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Effects of Foster Care Trauma on Foster Care Alumni's Mental Health in Adulthood

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This is to certify that the doctoral dissertation by

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Abstract

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Abstract

Child welfare system involvement leads to foster care more for racial minority children than White children, and after exiting foster care racial minority alumni face disparate outcomes. The purpose of this generic qualitative study was to explore the effects of trauma experienced in foster care on racial minority foster care alumni's mental health in adulthood. Trauma theory and information processing theory provided the frameworks for the study. Data were collected from semistructured interviews with eight racial minority foster care alumni age 18 and older. Findings from coding analysis indicated three themes and two subthemes. The adult mental health effects of the trauma experienced in foster care included severed relationships caused by foster care placement continuing, unintended behavioral consequences, and declined mental health treatment. Additional outcomes were alumni viewed foster care as challenging but lifesaving, and they suffered from poor sleep and anxiety. Findings may provide firsthand information regarding the effects of social work policies and practices that impact alumni outcomes, and may encourage those working with this population to prioritize family and supportive relationships and trauma healing.

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Dedication

I only made it this far because of God, so I must honor Him first. Thank you, Jesus, for everything! I dedicate this doctoral research study to my husband, James. Thank you for encouraging me not to quit when many times that is all I wanted to do, and for not complaining *too much* on all the late nights when the light of my laptop and the sound of my typing would keep you awake. I have reached all of my hardest goals in this life with you by my side, and I will appreciate you forever for that. I love you, Cakes.

To our children, Jase and Janae, affectionately known as J Squared: You two have inspired me to do amazing things while living life with joy, laughter, and being surrounded by love. I did this for you. To show you that you can do anything you set your mind to, and it does not matter how you start; finish strong. I love you both more than you will ever know, and I cannot wait to see your greatness throughout life.

To my mom, Sylvia Wilson, who supported me in immeasurable ways without ever expecting reciprocation. From childcare while I traveled and wrote all hours of the night to prayers and encouragement along the way. I finished because you told me I could. Thank you for never judging me or talking me out of my dreams and goals, even when they seem impossible. My love for you is relentless.

And to my best friend, Tiffany, I hate that you didn't get to see me finally accomplish this goal. Memories of your encouragement and talks will forever motivate me to go for my dreams, no matter how extreme they may seem. There is nothing too hard for God, and I can do all things through Christ who strengthens me; faith over fear. I will love you forever. RIH, BFF.

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To my work buddies/besties, Kelly G., Roz, and Melinda, thank you for always checking in and encouraging me to finish. Twana and Erica, your help in the final stages will never be forgotten, and I so appreciate you both. And to my boss, Kelly M., thank you for your support from Day 1 until the end that never wavered, even though it took me what felt like forever to finish. I would have quit long ago if it had not been for you all watching and reminding me of what I was capable of! I truly appreciate your push, support, and friendship, and I am glad to have been able to make you all proud.

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Chapter 1: Introduction to the Study

Child welfare is a social work specialty in which professionals work to monitor and affect child safety and well-being (National Association of Social Workers [NASW], n.d.). Those who work in child welfare are charged with providing a service for protecting vulnerable youths from parents who cannot or will not provide for their children (Berrick et al., 2017). Child protective services (CPS) is a child welfare subspecialty of investigation and decision making regarding child abuse, neglect, and dependency. If CPS workers find or substantiate abuse, neglect, or dependency, *foster care* placement of children could result.

Foster care provides safe homes and vetted caregivers for children who have experienced abuse or neglect (Darwiche et al., 2019). Foster caregivers provide homes free of the conditions that resulted in placement, facilitating children's basic well-being and social-emotional needs. The child welfare agency professionals, who are the children's custodians, and the foster parents' licensing agencies monitor foster care placements to ensure compliance with housing guidelines and requirements. Because foster care is meant to be a safe and temporary placement, the expectation is that children will reunify with their parents or obtain another form of living permanence within 12 months (NASW, 2020). However, foster care is often a traumatic experience that may cause young people to take unhealthy life paths (Barboza et al., 2017; Moten, 2018; Riebschleger et al., 2015). *Trauma* is a stressful and disturbing experience that threatens physical and psychological well-being (Fratto, 2016). One effect of foster care is that mental health diagnoses occur at higher rates for youth in foster care than for those in the

general population (Gypen et al., 2017). Mental health issues are one concern faced by young people in foster care.

Racial *disproportionality* and *disparities* are significant issues within CPS (Harp & Bunting, 2020). Due to racial disproportionality, Black, Hispanic, and Asian youths might take more *disparate* life paths than White young people. There is a statistical overrepresentation of racial minority youth within child welfare processes and programs and, subsequently, foster care and its adverse effects (Harp & Bunting, 2020). Racial minority youth undergo investigation, require services, are substantiated for abuse and neglect, and experience foster care placements at disproportionately higher rates than their White counterparts (Harp & Bunting, 2020). The focus of the current study was racial minority *foster care alumni,* defined as Black, Hispanic, and Asian youths, who turn 18 years old while in a state or county CPS custody (see Fusco & Kulkarni, 2018).

The purpose of the study was to explore the traumatic experiences of racial minority foster care alumni. There was a need for this research due to the overrepresentation of racial minority youth in child welfare and the prevalence of unfavorable outcomes (see O'Loughlin & O'Loughlin, 2016). Young people involved in child welfare and foster care have higher mental health diagnoses and trauma rates than the general public (Gypen et al., 2017; Riebschleger et al., 2015). Disparities in the life outcomes of foster care alumni appear when measured alongside individuals of similar demographics who have not been in foster care (Villagrana, 2017). The effects of racial minority foster care alumni outcomes extend beyond each person.

The trauma of racial minority foster care alumni is a societal issue. When children undergo foster care placement, there is an impact on the whole community (Collins-Camargo & Antle, 2018). Further complications occur when young people age out of the foster care system and become independent members of society. The current study was a contribution to social change through soliciting the perspectives of a marginalized group of racial minority foster care alumni. This research could also impact the child welfare system as a whole. The study may contribute to social change for the studied community, and the findings could affect the surrounding cities, states, and country. In this chapter, I present the problem, purpose of the study, research question, and theoretical frameworks. Chapter 1 also includes the nature of the study and its significance and limitations.

Background

Research is not lacking regarding foster care alumni, their disparities, or the racial disproportionality in CPS. About a third of foster care youths experience trauma exposure and experiences (Riebschleger et al., 2015), often resulting in poor adulthood outcomes (Liming et al., 2021). Included in that number is a significant number of racial minority children in foster care who experience trauma (Huggins-Hoyt et al., 2019; O'Loughlin & O'Loughlin, 2016). Disproportionate numbers of youths involved with child welfare agencies at all service levels (investigations, in-home services, foster care, and adoption) are racial minorities, often being seen in child welfare at percentages nearly double that of their total population (O'Loughlin & O'Loughlin, 2016). Racial minority children in foster care experience higher rates of trauma, suffering, and challenging outcomes in adulthood than their White peers (Liming et al., 2021; Webb et al., 2020).

Despite existing research on foster care alumni (Pecora et al., 2006; Villagrana, 2017), their disparities (Whittaker, 2017), and the racial disproportionality in CPS (O'Loughlin & O'Loughlin, 2016), a gap in the literature existed regarding racial minority foster care alumni and their trauma while in foster care or their post-foster-care and adulthood outcomes. Research on the trauma of foster care from racial minority foster care alumni's perspectives was needed because it is an issue that affects the child welfare world and the larger community (NASW, n.d.; Welcome to the Child Welfare League of America [CWLA], 2020). Child welfare social workers often work with foster care youth. Findings from the current study may provide valuable information regarding how child welfare social workers' practice can influence long-term outcomes. Findings may help the community understand alumni's challenges and know what support services should be accessible to benefit this population. Discovering the implications of foster care trauma was essential so that child welfare professionals, policymakers, community members, and service providers could understand their roles in reducing disparities.

Problem Statement

In 2017, there were approximately 428,000 children in foster care in the United States (Annie E. Casey Foundation, 2019). Children placed in foster care have often faced numerous adverse childhood experiences (ACEs), increasing their vulnerability and causing a negative impact on their lives throughout adulthood (Felitti et al., 1998). ACEs include child abuse and neglect, prerequisites for foster care placement, and the traumas experienced by children while they are in foster care (Fratto, 2016; Riebschleger et al., 2015). Children who end up in foster care are disproportionately Black, Hispanic, or

Asian and most often face disparate outcomes resulting from their foster care experiences (Huggins-Hoyt et al., 2019). Adverse mental health outcomes are prominent among foster care recipients and alumni (Vasileva & Petermann, 2017).

From July 2018 to June 2019, there were 16,964 children in foster care in North Carolina, which was targeted for the current study because this is where I reside (see Duncan et al., 2019). Of those children, 44% had spent more than 4 years in foster care, and 396 aged out during the year. Forty-two percent of the 396 were Black, Hispanic, or Asian and became racial minority foster care alumni by turning 18 while still in a state/county custody. For foster care alumni, that title or a mental health diagnosis frequently leads to further victimization, abuse, or other negative consequences in adulthood (Gypen et al., 2017).

Foster care alumni are also more likely to struggle with formal education, including rates of high school completion directly influenced by the amount of time they spent in foster care (Font et al., 2018). Fewer foster care alumni complete secondary education than their peers, and many experience substance abuse issues and meet abuse or dependency criteria (Pecora et al., 2006; Villagrana, 2017). Also, it is not uncommon for foster care alumni to experience homelessness after aging out (Pecora et al., 2006). Foster care alumni are also at risk of poverty outcomes, with many living in poverty and receiving government financial assistance. Compared to the general public of the same age, fewer are eligible for work (Pecora et al., 2006). The disparate outcomes experienced by foster care alumni are problematic.

Foster care and its traumatic effects are an issue for foster care alumni, social workers and policymakers, parents in every community, and all members of society. For over a decade, organizations such as the CWLA and the NASW have been significant promoters for societal change in regard to responding to child abuse and neglect and the impact of childhood trauma through legislation introduction and trauma-informed care advocacy (Welcome to the CWLA, 2020). New foster care legislation is common across the country every year (Foster Care and Adoption Legislation 2020, 2020). Before his passing, Congressman John Lewis helped introduce the Every Child Deserves a Family Act (Sciamanna & Ogletree, 2020c). The act bans discrimination in the placement of foster care youths and discrimination in foster and adoptive parents' recruitment.

Additionally, there is a big push to extend the age of foster care to 21 because the average 18-year-old is not ready to live independently (Sciamanna & Ogletree, 2020a). Other recent legislation aims to increase funding to child protective services agencies to prevent child abuse and neglect before it happens, thereby reducing the lifelong effects of the trauma from abuse and neglect experiences (Sciamanna & Ogletree, 2020b). Nationwide concerns regarding the impact of childhood trauma and ACEs often show up in legislation (Paipongna, 2019).

The problems caused by racial disparities suffered by young people in foster care and the mental health issues experienced by foster care alumni have been researched. Prior findings on these matters are detailed in the literature review in Chapter 2. However, there was little academic inquiry into the trauma experiences of racial minority foster care alumni in the United States (see Gourdine, 2019; Riebschleger et al., 2015).

Despite previous trauma research on foster youths in other countries, none of the studies had been racially specific (Riebschleger et al., 2015; Steenbakkers et al., 2019). The current study addressed United States racial minority foster care alumni, their trauma experiences while in foster care, and their mental health in adulthood.

Purpose of the Study

The purpose of this qualitative study was to explore the effects of foster care trauma on racial minority foster care alumni's mental health in adulthood. The term *trauma* was used to identify negative adverse events that occurred during foster care, and participants had the opportunity to describe what trauma means to them. Previous research showed the pervasiveness of mental health diagnoses and the societal hardships of this population (Gourdine, 2019; Liming et al., 2021; Riebschleger et al., 2015). An extensive search of the literature indicated no studies of United States racial minority foster care alumni's experiences and the effects of trauma on their adult lives. The current study, which included United States racial minority foster care alumni as participants, was a means of exploring the trauma young people in foster care have experienced and its effects on their mental health.

Research Question

What are the effects of the trauma experienced in foster care on racial minority foster care alumni's mental health in adulthood?

Theoretical Frameworks

The study's theoretical frameworks were trauma theory (van der Kolk et al., 1991) and information processing theory (Shapiro, 2018). Trauma theory dates back to

the early 20th century and is common in discussions regarding the symptoms experienced by war soldiers and veterans (Bećirović et al., 2017). A diagnosis of traumatic neurosis, later renamed *posttraumatic stress disorder* (PTSD), requires a precipitating traumatic event. Whereas trauma theory provides a framework for understanding the effects of abuse and neglect on children's development and behaviors, it also provides a way to understand the outcomes of individuals who have experienced trauma by detailing how the brain and body change from trauma (Dye, 2018). Further, the theory is a means of understanding a person's response to traumatic events. According to trauma theory, traumatic experiences are so impactful to the brain they could lead to stunted development and increased challenging behaviors in children (Dye, 2018). Also, untreated or improperly treated trauma could affect individuals throughout their lives and into adulthood.

Shapiro's (2018) information processing theory indicates that individuals derive pathologies from early life experiences, which they may develop in continued patterns of effects, behaviors, identity structures, and cognitions. According to the theory, inadequately addressed and processed childhood trauma presents as negative behaviors, characteristics, and emotions experienced by individuals even into adulthood. In other words, trauma is the root, and negative behaviors, characteristics, and emotions are the branches that form from trauma.

Though trauma theory has not been well delineated in research, its key concepts have been identified through discussion on the topic (van der Kolk et al., 1991). The basic tenets of information processing theory are available throughout the literature

(Landin-Romero et al., 2018; Shapiro, 2018). Previous researchers used trauma theory to describe trauma-related outcomes across behavioral, emotional, physical, and social domains (Bloom, 1999; van der Kolk et al., 1991). Information processing theory has been used in research to explain cognitive and behavioral changes that occur as a result of trauma (Landin-Romero et al., 2018; Shapiro, 2018). Potential trauma outcomes explained by the theoretical frameworks used in the current study were behavioral, cognitive, emotional, physical, and social. Key outcome concepts from the theoretical frameworks can be found in Appendix A.

Trauma and information processing theories were appropriate for framing the current qualitative study on trauma and trauma outcomes and responses. Qualitative methodology is best applied when studying lived experiences (Creswell & Creswell, 2018) and aligned with the research question for the current study addressing the foster care trauma experiences of racial minority foster care alumni. According to these theories, the trauma experienced by racial minority foster care alumni significantly affects their responses, actions, and outcomes in adulthood (Dye, 2018; Shapiro, 2018). The current study was also an inquiry into the adulthood outcomes of participants, specifically their mental health outcomes. In Chapter 2, I present more information on the theoretical frameworks.

Nature of the Study

Qualitative approaches are inductive and used by researchers to understand and make meaning of an individual's experiences (Creswell & Creswell, 2018); therefore, qualitative methodology was the best option for determining the effects of racial minority

foster care alumni's foster care trauma on their lives in adulthood. The inductive methodology began with collecting and organizing data through observation and interviews and ended with describing and interpreting discovered generalizations that support and further the theories that form the theoretical frameworks. Qualitative methodology enables researchers to explore human phenomena or participants' lived experiences without methodological constraints (Creswell & Creswell, 2018).

The generic qualitative approach used in this research is also sometimes referred to as basic or interpretive qualitative methodology (Merriam & Tisdell, 2016). The methodology provides an analytical lens to explore the data for credibility. Qualitative researchers stay close to the data, understanding the relevance of the results to broad clinical application. Although a generic qualitative approach does not have a specific design, it allowed for a thorough exploration and interpretation of racial minority foster care alumni's trauma (see Kahlke, 2018). The approach also enabled an evaluation of the participants' experiences as constructs of their worlds and outcomes while also providing meaning to their experiences.

This study was conducted from North Carolina, and I utilized the North Carolina LINKS (NC LINKS) program for initial participant recruitment. The NC LINKS program provides young people in foster care with the skills and support they need to live independently after aging out of foster care (NC Department of Health and Human Services [NCDHHS], 2019). The NC LINKS program was the optimal source for recruiting participants. I contacted independent living social workers in Mecklenburg County, North Carolina, for initial participant referrals before expanding throughout the

state. I initially sought to recruit a minimum of 10 racial minority foster care alumni to discover the richest information. Eight to ten participants were consistent with other studies of this genre and methodology (see King, 2020; Osok et al., 2018). In qualitative research, quantity is less important than quality, thereby requiring targeted and specific participant selection (Creswell & Poth, 2018). Participants had to meet race, age, and previous foster care experience requirements to qualify for the current study.

The participant population consisted of racial minority foster care alumni in North Carolina and, through snowballing, other states. The Black, Hispanic, and Asian young adult participants were to range in age from 18–21 years. The age range was selected due to participants being less removed from foster care at those ages and the range being a period when young adults are finding themselves (see Tyrell & Yates, 2018). I later had to change my age range to recruit more participation ages 18 and older. I first used nonprobability purposive sampling and encouraged snowball sampling to gain more participation. Purposive sampling enabled the selection of participants who had experienced the trauma of foster care to be sufficient to answer the research question (see Kahlke, 2018).

The data collection method for this study was semistructured interviews that were consistent with generic qualitative research (see Kahlke, 2018) and aligned with the purpose of the study. Semistructured interviews were selected over other methodology avenues because they allowed adequate time for all participants to speak and minimized researcher bias with the use of an interview guide (see Castleberry & Nolen, 2018). Face-to-face interviews enable researchers to observe nonverbal responses and emotions not

reflected in the interview transcripts (Castleberry & Nolen, 2018). Due to the COVID-19 pandemic, however, I used a phone and a virtual platform for conducting interviews. Although I could still see the participants during virtual interviews, we were not able to be in the same meeting space. I transcribed and analyzed the data concurrently with data collection. I continued to conduct participant interviews until the data became repetitive and no new themes emerged—in other words, the point of saturation (see Guest et al., 2020). The quality of the data, the research method, and the studied problem indicated when data were saturated.

Inductive, or thorough describing and interpreting, data analysis occurred to identify themes, insights, and recommendations for child welfare practice, policy changes, and future research. After transcribing each audio-recorded interview verbatim, I reviewed the transcripts for accuracy, listening to the recordings as I read the text. After compiling the data from each interview, I created a journal that included my observations and the interview notes. Journaling helped manage my potential biases (see Creswell & Poth, 2018). I securely stored all records using a locked file storage drive, ensuring to de-identify participant information, and only I had access to the materials. Thematic analysis is a way to identify patterns across the data sets (Azungah, 2018). During data analysis, analytical and naturalistic generalization enables the extraction of abstract concepts from each unit of analysis (Twining et al., 2017). The data underwent coding with support from qualitative data analysis software. Additional details regarding the methodology and research decisions are provided in Chapter 3.

Definitions

Disparate/Disparities /Disparity: The difference in outcomes that people experience based on their race or ethnicity (Harp & Bunting, 2020).

Disproportionality: The larger or smaller representation of a group than the same group's representation in the general population (Webb et al., 2020).

Dissociation: A disruption of or discontinuity in the normal integration of consciousness, memory identity, emotion, perception, body representation, motor control, and behavior (Vonderlin et al., 2018).

Early toxic environments: Homes in which early life, or toxic, stress, adversity, and negative exposures to adult issues occur (Busso & Sheridan, 2020).

Foster care: Out-of-home placement in the custody of state and local child welfare agencies for children under the age of 18 years (Darwiche et al., 2019).

Foster care alumni: Individuals who have spent time in the foster care system as children under the age of 18 years (Fusco & Kulkarni, 2018). In the current study, the alumni had aged out of care and turned 18 while still in the custody of a state or local child welfare agency.

Learned helplessness: A common issue faced by foster care alumni that translates into dependence on systems and a lack of motivation and self-efficacy (Armstrong-Heimsoth et al., 2020).

Maltreatment: An act or failure to act on the part of a parent or caretaker that results in neglect, serious physical or emotional harm, sexual abuse or exploitation, or imminent risk of serious harm to a child (Fratto, 2016).

Posttraumatic stress disorder (PTSD): A psychiatric condition presenting as a delayed and protracted response after experiencing or witnessing a traumatic event that includes actual or threatened death or serious injury to self or others (Bećirović et al., 2017).

Trauma: An experience that results in a threat to an individual's physical or psychological well-being (Fratto, 2016).

Assumptions

The study's assumptions affected the inferences that I was able to draw from the research, and they were necessary because, without them, the study could not have been conducted. Assumptions are an essential part of the research methodology and contribute to the credibility and reliability of the study; with them, the study can be replicated by other researchers (Marshall & Rossman, 2016). The assumptions that were built into the conduct of the study were as follows:

1. While in the child welfare system or foster care, the racial minority youths did not know of their disproportional representation within the system or the potential disparate outcomes of foster care.
2. The participants would be able to recall their traumatic childhood experiences. Also, depending on the trauma involved, the consistency among participants may have been uneven.
3. The participants would have common during foster care trauma experiences.
4. The participants would be forthcoming with the descriptions of their experiences.

5. The participants would communicate their experiences and understand how they relate to their adult life.
6. The participants would be able to differentiate between out of foster care trauma and in foster care trauma.

Scope and Delimitations

The study focused on racial minority foster care alumni because there was little literature on their firsthand experiences of trauma. Participants were foster care alumni in the United States. The initial recruiting location of North Carolina, specifically Mecklenburg County, was chosen for convenience because that is where I live. Mecklenburg is the state's largest county. The population is filled with a variety of races and socioeconomic statuses. Other larger counties in the state have similar demographics. Mecklenburg County has a population of just over 1 million, made up of about 46% White, 33% Black, 14% Latino, 6% Asian, and 1% other race persons (U.S. Census Bureau, 2019). The study did not include White foster care alumni because the research did not show disparities as significant for this population as those faced by racial minority young people (see Harp & Bunting, 2020). Attachment theory, common in other literature on foster care youth, did not contribute to the frameworks due to attachment generally being more significant at the time of removal from foster care, not aging out (see Font et al., 2018). Whether other scholars can generalize or transfer the results to different settings or contexts indicates the transferability of the study (Creswell & Creswell, 2018). Due to a thorough description of contexts and assumptions, there was a high potential for transferability in the current study.

Limitations

Racial minority foster care alumni's experiences could have resulted in distrust of public systems and public representatives; therefore, identifying and recruiting participants might have been a challenge. I addressed this by being transparent and acknowledging that I understood possible unwillingness to participate due to previous experiences with social workers, social services, and people in my position. I also assured participants that the study was unrelated to my employment and, through informed consent, ensured them that the information they provided would remain confidential and would not be shared with anyone they may still be involved with at social services.

Individuals could have felt reluctant to participate due to not wanting to recall old memories or feeling that their contribution would have no impact. Also, because being part of the child welfare system may have resulted in PTSD, I carefully considered the interview settings. I asked participants before each interview whether they were in a safe and comfortable place. Another potential limitation was my preexisting knowledge of child welfare. I had biases and perspectives that could have affected interpretation and analysis if not acknowledged and addressed (see Creswell & Creswell, 2018). Therefore, I remained aware of my positionality and bracketed assumptions to ensure that biases would not result in weak conclusions or an unaddressed research problem undermining my study's validity.

Biases and perspectives can impact participant responses and results (Corlett & Mavin, 2018). Researchers manage their biases by considering positionality and acknowledging its effects on data collection and analysis (Corlett & Mavin, 2018).

Member checking and reflexivity are common ways to manage potential researcher bias (Creswell & Poth, 2018). As a Black child protective social work professional who has been in the field for over 14 years, I understood and was aware of the trauma that occurs and results in child welfare involvement and have experienced my own ACEs and traumas. However, I lacked an understanding of what it is like to receive child welfare services or be in foster care. I wanted to understand more about racial minority foster care alumni's trauma and their outcomes due to being in foster care and experiencing trauma. In addition to positionality, I used reflexivity, which Ravitch and Carl (2016) identified as the conscious effort to assess identity and subjectivity throughout the research process. Validity occurs when there are accurate findings, according to the researcher, participants, and readers (Creswell & Creswell, 2018). I ensured reliability by providing thorough descriptions of the research process, carefully reviewing the transcribed interviews, and detailing the research approach so that other researchers could replicate the study.

Significance

The study's findings may have an important impact on the field of social work. The results may provide increased awareness of racial minority foster alumni's traumatic experiences, including the most helpful community services for these alumni. Scholars and policymakers may use the study's recommendations to inform program development and support services for foster youths, address before-care trauma, and reduce during-care trauma. This study could lead to discussions between child welfare policymakers and stakeholders. The results could also inspire expanded research throughout North

Carolina and the United States. Additionally, the study indicated the critical variables that scholars could explore using a quantitative approach.

This study's findings on the effects of the trauma experienced while in foster care may lead to awareness and policy recommendations to change the foster care system. Another implication is an additional rationale for practice changes consistent with trauma-informed care. Additionally, the findings could inspire positive changes in child welfare practices, from the decision making process and accepting cases to the processes of substantiating findings and removing children. Positive social change may result from providing the social work field with knowledge on the foster care system's effects.

From this study, the outcomes of racial minority foster youths may be improved through recognition of the impact of their experiences, many of which are driven by social work practices (see Riebschleger et al., 2015). The study may result in these youths receiving earlier interventions that reduce the long-term effects of trauma. The study may also influence the recruitment of foster parents and training, leading to youth access to more caring adults, better placements, better relationships with social workers and caregivers, and increased stability. Lastly, this study may increase the number of youths involved in policymaking and advocacy, positioning youths as owners and direct influencers in their outcomes.

Summary

The CPS subspecialty of child welfare is a means of protecting and advocating for vulnerable children (Berrick et al., 2017). However, when a primary caregiver has abused or neglected a child, the child's trauma does not end with foster care placement

(Riebschleger et al., 2015). Trauma experiences might result in mental health concerns for these young people, the overwhelming majority of whom are racial minorities (O'Loughlin & O'Loughlin, 2016; Villagrana, 2017). The purpose of the current qualitative study was to understand the effects of the trauma experienced during foster care on racial minority foster care alumni's mental health.

The research question centered on identifying and acknowledging the effects trauma has on racial minority foster care alumni's mental health. The theoretical frameworks of trauma theory and information processing theory were used to explain why the problem exists. In Chapter 1, the study's assumptions, scope, delimitations, and limitations were recognized. The study had significant potential to influence the field of social work. In Chapter 2, I provide a detailed review of the research relevant to this study.

Chapter 2: Literature Review

Foster care is traumatic and threatens individuals' well-being by affecting their development and responses to subsequent life happenings, and it is disproportionately experienced by racial minority children (O'Loughlin & O'Loughlin, 2016). Although meant to be short-term until reunification or another permanent plan can be achieved, foster care is often long-term. The traumas experienced before and during foster care can lead to disparate mental health outcomes and diagnoses (Gypen et al., 2017). Previous research has provided details regarding the racial and mental health disparities experienced by foster care alumni (Gourdine, 2019; Liming et al., 2021; Riebschleger et al., 2015), but there was little research on the trauma of racial minority foster care alumni in the United States.

The purpose of this qualitative study was to understand the effects of the trauma experienced during foster care on racial minority foster care alumni's mental health. Mental health diagnoses and societal hardships are prevalent for young people in foster care (Gourdine, 2019; Liming et al., 2021; Riebschleger et al., 2015). An extensive search of the literature produced no studies of United States racial minority foster care alumni's experiences and the effects of trauma on their adulthood. In the current study, I explored the effects of foster care trauma on adult mental health among a selection of racial minority foster care alumni.

Chapter 2 includes a description of the strategy used for searching the literature, more detailed information on the theoretical frameworks, and an exhaustive review of the literature relevant to the current study. The literature review begins with a review of the

literature that identifies and solidifies the problem by discussing the vulnerability of the chosen population, trauma faced during childhood and its brain impacts, and racial disproportionality and disparities in child welfare, foster care, and through the aging out process. Then, the literature is reviewed relating to the core concepts of the theoretical frameworks. Five major topics are discussed based on the theoretical frameworks' core concepts that lead to poor outcomes for racial minority foster care alumni. The concepts are foster care alumni and their (a) behavioral outcomes, (b) cognitive outcomes, (c) emotional outcomes, (d) physical outcomes, and (e) social outcomes.

Literature Search Strategy

I used the Walden University Library to search for literature related to the topic. The initial search included SAGE Journals, Taylor & Francis Online, and ScienceDirect to search peer-reviewed journals from 2014 onward for the keywords *foster care alumni AND trauma AND mental health*. The initial search took place in 2019. Though it would have been relevant, searches using those keywords *AND minority* did not yield results. The initial keywords search produced 124 studies; however, some were duplicates or irrelevant. Irrelevant articles were filtered out through abstract review. A review of the references for each selected article provided additional literature to review. A total of 61 articles were eventually reviewed. Several of the reviews for the 61 articles had to be removed due to their age by 2021. In 2021, another search was completed with the date range 2019 to the present. Four results were produced; however, two were duplicates, and one was a dissertation. The two research articles were reviewed, as were four other relevant articles found during the search for updated literature in reference reviews.

Further literature searches were completed on the theoretical frameworks, using the terms *trauma theory* and *information processing theory AND foster care*. The articles of substance and value were used in the theoretical frameworks section. After reviewing the theoretical frameworks literature, I completed multiple searches using the core concept keywords AND *foster care* or *foster care alumni*. Most searches produced materials only if *foster care* was used in lieu of *foster care alumni*. Thirty-one articles were initially identified and reviewed. A secondary search of reference lists yielded several more articles for review. The databases EBSCOhost Research, Academic Search Premier, PsycINFO, PsycARTICLES, SocINDEX with Full Text, Educational Resource Information Center (ERIC), as well as the Google Scholar search engine, were used to search for literature. I also located articles and relevant statistical information on the NASW, CWLA, NCDHHS, and Annie E. Casey websites. In the following section, I present the theoretical frameworks.

Theoretical Frameworks

Trauma theory (van der Kolk et al., 1991) and information processing theory (Shapiro, 2018) formed the theoretical frameworks for this study on racial minority foster care alumni's trauma experiences. The theories offer explanations for behaviors and outcomes following trauma exposure and experiences. Each theory is detailed, concluding with the key concepts derived from each.

Trauma theory dates back to the early 20th century, emerging in a discussion of symptoms experienced by war soldiers (Bećirović et al., 2017). Around this time, the combat survivor's experiences were designated as traumatic, and trauma theory

developed as a clinical paradigm informed by various aspects of psychological and psychoanalytic theories. In addition, the theory draws from deconstruction theory, de Man's theory of signification, and neuroscientific work concerning memory by Bessel van der Kolk. Trauma theory supports the development of mental conditions and disabilities, especially shell shock, also known as soldier's heart, combat fatigue, war neurosis, and, more recently, PTSD, which many combat soldiers suffered following traumatic experiences. PTSD is a psychiatric condition presenting as a delayed and protracted response after experiencing or witnessing a traumatic event that includes actual or threatened death or serious injury to self or others (Bećirović et al., 2017). The symptoms of PTSD can disrupt daily activities and normal life and are generally correlated to the type of trauma experienced.

Trauma is defined as an experience that results in a threat to an individual's physical or psychological well-being (Fratto, 2016; Riebschleger et al., 2015). Some literature also denoted trauma as an event without a witness, giving it an unassimilable and unknowable nature (Bećirović et al., 2017). Trauma is an external event that happens to a person; it happens from without, not within (Bloom, 1999). Therefore, trauma victims are not complicit with the trauma directed toward them. Trauma is an emotional blow that is sudden, unexpected, overwhelming, and intense from the outside. The events, though, quickly become incorporated into the mind.

Trauma theorists argue that traumatic events have a way of suspending themselves in a person's memory (Bloom, 1999). Trauma is encoded in the brain differently than ordinary memory. The memories are considered threatening, and they

become stuck in a special brain area that complicates their retrieval. The way this happens is dependent on the individual and how they receive and code the memory. Memories are traumatic when the events they recover have not been integrated into consciousness (Bloom, 1999). The memories are often associated with unknown meanings, wishes, fantasies, and sometimes an identity with or glorifying the aggressor. What is traumatic can differ from person to person because though something may not by nature be toxic or traumatic, what the mind does to the memory can make it traumatic. van der Kolk et al. (1991) argued that traumatization occurs when internal and external resources are inadequate to cope with the external threat. Lack of adequate resources frequently occurs in children who experience trauma with long-term impacts to the traumatization.

According to trauma theory, *early toxic environments*, such as homes in which a child is abused or neglected, result in hyperarousal and the overproduction of fight-flight-freeze brain chemicals that obstruct the natural development and connection of the neurons necessary for other positive reactions (van der Kolk et al., 1991). Over time, these significant changes in the brain could cause unstable emotional regulation, an inability to form positive social attachments, reduced impulse control, and slowed cognitive processing. However, the impact of trauma is as individualized as fingerprints. One event can cause these changes to one person, while another person could show little to no impact from the same event. Some people can live life as if nothing happened from one trauma, while others may find the same trauma debilitating. For example, a person who lives through a near-fatal car crash physically unscathed by wearing a seatbelt could

be grateful for life and continue following the rules of the road. In contrast, another person who went through the same experience could never want to drive again. Some people will need no support after trauma, while others will need every treatment option available. The impact is based on the resources a person has to cope with and how they have learned to cope from previous traumas (van der Kolk et al., 1991).

The traumatic events themselves do not do the damage, but rather how the mind and body respond and react to the experience coupled with how an individual's social group and family respond (Bloom, 1999). Trauma impacts the entire person, affecting how they think, learn, remember, feel about themselves and others, and make sense of the world. Multiple trauma experiences often lead to worsened results, but one significant trauma could cause all of the brain changes (van der Kolk et al., 1991). Children who have experienced trauma may have normalized maladaptive responses to subsequent trauma and everyday life. Trauma theory is a means of understanding why individuals who have experienced trauma behave in certain ways by exploring brain changes that lead to mental health effects and maladaptive behavioral responses.

When children face multiple traumas and stressors, the accumulation of experiences and risk factors has a dose-response relationship with later negative outcomes (Busso & Sheridan, 2020; Rebbe et al., 2018). The early experiences can have a wear-and-tear effect on the body and are detrimental to the developing child (Busso & Sheridan, 2020). The more trauma happens, the more significant the later impact. Dose-response relationships have also been found with exposure to adversity and attention deficit hyperactivity disorder (ADHD) diagnosis (Østergaard et al., 2016); multiple

negative foster care experiences including moves, abuse and neglect, and multiple caseworkers; and the ability to self-regulate emotions as an adult (Kang-Yi & Adams, 2017). Chronic stress changes the brain of children. The amygdala and hippocampus, which are involved in fear conditioning and response prediction based on previous experiences, are structurally changed by chronic stress. When this happens to children, they may be more fearful and have difficulty making sense of fearful memories. The process can trigger anxious behaviors resulting in mental and physical disorders. Toxic stress can chronically activate the body's stress response system and retard a child's capacity to thrive (Busso & Sheridan, 2020). Children's brains undergo rapid growth and are sensitive to environmental stimuli. Once childhood is over and the brain is no longer as sensitive, it is harder to change the brain formed through traumatic childhood experiences.

Trauma theory further purports that exposure to violence and other traumatic incidents during childhood and adolescence could later result in violent behavior and delinquency as reciprocal interactions (van der Kolk et al., 1991). Individuals with traumatized brains normalize stressful encounters with intense and intolerable emotions and cope with those situations with negative behaviors. Professionals have used trauma theory in trauma-informed programming for youths involved in juvenile justice and child welfare systems (NASW, 2020). Trauma-informed programs have staff who have been formally trained on the clinical origins of trauma and its impacts and treatments. Foster care systems are encouraged to seek trauma-informed service providers for foster care youths.

Although trauma theory provides a framework for understanding the effect of abuse and neglect on children's development and functioning, it also provides a way to understand the outcomes of individuals who have experienced trauma (Dye, 2018). The theory is a means of understanding a person's response to traumatic events. In a study of 74 individuals with mental health diagnoses, van der Kolk et al. (1991) used trauma theory as a framework for understanding the impact of trauma and found that childhood trauma and parental separation were significant predictors of self-destructive behaviors. Childhood trauma contributed to starting self-destructive behaviors, such as cutting, suicide attempts, and eating disorders, with a lack of secure and positive attachments resulting in continued self-destructive behaviors. Trauma theory also explained the resultant behaviors and needs of children exposed to the trauma of *maltreatment* or foster care in more recent studies (Liu et al., 2016; Seiler et al., 2016).

Through a trauma theory lens, Liu et al. (2016) explored traumatized Asian foster children with a sample of over 700 foster care youths in Singapore. The researchers used a quantitative cross-sectional study design to determine the proportion of children with interpersonal trauma exposure and the effect of trauma exposure on psychosocial functioning. A standardized assessment instrument, the Child and Adolescent Needs and Strengths (CANS) Tool, was used and adapted for the Singapore child welfare population. The CANS were rated by the researchers through case review and caseworker interviews or by trained and certified CANS caseworkers. The CANS tool measures four domains of functioning: life functioning, school, behavioral and emotional needs, and risk behaviors. The researchers found that 63% of the children experienced at least one

episode of interpersonal trauma, specifically abuse or exposure to domestic violence. Children who had suffered multiple traumas had higher outcomes of poor life functioning and behavioral and emotional needs than those who had not faced trauma.

Trauma theory indicates that the trauma during childhood and adolescence could cause individuals to behave counterproductively to positive development (van der Kolk et al., 1991). Individuals who have experienced trauma have not normalized positive reactions; therefore, they may engage in counterproductive behaviors such as criminal offenses, promiscuity, substance abuse, and skipping school. Attempts to cope with trauma often result in additional harm and adverse outcomes. Building on this knowledge, Seiler et al. (2016) studied 27 Chilean girls in foster care. The girls, age 6–17, were interviewed and assessed regarding their health-related quality of life, their ACEs, and their mental health using a host of assessment tools and feedback from caregivers. The researchers discovered that girls with high ACE scores had significantly higher rates of PTSD diagnoses, increased health issues, and greater behavioral and emotional problems.

The Sieler et al. (2016) study results were not atypical. Individuals exposed to trauma often receive mental health diagnoses, and trauma theory provides a means of understanding psychological problems (Bloom, 1999). Many World War II soldiers received a diagnosis of traumatic neurosis, which professionals later renamed PTSD. A PTSD diagnosis requires a precipitating traumatic event (Bećirović et al., 2017); therefore, it is a common concern for foster care alumni. Like trauma theory, information

processing theory indicates that reactions and results occur due to resultant changes in the brain from life experiences and happenings (Shapiro, 2018).

Information processing theory originated from Lang's theory of emotional imagery (Lang et al., 2016). In the theory of emotional imagery, Lang (1979, as cited in Ji et al., 2016) postulated that a mental imagery representation of an emotionally charged stimulus activates an associative network of stored information that overlaps with that activated during the actual stimulus experience in reality. For example, picturing a spider versus encountering a spider purports that mental imagery is a reproduction of reality and can evoke emotional responses. The theory of emotional imagery led to the development of information processing theory, which explains how stimuli are processed in the brain. Lang and other theorists agreed that information processing occurs through hierarchically organized brain components, each with a limited capacity (Lang et al., 2016). The processing occurs either top-down through concepts or bottom-up through stimulus input patterns. For example, if someone's handwriting is difficult to read, it is easier to decipher when reading in complete sentences compared to one word at a time. Top-down conceptual processing allows the meaning of the surrounding words to provide a context to support understanding the whole. On the other hand, bottom-up processing builds up from the smallest pieces of information to formulate the whole. For example, if a person sees one letter, then one word, then one sentence, their eyes transmit the information piece by piece to their brain, and their brain puts all of the information together.

According to information processing theory, when individuals do not process stressful and traumatic events adequately, the resultant developmental problems could

have lasting effects (Shapiro, 2018). The traumatic experiences become frozen in a state-specific form in an isolated neural network or part of the brain, unable to connect with neural networks or other areas of the brain that contain adaptive information. The frozen information is not processed through top-down or bottom-up means. The brain receives trauma like all other forms of incoming information, but trauma becomes frozen in the senses or sensory memory.

An individual can feel, taste, smell, see, and hear trauma but cannot process it through to short-term or working memory: rehearsing it over and over in their minds; or long-term memory like other information (Shapiro, 2018). The trauma is not forgotten; it is stuck in the memory, unprocessed, and therefore untreated and unhealed. The environment, the perpetrator, a noise, a taste in their mouth, or smell in the air can all be reminders of the event, but alone are only individual pieces of information that have never been processed through bottom-up or top-down methods for understanding the whole and overcoming any fear associated with the event. The event's pieces are bad handwriting in a not-yet-understood sentence. The frozen state of the information and experience often becomes a protective reaction (Shapiro, 2018). The brain will maintain the experience in its frozen state unless deliberately challenged to connect with information for adapting, reacting, and overcoming the trauma.

Shapiro's information processing theory indicates that individuals derive pathologies from early life experiences and develop those pathologies into continued patterns of effects, behaviors, identity structures, and cognitions (Shapiro, 2018). Essentially, although trauma affects individuals differently, each experience could

similarly impact a person's life, including a change in self-perception. Individuals who have experienced trauma know it has happened but cannot make sense of it. When it is frozen in the brain, it is not processed. The traumatic experience could significantly affect the way individuals think about themselves and the world while also reshaping their bodily experience and brain organization (van der Kolk et al., 1991). Trauma often leaves victims stuck in terror, isolation, or shame. Victims often blame themselves and take measures to prevent a similar event. Trauma could make victims more aware of their surroundings to keep them safe in the future or make them not want to leave the safety of their home for fear of what will happen outside. Children, for example, often blame themselves for abuse, which can result in poor behaviors and negative self-thoughts.

Trauma is a significant psychological event experienced differently (Shapiro, 2018). A person's mental health, level of support, or access to treatment and services following trauma are factors in the event's impact and the individual's response. There is no standard for the impact of trauma on a person. Still, according to information processing theory, individuals learn trauma responses in childhood that are closely related to upbringing, parenting, and caregiving (Shapiro, 2018). Trauma responses are learned through observation and how those closest to them respond to the trauma. Learned responses are how abuse and neglect can become normalized to children. Abuse and neglect by primary caregivers can significantly impact how one processes information and responds to trauma (Shapiro, 2018). The resultant negative behaviors, personality characteristics, attitudes, emotions, and physical sensations are reactions to past trauma

and manifestations of the physiological perceptions stored in memories that have not undergone adequate processing to long-term memory.

According to information processing theory, inadequately addressed or processed childhood trauma leads to negative behaviors, characteristics, and emotions that could occur into adulthood (Shapiro, 2018). Unaddressed trauma might be untreated or unacknowledged as having an impact. Young people in foster care often do not receive appropriate services, such as therapy, for addressing their trauma, often due to their refusal, the impact of which may then present into adulthood. Shapiro also developed the adaptive information processing model eye movement desensitization and reprocessing (EMDR), a favored and evidence-based treatment for trauma and PTSD (Landin-Romero et al., 2018; Shapiro, 2018).

EMDR is an approach for understanding how individuals who have experienced trauma process and store memories from disturbing traumatic thoughts. Shapiro (2018) used the method on herself and noticed that her eyes spontaneously moved rapidly back and forth when she experienced disturbing thoughts. The eye movement, she believed, caused her thoughts to disappear or significantly reduced their negative charge. Shapiro (2018) introduced the technique in a 1989 study on victims who had experienced sexual or combat trauma. After one session, the participants prescribed the eye movement methodology showed decreased anxiety and increased positive self-beliefs by their report (Shapiro, 2018). Ultimately, participants using EMDR can expect desensitization to their trauma, a restructuring of memories, and increased self-efficacy. There has not been much research on the use of EMDR on youth; however, data shows its efficacy in

decreasing trauma-related symptoms and behaviors in maltreated adolescents (Kirlic et al., 2020). No studies were found on EMDR use and foster care alumni specifically. Participants in the current study were asked about treatment modalities they had utilized to address trauma and mental health needs.

Trauma and information processing theories provide a useful lens for studying the trauma of racial minority foster care alumni. From these theories, key concepts in behavioral, cognitive, emotional, physical, and social outcomes are derived that guided my inquiry of trauma among racial minority foster care alumni. Some common behavioral outcomes in the chosen population include delinquency, violence toward others, and self-destruction (Perry & Price, 2017; van der Kolk et al., 1991). The theories tell us how trauma changes the brain, and cognitive outcomes include impaired thinking, *dissociation* and a negative worldview (Bertram, 2018; Villagrana et al., 2018). The most common emotional outcome is intense and intolerable emotions that impact overall functioning (van der Kolk et al., 1991). According to the theoretical frameworks, physical ailments and disorders and counterproductive development are common physical outcomes of trauma exposure (Carrellas et al., 2018). Social outcomes from these theoretical frames include relationship issues and sexual identity issues (Brandon-Friedman et al., 2020). These theories aligned with the research purpose due to their use in prior studies on the behaviors and outcomes of trauma victims. The current study contributes to the literature by exploring trauma experiences and the resultant mental health outcomes in an understudied population.

Review of Literature Pertaining to the Problem

Vulnerable Population: Children in Foster Care

Children involved with CPS, specifically those in foster care, comprise a vulnerable population (Traverso-Yepez et al., 2017). Vulnerable populations are individuals with limited access to resources who face higher risks of adverse outcomes than the general population. If a child cannot remain safely at home or does not have available kin or appropriate placement after CPS services, removal from the family home and subsequent foster care placement could increase vulnerability. Children in foster care tend to receive more mental health diagnoses than those in the general population (Gypen et al., 2017). Vulnerability contributes to continued disparate treatment and racial minority stereotypes in the United States, resulting in oppression, discrimination, and marginalization and leading to vulnerability (Harp & Bunting, 2020). Furthermore, there are disproportionate rates of Black and racial minority children involved with CPS (O'Loughlin & O'Loughlin, 2016).

There is further vulnerability in a foster care placement with traumatic experiences. Trauma and other ACEs, detailed later in the chapter, directly correlate with poor outcomes in adulthood (Felitti et al., 1998). Foster care is often unstable, with multiple moves leading to temporary relationships and a compromised ability to form secure attachments (Villodas et al., 2016). Attachments and relationships formed and secured during childhood are crucial for developmental and mental health. Because of their experiences, racial minority foster care alumni often have limited coping skills that result in poor decision-making capacities and the inability to reach optimal physical and

mental health (Villodas et al., 2016). The trajectories of racial minority foster care alumni began in their childhood.

Childhood Trauma

Childhood is a critical time for physical, emotional, and psychological development, with a strong correlation between childhood experiences and outcomes in adulthood (Fratto, 2016; Greeson & Thompson, 2017; Villodas et al., 2016). Childhood experiences remain embedded in memory and could permanently impact the developing brain. CPS involvement could present children with higher risks for poor outcomes than their peers in the general population (Greeson & Thompson, 2017). Further, traumatic childhood events frequently correlate with potentially severe, persistent, and long-term physical, psychological, and substance abuse issues (Fratto, 2016). The earlier the traumatic experiences occur in childhood, the worse and more debilitating the effects on self-esteem, coping skills, self-regulation, and critical thinking skills.

Experiencing childhood adversity and trauma in an early toxic environment is one of the most common risk factors for psychiatric disorders in adulthood, with adulthood mental disorders diagnoses having a strong correlation to living in an early toxic environment as a child (Busso & Sheridan, 2020). *Early toxic environments* are those in which early life, or toxic, stress, adversity, and negative exposures to adult issues occur that are linked to an increased lifetime risk for physical and mental illness, cognitive impairment, and decreased positive societal contribution. In the United States, children are commonly exposed to at least one of the adversities of poverty, domestic violence, loss of a parent, or other development compromising factors. Toxic environments impact

function, mental health, conduct, personality, coping and use of substances, weight, and physical health. Toxic environments expose children to high levels of chronic or toxic stress that shapes psychological and biological development in ways that predispose them to poorer life outcomes. Some stress is normal and even healthy for children, such as sibling rivalries and negotiating with peers. With a supportive caregiver, exposure to healthy stress is like an immunization; it aids against future issues with coping and managing stress. Traumatized children often do not have serve and return relationships with caregivers, making them more vulnerable to the effects of toxic environments.

Traumatic childhood experiences have other adverse effects, as well. Felitti et al.'s (1998) well-known ACEs study, which had nearly 10,000 adult participants, provided information on the health risks of childhood exposure to abuse and household dysfunction. Participants answered questions about childhood exposure to psychological, sexual, and physical abuse in the quantitative study and whether their childhood households included substance abuse, mental illness, domestic violence, or criminal behavior. The vast majority of participants experienced more than one type of adverse experience. Childhood abuse and household dysfunction are correlated to risky behavior in adulthood, such as smoking, physical inactivity, suicide attempts, alcohol or drug abuse, and promiscuity. The greater the ACE exposure, the higher the risk for poor adulthood health and disease, such as obesity, depression, sexually transmitted diseases (STDs), heart disease, cancer, stroke, and diabetes (Felitti et al., 1998). The results showed that, at the minimum, ACE exposure resulted in social, emotional, and cognitive

impairment and, at the worst, early death. Felitti et al. confirmed the long-term effects of childhood trauma, such as abuse and neglect, on health.

Traumas of Child Abuse and Neglect

There is an abundance of research on the trauma of abuse and neglect before foster care placement (Fratto, 2016; Jackson et al., 2016; Lang et al., 2016; McPherson et al., 2018; Rayburn et al., 2016; Riebschleger et al., 2015). Abuse and neglect are significant public health and social welfare problems that impact numerous children yearly in the United States (Lang et al., 2016). Most child welfare professionals recognize three types of childhood abuse: physical, sexual, and emotional (North Carolina Department of Health and Human Services [NCDHHS], 2020). Physical abuse occurs when a child experiences non-accidental physical harm to modify behavior that results in marks or bruises lasting longer than 24 hours and requiring medical attention. Sexual abuse is any sexual act inflicted on or allowed on a child by a caregiver, including viewing pornography. Emotional abuse entails causing or allowing severe emotional damage to a child that results in anxiety, depression, withdrawal, or aggressive behaviors toward self or others (NCDHHS, 2020). Encouraging, directing, or approving a child's delinquent acts, also known as moral turpitude, and human trafficking are also considered abuse. Except for dependency, when a child has no appropriate or willing caregiver, other forms of child maltreatment fall under the category of neglect.

Nearly 80% of children involved with child welfare have experienced neglect, which can potentially cause more harm than physical abuse (Fratto, 2016); in fact, most child maltreatment fatalities result from neglect. Neglect, which could be as mild as

living in a dirty home and as severe as an extremely strict discipline not quite to the level of physical abuse, can result in adverse outcomes in adulthood. The subcategories of neglect are improper care, improper discipline, abandonment, illegal placement or adoption, improper supervision, injurious environment, and improper medical or remedial care (NCDHHS, 2020). Children who lack the necessities of food, clothing, and shelter have experienced neglect due to a lack of proper care. Children also experience neglect when their caregivers leave them alone without responsible and appropriate supervision. An injurious environment for children could range from a home with domestic violence, caretaker substance abuse, or a lack of working utilities. Children who do not receive medical care or do not attend school regularly due to the fault of their caregivers experience neglect due to improper medical or remedial care. Beyond these listed situations, any maltreatment factors could show a child to be unsafe at home, leading to removal or foster care placement.

Trauma of Foster Care Placement

On average, nearly half a million children in the United States each year receive foster care placement due to a traumatic childhood experience (Font et al., 2018; Fusco & Newhill, 2021). The current study was initiated in the largest county in North Carolina, Mecklenburg County, where there have averaged 920 children in foster care each year since 2015 (see Duncan et al., 2019). Before a child receives foster care placement and becomes a dependent of the state, judicial officials must mandate the child's separation from their parents (Fusco & Newhill, 2021). Child welfare professionals always seek family or fictive kin placements first, opting for foster care as the last option. The

decisions made by child welfare agency professionals, judicial officials, and birth parents who may not have the ability to follow through with reunification determine a foster child's future, affecting the immediate and long-term outcomes and developmental trajectories of foster children. The current research was a way to ascertain the effects of traumatic foster care placement on participants' outcomes in adulthood.

Traumatic events or incidents could cause reduced coping capacity, various emotional or physical reactions, and feelings of terror or helplessness (Fratto, 2016; Neal, 2017). Though meant as a safe intervention, removal from biological families or primary caregivers and foster care placement is a traumatic experience for children (Fratto, 2016). Children in foster care may experience emotional and physical reactions to the trauma of removal, including poor sleep patterns, bedwetting, hypervigilance, racing heart, dizziness, and stomach aches (Dye, 2018). Because trauma occurring during the prime periods of brain development could have deleterious effects, mental health care is paramount.

Without consistent preventative measures, foster care could have a harmful impact on children's development and mental health trajectories (Villodas et al., 2016). Despite the intended temporary nature of foster care, placement can last four or more years, causing additional trauma for children who have already experienced abuse and neglect. Negative responses to foster care often include self-harm, worrying, repressing trauma-related thoughts, isolation, substance abuse, running away, property destruction, or aggression. Positive responses to foster care include support, focus on the strengths of the situation, and engaging in extracurricular activities.

In a study of 13 young people in foster care in the Netherlands between the ages of 15–23, Steenbakkers et al. (2019) found that 23% had experienced sexual abuse and lived in unsafe or unstable conditions, or had parents with substance abuse issues. In one-on-one interviews, participants shared their traumatic experiences and coping mechanisms. The study was one of the few that showed the importance of obtaining information directly from those most affected, an approach I used in the current research study.

Foster Care Trauma Experiences

The trauma experienced by foster care youths occurs not only before placement; instead, young people tend to experience trauma before, during, and after foster care (Riebschleger et al., 2015). In a study with 43 participants, over 70% of the young people in foster care shared examples of multiple traumas (chiefly, maltreatment) before foster care, and a third of the participants had experienced trauma during foster care (Riebschleger et al., 2015). Similarly, Fratto (2016) found that up to 90% of foster care youths had suffered trauma, half of them with four or more traumatic events. Thus, foster care could exacerbate emotional, physical, and behavioral reactions after experiencing multiple and complex trauma (Beal et al., 2019).

Foster care tends to cause confusion, fear, sadness, and anxiety as children enter unfamiliar surroundings with strangers (Chambers et al., 2020). Traumatic experiences during foster care comes from placements into congregate care instead of family homes, multiple moves, separation from siblings, and inconsistent or minimal visitation with biological parents and kin (Chambers et al., 2020). The traumas of foster care also

include frequent changes in caseworkers and schools and relocation from neighborhoods of origin. Each move could lead to trauma responses as children feel they do not belong to anyone.

Another during-care trauma is the lack of appropriate trauma-informed services, as service providers have insufficient knowledge or training of trauma (Collins-Camargo & Antle, 2018). In addition, young people in foster care aged 12 and older can usually decide whether or not to participate in services and thus may not address their trauma and increase the chances of adverse outcomes. Child maltreatment traumas can occur before and during foster care.

Physical trauma during foster care could cause serious injury requiring emergency room visits. Young people in foster care visit the emergency room twice as often as their non-foster care peers (Thackeray et al., 2016). Youths in foster care often require medical care for abuse, neglect, and general trauma, with the latter being the most common reason for hospitalization (Jackson et al., 2016; Thackeray et al., 2016). The trauma experienced by children in foster care can result in poor self-esteem, limited coping skills, diminished school performance, the inability to self-regulate and think critically, reduced self-motivation, and a failure to build healthy relationships (Fratto, 2016). Professionals must assess children independently to determine the impact of pre-foster care and during-foster care experiences, as each child will express trauma and mental illness symptoms differently. The research goal for the current study was to obtain trauma perspectives from foster care alumni, including details of their mental health.

Adverse experiences before foster care placement, further trauma due to separation from parents and communities, and potential multiple placements and social workers result in increased vulnerability for already-fragile young people dealing with a multitude of feelings and emotions (Kinarsky, 2017). Additionally, experiencing multiple types of maltreatment before and during foster care increases mental health symptomology and diagnoses (Gypen et al., 2017). Abuse and neglect in foster care without treatment or intervention could have a detrimental effect on a youth's mental health and outcomes. The presented study filled the gap in research by exploring the effects of trauma that has occurred during foster care on racial minority children and young adults (see Gypen et al., 2017).

Racial Minority Children in Foster Care

Racial disproportionality and *disparity* pose ongoing problems in the United States child welfare system (O'Loughlin & O'Loughlin, 2016). In North Carolina, 42% of young adults who aged out of foster care during the 2019 fiscal year were racial minorities (e.g., Black, Hispanic, or Asian); in comparison, however, racial minorities comprise about 30% of the state's population (Duncan et al., 2019). Once involved with child welfare, racial minority children and White children have different experiences (Huggins-Hoyt et al., 2019). Racial disproportionality and disparate outcomes for children of color involved with the child welfare system are common effects of institutional racism (Harp & Bunting, 2020).

Researchers have determined that institutional racism is inherent within child welfare and that racial disproportionality is a product of institutional racism (Harp &

Bunting, 2020). There is a history of child welfare disparities that influence other system disparities and disproportionality, including the Department of Juvenile Justice, which often mirrors the child welfare system. Lee (2016) expanded upon prior child welfare disparity research in examining the State of New York's child welfare system. Lee found that institutional racism and child welfare policies were a means of perpetuating inequalities due to the view that low-income individuals of color were unable to govern themselves and required state supervision. Lee also discussed how child welfare professionals separated families of color, failed to provide for children's emotional and mental health needs after separation and influenced the prison pipeline by criminalizing males of color. New York child welfare is a highly racially disproportionate system, and children of color face the same disparate outcomes as their counterparts throughout the country.

There is a disproportionate representation of racial minority children in every child welfare service, from intake to adoption (Harp & Bunting, 2020; Huggins-Hoyt et al., 2019; Lee, 2016; O'Loughlin & O'Loughlin, 2016). Although racial minority children do not experience abuse or neglect more than White children, investigations into racial minority children often result in more findings of abuse, transfers for in-home services, home removals, and terminations of parental rights (O'Loughlin & O'Loughlin, 2016). After involvement with the child welfare system, the disparities cause racial minority children to face worse outcomes than their White peers. Other research has shown that engagement with child welfare impacts racial minority children's future mobility and results in negative conditioning (Moten, 2018).

Gourdine (2019) reviewed racial equity in child welfare using critical race theory to explain the impact of racism on system equity. With the knowledge that Black children enter foster care at higher rates and exit at slower rates than White children, Gourdine utilized secondary data from child welfare agency reports to assess the disparities in child welfare. The examination of race and the services offered or provided to the families showed implicit bias from intake to service delivery. The chief finding was that all clients did not receive equal treatment; however, equal treatment would be inappropriate, as different families have different needs. Gourdine concluded that ignoring clients' race is not a means of curing disparities, as child abuse and neglect occur across race and socioeconomic statuses.

Further disparity research has shown that there are underreported child abuse and neglect cases for White families. The difference is that White families more often receive more lenient judgment than Black families (Webb et al., 2020). Webb et al. (2020) also found that due to biases and racism, CPS professionals report fewer findings of the need for services, substantiations, and foster care placements for White families. Additionally, when there is a need for removal, CPS professionals utilize kinship more frequently than for Black families. Lastly, due to victimization by institutional racism through involvement with the child welfare or the criminal justice system, CPS is more likely to deem Black families as inappropriate for placement.

Hanna et al. (2017) discussed the impact of institutional racism on foster parent recruitment, with high socioeconomic status and predominately White neighborhoods more frequently targeted. Also, Black individuals tend to avoid targeted recruitment

efforts due to mistrust of the child welfare system. Further, foster care guidelines withhold approval due to applicants' criminal history, previous involvement with child welfare, and the number of people living in the home. In addition, recruiters might not seek kinship placements for the same reasons and due to a narrow definition of kin, making them more accommodating for White families (Webb et al., 2020).

Researchers have explored the causes of disproportionality and disparity in child welfare. Using national and county intake data, Kim et al. (2018) found class-based visibility bias and stereotypes among professionals and nonprofessionals, which resulted in more reports of families in poverty to child welfare for racial minority families. The researchers also found that class-based visibility bias was not the cause for all the disproportionality of child welfare intake but part of the problem nonetheless.

Other authors have found that policies, especially those changed without prior evaluation of effectiveness, have resulted in higher risks of child welfare involvement and disparities for racial minority families (Janczewski & Mersky, 2016; Whittaker, 2017). One of those policies, the introduction of the differential response system, has caused more Black families to undergo investigation versus an assessment, the assessment process being more family-friendly (Janczewski & Mersky, 2016). The poor outcomes of racial minority youths in foster care include more removals from parental care, longer stays in state custody, multiple moves, frequent congregate care placements, and disconnection from the home community (Huggins-Hoyt et al., 2019). The consensus in the research about racial disproportionality and disparity is that significant issues exist nationally and that racial minority children have different and worse experiences in foster

care than White children. The presented study was a means of studying racial minority foster care alumni's experiences and outcomes.

Foster Care Trauma and Mental Health Diagnoses

Some researchers of PTSD and trauma have included the variable of foster care in their studies (Vasileva & Petermann, 2017). Vasileva and Petermann noted that youths in foster care presented PTSD symptoms at a young age, thus indicating the need for professionals to address PTSD while young people are in foster care. Following a review of 324 youths between the ages of 3–7 years, Vasileva and Petermann provided data on the manifestation of PTSD symptoms in very young children in foster care, subsequently stressing foster parents' role in recognizing PTSD symptoms. PTSD could present at any time in life, and some foster care alumni may have suffered from the disorder for over a decade by the time they have aged out.

Trauma of the Aging Out Process

In the United States, 23,000 young adults age out of foster care every year at 18 (Havlicek, 2021). Of the almost 17,000 children in foster care in North Carolina from July 2018 to June 2019, 396 had aged out, with 44% having spent more than 4 years in foster care (Duncan et al., 2019). In Mecklenburg County, between 2009 and 2019, 498 youths had aged out of foster care (439 were racial minority children), and 204 had been in custody for more than 4 years (Duncan et al., 2019). One in 10 foster youth age out of the system nationally (Greeson & Thompson, 2017); Mecklenburg County's age-out rate is about five times higher than the national average. Aged-out foster youths experience more vulnerability and susceptibility to poor social and health outcomes. After aging out,

these young people need a wide array of services that they are not always developmentally prepared for. Racial minority foster care alumni with long-term CPS involvement may experience higher incidents of homelessness, substance abuse, criminal justice system involvement, incomplete education, unemployment, emotional and mental health concerns, and decreased confidence in government agencies (Greeson & Thompson, 2017; Huggins-Hoyt et al., 2019; Kinarsky, 2017).

As mentioned, foster care alumni often suffer worse mental health outcomes than the general population, with a 25.2% rate of PTSD diagnoses compared to 4% (Villagrana, 2017). The transition to adulthood is a significant developmental stage that foster care alumni often experience without the support of biological families (Olson et al., 2017). Many foster youths struggle with the abrupt transition to adulthood at age 18 years, resulting in poor choices and emotional and mental health stagnation. Foster care alumni often have not received the opportunity to build human capital and social resources like others their age, making them ill-prepared and unsupported when facing issues that arise in life (Greeson & Thompson, 2017; Thompson & Greeson, 2017). The first year as a foster care alumnus is a significant period requiring more examination (Tyrell & Yates, 2018). In the presented study, I made an effort to research the initial alumni period and racial minority foster alumni outcomes; however, I ended up having to expand the participant age range to garner more participants.

Racial Minority Foster Care Alumni and Their Outcomes

Foster care alumni are young people who "aged out" of foster care when they turned 18 while in the custody of a state or local child welfare agency (Fusco & Kulkarni,

2018). Youth who have spent a long time in foster care often find themselves lacking human and social supports and resources (Greeson & Thompson, 2017). Many researchers on foster care alumni have not explored the youth's perspectives, though I found one that did. In their mixed-methods study, Armstrong-Heimsoth et al. (2020) studied 16 foster care alumni ages 18–20. Through semistructured interviews and questionnaires, the researchers gathered data regarding the alumni's experiences of the transition from foster care. The researchers found a need for earlier preparation for transition to include opportunities to practice and learn decision-making and life skills. Such preparation aids in preventing *learned helplessness* in adulthood. Having supports or mentors to aid through transition was also helpful as the alumni's relationships were vital in whether they chose to utilize available services. Supportive relationships and transition service availability are topics I explored in the presented study.

Other studies on foster care alumni have often focused on resiliency (Geiger et al., 2017; Harwick et al., 2017; Neal, 2017). Another topic of interest is the supportive services from which foster care alumni benefit the most (Chambers et al., 2020; Greeson & Thompson, 2017; Piel & Lacasse, 2017; Salazar et al., 2016; Thompson & Greeson, 2017). Researchers have also mentioned the need for trauma-informed service providers to work with young people in foster care (Collins-Camargo & Antle, 2018; Fratto, 2016). More study is needed on this population as the trauma experienced by foster care alumni impacts them and affects families, communities, schools, and taxpayers (Collins-Camargo & Antle, 2018).

Foster care alumni's outcomes have been researched (Fusco & Kulkarni, 2018; Tobolowsky et al., 2017; Villagrana, 2017). Racial minority children involved with child welfare and young people in foster care diagnosed with mental health disorders often face the same outcomes (Lang et al., 2016). Although scholars have studied the problems of racial and mental health disparities among foster care alumni, little has been specific to the lived trauma experiences of racial minority foster care alumni in the United States (Gourdine, 2019; Liming et al., 2021; Riebschleger et al., 2015).

An older but relevant study, Riebschleger et al. (2015), studied young people's trauma during and after foster care; however, they did not specifically explore foster care alumni or racial minority foster care alumni. Participants ranged from 15–23 years old, with their tenure in foster care not specified. In the study, 21% of the participants described the during-foster-care trauma of being forced to take medication. The young people also reported multiple instances of emotional abuse, the inability to maintain contact with siblings and other family members, and disrupted adoptions. After foster care, most participants identified significant traumatic experiences by way of unsafe or unstable housing and the inability to visit siblings and families. Though I used purposive sampling and excluded nonracial minority participants in my study, in the Riebschleger et al. study, the limitations were identified as utilizing a purposive, nonrandom sample and the exclusion of participants from races other than Black or White.

Pecora et al. (2006) completed possibly the most extensive study on foster care alumni, reviewing the records of nearly 700 foster care alumni aged 20–33 years who had been in foster care for at least 12 months. In addition, Pecora et al. interviewed almost

500 of the youths who resided in Washington or Oregon. Over a third of the participants had mental or physical health diagnoses, with ADHD being most prominent. The large sample size was a strength of the study, as was the racial representation, with 54% representing racial minorities. Findings on mental health were consistent with other literature, as were the disparate foster care alumni outcomes. Research limitations included a lack of generalizability, the age of the study, and a significant amount of information obtained from case records instead of the alumni themselves. The participants provided all of the data in the presented research.

The literature review related to the problem clarifies that the research on foster care being traumatic and leading to poor outcomes for foster care recipients has been plentiful. The narrower focus of research on racial minority foster care alumni and their outcomes is missing and what the presented research addresses. A review of the literature related to the outcome domains identified by the theoretical frameworks follows.

Review of Outcome Research

Experiencing and being exposed to trauma can change a trauma victim's life trajectory. Trauma can affect a person from their brain mechanics to their relationships (Shapiro, 2018; van der Kolk et al., 1991). Racial minority foster care alumni experience traumas from their primary caregivers (Fratto, 2016), and more often than not, trauma experiences continue throughout their stay in foster care (Riebschleger et al., 2015). Those trauma experiences impact their outcomes in many domains into adulthood, leaving them unsure of how to navigate and seek help when the adverse events start (Rome & Raskin, 2019). In a large multi-wave study of Midwest foster care alumni,

researchers found bleak quality of life outcomes (Bertram, 2018). Many foster care alumni struggle with having their basic needs for food and shelter met and fare worse than peers in obtaining stable employment and furthering their education. Health and mental health issues are common, as is involvement with the legal system (Font et al., 2018). Foster care alumni, especially racial minority foster care alumni, are an understudied population; however, foster care as a concept has been studied concerning outcomes, and foster care children have been participants in numerous studies. The following review of literature details the previously studied outcomes of foster care youth and alumni in the domains identified by the theoretical frameworks.

Behavioral Outcomes

Brain changes caused by trauma can lead to maladaptive behavioral changes (Shapiro, 2018; van der Kolk et al., 1991). Violence and delinquency are not uncommon for individuals who experienced childhood trauma, and even more so for individuals who spent time in foster care (Yang et al., 2017). Self-destructive behaviors often plague trauma victims (van der Kolk et al., 1991). In addition, behavioral concerns of hiding food, self-stimulation, hypervigilance, hyperactivity, and indiscrimination toward adults often show up in traumatized youths.

Substance use and abuse is also an area of concern for foster care alumni, especially those who have experienced physical or sexual abuse (Fusco & Newhill, 2021). In their quantitative study comparing foster care alumni with low-income adults, the alumni were more likely to have used marijuana. In fact, the alumni generally reported daily marijuana use. All 185 participants were ages 18–24 with regular places to

sleep, no sleep disorders, and no persistent mental illnesses. Trauma exposure, physical abuse, and anxiety positively correlated with daily marijuana use. Other predictors of marijuana use were entering foster care at a young age and spending more time there. Behaviors exacerbated by their foster care experience were a point of inquiry in the current study.

Perry and Price (2017) studied 160 children in foster care in San Diego. The children ranged in age from 4–13. Though not targeted, nearly half (49.4%) of the participants were Hispanic, and most were racial minorities. The researchers used quantitative methodology to determine whether placement type, family environment, and placement history correlated in any way to children's aggression. The participant's caregivers were interviewed at two points, four months apart. Regression analyses were used to analyze the data provided through three questionnaires completed during six interviews for each caregiver.

The researchers found that children with prior stays in group homes and currently placed in a non-kinship (traditional foster care) placement generally displayed higher physical aggression levels (Perry & Price, 2017). Children who had multiple moves and were placed in foster care due to neglect showed higher levels of relational aggression or a propensity toward physical or verbal violence with others. Children with higher levels of relational aggression, usually toward other children in the home, were generally not as physically aggressive unless the other children in the home were biological children of the foster parents. Under those circumstances, children were more physically aggressive and less relationally aggressive. Higher relational aggression was also found when

children had been in placements for more extended periods with multiple other children, at least one being a foster parent's biological child.

Essentially, type of placement, length of placement, number and variety of previous placements, and the reason for entry into foster care were all determinants on the level of aggression displayed by children in foster care and whether it is relational aggression, physical aggression, or both (Perry & Price, 2017). The findings of this research highlight the importance of seeking familial placements for children and ensuring caregivers are equipped or provided with appropriate education to cope with and combat aggression in foster children. Though Perry and Price's research was not conducted on alumni, 80% of their participants were racial minorities. They will one day meet the criteria for the current study if not reunified with their parents. Longer stays in foster care is a predictor for becoming a foster care alumni. The findings also give rise to the fact that untreated or unaddressed aggression will follow children into adulthood. The presented study targeted an older racial minority participant pool who, in their own words, provided details regarding behavioral characteristics they still carry from a traumatic childhood.

Traumatic childhoods can also lead to self-destructive behaviors (van der Kolk et al., 1991). The researchers found that many self-destructive adults were self-destructive children with histories of trauma and being removed from their parent's care. Self-destructive behaviors include cutting and suicide attempts. Dissociation frequently occurs before becoming self-injurious, where the traumatized often feel numb or dead and feel a sense of relief afterward; this was especially true with cutting behaviors. The researchers

studied between 74 and 124 participants in a longitudinal study over 8 years (1980-1988), with 74 individuals participating from beginning to end. Final participants were interviewed using a 100-item questionnaire in semistructured interviews. The participants ranged in age from 18–39 and were initially patients in a clinical setting; therefore, all had underlying mental health or personality disorders. The presented study participants may or may not have had a mental health diagnosis but shared similarities in age and had experienced childhood trauma, specifically abuse, neglect, and abandonment or separation from parents, which van der Kolk et al. (1991) found to be a predictor of self-destructive behaviors. My study also utilized semistructured interviews to gain the richest information regarding whether the participants engage in self-destructive behaviors and the origins of those behaviors.

Franklin et al. (2017) expounded upon the research of van der Kolk et al. (1991) by completing a meta-analysis of studies that have been used to longitudinally predict suicidal thoughts and behavior (STB) related outcomes. After analyzing 365 studies conducted over 50 years (1965-2015) to estimate the power and accuracy of risk factors, the results were unexpected. Whereas van der Kolk et al. (1991) argued that childhood trauma was a predictor of STBs, Franklin et al. found that existing risk factors were weak and inaccurate predictors of STBs. In fact, STBs have low predictive ability. Also, available data was not sufficient to evaluate hypotheses and theories about STBs. Ultimately, the researchers found that STBs have been studied incorrectly and with constrained study methods. They purport that no specific risk factors were strong in predicting STBs. Instead, there are likely many different STB paths, and one size fits all

algorithms for prediction is unlikely. The algorithm for racial minority foster care alumni will be different from adolescents, prisoners, veterans, preachers, or the elderly. A shift from risk factors to risk algorithms was recommended. The presented study could have helped formulate an algorithm for STB risk in racial minority foster care alumni if STB was indeed an outcome of this population.

Cognitive Outcomes

Trauma usually stays on the mind. Its immediate effects often begin in the brain, where unprocessed thoughts and the long-term impacts can include mental health disorder diagnoses (Shapiro, 2018; van der Kolk et al., 1991) and impaired thinking (Fratto, 2016). The brain's impact is how abuse and neglect can become normal and expected for child victims (Shapiro, 2018). Just one traumatic experience can alter the make-up of the brain, becoming stuck and remaining unprocessed and having detrimental effects. The mental health outcomes of racial minority foster care alumni were the main focus of the presented study.

The most common mental health diagnoses for foster care children and alumni are ADHD, oppositional defiant disorder, conduct disorder, anxiety, PTSD, and depression (Fusco & Newhill, 2021). Trauma experienced during foster care tends to increase the likelihood of a mental health diagnosis (Gypen et al., 2017). Once they age out, foster care alumni with mental health diagnoses often fall through the cracks and, in turn, experience worse outcomes (Kang-Yi & Adams, 2017). In their systemic review of literature on the topic, foster care alumni with mental diagnoses were found by Kang-Yi

& Adams to be at greater risk for a lower quality of life and worsening mental health conditions.

Though mental health disorders are common in foster care alumni, mental health service utilization often declines by 54-60% post-age-out (Villagrana et al., 2018). The prior named researchers set out to determine how stigma, self and public, may attribute to post foster care service participation. In their study of 13 foster care alumni, the researchers found that self-stigma developed in foster care due to being in foster care often negatively impacts mental health service participation post foster care. The alumni in the study reported concerns about being further labeled through service participation. They also acknowledged that it is not uncommon for people to lack understanding about mental illness and the services provided to address it. Alumni rejected services to avoid mental health stereotypes often given to those with mental health disabilities that they are incapable of independence and negative perceptions of being less competent than the average person. Failure to participate in services can further enhance already poor mental health and negatively impact self-esteem, self-efficacy, and resiliency. Foster care youth with mental health disorders are often also overmedicated and undereducated regarding medication purposes and side effects (Bertram, 2018; Font et al., 2018). In the presented study, I inquired about perceived stigma regarding diagnosis and treatment and whether their trauma was treated as a disease and medicated to determine whether similar results would be found.

Further research on service utilization has shown that racial minority foster care alumni do not utilize mental health services, with Latino foster care alumni having the

lowest utilization rates (Villagrana, 2017). There are also disparities in the types of services used. With a suspected underestimation of more than half (54%) of foster care alumni having a mental health diagnosis, there is a need to study the effects of the diagnoses and outcomes. Without regard to service provision being adequate or appropriate, youths in foster care tend to receive mental health services at higher rates than the general population; however, when they become alumni, the usage drops by more than 50%. Participants reported using individual behavioral therapy, group therapy, psychotropic medication, crisis intervention, residential services, or day rehabilitation in the study. Of each type, group therapy was the most common service utilized post foster care, followed by individual therapy, then medication. Piel and Lacasse (2017) also found that foster care alumni participate less in care and therapy after they age out of the system despite continued mental health issues. The validity of these claims was a topic explored in my research.

Dissociative symptoms are also a common adult outcome for foster care alumni (Vonderlin et al., 2018). *Dissociation* is a disruption of consciousness, memory identity, emotion, perception, body representation, motor control, and behavior. Dissociation produces a domino effect on one's development. Emotional learning and mental functions are disrupted, identity development is stalled, and self-control and regulation become difficult. Dissociation is also hard to treat and ranges from mild to severe, where one watches oneself living. Dissociation can happen when fight or flight responses are ineffective and often start in childhood when victims cannot fight or escape their adult abuser. Vonderlin and his peers used secondary data from 65 previous studies in their

study. In over 7300 victims of abuse or neglect, dissociation was common, but even more so when the individual had experienced sexual or physical abuse that started at a young age, was long-term, and was inflicted by a parent. The researchers used the Dissociative Experience Scale (DES) to measure dissociation in participants. Though their research was not specifically on foster care youths or foster care alumni, since most foster care alumni were abused or neglected during childhood leading to placement in foster care, dissociation symptoms were a point of inquiry in the current study.

Emotional Outcomes

The effects of trauma affect every area of a victim's life. Emotionally, trauma victims often have intense and intolerable emotions (van der Kolk et al., 1991). It is also common for trauma victims to be suspended in terror, isolation, shame, or self-blame due to unstable emotional regulation and slowed cognitive processing (Kang-Yi & Adams, 2017; van der Kolk et al., 1991).

In their study on 13 former foster care youths in the Netherlands ages 15–23, Steenbakkers et al. (2019) found that emotional problems were one of the three trauma impact areas. Their study participants had been in family foster care for at least 2 years and were older adolescents or young adults. Their ages were specific because they felt that the age range of participants would reflect on their childhood coherently and with detail. Episodic narrative interviews were conducted, and participants could elaborate on the stories they chose to share with detailed descriptions. The participants shared their trauma experiences before foster care, and a parent or other close adult had inflicted most traumas. Experiencing emotional and social problems were common for all participants.

The participants internalized their problems, which led to depression and sadness (Steenbakkers et al., 2019). Anxiety was also common and led to nightmares, fear of the dark, and trouble sleeping. Some participants also had a profound fear of being abandoned again. Ultimately, the trauma experiences impacted participants' self-esteem and caused them to feel inferior and ashamed of what they had gone through. Anger was a prominent emotion that stood out. They were angry about what happened before they were placed in foster care and angry about being in foster care. Angry outbursts were common but often misdirected at their new caregivers, who they could not trust not to do the same as their parents. For victims of sexual abuse, the anger was toward the perpetrator, people who knew about it and did not act on their behalf, and toward people who showed any romantic sexual interest in them. Foster care became an emotional loss of the participant's birth parents and the loss of physical closeness. The emotional loss led to feelings of loneliness and isolation. Some participants felt lost and jealous of other children who had normal families.

The Steenbakkers et al. (2019) study is similar to the presented research in that data was provided directly from individuals who experienced trauma and foster care. It highlighted the richness of information that can be provided through semistructured interviews with this population. In the presented research, I looked primarily at trauma experienced during foster care instead of before. I, too, was hopeful that with an older participant population, the details and descriptions provided would be rich.

I could not find any information or studies about positive emotions experienced by foster care alumni. In addition to anger, other emotions highlighted by foster care

alumni about their plight include frustration, betrayal, hurt, and grief (Chambers et al., 2018). In their research on the impact of multiple moves with 43 foster care alumni, participants self-reported these feelings and how the constant moves left them feeling unwanted and resulted in emotionally distant relationships in adulthood. The distance becomes a defense mechanism, as they expect relationships to be short-lived and end. Being close to someone is emotionally risky, so they often do not chance it. Emotionally distant relationships were common for all participants, and they reported coming to the point of expecting the worst from others and not being able to trust. Multiple foster care moves are traumatic and were one of the areas of discussion in my study's participant interviews.

Physical Outcomes

Physically, the impact of trauma often presents as stunted development (Seiler et al., 2016) and physical ailment diagnosis (Fratto, 2016). The victims of trauma can developmentally mature slower than their peers who have not been exposed to trauma. Later in life, diagnoses such as diabetes, high blood pressure, obesity, and STDs often occur (Felitti et al., 1998).

Sleep disorders and overall poor sleep patterns also linger after foster care (Fusco, 2020). In her study on 111 foster care alumni, Fusco found that nightmares and fewer hours of sleep were more common in foster care alumni than low-income adults in the same age range. Participants wore a Fitbit device for 5 days to measure their sleep patterns. The alumni slept around 4.6 hours a night and woke up an average of 7 times. It also took alumni nearly double the time to fall asleep (32 minutes versus 17 minutes), and

they were more likely to rate their sleep as poor. Spending time in foster care and anxiety were both positively correlated to fewer hours of sleep. Lee and Fusco (2021) had similar findings on alumni and found that more ACEs led to poorer sleep. Participants of the presented study were asked about their sleep patterns.

Among the physical health care issues foster care alumni face, access to oral health care has been a historical barrier (Carrellas et al., 2018). Though the population often has Medicaid, they frequently lack dental insurance. About 40% of the foster care alumni population fell into this category. In their mixed-methods study, Carrellas and peers explored factors contributing to foster care alumni's oral health care disparities. Nearly 94% of those without dental insurance were found not to have their oral health care needs met and were facing rotted, broken, or abscessed teeth needing to be pulled, wisdom teeth issues, and jaw alignment problems. Contributory factors also included lack of a support system and Medicaid not providing comprehensive oral care past age 20.

The study consisted of foster care alumni in Michigan (Carrellas et al., 2018). The researchers used convenience and snowball sampling methods for recruitment, utilizing child welfare agency contacts and foster care alumni networks. Also, like in the presented study, participants had aged out of foster care and were at least 18 years old. The study garnered 66 participants who were studied over 18 months from 2006 to 2008. Participants completed individual interviews (16), participated in a focus group (34), or completed a survey (16). The participants were from different races, with 91% Black or White. More than half had unmet dental needs. Race, placement type before aging out,

and gender were all insignificant independent variables for having unmet dental needs, with the significant barrier being whether they had dental insurance.

A significant number of the participants aged out of foster care without knowing their Medicaid eligibility would terminate eventually and lacked the income to pay for out-of-pocket dental expenses (Carrellas et al., 2018). Though NC offers Medicaid to foster care alumni until age 26 (NCDHHS, 2019), inquiring about participants' knowledge of the services available to them and whether they know how to enroll and maintain coverage yielded important information in the presented study. While oral health challenges do not seem to impact racial minority alumni disproportionately, it was worth inquiring about, especially because oral health issues can lead to heart and lung disease, strokes, and problems with diabetes or during pregnancy. Like all unmet physical health needs, oral health concerns can also contribute to stress and exacerbated mental health issues.

Despite being afforded Medicaid, foster care alumni are at greater risk for chronic health conditions than their peers who did not spend time in foster care (Rebbe et al., 2018). The researchers followed 732 transition-age youths in foster care from Illinois, Iowa, and Wisconsin in a longitudinal study. The participants, about 70% of whom were racial minorities, were followed from 17 until they were 26. Data from the Midwest Evaluation of the Adult Functioning of Former Youth in Foster Care study followed some of the same youths. Participants for the Rebbe et al. study were eligible if they were out of foster care for at least one year and were between the ages of 17–17.5 at the time of recruitment. Participants were divided into three subgroups identified by their ACE

histories. Complex adversity participants reported eight different types of adversities; environmental adversity participants reported about six, and lower adversity about three. Group mean statistics were applied to test differences between the groups for young adulthood physical and sexual health outcomes. The study informed the presented research because youths in the complex adversity group had the highest risk for poor physical and sexual health outcomes. ACEs histories were evaluated in the presented study to determine any consistencies in findings.

The participants' general health status in the Rebbe et al. (2018) study was assessed as poor, fair, good, very good, or excellent. The most common issues included being smokers, being obese, suffering heart conditions and sleep problems, managing personal STDs or caregiving for a partner with one, and self-reporting poor or fair health. About 61% also reported having a non-cardiovascular chronic physical health condition. The researchers advised about the potential for underreporting health conditions due to obtaining self-report versus using clinical or administrative data and encouraged assessing for duration and frequency of traumatic experiences and ACEs for more substantial and detailed data. The presented study extended this and previous work on dose-response relationships involving ACEs and outcomes and specifically targeted racial minority foster care alumni; a population not found to be targeted in prior literature.

Social Outcomes

The neighborhoods and communities where trauma victims reside are often exposed to and impacted by the social outcomes of trauma victims' experiences (Collins-

Camargo & Antle, 2018). Communities are impacted by trauma victims' behaviors, ranging from skipping school to criminal offenses (van der Kolk et al., 1991). Researchers have found that for foster care alumni specifically, relationships with individual family members can reduce the risk of substance abuse, criminal and other risky behaviors, and mental health disorders (Gypen et al., 2017; Rayburn et al., 2018). Social environments make a tremendous impact on development, as evidenced by the earlier discussion on the effects of early toxic environments. For foster youths, their social environments and relationships with supportive and important non-parental adults can determine whether their well-being and mental health outcomes are positive or negative (Rome & Raskin, 2019). In fact, those adults can be compensatory to foster youths, bringing about trauma healing, improving psychological functioning, lessening problem behaviors, reducing depression, improving self-esteem, and encouraging positive social relationships. Positive, impactful peer relationships can also bolster youth's self-esteem in foster care and minimize participation in risky behaviors (Thompson et al., 2016). That fact is used to recommend targeted therapeutic services focusing on self-image. Internal and personal social issues also exist, affecting the trauma victim's relationships and societal contributions (Brännström et al., 2020). In the presented study, an inquiry was made into the peer and non-parental relationships created and maintained while in foster care and after aging out. Further questioning delved into whether these relationships served or continue to serve any healing or protective roles in participants' lives.

Trauma victims can also deal with issues in their interpersonal relationships. Sexual identity concerns can exacerbate those relationship issues (Brandon-Friedman et al., 2020). Disparate sexual health outcomes are among foster care alumni's physical health outcomes due to their behavioral outcome of risky sexual behavior. Sociosexualization is defined as the impact of peers, family, social environment, and media on sexual identity development and sexual well-being. Brandon-Friedman et al. studied the impact of sociosexualization and sexual identity development on youth's sexual well-being who spent time in foster care. Over 200 such youths completed an internet survey to gather the data. The recruitment methods included reaching out to agencies serving foster care alumni, posts in social media groups for foster care alumni and foster parents, and advertisements in foster care related publications, which all proved successful in reaching potential participants. Like the presented study, participants were ages 18–24 and spent at least one year in foster care. The researchers compensated them $20 for their participation. Two factors that negatively impact sexual identity developments were ACEs and sexual abuse severity. Other negative impacts were discussions about sexuality had with foster parents and uncertainty about sexual orientation. The study results show that ACE questioning is imperative, and I could not overlook their effects in the presented research. It was also essential to consider alumni relationships with prior foster parents.

Another social outcome is involvement in unhealthy romantic relationships. To identify targeted prevention efforts, Katz et al. (2017) studied the disparate outcome of ending up in a relationship involving violence in the emancipated foster youth

population. They postulated that this population was more vulnerable to intimate partner violence due to violent trauma exposure and parental maltreatment, and being just out of foster care heightens the risk. In their longitudinal study, protective factors and risk factors were explored. With participants ages 23–24, over 20% had been in or were involved in intimate partner violence-filled relationships, most with bidirectional violence. Risk factors included past parental intimate partner violent relationships, neglect or maltreatment by a foster caregiver, and multiple foster care moves. It was also common for victims and perpetrators to have anxiety or PTSD diagnoses. Given that 20% of these study participants reported intimate partner violence, an inquiry into intimate partner violence in romantic relationships was warranted in the presented study.

Additional Outcome Research

Other researchers have also studied the outcomes of children who were in foster care or foster care alumni. Gypen et al. (2017) completed a systematic review of outcome literature, and the findings were bleak and showed that alumni struggle in most life domains when they leave care. However, another group of researchers, Font et al. (2018), found data that contradicts some other research about this population. In their study of nearly 8500 youths who had been in foster care in Wisconsin from 2005 to 2015, they found that youths who aged out of foster care had higher odds of graduating high school and enrolling in college than reunified youths and youths with other permanent plans. Alumni and youths who were adopted had similar rates of high school graduation and college enrollment. The researchers used secondary data for their study, with 22% of the participants being alumni, most of whom had been in care for more than 18 months (Font

et al., 2018). Like other studies on this population, Black youths were disproportionality represented in the aged out participants. Also, the number of placements, time in congregate care, and age at first removal were all negatively associated with high school graduation. Their research ultimately found that permanency alone is not a sufficient measure of foster youth's future educational and economic outcomes. Educational outcomes were a point of inquiry in the presented study.

Individuals who have been in foster care have also been studied at other age points and in different countries. Brännström et al. (2017) examined individuals who were placed in foster care in childhood and now aged 55, in midlife. Swedish data were used from a cohort of over 14,000 individuals born in 1953 who could be followed to age 55 in 2008. Midlife trajectories were examined in terms of social, economic, and health-related disadvantages, explicitly focusing on those in the cohort who spent time in foster care (n =881). About half of the participants did not have poor outcomes at age 55, but the results are more complicated than that.

Data were derived from available statistical outlets to determine whether the participants received social assistance to evaluate economic hardship, whether participants were unemployed, and whether they had mental health problems, as evidenced by hospital admission due to mental or behavioral disorders (Brännström et al., 2017). The exact length of time in foster care and the age of entry was unknown; however, from the record review, the researchers deduced that the majority entered care during preschool years and stayed less than 2 years. The study sought to add to the body of literature about the recipient of foster care outcomes by studying midlife outcomes.

Ultimately, having experience in foster care was associated with elevated odds of ending up in persistent disadvantage compared to peers. Many had episodic experiences of disadvantage, though. Alumni seem to do better as adults but remain overrepresented in terms of serious health problems and social marginalization. The overall suggestion is that today's alumni could have even worse odds than those in the study. The results support the thought that children who spent time in foster care are truly disadvantaged, as suggested by research produced in the late 70s. There are fewer employment opportunities for young people without formal education in this era, especially in Western countries, contributing to alumni disadvantages. The results also point to educational attainment being a significant factor in success and advantage and a factor that was assessed in the presented study with new alumni transitioning into adulthood.

Lastly, in their research on 65 foster care alumni ages 23–24 in Michigan, with 60% being a minority race, White et al. (2015) found disparate outcomes prominent in mental health, substance dependence, and education. Regarding mental health, one-third had three or more mental health diagnoses, with PTSD appearing most commonly followed by depression. Over 20% struggled with alcohol or drug dependence. The interview process of the study was important to note. Since some of the topics were sensitive, participants were given the option to answer those questions on a computer via a self-administered audio interview program. The study highlighted that the child welfare system has not kept up with the changing times to meet the needs and improve the outcomes of foster care alumni. At a minimum, the study provided suggestions on the

types of questions to ask participants in the presented research and a method to consider for the inquiry into sensitive topics.

Summary and Conclusions

This extensive literature review began with studies on the foster care population, child welfare trauma, and the resulting mental health concerns and ended with foster care alumni's outcomes. Prior researchers studied the existence and prevalence of racial disproportionalities and disparities in the child welfare system and the unequal treatment of service recipients (Huggins-Hoyt et al., 2019). The child welfare system is a means of protecting children after they have experienced traumas in unsafe homes. Racial minority young people receive CPS services at higher rates than Whites, making them susceptible to the poor outcomes of trauma and CPS involvement. After lengthy stays in foster care, alumni often experience mental health diagnoses, additional trauma, and problems that present into adulthood, such as homelessness and substance abuse (Greeson & Thompson, 2017).

Continued review of relevant literature included studies on the behavioral, cognitive, emotional, physical, and social outcomes of foster care youths and foster care alumni as suggested by the theoretical frameworks. Though highlighted in a specific area, several studies overlapped in outcome areas, unsurprisingly because cognitive and emotional issues often precede behavioral, physical, and social outcomes. Though researchers have extensively studied young people in foster care, there is limited information on racial minority foster care alumni and the effects of trauma on their mental health in adulthood. Despite the frequent occurrence of trauma in foster care,

there were no studies on racial minority foster care alumni's lives after they aged out of the child welfare system, especially from the alumni's perspectives (Font et al., 2018).

Significant exposure to trauma occurs in foster care, the results of which were the focus of the presented study with a concentration on mental health outcomes resulting from the trauma of foster care. However, physical and social outcomes exist as well. Those topics were explored concerning mental health outcomes, as research has found both to increase stress and exacerbate mental health issues. A purposeful sample of racial minority foster care alumni provided their experiences of trauma, mental health symptomatology, and treatment. Racial minorities were the specified population because racial minority foster care alumni experience the child welfare system at higher rates than Whites (see O'Loughlin & O'Loughlin, 2016). In Chapter 3, I present the research methodology for the current study.

Chapter 3: Research Method

The purpose of this qualitative study was to understand the effects of the trauma experienced during foster care on racial minority foster care alumni's mental health in adulthood. Previous research showed the pervasiveness of mental health diagnoses and the societal hardships of this population (Gourdine, 2019; Liming et al., 2021; Riebschleger et al., 2015). An extensive search of the literature returned no studies of United States racial minority foster care alumni experiences and the effects of trauma on adulthood. With United States racial minority foster care alumni as participants, I explored the trauma of foster care and the effects of trauma on their mental health. In Chapter 3, I present the research design and rationale, my role as researcher, methodology, participant selection logic, instrumentation, and procedures. The chapter also includes the plan for data analysis, issues of trustworthiness, and ethical procedures.

Research Design and Rationale

The problem addressed in this research was the effects of the trauma experienced in foster care on racial minority alumni's mental health. The research question was what at are the effects of the trauma experienced in foster care on racial minority foster care alumni's mental health in adulthood? A generic qualitative approach was the best method for answering this research question because the design facilitates exploration of human phenomena or participants' lived experiences without methodological constraints (see Creswell & Creswell, 2018). Although a generic qualitative approach does not have a specified design, it enabled a thorough description and interpretation of racial minority foster care alumni's trauma during foster care (see Kahlke, 2018). The approach allowed

me to evaluate the participants' experiences as constructs of their worlds and outcomes, giving meaning to their experiences.

The generic qualitative approach is useful for research that does not fit with prescribed methodologies (Kennedy, 2016). The selected methodology does not include philosophical assumptions, thereby providing flexibility for building on ideas, traditions, and practices from previous research (Kahlke, 2018). There are two subcategories of the generic qualitative approach: interpretive and descriptive. The interpretive approach entails developing research questions from practice to provide theoretically sound evidence usable in the practice setting. Descriptive qualitative research consists of a low inference description of the phenomenon and minimized inferences to protect the purity of the data. Additionally, the generic qualitative approach is a beneficial method for expanding the criteria for new research (Kahlke, 2018). I included rich, detailed descriptions and interpretive analysis of collected data.

The generic qualitative approach enabled me to discover the participants' beliefs, opinions, attitudes, and firsthand experiences. The purpose of the current study was to explore the trauma of foster care from racial minority foster care alumni's subjective perspectives. Answering the research question entailed collecting direct information about the participants' previous and current experiences. The selected approach enabled me to interpret and investigate participants' experiences, opinions, and perceptions, providing deep and contextual comprehension of participant outcomes.

Role of the Researcher

My role as researcher was to recruit, select, and interview participants; manage interview transcripts; and complete the analysis and interpretation of the collected textual data for this study. After selecting participants, I scheduled interviews and interviewed each participant. I reviewed the informed consent form and answered any participant questions before each interview. I ensured there were no issues regarding personal or professional relationships and prepared to manage any issues that may have developed or arisen.

The researcher is the instrument in a qualitative study. Generic qualitative researchers conduct their studies from a reflexive viewpoint, considering personal experiences and recognizing the influence of those experiences on the research process and outcomes (Green, 2020). Researchers must ensure that biases do not produce weak conclusions or unaddressed problems to avoid undermining the study's validity. Practicing reflexivity allows researchers to remain objective and intentional when analyzing methods and procedures. Researchers attend to and manage bias through reflective journaling, reviewing findings with participants, and acknowledging the study's limitations and assumptions (Creswell & Creswell, 2018). Generic qualitative researchers must also use an interpretive approach, which requires iterative data gathering, thematic analysis, and descriptions of the participants' subjective opinions (Kennedy, 2016).

Because I am a manager with the Department of Social Services, the participants could have viewed my professional position as a power differential. Participants may

have felt as if they had to comply or participate solely due to my role at the agency. Informed consent, a clear explanation of voluntary participation, and participants' ability to withdraw consent allowed me to manage the power differential. A researcher must adhere to ethical standards and codes to guide decision making during the research process (Kennedy, 2016), maintain boundaries, remain unbiased, and practice integrity. I had no personal or professional relationships with the participants.

Methodology

Participant Selection Logic

The population was racial minority foster care alumni in North Carolina and throughout the United States. The participating Black, Hispanic, and Asian young adults ranged from 18–21 years of age initially; then, the age range was changed to 18 and older. For over 2 decades, the period of emerging adulthood (18–25 years) has been of theoretical and empirical interest to researchers (Tyrell & Yates, 2018). During these years, young adults may explore their identities and experience self-reliance, optimism, instability, and the feelings that result from being between adolescence and adulthood. Foster care alumni have different experiences than their peers, yet are an understudied population (Tyrell & Yates, 2018). The original range of 18–21 was chosen due to those ages being in the emerging adulthood range and those ages having more recent experiences with foster care. The range was expanded due to limited participation.

Purposive sampling is appropriate for generic qualitative research to ensure that collected data align with the research questions (Kahlke, 2018). Purposive sampling enables a researcher to select participants who represent experiences rather than a

population (Creswell & Poth, 2018). The current study's goal was to understand each participant's experience, thereby indicating the need for purposive sampling.

The data collection method for this study was semistructured interviews, which I continued to conduct until the data became repetitive and no new themes emerged, thereby indicating data saturation (see Kahlke, 2018). Although qualitative studies often have anywhere from five to 50 participants, similar generic qualitative studies with participants in the presented age range or about mental health issues generally required between six and 12 participants to reach saturation (King, 2020; Osok et al., 2018). The goal for the current study was to recruit 10 participants; however, saturation was reached after eight.

Instrumentation

As the researcher, I was the primary instrument. Other instruments included an audio-recording application and a researcher-produced semistructured interview guide (see Appendix C). A semistructured interview consists of specific information desired from all participants and questions with varying structure levels (Merriam & Grenier, 2019). In the current study, the guide aligned with the research purpose and addressed issues that were explored during each participant interview, based on the literature review. The questions explored the outcome domains identified by the theoretical frameworks. While the questions were ordered by stages of life (before foster care, during foster care, after foster care/now), it was not necessary to maintain this sequence during each interview. To validate the interview guide, I sought guidance from two experts in the child welfare field: one who holds a doctorate in social work and one who

is a social services director. Following the guide's development, I determined the sufficiency of the interview questions by using them in a practice interview with a colleague who grew up and aged out of foster care. Through that, I confirmed that the questions would allow participants to tell their experiences in their own words and answer the research question.

The interviews were intimate conversations through which I obtained honest and reflective narratives about the participant's life experiences (see Merriam & Grenier, 2019). I made every effort to ensure that the appropriate questions were asked to obtain rich data to answer my research question regarding the effects of foster care trauma on adulthood mental health outcomes on racial minority foster care alumni (see Merriam & Tisdell, 2016). Though data-rich tangents were allowed and encouraged, following the guide and asking the same questions contributed to the content validity by enabling me to gather firsthand, detailed accounts of participants' traumatic foster care experiences (see Roller, 2019).

Participant interviews were recorded electronically. I coded and charted the data using NVivo data analysis software. NVivo software was also used for transcribing the initial interview. Subsequent interviews were transcribed using my phone's voice recorder application, which was more cost-effective. NVivo aids in analyzing, managing, and controlling qualitative data (Woods et al., 2016). The software program stored my downloaded audio data and displayed codes, categories, and emerging themes I created. I determined whether those themes were consistent with the phenomenon of trauma experienced in foster care and mental health outcomes.

The initial interview questions and background questions were emailed to ascertain ACEs. Though all of the questions can be considered sensitive, using electronic means for some of the sensitive questions can help put participants at ease (White et al., 2015). Also, a lack of ACE acknowledgment is not uncommon even when histories are known (Haselgruber et al., 2020). Therefore, answering these questions independently possibly aided in gathering truthful and accurate data. The use of email was also consistent with typical methods of communication used by the participant age range (see White et al., 2015).

I did not collect any historical or legal documents for the study. Participants were provided with the details regarding the study and its purpose initially through a recruitment flyer (see Appendix B); then through verbal or electronic communication; and lastly, if criteria were met and interest remained, through informed consent (see Azungah, 2018). I also provided assurance regarding maintaining participant confidentiality at all times through pseudonym use and not informing their referral source of participation or any information shared. Participants were able to withdraw from the study at any time or refuse participation in the study. I made concerted efforts to ensure no harm came to participants for being a part of the study.

Procedures for Recruitment, Participation, and Data Collection

The NC LINKS program provides young people in foster care with the skills and support they need to live independently after aging out of foster care (NCDHHS, 2019). NC LINKS was an optimal resource to recruit participants. I contacted independent living/LINKS social workers in Mecklenburg County for initial referrals. Initial contact

with the LINKS social workers was completed via email. I requested they share my recruitment flyer with clients who met the eligibility criteria. I further requested accepted participants to share the flyer with any friends or peers they knew who may have met the participation criteria. Recruitment was not limited to particular zip codes or regions. Eventually, I expanded recruitment to include all independent living social workers throughout the state of North Carolina to maximize participation. Potential participants were able to contact me via telephone or email as listed on the flyer. I screened for appropriateness and genuine interest during my initial communication with potential participants. I screened out those who did not meet the criteria or who could not feasibly participate in an interview due to cognitive limitations. Genuine interest was gauged through prospective participants' propensity to follow up and follow through as well as questions they asked. I used a screening form and a preinterview guide to aid in the management of communications, referrals, and scheduling (see Appendix C).

Recruiting eight participants allowed me to obtain the richest information. Qualitative studies depend on the quality of participants, not the quantity (Creswell & Poth, 2018). Individuals had to meet the specified race, age, and previous foster care requirements. The current study did not include any identifying information to protect the participants' privacy; instead, pseudonyms were used to classify and identify participants and their information in the data analysis.

In generic qualitative studies, data collection generally requires participant observation, questionnaires specific to the studied phenomenon, and interviews (Kahlke, 2018; Kennedy, 2016). Data collection in the current study occurred through

semistructured phone or virtual interviews with interview questions consistent with the theoretical frameworks of trauma theory and information processing theory. I began with demographic and rapport-building questions to create a trusting climate for participants to open up and offer honest narratives (see Merriam & Grenier, 2019). Questions such as "While in foster care, if diagnosed with a mental health disorder, did you ever feel that having a diagnosis was something you could not talk about with your friends?" allowed me to gather information regarding any self-stigma experienced by participants. The complete semistructured interview guide is included in Appendix C. Non-English speakers were excluded because I spoke only English.

Due to the COVID-19 pandemic, I conducted interviews with participants only through telephonic or virtual video conferencing. I conducted interviews in my private home office and spoke with participants about ensuring they were in a location that was private before beginning the interviews. The Zoom platform was used for virtual interviews. Whether telephonic or virtual, interviews were anticipated to take approximately 1.5 hours.

With the participants' permission, I audio-recorded the interviews. If participants did not permit me to record, I planned to take detailed and thorough notes; however, all agreed to record their interview. For every interview, I began to generic code the interviews and document any gestures and affect information. I cleaned the transcripts of recorded interviews by checking for accuracy and removing any insignificant or redundant utterances before sharing them with participants. Sharing the transcripts with participants for review allowed them to confirm the accuracy of their words, thereby

ensuring the data's trustworthiness (see Kahlke, 2018; Kennedy, 2016). Because of the nature of the current study and the discussions of trauma, debriefing occurred after each interview. I inquired about how participants were feeling, what they were thinking, and whether they were experiencing any stress symptoms. I asked about whether they had any thoughts of harming themselves or others, and I provided support resources as needed. Immediate referrals to Hope4NC (1-855-587-3463), which provides mental health and crisis support to North Carolinians, were able to be made, if necessary. I ensured participants knew how to reach me if they wanted additional resources following the interview. I followed up with participants a final time after transcript review to confirm receipt of their gift card for participating.

Data Analysis Plan

Data analysis in qualitative research involves rigorous interpretation of the data collected and transforming it to be understood by the world (Merriam & Tisdell, 2016). After completing the interviews, I performed inductive data analysis to identify themes, insights, and recommendations for child welfare practice, policy changes, and future research; and ultimately determine the effects of foster care trauma on racial minority foster care alumni's mental health in adulthood. Qualitative data typically undergoes written transcription after collection via text and audio (Kahlke, 2018). Each interview underwent transcription through a service. I checked the transcriptions for accuracy, attentively listening while reading along with the text. While compiling each interview data, I created a record of my written observations and interview notes.

Data analysis was simultaneous with data collection, typical in qualitative research (see Carcary, 2020). With the first interview, I transcribed and began analyzing a strategy that allowed me to make necessary adjustments along the way. I was able to acknowledge codes, categories, and themes throughout my study instead of after the last interview. The constant-comparative process was inductive, and I compared data units to others while looking for common patterns and codes. Though using NVivo or electronic coding as a measure of validity, I also manually verified all themes and codes produced by the software for accuracy, which was my responsibility as the researcher (see Saldana, 2016). My human analytic reflection combined with the software's abilities to produce useable information. I used a summative coding table to help organize throughout interviews. By starting the table with a priori codes identified from the theoretical framework literature on outcomes, I was able to sensitize myself to the potential of seeing those outcomes during my data analysis. After each interview, I added open codes, categories, and subcategories; then, I identified each participant, and the excerpt stated that aligned. I also used my peers and online demonstrations and tutorials for assistance with NVivo software.

Using NVivo allowed for electronic coding and generating themes and categories (Woods et al., 2016). NVivo is a highly rated program with multiple strengths, including using written and recorded data and organizing data by category into folders. For my study, I organized by outcome category and stage of life. The ability to add written input would have been useful for participants who declined to be audio-recorded. Additionally, the software allowed me to speculate about and prepare for future research questions on

my topic. Thematic analysis was also used to identify patterns across the data sets (see Azungah, 2018). Thematic analysis throughout also allowed me to determine when saturation was reached. During the analysis process, I used analytical and naturalistic generalization to extract abstract concepts from each unit of analysis, ultimately leading to a final report on findings, which I share in Chapter 4. Should any discrepant cases have occurred, or those with findings that differ from the majority (see Merriam & Tisdell, 2016), all evidence of the discrepancies would have been disclosed and thoroughly discussed to ensure validity.

Issues of Trustworthiness

Establishing trust and confidence in a study's methodology, procedures, and results is a significant challenge with qualitative research (Hadi & Closs, 2016). Therefore, there must be steps to ensure the data's trustworthiness through credibility, transferability, dependability, and confirmability. Research is credible when the findings are believable and supported by evidence (Twining et al., 2017). The participants reviewed their interview transcripts for accuracy and feedback in the current study. The transcript reviews allowed me to identify any unintended responses or misrepresentations and prevent bias.

To produce an audit trail, I explicitly detailed my theoretical, methodological, and analytical decisions (see Carcary, 2020). I maintained a log of all research activities, kept memos, maintained a research journal, and documented all data collection and analysis procedures. The journal entries and transcribed interviews are accessible for those who wish to view them. In addition to the audit trail, triangulation can help enhance

qualitative research's reliability by supplying specific details that help supplement and substantiate the data collected (Carcary, 2020). I triangulated through the use of multiple data collection methods, including interviewing and journaling. Having multiple participants was also a triangulation method. I also triangulated by gaining participants through North Carolina social workers and referrals, so participants came from various sources. Triangulation can reduce respondent and researcher bias, which can cause threats to internal validity.

Transferability in qualitative research means that the results can be understood in other contexts (Connelly, 2016). The current study included a detailed description of the interview settings and participants to achieve transferability. Dependability occurs when other researchers achieve similar results if they repeat the study (Connelly, 2016). The presented research included a thoroughly detailed audit trail to ensure dependability. Confirmability, or qualitative objectivity, consists of neutrality and control of researcher biases (Amankwaa, 2016). A qualitative researcher must ensure that the results present the participants' lived experiences and not the researcher's opinions or assumptions to control for confirmability. I conducted the interviews objectively and practiced reflexivity to acknowledge biases and protect the integrity of the results.

Ethical Procedures

Researchers must make efforts to ensure that participants do not encounter harm during a study (LaRossa & Bennett, 2018). I suggested a private location and allowed participants the opportunity to choose the times and locations of their interviews to optimize comfort and confidentiality. I assigned each participant a pseudonym to ensure

anonymity. I did not record any legal names and masked participant contact information on the interview documents at the conclusion of their participation, whether that was following withdrawal or compensation. Participation was voluntary, and participants could withdraw at any time, even during the interviews, without repercussions. Participating, not participating, or early withdrawal did not affect the participant's access to any current services or benefits. They were not be penalized for anything shared during the interview. In fact, though many participants were referred by their social worker, their participation and any communications with me were confidential and not shared. The informed consent document was a further means to safeguard the participants. Because participants presented trauma experiences, which could cause psychological distress, I provided additional safeguards through post-interview debriefing and supportive resources. See Appendix D for a list of resources available to participants post-interview.

The informed consent contained the current study's details, including the reason for the study, the researcher's university affiliation, the expected duration of participation, the procedures, and any risks and benefits. The informed consent also included the voluntary nature of participation, confidentiality assurance, contact information for addressing any questions or concerns, and that there would be a $25 Amazon gift card provided for the participant's time. Data collection did not commence until the participants responded with "I consent," after reviewing the informed consent form and expressing a complete understanding of the nature of the current study and voluntary participation.

One ethical issue that could have arisen stemmed from my position as a senior social services manager of the special victims unit with Mecklenburg County, as I recruited young adults with histories in foster care in the same North Carolina County. Given my professional role, I needed to prevent any consideration of coercion, as aged-out foster youths could have felt obligated to participate. As a social worker, I was also required to uphold ethical standards set forth by the NASW Code of Ethics, including those relating to maintaining confidentiality (see NASW, 2020). As such, all communication I had with participants, including the information shared during interviews, was confidential and will not be shared with any referring entity. I have not shared any data with my employer or any institutions where youths may be receiving services. I obtained Walden University Institutional Review Board (IRB) approval to address this limitation and other issues. Walden University's approval number for this study was 06-11-21-0743905. Scholars follow the IRB process to ensure that they uphold ethical standards before beginning research (LaRossa & Bennett, 2018). To obtain IRB approval, I had to ensure participants would not encounter harm due to the study, that no coercion would occur to obtain participants, and that I would minimize safety and privacy-breach risks. Further, I complied with the NASW Code of Ethics research and participant standards and guidelines, which, in part, required participants' voluntary, written informed consent (NASW, 2020).

I observed all procedures for protecting human participants, assigning participants pseudonyms to maintain confidentiality. I securely stored all data collected in this study in a password-protected electronic folder only accessible by me for 5 years after

dissertation publishing. At that point, I will delete and destroy all materials per Walden University guidelines. At no time will outside parties have access to participants' provided data or personal information.

Summary

In Chapter 3, I presented the chosen research design and the rationale for a generic qualitative approach. The chapter included a description of the generic qualitative methodology and how this approach would answer the research question. The selected methodology was the most appropriate for the current study's research question, purpose, and theoretical frameworks. In this chapter, I also provided detailed information about the researcher's role, issues of trustworthiness, and ethical considerations. In Chapter 4, I present the current study's procedures, including the research findings.

Chapter 4: Results

The purpose of this qualitative study was to understand the effects of trauma experienced while in foster care on racial minority foster care alumni's mental health in adulthood. In previous studies, researchers provided evidence of the pervasiveness of mental health diagnoses and the everyday hardships of foster care alumni (Gourdine, 2019; Liming et al., 2021). The theoretical frameworks (trauma theory and information processing theory) that guided the current study addressed the development of mental health diagnoses following traumatic experiences (see Shapiro, 2018; van der Kolk et al., 1991). I explored the effects of trauma experiences of racial minority aged-out foster care alumni from the United States. In this chapter, I present the study setting, participant demographics, descriptions of data collection and data analysis methods used, and evidence of trustworthiness. Additionally, I provide detailed study findings.

Setting

Due to the COVID-19 pandemic, interviews took place either over the phone or on Zoom's virtual platform. I used my home office and ensured with each participant before beginning the interview that they were in a place where they could speak openly and confidentially. A total of eight participants agreed to be a part of the study; four of the interviews took place over the phone, and four took place over Zoom. All participants expressed feeling comfortable sharing their experiences in their respective settings. I also ensured that I conducted each interview while no one was at my home so that there would be no distractions or confidentiality breaches on my end. The interviews lasted for an average of 41 minutes. I recorded each session via two methods: the recording feature in

Zoom and a voice recorder application as a backup in case of any technical error in Zoom. NVivo and my phone's voice recorder application were used to transcribe the interviews, which required data cleanup. Cleanup consisted of reviewing each transcript thoroughly to ensure that the words transcribed matched the vocal recordings and correcting any mistakes in wording. I emailed the cleaned interview transcript to each participant to review and check for accuracy. Each confirmed that the recordings captured their words accurately.

Demographics and Participant Profiles

The participants for this qualitative study consisted of eight racial minority foster care alumni. All participants volunteered and met the inclusion criteria, including being a racial minority, age 18 or over, in foster care for a year or more, and aged out of foster care. After some brief rapport building, I obtained demographic information from each participant at the beginning of each interview. Participants ranged in age from 18–46 years. There were more Black participants (n = 6) and females (n = 5). Several participants (n = 5) were college graduates with two holding master's degrees. All but two lived alone in independent housing. None of them were married. Two discussed present financial hardships, but most (n = 6) were employed. Participants were in foster care for an average of 8.5 years. The majority (n = 5) had aged out within the last 3 years. I did not obtain location information though the participants often shared it freely throughout the interview. Four of the parents also had a history of CPS involvement with their children. The participant's demographic characteristics are summarized in Table 1.

Table 1

Participant Demographics

Characteristic	Category	Number
Gender	Male	3
	Female	5
Race	Asian	1
	Black	6
	Hispanic/Latinx	1
Age	18–21	5
	22–30	1
	30+	2
Highest level of education	Less than high school	1
	Graduated high school	3
	College and beyond	4
Length of time in foster care before aging out	1–5 years	2
	5–10 years	2
	10+ years	4
Number of placements	1–5	4
	5–10	1
	10+	3

Gina is a 19-year-old Black female who was in foster care for 11 years before aging out. She has three small children, having her first at age 16 while in foster care. Gina felt unsupported by the county Department of Social Services she aged out of. She does, however, get a monthly stipend that will continue until she turns 21. Gina does not work, but the stipend helps her afford to live alone with her two youngest children. She is still working toward regaining custody of her oldest.

Brandon is a 19-year-old Asian male who aged out of foster care after just over a year. Brandon lives with a friend and works full-time. He shared that he felt supported by

the county he aged out of. He also receives a monthly stipend that he reported helped when he was out of work after contracting COVID.

Cedric is a 21-year-old Black male. He spent 17 years in foster care after being placed at 18 months old. Cedric went to college for free and stopped receiving a monthly alumni stipend after turning 21. Cedric lives alone and works in marketing but has a psychology degree.

Jasmine is a 33-year-old Black female. She spent 7 years in foster care before aging out. Jasmine has two children, having her first at 19 just after aging out. Jasmine felt supported by her agency after aging out through paid education and stipends to pay for her first vehicle and insurance. Jasmine lives with her family and has a master's degree in social work.

Brittany is an 18-year-old Black female. She spent just under 4 years in foster care before aging out. Brittany came into care at 14 and had a baby just after foster care entry. Brittany aged out just a few months before her interview. She reported having a good relationship with her social worker and guardian ad litem, who supported her transition into adulthood. Brittany lives with her daughter and former foster mother. She is currently attending community college.

Eva is a 46-year-old Black female. She spent over 12 years in foster care, going in at age 2 and reuniting with her parents a few times before finally staying for the last 8 years of her childhood. Eva reported getting no support from the agency she aged out from. She went on to earn a master's degree despite that. Eva lives with her youngest of

four children, the oldest of whom she had while in foster care at age 15. She is currently a homemaker but is a trained chef.

Hector is a 20-year-old Latino male. He spent 11 years in foster care before aging out. Hector reported his agency helped him obtain housing after aging out, and he receives a monthly stipend until he turns 21. Hector lives in an apartment with his brother and two other men, sharing common areas but each having their own bedroom and bathroom. Hector works full-time but does want to go to college one day.

Wanda is a 29-year-old Black female. She spent 12 years in foster care before aging out. Wanda had minimal contact with the agency she aged out of but felt supported by her group home staff. Wanda went to college and currently works as a teacher.

Data Collection

Data collection for this generic qualitative study began after receiving approval from the Walden University IRB. Except for one change, the data collection process aligned with the recruitment method discussed in Chapter 3. After 4 months of participant recruitment challenges with limited agreement to participate in the study, I went back to the IRB to request a change in the participant age range from 18–21 years to 18 years and above. After this change, I obtained five more participants bringing the total to eight, though two were still in the original age range of 18–21 years.

For recruitment, I sent my flyer and an email to independent living staff in all 100 counties in North Carolina. I received interest calls and texts from 18 potential research participants. However, only 14 met the eligibility criteria, and only eight followed through with an interview. Three more returned the informed consent and preinterview

questionnaire. Three did not answer when called or did not present on virtual platforms at scheduled times. Follow-up contact did not garner responses. Those who did not meet the eligibility criteria were White, under 18, or were not foster care alumni. Two were former foster parents.

Once I determined that an interested person met eligibility criteria through text or email conversation, I emailed them the informed consent form. Following response emails of "I consent," I emailed them the preinterview questionnaire. After that, interviews took place, two within the same day and six within 5 days. Each participant engaged in a scheduled, recorded semistructured interview in which I asked open-ended questions. After cleaning each transcript, I asked each participant to review their transcript as a means of ensuring validity (see Creswell & Creswell, 2018). Locations for participant interviews varied according to where they were comfortable being interviewed. Aside from the change in age parameters, there were no variations from the data collection plan discussed in Chapter 3. I encountered no unusual circumstances while collecting data other than the limited participation.

Data Analysis

I collected data through a preinterview questionnaire and a semistructured interview completed with each participant. I consulted the interview guide I created throughout each semistructured interview with participants. Codes came solely from the semistructured interview data. We discussed the preinterview questionnaires during the interviews; however, I used the questionnaires to gather background information on each participant and prepare the discussion of their trauma experiences.

The data were prepared by carefully reviewing each transcript provided by NVivo or the voice recorder application to ensure accuracy. I listened to each audio recording repeatedly and carefully to verify that the final transcript accurately reflected each participant's words. Transcripts were available within minutes after each interview. I read each transcript multiple times to ensure I understood the content. While reading them, I noted and considered similar information that other participants had shared. From that information, I developed initial codes. Then, I copied each preinterview questionnaire from the Google form and pasted it into each participant's interview tool. Table 2 summarizes the number of participants endorsing each ACE per preinterview questionnaire responses. To code and complete a thematic analysis, I imported each interview tool document into NVivo (see Saldana, 2016).

Table 2

Number of Participants Reporting Experiencing Each ACE

Number of participants	Adverse childhood experience
6	Experience being sworn at, insulted, put down, or humiliated
6	Experience being pushed, grabbed, slapped, or have something thrown at you
5	Experience being hit so hard that you had marks or were injured
5	Experience being touched, fondled, or made to touch or fondle someone else
1	Experience oral, anal, or vaginal intercourse with someone at least 5 years older than you
7	Go without food, shelter, or clean clothes
4	Not go to the doctor when you needed to
5	Witness your parents drunk or high
5	Witness domestic violence including seeing a parent pushed, grabbed, slapped, had something thrown at them, kicked, bitten, hit with a fist, hit with something hard, or threatened with a gun or knife
1	Have a parent who was depressed, mentally ill, or attempted suicide
4	Have a parent or sibling go to prison

Saldana's (2016) thematic analysis guided my analysis of the data collected in the study. I identified codes, categorized related codes, and developed relevant themes per Saldana's recommendations. A code often captures the essence of a portion of language-based data. I used a combination of in vivo coding (a word or phrase contained in the qualitative data) and descriptive coding (qualitative data summarized in a word or phrase) to code the data (see Saldana, 2016). I used a summative coding table to help me stay organized throughout the interviews. I started the table with a priori codes identified from the theoretical framework literature on outcomes. I then began to add open codes as they came up following the interview transcript reviews.

I read the interview transcripts line by line and labeled codes to phrases and answers consistent with different concepts and meanings. I went through every interview transcript and highlighted statements that seemed relevant to the effects of trauma on mental health in adulthood. I read each transcript several times to ensure nothing was missed, and coded as I did so. I originally had over 30 codes; however, some were vague or not relevant to all participants. I found the remaining codes among all or most of the participants. The codes provided an overview of the common meanings that recurred in the data. The codes were searched for more patterns and then themes. I continued the data collection process until saturation occurred, and I found no new patterns or themes.

I added and organized codes in NVivo software. NVivo displayed each code along with the quotes from each participant that matched the code. I used the auto-code feature to confirm accuracy in my coding and determine whether I had missed any possible codes or coding content. I organized codes into groups of related codes to form

categories. Categories allowed me to notice patterns and recognize emerging themes in the data. The concluding themes described the participants' adulthood experiences since aging out of foster care and answered the research question.

The themes that emerged conveyed meanings from the data related to the study's research question. The data collected and analyzed from the semistructured interviews supported answering the research question. I organized data into 16 codes: behaviors and habits, contacts and visitation, cultural impact, education, emotions and thoughts, employment, healing, if not for foster care, mental health, perpetrator(s), physical health, placements and moves, relationships, sleep, support system, and trauma experience(s). I then placed the codes into three categories: life outcomes, complex and compounded trauma, and mind and body results. Finally, the themes that emerged were as follows:

1. Severed or strengthened relationships caused by placement into foster care continue into adulthood.
2. Foster care can have unintended behavioral consequences, with a subtheme of foster care was challenging but also lifesaving.
3. Treatment and healing are attainable but often not pursued, which leads to the subtheme: poor sleep and anxiety diagnosis or symptoms can manifest.

In Table 3 and Figure 1, I display codes, categories, themes, participant quotes, and statements supporting the labeling.

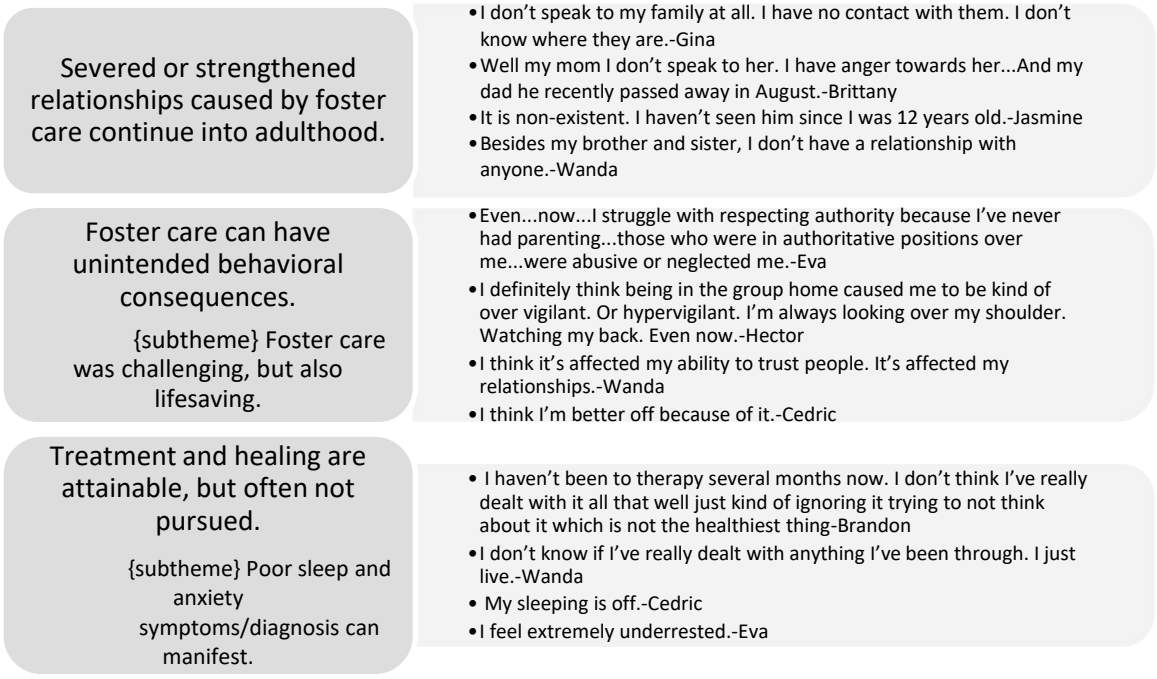
Table 3

Thematic Analysis Process: Codes to Categories

Code	Category
Behaviors and habits	Mind and body results
Contacts and visitation	Complex and compounded trauma
Cultural impact	Life outcomes
Education	Life outcomes
Emotions and thoughts	Mind and body results
Employment	Life outcomes
Healing	Mind and body results
If not for foster care	Life outcomes
Mental health	Mind and body results
Perpetrator(s)	Complex and compounded trauma
Physical health	Mind and body results
Placements and moves	Complex and compounded trauma
Relationships (severed)	Life outcomes
Sleep	Mind and body results
Support system	Life outcomes
Trauma experiences	Complex and compounded trauma

Figure 1

Thematic Analysis Process: Themes and Supporting Participant Statements



Although all of the participants' stories were different and none experienced the same foster care journey, there were shared qualities in all of their experiences. All participants went through traumas that led to placement in foster care and experienced traumas while in foster care. Even with the age change and participants who spent time in foster care in another decade, all experiences could be coded, categorized, and shared as themes. There were no discrepant cases.

Evidence of Trustworthiness

Trustworthiness in a qualitative study is established when there is confidence in the methodology and findings (Hadi & Closs, 2016). Trustworthiness is necessary so that the results are useful and maintain integrity. The principles of credibility, dependability,

transferability, and confirmability are applied to ensure trustworthiness and thoroughness. I followed the criteria outlined in Chapter 3 to ensure trustworthiness in this study.

Research is credible when the findings are believable and supported by evidence (Twining et al., 2017). In the current study, each participant reviewed their respective interview transcript for accuracy. If any changes were needed, I made those. All of the participants did not indicate there were errors with the transcripts. The transcript reviews allowed me and the participants to identify unintended responses or misrepresentations. I also used self-reflection in the analysis process to mitigate bias in interpretations. Often a participant's statement would remind me of a previous work experience with foster youth or alumni, and self-reflection helped to ensure that I could keep those experiences separate from the interview to avoid misconstruing what participants were saying.

Dependability occurs when the study findings can be repeated and are consistent (Twinning et al., 2017). I used an audit trail for study dependability. I described my methodological practices, theoretical choices, role as researcher, and recruitment methods to aid in study duplication. I also detailed my data analysis process. Additionally, I used feedback from my committee throughout the study to address any concerns.

Transferability allows the study results to be understood in different contexts (Connelly, 2016). For transferability, I included a detailed description of how and where I conducted interviews and descriptions of the participants. The sampling method used also improves transferability. I did not withhold any information in my study's write-up, and my interview notes and journal entries are available for review.

Confirmability refers to objectivity and neutrality to control for researcher biases (Amankwaa, 2016). I reviewed all of the interview sessions, transcripts, and journal entries with my observations for confirmability. I worked diligently to ensure all of the results were representative of the participants' experiences rather than my opinions or assumptions. I practiced reflexivity to acknowledge biases and protect the integrity of the results. The participants reviewing their interview transcripts also aided in confirmability. My data collection and analysis and the participants' review of transcripts lent to the trustworthiness of the data and the findings of this study (see Twining et al., 2017).

Results

The research question was the following: What are the effects of the trauma experienced in foster care on racial minority foster care alumni's mental health in adulthood? Participants of this study knew trauma. Trauma filled their childhoods, sometimes devastatingly, and they could easily and accurately define it. Trauma is an experience that results in a threat to an individual's physical or psychological well-being (Fratto, 2016). Participants described trauma in similar ways, as evidenced in Table 4. The participants had experienced three or more traumatic experiences before foster care and during foster care. Through participants' sharing of their foster care and adulthood experiences, I was able to obtain the information needed to answer the research question addressing the effects of the trauma experienced in foster care on racial minority foster care alumni's mental health in adulthood.

Table 4

Participants' Definition of Trauma

Participant	Definition of trauma
Brandon	"anything that affects you in a way that has a negative impact on your day to day life would be my definition."
Brittany	**"**Something that you've been through that causes you to either act a certain way due to the experience or think a certain way. Or do something."
Cedric	"I guess it's something that happens to you, that you don't have control over. But it impacts you…. It changes you."
Eva	"It means devastation. It means life altering. It means mentally emotionally disturbing; nothing good."
Gina	"when I hear the word trauma, I just think of incidents or things that may have happened to a person or somebody that causes an impact on your life."
Hector	"I think it's something that happens that's negative. Yeah. Something that's negative that happens to you."
Jasmine	"I think that it means something like something bad happens. Or something that's hard to move past happens."
Wanda	"To me, trauma is something that happens to you that you didn't cause or want, but it impacts you. Mostly in a negative way."

The data from the interviews fell into 16 different codes that constituted three different categories: life outcomes, complex and compounded trauma, and mind and body results. Three themes and two subthemes emerged from the categories. There were several data points repeated by most of the participants. They talked openly about how the bad things that happened stayed with them, how trauma took a toll on them, and how foster care changed their life. The participants shared their diagnoses and symptoms and how limited their support systems were today. Three of the eight participants did not report close relationships or support systems. With all of the information provided by the participants, I discovered that the effects of the trauma experienced in foster care on racial minority foster care alumni's mental health in adulthood were as follows: Severed

or strengthened relationships caused by placement into foster care continue into adulthood, foster care can have unintended behavioral consequences with a subtheme that foster care was challenging but also lifesaving, and treatment and healing are attainable but often not pursued with a subtheme of poor sleep and anxiety diagnosis or symptoms can manifest.

Theme 1: Severed or Strengthened Relationships Caused by Placement Into Foster Care Continue Into Adulthood

The first theme to emerge was severed or strengthened relationships caused by placement into foster care continue into adulthood. The participants felt firsthand the trauma of losing their parents by being placed in foster care. Participants described emotions including worry, regret, anger, loneliness, and sadness. Brandon, for example, reported his first suicidal thoughts emerging after placement into foster care. Meanwhile, Hector described being angry and holding it inside. Only Wanda reported feeling positive emotions, and those were paired with fear. She told of her placement experience as follows:

> I think I've tried to block it out so much ... . I remember crying in the bed. It was hard to sleep. They did put us in the same room. I remember being scared, but also a sense of safety. I remember the bed being warm and liking it. I remember enjoying the bath that night. I remember getting a hug from the group home parent and it feeling good. I remember wondering if my parents were going to come get us and be mad the social worker took us. But they never came. And we never went back.

Brandon and Eva were the only two placed into foster care as toddlers. They did not remember much about being placed; however, they shared similar feelings as other participants about their relationships with their parents today. Brandon shared “my mom is dead ... . She’s dead to me. I don’t know where she is or if she’s alive. I don’t want to know.” Eva reported an estranged and hostile relationship with her parents. She has learned how to keep the peace by embracing forgiveness and keeping her distance to prevent volatile situations.

The severing of relationships by being placed into foster care was evident among participants. None reported reconciling with their parents after aging out or at any point in their adulthood. Hector, who was placed into foster care after his mother was deported and his stepfather abandoned him and his siblings, expressed that he still talks to his mom but did not provide details of a close relationship. He reported “I still talk to my mom whenever I can. She’s in Honduras. I don’t speak to my stepdad.” Though Jasmine is currently helping her biological mother out by allowing her mother to live with her, she said the following when asked about their relationship and reconciliation “I think it’s a work in progress. I would say we’re closer than we used to be. I think there was a lot of resentment on her part because that’s what I chose.” Jasmine had the opportunity to reunify with her mother at the age of 16 after 5 years of being in foster care but chose to stay in care, not wanting to return to the same life and lifestyle. She was placed into foster care due to concerns about living conditions, though there was more to the story that social services did not know. Jasmine works as a social worker today, and her

knowledge of the child welfare system was evident in her description of what led to her placement into foster care:

> so I read the petition because one of my brothers went to get it for something he had to get proof of something about his grandma who had custody of them or something. I read it. And so it was the weakest petition I've ever read. I guess back in the 90s you know you had so many cases and if people didn't know their rights to fight back you know kids were placed in foster care for little to nothing. But anyway it was neglect. It said we weren't going to school; no stable housing was the gist of it. And I said wow this is it they didn't know everything else that was going on but that was the gist of it. They didn't have like all the details of everything they just had the basic stuff; not going to school I didn't have stable housing that type of thing; supervision.

None of the participants had current relationships with their biological parents in which they reported regular communication and support. Though Brandon visited with his dad while in foster care, as of the date of his interview, he said "My dad, I'm not really close to; I haven't talked to him since October." He does not have a relationship with his mom because she is the reason he was in foster care. Gina's experience was different as she never had a remembered relationship with either of her parents because she was placed in an adoptive home as a toddler that disrupted when she was seven, leading to her placement into foster care. Gina knows her biological parents, though, and reported she has not talked to her mom since she was a little girl. She stated her mom "reached out to me through Facebook one time. And she told me she was in Connecticut

... . And my dad he got out of prison, and he just moved on." Gina still hates her parents because she could not understand how they could abandon her. With three children of her own, she feels parents' responses to child protective services involvement should be different. She further stated:

> And I look at my parents like what were you doing? Like why couldn't you do that for me? … . Why did you just choose to give up? Why you couldn't go the extra mile for me, cuz I'm doing it for my kids, because I don't want them in the system.

Multiple examples like theirs made a theme of strained or severed relationships with parents after foster care. The participants further reported not calling on parents if they had any needs, not attempting to look for their parents, and lack of interest in developing close relationships with their parents. Jasmine has worked on her relationship with her mom, but her dad is in prison and their relationship "is non-existent. I haven't seen him since I was 12 years old." She does wish their relationship was different, though, and has considered writing him and introducing him to her children through pictures but had not done as of the date of her interview. Brittany reported not speaking to her mom because she still has "anger towards her." Unfortunately, her dad recently passed away in August. Brittany alluded to potentially having done things a bit differently. She conveyed "I should have been nicer. I should have, like, I don't know. Because as I got older, we got apart, and I went to foster care. So, you know there was separation and stuff, so we lost touch." Thus, there were some regrets about not making amends. Another participant expressed that her parents still battle with drug addiction

which is the issue that brought her and her siblings into foster care. While she has reached out to help before, she reported that praying for them is all she can do now.

Beyond parental relationships, relationships with extended family also remained severed after foster care. Before her grandmother's death in 2016, she was the only family member Wanda had contact with. She stated "And everybody else, I don't talk to." When participants had siblings who did not experience an identical or similar foster care journey, such as Brittany and Brandon, they were not as close to them as siblings who did go through foster care together. While they occasionally spoke with their younger brothers, they would not consider them supports. Gina also does not have contact with her younger brothers, who came into foster care with her, but all went on separate paths. She reported not speaking to any of her family and was the participant with the least amount of current support.

Regarding her extended family, she reported "I have no contact with them. I don't know where they are" and no interest in finding out where they are because they have never made any attempts to seek her. She further reported no interest in finding out where her brothers were. Contrarily, Jasmine wishes her relationship with her extended family, especially her brothers, was better. She stated "they only call me when they need me ... . When they call it's usually, they're in crisis or they need help navigating something. I don't ever feel like it's ever like hey let's go hang out. It's just this real weird dynamic."

However, not all relationships were severed, leading to the other part of Theme 1. When participants' siblings were in foster care with them consistently, their relationships tended to be stronger in adulthood. The shared experience seemed to make them closer.

So much so, they were often the only supports that the participants named. Hector stated that he does not "have relationships with any other family except my brothers and sister. I can go to them when I need anything. I can talk to them. They are there when I need them." Hector and his siblings were placed in foster care together and stayed together in various placements until they aged out. Wanda had a similar experience, and she reported that besides her brother and sister, she didn't have a relationship with anyone else in her family. Her brother and sister were her everything. She reported:

> They support me in everything I want to do. Everything I want to be, I have their support. And they have mine. We help each other out in every way. If I need something and call them, I'll have it. And I do the same for them.

Despite limited contact or non-existent relationships with their parents and siblings, some participants had created a circle of support in adulthood. Those supports were often aware of their foster care experience, and most had been friends with them since their foster care days. Eva reported she met her best friend while in foster care, and they are still close today. She also stated:

> I have relationships with some people in my church that I attend. I have friendships within my sorority that I feel I can trust to a degree. I feel I've been blessed with a good handful of people that I confide in that I can be completely transparent with.

Jasmine met three friends in foster care and stated they are "still my best friends today." They also knew all about her foster care journey and experiences. Lastly, Gina reported meeting a friend in foster care who she described as her only friend today. She

stated “She’s somebody that I can talk to about anything. She hasn’t gone through anything that I went through, but she’s a good friend. She’s a good support she’s somebody that try to understand at least and don’t judge.”

During this research, I found that foster care can often lead to a loss of family and relationships that are generally not recovered or reconciled by getting out of foster care. While some still engage with their biological parents, the relationships remain severed in adulthood. When alumni are in foster care with siblings, those relationships tend to be alumni’s strongest relationships in adulthood. However, when siblings are not a part of the journey, the relationship remains severed in adulthood. When alumni met a friend while in foster care, they reported those friendships to be strong in adulthood. Relationships can help mitigate or exacerbate mental health symptoms and diagnoses. Negative behaviors alumni develop during foster care can also impact mental health symptoms and diagnoses in adulthood.

Theme 2: Foster Care Can Have Unintended Behavioral Consequences

Ideally, upon aging out, alumni will leave with a support system, skills for independent living, and a host of resources to help them navigate their next phase of life. Most of the participants had a least one of these offerings, but most also left with more than they bargained for. After foster care, many of the participants had behaviors and habits that they expressed resulted from their stay in foster care; and that they did not feel they would have if they had not spent time in foster care. Generally, I found the unintended behavioral consequences resulted from traumatic experiences in foster care. While children are usually taken out of a troubled home and placed into foster care for

their well-being, sometimes they are placed in foster homes where they endure more abuse. The effects of that trauma can linger into adulthood and affect mental health and healing. Wanda shared the following regarding her foster care trauma:

> Being in foster care wasn't always safe. Me and my sister were abused by a foster father before. Molested and groped. And then blamed for it and kicked out. I've been beaten by a foster mother before. Punched in the mouth because I said something she didn't like. We were left on the side of the road by a foster mother before. She didn't like our attitudes. And we were like 10, 11, and 12, and we walked till we found a gas station. That was scary. This was before we were allowed cell phones. Might have been before cell phones were out and it was probably a couple miles at most looking back, but it seemed like the longest walk ever and it was getting dark. That was bad. There were probably more. I sometimes wondered how foster care was supposed to be better than living with our parents.

Participants who reported experiences of abuse while in foster care stated that it left them with similar thoughts about how being in foster care was supposed to be a safe option but was not, and they still feel that way about the foster care system today. Those abuse experiences were the most significant foster care experiences to them, the ones that stick with them in adulthood, even when their time in foster care was lengthy and not plagued by multiple abuse experiences. Cedric was physically abused by one foster parent and reported that the experience changed him, causing him to expect to be moved from future placements and initiating his lack of trust in the system. Gina's abuse was

sexual, but the results were the same. Her experience left her scarred, as she was groomed, introduced to pornography, and eventually raped, then called a liar after disclosing and asked to leave immediately by the angry foster mother. She reported that the experience started her teenage rebellion phase and distrust of authority. While in foster care, the abuse reported by participants was most often perpetrated by foster parents. The participants also reported anger toward licensing providers and county protection agencies for not doing a better job of ensuring the foster parents were vetted and good people, leading to a distrust of governments systems and people associated with them in adulthood.

A typical offering for older youths in foster care is independent living services. Participants who experienced traumas while in foster care often did not participate actively in those services due to their distrust of the system being firm by their late teenage years. Trust was lost as they experienced traumas that they were supposed to be protected from by foster care placement. Today, they avoid government systems. With no parents or authority figures they can seek guidance from, that often leaves them navigating adulthood alone and hesitant to seek assistance for things they do not know. They will use Google before asking an adult who may know, leaving them to figure out things like banking, insurance, taxes, and independent housing on their own.

Distrust of most people and systems were the most popular unintended behavioral consequences reported by participants. For one participant, Cedric, that lack of trust has further affected his desire to have children. He reported “I don’t ever plan to have kids. I probably would like kids one day if I hadn’t been a foster kid ... . But … . Yeah that’s it.”

In addition, five of the eight participants reported issues respecting and communicating with authority figures in adulthood due to their foster care experiences. Being in foster care further affected other participants parenting styles, number of friendships, and stability of romantic relationships today. Eva spoke candidly about her struggles in relationships, and other participants generally shared her perspective:

> I struggle with respecting authority ... . Because I've never had parenting and those who were in authoritative positions over me always abused it or were abusive or neglected me so my thing has always been why should I respect you? Because of that I've struggled in my personal relationships. I definitely I feel like those experiences made me extremely rough around the edges ... . Also, I'm very overprotective of my children to the point where it was very smothering for them. I did not trust people easily. Still don't trust people easily. I always think the worst before I think the best. My guards are always up. I still have a very strong survival type mindset ... . It's just something that I can't shake. I don't I like to give people the benefit of the doubt, they definitely have to earn it. Like I said I go into it thinking the worst before I think the best. I love people but I'm a loner at the same time. I don't develop relationships very easily. I tend to be crass, not because I don't care or not because I'm not a loving person. It's just those are the remnants I guess.

While abuse was the most common form of trauma reported by participants during foster care, Hector was the only participant who shared a traumatic cultural experience during foster care. A few other participants acknowledged that foster care

placement impacted their cultural bond and practices, from hair care issues to holiday observance changes. Still, Hector described the impact of being placed with a family of a different culture than his as traumatic and impactful in his adult life. He stated that "being placed with people who don't speak your language was traumatic. Maybe not the worst trauma, but it was traumatic." As the only Latino participant, Hector reported that foster care caused him to lose touch with his culture, diet, language, and practices. His accent was nearly obsolete, and he could no longer speak conversational Spanish. His experience also left him unable to trust and feeling stuck between two cultures.

Beyond behaviors, a few participants reported that foster care experiences caused them current challenges, which affect their mental state and responses, including flashbacks, negative worldview, and learned responses, or responding based on previous experiences and observations. Flashbacks were more common with those who had traumatic stays in group homes. Brittany and Hector described their experience living in a group home as one they would never forget. They described the homes as difficult places to live and often filled with violence. The group home experience leads to hypervigilance in adulthood, further contributing to the second theme of unintended behavioral consequences. The participants found themselves constantly looking over their shoulders, prepared to protect themselves from danger, even carrying weapons to do so, and dreading certain environments and routes on their day-to-day commute that may cause them to encounter certain people from their past.

Of note, some of the participants had concerning behaviors while they were in foster care, too. However, they often no longer reported those childhood problem

behaviors affecting their lives in adulthood. Eva, for example, used retaliation as a defense mechanism while in foster care, however in adulthood she reported, having matured and grown out of that. Gina also acted out while in foster care to get what she wanted, though admittedly, it rarely worked out the way she thought. And Cedric reported being a troubled kid "a bad kid." However, he is also one of the most successful in finances and independence today. None of the participants reported adulthood violence toward others, domestic violence, or substance use or abuse. A few incidents of self-destruction and delinquency were reported however they were not prevalent among several or the majority of participants, nor did they last into adulthood. Being able to overcome some of their childhood and foster care behavioral concerns led to subtheme one: foster care was challenging, but also lifesaving. Finding positives in a negative situation contributes to their overall mental health and optimism today.

Subtheme 1: Foster Care Was Challenging but Also Lifesaving

Despite experiencing traumas while in foster, most participants still felt foster care saved their lives while also reporting that their lives would be different if not for foster care, whether positively or negatively. Foster care ultimately changed their life trajectory, sometimes minimally, but more often, significantly. Brandon spent the least amount of time in foster care at just over a year and had planned to go to college directly after high school but ended up taking some time off after aging out to rethink his path. He lost connection with his closest friends and support system during his foster care stay, which impacted his actions following foster care. He still plans to finish college and has a few credits, but he is staying with a friend and getting acclimated to life without a social

worker and his parents to guide him and make decisions for him. Though being in foster care altered his initial life plan, Brandon reported that if it were not for foster care "I might not be here ... . It was definitely good for my mental health to get out of that situation." He was placed in foster care after his mom sexually abused and medically neglected him, refusing to give him his mental and physical health medications or attend doctor appointments.

The other participants also reported that their adult life would have likely differed if not for being placed in foster care. Using metaphors, one described the initial after foster care experience as taking a walk in the forest with no worn path ahead, just hoping they are going in the right direction; another, walking up a flight of stairs without ever knowing where they lead. Generally, they did not know where they would be if not for foster care. Eva, who experienced the highest number of traumas while in foster care, still saw it as the only reason she made it to college, where she could better herself. She reported:

> I had a lot of negative experiences in foster care but at the same time foster care is the reason why I went to college and that experience just opened up the doors for a lot of opportunity for me. Had I not been in foster care I probably would be dead. I don't think I would have survived had no one intervened. I don't think I would be here. As much as I despise the system at the same time because of all the things that happened while I was in foster care.

Though some foster care situations were challenging, most participants could see being placed into foster care as a positive thing in adulthood. The consensus was that they

likely would not have made it to where they are today, even if they are still navigating and trying to get to a better place, living how they were living pre-foster care. Being a foster child often made them feel abnormal and like they did not fit in among their peers. However, they have found positive in the experiences by remembering where they came from and how being removed from their home ultimately saved their lives.

While foster care was a means for protecting the participants from ongoing abuse and neglect in the care of their biological parents, it also tended to leave participants with negative behaviors and habits that continue in adulthood. Those behaviors include the inability to trust or respect authority, hypervigilance, and a tendency not to seek help in navigating new experiences. Though they experienced trauma while in foster care, the participants understood and shared how foster care took them out of something bad and gave them a path toward a better life. However, some of the lingering consequences and behaviors manifest as mental health symptomology in adulthood. The majority, six of eight, reported mental health diagnoses, and the remaining two reported mental health symptomology.

Theme 3: Treatment and Healing Are Attainable but Often Not Pursued

Foster care is recognized as a traumatic experience for youth. They are generally provided with the option to participate in therapy services while in care to address the trauma and life changes. Most child advocates and guardian ad litems will make therapy a part of each foster child's plan while in care. As youths get older, they get to decide whether or not they participate in treatment, and more often than not, they decline. Upon aging out, alumni have often not sought services to address the trauma of being placed

into foster care or any traumas that happened while in foster care. During the interviews, when we discussed healing and coping with the traumas experienced before and during foster care, only Jasmine reported using therapy to heal. She reported going to therapy a couple of times to address issues manifested in her adulthood due to her foster care experiences. Another participant, Cedric, did not report necessarily healing from therapy, but he did find it helpful in finding his purpose and college study interest. He stated "It went okay. I actually enjoyed it. It's what made me want to major in psychology. Even when I didn't talk, the therapists I had were good. I gotta say that."

Participants were often not interested in or against therapy today and during their stay in foster care. The responses when asked about therapy were consistent, as were those when asked about medication for diagnoses. Participants made statements such as "they offered me both, but I declined." As teenagers, the participants had no interest in participating in something their peers did not participate in or need. They refused the services and reported it not being their "thing." Brandon had tried therapy before, but it had been a while. During his interview, he said "I don't think I've really dealt with the traumas all that well. Just kind of ignoring it, trying to not think about it, which is not the healthiest thing." Other participants who had tried it also found no benefit in therapy or found it a waste of their time.

Instead, some participants found other ways to cope with their mental health symptoms and diagnoses and their emotions and thoughts per their report. Wanda stated she uses her sister or brother or boyfriend for therapy; however, "I don't know if I've really dealt with anything I've been through. I just live." Eva, though, reported she has

tapped into her spirituality for healing. She stated “I do a lot of praying, and I’m reading my Bible and talking to God. I’ve definitely come to terms with some things. I just have had to learn how to forgive.” Then, Brittany reported that she’s just “learned to like, you know, push forward ... . I’m very strong ... . So I learned to, like, let go of things.” Like Brandon, others also reported ignoring their issues and trying not to think about them. Living through trauma and not seeking help or treatment resulted in a subtheme of poor sleep and anxiety manifesting in adulthood.

Subtheme 2: Poor Sleep and Anxiety Diagnosis or Symptoms Can Manifest

Because trauma can compound and lead to physical and mental health symptoms if left unaddressed, the results of unaddressed trauma showed up as poor sleep and anxiety in the participants of this study. Several participants reported letting their trauma go or just living with it. Then, when asked about physical health and sleep, all participants reported sleep problems due to stress and anxiety symptoms. Five of the eight participants reported anxiety diagnoses, and the other three reported anxiety symptoms, including restlessness, uncontrollable worry, difficulty concentrating, and sleep disturbance. When asked about their sleep, the participants shared sentiments about their sleep being terrible, irregular, off, and interrupted by their thoughts and worries.

Ultimately, I found three primary mental health effects in adulthood of experiencing trauma while in foster care. Placement into foster care can cause severed or strengthened relationships that last into adulthood. Foster care can have unintended behavioral consequences, especially following additional trauma experiences. Those experiences can further affect adulthood mental health and lead to negative behaviors and

habits that might not have been present without foster care placement. However, alumni can still see the positives of being placed in foster care versus staying in the home where CPS removed them. Despite the challenges faced in foster care, they still view it as lifesaving while also feeling that their life would have been different if they had not been placed in foster care. Lastly, treatment and healing are attainable but often not pursued, leading to the subtheme of the manifestation of poor sleep and anxiety diagnosis or symptoms.

Summary

In this study, I interviewed the participants using a semistructured interview tool and then analyzed the data from their experiences. I looked for patterns in the data and pulled codes until there were no more patterns. From the patterns and codes, categories and themes emerged. The themes allowed me to answer the research question about the effects of the trauma experienced in foster care on adulthood mental health. The three overarching themes were: severed or strengthened relationships caused by placement into foster care continue into adulthood, foster care can have unintended behavioral consequences, and treatment and healing are attainable but often not pursued. There were two subthemes: foster care was challenging, but also lifesaving, and poor sleep and anxiety diagnosis or symptoms can manifest. The results were consistent with or extended the concepts of the theoretical frameworks, which I will expound upon in Chapter 5. In Chapter 5, I also will offer more detail about the interpretation of the results, limitations of the current study, implications for positive social change, and recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

For this research, I explored the foster care experiences and adulthood mental health of racial minority foster care alumni through the theoretical frameworks of trauma theory (see van der Kolk et al., 1991) and information processing theory (see Shapiro, 2018). There had been a lot written on mental health diagnoses and adulthood hardships among the foster care alumni population (Gourdine, 2019; Liming et al., 2021). However, I did not find any studies on United States alumni, their mental health, and their lives after foster care in a thorough search of prior research. Therefore, I conducted a qualitative study to understand the effects of the trauma experienced in foster care on racial minority foster care alumni's mental health in adulthood.

Eight racial minority foster care alumni were interviewed and provided the data to answer the research question. The results revealed that the trauma experienced in foster care affected mental health in adulthood for alumni in a variety of ways. Three themes and two subthemes emerged from the data: Severed or strengthened relationships caused by placement into foster care continue into adulthood, foster care can have unintended behavioral consequences with a subtheme of foster care was challenging but also lifesaving, and treatment and healing are attainable but often not pursued with a subtheme of poor sleep and anxiety diagnosis or symptoms can manifest. In this chapter, I present an interpretation of the findings, limitations of the study, recommendations for future research and social work practice, and implications for positive social change.

Interpretation of the Findings

In Chapter 4, the data presented represented the perspectives and experiences of eight racial minority foster care alumni participants and addressed the question I sought to answer through this research. The question that guided the study was the following: What are the effects of trauma experienced in foster care on racial minority foster care alumni's mental health in adulthood? There had been a significant amount of research on foster care trauma and outcomes of foster care alumni (Armstrong-Heimsoth et al., 2020; Fusco & Kulkarni, 2018; Geiger et al., 2017; Greeson & Thompson, 2017; Gypen et al., 2017; Harwick et al., 2017; Neal, 2017; O'Loughlin & O'Loughlin, 2016; Riebschleger et al., 2015; Tobolowsky et al., 2017; Villagrana, 2017). Participants in the current study mostly validated the findings of previous studies on foster care alumni outcomes.

For this study, eight racial minority foster care alumni shared their foster care experiences and how they affected their life and mental health today. Placement into foster care is considered traumatic and can lead to various adverse and unhealthy outcomes (Barboza et al., 2017). Trauma theory and information processing theory were the theoretical frameworks that guided the current study and provided five types of expected outcomes for trauma survivors: behavioral, cognitive, emotional, physical, and social (see Shapiro, 2018; van der Kolk et al., 1991). There was evidence to support the study's theoretical frameworks outcome predictions in all of the study's participants' histories; however, some types of outcomes had diminished or were not as prominent in adulthood. The most common outcomes reported by the participants in adulthood, and

most significant to their adult mental health, were cognitive in terms of mental health diagnoses and included behavioral, physical, and social outcomes.

All participants reported mental health diagnoses or symptomology consistent with an anxiety diagnosis. Participants also reported other outcomes that were cognitive and related to mental health. The other cognitive outcomes reported in the study and also found in the literature were learned responses (see Shapiro, 2018), negative worldview (see Bertram, 2018), and flashbacks (see Vonderlin et al., 2018). Although most of the participants did not report these outcomes, a few mentioned them. Though all of the participants experienced trauma in foster care, their experiences were different. They were not all in foster care at the same time, in the same location, with the same foster parents, or in foster care for the same reasons. They all experienced different traumas before and while in foster care. The differences among the participants' experiences accounted for them not experiencing identical outcomes.

The most common mental health diagnoses for alumni were previously found to be ADHD, oppositional defiant disorder, conduct disorder, anxiety, PTSD, and depression (Fusco & Newhill, 2021). Besides conduct disorder, participants of the current study reported all of the other common diagnoses, which is consistent with Fusco and Newhill's findings, all other studies found on this population, and the theoretical frameworks (see Bertram, 2018; Font et al., 2018; Fratto, 2016; Fusco & Newhill, 2021; Gypen et al., 2017; Kang-Yi & Adams, 2017; Shapiro, 2018; van der Kolk et al., 1991; Villagrana, 2017). I heard consistently from participants about their lack of understanding about their diagnosis or diagnoses and how the most they knew was what they learned

from Google and other internet searches. No one spent time educating the participants on their diagnoses or medications prescribed. Also, besides medication, providers only offered talk therapy for treatment.

Participants often declined or rejected the two offered mental health treatment options of talk therapy or medication. Only one participant had fully taken advantage of any professional treatment. The findings in this study supported prior studies on mental health treatment offerings in which alumni were found not to seek formal help for their diagnoses or to discontinue services after foster care (see Villagrana, 2017; Villagrana et al., 2018). The lack of diagnosis education for foster care alumni was also previously found (see Bertram, 2018). Although little is known about why alumni do not participate in therapy services, it could be attributed to lack of support (Villagrana, 2017) or self-stigma surrounding needing and participating in services (Villagrana et al., 2018). Treatment plans made by judges, guardian ad litems, attorneys, or social workers who have not been involved long also contribute to foster youths not participating in services (Bertram, 2018). The plan remains wrong for them after they become alumni. Each participant had their reasons for not seeking treatment, and the three reasons previously listed were among those provided. Most often, though, participants expressed feeling misdiagnosed or simply not needing services or medication.

Regarding behavioral outcomes, the participants reported behaviors after foster care that they felt would not have been present if not for their foster care experience, which was generally traumatic. Those behaviors included distrusting people and systems, issues communicating with and respecting authority figures, and hypervigilance.

Hypervigilance is a typical behavior displayed by foster children as a reaction to trauma (Dye, 2018). In the current study, participants who reported hypervigilance had traumatic group home experiences. A prior study on foster child aggression and placement type found a positive correlation between aggressive behavior and group home stays (Perry & Price, 2017). Though current participants reported no aggression, the hypervigilance reported by participants in adulthood offered an additional behavioral outcome concerning group home stays.

Other behavioral outcomes found in previous studies included violence, delinquency, suicidal thoughts and behaviors, and self-destruction (Franklin et al., 2017; van der Kolk et al., 1991; Yang et al., 2017). The current participants reported a few incidents of violence, delinquency, and self-destruction during their childhoods, but none during adulthood. Two participants reported hating themselves at specific points in their lives and no longer wanting to live, and one reported a suicide attempt while in foster care; however, none disclosed current suicidal thoughts or behaviors. Substance abuse, specifically marijuana use, was found to be a concern for foster care alumni to deal with trauma and life struggles such as housing instability, sleep problems, and mental health symptoms and diagnoses (Fusco & Newhill, 2021). Only one of the current participants reported previous marijuana use, and none reported current substance abuse; however, I did not ask specifically about substance use, only about coping methods. Though the findings were not the same as in previous studies, the behaviors reported by current participants were still maladaptive and supportive of the fact that brain changes caused by trauma can lead to various behavioral outcomes (see Shapiro, 2018; van der Kolk et al.,

1991). These findings suggest the possibility of more behavioral outcomes that may manifest that previous studies did not indicate.

Physically, the most consistent finding among all current participants was sleep disturbance. Sleep disorders and overall poor sleep patterns commonly linger after foster care. In a quantitative study on 185 foster care alumni and low income adults age 18–24, Fusco (2020) provided Fitbit devices for participants to wear for 5 days to track sleep. Fusco found that fewer hours of sleep were common in alumni compared to low-income adults, with the alumni averaging 4.6 hours a night, waking up seven times a night, and taking over 30 minutes to fall asleep. Though Fusco had a much larger participant pool, the findings were consistent with all of my participants. When it came to sleep, my participants agreed that it was a problem. They reported sleeping terribly, few hours per night, and irregularly. Lee and Fusco (2021) further found in their extension study on 143 alumni and low-income adults that spending time in foster care and having more ACEs can lead to poorer sleep. My participants averaged six ACEs along with spending time in foster care and had poor sleep.

As far as social outcomes after foster care trauma, the participants had limited support and unreconciled relationships with their biological parents and extended family, and often navigated adulthood alone. Prior social outcome research indicated various findings. One study on social outcomes focused on how the neighborhoods and communities where alumni and trauma victims reside become impacted by their trauma experiences (Collins-Camargo & Antle, 2018). The research highlighted how neighbors and neighborhoods felt the effects of alumni behaviors such as skipping school and

committing crimes. Other social outcome research focused on relationships mitigating social impacts of alumni behavior. Researchers found that having a support system and relationships with family members can reduce the risk of behaviors that impact communities (Gypen et al., 2017; Rayburn et al., 2018). I found that participants' relationships after foster care had a more significant impact on their mental health than on their communities.

The current participants were all removed from homes where neglect and abuse existed and taken from the care of their biological parents. The homes would have been considered early toxic environments (see Rome & Raskin, 2019). Like Rome and Raskin, I found that early toxic environments impacted alumni relationships and mental health outcomes. Being removed from their homes resulted in strained or limited contact with parents and family during foster care. Participants' relationships with their biological parents and extended family remained severed in adulthood. Relationships can positively or negatively impact mental health (Rome & Raskin, 2019). My study participants had few strong relationships to aid in trauma healing, psychological functioning improvement, or encouraging other positive social relationships.

Participants in this study did not heavily report emotional outcomes. Intense and intolerable emotions were more commonly reported in prior studies due to participants feeling isolation, shame, self-blame, and being suspended in terror (Kang-Yi & Adams, 2017; Shapiro, 2018; van der Kolk et al., 1991). Two current participants reported some angry outbursts during foster care, but other emotional responses were not disclosed. This study's lack of emotional outcomes is likely due to differences in foster care experiences.

It is also possible that the emotional outcomes found in prior research were more common for foster youths who spent time in foster care but did not age out, as Steenbakkers et al. (2019) found. Lastly, the differences in emotional outcomes and lack of emotional findings could be due to the participants' resources to cope with what they had been through, which influenced trauma responses and emotions (see van der Kolk et al., 1991).

In a prior study, foster care alumni did not report positive emotions from their foster care experience (Chambers et al., 2018). Consistent with my study, the findings of the Chambers et al. study included alumni feeling frustration, betrayal, hurt, and grief due to experiencing multiple moves while in foster care, leaving them feeling unwanted and having relationship issues in adulthood. Relationship issues were common among my study's participants. However, a study finding that does not fit in one of the outcome categories purported by the theoretical frameworks was viewing foster care as lifesaving despite its difficulties and the traumas experienced therein. Viewing foster care as lifesaving could be considered a positive emotion. Current participants acknowledged the trauma they experienced; they also distrusted the system but articulated how being in foster care saved them from a worse life. Emotionally, they could have been stronger because of that experience.

Generally, the findings of this study were consistent with prior research findings on the foster care alumni population and the assertions of the theoretical frameworks. As Barboza et al. (2017) found, the current participants were not exempt from trauma while in foster care. All of them reported experiencing more trauma after foster care placement.

Those experiences varied but were not surprising, and their varied experiences led to varying outcomes that generally fit into the outcome categories identified by the theoretical frameworks (see Shapiro, 2018; van der Kolk et al., 1991). Findings in prior literature showed that facing multiple traumas and stressors can often lead to adverse outcomes (Busso & Sheridan, 2020; Rebbe et al., 2018). I found some adverse effects in the participants in this study; however, in contrast to other studies, participants were able to view foster care as lifesaving, which was a positive finding.

Limitations of the Study

The participants of this study were from various locations and experienced foster care at different times and with different providers. The varied stories and experiences were a strength; however, the sample size of eight was a study limitation. The participants were mostly Black (n = 6), with one Asian and one Latinx participant. Because of the size and limited racial makeup, the generalizability of the findings to a larger alumni population is difficult (see Hadi & Closs, 2016).

I used purposive sampling to recruit participants for the study to identify and select participants with a wide range of foster care experiences to share (see Creswell & Poth, 2018; Kalkhe, 2018). I reached out to over 100 independent social workers via email to begin recruiting. Many of them did not respond. Those who did respond ensured that they would share my flyer with alumni on their caseloads who met my criteria. I was able to talk to several of them, who confirmed that the alumni they work with are hard to reach. Using social media as a recruitment method may have yielded an increase in participation numbers.

Though the topic of the study and the focus of the interview questions were difficult, and recounting the traumas experienced was hard for many survivors, the interview guide yielded thorough responses from participants. With the data they provided, I answered the research question. The participants reported no concerns about sharing their stories or experiences. It is unknown whether other potential participants who were provided with the recruitment flyer and opted not to participate were challenged with the prospect of discussing their trauma and foster care experiences; therefore, the topic of the study could have been a limitation to recruiting more participants.

Future Research Recommendations

Future research with a larger and more diverse sample size could confirm or refute the findings of this study and provide more data regarding areas requiring further observation or modification to serve alumni better. One of the most significant findings in this research was alumni's trauma treatment or lack thereof. Future research focusing on treatment could yield more useful information on better serving the racial minority foster care alumni population.

Targeting effective treatment modes for foster care youths and alumni could yield important information for providers who work with this population. The only treatment offered to the alumni in the study before and after aging out of foster care were medication and talk therapy. Both were commonly rejected. It could benefit racial minority and other foster care alumni to be introduced to different modes of healing and dealing with trauma besides talk therapy. With talk therapy being viewed as ineffective

and often declined by alumni, it behooves providers and those working with this population to seek alternative options. Some researchers have also found talk therapy to be ineffective and re-traumatizing for trauma survivors (van der Kolk et al., 1991); while EMDR does benefit trauma survivors, but no participants were offered this as a mode of treatment (see Landin-Romero et al., 2018; Shapiro, 2018). Future researchers may also want to focus on why treatment is declined. Discovering effective and more acceptable treatments for this population could help alumni begin their healing journey before aging out of foster care.

Implications

The study's findings are important for social work and positive social change. No other studies have targeted racial minority foster care alumni and their mental health outcomes in adulthood (see Gourdine, 2019; Riebschleger et al., 2015; Steenbakkers et al., 2019). This research gave the eight participants a voice. The results offer increased awareness of racial minority foster alumni's traumatic experiences in foster care and confirm that those traumas can lead to mental health diagnoses (see Fusco & Newhill, 2021). A significant finding of this study is that alumni do not heal or attempt to heal from their trauma, so those who work with alumni have to be creative in their approach to helping influence healing. While they can live good lives with traumatic backgrounds, healing would make them even more successful (Rome & Raskin, 2019; Thompson et al., 2016). Though no one should force treatment on alumni, clinical providers and social workers should offer different kinds of treatment regularly or repeatedly during foster care. The earlier intervention occurs, the better the outcomes.

For social work practice, the findings also inform those who work with this population what foster care experiences can lead to in adulthood and how they can influence the outcomes. Social workers, scholars, and policymakers could use the current study's findings to inform program development and support services for foster youths to address before-care trauma and reduce during-care trauma. Specifically, social workers must ensure that relationships foster care youths have with their biological parents, siblings, and extended family is prioritized and nurtured during foster care (see Armstrong-Heimsoth et al., 2020; Villodas et al., 2016). When the relationships do not get adequate attention, they remain severed in adulthood. Severed relationships with family and extended family leave alumni without the meaningful family connections that could form their support system in adulthood and promote their healing after foster care.

The results of the current study may be used to lead discussions between child welfare policymakers and stakeholders and are precisely the type of findings that the CWLA and NASW have used to promote change in the child welfare realm for years (see Welcome to the CWLA, 2020). These organizations have promoted social change by changing how social workers respond to abuse and neglect through advocacy and legislation. Additionally, they have sought to promote how communities can support children affected by abuse and neglect and advocate for ways service providers can help reduce the overall impact of trauma on victims and their families. The results of this study highlight the importance of continuing that work. The findings support the promotion of keeping families together legislations, encouraging kinship placements and

using foster care as a last resort, and ensuring foster care alumni have access to services and support that will encourage their trauma healing.

The findings support that changes in foster care practice that are more consistent with trauma-informed care may be helpful to alumni. Trauma-informed programs have formally trained staff on the clinical origins of trauma, its impacts, and appropriate treatments (NASW, 2020). With everything known about how and why youths end up in foster care, the service as an intervention should be trauma-informed; however, the results of this study confirmed that it is not. Foster care should afford youths and alumni services and providers who understand trauma and how to treat it effectively. Instead, as the results show, alumni rarely receive any services to treat their trauma and often age out of foster care feeling that it caused them adverse problems or behaviors. Trauma-informed services benefit communities and trauma victims and promote social change through programming that fosters healing, offers clinical support, and endorses behavioral changes (NASW, 2020).

The study's results also offer policy recommendations for the foster care system. Over the last few years, there have been several policy initiatives and changes, including increasing the age that foster care goes to and making efforts to prevent child abuse before it happens to reduce lifelong effects of trauma (Sciamanna & Ogletree, 2020a; Sciamanna & Ogletree, 2020b). Recommendations from the current study are consistent with the policy initiatives that have come about in the last several years. Policies around limiting multiple moves and what happens when additional traumas occur while in foster care are warranted. Current policies around keeping families together and ensuring that

foster care is only used when necessary should be continually monitored for appropriate use (see Annie E. Casey Foundation, 2019). Lastly, since most foster care trauma occurs at the hands of foster care providers, social workers, policymakers, and foster care agencies should continually ensure that the right people are licensed as foster parents. Foster parents should face appropriate repercussions when they violate that role. Providing the social work field with knowledge on the effects of the foster care system's practices and policies is a final way this study's findings may lead to social change.

Conclusion

This study extended current literature on foster care alumni, focusing on racial minority alumni and mental health outcomes in adulthood. Three themes and two subthemes were found from the participant interviews and data. The effects of foster care extend beyond aging out. The severed relationships it causes with parents are not easily rectified after foster care. However, when they go through foster care together, sibling relationships can be strong even after foster care. Foster care can change the life course of alumni, as all generally feel their life would be different in some way without foster care, even if they feel foster care saved their life. Lastly, though healing is possible, alumni often decline treatment, and poor sleep and anxiety can then manifest. These findings can serve as ways to better help and create positive social change for racial minority foster youths through making family relationships work a priority during foster care. The results also support ensuring foster care alumni have all the support needed. Racial minority foster care alumni should never view foster care as disruptive of their life path. Those

who work with foster youths and alumni should offer trauma treatment options often and early.

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Appendix A: Theoretical Frameworks Key Concepts

Behavioral Outcomes	Cognitive Outcomes	Emotional Outcomes	Physical Outcomes	Social Outcomes
violence[a]	brain changes[d]	intense & intolerable emotions/ emotional disturbance[i]	physical ailments and disorders[j]	relationship issues[l]
delinquency[a]	loss of volume control[d]		counter-productive development[k]	victim to victimizer[m]
self-destruction[b]	impaired thinking[e]		sleep disturbance[p]	sexual identity issues[n]
dependence/ learned helplessness[c]	flashbacks[f]			survivor mission[m]
substance abuse[o]	dissociation[f] skewed self-perception[g] negative worldview[g] learned responses[h]			

Note: From Yang et al. (2017)[a], Perry & Price (2017)[b], Armstrong-Heimsoth et al. (2020)[c], Gypen et al. (2017)[d], Fratto (2016)[e], Vonderlin et al. (2018)[f], Bertram (2018)[g], Shapiro (2018)[h], Kang-Yi & Adams (2017)[i], Carrellas et al. (2018)[j], Busso & Sheridan (2020)[k], Katz et al. (2017)[l], Steenbakkers et al. (2019)[m], Brandon-Friedman et al. (2020)[n], Fusco & Newhill (2021)[o], and Fusco (2020)[p].

Appendix B: Recruitment Flyer (Contents Only)

DID YOU AGE OUT OF FOSTER CARE?

SEEKING MINORITY ADULTS AGE 18-21 FOR A STUDY ON THE TRAUMA AND FOSTER CARE

Phone: 704-266-2650

Email: Adrian.Green@waldenu.edu

Participation Requirements:

- Must identify as a minority: Asian, Black, Hispanic
- Must have spent at least a year in foster care
- Must have aged out of the foster care system in NC
- Be willing to participate in an interview

INTERESTED? /HAVE QUESTIONS? ----- CALL, TEXT, OR EMAIL USING INFO ABOVE

FOR YOUR TIME ----- RECEIVE A $25 AMAZON GIFT CARD

Appendix C: Interview Tools

Screening Guide

- ☐ Participant is Asian, Black, or Hispanic
- ☐ Respondent is age 18+
- ☐ Respondent was in foster care for at least 1 year and aged out of foster care
- ☐ Respondent acknowledges no cognitive impairment and the ability to understand and answer questions
- ☐ Respondent eligibility
    - ○ Respondent is eligible to participate and has a private space to use for the interview
    - ○ Respondent is not eligible to participate

Preinterview Guide

Participant/Pseudonym: _____

Contact info: _____

Interview scheduled for: _____

- ☐ Interview will be virtual via video conferencing
- ☐ Interview will take place over the phone

- ☐ Participant provided with consent form

- ☐ Participant emailed ACEs questionnaire following signed consent receipt

Preinterview (ACEs) Questionnaire (Google form sent through text or email)
Please answer honestly and to the best of your recollection.

Name/Pseudonym (provided at screening) _____

Phone/Email _____

ACEs or adverse childhood experiences have been shown to have an impact throughout a person's life. Thinking about your childhood, did you ever:

- ☐ Experience being sworn at, insulted, put down or humiliated.
- ☐ Experience being pushed, grabbed, slapped, or have something thrown at you
- ☐ Experience being hit so hard that you had marks or were injured
- ☐ Experience being touched, fondled, or made to touch or fondle someone else
- ☐ Experience oral, anal, or vaginal intercourse with someone at least 5 years older than you
- ☐ Go without food, shelter, or clean clothes
- ☐ Not go to the doctor when you needed to
- ☐ Witness your parents drunk or high
- ☐ Witness domestic violence to include seeing a parent pushed, grabbed, slapped, had something thrown at them, kicked, bitten, hit with a fist, hit with something hard, or threatened with a gun or knife
- ☐ Have a parent who was depressed, mentally ill, or attempt suicide
- ☐ Have a parent or sibling go to prison

Interview Guide

The purpose of this qualitative study is to understand the potential effects of the trauma experienced during foster care on racial minority foster care alumni's mental health.

Background Information/Demographics

Pseudonym: _____ Total time in FC: _____

Current Age: _____ Age of Initial Placement in FC: _____

Race: _____ Number of Placements in FC: _____

Gender: _____ Highest Level of Education: _____

□ ACEs questionnaire returned Date of Interview: _____

Research question: What are the effects of the trauma experienced in foster care on racial minority foster care alumni's mental health in adulthood?

Face-to-face/Virtual Interview:

{Rapport building}
Tell me about you. Where do you live now? Who do you live with? What do you do for a living? What are your hobbies?
Can we talk a bit about race and your culture? How was your culture impacted by your time in foster care? What cultural practices were you not able to engage in because you were away from your family of origin?
How often were you able to visit with your extended family? What is your relationship like now with them? How do they support you?

When you hear the word 'trauma', what does it mean to you?

Looking at your ACEs responses-let's talk about some of these experiences. What do you remember about_____? What was it like when _____? How do you feel today about _____?

What is your relationship like today with your parents?

Thinking about your placement into foster care:

1. Do you remember what led to your being placed in foster care?
    a. What was the placement/removal experience like for you?/What still stands out about it?

b. If you remember, what emotions did you feel during those first few days in a new place?

While in foster care:

1. Was there anything that happened while you were in foster care that you feel had a negative effect on your life?
    a. What happened?
    b. Who was involved in those experiences?
2. {Cognitive} How would you describe your thoughts toward yourself while you were in foster care?
    a. What do you think others thought about your being in foster care?
3. {Behavioral} Was there ever a time that you "acted out" while in foster care?
    a. What did that look like?
    b. How did things go at school?
4. {Emotional} How would you describe the emotions you felt during your time in foster care? Toward yourself, your biological family, and your placement providers?
5. {Social} Who did you have contact with consistently throughout your time in foster care?
    a. How many social workers did you have?
    b. Who was your confidant? Who knew what you were going through?
    c. What type of placement were you in for the longest amount of time?
        i. What was it about that placement or the caregivers that made it different from the rest?
6. {Cognitive} Were you ever diagnosed with a mental health disorder?
    a. What is your diagnosis?
    b. What type of treatment did you participate in? Any medication?
    c. How were you educated on your diagnosis?
    d. {Stigma}Is having a diagnosis something you talked to your friends about? How did those conversations go?

Life today-Outcomes:

1. How would you say being placed into foster care affected your life path?
    a. How do you think life would have been different if you were never placed in foster care?

2. {Behavioral} What behaviors or personal habits do you think were caused by or exacerbated by what you experienced in foster care or just being in foster care?
3. {Behavioral/Social-Helplessness} When you aged out, in what ways did your county/agency support your transition?
    a. What services were you offered and did you utilize them?
4. {Cognitive} How have you dealt with the trauma/experiences that brought you into foster care or any traumas experienced during foster care?
    a. What made you choose the treatment methods you use?
    b. If you do not participate in any treatment, why not?
5. {Physical} How concerned are you about your physical health now that you are no longer in foster care?
    a. How often would you say you go to the doctor and dentist?
    b. What words would you use to describe your physical health?
    c. How would you describe your sleep patterns?
6. {Social-Relationships} Who do you consider to be part of your circle?
    a. How would you describe their support for you?
    b. What circumstances brought you and your support system together?
7. When you think about all of your foster care experiences, what lasting impressions/memories stick with you to this day?
    a. {Emotional}Are there any positive emotions you would associate with your foster care experience?
8. Is there anything else you wish to share about your time in foster care?

Post-Interview Guide

☐ Interview Completed

☐ Interview Incomplete

☐ Resources Provided

☐ Resources Declined

☐ Participant Compensated Date: _____

☐ Participant NOT Compensated due to:

Appendix D: Mecklenburg County Mental Health Resources

The following list is comprised of service providers who offer mental health support and treatment services in the greater Charlotte area. Many also offer substance abuse, grief and loss, and trauma-specific treatment as well.

Array of Brighter Beginnings
301 McCullough Drive, Suite 400, Charlotte, NC
980-216-6899

Behavioral Health at C.W Williams Community Health Center
3333 Wilkinson Boulevard, Charlotte, NC
1-866-299-4968

Cardinal Innovations Crisis Line
1-800-939-5911

Catholic Charities Counseling Services
1123 South Church Street, Charlotte, NC
704-370-3262

Mental Health America-Central Carolinas
3701 Latrobe Drive #140, Charlotte, NC
704-365-3454

Pinnacle Family Services
831 Baxter Street, Charlotte, NC
704-375-6310

Presbyterian Psychological Services
5203 Sharon Road, Charlotte, NC
704-554-9900

Sexual Trauma Resource Center
601 East Fifth Street, Charlotte, NC
980-771-4673

Additionally:

Aunt Bertha (www.AuntBertha.com) and **NC 211** (www.NC211.org) are useful online resource directories to assist you with finding the right resources to meet your needs; not just for mental health, but for all needs that may arise. Search for available services on their websites.