young

adults former foster youth experience a relative increase in mental health problems during

their early 20s, but given their past histories and often precarious resources, the

consequences of disrupting treatment are particularly detrimental (Courtney 2009b).

Indeed, more than just a time when mental health problems are more prevalent,

the transition to adulthood has also been more broadly conceptualized as a "critical

period of the life course" when a variety of social disadvantages begin to accumulate and

contribute to life long trajectories (Elo 2009; Hayward & Gorman 2004). Sociologists in

particular have emphasized that how well young people navigate their transition into

adulthood—the extent to which they smoothly transition into new roles and achieve

normative milestones —has significant influence on latter life outcomes related to health,

education and income attainment (Elo 2009; Shanahan 2000). Accordingly, young

people who experience significant challenges during young adulthood are more likely to

face continuing disadvantages throughout their life time (Elo 2009; Hayward & Gorman

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[70] Norms surrounding parental support during the transition to adulthood have changed considerably
during the last forty years, exacerbating a new form of disadvantage for young adults from marginalized
backgrounds. In the face of changing labor market conditions and a wide variety of other social and
cultural factors that have 'delayed the traditional markers of adulthood,' middle and upper class parents
have extend the timing and types of support provided to their adult children (Swartz 2009). Some have
estimated that in the US young adults on average receive the equivalent of $38,000 in housing, food and
cash assistance from their parents throughout their twenties (Schoeni and Ross 2004). Research also
indicates that young adults often rely on their parents for substantial social and emotional support during
acute periods of financial and social difficulties, and that such supports can buffer the mental health effects
of heightened stress (Swartz 2011). Given the uncertainties of most career paths, some have characterized
young adulthood as a time when parental supports play an important stabilizing role during what is
otherwise a "sink or swim" time in the life course (Furstenberg & Rumbaut 2005).

2004).[71] From this lens, a spike in emotional problems during the transition to adulthood represents not only a significant "health risk" into itself for foster youth, but is also a likely disruptive factor to their long-term development and success.

Drawing from this new life course perspective, several studies have explored the explicit role that untreated mental problems play in "derailing" young adulthood for already vulnerable youth. While the distinction between cause and effect is somewhat blurred in this literature, a variety of studies have found that psychiatric hospitalizations have "destabilizing effects" on a young person's transition to adulthood, and in particular can delay their finding stable employment, completing formal education and forming personal relationships during young adulthood (Jayakody, Danziger & Kessler 1998). Research drawing specifically from foster care samples have similarly found that mental health problems are associated with "disruptive events" known to delay adulthood, such as homelessness, (Fowler, Toro & Miles 2009) and becoming incarcerated (Cusick & Havlick 2012). In short, these and other findings have highlighted that "young adulthood is often a time when things come undone" for many foster youth, particularly those with unaddressed mental health issues (Osgood, Foster, Flanagan & Ruth 2009). Because it is assumed that these disadvantages and delays will only accumulate over the life course, some have even optimistically characterized the "transition to adulthood as a new window of opportunity" for public policies, and in particular mental health programs, to

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[71] Life course perspectives emphasize that transitional difficulties in one domain of life often have spill over effect on other domains; difficulties maintaining stable housing, for example, exacerbate education and employment challenges, leading to a "cascading set of disadvantages" that accumulate throughout the life course (Hayward 2004). Developmental psychologists have also argued that social and cognitive abilities are still under development during this phase of life and thus susceptible to deviation—leading some to even characterize the early twenties as a period of extended adolescence (Arnett 2000).

more effectively address the multitude of negative outcomes associated with former

foster youth (Osgood et al 2009).

It should be noted, however, that one of the few longitudinal studies that has

carefully tracked depression symptoms among former foster youth over time has not

supported the presumption that mental health needs necessarily spike in the first years

after youth leave care, or that the majority of former foster youth are hampered by their

mental health needs (Munson & McMillen 2012).[72] This and other research also suggest

that transitional interventions, like community mental health programs, may have limited

benefits on long term adult outcomes (Montgomery, Donkoh & Underhill 2006).

Nonetheless in the current context where concerns about young adulthood have become

more pronounced in public discourse, extending treatments and transitional supports to

former foster youth have gained considerable political support. It is telling for example

that Congress has successfully amended the Social Security Act three times during the

last three decades to specifically address the transitional challenges associated with foster

youth—starting with the passage of Title IVE in 1986 that created a new federal

entitlement associated aging foster youth and their access to transitional supports.   Most

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[72] In a latent class analysis of "depression trajectories" among 400 youth who aged out of care in Missouri, Munson and McMillen (2012) found that most youth (approximately 78%) experienced no significant changes in their mental well being for several years after they left care. While a minority of youth (approximately 16%) did experience a spike in mental health symptoms, most experienced "non-clinical levels" of distress throughout the course of the study. In contrast, only a small group in the sample (approximately 6%) experienced a gradual increase in depressive symptoms during the two-year period, eventually reaching clinical levels. Ironically this group consisted of individuals most likely to access mental health treatment in the community. While this one study does not invalidate the broader risks of young adulthood highlighted by the literature, these findings nonetheless suggest that the depth and frequency of mental health problems may be less severe as speculated by most child welfare researchers. In so far that only a small percentage of this representative sample experienced a decline in mental health, Munson and McMillen (2012) themselves argue that the "pathological framing" of former foster youth is likely inappropriate for the vast majority of young people aging out of care.

notably in 1999 Congress passed the Chaffee Foster Care Independence Act (PL 106-1691, also know as the Chaffee Act), which dramatically increased funding for independent living programs in the community to provide housing, education, vocational training and mental health services to former foster youth.[73] Recently these services were expanded even further through the Fostering Connection to Success and Increasing Adoptions Act of 2008 (PL 110-1351, also known as FCSIAA). In addition to broadening the definition of "transitional youth," FCSIAA also re-orientated transitional programs toward a more "protective scaffolding approach" — borrowing the vernacular of developmental psychology—so that services and benefits are staggered across longer periods of young adulthood. These legislative amendments have also prolonged the time that young people can effectively remain in the foster care system itself (in many states youth can remain in foster care until 21) as well as extended their medical insurance coverage through Medicaid.

Through the extension of these entitlement and services the state has in some ways broadened its role as the "corporate parent" for former foster youth (Courtney 2009b) by providing at least some semblance of continued support to young adults previously under its care. The political effort to broaden the state's "parental responsibilities" have clearly benefited from re-conceptualization of young adulthood as

[73] Independent living programs, or transitional services, vary considerably in terms of their structure and goals. Some programs are simply training groups done in foster homes or in the community focused on providing youth "life skills" and transitional planning. More formalized housing programs for youth after they leave care offer semi-structure living arrangements in single-unit apartments in the community. In these programs youth often pay a portion of the rent in exchange for their regular participation in services. Most of these programs also stipulate that youth pursue either full time employment It should also be noted that the Chaffee Act also expanded federal funding for "independent life-skills training" and "transition planning " programs for older foster youth before they age out of care. Bundled with many of these programs are components of a mental health intervention, such as offering counseling, group sessions and medication reviews.

an "extended stage of adolescence" (Arnett 2000), as well by research findings that highlight the normative trend for parents to support their adult children during the first years of their transition (Schoeni and Ross 2004). Nonetheless, as discussed by Courtney (2009b) these efforts have been also defined, and limited, by a broader political ambivalence in the US toward social programs, and in particular the perspective that the growth of public supports potentially incentivizes individuals to become more dependent on the state. Indeed, early efforts to provide services to former foster youth throughout the 1980s and 1990s were defined around an explicit prerogative that such services ultimately help young people become more *independent from, rather than dependent on,* state services over time. Speaking to what can be characterized as a neoliberal, or welfare retrenchment political logic (Soss, Fording & Schram 2011) the goals of nearly all transitional programs at this time were framed in terms of increasing self-sufficiency, independent living skills and labor force participation among former foster youth. To a certain extent this welfare-to-work language has been softened through the passage of FCSIAA 2008, which re-conceptualized transitional programs around more expansive and chronic needs (such as the extension of medical insurance), but to a large degree most transitional supports today are still by definition temporary in nature.

Perhaps reflecting this limited, and if not transient, nature of most transitional services, the research literature has yielded little evidence that these short-term interventions have substantial and prolonged impacts on a young person's life (Montgomery, Donkoh & Underhill 2006).[74] Though some research findings suggest that

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[74] Overall there is a limited body of research about the efficacy of independent living and related programs for youth aging out of foster care. A 2006 literature review examined studies of such programs from the

transitional programs provide some immediate benefits to former foster —particularly in

reducing their risk of homelessness and increasing their engagement with post-secondary

education— long term outcomes show little difference between individuals in these

programs and those not (Courtney 2011b).   One central issue reflects the limited

financial and housing supports actually provided by programs. Moreover, it is unclear

whether the few youth who remain engaged and do well with these services over time

would have not "transitioned well" regardless of their participation with these programs.

This self-selection methodological limitation, common to most evaluations studies, is

underpinned by the fact that many foster youth are reluctant to engage with social

services programs for prolonged periods of time after leaving care (Courtney 2011b;

McMillen & Raghavan 2010; Mares 2010). Indeed, as some researchers have reported,

many former foster youth in these programs express an "explicit aversion" to still being

"under the thumb" of child welfare services, and are not surprisingly eager to "to be out

of the system completely" which they sometimes associate with any service or program

implicated with the state (Mare 2010).

     While the lacking efficacy of transitional programs may in part stem from the

disparate between the extensive needs of youth and limited nature of services, it is likely

that the "explicit aversion" that many youth hold toward the state also plays an important

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1990s through October 2005, and identified eight evaluations that had promising, but limited, findings, due
to the fact that most were one-sampled observational studies (Montgomery, Donkoh & Underhill 2006).
However, one federally mandated study that incorporated random assignment into four programs in
California and Massachusetts, called the Multi-Site Evaluation of Foster Youth Programs, found little
evidence that such program have had substantial impacts on young people. A follow-up study by Courtney
(2011b), nonetheless, suggests that while foster youth who are engaged with these types of programs had
the same likelihood of success and challenges as non-engaged youth, individuals in program were overall
more securely established in education and employment.

role. The fact that that many youth may be unmotivated to extend their involvement with a state-sponsored program, will undoubtedly diminish the potential benefits of extended state supports. Given the only recent attention in the literature given to these issues, there is a dearth of studies that have explicitly explored foster youths' likely complex and embedded attitudes towards social services in the community—though a few studies have explored this reluctance explicitly toward mental health programs specifically. Nonetheless, despite the growing literature of mental health disparities in foster care, and the multitude of studies that point to the salient needs of aging foster youth, relatively few studies have reported on how former foster youth themselves view and understand these issues. As I review in the next section, among the few qualitative and focus group studies that have been conducted, findings suggest that former foster youth perceive a variety of barriers in the community accessing care more generally. These include dealing with the "maze" of adult welfare bureaucracies and the general lack of mental health services in the community (Davis 2006; Webster & Harrison 2008). Difficulty maintaining constant insurance coverage is also frequently cited in this literature. However, beyond these institutional barriers, studies also find that most former foster youth are active agents in their disengagement from service and programs. That is, when explicitly asked about the main barrier to service most foster youth discuss their disengagement in terms of a personal choice or decision (McMillen & Raghavan 2010). In general these studies have found that participants' have significant concerns about the stigma of accessing care as well harbor a general mistrust toward service providers. Moreover, some studies have pointed to a salient resentment among foster youth towards psychotropic medications,

and pessimism about the efficacy of mental health services more generally (Moses 2011; Munson 2010).

While there have been relatively few qualitative studies in this area, in the next section I summarize, and put into conversation, a set of similar findings and emergent themes about former foster youth that have been reported across these different projects. Because most of these studies have been informed explicitly by conventional health-seeking models of patient behavior, I begin the next section with a quick overview of this health-service approach to understanding why and how individuals access mental health treatment. Underpinned by a rational choice understanding of human behavior, these choice models presume that foster youth pay a high price, and receive few benefits of accessing services. Interestingly some studies in this area have incorporated but also extended these models, particularly as they pertain to the varied ways by which foster youth view the value and purpose of mental health treatment. In some situations child welfare researcher have taken inspiration by sociologists to broaden the concept of health-seeking itself to include the context dependent, and socially interactive, nature of seeking help itself.

Understanding Health Seeking Behavior

Understanding why individuals reject or refuse to engage with a mental health treatment has received considerable attention in various literatures, though often with researchers employing different terms and concepts such as *treatment adherence, medication compliance, service retention, premature termination* and general *health-seeking behavior*. Though there is a general lack of consistency in how many of these terms are

operationalized across studies (see review by Kim, Munson & McKay 2012), most of this research is based on the premise that a person afflicted with a mental condition is unlikely to improve their well being if they are not fully engaged in care (Horwitiz 1999). Many health researchers also share the belief that improving adherence to mental health treatment will have aggregated benefits to society, given that the majority of individuals afflicted with a mental illness never seek professional help (Kessler 2008) and among the few that do, most end their treatments prematurely (Pescosolido 1999).

The decision to seek professional help for a mental health condition, however, is a complex socio-psychological process not easily reducible to precise social research, particularly given the nebulous ways mental health can be both experienced and defined. Acknowledging that one has a mental health condition deserving professional attention also has deep implications for an individual's sense of self. Because mental health conditions often call into question how one *feels, thinks* and *perceives reality*, mental health patients cannot "keep at arms length their condition and how they view themselves" (Karp 1996: 54). In addition to negotiating a new illness identity, individuals seeking treatment must also contend with the risks of becoming labeled and internalizing the stigma of being mentally unstable (Link & Phelan 1999). Lastly, unlike other medical conditions, mental problems are not universally accepted as legitimate afflictions across different sectors of society, or cultures, complicating how individuals navigate the conventional norms and privileges associated with being sick—what Parsons (1939) described as "occupying the sick role." In short, mental conditions are chronic in

nature, ambiguous in form, and often implicated with an individual's sense of self and identity.

Despite these challenges, one of the most common ways that researchers have conventionally interrogated these issues—and in particular how researchers have thus far studied transitional youths' reluctance to access care— is to view mental health treatment through the lens of a "health-seeking" decision.   Accordingly, accessing mental health treatment is fundamentally a personal choice that individuals make to either act on, or ignore, their mental health needs (whether these needs are self-perceived or ascribed by a third party).   Early research that exemplified this approach often explored the hidden "covariates" underpinning the different hospitalization rates and treatment decisions observed across groups, in the hopes of uncovering the "social contingencies" that either motivated or deterred individuals from entering treatment. These contingencies often highlighted how sociological dimensions of class status, education, race and gender, shaped the pathways by which patients found themselves in treatment (Horwitiz 1999; Mechanic 1986).

Over time social researchers have gradually come to define health seeking more broadly in terms of stages, if not a process (Pescosolidio, Gardner & Lubell 1999), that start at some level of *illness recognition* to eventual *disease management*, but often also encompass individuals' perceptions of their needs, their beliefs about the efficacy of medicine, their access to resources and their self-assessments about potential benefits and costs of seeking care (Rosenstock 1996; Anderson 1995, Goldsmith 1988).[75] While

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[75] For example, Rosenstock's (1990) well-known *Health Belief Model* (HBM) views health-seeking as essentially an individualistic decision that stems from one 's perception of their illness vulnerability and

contemporary health-seeking models vary slightly in how they define these stages, or processes, it is important to emphasize that most are still underpinned by a similar econometric, rational-choice, understanding of human nature. Indeed, most models assume that patients respond to mental health needs similarly to how they confront other medical conditions—if not all life decisions—akin to a set of financial transactions. Accordingly, accessing treatment reflects a rational, cost-benefit, assessment of the health situation, as well as having "correct information" about one's options/choices for treatment.

Given this rational choice bias, it is worth noting that health-seeking models are limited in depicting what can be conceptualized as one of two rationalized situations of mental health consumers desisting from treatment (Pescosolido 1992) . One reality presupposes that individuals are motivated to seek care, and want professional help for their emotional disturbances, but nonetheless experience *barriers* and *obstacles* in their environment that increase the relative cost of accessing such treatments. Informed by this perspective, many heath service research studies document the barriers in the community that inadvertently increase the relative costs of seeking help (such as the lack of insurance or the social costs associated with stigma). In contrast, a second reality articulated by health seeking research is that would-be consumers are at the outset uninterested in addressing their mental difficulties. Either because individuals don't understand the severity of their conditions or don't know the efficacy of treatments available, health-

their judgment of the potential advantages of seeking care. Similarly, Anderson' *Sociobehavioral Model* (1998) characterizes the decision to seek care as an accumulation of one's *predisposition* to enter treatment (their health beliefs) the *enabling factor* they confront in their environment (their access to insurance) and the *need factors* present (the severity of their conditions).

seeking models presume that consumers are often ill informed about their mental health status or hold certain health beliefs inconsistent with seeking services. Indeed, public health campaigns surrounding mental health are often based on the premise that most people in society have *imperfect knowledge* about specific mental disorders and/or their effective treatment (Kasper 2000). While these health-seeking approaches are rather reductive, and certainly not inclusive of all frameworks used by mental health researchers, they have nonetheless structured the majority of studies related to mental health and in particular those conducted on former foster youth. In general these studies highlight the unique institutional, social and symbolic barriers (or costs) that former foster youth experience accessing care, as well as the particular health-beliefs implicated in their decisions not to address their mental health problems.

Institutional Costs of Seeking Care

Employing this econometric, health-seeking framework several researchers have explored the additional costs, and decreasing benefits, that foster youth contend with when they access mental health services in the community. Perhaps the biggest institutional barrier that foster youth face accessing care stems from the loss of medical insurance that many experience when they transition out of the child Medicaid system after turning 18 (Courtney 2005; Kushel et al. 2008; McMillen & Raghavan 2010; Raghavan et al 2009). Prior to the passage of the Affordable Care Act of 2012, only a handful of states provided Medicaid Insurance coverage to former foster youth during their transitional adult years, despite the federal government offering incentives for states to extend this coverage since the late 1990s. Even among states that had expanded their

insurance programs to include former foster youth, such as Minnesota where the cutoff

age was set at 21 , enrollment procedures reportedly remained complicated and

burdensome for youth to navigate, sometimes requiring participants to continually re-

enroll into the program on a monthly basis (Davis 2006). Left to contend with the

employer-based private insurance market, most former foster youth experienced

substantial gaps, or complete laps in their insurance coverage for their first years as

young adults (Courtney 2005). Longitudinal studies by Raghavan and colleagues (2009),

as well as by Courtney (2005) have documented that the majority of former foster youth

(between 60% to 70%) experienced disruptions in insurance coverage within a few

months of aging out of care.[76]

The financial challenges resulting from lost of insurance, and having to pay for

services out-of-pocket, undoubtedly impact the decision to seek care among a population

already associated with few resources. Analyses by Kuschel and colleagues (2008), as

well more recently by McMillen and Raghavan (2010) suggest that lack of insurance is

one of the more salient factors affecting service use among former foster youth, even

when controlling for other issues related to the severity of a mental health condition or

the geographical distance of mental health providers. From a more qualitative

perspective, focus groups and case studies based on former foster youth have found that

many participants express continuing concerns over "increasing co-pays," "hidden fees"

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[76] In a two-year longitudinal study of 400 former foster youth in one Midwest state, Raghavan and colleagues (2009) found that the majority of the sample (67%) lost access to public insurance coverage within a median of three months after exiting care, with many experiencing a gap of insurance for eight months or longer over the course of the study. Other longitudinal studies by Courtney and colleagues have similarly reported that the majority of foster youth experience one or more gaps in their insurance coverage during their first years as emancipated adults (2005).

and the general "high costs" of medication and therapy sessions, even at low-cost

community clinics where some participants seek services (Munson 2011; Webster &

Harrison 2008). Reportedly, several respondents in Munson's (2012) case study

perceived the five to ten dollar co-pay for services as a sufficient "burdens" to "skip

therapy" some weeks, or discontinue medication altogether. Similarly some respondents

also lamented at the substantial time commitment and weekly cost of traveling to

relatively far away mental health providers.

Qualitative studies in this body of research have also uncovered other institutional

"costs" not directly related to financial resources that impact treatment decisions.

Studies by Delman and Jones (2008), Mares (2010) and Munson et al. (2011) all similarly

report that many some foster youth experience considerable difficulty navigating the

"bureaucratic maze" of adult mental health systems, particularly after transitioning from

what are often more integrative and better funded children's mental health systems.

Indeed, public mental health systems for adults are usually more limited in scope and

organized around acute needs (such as services pertaining to entering or leaving a

psychiatric hospitalization), as compared to more comprehensive children's mental health

systems associated with more preventative and generalized interventions (Davis 2006).[77]

In Delman and Jones' (2008) focus group study with transitional youth and their former

foster parents, several respondents described being "shocked" at the lack of youth-

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[77] In a survey of public mental health systems across the country, Davis (2006) found that 97% of states
categorize Attention Deficit Hyperactivity Disorder (ADHD) as service eligible disorder within their
children mental health system, while for the adult system the diagnosis was eligible for only 39% of states.
This finding speaks to the fact that adult mental health system are often ill-equipped for the age-appropriate
needs of transitioning, young adults, and that there is a mismatched between community services available
and the needs of this population.

appropriate services in their community, but also the level of bureaucratic procedures,

paperwork and wait times required for accessing the few, limited services available.

This finding speaks to the general dearth of quality community-based mental health

programs still found in many regions of the country, despite state and federal efforts to

invest and develop a community-base mental health system since the 1960s (Bachrach

1976; Manderscheid 1999; Rochefort 1999)[78]. While communities have witnessed

substantial growth in their mental health infrastructure during the last decade—

particularly in states like Minnesota and California—research suggests that within some

communities former foster youth still transition into what is described as a "void of

services" after turning eighteen (Courtney 2009b; Davis 2006). Even within areas where

community programs are comprehensive, there is often little to no coordination or

integration between children and adult mental health systems (Davis 2006). As a result

some former foster youth with substantial mental health need literally "fall through the

cracks" when turning 18, even those with sufficient insurance coverage (Courtney

2009b). More than just an issue of lacking service, however, qualitative studies have

revealed that some youth simply don't know, or have the institutional insight, to access

mental health services (Delman & Jones 2008; Mares 2010; Munson et al. 2011).

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[78] While the US has made efforts to invest and develop a community-based mental health system since the 1960s (Community Mental Health Act of 1963)—as part of a general policy to de-institutionalize mental health (Bachrach 1976)—the service capacity of communities has remained quite varied and often times severely lacking, particularly within rural communities. Consequently, former foster youth generally experience what some researchers describe as "a void of services" as they age out of the comparatively comprehensive children's division of programs into a more limited "adult" system (Courtney 2009b; Davis 2006). Moreover, because child and adult mental health systems are essentially separate and uncoordinated systems, youth transitioning between these bureaucracies most often endure a complex process.

Given these institutional barriers, and costs, it is perhaps not surprising that several studies have found that foster youth are more likely to access mental health services if they are already enrolled in some a transitional program in the community—such as housing program or support group (Moses 2011; Munson et al. 2011). Clearly having access to a dedicated case manager, or social worker, affiliated with a transitional program can help youth locate appropriate services and navigate through complicated enrollment procedures. Munson and colleagues (2012) study also highlights that youth who report regular and informal contact with a caring adult in their lives, such as former foster parent or former case manager, are also more likely to be engaged in mental health services in the community. As explained by the logic of the health-seeking framework, these informal supports decreased the overall burden, or increased the relative ease, of accessing care, thus perpetuating its occurrence. Moreover, studies by Delman and Jones (2012) and Munson (2011) report that participants in their studies often experienced mental health as a "bundled service" being provided by the supportive housing or transitional program that they were already participants of. That is to say, researchers have found that a number of transitional programs offer some form of mental health treatment within their comprehensive list of services—such as an onsite counselor or therapist, and sometimes even regular medication reviews by a psychiatrist. Not surprisingly the convenience of onsite mental health resources, but also, the institutional support for residents to remain in therapy or on medication, increased the likelihood that that they continued with their treatments over time.

Social and Symbolic Costs of Seeking Care

Besides these institutional barriers, perhaps the most salient cost that former foster youth face accessing mental health treatment are the self-perceived high risks associated with being *labeled* mentally ill. As all of the qualitative studies highlight, concerns about "stigma" and "fears about being seen as crazy" can be pronounced and widespread within this population. Some have suggested that because issues related to identity development are already salient during this stage of the life course, many young adults are fearful of becoming permanently stigmatized by their peers if they become too involved with mental health providers (Leavey 2005). National surveys of young adults reveal a prevailing perception within this age group that the mentally ill are often ostracized, discriminated and rejected by their peers (Drauker 2010).

One aspect of this fear towards stigma is reflected in how young people attempt to manage "the visibility" of their mental health condition. As a broader mental health literature has suggested, the degree to which symptoms are visible, frequent and disruptive to daily routines, strongly shape how individuals, but also families and close social networks, react to a mental problem and the treatment decisions that are pursued (Horwitz 1982; Mechanic 1986).[79] Interestingly in Moses' (2011) mixed-methods exploration of why some youth discontinued their medication after leaving care, the researcher uncovered that symptoms self-perceived as disruptive and visible had strong predictive effects on medication compliance over time. That is to say, the more youth in his sample perceived that their symptoms were not only disruptive in their lives, but also

visible to others, the more likely they were to continue with their psychotropic medication after transitioning out of care. Certainly the severity and social visibility of a mental illness are interrelated, but Moses' analysis suggests that concerns about stigma and being out-ed for a mental health condition in part motivated some youth to continue their treatment as way of masking their symptoms from the broader public. Indeed, in his later survey comparison between youth who discontinued their medication and those who had not, Moses found that the latter were more likely to report personal experiences with stigma, and exhibit more anxiety and depressive symptoms associated these experiences.

This finding highlights the social dimensions of treating a mental health condition but also the unique symbolic costs that former foster youth can accrue, particularly in terms to their sense of self, when they become overly identified with mental health services and treatments. According to what some sociologists have described as *modified labeling theory* (Link & Phelan 2001), individuals who access health mental health treatment often experience both direct and indirect exposure to negative stereotypes associated with their conditions, that over time lead them to internalize these beliefs into a diminished self concept—what some describe as self-stigma (Corrigan 2007). Longitudinal studies tracking former mental health patients have found that this internalization of stigma can lead to increased depression and anxiety among formally labeled individuals, and can motivate some to even preemptively ostracize and isolate themselves from their social networks after accessing treatment out of fear of rejection (further exacerbating their diminished sense of worth) (Corrigan, Watson & Bar 2006; Link 1987). In an earlier qualitative study of former foster youth and their attitudes

toward diagnostic labels, Moses (2009) observed that concerns about stigma in part motivated some former foster youth to avoid "self-labeling" themselves with a mental health diagnoses despite their sometimes extensive treatment histories. As reported by Moses, the majority of the former foster youth he interviewed actively resisted the labels associated with their previously treated conditions because many felt the conations associated with these terms challenged their sense of normalcy. Even among youth who acknowledged that they had "problems" or "issues," most were nonetheless ambivalent, and inconsistent in how they used diagnostic terms to discuss themselves and their self-perceived problems. Because sociologists have argued that self-labeling with a diagnosis is often a necessary prerequisite to someone voluntarily seeking professional help for a mental health problem (see Thoits 1985; 1990), Moses (2009) argues that the reluctance to overly-identify with a diagnosis and the inter-related fear of self-stigma contributes significantly to former foster youth disengaging from treatment. Indeed, in the latter quantitative stages of the study Moses found that not self-identifying with a diagnosis was a significant predictor of individuals avoiding treatment after leaving care. Moses also reported that the few individuals who did self-label with their diagnosis were not only more likely to be seeking treatment but were also more likely to report negative experiences with stigma and self-stigma.

Moses' more recent (2011) exploration of how foster youth think about psychotropic medication also revealed that perceptions of "power" and "coercion" are deeply implicated in their attitudes toward diagnostic labels, stigma and treatment. Indeed Moses found that youth's perception that medication and labels were often forced

upon them while in care strongly anchored their later reluctance to self-label or seek treatment in the community. Employing a mixed-methodology analysis of surveys, qualitative interviews and institutional records, Moses' analyses highlighted that concerns about the "coercive use of medication" was one of the strongest predictors for participants to not engage with mental health providers after they left care. This aspect of the analysis suggests that power differentials that exist between staff and you within some child welfare institutions, particularly residential treatment centers, can perpetuate a perception among foster youth that mental health treatments are primarily about control and behavior management. In this institutional context it is perhaps not surprisingly that many youth would be resistant to continue medications that from their perspective stifle their sense of control and diminish their self-concept.

Interestingly, from a cost-benefit, health-seeking perspective the "stigma costs" of accessing care are also relatively high given the low benefits that many foster youth associate with mental health treatments overall. Indeed, several studies suggest that many youth view mental treatments as either ineffective, or relatively expensive compared to equally effective alternatives (Moses 2011; Munson et al. 2011; Webster & Harrison 2008). In Munson's (2010) study, some participants reported that consumption of alcohol and other drugs were perceived to be more effective for dealing with stress than either therapy or medication. Other studies on former foster youth, but on young adults more generally, find that consuming narcotics or other drug is a common, and socially acceptable way in youth culture, for coping with personal problems and distress (Shiner & Newburn 1998). Even among respondents in Moses' (2011) study that

acknowledged the effectiveness of medication, some nonetheless complained of their

undesirable side effects were not worth their therapeutic value.

Health Beliefs of Being Abnormal

While health-seeking models often emphasize the costs and limited benefits of seeking

care, these perspectives also posit that knowledge, and more specifically health-beliefs,

play an important role in treatment decisions (Anderson 1996; Rosenstock's 1996).

Health-beliefs sometimes refer to the *perceived benefit*s and *perceived costs* that

consumer associate with seeking treatment, but they also implicate how individuals

themselves *perceive the severity* of a condition and respond to its broader significance in

their lives (Rosenstock 1996).   Indeed, there is a presumption within most health-seeking

perspective that individual who enter treatment are both aware of mental health services

but also see themselves as needing help, and in particular mental health help. From this

perspective, some former foster youth are reluctant to access services less because of the

costs or limited benefits of therapy, but more that they have limited interest in doing so

given their understanding of mental health more generally.

Several of the qualitative studies thus far discussed, highlight that how former

foster youth interpret their distress shape their treatment decisions in the community.

Indeed most of these studies emphasize that former foster youth access mental health

services primarily after experiencing a precipitating "trigger event" or "crisis point"

during their transition out of care (such as losing a job, housing or experiencing violence)

but only if they interpret their emotional responses to these problems as symptoms of an

underlying health condition (Moses 2009; Munson et al 2011; Webster & Harrison 2004).

In their focus group study Webster and Harrison (2004) report that youth who accessed

services in the community described going through a series of prolonged interpretative

stages after experiencing the triggering event. These stages often highlighted the

different levels of insights that participants experience before they came to the resolution

that treatment was appropriate, such as: 1) acknowledging that one is suffering from

distress, 2) recognizing that distress can be a possible symptom of an underlying illness,

3) understanding the social consequences of the illness, and 4) viewing treatment as a

viable option for managing the illness.

More than other health afflictions, however, recognizing the severity of a mental

health condition can often elicit a set of contradictory introspections and self-reflections

about the nature of one's thoughts and emotions (Karp 1996; Kleinman 1978; Krammer

1994). Indeed, because mental health problems implicate how one *thinks*, *feels* and

perceives reality, acknowledging the need for treatment can be a prolonged and recursive

process marked by ambiguity and self-doubt (Aneshensel 1999; Karp 1996). As

succinctly conceptualized by Karp (1996) as the "dialectics of seeking help," the decision

to access mental health treatment reflects a paradoxical *thought-process* in which one

identifies one's own *thought-process* as aberrant and needing treatment. Moses' (2009)

study on self-labeling is again relevant in this regard given that many of his 'non-

labelers' and 'inconsistent-labelers' reportedly expressed an ongoing ambivalence

describing their personal problems as pathological. As reported by Moses, but as well as

in Munson's (2011) study, many participants acknowledged that they felt distressed and

had emotional problems, but most struggled with the "symbolic tension" of categorizing

these problems as fundamentally abnormal. Interestingly, Moses reports that some participants resolved this tension by characterizing their emotional struggles as "behavioral problems" more than symptoms of a mental health condition, which from their perspective denoted a less permanent category of pathology. All of the qualitative studies in this area of research nonetheless suggest that that most young people continually struggle identifying and interpreting the significance of their problems over time.

It is useful to consider these findings in the context of Peggy Thoits *self-labeling theory* (1989), which underpins much of Moses research in particular.   Rooted in Mead's (1934) notion of the "reflective self," *self-labeling theory* argues that mental health consumer *voluntarily* access treatment only after they have essentially internalized a generalized therapeutic other—a "third-person" perspective into their own emotional reactions that demarcates appropriate and inappropriate emotional responses. In short, this socialized third person perspective encapsulates society's "emotional rules" (Hochschild 1978) by which mental health patients recognize their own emotional deviance, and in turn their need for treatment.   Because Thoits *self-labeling theory* emphasizes the importance of socialization, and continued social interactions and exposure to therapeutic norms, it is interesting how much resistance many of Moses respondents reported toward their diagnostic labels, despite their previous and prolonged experiences with therapists, social worker and psychiatrists. While most of the respondents had been in the system for several years, and experienced various forms of therapy, only a minority self-labeled themselves with a diagnostic term or of needing

therapy. On the other hand, Moses found that self-labeling was often associated with more personalized experiences with stigma and self-stigma (as discussed earlier), suggesting that the more someone identifies with a diagnosis the more they internalize the negative stereotypes about their conditions.

Health Beliefs as Explanatory Models

More recently health service researchers have expanded the concept of 'health beliefs' to also incorporate what medical anthropologist describe as *explanatory models of illness* which refer to the ways in which symptoms, or an illness episode, are interpreted and made sense of, by a patient but also their broader community (Kleinman, Eisenberg & Good 1978). These cultural and interpretative frameworks often provide patients "broader explanations" of the root causes of their conditions (the etiology of their distress/disease) what they should expect during the course of the episode, and in turn the "appropriate response" that they should pursue in terms of an intervention or treatment (see review by Kleinman & Semman 2000). Indeed symptoms such as disorganized thinking can be interpreted as normal state of affair in certain cultural contexts, and bizarre and aberrant in others. Moreover, explanatory models often identify either the environment, the body, one's own moral failings or the cosmic/mystical order as the source of their distress or seemingly aberrant behavior, and in doing so, shape how individuals and communities respond to their occurrence.

While most researchers interested in health utilization patterns of former foster youth have yet to explore explanatory models fully, studies by Munson and colleagues (2011), Moses (2011), and Webster and Harrison (2008) all suggest that cultural and

interpretative frameworks play an important role in the treatment decision-making

process. In Moses (2011) study on medication, he found that positive experiences with

psychopharmacology often helped participants navigate the difficult self-work of re-

defining one's own illness identity. In particular, respondents who felt their medications

had been effective in alleviating symptoms, were much more likely to both see their

emotional problems as "organically based"—that is, based on a chemical imbalance or

genetic disorder—but also to be more comfortable with self-labeling overall. Indeed,

perceptions that distress was attributed to "chemical imbalances in the brain," as opposed

to "life stressors" were strongly correlated with participants continuing with medication

as well as seeking treatment in the community. Similarly, in Webster and Harrison's

(2008) study with former foster, the researchers reported that foster youth finding

"success with medication"—that is, finally being prescribed a particular medication that

worked and alleviated specific symptom— often played an important role in helping

participant come to terms with their own need for treatment. This finding resonates

with various qualitative projects that have found that having a positive experience with

medication can be an important "transformative event" in one's illness career and in

particular help individuals resolve their contradictory feelings toward seeking therapy

(Karp 1996; 1999; Martin 2007).[80] Munson's more integrative study that I discuss last

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[80] In his various studies that interrogate the "symbolic life worlds" of clinical depression, David Karp has uncovered that many consumers hold ambivalent, at times contradictory, attitudes about psychotropic interventions. At a symbolic level the effectiveness of medication can be both a source of empowerment but also an acknowledgement that one is not fully in control of their emotions and cognitions. Accordingly, the very fact that medication may noticeably alleviate the symptoms of depression solidifies got a patient that their problems are indeed chemically real but also that one has limited control over one's own emotions, thoughts and judgments. This troubling duality of psychotropic medication, as an intervention that liberates but also stifles one's sense of agency and control, renders the issue of whether or not one should take medication an inherently complicated but consequential step in coming to terms with a mental health diagnosis. Not surprisingly, Karp documents that most depression patients swing back and forth in their

suggests, however, that these symbolic transformations do not occur in a vacuum of

social networks and influences, but are highly mediated by one's immediate context.

Beyond Health-Seeking Models

It is important to note that while health-seeking models acknowledge the role that

health beliefs play in how individual make sense of their emotional struggles, they largely

limit these influences to the psychological dimensions of a health care decision. That is

to say, health-seeking models limit the role that culture and context play in how

individuals find themselves in treatment by virtue of the fact that mental health decisions

and behavior are constructed largely as choices employed by an individual. Given this

focus, it is perhaps not surprising that medical anthropologists and sociologists have

criticized health-seeking models for reducing the experience of illness into simplistic

exchanges devoid of cultural context, structural inequalities and above all personal

meanings (Kleinman & Semman 2000). Others have also argued that most health service

models reinforce assumptions that certain choices and health beliefs are *better* than

others, that professional treatment is ultimately the best outcome for patients, and "folk

interventions," (like seeking counsel from a close friend or a local pastor) are often

inappropriate (Horwitz 1999). Moreover, a variety of critical perspectives have long

debated the presumption that entering mental health treatment is often a choice, given

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assessment of how much their medication really helps them, at times even contradicting themselves about how much control they have over their mental states.

the historical fact that most mental patients have been coerced into treatment (Horwitz 1982; Szaz 1961; 1963).[81]

Interestingly, some child welfare researchers have taken inspiration from these criticisms and incorporated more "symbolic interactive" models from sociology in their study of foster youth and their complex attitudes toward mental health. In particular Munson's and colleagues (2012) mixed-methods study is organized around Pescosolidio's and colleagues (1998) *Network-Episode Model* (NEM) which frames "health seeking" less as an explicit decision made by an individual but more of a socially constructed process that unfolds within a specific context, or social network, in which a person embedded. Consistent with Thoit's (1985) *self-labeling theory*, discussed earlier, the NEM acknowledges that mental health patients are largely socialized to enter treatment by virtue of internalizing certain therapeutic norms for how they should identify and respond to their emotional deviance.[82] The NEM emphasize, however, that

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[81] Early mental health treatments in the US (such as the use of asylums, involuntary hospitalizations or outcaste communities) were often more coercive in nature if not resembled a form of psychiatric incarceration (Szaz 1961; 1975). Sociologists that have emphasized this more coercive aspect of traditional mental health treatment have stressed the power differentials complicit in the process of "labeling" and treating mental deviance (Scheff 1971). Accordingly, admission into a large mental state hospital was in part a reflection of one's lacking social standing and status in society, underpinning the fact that the vast majority of mental health patients were from poorest sectors of society. In Horwtiz's review of this literature (1983) he suggests that class and education continue to play important roles in whether individuals enter treatment on their own prerogative or the prerogative of an agent of "social control" (such as a social worker, physician or a police officer). Following the de-institutionalization of mental health during the second half of the century, and the closing of most large state hospitals in the US, this coercive framework has become less popular in the literature as well as empirically challenged (see critiques by Gove 1979 and Thoits 1990). Nonetheless, some researchers have recently pursued similar "modified-labeling" perspectives (Link & Phelan 2001) for understanding the subtle and insidious ways "coercive" institutions shape how mental health consumers manage their symptoms, particularly after leaving care.

[82] As suggested by Thoits individual's self-label themselves as "emotionally-deviant" in a context of socialized norms about appropriate and inappropriate emotional responses. Similarly, the NEM suggests that parameters of what constitutes a deviant behavior or an emotion disturbances requiring professional attention are highly mediated by the both proximate normative pressures that one may be experiencing in their environment (one's immediate family context), but also the broader cultural values associated with

this socialization occurs not only within the confines of a therapy session, but also within an individual's broader social network of families, friends and peer groups. In short, social institutions and peer networks play an important interactive and social feedback role in how individuals come to understand their particular symptoms, illness and options for treatment. Particularly if one's social network consists of individuals who have themselves confronted mental health problems, or accessed treatments in the past, the more likely that individual will recognize their own emotional problems and seek treatment.

It should be emphasized that Network-Episode Model (NEM), and its later iterations (NEM-II and NEM-III), focuses on *patterns of service use* during episodes of illness, rather than the singular event of entering treatment. Indeed the framework is based on the empirical observation that the entrance into treatment is rarely a discernable decision made by an individual at a particular moment in time. Rather most health consumers "muddle through" health service systems, entering and exiting care several times during their illness careers.

According to the NEM this reflects the interactive and dynamic nature of social networks to exert pressure, if not coercion, for individuals to enter or access treatments at different points in time. Depending on how integrated individuals are at one time with their network of social supports, specific social institutions and the broader circuit of service provider, strongly shape how individuals come in and out of care. Later iterations of the NEM (such as the NEM-II and NEM-III) also emphasize that broad communal

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mental health.

conditions, as well as micro molecular-genetic factors, contribute to how individuals are exposed to stress and negative life events precipitating an illness episode. In short, social networks structure the exposure that individuals have to the risk of developing a mental health problem, but also shape how they respond to them over time.

Munson's use of NEM to structure her qualitative study of foster youth highlight the complex role that social network play in the mental health seeking process. Her analysis reveals that youth having ongoing interaction with a case manager, and/or knowing peers who were accessing services, facilitated their coming to terms of their own needs to seek help, particularly after dealing with a personal crisis. That is to say, being associated with a social network in which it was largely normal for individuals to access professional help for emotional problems, not surprisingly normalized the notion of therapy itself. Moreover, participants felt more normal accessing help for their emotional problems when they were more generally "in contact" with caring adults in their lives, such as their former foster parents or case manager, and were overall integrated in a social network of supportive of peers, such as in the case of being in a transitional program (as previously discussed). This finding was consistent with Nebitt's (2010) small-scale study of former foster youth, that reported that "positive adult interactions" had a significant "buffering" and "neutralizing" effect when participants were distrustful of mental health provider; a factor that otherwise increased desistence from care. In other words, the more that individuals had positive interactions in their lives, the less it mattered that they distrusted therapists or faced other barriers to service. Indeed in Moses (2011) mixed method study that combined surveys and depth

interviewing, the researcher found that positive perceptions of case managers, family supports and peers were all related with greater commitment toward treatment by former foster youth. In contrast, youth who were more isolated reported less motivation to seek care regardless of the severity of their conditions.

In sum these studies highlight the "importance of context" in understanding the complex attitudes that youth may have toward services. While former foster youth may have great distrust of service providers, and mental health interventions more generally, these attitudes can be somewhat bracketed if their social network is overall conducive to the ideas of mental health treatment. But while context seems to be an important factor in how youth come to understand their mental health needs, the existing literature has yet to examine explicitly what this "context" means to youth themselves as they age out of the system of care. Indeed, studies have often operationalized "context" simply in terms of the type of interactions that former foster youth have with adults and peers, but rarely explored the meaninings that youth associate these interactions and their institutional environment more broadly. In particular, few studies have incorporated how individuals view their time in the foster care system, how they feel transitioning out of it and the varied meanings that they can attach with seeking help from social services.

Conclusion: Past research and New Questions

Why do former foster youth dis-engage from mental health services and social services more broadly, after aging out of care? And does this phenomenon have broader significance to their status as vulnerable young adults? In the preceding three-part review I have summarized a set of distinct literatures implicated in this broad question that

highlight: 1) the high prevalence of mental health problems in foster care but also the high use of mental health services provided foster youth, 2) the decline in the use of mental health services exhibited by most former foster youth during the transition to adulthood, and 3) the varied reasons former foster youth disengage from health-seeking behaviors after leaving care.

As discussed in the first section, foster youth are one of the most targeted groups for mental health services in the United States. While being diagnosed with a mental disorder is not a criteria for being in foster care, the majority of long term foster youth will have experienced at least some therapeutic treatment while in care and be on multiple forms of psychotropic medication by the time they age out (dosReis et al. 2005; McMillan et al 2003; Shin 2005, Pecoria et al. 2005; Zito et al.2008). This high rate of services is partly explained by the prevalence of mental health problems among foster youth, but it also clear that foster care is underpinned by an institutionalized culture that can at times over-emphasize the pathology of youth, particularly for legitimatizing purposes (Epstein 1998; Fedorvacicus et a. 2008; Specht & Courtney 1995).

Though it is unclear whether youth are being over-medicated or not provided enough mental health access, the literature is nonetheless clear that when youth age out of care this high rate of service abruptly ends. As discussed in the second section the majority of youth on medication and receiving services effectively end their treatments within the first year after that they leave the system (Courtney et al. 2009a; McMillen & Raghavan 2008; Pottick et al. 2009). Because this disruption in treatment occurs during a particularly challenging period of the life course associated with the transition to

adulthood, researchers and policy advocates have increasingly called attention to the long

term consequences that untreated mental health problems can have on a young person's

life (Courtney 2009b; Osgood et al. 2009). The transition to adulthood has been recently

conceptualized as period heightened mental disturbances, but also as a time when an

untreated mental health problems can significantly derail a young person's future

trajectory.

As I reviewed in the last section, the few studies that have explored explicitly the

reasons why foster youth disengage from services have been informed by conventional

health-seeking models that characterize the decision to seek care akin to a financial

transaction of costs and benefits. While conceptually somewhat limited, this body of

research has nonetheless highlighted important institutional barriers and other social costs

that likely make accessing care more difficult for former foster youth in the community

(such as gaps in insurance, lack of service capacity, and the general "bureaucratic maze"

of most public health programs). These studies have also uncovered that former foster

youth have significant concerns about being stigma associated with accessing mental

health resources as well as express a general distrust toward medication (Moses 2009;

2011; Munson et al. 2011; 2012). Moreover, research implicating Pescosolido's (1998)

NEM model suggest that accessing care is less of an explicit decision that young people

make, but more of a interactive process between their self-perceived needs, immediate

environment and their embedded sense of identity. Indeed, more symbolic and cultural

perspectives in medical sociology and anthropology suggest that accessing care is often

implicated with a person's sense of identity, as well as related to the ways in which they

make sense of their broader life worlds (Kleinman, Eisenberg & Good 1978).

I have argued, however, that while some recent research has suggested that

context, institutions and *social networks* "matter" in how former foster youth confront

issues pertaining to their mental health, these very concepts have been themselves

underdeveloped in this literature. That is to say, what context actually means to young

people exiting the foster care system and how these individual youth make sense of their

transition out of care, have been largely glossed over in studies on health-seeking

decisions. As will be discussed in the next chapter, to better understand the

contextualized reasons why former foster youth are reluctant to access care, requires a

broader appreciation of how youth themselves come to understand the terms mental

health, their identity as former foster youth and the ambivalent relationship they have had

with the foster care system itself. To interrogate these inter-related topics beyond the

confines of a treatment decision, my multi-method qualitative case study employs a new

conceptual model of why foster youth are reluctant to seek care and help from the state.

As is discussed below this model was informed by the above literature review in terms of

key concepts, relationships, and importantly, new questions that were raised in regards to

foster youth and their complicated relationship with mental health.   Given the iterative

and recursive nature of qualitative research—and in particular the simultaneous

interrogation of theory and data implicated during the stage of qualitative analysis—

concepts and questions were continuously revised during the course of the project.

A New Conceptual Model for Understanding Foster Youth

Conceptual models broadly refer to a framework of analytical concepts and relationships that help qualitative researchers structure and organize their analysis (Bloomberg & Volpe 2008). Sometimes described as a "working tool" or type of "data repository" for qualitative analysis, conceptual frameworks help specify the key concepts and relationship of interests to a study, as well as structure the set of empirical questions that the analysis pursues (Merriam 1998). Though qualitative orientations differ in how conceptual models are developed, and when in the research process they are constructed, most researchers construct an initial model after conducting a formal literature review that highlights the key concepts and tensions identified in previous research. It is nonetheless assumed that analysts continually modify their model as new themes and relationships, and questions, emerge out of the data analysis stage itself (Bernard & Ryan 2011).

As discussed in chapter one my initial review and critique of this literature, combined with my own professional experiences as a case manager in the foster care system, contributed to an initial framework that organized my case study around concepts and questions related to how participants understood their experiences with self-labeling, medicalization and stigma. Given the iterative nature of qualitative research, and the varied ways that participants in the study responded to my questions, this conceptual framework evolved considerably, particularly during the later stages of data analysis when broader concepts and questions emerged from the data itself. As will be elaborated in chapter four, because qualitative analysis is often a ongoing process of interrogating

both theory and data simultaneously, the conceptual model went through various iterations, as did the literature review itself. As I briefly summarize below, the final iteration of the model interrogate four clusters of concepts that my analysis will highlight related to attitudes toward mental health, the troubling transition into adulthood and the system.

Attitudes toward Mental Health

According to conventional health seeking models, young people access mental health services when they identify that they have a need for treatment, have access to services and see benefits for doing so. As discussed above, this econometric perspective suggests that unmotivated consumers either experience substantial barriers accessing servicers in the community and/or lacking adequate information about their condition and available health resources.

Given their institutional history most young people aging out of care likely have extensive experiences with mental health professionals, and as the literature suggests sometimes even harbor substantial negative feelings toward mental health interventions. Given this dynamic it is unlikely that unmotivated foster youth are simply unaware of mental health interventions or the benefits of seeking care. While it is clear that youth resent the coercive context under which mental health services were sometimes provided, studies also suggest that some youth are not completely dismissive of the benefits of mental health interventions.

Figure 2: A Conceptual Model for Foster Youth Health Avoidance
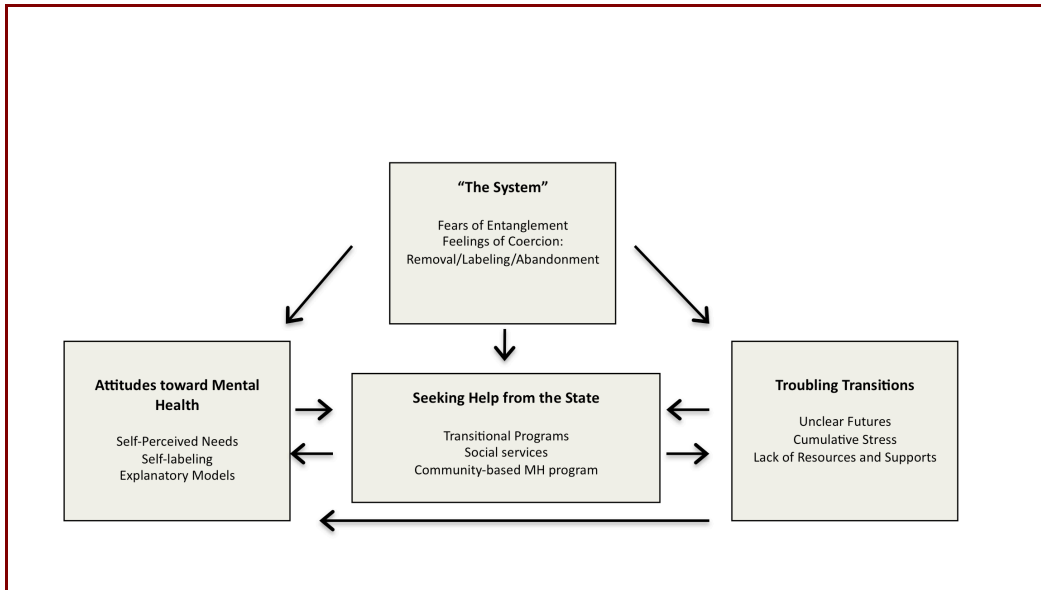
Because health-seeking models somewhat gloss over the nuanced ways that individuals can know about mental health, an initial question that this dissertation explores is how former foster youth perceive the term "mental health" more generally? More specifically, what does it mean to be associated with a mental health diagnosis for a former foster youth, and what does "receiving help" signify in terms of their sense of identity as young adults who were former wards of the state?

To answer these questions the study will interrogate a broad set of concepts related to how participant self-perceive their needs/vulnerability in the context of their transition out of care, how they self-label with mental health diagnosis, and the types of explanatory models they use to talk about their stress.

The troubling transition to adulthood

As discussed above, the sudden disruption in mental health treatment by many former foster youth has gained substantial attention by researchers and policy advocates in recent years because of the presumed vulnerabilities associated with young adulthood. A growing literature suggests that mental health challenges are exacerbated during the transition to adulthood because of the stress and uncertainty associated with the multiple transitions that young people traditionally negotiate during this time. Moreover, because the transition to adulthood is seen as a critical time when adult skills are developed and long-term trajectories formed, untreated mental problems are often characterized as contributing to the general precariousness that former foster youth experience in their first years out of care.

Indeed conventional perspectives in the child welfare literature suggest that after leaving care former foster youth often experience feelings of euphoria due to their increased independence and freedom from the system. But this optimism is often short-lived as most former foster youth confront significant challenges related to housing, employment and social isolation. Many of these events have been highlighted as "precipitating events" or triggers to significant mental health impairment for this population, which if left untreated can presumably exacerbate the challenges associated with their transition out of care.

Unclear, however, is how former foster youth make sense of these stressors/mental health issues in the context of their lived experiences (which in the study often consisted of housing instability, social isolation, financial challenge and encounters with violence). That is to say, to what extent do former foster youth really consider "mental health" and

"poor mental functioning" significant issues in their lives?[83] Upon exiting the system, do

they self-identify as individuals in need or who could benefit from mental health or social

service interventions? Do these perceived needs change or remain static during the

course of their transition?

To address these questions my analysis will explore how participants made so their

troubling transition out of care and in particular the varied, and cumulative sources of

stress in their lives, their uncertain futures and their general lack of resources.

The System

According to the NEM accessing care is less of a distinct decision that former

foster youth explicitly engage at a particular moment in time, but instead resembles a

prolonged set of behaviors that occurs within a broader context of actors, institutions and

their general culture milieu. This emphasis on the symbolic role that "social networks"

play in shaping health seeking suggests that a study on former foster youth requires an

analytical focus on what is perhaps the most important and consistent network of their

lives—the system of foster care itself.

Indeed the existing literature clearly identifies that the experiences that youth had

while in care strongly anchor their attitudes toward mental health services and medication

specifically. In particular, Moses (2009) found that perceptions that one had been

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[83] According to conventional health-seeking models of patient behavior, that informs much of this area of foster care research, accessing care is predicated on a person first exhibiting mental health "symptoms" but also recognizing the significance of these symptoms as signs of a broader mental health problem (Kasper 2009). From a largely rational-choice perspective many foster youth are unmotivated to seek care in part because they lack the "mental health literacy," or adequate *explanatory model* (Kleinman, Eisenberg & Good 1978) for understanding the medical significance of their mental health needs and/or the options available to them for effective treatment. As is explored in chapter five, this first question directly assesses this presumption by directly exploring the interpretative frameworks that former foster youth use to describe their past and present experiences with mental health issues and problems, particular as they confront the often difficult and stressful of transitioning out of care.

coerced to take medication while in care had significant predictive value on whether or not youth continued seeking treatment afterwards. Moreover, the foster care system has at times been characterized as a "gateway for mental health" because it is often the very institution in which youth are first introduced to mental health treatments, medication and therapeutic norms. While these studies have highlighted the "importance of context" in understanding the conflicting attitudes that youth of services, the existing literature has yet to examine explicitly what this "context" means to youth themselves as they age out of the system of care. Beyond highlighting the low-quality of services that youth may have experienced in care, studies have not interrogated more specifically how youth make sense of their time in care and the troubled relationship many have developed with public welfare institutions more broadly.

Consequently, it is important to consider the impacts that this social network—particularly as a meaning system—has had in shaping participants' beliefs about accessing services in the community. As highlighted in the diagram, the experiences of the system, and the types of relationships that youth have with it as foster youth, are hypothesized to directly inform many of the specific health beliefs they still hold. Chapter six will explore the nature of this relationship more directly, by pursuing a set of questions related to how foster youth talk about their experiences as recipients of state care. Specifically, what are the key sources of contention that former foster youth hold toward the system of care, and what do these experiences problems reveal about the nature of services provided by the state? How do former foster youth assess the usefulness of the foster care system and how do they evaluate the impacts that it has had

on their lives. The analytical concepts developed in this chapter will be related to their

fears of becoming entangled in the system, resentment towards coercion and concerns

about being abandoned. Together these concepts reveal the nuanced ways foster youth

make sense of the welfare apparatus and the challenges of being entangled within it.

These concepts also highlight the different, and often troubled, relationships that former

foster youth have with services offered by the system, as well as individuals that provide

them. As will be reported in this chapter, the reluctance to access care often reflects a

deeper ambivalence that former foster youth have with the system itself.

Chapter 4: Methods

Introduction

The purpose of this dissertation is to investigate the subjective ways that former foster

youth understand their mental health needs in the context of their transition out of care.

Some of the central questions that the dissertation will seek to answer include: what does

the term "mental health" mean to a young adult who has spent a considerable amount of

their time in care? What does it mean to access help and support from programs in the

community during a period of transition? How do foster youth understand their risks and

ambitions as young adults?

As stated previously, this project is less interested in restating the obvious claims

that former foster youth are a vulnerable population, or that they are deserving of

extended resources and services after care. Rather, this project interrogates how foster

youth themselves understand their risks, ambitions and challenges after state care, and

how these attitudes may shape their orientation toward mental health and other social

service supports. As such, representative claims are less important for this type of

project, as are more nuanced insights into the different ways that the transition out of

state care can be understood by former foster youth.

This chapter will consequently highlight the appropriateness of a multi-method

qualitative approach for interrogating these dynamics and review the methodological

decisions and overall research design I pursued to conduct this study. In the sections that

follow I will overview: (a) the central rationale for a multi-method qualitative research

design, (b) the research sample collected and description of field sites, (c) the research

design and methods of data collection encompassing open-ended longitudinal interviews

and ethnographic observation, (d) analysis and synthesis of data, and (e) limitations and sources of bias within the study. The chapter will conclude with a discussion of the unique challenges and ethical considerations I encountered conducting the study.

Rationale for Qualitative Research

A central tenet underlying most social constructionist perspectives like symbolic interaction, ethnomethodology and phenomenology is that all social objects, events and life situations acquire meaning through a process of interpretation, social negotiation and re-negotiation (Berger & Luchman 1966; Blumer 1969; Garfinkel 1967; Goffman 1967). In short, daily social life is an ongoing exercise of interactive "sense-making" by different actors and co-actors in particular contexts. However, as eluded by even early sociologists like Durkheim, social interactions and their resulting meanings do not emerge in a vacuum—"social facts" are both shaped by, but also shape our social interactions reflecting an internal but also external preexisting system of beliefs, meanings and values (Durkheim 1894). Our negotiation of the moment is both an artifact of the immediate reality but it also calls upon the taken-for-granted assumptions of a particular environment, the actors involved and their past institutionalized experiences. Pierre Bourdieu's (1984) notion of *structured constructivism* captures well this complex duality of social life; "agents of social action" as he characterized them are both the recipients but also producers of the "structuring structures that structure them."[84]

Much qualitative research is based on this social constructionist tradition, in the

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[84] The reference of "structuring structures" is taken from Bourdieu's (1984) description of habitus —an embodied form of cultural capital that social agents acquire and use in their "social intercourse" with their social and symbolic environment.

sense that nearly all qualitative studies at some level interrogate how social life is

experienced, interpreted and reinforced by individuals in particular contexts. Whether

through interviews, case studies or varied forms of ethnography, qualitative

methodologies imply an *inductive*[85] approach to describing the "life worlds" of

individuals, but also how one's "sense-making" reflects and contributes to broader social

structures. This is often contrasted with more *deductive* and hypothesis-driven

quantitative approaches where the goal is a reductive understanding of social life,

consisting primarily of clearly delineated relationships between social variables. Indeed,

qualitative researchers are often less interested reducing social life to a set of testable

hypotheses, or confirming theories as they are in providing a holistic "thick description"

of social actions, institutions and their complex interplay (Geertz 1973).

Given these attributes, a qualitative analysis of how former foster youth

understand the idea mental health, or more basically what the term *mental health* even

signifies to some, not only has the potential to reveal the particular experiences of these

individuals, but also to speak more broadly of their contexts, or life worlds, in which

foster youth are embedded. Put differently, a study of how foster youth narrate, and

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[85] While no research is purely inductive or deductive in its approach toward data analysis and the use of aprior theories, projects in sociology and social science more broadly, are often framed as encompassing one or the other these idealized forms of inquiry. Research inspired by a deductive approach often incorporates the use of past research and theoretical orientations to form and frame the questions (or hypothesis) it seeks to answer, using observations to test a theory, as well as confirm/disconfirm particular hypotheses. In contrast, inductive research, in its idealized form, starts first with observations of the phenomenon directly, in search of patterns and emergent relationships from the data itself, leading over time to development of theories and conceptual frameworks to explain these patterns. Given the emphasis of direct observation, and development of theory from the ground up, most qualitative researchers often define themselves in reference to the inductive form of inquiry. In practice, however, and in this study in particular, a mix of inductive and deductive approaches toward data, theory development and past research are used.

make sense of their needs as troubled youth, ideally reveals the institutional context of

these terms, but also the particular roles and positions embodied by youth transitioning

out of the foster care system. In this way the focus of this research is less on the

outcomes of foster youth or whether they accessed services but on the *process* of how

they did or did not do so. Indeed, while a number of quantitative and survey studies have

importantly documented the precipitous pattern of declining health service use among

youth exiting the system (Courtney 2005; McMillen & Raghavan 2009), as well as

highlighted the large percentage of youth who hold negative opinions toward mental

health services, little research has explored the embedded and institutional processes by

which these attitudes and behavior may emerge. In short, a qualitative inquiry into the

subjective nature of how former foster youth make sense of their needs, holds much

potential to illuminate how these perspectives may be shaped and develop within a

particular institutional context.[86]

Another important advantage to qualitative research, particularly in respects to a

potential study on former foster youth, is how researchers trained in this tradition often

embrace an *epistemological relativism* toward their subjects and the social phenomena

they study (Agar 1996; Hess 2001; Gray 2002; Patton 2001). That is, it is often assumed

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[86] As discussed in the previous chapter, recently there have been a number of qualitative projects that interrogate the negative appraisals that some foster youth have of mental health interventions (Munson 2009). There have also been studies that have focused on how youth employ a range of resisting techniques to re-frame the rather pathological labels ascribed them by social workers, therapists and the system more broadly (Moses 2008). While these and other studies explored how former foster youth talk about the stigma of mental health, or their dislike with pathological labels, little work has explored how these attitudes are linked to their unique institutional context. An exception to this is perhaps Munson's application of the Network Episodic Model (NEM) in her qualitative analysis of mental health attitudes among former foster youth living in the community, but even here the conceptualization of "social network" is limited to one's interaction with social workers, therapists and other mental health consumers.

that social meanings, or the truths of a situation, are not only relative but they can only be

properly understood within the confines and standards of their particular context (Hess

2001).[87] In this way ethnographers are not interested in making universalistic claims

about a population, or uncovering the Truth of a situation, but rather how truth is itself

constructed in a particular time, place and culture. Toward this end qualitative

researchers often use their subjects' own words and terminology when developing

analytical concepts, or when presenting their finding, as a way of emphasizing the

particular contextualized frame or logic being enacted by their subjects (Patton 2001).

Moreover, researchers, particularly ethnographers, often discuss suspending their own

judgments, or at least acknowledging their own biases, so that they can more effectively

immerse themselves within the life worlds that they are studying (Gray 2002; O'Reily

2012). As a salient example of this, Bourgois and Schonberg (2009) recently described

the necessity of suspending their own morality toward illicit drug use during their

ethnographic study of homeless heroin users in San Francisco. Accordingly, to

understand the complex "social reciprocity of needle sharing" that occurs in this setting,

the medical anthropologists had to first to discover how their subjects interpreted the

effects of heroin in their words and in the context of their own moral community (as for

instance how participants shared a collective fear toward heroin withdrawal or what they

called "dope sickness").

      Epistemological relativism is an important consideration to my study given that

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[87] The basic thesis of relativism is that claims about knowledge, or truths of the social world, are relative to
the specific standards used in a particular context for evaluating such claims. From this position there is no
neutrally, all encompassing Truth of a situation, but rather ethnographers must discover how truths are
themselves defined and constructed in a particular time, place, society and culture (Hess 2001).

while there has been a large literature written on former foster youth and their various problems, as discussed in the previous chapter, much of this has been based on many taken-for-granted assumptions about this population and their inherent pathologies. Indeed, because most foster youth have been rescued from troubled homes, and experienced non-conventional childhoods, there is a tendency to characterize many of their outcomes, lives and activities as inherently non-normative and problematic. While the dire situations and mental and social vulnerabilities of many youth should not be dismissed, there is a danger that research done on their behalf inadvertently reinforces a pathological framing of their lives. Precisely because foster youth occupy a troubled social space in public policy, there is an almost institutional prerogative within child welfare research to continually characterize their behaviors in terms of deficiencies and unmet needs[88]. In short, I contend that many conventional perspectives on foster youth gloss over the complex realities that many of these young adults face. Moreover, because cultural ideas surrounding "mental health needs" are still developing and varied across society, I believe it is important to continually investigate how foster youth themselves view these terms, and their own "needs" more broadly, if we want to understand their social reluctance to access mental health services, and accept help, in the community.

A discussion on epistemological relativism also implicates the unavoidable subjectivity of social research itself. Indeed qualitative tradition often emphasize that researchers must acknowledge that their subjectivity, biases and social positions will always affect the research process in some way. Accordingly all research is

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[88] There is a thin line, in my view, between child welfare advocacy and child welfare research, wherein the desire to provide more services and resources to a population are conflated/blurred with a research prerogative to identify ever more "unmet needs" within this population.

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subjective/biased to a certain extent, and thus qualitative researchers in particular should explicitly self-reflect on their interpretative limitations and relationships to their objects/subjects of their studies. This emphasis on self-reflectivity is an important consideration when conducting research on former foster youth. Indeed, because foster youth have so often been objectified as a distinct and disturbed population, it is helpful to continually question one's professional and clinical assumptions, biases as they engage with members of this group.

Indeed, many of the former foster youth I met during this study did seem to have "mental health problems" from my perspective, and as former case manager who has worked in foster care settings I often found myself implicitly viewing their behaviors and attitudes through the lens of specific diagnoses and categories. When Billy, a 19-year old I met halfway through the study, reported that he had been diagnosed with Bipolar, it became difficult not to view his colorful descriptions of his past, or the extreme optimism by which he described his future, as consistent with the delusions of a manic person. Nonetheless, I worked hard to practice an epistemological relativism in interpreting what Billy had to say about his life and not view the substance of his narrative as simply deriving only from an altered state of mind. While I do believe Billy was likely experiencing some form of mania when I interviewed him, particularly because he reported to me that he had recently flushed all his "meds down the toilet," the narrative of his life, and the particular way he framed his situation, still provided me insight into the particular context and life world that transitioning youth experience. Nonetheless, in reflecting about my feelings toward Billy and his behavior I was able to acknowledge that

my professional experiences in foster care likely shaped, if not hindered, some of my interpretations of the data if not Billy himself. Moreover, this embedded self-reflectivity of qualitative research also helped me better understand how my status as white, Latino, male academic researcher likely also shaped my interactions with my respondents as well.

Review of Research Methodology
In the preceding discussion I highlighted the general appropriateness of using a qualitative orientation for a study on former foster youth. In this section I describe more specifically the methodological traditions that I incorporated in my study, while in the next section I elaborate on how these tradition informed particular methods of data collection and analysis used in this study.

Within the various traditions associated with qualitative research my study most closely resembles the case study methodology. According to advocates of this tradition, case studies imply an intensive description and analysis of a particular social phenomenon bounded by time, place and institutional context (Creswell 1998; Merriam 1998). As Merriam goes on to elaborate, case studies provide an in depth understanding of a situation where the focus is on "process rather than outcome, in context rather than a specific variable and in discovery rather than confirmation" (Merriam 1998 p 19).

In this way, my project can be understood as a case study of marginalized young adults in modern society and the process by which many interact with service provider during their transition to adulthood. The former foster youth "case" is interesting in this regard because the study explores attitudes toward services during a unique period of

time when, according to the literature, the use of such supports declines precipitously among this population. While mental health concerns have become ubiquitous in modern society, I argue that former foster youth often have a unique institutional relationship with these services given their prolonged experiences with the state, resulting in complex and theoretically interesting set of attitudes and perspectives toward state supports more broadly.

In seeking to understand how former foster youth understand their transition out of care, and their needs, my case study incorporates two general categories of information that I characterize as *perceptual and contextual information*. Perceptual information refers to the thoughts, feelings and general cognitive frameworks that former foster youth evoked when describing their situations and challenges as transitioning youth, which were gathered in the study primarily through in-depth semi-structured interviews (the steps of which I outline below). In addition, I also conducted a series of focus groups with former foster youth living in the community or in a transitional program. At a general levels these methods allowed me to uncover how participants described the process of entering and leaving foster care, what elements of these experiences they perceived as important, how these experiences influenced the decisions they made out of care, and whether these attitudes changed or remained constant during the first months of their transition.

While an analytically important component of my study, perceptual information nonetheless introduced its own limitations and "threats to validity" in regards to how participants self-reported their interactions with service providers and their institutional

experiences more generally (Babbie 2007). Though semi-structured interviews provided

insight into how participants understood these situations, they nonetheless provided only

one lenses and perspective into the actions and behaviors of others.[89] To enhance the

validity of the case study, I therefore also conducted interviews with case managers,

foster parents and other professionals that work with this population. Information

gleamed from these interviews not only allowed me to verify some of the comments

made by respondents about the types of interactions that foster youth experience, but they

also provided "contextual information" of the broader institutional environment of foster

care itself.   Contextual information was also gathered through my ethnographic

observations of two social services programs for young people who had recently aged out

of foster care. While not an intentional part of the initial study design (as I discuss

below), my ethnographic observations of these field sites gradually became an important

component of my analysis.

        In short, by blending, and incorporating both these type of information—

perceptual and contextual—I was striving to triangulate the benefits, and reduce the

limitations, of any one qualitative methodology (Babbie 2007, Patton 1998). In the

following section I will elaborate more specifically on the interviewing and ethnography

components of my case study in terms sampling, design and types of questions pursued.

Methods of Data Collection: Qualitative Interviewing
The interview sample for this project draws from the larger Minnesota Entries and Re-

Entries Project (MEEP) a qualitative study of approximately 200 young adults

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[89] As highlighted by the example of Billy, the respondent I discussed earlier, his accounting of how "social workers and foster parents" had always undermined him provided an important perspective on service providers, but one that was likely skewed.

transitioning out of various institutional settings including foster care, the military,

corrections, and mental health settings.   The general objective of the MEEP study was to

investigate the similarities and differences in how different institutionalized populations

experience their transition back into the community, with a particular focus on young

adults. As will be highlighted throughout this description I played an integral role in the

planning and implementation of the MEEP project as one of the five graduate students

and three faculty members involved in this larger study. I was an active collaborator in

all stages of the study's development, but also facilitated nearly 100 interviews across all

of the institutional domains. Because of my interests and experiences in foster care I

conduced the majority of the 40 interviews within this domain as well as modified some

question prompts to fit my dissertation objectives.

The Interview Sample

Purposive sampling was used in all of the MEEP domains to interview young adults

between the ages of 18 and 24 who had experienced at least 30 days in a public

institution and were anticipating an exit and "transition" back to the community. While

this basic inclusion criteria applied to all institutional domains it should be noted that

some additional requirements were applied to some domains to ensure that participants

had substantial experiences in a specific institution.[90] In respects to foster care,

respondents had to have been in long term foster care for a period of over 2 years. While

many young people enter and exit foster care, the goal of the study was to focus on

individuals who had prolonged experiences in the child welfare system and had

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[90] For instance, military respondents were recruited if they had been actively deployed for a period of over year.

effectively grown up while in state care.

MEEP relied on four different strategies for participant recruitment: (a) pamphlets and ads announcing the study were posted in social service agencies and programs that served young people exiting foster care (b) community presentations were facilitated with social workers, case managers and former foster youth at different transitional programs c.) self-addressed postcards were mailed to 30 foster and group homes in the immediate two counties announcing the study and (d) snowball, participant-driven, sampling was encouraged with some respondents by asking them to distribute cards describing the study to others who might qualify and be interested in the project.

The resulting sample consisted of an almost equal distribution of participants coming from each of these recruitment strategies. As highlighted by table 4, the sample was overall racially diverse with 81% of respondents (21 out of 26) identifying themselves as a non-white ethnic minority. Most individuals also reported extensive histories with the child welfare system, having experienced on average 7 years, and 4 or more placements, in foster care. Individuals in the sample also reported a varied distribution of placement experiences, from community foster homes to group homes and residential treatment centers (RTC). As discussed in chapter 2, placements in foster care vary considerably in terms of structure and environment, so this diverse collection of placement histories contributed to an overall richness of the data. It is interesting to note that while this was not a random sample of former foster youth in Minnesota, many of the demographic aspects of this group nonetheless approximated a representative composition of the broader population from which it was drawn. As indicated in the

second column of table 4.1 available data on the approximately 600 individuals who age

out of the foster care system each year in Minnesota suggests that the sample

approximated similar demographic proportions to the broader transitional youth

population. Analyses based on computed t-scores of the differences between sample and

state demographics, indicate that on the surface the sample was overall similar to, if not

demographically representative of, the broader state population in regards to gender, age,

placement histories and some racial identifications. Despite these similarities the t-scores

above 2.06 (the conventional 95% confidence "cut off" level used associated with a

sample of 26 in inferential statistics) suggest two noteworthy demographic exceptions in

the sample. First, the sample contained a smaller proportion of White respondents (19%),

and a corresponding larger proportion of Black respondents (54%) than what is reported

for the broader transitional youth population in Minnesota (68% and 14% respectively).

This over-sampling of Black respondents was likely due, in part, from the fact that most

interviews were conducted within the two largest and most metropolitan counties of the

state where the proportions of Black youth are at least two times larger than the state

average.[91] The sample also differed from the state population in regards to the greater

amount of time that respondents in the study had on average spent in care (7 years

compared to the state average of 5 years), but also the less frequent number of placements

that they experienced during that time (4 placements compared to the state average of 6).

One possible explanation for this dynamic was perhaps the relatively higher proportion of

youth in the sample

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[91] According to US Census data from the American Community Survey of 2006, Black youth comprised
7.1% of the under 18, child population in the state, whereas in Ramsey County and Hennepin County the
rates were 15.7% and 17.4% respectively.

Table 4 Sample Demographics

Comparisons between Study Sample (n=26) and State population of transitioning youth (N=620)

	Sample (n)	State^	T-score^
Gender			
Female	42% (11)	49%	-0.72
Male	58% (15)	51%	0.72
Race			
White	19% (5)	68%	-6.3***
Black	53% (14)	14%	4.09***
Asian-Hmong	8% (2)	8%	0
Latino	12% (3)	3%	1.41
Native American	8% (2)	7%	0.18
Placement Type			
Foster Home	54% (14)	53%	0.08
Kinship	23% (6)	13%	1.21
Group Home-RTC	23% (6)	22%	0.13
Missing-Other	NA	12%	
Mean Age	19.1	18.05	1.84
(SD)	(2.9)		
Mean Years in Care	6.9	4.9	2.49**
(SD)	(4.1)		
Mean # of Placements	4	6	-3.09***
(SD)	(3.3)		

* p<.05   **p<.01   ***p<.001 df 25

^ State demographics as reported by US Department of Health and Human Services (2008)

^ One-sample t-tests of proportions and averages

as compared to the state, who reported residing in "kinship foster care;" situations in which a youth lives with a family member designated as the foster parent. Nearly a quarter of participants reported living with a relative in their last foster care placement and because these arrangement are typically more permanent in nature than traditional group homes, it is not surprising that the youth in the sample reported more years in care but less number of placements.

More substantively it should be stressed, however, that this case study should not be considered truly representative or generalizable of the broader transitional population, despite some of the demographic similarities highlighted above. As will be discussed later in the limitations section, the purposive and non-random sampling in my design introduces a high likelihood that both observed and unobserved biases affected the selection process of my participants. Nonetheless the above table suggests that the sample represented a variety of experiences related to foster care, was gender and ethnically diverse, and contained individuals who had extensive histories with social service providers.

Interview Research Design

As part of it longitudinal research design MEEP participants were interviewed twice; a pre-interview was conducted at the time, or near the time, when an individual was preparing to exit an institution, and later a second interview was conducted 3 to 6 months after this point. The purpose of this pre and post design was to capture the dual aspects/phases of a "transitional experience" in terms of how an individual prepares to leave an institution, and later, how they integrate into the community. One strength of

this design was that it not only illuminated how young people planned and anticipated their transition, but also how these attitudes changed or remained constant over time. Indeed, because many interview projects typically collect data during one period in time, there is often a danger to depicting attitudes, perspectives and relationships as somewhat static, time-invariant, entities (Patton 2001). In contrast, the MEEP longitudinal design allowed for analyses to capture the dynamism and inherent interactive nature of some attitudes, as well as highlight the consistency and stability of others. In this way the interviews allowed for two "snapshots" of the transition experience as well as allowed the analysis to interrogate the temporality of certain issues more explicitly.

It should be noted, however, that the concept of a "*transition*[92]," particularly in respects to how the timing of pre and post interviews were structured, was initially loosely defined and required some methodological reconsideration during the course of the MEEP study. First, as we began our research we discovered that institutional domains were associated with very different processes/experiences for exiting an institution particularly in regards to the types and number of transitional, or step-down, programs available to individuals entering their communities. While some populations

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[92] The term *transition* broadly means moving from one stage to another, and within the life course literature it further implicates the multiple social changes—or continuities and discontinuities—one must navigate as they exit from one institutionalized phase of life and into another, particularly in terms of age-graded social roles, normative pressures, behaviors and attitudes (Johnson & Crosnoe 2003; Sampson & Laub 1992; Shanahan 2000). Anthropologists have often interrogated transitions also in terms of a ritualized liminal status acknowledge in most cultures, inwhich one is neither in one phase or the other. Rather, *liminality* implies occupying an uncertain, if at time dangerous, 'inbetween' status where customs and norms from both stages are being simultaneously being applied and disregarded. In the MEEP study, our conceptualization of a transition implicated more of a life course understanding of the term—given our interest in how individuals navigate new non-institutionalized roles in the community—but we also explored how they confront difficulties integrating in this community and hence their temporary experiences with liminality.

experience a gradual exit from an institution, such as the example of an incarcerated

individual transitioning into a half-way house, or other scaffolding type of programming,

for other groups the exit is much more abrupt and distinct (as for instance National

Guardsmen exiting the military and "returning home" with little in the way of

reintegration services). In the case of foster care the transitional experiences varied

considerably with some young people moving into apartments, or at times shelters,

directly out of their foster homes, while others moved into transitional housing programs.

Because one of the primary research objectives of MEEP was to explore how individuals

navigated their independence in the community, it was decided upon by the MEEP

research team that a "transition" would be conceptualized as any exit from a program or

institution where the re-entry into another program was not planned for at least 30 days.

This criterion was established so that interviews more accurately captured how

participants anticipated and experienced their integration into the broader community and

not necessarily their transition into another program, which in the case of foster care

could resemble a much more structured setting than the original institution. Nonetheless,

individuals were not excluded from the study if they experienced an unanticipated stint in

a transitional program after their official exit from care. In addition some individuals

were directly recruited from transitional programs preparing to integrate into the

community (representing situations in which an individual had already exited the

institution a few months prior but had nonetheless transitioned directly into another

program, and "now" several months later was preparing to enter the community). As

such a "transition" could consist of youth leaving their foster home after turning 18, but it

could also consist of individuals exiting out of a transitional housing program, or even a period of incarceration, six months to a year after they initially "aged out of care."[93]

Another methodological challenge to this pre-post design that was unique to the foster care domain was the fact that IRB approval for MEEP was limited to adults over the age of 18. Given these limitations on several occasions it was impossible to interview foster youth while they were still in care—given their status as minors—so approximately two-thirds of pre-interviews were only conducted after they had left their last foster home. In these instances interviews were scheduled as soon as possible to a youth's initial exit date, usually a few weeks into their transition. [94]

MEEP interviews were conducted in various institutional and community settings. Pre-interviews were often conducted in a foster home, group home or a transitional program. On the occasions when pre-interviews were schedule after a youth had already left care, interviews were usually scheduled in a public setting, such as the mall or the public library. Most post-interviews were conducted in these public settings as well, though on occasion they occurred within a transitional program or in a corrections facility. On a few occasions participants asked for transportation assistance to the

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[93] This broader definition of transition also lead the MEEP team to exploit instances in which individuals were involved in more than one institutional domain. For example, a number of respondents sampled from the mental health, chemical dependency and corrections domains reported histories of foster care in their past. On three occasions we met former foster youth who had been incarcerated for a crime within the first year of their emancipation from the state foster care system. Because these individuals provided an important aspect of the transition experience they were included in my study sample, even though their pre-interview was conducted in a corrections facility and not a foster home.

[94] It should be noted that in Minnesota most youth emancipate from state care only after they have finished their last year in high school (usually in June) even if they have already turned 18. Moreover, all foster youth in Minnesota have the option of extending their time in care until they are 21. As a result of these policies a substantial number of interviews (approximately a third) were conducted while youth were still in care.

interview site and were picked up at their new homes, shelters or transitional program. A few post-interviews were conducted over the phone given that the participants had moved out of state.

Within the foster care domain individuals received incentives for their initial participation in the study in the form of either a set of movie passes for a local theater or a ten dollar coupon for a fast-food restaurant. During the second interview, if it was successfully completed, participants were provided with a fifty-dollar gift card for Target. To minimize attrition between the two interviews participants were asked for two phone numbers, an email and physical address at where they could be contacted in three months time. Participants were also asked if the researcher could contact their case managers, foster parents or other adults involved in their lives. In addition participants were encouraged to keep in contact with the research team during their transition and in several situations participants interacted with the research team intermittently throughout the three to six months between the interviews.[95] The overall retention rate for the study was approximately 70% between the first and second interview, which approximated results of similar studies (Courtney 2005).

In some instances, contact with some respondents was only re-established after they had been enrolled, admitted or incarcerated in another institution, so some post-interviews were also conducted several months after the 3 to 6 month time frame. Two individuals contacted the MEEP team a year after their initial contact with the study—

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[95] To encourage participation I remained an active presence in some transitional programs where participants were active members. Several managers suggested that I volunteer at programs and make myself a presence in these settings as a way of establishing trust, rapport and familiarity with potential participants.

one individual had moved to the other side of the country, while another participant had been incarcerated for 8 months during the intermittent period.

Interview Protocol

A semi-structured interview protocol was developed in collaboration with the MEEP research team to explore the transitional experiences and challenges associated with exiting a public institution and reintegrating with the community. The resulting interview guide explored seven core open-ended discussion topics, and follow-up prompts, that probed participants about: (1) their life experiences prior to entering an institution, (2) their trajectories or pathways once in an institution, (3) their anticipations and plans for exiting the institution, (4) their immediate living situation in the community (housing, employment and educational status), (5) their interactions with peer and familial networks, (6) their access to services and public supports (including mental health), and finally (7) their long term life goals and plans. While some questions were modified to fit the particular situations of different institutions (as for example asking foster youth about their relationship with both their foster and biological parents), the interview guide focused on issues that were assumed to have resonance across all the domains. In some respects, the interview guide assumed a certain universality to the experiences of leaving an institution and reintegrating back into a community, by focusing on the common transitional challenges related to housing instability, struggles in employment, and isolation, identified in the relevant literatures.

Despite this organization of the interview protocol its semi-structure format nonetheless afforded participants considerable flexibility to elaborate on their answers

and guide discussions to whatever topics and issues most relevant to them and their experiences. While there was an implied order to the seven open-ended questions, and their follow-up prompts, interviewers often let participant guide the discussion and sequence of issues raised. Given the inductive orientation of MEEP, the goals were less to test specific theories related to life course, criminology or health service, as it was to develop data emergent-theoretical models for how participants understand their transitional experiences and challenges. Consequently MEEP interviewers were trained to ground interviews to certain topics, without at the same time overly-structuring the issues that participants raised or how they did so. As was the case for many of the foster youth interviewed, for example, some participants ignored the linear orientation of the interview protocol by continually evoking sentiments of their past, and time spent in foster care, as they talked about their anxieties about the future[96]. As a result, some foster youth continually re-visited similar themes and topics of having been in foster care in their interviews.

Given the initial focus of this dissertation on former foster youth and their relationship with service providers the data for this study is primarily drawn from the discussions related to participant's use of services and public supports (discussion topic #6). For these probes participants were specifically asked if they were receiving mental health services while in the institution and whether they would seek such services in the community. They were also asked about their appraisal of such services (their health beliefs about the efficacy of treatment) and if they had concerns accessing services (fear

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[96] While in other domains participants experienced and expressed a more clear break between institutional life and community life, this distinction was at times less salient for some youth who had already lived in the community during their time in care, albeit in a state accredited family home or group home.

of stigma) and any challenges that they anticipated or had experienced (access to insurance and/or navigating the maze of service). As just discussed, respondents were allowed to visit, and re-visit, these topics throughout the interview, as many did, so my analysis often included various parts/topics of interview transcripts. Like many qualitative projects the focus of the study emerged, and evolved as the data was collected, coded and analyzed.[97]

Most interviews were digitally recorded, transcribed[98] and coded using Atlas-ti as will be discussed later. However, not all interviews were transcribed either due to technological failures with the recorder or because respondents chose not to be recorded after signing the consent form. Moreover, on several occasions respondents elaborated on their discussions on a specific point only after I had turned off the digital recorder. While I would sometimes pause the conversation to re-start the recorder in these impromptu continuations of interviews, I often found it awkward to do so without breaking the flow of conversation. In some situations when participants were picked up and transported to the interview location, for instance, interviews essentially started before the recorder was activated. In these and similar occasions I always clarified with

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[97] In part inspired by a "grounded theory" approach to interviewing this study did not begin with explicit hypotheses to be tested or confirmed. Instead I began the study with a broad set of questions about the explanatory schemas persons employ to negotiate the ambiguity of not only mental health, but of the transition experience itself. Conducive to an inductive mode of inquiry I started the study with a specific set of what Charmez (2002) calls "sensitizing" concepts about what a study on foster youth and their ideas of mental health would entail. Nonetheless, because the research team developed concepts and probes in relation to the prior literature, this case study is more inspired by "grounded theory" techniques rather than adhering to the grounded theory model itself.

[98] While I transcribed a number of foster care interviews, the majority of MEEP recordings were later transcribed by undergraduate research assistants, who were trained by myself or other members of the graduate research team. During the course of the project a transcription guide was developed to orient assistants to the norms of transcribing certain utterances, phrases and idioms of speech. The resulting transcriptions captured a rendering of the interview interactions complete with breaks in speech and idiosyncratic use of speech.

respondents before leaving whether I could use these additional comments for my research, which all respondent agreed. To the best of my abilities I tried re-creating these conversations with notes that I had taken on these interactions.

Professional Interviews and Immersion Ethnography
As previously discussed, in an effort to verify/triangulate some of the information provided by participants regarding their experiences in foster care I interviewed various professionals that work with this population including therapists, social workers/case managers, foster parents and child welfare advocates. Though I never shared with these professionals the specific conversations I had with respondents, or the particular life situations discussed, I did ask questions about services and programs that participants occasionally referenced in their interviews. As an example of this, after some youth discussed how they had been "kicked out" of a transitional housing program due to unclear reasons, I asked a number of case managers and program directors to elaborate on the reasons why a person may be asked to leave their programs. More broadly these professional interviews provided me *contextual information* about the options and constraints that participants faced in terms of the program and special services that could enroll in. As will be discussed in chapter 6, interviews with social workers and foster parents were particularly important in shedding light on the unique institutional conflicts that foster youth sometimes experience while in care, and provided a lens for understanding the somewhat contradictory statements occasionally made by respondents.

Many of these case managers and child welfare professional I had met during the initial recruitment phase of the study when I, along with other MEEP collaborators,

facilitated community presentations about the project in an effort to recruit participants as well as gain buy-in from stakeholders. Moreover, in the summer before MEEP had started I had also conducted a pre-study of child welfare professionals as part of a fellowship, which helped me develop rapport with a number of professionals by the time the project formally started. To help with my efforts to advertise the MEEP study and recruit participants in the community, case managers occasionally invited me to program activities, conferences, support groups facilitated by their programs as well as encouraged me to do "ride alongs" with them as they visited their clients. Though some of these events afforded little actual opportunities to recruit participants, I nonetheless pursued most invitations to events, as my goal was less to collect data at this point but rather to immerse myself in this particular context. Case managers also encouraged me to become more involved in their programs and during two six-month periods I volunteered at two transitional services for former foster youth.

One program, or field site, that I spent considerable time was a private non-profit service organization contracted by the county to provide case management services, and weekly "life-skill" training sessions, to a group of 4-12 foster youth.[99] The other program was a county run department of social service established to specifically help foster youth

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[99] The first program that I became involved in was a once-a-week "life skills" support group for youth who had emancipated out of foster care during the last eighteen months. Contracted by the county to facilitate a 12-week life-skills curriculum to young adults, this private human service agency had a long tradition of working with troubled teens and vulnerable adults in the community, though only recently had it gotten involved explicitly with former foster youth. While the agency provided incentives for youth to attend these sessions, which were scheduled in the evenings, the requirements of the program were themselves quite relaxed. As a result attendance at these groups, which were facilitated by either one or two case managers, fluctuated widely from between 4 to 12 former foster youth from week to week. My "official" volunteer duties consisted primarily of setting up chairs for the session, helping cook the incentive dinner from the donated stock from the local food bank, assist participants with the activities as well on occasion facilitate discussions related to the transition to college life. I also assisted participants with transportation.

transition out of care and locate housing, education and employment resource in the local area. While not an intentional aspect of the original study, the months spent with case managers and respondents were carefully documented with field notes and additional interviews with staff. On several occasions case managers invited me to staff meetings, their sessions with clients and some of their program activities. In each of these settings I introduced myself as a researcher from the university and asked if I could take notes on what I was observing. At the end of my volunteer experiences I also conducted two focus groups about some of the themes that had emerged in my interviews, and observations, at which time I also asked participants to sign the MEEP consent forms.

The substantial field notes I collected during this time proved to be an invaluable source of information about social services available to former foster youth and the problematic interactions that at times occur between providers and their clients.   Because these participant-observer experiences informed the way I analyzed my interview data I am characterizing them here as part of an *immersion ethnography* that I conducted concurrently with my case study. While perhaps not a formal ethnography, my detailed thick descriptions (Geertz 1973) of these events captured in my field notes, nonetheless helped me develop a more holistic understanding of the issues and challenges my participants described in their interviews.

Moreover, because participant recruitment was often a prolonged effort in this project—sometimes requiring several meetings between social workers, foster parents and foster youth themselves before interviews could be scheduled—my empirical chapters often draw from ethnographic observations of the interview process itself. As

depicted in the Brendon's story in the introduction of chapter one, my substantial

interactions with participants, captured in my field notes, provide important context

information of how I came to know my participants and the relationships I developed

with many of them over time.

Methods of Data Analysis
At a general level qualitative data analysis consists of identifying significant patterns

within the data collected and developing a working framework, or a theory, for

organizing key themes, findings and overall conclusions (Bloomberg & Vlope 2008;

Charmaz 2000). Qualitative analyses often also implicate a simultaneous engagement

with theory and past research as themes, conceptual models and questions are continually

modified and developed (Bernard & Philip 2009). Indeed, because I continually re-

defined my analytical concepts, the conceptual model and the purpose of the project

itself, it is difficult to capture the process with a prescriptive description of clear

procedures and linear steps I pursued. Nonetheless, because I took inspiration from a

variety of traditions and strategies associated with qualitative research (such as grounded

theory, narrative and discourse analysis as well as institutional ethnography) below I

describe the different *phases of analysis* I pursued in terms: *immersion, memoing*, *coding*

and *synthesis*. It should be stressed, however, that these phases were often non-linear

(with the analysis going back and forth between phases) and at times merged together at

different points of the projects.

During the first phase of analysis I immersed myself with the various aspects of

the project by closely reading each interview and focus group transcript in their entirety

as well as reviewing all of the field notes I had collected. During my first read of

transcripts I marked key points in the narratives that struck me as interesting, unique and

salient as well highlighted areas where participants expressed tension or ambivalence

with a certain topic. During my first and second read through of my interview transcripts

and fields note I began *memoing* my reflections about each participant by summarizing

key points, demographic information and critical life events gleamed from their life

narratives. Some of these memos became converted into more formalized "interview

face sheets" during the course of the project and were later attached to each transcript

document on Atlas-ti. Other memos remained more analytical and were used to develop

and refine my coding scheme.

It should be noted that an immersion phase also occurred in respects to the ethnographical

component of the study. During the first months of the project I followed-up on as many

opportunities as possible to engage with social service providers, social programs and

activities associated with transitioning foster youth in the community[100]. While at the

time I was unsure what information I was collecting at these events, my general goal at

this phase of the project was to immerse myself in the world of community programs and

social services associated with transitional youth. During these experiences I took

detailed notes of my observations and reflections, which eventually I developed into a set

of analytic memos.

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[100] As previously discussed on several occasions I was invited by case managers, foster parents and other stakeholders to attend a particular event, conference or gathering where I could hear and interact with a variety individuals involved with this population.

An ongoing challenge throughout this first phase of analysis was simply managing, and not becoming overwhelmed, by the large amounts of information I had collected. The goal of the second phase of data analysis was therefore to reduce the sheer volume of data into meaningful units and segments. As described by Glaser (1992) qualitative analysis implicates an interesting tension between continually fragmenting (coding) and de-fragmenting (synthesis) texts into more inclusive categories, conducive to theorizing.

During this second phase of the project various types and levels of coding were conducted using Atlas-ti to partial out, and fragment, the data (see table 4.2). In general coding occurred at two analytical levels. At the first level, coding simply identified and located segments of the interviews when participants addressed key issues related to the 7 topics of the MEEP interview protocol. These first level, *topical codes* also located segments of interviews when participants discussed issues directly related to my conceptual framework; as for instance when individuals talked about their health beliefs, the stigma of mental health and their distrust of service providers. A final set of first-level codes that I called *time codes* segmented interviews in terms of the temporal point of reference that participants implied when they discussed these topics. That is, time codes noted whether participants were referencing the past, present or anticipated future as they talked about different topics (whether they talked about mental health in the past, present or future tense). Because the query tool of Atlas-ti allows a researcher to cross reference codes, and essentially overlay different types of codes in an output report, these time codes helped me better organize the longitudinal dimension of the interviews.

While first-level codes helped me manage the large amounts of information collected, second-level codes implicated a more substantive analysis of the data itself in terms of identifying patterns and themes. As such, the development of these second-level codes reflected a more iterative process, starting first with a line-by-line analysis of what participants were expressing at different segments of the transcript. Similar to what Charmaz calls open-coding (2002), this process consisted of inserting short descriptions in the margin of transcripts that highlighted my interpretation of participants' intentions and meanings, expressed within each line of text. Due to the length of some interviews, this second level coding was sometimes constricted to segments I had already pre-identified with first-level codes to be most relevant to my project.

After initial sets of *open codes* were developed across different topics I then attempted to refine and synthesize these descriptors into more generalizable *thematic codes*. At an essential level *thematic codes* captured the similar or different ways that participants talked about a particular topic (as for instance how participants could talk similarly or differently about leaving foster care) but these more expansive, second-level, codes could also identify broader sentiments that transcended various topics (as for instance the general ambivalence by which participants talked about the various challenges in their lives). Throughout this phase, I continued memoing my application and development of codes, and gradually this process merged into the next *synthesis-phase* of the analysis.

Indeed, whereas the coding phase consisted primarily of fragmenting the

transcripts into distinct categories or themes, the synthesis phase involved defragmenting codes into more inclusive constructs. The goal of this phase was in short, to refine and coalesce my thematic codes, but as well as to update my conceptual model so that I could develop a more holistic description of my data. Employing what Bernard and Philip (2009) call the "pile and sorting method" I organized my thematic codes together into thematic clusters based on similarities, differences and assumed relationships to my conceptual framework. In piling and sorting, thematic clusters were renamed into broader categories but also spatially organized in charts to distinguish their *centrality* to my conceptual framework and their *saliency* in the data (Glaser 1992). As a result of this process some thematic clusters were merged, or eliminated altogether, to reduce redundancies whereas others codes were more clearly refined.

To assess the validity of my clustering of themes, I employed a strategy similar to what grounded theorists call the *constant comparison method* (Charmaz 2002; Glaser 1992) of looking at how these new constructs fit or contradicted the different empirical examples in my data. Toward this end I used my refined themes to code new interviews, as well as re-code previous ones. When these constructs misaligned with interviews they were modified or at times fragmented into new themes (leading to another piling and sorting process). My conceptual model during this stage was also being continually updated and amended to include new constructs and categories.

Table 5: Description of Coding Phase

Levels and Types of Coding	[Code Example]	Text

First Level Analysis
 	
    Topical Codes
 	
    Time Codes
	[Transition Out]
	
	[Past-Future]	

Second Level Analysis
 	
    Open Coding
 	
    Thematic Coding
 	
    Thematic Cluster
	[Maybe not ready to go, but tired of being in care]
	
	[Ambivalence of living/leaving care]
	
	["Ambivalence with the System"]
		"Maybe I'm not ready to be on my own, I don't know, but It's just time to go, you know, I've just been in the system for too long"

Another aspect of the synthesis phase consisted of identifying the explicit linkages, or relationships, between themes and constructs. In piling and sorting themes, I organized thematic clusters based on possible relationships with each other, as well how they related to the empirical questions that I had posed at the start of the project.

Inspiration for these relationships drew from my ethnographic field notes, and various

analytical memos, but also from my holistic understanding of the data itself that I was

developing by this time. Once these relationships were established a type of constant

comparison method was again employed to assess their validity across different cases of

individuals/situations. For example I examined whether these relationships existed

within similar types of cases (whether the theorized relationship between two constructs

were present within similar participants based on their outcomes, gender or placement

histories). Similarly, I also explored whether and how these relationships were different

across contrasting situations (how relationships differed or were the same between

different categories of individuals). This comparison of *within vs. between* cases allowed

me to not only to test the validity of constructs but also helped me theorize why certain

relationships did or did not fit cases, leading to refinement of my model.

Finally, during the synthesis phase it should be noted that I often reflected back

on my literature review for inspiration, sometimes searching out for new studies being

conducted on the topic of transitioning foster youth and mental health. This last aspect

of my synthesis contradicts a purely inductive approach to data analysis, and in particular

violates the notion of generating grounded theory (Glaser 1992). Nonetheless I felt it was

important to engage with ongoing research on foster youth to assess how my developing

conceptual framework contrasted or compared with issues and tensions being raised by

other researchers. While my case study should not be seen as an attempt to test or

confirm theories from this literature, I was interested in constructing and organizing my

analysis so that it contributed to this body of knowledge with a clear set of findings and

conclusions.

Table 6: Phases of Analysis

Phase of Analyses	Goals of Phase	Examples of Research Activities
Immersion	To become familiarized with the data & key issues/tensions of the filed	Entering the field & generating "thick descriptions" Reading transcripts in their entirety
Memoing	To identify significant pattern & emerging themes	Memoing reflections and responses to data Summarizing each participant (Face Sheets)
Coding Synthesis	To organize and manage the data ("Fragmenting the data")	1st Level Topical Coding & Time Coding Cross referencing codes and outputs 2nd Level Open Coding & Thematic Coding Pile & Sorting Codes
	To synthesizing codes into more inclusive concepts and relationships ("Defragmenting the data")	Clustering Thematic Codes by saliency and centrality Validating Codes via Constant Comparison Method Revising Conceptual Model Identifying Relationships/Linkages Verifying relationships via Constant Comparison Review of Literature

Overall my analysis of the data reflected a prolonged, iterative and at times recursive process that implicated both an inductive and deductive strategies.

Limitations

Given the qualitative orientation of this project, my case study is limited by the often-noted challenges associated non-random, purposive sampling (Babbie 2007). Readers should be cautious about inferring too broad of conclusions from the following analyses and conclusions given that individuals who self-selected into the study may have not been representative of the overall foster care population. While demographically the sample appears similar to the transitional youth population in Minnesota, as previously discussed, there may be some unobserved differences between the sample and the broader group from which it was drawn that could have affected the topics that participants brought up and how they did so.[101]

However, it should be stressed that the goal of a qualitative case study is not to present generalizable and representative findings about outcomes, but rather to provide an in-depth description of a process, and context, for a particular group or social phenomenon (Merriam 1998). While the experiences of my sample may not necessarily be generalizable to all young adults that have aged out of care, they nonetheless represent important cases of how some young adults can experience these situations. Irrespective of their true frequency in the population—whether such experiences are in fact the majority or minority of all foster cases in Minnesota—these situations are nonetheless

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[101] Indeed it is difficult to assess what and how sampling biases may have shaped some of the patterns, themes and discussion that emerged in my interviews. For example, because youth self-selected into the study there is the possibility I interviewed and collected more "successful" stories than is typically present in a representative sample of this population. The same internal qualities that motivate a person to volunteer for a study, and stay persistent with the project over time, are likely to be the same personal attributes associated with more positive transitional outcomes, and hence, positive transitional narratives. Unlike quantitative research, however, qualitative researchers are less interested in identifying particular biases within their data, nor controlling for them in their analysis, but rather aim to provide a holistic, in-depth description of a particular case, however, confined or representative it may be in the population.

significant to some foster youth, and therefore theoretically relevant to the literature.

Moreover, my central concerns as a qualitative researcher was on the relative *trustworthiness* and *creditability* of my data (Guba & Lincoln 1994)—the extent to which my methods of data collection and analysis yielded a "truthful" and "authentic" depiction of the cases I was studying.[102] Toward this end I pursued several strategies, some already highlighted above, to mitigate the threats to authenticity that invariably impact qualitative research. First, during the data collection stage of my projects (and the immersion phase of my analysis) I continued to interview new participants in the field until I reached what some qualitative researchers call *data saturation*; the point at which I began observing the same recursive situations, themes and narratives across interviews. While I initially worried that each of my participants had very unique histories and idiosyncratic experiences with institutions and service providers, and that perhaps the sample was too diverse, overtime I gradually became sensitized to a general set of recursive themes that continually emerged across different situations. This data saturation provided me confidence that many of these narrative patterns had significant saliency to this particular

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[102] In contrast to the concepts of *validity* and *reliability*, that are conventionally used to assess rigor in quantitative studies (Babbie 2007), some methodologists have proposed the alternative terminology of *credibility* and *transferability* to convey similar, though slightly modified, criteria for judging qualitative research (Lincoln & Guba 1985; Guba & Lincoln 1994, Seale 1999). In most contexts *validity* generally denotes the degree to which methods and measures in a study accurately captured the reality of a phenomenon. In a variation of this, credibility assesses the trustworthiness of the qualitative researcher and his/her participants to speak to the relative truthfulness of a situation as understood by the members of the group being studied. Because truthfulness can have multiple perspectives, Guba and Lincoln (1994) have also discussed this issue as related to authenticity (whether the research is consistent with the most prevalent truths of the particular community). In contrast to validity, reliability typically refers to how well a quantitative measure, or study, is repeatable to the extent that it would consistently yield the same results/outcomes over time. For most qualitative researchers, reliability is seen as an inappropriate concept to compare studies based on non-representative sampling and are in their nature strongly shaped by the unique characteristics of the researcher. Instead, some have proposed the alternative concept of transferability, that assess whether findings and conclusions from a qualitative study can be transferred to groups similar to the one that was studied.

group of former foster youth and their experiences.

Nonetheless, to guard against the risk of perhaps over-generalizing some themes, or overstating their significance, I also employed what grounded theorist call the constant comparison method of checking for discrepant findings across negative cases (whether these themes/relationships were present within/across different cases). In the reporting of my findings readers will note that I make considerable effort to describe important variations in themes (how for instance men and women talked differently about their life goals) as well as cite discrepant patterns (how some young people actually reported positive interactions with social service providers). Because social life is rarely composed of one monolithic perspective or experience, addressing these contrary perceptions increases the credibility of my study.

As already discussed I also triangulated strategies to collect both perceptual and contextual information on the situations that participants described. While I was primarily interested in how participants' perceived their experience in and out of care, I nonetheless sought out multiple sources to corroborate their reports, and my own interpretations, of these settings. Indeed the risks of relying solely on self-reported information have been well documented in the literature, particularly in reference to desirability/deference effects wherein participants implicitly mold their narratives to fit the expectations of the interviewer. In the foster care context participants may have felt compelled to overstate their successes in the community, or alternatively intentionally skew their negative interactions with service providers, to convey a strategic rendering of their situations.

To mitigate these issues I conducted interviews with adults that work with this population, as well as conducted prolong observations across multiple settings. The longitudinal nature of the interviews also let me check the consistency of participants' perceptions over time. Lastly, during the end stages of my analysis I discussed my findings and conclusions from my research with members of the foster care community (peer foster youth advocates, social workers and state works). Consistent with what Guba and Lincoln (1994) call "membership checks," these meetings yielded general positive appraisal of my research by most of these individuals, suggesting that my analysis is likely transferable to similar situations (other foster youth who have had similar experiences) as well holds significant levels of authenticity (see footnote 19).

One particular bias in sampling that should be noted, however, pertains to the potential gendering of the data and my subsequent analysis. As a male researcher I sometimes felt ambivalent recruiting as well as interviewing female participants, resulting perhaps in an over-emphasis of the male, foster care experience presented in this study.[103] Though numerically the gender composition of the sample was approximately equivalent to demographic data provided by the state, it is likely that certain female experiences were silenced and underreported in the data and the following analyses. For

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[103] Despite my experiences working with female teens as a case manager, and more recently teaching at a large public university, I was sometimes hesitant to engage in what could be considered intimate conversations with potential female respondents. I employed a certain level of friendliness with all respondents but at time I was cautious about these interactions being misinterpreted. In some situations female respondents appeared clearly uncomfortable talking to me as a male researcher, but more perplexing to negotiate was when some female respondents exhibited an almost over-willingness to exchange phone numbers and engage in conversation. After one female respondent called my office continuously for several weeks to follow-up on our interview, I became reluctant to engage in such detailed interactions with subsequent respondents. Because the MEEP research team consisted of female interviewers, and one female faculty member, I requested their assistance interviewing female respondents.

instance, there have been recent concern in the literature that female foster youth are particularly vulnerable to being coerced or recruited into human/sex trafficking, and or engage in other forms of sex work, during their transition out of care (Fong & Cardoso 2010; Kotrla 2010). With a few notable exceptions, these experiences were largely absent in the MEEP data but could have had important ramifications in a study about mental health and the transition back to the community. Moreover, given the feminized sentimentality sometimes associated with the topics of mental health and emotions in the American culture, and that fact that I often had stronger rapport with male participants, it is likely that certain dimensions of the analyses are underdeveloped.

Similarly this study is invariably limited by own subjectivity. As previously discussed I have had substantial experiences working with foster youth in the past, and while this brought me a certain insight into the challenges and struggles associated with this population, it also constrained the way I interpreted and detected patterns in my data. My status and privilege as white, educated, Latino male also affected the way I entered the field and how participants interacted with me during interviews. Nonetheless, it should be stressed that qualitative projects are inherently individualistic and are themselves social products in the sense that no two researchers will or can duplicate the exact same study. To the extent possible, I make my biases, self-reflections and perspectives explicit both in this chapter but also within the empirical sections of the dissertation, so that reader can assess for themselves the limitations of my analyses.

Lastly it should also be noted that MEEP sample was not a clinical sample in which the reporting of a mental health condition was an explicit eligibility criterion for

the study. Only two thirds of respondents reported having a mental health condition in the past or had received treatment while in care. This represents some limitation to a study on mental health, as this topic or issue was not universally salient to all of the participants. Nonetheless, all participants did report having some experience with therapists, mental health workers and social workers more broadly in their past. Because the focus of the study was an investigation into how foster youth more broadly talk about mental health, and even the social significance of the term in and out of care, there is significant value to a study that explores these issues more generally. While some have recently advocated for sociologists to abandon overly-broad analyses of generic conditions like mental health, and instead be more focused on the "ontological realities of specific diseases and diagnoses" (Timmermans & Hass 2008), within the context of foster care I contend that the term "mental health" is a particularly loaded and salient term that deserves to be carefully analyzed in terms of its contexualized meaning.

Conclusions: Ethical Consideration
In this chapter I have highlighted the specific steps, strategies and rationale I pursued to conduct a multi-method qualitative study of former foster youth transitioning out of care. By way of concluding this chapter, in this last section I will discuss some of the ethical considerations and unique challenges that emerged during the course of a study where the focus was on a vulnerable group of young adults facing a daunting set of challenges and difficulties.

Because of its critical orientation against universal and reductive knowledge claims, qualitative research is often characterized as an emanicipatory form of research

enterprise. Particularly because qualitative research holds the potential to challenge and contest taken-for-granted assumptions about a population, as well as shed light on alternative ways of knowing about a group, advocates of this tradition have argued that ethnographies can play an important role in destabilizing the power structures and systems of oppression affecting subjugated groups (Biehl, Good, & Kleinman 2007; Collins 1999; Zuberi, Tukufu, and Eduardo Bonilla-Silva 2008). While these assertions certainly highlight the political nature of any research project, and in particular the politics of representation, I believe they can also obscure and overly abstract the limited benefits that academic research has on the very individuals being researched. Indeed, while I hope that my research will contribute to a more critical understanding of foster youth, if not as well increase a sympathetic gaze on this population from other researchers, I do not believe that any of my research participants benefited substantially from my research activities, nor do I believe they ever will.

This is not to say that I believe any of my participants were harmed or experienced some form of detriment as a result of participating in the study, nor am I implying that any IRB protocols were violated. In fact nearly all of the young adults I interviewed and that I came into contact during the course of the study stated that they had liked being part of the project and in particular enjoyed the fact that somebody "simply listened" to them. Given the semi-structured nature of the interview participants exercised substantial control in telling their own life narrative, and because I was affiliated with a university, some participants appeared clearly impressed that their feelings, thoughts and perspectives were being recorded, analyzed and given serious

attention. For foster youth who often feel neglected and dismissed by broad institutions

(and "the system" more specifically) the opportunity to go on the record about their

experiences seemed "important" and "validating" to them, as more than one of my

participants described. But while I sense that many participants felt validated, and

perhaps even temporarily empowered by our conversations, I don't believe these

interactions had, or will have, substantial impacts on their lives, situations and the very

real challenges facing them.   Like many of the services, supports and "caring adults" that

transitional youth come into contact with, these benefits were limited, fleeting and by

their nature temporary.

 I stress this point because it is important to highlight the extreme form of isolation

and general disconnection from others that many of my participants were experiencing

when I interviewed them. In many ways this disconnection was emblematic of their

general existence in foster care itself, in which several participants described bouncing in

and out of various placements throughout their childhood, and sadly this reality only

worsened for some when they left care. I believe that as result of this precariousness and

perpetual isolation, some individuals were very quick to warm up during interviews and

almost too eager to establish rapport with me, not as a researcher, but as an adult that

appeared to care about them. That is to say, some of these individuals expressed a real

need, if not desperation, to connect with anyone willing to listen to them, and while this

presented itself as strategic opportunity to collect/extract more data, it also opened the

possibility of an exploitative dynamic that I had to continually be careful not to take

advantage.

Because qualitative research stresses the need for researchers to enter the field and establish relationships with their participants, the informality of these interactions can present a real danger, in my mind, of setting up a ruse, or a false expectation for participants about the nature of these relationships and how long they will last. Indeed, after two to three hours of being interviewed, participants can understandably feel that they have established a real connection to someone who cares and who is able to provide ongoing social support and other resources to them over time. Particularly because participants are unfamiliar with research, and the nuances of qualitative methodologies more specifically, it is only natural that some would misunderstand the project and the ultimate purpose of the interview.

This not to say that I did not genuinely care for the participants that I interacted with, nor that I faked relationships with any of them, but it became very clear to me that I had to establish real boundaries, particularly for myself, about the nature of these conversations and friendships, and continually re-evaluate the role I was playing as a researcher. Perhaps this danger is less substantive in other qualitative projects where participants have a more solid grounding to their environment and their social networks, but in a case study involving isolated former foster youth the risk of setting up a false sense of support, seemed ever-present. At the end of interviews I was sometimes troubled when participants declined the incentive gift cards or coupons associated with the project because of our friendship—one participant at the end of the first interview said that he "really liked meeting me" and that I should instead take my "girl out" on him with his movie passes. When asked to name some close friends that he trusted six month

later, as part of the interview protocol, he cited me as one of the few adults that he could talk to.

I think this danger of false expectations ironically increases when qualitative researchers start to believe that because of their unique insights or empathetic abilities for caring, that they can offer something substantive, or symbolic, to their participants. Precisely because many foster youth will express genuine gratitude for being involved in a project where they are listened to, and validated, I believe that researchers can easily lose sight of the inherent limitations that constrain and structure the relationship between themselves and the people they research. I would argue that this relationship is not a real one, at least not in the conventional social sense, given that as qualitative researchers we purposively sample, and recruit participants, on their objectified statuses. We come to know and talk to participants not as individuals but as members of group that we want to better understand and study. While we might illuminate their individual stories in our research, their individualities are not the starting basis of these relationships or the real reason why we continue to maintain them. This can become difficult to appreciate because as participant-observers we often rely in our self-reflections and internal thoughts to make sense of our data and interactions, resulting in a research project that feels incredibly personal to us as researchers. I also feel many of us also come to genuinely care about our participants. But caring for a stranger and becoming involved in their lives are distinct realities that can be confused in a research setting.

This is confusion is not so much the result of "going native" as described by some anthropologist, but reflects the inherent appeal of the "caring adult" role that the

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interview process naturally elicits, and interviewers inadvertently take up, in this context. It can be gratifying and self-fulfilling to enact the role of an adult that listens and cares about someone who is otherwise dismissed and silenced in society. But as researchers we must be careful not to overly involve our sense of self, or become enamored, with this identity. Otherwise we set false expectations, particularly among ourselves, about the duration of these relationships, the sources of support that we can actually offer our participants and the amount of time and effort we can reasonably devote to their problems.

Ironically, this ethical challenge is compounded and made more salient with foster youth given their past experiences with "caring adults" who came in and out of their lives throughout their experiences in the system. As will be discussed in chapter 6, this is one of the pernicious dynamic of the system that many foster youth resent—the willingness of social workers, foster parent and case managers to try and make a connection with them and "pretend to really care" all the while "knowing that they would one day leave." To simply re-enact this dynamic of putting up the appearance of caring, for the sake of establishing rapport or getting data, seemed be an ironic, even if an unintended, form of cruelty that I was strongly motivated to avoid.

On the other hand, maintaining a strictly distanced and objective role in this context also seemed ethically problematic at times. Particularly given the longitudinal design of the study it often became apparent that participants were not only struggling, but would continue to do so in the intervening months between interviews. To simply step back from these situations and observe participants struggle down a path that they

were unlikely to come back from, seemed morally reprehensible, particularly in situations when a minor intervention would likely make a substantial impact on their lives. Indeed, in some instances participants simply lacked information and experiential insight navigating academic bureaucracies, dealing with financial aid or signing up for insurance. Some participants were also unaware of the services and programs available to them in the community such as free health clinics, housing programs and transitional services. More troubling, some youth were unaware of the legal risks they were putting themselves in certain situations; Brendon, the respondent discussed earlier, bought a car with cash from a friend but had not filled, or known about the appropriate "pink slip" title paperwork required by the state for transferring ownership. As a result Brendon drove around for several weeks in car without insurance, registration and or valid license plate before he realized that he was in high risk of getting arrest for driving a likely stolen car. In these instances the choice to get involved seemed clear. Helping Brendon track down his registration, helping someone fill out his or her financial aid, or assisting a person enroll in a public insurance program seem justifiable.

The balance in my mind was offering support, help and connections to resources while at the same time conveying to participants my own temporality in their lives. When participants asked for help—as for instance information about applying to school—I always referenced first their case managers or a social service provider they could access. Even if I pursued the information participants were seeking—such as calling the enrollment office at a community college—I always stressed that it was important to get their case manager involved in the process because they would be able to

provide more "consistent help." Indeed, when participants shared with me a particular challenge that they were facing—such as the fact that they were running low on diabetes medication, or were about to become homeless—I would at times act as an in-between resource by asking the participant if I could contact their case managers on their behalf. In instances when case managers were not involved, or participants did not trust or wanted their case managers to know about their problems, or at times illicit activities, I helped participants search another program or service. Throughout these interactions, however, I would always stress my limitations to participants. As I stated to participants several times, I was no longer a social worker and in particular had never been one in Minnesota, so my knowledge and expertise of how to help them were quite constrained. I was lucky at this time to have befriended a number of case managers that I knew, from my observations, were quite dedicated and effective working through these problems with their clients, and so on several occasions I would either put them in contact with the youth in question or ask their advice about what I could do.

Finally, I was also lucky in this respects to have the benefit of conducting this study alongside other researchers and faculty members involved in the MEEP project, several of whom had significant experiences in the social services and were well aware of the challenges of maintaining professional boundaries. Indeed my experiences with participants becoming overly attached after interviews were not unique as other MEEP researchers reported similar situations of participants calling them in the middle of the night or attempting to extend their relationships.   As a result of these instances the MEEP team collaborated several times to develop certain steps and procedures to

maintain a sense boundary between the goals of the research project, the research

participants and ourselves. These included always interviewing participants in a public

setting, bringing another researcher to interviews and properly debriefing participants

about the nature of the study at the end of interview. The MEEP team also generated a

call sheet of local social service providers, mental health resources and community

supports that participants could pursue, attached to the a copy of the consent sheet for the

study. More importantly, MEEP faculty made themselves available to discuss and

process difficult situations as they came up during the interview stage. These and other

steps that the MEEP research team pursued, and institutionalized, helped me become

more attuned to these issues and mitigate the real danger of perpetuating the of

abandonment that many of the foster youth had associated with their time in care.

Chapter 5: Mental Health and the Trouble with Labels

Introduction

"I've been pretty much diagnosed with everything; ADD, Oppositional Defiant,
Depression, Bipolar. Whatever you can think of and I've been on it, Ativan, Xanax,
Adderall, Klonopin, Seroquel ...all that, you know what I'm saying, I mean I'm probably
a little Bipolar. I mean who isn't? I can get a little...you know...'Out of it'. But it's all
bullshit, I mean, I just flushed all those pills down the toilet (a few days ago). Fuck it,
you know what I'm saying. I was supposed to go to the aftercare clinic, but fuck that as
well, (I've) been taking pills all my life, so what's the point of being out (of foster care)
and still taking it. I know I have issues, I can take care of it (on my own) now...I don't
need that bullshit in my life no more"
-Billy, 19

One of the primary purposes of this qualitative study is to explore the varied ways former

foster youth perceive and understand ideas related to mental health and mental health

interventions, in the hopes that doing so will reveal some of the contextualized reasons

why most are reluctant to access such services after aging out of care. As discussed in

the previous chapter, foster youth are typically exposed to high levels of mental health

treatment during their time in care[104], but when these presumably high-need youth age

out of the system most immediately withdraw from mental health services altogether

(Courtney, Dworsky & Cusick 2005; Delman & Jones 2012; Mares 2012; McMillian &

Raghavan 2009). Undoubtedly, former foster youth face significant barriers accessing

services in the community, and these are invariably linked to the general dearth of mental

health resources in most areas, the social stigma associated with mental health, as well as

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[104] While concerns about service disparities and quality issues are well cited in the literature (see), the
majority of young adults aging out of care have likely experienced some form of therapy and or medication
while in the system. Estimates range that between 50% to 90% of long term foster youth have experienced
one or more mental health services by the time that they age out of care.

the limited, and often spotty, access to insurance that many youth experience when out of the system (Delman & Jones 2012; Moses 2008, 2011; Munson et al. 2012; Webster & Harrison 2008). . But it is also clear that many of these young adults harbor ambivalent attitudes toward continuing their treatment, and as highlighted by Billy's comments above, such perspective likely inform a decision to stop seeking professional help for their ongoing emotional problems. Indeed, various studies have highlighted that "once on their own," many foster youth make the decision "on their own" to disengage with their therapists, discontinue their medication and avoid social services more generally (Munson & McMillan 2012; Moses 2009). A primary goal of this dissertation then, is to shed light on the complex, and I argue highly troubled, relationship that many former foster youth have with mental health services, and how these attitudes reveal some of the broader tensions and ambivalence that this population experience as former recipients of state care.

In this empirical chapter I address two central questions of the dissertation in respects to its broader exploration of these issues. First, to what extent do former foster youth consider "mental health" and "poor mental functioning" as significant issues in their lives? That is, do foster youth believe they have "issues" that they themselves categorize as a mental health problem and are these issues seen as significant enough, from their perspective, to warrant an intervention by a mental health clinician? According to conventional health-seeking models of patient behavior, that informs much of this area of research, accessing care is predicated on a person first exhibiting mental health "symptoms" but also recognizing the significance of these symptoms as signs of a

broader mental health problem (Kasper 2000). From this rational-choice perspective many foster youth are unmotivated to seek care in part because they lack the "mental health literacy," or adequate *explanatory model* (Kleinman, Eisenberg & Good 1978),[105] for understanding the medical significance of their mental health needs and/or the options available to them for effective treatment. My first question directly assesses this presumption by directly exploring the interpretative frameworks that former foster youth use to describe their past and present experiences with mental health issues and problems, particular as they confront the often difficult and stressful of transitioning out of care. The fact that many foster youth have experienced years of mental health treatment, if not experienced a saturation of services, challenges the presumption that many are unaware of their mental health needs, or illiterate to treatment options or resources, though it is very likely that some hold nuanced, and unique perspectives about their ultimate need for help in the community.

The second question that this chapter addresses is, how do former foster youth more generally perceive the terms *mental health* and *mental health services*? More specifically, what does it mean to be associated with a mental health diagnosis for a former foster youth, and what does "receiving help" signify in terms of their sense of identity as young adults who were former wards of the state? Previous research has suggested that many former foster youth acknowledge they have "problems" and "needs"

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[105] As the term implies, explanatory models (EMs) refer to the ways in which symptoms, or an illness episode more broadly, are interpreted, and made sense of, by a patient but also their broader community (Kleinman, Eisenberg & Good 1978). These interpretative frameworks often provide patients an explanation of the root causes of their conditions (the etiology of their distress/disease) what they should expect during the course of the episode and appropriate interventions and treatments (see review by Kleinman & Semman 2000). Though initially introduced by medical anthropologists explanatory models have been more recently incorporated by a variety of health service researchers that view the stage of illness recognition as a key perquisite to effective health-seeking behavior (see review by Kasper 2009).

but most are reluctant, and in some cases openly hostile, to apply mental health labels to describe themselves (Moses 2009). Some have suggested that this reluctance to self-label (Thoits 1985) stems primarily from the stigma associated with mental health but also the age-specific symbolic consequences that being labeled may have on one's self-concept as a competent, and socially accepted, young adult (Leavey 2005; Moses 2009; Mowbray Mergivern and Strauss 2002; Munson et al. 2012; Wisdom and Green 2004). Particularly because young adulthood is a time when identity issues are already heightened, some have postulated that young adults are reluctant to associate with labels or services that challenge their sense of normalcy, competence, and autonomy (Leavey 2005).[106] My second question therefore explores how former foster youth describe their reluctance to seek service in terms of their identity but also the challenges that they perceive with accessing such services in the community.

To address these questions I summarize a series of 'emergent themes' that were derived out of my qualitative analysis of approximately 40 semi-structured interviews with 26 former foster youth who had recently transitioned out of care. Focusing on segments of the interviews when respondents elaborated on the issues related to mental health, I report on themes related to: a) the reluctance to talk about mental health directly, b) the controversies surrounding medication, c) the social context and meanings of labels, d) mental health inconsistencies, and e) troubled transitions and the social structuring of

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[106] Developmental psychologists, as well as life course sociologists have described young adulthood as a time when issues of identity, and identity development are being actively negotiated and developed (Arnett 2000; Shannon 2001). Accordingly, seeing one's self as an adult often hinges on one establishing a sense of autonomy, competence as well as normalcy. Some have suggested that these norms can be seen as inconsistent with notions of seeking help for a mental health condition (Leavey 2005). Other studies on young adults have also revealed salient fears among this population of being ostracized, denigrated or pitied for having a mental health condition (Drauker 2010; Leavey 2005).

stress. Lastly, I report on how respondent responded to my explicit questions of mental

health service use during their time out of care, and how many characterized a complex

ambivalence toward seeking help from the state more broadly.

Why are we talking about Mental Health?
When asked directly if they were planning to use mental health resources in the

community, most participants stated that they neither had the need nor interest in

accessing such services. Often participants dismissed the question quickly through a

simple non-verbal turn of the head, or concise "no" or "nope, not for me." Brendon who

had been otherwise talkative throughout our three interviews had in contrast relatively

little to say about mental health when I first broached the topic with this question.

Though he would eventually divulge a variety of opinions on medication, therapy and

diagnoses, he initially had little to say in response to my question about service use.

Indeed, the somewhat awkward phrasing of my question seemed to deflate his otherwise

high energy in our first interview.

> Arturo*: "Now thinking about the kind of help you might need now that you're by yourself, do you think you're going to need to use mental health services, like at the county, like to talk to somebody?…I mean did you ever use…?*
>
> Brendon: *"Naw, that's stuff is not for me…had enough of that stuff growing up."*
>
> Arturo: *"So you had therapy and stuff like that growing up?"*
>
> Brendon: *"Yea"*
>
> Arturo: *"And you don't think you…*
>
> Brendon: (interrupting)*"No"*
>
> Arturo: *"So you don't think…"*

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Brendon: (interrupting)*"No"*

Arturo: *Okay, so you're not going to use that, but what about, like seeing a case manager…*

Brendon: (interrupting)*"No I don't think so…"*

While Brendon had maintained a rather talkative demeanor throughout much of the interview, these curt responses in comparison suggested he was generally uncomfortable discussing the topic of mental health services. Perhaps because of our lacking familiarity with each other, or my poor framing of the question altogether, Brendon's short answers indicated a clear desire to move on with the conversation, which we did. While Brendon would nonetheless open up to this topic quite extensively later in the interview (as I elaborate below) at this stage of the interview my questions elicited quite reserved responses from him. Other participants were similarly unresponsive to the question altogether, sometimes giving the impression that they either didn't hear what I had asked or were confused by the term mental health. "I'm sorry I didn't hear correctly," Tony one of the few openly gay teens I interviewed responded. "Did you say *mental services*?" After I clarified the term mental health services, Tony continued, "No, I don't need *mental services*, I think," he said in an exaggerated tone. "But I know some people who do."

These awkward exchanges highlighted the initial poor wording that I had used to construct these questions about mental health, but also the sensitive manner by which I would need to ask about these topics with subsequent participants. Indeed a few respondents dismissed my service use question altogether by implying that by asking

about mental health I was unfairly presuming that all foster youth need medication.

"When you say mental health, it's like thinking all foster kids are messed up," Janelle, a

twenty-one year old who had recently moved into a shelter after she lost her apartment,

responded. "It's really not fair, because we might have our issues, but we're not messed

up." Rejecting what she felt was unfair the premise of the question, Janelle continued in

a diatribe about the way society views foster youth as generally 'messed up.' "It's like

we finally get out and need a little help and the first thing you want to do is put kids on

meds." Though Janelle would eventually discuss that she herself was seeing a therapist

and on medication for "PTSD stuff," she nonetheless seemed annoyed that my question

presumed that she needed mental health help because she was a foster youth.

Ashley, a sharply dressed nineteen old student of color, was not as reactive as

Janelle to my question, but she nonetheless similarly complained that in asking about

mental health resources I was coming off too much like "social worker or therapist."

After our last interview she recounted how she had in fact been reluctant to "open up"

during our first interview mainly because of the way I had broached the topic of mental

health.

> *Just the way you said or asked about mental health, service or resources, or*
> *whatever you said, just to way you talk sometimes reminds of me a social worker,*
> *and I know you now and I like how you let me talk and really are trying to*
> *understand, but at first I was like he's another social worker, or a therapist trying*
> *to get into my head, maybe just don't say things like that, when you talk to other*
> *kids…I didn't really want to talk to you…all my life you*

Overall such responses suggest that the vey term "mental health" can often be interpreted

as a loaded concept by many former foster youth, one supposedly implicated in a set of

assumptions and expectations that social workers, but also broader society, have about

foster youth. For Ashley, the substance of my mental health questions, as well as the overly empathetic way I asked them, evoked the sentiments of a social worker, a profession that Ashley generally distrusted. While I knew Ashley had a good relationship with her current case manger, she nonetheless felt that many social workers were manipulative, particularly when talking about mental health. Indeed, when Ashley thought I was a social worker or therapist her instincts were to close up and "not share too much."

> *Social workers are always asking questions like that, trying to get you to 'open up.' Trying to get into your business without really getting to know you. But sometimes that stuff can be used against you. You never know who's reading your file or what they're going to do with that information…so yea, I didn't really know if I could trust you at first but Charles (her case manager) said you were cool.*

Though not all participants were as reserved as Ashley, or as concerned about the intentions of my questions, her comments highlighted a general ambivalence toward mental health intervention shared by several participants. Even while I would experiment with the specific phrasing of my questions in later interviews, as well as worked to better establish rapport with participants as suggested by Ashley,[107] the specific wording of 'mental health' and 'mental health services' continued to elicit mixed responses among several participants. Interestingly, among their varied responses, nearly all participants discussed at some point the "unfair labels" associated with mental heath diagnoses and the over-use of psychotropic medications in the system. Like Janelle, some participants interpreted my inquiries about mental health services as perpetuating the stigma that all

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[107] Following Ashely's advice I also made more of an attempt to establish trust and rapport with participants, sometimes meeting with them several times before doing the formal interviews. The support groups I attended, and incorporated as my ethnographic observations, were in part my attempt to have a continuing presence with several of the youth that interviewed during a six-month period.

foster youth had "problems" and as a result needed to be treated with medication. As with most of these conversations, the complaints culminated to a broader discussion about the over-use of meds in foster care and the shortcomings of the system itself.

Not all youth were ambivalent talking about mental health, as some appeared comfortable and at ease describing their emotional problems as well as their interactions with therapists (as will be discussed later in the chapter). But most respondents, regardless of their trajectories in foster care, could reflect on the problems of over-medicating youth in the system and the broad structural issues that this represented.

Medication Critiques
In asking youth about their attitudes and experiences with mental health services, several respondents were quick to re-orient our conversation to the topic of "meds" and their apparent over-use in foster care. Perhaps reflecting my lack of rapport with some participants my mental health questions were at these times interpreted less as being about one's own mental well being, or emotional distress, but more about the broader problems of foster care itself. Indeed, for many respondents to inquire about mental health was an indirect question about their need to be on medication, and medication for them often represented the central contention they had against an over-controlling system.

"I don't need any more meds," replied Michael when I asked whether he would seek mental health services in the community. "I had some anger problems when I was younger, and so they put me on something, I don't remember what. But I'm *not* looking

to be on that again, I mean, I probably could have done without in the first place…I mean sometimes they get kids on all kind of things that they probably don't need."

It is worth highlighting that at a general level nearly all youth in the sample discussed what could be described as the over-proliferation of medication in the foster care system. Both youth who reported being prescribed several medications while in care but also those adamant that they had "never been on any meds," shared the same perception that it is overused in the system. It is telling, for instance, that when asked at the end of the interview what three things they would hypothetically change about foster care, nearly every youth indicated that they would address some issue/problem related to over-medication. Ashley, the twenty-year-old student discussed earlier, and who revealed that she had "never been in treatment for anything," elaborated on her position to reduce all the "medications they give kids in care."

> *Well, it's not like I hate medications, I just don't think medication's good. I mean, there's some people that need medication to make it out there, that's okay, but there's a line. The line is thin, but it's a line. I think sometimes they put people on medication just to put them on it. I don't think there's actually a strong purpose for it.*

Having no use for medications herself, Ashley was unclear on whether this type of intervention was always wrong or, in contrast, helped some people get through their day-to day struggles. But from her perspective "the line" of when medication helped or was itself abused was often crossed in foster care. This was evident to her when she was first removed from her biological mother and placed in a group home where several of her housemate appeared clearly "drugged" and "out of it." "I just remember (being) in the

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group home for the first time and seeing all these kids, *just not right and out of it,* and being drugged with these little cups with pills after breakfast….I'm glad I got out of there, and my (foster) mom never let them put me on any medication."

Like most respondents, Ashley first became familiar with medication in the context of the foster care system. Similar to other youth who remembered being disturbed by the sight of "kids on meds" at their first foster home, Ashley seemed to associate the shock and disorientation of being placed in care with the general strangeness of seeing youth taking "pills" for the first time. Indeed, during a later part of the interview Ashley implied that the coercive way that the state removes "kids from their parents" was similar in form to its ability to put youth on medication. While she had never been "put on medication" herself, she presumed that foster youth often have little say in the "pills" they take or the treatments they were forced to participate. According to Ashley, if it weren't for the attentiveness of her foster mother, whom she lived with for eight years and was in many ways her "real mom," she might have been on medication herself.[108]

Like Ashley, most respondents cited seeing the side effects of medications, such as youth "drooling," "spacing out," "gaining weight" and struggling with trembling hands, after coming into contact with the foster care system. Likely because these side effects are rarely observed in the general population, many participants were taken aback by the relative frequency in which they were encountered within the confines of a group home or residential treatment center. Indeed, several participants described these side

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[108] In the absence of a caring adult who could presumably block attempts to prescribe psychotropic medication, Ashley believe that foster youth are essentially vulnerable to being over-medicated.

effects as clear evidence that the system prescribed "way too many pills." And like

Ashley many described that being overly medicated was itself a risk factor of being in the

system. Brendon similarly described this danger as he reflected upon what had happened

to his brother who had recently been re-placed in a residential treatment center.

> *Well, I mean like, with some places like, like for my brother, he's getting ready, about to move, out of foster care, he's a perfect example. He wasn't on that many medications but maybe like six months ago or so, he was placed back in (a residential treatment center), you know because of his behavior. So once you get back into the system...back in like treatment centers, or shelters other than a group home or foster home then that's when they feel you know, put you on more medication to make you better. So like my brother he's got like five different medications you know, three or four different medications right now, and the medication having him looking like a basket case…like…sometimes you be talking to him and he's not really there. It's really messed up.*

Similar to Ashley, Brendon described that being put on medication represented one of

the risks of coming into contact with the system. His brother had been almost out of

foster care six months earlier, but now, by virtue of coming back into a residential

treatment center, he was now on four or five different medications. Even though

Brendon's brother believed he needed these meds, Brendon was convinced that his

bother's prescriptions were excessive. "You don't have to drug a kid up," Brendon

described his brother. "Okay maybe they need it, he says it helps him, but I still don't

think drugging kids up… I don't think is good."

While these self-reports of medication over-use, or misuse, may seem exaggerated

it is interesting to note that a recent congressional report titled: "*The Financial and*

Societal Costs of Medicating America's Foster Children" (US Senate 2011) state

witnesses largely corroborated the view that a number of foster youth are prescribed an

excessive amount of psychotropic medication. According to the Commissioner from the Administration of Youth and Families who testified at the hearing, foster youth are much more likely to be taking multiple classes of psychotropic medication than almost any other group in society. Interestingly psychotropic prescriptions are highest within residential treatment centers, like those where Brendon and his brother resided, and lowest in traditional foster homes, where Ashley lived. These findings are consistent with a growing literature that documents both a high use of mental health services among foster youth, but also a reliance on psychotropic medications as the primary mental health intervention for such youth (Halfon et. al 1992; Zito et al 2008)

David, a slightly older respondent who I interviewed while he was serving the end of a sixteen-month prison sentence[109], also reflected on what he perceived as the almost indiscriminate use of medication in foster homes. Having experienced a variety of out-of-placements, ranging from structured residential treatment centers to "more relaxed foster homes," David described the over-use of medication as a system-wide phenomenon.

> I know like the 80's, (or maybe) the 90's they were handing out pills like crazy and you know, I know a lot of people my age that took the same medications, dealt with the same stuff, and a little (with) counselors, whatever, you know, all sorts of whatever. And then, it was crazy it really was back then.

Coming in and out of foster care several times during his youth in the 1990s, David

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[109] David was first interviewed while he was finishing a sixteen-month sentence for assault, that he committed shortly after turning eighteen. He had been originally interviewed as part of the MEEP study's prison sample (see chapter two for a description of the MEEP study). However, during my interview with David I learned that he had spent a considerable part of his youth in the foster care system, and had aged out shortly before being incarcerated. David represents a number of young adults who had two or more affiliations with different institutions. Because of his time in the foster care system, and his extensive experiences with mental health services, I include his interview as part of my foster care sample.

experienced in-home interventions by the state intended to keep his family intact. When

he was still living with his with his biological parents and brother, he remembered a

number of counselors and social workers coming into the home to help address some of

his behavioral problems. Though he acknowledged that he had problems with ADHD and

Bipolar, like several respondents he felt mental health interventions by the state were

more about prescribing medication and managing behaviors than helping him, or his

family.

> *I just had social workers and like doctors and therapists and people putting me on medications and telling my parents they needed to raise me a certain way and blah blah blah, you know, bunch of medical jargon, a bunch of nonsense I guess. I mean some of it was good and I do believe in therapists, in psychology, but my approach on psychology is (different)… I think they should of just let (foster youth) a lot of them be. So you know in a way I embrace the, say, the "mania" of it. And I try to utilize it the best I can.*

With a bit of irony, David described his acceptance of his mania; the up swings of

his Bipolar condition, in the context of an almost manic system that hands "out pills like

crazy." Similar to other respondents who talked at length about this issue, David

suggested that mental health interventions masked the underlying problems that youth

were experiencing. Rather than learning to accept his mania, and in some respects his

personality, the treatments he experienced by the system were more focused on

controlling but also masking his real self. Accordingly social workers were interested in

labeling, medicating but not really understanding his problems, or even him.

Various researchers have reported that antagonisms toward psychotropic

medication, such as those described by David, are not uncommon among many mental

health consumers. Particularly among individuals afflicted with Bipolar Disorder there

can often be resentment against medications that presumably "dull," or "mellow out"

feelings of energy and excitement associated with a manic state (Martin 2009; Moses

2011; Munson et al. 2010). In her ethnography of mental health support groups Emily

Martin (2009) describes a common perception within the Bipolar community that these

medications decrease an individual's sense of creativity and from the perspective of some

patients, their true sense of self. In stark contrast to some individuals who reportedly

only feel like their real self *when* consuming medication, a sentiment heard by many

patients responding well to depression medication (see Krammer 1994; Rose 1999; Karp

2001) many Bipolar patients can find psychopharmacology, while functionally necessary,

somewhat stifling to their sense of identity.[110] David's comments clearly reflect aspects

of this ambivalence—in that he believe its best to embrace one's mania rather than trying

control it with pills—but rather than rooting this negative aspect of treatment with the

medication itself, he linked it to the general nature of mental health treatment associated

with foster care.   That is, he described the myopic focus of medication-based treatment

as a broader problem with mental health services provided by the state, not a shortcoming

of medication itself. Indeed, David was thinking about getting on medication once he

was out on his own, something that ironically he had fought against much of his life

while in foster care:

> *I mean I've dealt with therapy and medications the majority of my life so I'm a little reluctant. But I'm trying to get on antidepressants, or something, so I can get a little bit of a balance going on. Because I have way too many ups and*

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[110] Treatment of Bipolar Disorder often focuses on modulating the dramatic mood swings that individuals can experience between feelings of mania and severe depression. Because mania can often lead to self-destructive tendencies, reduced inhibitions and increased impulsive behaviors, pharmacological interventions will often be designed to decrease these sensations, which many Bipolar patients associate with the "feelings of life" (Martin 2007).

downs throughout the day. And to go in and talk to somebody I believe that's important but… to keep it so it helps and it's a positive thing, that's what I want to do instead of feeling that it's something that I have to go against. You know?

Later David elaborated that mental health really depends on the specific therapist, and in particular whether they viewed treatment as way of helping a person "learn about themselves" or in contrast as way of controlling them. In reflecting on the therapy he experienced while in care, he felt that most were about labeling behavior than providing insight. "I think its another form of, kind of a label in a way, kind of name calling…I don't feel that I need somebody else to tell me what I am, because if I can't know what I am and be real with myself, (then) how am I supposed to be real with the next person."

Janelle, the twenty-one year old who had struggled significantly during her first two years on her own and was staying in a homeless shelter when I first interviewed her, also shared this view that that medications and labels over-simplified a person's behaviors. In particular Janelle described that therapists were quick to judge youth like her by their "surface behaviors" and not delve in the real problems. "They'd be like: 'why do you do this (behavior), then they'd be like, 'okay here's some Ritalin.'   We just need someone to pay attention. That's what we need." Indeed, like David, Janelle associated medication with a tendency among social workers to make perfunctory judgments about foster youth's problems, and to essentially ignore, and not listen, to the real issues they were facing.

All you need to do is sit down and get to know us, we ain't nothing, I mean we are not bad, we're human, I mean we do what everybody else does, they might look at us like I said, some fucked up kids, but if you really look at it we're really normal, we might have been through some things but we're still normal.

Again, because medication implied the lack of attention, Janelle, like David, similarly felt

that therapy was less an intervention for self-discovery, empowerment or recovery, but

more about categorizing youth as essentially abnormal. Particularly because foster youth

had experienced some traumatic events, Janelle felt that medication essentially

perpetuated their abnormality.

From a slightly different perspective, Ashley, who claimed she had never been on

medication, also emphasized that mental health in the system resembled little more than a

perfunctory judgment of kids who had gone through substantial struggles in their lives.

Indeed, medication for Ashley represented a type of stereotyping that social workers, but

society more broadly, associated with foster youth and other people who had gone

through significant challenges in their lives. Accordingly, medication is based on

presumption foster youth needed help, or were somehow broken, just because of their

past.

> *I think people are looking at the situations more than the person. They think that: 'Okay, they come out of this situation (so) they must be depressed, or they must have some kind of psychological issues because it's so traumatic.' But people have gone through worse things, and they're not on medication, they haven't gone through therapy. They're just..,it's life and they deal with it. So I don't know, I think people throw out ADHD and depression too much without really getting to the root of the real problem. It could just be stress, or something. I don't think it's that serious, for medication.*

Within these criticisms of mental health services is a similar conflation of

medicating and *labeling* negative behavior—how being prescribed medication is another

way labeling a person and minimizing their experiences. While perhaps reflecting in part

the stigma associated with a mental illness requiring medication, such comments also

suggest that treatment for mental health could often feel like an explicit form of social-

chemical control. Rather than providing insight to their distress, or as David described, knowing more about his real manic self, medications were about labeling and managing deviant behaviors.

Brendon who discussed being treated for anger issues, more explicitly conflated notions of treatment and being managed. "I think it's more about control than helping," Brendon responded when I asked him if he thought these service could be helpful for him. Because he had been in over twelve placements during his ten years in care he had trouble remembering the various treatments that he had received. However he recollected being "locked up" at one point because of his "anger management problems," and presumably at this treatment center he was prescribed several pills, though he could not remember the names. Because he believed that these drugs were given to essentially control him more than help, he felt ambivalent that his brother was on so many medications today, as discussed earlier. Even though his brother believed the meds were helping his condition, Brendon felt that such treatments were essentially drugging him beyond comprehension.

Other youth, and more generally females, held more nuanced views about the underlying reason why medication was so prevalent in foster care. Whereas youth like Brendon described "meds" almost as a chemical restraint—an intervention that physiologically prevented youth from acting out—others like Shelly, a nineteen-year-old pre-med student attending University, felt these intervention were more "band aides" for problems that the system was too overwhelmed to confront. Indeed the problems of over-medications according to Shelly stemmed from the fact that foster care was

"overfilled with kids;" it was an overburdened institution that from her perspective more often "neglected" rather than "helped youth." "I think they want to help," Shelly described the various caseworkers she worked with during her relatively short two years in care. "But you have to be careful with what you say to them, because they're always coming and going, and they usually have lots of kids on their caseloads." Suggesting that medication functioned often as a minimalist solution to problems that were beyond the capacity of *transient* case managers, Shelly warned that opening up to caseworkers about one's problems might result in having to talk with a psychiatrist about medication. "They might want to put you on something (by seeing a psychiatrist), just to help you to deal with things because they know they can't really help you with your issues," she discussed. In these situations youth were prescribed medication less because they really needed it, but more that "meds provide some help" in the absence of real support.

From this perspective medication almost represented a type of surrogate parenting by the state—instead of providing emotional support and care, the system (and psychiatrists specifically) just dealt with the immediate symptoms that were presenting themselves on a day-by-day basis. This triage approach to mental health meant that medication was often prescribed more than it needed to be, even though it likely brought some relief to youth. Nonetheless, Shelly was ambivalent about getting caught up in this system, and was particularly concerned about her sister who was a few years younger than her, and "often had a lot on her mind." "I think it's good that she can trust her case worker and that she wants to work on her issues," Shelly described her sister, who was more comfortable seeking emotional support from her social worker. "But I think she

can be too open about that stuff sometimes…I think it's not really going to help. We have a pretty good situation going so I don't want her to lose it by talking too much." Shelly described that when she and her younger sister were finally removed from the chaos of their mother's care two years ago, the state had allowed them to stay at a friend's house which eventually became an accredited foster home. This was unique opportunity that Shelly did not want to jeopardize. Suggesting that the state might re-evaluate her sister's placement if she was deemed "too troubled," Shelly encouraged her sister to be a bit more cautious of what she said and to whom. "I just don't want her to go to a different place if they think she has serious problems," Shelly described. "So I've been telling her that she can just to talk to me when she problems."

Overall, whether medication exemplified the unique form of institutional neglect that one that had to contend with as a ward of the state, or, the heavy-handed way the system handled problems, for most youth these issues spoke to the central problems of the foster care system itself. The implied carelessness by which social workers and psychiatrists supposedly "just put kids on meds"— highlighted at general level the depersonalized and bureaucratic form of care that the state could provide. While no respondent used the exact term "medicalization," several suggested that mental health interventions functioned primarily to categorize problems, so that could be quickly managed, documented and as quickly dismissed.

Labeling in Context
The relationship that participants discussed between *labels* and *medication*—treating these words almost as synonyms in their conversations— likely reflect a variety of

institutional factors that shaped the mental health experiences that respondents reported in foster care. First it is interesting to note that the perception that medicating and labeling are essentially the same thing, is somewhat consistent with the symptom-based emphasis of modern psychopharmacology. That is to say, psychotropic medication is often prescribed, by either a psychiatrist or physician, under the pretense that its pharmacological qualities will alleviate the specific symptoms associated with an identified diagnosis. As described by one of the several social workers that I interviewed about this issue, the topic of medication is often precipitated by a search for the right diagnosis,

> *"The search for the right medication often starts with the right diagnosis. So when we're trying to get the meds right we're also trying to get diagnosis right at the same time. Ideally we try and get everyone together, the foster parent, the social worker, (and) the therapist with the doctor (psychiatrist) and try help him get to the bottom of what's going on."*

Accordingly, when a foster youth presents with new behavioral and emotional problems, particularly those that seem to necessitate a psychopharmacological intervention, there is often an institutional prerogative to re-evaluate a youth's medication but also their diagnosis/diagnoses. Under this context where "to get the meds right," means also getting "the diagnosis right at the same time," it is reasonable to assume that many foster youth experienced these processes as one in the same. Discussions about one's medications were likely interwoven with discussions about their clinical diagnoses— labels that most youth were unlikely to be familiar with as well are unlikely to hear much of again outside the context of a medication consult. Indeed several respondents reported that these "labels" had little significance to them and to their day-to-day lives in care.

Some claimed that they their diagnosis had only been mentioned to them once or twice once, and some respondents like Brendon had a hard remember the specific wording of their mental condition. This suggests that while labels play an important institutional role justifying the use of medication, as well as more broadly legitimizing the use of medical insurance to fund certain services, some youth were only peripherally aware of them. While I was unable to investigate this issue further, given the limits of my case study, several participants implied that the topics of medication and labels were almost always discussed together.

Secondly it is also illuminating that several youth associated 'medications' with perfunctory judgments of their behavior. As discussed by several respondents above, medication implied a superficial interrogation of their problems; a fixation on surface behaviors rather than the underlying real issues that they were facing. Indeed, David hoped to find a therapist who would essentially look past the label of Bipolar; while he acknowledged he had to manage his Bipolar swings he was looking for a clinician who could provide more insightful therapy about himself. Janelle, more succinctly described that youth needed less Ritalin in their lives, but more caring adults who were willing to just listen to them. In short, the problem, or danger, of using medication is that it puts too much of an emphasis on symptoms and clinical diagnoses, rather than on the feelings, thoughts or insights of the youth themselves. Interestingly this criticism is consistent, and likely reflects, the orientation of modern psychiatry to primarily focus medication-symptom-management than traditional psychotherapy. Since the late 1970s psychiatry has embraced a more objective system of diagnoses over the subjective interpretations of

clinician or patients (Horwitz & Wakefied 2007; Lurhmann 2000; Rose 1997). Indeed, in today's modern context only a small minority of psychiatrists commit much of their time to conventional psychotherapy with patients, as the profession as a whole has largely embraced its new role to primarily conduct medication consultations (Lurhmann 2000). In this context, it is likely that several respondents had at most curt, and brief sessions with psychiatrists, during which time the focus was likely on symptom management rather than interpretation or underlying meanings of these issues. Though most respondents had access to a therapist or counselor where such issues were, and could be, discussed and elaborated upon, the conflation of medication and perfunctory labeling is consistent with the limited therapeutic role of modern psychiatry.

However, within the context of foster care the emphasis on 'symptom management' may be even more pronounced given the lacking familiarity that foster youth often have with the specific psychiatrists and clinicians conducting their "diagnostic searches." In my interviews with social workers in the child welfare field, many discussed that it was not uncommon for youth to have several different psychiatrists over time. Moreover, some social workers discussed that youth themselves sometimes play a minimal role in the "diagnostic searches," or what some more cynically described as the "naming game." As such, youth could feel somewhat disconnected if not alienated from this process given the limited role they often played in their treatment decisions.

> *"After meeting with a psychiatrist once they (the foster youth) might not know, or really understand that their meds are getting changed and sometimes even their diagnosis, I mean it's different on a case by case (situation)… but typically if it's*

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an older youth there has to be more of a conversation about their medication…but that's not really possible if the kid is young…so that doesn't always happen…so yea, I'm not surprised some kids coming out of the system don't know what they have been diagnosed with or what meds that they were taking…things are changing now so there's going to be more oversight with that.

Contributing to the perception that medication was also more coercive than therapeutic is the fact that most respondents had little to say, and often little awareness, about the specific medication that they were prescribed while in care. While the majority of respondents in the sample reported that they had "been on" at least one or more psychotropic medication while in care, only a hand full of respondents could remember the names of the "pills" and the clinical reasons why they were taking them. Interestingly, some participants associated pills with certain emotions and behavioral issues that they were "working on". Brendon, for example, remembered taking a "blue pill for anger," while Janelle said she had taken "something for depression." Max, who remained homeless throughout the course of the study, elaborated that he had taken medication for his extreme moods swings

I had medication for mood swings and anger pretty much. They had me on one for mood swings, cause I have mood swings I guess, cause one minute I feel okay the next minute I don't. They had me on medication for anger, I think they had me on medication at a time for depression; um…I think that about it. I think those were the only 3 things they tried to cover me with medication.

While some participants were largely unfamiliar with the medication they had taken in care, others were well versed in the lexicon of psychotropic pharmacology. This was the case of Billy who provided a laundry list of medications that he taken during his life. "I've been on everything," he stated rapidly during our interview. "Ativan, Xanax, Adderall, Klonopin, Seroquel," he listed quickly. "What else, let me see Dexedrine,

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Risperdal". Likely because Billy claimed to have been "diagnosed with everything," his list of past prescriptions transcended multiple classes of psychotropic medication from *benzodiazepines* and *antidepressants* (conventional treatments for the mood swings associated with Bipolar or Clinical Depression) to *psychostimulants* (treatments associated with ADHD) and even *antipsychotics* (like Risperadal sometimes used to treat Bipolar but also psychotic behavior). The day I had interviewed Billy, he had claimed to have washed all of his pills of his current prescription down the toilet and appeared, likely as a consequence, jittery, hyper and unfocused for much of our conversation (though I also speculated that he might have been on something different as well). He explained that he had just been recently discharged from the hospital—for reasons he did not want to elaborate on—and had been given a week's worth of medication with instructions to do follow-up care at the community clinic. "I just thought, fuck it, I don't need that shit in my life," he said about his decision to abruptly stop taking medication. "I mean they say I'm a little Bipolar, I'm not going to say I don't have issues," he continued rapidly. "I do, everybody does! I can get pretty edgy, (for example) because of my Bipolar acting up, but I don't like calling people names like that."

While Billy was open to the fact that he had some Bipolar tendencies, and in particular could act impulsively, his discussion nonetheless went back and forth on whether he fundamentally agreed or disagreed with diagnostic labels or their treatment. "All that shit is bullshit," he stated concisely at one point. "I was always on something. Or somebody trying something different for some reason or other, like I said ADHD, Bipolar, whatever." "I've been pretty much on everything," he said again. Nonetheless

as he elaborated on the chaotic circumstances of his youth—the death of his mother, the countless group homes and treatment centers that he had been placed, the constant conflict with social workers, foster parents and nearly almost everyone in his life—the Bipolar label also made a certain amount of sense to him. He could "act out" and be "manicy," he acknowledged. He elaborated that without "meds" he could find himself getting "paranoid" and be "too impulsive" which often put a strain on his relationships. Within the same discussion Billy blamed a number of people in his life for his many of his misfortunes, but he also acknowledged that he could be "a pain at times" and likely caused many of these problems himself. When I asked him if he was worried about being completely off medication given these interpersonal problems, and if he should considering going to the county clinic, he quickly shrugged off the suggestion, "Naw, I'm cool, like I said, I don't need that shit anymore."

Billy more than any other participant highlighted, if not embodied, the salient contradictions of using diagnostic terms to talk about one's self, while at the same time seeming to dismiss most diagnostic labels altogether. Whether because he was feeling the withdrawal symptoms of abruptly stopping his medication on the day of our interview, or because he was under the influence of some other drug, his discussions and behaviors were rarely consistent and overall difficult to interpret. Nonetheless, Billy's impressive familiarity with diagnostic labels and the slue of medications that he was aware of taking, highlighted a broader relationship between medication and self-labeling. As suggested by other research on foster youth and their relationship with medications, young people who more clearly identify with a diagnosis are more likely to have been on

medication for longer periods of time, believe in the efficacy of medication as well as endorse more organic/biological understandings of their disorder/behavior (Moses 2009). More so than other youth, Billy had a strong familiarity with the names of medications and diagnoses, and at times he seemed to believe in their efficacy, though often in contradictory ways. Indeed one could sense a deep ambivalence in how Billy talked about medication in his life, particularly as an intervention that both "worked" in terms of managing some undesirable tendencies, but also were "bullshit" in part because they had been forced on him. As also highlighted by research on former foster you, the perception that one was forced take medication while in care can often anchor strong resentment and anger towards treatment (Munson et al. 2011). Indeed Moses (2011), finds that coercion is one of the strongest predictor of youth disengaging with services in the community (Moses 2011). Billy who acknowledged the benefits of medication, but also clearly resented being forced to take medications, seemed to be pulled by these two tensions as he elaborated on his nuanced perspective on treatments. "To be honest, a little Adderall is probably all I need these days," Billy described to me after the interview. "But fuck if I'm going to a psychologist to get that…I can get that shit on the street by myself, today if I wanted it."

Jamie who was twenty, and who I had met in prison serving a four month sentence for shoplifting, also self-identified with being Bipolar but expressed a more coherent attitude toward the efficacy of medication than Billy. Perhaps because her recent treatment and diagnosis had been more of a choice, than coerced option, she expressed a newly discovered openness toward mental health treatment that she admitted

was different than her past. "They said I had problems when I was a kid, but it wasn't until I talked to a therapist here (in the prison) that I realized that I really was Bipolar." Jamie elaborated that while she had been mostly dismissive with therapists and labels in the past, more recently she's been more convinced about her latest condition after noticing the positive impacts of her medication:

> *I started taking medications a couple of months back and I can feel the difference…just the swings I used to have. That used to be my normal so I thought that was normal you know. It's been better for me, and knowing (to) manage my Bipolar and it really explains a lot in my life, you know all the crazy stuff that happened in my life. Going in and out of foster care. Like my mom was probably Bipolar too, you see it because it can run in families, my therapist told me that.*

Jamie's apparent positive attitude towards treatment seems interrelated to her positive experiences with medication as well as her comfort self-identifying with the label Bipolar Disorder. As others have documented (see for example Munson et al. 2010 or Karp 1999), the effectiveness of psychotropic medication, particularly in alleviating disruptive symptoms, can sometimes help individuals clarify and come to terms with the contradictory tensions of needing mental health in needs. In particular, psychotropic medications can symbolically confer the realness of a condition to an individual, by transforming otherwise inchoate and nebulous symptoms into a coherent condition.[111] It is also useful to consider Jamie's insights into her awareness of "normal" in the context

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[111] As succinctly conceptualized by Karp (1996) as the "dialectics of seeking help," the decision to access mental health treatment reflects a paradoxical *thought-process* in which one identifies one's own *thought-process* as aberrant and needing treatment. Indeed, because mental health problems implicate how one *thinks*, *feels* and *perceives reality*, acknowledging the need for treatment can be a prolonged and recursive process marked by ambiguity, contradictory thoughts and self-doubt (Aneshensel 1999; Karp 1996; Kleinman 1978; Krammer 1994) Karp has suggested that within illness narrative the discovery of effective medication can often play consequential and transformative role in help individuals resolve the contradictory view that they rationally need mental health treatment.

of Peggy Thoits *self-labeling theory* (1989), which suggests that that coming to terms that one needs treatment is in part about recognizing one's own emotional deviance to socialized emotional rules.[112] This self-reflective process seems evident by Jamie's recent insights into her past mood swings; and her re-interpretation of her old normal as abnormal.

Three months later when I re-interviewed Jamie she was living in a halfway house with other ex-felons and attending weekly groups at the an outpatient community clinic where she also met with a psychiatrist for medication evaluations. When asked how she felt about her diagnosis and treatment Jamie responded in the same positive fashion as before. "I think it's just better knowing what you're up against and you can figure out why you're always doing the same thing, over and over again, so I think it's important." Jamie also discussed that she was trying to get her mother to also see a therapist as she suspected that Bipolar ran in families.

> *"We still get at it (fighting with each other), when I see her, and I want her to see someone (a therapist) because I can see now her mood swings…and they cycles…I understand them now and not just react, like it's just like what I used to be."*

Jamie more than most other youth I interviewed seemed empowered by her diagnosis and believed that treatment held much potential to change the many problems in her life. Beyond just self-labeling with her condition, Jamie used her Bipolar to re-

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[112] Rooted in Mead's (1934) notion of the "reflective self," *self-labeling theory* argues patients like Jamie who are positive about their diagnosis and treatment options have internalized a generalized therapeutic other—a "third-person" perspective into their own emotional reactions. In short, this socialized third person perspective encapsulates society's "emotional rules" (Hochschild 1978)—the norm of appropriate emotional responses— by which mental health patients recognize their own emotional deviance, and in turn their need for treatment.

arrange the whole story she told of herself. Indeed consistent with what medical

sociologist describe as an "illness narrative,"[113] Jamie had clearly re-constructed and re-

narrated the struggles of the past around the symptoms of her newly discovered

condition. Within her new narrative, Bipolar provided a certain structure and coherence

into what was otherwise a chaotic life of coming in and out of foster care, and by doing

so, seemed to give Jamie certain sense of control and empowerment toward her future.

Indeed Jamie's awareness and insight about her Bipolar life was strongly reminiscent

what Frank (1993) describes as the *epiphany of the illness narrative*:

> The illness becomes an epiphany, that is to say, a repetitive event around which
> all change revolves and where cause is situated. In some respects, it could be said
> that in this kind of illness narrative life is seen in the light of the illness. The
> illness is the vantage point from which all other events are viewed and to which
> all other events are related. (Frank 193: 95)

Indeed, by arranging the erratic, Bipolar events of her past in a temporal order and

relating them to other events in her life, Jamie conveyed a certain coherence, clarity and

consistency to her biographical narrative that was relatively uncommon in the sample.

Indeed, while Jamie seemed stressed about her current life during the second interview—

struggling to find a job, a place to live and some sense of reconciliation with her

biological mother—she nonetheless seemed optimistic about her future. By learning

about her Bipolar condition and the corresponding new definitions of normal and not

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[113] Illness narratives have been important medium by which sociologist study how patients deal with their
life situations and, above all, with the problems of identity that chronic illness brings with it. Hyden (1996)
argues that an illness narrative provides a rich lens into how a patient understands their world, or more
specifically their newly imagined illness world

normal emotions, Jamie was able to remain more positive about the upcoming months than most participants.

The Inconsistencies of Mental Health

It is important to note that many individuals I interviewed were inconsistent in how they talked about mental health issues, particularly when directly asked if they had ever been diagnosed with a mental health issue, or were themselves interested in accessing such service in the future. Sometimes these inconsistencies would present themselves during the second or later interviews, when participants directly contradicted something they had reported earlier in my first encounters with them. Michael, who on our first interview reported that he had never "been on meds" or had seen a therapist nonetheless discussed in the second interview that he preferred working with male therapists. Beyond these biographical inconsistencies, that may have been in part shaped by a social desirability bias (Barbi), participant's attitude toward mental health could also substantially shift between the two interviews. David, for example, contradicted his general enthusiam for therapy while in prison who expressed a seemed less motivated, and less interested, to seek help from a therapist . Participants could also be inconsistent in the same interview, as was the case of Billy who seemed to simultaneously endorse and reject labels as he described his complicated relationship with mental health interventions.

As previously discussed in the literature review, past qualitative studies have found that most foster youth are reluctant to self-label themselves with a psychiatric diagnosis, often find little meaning in clinical terms, and can be inconsistent in how they talked about these issues more generally (Moses 2011; Munson et al. 2012). In the study

by Moses (2011) a large percentage of youth in his sample were open about having behavioral problems but were often inconsistent in how they talked about and identified with their previous diagnoses. According to Moses these inconsistencies stem from a deeper ambivalence that many participants have about being seeing themselves as pathological and abnormal. My interviews largely corroborate these finding, as many participants in the case study either could not remember their specific diagnoses or dismissed labels all together. And while most participants were candid about the emotional and behavioral problems in their lives, many were particular ambivalent about being seen as abnormal. Billy, who claimed to have been "diagnosed with everything," seemed to both endorse and reject his varied diagnoses, as he reflected upon the different challenges in his life.

Throughout this project I occasionally struggled to decipher the "truth" from my respondents, and when to challenge them when they contradicted themselves. In Michael's case I probed him to clarify whether the "sessions" he described with "this dude in the county" consisted of a mental health intervention, which it likely did, though in our first interview he had been adamant that he had never had help for mental health. In the awkward exchange that followed when I tried to clarify this point, Michael initially denied that he had said as much during our first interview. A few moments later he instead claimed that he had misunderstood my question as being about just "meds" and not mental health more generally. Because he had avoided "meds" throughout his experience in foster care he had simply told the truth as had understood the term mental health. Though this answer provided some insight into how some of my respondents

were understanding the nature of my questions—that in asking about mental health services some understood this as a question directly about medication—it also highlighted a tension of when and how to confront participants about their inconsistencies.[114]

Over time I developed my own sense of when and how to clarify such issues without confronting participants, though this general dynamic speaks to the difficulty of assessing an individual's "mental health status" through one-time interviews and surveys, particularly with this population. Indeed, the literature on self-reported data is clear that an objective re-collection of one's health status can be fraught with complications and inaccuracies. Moreover, as highlighted by Pescosolido (1992), the same individual can exhibit varied and dynamic patterns of using mental health services across time, resulting in varied and dynamic ways of describing this service use. But because I was less interested in an objective telling of one's health status, but more how participants talked about these issues, I felt this limitation was a secondary concern to the primary objectives of the study. The fact that I was able to re-interview most participants over time, I was able to capture a more nuanced perspective of how participants thought about their mental health, rather than the singular truth of their mental health.

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[114] The fact that I had challenged Michael on an inconsistency in his story put him on a defense stance toward my future questions. Because I did not want my interviews, and particularly my second or third interviews, with respondents to give the impression of a confrontation or an intervention on the importance of truth telling, I sometimes allowed respondents some wide latitude to change their stories, or perspectives. Indeed, because this interviews project sometimes afforded little time to establish rapport and trust with respondents, it was reasonable for some respondents to need time and warm up to a truthful retelling of their situation. On the other hand, clarifying questions and following-up on inconsistencies during an interview were important strategies that I felt compelled to pursue for the sake of improved validity and trustworthiness of my data. I also found that asking participants to clarify an inconsistency could sometimes help establish rapport with respondents, indicating that I was closely listening to their story.

An important variation, however, was my observation that female respondents generally had a better understanding of mental health and as consequence tended be more consistent in how they talked about specific diagnoses, disorders and their emotions more broadly. For example, while most males often referred to amorphous anger problems as their main mental health issue, female respondents seemed more comfortable talking about specific diagnoses, such as Bipolar, Depression, ADHD and PTSD. Whether this reflect the gendered way mental health is coded in Western culture, or the limited emotional vocabulary associated hegemonic masculinity, female respondents exhibited a better dexterity talking about their emotional health, and in particular citing diagnostic labels. "I remember my foster mom talking about me having PTSD because of the things that happened with my uncle," discussed Keri a nineteen-year old who had recently moved into her first apartment when I met her. "I mean I was Clinically Depressed for a long time and went to therapy for a while…we tried some prescriptions, but I'm not on them anymore." When I asked Keri why she had stopped seeing a therapist she replied "I don't know, it just kind of stopped…and I guess case I don't need it anymore, my (older) sister thinks I should think about it, because with PTSD things can come up years later."

Tiffany, who had been orphaned after her mother past away to cancer, similarly discussed that she had seen a therapist while she was in care. But similar to Keri, Tiffany also implied that she probably still needed care even though she was unlikely to access it herself for unclear reasons. "I've talked to my boyfriend about it, and I know I probably need to go talk to somebody, maybe at the student center (at my university). I know I should probably do it but I honestly haven't done it yet…I don't know I don't really have

time now, but maybe next semester."   Interestingly, while female respondents were more open to talking about their emotional health, and more consistent talking about their experiences with treatment, they nonetheless exhibited the same reluctance to seek care in the community as male respondents.

Troubling Transitions and the Social Structuring of Stress
While most youth asserted that they were not interested in accessing mental health resources in the community, many nonetheless discussed a variety of emotional problems by their second interview. Indeed, when not asked about their mental health directly but probed about the challenges in their lives many respondents discussed the emotional toll, behavior problems, and increasing stress that they were feeling. Sadly, within a few weeks of transitioning out of care, or in some instance out of prison, several participants had experienced an accumulation of negative events in their lives related to housing, school, employment and finances. While it should be emphasized that not all participants struggled and that some were doing relatively well during the second interview, many nonetheless encountered a startlingly number of "bumps in the road" in the three to six month months between our interviews.[115] Approximately 30% of participants re-interviewed (5 out of 15) were effectively homeless, and were staying either at a shelter or "couch surfing" with friends. Within this group, most (4 out of 5) were unable to continue with their school plans and had dropped out by the second semester, when most post-interviews were conduced.

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[115] It is interesting to note that some social workers and state officials that the MEEP team had coordinated with to collect the sample, had suggested that the three to six months follow-up period between the interviews would be too short of a time spans to capture significant transitional challenges. Nonetheless it was clear that some participants had experienced challenge almost immediately after leaving care.

In addition to these challenges some participant were also remarkably unlucky with seemingly random events in their lives; such as getting mugged, having property stolen from their apartments, losing their wallets, car troubles, break-ups with significant others, fights with friends, loss of jobs, early pregnancy, health problems, exposure to violence, sexual assault, run-ins with the police, problems with drugs and alcohol and sadly in one situation early death. In listening to participants describe these challenges it was difficult not to appreciate the cumulative effect that these events were having on their apparent well being and in their lives overall.   Indeed some of these events were innocuous on their own such as losing a wallet or having car problems. But the fact that these incidents were often interconnected and occurred simultaneously exacerbated participants' precarious situations. Brendon, for example, lost his housing, was dropped from his college courses, bought a car that broke down, and lost his wallet in the span of a few weeks. Broke, homeless and spending the few savings he had on broken down car that later turned out to have been stolen, Brendon struggled significantly throughout the course of the study.[116]

It is interesting to note that while these events reflect in part some poor choices made by individuals as well as some bad luck, they also reveal what sociologists describe

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[116] Brendon lost his apartment because he had not realize he needed a co-signer for the lease with a good credit history, and as a result ended up moving in with his biological mother who lived in the other side of town from his school and work. This meant that Brendon was spending two to three hours a week commuting from school to work to home, which soon limited the time he could commit to work but also leading him to miss a number of classes. A few weeks in the semester Brendon used part of his school stipend to buy a used car from a friend in the neighborhood for $600, which he was able to use for a week before it broke down. Worse because Brendon had dropped two of his classes, he was no longer a full time student reducing the stipend he received from the state. Six months after I first interviewed Brendon still homeless, out of school, and with little money. While he was still employed at a grocery store, he was anxious about the future given that he recently had discovered that his girlfriend was a few months pregnant.

as the social structuring of stress (Pearlin 1989). As posited by a variety of sociological

perspectives, the distribution of negative life events, and their resultant stress-induced

health effects, is unequally distributed across segments of society (see for example

Pearlin's 1980 *social stress process*). Seemingly random bad luck events, such as

Brendon buying a stolen used car, appear less non-random when considered in the

context of his limited resources and overall disadvantaged status in society. Sociologists

argue that marginalized groups in society not only experience disproportionately more

stressful events in their lives than others, but they also have less resource to effectively

cope and navigate such stressors. Recent perspectives also suggest that chronic stress,

such as those related to finances, can negatively impacts effective decision-making,

leading high-stress individuals to perpetuate their own high-stress environments (see

Shannon 2001)

In the context of this turmoil, it was clear that the term mental health had a

different meaning for most participants, particularly in respects to describing the stress in

their lives. By the second interview, many of the participants openly report feeling

"stressed out," "overwhelmed" and "depressed" as they negotiated the difficult transition

out of the foster care system. Some spoke of an enduring sense of loneliness, if not

complete isolation, as they confronted one challenge after the other, mostly by

themselves. Others discussed their pessimistic fears that they may "lose it," or have a

"break down" in the face of financial setbacks.   Maria, who I would only meet once,

stated that she was worried about her "mental state," as she confronted the prospects of

certain homelessness.   During her many runaway attempts in foster care Jaime Maria

witnessed several friends "get sick" from living on the streets for too long, she described, and now that her apartment plans had been put in jeopardy because of finances, she worried that this might happen to her as well. Even for respondents who were successful securing stable employment and housing within the first weeks out of care hinted of concerns related to their diminished mental well being. Michael, identified by his case manager as the "poster child for foster kids" because of how smoothly he had moved into an apartment and found work at a nearby Target, nonetheless recounted that he was secretly feeling "depressed" on the weekends. As he explained, he was beginning to doubt that he had much to work for in his life and that his supposedly "good job" felt pointless at times. He occasionally worried that he would never belong anywhere, he admitted, and that perhaps his life would be one of continual isolation. There were days he described, when he struggled to even get out of bed.

A significant finding from this study is that while nearly all the former foster youth interviewed discussed an ambivalence towards "labels" associated with mental health, nearly two thirds of respondents (10 out of the 15) nonetheless described having concerns about their emotional well being during their transition out of state care. While most individuals expressed a clear uneasiness with using explicitly medicalized categories to self-label themselves, the majority of respondents openly discussed having a mental, emotional, or behavioral problem that substantially impacted their lives. Given their troubled and often traumatic pasts, most respondents acknowledged that they had recurring "emotional issues," "triggers" and "baggage" that would both contribute and be a consequence of the compounding pressures in their lives. As highlighted above, some

individuals could at times be rather candid about the emotional difficulties that they were experiencing, or feared they would experience in the months to come.

Indeed as the study progressed and some individuals confronted an often-dire set of circumstances related to housing, financial insecurity and extreme isolation,[117] their interviews became more centered on "stress" and the impacts it was having on their personal well being. "I just feel overwhelmed sometimes," described Janelle almost on the verge of tears. "I just get down on myself for days, depressed, I know I have issues with depression." Somewhat ironically a few individuals described that the stressors of their lives were exacerbating the very "behaviors" and "issues" that they had resented being treated for in care—at times touching upon mental health terms and diagnoses, that at other times in the interview they also rejected. "I fucking get sick of this," lamented Billy about being homeless again when I re-interviewed him over the phone. "I'm just trying to figure this job shit, it's just fucking stressful, I don't know, I can see my ADD acting up and I just lose it with people." While there was a clear resentment among some respondents about have been labeled a diagnosis, or similarly have been objectified as an "at-risk" youth, most individuals acknowledged rather candid self-assessments about their vulnerability to such problems.

Indeed even Brendon, who resented the mental health treatments that had "drugged up" his brother, nonetheless drew upon a vocabulary of therapeutic terms to frame the challenges of transitioning out of state care. He had a range of "emotional triggers" in his life, he explained, ranging from concerns about money and finding stable

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[117] Similar to other studies on former foster youth, within a few weeks of leaving care a substantial number of participants became homeless, were entangled with legal issues, and had ongoing challenges with school and work.Some also experienced forms of violence

work to "problems with females." On occasion these triggers could compound what Brendon described as his "anger-management problem," an issue that he admitted was occasionally getting the better of him. "The biggest thing that will be for me (moving out), to be honest, is that I have a hard time dealing with stress," Brendon had described during the first interview. "I know there will be a lot of it and I'm no good with it." Indeed, there were times in his life when Brendon was always angry, he described, when the "littlest things" could set him off. He would like to think that he has mostly gotten over this problem—that he's learned to monitor the signs of when he's getting upset and "to think before you act"—but on that Saturday morning, a few days before he was move out his last foster home, Brendon seemed to suggest to that these issues may once again resurface in the upcoming months. "I can still get angry at times, and I have to watch myself."

Brendon's self-reflexive way of talking about himself and his emotional problems, the way in which he could narrate himself almost in the third-person as somebody who has anger problems and triggers, had surprised me the first times I met with him. Sitting in the park table that day across the street from his mother's apartment he visibly presented himself like many of the young African American young men I encountered in the North East neighborhood that Brendon liked to call his real home. Though on occasion he had a sweet and gregarious way of talking, most of the time he displayed a cool, almost cold, facial expression particularly when we walked around his neighborhood. In a deep almost raspy voice, he spoke of his past fights, his love of football and with a bit of exaggerated bravado, the "females" in his life. The open

discussion of emotions, and the behavioral problems of his life, seemed to contradict the

outwardly, masculine demeanor by which Brendon carried himself.   Though in

Brendon's case, he certainly lacked a clear command of the therapeutic and emotional

language of social worker, he nonetheless surprised me when on he discussed that he was

"working on issues" had "emotional triggers" related to depression, and was overall

concerned about his anger management. During these times Brendon would suddenly

appear out of place to the environment—his neighborhood—that he called his home.

Indeed, like several of the foster youth that I talked with, Brendon could give off the

impression that his presentation of self was subtly off to what he intended in terms of

being "another kid from the hood," as he often described himself.[118]

In particular many respondents relied in distinctive therapeutic narrative structure

to talk about the recurring difficulties in their lives, linking the past with the present, to

describe and make sense of their emotional response to stressors. Similar to Jamie

discussed, earlier, Brendon evoked a clear illness narrative when talking about his anger

problems,

> *It was everything combined, like my dad passing away and me getting taken away*
> *from my mom and me not being able to grow up around my brothers and sisters*
> *me just not having a teenage life, just not coming up like a regular teenager is all*
> *that stuff combined, but everything combined, I just, I've had anger problems*
> *since I've known, it all started with my dad passing away, that's when the anger*
> *came in but then I've just been an angry person.*

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[118] On the day of our first interview Brendon was similarly dressed like a few of the young men playing basketball at the other side of the park where we met for the interview; he sported an undersized white, almost translucent, sleeveless undershirt, accessorized with thin silver necklace and a baggy pair of off-brand jeans. But like several of the youth that I talked with, Brendon could give off the impression that his presentation of self was subtly off to what he intended in terms of being "another kid from the hood," as he often described himself. Perhaps because he had spent a large part of his childhood in the presence of social workers, therapists and other emotional care workers, Brendon possessed a set of linguistic expressions seemed out of character to how one would conceives of a typical teenager from the hood.

Like Jamie, Brendon connected his life narrative around the emotional problems of his youth, with his anger connecting all of the key points in his biography. Unlike Jamie, however, Brendon did not self-identify with his diagnoses, likely in large part because he still disagreed with his general treatment in foster care.[119] Instead, Brendon viewed his anger issues mainly within the domain of a "behavioral problem", and less so a mental one, a symbolic distinction that other respondents similarly navigated as they discussed issues related to mental health.

Consistent with other qualitative studies on foster youth (see Moses 2009), a number of respondent implicated this distinction between having "behavioral problems" and having a "mental health condition," in part to normalize their emotional deviance. Accordingly one could act out and even take medication, but not be mentally ill. " Just because you're in foster care doesn't mean you're crazy," described Janelle, when discussing her emotional distress. "We've just had a lot things (happen) in our lives, anybody would *act out* if they had things like that, happen in their lives." Like other respondents, Janelle situated her "acting out"—which she described as moments when she starts crying uncontrollably or shouting at people—as an almost a natural behavioral-response to the difficult and chaotic incidents in her life. Accordingly, she exhibited a set normal of behaviors in response to a life of abnormal life events. "I've had a lot of shitty things happen to me, and I used to act out a lot," she described. Though Janelle implied

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[119] In particular while Brendon acknowledged that he had been helped by medications, he was at the same time clearly proud to be off "meds" and not "drugged up" during his last two years in care. Indeed, as discussed above, he resented how foster kids were always drugged up and often had little voice in the matter. Indeed, Brendon was reluctant to attribute his improved behaviors to therapy or medication even though he described these things, at times, as "helping some." Instead Brendon emphasized that his maturity had increased the last few years, and that this has been what contributed most to his success.

that she's gotten a better handle on her "acting out," over the years, she admitted that more recently her "behaviors" had gotten out of control again. After transitioning out of foster care Janelle had moved into her own apartment, had a job and was going to school, but "the stress of it all," and in particular "being all alone," got to her after several months. By her account she "lost it for a while" and became homeless for a time. Still, despite having this episode in which she would be hospitalized for a few days, Janelle was adamant that she was not "crazy," "broken" or sick—words that hinted at the pejorative and stigmatized meanings that she associated with a mental health diagnoses.

Robbie, another participant in the support group where I had met Janelle, similarly described that "a lot of kids in group homes have *behavior* problems," but only a few "were really crazy." Having lived in the same group home for several years, and seen many foster youth "come and go," Robbie attested that most of the "behaviors" he saw were related to the "their situations."

In discussing these behavioral difficulties most participants provided a particular explanation of their condition that rooted their problems mainly in terms of stress, triggers and past experiences. In many ways most youth endorsed a sociological "explanatory model" of mental illness (Kleinman and Goode 1978) one in which past experiences and current stressor caused problems that were fundamentally behavioral in nature. As several participants pointed, their at times erratic behaviors of acting made sense given their situation, or context, particularly in the past "I think it's all about your environment, it's all what you've grown up around" Brendon described. "You grow up around violence, more likely you'll be violent. And that's what I was like when I was

young, violent, that's how I know." As discussed by other participants, their behaviors were less problematic and pathological, as they were more consistent and normal with their environment. Accordingly, they weren't abnormal; they just experienced a lot of abnormal situations.

Interestingly, while some participants felt that medications were helpful in managing these problems, most rejected a purely biological explanation of their conditions. With a few notable exceptions, most participants did not believe that chemical imbalances in the brain, or their genetics, had lead to their conditions, even though they acknowledged that medication could help alleviate them. Consistent with broader researcher on modern perceptions of stigma and biological reductionism, participants expressed the view that biological explanatory models, further stigmatized mentally ill individuals (Phelan et al. 2008). When I asked Brendon how medications worked, and how it had at one point helped him, he provided a nuanced perspective of the change he had experienced, which seemed to both acknowledge the impacts of medication, without citing biology as the causal factor.

> *I don't think the person changes (when on medication). I think maybe their actions, the medications help control their actions, as a person I don't think they change. I think it's still in there, it's just buried deeper, the medication just buried it, but I still think it's in there. I still have anger, if I get mad enough I fill I still gotta do something stupid, that why I just try to avoid it. When I was on medication it didn't stopped me from having anger, cause I still got it.*

In stark contrast, Jamie embraced the genetic explanation of her mental illness, in part because it helped explain not only her chaotic past, but also her family's. As previously described, Jamie believed that both her mom and herself were Bipolar in part because she knew that these conditions "run in families." Further evidence that this was a genetic and

biological condition, her medication had substantially reduced the erratic mood swings of her past. Interestingly, rather than feeling stifled by a biological explanation of her condition, as somehow depicting her problem as a permanent part of her biology, Jamie appeared empowered by it. As suggested by the research on stigma, modern perceptions and meanings associated with biological reductionism appear to be evolving in complex and nuanced ways in broader society as new understanding of mental illness, and the proliferation of medication, become more ubiquitous.

Regardless of whether participant endorsed biological or sociological explanations of their problems, or sometimes a mixture both, in the context of their many stressor many relied on distinctive therapeutic narrative that often highlighted the triggers in their lives. Some evoked a series of emotional words to talk about the precipitating circumstances –of the "bad feelings" of a moment—under which they would start to have an episode. Janelle would "act out" when she "felt abandoned," she discussed, or when she felt people were trying "to take advantage" of her. Michael described that he often felt isolate and depressed and longed for some type of connection with people, whenever he was home alone. When he came home after work and his roommate wasn't there he described feeling an overwhelming sense of loss. Keri, who had been abused by her uncle, described that certain men could be her triggers and they way interacted with her.

For Brendon, he explained that a lot of the times he had gotten angry in foster care when he missed his family and had feelings of wanting to be desperately back home. There were times when he "acted out everyday" at a residential treatment center because as he recollected he had secretly hoped the system would "give up" on him and send him

back to live with his biological mother.   Overall Brendon attributed his outbursts to a complicated mix of issues, related to "being lied to," to being disrespected, to feelings of abandonment.   His decision to not only move back to his old neighborhood after foster care, but also to re-establish contact with his biological mother had brought up "painful memories" for Brendon; memories that made him "angry," "confused" and at times "depressed." Of the "triggers" in his life, the emotional ones related to his family and his past seemed to be on his mind that day.

Conclusion: The Ambivalence of Seeking help

During the course of the study I could only verify that three participants accessed any formal mental health services. Two participants, Billy and Jamie, received individual counseling, medication management and group therapy sessions at a county run "community clinic." At one point Billy also became hospitalized after making threats to harm himself while staying at a shelter and spent a couple of days in the "locked down" ward of the county hospital for assessment. A third participant, Janelle, accessed services through the support program where she attended regular groups, but also met with a psychotherapist to work on issues related to her depression and PTSD. The remaining participants largely avoided accessing any formal mental health services though few framed this as a deliberate decision or choice on their part. Rather, and as I discuss below, seeking help from social services providers, or the system itself, simply seemed inconsistent with their notion of finally being out of the system.

Billy and Jamie periodically visited with a psychiatrist who managed their medications at the outpatient, community clinic. During the time that Billy was

reportedly compliant with the medication schedule setup by his caseworker, he also attended some support groups at the clinic though these seemed more sporadic. At our first interview Billy had claimed to have flushed all his pills down the toilet a day earlier, though I sensed this was an exaggeration, as it seemed like he might have accessed these services at least once after our first interview. Nonetheless, Billy expressed ranging levels of antagonism toward the services he received at the clinic and by the second interview it clearly seemed that he had stopped accessing services altogether. "I maybe went there once in the last couple of months, but then I just left town, I just needed to leave that crap behind," Billy stated over the phone.[120]

Jamie, in contrast, was more consistent in her engagement with the mental health services provided by the county. "Yeah, I just go down there every week for group and every other week for my one-on-ones," described Jamie. "Groups are okay, we talk about different things, sometime it's helpful, I like the one-on-ones better." Speculating that by "one-on-ones" Jamie meant that she preferred individual therapy sessions with a clinician, I encouraged her to elaborate on why they were better than group sessions. "Well it depends on who goes to group, usually it's okay, but then sometimes you have some people who just, I don't know… they just waste time, they got lots of issues and so one-on-ones are better, I think for me at least." Jamie also discussed that she liked her individual sessions because she trusted her therapist who was a "good listener." In addition the therapist was also "good" because she was providing Jamie weekly

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[120] Billy had re-initiated contact six months after our first interview and was now living in Idaho. He had hitchhiked across several states to stay with a friend that he had met at a residential treatment center. Though Billy found himself with little money, and in a small town with limited employment opportunities, he claimed he was glad to have left Minnesota. "Everybody knew me there, so I just had to start over."

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homework assignments to work on. Referring to cognitive-behavioral therapy as simply "cog," Jamie described that these homework assignments were helping her better understand her reactions to situations, as well as helping her better manage her Bipolar swings.

Despite their different trajectories, an important similarity between Billy and Jamie, particularly in respects to representing the few participants that accesses mental health services in the community, was the fact that both had experienced an intermediate transition after leaving foster care. At the time of our interviews both were transitioning out of more structured, institutional settings than was the case for most participants. For Billy, he had been psychiatrically hospitalized after a shelter staff heard him make threats to harm himself over some dispute that he had gotten with another person in the shelter (the details of which Billy was not willing to discuss). After spending a few days in the hospital and transitioning to a type of community halfway house funded by the county, Billy had been referred to the outpatient clinic. In a slightly different situation, Jamie had re-started seeing therapist, and later a psychiatrist during her three-month stint at the county jail. When she transitioned back into the community, her probation officer had emphasized that Jamie would need to do regular "check-ins" at the community clinic at least once a week for treatment. While I was unable to verity whether her treatment was part of her probation requirements, or if Jamie had herself been assigned to the clinic after attending the county's Mental Health Court, it was clear that she nonetheless was interested in seeking services. Though the group therapy sessions felt more like a requirement that she would not follow-up on after probation, she appeared genuinely

happy to have access to a counselor and regular medication consultation with a psychiatrist.

Janelle also accessed formal mental health services during the course of the study. As discussed previously I met Janelle at a transitional program for former foster youth, which provided youth a variety of support and case management services. At the time that I interview Janelle she was currently residing in a shelter, though she hoped her transitional program would help her find a new apartment soon. While she was sensitive to questions about mental health she described herself as having Depression as well as PTSD, and had struggled significantly during the last six month. Indeed she discussed that her caseworker had helped her get "hooked up" with a therapist, though I was unclear where, and she had recently begun some type of medication. Janelle was very emotional during the interview, crying several times as she talked about the difficulties of her life. For these reasons I ended the interview early as well as tried to steer the conversation away from sensitive issues. Because I was unable to reinitiate contact with Janelle three and six months later it remains unclear where exactly she was receiving services at the time of our only interview or if she remained engaged with this treatment over time.

It should be stated that more often than not, accessing mental health treatment remained an abstract idea, with little reference to any concrete type of service, like that of Billy and Jamie's examples. Sometimes mental health services could refer to a variety of support services provided by a case manager, counselor or program staff.[121] Rather than

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[121] Rather than seeing a psychiatrist or going to a therapy session, more often mental health translated to set of informal services that different programs provided. At one transitional education program where

seeing a psychiatrist or going to a therapy session, sometimes mental health could signify almost any situation in which one "talked to somebody about their problems." For example, Sarah who had recently transitioned into an independent living program where she lived almost semi-autonomously in a shared apartment, stated that her housing program provided "people to talk to when you have issues," and that "counselors lived right there on the (same) floor" as other participants of the program. Though Sarah's case manager's was a licensed social worker, the counselor that she spoke about was a bachelor's level staff member with no formal clinical degree or training.

Interestingly, while most respondents in the sample did not access any type of mental health service in the community many of these individuals nonetheless discussed the importance of "getting help when you need it," when asked about these services. In these instances respondents could describe a number of programs that they could access—ranging from transitional programs that they had heard about to free or low cost mental health clinics—but often were reluctant to self-identify themselves as needing this type of help themselves. Nonetheless, most participants conveyed a more nuanced view that such services could be "helpful for people," and that it was even important for foster youth in general to "know when to ask for help." Indeed, when asked explicitly what they would tell other foster youth aging out of care and facing similar predicaments as theirs, several respondents—and particularly those experiencing a troubling transition at the time of the interview—replied that one should "seek help," "talk to a therapist," or if

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participants received their stipend checks twice a semester and were required to attend bi-weekly meetings, mental health was framed as simply another requirement of the program. An intern social work student who was accruing clinical hours, provided a mental health check-in that participants were encouraged to attend at least once month, and required to check in at least twice in the semester.

the situation was dire enough, "work with their social workers to get their meds figured out." "Being on your own means knowing when to ask for help," stated Brendon when I asked about services that former foster youth like himself could access in the community. "That's the thing about me, I'm not ashamed to get help and learn from someone who's willing to give it."[122]

But while nearly all respondents signaled a belief that transitional aged youth can benefit from "talking to somebody" regularly about their issues, most respondent were not currently interested in pursuing these activities themselves. In some instances it was clear that respondent simply did not view themselves as having mental health needs. But even among respondents who clearly were under significant distress, and identified themselves as responding poorly to one stressful situation after the other, the idea of seeking help from the "system" seemed inconsistent to their broader desire to be "free from the system." As Brendon once described, "I've been in the system for so long, doing what everybody says…it's time to be out, it just time to play my own game." Later when he responded to my questions about mental health, he emphasized that he had enough counselors and treatment in his life. "I know I need some help, and there's people

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[122] As previously discussed I had met Brendon in the context of a "life skills" support group for former foster youth facilitated by a nearby non-profit once a week. "I go these programs, like our group even though I know what they're going to say already (about) half the time, because you never know when you can learn something new." The groups, which met for approximately two hours every Monday evening on the top floor of the non-profit's office building, was based on a ten-week "evidence-based curriculum" activities meant to impart a series of life-skills to foster youth related to balancing a checkbook, finding employment and accessing health services. While Brendon had already attended similar groups while in care, and had also in fact already completed and graduated from this particular ten-week course before I met him, he was nonetheless attending the entire curriculum a second time. "If there's a chance I can learn something new, than I'm going to keep going," he described.

In the context of his relative isolation I initially sensed that the groups were more socially important to Brendon than the actual life skills that they supposedly provided him. Indeed, Brendon already had a job, a bank account, and knew of the several culturally appropriate mental health services that he could access in the county

I trust, but I can't go back into the system, I'm done with it." Conflating the foster care system with mental health services, as well as the criminal justice system, Brendon implied that by accessing almost any community resource he was risking becoming re-entangled again in the system. Indeed, Brendon's now over-medicated brother exemplified the risk of becoming re-entangled in programs. Maria, an eighteen year-old I would only meet once, also described this apprehension toward seeking "system" services now that she was transitioning into the community: "I grew up in the system, I'm out now, so why would I want to go back in…even if it's to talk to somebody, I'm not going to do that." David, who spoke positively about seeking a counselor on his own terms while in prison, had largely lost interest when he was back in the community. "Honestly, it's not a priority for me right now, maybe later," David explained. "I just got out, and I need a little break from people telling me what to do."

While these youth were often accessing some transitional supports such as receiving a stipend to go to school or a housing service, this resentment toward the system seemed particularly focused on mental health services. "All my life they've told me that I've had problem, that I was mental or whatever," Maria continued. "I don't need that anymore, I don't need people telling me that anymore."

Ashley seemed even more distrustful of the system despite her overall positive experiences in foster care and the strong relationship she had developed with her foster parent. Perhaps because Ashley did not associate her foster parent of eight years as part of the system, but rather as her real mother, the system to her would always represent to her an amorphous set of programs and services. " I think it's good to get help and know

who to talk to," Ashley discussed at the end of our second interview. "But if I need help, I need to get it outside of the syste,, you know. I mean if you've been in foster care, you know, things are always being done for you and you have not control or say, and nobody is going to want that." Ironically, while some youth held would be considered a positive attitude towards seeking mental health, many were fearful of how they may be treated by the system of care. The price of seeking care was the risk of becoming re-entangled in the system.

Overall this chapter has highlighted the varied meanings that former foster youth can associate with the terms *mental health* and *mental health services*. As discussed, these services often conjure salient feelings about the coercive nature of the system, the over-medication of youth, and the institutional neglect that some experienced as wards of the state. Nonetheless, given their traumatic pasts and continuing challenges in the community, and some, their positive experiences with mental health interventions, many former foster youth are not completely dismissive of mental health services or their need for such treatment. Though clearly some youth are concerned about being labeled abnormal if they become too associated with a mental health problem, this seems to be less a concern about the stigma of mental health itself, but more reflective of their broader distrust with the child welfare system. Indeed, several youth suggest that mental health services are useful resources for youth to access in the community, though many are reluctant to do so themselves out of a salient ambivalences of becoming re-entangled in the collection of services and programs that youth associate with the system. In the

next chapter I unpack the structural nature of this ambivalence; while the ambivalence

with the system is broader than the topic of mental health services, it clearly implicates

how youth think about mental health. "Yeah, yeah, I know how to get help if I need it,"

stated Thomas dismissively when I asked him about mental health services in the

community. "I can talk to Rick (his case manager) or something, I guess, but I don't think

that's going to happen."

Chapter 6: Talk of the System

Introduction

The goal of this dissertation is explore the varied ways that former foster youth understand notions of mental health, but also more broadly what it means to seek help from state-sponsored services. An important aspect of the dissertation is then to provide an understanding, and put into context, the different ways foster you imagine and experience their interactions with state care.

In the last chapter I summarized the complicated relationship that former foster youth can report with medications, diagnoses and mental health more broadly in the context of transitioning out of the foster care system. As discussed, while several participants in my sample self-identified with having emotional problems requiring help, and some even believed that such help could alleviate some of their distress, most were reluctant to engage with services which may inadvertently re-entangle them with the system. In this chapter I unpack further the varied meanings that participants associated with the "system" and address the following questions: How do former foster youth reflect upon their time as past recipients of public care, and how do these attitudes inform their relationships with service providers today in the community?   Do factors associated with race and gender affect how some youth perceive their time in, and their relationship with, the system?

It is important to note that when participants discussed "the system," they not only implicated a nebulous collection of different state institutions (such as the welfare, correction and court systems) but as foster youth the term also seemed to convey their liminal status within these institutions. That is to say, in listening closely to *how*

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respondents talked about the "system" it gradually became clear that they were often not

referencing a particular *institution*, *place* or even a *thing* but rather a *situation*; and more

specifically the marginalized situation of being a foster youth. Indeed in this chapter I

will argue that one way of understanding the prevailing fear of getting "re-entangled in

the system" among former foster youth, is to consider the *structurally ambivalent*

position that most of these individuals occupied as recipients of state social services. For

many respondents being a foster youth meant being in a perpetually ambivalent position

of conflicting tensions —one in which respondents could simultaneously report feeling

empowered, shame, anger but also pride about their statuses as former foster youth—and

the ways in which these descriptions seem to illustrate broader inconsistencies to how

these services were provided and organized. As recipients and targets of an often under-

coordinated, and underfunded system of care, respondents appeared to generalize their

ambivalent experiences with foster care to what many feel they will experience again if

they become entangled in the welfare system, mental health service or almost any

program involving the state.

　　　　While much has been written on the concept of ambivalence, particularly from

psychological and cultural perspectives, this analysis takes inspiration from Merton's

(1969) classic examinations of particular institutional contexts under which roles and

status are put into conflict by an overarching structure. An extension of his work on role-

strain theory and deviance, Merton developed the concept of structural ambivalence in a

series of studies that examined the competing roles and norms that are perpetuated in

specific professional settings.[123] In short, this perspective emphasizes how feelings of

ambivalence—the sensation of being figuratively pulled in two directions—can be

institutionalized by conflicting pressures and tensions. While I deviate from the

functionalist tradition in which Merton's formulation was developed, the concept of

structured ambivalence provides a useful framework for understanding the complex

resentment that many respondents expressed toward the "system." From this perspective,

the contradictory ways that foster youth talk about their experiences of foster care—how,

as one respondent described, it as a system that both "saved" him, but also stole his

childhood—reveal the conflicted role that foster youth have to occupy as beneficiaries of

a system that often has institutionalized unclear and competing goals.

My interviews revealed three structural aspects of "the system" that perpetuated a

conflicted foster care existence. First, many respondents provided complex, and at times

contradictory, narratives of how the system coercively and intrusively entered their lives.

What I term as "removal stories," are the bifurcated life narratives that many foster youth

tell of their lives before and after entering foster care, which reveal how the system can

both be protective to children but nonetheless destructive to their families. Moreover,

because most individuals enter foster care under the presumption that it will be a

temporary status, and that they will eventually return home, the story of how and why

one became a *permanent* foster youth involves a series of setbacks and restarts, as some

youth continually entered and exited care several times. At each of these narrative

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[123] Given his interests in the institution of science and knowledge production, Merton developed the concept of structural ambivalence in a series of studies and monographs that examined the competing roles and norms that can be encountered by young scientists early on their careers. However, he later extended the notion of structural ambivalence.

junctions the rationales and justifications given to youth about their need to be in foster

care, or in foster care again, were ever changing and often convoluted. Ultimately, many

long foster youth remain unclear as to the reasons why they never returned home—even

at the time that they are leaving the system—or what their foster care placement

accomplished and achieved. This ongoing confusion of why one was in the system

complicates the transition home and one's continuing relationships with biological

parents, siblings and extended family.

A related, and second aspect of the structural ambivalence of foster care relates to

the at-risk status and label given to foster youth children. While the at-risk designation

functions as a justification for why these youth deserve support, help and compassion in

the broader culture, many of the youth I interviewed believed these conations were

themselves threatening to their sense of self worth. Most individuals recognized that

their precarious situations and troubled histories warranted special attention, but many

nonetheless resented being objectified as an at-risk youth; a designation that many found

ultimately stigmatizing. In addition various respondents of color elaborated that the

stigma associated with being from a broken home could often be conflated with racial

and socioeconomic stereotypes, particularly by social workers from more privileged

backgrounds.

Finally, several respondents described a salient sense of ambivalence, distrust and

disappointment with many of the social workers, foster parents and therapist that they

interacted with you while in the system. While most respondents reported having

important relationships with some people during their time in care, many of the

relationships they encountered with presumably "caring adults" were often fleeting and transient in nature. Moreover, many respondents felt conflicted by the confusing roles of professional care workers and the limited support they actually provided over time. These descriptions illustrate the contradictory dynamics of "emotional labor" (Horchschild 1983) that social workers, therapists and foster parents often provide to foster youth on a limited and often temporary nature. As I show below, from the perspective of many foster youth the dynamics of paid, emotional care are highly confusing and inconsistent, and often engender a strong reluctance to engage with these types of therapeutic relationships again in the future, as in the example of a mental health provider in the community.

Removal stories
It should be stated that while it was not my intention to interview respondents about their particular circumstances under which they entered foster care—in part to avoid probing topics related to respondents' traumatic experiences with abuse and neglect— I quickly discovered that such discussions were at times impossible to circumvent. Though not universal to all respondents, for some the story of how they became entangled in the child welfare system was the natural starting point to the overall narratives that they told of themselves and their unique situations. "My past, I've had a long past," discussed Thomas in the initial minutes of our first encounter. "The reason I'm in foster care is cause my mom was a drug user, ever since we was younger. So that went on my whole life. (I) don't really know if it's still going on it cause I'm not with her." Maria, the homeless Hispanic young woman discussed earlier, similarly introduced herself in the

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interview by succinctly describing that she's been in "foster care on and off for five years" because as she attested, "mom is an alcoholic." Though not all the individuals I interviewed were interested in discussing their traumatic pasts and family histories in such blatant terms, respondents like Thomas and Maria, appeared adamant to broach the stories of how and why they entered foster care, "head on," and unapologetically. Ignoring my suggestion that we focus on his experiences leaving foster care, Thomas emphasized that it was important for him to tell me his own story, to give his own account of what happened to him and his family.

For these respondents the stories they told often touched upon a similar narrative structure that first highlighted the "hectic days" they experienced before entering foster care. Though not necessarily identifying the specific victimization from physical and emotional abuse, respondents would nonetheless emphasize the chaos and "craziness" of their family life before entering care. As Donald, a nineteen year old discussed the "bad experience" in his life prior to entering foster care, "when mom got back on drugs and stuff, starting smoking crack again and stuff like that." Shelly who had been removed from her mother's care two year ago, along with her sister, seemed resigned to the fact that her mother "finally lost it this time around." "There were times that she would get her stuff together," Shelly described. "But she got into drinking and crack again those last two years, and even bringing *Johns* back into the house, so we needed to be out of there. It was just too crazy at times, really bad."

While removal stories often painted the circumstances of one's removal with disturbing vagueness, the narratives sometimes culminated to a detailed description of

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'that day' when respondents were removed from their homes. Tony, a gregarious and talkative 19-year old, spent nearly the first 45 minutes of our three hour interview portraying in exact detail the day social workers at his school notified him he would not be returning home. He described what he ate that morning, the shirt he wore and the minute-by-minute dialogue that transpired between himself and the different parties involved. Other respondents provided a more generalized description of the removal, though at different moments in the narrative they would interject precise descriptions of innocuous details similar to David. Janelle, who stated generically that she had been removed from her home because of abuse, described in vivid detail how at the end of that day she was "sitting in a gray room" drinking a "can of coke" and talking to a social work who wore black-rim glasses.

Such detailed accounts of the event, or the initial encounters with the police or a social worker, suggest that some respondents were used to telling, and re-telling, their removal stories. For many it was clearly an event that they have thought about several times, and relived in their minds, while in care. Some would also return back to their removal story at emotional points of the interview. "They just fucking yank us out of our home," Janelle said crying. "And they give you a shitty coke and you're talking to some social worker you've never seen before."

The raw emotions sometimes expressed in these stories—that I often tried to avoid and re-direct— highlighted both the unresolved saliency of these events, but likely also the precarious situations youth were now finding themselves in the current context. Janelle was homeless and living in a shelter at the time of the interview and clearly angry

and anxious at her situation that she still connected to her initial removal from home. "They break up your family and now throw you out in the street," Janelle stated almost yelling. "People are dying out there on the streets… they really are!" she said before I stopped the interview. Though it was sometimes unclear what event respondents were exactly citing, or perhaps if they were describing various events, the saliency of these stories would often give the impression that they had just happened a few days ago, and not years.[124]

Taken together these stories highlight the obvious traumatic nature of being removed from one's family. That despite whatever abuse and neglect present at one's home the entrance into the child welfare system was often a life-altering event, that effectively ended one type of life and started a very different one. But central to a discussion on structural ambivalence these stories also reveal the obvious, perhaps unavoidable, sources of conflict and contradiction that these removals play in the self-narratives of respondents. Many respondents even to this day still grapple to make sense of, and give meaning to, why they were removed and for what significance.

Indeed, listening to these stories impressed upon me the inherent disorientation and confusion implicated when one is removed for one's own protection from one's own parents. Though most respondent were readily candid that their home environments were unhealthy and unsafe, many nonetheless felt a certain amount of guilt that they had been placed in foster care. Some youth subtly suggested that their removal from home was

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[124] For respondents who had been removed several times, and not just once, removal stories would either emphasize the first time they had been placed in foster care, or the very last time. However, other foster youth, in contrast, would only make a slight reference to the fact that they had been removed.

somehow the result of their doing; of saying something wrong to the wrong person, or doing something bad that put their parents in the wrong light. Cindy, a strong, self-reliant young woman hinted at this sense of guilt and conflict when she discussed the anger she still feels towards the social workers who removed her and her sister from their mother. Even though Cindy reported that her mother "lacked maturity to take care of kids" and that she herself had to take on the "parent role" for many years, she still resented how she had been removed from home.

> *I was mad because the year they took us out, they came to our school and asked us questions about my mom. I didn't know who they were and why they came and asked us, and so I was like,… it was bad. I said stuff I wasn't supposed to say, because it was kind all of sudden, cause we didn't go to school one day, me and my sister. And when they asked us questions I didn't understand what they were asking.*

Cindy's comments highlight the conflicted position many foster youth occupy toward their parents and families while in care. In part some respondents felt that they had betrayed their parent by divulging family matters to strangers, resulting in the family breaking up. Some felt that their complaints about their parents had been taken out of context, exaggerated or misinterpreted.

Other respondents in contrast discussed that their removal was likely necessary given the common recurrence of abuse, neglect and chemical addiction in their family. Yet, even while these respondents identified their parents as the responsible parties for their displacement, many still held resentment to *how* their removals had taken place. In particular most respondents resented how the families had been broken up by the system, how siblings were sent to different group homes and foster homes. While this was not

always the case, and some respondents reported that were able to remain in contact with siblings that were placed in nearby homes, several respondents stated that the state had permanently severed their connections with their families and communities.

Though Cindy was unclear whether she thought the foster care home she was placed was ultimately a bad experience for her and her sister, she still resented how the removal had been done. In their first group home they were placed together, but for reasons that were unclear to Cindy her sister was later placed in a different foster home on the other side of town. "I don't know why they split us up," discussed Cindy. "Maybe they thought I could handle the group home but my sister couldn't. But I was like a mother to her because that's what I've been to her the last ten years. And it was really messed up that they split us."

Cindy's comments also speak to the lack of clarify that many foster youth have about the precipitating event that lead to their removal from their families, and more broadly why they and their siblings are occasionally transitioned to different placements. While nearly all respondents discussed that they likely benefited from the removal from this environment, many still struggled on the day of their emancipation to explain what exactly had happened in their past that lead to their removal.

Indeed, because many respondents experienced their removals as young children, most have unclear understandings, even as adults, to the specific reasons and official justifications of not only why they were removed, but more consequential, why they never returned back to their parent's custody. Though it is likely that respondents were uncomfortable giving detailed accounts of the abuse and neglect that they suffered as

children, their removal stories often hinted at convoluted rationales given to them for the continuation of their out-of-home placements. Brendon, who I had regular contact with for several months because of his participation at a program where I was conducting fieldwork, narrated different explanations for his involvement in the foster care system throughout the course of the study. At times Brendon discussed how his placement had been "50/50" the fault his mom, but also the fault of he and his brothers that often acted out at school. As he explained, his single mother struggled to provide for the family and often had to work nights. "The supervision thing wasn't always there and we got kind of wild, Brendon elaborated. While the lack of supervision, and neglect, may have been one of the reasons why Brendon was removed from the home, during other conversations Brendon would also suggest that the home environment could also be unsafe and abusive. "I have some bad memories of being back home, Brendon described during one our first interactions. "There's just some things I can't forgive my mom for yet; not at this moment." In a later interview Brendon gave yet a third reason for why he had remained in foster care for so long, citing this time his anger problems. "My brothers got to go home, at least for a little, but they said I had too many anger problems, so I never went home."

According to my interviews with social workers and child welfare case managers, many foster youth have "incomplete pictures" of their family's situation, of not only what actually precipitated the state removing them, but what happened to their parents' situations in the intermittent period while they were in care. In part, some social workers discussed that young children may be kept in "the dark" of the particulars of their case;

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that at times they will shield young children of the tragic events unfolding in their parents' lives. "Their parents may be going in an out of rehab and just struggling to keep it together," discussed one social workers "In those situations there's no real reason to say more to a kid than that their parents are working on their issues." Though foster youth will be updated of their family's situation during court proceedings, social workers discussed that at different times youth can be given conflicting accounts of what is really going on. "Cases can really go different direction as time goes on, you want the mother to get her act together and sometimes she does, but things can also fall apart again, so you have to be careful with information.[125]" In short, a combination of social workers not wanting to give youth false hope about their parents, or too many details of their parents' struggles, likely contributed to why many respondents had unclear understandings of their family situations.

One dynamic underpinning this issue to share or not share, pertains to the dual mandate of the child welfare system to simultaneously pursue family reunification efforts—required attempts by social workers to help parents rehabilitate their home environment and reunify the family—while at the same time that state prepares youth for adoption by permanently severing them from their families. This paradoxical orientation of the system reflects a compromise between the goals of *child permanency* and *family preservation* discussed in chapter two as the "swinging pendulum" of child welfare policies. In short these policies increase efforts to reduce the time that youth spend in

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[125] In some situations foster youth remain in regular contact with their parents—often as conditions of their parent's family unification plans—but even then the information that youth receive about their family status can be confusing. "My mom used to call every once in while, Thomas discussed, and she was always saying that thing were changing and getting better but it never did."

foster care by transitioning them as quickly as possible back to their parents and if that is deemed possible, prepare them for adoption by terminating parental rights. Some have suggested that the competing goals of 'preserving families' and ensuring that "children experience permanency more quickly," while not mutually exclusive nonetheless compete against each other in some family situations. Indeed, some have suggested that some youth are transitioned too quickly back home without providing some parents enough time and support to improve the conditions of their homes (Roberts 2005).

Indeed, while these policies have had clear benefits for many youth who are successfully re-unified with their families relatively quick, it has also meant that some youth are returned home early only to be later re-removed from their parents again. Particularly for long-term youth the current policy of returning children as quickly as possible to their families has had the unintended effect of increasing the number of times that they experience traumatic removals from home. As reported by many respondents their time in foster care was sometimes marked by continually coming in and coming out of foster care.

To be sure, there is likely no ideal solution for the difficult, paradoxical logic of foster care placements, and one could argue that the system today works reasonably well for the majority of youth that come into contact with the system.[126] But for the youth who remain in care for prolonged periods of time, these policies ironically contribute to the increased unpredictability and tumultuousness that these youth associate with the system. For some foster youth, being in "the system" represents a situation marked by

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[126] As discussed in chapter two, the majority of youth removed from their families, approximately 65% to 70%, return home within twenty-four months of their initial removal (Child Welfare Project 2012).

instability, lack of certainty and coercive state intrusions into their family life. Indeed all of the individuals interviewed for this study eventually transitioned from their temporary status to one in which they became permanent wards of the state. But this transition from temporary to permanent was rarely a linear process that could be told in a coherent narrative. Indeed, with the exception of one case in which a respondent was orphaned by the death of her parents, respondents' trajectories remained unclear for the majority of time that they were in care; whether they would be adopted out, returned home or remain in limbo for several years.

Moreover, because most respondents returned home several times, they often re-entered the system for different justifications. As another social worker explained, foster youth are "given different reasons of why there are in care at different times," and that it's natural for some kids to get confused about the "ultimate reasons that they are in care today." Such ultimate reason might include a specific event, a recurring issue of neglect, a parent's mental illness or health issue, chemical dependency or the needs of the youth themselves exceeding the capabilities of the parent. In addition to the changing rationales of why they were in care, youth also had to contend with the changing goal of their placement. As one social worker explained, "at one point in time we're trying family reunification with the parents, then we might try setting up a legal guardianships with an older sibling or something, or maybe kinship foster care with an uncle, then maybe we'll try and adopt the kid out, or we'll try and keep the siblings together in a nice foster home, or maybe we won't, it can be really confusing what the placement goal is at any one time."

For a few relatively lucky individuals who stayed in the same foster home for several years, the ultimate reason they were in care, as well as their placement goal seemed inconsequential to them. Ashley, for example, had long ago accepted that her biological mother was person with a drug problem, and that ultimately she preferred living with her foster parent, who now she considered "her real mom." Whatever the placement plan might have been, or the reason why she never returned home, Ashley seemed happy to be in a home that was consistent and the same over time.

But for others, their relationship with home and the system were continually being redefined by changing and unclear rationales. Most youth were unclear to the reasons why there were in care, why they never returned home and what the broader significance of their time in foster care meant. This perpetual in-between-ness, of neither being permanently removed nor making progress to return home defined for many foster youth what it means to be in the system. A prolonged liminal experience in which one was constantly caught between prospects of re-unifying with their parents and staying in foster care forever. In this context, not surprisingly most youth missed but resented their parents, felt that the system had both saved them but also uprooted their families, wanted to return home but were also glad at some level that they never have returned to their old environments.

All of the respondents in the study would say that their home environments were problematic and unhealthy, but most would find it difficult to say there were glad to have been in foster care as well.

Ambivalence with the At-risk Identity

Because of their often traumatic backgrounds and complicated family histories it is not

surprising that foster youth are described as one of the most at-risk groups in society

(Courntey 2009b). Many foster youth have been physically abused, emotionally

traumatized and often have enduring emotional scars that contribute to the difficulties

they encounter as adults (Courtney 2009b; Jayakody, Danziger & Kessler 1998; Osgood

et al. 2009).

But while the at-risk category of former foster youth is an unquestioned truth in

the field of social work, interviews with former foster youth themselves reveal that there

exists an ambivalent tension to how these individuals identify with this status. Perhaps

not surprisingly, many respondents resent being objectified and reduced to an at-risk

entity or essentially troubled person. "I think people are looking at the situations more

than the person," reflected Ashley when talking about mental health and foster yout.

"They think that: 'Okay, they come out of this situation (so) they must be depressed, or

they must have some kind of psychological issues because it's so traumatic." Ashley,

moreover, did not like even identifying herself as a foster youth. "I think it's almost like

something you're supposed to be ashamed of, so I don't really think of myself as a foster

youth. I live with my mom and sisters," Ashley referred to her foster mother, who she

considers her real mother. For Ashley she felt that perhaps the label foster youth did not

really apply to her since she was stable and had a family. Foster care was just a

bureaucratic designation, a check that came in the mail each month to help her mom pay

for the bills.

Michael who had been relatively successful transitioning into an apartment and a job after leaving care, similarly felt that the foster care label implied that one came from a broken home, and likely had problems. "In high school I didn't really tell people I was in foster care. I'm Black, my foster parents are Black. So people just thought my foster parents were my parents, and that's how I see them too, as my real family." Michael continued that because he could pass as having a real family there was little reason to divulge his past to his friends in school. "I just don't see the point of telling anyone in school that you're in foster care, it would be like saying that you came from a broken home, you're just not going to say that, unless you really want people to know." During his last year in high school Michael discussed that he had told some friends at school about his unique situation. "I felt at one point that I didn't want to lie to my friends so I told them since I had known for a while, they were cool with it and I asked them not to tell other people at school."

Cindy similarly discussed that she was comfortable telling only close friends that she was in foster care. As the only openly lesbian person in her dorm, Cindy felt like she was "strange enough," she said half kiddingly, so she did not like bringing any extra attention to herself. "If I feel like I know you really well, and trust you, then I usually tell people about it, and they're usually okay, but they don't really understand."

Brendon in contrast, felt no shame about his foster care status. "I got no problem with telling people about my past." "I'm straight up with people," Brendon stated frankly. "This who I am this what I've gone through and you can ask me any questions about it." Brendon described that most people didn't know what foster care means so

that was the only challenge, which he considered minor. "I just tell people it's when you live with people that are not your parents because of past issues, and if they want to know about those I tell them as well." Other respondents were less positive about the label, but nonetheless as upfront about it.

Janelle felt she had been ascribed the foster youth identity by social workers, and society more broadly, that associated "kids in the system" as "people who have problems." "They might look at us, like I said, some fucked up kids," described Janelle. "But if you really look at it we're really normal, we might have been through some things but we're still normal." According to Janelle there was a common perception that foster youth were already abnormal and had problems by virtue of being placed in group home. "You live in a group home and people kind of know in the neighborhood that we're there, that we're this house full of troubled kids." Perhaps because Janelle lived in a group home and not a traditional foster home she felt the stigma was more visible to others. In reality, foster youth just had problems like everyone else, she claimed, but because they were foster youth these problems were always exaggerated and seen through a different lens.

Other respondents believed that foster care was explicitly stigmatizing to both them but also their families more generally. Maria who on the day of our interview faced uncertain prospects of finding stable housing in the new few weeks, speculated on what some of her past social workers might think of her dire predicament. She always had problems with social workers who she felt looked down on her because of where she came from. "They just saw me as a fucked up," she described exaggeratedly. "With a

mom who's a crack head and (whose) brothers (are) in gangs." "They'd probably think: '

That's right, that's where we though she would end up." While Maria did not dispute

that her mother had been an addict, nor the fact that she herself worried about her

brothers' gang affiliations, she nonetheless resented how the system simply dismissed her

because of these facts. Her life prospects were seen as limited and pre-determined

because of her at-risk background. "They never thought I'd graduate from high school or

that I be applying to college after summer," Maria stated defiantly of her recent

accomplishments. "They just see your file and they think okay, she's not going anywhere

because of her family, I hate that." From Maria's perspective the system was always

writing people like her off as a "lost cause" with little hope for a better life.

Indeed, Maria and other respondents suggested that the foster youth label was less

a community but more of designation endemic to the system. That is to say, the problem-

prone foster youth was a conation primarily perpetuated within the group home

environment itself. In this respect, Maria discussed how staff were often the ones who

made the "biggest deal" about foster youths' background. "They just throw it in your

face (your personal problems) because they read your case files and think they know your

issues," lamented Maria. One of the county social workers I interviewed explained he

was wary of staff in some group who often got into power-struggles with youth, and at

time would resort to "psychologizing" the youth's problems. Because foster youth's case

files were readably available to staff, and contained semi-detailed histories of family

problems, he described that foster youth lost some privacy in the group home.

Other respondents that had also experienced living in group homes, described that they were happy to be out of the trappings of their families but nonetheless resented the somewhat coercive conditions of these structured and at time highly-supervised environments. "They take you out of a bad situation, but some group homes can be worse than before," described Maria. There were rules, a schedule and structure that took a while for one to acclimate, but most respondents also described feeling perpetually judged by staff who would occasionally make disparaging remarks about their family background. "When you made a mistake that they would stick you nose in it, and say it's because you came from a messed up family," Nicki complained about staff at one group home. Likely contributing to the sensation of being objectified she continued, "they would get up in your business and bring up your issues whenever they wanted."

Shelly who had also spent some time in a group home could not recollect staff ever doing anything like that with her, though she did feel staff and social workers could be intrusive in other ways. "You're in a new place and you have people asking a lot of question about your past, well you don't really know what they know or don't know, but maybe they read this or that in your file." Shelly reported nobody every cited aspects of her file to her, as described by Nicki, but she did suggest that there was a common perception among her roommates that staff were reading their business. What Shelly resented more, however, was this presumption that social workers and staff could ask such private questions about her life and past without really knowing. Perhaps reflecting her more reserved nature, Shelly seemed annoyed that people thought it was okay to ask questions about one's family, feelings and personal life.

It is impossible to confirm the extent to which individual social workers and foster parents actively acted in ways to perpetuate the stigmatizing dynamics of foster care. Given the limitation of this study, it is difficult to explore the institutional dynamics by which the foster youth are objectified in the system. Moreover, given the diverse qualitative differences across foster care placements, spanning highly institutionalized settings to private traditional homes in the community, it would be problematic to specify the exact interactional dynamics in which respondents were made to feel conflicted by their status. Indeed, in Goffman's treatment of total institutions (1963) he explicitly excluded from his analysis orphanages and groups homes precisely because of their highly fluid structures.

Nonetheless, it is telling that individuals across placements were ambivalent about their foster care status in part because of its marginalized status in the broader culture. To some, the term foster care was an implicit way of categorizing youth who had problems and came from problem families. To a certain extent a few youth appeared a bit embarrassed by these connotations, and not surprisingly were not interested in elaborating upon the particulars of their family dysfunctions. But more centrally the discomfort with the foster care term rested on what respondents argued was a cultural assumptions about foster youth. Again, respondents expressed ambivalence to being objectified and minimized as simply at-risk by both social workers but society more broadly. While some youth appreciated the attention that foster youth received by the state in some respects to programs and services, many resented the implications that to

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get help, they had to agree to a certain narrative of what it means to come from a broken family.

A clear pattern across interviews, however, was the salient way that race became implicated in these narratives. For instance, individuals of color—in particular African American, Hmong, Hispanic and Native American respondents—often felt the negative assessments that the system made of their precarious situations were conflated with the "stereotypes" that some social worker supposed had toward minority communities. Maria, whose brothers were involved in a local Hispanic gang in the cities, explained that her life fit an almost ironic narrative of what it means to be "a little Mexican girl with problems," as she described it. "A lot has happened in my life, a lot of drugs and violence, the system sees this little Mexican girl with problems and they probably don't think she couldn't maintain a job, but I'm doing it." For Maria, though she faced an uncertain housing situation, saw herself almost as contesting a dominant narrative that the system but also the broader culture had of her ethnic identity. Similarly, Nicki, a Native American foster youth who described being raised on the "reservation," stated that the family conflict in her life reinforced this perception that Native Americans were alcoholics. While she felt uncomfortable talking about her past, she described how she was looking forward to getting out of foster care because it was a constant reminder that she had a messed up family. "I'm Native, I live in Minnesota and I'm in foster care, and I'm just tired of carrying these labels with me wherever I go…I just want a normal life, and I think that's what it means to leave foster care."

But perhaps more than other groups, African American respondents expressed more explicit sentiments regarding racialized narratives of being an at-risk youth. Thomas who was starting his first semester in college proudly stated that he wanted to do something in his life to explicitly disprove the cultural narratives surrounding poor, urban black males in America. Indeed, like Maria, Thomas felt objectified by the system, and as well as reduced to a high-risk statistic

> *"You see all these statistics about young black people: young black people this, young black people that. You think that all black people can do is play basketball or be a rapper to be successful. I want to show people I can go to school and get a job I want to be one of those good statistics, one of those statistics of somebody that makes it"*

Brendon similarly felt objectified as a statistic, youth of color, particularly given his already extensive history with "the system." After our last interview Brendon reflected on the struggles and challenges—the "bumps on the road"—that he encountered during the last months since we had seen each other. Perhaps sensing the somewhat depressing tone that he had finished our interview, he encouraged me not to dismiss him quite yet as a failure, as another statistic.

> *I know I've had some bumps on the road. There's no thought about it, but that's okay, that's life. But my story is still going. And I know I came from the 'hood and things might not be looking too good. But I'm always going to try. Try and get my story out there and maybe show other kids in the system growing up that they can make it. That they can make it, because honestly there are not a lot of people like me to look up to. I kind of what to be that for someone, because I didn't really have that. So I'm keep trying and not be another statistic, you know another kid from the system who back into the system*

Ambivalence with Paid Emotional Labor

In listening to former foster youth complain about the conditions of being in the system, I would often hear descriptions of the challenges of living in an environment that often felt emotionally cold and sterile. Indeed, while life before foster care had certainly been chaotic and sometimes unsafe, foster care itself could be described as a mixed blessing. Particularly if participants had spent time in a congregate type of placement—a group home, a residential center or even a large foster home —there would often be a discussion about the detached relationships, "cold staff" and "fake social workers" that youth had to contend with during their time in these institutions.

Brendon who also had resided in several group homes felt that staff were often more interested in rules, than the youth themselves. "You had staff that just had big power trips," complained Brendon. "If you didn't do what they said, when you said, then you were acting out." Other youth similarly discussed a fixation on rules and structure in what often felt likely highly controlled environments. "You come into some group homes and they have all these rules that you don't know about, and the first week there they're just telling you all the rules you are breaking," complained Janelle. "Other places there are no rules and kids are just doing what they want, so you never know what you get." Maria agreed that figuring out the rules usually took an adjustment period in any placement, and that it was difficult to gauge how strict a particular group home or residential treatment center was going to be. "You had different staff, some were good and okay, and others just liked telling you that what you were doing was wrong for this or that rule."

Maria herself was frustrated that the foster care system didn't do more to empower youth in their programs. According to her, most foster placements did little more than warehouse and control youth. Consequently, many foster youth simply spent their time rebelling against the system instead of making the most of their opportunity, like she had, to change their lives. If there were "more respect there," and "less judgment" against foster youth and where they came from, Maria speculated, foster youth would be more successful in overcoming the challenges of their backgrounds.

It should be noted that all the respondents discussed meeting nurturing and caring adults in their foster care careers, and this was especially the case with youth who had been in a traditional foster home. But nearly all respondents complained that the system contained many apathetic social workers, case managers, foster care parents and staff. These could range from incompetent case managers to emotionally abusive staff. Social workers who worked at these group homes acknowledged that staffing could often be a problem in the child welfare field. "You have some really great staff at these places…people who really care and know what they are doing," described one social worker. "But many times you have people who are burned out and get into power struggles with the kids, they can really antagonize the kids." Another social worker similarly described that some staff almost bullied foster youth, "let's face it, it's not the best paid job, so sometimes you don't get the best people, who don't have the training or clinical background to handle the level of trauma that many kids have, so they just bully the kids, so you have watch that." Other social workers disagreed with assessments that staff were often ill equipped to handle youth. "It's a thankless job, you have really

challenging kids who really like pushing buttons and make allegations against staff. I

find that nine times out of ten kids are just angry about something else and blaming staff.

I think it's important to support staff whenever I can."

In some respects, however, respondents described that foster care professionals

were less mean-spirited as they were emotionally unavailable. One ironic aspects of the

fixation on rule, described Maria, was that it often encouraged youth to act out for

attention that they would otherwise not get. "You just had some kids act out because

they wanted the attention, I mean if you figure out the rules, then they would just leave

alone, and almost forget that you were there." Brendon agreed that some staff didn't

really care "if you were acting good, but just when you were acting bad." Accordingly,

staff attention was often focused on youth who were struggling and having behavioral or

disciplinary issues, and less those that were complaint, which often reinforced the

behavior. This dynamic was not lost on social workers who complained that staff could

often "negatively reinforce" some behavior in these group settings. "It's really hard to

not reinforce the same negative behaviors that some kids present, having been in the

system for so long they have learned over time that this is the way to get what they want

which is attention." Another social worker felt more depressed about what she called the

"feedback loop" that this represented, "It's like they learned these behaviors in the home

(of their parent) and they get worse in the group home setting because now they're

competing with eight or ten other youth who all want attention from the counselor or

staff." Other social workers were optimistic about the staff in the group homes they

visited and believed that most staff were generally well trained for such encounters and

could implement an intervention that some referred to as "planned ignoring." "Staff know which behaviors to ignore and which ones to reinforce with attention and most kids get wise to this and so it's not really a problem for most kids. They may struggle with it at first, but usually the planned ignoring works if all the staff are doing it together. This is just a problem with new staff."

More fundamental to youth however, was less the concern of the problematic behaviors perpetuated in group homes, but more the underlying apathy that they felt from some staff in these settings. "You could just tell that they didn't really want to be there and really didn't care that much about us," complained Janelle. "As long as you were doing what you're supposed to be doing they were fine, but it's not like they really cared about you. It's not like they were your family." This was not a dynamic just in group homes and residential centers but also some foster homes. "Some foster homes are better but it's always strange," described Michael who had been to at leas three different ones in his life. "The first home we lived it was this older lady who just had all these rules and basically wanted us not to be there, we basically lived in the downstairs basement and could never go upstairs." Jason who was staying at a foster home at the time our of first interview similarly complained feeling spatially restricted in last foster home. "I basically live in the back and I just go in and out (with my own door)and so she doesn't really need to see me," he described his foster parent. Nicki described that her last foster parent was this "white guy" that while was nice to her, didn't really understand her either. "Just culturally he didn't get me, I think he was nice enough but we didn't really connect...and I don't think he really cared that much."

One very common complaint that all youth discussed was the perception that most people that worked in the child welfare field "just did it for the money." In reference to apathetic staff at group homes and residential treatment center, several respondents claimed that most workers were only concerned about getting "a pay check." "It was job to them, they just show up, work a shift, then leave, and then somebody else comes," discussed Janelle. Jamie who had been to several different group homes shared this perception. "It's not like people there really cared for you, it was just a job to them, so some did a good job I would say, but that doesn't mean it was great place to grow up, it was okay, but not nice."

The complaint that many people just did it for the money, also applied to some foster parents who youth claimed sometimes mis-managed their money. "I'm supposed to get a set amount every month for food and clothes but she says I have to earn my own money for clothes," complained Maria about her last foster parent. "I had to work to get my prom dress and she didn't understand that's what the money from the state was for, I told the social worker but she didn't change it." Maria generalized this problem to a variety of foster parent out there, that just do it for the money. "They're just doing it to get a check, but it's really our money not theirs." Michael, who described "loving," and "being loved," by his last foster parents—whom he considered as his "real mom and real data"— nonetheless felt strange about the checks they received from the state. "I know she got money from the state, I don't know how much, but it was basically for food and stuff." While he reported that the state money "didn't really change anything" about their relationship he nonetheless appeared unsettled about the subtle distinctions in the home

created by the state subsidy. "There was always this rule about what I could eat and not eat, because she got money to buy food for me and so that was my food, but there was this other food that was just her and dad's. And I would forget so he would get upset if I was using their bread for a sandwich." Now that Michael was not longer a subsidized foster youth he discussed that the ambivalence he felt from his father had gotten worse whenever he visited his "real parents." "When I come home and visit I try and not be in the kitchen because I know I can eat a lot and he's already said I shouldn't be eating anything at the house now that they're not getting paid for it." While depicting his parents as loving, Michael nonetheless implied that his relationship with his previous foster father had gotten distanced. "Sometimes I feel like he doesn't want me to come around anymore. I don't know what's going to happen this next Thanksgiving."

Other youth also complained about this distinction between food that they could eat and not eat. "They get two-hundred or three-hundred dollars to just buy food," complained Billy about one of foster homes. "And they just buy all this cheap crap peanut butter and that's what we had, and was like what are you doing with the rest of the money?" Maria similarly suspected that foster parents intentionally bought cheap food so that they could keep the rest of it. "She (my foster parent) knew that I was already working and that I could just buy my own food and that's what I did, but she should have been passing that money to me and not pay for cable and the other things she used to have at the house."

Interestingly the critique held by most foster youth that "many people work in foster care do it for the money, not the kids" was also applied to social workers and

therapists. Many respondents complained that social workers could be "emotionally fake" and only "pretended that they cared." Janelle who described having a strong attachment with her last caseworker was nonetheless angered that she left. "We had this really great connection and she really understood me, but then like everybody else she just leaves after two years, she got another job and just left." Other youth similarly described feeling betrayed when caseworkers or therapists moved on to different positions or pursued employment opportunities at a different agency. "One day you would realize that the person who used to come every month is no longer coming, and you would be like what happened to Jerry, and they would be like he left, he's got another job," discussed Andrew. "And it's not like he said bye or anything, he was just gone." Dave who could identify with this problem, nonetheless described that a lot of foster youth "don't understand that this is just a job for people." "This is their occupation, they get up and go to work, that's it, they have their own kids and lives and it has nothing to do with you, that's just the way it is."

From the perspective of social workers managing what kind of relationship they were going to have with their clients represented one of the most challenging aspects of their jobs, and often something that new social workers "right out of college" struggled with. "You have all these kids (young social workers) coming out straight from their masters program ready to save the world," an older social worker described almost disparagingly. "And they don't understand that you can't save everyone, you can't save every kid and adopt them, that's not what the job is about." A younger social worker who had been in the field less than a year agreed that establishing professional boundaries

with clients, and with this type of "emotional work" generally, was difficult for her colleagues and herself. "It's hard not to take this stuff back home with you at the end of the day, I honestly struggle sometimes, but you have to find ways of de-compressing and taking care of yourself first." Reflecting on the type of relationships that she currently had with youth on her caseload she acknowledged that managing boundaries could be a confusing endeavor. "When you first start with a client there is usually a lot of distrust there and so you have to work to establish rapport and just try to get them to open up, just try and get them to talk about anything really." Ironically, these strategies can backfire when youth become too attached she described. "Right now I have a situation where one client has become too attached, or too dependent on me, and I'm trying to figure out how to re-establish some boundaries with her." By becoming too attached, some social workers often implied that clients had misread and misinterpreted the nature of their relationship. "I see it sometimes," discussed one of the more "experienced" social workers. "Kids get confused about the nature of the relationship and you have to tell them really honestly but delicately that you're their advocate, their ally, you're their social worker, and yes you care about them, but you're not their friend, and that this is a professional relationship." She continued that while one should not necessarily explicitly emphasize that "clients are not family," social workers need to nonetheless convey the point. "Like I said I think part of it is that young social workers haven't figure out how to do this themselves, they've read book about the therapeutic relationship and maintaining client boundaries but they've never really done it themselves, so they confuse the kids."

To a certain extent these comments suggest that foster youth can sometimes hold unrealistic expectations of the relationships they form with adults in the foster care system. Indeed, it may have been less the case that staff, social workers and foster parent in the system were emotionally cold, as they were being "professional" and "establishing boundaries." As social workers sometimes attested, "kids don't want to be told that they're not your friend, that you're not their family, but that doesn't change the fact that you have to maintain boundaries." Moreover, it was clearly unrealistic that staff and social workers would never move on to other positions, or that they would not pursue other career opportunities, particularly after several years working in the same organizations. It is understandable and unavoidable that long term youth would likely experience a number of transient adults in their lives.

On the other hand, these comments also reveal the contradictory and confusing nexus between "professional boundaries" and emotional care. Indeed, in talking to social workers about their relationship with clients it often seemed unclear how they distinguished the boundaries of genuinely caring about someone while at the same time maintaining professional distance. Particularly because social workers often evoked emotional work in their interactions with foster you—providing mental health interventions that often resembled genuine caring—the logic of how and when it was appropriate for foster youth to receive and reciprocate this care appeared contradictory. Youth were encouraged to overcome their distrust of social workers but not develop attachments. Youth were encouraged to open up, and reveal their emotions, yet it was inappropriate for youth to expect social workers to reciprocate such personal expression

back. As one social worked highlighted the irony of this relationship, " you have kids all

the time asking about your personal life, about who your husband is, if you have kids,

and for me, I don't like to tell them anything about my personal life, or if I do I keep it

very general and professional." While reasonable and likely advisable, this professional

orientation about remaining boundaries between work and home nonetheless belied the

way that social workers themselves intruded into the personal and home matters of their

clients. In the same conversation the social work from above, that she was adept at

getting "reluctant" and "initially cold" foster youth to open up. "For me the trick is being

warm, and receptive to whatever they have to say, and encouraging them that they can

say and talk about anything that they want. That they can trust me…and so hopefully

they will open up and tell me what they're feeling." While the dual logic underpinning

being a professional social worker, and one that also cares, is understandable and makes

professional sense, for many foster youth the logic was fundamentally confusing if not

manipulative. "They pretend to care," complained Ashley about social workers in

general. "They have all these things they say, to try and prove that they care, but for me I

don't know them, and they don't really know me, so they don't really care." Maria

shared this sentiment that social worker often tried too hard to convey that they care but

often unconvincingly. "On the first day they come and pretend they know you, but they

don't know you, they know your file maybe, but they don't know you, it's not like we

have a relationship." Hinting at the fact that she had likely been burned by a past social

work relationship, Maria emphasized that these weren't real relationship. "My new

social worker is cool, she tries her best and I like her, but she's not going to be there like

my brothers, she not family, it not like I can always count on her." Maria juxtaposition of real relationships and family, highlight the understandable, though unrealistic, expectations that many foster youth have had at some point that social workers were like a family member.

In sum, though many social workers were sensitive to accusations that "do their job for the money," particularly given the relatively low-salaries commanded by their professional degrees, they were at the same time the first t emphasize the importance of establishing 'professional' clear work-home boundaries. Yet, for many foster youth this was not a professional relationship in part because the foster home was not professional setting for them, but rather their real home. The distinction between private and public sphere, while clear for social workers, was fundamentally confused for foster youth. "They all come in saying they want to be your friends and support you," described Janelle. "But they all leave eventually, they never stay, they say they care but they have to move on, and I think that's really shitty." For Janelle it was particularly painful to interact with social worker who appeared "nurturing and caring" but who would nonetheless leave over time. As highlighted by Horschild's research on emotional labor, when emotionality is commodified, or in this case professionalized, the confusion over authenticity and genuine emotional expression becomes fundamentally confused and difficult to decipher, for both the emotional worker and the client. Whether staff really cared about them, or whether attachments were authentic and would last, were perpetual issues that foster youth faced in the "system." Indeed, it is understandable that caring adults, who express interest in their lives, are occasionally mistaken by foster youth to be

parental figures, and as family, but this seems to be a mistake that most long term foster youth learn not to make after a while. Given that emotionality, and emotional management are key aspects of mental health services further complicates this relationship, if not enhance the perception among foster youth that social workers are manipulative. Not surprisingly several respondents were reluctant to put themselves in the same emotionally confused situation of managing therapists, social workers and other professionals paid to care. "I know I need to talk to someone," Brendon explained. "And I think there are good people out there who work with kids, but you really have to find people who don't do it for the money you know, and I don't think the system is the best place to look for that."

Chapter 7: Conclusions

Concluding On Mental Health

In this dissertation I have reported on some of the complex ways that former foster youth can talk about topics related to mental health. Often reflecting contradictory attitudes that at times endorsed diagnostic labels and treatments, and at other times rejected them, many of the youth in the study discussed their mental health needs while evoking a general ambivalence about their time in foster care. For many, the term mental health was synonymous with medication and was often associated with efforts by "system" to intentionally over-medicate and over-label foster youth. Others viewed mental health treatments more benignly, but nonetheless as inadequate "band aide" solutions that only partially addressed the real needs and problems faced by most youth in care. Interestingly despite these mostly negative appraisals regarding mental health interventions, most respondents nonetheless endorsed a therapeutic perspective on their own personal problems. Many also acknowledged that interventions like therapy and medications were potentially useful for youth in their situations, particularly "when done right." In this respect the case study highlighted how foster care may be a unique type of institution, or *situation*, for young people to learn about and receive mental health treatment. The institutionalized experiences of having been placed in care, and the unresolved conflicts that this seemed have engendered, continue to shape and color how many of these young adults think about the costs and benefits of mental health treatment and risks of engaging the state/system for help. I have argued that because these unresolved feelings stem from the contradictions and tensions of the system itself—what I conceptualize as a structured form of ambivalence—the reluctance to access care should

be seen more as an institutionalized response to the inconsistent forms of care provided by the state, than as an individual choice by foster youth to disengage from services.

In this concluding chapter I highlight how this conceptualization of structural ambivalence has a number of implications to different literatures both in social work and sociology. First, and more directly, I discuss how the case study improves our understanding of why young people aging out of care are reluctant to access mental health resources available to them in the community, and the direct policy and clinical implications that can be drawn from these findings. Next, I discuss how structural ambivalence also has broader implications to the sociology of mental health, and in particular contemporary theories of how individuals come self-identify with a mental health problem and eventually seek treatment. Even more broadly, I later discuss the implications of this research to the current conceptualization young adulthood more generally and the growing challenges associated with this stage of the life course.

In this final chapter I also elaborate on future iterations of my research that stem from the findings of my case study but also from its design-limitations. Indeed because my case study drew primarily from interview data, I was not able to adequately explore how race, class and gender are implicated in the tensions of structural ambivalence, particularly as they might exist in the community. More substantively the case study was also limited by its single population design, which hindered my ability to systematically compare the experience of my former foster youth participant with those of other young adults more generally. As I elaborate in the end of this chapter, the therapeutic narratives expressed by former foster youth and the troubled transitions they experienced out of care

as young adults, may not be in of themselves unique to foster care.[127]

Implications for understanding the reluctance to seek care

One of the primary motives for this case study was to investigate the subjective process

by which some of these young adults come to understand their "mental health needs," in

the hopes of illuminating the complex reasons some are reluctant to access care. Despite

a variety of reforms to expand new services and programs to former foster youth, a

number of studies find that many in this population are reluctant to access mental health

providers in the community, continue with their treatments over time or remain engaged

with any type of program for significant periods of time (Courtney, Dworsky & Cusick

2005; Delman & Jones 2012; Mares 2012; McMillian & Raghavan 2009; Moses 2011;

Munson et al. 2012; Webster & Harrison 2008).   Some researchers have suggested that

these dynamics lead not only to the high prevalence of "untreated mental health

problems" among former foster youth but contribute significantly to their high risks of

experiencing homelessness, incarceration, and other negative outcomes after leaving care

(Osgood et al 2009; Courtney 2009b).

As I discussed in chapter three, research based on conventional health-seeking

perspectives have suggested that dramatic declines in mental health service use by

transitioning foster youth, stem from the lack of mental health programs in most

communities, the bureaucratic barriers that exist between child and adult mental health

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[127] As discussed by a variety of life course scholars as well by cultural sociologists, the transition to adulthood has become unstructured, uncertain and highly diverse in the modern period for a variety of populations. Cultural sociologists have suggested that within this context, young people have come to individualize, or psychologize (Karp 1996), this structural uncertainty within self-reflexive and therapeutic narratives of identity. As I discuss, this foster care case study corroborates the finding that more young adults are embracing therapeutic narrative to make sense of their lives.

programs and the gaps in insurance that most foster youth experience during their first years out of care (Courtney, Dworsky & Cusick 2005; Davis 2005; McMillian & Raghavan 2009). Researchers have also suggested that many former foster youth distrust service providers, fear the stigma of accessing mental health resources and lack the social relationships that support their engagement in therapy for a prolonged period of time (Moses 2011; Munson et al. 2012; Webster & Harrison 2008).

Overall the findings of my case study suggest that while all these community and social factors likely play important roles in why youth disengage from service, it is also important to consider the particular institutional context and specific meanings that youth associate with these services given their experiences in care. In describing their complicated relationship with the system, former foster youth often discussed the disruptive nature of being placed in care, the confusing relationship that many had with "paid" care workers and therapists, and the psychological toll of being continually objectified as an at-risk/troubled youth. According to my analysis young people who are finally emancipated, and free from these sources of ambivalence, are often highly skeptical of re-engaging the state for mental health help. While many participants in the case study acknowledged that they had significant emotional and behavioral issues, as well as believed that they could be helped by therapy, most were unwilling to take the risk of accessing services that, from their perspective, put them back into the purview of the system, and in turn these tensions. In this respect not accessing services was less a decision made by respondents but more of an institutionalized response cultivated over years of being in the system.

From my assessment these tensions and contradictions are largely unavoidable given the broader context of inequality in which foster care operates and the limited resources, and societal investments, allocated to its funding. Foster care is intentionally structured to be a temporary status for foster children, most of who either return home to their parents or are adopted out to new families. Given the explicit family-biases of child welfare policies to move children quickly out of the system—which from one perspective benefits the majority of foster youth—young people who experience prolonged periods of time in care are likely to always experience contradictory and inconsistent forms of care by the state. Nonetheless the case study highlights a set of findings and observations that point to some pragmatic policy recommendation that I believe could mitigate some of these tensions.

First, child welfare advocates and institutions should embrace new developments in the mental health field that de-emphasize diagnostic labels and disease classification of mental illness and promote instead more generalist notions of recovery and wellness (Copeland 2002). New "recovery models" of mental health provision posit that mental illnesses are rarely cured, but rather managed, and as a consequence are focused on empowering patients to better understanding their symptoms different options for treatment. While these developments have not lead to an abandoning diagnostic labels, or specialized treatments, this approach has nonetheless emphasized increasing an individual's sense of control. My case study reveals that lack of empowerment and control are precisely what many former foster youth resent while in the system. To the extent that mental health providers and clinicians can explicitly disabuse notions that

therapy and medication are external tools of control, the more likely youth are to engage

with these services. Though most trained therapists are likely already well aware of the

importance of empowering patients, my case study illuminates the need for clinician to be

specifically aware of the unique institutional experiences of their foster youth patients.

As highlighted by my sometimes-awkward exchanges with participants, some foster

youth are wary of adults that appear too empathetic and too eager to learn about their

personal troubles. Because many have experienced frustration and abandonment by

many of these empathetic types, who intermittently entered and left their lives, former

foster youth adults are likely to remain skeptical and ambivalent toward the typical

therapeutic conventions employed by most clinicians.

Secondly, my analysis suggests that social workers should also embrace new

service models that essentially broaden the notion of mental health services to not only

include individualized, medicalized treatments, but also more generalized social

interventions. Indeed mental health problems often occur in particular social contexts,

and interventions that address just the biochemical imbalances and psychological

pathologies of individuals are unlikely to mitigate the broader problems these youth face

in terms of isolation, lack of employment, housing and general disconnection from social

institutions. Perhaps the best and most expansive example of this approach is reflected in

California's Mental Service Health Act (MSHA or proposition 63) that passed in 2005.

In addition to funding a variety of new programs for transitional youth living in the

community, MHSA has also created a vast number of community programs inspired by

this approach to broaden mental health treatment to include political activism, community

events, employment, housing and new mental wellness services. Funded by a unique

"1% millionaires income tax," the program (really programs) administers approximately

$7.5 billon dollars a year to a variety of new community initiatives to improve the general

well being of those afflicted with mental health conditions (CDMH 2012). While too

early to formally evaluate, as the program has taken several years to plan and administer

across California's 58 counties, early reports indicate the program has developed

hundreds of new services related to education support, employment, training, social

support groups, housing and anti-stigma campaigns (CDMH 2012). New services that

emphasize harm-reduction strategies, recovery- wellness, and that overall encourage

patients to engage in services on their own terms are likely to draw former foster youth

who feel they have needs for services but are otherwise nervous about being overly-

constricted/controlled in program. As these generalist programs become more expansive

and well known in California and beyond I anticipate that more former foster youth will

become involved in services, particularly among those, who from my observations are

eager to get involved, and often long for community.

Implications for sociology of mental health
While most foster youth in my study conflated notions of mental health with medication,

pejorative labels and the system more broadly, many nonetheless adopted a generally

therapeutic frame to talk about themselves and their struggles. Respondents not only

asserted that they felt distressed during challenging periods of their lives, but most relied

on a distinct social work language of *triggers*, *issues* and *diagnoses* to make sense of

these difficulties. Several participants, particularly males, were at times surprisingly

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introspective and self-reflective about the source of their emotional turmoil. Employing

what I described as an illness narrative, respondents could skillfully discuss their

behavioral problems both in terms of their current stressors, but also of "triggers," which

were often linked their emotional problems to specific traumas of their past. In

elaborating about his anger management problems to me, for example, Brendon

described that "females" were often his "triggers" that he had to "watch out for" in part

because of the "bad memories" and "resentment" that that he still had toward his mom.

Though Brendon was reluctant to seek treatment for his anger problem he was

nonetheless worried about being over-whelmed by stress and lashing out on a female.

"The biggest thing for me is going to dealing stress," he recounted. "And I'm just not

good with it"

Participants could also report perplexing, if not contradictory attitudes toward

medication and their diagnoses. Though nearly all participants expressed the view that

medications were over-used in foster care, and often prescribed for the purpose of

controlling youth, several of these same participants also discussed having benefited from

specific medications. Similarly, while most participants could be cynical about the nature

of diagnostic labels, many nonetheless would refer to specific diagnoses, and sometimes

several diagnoses, when they discussed ongoing challenges in their lives, their sense of

identity and the role they played in creating their own problem. In some instances, like

Jamie's relationship with her Bipolar condition, respondents used mental health terms to

explicitly ascribe meaning and order to what were otherwise chaotic life narratives.

Overall these findings not only have direct relevance to the issues of former foster

youth, but they also have broader implications for the sociology of mental health, particularly in respects to theories of self-labeling, stigma and health-seeking behavior.

Because therapy has been typically associated with middle class values and mores, sociologists have for some time described an inverse class relationship between the propensity toward self-labeling and the need for these services (Horwitz 1982; Illouz 2008; Karp 1996; Mechanic 1986). Ironically, while lower classes have a higher prevalence of mental health problems than more privileged groups they are generally the least likely to identify and acknowledge these needs in terms of a mental health condition (see Horwitz's 1982 detailed exploration of this issue). Some have suggested that therapy, and the pursuit of improving one's mental health, resonate more clearly with middle class values associated with higher levels of education and a proclivity toward self-expression/self-exploration (Illouz 2008). As a consequence, middle class individuals may already indirectly be more *socialized* toward therapy given their educational experiences, expressive modes of communication, but also their social networks that often include others who have experienced therapy (see for example Illouz 2008).[128] From a power-differential perspective, some have suggested that lower class individuals are more likely to experience more coercive forms of mental health treatment as well be more stigmatized after being diagnoses with a mental health condition

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[128] While Thoists (1985) argues that socialization toward mental health treatment often takes places during the confines of therapy, others have also suggested that this acculturation process occur more broadly within one's environment, social networks and broader culture (Pescosolido et al 2008).

    Moreover Horwitz (1983) has suggested that because lower class individuals are more likely to have been labeled a mental illness in the context of an institution, rather than have had the privilege to self-label themselves in the context of an individual therapy session, they are generally more reluctant to see the need or have interest in access services. Because lower class groups are at a higher risk of being labeled a mental health condition, rather than labeling themselves, these individuals are inherently more sensitive to the clear power differentials complicit in labeling.

(Horwitz 1982; Link &Phelan. 2001; Scheff 1971). As a consequence individuals from lower and working class backgrounds are assumed to be much more reluctant to identify, and self-label themselves with a mental illness given the high social costs that they accrue doing so.

My case study with former foster youth suggests that the dynamics of self-labeling remain largely a problematic identity for marginalized adults to occupy. As previously discussed, former foster youth in my study neither rejected nor accepted diagnostic labels outright, but rather employed a more nuanced version of what Moses (2009) described as *inconsistent self-labeling*. While foster care does not constitute a total institution as originally conceptualized by Goffman (1963) it nonetheless resembles a situation in which recipients were clearly aware of the power differentials that dictated many aspects of their lives. From this perspective the language of therapy and diagnoses was viewed by most respondents largely a *system language* and not necessarily their own. Indeed when asked about mental health services most respondents assumed I was asking them about medication, and often their thoughts about why the system over-medicated them. Given this clear implication of power-differentials many respondents were wary of legitimizing terms and labels that were stigmatizing to their sense of self. On the other hand, self-labeling had clearly been partially achieved among several participants, especially those that used their diagnosis to frame their life narratives. After years of therapy and therapist some respondents had clearly become socialized to their own

deviance as postulated by Thoits self-labeling theory (1985).[129] Indeed while most

participants outwardly rejected labels, most tacitly acknowledged that they had issues and

problems deserving attention.

It is interesting to note, however, that most participants were antagonistic to ideas

that their mental health problems derived from neuro-chemical imbalances in their brains

or other biological *explanatory models* of their conditions. Though most participants

believed in the effectiveness of some medications, most endorsed beliefs that their

emotional and behavioral problems stemmed primarily from their traumatic pasts and not

their biology. "We're really normal, stressed Janelle when I asked about the nature of

mental health problems. "We might have been through some things but we're still

normal." This suggests that self-labeling, at least among some foster youth, occurred

more easily when individual could in effect normalize certain behaviors in the context of

their past experiences. Participants appeared comfortable labeling their deviant behaviors

and emotions insofar that they could link it their problematic interactions with their

parents and the other non-normal experiences of their past. Nonetheless, participants

were uncomfortable fully medicalizing their problems. In particular, most participants

were uneasy locating the root causes of their pathology and deviant behaviors within

themselves or their biology.

Research on mental health stigma has been inconsistent on whether the

proliferation of biological explanations of mental health that has occurred during the last

thirty years have de-stigmatized or further stigmatized those afflicted with emotional

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[129] Thoit's original conceptualization of self-labeling (1985) emphasized that mental health consumers require a far amount of socialization before they can recognize their need for professional help and in turn voluntarily engage with treatments.

problems (see review by Schnittker 2008). . Though nature-nurture debates about the

nature of human behavior have gone mostly out of fashion in the field of mental health

and social research more broadly—and been replaced by discussions of gene-

environment interactions that supposedly emphasize both nature and nurture— several

commentators have suggested that dominant perspectives in science, and in particular

psychiatry, still emphasize the biological, and essentialist, aspects of human pathology

(Horwitz 1999, Rose 2003). While this shift to biochemical explanations of human

behavior has done much to establish the legitimacy of psychiatry and the treatment of

mental illness during the last thirty years, some have warned that it has also increased the

medicalization of social life, de-contextualized the nature of some conditions, and

legitimized the stigma that many associate with mental health conditions (Conrad 2008;

Rose 2003). Indeed Troy Duster (2003) has suggested that ongoing genetic explanations

of health disparities, including mental health, represents a significant danger of medicine

regressing to an earlier tradition of scientific/biological racism.

The research literature thus far, however, is unclear whether stigma in the

biochemical age has operated in this fashion,[130] but sociologist have already suggested

that societal reactions to biological explanations of mental health differ across different

conditions, in part because they often refer to different social groups (Aneshensel, Phelan

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[130] Research on stigma has been inconsistent on whether prejudices and biases against individuals with mental illness have worsened or improved in the biochemical age (see Aneshensel, Phelan & Bierman 2013). One challenge of this research literature reflects the fact that organic conditions are already highly stigmatized in society. Some conditions that appear clearly organic in etiology, such as schizophrenia and borderline are often associated with the most severe symptoms and in turn are more stigmatized. As result, less serious conditions, such as those associated with clinical depression and bipolar disorder, may become further stigmatized the more they become associated organic biological explanatory models. In contrast, less-serious conditions may de-stigmatize more serious conditions for the same reason. Thus the research has provided contradictory evidence of these dynamics.

& Bierman 2013; Schnittker 2008). The fact that schizophrenia disproportionately affects individuals of color, for example, and is also one of the most stigmatized conditions, reflects in part the racialized aspects of stigma that will likely worsen in the biochemical age (Metzl 2010).

Participants of color in my study may have been responding to these new forms of biochemical-racialized stigma, given that many of these individuals were the ones int the most vehement in their rejection of purely biological explanations of their problems than others. "I think it's more of where you grew up," discussed Brendon when I asked about the cause of his anger problems. "I don't think it's because of your brain but of the type of life you had, the type of things you experience." Janelle was similarly sensitive of purely biological explanations of her emotional struggles. "It's not a problem in our heads, it's not like we're fucked up in the head, people look at us like we are, it's just that we've had fucked up things happen to us," she reiterated to me during our initial conversations about mental health. Though participants like Brendon and Janelle were more explicit in their rejection of biological explanations than others, this was not a universal experience across all participants of color. Jamie a twenty-year-old African American, was more accepting of the genetic explanations she had heard from her therapist about her bipolar condition. The fact that her condition had a lineage back to her mother, and her mother's struggles, provided Jamie a coherent framework for understanding the chaotic circumstances of her childhood. "I know now that she couldn't really help it," Jamie described during our conversation about her past. "She was probably bipolar but undiagnosed her whole life, but I see it now."

Overall and more consistently these findings highlight the continuing challenge that people from marginalized backgrounds have self-identifying with labels that many feel were ascribed on them by the system but also the broader social—if not racialized—structure. Though most participants were able to acknowledge that they had problems, and were exhibiting what Thoits describes as a form of emotional deviance, some were clearly ambivalent about fully accepting the possibly pejorative conations of these terms. In a way participants expressed a type of *modified self-labeling*, insofar that most were willing to accept mental health labels but only in terms that did not threaten their sense of worth and relative status in broader society.

These findings of modified self-labeling, as well of the broader structural ambivalence discussed earlier, are consistent with Pescoloidio's (1992) Network-Episodic Model (NEM) of health-seeking behavior (see also Pescosolido et al .1998). According to the NEM, individuals make sense of their mental health needs, and their options of treatment, in the context of their social interactions with friends, families and community institutions. In short, the ability to self-label one's mental health needs reflects an ongoing socialization process wherein individuals gain insight into their mental health problems, and in turn their need to access mental health services.[131] From this perspective health-seeking is less an individual choice/decision, but a socialized pattern of behavior that individuals adopt over time.

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[131] According to Pescosolido's Network Episodic Model (NEM) individuals experiencing a mental health episode make sense of their mental health needs, and options for treatment, through their interactions with friends, families and the broader institutions that come into contact. In short, coming to terms that one has a need for mental health services reflects an ongoing socialization process that occurs within one's particular social context. Knowing someone who has experienced therapy, or a mental health episode himself or herself, increases the odds that one understand their need for treatment and what treatment actually means.

As already discussed it appears clear that former foster youth have become socialized to viewing their problems as forms of emotional deviance even though some were uncomfortable or resentful toward clinical and therapeutic terms. While I was not able to observe how this process occurred in the context of the institution itself, I interpreted the clear comfort some participants displayed to talk about themselves in a therapeutic frame as an indication of this socialization. On one level many participants outward rejected the labels of the system, but on another more implicit level nearly of all these participants felt comfortable identifying with the very emotional deviance that these labels represented. Overall these dynamics lend support of the NEM's basic premise that one's interpretation of their mental health needs is an ongoing interpretive process that occurs over time and within the context of specific institutions. Moreover, similar to NEM the concept of structural ambivalence highlights that accessing mental health care is less an explicit decision made by individuals, but more of an institutionalized response. Though at some level individuals make a choice not to access care, structural ambivalence suggests that this reluctance to access care should be viewed as a learned pattern of behavior derived out of several years of being in care.

However, more context-specific than the NEM, structural ambivalence highlights the contradictory nature of mental health labeling in the particular institution of foster care. Structural ambivalence not only asserts that context is important, but specifies exactly how this institutional context creates tensions and contradiction as a meaning-making system in foster care. Foster youth come to learn about their problems, therapy and medication in a confusing context in which relationships are always in flux, their

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status as wards of the court are unclear, and pejorative labels and diagnostic terms are used interchangeably. Overall structural ambivalence reminds that sociologists need to be mindful of what context actually means when conceptualizing the diverse ways that individuals can come understand and respond their mental health needs.

Limitations and Future Directions

It is important to note that I was not able fully develop these theoretical implications of my study in part due to the design limitations of dissertation. Indeed, given its one-sample, inductive focus, the case study could not directly test the assumptions of self-labeling theory, the NEM, or other models of health seeking behavior. More importantly, the qualitative study was also limited by its dependence on interviews; while I used ethnography to observe how participants on occasion interacted with program staff and their social workers I did not engage in enough of these observations to include them centrally in my analysis. This shortcoming is also reflected in the limited observations that I made of participants living and interacting in their own community. Because the NEM emphasizes the social interactive nature of meanings and symbols, I was unable to directly observe how participants likely made sense of their mental health problems in the context of their relationships with friends and other individuals living in their proximity.

Indeed, how young people may continually feel a structural ambivalence in the community, after leaving foster care, could have been further developed if my project had included a more concerted ethnographic component. Whether former foster youth socialize with other youth who have their own emotional problems, if not other former foster youth, and how these relationships respond when individuals experience severe

episodes of stress could be further explored in a subsequent analysis this is more focused on community and social interactions. While respondents generally reported limited interactions with others during my interviews, and indeed often discussed being generally isolated from others, in my next study I will explore the particular social relationships that some youth are likely to cultivate with others over time. How respondents talk about their mental health problems, as well as how they describe their general past, to acquaintances and whether these relationship support or hinder their engagement with care, could be explored through a community-based ethnography across several residential and housing programs that target transitional-aged youth.

Such an analysis of foster youth could also better address how the dimensions of race, class and gender are implicated in the narratives of health seeking. While I partially addressed the racialized nature of the system discourse—in particular how participants of color felt the system perpetuated racial stereotypes of the families it served—a future analysis could explore how feelings of surveillance and racial profiling might also be perpetuated in the community.

A final limitation of this dissertation, which I feel ironically also speaks to one of its more promising extension in the future, is the fact that the case study was intentionally limited to young adults who had experiences with foster care. While this focus allowed me to exclusively structure the analysis around the unique aspects of this institution, it nonetheless limited my ability to systematically compare the experiences of foster youth with that of other young adults. As I implied throughout the case study, foster youth experience a dual transition in respects to aging out of care, but also of entering a new

phase of adulthood. During a relatively short phase of life that sociologists associate with the transition to adulthood, most young people navigate new adult roles, experiment with new freedoms and struggle to define and purse long-term life plans (Hartmann & Swartz 2006; Shannon 2000; Setterson, Furstenbert & Rumbaut 2005). In the first chapter I explicitly characterized this as "troubled transition" to encourage reader to understand the increased mental health challenges that participants were likely to experience in the context of their uncertain futures and limited social support. While most young adults normatively rely on parental support to navigate the vicissitudes of young adulthood, most former foster youth confront the challenges of housing, education, employment and with few sources of support and guidance. And as highlighted throughout this dissertation a number of these young adults also struggle with significant emotional and mental health problems that can often times complicate their transition to adulthood (Osgood et al. 2009). While their futures were far from pre-determined, it is not surprising that so many participants experienced heighted levels of stress and mental health problems during their "troubled transition" into adulthood" marked by unemployment, homelessness and periods of acute isolation.

But while I implicated the transition to adulthood frame, my sample did not allow for a systematic comparison of how these transitional narratives were themselves unique or similar to what other young adults experience. Indeed, foster youth are not alone in experiencing uncertainty during their transition to adulthood, and recent research suggests that a reliance on therapeutic narrative to make sense of these struggles have become more commonplace in young adulthood culture (Silva 2012). As I discuss in the

next section, a future analysis that explores the challenges of former foster youth more broadly, in the context of other vulnerable adults, may help extend the concept of structural ambivalence to be generalizable to other groups.

Therapeutic Young Adulthood

Life course sociologists have observed that young adults in the contemporary context experience trajectories that are far more diverse than previous generations(Shannon 2000; Setterson, Furstenbert & Rumbaut 2005). . In contrast to the normative sequence of life events that most adults previously experienced in respects to finishing school, finding employment, entering marriage and raising children, modern young adulthood has become far more individualized and unstructured. It is not uncommon for young adults today to continually re-define their career goals and ambitions, delay marriage and child rearing, prolong their education plans, and enter and exit intimate relationships several times throughout an extended adulthood (Shannon 2000). Sociologists have posited that a variety of social, cultural and macro-economic factors have contributed to this unstructuring of the life course, such as changing gender norms, extension of higher education to new groups, and fluctuating labor trends associated with post-industrial capitalism. Accordingly all of these factors have re-shaped the traditional institutions that had previously shaped the orderly transition into young adult life. As a result young adulthood has become far more diverse, if albeit less structured and uncertain, phase of life today (Shannon 2000). .

Cultural sociologists have suggested that within this broader post-industrial/post-modern context, young people have come to individualize, or psychologize (Karp 1996),

the uncertainties of their lives within self-reflexive and therapeutic narratives of identity (Bauman 2013; Illouz 2008; Giddens 1991).[132] In the absence of a singular normative road map to navigating adulthood, many individuals must negotiate their own understanding of relationships, career goals and parenting given their individual values and goals. Whereas past generations relied on external and traditional adulthood markers to signal their role and status as adults—such as getting married, gaining stable employment and having children—today most individuals have to turn to themselves to construct more idiosyncratic, and individually negotiated notions of being an adult.[133] In this respect some have emphasized that adulthood identity has also a result become more individualized, self-reflective and focused on notions of self-discovery and self-actualization (Bauman 2013; Illouz 2008; Giddens 1991; Moskowitz 2001; Rieff 1987). Illouz has further argued that the "therapeutic model"—an outgrowth of the psychoanalytic tradition during the twentieth century—has become a dominant frame/discourse by which middle class individuals ascribe meanings and order to their otherwise idiosyncratic lives. Accordingly as social life has become more unpredictable and uncertain in the modern age, young people, particularly those of privileged backgrounds, have become more internally fixated on managing their emotions, finding their true authentic self and improving their sense of well being.

Not surprisingly a number of critical scholars have suggested that with this new

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[132] A variety of cultural theorists have suggested that within this context, traditional models of identify for young adults, and construction of the self, have themselves become unstructured, liquefied and more individualized in the modern (or postmodern) era.
[133] Gidden has suggested that the search for self-hood has become less guided by external institutions such religion, work and family, but has fallned more on the individual to define and self-structure. As such modern identities have become more individual and self-reflexive process of social construction.

fixation on the authentic self, the importance given to issues of mental health, and therapy itself, have become more resonant with post-industrial cutlure, and American society more specifically (Moskowitz 2001).[134] This critical and somewhat cynical view of the growing acceptance of mental health in modern culture, suggests that therapeutic narratives function primarily as a coming of age ritual for many young adults. In the absence of achieving the traditional markers of adulthood, many young people pursue a search for their true and mature self but continually re-evaluating their thoughts and feeling, finding meaning in them within their biographical past, and to triumph over them in a reconstructed, therapeutic self.

More recently sociologists have suggested that this therapeutic ritual has become more prevalent among working class and lower-class groups in the US (Silva 2012). Whereas Illouz (2008) presents therapeutic discourses as primarily a class based, bourgeois form of cultural capital, Silva (2012) has recently provided evidence that these models of meaning have also become more common among working class young adults. Given the dramatic declines in unionized work opportunities, the lack of stable pathways to permanent employment and the increasing privatization of risk, Silva argues that a growing number of young adults have struggled to achieve traditional marks of adulthood, and turned to therapeutic narrative to re-define and overcome their painful pasts. In short of achieving the normative traditional milestones of being an adult—often

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[134] Indeed, an internal fixation on the self not only has implication for a more self-indulgent culture and economy, but also speaks to a growing form self disciplinary power (Foucault 1973). Moreover, Rose (2005) has suggested that as mental health treatments have become more based on psychopharmacology, the search for one's true self will often become supplanted for a search of one's true medication. As he argues individuals increasingly turn to medication to make sense of, and optimize their self—embracing what he calls a more disciplined neuro-chemcial identiy.

due to the challenges of finding gainful employment and/or delaying child rearing—the working class have turned to the language of therapy to make sense of themselves. This therapeutic language has also become more readily accessible within a variety of institutions in which working class and lower class individuals come into contact—such as chemical dependency clinics, corrections and the military—contributing to their growing presence in American social life.

From this light, it is perhaps not surprising that participants in my case study similarly discussed the challenges in their lives from a therapeutic frame. According to Silva, Illouz and other cultural sociologists, the therapeutic narrative has become an increasingly important way for young adults to make sense of themselves, but also of their uncertain futures. Silva further provides an important reconceptualization of how therapy, and achieving a therapeutic self, may serve as a new marker of adulthood by which young people measure themselves. As a cultural schema the therapeutic narrative compels the individual to continually re-construct their sense of self by closely paying attention to their thoughts and reactions in search of a more mature self. In this sense former foster youth more than other adults may rely on a therapeutic narrative to make sense of their troubled transition out of care, and as Silva suggests, achieve a more mature self through self-discovery and self actualization.

But as is the case with some cultural sociology, Silva describes this cultural phenomenon with broad strokes, obfuscating the different circumstance, and different needs, that a therapeutic narrative might serve individuals. Former foster youth may be both making sense of their transition to adulthood by implicating a therapeutic narrative,

but I would contend that many are also suffering from the traumas and wounds of their past. Unlike other adults who may pursue a therapeutic self primarily as a ritual of identity and coming of age, most of the former foster youth I met appeared severely troubled and in need of professional attention. Though her framework has the potential to incorporates mental health both as a form of identity, but as well as an outcome of adult uncertainty, currently this works focuses primarily on the former.[135]

Given this, a future analysis of my case study could more explicitly this duality of mental health; as both an outcome and source of identity for young adults. One way to extend my work in this direction would be to explore how narratives of structural ambivalence, therapeutic selfhood and the challenges of young adulthood vary across the different populations sampled in the Minnesota Exits and Entries Project (MEEP). As Silva herself argues, therapeutic model have proliferated across several different institutions (from education, criminal justices, social services and even to some extent the military) suggesting that coming of age stories and being self-reflective about one's self are likely constituted differently across these settings, as well as across groups. By comparing the saliency and consistency of therapeutic narrative across the different institutions sampled in MEEP, this analysis may lead to more generalizeable concepts related to the social vulnerabilities faced by a variety of young adults transitioning out of care. Given the continuing uncertainties of young adulthood, and the relative lack of support that marginalized youth experience during this time, mental health and chemical

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[135] While Silva's conceptualization emphasizes the new social vulnerability that many young adults face in the new global economy—which also illuminate the challenge of former foster youth also face—it nonetheless dismisses the real mental health needs and trauma that some young people may be experiencing.

dependency problems are likely to become even more ubiquitous in the near future. How these narratives of need and narratives of identity merge, co-develop and fluctuate over time should continued to be studied and conceptually developed.

A final note on foster youth and the risks of medicalizing young adulthood
As discussed in chapter two, the history of child welfare reveals that societal efforts to protect destitute children have been largely dependent on occasional moral panics about the proper treatment of the young. These crises have been more than just about the humanitarian treatment of children, but also reflected cultural anxieties about the broad social changes occurring in society.

More pertinent to this dissertation, the history of child welfare also suggests that aging out of the foster care system is a particularly troubling and problematic form of cultural transition. Much of the legitimacy underpinning child welfare efforts have been predicated on an evolving understanding of childhood as being a stage of life marked by vulnerability and preciousness, but most importantly by what Katz (1988) describes as the "deserve –ability" for extended societal protections.

As foster youth age out of their protected status of being poor and at-risk children, to simply being poor adults, they enter an almost liminal status in our culture in respects to social welfare; of being at-risk but no longer deserving citizens. Indeed, the perpetual crisis of child welfare has in some ways always been about defining the parameters of children's inherent vulnerability but also innocence, and hence the aging foster child has always problematized the cultural designation of deservingness. However, as discussed in chapter two, the extension of state supports and social welfare to the "deserving poor"

have been more recently predicated on new definitions of medical needs particularly

among children (Conrad & Schneider 1982; Conrad 2008).[136]

In this sense it is interesting that former foster youth are in the crux of new

definitions of an *extended adolescence-young adulthood* stage; a stage at which both the

risks, and consequences, of mental health problems are assumed be at their highest

(Courtney 2009b; Kessler 2008). As some have suggested that mental health problems

not only spike during this time, but contribute, if not reflect, the ongoing uncertainty and

risks associated with the transition to adulthood, and in turn their long term life

trajectories (Osgood et al. 2009; Silva 2012).   Given these dynamics, it is very likely that

young adulthood will increasingly become the target of medicalization, particularly for

vulnerable young adults as discussed in this dissertation.   Give the broader context of

growing inequality, welfare retrenchment, and the increasing political contention over

social welfare eligibility, it is likely that the medicalized 'adolescent-adult' will become

the new way that child welfare advocates extend supports to this increasingly vulnerable

stage of life. Indeed the growing number of programs that have been established during

the last twenty years to help young people aging out of care have often be predicated on

the unique vulnerabilities associated with the transition to adulthood, and often refering

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[136] While child welfare and foster care are predicated on the vulnerabilities of childhood, these
vulnerabilities have themselves evolved over the years to become more medicalized in nature, something
my interviews saliently highlighted (Pholf 1977). The medicalization of child abuse in the second half of
the twentieth century by radiologists and psychiatrists did much to not only extend and legitimate services
and supports to children, but they also bolstered an entire child welfare industry and profession framed
around notions of health, well being and the medical necessary of services. Not withstanding the fact that
many abused and neglected children have real mental and physical health issues deserving professional
attention, it is nonetheless important to note this legitimization dynamic within the child welfare system.
The institutional context of modern child welfare practices is one in which medical diagnoses, and in
particular mental health and developmental disorders, are paramount to justifying the continued expense of
providing long-term services to children.

to former foster youth as simply *transitional youth*. More recently the term transitional

youth has been expanded to not only included young people who have had experiences in

state care, but also now a variety of other young adults associated with marginalized

backgrounds (young people transitioning out of jail, with special needs and from poor

backgrounds). The term transitional youth has also been increasingly associated with

mental health problems and the ongoing need of medical attention (Courtney 2009b).

Not withstanding the fact that many abused and neglected young people have real mental

and physical health issues deserving professional attention, it is nonetheless important to

note this legitimization dynamic of our new medicalized welfare system. While

medicalizing young adults may certainly increase the resources and supports allocated to

their plight, it may also obscure the very factors and social conditions placing them at-

risk in the first place.

Bibliography

Abramson, Lyn Y., Gerald I. Metalsky and Lauren B. Alloy. 1989. "Hopelessness depression: A theory-based subtype of depression." *Psychological Review* 96(2):358.

Achenbach, T. M. and T. M. Ruffle. 2000. "The Child Behavior Checklist and related forms for assessing behavioral/emotional problems and competencies." *Pediatrics in Review / American Academy of Pediatrics* 21(8):265-271.

Anderson, Norman B. 1998. "Levels of analysis in health science: A framework for integrating sociobehavioral and biomedical research." *Annals of the New York Academy of Sciences* 840(1):563-576.

Aneshensel, Carol S., Jo C. Phelan, and Alex Bierman. 2013. "The sociology of mental health: surveying the field." In *Handbook of the sociology of mental health*, pp. 1-19. Springer Netherlands.

Ariès, Philippe. 1970. *Centuries of Childhood: A Social History of Family Life. Transl. from the French by Robert Baldick.* Chicago: AA Knopf.

Arnett, Jeffrey J. 2004. *Emerging adulthood: The winding road from the late teens through the twenties.* Oxford University Press.

Baldessarini, Ross J., Leonardo Tondo, Carmen Ghiani and Beatrice Lepri. 2010. "Illness risk following rapid versus gradual discontinuation of antidepressants." *American Journal of Psychiatry* 167(8):934-941.

Barth, Richard P. 1990. "On their own: The experiences of youth after foster care." *Child and Adolescent Social Work Journal* 7(5):419-440.

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Barth, Richard P., Betty J. Blythe, Steven P. Schinke and Robert F. Schilling. 1983. "Self-control training with maltreating parents." *Child Welfare: Journal of Policy, Practice, and Program.*

Bauman, Zygmunt. 2013. *Liquid modernity.* New York*:* John Wiley & Sons.

Belsky, Jay, Gabriel L. Schlomer and Bruce J. Ellis. 2012. "Beyond cumulative risk: distinguishing harshness and unpredictability as determinants of parenting and early life history strategy." *Developmental Psychology* 48(3):662.

Berk, Sarah F. 1985. *The gender factory.* Springer.

Biehl, João G., Byron Good and Arthur Kleinman. 2007. *Subjectivity: ethnographic investigations.* University of California Press.

Bloomberg, Linda D. and Marie Volpe. 2012. *Completing your qualitative dissertation: A road map from beginning to end.* Thousands Oaks*:* Sage.

Bourgois, Philippe I. and Jeffrey Schonberg. 2009. *Righteous dopefiend.* University of California Press.

Burns, Barbara J., Susan D. Phillips, H. R. Wagner, Richard P. Barth, David J. Kolko, Yvonne Campbell and John Landsverk. 2004. "Mental health need and access to mental health services by youths involved with child welfare: A national survey." *Journal of the American Academy of Child & Adolescent Psychiatry* 43(8):960-970.

California Child Welfare Project. 2012.

Cameron, Theresa. 2002. *Foster care odyssey: A black girl's story.* University Press of Mississippi.

Child Abuse Prevention and Treatment Act (CAPTA). Pub. L. 93-247.

Child Welfare Information Gateway. 2011.

Clausen, June M., John Landsverk, William Ganger, David Chadwick and Alan Litrownik. 1998. "Mental health problems of children in foster care." *Journal of Child and Family Studies* 7(3):283-296.

Cohen, Stanley. 2002. *Folk devils and moral panics: The creation of the mods and rockers.* New York: Psychology Press.

Collins, Patricia H. 1990. *Towards an Afrocentric feminist epistemology.* New York: Routledge.

Commissioner, Administration on Children, Youth and Families. 2011. "The Financial and Societal Costs of Medicating America's Foster Childre."(US Senate Homeland Security and Governmental Affairs).

Conrad, Peter. 2008. *The medicalization of society: On the transformation of human conditions into treatable disorders.* John Hopkins's University Press.

Conrad, Peter and Joseph W. Schneider. 1980. *Deviance and medicalization: From badness to sickness.* Temple University Press.

Conrad, Peter. 2005. "The shifting engines of medicalization." *Journal of Health and Social Behavior* 46(1):3-14.

Cook, Ronna. 1991. "A National Evaluation of Title IV-E Foster Care Independent Living Programs for Youth. Phase 2 Final Report. Volumes 1 and 2.".

Corrigan, Patrick W. 1999. "The impact of stigma on severe mental illness." *Cognitive and Behavioral Practice* 5(2):201-222.

Corrigan, Patrick W., Amy C. Watson and Leah Barr. 2006. "The self-stigma of mental
	illness: implications for self-esteem and self-efficacy." *Journal of Social and
	Clinical Psychology* 25(8):875-884.

Corrigan, P. W. 2007. "How clinical diagnosis might exacerbate the stigma of mental
	illness." *Social Work* 52(1):31-39.

Courtney, Mark E. 2009. "The Difficult Transition to Adulthood for Foster Youth in the
	US: Implications for the State as Corporate Parent. Social Policy Report. Volume
	XXIII, Number I." *Society for Research in Child Development*.

Courtney, Mark E., Richard P. Barth, Jill D. Berrick and Devon Brooks. 1996. "Race and
	child welfare services: Past research and future directions." *Child Welfare: Journal
	of Policy, Practice, and Program*.

Courtney, Mark E. and Amy Dworsky. 2006. "Early outcomes for young adults
	transitioning from out-of-home care in the USA." *Child & Family Social Work*
	11(3):209-219.

Courtney, Mark E., Amy L. Dworsky, Gretchen R. Cusick, Judy Havlicek, Alfred Perez
	and Thomas E. Keller. 2007. "Midwest evaluation of the adult functioning of former
	foster youth: Outcomes at age 21.".

------. 2007. "Midwest evaluation of the adult functioning of former foster youth:
	Outcomes at age 21.".

Courtney, Mark E., Jennifer L. Hook and JoAnn S. Lee. 2012. "Distinct subgroups of
	former foster youth during young adulthood: Implications for policy and practice."
	Child Care in Practice 18(4):409-418.

------. 2012. "Distinct subgroups of former foster youth during young adulthood:
	Implications for policy and practice." *Child Care in Practice* 18(4):409-418.

Courtney, Mark E., Irving Piliavin, Andrew Grogan-Kaylor and Ande Nesmith. 2001. "Foster youth transitions to adulthood: A longitudinal view of youth leaving care." *Child Welfare-New York*- 80(6):685-718.

------. 2001. "Foster youth transitions to adulthood: A longitudinal view of youth leaving care." *Child Welfare-New York*- 80(6):685-718.

Courtney, Mark E., Sherri Terao and Noel Bost. 2004. *Midwest evaluation of the adult functioning of former foster youth: Conditions of youth preparing to leave state care.* Chapin Hall Center for Children at the University of Chicago.

Crenson, Matthew. "A.(1998)." *Building the Invisible Orphanage.A Prehistory of the American Welfare System.* Thousands Oaks, CA*:* Sage.

Cresswell, John W. 1998. *Qualitative inquiry and research design: Choosing among five traditions.* Thousands Oaks, CA*:* Sage.

Cusick, Gretchen R., Judy R. Havlicek and Mark E. Courtney. 2012. "Risk for arrest: The role of social bonds in protecting foster youth making the transition to adulthood." *American Journal of Orthopsychiatry* 82(1):19-31.

Delman, Jonathan and Amanda Jones. 2002. "Voices of youth in transition: The experience of aging out of the adolescent public mental health service system in Massachusetts: Policy implications and recommendations."

DosReis, Susan, Julie M. Zito, Daniel J. Safer and Karen L. Soeken. 2001. "Mental Health Services for Youths in Foster Care and Disabled Youths." *American Journal of Public Health* 91(7).

Dosreis, S., Y. Yoon, D. M. Rubin, M. A. Riddle, E. Noll and A. Rothbard. 2011. "Antipsychotic treatment among youth in foster care." *Pediatrics* 128(6):e1459-66.

Duster, Troy. 2003. *Backdoor to Eugenics.* New York: Psychology Press.

Dworsky, Amy and Mark Courtney. 2009. "Addressing the mental health service needs of foster youth during the transition to adulthood: how big is the problem and what can states do?" *Journal of Adolescent Health* 44(1):1-2.

Empey, LaMar T., Mark C. Stafford and Carter H. Hay. 1982. *American delinquency: Its meaning and construction.* Homewood, IL: Dorsey Press.

Epstein, Laura. 1996. "The trouble with the researcher-practitioner idea." *Social Work Research* 20(2):113-117.

Farmer, Elizabeth M., Barbara J. Burns, Mimi V. Chapman, Susan D. Phillips, Adrian Angold and E. J. Costello. 2001. "Use of mental health services by youth in contact with social services." *Social Service Review* 75(4):605-624.

Farmer, Paul, Philippe Bourgois, Nancy ScheperHughes, Didier Fassin, Linda Green, HK Heggenhougen, Laurence Kirmayer, Loc Wacquant and Paul Farmer. 2004. "An anthropology of structural violence 1." *Current Anthropology* 45(3):305-325.

Fedoravicius, Nicole, J. C. McMillen, Jill E. Rowe, Njeri Kagotho and Norma C. Ware. 2008. "Funneling child welfare consumers into and through the mental health system: Assessment, referral, and quality issues." *The Social Service Review* 82(2):273.

Fergusson, David M. and Lianne J. Woodward. 2002. "Mental health, educational, and social role outcomes of adolescents with depression." *Archives of General Psychiatry* 59(3):225-231.

Finn, Janet L. and Barry Checkoway. 1998. "Young people as competent community builders: A challenge to social work." *Social Work* 43(4):335-345.

Foucault, Michel. 1973. "The Birth of the Clinic, trans." *A.Sheridan, London: Tavistock.*

Fowler, P. J., P. A. Toro and B. W. Miles. 2009. "Pathways to and from homelessness and associated psychosocial outcomes among adolescents leaving the foster care system." *American Journal of Public Health* 99(8):1453-1458.

Fry, Annette R. 1974. *The children's migration.* New York: American Heritage.

Furstenberg, Frank F. 2006. "Diverging development: The not-so-invisible hand of social class in the United States." *Network on Transitions to Adulthood Research Network.Available at Http://www.Transad.Pop.Upenn.Edu*.

Gainsborough, Juliet F. 2010. *Scandalous Politics: Child Welfare Policy in the States*. Georgetown University Press.

Garcia, Antonio. 2009. "Contextual pathways to Latino child welfare involvement: A theoretical model located in the intersections of place, culture, and socio-structural factors." *Children and Youth Services Review* 31(12):1240-1250.

Garcia, Antonio R., Lawrence A. Palinkas, Lonnie Snowden and John Landsverk. 2013. "Looking beneath and in-between the hidden surfaces: a critical review of defining, measuring and contextualizing mental health service disparities in the child welfare system." *Children and Youth Services Review* 35(10):1727-1733.

Garland, Ann F., John L. Landsverk, Richard L. Hough and Elissa Ellis-MacLeod. 1996. "Type of maltreatment as a predictor of mental health service use for children in foster care." *Child Abuse & Neglect* 20(8):675-688.

Garland, David. 1985. *Punishment and welfare: A history of penal strategies.* Boston MA: Gower Aldershot.

George, Linda K. 1993. "Sociological perspectives on life transitions." *Annual Review of Sociology*: 353-373.

Giddens, Anthony. 1991. *Modernity and self-identity: Self and Society in the Late Modern Age.* Oxford, UK: Polity Press.

Glaser, Barney G. 1999. "The future of grounded theory." *Qualitative Health Research* 9(6):836-845.

Goerge, Robert M., Lucy Bilaver, B. J. Lee, Barbara Needell, Alan Brookhart and William Jackman. 2002. "Employment outcomes for youth aging out of foster care." *Chapin Hall Center for Children, University of Chicago*.

Goffman, Erving. 1963. *Stigma: Notes on the management of spoiled identity.* New York: Simon and Schuster.

------. 1961. *Asylum.* New York Press.

Gove, Walter R. 1979. "The Labeling Versus the Psychiatric Explanation of Mental Illness: A Debate That Has Become Substantively Irrelevant: Reply." *Journal of Health and Social Behavior*:301-304.

Halfon, Neal, Ana Mendonca and Gale Berkowitz. 1995. "Health status of children in foster care: The experience of the Center for the Vulnerable Child." *Archives of Pediatrics & Adolescent Medicine* 149(4):386-392.

Halfon, Neal. George Berkowitz and Lyn Klee. 1992. "Mental health service utilization by children in foster care in California." *Pediatrics* 89(6 Pt 2):1238-1244.

Hareven, Tamara K. 1991. "The history of the family and the complexity of social change." *The American Historical Review*:95-124,

Harman, Jeffrey S., George E. Childs and Kelly J. Kelleher. 2000. "Mental health care utilization and expenditures by children in foster care." *Archives of Pediatrics & Adolescent Medicine* 154(11):1114-1117.

Hartmann, Douglas and Teresa T. Swartz. 2006. "The new adulthood? The transition to adulthood from the perspective of transitioning young adults." *Advances in Life Course Research* 11:253-286.

Havlicek, Judy R., Antonio R. Garcia and Douglas C. Smith. 2013. "Mental health and substance use disorders among foster youth transitioning to adulthood: Past research and future directions." *Children and Youth Services Review* 35(1):194-203.

Hayward, Mark D. and Bridget K. Gorman. 2004. "The long arm of childhood: The influence of early-life social conditions on men's mortality." *Demography* 41(1):87-107.

Healy, David. 2003. *Let them eat Prozac.* Chicago: James Lorimer & Company.

Hochschild, Arlie R. 1979. "Emotion work, feeling rules, and social structure." *American Journal of Sociology*:551-575.

Horwitz, Allan V. 1999. "The sociological study of mental illness." Pp. 57-78 in *Handbook of the sociology of mental health*: *The sociological study of mental illness.* New York: Springer.

------. 1982. *The social control of mental illness.* New York:Academic Press

Hurlburt, Michael S., Laurel K. Leslie, John Landsverk, Richard P. Barth, Barbara J. Burns, Robert D. Gibbons, Donald J. Slymen and Jinjin Zhang. 2004. "Contextual Predictors of Mental Health Service Use Among Children Opento Child Welfare." *Archives of General Psychiatry* 61(12):1217-1224.

------. 2004. "Contextual Predictors of Mental Health Service Use Among Children Opento Child Welfare." *Archives of General Psychiatry* 61(12):1217-1224.

Illouz, Eva. 2008. *Saving the modern soul: Therapy, emotions, and the culture of self-help.* University of California Press.

Ingrassia, M., & McCormick, J. 1994, April 25. "Family: Why Leave Children with Bad Parents?" *Newsweek,* pp. 53-58.

Jayakody, Rukmalie, Sheldon Danziger and Ronald C. Kessler. 1998. "Early-onset psychiatric disorders and male socioeconomic status." *Social Science Research* 27(4):371-387.

Jones, Loring. 2011. "The first three years after foster care: A longitudinal look at the adaptation of 16 youth to emerging adulthood." *Children and Youth Services Review* 33(10):1919-1929.

Karp, David. 1996. *Speaking of sadness: Depression, disconnection, and the meanings of illness.* Oxford University Press.

Karp, David A. 1993. "Taking anti-depressant medications: Resistance, trial commitment, conversion, disenchantment." *Qualitative Sociology* 16(4):337-359.

Katz, Michael B., Michael J. Doucet and Mark J. Stern. 1982. *The social organization of early industrial capitalism.* Harvard University Press Cambridge, MA.

Kessler, Ronald C., Peter J. Pecora, Jason Williams, Eva Hiripi, Kirk O'Brien, Diana English, James White, Richard Zerbe, A. C. Downs and Robert Plotnick. 2008. "Effects of enhanced foster care on the long-term physical and mental health of foster care alumni." *Archives of General Psychiatry* 65(6):625-633.

------. 2008. "Effects of enhanced foster care on the long-term physical and mental health of foster care alumni." *Archives of General Psychiatry* 65(6):625-633.

Kessler, Ronald C. and Philip S. Wang. 2008. "The Descriptive Epidemiology of Commonly Occurring Mental Disorders in the United States." *Annu.Rev.Public Health* 29:115-129.

Kim, Hansung, David Chenot and Juye Ji. 2011. "Racial/ethnic disparity in child welfare systems: A longitudinal study utilizing the Disparity Index (DI)." *Children and Youth Services Review* 33(7):1234-1244.

Kim, HyunSoo, Michelle R. Munson and Mary M. McKay. 2012. "Engagement in mental health treatment among adolescents and young adults: A systematic review." *Child and Adolescent Social Work Journal* 29(3):241-266.

Kleinman, Arthur, Leon Eisenberg and Byron Good. 1978. "Culture, illness, and careclinical lessons from anthropologic and cross-cultural research." *Annals of Internal Medicine* 88(2):251-258.

Kutchins, Herb and Stuart A. Kirk. 1988. "The business of diagnosis: DSM-III and clinical social work." *Social Work* 33(3):215-220.

Landsverk, John and Ann F. Garland. 1999. "Foster care and pathways to mental health services." *Child Welfare* 45(9):9-16.

------. 1999. "to Mental Health Services." *The Foster Care Crisis: Translating Research into Policy and Practice*:193.

Landsverk, John, Ann F. Garland and Laurel K. Leslie. 2002. "Mental health services for children reported to child protective services." *The APSAC Handbook on Child Maltreatment* 2:487-507.

Leavey, JoAnn E. 2005. "Youth experiences of living with mental health problems: Emergence, loss, adaptation and recovery (ELAR)." *Canadian Journal of Community Mental Health (Revue Canadienne De Santé Mentale Communautaire)* 24(2):109-126.

Leslie, Laurel K., Michael S. Hurlburt, Sigrid James, John Landsverk, Donald J. Slymen and Jinjin Zhang. 2005. "Relationship between entry into child welfare and mental health service use." *Psychiatric Services* 56(8):981-987.

Leslie, Laurel K., Michael S. Hurlburt, John Landsverk, Richard Barth and Donald J. Slymen. 2004. "Outpatient mental health services for children in foster care: A national perspective." *Child Abuse & Neglect* 28(6):697-712.

Leslie, Laurel K., John Landsverk, Roxanne Ezzet-Lofstrom, Jeanne M. Tschann, Donald J. Slymen and Ann F. Garland. 2000. "Children in foster care: Factors influencing outpatient mental health service use." *Child Abuse & Neglect* 24(4):465-476.

Lindsey, Michael A., Sean Joe and Von Nebbitt. 2010. "Family matters: The role of mental health stigma and social support on depressive symptoms and subsequent help seeking among African American boys." *Journal of Black Psychology*.

Link, Bruce G. 1987. "Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection." *American Sociological Review*:96-112.

Link, Bruce G., Francis T. Cullen, Elmer Struening, Patrick E. Shrout and Bruce P. Dohrenwend. 1989. "A modified labeling theory approach to mental disorders: an empirical assessment." *American Sociological Review*:400-423.

------. 1989. "A modified labeling theory approach to mental disorders: an empirical assessment." *American Sociological Review*:400-423.

Link, Bruce G. and Jo C. Phelan. 2001. "Conceptualizing stigma." *Annual Review of Sociology*:363-385.

Martin, Emily. 2007. *Bipolar expeditions: Mania and depression in American culture.* Princeton University Press.

McMillen, J. C. and Ramesh Raghavan. 2009. "Pediatric to adult mental health service use of young people leaving the foster care system." *Journal of Adolescent Health* 44(1):7-13.

McMillen, J. C., Lionel D. Scott, Bonnie T. Zima, Marcia T. Ollie, Michelle R. Munson and Edward Spitznagel. 2004. "Use of mental health services among older youths in foster care." *Psychiatric Services* 55(7):811-817.

------. 2004. "Use of mental health services among older youths in foster care." *Psychiatric Services* 55(7):811-817.

McMillen, J. C., Bonnie T. Zima, Lionel D. Scott Jr, Wendy F. Auslander, Michelle R. Munson, Marcia T. Ollie and Edward L. Spitznagel. 2005. "Prevalence of psychiatric disorders among older youths in the foster care system." *Journal of the American Academy of Child & Adolescent Psychiatry* 44(1):88-95.

Mead, GH. 1934. "Mind, Self, and Society from the Standpoint of a Social Behaviorist."

Mechanic, David. 1986. "Illness behaviour: An overview." Pp. 101-109 in *Illness behavior*: *An Overview*." New York: Springer.

Merriam, Sharan B. 2002. "Assessing and evaluating qualitative research." *Qualitative Research in Practice: Examples for Discussion and Analysis*:18-33.

Metzl, Jonathan. 2009. *The protest psychosis: How schizophrenia became a black disease*. Boston, MA: Beacon Press.

Moses, Tally. 2011. "Adolescents' commitment to continuing psychotropic medication: a preliminary investigation of considerations, contradictions, and correlates." *Child Psychiatry & Human Development* 42(1):93-117.

------. 2009. "Self-labeling and its effects among adolescents diagnosed with mental disorders." *Social Science & Medicine* 68(3):570-578.

Moskowitz, Eva S. 2001. *In therapy we trust: America's obsession with self-fulfillment.* John Hopkins's University Press.

Mowbray, Carol T., Deborah Megivern and Shari Strauss. 2002. "College students' narratives of high school experiences: Coping with serious emotional disturbance." *Handbook of Serious Emotional Disturbance in Children and Adolescents*:14-29.

Moynihan, Daniel P., Lee Rainwater and William L. Yancey. 1967. *The Negro family: The case for national action.* Cambridge, MA: MIT Press.

Munson, Michelle R., James Jaccard, Susan E. Smalling, Hyunsoo Kim, James J. Werner and Lionel D. Scott Jr. 2012. "Static, dynamic, integrated, and contextualized: A framework for understanding mental health service utilization among young adults." *Social Science & Medicine* 75(8):1441-1449.

Munson, Michelle R., Lionel D. Scott Jr, Susan E. Smalling, HyunSoo Kim and Jerry E. Floersch. 2011. "Former system youth with mental health needs: Routes to adult mental health care, insight, emotions, and mistrust." *Children and Youth Services Review* 33(11):2261-2266.

Nagi, Saad Z. 2013. *Child maltreatment in the United States: A challenge to social institutions.* Columbia University Press.

National Incidence Study of Child Abuse and Neglect (NIS-4). 2010.

Needell, B., S. Cuccaro-Alamin, A. Brookhart, W. Jackman and A. Shlonsky. 2002. "Youth Emancipating from Foster Care in California: Findings Using Linked Administrative Data. Berkeley, CA: Center for Social Services Research." *University of California at Berkeley*.

------. 2002. "Youth Emancipating from Foster Care in California: Findings Using Linked Administrative Data. Berkeley, CA: Center for Social Services Research." *University of California at Berkeley*.

Needell, Barbara, Stephanie Cuccaro-Alamin, Alan Brookhart, William Jackman and Aron Shlonsky. 2002. "Youth emancipating from foster care in California: Findings using linked administrative data." *Center for Social Services Research, University of California at Berkeley*:27-29.

Osgood, D. W., E. M. Foster and Mark E. Courtney. 2010. "Vulnerable populations and the transition to adulthood." *The Future of Children* 20(1):209-229.

Patton, Michael Q. 1990. *Qualitative evaluation and research methods* . Thousand Oaks, CA*:* Sage.

Pearlin, Leonard I., Elizabeth G. Menaghan, Morton A. Lieberman and Joseph T. Mullan. 1981. "The stress process." *Journal of Health and Social Behavior*:337-356.

Pecora, Peter J., Ronald C. Kessler, Kirk O'Brien, Catherine R. White, Jason Williams, Eva Hiripi, Diana English, James White and Mary A. Herrick. 2006. "Educational and employment outcomes of adults formerly placed in foster care: Results from the Northwest Foster Care Alumni Study." *Children and Youth Services Review* 28(12):1459-1481.

Pecora, PJ, R. Kessler, J. Williams, K. O'Brien, AC Downs, D. English, J. White, E. Hiripi, C. White and T. Wiggins. 2005. "Improving family foster care: Findings from the Northwest foster care alumni studyCasey Family Programs." *Seattle, WA*.

Pecora, PJ, J. Williams, RC Kessler, AC Downs, K. O'Brien, E. Hiripi and S. Morello. 2003. *Assessing the Effects of Foster Care: Early Results from the Casey National Alumni Study.Seattle, WA: Casey Family Programs*.

Pecora, P. J., P. S. Jensen, L. H. Romanelli, L. J. Jackson and A. Ortiz. 2009. "Mental health services for children placed in foster care: an overview of current challenges." *Child Welfare* 88(1):5-26.

Pescosolido, Bernice A. 1992. "Beyond rational choice: The social dynamics of how people seek help." *American Journal of Sociology*: 1096-1138.

Pescosolido, Bernice A., Carol B. Gardner and Keri M. Lubell. 1998. "How people get into mental health services: stories of choice, coercion and "muddling through" from "first-timers"." *Social Science & Medicine* 46(2):275-286.

Platt, Anthony. 1966. *The child savers.* University of Chicago Press.

Popple, Philip and P. N. Reid. 1999. "A profession for the poor? A history of social work in the United States." *The Professionalization of Poverty*:1-28.

Pottick, Kathleen J., Scott Bilder, Ann Vander Stoep, Lynn A. Warner and Mike F. Alvarez. 2008. "US patterns of mental health service utilization for transition-age youth and young adults." *The Journal of Behavioral Health Services & Research* 35(4):373-389.

Quadagno, Jill. 1994. *The color of welfare: How racism undermined the war on poverty.* Oxford University Press.

Raghavan, Ramesh, Peichang Shi, Gregory A. Aarons, Scott C. Roesch and J. C. McMillen. 2009. "Health insurance discontinuities among adolescents leaving foster care." *Journal of Adolescent Health* 44(1):41-47.

Rieff, Philip. 1987. *The triumph of the therapeutic: Uses of faith after Freud.* University of Chicago Press.

Roberts, Dorothy. 2002. "Shattered bonds: The color of child welfare." *Children and Youth Services Review* 24(11):877-880.

------. 2002. "Shattered bonds: The color of child welfare." *Children and Youth Services Review* 24(11):877-880.

Roberts, Dorothy E. 2007. "Child welfare's paradox." *Wm.& Mary L.Rev.* 49:881.

Roche, Timothy. 2000. ""The Crisis of Foster Care." *Time Magazine* November 2000.

Rose, Nikolas. 2003. "Neurochemical selves." *Society* 41(1):46-59.

Rosenstock, Irwin M. 1990. "The health belief model: Explaining health behavior through expectancies."

Rothman, David J. 1971. *The discovery of the asylum.* New York: Transaction Publishers.

Rubin, David, Meredith Matone, Yuan-Shung Huang, Susan dosReis, Chris Feudtner and Russell Localio. 2012. "Interstate variation in trends of psychotropic medication use among Medicaid-enrolled children in foster care." *Children and Youth Services Review* 34(8):1492-1499.

Scheff, Thomas J. 1971. *Being mentally ill: A sociological theory.* New York*:* Transaction Publishers.

Sedlak, Andrea J., Jane Mettenburg, Monica Basena, I. Peta, Karla McPherson and A. Greene. 2010. "Fourth national incidence study of child abuse and neglect (NIS-4)." *Washington, DC: US Department of Health and Human Services.Retrieved on July* 9:2010.

Shanahan, Michael J. 2000. "Pathways to adulthood in changing societies: Variability and mechanisms in life course perspective." *Annual Review of Sociology*:667-692.

Schnittker, Jason. 2008. "An Uncertain Revolution: Why the Rise of a Genetic Model of Mental Illness Has Not Increased Tolerance" *Social Science and Medicine* 67:1370-1381.

Shin, Sunny H. 2005. "Need for and actual use of mental health service by adolescents in the child welfare system." *Children and Youth Services Review* 27(10):1071-1083.

Shiner, Michael and Tim Newburn. 1997. "Definitely, maybe not? The normalisation of recreational drug use amongst young people." *Sociology* 31(3):511-529.

Singh, S. P. 2009. "Transition of care from child to adult mental health services: the great divide." *Current Opinion in Psychiatry* 22(4):386-390.

Soss, Joe, Richard C. Fording and Sanford Schram. 2011. *Disciplining the poor: Neoliberal paternalism and the persistent power of race.* University of Chicago Press.

Specht, Harry and Mark E. Courtney. 1995. *Unfaithful angels: How social work has abandoned its mission.* New York: Simon and Schuster.

Stacey, Judith. 1996. *In the Name of the Family.* Boston MA: Beacon Press.

Stahmer, A. C., L. K. Leslie, M. Hurlburt, R. P. Barth, M. B. Webb, J. Landsverk and J. Zhang. 2005. "Developmental and behavioral needs and service use for young children in child welfare." *Pediatrics* 116(4):891-900.

------. 2005. "Developmental and behavioral needs and service use for young children in child welfare." *Pediatrics* 116(4):891-900.

Steinar, Kvale. 1996. "Interviews: An introduction to qualitative research interviewing." *Lund: Studentlitteratur*.

Swartz, Teresa T. 2009. "Intergenerational family relations in adulthood: Patterns, variations, and implications in the contemporary United States." *Annual Review of Sociology* 35:191-212.

------. 2004. "Mothering for the State Foster Parenting and the Challenges of Government-Contracted Carework." *Gender & Society* 18(5):567-587.

Szasz, Thomas. 1961. *The myth of mental illness: Foundations of a theory of personal conduct.* New York: Hoeber-Harper.

Szasz, Thomas S. 1975. *The age of madness: the history of involuntary mental hospitalization, presented in selected texts.* New York: Taylor & Francis.

Takayama, John I., Abraham B. Bergman and Frederick A. Connell. 1994. "Children in foster care in the state of Washington: Health care utilization and expenditures." *Jama* 271(23):1850-1855.

------. 1994. "Children in foster care in the state of Washington: Health care utilization and expenditures." *Jama* 271(23):1850-1855.

The Adoption Assistance and Child Welfare Act (AACWA). 1980. P.L. 96-272.

The Social Security Act (SSA). 1935. Pub.L. 74–271.

Thoits, Peggy A. 1985. "Self-labeling processes in mental illness: The role of emotional deviance." *American Journal of Sociology*:221-249.

Toth, Jennifer. 1998. *Orphans of the Living: Stories of Americas Children in Foster Care.* New York: Simon and Schuster.

U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *2007*.

Webster, Sue and Lindsey Harrison. 2008. "Finding a way: a grounded theory of young people's experience of the pathway to mental health care." *Australian Journal of Advanced Nursing, the* 26(2):85.

Williams, D. R., Yu Yan, J. S. Jackson and N. B. Anderson. 1997. "Racial Differences in Physical and Mental Health: Socio-economic Status, Stress and Discrimination." *Journal of Health Psychology* 2(3):335-351.

Wulczyn, Fred and Bridgette Lery. 2007. "Racial disparity in foster care admissions.".

Zelizer, Viviana A. R. 1985. *Pricing the priceless child: The changing social value of children.* Princeton University Press.

Zito, Julie M., Daniel J. Safer, James F. Gardner, Laurence Magder, Karen Soeken, Myde Boles, Frances Lynch and Mark A. Riddle. 2003. "Psychotropic practice patterns for youth: a 10-year perspective." *Archives of Pediatrics & Adolescent Medicine* 157(1):17-25.

------. 2003. "Psychotropic practice patterns for youth: a 10-year perspective." *Archives of Pediatrics & Adolescent Medicine* 157(1):17-25.