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Mental Health, Ethnicity, Sexuality, and Spirituality Among Youth in Foster Care

Findings from the Casey Field Office Mental Health Study



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Executive Summary

Study Overview

The Casey Field Office Mental Health Study (CFOMH) focused on the mental health of youth receiving foster care services from Casey Family Programs (Casey). In addition, the study explored the areas of ethnic identity, gender identity and sexual orientation, and spirituality. The study surveyed 188 youth between age 14 and 17 who were receiving foster care services at one of eight Casey field offices (located in the states of Arizona, California, Idaho, Texas, and Washington). Trained interviewers from the University of Michigan's Survey Research Center conducted in-person interviews between August 2006 and November 2006. The response rate was 88.7%. Participants were 51.1% females and 67.7% youth of color, and the average age was 16.1 years.

Findings

MENTAL HEALTH

Despite difficulties endured related to child maltreatment, removal from their biological families, and placement in foster care, most youth were doing well in terms of their current mental health. Mental health diagnoses were assessed using the Composite International Diagnostic Interview (CIDI), a standardized instrument administered by interviewers that provides lifetime and past-year mental health diagnoses. Findings are summarized below:

- » **Rates of nine lifetime mental health disorders (of 21 assessed) were significantly higher among youth in care than among youth in the general population.** Rates of two lifetime mental health disorders were higher among youth in the general population than among youth in care, and rates were similar for ten diagnoses. Youth in the current study had particularly high lifetime rates of attention-deficit hyperactivity disorder (ADHD; 15.1% compared to 4.5% in the general population), conduct disorder (20.7% compared to 7.0%), major depressive disorder (19.0% compared to 11.9%), and post-traumatic stress disorder (PTSD; 13.4% compared to 5.2%).
- » **Females experienced significantly higher rates of several internalizing mental health disorders compared to males.** Controlling for demographics and foster care experiences, females had significantly higher rates of lifetime and past-year major depressive episode, lifetime panic attack, and lifetime and past-year PTSD. The lifetime rate of PTSD among females, for example, was 21.4% compared to 5.1% for males. For some of these disorders, this is similar to what is found in the general population.¹ Females were more likely to have two or more past-year diagnoses than males.
- » **Rates of mental health disorders among youth currently in care were significantly lower than among alumni of care.** Comparison data from the Northwest Alumni Study, a study of 479 alumni age 20–33, indicated that alumni of care had significantly higher rates of mental health disorders for almost all lifetime and past-year diagnoses assessed. There were no disorders for which youth currently in care had higher rates than alumni.
- » **Most youth (64.2%) had no mental health diagnosis in the past year.** While less than two in five youth (36.7%) had no lifetime mental health diagnosis, the percent of youth with no past-year diagnosis (64.2%) was much higher. In fact, the percent of youth with no past-year mental health diagnosis was similar to that of youth in the general population (63.8%).

¹ National Institute of Mental Health (2006).

ETHNIC IDENTITY

Exploratory questions examined youth's perceptions of their ethnic identity, including their development of ethnic identity while in foster care and experiences with discrimination.

- » **Youth felt that they had opportunities to develop their ethnic identity in foster care, but most wanted to learn more.** Many youth (57.3%) felt that they had opportunities to develop their ethnic identity while in foster care, but most (69.3%) said they wished they could learn more about their ethnic background. There were significant differences by ethnic group, with black and Hispanic/Latino youth endorsing both statements to a greater degree than white youth. Several Hispanic/Latino youth commented on the difficulty of maintaining their Spanish language skills while in foster care.
- » **Although youth reported relatively low levels of experiences of discrimination, differences existed by racial/ethnic group.** A scale was created to measure experiences of discrimination to assess personal encounters with racism, such as unfair treatment at school, experiencing verbal harassment, and experiencing violence. Black youth reported significantly more experiences of discrimination based on race/ethnicity than Hispanic/Latino youth or white youth.
- » **About three in four youth reported having at least one caregiver of the same race/ethnic group as themselves at the time of the interview, but significant differences existed by group.** The percent of youth with at least one caregiver of the same race/ethnic group as the youth was 86.5% for white youth, 81.1% for black youth, and 45.0% for Hispanic/Latino youth.
- » **About half of youth believed that it was important to have foster parents of the same racial/ethnic group as themselves.** Just over half of youth (51.0%) somewhat or strongly agreed with the statement, "Having foster parents of

the same race or ethnicity is important to me." There were significant differences by racial/ethnic group, with black youth endorsing it to the greatest degree (69.8%), followed by Hispanic/Latino youth (50.4%) and white youth (27.5%).

GENDER IDENTITY AND SEXUAL ORIENTATION

Youth were asked questions related to gender identity and sexual orientation. Youth who identified as gay, lesbian, bisexual, transgender, or questioning (LGBTQ) were asked additional questions about their experiences and unique needs in foster care.

- » **Ten youth (5.4%) identified their sexual orientation as gay, lesbian, bisexual, or questioning. No youth identified as transgender.** Almost one in eight youth (11.5%) reported having questioned their sexual orientation at some point in their lives.
- » **Most youth reported feeling comfortable around youth who are LGBTQ, but fewer reported feeling comfortable living in a foster home with an LGBTQ person.** Nearly two-thirds of youth (65.8%) said that they felt moderately or very comfortable around other youth who are LGBTQ, and nearly three in five youth (57.7%) said that they had an LGBTQ friend. Fewer (45.9%) reported feeling moderately or very comfortable being placed in a foster home with an LGBTQ person, however.
- » **Few LGBTQ youth reported having experienced discrimination because of their sexual orientation.** Although a high percentage of youth (including heterosexual youth) had witnessed or heard of discrimination towards LGBTQ youth based on their gender identity or sexual orientation, such as unfair treatment in school or verbal harassment, most of the 10 youth in this study who identified as lesbian, gay, bisexual, or questioning had not personally experienced discrimi-

nation. All LGBTQ youth felt the need to hide their sexual orientation at some point, however, and many said that was because they feared not being accepted.

SPIRITUALITY

Youth were asked to share their spiritual beliefs, how they feel about spirituality, and what activities they participate in that they consider spiritual.

- » **The vast majority of youth (94.6%) said they believe in God, a Creator, or a Higher Power.** This is similar to the rate found among adolescents in the general population (95%). The most commonly reported descriptions of “God/Creator/Higher Power” were Creator (77.9%), Love (71.7%), and Protector (55.5%).
- » **Most youth participated in spiritual activities on a regular basis and considered those activities helpful.** About one in four youth (24.9%) participated in spiritual activities two or more times per week, slightly less than one in five (18.7%) participated once a week, and one in four (24.1%) participated one to three times per month. More than four in five (82.5%) said that spiritual activities helped them in their daily lives.
- » **Youth employed a variety of coping mechanisms when something bad or tragic happened in their lives.** The most commonly endorsed coping mechanisms include spending time alone (67.4%), praying (58.9%), sharing the problem with someone (55.9%), writing in a journal or diary (35.5%), or doing something creative (33.2%). Potentially harmful coping mechanisms were endorsed to a lesser degree: not eating enough (12.5%), eating too much (9.4%), getting aggressive (7.2%), using alcohol or drugs (5.0%), and hurting oneself in some way (2.0%).

Policy, Program, and Research Recommendations

MENTAL HEALTH

1. Regularly screen youth in foster care for mental health disorders and provide effective mental health treatment to youth who need it.

Results indicated that a high number of youth have struggled with certain disorders during their lifetime. Discreet screenings should be administered regularly to all youth in care, and full assessments should be provided to those who need them. The Warning Signs Project, which was developed for use by parents, educators, and health professionals, is an example of a quick screener for emotional and behavioral problems among children and youth.² Additionally, the Peabody Treatment Progress Battery provides a cohesive set of short, reliable instruments to assess clinical processes and mental health outcomes for youth between age 11 and 18.³

2. Pay particular attention to internalizing disorders among female youth in care.

Females were significantly more likely to have internalizing disorders, including depression, panic attack, and PTSD. Social workers need to pay particular attention to these types of disorders when working with female youth.

3. Explore why lifetime rates of diagnoses were higher than past-year diagnoses for many disorders.

Although youth in foster care may have had numerous mental health disorders in the past, many are not currently struggling with a mental health disorder. It may be that the lives of these youth have stabilized since their placement with Casey, given the nurturing and protective environment of their foster families, or it may be due to other factors. Future research should

² See Jensen et al. (undated). For more information about screening for behavioral problems, see Bergman (2004).

³ For information about the Peabody Treatment Progress Battery (PTPB), visit the PTPB Web site at peabody.vanderbilt.edu/ptpb.xml.

compare when initial placements were made and when recovery occurred to identify factors associated with recovery.

4. Provide training on mental health disorders to foster parents and social workers.

Social workers and families can assist children and youth in grieving, developing relationships with other people, and strengthening their personal identity through programs such as the 3-5-7 Model, which helps prepare for permanency in a family.⁴ Training in behavior management, through the Oregon Multidimensional Treatment Foster Care model for example, may be most effective in helping foster parents work with youth who have behavioral problems.⁵

5. Empower youth and foster parents to advocate for mental health services.

Empowered and informed youth can more effectively advocate for mental health services. Additionally, well-trained foster parents and social workers are able to discern typical from atypical adolescent behavior, and can be allies in ensuring that youth receive mental health treatment when needed.⁶

6. Help youth in care and alumni of care who are doing well to keep doing well.

Nearly two in three youth in the current study and about half of the alumni in the Northwest Alumni Study had no past-year mental health diagnosis. Support (in the form of extracurricular activities, mentors, etc.) should be provided to these youth and alumni to help them continue to do well.

7. Ensure that alumni of foster care have access to effective mental health services.

For many mental health diagnoses, rates among alumni in the Northwest Study were three to

five times those of youth in the current study, suggesting that alumni of foster care may be more at risk for mental health problems than youth still in care. Alumni of foster care need access to effective mental health services, such as those available through the Chafee Medicaid waiver—perhaps to an even greater degree than youth still in care. Many youth who are leaving care go through difficult experiences as they leave care, such as joblessness and homelessness. Support services to help stabilize educational, vocational, and economic aspects of their lives could improve the mental health of alumni.

8. Replicate the current study among youth served in public agencies.

The current study interviewed youth served through Casey, whose experiences may be significantly different from those of youth served in public agencies. As such, the findings reported here may not be generalizable to the national population of youth in foster care.

ETHNIC IDENTITY

1. Ensure that youth in foster care have multiple opportunities to explore and develop their ethnic identity.

This research highlights the importance of ensuring that all youth in foster care are offered opportunities to develop their ethnic identity. Discovering and promoting ways to nurture positive ethnic identity development of youth in foster care could provide them with a means to cope with challenges in their lives (such as the trauma associated with child maltreatment, frequent placement and/or school changes, and discrimination experienced in the broader social environment). In particular, youth should be provided with skills to address racial and ethnic discrimination.

4 The 3-5-7 Model consists of three components: completing three “tasks” (e.g., developing an understanding of one’s life events), answering five questions (e.g., “What happened to me?” to explore loss), and using seven elements that are considered critical to preparing children for permanency (e.g., creating a safe space for the child to go through the process). See Henry (2005) for more information.

5 Chamberlain (2003).

6 For training materials to help caregivers and youth advocate regarding mental health, visit the Reach Institute (REsource for Advancing Children’s Health) Web site at www.reachinstitute.net.

2. Recruit foster parents of diverse racial and ethnic backgrounds.

Less than half of Hispanic/Latino youth reported being currently placed with a foster parent of the same race/ethnicity. To better reflect the population of youth in foster care, recruitment of foster parents should focus on people of diverse racial and ethnic backgrounds. Additionally, it would be beneficial to youth to have mentors from diverse backgrounds for when the race/ethnicity of the foster parent does not match that of the youth.

3. Provide training on ethnic identity development to foster parents and staff.

Teach foster parents, social workers, teachers, and mental health practitioners how to explore their own ethnic identity and awareness of prejudices so they can create a supportive environment for the youth to engage in similar exploration. Foster parent training should include curriculum on diverse identities and healthy identity development, and effective communication with children and adolescents. Social workers can encourage foster families to engage youth in nonjudgmental conversations about youths' ethnic and cultural identity.⁷

4. Conduct studies on American Indian and Alaska Native youth and Asian American and Pacific Islander youth in care to examine their unique needs and experiences in foster care.

The sample size in the current study was far too small to be able to draw any conclusions about American Indian and Alaska Native youth or Asian American and Pacific Islander youth in foster care. Future studies should include a sufficient sample size of youth in these groups to thoroughly examine their mental health, ethnic identity, gender identity and sexual orientation, and spirituality. Survey questions may need to be reviewed to ensure that they are culturally appropriate for each group.

GENDER IDENTITY AND SEXUAL ORIENTATION

1. Ensure that all youth in care feel accepted—whatever their sexual orientation or gender identity may be.

All of the LGBTQ youth felt the need to hide their sexual orientation at some point, and many said that was because they feared not being accepted. This illustrates how important it is for foster care agencies, social workers, foster parents, and all other important people in a youth's life to make their acceptance of a youth's sexual orientation or gender identity clear. This can be done in part through staff and foster parent training, choosing appropriate foster care placements, and using physical office space to display supportive LGBTQ-friendly statements.

2. Teach all youth to accept and support LGBTQ youth.

Organizations such as the Safe Schools Coalition and Parents, Families and Friends of Lesbians and Gays (PFLAG) offer materials and resources that are helpful in educating all youth to be supportive of LGBTQ youth. Additionally, student organizations such as the Gay-Straight Alliance (GSA) encourage acceptance of LGBTQ students by peers and staff and can advocate for school policies that are supportive of LGBTQ students.

3. Conduct further research on LGBTQ youth in foster care to document their experiences and identify how they can be supported in the child welfare system.

More extensive research should be conducted on LGBTQ youth in foster care. An in-depth study should be done with a larger sample to more deeply investigate their experiences and needs in the foster care system, specifically focusing on the unique challenges that these youth may face. Additionally, some of the findings from this exploratory study invite further investigation, such as why many youth reported

⁷ See www.casey.org/Resources/Projects/REI/ for training materials related to ethnic identity development in foster care.

being comfortable around LGBTQ peers, but not feeling comfortable being placed in a home with them.

SPIRITUALITY

1. Purposefully inquire about spirituality, religion, and culture.

Social workers and other direct-service staff can build knowledge of diverse spiritual practices, religious beliefs and norms, and cultural backgrounds. Assessment tools that incorporate these aspects of spirituality can be helpful for learning more about individual youth and their families of origin, and also for improving the match between youth, foster families, and potential mentors.

2. Integrate spirituality into casework.

Agencies and social workers should be equipped to support youth who find spirituality helpful. Spiritual resources should be developed and referrals and supports should be offered to youth in the same manner as are other supports and services. Because of the diversity of beliefs and practices, social workers can be trained to encourage foster families to engage youth in nonjudgmental conversations about youths' spiritual and religious backgrounds.

3. Help youth experience spiritual activities positively.

Youth should be supported by workers and foster families to continue, and perhaps increase, their participation in communities that share their spiritual and religious values and beliefs. Youth should also be encouraged to engage in coping mechanisms and other activities that they find helpful for reducing stress and understanding their life experiences. It is also

important for social workers to consider what supports and resources a young person might need to participate in spiritual activities as often as they wish. This may include assistance with transportation, which was cited as a barrier to involvement.

Conclusion

Most youth in this study were doing well despite struggles they have endured related to maltreatment as children, removal from their biological families, and placement in foster care. In fact, rates of most past-year mental health diagnoses among youth in this study were similar to those found in the general population of adolescents, although lifetime rates were higher for many disorders. This suggests that placement into foster care may provide a nurturing, stable environment which allows youth to recover from mental health disorders. As documented in the Northwest Alumni Study and other studies, however, the high rates of mental health disorders among alumni of foster care strongly suggest that youth preparing to leave care and young adults who have left care need more support.

Exploratory results presented related to ethnic identity, gender identity and sexual orientation, and spirituality suggest that these are important areas in the lives of many youth in foster care. To better understand these areas, standardized scales should be developed in studies with larger sample sizes. In the meantime, the implementation of policy and program recommendations included in the current study may benefit youth currently in care.

I. Introduction

In fiscal year 2005, over 800,000 children were served in the foster care system, with 513,000 in care on a given day.⁸ Many children spend a substantial amount of their childhood in foster care: the 287,000 children exiting foster care in 2005 spent an average of 21 months in care, and 28% had spent two years or more in care.⁹

The costs of foster care are high, both financially and in terms of child well-being. The child welfare system costs more than \$24.3 billion annually.¹⁰ Children in foster care and former recipients of foster care (“alumni”) struggle in areas such as mental health, employment, and education.¹¹ One area of child well-being of particular concern is mental health. Recent studies have documented high rates of mental health disorders among alumni of foster care. For example, the Northwest Alumni Study found high rates of post-traumatic stress disorder (PTSD), depression, anxiety, and social phobia among alumni in Oregon and Washington.¹² Other studies have also found that alumni in other areas of the country struggle with mental health.¹³

In response to these findings and the lack of research about the mental health functioning of youth currently in care, the Casey Field Office Mental Health Study (CFOMH) was conducted. The study’s purpose was to gain a better understanding of the mental health status of youth currently in care. Learning more about the mental health functioning of youth in care can assist in service planning and positively affect mental health among youth in care and alumni of care.

In addition to assessing mental health, the study also explored three areas that have not been extensively researched in foster care populations: ethnic identity, gender identity and sexual orientation, and spirituality. Anecdotal evidence from social workers suggests that positive experiences in these important areas may help youth cope with adversity. Formally exploring how youth in foster care think about these aspects of their lives may provide evidence to help improve practice.

8 U.S. Department of Health and Human Services (2006).

9 U.S. Department of Health and Human Services (2006).

10 Scarcella, Bess, Zielewski, Warner, & Geen (2004)

11 American Academy of Pediatrics Committee on Early Childhood Adoption and Dependent Care (2000); McMillen et al. (2005); Vandivere, Chalk, & Moore (2003); White, Havalchak, O’Brien, & Pecora (2006); Williams, Pope, Sirles, & Lally (2005).

12 Pecora et al. (2005).

13 See, for example, Courtney et al. (2005).

II. Method

Sample

ELIGIBILITY CRITERIA

Eligible participants were between age 14 and 17 on July 1, 2006 and were receiving foster care services from Casey Family Programs (Casey) at one of eight field offices (Austin, TX, Boise, ID, Oakland, CA, Phoenix, AZ, San Antonio, TX, San Diego, CA, Seattle, WA, and Yakima, WA). Participants had to be mentally able to complete the interview. Youth whose cases were closed or who were placed in detention, returned to their birth family, or moved out of state at any time during the interviewing period were deemed ineligible.

Youth were eligible to be in this study if they currently lived in one of the following settings:

- » Casey foster care
- » A group home (but originally in a Casey foster home)

- » A residential treatment facility (but originally in a Casey foster home)

Youth were not eligible if they currently lived in one of the following settings:

- » With the birth family as a permanent placement
- » As a runaway
- » Independently (emancipated)
- » In a psychiatric hospital
- » In juvenile detention

No youth were ineligible because of placement in a psychiatric hospital. Therefore, excluding youth who were in a psychiatric hospital did not affect the percent of youth with mental health diagnoses as reported in the interviewed sample.

A total of 212 youth were eligible for the study.

RESPONSE RATE

A total of 188 youth participated in the study for a response rate of 88.7%. (See Figure 1.) Nineteen youth refused participation in the study, and five did not complete the interview for other reasons (e.g., due to deafness, incomplete interview, or running away after the interviewer had already made contact). At one site, a foster parent refused participation of two youth.

Figure 1. Response Rate.

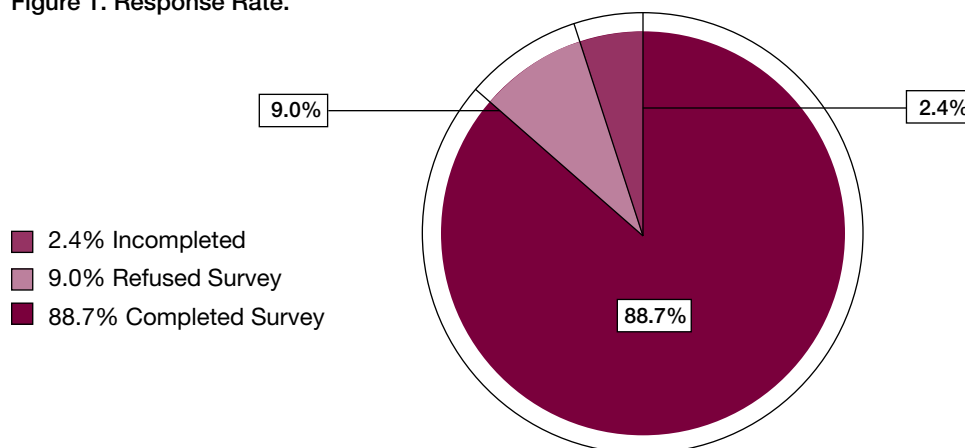
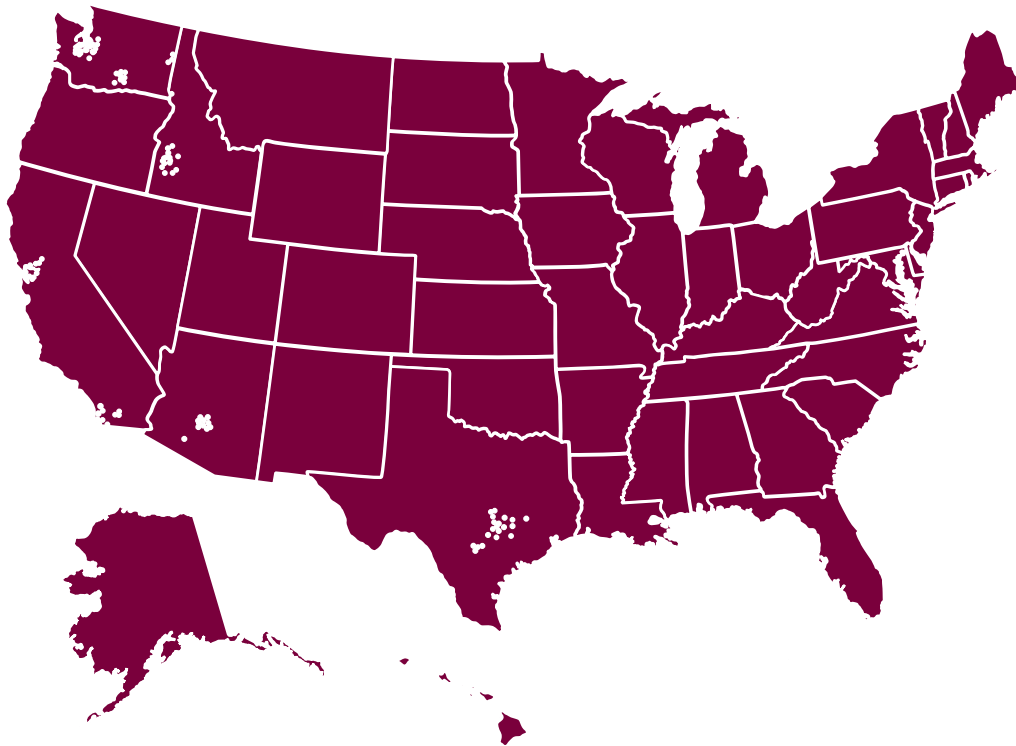


Figure 2 shows the distribution of participants by location, with each dot representing the ZIP code of youth who participated in the study (note that in some cases, more than one youth is represented by a dot because more than one youth shared a ZIP code).

Figure 2. Locations of participating youth.



DEMOGRAPHICS

The average age of the interviewed youth was 16.1 years, and just over half (51.1%) were female. Over two-thirds (67.7%) of the interviewed youth were of color. (See Table 1.) Five American Indian or Alaska Native youth (2.7%), two Asian or Pacific Islander youth (1.0%), and one youth of Chaldean descent (0.5%) are represented in the “Other” primary race/ethnicity category.

Table 1. Demographic Characteristics of the Interviewed Youth

Demographics	Percent
Primary Race/Ethnicity	
Hispanic/Latino	22.1
Black	41.4
White	32.3
Other	4.2
Age (on July 1, 2006*)	
14	24.7
15	21.2
16	25.0
17	29.0
Gender	
Male	49.9
Female	51.1

* To be eligible for the study, youth had to be between age 14 and 17 on July 1, 2006. Some participants were 18 by the time of the interview.

Procedure

DATA COLLECTION

Professionally trained interviewers from the University of Michigan's Survey Research Center conducted in-person interviews between August 2006 and November 2006. Interviews lasted approximately two hours, and most took place in the youth's place of residence. Participants received \$50 for their participation.

The study protocol received approval from the University of Michigan's Institutional Review Board and Casey's Human Subjects Review Committee. Consent to participate in the study was provided by the field office director; in one field office, consent from county social workers was also required. Participants age 14 to 17 signed an assent form; those who were 18 at the time of the interview signed a consent form.

Demographic information was gathered from case files available through Casey's management information system (Harmony).

MEASURES

Mental health

The Composite International Diagnostic Interview (CIDI) was used to assess mental health; it comprised the majority of the survey. The CIDI uses type and severity of experienced symptoms to determine whether a youth has a specific mental health diagnosis. Diagnoses are classified into lifetime diagnoses (ever had the diagnosis?) and past-year diagnoses (had the diagnosis within the past 12 months?). The CIDI provides diagnoses for a number of mental health disorders, such as depression, conduct disorder, post-traumatic stress disorder (PTSD), and social phobia, and has been

shown to have high validity.¹⁴ This was the first study to use the CIDI version 3.0 to assess the mental health of youth in foster care.

Ethnic identity

Ethnic identity was measured through the Multigroup Ethnic Identity Measure (MEIM), which assesses ethnic identity using two subscales: (1) affirmation, belonging, and commitment, which measures connection and pride; and (2) ethnic identity search, which measures the extent to which youth think about and explore their ethnic identity.¹⁵ The scale of measurement ranges from 1 to 5, with higher scores indicating greater endorsement. Previous studies using the MEIM indicate that it is a valid and reliable instrument for assessing ethnic identity.¹⁶ Cronbach's alpha for the overall score in a study of 5,423 young adolescents was 0.84.¹⁷ The instrument has been modified somewhat since the studies were conducted. In the current study, Cronbach's alphas for the MEIM were 0.86 for the affirmation, belonging, and commitment subscale, 0.69 for the ethnic identity search subscale, and 0.85 for the overall score. Additional questions in this section were adapted from a study of bicultural identification.¹⁸

A scale of discrimination experienced because of race/ethnicity was created for this study. The scale is called the "Experiences of Discrimination" scale. Its eight items include unfair treatment at school; by a doctor; by a counselor; by a judge; by police; experiencing verbal harassment; being made to feel ashamed; and experiencing violence (by someone outside of the foster family). The scale of measurement ranges from 1 (never experienced discrimination) to 4 (often experienced discrimination), with higher scores indicating more frequent experiences of discrimination. Cronbach's alpha for this scale was 0.67.

14 Kessler & Üstün (2004); Haro et al. (2006).

15 Phinney (1992).

16 Roberts et al. (1999).

17 Phinney & Devich-Navarro (1997).

18 Phinney & Devich-Navarro (1997).

Gender identity and sexual orientation

Currently, few instruments exist to measure gender identity and sexual orientation among adolescents. In collaboration with subject matter experts and drawing from available instruments, a set of questions was developed to explore these issues among youth in foster care. Data from the questions did not produce any scales, so results are presented at the variable level.

Spirituality

Similarly, few instruments exist to measure spirituality among adolescents. A set of questions was developed to explore spirituality among youth in foster care with consultation from subject matter experts. In addition, some spirituality questions were adapted from a UCLA study of spirituality among college students.¹⁹ The data did not suggest any scales, so results are presented at the variable level.

WEIGHTING OF DATA

Data were weighted to account for youth who were not interviewed. Weighting improves the ability to generalize findings to the population of eligible youth by adjusting data for differences between the population of eligible youth and the sample of interviewed participants. The variables included in the weighting process were age, sex, field office, race/ethnicity.

During the weighting process, no significant differences were found between the population of eligible youth and the interviewed sample in age or sex. Differences in race and field office location were found between the population and the interviewed sample and were subsequently included in the weighting process. The response rate was lower among white youth (82.4%) than among youth of color (92.0%), and lower among people from the Bay Area, Seattle, and Yakima (79.3% combined) than from other field offices (94.6% combined).

DATA ANALYSIS AND REPORTING

Descriptive findings

Simple descriptive findings are presented at the beginning of each section. Significant results were tested using a significance level of $p < .05$. Because few established scales exist and because of the exploratory nature of the Ethnic Identity, Gender Identity and Sexual Orientation, and Spirituality sections, many of the findings for these areas are presented at the variable level.

Where appropriate, quotes from youth are presented to highlight their experiences and opinions in their own words.

Subgroup analyses

Where appropriate, analyses by subgroup (e.g., gender, race/ethnic group) are presented. Differences by subgroup were tested for significance after controlling for demographics and foster care experiences, which were collected through the interview. The variables below were controlled for when conducting subgroup analyses:

Demographics

- » Gender
- » Age on July 1, 2006
- » Race/ethnicity

Foster care experiences

- » Age at entry into foster care
- » Number of foster care placements
- » Field office

Given the different focus of the sections, the Ethnic Identity section is primarily comprised of subgroup analyses, whereas the Spirituality section does not contain subgroup analyses. Subgroup analyses in the Gender Identity and Sexual Orientation section are presented at the qualitative level because of the small number of people who identified as lesbian, gay, bisexual, or questioning.

The primary subgroup analyses for each section are listed below:

Mental health

- » Gender
- » Age
- » Race/Ethnicity

Ethnic identity

- » Multigroup Ethnic Identity Measure scores
- » Ethnic identity development in foster care
- » Experiences of discrimination

Gender identity and sexual orientation

- » Experiences of lesbian, gay, bisexual, and questioning (LGBQ) youth²⁰

Spirituality

- » None

Relation to mental health

Lastly, at the end of the Ethnic Identity, Gender Identity and Sexual Orientation, and Spirituality sections, analyses are presented to explore the relation between those areas and mental health (after controlling for the demographics and foster care experiences listed above).

²⁰ No controls were used in the gender identity and sexual orientation analyses because results do not compare one subgroup to another; rather, descriptive findings of all lesbian, gay, bisexual, and questioning youth are presented.

III. CFOMH Findings: Mental Health

Background

Most youth in foster care come from a traumatic family history and difficult life experiences, increasing their risk for mental health disorders.

Very few studies have used the Composite International Diagnostic Interview (CIDI) to assess mental health among youth in care (an exception is the Midwest Study, which used a short form of the CIDI among 17-year-olds preparing to leave care).²¹ Most of what is known about the mental health of youth in care is therefore based on findings using other instruments. A study of 267 children in California found consistently high rates of mental health problems among children in foster care using the Child Behavior Checklist, with rates of children in the borderline or clinical range at 2.5 times that found in a general population.²² Additionally, a large study of 15,507 children receiving medical assistance aid found that the rate of mental health disorders among children in foster care was twice that of youth who were receiving Supplemental Security Income (SSI) and close to 15 times that of children who were receiving other forms of medical assistance aid.²³ Further, a study of 373 17-year-olds in foster care (using the Diagnostic Interview Schedule for DSM-IV) found that three in five youth (61%) had at least one lifetime mental health disorder and just over one-third (37%) had at least one past-year disorder.²⁴

Many foster care agencies provide mental health treatment to youth in care because of their history of child maltreatment and removal from the birth home. This section of the report includes findings

about the rates of lifetime and past-year mental health disorders among youth in Casey care. By better understanding which disorders youth struggle with, social workers, other agency staff, and foster parents can better determine how to serve youth in care.

CFOMH Findings

PREVALENCE RATES AMONG YOUTH

Mental health findings are presented in Table 2. About three in five youth (63.3%) had a lifetime Composite International Diagnostic Interview (CIDI) diagnosis, and about one in five (22.8%) had three or more lifetime diagnoses. Of the 22 lifetime diagnoses assessed, six were diagnosed for 15% or more of the sample: oppositional defiant disorder (29.3%), conduct disorder (20.7%), major depressive disorder (19.0%), major depressive episode (19.0%), panic attack (18.9%), and attention-deficit hyperactivity disorder (15.1%).

Over one third (35.8%) had at least one past-year diagnosis, and a much smaller percentage (7.7%) had three or more past-year diagnoses. Of the 20 past-year diagnoses assessed, none were diagnosed for 15% or more of the sample. The five most common past-year diagnoses were major depressive disorder (10.9%), major depressive episode (10.9%), PTSD (9.3%), intermittent explosive disorder (8.6%), and conduct disorder (8.3%).

21 Courtney, Terao, & Bost (2004).

22 Clausen, Landsverk, Ganger, Chadwick, & Litrownik (1998).

23 dosReis, Zito, Safer, & Soeken (2001).

24 McMillen et al. (2005).

Table 2. Mental Health Functioning: Lifetime Diagnoses and Diagnoses in the Past Year

MENTAL HEALTH DIAGNOSES	Casey Field Office Mental Health Study (age 14–17)		NCS-A (Adolescent General Population, age 14–17) ^a		Northwest Alumni Study (age 20–33)	
	Lifetime (%)	Past year (%)	Lifetime (%)	Past year (%)	Lifetime (%)	Past year (%)
At least one CIDI DSM diagnosis ^b	63.3	35.8	45.9*	36.2	65.6 ^c	54.4 ^c
Three or more CIDI diagnoses ^b	22.8	7.7	14.7*	9.1	28.9 ^c	19.9 ^c
Alcohol abuse	7.7	3.6	5.9	4.4	--	11.9 ^{ad}
Alcohol dependence	3.6	2.0	1.1*	0.8	11.3*	3.6
Anorexia	0.0	0.0	0.2	0.1	1.2	0.0
Attention deficit hyperactivity disorder (ADHD)	15.1	-- ^e	4.5*	--	--	--
Bulimia	3.2	1.1	1.1*	0.8	4.9	3.6
Conduct disorder	20.7	8.3	7.0*	3.8*	--	--
Drug abuse	14.1	2.1	8.8*	5.7*	--	12.3 ^{ad}
Drug dependence	4.2	1.5	1.8*	1.2	21.0*	8.0*
Dysthymia	4.5	2.0	3.7	2.7	--	--
Generalized anxiety disorder	4.7	2.1	2.5	1.7	19.1*	11.5*
Hypomania	0.0	0.0	3.7*	3.0*	--	--
Intermittent explosive disorder	13.9	8.6	14.4	11.8	--	--
Major depressive disorder	19.0	10.9	11.9*	8.4	--	--
Major depressive episode	19.0	10.9	14.1	10.2	41.1*	20.1*
Mania	9.3	5.5	1.7*	1.3*	--	--
Nicotine dependence	3.1	2.0	6.7	5.1	--	--
Oppositional defiant disorder	29.3	-- ^e	--	--	--	--
Panic attack	18.9	6.8	20.3	11.2	--	--
Panic disorder	0.0	0.0	2.5*	2.1*	21.1 ^{af}	14.8 ^{af}
Post-traumatic stress disorder (PTSD)	13.4	9.3	5.2*	3.6*	30.0*	25.2*
Separation anxiety disorder	12.0	0.0	8.9	2.1*	--	--
Social phobia	10.5	7.2	14.6	13.1*	23.3 ^g	17.1 ^g
Sample size	188		7753		479	

Notes: "--" indicates that the diagnosis was not assessed. An asterisk ("**") indicates that rates were significantly different between the CFOMH study and other studies.

^a Data from the NCS-A Study are weighted on age, race/ethnicity, and sex to match the demographics of the current study.

^b All diagnoses listed in this table were included in the variables "At least one CIDI DSM diagnosis" and "Three or more CIDI DSM diagnoses" except major depressive episode, oppositional defiant disorder, and panic attack. These diagnoses were excluded to match those included in the NCS-A (further, major depressive episode overlaps with major depressive disorder, and panic attack overlaps with panic disorder). If a youth had both alcohol abuse and alcohol dependence, it was counted as only one disorder; the same was true for drug abuse and drug dependence. ADHD was included in the lifetime rates but not in the 12-month rates.

^c Comparisons with the Northwest Alumni Study in terms of number of diagnoses must be made with caution, given that the current study measured significantly more diagnoses. Statistical tests were not run because of the differences in included diagnoses. Lifetime diagnoses in the Northwest Study include alcohol dependence, anorexia, bulimia, drug dependence, generalized anxiety disorder, major depressive episode, modified social phobia, panic syndrome, and PTSD. Past-year diagnoses included all lifetime diagnoses, with the addition of alcohol problem and drug problem.

^d The Northwest Alumni Study measured alcohol problem and drug problem.

^e The CIDI does not create past-year diagnoses for ADHD or oppositional defiant disorder.

^f Panic syndrome. The Northwest Alumni Study did not technically assess panic disorder because one question was inadvertently omitted from the survey.

^g The Northwest Alumni Study measured modified social phobia.

COMPARISONS WITH OTHER STUDIES

Mental health comparison data, weighted on age, gender, and race/ethnicity to match demographics of the current study, were provided by the National Comorbidity Study – Adolescent (NCS-A) survey. This survey, conducted from April 2001 to April 2003, used the CIDI in a nationally representative sample of 10,148 youth age 13 to 17.²⁵

Comparisons yielded mixed results. Youth in the current study were significantly more likely to have at least one lifetime diagnosis (63.3%) than adolescents in the general population (45.9%). However, rates of diagnoses in the past year were similar between the two samples: 35.8% among youth in the current study, compared to 36.2% of adolescents in the general population. Youth in the current study were significantly more likely to have three or more lifetime diagnoses (22.8% in CFOMH compared to 14.7% in the general population).

Rates of mental health diagnoses were significantly higher among the CFOMH sample for nine of 21 lifetime diagnoses and three of 20 past-year diagnoses (See Table 3.).²⁶ Rates were higher in the

general population for two of 21 lifetime diagnoses and five of 20 past-year diagnoses. Youth in CFOMH had significantly higher lifetime and past-year rates of conduct disorder, mania, and PTSD compared to adolescents in the general population. Lifetime rates of attention-deficit hyperactivity disorder (ADHD), bulimia, drug abuse, drug dependence, and major depressive disorder were higher for youth in the current study.²⁷ Compared to the general population, however, youth in CFOMH were less likely to have lifetime drug abuse, lifetime and past-year hypomania, lifetime and past-year panic disorder, past-year separation anxiety, and past-year social phobia.

There were no differences between the two samples for 10 of 21 lifetime diagnoses or for 12 of 20 past-year diagnoses. Both samples of youth experienced relatively high lifetime rates of panic attack (18.9% in the current study and 20.3% in the general population, respectively), major depressive episode (19.0% and 14.1%, respectively), social phobia (10.5% and 14.6%, respectively), and intermittent explosive disorder (13.9% and 14.4%, respectively).

25 Sampson (2007).

26 The number of lifetime diagnoses presented here excludes oppositional defiant disorder because general population rates were not available for this disorder.

27 Substance abuse (e.g., alcohol abuse or drug abuse) is defined in the Diagnostic and Statistical Manual of Mental Disorders as a “maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances” (American Psychiatric Association, 2000). Substance dependence (e.g., alcohol dependence or drug dependence) is more severe than substance abuse, involving physical changes such as tolerance and/or withdrawal, inability to curtail substance use, spending a lot of time to acquire substances (and recover from use), etc.

Table 3. Comparisons in Mental Health Diagnosis Rates between Youth in CFOMH and Youth in the General Population

Higher Rates Among Casey Field Office Mental Health Study (age 14–17) Sample	Lifetime	Past Year
At least one CIDI DSM diagnosis ^b	•	
Three or more CIDI DSM diagnoses ^b	•	
Alcohol dependence	•	
Attention-deficity/hyperactivity disorder (ADHD)	•	
Bulimia	•	
Conduct disorder	•	•
Drug abuse	•	
Drug dependence	•	
Major depressive disorder	•	
Mania	•	•
Post-traumatic stress disorder (PTSD)	•	•
Higher Rates Among NCS-A (General Population, age 14–17) ^a Study Sample	Lifetime	Past Year
Drug abuse		•
Hypomania	•	•
Panic disorder	•	•
Separation anxiety		•
Social phobia		•
No Rate Difference Between CFOMH and NCS-A Study Samples	Lifetime	Past Year
At least one CIDI DSM diagnosis ^b		•
Three or more CIDI DSM diagnoses ^b		•
Alcohol abuse	•	•
Alcohol dependence		•
Anorexia	•	•
Bulimia		•
Drug dependence		•
Dysthymia	•	•
Generalized anxiety disorder	•	•
Intermittent explosive disorder	•	•
Major depressive disorder		•
Major depressive episode	•	•
Nicotine dependence	•	•
Panic attack	•	•
Separation anxiety disorder	•	
Social phobia	•	

^a Data from the NCS-A Study are weighted on age, race/ethnicity, and sex to match the demographics of the current study.^b See Note “b” in Table 2 for information about which diagnoses were included in these variables.

Results from the current study are very similar to what was found in a study of 373 17-year-olds in foster care, which used the Diagnostic Interview Schedule for DSM-IV. This study by McMillen et al. found that three in five youth (61%) had at least one lifetime mental health disorder (compared to 63.3% in the current study), and just over one-third (37%) had at least one past-year disorder compared to 35.8% in the current study.²⁸

Comparison data are also provided by the Northwest Alumni Study, which examined outcomes for 479 alumni of foster care age 20 to 33.²⁹ Rates of mental health diagnoses were significantly higher in the Northwest Alumni Study for seven of nine lifetime diagnoses and eight of 11 past-year diagnoses. (See Table 2.) There were no diagnoses for which youth in CFOMH had higher rates than alumni in the Northwest Study. For many diagnoses, rates among alumni in the Northwest Study

were three to five times those of youth in the current study. For example, the rate of past-year PTSD in the Northwest Study was 25.2%, compared with 9.3% in the current study. This pattern of results suggests that alumni of foster care may be more at risk for mental health problems than youth still in care. This may be because unresolved issues surface in the difficult years after emancipation, when young adults may not have the means or supports to address them properly.

Comparison data were also provided by the Midwest Study of 17-year-olds (N=732) preparing to leave state care in Illinois, Iowa, and Wisconsin (see Table 4).³⁰ This study used a short form of the CIDI to examine lifetime rates of a select number of diagnoses. There were no diagnoses for which the Midwest sample had significantly higher rates. The CFOMH sample had significantly higher rates for three of seven lifetime diagnoses assessed: depression, social phobia, and drug abuse.

Table 4. Lifetime Mental Health Disorders: Comparisons to the Midwest Study

Diagnosis	CFOMH (%)	Midwest Study (%)
Post-traumatic stress disorder	13.4	16.1
Alcohol abuse	7.7	11.3
Alcohol dependence	3.6	2.7
Any depression ^a	19.0*	2.9
Drug abuse	14.1*	5.0 ^b
Drug dependence	4.2	2.3 ^b
Social phobia	10.5*	0.4
Sample size	188	732

* $p < .05$

^a In the Midwest Study, “any depression” was measured as having mild, moderate, or severe depression (single episode and/or recurrent). The comparison provided for CFOMH is for major depressive episode only, which is likely an underestimate of “any depression.” Therefore, the difference between the CFOMH and Midwest Study samples in rates of depression is likely larger than presented here.

^b The Midwest Study measured substance abuse and substance dependence.

28 McMillen et al. (2005).

29 For more information about the Northwest Alumni Study, see Pecora et al. (2005).

30 Courtney et al. (2004).

Subgroup Analyses

GENDER DIFFERENCES IN MENTAL HEALTH DISORDERS

Males and females had similar rates for most mental health disorders. Controlling for demographics and foster care experiences, however, females had significantly more past-year diagnoses than males. In particular, females had significantly higher rates for three disorders: major depressive episode, panic attack, and PTSD. (See Table 5). Females had particularly disproportionately high rates of PTSD, with eight times the rate of past-year PTSD (16.3% vs. 2.0%) and four times the rate of lifetime PTSD (21.4% vs. 5.1%) compared to males.

Table 5. Significant Gender Differences in Mental Health Disorders

DIAGNOSIS	Female (%)	Male (%)
Two or more diagnoses (past year)	24.1*	8.2
Major depressive episode (lifetime)	26.9*	10.7
Major depressive episode (past year)	16.0*	5.6
Panic attack (lifetime)	26.0*	11.5
Post-traumatic stress disorder (lifetime)	21.4*	5.1
Post-traumatic stress disorder (past year)	16.3*	2.0
Sample size	96	92

* $p < .05$

AGE DIFFERENCES IN MENTAL HEALTH DISORDERS

Rates for most mental health disorders were similar across age. Controlling for demographics and foster care experiences, however, older youth had significantly more lifetime diagnoses than younger youth. (See Table 6.)

Table 6. Significant Age Differences in Mental Health Disorders

DIAGNOSIS	Age 14 (%)	Age 15 (%)	Age 16 (%)	Age 17 (%)
At least one diagnosis (lifetime)	49.2	55.0	66.4	78.9
Sample size	46	41	47	54

Note: Overall chi-square test was significant at $p < .05$.

RACIAL/ETHNIC DIFFERENCES IN MENTAL HEALTH DISORDERS

Controlling for demographics and foster care experience variables, there were no significant differences by race/ethnic group when examining mental health diagnoses.

IV. CFOMH Findings: Ethnic Identity

Background

To date, few studies have been conducted to examine the ethnic identity development of youth in foster care. Rigorous research pertaining to the ethnic identity of youth in care has been scarce. Only nine studies examining the ethnic identity development of foster youth could be found in published literature. Exploring how youth in foster care identify ethnically and how it helps them cope with adversity may lead to the enhancement of services provided to youth.

Youth in foster care may struggle between wanting to “belong” to their foster family and wanting to maintain connections to their biological family, which can cause difficulty in the development of their ethnic identity when the race/ethnicity of the youth does not match that of the foster family. A qualitative study of 17 youth in foster care (age 15 to 19) who were African American, Hispanic, or Asian/Pacific Islander found that being in foster care had a negative impact on youth identity development.³¹ Youth in the study reported feeling “devalued” because of their status as foster children, which negatively affected their identity development.

Some studies have found that higher scores on the Multigroup Ethnic Identity Measure (MEIM) are related to academic success, better mental health, and better behavior in adolescents.³² The MEIM was used in this study to assess levels of ethnic identity development and to examine the relation between ethnic identity and mental health.

Subgroup Analyses

Only eight youth were in the “other” ethnic identity category. This category was excluded from subgroup analyses because the group was too small and heterogeneous to analyze separately. Their data are included when results are presented for the entire sample of youth (N=188) but not when reporting differences by racial/ethnic group.

MULTIGROUP ETHNIC IDENTITY MEASURE SCORES

The Multigroup Ethnic Identity Measure (MEIM) was used to measure ethnic identity among youth. It produced an overall score and scores for two subscales: (1) affirmation, belonging, and commitment, and (2) ethnic identity search. For the full sample, the overall mean score was 3.7 on a five-point scale of measurement (1—low endorsement to 5—high endorsement). Mean scores on the subscales were 4.1 for ethnic identity affirmation, belonging, and commitment and 3.1 for ethnic identity search (See Table 7).

Comparison data for the most recent version of the MEIM were difficult to find. A study of 5,423 young adolescents used the MEIM on a four-point scale.³³ Adjusting the overall mean scores in that study to a five-point scale resulted in the following scores: Hispanic/Latino, 3.8; black, 3.8; and white, 3.4. While black youth in CFOMH had slightly higher scores than in the comparison study, scores for Hispanic/Latino youth were the same between the two samples.

31 Kools (1997).

32 See, for example, Yasui, Dorham, & Dishion (2004).

33 Roberts et al. (1999).

There were significant differences between racial/ethnic groups on both subscales and the overall score, controlling for demographics and foster care experiences. Black youth and Hispanic/Latino youth had significantly higher scores than white youth on the ethnic identity search subscale. Black youth had significantly higher scores than Hispanic/Latino youth and white youth on the affirmation, belonging, and commitment subscale and on the overall score. These differences by race/ethnicity are consistent with other research indicating differences in the salience of ethnic identity for youth of color compared to white youth.³⁴

Table 7. Multigroup Ethnic Identity Measure (MEIM) Scores by Race/Ethnicity

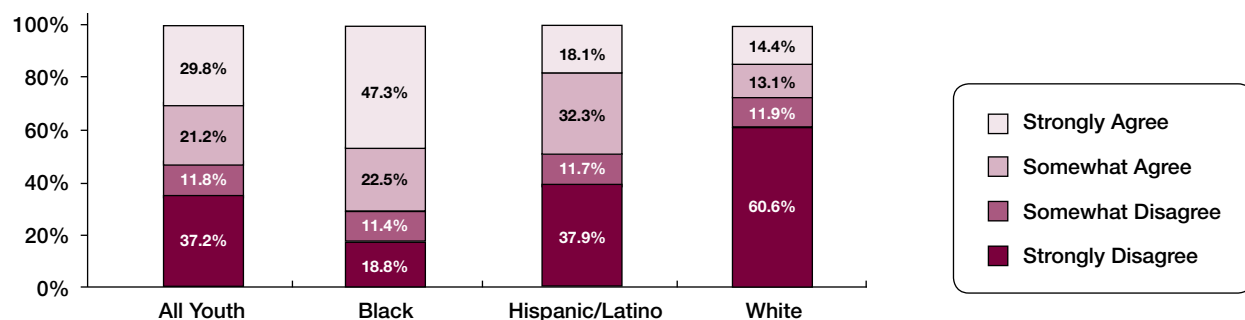
MEIM SUBSCALE	All Youth ^a	Hispanic/Latino	Black	White
Ethnic identity search	3.1	3.3	3.4	2.5
Ethnic identity affirmation, belonging, and commitment	4.1	4.1	4.5	3.8
Overall MEIM score	3.7	3.8	4.1	3.2
Sample size	188	44	79	57
Overall MEIM score in Roberts study (1999)	—	3.8	3.8	3.4
Sample size	5,423	1,008	1,237	755

^a The sample of 188 includes eight youth who were in the “Other” category.

FOSTER PARENTS OF THE SAME RACE/ETHNICITY

Respondents were asked several questions about their experiences in foster care and how they relate to ethnic identity. One question asked participants to state the degree to which they agreed with the statement, “Having foster parents of the same race or ethnicity is important to me.” Overall, about half of the youth (51.0%) somewhat or strongly agreed with this statement. (See Figure 3.) There were significant differences in response by race/ethnicity (controlling for demographics and foster care experiences). Black respondents endorsed this statement to the greatest degree, with 69.8% agreeing or strongly agreeing that they preferred foster parents whose ethnicity was the same as theirs, while white youth endorsed this statement the least, with only 27.5% agreeing or strongly agreeing.

Figure 3. Having foster parents of the same race or ethnicity is important to me.



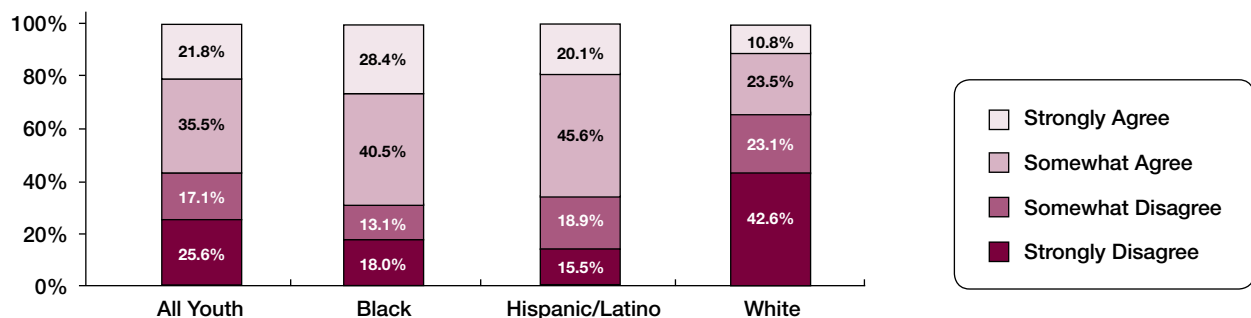
Note: Overall chi-square was test significant at $p < .05$.

Overall, about three quarters of the youth (73.5%) reported having at least one caregiver whose ethnicity was the same as theirs at the time of the interview. There were significant differences by race/ethnicity, controlling for demographics and foster care experiences. The percent of youth who had at least one caregiver who was the same ethnicity as theirs was 86.5% for white youth, 81.1% for black youth, and 45.0% for Hispanic/Latino youth.

ETHNIC TRADITIONS IN FOSTER CARE

Respondents were asked whether they have learned about their ethnic traditions while in foster care. Overall, 57.3% of respondents agreed or strongly agreed that they had. (See Figure 4.) There were significant differences in response by race/ethnicity (controlling for demographics and foster care experiences), with more black and Hispanic/Latino youth stating that they had learned about their ethnic traditions while in care than white youth.

Figure 4. I have learned about my ethnic traditions while in foster care.



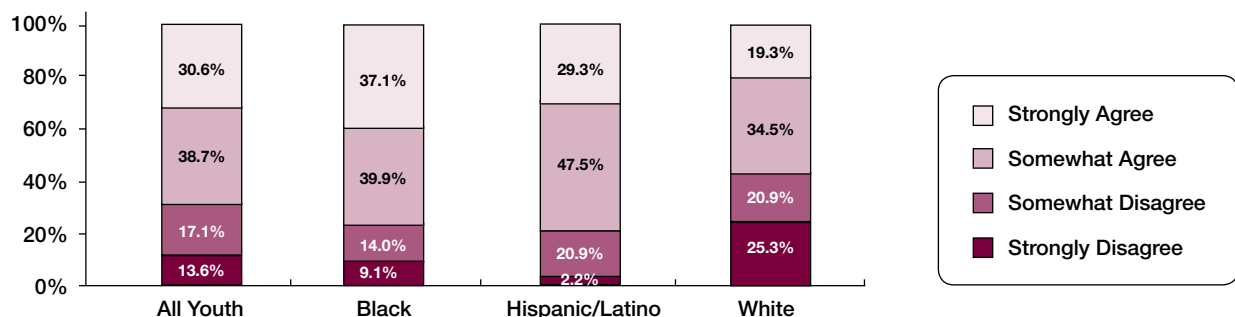
Note: Overall chi-square test was significant at $p < .05$.

Most youth agreed (69.3%) that they would like to learn more about their ethnic background. (See Figure 5.) There were significant differences in response by race/ethnicity (controlling for demographics and foster care experiences), with black and Hispanic/Latino youth endorsing the statement to a greater degree than white youth.

In the youth's words:

"You go to so many foster homes with different races that you start forgetting your own race."

Figure 5. I wish I could learn more about my ethnic background.

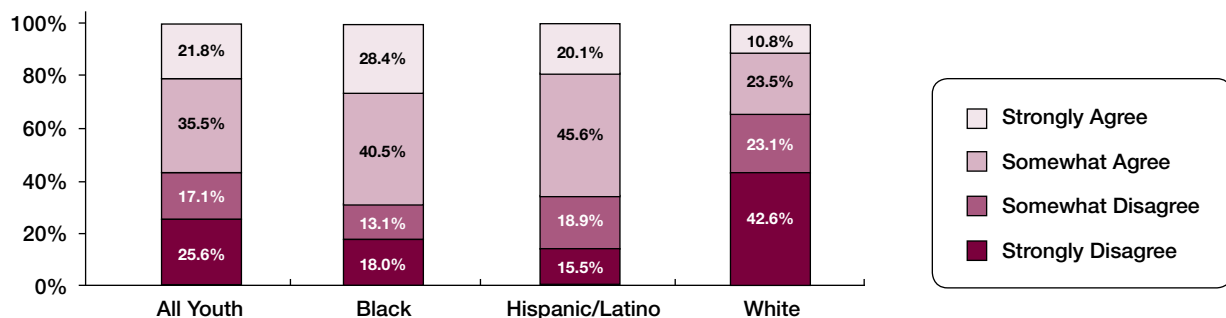


Note: Overall chi-square test was significant at $p < .05$.

ETHNIC IDENTITY DEVELOPMENT IN FOSTER CARE

Overall, about two in five respondents (42.6%) said that it is hard for youth in foster care to develop their ethnic identity. (See Figure 6.) There were significant differences in response by race/ethnicity (controlling for demographics and foster care experiences), with Hispanic/Latino youth endorsing the statement to the greatest degree, followed by black youth.

Figure 6. It is hard for youth in foster care to develop their ethnic identity.



Note: Overall chi-square test was significant at $p < .05$.

Several youth shared how being in foster care has affected relationships with people of their own culture, specifically as relates to language:

In the youth's words:

"If I still lived with my mom and dad, I would probably know how to speak Spanish. Me and my brother are the only ones in my family who cannot speak Spanish."

"I don't speak Cambodian anymore and I did before foster care."

"I don't speak Spanish ... people expect me to be able to."

EXPERIENCES OF DISCRIMINATION

The Experiences of Discrimination scale included eight items: unfair treatment at school; by a doctor; by a counselor; by a judge; by police; experiencing verbal harassment; being made to feel ashamed; and experiencing violence (by someone outside of the foster family). Scores on the measure could range from 1 (never experienced discrimination) to 4 (often experienced discrimination). The mean score among all youth was towards the lower end of the scale (1.25), which indicates youth did not frequently experience discrimination based on race/ethnicity. Significant differences in experiences of discrimination were found between racial/ethnic groups ($p < .05$). Controlling for demographics and foster care experiences, black youth reported the highest degree of discrimination; their scores were significantly higher than both Hispanic/Latino youth and white youth. (See Table 8.)

Table 8. Experiences of Discrimination Scores by Racial/Ethnic Group

RACE/ETHNICITY	Mean score	N
All youth ^a	1.25	188
Hispanic/Latino	1.23	44
Black	1.37	79
White	1.13	57

^a Includes eight youth who are in the “Other” race/ethnicity category.

Youth were also asked about experiences of discrimination specifically related to being a youth of their particular race/ethnicity in foster care. They were asked whether they had experienced (1) rejection or (2) violence from their foster family because of their race/ethnicity. The vast majority of respondents reported never having experienced rejection (97.8%) or violence (98.3%) from their foster family, and there were no significant differences in experiences by racial/ethnic group.

Relation Between Ethnic Identity and Mental Health

Tests were conducted to examine the relation between scores on the Multigroup Ethnic Identity Measure and the presence of a lifetime or past-year CIDI diagnosis. There was a significant relation between scores on the ethnic identity search subscale and presence of a lifetime CIDI diagnosis: controlling for demographics and foster care experiences, higher scores on the ethnic identity search subscale were associated with having at least one lifetime diagnosis. This finding is inconsistent with previous research, which has found that exploring one’s ethnic identity is generally considered to be positive.³⁵

Controlling for demographics and foster care experiences, there was no significant association between scores on the discrimination scale and presence of a lifetime or past-year CIDI diagnosis, meaning that youth who reported having experienced a high degree of discrimination were no more or no less likely to have a mental health disorder than those who experienced a low degree of discrimination.

³⁵ See, for example, Yasui et al. (2004).

V. CFOMH Findings: Gender Identity and Sexual Orientation

Background

An underexplored subpopulation of youth served in foster care is that of lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. While many youth begin to be aware of their gender and/or sexuality at a very young age, it is common for adolescents to be exploring their sexual orientation and possibly be in the process of identifying as lesbian, gay, bisexual, or transgender. Research has found that, in general, sexual awareness begins at an early age, while identifying or self-labeling is a complicated process that often happens in late adolescence to early adulthood.³⁶

Despite the many lesbian and gay adolescents present in the child welfare system, these youth are often an “invisible population,” and this invisibility allows administrators and staff to believe that there are no gay or lesbian young people in their care.³⁷ In addition to the abuse and neglect that may have been perpetrated by their birth families, LGBTQ youth often encounter problems perpetrated by school peers, foster families, and social work staff. For example, in 1994, New York City’s child welfare system reported that over two-thirds of lesbian and gay youth had been victims of violence in the system due to their sexual orientation and seven in ten had tried to hide their sexual orientation from staff and peers out of fear of mistreatment.³⁸

While many public and private child welfare agencies—including Casey—are working to recognize and address the needs of LGBTQ youth, there is still little information about their presence in the system, their experiences in care, and what supports they need and desire. This section of the CFOMH study aimed to explore these areas.

CFOMH Findings

GENDER IDENTITY

All of the respondents reported feeling comfortable with their gender. None identified as transgender, and all of the self-reported gender identities (male, female, intersex, transgender) matched those found in case records. In other words, all youths’ gender identities matched those of their physical or genetic gender. Because no youth identified as intersex or transgender in the study, there are no results presented on gender identity.

SEXUAL ORIENTATION

Ten youth (5.4%) identified their sexual orientation as lesbian, gay, bisexual, or questioning (LGBQ).³⁹ One respondent identified as lesbian (0.5%), one as gay (0.7%), six as bisexual (3.1%), and two as questioning their orientation (1.0%). These percentages are lower than expected, compared to general population statistics. About 4% of adults in the United States age 18 to 44 reported being homosexual (gay or lesbian) and about 5% reported being bisexual; 8% reported being “something else.”⁴⁰ The lower rates in this study are likely due to the young age of the respondents, who ranged in age from 14 to 17. The older youth in the sample were more likely to identify as LGBQ; half ($n=5$) of those who identified as LGBQ were 17 years old and three of the youth were 16 years old. Only one each of the 14 and 15 year olds identified as LGBQ. The median age for identifying sexual orientation to themselves among the youth in this study was 14, with a range of 12 to 17, which means that some of the youth in the sample who identified as heterosexual may later change how they identify their own sexual orientation. Additionally, though

36 Ryan & Futterman (1998); Smith, Dermer, & Astramovich (2005).

37 Mallon (1999).

38 New York City Child Welfare Administration and Council of Family and Child Caring Agencies (1994).

39 The “T” in LGBTQ has been omitted when referring to the youth in this study because no youth identified as transgender.

40 Mosher, Chandra, & Jones (2005).

youth may identify their orientation to themselves at a relatively early age, they often wait to reveal that information to others.⁴¹

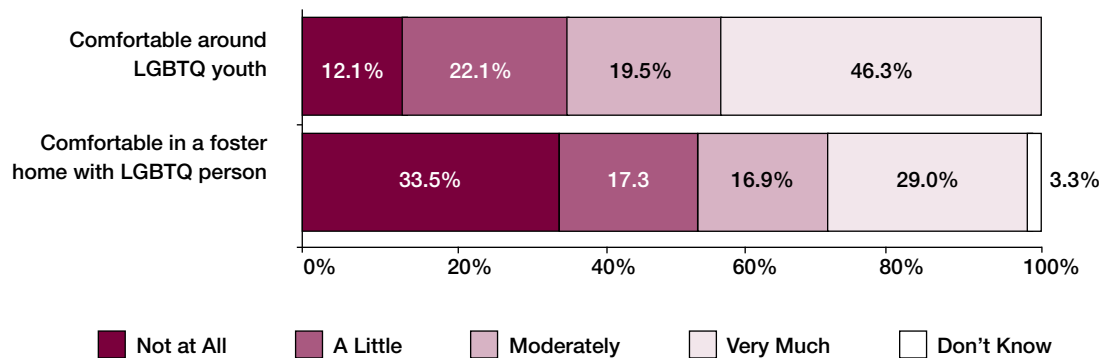
A more substantial percentage (11.5%) of the youth reported having questioned their sexual orientation at some point in their lives. About one-third of the youth (37.1%) who had questioned their sexual orientation said that there was a counselor or therapist available with whom to discuss these issues. About one in five of all youth (18.2%) said that Casey has offered supports and information around the issue of sexual orientation, such as activities, community groups, or counseling.

SUPPORT AND TOLERANCE OF LGBTQ YOUTH

All participants in this study were asked questions about how supportive and tolerant an environment foster care was for LGBTQ youth. While 41.0% of youth did not know if Casey social workers were supportive of LGBTQ youth, half of the youth (50.4%) felt that they were supportive of LGBTQ youth and fewer than one in ten (8.6%) felt that they were only a little or not at all supportive.

Nearly two-thirds (65.8%) of youth said that they felt moderately or very comfortable around other youth who are LGBTQ and nearly three in five youth (57.7%) said that they had an LGBTQ friend while in foster care. Fewer (45.9%) reported feeling moderately or very comfortable being placed in a foster home with an LGBTQ person, however. (See Figure 7.)

Figure 7. Comfort with LGBTQ Youth.



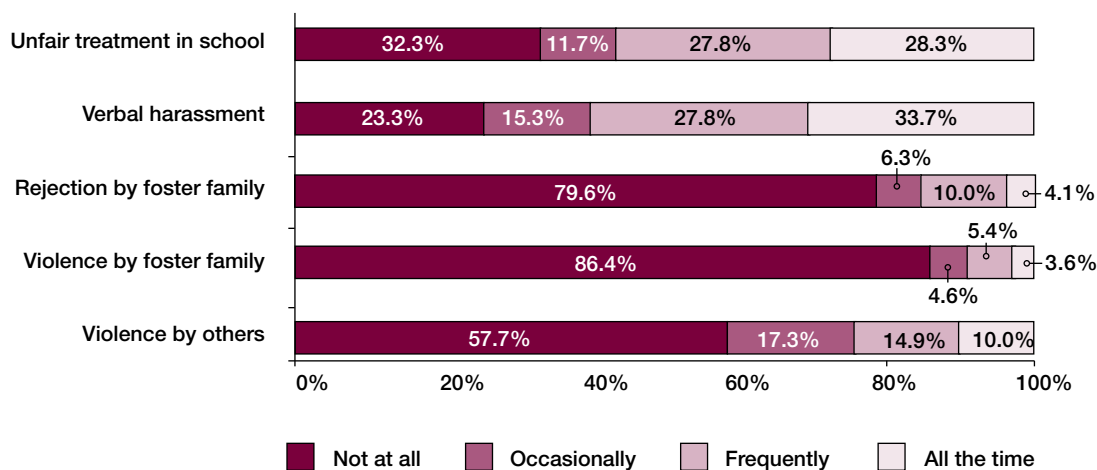
PERCEPTIONS OF DISCRIMINATION TOWARDS LGBTQ YOUTH

Youth were also asked a series of questions regarding their perceptions of discrimination toward LGBTQ youth. Many youth had seen or heard about LGBTQ youth being treated unfairly in school or being verbally harassed by adults or other youth. (See Figure 8.) This is consistent with other research which has found high rates of verbal harassment in the general population. For example, in a 2005 study conducted with LGBT students nationwide, 75.4% reported hearing derogatory remarks related to sexual orientation, and in a study with general population students, 62.5% reported the same.⁴² Over two in five (42.3%) Casey youth had seen or heard about an LGBTQ youth being the target of violent behavior by someone other than a foster family member. Some had seen or heard about an LGBTQ youth having faced rejection (20.4%) or violence (13.6%) in their foster family.

41 D'Augelli, Grossman, & Starks (2006).

42 Kosciw & Diaz (2006).

Figure 8. Perceptions of Discrimination towards LGBTQ Youth.



Subgroup Analyses

Since the sample of LGBTQ youth in this study was small ($n=10$), conducting generalizable analyses was not possible. However, the following is a descriptive analysis of the experiences of the ten LGBTQ youth.

OPENNESS TO SHARING SEXUAL ORIENTATION

All ten youth who identified as LGBTQ reported that they had felt the need to hide their sexual orientation at some point in their lives. Reasons for this included:

- » Thinking people would neither understand nor accept them
- » Fear of being judged or ridiculed
- » Fear of being the victim of violence
- » Having not identified orientation to him/herself

In the youth's words:

"I felt I had to hide [my sexual orientation] at school because I noticed that some of the students were being beaten up by other students because they were gay or bisexual."

The youth were very open about their sexual orientation with their peers, but less so with parents and other adults. Almost all (9 of 10) of the LGBTQ youth said that at least some of their friends and other students at school knew their sexual orientation and all of these youth were comfortable with their peers knowing. Only four, however, said that their social workers knew; eight of the youth were or would have been at least a little comfortable with their social workers knowing their sexual orientation. Only four of the LGBTQ youth had told their birth parents. Two youth reported feeling not at all comfortable with their mothers knowing their sexual orientation, while six felt not at all comfortable about their fathers knowing. This is consistent with other research that found many more LGBTQ youth disclosed their sexual orientation to their mothers than their fathers.⁴³

In the youth's words:

"[I hid my sexual orientation because] I thought people would make fun of me, but everybody is cool with it."

SUPPORTS FOR LGBTQ YOUTH

Providing support to LGBTQ youth can be challenging for several reasons, including a lack of recognition or acknowledgment by social workers of the LGBTQ presence in the foster care system and the reluctance of many youth to “come out” in foster care.⁴⁴ Casey has put an emphasis on supporting and nurturing LGBTQ youth in its care. The majority (eight of ten) of youth felt that Casey social workers are supportive of LGBTQ youth needs and know where to refer them for services. Four of the eight youth who had “come out” while in Casey care, however, felt strongly that Casey social workers were *not* supportive during their coming out period. This could be due to a lack of awareness that youth were going through such a period or perhaps that staff were not equipped with the resources or knowledge they needed to support the youth. More youth felt that their foster family was supportive during their coming out period (six of eight). Only three of the ten youth said that their foster family had received any services to learn how to support them as an LGBTQ youth. Only one youth reported wanting to have this available to his or her family, however.

EXPERIENCES OF DISCRIMINATION BASED ON SEXUAL ORIENTATION

Few LGBTQ youth reported having experienced discrimination because of their sexual orientation. (See Table 9.) Some had been made to feel ashamed or been the victim of verbal harassment. None of the LGBTQ youth reported experiencing violence by anyone because of their sexual orientation.

Other studies show much higher rates of discrimination. For example, a study of 954 LGBT adults in Philadelphia found that 31% of gay men and 29% of lesbian women reported experiencing harassment or physical violence from family members on the basis of their sexual orientation; this difference could be partially attributable to the older age of participants.⁴⁵ A nationwide study found that over one in three (37.8%) LGBTQ adolescents experienced physical harassment at school and nearly one-fifth (17.6%) had been physically assaulted at school because of their sexual orientation. Gender expression was also a reason for physical harassment (26.1%) and physical assault (11.8%) at school.⁴⁶

Almost all of the Casey LGBTQ youth in this study (nine in ten) felt comfortable with their sexual orientation and did not feel that they had unique needs because they were LGBTQ.

Table 9. Experiences of Discrimination by LGBTQ Youth^a

DISCRIMINATION ITEM	Never (n)	Rarely (n)	Sometimes (n)
Unfair treatment in school	8	2	0
Unfair treatment by doctor	9	1	0
Verbal harassment	7	3	0
Made to feel ashamed	6	2	2
Rejection by foster family	9	1	0
Sample size	10		

^a “Often” was a response category, but was not endorsed for by any youth for any of these items.

44 Mallon (1999); Ryan & Futterman (1998); Woronoff, Estrada, & Sommer (2006).

45 Gross, Aurand, & Address (2000).

46 Kosciw & Diaz (2006).

One recommendation for supporting LGBTQ youth in foster care is to place them in homes with LGBTQ caretakers. Interestingly, only four of the ten Casey LGBTQ youth reported feeling that this was important to them; five felt strongly that it was not important to have an LGBTQ caretaker.

Relation Between Gender Identity and Sexual Orientation and Mental Health

Due to the small sample of LGBTQ youth in the current study, drawing conclusions about the relation between sexual orientation and mental health was not possible. While very little research exists on the mental health of LGBTQ youth in foster care, research on LGBTQ youth in the general population shows that these youth are more likely to experience sexual, verbal, and physical abuse; this victimization has been linked to higher rates of PTSD.⁴⁷ Suicide rates and attempts as well as alcohol use and depression have been found to be higher for LGBTQ youth than heterosexual youth.⁴⁸ Some research has found that lesbian, gay, and bisexual adults in the general population are at higher risk of experiencing mental health problems than those who identify as heterosexual,⁴⁹ while other research has not found a difference between the two groups.⁵⁰

The LGBTQ youth in this study reported hiding their sexual orientation and worrying about being rejected or ridiculed by others because of their orientation. Other research with larger samples has also shown high rates of these types of stresses in the daily lives of LGBTQ youth, which could potentially lead to mental health problems.⁵¹

Research has also shown that the developmental trajectories of LGBTQ youth are not uniformly slower or quicker than heterosexual youth.⁵² It is important to consider lesbian, gay, bisexual, transgender and questioning youth as unique, and not simply part of one LGBTQ group.⁵³ Their physical, emotional, and psychological experiences will differ based on their individual development; thus, mental health assessments should be conducted taking this into consideration.

The frequent placement changes, school changes, and other instability that comes with being in foster care, paired with the stress and victimization that LGBTQ youth often experience, could have a unique effect on the mental health of these youth. In-depth research on a sizeable sample of LGBTQ youth in foster care is necessary to determine what role, if any, gender identity and sexual orientation play in the mental health of this particular population.

47 D'Augelli et al. (2006); Saewyc et al. (2006).

48 Galliher, Rostosky, & Hughes (2004); Goodenow (2005).

49 Cochran & Mays (2000a, 2000b); Meyer (2003).

50 Hooker (1993).

51 D'Augelli et al. (2006); Meyer (2003); Ryan & Futterman (1998).

52 Picavet (2005); Savin-Williams & Ream (2006)

53 Picavet (2005).

VI. CFOMH Findings: Spirituality

Background

Spirituality is an important facet of life for people in diverse communities in the United States and around the world. While no universal definition exists, spirituality is commonly cited as complementary to physical and mental health, beneficial for well-being, and interlinked with culture, ethnic heritage, and racial/ethnic identity.⁵⁴

The degree to which spirituality is an important part of life for youth in foster care is an understudied area of research. The purpose of this portion of the study was to explore what youth believe and how they feel about spirituality, what spiritual activities youth participate in, coping mechanisms, and the relation between spirituality and mental health.

CFOMH Findings

SPIRITUAL BELIEFS

The vast majority of youth in the CFOMH study (94.6%) said they believe in God, a Creator, or a Higher Power. This is comparable to the

percentage reported of adolescents in the general population, in which belief in God is estimated at 95%.⁵⁵

Youth defined “God/Creator/Higher Power” in ways that reflect many religious traditions. The most commonly reported descriptions were Creator (77.9%), Love (71.7%), and Protector (55.5%). Other commonly endorsed descriptors included Father (47.9%), Part of Themselves (46.4%), and Teacher (42.3%).

Spirituality is often measured by whether people believe in God, how often they attend religious services, or what their religion is.⁵⁶ The CFOMH study was more inclusive in the measurement of spirituality. Youth were asked, “What, if anything, do you consider spiritual?” Even though this study did not confine spirituality to the traditional religious interpretations, the most common responses from youth were traditional, such as belief in a God, a Creator, or a Higher Power (86.6%), prayer (78.7%), and “worshipping with a community of people with similar beliefs” (45.3%). (See Table 10.)

Table 10. What Youth Consider “Spiritual”

ITEM	Percent
Belief in a God, a Creator, or a Higher Power	86.6
Prayer	78.7
Worshipping with a community of people who have similar beliefs	45.3
Poetry/spoken word	26.2
Being inspired	23.7
Belief in a spiritual connection between all human beings	23.6
Sample size	188

54 Cross (2002); DiLorenzo & Nix-Early (2004); Haight (1998); Pearce et al. (2003); Rodriguez (2002); Witvliet (2001).

55 Cotton, Zebracki, Rosenthal, Tsevat, & Drotar (2006); Pearce et al. (2003).

56 Smith, Denton, Faris, & Regnerus (2002).

SPIRITUAL AND POSITIVE ACTIVITIES

Little is known about how adolescents express spirituality in their everyday lives. Among youth in the general population, about 50% attend religious services at least once a month and frequently pray alone, and 85 to 95% of youth say religion is important in their lives.⁵⁷

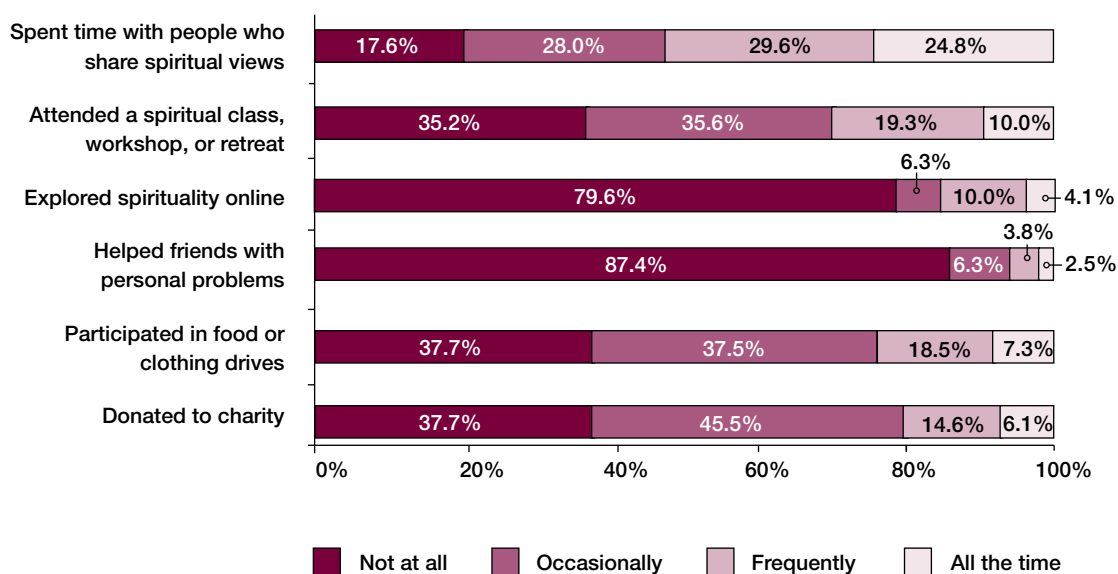
In the current study, most youth (87.7%) participated in spiritual activities at least once during the past year. About one in four youth (24.9%) participated in spiritual activities two or three times a week or more, slightly less than one in five (18.7%) participated once a week, one in four (24.1%) participated one to three times per month, and one in five (20.0%) participated only one to three times during the past year.

Over half of youth (54.4%) frequently or always spent time with others who share their spiritual beliefs, while three in ten (29.3%) attended spiritual classes, workshops, or retreats frequently or all the time. (See Figure 9.)

In the youth's words:

"Introduce me to people who have my beliefs."

Figure 9. Participation in Spiritual and Positive Activities.



⁵⁷ Cotton et al. (2006); Wilson, Carraway-Wilson, & Jackson (2005).

In addition to spiritual activities, youth participated in a number of positive activities. Most youth were engaged in other positive activities frequently or all the time, including:

- » 67.5% helping friends deal with personal issues
- » 25.8% assisting with community food or clothing drives
- » 20.7% making donations to charity

The vast majority (90.6%) of adolescents in this study found spirituality helpful, and more than four in five (82.5%) specifically said that spiritual activities helped them in their daily lives.

In the youth's words:

"I honestly don't think that there's anything anyone could do to help with [my spirituality] because I'm the kind of person who likes to find things out for myself and make up my own mind."

SPIRITUAL AND OTHER COPING MECHANISMS

Whether aspects of spirituality act as protective factors in young people's most difficult times is an important unanswered question. Youth are faced with the challenging, normative tasks of adolescent development, such as developing a greater sense of autonomy and self-efficacy; making meaning of life's circumstances; and identity development.⁵⁸ Yet youth in foster care may also

be grappling with issues associated with separation and loss; child abuse and re-victimization experiences; rejection; isolation; and stigma or additional positive and negative stressors associated with living in a foster home or transitioning to independent living.⁵⁹

More than half of the youth in this study reported feeling that their lives were filled with stress and anxiety—38.3% occasionally, 14.3% frequently, 4.4% all the time—and just under half (46.4%) said they occasionally, frequently, or always struggled to understand evil, suffering, and death. These results indicate the importance of youth having consistent access to spiritual and other supports they feel positive about as they face challenges that may be severe and are often unpredictable.

Table 11 shows a breakdown of coping mechanisms youth in this study employ when bad or tragic things happen in their lives, some of which are related to youth's definitions of spirituality as reported in Table 10. Over two in three youth (67.4%) reported spending time by themselves. More than half cope through prayer or sharing with others (58.9% and 55.9%, respectively). Few youth reported engaging in potentially harmful coping mechanisms: 12.5% reported underreating, 9.4% reported overeating, 7.2% become aggressive, 5.0% use drugs or alcohol, and 2.0% said they do harm to themselves.

Table 11. Coping Mechanisms when Something Bad or Tragic Happens

COPING MECHANISM	%	COPING MECHANISM	%
Spend time alone	67.4	Ask a spiritual leader for advice	23.3
Pray	58.9	Not eat enough	12.5
Share the problem with someone	55.9	Eat too much	9.4
Write in a journal or diary	35.5	Meditate	7.4
Do something creative	33.2	Get aggressive	7.2
Exercise	30.5	Use alcohol or drugs	5.0
Ignore it	28.6	Hurt myself in some way	2.0
Sample size	188	Sample size	188

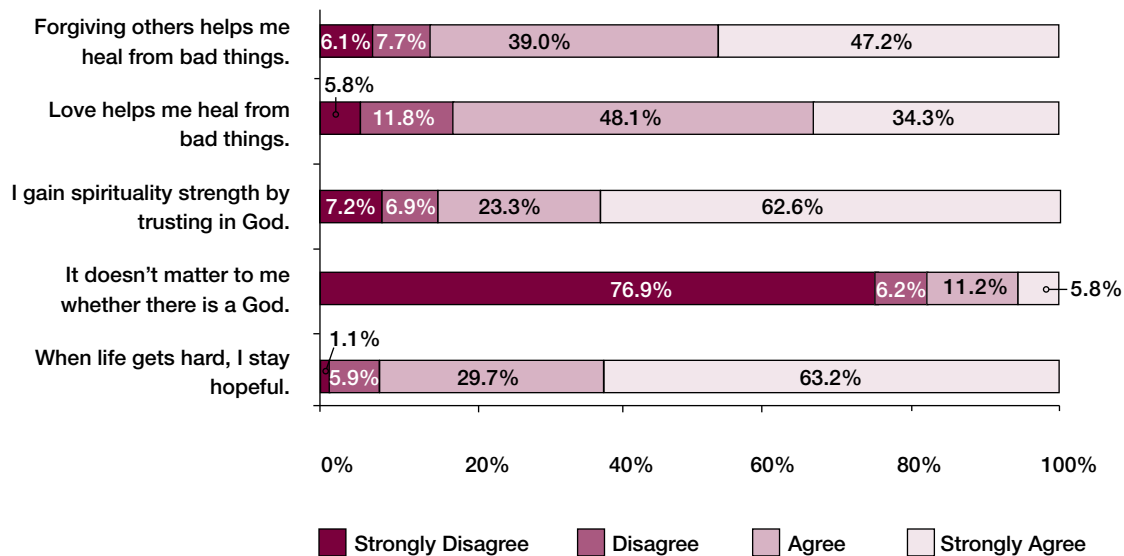
58 Wilson et al. (2005).

59 DiLorenzo & Nix-Early (2004); Edmond et al. (2006); Hochman et al. (2004); Howe & Fearnley (2003); Rest & Watson (1984); Rushton & Dance (2003).

THE ROLE OF SPIRITUALITY IN YOUTH'S LIVES: BELIEFS, THOUGHTS, FEELINGS AND GOALS

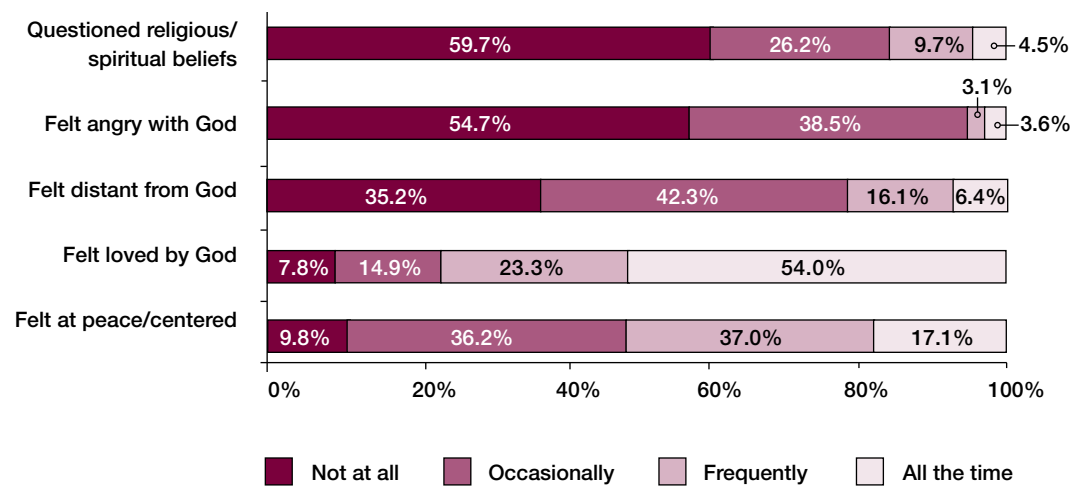
In spite of any hardships these youth may have faced, they appear fortified by their spiritual base. (See Figure 10.) More than four in five youth somewhat or strongly agreed with the statements, “Forgiving others helps me heal from bad things” (86.2%); “Love helps me heal from bad things” (82.3%); and “I gain spirituality strength by trusting in God, Creator, or Higher Power” (85.9%). Most youth (83.1%) somewhat or strongly disagreed with the statement, “It doesn’t matter to me whether there is a God, a Creator, or a Higher Power.” Over nine in ten (93.0%) somewhat or strongly agreed with the statement, “When life gets hard for me or others, I stay hopeful.”

Figure 10. Selected Spiritual Beliefs.



Youth were asked to indicate the frequency with which they experienced select thoughts and feelings in the past year. (See Figure 11.) A small proportion of youth (6.7%) felt angry with God “frequently” or “all the time” in the past year. Relatively small proportions of youth questioned their religious or spiritual beliefs (14.2%) or felt distant from God (22.5%) “frequently” or “all the time.” Just under half of youth (45.9%) felt at peace or centered “not at all” or “occasionally” in the past year.

Figure 11. Selected Thoughts and Feelings about Spirituality in the Past Year.



Youth were asked to describe what their ultimate spiritual goal was. The vast majority of youth chose a response (only 6.7% reported not having an ultimate spiritual goal). The top three spiritual goals for these youth were: 1) To follow God, a Creator, or a Higher Power (34.4%); 2) to become a better person (23.6%); and 3) to know their purpose in life (14.5%).

Relation Between Spirituality and Mental Health

Analyses were conducted to examine the relation between Belief in a God, a Creator, or a Higher Power and mental health (past-year and lifetime) diagnoses controlling for demographics and foster care experiences. Results revealed no significant differences in mental health between youth who expressed a belief in God, a Creator, or a Higher Power, and youth who did not hold this belief. This is in line with results from a study of adolescent girls who had been sexually abused and were living in foster care, which found no significant relation between religiosity (religious membership and attendance) and mental health and behavior outcomes.⁶⁰ In a study of adolescents, Pearce, Little, and Perez (2003) found that religious attendance, private religious practice (e.g., prayer), and self-ranked religiousness and spirituality did not have a statistically significant effect on depressive symptoms.⁶¹ A study of adolescents in the general

population in Ontario, Canada, however, found that adolescents who attended church once a week or more used substances (i.e., alcohol, cigarettes, and marijuana) to a lesser degree and had stronger interpersonal relationships than youth who never attended church.⁶²

Many of the youth in CFOMH reported healthful coping practices, as presented in Table 11. It may be that those behaviors are as effective as belief in God (regardless of definition) in protecting youth against mental health problems. It also may be that youth whose problems persist despite strong faith and healthful practices have experienced more trauma, stress, or victimization; have more severe/resistant mental health problems; have not received necessary services or supports; or have a greater number of co-occurring mental health problems.

60 Edmond et al. (2006).

61 Pearce et al. (2003).

62 Good & Willoughby (2006).

VII. Policy, Program, and Research Recommendations

Mental Health

While the rate of lifetime mental health diagnoses among youth in this study is high, it should be noted that nearly two-thirds of youth had no past-year mental health diagnosis. In fact, the percent of youth with at least one past-year diagnosis was similar to what was found in the general population. This finding highlights the importance of not assuming all youth in foster care have mental health problems. It also highlights the importance of ensuring that all youth in foster care are regularly assessed for mental health problems, given their high rate of lifetime diagnoses and evidence from alumni studies of struggles after emancipation.

Recommendations related to mental health include the following:

1. Regularly screen youth in foster care for mental health disorders and provide effective mental health treatment to youth who need it.

Results indicated that a high number of youth have struggled with certain internalizing and externalizing disorders. While externalizing disorders, such as oppositional defiant disorder and conduct disorder, are more visible to others and therefore more likely to be identified, the high percentage of youth who have struggled with internalizing disorders, such as major depressive disorder, major depressive episode, panic attack, and PTSD, indicates that many youth in care may need treatment for these disorders. Staff in Casey field offices reviewing study findings suggested that the rates of mental health disorders found in CFOMH may actually be an undercount. Discreet screenings should be administered regularly to all youth in care, and full assessments should be provided to those

who need them. The Warning Signs Project, which was developed for use by parents, educators, and health professionals, is an example of a quick screener for emotional and behavioral problems among children and youth.⁶³ The Peabody Treatment Progress Battery provides a cohesive set of short, reliable instruments to assess clinical processes and mental health outcomes for youth between age 11 and 18.⁶⁴ Additionally, a number of state mental health and child welfare agencies are implementing standardized mental health screeners.⁶⁵

2. Pay particular attention to internalizing disorders among female youth in care.

Females were significantly more likely to have internalizing disorders, including depression, panic attack, and PTSD. While this is consistent with general population data (and may partially be due to gender differences in the reporting of mental health symptoms), it indicates that social workers may need to pay particular attention to these types of disorders when working with female youth.

3. Explore why lifetime rates of diagnoses were higher than past-year diagnoses for many disorders.

Rates of mental health diagnoses were significantly higher in the CFOMH sample compared to the general population for 9 of 21 lifetime diagnoses but for only 3 of 20 past-year diagnoses. This suggests that, although youth in foster care may have had numerous mental health disorders in the past, many are not currently struggling with a mental health disorder. It may be that youth's lives have stabilized since being placed with Casey, given the nurturing and protective environment of their foster families. Youth may experience a recurrence of a mental

63 See Jensen et al. (undated). For more information about screening for behavioral problems, see Bergman (2004).

64 For information about the Peabody Treatment Progress Battery (PTPB), visit the PTPB Web Site at peabody.vanderbilt.edu/ptpb.xml.

65 Visit the Reach Institute (Resource for Advancing Children's Health) Web site at www.reachinstitute.net for mental health screening tools.

health disorder as they prepare to leave care or after they leave care, however. Alternatively, the discrepancy in lifetime and past-year rates may be due to other factors such as an initial “honeymoon” period, during which youth mental health improves temporarily. Future analyses should compare when placement with Casey was made and when recovery occurred to identify factors associated with recovery.

4. Provide training on mental health disorders to foster parents and social workers.

Well-trained foster parents and social workers are able to discern typical from atypical adolescent behavior, and can be an ally in ensuring that youth receive mental health treatment when needed. Social workers and families can assist children and youth in grieving, developing relationships with other people, and strengthening their personal identity through programs such as the 3-5-7 Model, which helps prepare for permanency in a family.⁶⁶ The Los Angeles Unified School District is training school social workers and school counselors to provide a trauma treatment intervention via groups within schools during the school day.⁶⁷ For youth who have externalizing behavior disorders, caregivers trained in behavior management, such as through the Oregon Multidimensional Treatment Foster Care model, may be most effective.⁶⁸

5. Empower youth and foster parents to advocate for mental health services.

Informed and empowered youth and foster parents can more effectively advocate for mental health services. Programs with potential, such as Parent Engagement and Self-Advocacy (PESA) and Youth Empowerment (the “Tak-

ing Control” groupwork curriculum), are being implemented and evaluated to determine their effectiveness.⁶⁹ If these programs are found to be effective in helping youth in foster care obtain the mental health treatment they need, they should be expanded.

6. Help youth in care and alumni of care who are doing well to keep doing well.

Nearly two in three youth in the current study and almost half of the alumni in the Northwest Study had no past-year mental health diagnosis. Support should be provided to these youth and alumni to help them continue to do well. Although the youth or alumnus may not be currently experiencing a mental health disorder, it is probable that they still must grapple with the difficult experience of maltreatment by and removal from their biological family. All youth in care should be provided mechanisms for coping with these experiences and should know how to access services if mental health problems arise. Additional types of support could involve mentoring, informal support groups, and assistance with extracurricular activities that the youth enjoy. One program with the potential to help alumni of care succeed is A Home Within, a San Francisco-based agency, which provides trained mentors to youth who are about to leave foster care. Focusing on the youth’s strengths, mentor and youth meet weekly for a year to discuss career plans, educational plans, and personal goals.⁷⁰

7. Ensure that alumni of foster care have access to effective mental health services.

For many diagnoses, rates among alumni in the Northwest Study were three to five times those of youth in the current study. This pattern of

66 The 3-5-7 Model consists of three components: completing three “tasks” (e.g., developing an understanding of one’s life events), answering five questions (e.g., “What happened to me?” to explore loss), and using seven elements that are considered critical to preparing children for permanency (e.g., creating a safe space for the child to go through the process). See Henry (2005) for more information.

67 Stein et al. (2003).

68 Chamberlain (2003).

69 For training materials to help caregivers and youth advocate regarding mental health, visit the Reach Institute (REsource for Advancing Children’s Health) Web site at www.reachinstitute.net.

70 For more information, visit A Home Within’s Web site at www.ahomewithin.com.

results suggests that alumni of foster care may be more at risk for mental health problems than youth still in care, possibly because unresolved issues surface in the uncertain years after emancipation or because they face difficult experiences as they leave care, such as joblessness and homelessness. Alumni of foster care need access to effective mental health services, perhaps even to a greater degree than youth still in care given the high rates of mental health disorders found in alumni studies. Chafee Medicaid waivers allow alumni of foster care access to mental health treatment until the age of 21. More effort should be made to encourage use of these benefits and to extend the age of eligibility until age 25 or older. Support services to help stabilize educational, vocational, and economic aspects of their lives could also improve the mental health of alumni.

8. Replicate the current study among youth served in public agencies.

The current study interviewed youth served through Casey, whose experiences may be significantly different from those of youth served in public agencies. As such, the findings reported here may not be generalizable to the national population of youth in foster care. Replicating the current study nationally with a larger sample would allow examination of regional differences and a more thorough examination of subgroups (e.g., LGBTQ youth in care; see below).

Ethnic Identity

The results of this study suggest that youth of color, particularly black youth, are more cognizant of their ethnicity and its implications than white youth. White youth reported lower rates of interest in learning about their ethnic identity. They also placed less emphasis on whether or not their foster parents' race or ethnicity was the same as

theirs. This may be partly due to the fact that they do not often experience transracial placements. In contrast, youth of color are much more likely to be placed transracially where ethnic identity is often not addressed. Youth of color are also exposed to negative media stereotypes that are often echoed by teachers, social workers, and the general public, making them more aware of the implications of their race/ethnicity than white youth.

Some alumni of care have suggested that they receive more discrimination based on being in foster care than based on their race or ethnicity. Others have experienced discrimination from both people of their own culture and people from different cultures. For example, a Hispanic/Latino youth living with a white family may experience discrimination from other Hispanic/Latino people because she does not speak Spanish well and lives with a white family, while simultaneously feeling excluded from the white community because of her Hispanic/Latino background.

Recommendations related to ethnic identity include the following:

1. Ensure that youth in foster care have multiple opportunities to explore and develop their ethnic identity.

This research highlights the importance of ensuring that all youth in foster care are offered opportunities to develop their ethnic identity. Discovering and promoting ways to nurture positive ethnic identity development of youth in foster care could provide them with a means to cope with challenges in their lives (such as the trauma associated with child maltreatment, frequent placement and school changes, and discrimination experienced in the broader social environment). In particular, youth should be provided with skills to address racial and ethnic discrimination in society. Youth leadership trainings focusing on diversity and anti-rac-

ism, such as Anytown Arizona and Freedom School, can be useful in providing youth with tools to deal with racism while building cultural competency and increasing youth's sense of personal empowerment.⁷¹ For some youth who have been removed from their culture through placement in foster care, staff and foster parents should be sensitive to the fact that reintroducing the youth to the culture could bring back painful feelings of the loss they experienced through removal from their biological family.

2. Recruit foster parents of diverse racial and ethnic backgrounds.

To better reflect the population of youth in foster care, recruitment of foster parents should focus on people of diverse racial and ethnic backgrounds. Although not all youth agreed that placement with a foster parent of the same race/ethnicity is important, it may be helpful in promoting ethnic identity development and would be helpful to have as an option. Less than half of Hispanic/Latino youth reported being currently placed with a foster parent of the same race/ethnicity, yet three in four said they wished they could learn more about their ethnic background and three in five said it was hard to develop their ethnic identity while in foster care. Several youth noted that they did not speak Spanish, yet wished they could. Additionally, it would be beneficial to youth to have mentors from similar backgrounds for placements in which the race/ethnicity of the foster parent does not match that of the youth. This could alleviate the potential disconnect with one's own race/ethnicity.

3. Provide training on ethnic identity development to foster parents and staff.

Teach foster parents, social workers, teachers, and mental health practitioners how to explore their own ethnic identity and awareness of prejudices so they can create a supportive environment for the youth to engage in similar exploration. Foster parent training should include curriculum on diverse identities and healthy identity development, and effective communication with children and adolescents. Social workers can encourage foster families to engage youth in nonjudgmental conversations about youths' ethnic, cultural, spiritual, and religious backgrounds.⁷² Workshops such as Undoing Racism and curricula such as Knowing Who You Are (which includes a video, e-learning, and in-person trainings) can be beneficial in training foster parents and staff to best serve youth of all backgrounds.⁷³ It is also useful for staff to attend diversity trainings alongside youth.

4. Conduct studies on American Indian and Alaska Native youth and Asian American and Pacific Islander youth in care to examine their unique needs and experiences in foster care.

The sample size in the current study was far too small to be able draw any conclusions about American Indian and Alaska Native or Asian American and Pacific Islander youth in foster care. Future studies should include a sufficient sample size of youth in these groups to thoroughly examine their mental health, ethnic identity, gender identity and sexual orientation, and spirituality. Survey questions may need to be tailored to ensure that they are culturally appropriate for each group.

71 For more information about Anytown Arizona, see www.anytownarizona.org. For information about Freedom School, go to www.pisab.org and click on Programs and Services.

72 DiLorenzo & Nix-Early (2004).

73 The People's Institute for Survival and Beyond (2006); Casey Family Programs (2007).

Gender Identity and Sexual Orientation

Although the number of youth in this study who identified as LGBQ was small, important recommendations can be drawn from the results. Additionally, beliefs expressed by heterosexual youth provide insight for practice. The smaller than expected number of LGBQ youth in this study could be due to both the young age of the sample and the hesitancy of youth in foster care to identify as LGBQ to anyone because of fears of reprisals, rejection, and harassment.⁷⁴ Nearly all of the LGBQ youth were comfortable with their sexual orientation, felt supported, and did not view themselves as having any unique needs. They did, however, feel undersupported in their coming out process. It was important to LGBQ youth in this study to be accepted and supported by their foster families, but not necessarily placed in homes with LGBQ caretakers.

The perceptions of all CFOMH adolescents about discriminatory behavior toward LGBQ youth were consistent with the relatively high rates found in other studies. Most youth had LGBQ friends while in foster care and felt comfortable around LGBQ youth. Fewer were comfortable living with an LGBQ person in their home, however. This raises the question of the extent of acceptance and comfort with LGBQ youth within foster homes and the ability to provide them with the safe, stable, and accepting homes that they need.

Recommendations related to gender identity and sexual orientation include the following:

1. Ensure that all youth in care feel accepted—whatever their gender identity or sexual orientation may be.

All of the LGBQ youth felt the need to hide

their sexual orientation at some point, and many said this was because they feared not being accepted. This illustrates how important it is for foster care agencies, social workers, foster parents, and all other important people in a youth's life to be clear in their acceptance of a youth's gender identity or sexual orientation.⁷⁵ This can be done in many ways. Staff and foster parent training is critical, as is choosing appropriate placements (e.g., is the family comfortable with an LGBQ youth?). Using physical office space to display supportive LGBQ-friendly reading material and posters can be a way of making youth feel comfortable and safe. Providing some concrete examples and experiences of LGBQ role models or mentors in the youth's life, such as adult friends, social work staff, and other youth who have come out can be indicators to youth that it is "okay" to be LGBQ. The GLBT Youth Support project offers training in how to support GLBT youth and their families to schools and agencies serving youth.⁷⁶ Finally, if appropriate, discussing with youth how they would like their "coming out" process to happen is important in making youth feel safe.

2. Teach all youth to accept and support LGBQ youth.

Organizations such as the Safe Schools Coalition (www.safeschoolscoalition.org) and Parents, Families and Friends of Lesbians and Gays (PFLAG; www.pflag.org) offer materials and resources that are helpful in educating all youth to be supportive of LGBQ youth. Additionally, student organizations such as the Gay-Straight Alliance (GSA; www.gsanetwork.org) encourage acceptance of LGBQ students by peers and staff and can advocate for school policies that are supportive of LGBQ students. Where they don't exist, these types of organizations should

74 Woronoff et al. (2006).

75 The National Court Appointed Special Advocate Association has created an annotated bibliography with resources (Resources for Working with Lesbian, Gay, Bisexual, Transgender and Questioning Youth and Families in the Foster Care System). Contact the National CASA at nationalcasa.org.

76 For information about the GLBT Youth Support project, visit www.hcsm.org/glys/glys.htm.

be fostered. The National School Climate Survey found that LGBT students in schools with a GSA were more likely to feel safe, to attend class, and to feel a sense of belonging at school than those who did not have a GSA.⁷⁷

3. Conduct further research on LGBTQ youth in foster care to document their experiences and identify how they can be supported in the child welfare system.

More extensive research should be conducted on LGBTQ youth in foster care. An in-depth study should be done with a larger sample to more deeply investigate their experiences and needs in the foster care system, specifically focusing on the unique challenges that these youth may face. Additionally, some of the findings from this exploratory study invite further investigation, such as why many youth reported being comfortable around LGBTQ peers, but not feeling comfortable being placed in a home with an LGBTQ person. It could also be helpful to know how comfortable heterosexual youth would feel being placed with lesbian or gay foster parents.

Spirituality

Spirituality is an important part of life for many youth in foster care. Discovering and promoting ways to nurture the spirituality of youth in care could provide them with a means to cope with challenges in their lives. Results show that youth in foster care find strength and support for healing in their spiritual beliefs, spiritual practices, and spiritual communities. Second, spirituality is defined in multiple ways. Although there are numerous ways to define spirituality, most youth embraced a view of spirituality that includes reverence for God, a Creator, or a Higher Power as a source of protection, love, and fulfillment.

Recommendations related to spirituality include the following:

1. Purposefully inquire about spirituality, religion, and culture.

The outcomes of this study show that many youth in foster care find strength and support for healing in their spiritual beliefs, spiritual practices, and spiritual communities. Social workers and other direct-service staff should build knowledge of diverse spiritual practices, religious beliefs and norms, and cultural backgrounds. Assessment tools that incorporate these aspects of spirituality can be helpful for learning more about individual youth and their families of origin, and also for improving the match between youth, foster families, and potential mentors. Alumni of foster care have noted that many youth in care change religions every time they move to a new foster home; it could be helpful to consider youth's spiritual beliefs when making placement decisions.

2. Integrate spirituality into casework.

Agencies and social workers should be equipped to support youth who find spirituality helpful. Spiritual resources should be developed and referrals and supports should be offered to youth in the same manner as are other supports and services. Because of the diversity of beliefs and practices, social workers can be trained to encourage foster families to engage youth in nonjudgmental conversations about youths' spiritual and religious backgrounds.

3. Help youth experience spiritual activities positively.

Youth should be supported by workers and foster families to continue, and perhaps increase, their participation in communities that share their spiritual and religious values and beliefs. Youth should also be encouraged to engage in

coping mechanisms and other activities that they find helpful for reducing stress and understanding their life experiences. Because some populations have been excluded from participation in religious or spiritual and social groups due to aspects of their identity (such as sexual orientation, race, ethnicity, or religious background), some youth may need additional help finding faith-based and social organizations where they feel welcome and strengthened. It is also important for social workers to consider what supports and resources a young person might need to participate in spiritual activities as often as they wish. This may include assistance with transportation, which was cited as a barrier to involvement.

VIII. Conclusion

Most youth in this study were doing well despite struggles they have endured related to maltreatment as children, removal from their biological families, and placement in foster care. In fact, rates of most past-year mental health diagnoses among youth in this study were similar to those found in the general population of adolescents, although lifetime rates were higher for many disorders. This suggests that placement into foster care may provide a nurturing, stable environment which allows youth to recover from mental health disorders. As documented in the Northwest Alumni Study and other studies, however, the high rates of mental health disorders among alumni of foster care strongly suggest that youth preparing to leave care and young adults who have left care need more support.

Exploratory results presented related to ethnic identity, gender identity and sexual orientation, and spirituality suggest that these are important areas in the lives of many youth in foster care. To better understand these areas, standardized scales should be developed in studies with larger sample sizes. In the meantime, the implementation of policy and program recommendations included in the current study may benefit youth currently in care.

IX. References

- American Academy of Pediatrics Committee on Early Childhood Adoption and Dependent Care. (2000). Developmental issues for young children in foster care. *Pediatrics*, 106, 1145-1150.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. Washington, DC: American Psychiatric Press.
- Bergman, D. (2004). *Screening for behavioral developmental problems: Issues, obstacles, and opportunities for change*. Portland, ME: National Academy for State Health Policy.
- Branch, C. W., Tayal, P., & Triplett, C. (2000). The relationship of ethnic identity and ego identity status among adolescents and young adults. *International Journal of Intercultural Relations*, 24, 777-790.
- Casey Family Programs. (2007). Knowing Who You Are curriculum. Retrieved June 18, 2007, from <http://www.casey.org/Resources/Projects/REI/>
- Chamberlain, P. (2003). The Oregon Multidimensional Treatment Foster Care model: Features, outcomes, and progress in dissemination. *Cognitive and Behavioral Practice*, 10(4), 303-312.
- Clausen, J. M., Landsverk, J., Ganger, W., Chadwick, D., & Litrownik, A. (1998). Mental health problems of children in foster care. *Journal of Child & Family Studies*, 7(3), 283-296.
- Cochran, S., & Mays, V. (2000a). Lifetime prevalence of suicidal symptoms and affective disorders among men reporting same-sex sexual partners: Results from the NHANES III. *American Journal of Public Health*, 90, 573-578.
- Cochran, S., & Mays, V. (2000b). Relation between psychiatric syndromes and behaviorally defined sexual orientation in a sample of the U.S. population. *American Journal of Epidemiology*, 151, 516-523.
- Cotton, S., Zembracki, K., Rosenthal, S. L., Tsevat, J., & Drotar, D. (2006). Religion/spirituality and adolescent health outcomes: A review. *Journal of Adolescent Health*, 38(4), 472-480.
- Courtney, M. E., Dworsky, A., Ruth, G., Keller, T., Havlicek, J., & Bost, N. (2005). *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 19*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago.
- Courtney, M. E., Terao, S., & Bost, N. (2004). *Midwest evaluation of the adult functioning of former foster youth: Conditions of youth preparing to leave state care in Illinois*. Chicago: Chapin Hall Center for Children at the University of Chicago.
- Cross, T. (2002). Spirituality and mental health: A Native American perspective. *Focal Point: A National Bulletin on Family Support and Children's Mental Health*, 16(1), 22-24.
- D'Augelli, A. R., Grossman, A. H., & Starks, M. T. (2006). Childhood gender atypicality, victimization, and PTSD among lesbian, gay, and bisexual youth. *Journal of Interpersonal Violence*, 21(11), 1462-1482.
- DiLorenzo, P., & Nix-Early, V. (2004). Untapped Anchor: A Monograph Exploring the Role of Spirituality in the Lives of Foster Youth. Retrieved May 27, 2007, from http://pccyfs.org/practice_resources/Final%20Monograph.pdf
- dosReis, S., Zito, J. M., Safer, D. J., & Soeken, K. L. (2001). Mental health services for youths in foster care and disabled youths. *American Journal of Public Health*, 91(7), 1094.
- Edmond, T., Auslander, W., Elze, D., & Bowland, S. (2006). Effects of child sexual abuse on youth: Signs of resilience in sexually abused adolescent girls in the foster care system. *Journal of Child Sexual Abuse*, 15(1), 1-28.
- Galliher, R. V., Rostosky, S. S., & Hughes, H. K. (2004). School belonging, self-esteem, and depressive symptoms in adolescents: An examination of sex, sexual attraction status, and urbanicity. *Journal of Youth and Adolescence*, 33, 235-245.
- Good, M., & Willoughby, T. (2006). The role of spirituality versus religiosity in adolescent psychosocial adjustment. *Journal of Youth and Adolescence*, 35(1), 41-55.
- Goodenow, C. (2005). *Youth Risk Behavior Survey Results*. Boston: Massachusetts Department of Education.
- Gross, L., Aurand, S., & Address, R. (2000). *The 1999-2000 Study of Discrimination and Violence against Lesbians and Gay Men in Philadelphia and the Commonwealth of Pennsylvania*. Philadelphia: Philadelphia Gay and Lesbian Task Force.
- Haight, W. L. (1998). "Gathering the Spirit" at First Baptist Church: Spirituality as a protective factor in the lives of African American children. *Social Work*, 43(3), 213-221.

- Haro, J. M., Arbabzadeh-Bouchez, S., Brugha, T. S., de Girolamo, G., Guyer, M. E., Jin, R., et al. (2006). Concordance of the Composite International Diagnostic Interview Version 3.0 (CIDI 3.0) with standardized clinical assessments in the WHO World Mental Health Surveys. *International Journal of Methods in Psychiatric Research*, 15(4), 167–180.
- Henry, D. L. (2005). The 3-5-7 Model: Preparing children for permanency. *Children and Youth Services Review*, 27, 197-212.
- Higher Education Research Institute. (2005). *The Spiritual Life of College Students: A National Study of College Students' Search for Meaning and Purpose*. Los Angeles, CA: Graduate School of Education and Information Studies, UCLA.
- Hochman, G., Hochman, A., & Miller, J. (2004). *Foster care: Voices from the inside*: The Pew Commission on Children in Foster Care.
- Hooker, E. (1993). Reflections of a 40-year exploration: A scientific view on homosexuality. *American Psychologist*, 48, 450-453.
- Howe, D., & Fearnley, S. (2003). Disorders of attachment in adopted and fostered children: Recognition and treatment. *Clinical Child Psychology & Psychiatry*, 8(3), 369-387.
- Jensen, P., Bornemann, T., Costello, E. J., Friedman, R., Kessler, R., Spencer, S., et al. (undated). *The Warning Signs Project: A toolkit to help parents, educators and health professionals identify children at behavioral and emotional risk*. New York: Center for the Advancement of Children's Mental Health at Columbia University.
- Kessler, R. C., & Üstün, T. B. (2004). The World Mental Health (WMH) Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). *International Journal of Methods in Psychiatric Research*, 13(2), 93-121.
- Kools, S. M. (1997). Adolescent identity development in foster care. *Family Relations: Journal of Applied Family & Child Studies*, 46(3), 263-271.
- Kosciw, J., & Diaz, E. (2006). *The 2005 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in Our Nation's Schools*: Gay, Lesbian and Straight Education Network.
- Mallon, G. (1998). *We don't exactly get the welcome wagon: The experiences of gay and lesbian adolescents in child welfare systems*. New York: Columbia University Press.
- Mallon, G. (1999). *Let's get this straight: A gay- and lesbian-affirming approach to child welfare*. New York: Columbia University Press.
- McMillen, J. C., Zima, B. T., Scott, L. D., Auslander, W. F., Munson, M. R., Ollie, M. T., et al. (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.
- Meyer, I. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697.
- Mosher, W. D., Chandra, A., & Jones, J. (2005). Sexual behavior and selected health measures: Men and women 15–44 years of age, United States, 2002. *Advance Data from Vital and Health Statistics*, 362 (September 15, 2005).
- National Institute of Mental Health. (2006). The numbers count: Mental disorders in America. *NIH Publication No. 06-4584*. Retrieved February 6, 2006, from <http://www.nimh.nih.gov/publicat/numbers.cfm#KesslerPrevalence#KesslerPrevalence>
- New York City Child Welfare Administration and Council of Family and Child Caring Agencies. (1994). *Improving Services to Gay and Lesbian Youth in New York City's Child Welfare System: A Task Force Report*.
- Pearce, M. J., Little, T. D., & Perez, J. E. (2003). Religiousness and depressive symptoms among adolescents. *Journal of Clinical Child and Adolescent Psychology*, 32(2), 267-276.
- Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., English, D., et al. (2005). *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study*. Seattle, WA: Casey Family Programs.
- Phinney, J. (1992). The Multigroup Ethnic Identity Measure: A new scale for use with adolescents and young adults from diverse groups. *Journal of Adolescent Research*, 7, 156-176.
- Phinney, J., & Devich-Navarro, M. (1997). Variations in bicultural identification among African American and Mexican American adolescents. *Journal of Research on Adolescence*, 7, 3-32.
- Picavet, C. (2005). Lesbian, gay, and bisexual identities and youth: Psychological perspectives. *Archives of Sexual Behavior*, 34(6), 713-714.
- Rest, E. R., & Watson, K. W. (1984). Growing up in foster care. *Child Welfare*, 63(4), 291-306.
- Roberts, R. E., Phinney, J. S., Masse, L. C., Chen, Y. R., Roberts, C. R., & Romero, A. (1999). The structure of ethnic identity of young adolescents from diverse ethnocultural groups. *Journal of Early Adolescence*, 19(3), 301-322.

- Rodriguez, G. M. (2002). DeAlmas Latinas (The souls of Latina women): A psychospiritual culturally relevant group process. *Women & Therapy: A Feminist Quarterly*, 24(3/4), 19-33.
- Rushton, A., & Dance, C. (2003). Preferentially rejected children and their development in permanent family placements. *Child & Family Social Work*, 8(4), 257-267.
- Ryan, C. G., & Futterman, D. (1998). *Lesbian and gay youth: Care and counseling*. New York, NY: Columbia University Press.
- Saewyc, E., Skay, C., Petingell, S., Reis, E., Bearinger, L., Resnick, M., et al. (2006). Hazards of stigma: The sexual and physical abuse of gay, lesbian, and bisexual adolescents in the United States and Canada. *Child Welfare*, 135(2), 195-213.
- Sampson, N. (2007). Personal Communication, May 30, 2007.
- Savin-Williams, R. C., & Ream, G. L. (2006). Pubertal onset and sexual orientation in an adolescent national probability sample. *Archives of Sexual Behavior*, 35(3), 279-286.
- Scarcella, C. A., Bess, R., Zielewski, E. H., Warner, L., & Geen, R. (2004). *The cost of protecting vulnerable children IV*. Washington, D.C.: The Urban Institute.
- Smith, C., Denton, M. L., Faris, R., & Regnerus, M. (2002). Mapping American adolescent religious participation. *Journal for the Scientific Study of Religion*, 41(4), 597-612.
- Smith, S. D., Dermer, S. B., & Astramovich, R. L. (2005). Working with nonheterosexual youth to understand sexual identity development, at-risk behaviors, and implications for health care professionals. *Psychological Reports*, 96(3), 651-654.
- Spencer, M. S., Icard, L. D., Harachi, T. W., Catalano, R. F., & Oxford, M. (2000). Ethnic identity among monoracial and multiracial early adolescents. *Journal of Early Adolescence*, 20(4), 365-387.
- Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., et al. (2003). A mental health intervention for schoolchildren exposed to violence. *Journal of the American Medical Association*, 290(5), 603-611.
- The People's Institute for Survival and Beyond. (2006). Undoing Racism workshop. Retrieved June 18, 2007, from <http://www.pisab.org/>
- U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2006). Adoption and Foster Care Analysis and Reporting System (AFCARS) Report: Preliminary FY 2005 Estimates as of September 2006. Retrieved November 14, 2006, from http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report13.htm
- Vandivere, S., Chalk, R., & Moore, K. A. (2003). Children in foster care: How are they faring? (Research Brief). *Child Trends*.
- White, C. R., Havalchak, A., O'Brien, K., & Pecora, P. (2006). *Casey Family Programs Young Adult Survey, 2005. Examining Outcomes for Young Adults Served in Out-of-Home Care*. Seattle, WA: Casey Family Programs.
- Williams, J. R., Pope, S. M., Sirls, E. A., & Lally, E. M. (2005). *Alaska foster care alumni study*. Anchorage: University of Alaska Anchorage.
- Wilson, M., Carraway-Wilson, C., & Jackson, N. (2005). Adolescent heart & soul: Achieving spiritual competence in youth-serving agencies. Retrieved May 29, 2007, from www.nenetwork.org/publications/Heart.and.Soul.pdf
- Witvliet, C. O. (2001). Forgiveness and health: Review and reflections on a matter of faith, feelings, and psychology. *Journal of Psychology and Theology*, 29(3), 212-224.
- Woronoff, R., Estrada, R., & Sommer, S. (2006). *Out of the Margins: A Report on Regional Listening Forums Highlighting the Experiences of Lesbian, Gay, Bisexual, Transgender, and Questioning Youth in Care*: Child Welfare League of America and Lambda Legal Defense & Education Fund.
- Yancey, A. K., Aneshensel, C. S., & Driscoll, A. K. (2001). The assessment of ethnic identity in a diverse urban youth population. *Journal of Black Psychology*, 27(2), 190-208.
- Yasui, M., Dorham, C. L., & Dishion, T. J. (2004). Ethnic identity and psychological adjustment: A validity analysis for European American and African American adolescents. *Journal of Adolescent Research*, 19(6), 807-825.

