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Sarah Alissa Cartier
Self-Image in Adolescent
Foster Youth Who Have Had
Multiple Out-of-Home
Placements

ABSTRACT

This study was undertaken to determine the feasibility of data collection from adolescents in foster care. Additionally, how do adolescent foster youth who have had multiple placements perceive their self-image and is it comparable to the self-image of an adolescent population not in foster care? Adolescent foster youth who have had multiple placements are at higher risk for negative personal, familial, environmental, communal, and societal relations. Areas of self-image identified as positive should be supported and areas identified as reflecting a lower self-image should be addressed both clinically and pragmatically.

Adolescent foster youth in the custody of the Department of Children and Families in Holyoke, Massachusetts between the ages of 13 and 19 were given the Offer Self-Image Questionnaire for Adolescents, Revised. The youth sampled did not have statistically significant differences in self-image from that of the normal reference population. However, findings of interest provide valuable insight into the adolescent foster youth sample's self-image in various life domains. Since out-of-home placement continues to affect youth nationally, there is an ongoing and pressing need for additional research to assist this population in successful, stable, supportive and nurturing transitions to out-of-home care. Additional understanding of the effects of early childhood trauma, self-image, and out-of-home placement are needed to shape positive

adolescent development in this context and to provide empirical evidence to support and enhance public policy and additional resources to our nations children.

SELF-IMAGE IN ADOLESCENT FOSTER YOUTH WHO HAVE HAD MULTIPLE
OUT-OF-HOME PLACEMENTS

A project based upon an investigation at the
Department of Children & Families, Holyoke,
Massachusetts, submitted in partial fulfillment
of the requirements for the degree of Master of Social
Work

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Northampton, Massachusetts 01063

2009

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CHAPTER I

INTRODUCTION

In this study I will focus on the self-image of adolescent foster youth who have had multiple out-of-home placements. The National Data Analysis System for the Child Welfare League of America (2007) reported that in 2005 there were 12,197 children in Foster Care in Massachusetts, and these 12,197 children experienced an average 4.4 different foster placements. Multiple placement moves, an issue that affects foster youth nationally, has been addressed extensively in the literature (Barber, J.G., Cooper, L.L., & Delfabbro, P.H., 2001; Chamberlain, M.M., 2007; Farmer, E.M.Z., Mustillo, S., Burns, B., & Holder, E.W., 2008; Lawrence, C.R., Carlson, E.A., & Egeland, B., 2006; Newton, R.R., Litrownik, A.J., & Landsverk, J.A., 2000; Oosterman, M., Schuengel, N., Slot, N.W., Bullens, R.A.R., & Dorleijers, T.A.H., 2007; Palmer, S.E., 1996; Scannapieco, M., Connell-Carrick, K., & Painter, K., 2007). The mean number of placements experienced nationally by foster youth ranges from 1.9 to 5.7 (Child Welfare League of America, 2007).

Much of the recent literature has focused on multiple foster placements as a contributor to attachment and developmental disruption (Chamberlain, M.M., 2007; Lawrence et al., 2006; Palmer, S.E., 1996; Scannapieco et al., 2007) and its impact as a risk factor (Barber et al., 2001; Chamberlain, M.M., 2007; Farmer et al., 2008; Lawrence et al., 2006; Oosterman et al., 2007; Palmer, S.E., 1996; Roosa, M.W., Wolchick, S.A., & Sandler, I.N., 1997). It has also examined the effect out-of-home care and multiple

placement moves has on how the foster youth perceives herself (Helgerson, J., Martinovich, Z., Durkin, E., & Lyons, J.S., 2005) and the protective factors (Fitzgerald, 1994; Walter & Petr, 2008). However, the primary focus of most studies on foster youth has been from the perspective of those working with or living with these displaced children (Barth, R.P., Lloyd, E.C., Green, R.L., James, S., Leslie, L.K., & Landsverk, J., 2007; Fox, A., & Duerr-Berrick, J., 2007; Palmer, S.E., 1996). Other studies have explored the experience of foster youth from their own point of view, but have been retrospective and relied on the memories of the experiences of the now adult foster youth (Fox, A., & Duerr-Berrick, J., 2007). Some researchers have obtained data from current foster youth, but have not examined multiple placement moves. There is an absence of research on multiple placement moves from the perspective of those who experience them: the foster youth.

This study poses two research questions: is it viable for me to obtain data from adolescents in foster care in the state of Massachusetts? Secondly, how does the self-image of adolescent foster youth in the state of Massachusetts compare to the self-image of the general population of adolescents not in foster care? It is the intent of this study to assess how foster youth who have had multiple placement moves perceive their self-image and explore this phenomenon from a developmental perspective.

Self-image was assessed quantitatively in this fixed method cross-sectional study to test the efficacy of surveying foster youth who are currently in state custody, to develop a better understanding of this measure, and to obtain data from more participants than a flexible study would allow. The assessment instrument, the Offer Self-Image Questionnaire for Adolescents, Revised (OSIQ-R) provides a measure of the adolescents

level of adjustment in 12 life domains, culminating in their overall self-image (Offer, D., Ostrov, E., Howard, K.I., and Dolan, S., 1992). I was interested in learning how these foster youth perceive their self-image in myriad life domains so that in domains of positive adjustment, self-image can be reinforced and strengthened. Domains identified that indicate lower levels of adjustment should be further explored to identify risk factors and explore how these could be reduced. These data can help guide program development, such as how children are transitioned into particular placements or through the types of additional services and resources that are offered to them and their families. At the policy level, child welfare advocates' knowledge of adolescents' self-image as it is associated with particular life domains can help these advocates further develop current policy, or provide illustrative data for consideration when creating new policy.

I approached the Massachusetts Department of Children and Families (DCF) and proposed to conduct this study under their auspices. The Executive Office of the DCF approved implementation of the study and offered assistance from the Assistance Commissioner for Planning and Program Development. Locally, administrators and caseworkers of the Holyoke area office provided assistance in carrying out this project. This study was designed to give voice to the foster youth in Holyoke, Massachusetts who are experiencing multiple placement moves.

CHAPTER II

LITERATURE REVIEW

Introduction

The purpose of this study was to measure the self-image of adolescents in out-of-home care (i.e., foster care) in the custody of the Department of Children and Families (DCF) in the state of Massachusetts. Thus, this review will explore literature around the following themes: Out-of-home placements, multiple placement moves, adolescent development, adolescent self-image, the risk and protective factors associated with adolescents in out-of-home care and self-image assessment tools. Multiple placements of children in foster care is a risk factor that has been extensively addressed in the literature (Barber et al., 2001; Chamberlain, M.M., 2007; Farmer et al., 2008; Lawrence et al., 2006; Oosterman et al., 2007; Palmer, S.E., 1996). However, the primary focus of most studies on this topic has been from the perspective of those working with or living with these displaced children (Barth et al., 2007; Fox, A., & Duerr-Berrick, J., 2007; Palmer, S.E., 1996), and few researchers have asked adolescents themselves for their perspectives. In fact, studies in this review that have explored the experience of foster youth from their point of view have been retrospective in nature relying on the now adult's memory of his or her past experiences (Fox, A., & Duerr-Berrick, J., 2007). There is a dearth of research on multiple placement moves from the perspective of those who are currently experiencing them: the foster youth.

Out-of-Home Placements

Current policy, specifically the Adoption and Safe Families Act (ASFA) of 1997 PL 105-89, was established to address the foster care population. It replaced the prior law dating from 1980, the Adoption Assistance and Child Welfare Act PL 96-272, with the intent of reducing the time frame that children spend in non-permanent out-of-home care, as well as the number of placement moves. The process enacted to address this problem is known as *concurrent permanency planning* (including adoption), occurring when children enter the foster care system. Despite the policy creator's best efforts, many children continue to experience myriad placement moves in the foster care system.

Currently in this country, there are around 500,000 children in out of home care (Child Welfare League of America, 2007). The most recent data in the state of Massachusetts identified 10,595 children in out-of-home care for the Fiscal Year 2009, 1st Quarter (Department of Children and Families DCF, 2009). Out-of-home care, also called foster care (Child Welfare League of America, 2007), includes children placed in family foster care, kinship care, treatment foster care and, residential & group care (also called congregate care). In the state of Massachusetts when children are placed in DCF custody in out-of-home care there are 9 goals for permanency: Family reunion, adoption, alternate planned permanent living arrangement (APPLA), permanent care with kin, guardianship, stabilization of family, living independently, long-term substitute care and long-term care with Adult Service Agency (ASA).

The Department of Children & Families in the state of Massachusetts is divided into 6 geographic regions: Western, Central, Northeast, Metro, Southeast and Boston. The Western region had a total of 241 adolescents in congregate care, accounting for

72% of adolescents in out-of-home placements in the Western region in FY 2009, End of 1st Quarter (DCF, 2009). This placement setting differs significantly from a family setting in which adolescents receive support and guidance from a consistent caregiver(s). Group living also places new demands on adolescents which require their adjustment to new schedules, rules, routines, loss of privacy and shared space with unknown peers. Walter and Petr (2008) write, “On the continuum of restrictiveness, residential care is second only to inpatient and juvenile justice facilities and thus considered a ‘last resort’ for youth who cannot be served adequately in less restrictive environments through community based- programs or in foster homes” (p. 3). Youth in residential placements, in most cases, have already experienced foster care, usually in more than one foster home, and were not able to successfully negotiate living in the foster home environment.

Multiple Placement Moves

Foster children typically experience at least three moves due to administrative reasons unrelated to their behavior (Barth et al, 2007). In the state of Massachusetts, 4.4 is the average number of placement moves experienced by foster youth (Child Welfare League of America, 2007).

Placement in foster care exposes children to a higher risk of future placement disruption and to countless future placements (Palmer, S.E., 1996; Newton et al., 2000). Children in placements who have externalizing behavioral problems are at even greater risk for placement disruption (Barth et al., 2007; Newton et al., 2000). As a consequence of multiple placements some children manifest self-defeating behaviors (Newton et al., 2000) and it is damaging to their ability to attach (Chamberlain, M.M., 2007; Lawrence et

al., 2006; Palmer, S.E., 1996; Scannapieco et al., 2007) and to their self-esteem (Fein, E., Maluccio, A., & Kluger, M., 1990; Hicks, C. & Nixon, S., 1989; Lyman, S.B. & Bird, G.W., 1996; Sullivan, P., 2008). Finally, placement instability may have myriad consequences on top of emotional and behavioral disorders (Barth et al., 2007).

The phenomenon of multiple placement moves for foster youth has been explored from different perspectives by many researchers. Unsuccessful placement was studied by identifying which baseline characteristics of children predicted successful or unsuccessful transitions to foster care (Barber et al., 2001). Risk and protective factors were identified both from existing research (Oosterman et al., 2007) and individual empirical studies (Famer et al., 2008; Lyman, S.B. & Bird, G.W., 1996). Placement instability was found to be most notably associated with older children (Barber et al., 2001; Farmer et al., 2008) and children with conduct disorders, hyperactivity, emotional disturbance and difficulty in social adjustment (Barber et al., 2001). Newton et al. (2000) found that the relationship between placement instability and problem behaviors in foster youth was statistically significant in a sample of 415 foster youth. For children entering care who had no previous behavioral problems, number of placements was a consistent predictor of increased behavioral problems as measured at 18 months. Another protective factor identified with reduced number of placements includes the involvement of parents in the foster placement process (Palmer, S.E., 1996).

Adolescent Development

Adolescence is a period of growth and development that brings with it great change in a child's life. Adolescents undergo major changes in all their life domains on

biological, psychological, social, emotional, physical and cognitive levels and all within a cultural context.

Historically, a number of prominent theorists have explored the period of adolescence. G. Stanley Hall, the first president of the American Psychological Association and a developmental psychology theorist, posited that adolescence is a period of both storm & stress and recapitulation (M. Cole, S.R. Cole, and Lightfoot, C., 2005). Hall's fellow psychologist, Sigmund Freud, shared his biological-maturational perspective on recapitulation, and added that it was a time of regression to re-work unresolved earlier childhood issues. Freud's psychosexual stages of development termed adolescence the genital stage because it is when sexual intercourse becomes a motivating force for behavior (Cole et al., 2005). Blos, influenced by Freud, referred to adolescence as the second individuation process (Cole et al., 2005). It is at adolescence that the more mature individual re-experiences, and masters, his or her inferior ego, regression and corrects traumatic responses. At this time, he or she is also in the stage of forming his or her identity. Erik Erikson, a psychoanalyst, also influenced by Freud, referred to identity formation as the process of constructing oneself as an individual while also constructing oneself in his or her communal culture, which as he stated is establishing "the identity of those two identities" (Erikson, 1959, p. 48). Erikson (1963) also posits that children's identities and social competence are developed by completing sequential stages of maturation, with each building on the one before it.

Erikson is most notably known for his psychosocial theory of development, the eight-stage model of the Human Life Cycle. During adolescence (the fifth stage), the primary goals and challenges one faces are Identity versus Role Confusion (Erikson,

1959). Based on Erickson's theory of identity formation, James Marcia (1966), a developmental psychologist, identified four patterns of coping with the challenge of identity formation: identity achievement, foreclosure, moratorium and identity diffusion. In *identity achievement* an individual has committed to future goals he has determined for himself and successfully negotiated his identity crisis. Individuals in *foreclosure* take over the pattern of identity of their parents because they have not undergone their own identity crisis. *Moratorium* is the state of being in an identity crisis. In the state of *identity diffusion*, an adolescent has tried out several identities without settling on one. In sum, "Marcia posited that the adolescent stage consists neither of identity resolution nor identity confusion, but rather the degree to which one has explored and committed to an identity in a variety of life domains from vocation, religion, relational choices, gender roles, and so on" (Learning Theories Knowledgebase, 2009).

Jean Piaget (1954) made another major contribution to the knowledge of adolescence. He posited four stages of mental growth. Adolescents' are in the formal operational stage (the fourth and final) of Piaget's stages of cognitive development. That is, they are able to think both logically and abstractly; they can apply thinking systematically as well as think about thinking. Because of this, adolescents have the capacity to access their emotional world with some insight, which allows them to be the best reporters of their internal states, including their self-image. Adolescent development is a complex answer to the question, "Who am I?" and requires one to organize her drives, abilities, beliefs, and history into a view of herself that is inclusive of the aforementioned theoretical perspectives.

Narramore and Lewis (1990) provided a more modern conceptualization of adolescence, where the emphasis is on levels of dependency. They conceptualized three stages: early adolescence (age 11-14); middle adolescence (age 15-17); and late adolescence (age 18-21). During early adolescence (termed *dependant but looking outward*), the child is experiencing physical bodily changes and becoming more self-absorbed. However, his identity is defined in terms of family. Once a child moves into middle adolescence (*inter-dependent*), he becomes more peer oriented and self-identity is more readily influenced by his social world as he begins to separate more from parents. At late adolescence (*independence*) the young person achieves a sense of autonomy, having the ability to self-regulate and think things through. This is also around the time his identity is more fully developed and he is ready to move into the world in his own way.

Finally, the pre-frontal cortex is not fully developed at adolescence (12-18 years of age) as there are myriad structural changes occurring in the brain during this period of life (Cozolino, 2006). From a neurological perspective, the brain is reorganizing and gaining enhanced plasticity, which responds to and is shaped by the developmental milestones and social transitions occurring in adolescence. More specifically, Cozolino (2006) posits that this process improves cognitive processing by way of increasing efficiency and communication within the brain structures and integrating these functions into various parts of the nervous system (p.44). Empirical studies cited in Cozolino (2006) indicate that cognitive & emotional integration, memory storage & retrieval, planning, foresight, language capacity and self-regulation are all enhanced during the period of adolescence. Severe and prolonged early stress along with inadequate

stimulation and regulation (i.e. provided by an inattentive caregiver) result in inadequate social brain development and abnormal biochemical processes that perpetuate this state (Cozolino, 2006). Therefore, it is crucial to provide stable and supportive environments to allow for the optimal development of these brain functions.

As his identity is formed, the adolescent experiences both positive and negative aspects of his identity, which provides the foundation of his self-image. Within the context of the disruption of out-of-home placement, self-image formation is influenced by myriad factors beyond the scope of “normal” adolescent self-image development.

Adolescent Self-Image

Self-image is defined as “the opinion that you have of your own worth, attractiveness or intelligence (Encarta World English Dictionary, 2009) or “the conception of oneself and one’s role” (Merriam-Webster Online Dictionary, 2009). Given the adolescent experience of identity formation, self-image is a relational term that varies according to the role of the adolescent. Self-esteem is defined as “a confidence and satisfaction in oneself or self-respect” (Merriam-Webster Online Dictionary, 2009). Offer et al. (1981) wrote, “While both self-image and self-esteem are generally conceptualized on a positive-to-negative continuum, self-esteem is a unidimensional, global, measure of self-acceptance, whereas self-image approaches multidimensionality” (p. 20-21). This construct of self-image, therefore, involves an individual’s evaluation of the various aspects of him or herself (i.e., as a friend, student, parent). The individual attributes more or less importance to each aspect, more or less meaning and with the accumulation of all aspects, generates an overall estimation of self (self-image). Conversely, “given

[Rosenberg's] belief that the individual cannot reconstruct the hierarchy leading to one's feelings of self-worth, [he] has been content to assess the global phenomenological appraisal itself, ignoring the complexities of the hierarchy that may underlie such an appraisal" (Leahy, 1985, p. 64).

The process of individuation and defining oneself, a task of adolescence, becomes "even more complicated and demanding for those youth who have come from hurtful and unsupportive home lives and who find themselves, voluntarily or not, in group residential care" (Fitzgerald, 1994, p. 366). During this time of identity formation, these youth must also adjust to being in care, the stigmatization of being in care, ongoing changes in staff, past and current family relational problems, personal problems, and the group living experience. Therefore, among the myriad factors influencing the self-image of foster youth are the same variables that affect their outcome in foster care.

Risk and Protective Factors Associated with Adolescents in Out of Home Care

"Resiliency- our ability to cope with life's ups and downs- is closely tied to the extent and quality of our support systems" (Cozolino, 2006, p. 229). Without these, a child is left with immature coping skills to manage his life stressors and more mature and effective long-term coping skills are not learned in the absence of modeling in the context of a supportive environment.

Roosa et al. (1997) remarked that researchers of diverse orientations have identified many of the same or similar risk and protective factors of children's adjustment to out-of-home care in addition to their own individual characteristics. Some of these factors are: social support including school, community, and culture; coping behavior;

family functioning; home environment; & parenting behavior. Fitzgerald (1994) offered specific protective factors that can be incorporated by foster parents, caseworkers or program staff. These include: creating situations for youth to have some control of their lives; increasing time spent in positive interactions (for youth to draw on in times of stress); providing opportunities for leadership and; respecting youth even when they are demonstrating undesirable behavior (p. 371-373).

Roosa et al. (2007) posited that the closer the stressor or risk factor to the child's environment, the more direct impact it will have on his development. In the context of youth in out-of-home placements, the influence of family functioning, home environment and parenting behavior is most salient. For, it is most often one of these systems that is the cause of the child's removal from her home. In rare instances is it the child herself (i.e. exhibiting unmanageable externalizing behaviors) who necessitates the disconnect from her family. In either case, the child experiences an attachment disruption.

Cozolino (2006) noted that secure and mutually supportive attachments provide one with a sense of security and reduce arousal. It is a commonly held view that the family system provides the first line of defense for children in the social world. Additionally, "parental interest is, we find, closely related to the child's self-esteem" (Rosenberg, 1965, p. 52.). In the case of children and adolescents in out-of-home care, they have been placed in care for various reasons relating to their parent(s) inability to provide adequate safety. For instance, children with early abuse or neglect face severe challenges to their developing social brain and consequent difficulty in social relationships (Cozolino, 2006). Rosenberg noted that children from "broken homes"

(divorce, separation, separation by death) often exhibit emotional disturbance and delinquency due to a plethora of variables which are out of the child's control.

Palmer (1996) discussed the importance of including the parents in the placement process for ease of transition to foster care placement. Her work showed that maintaining contact to family was important for children's ability to draw on the mental image of their caring parent which then bolsters their attachment and their sense of worth. Walter & Petr (2008) supported the inclusion of parents in the treatment process and urged continuing support of the adolescent and his family after discharge as an emerging best practice. However, Newton et al. (2000) noted that across the studies in their literature review, problematic behaviors resulting from attachment deficits were difficult to determine.

Additionally, Barber et al. (2001) identified age entering into care and presence of conduct disorder as risk factors for children in foster care. On the flip side, this study found that protective factors for children in foster care were younger age upon entering care and lowered conduct disorder prevalence. It is in this vein that Barber et al. (2001) suggested residential placements be considered a practicable option for adolescents in need of out-of-home care. In consideration of this need, Helgerson, J., Martinovich, Z., Durkin, E., & Lyons, J.S. (2005) found that children's level of functioning improved over the course of residential treatment, noting that the rate of improvement for children varied among residential programs. Likewise, Gilman, R. & Barry, J., (2003) also found life satisfaction across a number of domains significantly increased as a function of time.

In their study, Trout et al. (2008) found that children entering residential care present with high levels of risk; primary risks included adverse externalizing &

internalizing behaviors, mental illness, and poor academic performance. Some additional higher risk factors for those in care, which often result in the aforementioned risks, include: a history of physical and/or sexual abuse and/or neglect and /or witness to violence.

Rosenberg (1965) pointed to the importance for future study of how the self-images of individuals change as a result of their life experiences. What stimuli, influences, experiences, and under what conditions, acting upon what kinds of people, produce what kinds of change in what part of self-image? Children entering foster care have been removed from their homes for a variety of reasons and are exposed to a multitude of influences, experiences, conditions, and people. So then, what factors and specific life experiences cause certain domains to be more important to one individual than to others? Harter in Leahy, (1985, p. 116), asserted that a critical component of how one perceives herself is influenced by how much control she has in her life and how well she is able to alter her worldview to suit her needs.

Self-Image Assessment Instruments

There are several self-image assessment instruments utilized in some of the empirical studies in this literature review. Perhaps the most well known is the Rosenberg Self-Esteem Scale for Adolescents (Rosenberg, 1965). This measurement is limited to assessing one's general perception of self-worth. In addition to measuring one's global self-worth, the Harter Self-Perception Profile also measures youth's perception of competency in six life domains (Harter, 1985). The Offer Self-Image Questionnaire for Adolescents, Revised (OSIQ-R) (Offer et al., 1982, 1992) covers 12 different life

domains that contribute to one's sense of self-worth, which they posit, in turn creates self-image. The OSIQ-R was developed in 1962 with the goal of assessing the self-image of the general population of mentally healthy adolescents. Offer's et al. (1984) conceptualization of self-image in mentally healthy adolescents' consists of five selves: the psychological self, the social self, the sexual self, the familial self and the coping self. The OSIQ-R is a widely utilized self-reporting inventory research instrument designed to measure adjustment and self-image in adolescents ages 13 to 19 (Offer, D., Ostrov, E., Howard, K.I., & Dolan, S., 1982). This quantitative structured assessment instrument provides an individual's general perception of self-image as well as a measure of her adjustment in twelve specific domains, to elicit focal detail.

Offer et al. (1988) found that adolescents from diverse countries and cultures expressed many common concerns, thoughts and interests. The authors quoted Chomsky who believed in the possibility of core aspects of the self across cultures. He stated that "the 'surface structure' varies, but the 'deep structure' of the self is similar". Offer et al. expanded on this idea: "When the many layers of apparent layers of human diversity are peeled away (like language, race, or religion), we are left with core attitudes and values that motivate and guide many of us" (Offer, D., Ostrov, E., Howard, K.I. & Atkinson, R., 1988, p. 112).

The OSIQ-R has been administered to over 30,000 adolescents globally. Offer et al. (1981) noted, "The portrait of an adolescent is best drawn by him/herself" (Offer, D., Ostrov, E. & Howard, K.I., 1981, p. 129). Adolescents have the capability to access their emotional world with insight also allowing them to be the best reporters of their own self-image. Through use of OSIQ-R, adolescents are able to "report" what they perceive as

their problems. Additionally, OSIQ-R was selected for this current study for its usefulness in discerning when an adolescent may have mastered one aspect of his or her life and feel quite competent, while struggling and failing to adjust to another. It is the ability of this instrument to differentiate between these so that areas of lower self estimation can be identified and tended to while areas of higher functioning can be supported.

In closing, the results of a longitudinal study of normal adolescent boys accurately predicted the boys' future psychological functioning (Offer, 1969; Offer & Offer, 1975). Although this predictability is untested on the adolescent Foster Care population, the empirical evidence of this on future functioning is something that may be useful to study in this population in the future. Other instruments, such as the Rosenberg Self Esteem Scale for Adolescents (Rosenberg, 1965) or The Harter Self-Perception Profile (Harter, 1985) provide much less specific measures of the entire scope of adolescent self-image. Additional *perception of adjustment* domains assessed in the OSIQ-R are more congruent with this present study.

Summary and Hypotheses

Research addressed in this literature review has examined the effects that multiple placements have on foster youth and helps illustrate the comprehensive experience of youth in state care. Much of the literature however has failed to measure the experiences as reported directly by the foster youth. It is my goal to explore further the effects of multiple placements on foster youth's self-image, from their point of view.

In this study I intend to identify the level of adjustment foster youth have in 12 life domains in order to (1) add to existing data and bodies of literature (2) identify possible areas of lower adjustment to provide a starting point for future studies to explore risk factors and (3) identify areas of greater adjustment for continued support and identification of protective factors.

I hypothesize that I will be able to obtain data from the adolescent population in DCF care. I expect to find that this population has an overall lower self-image than that of the general population of adolescents not in care.

CHAPTER III

METHODOLOGY

In this study, I used a quantitative, cross-sectional design, employing Offer's Adolescent Self-Image conceptual model (Offer et al., 1982). Offer's construct of self-image represents a method of measuring a multidimensional self-esteem by providing a specific assessment of components across 12 various dimensions or aspects of life (Offer et al., 1982). The purpose of this study is to get a better understanding of how foster youth who have had multiple placement moves perceive their self-image.

I am interested in determining what is considered "normal" self-image in foster youth who have experienced multiple placements. Such "normative data...is information gathered to provide a straightforward description of what is seen to exist in the population" (Anastas, 1999, p.124). Knowledge of an individual's self-image illuminates the context for both risk and protective factors. Self-image is defined as "the opinion that you have of your own worth, attractiveness, or intelligence" (Encarta World English Dictionary, 2009). For this study, measures of self-image are described as an individual's level of positive adjustment and self-worth as operationalized by the Offer Self-Image Questionnaire for Adolescents, Revised (OSIQ-R) (Offer et al., 1992).

According to the DCF Fiscal Year 2009 First Quarter report, adolescents were the primary age group in congregate care (group homes, residential placements, and short-term residential placements), ranging from 64% to 77% across the regions, with the Western region having the highest proportion of adolescents residing in group homes. In

addition, the adolescent age group had the highest proportion of children legally free for adoption (DCF, 2009) yet adolescents accounted for only 8% of all adoptions in the DCF Fiscal Year 2008 report. These figures reflect the difficulty in achieving adoptions for older children in out-of-home care. Adolescents placed in congregate care represent a very vulnerable population and one that is unlikely to be adopted into a permanent home, as recent data have shown (DCF, 2008, 2009).

Variables

Demographic data collected include: gender, ethnicity, age when entered into out-of-home care, actual number of placements, adolescent's count of number of placements, sibling(s) in placement, contact with biological family, participation in extra-curricular activities, educational attainment, educational goals, employment, mental health diagnosis, history of violence, sexual abuse, or physical abuse in the biological home, and substance abuse (by caregiver) in the biological home (Appendix A). The 12 life domains assessed by the OSIQ-R include: impulse control, family functioning, emotional tone, self confidence, body image, vocational attitudes, social functioning, ethical values, self reliance, mental health, sexuality, and idealism.

Definition of Terms

For the purposes of this study the criterion *multiple placement moves* constitutes three or more out-of-home placements. Foster youth are children who are in the custody of the state. In this section, *foster youth* are in the custody of the Department of Children and Families (DCF) of the Western Massachusetts Holyoke area office. *Residential care*

in this study refers to a type of out-of-home group placement setting including group homes or institutions.

Sample

The sample population is one of non-probability and is comprised of 21 foster youth from five different residential programs. The participants were voluntarily recruited volunteers and were all between the ages of 13 and 19. This was a convenience sample due to feasibility. Sampling was obtained from adolescent youth meeting the above inclusion criteria who were in residential programs at the time of test administration. Exclusion criteria include those: who are below average intelligence (as this introduces another variable that is beyond the scope of this study); are no longer in DCF custody; or are below age 13.

Informed Consent & Recruitment Process

I received approval from the executive office of the Massachusetts DCF to conduct this study with the requirement that I send a final report to the Assistant Commissioner for Continuous Quality Improvement. Additionally, the legal guardian of each potential foster youth participant (the DCF caseworker or Supervisor) was required to pre-authorize each adolescent by co-signing the consent form.

Residential program directors were given a Letter of Project Intent (Appendix B), which reviewed the purpose, benefits, and potential risks associated with this study and a copy of the DCF Approval Letter (Appendix C). I obtained verbal consent from all program directors. Each participant voluntarily consented to partake in this study. In face-

to-face discussions I provided each participant with an Informed Consent (Appendix D) detailing what involvement in this study entails and gave them a copy of the DCF Approval Letter (Appendix C). To maintain the integrity of data collection I administered each informed consent and the OSIQ-R to participants. To maintain confidentiality, I assigned each participant an ID rather than record their name in conjunction with their questionnaire data.

It is prudent to maintain awareness of personal and professional biases. Therefore, because I am a foster care review volunteer for the DCF in the Holyoke, Springfield, and Van Wart offices I did not recruit youth whose cases I have reviewed. To further reduce researcher bias foster youth who receive services from the Family Advocacy Center located at Baystate Medical Center in Springfield, Massachusetts, were excluded from participation since I was a clinical intern there at the time of the study.

Finally, I have worked with many children who meet the selection criteria of this study at my former clinical placement at the Acute Residential Treatment Program at Providence Hospital in Holyoke, Massachusetts and therefore these adolescents were not included in this study.

Data Collection

The OSIQ-R test manual, administration booklets, scoring sheets and scoring software were purchased through Western Psychological Services (WPS), the copyright holder. WPS required student researchers submit a Student Research Request Letter (Appendix E) that outlined the scope of the study and the materials needed. Additionally, student researchers must be under the supervision of a licensed professional. I provided

proof of my student status and that I would be conducting this research under the supervision of a licensed professional (Appendix F). WPS granted approval of my use of the OSIQ-R; because it is copyrighted material, I am unable to publish the actual test instrument (Appendix G).

After executive office DCF approval but prior to data collection, I presented my study to the Holyoke office supervisors at their weekly meeting. I solicited feedback from them, as knowledgeable field experts on their population. Based on ensuing discussion, and information identified from the literature review, I constructed a demographic data collection tool comprised of variables thought to impact an adolescent's level of adjustment & self-worth. All of the supervisors were asked to let their staff know that I was conducting research at their office and may approach some of them for assistance.

Next, I obtained a list of adolescents from the supervisors in the Child in Need of Services CHINS unit who met the study inclusion criteria. Using this list, I conducted record reviews via Family Net (DCF Database system) on each of the adolescents provided to me. This was a lengthy and time-consuming process that required navigating the many fields for each record (i.e. participant) in the Family Net database. Some of the identified adolescents were no longer in care (i.e. were on the run, aged out of care) or their case information was classified as restricted.

I confronted difficulty when I attempted to meet with the adolescents one-on-one in their foster homes; it was suggested that I go with the caseworker so that I was not alone. However, this was not feasible since caseworkers typically visit with their clients once a month and due to time constraints, I could not wait to coordinate with them for their next home visit. I discussed this with my Research Advisor who suggested that I

meet the adolescents in a common location. The location had to be DCF approved. I decided the DCF office would be a centrally located, accessible, and DCF sanctioned location familiar to all the adolescents. Therefore, once I had records for 39 potential participants, with the consent of their caseworkers I mailed the youth a letter to invite them to participate in my study (Appendix H). This letter outlined the scope of the study including the compensation they would receive for participating; they would get free pizza and soda just for coming to learn more about participating and a \$5 gift card to McDonalds upon completion of the OSIQ-R questionnaire. The letter also provided information on where and when they could participate and let them know that I would be calling them in a few days time to inquire about their interest.

I made calls to the adolescents (whose placements had phone service) during the after-school and early evening hours. Of the few adolescents I spoke to; they all expressed interest in participating but were unable to obtain transportation to the DCF office. Most phone calls resulted in me leaving a message. Despite the poor participation that I anticipated based on my phone calls, I reserved the large conference room in the DCF office, ordered pizza & soda and waited for youth to come. One adolescent came the first day. Two adolescents came the following day. I followed the same protocol with all three.

It became clear to me that the adolescent foster youth population was not easily accessible by my criterion. I had to re-strategize again on how to obtain data from this population. I discussed this dilemma with DCF workers who proposed that I recruit adolescents in residential programs, since many who met my inclusion criteria were placed together and it was a staffed environment. I requested a copy of adolescents

currently in residential placement from the Family Networks department of the DCF and received the list right away. I obtained the contact information for the director of each of the programs that Holyoke DCF adolescents were placed in.

I spoke on the phone to the directors of three of the group homes and the institutional home and had a face-to-face meeting with the director of the fourth group home. I explained my research project to each of them and provided each with the DCF letter of approval (Appendix C) and the project intent (Appendix B) through email (with the exception of the face-to-face meeting). I encouraged questions. All of the directors granted their verbal approval for the adolescents in their respective residential programs to be eligible to participate.

The program directors coordinated with their staff and arranged dates and times for me to meet at their respective residential programs to recruit volunteers. I brought enough donuts and chocolate milk for all of the adolescents at each placement, including those who I knew ahead of time were not eligible to participate. In general the eligible participants in the group home were very eager to participate, as were the non-eligible members. They were also very friendly and engaged in conversation. I met with participants in either the living or dining rooms of their placements.

I gave copies of the informed consent (Appendix D) and the approval letter (Appendix C) to each youth and discussed the nature of my study and what was required of them. I also answered questions the youth had about the process. A staff person at one group home took copies of the informed consent (Appendix D) and the approval letter (Appendix C) for an eligible youth (who was out on a visit) to read so she could decide if she would like to participate. I returned in a few days to meet with this youth who

completed the OSIQ-R. The details of the test administration process are included in subsequent paragraphs, as they are the same at each placement. I spent between one and two hours at each group home depending on the length of time it took the youth to complete the questionnaire (i.e. one youth needed to take several breaks while completing the questionnaire).

The last placement I visited was the institutional residential placement. There were eight eligible participants and seven agreed to participate after receiving the study information. I met with these youth in an auditorium. I also brought them chocolate milk and donuts although no one had any before or during the OSIQ-R administration, which differed from all four other group homes. Additionally, three of the seven who agreed to participate did so only after they were told that they would have to wait for their peers to complete the OSIQ-R before they were allowed back to their rooms; they decided to earn the five dollar McDonalds gift card instead of sitting and doing nothing. During the administration, adolescents were making comments about some of the questions and were talking back to the staff. It seemed to me to be a very disruptive process and was drastically different than my previous experiences at the group homes. I spent about one hour and a half at this placement.

Test Administration

Sessions with participants began with me reading them the purpose of the study and providing an informed consent for each youth to sign. Participants were verbally given standard directions (from the administration book) on how to fill out the questionnaire answer sheet. I explained the six point Likert scale and hung up a poster for

their reference that illustrated each description and its corresponding number. I was the sole administrator of these directions in order to maintain participant confidentiality and consistency within this study. I offered to read the entire 129 statements on the OSIQ-R at each residence and some participants requested I do so in order to make the completion process easier and faster for them. Prior to visiting each site, I collected demographic information (age entered into out-of-home care and number of placements) on each identified potential participant via Family Net in the Holyoke DCF office. I wrote this on the data collection instrument (Appendix A) *after* the participants filled out the rest (so their response to the placement count item was not affected by seeing their actual number). I assigned an ID number to each participant and asked them to write this number on their data and answer sheets in lieu of their name to protect confidentiality. They placed their answer sheets in a manila envelope when they were finished. In this way data remained confidential and was not traceable to any individual.

Although I expected the questionnaire to take about 30 minutes to complete (based on the administration booklet), it took between 40 and 90 minutes for individual adolescents' to complete. Upon test completion, I gave each participant a \$5.00 gift card to McDonald's to compensate them for their time.

Data Analysis

The OSIQ-R was scored utilizing the CD software program that accompanied the questionnaire and was purchased through Western Psychological Services (WPS). I manually entered the data from each answer sheet into the software program. The program reviewed the data and presented me with an indicator of missing or complete

information so that I could make corrections prior to the data being scored. The software generated 3-6 page reports for each participant's answer sheet. Two sample reports (one from a male participant, one from a female participant) are provided in Appendix I. The report contained: T-scores for all 12 domains; a validity analysis; a T-score and short analysis of the Total Self Image, identified domains with significant deviations from the reference sample mean (higher or lower scores); evaluation of intra-individual strengths and weaknesses; critical item analysis; and if appropriate, a clinical profile analyses based on comparison with same age peers to four available diagnostic groups.

The T-scores are based on the Offer et al. (1988) data from the responses of same sex and age peers in the normative population. The WPS software runs two validity checks to measure response bias, completeness and, consistency and determine whether the youth's responses truly reflected his or her feelings (i.e. did the participant leave items unanswered; did she provide similar answers to similar test statements).

I then created a codebook in a Microsoft Excel spreadsheet. This included variable name, label, level of measure, value labels and missing values for each of the OSIQ-R test report and the demographic data. I provided the codebook to Marjorie Postal, statistical analyst from Smith College for analysis. She utilized the Statistical Package for the Social Sciences (SPSS) software to run frequencies for the OSIQ-R test score variables and the demographic variables. After reviewing the data frequencies together, we created some ratio level variables based on preliminary findings that provided another way of understanding the data. Additional statistical tests she ran include: T-tests, Pearson's correlations, Cronbach's Alpha Crosstabulation and oneway Anova's.

CHAPTER IV

FINDINGS

The major findings were that the overall Total Self-Image (TSI) of the adolescent foster youth in this study was not statistically different from the TSI of the normative adolescent population and that the adolescent females in this study had much lower TSI scores than their male counterparts. Not surprising for these youth in out-of-home care, is that the life domain with the greatest difficulty in adjustment, indicated in this study, is the Family Functioning (FF) domain. The Sexuality (SX) domain was another area in which the adolescents experienced difficulty and adjustment in this life domain was poor.

Test Measurement Interpretation

Total Self-Image (TSI) is measured by the combination of 10 of the 12 component scales. Cronbach's Alpha was run to test the internal reliability of the TSI scale. The TSI scale had strong internal reliability ($\alpha = .928$, $n = 21$, N of domains = 10). TSI includes scores from all domains except Sexuality (SX) and Idealism (ID). In the Sexuality (SX) domain both high and low T-scores are indicative of potentially problematic areas. In the Idealism (ID) domain there are too few items to provide a reliable measure and to provide a correlation with the other domains.

The OSIQ-R scores each life domain and the TSI in T-score units. With the exception of the Sexuality (SX) domain (as mentioned above), higher T-scores indicate the adolescent is well-adjusted in that area. Lower T-scores indicate that the adolescent

has difficulty adjusting to the measured domain or it is problematic to them in some way. Offer (1992) notes that domains with T-scores below 40 are interpreted as possibly troublesome and those below 30 are very unmanageable for the adolescent. T-scores above 60 signify an adolescent who is quite well-adjusted and those T-scores above 70 signify an adolescent who is unusually well-adjusted.

The OSIQ-R software scoring program has a built-in validity check that measures internal consistency and reliability. Specifically, there is a R-check that reviews response bias and completeness; an I-check that reviews improbable endorsement of items and measures infrequency; and a C-check that reviews consistent use of extreme categories within domains.

Two sample WPS Test Reports are provided in Appendix I. The test instrument itself, in addition to specific test items, is not appended since that is a violation of the commercial copyright and proprietary interests of the test publishers, Western Psychological Services (WPS) (Appendix G).

Descriptive Data

Demographic data were collected and recorded for analysis purposes to illustrate diversity of population and to provide correlation to the 12 life domains measured in the OSIQ-R. A summary of these data are provided in Table 1.

There were 14 males and seven females who participated in this study. The mean age of participants is 15.38, with a minimum age of 13 and a maximum age of 17. The ethnic breakdown of participants is: six Latino, five African-American, eight Caucasian, one Other and one who did not identify. Twenty participants were in residential

placements and one was in specialized foster care. The mean number of placements (n=19) was 8.53 with a minimum of one and a maximum of 26. However, the median was 5.00, illustrating that half of the sample had fewer than five placements and the other half had more than five. This is rather consistent with the state average of 4.4 placements (Child Welfare League of America, 2007). The mean age of participants (n=14) when they entered into out-of-home care was 9.71 (median = 10.00) with a minimum age of two and a maximum age of 17.

Table 1

| Summary of Demographic Data | | | |
|--|--------------|-------------|----------------|
| Variable | Yes <i>n</i> | No <i>n</i> | Total <i>n</i> |
| Contact with Biological Family | 10 | 1 | 11 |
| Have Siblings | 13 | 0 | 13 |
| Siblings in Out-of-Home Care | 6 | 6 | 12 |
| Participate in Extra-Curricular Activity | 8 | 6 | 14 |
| Currently Employed | 2 | 12 | 14 |
| Non-DCF Legal Involvement | 9 | 4 | 13 |
| History of Domestic Violence | 3 | 9 | 12 |
| History of Neglect | 3 | 11 | 14 |
| History of Sexual Abuse | 2 | 12 | 14 |
| History of Physical Abuse | 4 | 10 | 14 |
| Biological Caregiver Abused Substances | 3 | 10 | 13 |

n = total number of responses

| | | |
|-------------------------|--------------|---|
| Educational Goal | <i>n</i> =12 | 1 <i>n</i> graduate high school 1 <i>n</i> trade school 2 <i>n</i> attend 2 year college 5 <i>n</i> attend 4 year college 3 <i>n</i> unsure |
| Mental Health Diagnosis | <i>n</i> =7 | 1 <i>n</i> Bi-polar 4 <i>n</i> ADHD 3 <i>n</i> none |

I hypothesized that the mean TSI of adolescents in foster care would be lower than the normal reference adolescent population. The findings indicate that the adolescents in foster care in this study had a mean TSI of 46.57 with a median of 48.00. This suggests that 52.38% of the foster youth measured had TSI T-scores in the average range. There were 28.57% foster youth who had below-average TSI T-scores and 19.05% of youth had above-average TSI T-scores. I will note that the mean TSI T-score for the population in this study falls on the lower end (46.57) of the average range (40-60), which moves toward confirming my hypothesis.

The breakdown of Total Self-Image (TSI) T-scores by gender is illustrated in Table 2. Based on the interpretation of the OSIQ-R T-scores, there are three general categories of adjustment to each domain: below-average (<40); average (40-60); above-average (>60). Therefore, I grouped my data in each of the three categories to determine the level of adjustment of TSI of participants (n=21). I then introduced Gender as a variable to determine if there was a difference between adolescent males and females.

Table 2 illustrates that a total of six participants (28.6% of total n) had a TSI score in the below-average range; 11 participants (52.4% of total n) had TSI scores in the average range; and four participants (19.0% of total n) had above-average TSI scores. Most striking however, is that male participants (85.71%) have average or above-average TSI scores, while less than half of the female participants (42.89%) had average TSI scores and none had scores in the above-average range. Put another way, the majority of female participants (66.7%) have a TSI score that is below-average and none (0%) have TSI scores that are above-average. There were not enough participants to complete a chi-square analysis. But, this trend indicates that there is a substantial difference in TSI

between male & female foster youth. Regrettably for the females this difference highlights that they are suffering.

The OSIQ-R contains 57 items that are identified as producing relatively rare, extreme responses that are not diagnostic in and of themselves, but that should be considered so as to provide insight into themes or domains of potential difficulty. These 57 items are called *critical items* and were given more extreme ratings than those given by the most extreme 4% of the normal reference sample population (Offer, 1992, p. 63). The OSIQ-R test report features a Critical Item Analysis of these 57 items (refer to Appendix I). In this study, there were a total of 78 responses (n=21) to critical items.

Table 2
Crosstabulation of Total Self-Image (TSI) by Gender

| Gender | Below-Average | Average | Above-Average | Total |
|---------------------|---------------|---------|---------------|-------|
| MALE- count (n) | 2 | 8 | 4 | 14 |
| MALE- % within TSI | 14.3% | 57.1% | 28.6% | 100% |
| FEMALE- count (n) | 4 | 3 | 0 | 7 |
| FEMALE-% within TSI | 66.7% | 27.3% | 0% | 100% |
| Total Count (n) | 6 | 11 | 4 | 21 |
| Total % within TSI | 100% | 100% | 100% | |

There is one life domain that had the most critical item responses, and therefore is indicated as the most problematic to the participants. It is the Family Functioning (FF) domain. In fact, 70% of participants in this study gave an extreme rating response to at least one of the critical items in the FF domain, indicating that in this domain the adolescent experiences distress. Other critical item responses were given in the following

life domains: Mental Health (MH); Social Functioning (SF); Vocational Attitudes (VA); Self-Confidence (SC); Self-Reliance (SR); Sexuality (SX); Ethical Values (EV); Emotional Tone (ET); and Impulse Control (IC). There were no critical item responses by any participant in the Idealism (ID) and Body Image (BI) life domains, which indicates that this is an area in which they experience a higher level of adjustment, or at least it is not distressing to them.

Table 3

| Frequencies of Critical Item Responses | | |
|--|---------------------|-------------------------|
| Domain | Number of Responses | Percent of Participants |
| Emotional Tone | 6 | 30% |
| Impulse Control | 2 | 10% |
| Mental Health | 9 | 45% |
| Social Functioning | 9 | 45% |
| Family Functioning | 14 | 70% |
| Vocational Attitude | 9 | 45% |
| Self-Confidence | 9 | 45% |
| Self-Reliance | 7 | 35% |
| Sexuality | 7 | 35% |
| Ethical Values | 6 | 30% |
| Total Responses: 78 | | |

As described earlier, each life domain is scored in T-score units. These T-scores can be put into one of three categories for each of the measured life domains: below-average (<40), average (40-60), or above-average (>60). I will refer to the below-average T-score range as “low” scores and the above-average T-score range as “high” scores. Below I provide a summary from the OSIQ-R manual (1992) of what is being measured, for both levels of adjustment, and for each life domain in the OSIQ-R. I also highlight the results of the sampled adolescent population in each domain. Table 4 depicts the number

of participants whose adjustment levels were in the average (40-60) range; they are reported as frequencies and as a percent of the total sample for each domain.

Emotional Tone (ET) is a ten-item scale that measures one's level of affective harmony within the psychic structure and the degree of emotional lability; a low T-score indicates a youth who tends to be depressed and pessimistic; a high T-score indicates a youth who experiences a wide range of affects and is generally in a good mood. In the ET category 6 participants (28.6%) had low scores; 12 participants (57.1%) had average scores; 3 participants (14.3%) had high scores. The mean ET was 49.05 with a median of 52.00.

Impulse Control (IC) is a nine-item scale that measures the ability of the ego to manage stressors without resorting to unacceptable methods of discharging frustrations; a low score indicates a youth with a low frustration tolerance and who acts on impulse for short-term gain; a high score indicates a youth who has well developed coping skills and is able to delay gratification. In the IC life domain: only 2 (9.5%) had low scores; 16 (76.2%) had average scores; 3 (14.3%) had high scores. The mean IC was 50.81 with a median of 51.00.

Mental Health (MH) is a 13-item scale that measures the absence of psychopathological thought processes; a low score indicates possible severe psychopathology that is on a clinical level; a high score indicates a lack of overt symptomatology. In the MH domain: 5 (23.8%) had low scores; 14 (66.7%) had average scores; 2 (9.5%) had high scores. The mean MH was 47.29 with a median of 47.00.

Social Functioning (SF) is a nine-item scale that assesses patterns of interpersonal relationships and friendships; a low score indicates a youth who feels isolated and lonely

and may be unable to maintain close relationships or is uncomfortable socializing with peers; a high score indicates a youth who has the capacity for empathy, is in tune with others and is able to develop meaningful relationships with peers. In the SF life domain: 5 (23.8%) had low scores; 12 (57.1%) had average scores; 4 (19%) had high scores. The mean SF was 47.43 with a median of 47.00.

Family Functioning (FF) is a 19-item scale that addresses the youths feelings about and relationships with his parents; it also examines the emotional atmosphere in the home; a low score indicates that the youth feels tension in the home and is not allied with his parents, nor does he think his parents are allies and they are a disappointment to him rather than a model worth emulating; a high score indicates the youth openly communicates and has a positive alliance with his parents and, the home is regarded as a warm, supportive and positive place. In the FF life domain: 9 (42.9%) had low scores; 10 (47.6%) had average scores; 2 (9.5%) had high scores. The mean FF was 43.67 with a median of 43.00.

FF has the most items in it's scale. Since the 70% of participants had a critical item in the FF life domain, and it is such a reliable domain due to the number if test items, I was interested if the age each participant entered into care was related to their level of functioning in this domain. There were six participants who were in the low score category of FF and their mean age entered into care was 9.17 with a Std. Deviation of 5.345. There were seven participants whose FF adjustment was in the average range and their mean age entered into care was 10.71 with a Std. Deviation of 4.680. In a Levene's test for equality of variances the f was .182 and the sig. was .678. I also examined the TSI and the mean age entered into care; a Levene's test for equality of variances resulted in a

f of .002 and the sig. was .962. Ten individuals with average TSI scores had a mean age of 9.6 with a Std. Deviation of 5.060 and 3 participants with high TSI scores had a mean age of 9.00 with a Std. Deviation of 5.196.

Vocational Attitudes (VA) is a ten-item scale that measures how confident the youth is in learning about and prepared for a vocation; a low score indicates a youth who is alienated from the work and/or educational world and has not focused attention on future goals; a high score indicates one who is future-oriented and is planning work or educational goals. In VT life domain: 7 (33.3%) had low scores, 9 (42.9%) had average scores; 5 (23.8%) had high scores. The mean VA was 44.86 with a median of 46.00.

Self-Confidence (SC) is a 10-item scale that assesses how well a youth adapts to his immediate environment; a low score indicates a youth who expects to fail as he does not have a positive attitude about his abilities and therefore goals are not worthwhile; a high score indicates a youth who is able to maintain a positive orientation to frustration and who feels competent due to a history of positive coping. In SC life domain: 4 (19%) had low scores; 15 (71.4%) had average scores; 2 (9.5%) had high scores. The mean SC was 50.24 with a median of 54.00.

Self-Reliance (SR) is a 14-item scale that measures how well the youth copes with himself, other people and his world and it provides a measure of ego strength; a low score indicates that a youth does not adequately deal with his environment and views long-term achievement as a potential source of failure; a high score indicates a youth has a well developed and fully functioning coping system that enables planning for long-term goals. In SR life domain: 6 (28.6%) had low scores; 13 (61.9%) had average scores; 2 (9.5%) had high scores. The mean SR was 45.05 with a median of 44.00.

Body Image (BI) is a nine-item scale that indicates the youth's level of adjustment to his body; a low score indicates that he has confusion about body boundaries or feels badly about his body in some way; a high score indicates a youth who is comfortable with his body concept and has clear body boundaries. In the BI life domain 2 (9.5%) had low scores; 16 (76.2%) had average scores; 3 (14.3%) had high scores. The mean BI was 51.33 with a median of 52.00.

Sexuality (SX) is a 10-item scale that elicits feelings, attitudes and behavior toward the opposite sex; this domain is measured differently in that both high and low scores indicate an unhealthy adjustment; a low T-score indicates that a youth withdraws or is fearful or reactive about sexuality and may not be comfortable with his own sexual feelings; a high T-score is also indicative of problematic adjustment, but this score suggests an individual who is likely to act out sexually or has an unusual openness to sexual expression; a T-score in the average range indicates an individual whose attitude toward sexuality is accepting and is considered healthy. In the SX domain of the 21 participants, only two had T-scores in the best adjustment (40-60) range. The majority of participants (n=15) had low scores (<40) and four had high scores (>60). This means that only 9.5% of my sample had a "healthy" attitude about their sexuality.

Ethical Values (EV) is a 10-item scale that measures the extent to which the conscience or superego is developed; a low score indicates an adolescent who has poor assimilation of cultural norms and values either through lack of exposure or ambivalence to them; a high score indicates an adolescent who is able to consider and care about the viewpoint of others. In the EV life domain: 5 (23.8%) had low scores; 13 (61.9%) had

average scores; 3 (14.3%) had high scores. The mean EV was 48.10 with a median of 50.00.

Idealism (ID) is a six-item scale that measures an adolescent's ideals and willingness to help others; a low score indicates that an adolescent is more concerned with himself than with others, he is more egocentric; a high score indicates an adolescent who is willing to help others and who cares about social problems. In the ID life domain 2 (9.5%) had low scores; 14 (66.7%) had average scores; 5 (23.8%) had high scores. The mean ID was 52.62 with a median of 53.00.

Table 4

| Average Level of Adjustment (T-scores between 40-60) by Domain | | |
|---|------------------|----------------|
| <u>Domain</u> | <u>Frequency</u> | <u>Percent</u> |
| Emotional Tone | 12 | 57.1% |
| Impulse Control | 16 | 76.2% |
| Mental Health | 14 | 66.7% |
| Social Functioning | 12 | 57.1% |
| Family Functioning | 10 | 47.6% |
| Vocational Attitude | 9 | 42.9% |
| Self-Confidence | 15 | 71.4% |
| Self-Reliance | 13 | 61.9% |
| Body Image | 16 | 76.2% |
| Ethical Values | 13 | 61.9% |
| Idealism | 14 | 66.7% |

I hypothesized that the more placement moves an adolescent experienced, the lower his self-image would be. To analyze if a relationship between Total Self Image (TSI) and Number of Placements (NPLAC) existed with the adolescent population in this study, a Pearson correlation was run. It showed no significant correlation.

There were five participants who thought they had fewer placements than they actually had; four who knew exactly how many they had; and nine who thought they had more placements than they actually had. Of the five adolescents who thought they had fewer placements, three were in the below-average TSI range and two in the average TSI range. Of the four who knew their exact number, one was in the below-average TSI range, two in the average TSI and one above average TSI. Of the nine who thought they had more placements than actual, two were in the lower TSI, four in the average TSI and three in the above average TSI. With such a small sample no correlations can be made between the TSI of youth who thought they had less than, more than or knew the exact number of placements they had. There is no significant correlation between the actual and the youth reported number of placements.

In the Clinical Profile Analyses, the test report is compared with a mean profile of several clinical diagnostic groups using a Pearson correlation algorithm as a similarity coefficient (Offer et al., 1992). There are five clinical profiles in the current OSIQ-R data set: Single Episode Depression, Recurrent Depression, Eating Disorder, Suicide Attempt or At Risk and Delinquent. There were only two individual participants whose T-scores were similar to those of a clinical diagnostic group who matched them in gender and age. One individual was matched to the Suicide Attempt or At Risk group and another was matched with Recurrent Depression.

CHAPTER V

DISCUSSION

OSIQ-R Test Findings

Findings indicated that there were no significant differences in TSI between the adolescent foster youth population and the normal reference sample population. This is contrary to what I would have expected to find based on the literature that reported that foster youth have more risk factors in their lives than non-foster peers and they exhibit high levels of problematic behaviors. There are several considerations that may likely play a role in this finding that I discuss as limitations.

I was also disheartened to find that there is a considerable discrepancy in TSI among male foster youth and female foster youth, in that the trend in the female population showed evidence of below-average levels of overall adjustment in TSI. Findings reported in a study by Adeniyi (2000) suggest that girls need more support in areas of self-acceptance and realistic goal setting. Both these areas were assessed in the OSIQ-R and appear to agree with her findings. Perhaps an exploratory qualitative study with the adolescent foster youth female population would best uncover the reasons that they are experiencing such discordant levels of adjustment.

Both the Family Functioning and Sexuality life domains revealed areas of maladjustment in the sampled population of this study. There is abundant research and theory on the significance of the role of family (however family is defined for each

individual) in the success in social functioning and relational attachments. The importance of family as a protective factor is aptly highlighted by Walter and Petr (2008):

Together, empirical outcome research; the insights of families, youth, and professionals; and the values expressed in national standards converge to support and inform family-centered residential treatment as an emerging best practice for youth with emotional and/or behavioral disorders. Specifically three central factors are highlighted: (a) maximizing regular contacts between child and family, (b) actively involving and supporting families in the treatment, and (c) providing ongoing support and aftercare once the child returns home.

Finally, an often overlooked risk factor is academic delay. A major finding in Trout et al. (2008) was that children entering care have significant academic delays in at least one subject area. While the present study did not determine this conclusively, one of the lower positive adjustment domains was the vocational attitude. This 10-item scale measured how confident that adolescent felt in learning about and planning for a vocation (Offer et al., 1992). The vocational attitudes as measured in the present study indicate that the adolescent population surveyed has a rather negative view of his or her ability to plan and work towards a vocation. This indicates that the need for increased academic support while in care is an area in need of strengthening.

Procedural Findings

Once the myriad difficulties of navigating the bureaucratic systems were successfully negotiated, the present study moved forward at a steady pace. Initially, the plan was to measure the self-image of adolescents in out-of-home care placed in foster families. However, this population was not readily available to the needs that I imposed on them for participating in this study. Due to time constraints, I required that the

adolescents come to a location that I specified at a time that I also determined. I was not able to provide transportation for them and their foster parents were not able to either or were unwilling to transport their foster child to the DCF office simply to participate in a research study. I posit that foster families have often already overextended their time in order to provide a safe home for a child in state custody.

As a testing instrument the OSIQ-R was found to be effective and served the desired purpose of eliciting adolescents level of adjustment to multiple life domains. The instrument was easy to administer to this population. And, despite the impression of several caseworkers, the adolescents were able to complete the test in its entirety in a meaningful way, as is indicated by the software validity checks. This is an instrument that I believe would be useful to utilize in future studies on this population.

Limitations

This study compared the self-image of a small, non-random sample of foster care children in one metropolitan area of Massachusetts to the general population of adolescents sampled in the U.S. by Offer, Ostrov & Howard (1982). The cross-sectional nature of this study provided the cumulative estimation of self-image of participants but cannot indicate causality, such as whether low self-image may be caused by multiple placements, foster care in general or other variables. An area for future study intending to elicit such causality could obtain self-image measures of children upon entry to foster care (including other factors such as are they leaving an undesirable home situation, have they been traumatized) and again at later intervals during their time spent in care or exiting care.

Some studies reviewed in the literature found that adolescent functioning improved over the course of their residential placement. Based on these findings, the importance of outcome trajectories- that is, measuring one's level of functioning (LOF) at intake and at discrete periods during treatment and at discharge, is a needed and valued measure. In the case of future studies the self-image of adolescents coming into care could be measured and then re-assessed at various intervals during out-of-home placement to direct influential factors on a child-specific basis such as appropriateness of placement, mental health diagnosis & treatment and the other life domains measured in the OSIQ-R. This measure could also be examined with relation to the number of placement changes an individual has and may help establish causality and the impact placement moves has on self-image.

There was a limitation in the data collecting process in this study. The demographic data instrument that I utilized was developed to draw out the many variables associated with adolescent foster youth's adjustment to their experience of being in out-of-home placement. However, much of the information on the form is not easily known by the individual herself. It is information available in the Family Net database which requires a significant amount of time for the researcher to gather. After shifting from a population in foster homes to a population in residential homes, I was unable to complete a thorough records research a second time and therefore only retrieved data on the number of placements and the age entered into care for each participant. This meant that because some individuals did not know any of the other information requested on the form, it was not be provided and it created gaps in the data prohibiting analyses. Additionally, since limited time was a factor in this study I was

unable to go to the foster homes for data collection. Additionally, with more time I could have solicited the approval of other area offices for their youth in the residential programs I visited to participate.

A possible limitation of the testing instrument is that the normal reference sample population data are teens from the 1980's. With a more recent control group (i.e. teens from 2000's) I would if there have been a stronger or weaker association between the sample in this study and the reference sample.

Another possible limitation is one measure in the OSIQ-R Sexuality scale. This scale measures feelings, attitudes and behaviors about the opposite sex. Is this measure reliable for lesbian, gay, bi-sexual or transgendered youth?

Future Research

Future studies may also consider *time spent in current placement* as a variable, particularly when studying data on foster youth in residential placement. Findings from Friman et al. (1996) and Leichtman, Leichtman, Barber, & Neese (2001) found that residential youths perceived quality of life (QOL) changes as a function of time spent in placement and Gilman & Barry (2003) found that the longer the placement the greater the perceived QOL. Therefore, examining time as an important variable with regard to length of time spent in care or in current placement at the time of test administration to see if this variable revealed any differences in TSI.

Implications and Conclusion

From the data on youth placed in out-of-home care from the Child Welfare League of America (2007) I suggest that out-of-home care remains a common practice for youth in need of alternate care and services. Therefore, there is an ongoing and pressing need for additional research to assist this population in successful, stable, supportive and nurturing transitions to out-of-home care. My hope is that additional empirical studies continue to investigate the effects of and relationships between early childhood traumas and subsequent out-of-home placements with youth self-image and quality of life. Understanding these effects and continued illumination of the sustenance needed to shape positive adolescent development in this context, will provide evidence to support and enhance public policy and additional resources to our nations children.

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Appendix A

Demographic Data Collection Instrument

| | | | |
|---|----------------------------------|------------------------------------|--|
| Participant ID: | Name: | | Today's Date: / /2009 |
| Age: | | Gender: | M / F / T / O |
| Race: | | | |
| Number of Placements on File: | Number of Placements Child says: | Age Entered into Out-of-Home Care: | |
| Type of Current Placement: | | Mental Health Diagnosis: | |
| Contact with Biological Family: Yes / No | Have Siblings: Yes / No | Sibling(s) in Placement: Yes / No | |
| Participation in Extra-Curricular Activities: Yes / No | List: | | |
| Educational Attainment: Current Grade Graduate GED | | Educational Goal: | Associate Degree, 2 Year College, 4 Year College |
| Employment: Yes / No | | Legal Involvement: Yes / No | |
| DV in Home: Yes / No | | Neglect Hx: Yes / No | |
| Physical Abuse Hx: Yes / No | | Sexual Abuse Hx: Yes / No | |
| Substance/Drug Use in Home: Yes / No | | Has Child: Yes / No | |

Appendix B

Letter of Project Intent

Dear Caregiver,

Who I am: My name is Sarah Cartier. I am conducting a research study to fulfill my requirements as a social work student, earning a Master's Degree from Smith College in Northampton, Massachusetts. This research will also be used in future presentations and publications. I will provide a final copy of the thesis to DCF who will be able to share the information with you if you so request. I am interested in how adolescents in foster care perceive their self-image. I have worked with many youth who have been in foster care and have met others through my volunteer work. Therefore, they are part of a very meaningful group of adolescents to me and are what make this project extra special to me. This study is also unique because the adolescents *themselves* will be providing the information about themselves- not other adults in their lives. But, I really need *their* help and *your* consent to make it happen!

Why this is important: My hope is that the data that I collect from all of the surveys will help me to identify areas in their lives that are going well and how DCF, foster parents, program staff, teachers and the other people involved in their lives can support these areas of their existing strength. Additionally, if there are areas identified in the survey results that indicate more support would benefit these youth then their circle of care will have a better sense of what their needs are. I encourage you to support and consent to your child's participation since I believe this is a very valuable project.

What will be expected of my child? All participants will be given a survey to fill out that consists of 129 questions regarding their view of their self-image in different areas of their life i.e. family, social, ethical values etc. I will also obtain information about each participant such as age, gender, how long s/he has been in foster care etc. I will administer the survey face-to-face. It will take about 20-30 minutes to complete. I will code all surveys and additional information collected numerically to ensure each participants confidentiality. So, even though I will know who participates (because s/he will sign the consent form) I will not know what her/his particular answers to the survey are.

Are there any benefits to participation? I am sorry that I cannot pay your child to participate in this study. However, I will provide him or her with a gift certificate to McDonalds. In addition, he or she may benefit from knowing that he or she has contributed to the knowledge of the impact of foster care on adolescent youths' self-image. It is my hope that this study will help social workers and policy makers have a better understanding of specific strengths and needs of adolescents in foster care. Participants may also benefit by gaining a new perspective on their own self-image.

Are there any risks? The potential risk of participating in this study may be that some survey questions could trigger uncomfortable thoughts and feelings. In case your child feels the need for additional support after participation in this study, he or she should notify his or her caseworker and/or caregiver who will provide guidance or help seek additional resources.

Always remember, participation in this project is voluntary. That means that the participant has the right to decline to answer any question and s/he will not have

to complete the survey if s/he does not wish to once s/he has begun. If you have additional questions about the study please feel free to contact me at the information provided below. If you have concerns about your child's rights or about any aspect of this study, I encourage you to call me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Most Sincerely,

A handwritten signature in cursive script that reads "Sarah Cartier". The signature is written in black ink on a light-colored, slightly textured background.

Sarah Cartier
(413) 794-4986
scartier@smith.edu

Appendix C

Department of Children & Families Approval Letter



DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

JUDYANN BIGBY, M.D.
Secretary

ANGELO MCCLAIN
Commissioner

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Children and Families

24 Farnsworth Street, Boston Massachusetts 02210
Tel (617) 748-2000 ♦ Fax (617) 261-7435

February 12, 2009

Sarah Cartier
Smith College School of Social Work

Dear Ms. Cartier:

The Department received your request for approval of the following research proposal:

Self-Image of Foster Care Youth

You have submitted all of the necessary information in accordance with DCF policy and procedures, and the Department has completed its review of your proposal. I am pleased to inform you that the outcome of the Department's review is that the research proposal is approved.

DCF has determined that to prepare and provide the information necessary for the research study:

DCF must assess a fee

DCF will not need to assess a fee

As part of its approval of your research proposal, the Department requires that you:

- Provide to any DCF staff or client who participates in this research the opportunity to read a copy of this approval letter. Please attach a copy of the DCF Research Proposal Review Committee's Letter of Approval to all requests for consent from research subjects and guardians.

~ Formerly the Department of Social Services ~

- Mail a copy of the final draft report of the research study to the DCF Assistant Commissioner for Continuous Quality Improvement for review and comment.
- Ensure that any article or report that is published as a result of this research acknowledges DCF support.
- Provide to DCF a copy of any reports/publications resulting from this research for placement in the DCF library at Central Office.

We appreciate your assistance in ensuring that the research is carried out in a manner that is respectful of DCF staff and clients. If you have any questions or require further assistance, please contact:

Robert Wentworth,
Assistant Commissioner for Planning and Program Development
617-748-2359

Sincerely,

Jan Nisenbaum
Assistant Commissioner for Continuous Quality Improvement

Appendix D

Letter of Informed Consent

Dear Potential Participant,

My name is Sarah Cartier. I am conducting this research study to fulfill my requirements as a social work student, earning a Master's Degree from Smith College in Northampton, Massachusetts. This research will also be used in future presentations and publications. I am interested in how *you*, adolescents in foster care, perceive your self-image. I have worked with many youth who have been in foster care and DCF custody and have met others through my volunteer work. Therefore, you are part of a very meaningful group of adolescents to me and you are also what make this project extra special to me. This study is also unique because *you* are providing the information about yourselves- not other adults in your life or adults who used to be in foster care years ago. But, I really need *your* help to make it happen!

My hope is that the data that I collect from all of the surveys will help me to identify areas in your lives that are going well and how DCF and the other people involved in your life can support these areas of your existing strength. Additionally, if there are areas identified in the survey results that indicate more support from DCF and the other people in your life would be helpful to you, they will have a better sense of what your needs are. I encourage you to participate since I believe this is a very valuable project.

I am requesting your help because you are an adolescent between the ages of 13-18 and are currently in foster care or DCF custody. If you choose to participate, you will be given a survey to fill out that consists of 129 questions regarding your view of your

self-image in different areas of your life i.e. school, family, social etc. I will also ask you to provide information about yourself such as your age, your gender, how long you have been in foster care etc. The survey will be done face-to-face and administered by myself. The survey will take you about 20-30 minutes to complete. All surveys and additional information collected will be coded numerically to ensure your confidentiality and anonymity. So, even though I will know who participates (because you sign the consent form) I will not know what your particular answers to the survey are.

The potential risk of participating in this study may be that some survey questions could trigger uncomfortable thoughts and feelings. In case you feel the need for additional support after participation in this study, you should notify your caseworker and/or caregiver who will provide guidance or help you seek additional resources.

I am sorry that I cannot pay you to participate in this study. However, I will provide you with a gift certificate to McDonalds. In addition, you may benefit from knowing that you have contributed to the knowledge of the impact of foster care and out of home placement on adolescent youths' self-image. It is my hope that this study will help social workers have a better understanding of how to better serve adolescents in state care. You may also benefit by gaining a new perspective on your own self-image.

Strict confidentiality will be maintained, as consistent with Federal regulations and the mandates of the social work profession. Your name will NOT be on the survey you complete. Your name will NEVER be associated with the information you provide in the survey. Because of this, once you have completed the survey you *cannot withdraw from the study* since we will have no way of identifying your survey data. The only people who will be handling the raw data are me, my advisor, and the Smith College

statistician, Marjorie Postal. In publications or presentations the data will be presented as a whole and will therefore be untraceable to you. All data will be stored in a secure location for a period of three years per Federal regulations; beyond three years data will continue to be kept in a secure location and it will be destroyed when it is no longer needed.

Always remember, participation in this project is voluntary. That means that you have the right to decline to answer any question and you will not have to complete the survey if you do not wish to once you have begun. Again, you will not have to provide your name to the researcher. If you have additional questions about the study please feel free to contact me at the information provided on the signed consent form. If you have concerns about your rights or about any aspect of this study I encourage you to call me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Most Sincerely,

Sarah Cartier

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant
Participant's Case Worker/ Supervisor

Signature of

Printed Name of Participant
Worker/ Supervisor

Printed Name of Case

Date

Date

Signature of Researcher,
Sarah Cartier

c/o The Family Advocacy Center
2 Medical Center Drive, Suite 205
Springfield, MA 01199
(413) 794-4986
scartier@smith.edu

Date

PLEASE KEEP A COPY OF THIS FOR YOUR RECORDS.
THANK YOU FOR YOUR TIME AND YOUR PARTICIPATION!

Appendix E

Student Research Request Letter

February 2nd, 2009

WPS Rights & Permissions
12031 Wilshire Boulevard
Los Angeles, CA 90025
Fax: 310-478-7838

Dear WPS Rights & Permissions,

I am a Master's student at Smith College School for Social Work (SCSSW) conducting the following research study to fulfill my degree requirements.

The purpose of this study is to get a better understanding of how foster youth in the state of Massachusetts, who have had multiple placement moves, perceive their self-image. By utilizing the *Offer Self-Image Questionnaire for Adolescents, Revised*, it is my hope to identify areas of higher self-image adjustment in these youth so that the people in their lives can enhance and provide support to these existing areas of strength. Additionally, should I find areas of lower self-image adjustment, the identification of these specific life domains would enable workers and caregivers involved with the foster youth to take measures to reduce such risk factors. The estimated period of completion of data collection and discussion is June 1st, 2009.

In order to conduct this research I will need to administer around 60 tests. Since I will personally be administering each test, I have determined that I will need:

- 1 Manual (W-274C)
- 1 Administration Booklet Pack (W-274A)
- 1 OSIQ-R PC Answer Sheet Pad (W-274D)
- 3 OSIQ-R CD's (W-274U)

This research will be in my thesis, which will be made available through the SCSSW to other scholars; I will also disseminate my results at the SCSSW. Finally, the Department of Children and Families, in the state of Massachusetts will receive a copy of the final research product per their request and as gratitude for their sanction of this project.

Sincerely,

Sarah Cartier, Smith College School for Social Work student

Appendix F

Student Documentation Letter



Smith College
Northampton, Massachusetts 01063
T: (413) 585-7226
F: (413) 585-7204

February 4, 2009

WPS Rights & Permissions
12031 Wilshire Boulevard
Los Angeles, CA 90025
Fax: 310-478-7838

Dear WPS Rights & Permissions,

I am writing to inform you that I am advising Sarah Cartier's in her research study at the Smith College School for Social Work. I will supervise her in the use of *The Offer Self-Image Questionnaire for Adolescents, Revised*, in accord with recognized professional and ethical principles. Please do not hesitate to contact me at mmurphy2@smail.smith.edu or at (413) 585-5312 if you have any questions or concerns. Thank you.

Sincerely,


Michael Murphy, Ph.D.
Research Advisor

Appendix G

WPS Copyright Policy Letter

wps®

Western Psychological Services
A Division of Manson Western Corporation
12031 Wilshire Boulevard
Los Angeles, CA 90025-1251
www.wpspublish.com

Dear Graduate Student:

Thank you for contacting Western Psychological Services for permission to reprint copyrighted test material within an appendix of your dissertation. When widely-distributed commercially produced tests are used, guidelines at most research universities do not call for inclusion of full instruments in thesis or dissertation volumes. In such cases, university policies are generally sensitive to the threat to commercial copyright and proprietary interests that is implicit in such copying or redistributing materials. The inclusion of instruments is generally limited to use of materials that are original to the dissertation author or that are otherwise unpublished and so might be considered difficult for subsequent readers to obtain.

As a publisher of formally developed test materials, WPS policy in such matters is to not authorize reprinting of our tests, subtests, or scales in their entirety, unless there is a committee requirement or other research-based reason that (1) requires you to reprint a test, subtest or scale in its entirety, and that (2) prevents the inclusion in your dissertation of original test forms. We can, as an alternative, readily provide authorization the reproduction of up to five representative sample items from the instrument upon receipt of your written request to that effect, including the specific item numbers desired for reprint. Also, if you need to reprint any other material from the test, including and not limited to material from the instrument's manual, please provide details by page, figure, table numbers, etc., for our consideration in authorizing inclusion of that material within your work.

If you need to pursue reprinting of the instrument in its entirety, please write again to WPS Rights and Permissions: Provide us with the reason you must reprint the subtests in their entirety (as opposed to selecting representative sample items); explain specifically why you are required to reproduce the original subtest (as opposed to binding an original protocol); and arrange for a supervising faculty member to co-sign the request. For expedience, please note that you may fax the letter to my attention at 310/478-7838, or have your professor e-mail it to me through his/her university e-mail address. For your additional reference in the event that your dissertation will be microfilmed, WPS will not authorize reproduction of our tests by microfilm, due to the public availability of the medium. While we regret any inconvenience our position may cause, we hope you appreciate our concern with ethical considerations.

We appreciate your interest in our material, as well as your consideration for its copyright. Please contact me if you have any questions.

Sincerely yours,

SusanW
Digitally signed by SusanW
DN: cn=SusanW, o=WPS,
ou=Admin,
email=weinberg@wpspublish.
com, c=US
Date: 2007.10.22 10:34:35 -0700

Susan Dunn Weinberg
Assistant to the President
WPS Rights and Permissions
e-mail: weinberg@wpspublish.com

SDW:se

Appendix H

Recruitment Letter

March 31st, 2009

Dear _____,

I am a social work student at Smith College and I need YOUR help! I am doing a research project through the Department of Children and Families (DCF). The purpose of the project is to better understand the self-image of teens in Foster Care. My goal is to be able to use this information to make recommendations to DCF about how they can help support the needs of teens in Foster Care.

How you can help: Complete a 25-30 minute questionnaire (your answers will be anonymous = me, your parents, your foster parents, DCF and anyone else will NOT know what your answers are)

What you get: FREE pizza and soda, plus a gift certificate after you complete the questionnaire!

Where: The Holyoke DCF Office, 261 Main Street, Holyoke, MA

When:

- Monday, April 6th 12Noon-5PM* OR
- Wednesday, April 8th 4-5PM* OR
- Friday, April 10th 12Noon-5PM*

*You only need to stay as long as it takes you to complete the questionnaire- about 30 minutes.

Contact me: Please call or email me to let me know which day you will be coming- I want to make sure I have enough pizza!

IF YOU WOULD LIKE TO TAKE THIS QUESTIONNAIRE & GET A GIFT CERTIFICATE BUT YOU CANNOT GET TO THE HOLYOKE DCF OR CANNOT GO ON THE DATES LISTED ABOVE PLEASE CALL ME AT **413-794-4986** OR EMAIL ME AT scartier@smith.edu AND I WILL TRY TO ARRANGE TO MEET YOU AT A DIFFERENT TIME.

Also, please contact me if you have any other questions about participating. Your help means so much to me! THANK YOU!!!!!!!!!!!!!!

Most sincerely,

Sarah Cartier

Appendix I

Sample WPS Test

Reports

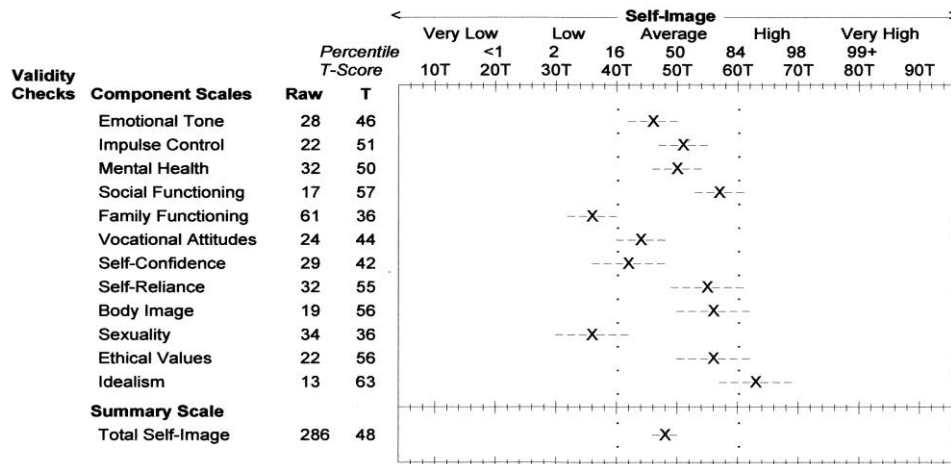
Offer Self-Image Questionnaire for Adolescents, Revised (OSIQ-R)

A WPS TEST REPORT by Western Psychological Services
 12031 Wilshire Blvd., Los Angeles, California 90025-1251
 A Computerized Scoring and Interpretation System
 by D. Offer, M.D., E. Ostrov, J.D., Ph.D.,
 K. I. Howard, Ph.D., and S. Dolan, M.A.
 Version 3.212
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ID Number: 41104
Age: 17
Gender: Male
Ethnicity: White
Name: Not Entered
Examiner Name: Sarah Cartier

Administration Date: 04/11/09
Processing Date: 04/25/09
Examiner ID Number: 1

The technical information that forms the foundation for this report is presented in the Manual for the Offer Self-Image Questionnaire for Adolescents, Revised (WPS Product No. W-274C) published by Western Psychological Services. Interpretation and use of this report should be undertaken only after a careful reading of the Manual, including the discussions of user qualifications, reference sample and test score qualities, and reliability and validity evidence.



Display of T-score with one SEM (68%) confidence interval (---X---)
 Validity Checks: No validity problems were indicated.

VALIDITY ANALYSES

The adolescent's responses were inspected for indications of unusual or unacceptable response patterns (R-check) that could suggest inattentiveness or willful noncompliance. These checks included searches for sequences of identical responses and counts of omitted items. No such problems were noted, indicating that no gross pattern of response biases appeared to be present.

The set of most infrequent responses was checked (I-test). This youth's use of infrequent

responses appeared to be within normal limits. This result reduces the likelihood of an effort to "fake bad" (appear more disturbed than is warranted).

The consistency of responses to items on each OSIQ-R scale was inspected (C-check). This teenager showed no undue tendency to use opposite extreme responses to items from the same scale. The scale scores and interpretations provided in this report are therefore likely to show the level of reliability and accuracy attributed to results in the OSIQ-R Manual.

STANDARD NORMATIVE RESULTS

This teenager's Total Self-Image summary scale T-score was 48. This indicates that his self-evaluation in this area is consistent with that of a middle rank 41 percentile of his sex and age peers.

The overall finding does not suggest an individual diagnostic or clinically significant problem. Nevertheless, later sections of this report evaluating areas of intraindividual strength and weakness and possible matches to diagnostic OSIQ-R profiles should be carefully reviewed. Information from these sections must be interpreted conservatively, in view of the absence of significant overall findings, but it may prove useful in guiding discussion during initial evaluation interviews or therapeutic intervention sessions.

In addition to this overall finding, 3 scales showed a significant deviation from the reference sample mean, suggesting an unusual mix of both significant strength and significant weakness relative to normal adolescent self-evaluation in these areas.

Area of Higher Self-Image

The Idealism T-score of 63 suggests an adolescent who is clearly willing to help others and who is concerned with social problems. He has transcended his own perspective, and can accept the fact that others may have different interests and perceptions from oneself.

Areas of Lower Self-Image

The Family Functioning T-score of 36 indicates that there is some tension in the home and that this adolescent gets along rather poorly with his parents. He is not allied with his parents, whom he perceives as being nonsupportive of each other and other family members. This teenager considers his parents to be a disappointment, persons more fit for rejection than emulation.

The Sexuality T-score of 36 indicates that this teen takes a relatively conservative attitude toward sexuality. He does not feel comfortable with his own sexual feelings. His attitude is that, at least for him, expression of sexuality at this time is best deferred.

INTRAINDIVIDUAL RESULTS

Additional analyses of this teenager's pattern of scores indicate that there are some areas of intraindividual discrepancies among scales. These analyses are based on comparisons between the adolescent's performance on individual scales and his own overall self-evaluation as measured by the Total Self-Image scale.

Note that for adolescents like the present individual, whose self-evaluations tend to fall into the average range, the additional interpretations provided here can help provide a more sensitive

framework for understanding the internal dynamics of the individual's adjustment. The test user should be careful, however, to maintain a balanced interpretation that does not suggest a higher level of concern than is warranted by the overall findings discussed in the previous section.

Area of Intraindividual Strength

Intraindividual strength was noted in the area of Social Functioning. This adolescent's strengths, relative to overall self-image, are his apparent

capacity for empathy and his ability to interact with other people his age.

CRITICAL ITEM ANALYSIS

The items listed below were given more extreme ratings by this teen than those given by the most extreme 4% of the normative reference sample.

Extreme ratings on individual items are unstable indicators and should never be considered diagnostic in and of themselves. However, review

of the complete set of extreme endorsements can provide insight into the teen's most pressing concerns and may help illuminate themes of potential difficulty. Hypotheses generated by the clinician during this review can then be used to help guide discussion during subsequent diagnostic or therapeutic sessions.

Family Functioning

4. I think that I will be a source of pride to my parents in the future.
(6 Does not describe me at all. < 3% of reference sample)
111. Most of the time my parents are satisfied with me.
(6 Does not describe me at all. < 3% of reference sample)

PROFILE ANALYSES

The following analyses show how closely this adolescent's profile on 11 of the OSIQ-R scales (Idealism is excluded) matches the mean profile of a limited set of diagnostic groups. The profile of scale means for the diagnostic groups was drawn from research using the OSIQ-R as reported in the Manual. The actual set of diagnostic profiles compared with the client's profile will differ depending on sex and age, and will vary from one OSIQ-R report to another.

Similarity Comparisons

In the analyses, the adolescent's profile is compared with the group profiles using an index that is comparable to a correlation coefficient. Positive values greater than .30 suggest the possibility of a match, with values closest to .99 showing the highest possible match. Middle values, between -.30 and .30, indicate little similarity. Values lower than -.30 show

dissimilarity.

This client's Total Self-Image score and profile of Component Scales suggest some divergence from average results, but not sufficiently below average to support the full profile analysis. For this reason, no extended clinical description will be printed.

The client's profile similarity to the four available for comparison at his age is printed below and may give some insight into diagnostic issues. The lack of strong clinical results should be used as a substantial check: The symptomatology in this adolescent is likely to be lower than is typically represented in the diagnostic groups, regardless of the size of the similarity coefficient printed.

| | |
|----------------------------|-------|
| Single Episode Depression | 0.09 |
| Recurrent Depression | 0.35 |
| Suicide Attempt or At Risk | 0.39 |
| Delinquent | -0.17 |

DISPLAY OF THE CLIENT RESPONSES

The following table lists the actual item responses for this client. Missing responses have been indicated with a dash (-). In this case, the

program will produce a scorable record by substituting normative sample median responses within the limits indicated by the R-check in the attached report and discussed in the Manual.

| | | | | | | |
|-------|-------|-------|-------|--------|--------|--------|
| 1. 5 | 21. 6 | 41. 3 | 61. 5 | 81. 3 | 101. 6 | 121. 3 |
| 2. 4 | 22. 5 | 42. 2 | 62. 2 | 82. 1 | 102. 4 | 122. 2 |
| 3. 2 | 23. 5 | 43. 2 | 63. 6 | 83. 1 | 103. 4 | 123. 2 |
| 4. 6 | 24. 6 | 44. 4 | 64. 2 | 84. 3 | 104. 2 | 124. 2 |
| 5. 1 | 25. 6 | 45. 3 | 65. 3 | 85. 4 | 105. 6 | 125. 2 |
| 6. 2 | 26. 6 | 46. 2 | 66. 5 | 86. 6 | 106. 5 | 126. 2 |
| 7. 2 | 27. 5 | 47. 5 | 67. 2 | 87. 1 | 107. 2 | 127. 2 |
| 8. 4 | 28. 6 | 48. 5 | 68. 2 | 88. 1 | 108. 4 | 128. 2 |
| 9. 6 | 29. 5 | 49. 6 | 69. 2 | 89. 6 | 109. 2 | 129. 5 |
| 10. 4 | 30. 2 | 50. 6 | 70. 6 | 90. 3 | 110. 6 | |
| 11. 1 | 31. 3 | 51. 5 | 71. 6 | 91. 3 | 111. 6 | |
| 12. 3 | 32. 2 | 52. 6 | 72. 6 | 92. 2 | 112. 1 | |
| 13. 5 | 33. 3 | 53. 4 | 73. 2 | 93. 6 | 113. 5 | |
| 14. 5 | 34. 3 | 54. 6 | 74. 5 | 94. 6 | 114. 6 | |
| 15. 6 | 35. 3 | 55. 6 | 75. 2 | 95. 1 | 115. 2 | |
| 16. 3 | 36. 2 | 56. 3 | 76. 2 | 96. 5 | 116. 2 | |
| 17. 4 | 37. 3 | 57. 2 | 77. 1 | 97. 6 | 117. 6 | |
| 18. 2 | 38. 1 | 58. 2 | 78. 1 | 98. 2 | 118. 2 | |
| 19. 2 | 39. 5 | 59. 5 | 79. 1 | 99. 2 | 119. 1 | |
| 20. 6 | 40. 5 | 60. 6 | 80. 3 | 100. 6 | 120. 2 | |

Response Key

- 1 Describes me very well.
- 2 Describes me well.
- 3 Describes me fairly well.
- 4 Does not quite describe me.
- 5 Does not really describe me.
- 6 Does not describe me at all.
- Missing Response.

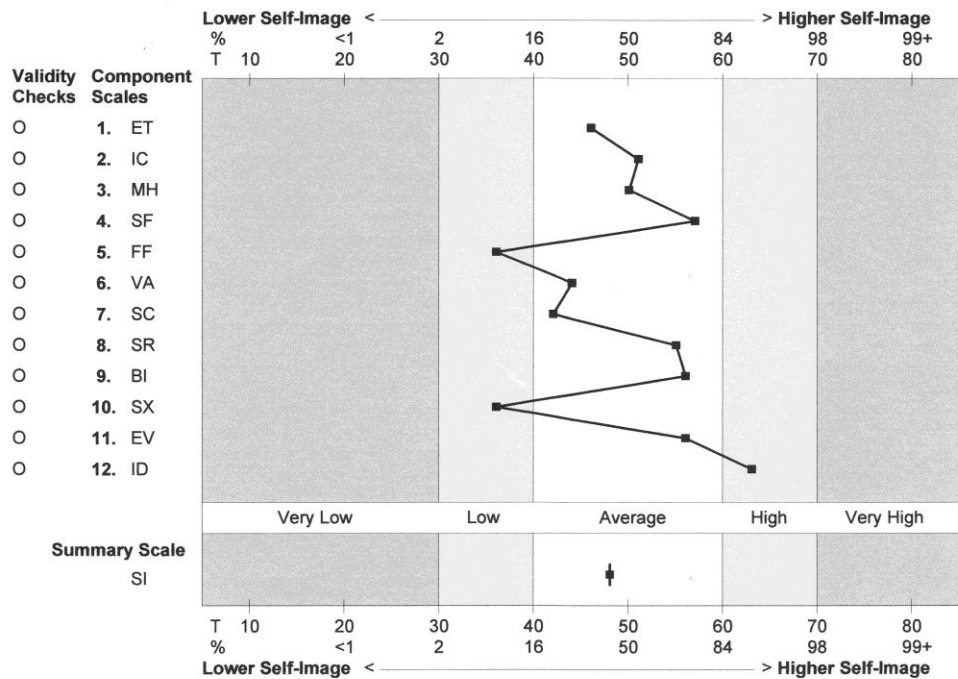
Number of Missing Responses: 0

This report was generated based on WPS TEST REPORT Microcomputer Data Entry.

END OF REPORT

ID Number: 41104
 Gender: Male
 Age: 17

Processing Date: 04/25/09



Validity Check Key:
 O No validity problems were indicated.
 C Poor response consistency may weaken scale validity.
 R Missing responses may weaken scale validity.
 X Too many missing responses to score scale.

Key to Profiles:
 ■ Client
 No clinical profiles show an adequate match

- ET -- Emotional Tone
- IC -- Impulse Control
- MH -- Mental Health
- SF -- Social Functioning
- FF -- Family Functioning
- VA -- Vocational Attitudes
- SI -- Total Self-Image
- SC -- Self-Confidence
- SR -- Self-Reliance
- BI -- Body Image
- SX -- Sexuality
- EV -- Ethical Values
- ID -- Idealism

Offer Self-Image Questionnaire for Adolescents, Revised (OSIQ-R)

A WPS TEST REPORT by Western Psychological Services
 12031 Wilshire Blvd., Los Angeles, California 90025-1251
 A Computerized Scoring and Interpretation System
 by D. Offer, M.D., E. Ostrov, J.D., Ph.D.,
 K. I. Howard, Ph.D., and S. Dolan, M.A.
 Version 3.212

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ID Number: 4102

Age: 17

Gender: Female

Ethnicity: White

Name: Not Entered

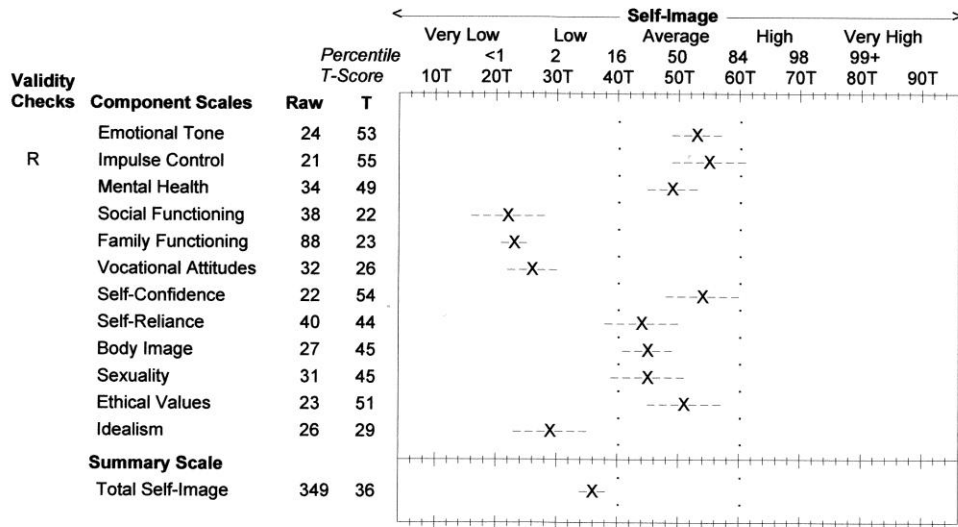
Examiner Name: Sarah Cartier

Administration Date: 04/10/09

Processing Date: 04/25/09

Examiner ID Number: 1

The technical information that forms the foundation for this report is presented in the Manual for the Offer Self-Image Questionnaire for Adolescents, Revised (WPS Product No. W-274C) published by Western Psychological Services. Interpretation and use of this report should be undertaken only after a careful reading of the Manual, including the discussions of user qualifications, reference sample and test score qualities, and reliability and validity evidence.



Display of T-score with one SEM (68%) confidence interval (---X---)
 Validity Checks: C - Poor response consistency, may weaken scale validity.
 R - Missing responses, may weaken scale validity.

VALIDITY ANALYSES

The adolescent answered sufficient items to permit scoring of the OSIQ-R, but the following limitations on scoring should be noted. Where more than 20% of items for a scale were omitted, the scoring of the scale has been omitted from the profile and the report. Where between 10% and 20% of items for a scale were omitted, an "R" has been placed in the Validity Check column on the profile for this report. (See the OSIQ-R Manual for a discussion of response substitutions.)

When one or two scales are omitted or when two or more scales have been marked "R," substantial caution should be exercised in interpreting test results--in some cases, a willful lack of compliance by the respondent may be

indicated; in other cases, the necessary substitutions for missing responses may diminish the clinical elevation of results.

The set of most infrequent responses was checked (I-test). This youth's use of infrequent responses appeared to be within normal limits. This result reduces the likelihood of an effort to "fake bad" (appear more disturbed than is warranted).

The consistency of responses to items on each OSIQ-R scale was inspected (C-check). This teenager showed no undue tendency to use opposite extreme responses to items from the same scale. The scale scores and interpretations provided in this report are therefore likely to show the level of reliability and accuracy attributed to results in the OSIQ-R Manual.

STANDARD NORMATIVE RESULTS

This teenager's Total Self-Image summary scale T-score was 36. This indicates that her self-evaluation in this area is consistent with that of the lower 9 percentile of her sex and age peers.

The overall self-image of this adolescent is negative. This may suggest poor self-cohesiveness and poor self-functioning. Some psychopathology may be present and the result warrants further discussion during the initial evaluation interviews or therapeutic intervention sessions.

In addition to this overall finding, 4 scales showed a significant deviation below the reference sample mean, suggesting a particular weakness relative to normal adolescent self-evaluation in these areas.

Areas of Lower Self-Image

The Social Functioning T-score of 22 indicates that this adolescent has very poor object relations and feels lonely and isolated. She is not able to keep and maintain close relationships with individuals her own age, and feels very uncomfortable

socializing with peers.

The Family Functioning T-score of 23 indicates that there is extreme tension in the home and that this adolescent gets along very poorly with her parents. She is adversarial toward her parents, whom she perceives as being very nonsupportive of each other and other family members. This teenager considers her parents to be disappointing and fit for rejection.

The Vocational Attitudes T-score was 26. Such a low score indicates an adolescent who is unable to work within the school system and who cannot make any plans for the future. She is very alienated from the world of work and education. Whatever her goals, they are clearly not focused on the traditional routes of achievement through school and career.

The Idealism T-score of 29 suggests that this teenager is far more concerned with herself than with others. Others are viewed as exclusively instrumental for her own gratification. In developmental terms, she is still in the egocentric stage, in which the view of others is not important.

INTRAINDIVIDUAL RESULTS

Additional analyses of this teenager's pattern of scores indicate that there are some areas of intraindividual discrepancies among scales. These analyses are based on comparisons between the adolescent's performance on individual scales and her own overall self-evaluation as measured by the

Total Self-Image scale.

These additional interpretations are only included for scales not interpreted in the preceding section.

Areas of Intraindividual Strength

A relative strength was found in the area of Emotional Tone. This adolescent's strength is her capability to experience a range of affects. Relative to her Total score, this score indicates that she tends to have a positive outlook toward the world.

In relation to her Total score, this adolescent shows particular strength on the Impulse Control scale. Her strengths are her abilities to cope with stress and to use problem-solving skills to resolve issues.

A relative strength was found in the area of Mental Health. In comparison to her Total score, this score indicates that she shows resiliency in the sense that she suffers fewer marked symptoms of mental distress than would be typically expected.

Self-Confidence is a particular intraindividual

strength for this adolescent. In relation to her other scales, this score indicates that she is able to deal with frustration and that she feels relatively confident of ultimate success. As a result, she may tend to show more increased effort when failures occur than might be anticipated.

The Body Image score of this adolescent is significantly above the level of her Total Self-Image score. In relation to her other scale scores, a particular strength of this teen is her confidence about her body. She feels relatively healthy, strong, and attractive.

Ethical Values are a particular intraindividual strength for this teenager. In comparison to self-image in other areas, she has a more highly developed sense of duty and responsibility than might otherwise be expected. She is especially able to take the viewpoint of others.

CRITICAL ITEM ANALYSIS

The items listed below were given more extreme ratings by this teen than those given by the most extreme 4% of the normative reference sample.

Extreme ratings on individual items are unstable indicators and should never be considered diagnostic in and of themselves. However, review

of the complete set of extreme endorsements can provide insight into the teen's most pressing concerns and may help illuminate themes of potential difficulty. Hypotheses generated by the clinician during this review can then be used to help guide discussion during subsequent diagnostic or therapeutic sessions.

Emotional Tone

31. Most of the time I am happy.
(6 Does not describe me at all. < 3% of reference sample)

Mental Health

44. I feel empty emotionally most of the time.
(1 Describes me very well. < 4% of reference sample)

Social Functioning

112. I do not have a particularly difficult time in making friends.
(6 Does not describe me at all. < 4% of reference sample)

Family Functioning

4. I think that I will be a source of pride to my parents in the future.
(6 Does not describe me at all. < 3% of reference sample)
15. My parents will be disappointed in me in the future.
(1 Describes me very well. < 2% of reference sample)
105. I have been carrying a grudge against my parents for years.
(1 Describes me very well. < 3% of reference sample)
111. Most of the time my parents are satisfied with me.
(6 Does not describe me at all. < 3% of reference sample)
117. Very often I feel that my mother is no good.
(1 Describes me very well. < 3% of reference sample)

Vocational Attitudes

78. I feel that there is plenty that I can learn from others.
(5 Does not really describe me. < 3% of reference sample)
114. School and studying mean very little to me.
(1 Describes me very well. < 3% of reference sample)

Sexuality

76. I think that boys/girls find me attractive.
(6 Does not describe me at all. < 4% of reference sample)

Ethical Values

91. If you confide in others you ask for trouble.
(1 Describes me very well. < 4% of reference sample)

PROFILE ANALYSES

The following analyses show how closely this adolescent's profile on 11 of the OSIQ-R scales (Idealism is excluded) matches the mean profile of a limited set of diagnostic groups. The profile of scale means for the diagnostic groups was drawn from research using the OSIQ-R as reported in the Manual. The actual set of diagnostic profiles compared with the client's profile will differ depending on sex and age, and will vary from one OSIQ-R report to another.

Similarity Comparisons

In the analyses, the adolescent's profile is compared with the group profiles using an index that is comparable to a correlation coefficient. Positive values greater than .30 suggest the possibility of a match, with values closest to .99 showing the highest possible match. Middle values, between -.30 and .30, indicate little similarity. Values lower than -.30 show dissimilarity.

The client's profile similarity to the five profiles available for comparison at her age is as follows:

| | |
|----------------------------|-------|
| Single Episode Depression | 0.22 |
| Recurrent Depression | 0.19 |
| Eating Disorder | -0.24 |
| Suicide Attempt or At Risk | 0.32 |
| Delinquent | 0.01 |

Matching Group Description

As the comparison with the clinical profiles shows at least one similarity coefficient in an interpretable range, a clinical description of the diagnostic groups will be printed. Note that the descriptions stem directly from the clinical groups

on which the group profiles were based and so apply only indirectly to the teenager described in this report. The descriptions are presented solely to assist the OSIQ-R user in generating diagnostic hypotheses; more direct attribution of clinical features to the client should be based on a thorough review of all information collected during the complete evaluation.

This adolescent's profile is most similar to the Suicide Attempt or High Risk profile. Adolescents within this diagnostic group are in a state of acute crisis. There is almost no area in which they feel good about themselves. Negative feelings about their families are most prominent and quite intense. As negative as they are about themselves, they are even more negative and angry regarding their families. These teenagers seem to strike out at the family, and at the same time take some action with respect to their own despair, even if that means taking or attempting to take their own lives. They are depressed, they lack self-confidence, and they feel hopeless. Only their ideals are intact, but they feel that they fall short of them. They see themselves as impulsive and have no motivation to act in any other way. Combined with their despair and anger, their compulsivity can, in extreme cases, be lethal.

Hospitalization for these adolescents may be indicated. Appropriate medication can provide immediate relief and the emotional strength to address long-term psychological concerns, particularly family issues. With respect to the latter, participation of significant family members in treatment is critical. Long-term insight-oriented psychotherapy is probably advisable. After the acute crisis is past, and after treatment, their prognosis is good.

DISPLAY OF THE CLIENT RESPONSES

The following table lists the actual item responses for this client. Missing responses have been indicated with a dash (-). In this case, the

program will produce a scorable record by substituting normative sample median responses within the limits indicated by the R-check in the attached report and discussed in the Manual.

| | | | | | | |
|-------|-------|-------|-------|--------|--------|--------|
| 1. 6 | 21. 1 | 41. 1 | 61. 4 | 81. 1 | 101. 1 | 121. 4 |
| 2. 6 | 22. 6 | 42. 2 | 62. 1 | 82. 1 | 102. 5 | 122. 4 |
| 3. 5 | 23. 3 | 43. 2 | 63. 6 | 83. 5 | 103. 1 | 123. 3 |
| 4. 6 | 24. 2 | 44. 1 | 64. 6 | 84. 1 | 104. 1 | 124. 3 |
| 5. 1 | 25. 3 | 45. 1 | 65. 6 | 85. 5 | 105. 1 | 125. 2 |
| 6. 4 | 26. 1 | 46. 3 | 66. 6 | 86. 1 | 106. 6 | 126. 2 |
| 7. 3 | 27. 6 | 47. 5 | 67. 1 | 87. 4 | 107. 6 | 127. 6 |
| 8. 5 | 28. 1 | 48. - | 68. 2 | 88. 4 | 108. 5 | 128. 6 |
| 9. 4 | 29. 4 | 49. - | 69. 3 | 89. 1 | 109. 6 | 129. 6 |
| 10. 3 | 30. 6 | 50. 4 | 70. 4 | 90. 6 | 110. 6 | |
| 11. 5 | 31. 6 | 51. 4 | 71. 6 | 91. 1 | 111. 6 | |
| 12. 5 | 32. 5 | 52. 6 | 72. 6 | 92. 4 | 112. 6 | |
| 13. 2 | 33. 4 | 53. 6 | 73. 4 | 93. 6 | 113. 6 | |
| 14. 5 | 34. 3 | 54. 6 | 74. 1 | 94. 6 | 114. 1 | |
| 15. 1 | 35. 2 | 55. 1 | 75. 1 | 95. 1 | 115. 1 | |
| 16. 4 | 36. 1 | 56. 4 | 76. 6 | 96. 6 | 116. 3 | |
| 17. 4 | 37. 2 | 57. 1 | 77. 5 | 97. 1 | 117. 1 | |
| 18. 2 | 38. 3 | 58. 2 | 78. 5 | 98. 3 | 118. 2 | |
| 19. 4 | 39. 4 | 59. 3 | 79. 1 | 99. 1 | 119. 3 | |
| 20. 6 | 40. 5 | 60. 4 | 80. 6 | 100. 3 | 120. 4 | |

Response Key

- 1 Describes me very well.
- 2 Describes me well.
- 3 Describes me fairly well.
- 4 Does not quite describe me.
- 5 Does not really describe me.
- 6 Does not describe me at all.
- Missing Response.

Number of Missing Responses: 2

This report was generated based on WPS TEST REPORT Microcomputer Data Entry.

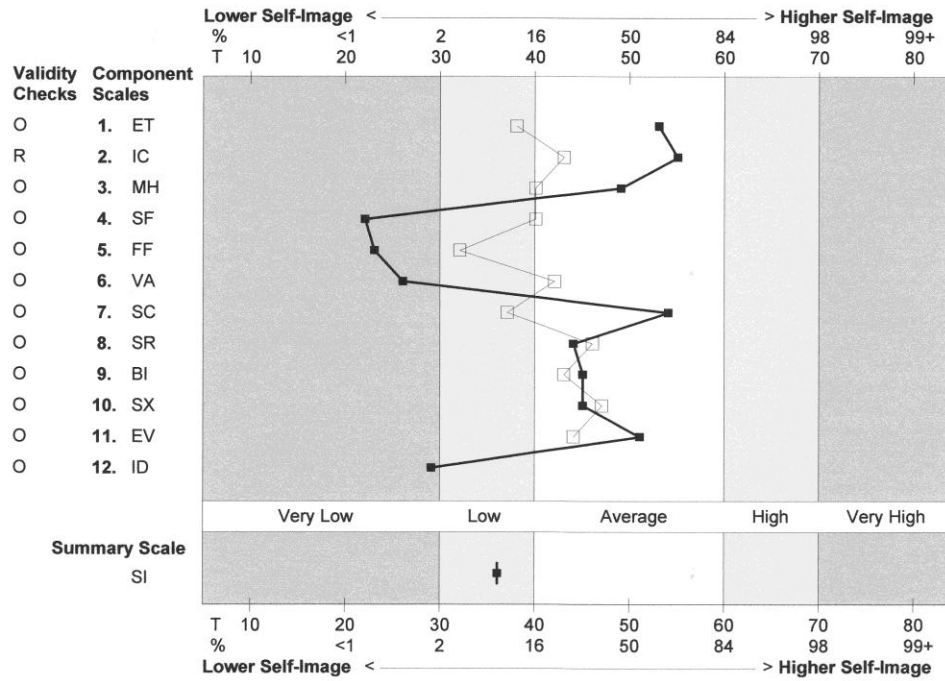
END OF REPORT

ID Number: 4102

Gender: Female

Age: 17

Processing Date: 04/25/09



Validity Check Key:

- O No validity problems were indicated.
- C Poor response consistency may weaken scale validity.
- R Missing responses may weaken scale validity.
- X Too many missing responses to score scale.

Key to Profiles:

- Client
- Suicide Risk

- ET -- Emotional Tone
- IC -- Impulse Control
- MH -- Mental Health
- SF -- Social Functioning
- FF -- Family Functioning
- VA -- Vocational Attitudes

- SC -- Self-Confidence
- SR -- Self-Reliance
- BI -- Body Image
- SX -- Sexuality
- EV -- Ethical Values
- ID -- Idealism

SI -- Total Self-Image