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# HELP-SEEKING BEHAVIOURS OF ADOLESCENTS IN FOSTER CARE: A QUALITATIVE APPROACH

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HELP-SEEKING BEHAVIOURS OF ADOLESCENTS IN FOSTER CARE: A  
QUALITATIVE APPROACH

By

Emily M. Johnson

A Thesis  
Submitted to the Faculty of Graduate Studies  
through the Department of Psychology  
in Partial Fulfillment of the Requirements for  
the Degree of Master of Arts  
at the University of Windsor

Windsor, Ontario, Canada

2014

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September 11, 2014

## DECLARATION OF ORIGINALITY

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## ABSTRACT

Adolescents in foster care are at high risk for mental health and emotional problems, however, many do not receive the services they need (Burge, 2007; Burns et al., 2004). It is important to examine the help-seeking behaviours of this population, to ensure they have these skills when they leave foster care. The present study sought to examine the subjective experiences and perceptions related to mental health and help-seeking of adolescents in care. Participants were seven adolescents (1 male, 6 female) aged 16 to 20 ( $M = 17$ ,  $SD = 1.53$ ). They completed semi-structured interviews, which were analyzed using grounded theory analysis. Themes related to level of need, predisposing and enabling factors (e.g., previous help-seeking, awareness of sources), seeking help, and stages of help-seeking emerged during analysis. Existing theoretical models were adapted to represent the help-seeking behaviours of youth in care. Findings address gaps in the literature, and suggest targets for intervention.

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# CHAPTER I

## Introduction

Children and adolescents in foster care are at high risk for mental health problems. They are more likely to experience mental health problems during childhood and adolescence, and later in life (Unrau, Conrady-Brown, Zosky, & Grinnell, 2006; Bilaver, Kienberger Jaudes, Koepke, & Goerge, 1999; Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). Approximately 30,000 children under the age of fourteen are currently living in foster care in Canada, with reasons for removal from their former homes most often including abuse, neglect, abandonment, and unavailability of parents (Statistics Canada, 2011; Ministry of Children and Youth Services Ontario, 2011). Some of these children are permanently under legal guardianship of the Children's Aid Society (i.e., crown wards). In one recent study, the prevalence of mental health disorders among children and adolescents in foster care in Ontario was estimated at 31.7%, based on a survey of case files, compared to 18% in the general population (Burge, 2007). Other estimates are higher, ranging up to 50% of foster children experiencing mental illness (Burns et al., 2004). Although adolescents in foster care utilize more mental health services than other adolescents in the general population, these services are often sought out for them by caretakers or other adults involved in decisions about their care (e.g., judges, social workers), and not by adolescents themselves (Unrau et al, 2006). There also appears to be a discrepancy between need and service use, as children and adolescents who are identified as being in need of services often do not receive them (Burns et al., 2004; Bilaver et al, 1999). As such, many of these individuals are underserved, and few of them appear to be asking for assistance or help.

Help-seeking is defined as any action taken by an individual to obtain assistance with a problem, and may include formal sources (i.e., professional health service providers, such as social workers, counsellors, psychologists) and informal sources (i.e., peers and family) (Srebnik, Cauce, & Baydar, 1996; Unrau et al., 2006). Asking for help with a mental health problem has been recognized as a learnable skill (Unrau et al., 2006). Given the associated risks of living or having lived in foster care, this skill, which is instrumental and adaptive, may be especially important for children and adolescents in foster care to acquire. In most cases, when adolescents reach the age of exit from the foster care system, which in most provinces is 18 years, they no longer have others seeking resources for them, and must be equipped to seek any assistance they need for themselves (Unrau & Grinnell, 2005). Thus, research on the help-seeking skills of adolescents in the foster care system is essential, as the development of such skills may help to reduce mental health problems after they have left the system, and throughout their lives (Unrau et al, 2006).

Although research with adolescents in the general population has identified many influential factors and barriers to help-seeking behaviour (Bergeron, Poirier, Fournier, Roberge, & Barreette, 2005; Kuhl, Jarkon-Horlick & Morrissey, 1997; Schonert-Reichl & Muller, 1996; Timlin-Scalera, Ponterotto, Blumberg & Jackson, 2003), research with adolescents in foster care is lacking. In fact, the absence of research on help-seeking behaviours of youth in foster care has been identified as a gap in the literature (Unrau et al., 2006). Accompanied by their increased rates of mental health problems, adolescents in foster care may lack a familial support system, may have unstable peer groups due to home moves, and may have decisions about health made for them without opportunity to

make their own decisions (Unrau et al., 2006). As such, it cannot be assumed that research on the general adolescent population can be directly applied to these individuals. Thus, some researchers have taken an interest in the mental health service use and help-seeking behaviours of adolescents in the foster care system (e.g., Unrau & Grinnell, 2005; Burge, 2007).

The majority of studies in this area have analyzed records of service use as a proxy for help-seeking behaviour, rather than examining actual attitudes, intentions, and behaviours of adolescents (e.g., Burns et al., 2004; Burge, 2007). Furthermore, the majority of this research has employed large samples and surveys, case files, or medical records to gain information about mental health, service use, and help-seeking behaviour (e.g., Bergeron, et al. 2005; Kuhl, Jarkon-Horlick & Morrissey, 1997; Saunders, Resnick, Hoberman, & Blum, 1994). It has been suggested that these methodologies are not sufficient to address adolescents' perceptions and subjective experiences related to this topic (Timlin-Scelera, Ponterotto, Blumberg, & Jackson, 2003). Although it is useful to determine whether or not services are being utilized by these youth, research of this nature does not provide information about adolescents' help-seeking skills, or the impact of entry into the foster system on their perceptions of mental health issues and help-seeking behaviour. The purpose of the present study was to address this gap in the literature, and to gain insight into subjective experiences and perceptions related to help-seeking behaviour in adolescents in foster care. To this end, the present study employed a qualitative design.

## **Help-Seeking in Adolescence**

A variety of research has been conducted on help-seeking for different concerns (e.g., physical health, mental health, and school difficulties). The proposed study focuses on help-seeking for mental health problems and emotional difficulties. According to research on this topic, many adolescents in the general population experience distress, and the majority of them do not ask for help (Bergeron et al. 2005; Sears 2004; Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003; Unrau & Grinnell, 2005). In a Canadian sample of adolescents and young adults aged 15 to 24, it was found that only 25% of youth with mental health difficulties sought help (Bergeron et al., 2005). Research has thus focused on the factors that encourage and discourage youth from seeking help with their mental health and emotional issues, in an attempt to better understand why the discrepancy between rates of mental health problems and rates of help-seeking for these problems exists. In addition, because adolescence has been identified as being distinct from adulthood in terms of parental and peer influence, and due to developmental considerations, research has recently focused on factors that may be important specifically during this period of life (Srebnik, Cauce, & Baydar, 1996).

It is important to distinguish between research on mental health utilization and research on the topic of help-seeking. Although both address whether or not the individual ultimately receives mental health services, they have important differences. Mental health service utilization is often a dichotomous outcome considering the receipt of help from formal sources, while research on help-seeking also often considers help-seeking from informal sources. Help-seeking models also distinguish stages of decision making and behaviour that may occur before help is actually obtained (Kessler, Brown,

& Broman, 1981). The theoretical models used to explain mental health service use and help-seeking behaviour in adolescence are typically the same as those that have been developed in research with adults. The proposed study draws from models that have previously been established in the literature on help-seeking behaviour in adolescence.

### **Theoretical Models**

**Behavioral Model of Health Service Use (Andersen & Newman, 1973; Andersen, 1995).** The “Behavioral Model of Health Service Use” was developed to explain health service use for a variety of health concerns. Andersen and Newman (1973) distinguished three different types of factors (i.e., predisposing, enabling, and level of need) that influence an individual’s likelihood of utilizing health services. Predisposing factors are demographic or attitudinal factors that exist prior to the individual’s illness or need for services. Examples of this type of factor include the individual’s sex, race, attitudes and beliefs toward health care, and previous episodes of illness and health service use. Second, enabling factors include the means that allow an individual to utilize services, such as financial resources, knowledge of sources of help, and support of others in accessing services. Finally, level of need is the factor most directly linked to service use, and includes the individual’s perceived need and evaluated need (i.e., by another health professional) for health services. This model has been used as a framework to describe the factors that influence help-seeking behaviour for mental health problems and emotional concerns (e.g., Bergeron et al., 2005; Unrau & Grinnel, 2005). It has also been used in the child welfare literature to address factors that influence foster parents’ health service utilization for the children in their care (Zima, Bussing, Yang, & Belin, 2000).

**Stage Model of Help-seeking (Kessler, Brown & Broman, 1981).** Research has found evidence that seeking help, or using mental health services, has several stages and is not adequately explained by considering only whether or not the individual ultimately decides to obtain assistance. Kessler, Brown, and Broman (1981) first used a stage model to consider sex differences in psychiatric problems and the propensity to seek help for them in adults aged 25 to 74. Specifically, the authors sought to address the previous finding that more women than men utilized mental health services. In their model, three stages were considered: 1) problem recognition (i.e., recognizing that there is an emotional problem), 2) perceived need for help (believing or admitting that professional help is needed to resolve the problem), and 3) obtaining help, that is, actually asking for help from a professional health service provider. The authors found that the higher rate of help-seeking seen in women was best explained using the stage model. In this study, the higher rate of service use among women resulted from a greater likelihood of problem recognition. Women in the study were more likely than men to consider their emotional cues and label their symptoms as a mental health-related issue, and thus were more likely to access services for their symptoms. Men who did not label their symptoms as a mental health concern did not seek mental health services, and fewer men endorsed this stage of problem recognition. Those men who recognized a problem were equally as likely as women to obtain help. The authors were unable to explain sex differences in problem recognition, though they suggested that differences in typical male and female roles, and willingness to admit illness might have contributed. This research provided the first evidence that individual differences in propensity to seek help may stem not from the ultimate decision to seek help, but from earlier stages in the process.



Kessler, Brown, and Broman's (1981) model has since been validated in work on adolescent help-seeking. Saunders, Resnick, Hoberman, and Blum (1994) tested the stage model of help-seeking with a sample of 17,193 American children and adolescents in grades 7 to 12. This study considered the stage model for formal help-seeking behaviour. Participants completed a battery of self-report measures in school, in which they were asked whether they had experienced a "personal, emotional, behavioural or mental health problem that you felt you needed help with during the past year." Those who endorsed having experienced a problem, whether or not they felt they needed help with it, were included in the sample for analyses. Of the original sample, 25% indicated that they had a problem (stage 1), 50% of those who recognized a problem acknowledged a need for help (stage 2) and only 50% of those who answered affirmatively for stage 2 actually sought help for the problem (stage 3). In these adolescents, therefore, there was a large discrepancy between endorsement of each of the stages, the most important of which being between stage 2 and stage 3; adolescents felt they needed help, but did not access it.

The authors also considered individual differences between those who endorsed and those who did not endorse a need for help, and those who sought help and those who did not. They found no differences in emotional or social functioning between those who did or did not identify a need for help, nor between those who obtained help or did not. Those who identified a need also showed no differences in informal help-seeking when compared to those who did not identify need. Those who obtained formal help, however, were significantly more likely to have sought informal help than those who did not. Thus, the stage model may also inform researchers about factors that influence likelihood to

engage in each of the three stages. Distinctions between ability to recognize need and ability or decision to seek help are important in understanding help-seeking skills; these two different problems may relate to different predisposing and enabling factors or barriers, and imply different interventions for targeting help-seeking skills.

### **Influential Factors and Barriers**

Previous research has supported the presence of many influential factors and barriers to help-seeking behaviour for mental health or emotional problems. These findings will be discussed within the framework of the Behavioral Model of Health Service Use, as predisposing and enabling factors, and level of need (Andersen & Newman, 1973; Andersen, 1995). Identified barriers to help-seeking behaviour will also be discussed.

**Predisposing Factors.** Several factors that exist prior to the illness or emotional disturbance influence help-seeking behaviour. These include demographic variables, psychological variables such as self-worth and emotional competence, beliefs and attitudes, and prior help-seeking experiences.

Gender and age have been identified as predisposing factors related to help-seeking behaviour. Schonert-Reichl and Muller (1996) conducted a study on variables associated with help-seeking in 221 Canadian adolescents aged 13 to 18. Participants completed a battery of self-report measures on help-seeking behaviour and psychological variables, specifically self-worth, self-consciousness, and locus of control. The authors found that older adolescents were more likely to seek help, and that girls were more likely than boys to seek help from both formal and informal sources. When considering the psychological variables, the authors also found that self-worth and locus of control

were related to help-seeking. Adolescents who sought help from formal sources had lower self-worth. The authors suggested that those with higher self-worth may have had a greater sense of efficacy or independence, thereby perceiving less need for help, while those with lower self-worth may have been more likely to perceive a need for help. In addition, girls with internal locus of control were more likely to seek help from their mothers, while girls with external locus of control were more likely to seek help from their friends. The authors noted that this finding was consistent with research indicating that adolescents with internal locus of control are more comfortable receiving help from adults, while those with external locus of control prefer help from their peers.

Saunders and colleagues (1994), in the aforementioned study on stages of help-seeking, found that an individual's race influenced likelihood of identifying need for, and obtaining help. Caucasian adolescents were more likely to endorse perceiving a need and having obtained help than were adolescents of "other" non-identified races. Gender differences were observed in this study as well, with girls both identifying need and obtaining help more frequently than boys.

Rickwood, Deane, Wilson, and Ciarrochi (2005) conducted a series of studies to determine what factors influence help-seeking behaviour in Australian adolescents. In one study, 217 adolescents in grades 8 to 11 completed a battery of self-report surveys on help-seeking intentions, difficulty describing feelings, hopelessness, and social support (Ciarrochi, Wilson, Deane, & Rickwood, 2003). The authors found that higher emotional competence (i.e., being aware of one's emotions and being able to use language to express feelings) was associated with greater help-seeking intentions, while lower emotional competence was associated with a greater likelihood of intending, but not

seeking help from another person. In addition, consistent with other research (e.g., Kessler, Brown, & Broman, 1981; Rickwood & Braithwaite, 1994; Bergeron et al., 2005; Schonert-Reichl & Muller, 1996; Rickwood, Deane, Wilson, & Ciarrochi, 2005), the authors also found that girls were more likely than boys to report intentions to seek help.

In another study on adolescent opinions of help-seeking and barriers, Wilson and Deane (2001) conducted focus groups with 23 adolescents aged 14 to 17. Groups were asked several questions related to help-seeking, including what feelings they experienced when seeking help, how they learned where to go for help, and how barriers to help-seeking may be broken down. Using an Immersion/Crystallization approach to analyze results, the authors found that adolescents generally saw help-seeking as a positive behaviour, and were more likely to seek help if they had had positive prior experiences as a result of help-seeking. In addition, adolescents felt that increased knowledge about the help-seeking process was important to help-seeking behaviour, and that education on this topic may act to minimize barriers.

**Enabling Factors.** Enabling factors are those aspects of an individual's environment that make accessing services possible. Saunders and colleagues (1994) found that socioeconomic status influenced adolescents' likelihood to seek help. This influence was not significant at the level of perceiving need, but only at the level of actually obtaining help. This may be due to the perceived or actual cost of formal mental health services. Those without the financial means to access services, or without the knowledge of how to go about obtaining them despite lack of financial resources, may not seek professional help when they need it. The authors also found that the interaction

of socioeconomic status and race predicted help-seeking: those who were of higher socioeconomic status and who were also Caucasian were more likely to seek help.

Parents may also serve as enabling factors to adolescent help-seeking.

Zwaanswijk, van der Ende, Verhaak, Bensing, and Verhulst (2007) tested a sequential model of help-seeking behaviour. The authors considered the influence of self-, parent-, and teacher-reported adolescent functioning, and interview data for 114 Dutch adolescents aged 12 to 17 who were identified as being in need of services. Teachers' perceptions of functioning did not influence adolescent or parent help-seeking for the adolescents' issues. Adolescents' and parents' reports of presence of problems were related to each other, and both parents' and adolescents' reports of perceived need were related to obtaining services. The authors concluded that adolescents' increasing need for autonomy was a factor in help-seeking behaviour, but that parental influence was still an important factor in whether or not services were obtained.

Informal sources of help are particularly important during adolescence, as the presence of a parent or friend who is aware of the problem and need for services may enable the child to obtain help, and research has suggested that adolescents often rely on these sources (Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003; Rickwood et al., 2005). Rickwood, Deane, Wilson, and Ciarrochi (2005) found that Australian adolescents were more likely to seek help from trusted relationships like parents and friends than from formal sources. Similarly, in the aforementioned study, Schonert-Reichl and Muller (1996) found that 52.3% of adolescents aged 13-14 years old, and 65% of adolescents aged 15-18 sought help from their mothers. Saunders and colleagues (1994) also found that informal help-seeking from family and friends was related to formal help-seeking,

suggesting that informal sources acted to encourage asking for help from formal sources. The presence of trusted relationships is thus an enabling factor, as trusted friends and family members act as resources that may encourage or make possible formal help-seeking behaviour. These findings highlight the importance of considering informal as well as formal help-seeking behaviour.

**Level of Need.** Greater need has been linked to greater likelihood of seeking help (Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003). Rickwood and Braithwaite (1994) obtained self-report measures from a sample of 715 adolescents aged 16 to 19. They found that, of a set of social-psychological factors including loneliness, confidence in doctors, and willingness to disclose, the number of symptoms experienced was the only factor associated with professional help-seeking. It is likely that before a decision to seek help is made, individuals must identify a problem and perceive it as being troublesome enough to need help with it. Severity and number of symptoms may thus be associated with the initial stages in help-seeking (Kessler, Brown, & Broman, 1981; Saunders et al., 1994).

**Barriers.** In a review of research on barriers and facilitators to help-seeking in adolescence and young adulthood, Gulliver, Griffiths, and Christensen (2010) identified commonly reported factors that inhibit help-seeking in adolescents and young adults. In order of most frequent findings, they found that stigma, followed by issues surrounding confidentiality and trusting professional health service providers, difficulty knowing when it was appropriate to seek help, concerns about the health service provider, and need for autonomy were the most commonly observed barriers in research on help-seeking behaviour.

Research has shown that boys are less likely to seek help than girls (e.g., Rickwood & Braithwaite, 1994; Bergeron et al., 2005; Schonert-Reichl & Muller, 1996). Timlin-Scalera, Ponterotto, Blumberg, and Jackson (2003) conducted a grounded-theory qualitative study of help-seeking behaviours of Caucasian American male adolescents aged 14 to 18. The main sample consisted of 22 male students. Additional informants, specifically four female students, five guidance counselors, and four parents from the community, also completed interviews about the help-seeking behaviours of the male adolescents, who were the focus of the study. All participants completed semi-structured interviews. Male students expressed that they were more comfortable seeking help from friends, parents, and sports coaches than from formal sources. The students based their decisions to seek help from another person on their level of trust and familiarity with the person, the perceived availability of the person, and the severity of their problem. Barriers to seeking professional help that emerged in the interviews were: a lack of knowledge and awareness, negative perceptions of formal sources of help, and the perception that asking for help was a sign of weakness and failure. These results suggest potential reasons for the consistent findings of gender differences in help-seeking behaviour, and imply that social pressures may be especially salient barriers to help-seeking for male adolescents.

Some other factors that have been identified as predisposing factors may also act as barriers, in their absence. Rickwood and colleagues (2005) found that, whereas the presence of emotional competence was a predisposing factor, a lack of emotional competence was a barrier to help-seeking. In a review of studies conducted with Australian youth, the authors concluded that individuals who could not identify, label, or

manage emotions were least likely to have sought formal help, and had the lowest intentions to seek help. Similarly, although positive attitudes and positive experiences of prior help-seeking predisposed individuals to seek help from formal sources, negative attitudes and beliefs acted as barriers. Such negative beliefs and attitudes included opinions about the abilities of formal health service providers and the effectiveness of formal help, fears of stigma, and confidentiality concerns.

Other beliefs may also influence help-seeking. Wilson and Deane (2012) specifically studied the influence of beliefs on help-seeking behaviour in 1037 Australian adolescents and young adults aged 13 to 21. Using self-report information, the authors examined the influence of fears of help-seeking, beliefs that prior help-seeking was helpful, and a need for autonomy in predicting intentions to seek professional help. They found that a need for autonomy, or believing that one should be able to solve his or her own problems, was the most influential barrier to help-seeking intentions. Higher perceptions of need for autonomy were associated with lower intentions to seek help. Thus, even if predisposing and enabling factors are present, there is still the potential for other factors to act as barriers to seeking help.

### **Children and Adolescents in Foster Care**

#### **Mental Health and Service Use**

The majority of research on the topic of mental health of children and adolescents in foster care has focused on rates of mental illness and rates of service use. Although it is not directly related to help-seeking skills and stages of seeking help, research on service use provides insight about whether or not the need for services is being met in this population. This research also provides clues to the types of health-related decisions



being made on the behalf of adolescents in care, and these decisions may influence help-seeking skills. Because much of the literature on the topics of mental health and service use overlap, research on these two variables will be reviewed together.

**Mental health and service use during childhood and adolescence.** Rates of mental illness are higher among children in foster care than in children in the general population, and it is well documented that adolescents in foster care use more mental health services than those not in care. Among children who are crown wards in Ontario (i.e., legally prohibited from returning to live in their parents' care) aged 0 to 18, Burge (2007) found a prevalence rate of 31.7% for diagnosed mental illness (e.g., ADHD, mental retardation, anxiety, mood, and conduct disorders, etc.), compared to rates of 18% in the general population at the time of data collection.

Bilaver, Kienberger Jaudes, Koepke, and Goerge (1999) used administrative records of families accessing a public health aid service from 1994 to 1995 in the United States to compare the health statuses, diagnoses, and service use of children aged 0 to 17. The study compared those who were currently in foster care, who had never entered care, and who had entered foster care within the twelve months of surveyed data. Entrance into the foster care system was found to increase the likelihood of receiving help. Children who were currently in care were 5 times more likely to have a psychiatric diagnosis compared to those who never entered care, and were 4 times more likely to receive "some type of mental health service" (p. 414). Those who eventually entered foster care were 2.5 times more likely than those who never entered care to receive a diagnosis. They were also 7 times more likely to have received inpatient psychiatric treatment, and 50% more likely to use supportive services compared to those who were never in care. Thus,

even among families who qualify for health service aid, children at risk for foster care placement or currently in foster care experienced higher rates of mental illness and higher rates of service use.

Research has also addressed the individual factors that influence whether or not a child in care is referred for mental health services. Mental illness in this population has been linked to maltreatment (Burge, 2007). Garland, Landsverk, Hough, and Ellis-MacLeod (1996) specifically studied maltreatment as a predictor for service use in 934 children aged 0 to 17. Caretakers completed interviews about service utilization and measures about child behaviour, and case files were consulted for information about the type of maltreatment children had experienced prior to foster care placement. The most common type of maltreatment experienced by children in the study was neglect (67.3%), followed by absence of caregiver (46.8%), and physical abuse (26.1%). Children in the study had also experienced sexual abuse (15.1%) and “other” types of maltreatment (19.8%).

The type of maltreatment experienced by a child influenced the likelihood of them obtaining mental health services, even when child problem behaviours and symptoms were controlled for. Those who were victims of “overt” abuse, that is sexual, physical, or multiple forms of abuse (sexual, physical, and emotional) were more likely to be receiving mental health services (77.3%, 68.9%, and 69.1% of each group, respectively), regardless of their scores on measures of behavioural and emotional problems. Those who had experienced neglect/caretaker absence or protective issues received mental health care less often as compared to cases of “overt” abuse (45.4% and 47.4%, respectively). In fact, experience of neglect decreased children’s likelihood of service

use. The authors found a significant interaction between scores on measures of behavioural and emotional problems, and type of abuse experienced: for victims of sexual abuse, rates of service use did not differ based on symptoms or problems reported, whereas victims of neglect were more likely to be receiving services if more behavioural and emotional problems were reported. Given the likelihood of victims of sexual abuse to receive mental health services regardless of their level of symptoms, these results indicate that referral for services may not have been based on need identified by the child, but may have been, in some instances, a result of perceptions of need based on kind of abuse listed in the child's file.

The authors also contrasted foster-parent-reported child symptoms and mental health service use. They found that children with parent-reported clinical-level scores were more likely than those without clinical scores to be receiving help. Thus, while receipt of services may have been biased based on the circumstances of the child, these findings indicate that foster parents' perceived need is positively related to service use.

Burns and colleagues (2004), however, found conflicting information in a similar study design. Caregivers of 3, 803 American foster children aged 2 to 14 years completed many of the same measures used in Garland and colleagues' (1996) study, to assess need for services. With older children, teacher and child self-report measures were also used. Although the authors found that greater need was associated with higher rates of service use, they found a discrepancy between need and attainment of services. Whereas half of the children were reported to have scores in the clinical range, only one third of those in this range, and who were therefore identified as being in need, actually received any form of help for their problem. Thus, although level of need is associated with mental health

service use, or the appointment of children to these services, there appears to be a discrepancy between need and attainment of services. It has been suggested that children and adolescents have decisions regarding their health made for them by the adults responsible for their care (Unrau et al., 2006). This research indicates that the decisions being made are not adequately addressing the needs of the children.

**Alumni.** The literature has shown a clear connection between mental illness and foster care placement. Recently, research has also considered the mental health of foster care alumni, to determine the long-term outcomes for those who have spent time in care. Pecora, Jensen, Romanelli, Jackson, and Ortiz (2009) reviewed results from three major national studies on foster care alumni in the United States. All of these studies indicated higher rates of mental illness among foster care alumni compared to rates in the general population. For example, one study compared mental health in 479 alumni aged 20 to 33 to matched individuals from the general population. Prevalence rates for depression, panic syndrome, social phobia, generalized anxiety disorder, post-traumatic stress disorder, alcohol and drug problems and dependence, anorexia, and bulimia were higher among alumni. Thus, not only do those in care frequently experience more mental health problems, they may experience higher rates of illness later in life. These negative long-term outcomes highlight the importance of the acquisition of help-seeking skills, as it is likely that adolescents leaving foster care will experience some need for help in the decade after their exit from the system.

### **Help-Seeking Behaviour**

Research on the topic of mental health service use in adolescents in foster care has, in the great majority, focused on service utilization. Although studies about service

use are informative, they do not address the skills or experiences related to stages of help-seeking, which are of greatest interest in regard to studying help-seeking behaviour. Little research has focused specifically on help-seeking behaviours in this population, and some of this research has focused on foster parents' help-seeking for their children rather than the children's own help-seeking behaviour (Zima, Bussing, Yang, & Belin, 2000).

In a rare study specifically considering help-seeking by adolescents in this population, Unrau and Grinnell (2005) compared rates of mental illness, interpersonal, and school difficulties and associated help-seeking behaviours of adolescents in foster care to those of adolescents not in foster care from the same American study sample. The authors used data from a large national study conducted in 1985 to 1986, in which adolescents who attended public health clinics were asked about their symptoms and help-seeking for various physical and mental health problems. The 136 adolescents in foster care were compared to a random group of adolescents from the same sample, as well as a group matched for predisposing and enabling demographic factors. Both comparison groups were composed of adolescents who were not in foster care. Adolescents in care reported higher rates of anxiety, depression, substance use, school problems, conduct problems, and interpersonal problems than individuals not in care. Considering only those who had reported the presence of a problem, and not controlling for any other factors, those in foster care were more likely to report seeking help for depression, conduct problems, interpersonal problems, and post-traumatic stress symptoms. When controlling for other predisposing and enabling factors (e.g., gender, age, race, and level of need), however, the experience of having lived or currently living

in foster care significantly predicted help-seeking behaviour for only conduct problems and depression.

Using the Behavioural Model of Health Service Use (Andersen, 1995), the authors also sought to determine whether the experience of living in foster care acted as an enabling or predisposing factor for seeking help with depression and conduct problems. They compared the help-seeking behaviours of those currently living in care to those who had already exited the system. Seeking help for conduct problems was more likely among those who were currently living in foster care, as compared to those who were no longer in care. The authors therefore concluded that living in foster care acted as an enabling factor for youth with conduct problems. There were no significant differences, however, between the two groups in seeking help with depression. Because both of the groups were more likely to seek help with depression than those who had never lived in care, the authors suggested that the experience of living in foster care might have produced a lasting change resulting in higher likelihood to seek help with depression. Thus, they concluded that living in foster care acted as a predisposing factor for youth with depression.

The authors concluded that the results indicate the benefits of placement in foster care, and provide a starting point for future research. The sample, however, was biased in that the adolescents in the study were already attending health clinics. The study may therefore have in effect considered help-seeking among those who were already seeking help, and ignored those who were not accessing services at all. Furthermore, informal help-seeking and stages of help-seeking were not considered, making the study limited in regard to potential sources of help and process level information about help-seeking

skills. Nevertheless, this work indicates that foster care may positively influence mental health service use for some types of concerns.

In a review article on this topic, Unrau, Conrady-Brown, Zosky, and Grinnell (2006) highlighted the lack of research on help-seeking among adolescents in foster care, and the importance for future research to address this gap. They proposed that life changes that often accompany entry into the foster care system or placement moves, such as moving to a new community, severing ties with family and peers, and school changes, are costs related to the help-seeking skills and behaviours for these adolescents. Given these important considerations, it would be inappropriate to apply all findings from previous research to this population.

The authors also suggested that, although rates of service use are higher for adolescents in care, the foster care system does not allow youth to make decisions regarding their own health. They instead suggested that the system views youth as a “passive participant in organizing their own care,” and as “help-receivers” (p. 106). In light of Garland, Landsverk, Hough, and Ellis-MacLeod’s (1996) findings that the type of abuse experienced is associated with a youth’s likelihood of receiving services, these suggestions imply the possibility that children are identified as having need and are appointed services based on expectations of the adults responsible for their care (i.e., based on their case files), and not because of the adolescent’s actual level of experienced distress. Thus, if they are not motivated or able to seek help for themselves, some adolescents in care may not receive the services they need. Research acknowledging the unique experiences and perceptions of adolescents in care within existing models of help-seeking behaviour is needed to determine whether this is the case, and if so, why.

## **Present Study**

The present study explored, in-depth, the help-seeking attitudes and behaviours of a sample of adolescents with current or previous crown ward status, who currently or recently resided in foster care. Participants were asked questions related to their level of distress and emotional problems, help-seeking intentions and behaviours, and their level of knowledge, attitudes, and beliefs about mental health problems and mental health services. The purpose of this research was to address the gap in literature on adolescents in foster care, by gaining more information about subjective experiences and perceptions of help-seeking. As the literature has primarily addressed formal help-seeking and service use, the present study aimed to gain more information about informal help-seeking in addition to formal help-seeking in this population. Finally, employing a qualitative grounded theory design (Glaser & Strauss, 1967; Strauss & Corbin, 1994), the study aimed to inform existing help-seeking theory, so that it may be applied to this population.

### **Research Questions**

Several research questions were developed based on a review of the literature. These were used to guide interviews and analyses.

In adolescents currently or previously having crown ward status:

1. *Level of need.* What types of distress and emotional problems are being experienced or have been experienced, and how severe is/was the problem?
2. *Predisposing factors.* What knowledge of emotional and mental health difficulties and sources of help do adolescents possess? What are their feelings toward mental problems and sources of help?



3. *Enabling factors*. Do adolescents feel that they are in control of their own mental health and related needs?
4. *Seeking help*. How often are informal and formal sources of help consulted for emotional problems or mental health problems, and who specifically is consulted (e.g., peers, foster parents; social workers, psychologists)?
5. *Stages of help-seeking while living in care*. Are there differences in ability or willingness to identify a problem, perceive need, and obtain help? What factors influence each stage of the process?

## **CHAPTER II**

### **Method**

#### **Research Design**

The present study employed a qualitative grounded theory design. The grounded theory approach was proposed by Glaser and Strauss in 1967 as a research methodology for developing new theory. Originally, this approach emphasized that researchers should begin the process of analysis without consulting any existing theory, to avoid bias. However, the grounded theory approach has evolved to focus on theory elaboration and modification as well as theory generation (Strauss & Corbin, 1994; Richardson & Kramer, 2006). In fact, it has been proposed that existing theory can be used in the grounded theory method to assist in formulating conclusions and creating new theories (Richardson & Kramer, 2006), and Strauss and Corbin (1994) have acknowledged that appropriate existing theories may be “elaborated and modified” through the discovery and coding of themes within new data (p. 273). In the grounded theory approach, conceptual themes in interview data are categorized and compared, and a theory is developed, or existing theories are elaborated through the process of uncovering patterns in the data (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1994; Rennie, Phillips, & Quartaro, 1988).

This design was chosen due to its appropriateness in answering the present research questions. Use of a qualitative design allowed for rich description of the participants’ subjective experiences relating to the topic. More specifically, a grounded theory design was chosen in light of the lack of research in this area, and due to the need for a help-seeking theory applicable to this population. In the present study, this approach

allowed for positioning of conceptual themes in the data within existing help-seeking theory, with freedom to explore any experiences or perceptions unique to this population (Daly, 2007; Wasserman, Clair, & Wilson, 2009; Strauss & Corbin, 1994).

The present design employed semi-structured interviews, with open-ended and non-directive questions, to accomplish the aims of the study. The interviews were structured to ensure they captured all the necessary information and answered the research questions. However, care was also taken to make participants feel comfortable, and to allow them the opportunity to express their full experiences and feelings toward the topic.

### **Participants**

Participants were seven (6 female, 1 male) crown wards or previous crown wards between the ages of 16 and 20 years old ( $M = 17$ ,  $SD = 1.53$ ). Participants aged 18 and under were all in foster care, and those who were over the age of 18 were all enrolled in continuing care at the Windsor-Essex Children's Aid Society (WECAS). Continuing care is a program designed to support crown wards who choose to pursue post-secondary studies after they exit the foster care system. Youth in continuing care have continuing care social workers, and receive financial support from WECAS.

Four participants identified as Caucasian, one participant identified as Caucasian and Black, one as Asian/Pacific, and one as Hispanic. All participants were attending school at the time of participation; the majority attended high school, and one attended college. Total length of time in foster care ranged from 3.5 years to 15 years ( $M = 11.0$ ,  $SD = 4.9$ ). All participants had resided in more than one foster home during their time in care, with the minimum being two homes and the maximum being an estimate of over ten

homes ( $M = 6.0$ ,  $SD = 4.0$ ). Length of time in current foster home ranged from several months to four years ( $M = 2$  years, 8 months,  $SD = 1$  year, 3 months). Although the majority of youth lived in foster homes with two foster parents, two participants lived in single-parent foster homes, and one participant lived independently. Most of the youth lived in foster homes with other children or adolescents. Detailed demographic information is located in Table 1.

**Sample size considerations.** Decisions about sample size were informed by recommendations in the literature. Although the number of interviews required in qualitative research depends on the population participating in the study, as well as the research questions and purpose of research, the goal in data collection using a grounded theory approach is to reach the point of theoretical saturation. Theoretical saturation is the point at which very few or no new concepts are discovered in the data (Guest, Bunce & Johnson, 2006). In the present study, every attempt was made to recruit as many participants as possible. However, it has been reported in the literature that estimates for appropriate sample size in qualitative research with a homogeneous sample range from four to eight interviewees (Creswell, 2009; Guest, Bunce, & Johnson, 2006), indicating that the present sample size was sufficient to draw conclusions from the data.

### **Recruitment and Procedure**

After receiving clearance from the University of Windsor Research Ethics Board and the Windsor-Essex Children's Aid Society Ethics Board, participants were recruited via their social workers and using in-person recruitment at an extracurricular youth group at WECAS.

Table 1

*Participant Demographic Characteristics*

Characteristic	N	%
<b>Gender</b>		
Male	1	16
Female	6	86
<b>Age</b>		
16	4	57
17	1	16
18-20	2	29
<b>Ethnicity</b>		
Caucasian	4	57
Caucasian/Black	1	16
Asian/Pacific	1	16
Hispanic	1	16
<b>Education Level</b>		
High School	6	86
College	1	16
<b>Total Length of Time in Care</b>		
3-5 years	1	16
5-7 years	1	16
7-10 years	1	16

Table 1 (Continued).

Characteristic	N	%
Total Length of Time in Care		
>10 years	4	57
Number of foster homes resided in		
1-2	3	43
2-5	1	16
2-10	2	29
>10	1	16
Length of time in current home		
<1 year	2	29
1-2 years	1	16
2-4 years	3	43
N/A	1	16

Social workers were notified by email about the study. In order to be eligible, youth had to have presently or previously had crown ward status. Workers were asked to contact the researcher by email or phone on behalf of youth who were under the age of 18 and interested in participating in the study. Upon contact, the worker was provided with additional study information and the opportunity to ask questions before scheduling an interview time for the youth. Continuing care workers were also contacted by email, and asked to inform their youth about the study. Youth over the age of 18 contacted the researcher themselves, at which point they were provided more information and the

opportunity to ask questions before arranging an interview time. Youth who were recruited at the extracurricular youth group listened to a brief description of the study and question period. They were then asked to provide the researcher with their name and their worker's contact information if they were interested in participating. Their workers were then contacted to provide study information and set up an interview.

Interviews took place at the Windsor-Essex Children's Aid Society building in a private office. Prior to completing any part of the study, informed consent was explained. Care was taken to clearly explain the limits of confidentiality; participants were informed that interviews would be confidential, except in the event that information implying potential harm for the participant or another person was shared. Participants were also reminded of their right to refuse to answer any questions. After informed consent was explained and questions were answered, participants were asked to read and sign informed consent for participation forms and consent for audio recording forms. For interviews with youth under the age of 18, the participant's social worker also took part in the informed consent process and completed consent forms as the participant's legal guardian. Next, participants and their workers were provided the opportunity to ask questions about the study or interview prior to beginning the interview. Following this, social workers left the office and remained available in the building until the end of the interview.

Participants were next asked to complete a short background information questionnaire (Appendix A), either on their own, or with assistance from the researcher. The semi-structured interview followed (Appendix B). Each interview began with rapport-building questions before progressing into formal interview questions. All

interviews were conducted by the researcher and audio-recorded using a small recording device, for future transcription. The length of interviews ranged from 42 to 89 minutes ( $M = 60$  minutes). After each interview, participants were again provided the opportunity to ask questions about the research. They were then given a copy of the consent to participate in research form as well as a debriefing form containing study information and a list of mental health service providers in the community, which they were encouraged to consult if needed. Finally, all participants received a \$20 gift card to a local coffee shop as a token of appreciation for their time. For participants under the age of 18, social workers were provided a copy of the consent to participate in research form, and were instructed about how they could access study results.

**Transcription.** Following each interview, interview audio was converted from the recording device into .mp3 files on a lab computer. Audio was then transcribed by the researcher or by a trained research assistant using the computer program InqScribe. This program allows for pausing, rewinding, and slowing down of audio to facilitate transcription. Transcriptions followed a consistent format, and interviews were transcribed verbatim, including long pauses, mispronounced words, repetitions, filler words, and laughter. Attempts were also made to indicate emphasis in the participant's speech. Transcription began during the rapport-building portion of the interview, and ended after the participant was provided the opportunity to add additional thoughts or ask questions at the end of the interview. Interviews that were transcribed by the research assistant were checked for accuracy by the researcher. Following transcription and accuracy checks, all audio files were destroyed.



## **Measures**

Participants completed a background questionnaire (Appendix A) which included questions about age, gender, race, length of time in foster care, number of homes lived in, and information about current foster care placement (e.g., number of caregivers and other children in the home).

An interview outline was developed for the proposed study (Appendix B). This outline consisted of open-ended questions addressing the themes in the research questions. Previous research and commonly used measures of help-seeking behaviour were consulted in the development of questions. Examples of measures consulted are the Barriers to Adolescent Help-Seeking questionnaire (BASH; Kuhl, Jarkon-Horlick, & Morrissey, 1997), which consists of questions about perceptions of formal help, and the Barriers to Informal Help-Seeking questionnaire (Stanhope, 2002), which was developed to address similar issues in seeking help from informal sources. During its development, the interview protocol was piloted in a role-play situation with graduate students and with family members of the researcher who were 13 to 18 years old, to address issues such as interview length, comprehensibility of questions, and appropriateness of language.

The interview outline was followed as closely as possible during interviews, though ordering, timing, and specific wording of questions was modified at times to increase flow within the conversation of each interview, and based on participant responses. The practice of allowing flexibility in following the protocol ensured that the interview process was natural and comfortable for the research participants. This practice also allowed participants freedom in expressing their experiences, and ensured that the interviews were not limited by previous research or researcher expectations.

## **Analytical Approach**

To analyze interview data, I used a grounded theory-based coding procedure, following the guidelines proposed by Corbin and Strauss (2008).

In grounded theory coding (Corbin & Strauss, 2008), a *concept* is a title that “stands for groups or classes of objects, events, and actions that share some major common property(ies)” (p. 45). Concepts are identified by the researcher through the process of coding, beginning in the first stage of analysis. As the analysis unfolds, data that are conceptually similar are appointed the same “code.” That is, excerpts of data expressing the same idea or meaning are labeled as belonging to the same concept, with the same conceptual code label. Concepts may be redefined through the process of comparison across interviews. Lower-level concepts are grouped into *categories* (i.e., higher-order concepts). Categories are often referred to as “themes” in the qualitative research literature. Next, relationships between categories are established, and a theory is created, connections are made to existing theory, or existing theory is modified. Through the process of analysis, it is expected that interpretations, concepts, and categories will evolve and be modified, as it is not possible for the researcher to begin the coding process having the answers pre-determined (Corbin & Strauss, 2008; Rennie, Phillips, & Quartaro, 1988; Daly, 2007; Kohler Riessman, 2008). This fluid coding process ensures that the conclusions drawn from the research are closely linked to the data, do not misinterpret the meaning behind the data, and do not omit important findings that were not expected by the researcher.

In qualitative analysis, the use of *memos* is also important (Corbin & Strauss, 2008; Creswell, 2009; Rennie, Phillips, & Quartaro, 1988). Memos are notes written throughout the process of analysis to describe the thinking process of the researcher.

All interviews in the present study were analyzed with the use of the computer program Dedoose, which allows users to upload and code data. Using this program, I highlighted important excerpts in interviews and attached relevant conceptual codes to them. I was able to easily identify, elaborate on, modify, and redefine new and existing conceptual codes throughout the process of analysis, making the fluid coding process more natural. I was also able to use Dedoose to record memos throughout the analytical process, to describe my thoughts in development of conceptual codes, and to record my personal reactions. My analysis proceeded in several stages.

**Stage 1: Immersion in data.** My analysis began while transcribing the first interview. During transcription, I made an effort to get an overall “feel” for the ideas expressed in the interview, and to get a sense for the participant’s impressions of the topics discussed. This was followed up by a preliminary reading of the interview, during which I highlighted interesting or important quotes, and took rough notes about my impressions of the meaning behind the participant’s responses.

**Stage 2: Microanalysis and open coding.** Next, I began the process of defining concepts in the first interview and entering them as codes in Dedoose. To accomplish this, I used the process of open coding (Corbin & Strauss, 2008). In using this approach, I attempted to remain open to all possible interpretations of the data, without limiting my labeling of codes to my expectations, or to the research questions. The research questions were not consulted during this phase. I used a process of microanalysis (i.e., dissection of

data and use of close interpretation of each component) to ensure that my initial coding was thorough and true to the data.

During this stage, I highlighted important transcript excerpts and attached relevant “codes” (i.e., descriptions of concepts) to each excerpt in Dedoose. My goal was to capture the true meaning behind the participant’s responses. I also recorded a large volume of memos to track my analytical process and personal thoughts, and to denote areas I felt needed expansion or further thought. This preliminary round of coding resulted in a large amount of codes and several areas in need of development.

**Stage 3: Comparison, expansion, and assimilation.** It has been recommended that grounded theory analysis should be emergent; codes should be revised and expanded to address overlapping components and gaps as they emerge throughout the process of analyzing the data (Rennie, Phillips, & Quartaro, 1988; Daly, 2007; Kohler Riessman, 2008). It was important to acknowledge that not every interview would contain the same information. I was prepared for changes to occur and for categories to emerge through comparison of coded concepts in each interview.

Coding for each of the six remaining interviews thus proceeded in the same way: I first read the interview to get an overall sense of the main ideas expressed, highlighting interesting and important portions of each interview and taking notes to record my thoughts. I then read the interview a second time, this time defining excerpts, identifying concepts, and applying appropriate codes in Dedoose. Codes that were derived in Stage 2 were applied to interviews when appropriate. However, through this process, I also compared relevant concepts across interviews, modifying some codes, adding additional codes, and discarding others.

At this stage, I also began to group concepts into categories with sub-conceptual codes, thereby assimilating related concepts into broader categorical groupings. For example, one category became “Barriers to Help-Seeking,” which contained sub-codes to represent the concepts that described each barrier (e.g., “stigma”). Throughout this entire process, I kept memos to track my thoughts and impressions.

**Stage 4: Revision and conceptualization of relationships.** After coding all seven interviews, I re-read each interview and the codes applied to ensure that each of the codes were appropriate, and to ensure that my application of codes was consistent across interviews. I also attempted to simplify and remove noise from my list of codes, and expand on other codes as needed in order to more clearly establish relationships between the identified categories. I began to conceptualize the relationships between the concepts and categories. To facilitate this, I consulted my original research questions for the first time since beginning data collection, and ensured that I had identified data (or absence of data) in the interviews to answer each research question. However, I took care to preserve the concepts that did not fit neatly within the groupings of the research questions, to ensure that my analysis remained grounded in the data.

**Stage 5: Establishment of relationships and positioning within theory.** In the final stages of my analysis, I sought to create an “analytic story,” to bring cohesiveness to the categories and concepts, and the relationships between them. I copied the title of each of the categories onto index cards. I then sorted the index cards into groupings for each of the five research questions, according to which question I felt the category best represented. This allowed me to position my findings within existing help-seeking theory, further conceptualize the relationships between categories, and identify categories that

did not fit within the research questions or existing help-seeking theory. The identification of unique categories facilitated my final conceptualization of the relationships between concepts. This process of organizing the categories also allowed me to search for gaps in my logic, and for redundancies in my coding. I conducted a final round of refining my coding labels, merging redundant concepts together, and more clearly articulating the conceptual meaning of the categories and sub-concepts. Finally, I created a diagram to depict the relationships between the categories present in the data (Figure 1). This diagram came to represent my reformulation of the existing help-seeking theory as it applies to youth in foster care.

### **Trustworthiness of Data**

It has been suggested that in qualitative work, it is not possible for the researcher to completely remove his or her influence; the data is shaped not only by the interviewee, but also the interviewer (Daly, 2007; Strauss & Corbin, 1994; Corbin & Strauss, 2008). Thus, it is important to acknowledge potential bias or researcher influence. My personal background in clinical psychology and developmental psychopathology likely influenced my approach to interviewing and interacting with the youth, and may have impacted the research participants' experiences in the study. While conducting the present study, however, I sought to manage potential researcher influence through the development of rapport with interviewees; I made every effort to ensure that participants were comfortable, and that they felt safe in being honest. I also acknowledged potential researcher influence through adherence to the interview guide, and through the careful keeping of memos and written reflections after each interview and during analysis of the data.

Throughout analysis, I read each interview several times to ensure that my codes remained grounded in the data, and to ensure that my interpretation remained true to the information collected from participants. While I attempted to identify concepts related to the research questions, my analysis began with an open approach whereby I coded all concepts that were present in the interviews.

## CHAPTER III

### Results

In this section, I will present the results that answer each of the five research questions. That is, I will describe the categories and concepts (i.e., themes) that were grouped under the umbrella of each of the five areas of interest: 1) level of need; 2) predisposing factors; 3) enabling factors; 4) seeking help; and 5) stages of help while living in care. Concepts and categories will be described in order to provide a basis for understanding my adaptation of existing help-seeking theory (Figure 1). In describing the results, I have used the following descriptors to denote how frequently each concept emerged (i.e., how many interviews contained each concept): the use of the word “all” refers to all seven interviews/participants; “most” represents five or six interviews/participants; “several” represents three or four interviews/participants; and “few” or “a few” represents one or two interviews/participants.

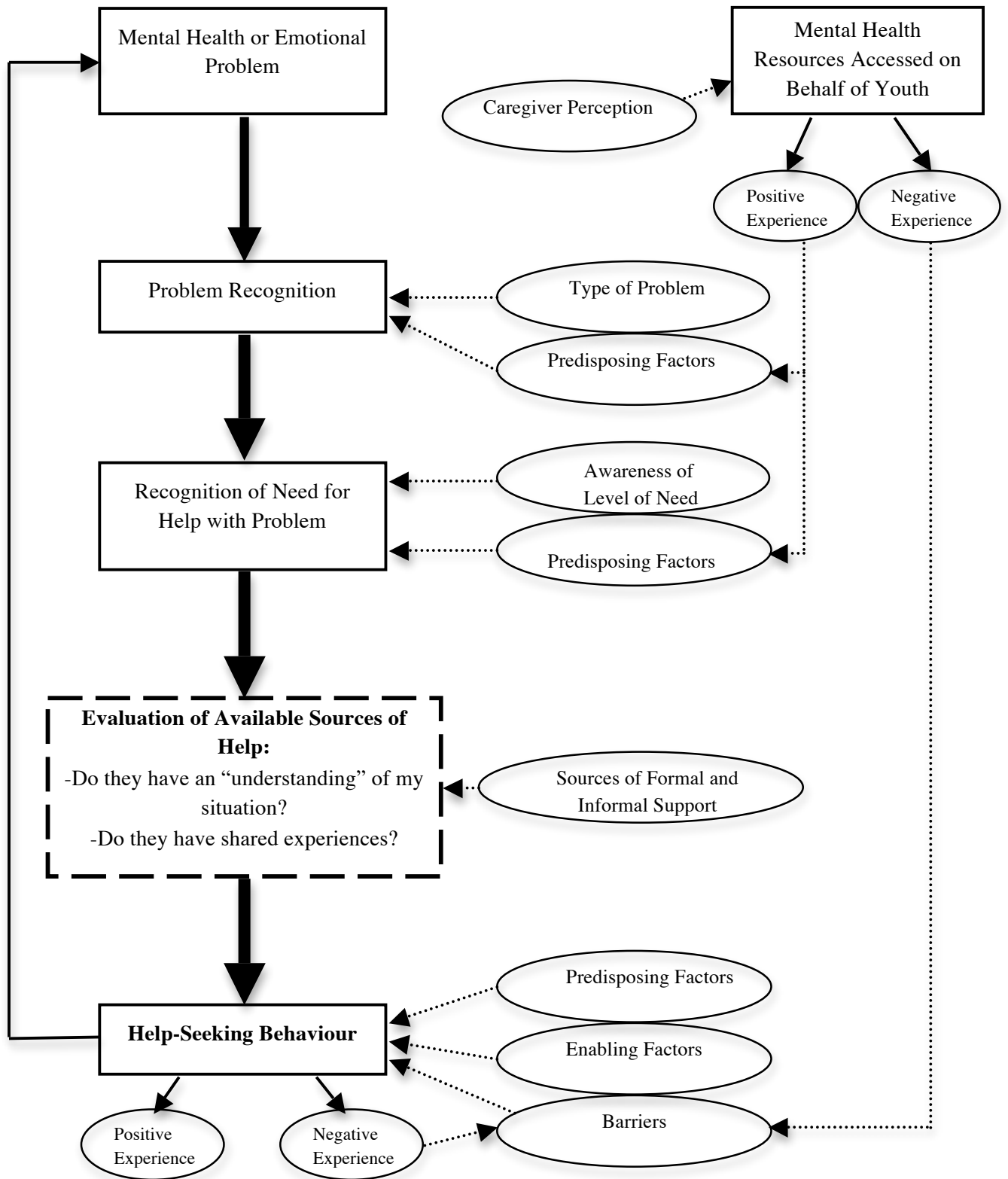
As expected, the interviews varied in their extent and depth of relevant information, and therefore in the number of codes applied. However, each interview contributed significantly to the results. During coding of the last two interviews, no new categories (i.e., higher-order concepts), and less than five new sub-concepts were discovered. Therefore few new codes were added, implying that theoretical saturation was nearly, if not totally, achieved.

#### **1. Level of Need**

Research has shown that level of need influences help-seeking behaviour (Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003; Rickwood & Braithwaite, 1994). Thus, it was important to determine what types of distressing,



Figure 1. Model of Help-Seeking Behaviour Among Adolescents in Care



emotional, and stressful problems that participants had experienced, and to evaluate their perceptions of the situation, how they felt during the experience, and how distressing the experience was. Participants described the stressful situations they had recently experienced, giving rise to the category “types of stressful situations.”

**Types of stressful situations.** Participants were asked to describe stressful or emotional problems they had experienced within the last six to twelve months, and how they felt during this experience. They were asked only to describe those situations that they were comfortable sharing with the researcher. All participants described at least one stressful or emotional problem they had recently encountered, although most participants shared several problems, and several participants also described situations that they had encountered more than one year previous. The youth had experienced a variety of different types of stressful situations, and had different perceptions of these situations; situations that were stressful to some individuals were not stressful to others. “Types of stressful situations” was coded only if the participant described the experience as being subjectively stressful, upsetting, or emotional to them. Thus, this category represents the youths’ perceptions of stressful situations. A list of the sixteen sub-concepts identified within this category is found Table 2.

One particularly important sub-concept was “school stress.” Most participants expressed having felt, or currently feeling stressed about their grades, studying for exams, or managing their workloads at school. Other concepts that emerged frequently in this category were related to family. Specifically, the sub-concepts “family death,” “family illness,” and “biological family issues” emerged in several interviews. The latter concept captured a broad variety of issues, including conflict with biological siblings, parents, and

Table 2

*Types of Stressful Situations: Sub-Concepts*

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Category: Types of Stressful Situations (Sub-concepts)

---

**1. Biological family issues\***

2. Car accident

3. Caring for another person\*

**4. Changing schools**

**5. Conflict with other people in the system**

6. Family death (biological or foster family)\*

7. Family illness (biological or foster family)\*

8. Financial stress

**9. Housing issues (issues with current or past foster placements)**

10. Interpersonal stressors (e.g., problems with friends)

11. Life challenges

12. Personal medical issues and injuries

**13. Moving**

**14. Past trauma**

15. Romantic dating issues

16. School stress\*

---

*Note.* \* = frequent codes; **bold** = unique stressors to youth in care.

Types of stressful situations are presented in alphabetical order.

grandparents, and issues surrounding access visits with biological parents. For example, one participant said:

*[...] I'm still in contact with my mom and my dad but not so much my mom, um, I dunno. I just, there's a lot of drama with my family so I just pull myself out, cause I don't need that on top of school.*

Similarly, another participant described her relationship with a biological parent as being stressful:

*But it's just, it's like, I love my mom to pieces but sometimes she can be... even for a mom, she can be a handful.*

Several participants also identified “moving” between foster homes as being stressful to them. One participant articulated this concept, saying:

*Moving around. I'm a pro packer though. And un-packer. I can do that really quick. [...] Yeah, like moving a lot it's really stressful, switching schools, really stressful.*

“Caring for another person” also emerged as an important concept in this category; several participants cared for their friends’, biological families’, and foster families’ physical and emotional needs (e.g., caring for a dying loved one, caring for a friend in distress, or caring for a sick parent).

## **2. Predisposing Factors**

Previous research has identified factors that may predispose an individual to seek help for a mental health issue. Although I did not specifically search for the concept of predisposing factors during coding, the interview outline was designed to address this area of interest, and these concepts therefore emerged. Categories and concepts that were thematically similar to the predisposing factors identified in the literature were grouped together for discussion here. These included: a) emotional awareness; b) attitudes toward help-seeking; c) previous therapy experiences; and d) suggestions for encouraging help-seeking behaviour.

**a) Emotional awareness.** In the present study, the concept of “emotional awareness” was coded when participants were able to articulate how another person may feel while experiencing a stressful time, and when participants were able to articulate how they had felt during stressful or upsetting periods of their own lives. This concept emerged in all interviews. Although some participants were more reserved, they all expressed some emotional awareness, and were comfortable discussing their feelings and others’ feelings. For example, when asked how a person who was having a hard time, feeling stressed, or experiencing emotional difficulties might be feeling, one participant stated:

*Like they like have no hope I guess. Kind of feel alone. Like they don't have... like they're trapped in like a wall and no way of getting out. Kinda like, have to help them. Give them a... encourage them to try to come out of it.*

Another responded to this question by saying:

*They're probably feeling anger, probably, maybe some disappointment, sadness, confusion.*

This finding indicates that youth in the present study generally possessed at least some level of emotional awareness. The topic of mental health issues (e.g., depression, anxiety), however, did not emerge. Awareness of emotions was limited to awareness of feeling states.

**b) Attitudes toward help-seeking.** As participants discussed how they felt during stressful experiences, who they would talk to and what they would do to feel better in times of distress, and their previous experiences in therapy and with seeking help, their attitudes toward help-seeking emerged. Four sub-codes were used to represent this category. These lower-level concepts denoted the nature of the participant’s attitude

toward help-seeking (positive attitude; negative attitude) and which type of help-seeking their opinion represented (formal; informal).

A few participants expressed mixed feelings toward help-seeking, and a few expressed negative opinions. For example, one participant clearly expressed that she does not find counseling, or getting help from professionals, to be helpful. However, this participant implied that she had more positive opinions of seeking help from informal sources.

*[Interviewer] [...] And was that [therapy experience] helpful?*

*[Participant] No.*

*[Interviewer] No? Is it just that you don't like talking about it?*

*[Participant] I just don't like talking about it and they're not helping me. They don't help me. [...] I don't like their advice. I'd rather like, someone I know.*

*[Interviewer] Okay, so like a friend or like your foster mom or somebody?*

*[Participant] Yeah.*

The same participant also expressed a positive attitude toward seeking help from other informal sources:

*[Participant] I hear like people at my school, they go talk to the student success teacher at our school [...]. And like, I hear like a lot of people go and talk to her about stuff and she'll give you advice. I like to go to my vice principal and talk to her.*

*[Interviewer] Mmhmm. And does it help?*

*[Participant] Yeah, cause she gives me like her advice on it and everything, so. I like it like that, I like another person's opinion.*

In contrast, most participants expressed positive opinions of both formal and informal help-seeking. One participant suggested that talking with a psychologist or psychiatrist would be helpful:

*Like, you can just tell them whatever you want and get everything off of your mind and just come out refreshed and if it starts again you could go back and just do it weekly and refresh again.*

Another participant captured the core of the concept of positive attitudes toward help-seeking in the following excerpt:

*I'm sure a lot of people have said this but if you're stressed out or something I find it best, to like, that like talking to someone is best because, like people have said before, probably, that it's better to get things out than to hold them in. So, I actually kind of found that that's true. Because holding it in kind of makes you more stressed and makes you think about it more, whereas getting it out, it's like a relief, and then like a heavy weight's off your shoulders, or whatever.*

**c) Previous therapy experiences.** Previous episodes of illness and health service use have been identified as predisposing factors to seeking health services (Andersen & Newman, 1973; Andersen, 1995). All of the participants in the present study had attended some form of psychotherapy at some point in their lives. Most had attended individual psychotherapy, several had also attended art therapy or music therapy, and few had spent time in inpatient mental health treatment centers. None of these previous therapy experiences were initiated by the youth themselves. In most situations, the youth's worker had arranged for therapy. Other reasons for attending therapy were acting in accordance with a court mandate (one instance) and attending therapy with a family member and then continuing to receive individual therapy (one instance). Furthermore, consistent with Garland, Landsverk, Hough, and Ellis-MacLeod's (1996) findings that a

fostered youth's likelihood of receiving mental health services is associated with the type of abuse they experienced, one youth said:

*Um, I remember when I was like around 10 or 11 they gave me an art therapy, I don't know why. I think once I went to foster care they thought I needed someone, so I did that for a couple months.*

Most participants had strongly positive impressions (four participants) or strongly negative impression (four participants) of their past experiences in therapy, whereas one participant seemed conflicted about their impressions of the experience. Thus, the concepts “positive therapy experience” and “negative therapy experience” were coded an equal number of times. The reasons why participants had positive or negative impressions of their therapy experiences were also varied. All of the youth who did not enjoy therapy stated that it was because they did not want to talk about their problems with their therapist. For example, one participant explained her dislike for counseling and her negative past experiences, saying:

*[Participant] [...] I don't like counseling.*

*[Interviewer] How come?*

*[Participant] I just. (Sigh). They just bug me sometimes.*

*[Interviewer] What do you mean?*

*[Participant] (Laughs). Like, I know like I'm just sitting here talking to you but...*

*(Both laugh)*

*[Participant] That's different. I don't know, it's just, I hate [...] I don't want to sit there and talk about it. Anymore. Like, I had to... I don't know, I just kinda put it behind, or beside me now, behind me so. And I just hate sitting there and telling them how I feel. Like 'how do you feel about this.' [...] Well, look at what I just told you and think about how I would feel about it! And then I had this one counselor where she'd just give me like modules on self-esteem. Like... this is really helping me (sarcastic tone).*



*[Interviewer] So you don't feel like it helps you?*

*[Participant] No, not at all.*

*[Interviewer] And is it like, you feel like once it's over you don't want to talk about it anymore?*

*[Participant] Yeah. And it just gets me more upset, than I was about it. 'Cause they just bring it all back.*

In contrast, several participants felt that their experience in therapy was positive because they had learned useful skills, and had felt better afterward. One participant explained how therapy had helped them overcome their worries:

*Well I used to go to [a psychologist]. And he helped me with like [my problem] too when that happened, and he's always supportive and stuff. Just helped me with worrying and stuff, and helped me overcome that too.*

Another explained how therapy was helpful in solving the problems they were experiencing at the time, saying “it helped me with the problems at hand.” A few participants found group therapy to be enjoyable because of the mutual support they received from others in foster care. One participant said:

*[Participant] [...] I've been in groups where as well with the agency [WECAS], where people can talk about different things.*

*[Interviewer] Yeah, and what were those like?*

*[Participant] Pretty good. 'Cause you realized peoples' situations were similar and a lot of people think, 'oh I'm going through this by myself,' or you see the younger ones are like 'you don't know anything of what's going on, yadda, yadda,' and it's like, look at other kids or look at their foster parents, and maybe people are like, uh, maybe not exactly in the same lines you've gone but believe me, we've gone through it.*

The category ‘previous therapy experiences’ is important because these concepts appear to influence the youths’ attitudes toward help-seeking, and their intentions to seek help in the future.

*[Interviewer] Um, so you said you would go back and talk to your counselor again if you weren't so busy, right? [...] Do you think that in the future, down the road, you would ever go to see a counselor?*

*[Participant] No, I just have this love/hate thing with counseling.*

*[Interviewer] Yeah, what do you mean?*

*[Participant] Um, I don't know. I find it helpful I guess, and then like some days I like it, but most of the time I hate it and if I had the choice I never would have went.*

This highlights the importance of ensuring youth have a positive experience when they attend counseling, in order to encourage them to seek similar supports when needed in the future.

**d) Suggestions for encouraging help-seeking.** Participants were asked for their opinion about what might encourage them or someone else to seek mental health services when needed. From their responses, the category “suggestions for encouraging help-seeking” emerged. Seven different suggestions for encouraging others to seek professional mental health services were present in the data: improving trust in the foster care system, making therapy more “natural,” increasing awareness of the benefits of therapy, attending group therapy to remove pressure on the individual, support of others (parents, social workers), making therapy more enjoyable or “fun,” and de-mystifying the therapy experience/knowing what to expect. One participant articulated two of these concepts in the following excerpt:

*I think it's, if they set up a meeting for them to say casually just, and them like have a casual meeting with the person, you get to talk to the person for a little bit then say okay at the next meeting we could meet here or the person who recommends the therapist or whatever, even if your social worker did, the social worker comes with you, goes there because you may not feel comfortable all by yourself. Having somebody you know either go with you the first time few times maybe, to understand what's going on.*

Another youth suggested implementing a course or slideshows in schools to make the benefits of therapy better known to others, and to educate others on “the outcomes and how [therapy] can really help.” Another suggestion focused on improving trust in the foster care system:

*[...] I think, honestly I think workers should have a workshop with their kids, with their caseloads, because like, um, just trusting exercises, and just to talk to them, like I think a lot of workers have way too many people on their caseload so they can't really connect with their kids but I think that they should try and have some type of workshop or something so the kids don't feel like they're out to get them.*

These concepts are important clues that point to strategies for enhancing help-seeking skills and reducing barriers to help-seeking among this population. The concepts in this category also reflect hope for improving help-seeking skills and encouraging youth to seek help with mental health, emotional, or stressful problems. The message delivered by one participant was particularly hopeful:

*[Interviewer[...] what do you think would be some things that would encourage them to go? [...]*

*[Participant] You can feel better! [...] You want to feel better. You want to feel happy. You want to make yourself happy again. And you don't want to feel this negativity, you don't wanna feel this blah anymore, you want to be good.*

### **3. Enabling Factors**

Overall, the data suggest that in the present study, decisions were made on behalf of participants by others in their support networks, particularly their social workers. None of the participants had made the decision to access mental health services for themselves, and a few of the youth felt that their therapy attendance was unnecessary. For example, one participant described a positive therapy experience, but felt it was not needed:

*[Interviewer] [...] So you've told me that you talk to your worker and you say you went to your therapist for a little bit...*

*[Participant] That was actually a building I went to I had like an appointment with her for a while but then we were done because we were like yeah, you're good.*

*[Interviewer] So what was that experience like for you?*

*[Participant] Very good. She was very nice. They asked questions, sometimes, 'cause I'm not stressed but sometimes eventually at one point there's probably a target.*

Furthermore, several participants expressed that they did not have a choice in whether or not to participate in therapy, and in general, those who had attended required therapy described more negative therapy-related experiences. For example, one participant said:

*And like I found that just talking about it made it worse, like it made me even more upset. So I didn't like talking about it. And I complained to her like, why do I have to come to this?*

Three additional categories that were classified as enabling factors emerged from the data: a) awareness of adaptive coping methods; b) awareness of sources for help; and c) determinants of positive personal change.

**a) Awareness of adaptive coping methods.** Although the focus of the present study was on help-seeking or talking to others as a method of coping with mental health issues or emotional problems, it is important to acknowledge the other strategies these youth possess in their coping repertoires. All participants identified at least one adaptive coping strategy, and most identified three or more strategies. Seven different methods of adaptive coping were identified in the data, and labeled with the following sub-codes: 1) engaging in prosocial activities; 2) use of problem-solving strategies; 3) self-care; 4) positive reframing of the problem; 5) self-distraction; 6) talking about experiences; and 7) exercise/sport.

Participants were asked about what they, or someone else who was experiencing a stressful situation, could do to feel better. Many of the concepts related to adaptive coping emerged in responses to this question, although these concepts also emerged when participants discussed stressful times they had experienced, and how they had coped with these situations. One participant noted that being involved in prosocial activities was positive, because it encouraged talking with others:

*Just like, when I get involved in stuff then I feel like, better. [...] Like groups [and clubs] and stuff, you know. So like, I feel like. I like getting involved in stuff so like, so then people will know like, if I get involved in a group and we're talking about it then I can talk about it when it's happening instead of letting it all build up like it did [before].*

The concept of talking to others also emerged as a coping strategy when another participant highlighted the importance of asking for help and getting support from others:

*Well, [...] venting, talking to somebody about it. Having somebody to listen to them. They could find, maybe if it could be the schedule maybe they could take a break from whatever they're doing and ask for help. Even though sometimes it's hard, and even if they didn't want to ask for help, look up some information, or maybe if they didn't want to talk to a parent talk to a friend who may be able to help them.*

Although most participants suggested that talking to someone was a positive coping strategy, only one participant suggested that an individual in distress could cope by seeking professional mental health services, saying: “Um, they could go to like a psychiatrist or something. Psychologist.”

**b) Awareness of sources for help.** Awareness of where one could go to receive professional mental health services is an important factor in the individual’s decision to seek help. A lack of awareness of sources for help may prevent the individual from accessing services. Participants were asked if they knew where or to whom they could go,

or where others could go if they needed help with a stressful or emotional problem. Both formal and informal sources of support were coded. Several informal supports were identified: friends, family members, and foster family. Most participants identified awareness of at least one formal source where they could access support. Formal sources identified were teachers, youth centre leaders, telephone hotlines (e.g., Kids Help Phone, hotlines provided by schools), therapists, and social workers.

Most participants identified their social worker as a source of help. This concept, “awareness of CAS worker as source for help,” emerged so frequently that it was coded as a sub-concept within this category. One participant articulated the importance of being able to count on their worker as a source of support:

*[Participant] [...] My worker always says that if I ever need to talk to her I can just call and leave a message and she says that I can vent on the phone. She's a pretty good worker, I've had some crappy ones, but she's the best.*

*[Interviewer] Do you talk to her about stuff, like do you go to her with issues?*

*[Participant] Yeah, not so personal stuff, but sometimes yeah.*

*[Interviewer] And does it help?*

*[Participant] Yeah. It's like, she has more of an insight than anybody because she deals with all of these kids and they have all of these different problems, different scenarios, and she gets to sort of feed off of that for her experience so it helps.*

Another participant articulated that their social worker would be the first person they would consult if they were unsure about how to handle a personal problem:

*[Interviewer] Let's say you had something stressful come up in the next little while and it was really stressful and you were having a hard time [...]. What do you think you would do?*

*[Participant] [...] I probably wouldn't know what to do. I don't know, I'd probably just talk to my worker and like, ask for advice from her, and then just see what she thinks.*

However, two participants noted that their worker or other workers at their agency were busy, and therefore sometimes difficult to access. For example, one participant explained the difficulty with relying on her worker as an immediate source of help:

*[Participant] Um, well not like right away but eventually, yeah. Once I talk to other people I would go to her. It's hard. I would probably go to her if I could, but it's harder because it's harder to get into contact with her and make all the arrangements.*

**c) Determinants of positive personal change.** This category was related to the idea of youths' control over their mental health and related needs, and captures participants' impressions of how they had accomplished positive personal change or growth in the past. Two determinants of positive personal change emerged from the data: 1) gaining confidence in the ability to face challenges, and 2) developmental progression of understanding of the foster care system.

The first determinant of positive personal change, “gaining confidence in the ability to face challenges,” emerged in several interviews. These participants expressed that they had, at some point during their stressful experience, felt an increase in their confidence to successfully manage stress or face difficult situations. This concept was articulated by the following quote:

*Like um, like a switch went off and it was like okay, you can deal with this [...], you can do it.*

None of the concepts in this category included accessing mental health services as a method of personal change. However, the second determinant of positive personal change, the concept of “developmental progression of understanding of the foster care

system,” pointed to a willingness to accept help from the child protection agency. Both participants who were in continuing care alluded to the fact that younger youth in the system feel misunderstood and in turn subscribe to the belief that others will not be able to help them. The participants who were in continuing care also shared how they had changed their own perspectives about their circumstances, and the role of Children’s Aid in their lives. One participant described how she came to understand that CAS could help her:

*[...] Before, I was like, I hate CAS, I'm gonna sign myself out when I'm 16 and I'm gonna live on my own and figure it out from there. But [...] I'm still here, um because like, I realize that they do help you, they do want the best for you, and they don't want you to fail, they want you to succeed, they want you to be better than the other generation in your family.*

The concept of a progression toward a healthy understanding of the role of CAS suggests a reason why some youth may not seek help from their workers or from their child welfare agency in times of distress. That is, prior to this development of a healthy understanding, some youth may be hesitant to access help due to a lack of understanding of the helping role of their child welfare agency, or a feeling that they cannot be helped.

#### **4. Seeking Help**

In the present data, the concept of seeking help emerged in most interviews, in different capacities. Most youth discussed their previous help-seeking behaviour, as well as their intentions for coping with future stress or emotional problems. This gave rise to the categories a) previous help-seeking: formal sources, b) previous help-seeking: informal sources, c) talking to people with shared experiences or an understanding of the youth’s circumstances, d) intentions for future coping, and e) barriers to seeking help.



**a) Previous help-seeking: Formal sources.** Despite the fact that none of the youth had accessed professional mental health services, most of the youth said they had sought help from formal sources. A few had accessed support from school administrators (principals and vice-principals) and from student success teachers, some had asked their classroom teachers for help, and one had asked youth group leaders for help. Most participants had accessed help from their current or past social worker. One participant highlighted the importance of their relationship with their worker, and shed light on the lengths to which their worker has gone to provide support:

*Yeah. I talk to [my worker] a lot. I actually text her way too much. Sometimes to the point where she [...] just like tells me to stop texting so much. That if I need something to call after hours or whatever.*

Although the amount of contact the youth had with their current workers appeared to vary, all of the youth who participated in the present study reported having positive relationships with their current workers. A few viewed their workers in a parental role:

*[...] 'Cause like [my worker's] like my mom. Like she even acts like it, so like I don't know it just felt good to like have her there with me, like by my side. And like go through it with me [...].*

The present study found that mental health services had been accessed on behalf of the youth by their social workers in the vast majority of cases. It is encouraging, then, to know that most of the youth were comfortable seeking help from their workers and going to their workers with problems.

**b) Previous help-seeking: Informal sources.** All of the study participants reported previously having sought help from at least one informal source, and most identified a variety of informal sources. Several identified biological family (siblings, fathers, mothers, aunts, uncles, grandmothers) as a previous source of help, most

identified friends and foster family (foster parents and foster siblings), and few identified romantic partners. Most of the youth identified a preference for seeking help from informal sources, particularly from their friends or foster families. However, the decision of which source to seek help from was very important to them.

**c) Previous help-seeking: Talking to people with shared experiences or an understanding of the youth's circumstances.** A concept that emerged in all of the interviews, and that was integral in the analytical story of the present data, was the concept of seeking help from, or talking to, other people who would understand the youths' problems. This concept emerged in reference to previous help-seeking behaviour as well as help-seeking intentions. Youth who stated that they would seek help from other, less familiar sources nevertheless said that they typically seek help from individuals who know about their circumstances, or who have experienced situations similar to those they have experienced (e.g., foster care). For example, one youth explained:

*[Interviewer] Yeah? What's helpful about talking to your best friend and your sister?*

*[Participant] Because they know my situation so like I don't know, I just find that they can help me more because they understand it better, whereas some people don't know my situation so they don't really know what I'm going through. So they don't really like, understand.*

Several of the youth stated that they would only seek help from trusted sources who have an appreciation of their past or present "situation." One participant explained why she was selective in her sources of help when she said:

*[Interviewer] Yeah, why do you like talking to [your family member]?*

*[Participant] Because both her and [other family member] have been in my shoes, they've both been in care since they were really little.*

*[Interviewer] Okay.*

*[Participant] And they know what I'm going through.*

*[Interviewer] [...] So that helps 'cause she's kinda been in your shoes before? You said she knows what you're going through, what do you mean?*

*[Participant] Um, she's, her and my [other family member] have both been in like, more foster homes and groups than I can even remember what they told me, that they've been in, and it, that, and uh they've been in the same position as I am, they've been in CAS's care, they've been in different foster homes, they've done a lot of the same things I've done.*

This finding highlights the importance that youth have trusted individuals in their support networks, or that they have positive relationships with social workers and therapists, so that they possess resources that they feel comfortable approaching for help.

**d) Intentions for future coping.** Participants were asked how they would cope with a stressful situation they had experienced previously, if they had to experience it again. From their responses, the category “intentions for future coping” emerged. Most participants indicated that they intended to seek help from informal sources in the face of future stress or emotional difficulties. Several youth expressed that they intended to use coping strategies including those discussed previously (i.e., engaging in prosocial activities, use of problem-solving strategies, self-care, positive reframing of the problem, self-distraction, talking about experiences, and exercise/sport), and one participant intended to use maladaptive coping strategies (e.g., partying and skipping school). When directly asked if they would ever seek professional services (e.g., go see a therapist or counselor), participants’ responses varied. A few participants expressed that they would go back to a previous counselor if a stressful situation arose and if they had the time.

*I'd probably pop up and see [my old therapist]. [...] Because she knows my situation. She has more experience with helping people. So, I don't know, I think that would be helpful.*

Few participants also expressed that they would access anonymous services for support (e.g., Kids Help Phone or college help-lines).

*There's always like, well with my school there's a care help line so there's like um, therapists, lawyers, stuff like that and it's all free. [...] The school pays for it and it's anonymous, so if like I just had a really crappy day I can't tell anybody about it but I could go call them and they would try and help me out.*

Several participants expressed that they would not seek services because they did not feel they currently needed them. For example, when asked if they would attend group therapy again, one youth said, “to meet people probably but I'm okay with it. I don't really need it.” Few participants also said that they did not enjoy counseling, and would therefore be hesitant to seek professional services. For example, one youth explained why she would not access her school guidance counselor:

*[Participant] I didn't really talk to [my guidance counselor]. She made me sit there, and I couldn't really like...*

*[Interviewer] So you don't think you'd go talk to her again?*

*[Participant] (Yawns and shakes head).*

**e) Barriers to help-seeking.** Participants were asked what types of things might discourage them, or other people, from seeking help from formal and informal supports. In their responses to this question, the concept of “barriers to help-seeking” emerged. In all, 12 different barriers emerged (Table 3). The most important sub-concepts that emerged were “self-reliance,” “discomfort sharing personal or past experiences,” “negative or failed previous therapy or help-seeking experiences,” “stigma,” and the desire to “put it in the past.”

Table 3

*Barriers to Help-Seeking: Sub-Concepts*

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Category: Barriers to Seeking Help (Sub-concepts)

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1. Belief that others will not understand
2. Desire for independence ("nobody bosses me around")
- 3. Desire to "put the past in the past" and "move forward"\***
4. Discomfort sharing personal and past experiences
- 5. Distrust of the system ("CAS will use the information against me")**
6. Family or friends as sufficient
7. Fear of others finding out about their problems
8. Feeling that therapy is "forced" or "unnatural"
9. Negative or failed previous therapy or help-seeking experiences\*
10. Nervous to ask others for help
11. Self-Reliance\*
- 12. Stigma\***

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*Note.* \* = frequent codes; **bold** = unique stressors to youth in care.  
Barriers to help-seeking are presented in alphabetical order.

The desire to “put it in the past and move forward” was a concept that emerged in several interviews. Several youth identified that they had been encouraged by their caregivers to “live in the present.”

*[Participant] [...] Like I found out I didn't realize it myself, but [my foster parents] would point it out and I'd realize yeah it's true I was, like a lot of kids in care, they're traumatized from when they're gone from their home, like from their original home. [...] I realized, 'cause I know I was talking about my family a lot in the past, memories and all that, then I found out I didn't realize that I was traumatized for a long time. I got this pointed out and I was like oh, okay well I'm gonna stop that! (Laughs).*

*[Interviewer] Yeah, so what did you do stop that?*

*[Participant] Well I stopped bringing it up. Like they tell us to stop you're living in the past, you want to live in the present. Certain things people say, they connect, I'll bring it out, but usually I'll keep it back.*

This advice, while potentially helpful to some youth, may act as a barrier to others. Being told not to think about or discuss parts of their histories may discourage youth from seeking help about issues pertaining to their pasts when such help is in fact needed.

Another unique barrier was conceptualized as a “distrust of the foster care system.” A few of the youth identified that they, or others, had a fear of CAS receiving information from therapy sessions that could be “used against them.”

*Um, because, kids and teens and everybody, even parents of foster kids think it's CAS's fault. So they're like well, I don't want to tell them my problems because that's just another thing to keep me here.*

The concept of “stigma” as a barrier to seeking help, present in several interviews, captured the stigma of attending therapy (“there must be something wrong with you” if you are seeing a psychologist), and more frequently, stigma due to being in foster care. One participant was uncomfortable with the attention she received from others after disclosing her involvement in CAS.

*[Interviewer] [...] If you needed advice or something, do you think you would go to somebody besides you know your friends or your worker [...]?*

*[Participant] It depends. 'Cause you got to be careful what you say for teachers.*

*[Interviewer] What do you mean?*

*[Participant] Like, I always had, I don't know why, but whenever I mention that I'm in foster care to teachers they always pity me in a way and they're always like, nicer. I'm like, why? They treat it like it's something, I don't know, bad or something. And I don't like how they'll just treat me differently. So I try to avoid that. So I won't mention foster parents.*

Another participant explained that some youth in care might be aware of negative stereotypes about children and adolescents in the foster care system:

*Well sometimes people might think that just going to sit there, they're just going to analyze you, or there's also the reverse effect where there's people, [doctors], who don't want to take on the child because of the stereotype of foster kids. The stereotype that's been around for foster kids and teenagers is that they're all bad kids.*

Finally, the importance of having successful help-seeking or therapy experiences was evident. The concept of “negative or failed previous therapy or help-seeking experiences” emerged in several interviews as a barrier to seeking help. One participant described failed help-seeking experiences in the past:

*[...] Some workers don't seem so approachable with it, but this worker is really, really good [...] she'll just I don't know, she's just easy to talk to. [...] And like my other worker, she tried to explain it to me, she tried to like do whatever and it just, I don't know I just made my mind up about her and I was done, I was just like I can't deal with you because you don't listen, you don't. And it would take forever for her to call me back and all of that [...].*

## **5. Stages of Help-Seeking While Living in Care**

According to the Behavioral Model of Health Service Use (Andersen & Newman, 1973; Andersen, 1995), certain predisposing, enabling, and level of need factors may influence an individual to seek mental health services. The present study sought to determine which of these factors were important to adolescents in care. However, the present study also drew from Kessler, Brown, and Broman's (1981) Stage Model of Help Seeking, which has shown that there are different stages in the help-seeking process. Thus, one aim of the present study was to examine which predisposing, enabling, and level of need factors influence youth in care at different stages in the help-seeking process.

All participants in the present study were able to discuss problems that they had recently experienced as being stressful or emotional (Table 2), indicating that they were successful in the first stage of problem recognition. Some of the categories that emerged

in the present data shed light on the other stages of the help-seeking process: a) awareness of need, b) support without asking, and c) use of maladaptive coping. Finally, an adapted theoretical model of help-seeking behaviour among adolescents in care emerged from positioning the present data within existing theory.

**a) Awareness of need.** This category represents three lower-level concepts that emerged from the data: i) awareness of need: lacking (in the presence of a distressing, stressful, or emotional situation); ii) awareness of need: present; and iii) awareness of current absence of need (“I’m okay right now, I don’t need therapy”). Participants had varying levels of awareness of need for help in stressful or upsetting situations. Several participants articulated that they were currently doing well, and felt they had no current need for mental health services. One participant said:

*[Interviewer] Would you go see a [psychologist] again?*

*[Participant] Um, I don't think I need one.*

*[Interviewer] No? How come?*

*[Participant] Just overcome... [I have] more self-confidence.*

All of these participants who identified a current absence of need for mental health services also articulated that they would access services if they felt the need, or if a serious stressor occurred.

Several participants were able to identify a need for help. A few of these participants acknowledged that their previous therapy experiences were needed at the time. Unfortunately, a few also acknowledged that they had probably needed help in recent stressful situations, but they had not accessed help, for various reasons. For example, one youth identified a need but did not know whom to approach, as she felt others would not understand.



*[Participant] Sometimes I did but like, I was like who would I talk to about it, like who would really understand what I'm going through? And when I ask that, I'm just like nobody, because nobody's gone through this [...]. So, I just kinda lost myself in [song] lyrics and just pushed it aside, and honestly it sort of diminishes, it goes away.*

Finally, several participants expressed that they had experienced stress or emotional difficulties, but did not articulate that they needed help, nor did they acknowledge that they could have coped by talking to other people about their issue. The following excerpt showcases one youth's lacking awareness of need for help with her emotions:

*[Participant] Yeah, I don't know. A lot of things have been like making me cry [...].*

*[Interviewer] [...] so do you think that when you do cry, do you feel better after or do you need to do other things to make you feel better?*

*[Participant] Um, sometimes when I cry I end up falling asleep. And other times I just don't know what to do. I try to stop crying and I just tell myself to suck it up.*

There was also variability within participants regarding their awareness of need. A few participants appeared to lack awareness of need regarding some issues, but articulated an awareness of need regarding other issues they had experienced. Thus, this category contained variability in terms of both the participants' level of awareness, and the situations that participants evaluated regarding their need for help.

**b) Support without asking.** This concept emerged when participants were asked if they had asked for help with their stressful or emotional problems. Several participants expressed that they had recognized a need for help, but had not needed to ask for it, because others in their support networks had offered support without being approached.

*[Interviewer] So it sounds like you asked for help when you were feeling stressed out?*

*[Participant] Or [my foster parents] noticed it, or sometimes I would... I didn't say anything sometimes. You know like sometimes you would feel nervous about asking, sometimes you take the step, or sometimes they may notice something, or just in the way you talk they'll be like 'what's wrong,' or, 'okay, settle down.'*

**c) Use of maladaptive coping.** Several participants articulated that they had engaged in maladaptive coping behaviours in the face of stressful situations. That is, the participants were aware that they had a problem, but they chose to engage in maladaptive coping rather than adaptive coping. All of the participants who admitted to using maladaptive coping strategies said they had isolated themselves from others in their home and/or support network. One participant said that when she was experiencing a difficult time, she “wouldn't even come down for dinner,” and another said:

*I like stayed in my room, like I'd go to school and then I'd come back and go straight to my room and like, it was like that for like 2 and a half weeks or whatever.*

A few participants stated that they had engaged in other maladaptive coping strategies such as breaking objects in the home, skipping school, and binge drinking.

**d) Theoretical model of help-seeking behaviour among adolescents in foster care.** It has been suggested that it is not appropriate to apply existing help-seeking theory to the foster care population, due to the unique experiences and challenges encountered by these youth (Unrau, Conrady-Brown, Zosky & Grinnell, 2006). As part of the grounded theory analysis, I consulted existing help-seeking theory as I established relationships between the categories and concepts in the present data. Through this process, I created a diagram to represent connections between concepts and categories. The resulting diagram represents an expanded theoretical model to explain the help-seeking behaviours of the participants of the present study, adolescents in foster care (Figure 1).

The model represents the help-seeking process through time, beginning when no mental health resources have been accessed by the youth or on the youth's behalf. At this point, resources may be accessed on behalf of the youth (e.g., by the court, a social worker), as was the experience of most of the research participants in the present study. Access of resources on the youth's behalf may occur in the presence or in the absence of a mental health or emotional issue, depending on caregivers' perceptions of the youth's need. At any time, prior to or following the receipt of services, should an upsetting experience or a mental health or emotional problem arise, the help-seeking process may begin. I have used Kessler, Brown, and Broman's (1981) Stage Model of Help Seeking to represent this process. In the event of a mental health, emotional, or stressful issue, a youth begins at the stage of problem recognition, and from there may proceed to recognition of need for help with the problem. As the youth proceeds through these stages (or when they fail to proceed through them), the predisposing, enabling, and level of need factors observed in the present study, and presumably those identified in previous studies, may influence the decision-making process.

The main revision made to Kessler, Brown, and Broman's (1981) model concerns what happens after an appraisal of need for help with a problem. The data in the present study indicated that at this point, youth evaluate the availability of an appropriate source from whom to seek help. Youth in this study were particularly concerned with finding a source of support who knew about their history or current situation, who had personally been "in their shoes," or could understand their situation of being in care. This concept of "talking to people with shared experiences or an understanding of the youth's circumstances" emerged as an important concept in the present analytical story, and in

the relationships between other concepts. This concept was so important that it fit best as a stand-alone stage in the help-seeking process, rather than as a factor influencing the stages in Kessler, Brown, and Broman's (1981) model.

The presence and quality of formal and informal support may influence the youth at this evaluative stage. After evaluating whether or not "appropriate" sources are available, the youth may decide to seek help for their problem. Again, influential factors may come into play; particularly important at this stage are the barriers to help-seeking behaviour seen in the present study, such as discomfort sharing personal and past experiences, negative or failed previous therapy or help-seeking experiences, and stigma. As discussed, barriers that are both common to the general population and unique to youth in the foster care system exist, and may impact the help-seeking behaviours of youth in care. Finally, prior help-seeking experiences or experiences with mental health services may in turn influence future help-seeking behaviour.

## CHAPTER IV

### Discussion

*[Interviewer] Do you have any questions for me?*

*[Participant] Why are you doing this research?*

*[Interviewer] [...] I'm really interested in how people feel about these issues, like when they're stressed or when they're going through something, or you know, when they're having issues, and what they do about it. [...] and I realized nobody has ever [...] talked to kids who are in the [foster care] system.*

*[Participant] Is that why you chose CAS?*

*[Interviewer] Yeah. And I think that you guys go through things that are...*

*[Participant] (Interrupts interviewer) That most kids never really go through.*

The present study aimed to address the gap in research on help-seeking behaviours of adolescents in foster care. Specifically, the purpose of the study was to explore the subjective experiences and attitudes related to mental health and help-seeking of adolescents currently or previously in care. With use of grounded theory analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1994), the study expanded upon existing help-seeking theory, to make it more applicable to the foster care population.

Through analysis, themes in the data were identified and matched with the areas of interest of the present study: level of need, predisposing factors, enabling factors, seeking help, and the stages of help-seeking while living in care. Finally, as part of the exploration of the stages of help-seeking while living in care, existing theoretical help-seeking models (Andersen & Newman, 1973; Andersen, 1995; Kessler, Brown & Broman, 1981; Saunders, Resnick, Hoberman & Blum, 1994) were adapted to represent the relationships in the data and to better suit the present population. In this section, I will review the results, position the results within existing research and help-seeking theory,

discuss study strengths and limitations, and highlight contributions to the literature and areas in need of further exploration.

### **Summary and Exploration of Categories and Concepts**

Here, I will summarize and explore the categories and concepts grouped within the five research questions, or areas of interest. I will also position the findings within the context of previous research, and discuss their implications. Suggestions for addressing the findings in the real world, as well as potential interventions for fostering help-seeking skills, will be discussed throughout.

**1. Level of need.** Participants identified many types of stressful situations that they had experienced in recent months and years (Table 2). Some of the experiences described were unique to this population. The biological family issues experienced by these youth were distinctive, as were the experiences related to the foster care system (conflict with other people in the system, housing issues, moving, and changing schools), and the concept of “past trauma” as a stressor. This finding confirmed previous postulations that such stressors are important to youth in care (Unrau, Conrady-Brown, Zosky & Grinnell, 2006).

It is important to note that participants were instructed only to share those situations that they were comfortable discussing with the researcher. Most youth appeared to be comfortable discussing the topic of past and current stress. Nevertheless, the lack of anonymity may have filtered the types of responses given by the participants of this study. Thus, it is important to be aware of the possibility that this list of past and current stressors is not complete.

**2. Predisposing factors.** Previous research has identified many predisposing factors to seeking help, including demographic variables, emotional competence, and prior help-seeking experiences (Rickwood et al., 2005). Furthermore, research has shown that positive attitudes and beliefs may act as predisposing factors, or, in the negative sense, as barriers to help-seeking (Rickwood et al., 2005). Several concepts, or themes, that emerged in the present study were classified as predisposing factors according to their similarity to the factors identified in the literature.

Participants generally appeared to possess emotional awareness, as they were able to articulate how they felt or how others may feel when experiencing a stressful or distressing time. The concept of attitudes toward help-seeking also emerged as a predisposing factor. Consistent with previous research, the concept of “positive attitude toward help-seeking” emerged significantly more often than did the concept of “negative attitude toward help-seeking” (Wilson & Deane, 2001). The concept of “previous therapy experiences” also emerged. Consistent with suggestions in the literature that youth in foster care are “help receivers,” (Unrau, Conrady-Brown, Zosky, & Grinnell, 2006), all of the youths’ therapy experiences had been initiated by other people in the foster care system, most often their social workers. Furthermore, these therapy experiences, though sometimes perceived as being necessary by the youth, were at times perceived by the youth as unnecessary and not based on need. Overall, the youths’ impressions of their therapy experiences were equally positive and negative. Specifically, several youth expressed very positive impressions of their experience in therapy, several expressed definitively negative impressions of therapy, and one was conflicted about their impressions of their experience. The quality of the therapy experience, or the quality of

the relationship between the therapist and the youth, appeared to be related to youths' intentions to seek professional services in the future. Consistent with previous findings that help-seeking intentions are related to the quality of the result of prior help-seeking (Wilson & Deane, 2001), youth who expressed negative opinions toward seeking help from formal sources noted that they had had negative previous therapy experiences.

The fact that all of the youth in the study had attended some form of therapy, and the fact that other youth in care may be in a similar position (Bilaver, Kienberger Jaudes, Koepke & Goerge, 1999), highlights the importance of ensuring that youth have positive therapy experiences when they are young. Ensuring that youth have positive experiences may depend on client-therapist and therapy style-client compatibility, as well as factors such as those identified in the present study as encouraging for others to seek help. That is, increasing awareness of the benefits of therapy, attending group therapy to remove pressure on the individual, the support of others (parents, social workers), making therapy more enjoyable or "fun," and de-mystifying the therapy experience may not only encourage youth to seek help, but also improve their experiences in therapy. This, in turn, may set a positive precedent and increase the likelihood that youth seek help in the future.

**3. Enabling factors.** The idea that youth in care may not have had the need or opportunity to practice their help-seeking skills has been proposed (Unrau, Conrady-Brown, Zosky, & Grinnell, 2006). It has been suggested that having others advocate for them may mean that youth in foster care are not in the position to make decisions regarding their own health, but rather have decisions made for them (Unrau, Conrady-Brown, Zosky, & Grinnell, 2006). Freedom to make decisions may influence whether or not an individual is motivated to seek help. Youth in the present study had previously had



mental health services accessed on their behalf, and many had attended therapy without being given a choice. None of the previous therapy experiences had been initiated by the youth themselves. One positive aspect of this finding is that social workers, as the youths' legal guardians, appeared to be strong advocates for their mental health. However, this also implies that the youth were not always in control of their mental health and related needs, and had not practiced their help-seeking skills.

Despite the finding that youth did not seem empowered to access mental health services, other mechanisms for positive personal change and development emerged from the data. Some youth expressed that they had achieved personal progress through gaining confidence in their ability to handle challenges. Interestingly, the concept of a “developmental progression of understanding of the foster care system” also emerged from the data. Youth in the present study appeared to develop a better understanding of their circumstances and the role of CAS over time. It is encouraging to know that, although a distrust of the foster care system was identified as a barrier to help-seeking, there is potential for this barrier to be dissolved over time. Determining how youth can progress quickly to a healthy understanding of their situation may encourage acceptance of services, and seeking out services from their child welfare agency in the future.

The concept of awareness of adaptive coping also emerged from the present data as an enabling factor. The youth communicated an awareness of positive ways to cope with stress or emotions, including talking to other people as a way of feeling better during difficult times. The research participants also communicated an awareness of sources for help, although informal sources were identified more frequently than formal sources. Possessing knowledge of sources of help has been identified in the literature as an

enabling factor for help-seeking behaviour (Andersen & Newman, 1973; Andersen, 1995). The formal source that was identified most frequently in the present study was the youths' social workers. Most of the youth felt that they could turn to their social worker in times of need, although some youth expressed that their workers were busy, and therefore not always the most accessible source of help. These findings are positive, as they indicate that the youth in the present sample were generally aware of positive ways to deal with times of stress.

**4. Seeking Help.** The concept of previous help-seeking from formal sources emerged from the data. The youth had accessed support from their principals and vice-principals, student success teachers, classroom teachers, and youth group leaders. However, in terms of formal sources, participants had most frequently accessed help from their current or past social workers. This is positive in that, in the present study, the youths' workers were strong advocates for their mental health and related needs. Therefore, seeking help from their social workers may in turn have guaranteed that their needs were met and that the appropriate services were accessed. All of the youth in the present study reported having a positive relationship with their current social worker, and this likely influenced the finding that they had sought help from their workers. However, the present sample may have been biased with respect to this finding. Many of the participants were recruited via their social workers (i.e., the youth were asked by their social workers to participate). Even in cases when the youth were not recruited directly by their workers, the assistance of youths' social workers was required in arranging all interviews. Youth with less positive relationships or less frequent contact with their workers may not have been contacted to take part in the study, or may not have accepted

their workers' requests to participate. As I was not informed about those youth who were asked to participate and declined, or about how many youth were asked to participate by their workers, this potential confounding factor cannot be dismissed. Thus, it is possible that the concept of previous help-seeking from social workers may only represent those youth who have positive relationships with their social workers.

It is also possible that youth in the present study did not view their social workers as "formal" sources, in the same sense as counselors or therapists. The youth in the present study were crown wards, meaning that their social workers were in fact their legal guardians. Furthermore, the youth had positive relationships with their social workers, and some appeared to view their workers in a parental-type role. Thus, social workers may have been akin to an "informal" source to these youth. The concept of seeking help from informal sources was in fact important in the present study. Youth reported seeking help from a variety of informal sources, and reported more frequently seeking help from these sources in the past and intending to seek help from these sources in the future. The tendency to access informal sources is consistent with past research on the help-seeking behaviours of adolescents in the general population. Rickwood, Deane, Wilson, and Ciarrochi (2005) found that adolescents often relied on trusted relationships such as friends and parents, and Schonert-Reichl and Muller (1996) found that a large percentage of adolescents between the ages of 13 and 18 sought help from their mothers. In the present study, the most important informal sources were foster family and friends, although biological family members also emerged several times as sources for help. This is significant as past research has shown that informal help-seeking is related to formal

help-seeking (Saunders, Resnick, Hoberman & Blum, 1994; Rickwood, Deane, Wilson & Ciarrochi, 2005).

Youth sought help from sources they felt would understand them and their circumstances. The concept of “talking to people with shared experiences or an understanding of circumstances” went beyond previous findings that adolescents typically rely on trusted sources (Rickwood, Deane, Wilson, & Ciarrochi, 2005). In the present study, youth found it to be very important that their sources of help could identify with or understand their circumstances, and they valued the support of others who had been in their shoes or who knew others who had been in a similar position. This finding implies that youth in care may feel that their struggles are unique. This emphasizes the importance of building positive support networks for youth in care, and for establishing connections between youth in care who can share their experiences and reduce feelings of isolation. Some research participants noted that participating in group therapy with other children and adolescents in care had been helpful for them, because they learned that their struggles were not exclusive, and that others had been in similar positions. Such services appear to be very important to youth in establishing a healthy perspective of their circumstances, and establishing a positive support network.

Participants also shared their “intentions for future coping.” Intentions captured in this category included the use of positive coping methods (e.g., those identified in “awareness of adaptive coping”), as well as some maladaptive coping strategies (e.g., self-isolation and “partying”). It was encouraging that the concept of engaging in adaptive coping emerged most often. However, when asked if they would ever consider seeing a professional health service provider in the future, there was variability in

participants' intentions. Positively, many of the youth said that they felt they did not currently need therapy but would seek services if they felt the need or if their schedules allowed. However, some youth, particularly those who expressed having negative previous therapy experiences, said that it was unlikely that they would access help from a mental health service provider. This relates to the previous discussion about the importance of ensuring that youth in care have positive experiences in therapy early in their lives.

Finally, the category "barriers to help-seeking" emerged from the present data when youth were asked what might prevent them or other people from seeking help in the future. Several barriers were identified (Table 3), many of which were consistent with those identified in previous literature. For example, the concept of a need for autonomy and issues related to trusting service providers and confidentiality policies emerged, consistent with Gulliver, Griffiths, and Christensen's (2010) findings. Also, consistent with Rickwood et al.'s (2005) finding that negative attitudes and beliefs about help-seeking acted as barriers to help-seeking among adolescents, the concept of negative or failed previous therapy or help-seeking experiences emerged as a barrier. Other barriers emerged elsewhere in the interview data, such as when youth recounted their previous therapy experiences and when they expressed their intentions for coping in the future. A few participants expressed a lack of knowledge about where to turn for support, and a few also evidenced an absence of available sources of support.

Several other barriers identified in the present study appeared to be unique to the present population: the desire, at the instruction of caregivers, to "put it in the past and move forward"; distrust of the foster care system; and stigma due to being in foster care.

Some of these barriers may be attenuated with effort on behalf of those working in the foster care system, and other professionals working with youth in care. Fostering trust in the system, and educating other people, particularly mental health service providers, about foster care stereotypes and their falsehood may help to eliminate these barriers in the future. Finally, the policy of “living in the present” appears to be a healthy perspective for many youth in the system. However, foster parents and social workers should take special care to ensure that this advice is not given in the place of a genuine need for mental health services. The assumption that adolescents will surpass mental health problems or that youth should focus on their present situation may be accurate for some, but may not be sufficient for healing the emotional or psychological wounds of all adolescents.

**5. Stages of help-seeking while living in care.** Participants were able to identify instances of stress or emotional problems. Thus, the present data pointed to successful recognition of problems. The category “awareness of need” shed light on the second and third stages of the help-seeking process. Some youth appeared to lack awareness of need for help in the presence of a stressful, distressing, or emotional problem. Others exhibited an awareness of their current and past levels of need. Specifically, some youth felt they currently did not need mental health services, and many youth were able to articulate that they had previously needed help. Unfortunately, however, some of the youth who acknowledged a need for services admitted that they had not accessed services because of the barriers discussed above. The concept of “support without asking” was also relevant in that some participants who identified a need for help did not need to seek help because their friends or foster families offered support without being approached.

Some participants were inconsistent in their ability to determine when they needed help with a problem, depending on the type of problem they had experienced. Some participants also discussed engaging in maladaptive coping strategies when they had experienced a stressful situation (e.g., self-isolation, skipping school, and binge drinking), rather than identifying a need or accessing help in dealing with the problem. These findings suggest possible areas of intervention for fostering help-seeking skills among youth in care. Consistent with past research (Saunders, Resnick, Hoberman, & Blum, 1994), youth were not always able to identify a need for help with a problem, and those who identified a need often did not access services. Thus, attempts to foster stronger help-seeking skills among youth in care may target the stages of recognition of need and help-seeking.

***Theoretical model of help-seeking behaviour among adolescents in foster care.***

Previous research has not determined which predisposing, enabling, and level of need factors are important at which stage of help-seeking for youth in care. Similarly, exploration of the influence of being in care on the stages of help-seeking has thus far been absent in the literature. In the present study, previous help-seeking models were expanded to represent the relationships between the categories and concepts in the data, and to better suit this population (Figure 1). The expanded model summarizes the research findings.

The ultimate goal of grounded theory research is theory creation or elaboration. As the present data generally fit existing help-seeking theory, modification and elaboration of existing models was appropriate. Corbin and Strauss (2008) stated that: “any theoretical formulation that is generated based on [...] concepts should have general

applicability to all cases” (p. 103). The theory presented here is flexible in that it proposes that different factors may influence different individuals at each of the stages in the help-seeking process. However, care was taken to ensure that the stages proposed in the model applied to each of the interviews in the present data.

This expanded model aims to increase understanding of the help-seeking process undertaken by youth in care, and is proposed as a basis for improving help-seeking skills and targeting areas of need. In this model, an additional stage was added to the help-seeking process, namely, the evaluation of the availability sources of help. The youth in the present study found it to be particularly important to find sources of help who were sympathetic or understanding of their history or current placement in the foster care system. As discussed, some of the predisposing factors, enabling factors, and barriers in the adapted model were also unique to the foster care population.

### **Study Strengths and Limitations**

To the knowledge of the researcher, the present study is the only one of its kind to date. A need has been expressed for research about the subjective experiences of adolescents in foster care regarding help-seeking behaviour (Timlin-Scelera, Ponterotto, Blumbert, & Jackson, 2003; Unrau, Conrady-Brown, Zosky, & Grinnell, 2006). The present study specifically targeted this need, and the findings addressed several of the gaps in the literature. The interviews were rich in information, and the participants appeared to be comfortable and motivated to provide honest, thoughtful answers, speaking to the quality of the data.

Despite its many strengths, however, the study has some limitations. Although it is expected that thematic saturation was achieved, or nearly achieved, the study would



have benefitted from additional interviews, and particularly interviews with male adolescents. Additional interviews would ascertain whether thematic saturation was in fact achieved. Interviews with more males would have been beneficial, given previous findings that male and female adolescents differ in rates of help-seeking behaviour, and that different barriers exist for male and female adolescents (Schonert-Reichl & Muller, 1996; Richwood, Deane, Wilson, & Ciarrochi, 2005). This population is unfortunately difficult to access, and this type of research is time consuming for both youth and their workers. This led to challenges in recruitment.

As previously stated, it is also important to note that the present sample may have been biased in terms of the relationships youth shared with their social workers. In addition, it is possible that the sample may have been biased in terms of the personality characteristics of the research participants. Several social workers commented to the researcher that they had carefully considered which youth from their caseloads to refer for the study. For example, workers noted that they had referred youth who they felt would be able to discuss the subject matter comfortably. Some recruitment was also conducted in-person at an extracurricular group at WECAS. This could have potentially biased the sample in that the youth who took part in this group already had relatively positive opinions toward the agency, and were motivated to participate in prosocial activities. Nevertheless, the variability observed in the attitudes and perceptions of the present sample suggests that this potential bias does not invalidate the findings.

Finally, although every attempt was made to ensure that participants were comfortable, and that they had an opportunity to fully express their opinions, it is important to be aware of potential researcher influence. It has been suggested that in

qualitative research, it is impossible for the researcher to avoid any emotional reaction during data collection. This may have been particularly true in the present study, as youth discussed difficult topics. The concept of a co-constructed reality is also important to acknowledge (Corbin & Strauss, 2008; Daly, 2007; Strauss & Corbin, 1994). That is, the data were not purely a representation of the participants' perceptions of reality, but more aptly described as a reality constructed through the interaction of the researcher and research participants. Though I attempted to remain open and to let participants direct the content of interviews, it is impossible to suggest that no amount of researcher influence impacted the process of data collection. Instead, it is important to acknowledge this potential researcher influence. As noted, my background in clinical psychology and developmental psychopathology may have influenced my interviewing style and the way I interacted with the youth.

### **Contributions to the Literature and Directions for Future Research**

The present study addressed several gaps in the literature on help-seeking behaviours among adolescents in foster care. The data gave rise to an expanded theoretical model of help-seeking behaviour among adolescents in foster care, and identified many unique aspects to the help-seeking process for these youth.

Future research should continue to address the gaps previously identified, in order to more fully understand the present issue. The theoretical model would benefit from validation and from further exploration in samples comprised of youth with different demographic characteristics (e.g., sex and ethnicity), and in the care of different child protection agencies. Further, it would be useful to examine whether the model represents all youth in care, or whether it is specific to crown wards.

Future research may also consider potential interventions for enhancing help-seeking skills among this population. The present study identified several potential target areas for intervention, and it would be beneficial to ascertain whether intervention can in fact bolster the help-seeking skills of youth in care. Use of a longitudinal design would be beneficial in order to track youths' help-seeking skills and understanding of the foster care system over time.

### **Conclusions**

Although youth in foster care face the same challenges that other adolescents experience, they also face additional challenges that deserve attention in the research literature. The youth who participated in the present study had positive reactions to this research, and they expressed a genuine desire to help other people.

The present findings shed light on the experiences and opinions of these youth related to mental health and help-seeking behaviour. However, more work is needed to target the discrepancy between the need for services, and the services these youth access. Such work has at its core a goal to provide appropriate, adequate services to children and adolescents in care, and to ensure that their futures are bright.

*[Interviewer] I think I've asked most of the things I wanted to ask you about. Is there anything else? Anything, any other thoughts you have?*

*[Participant] Don't give up, stay strong.*

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APPENDICES

Appendix A

**Background Information Questionnaire:**

1. What is your age? Please give the month and year: \_\_\_\_\_
2. What gender are you? \_\_\_\_\_
3. If you are in school, what grade are you in? \_\_\_\_\_
4. What race or ethnicity do you most identify with?
  - Caucasian
  - Black
  - Hispanic
  - Asian/Pacific
  - First Nations
  - Arabic
  - Other (please specify) \_\_\_\_\_
5. How long have you lived in your current foster home? Please give your closest guess if you are not sure, on the lines below:  
\_\_\_\_\_ years \_\_\_\_\_ months
6. How many foster *parents* live in your current foster home? \_\_\_\_\_
7. How many *other children* live in your current foster home? \_\_\_\_\_
8. How old were you when you lived in foster care for the *first time*?  
\_\_\_\_\_ years old
9. In your *whole life*, how long have you lived in foster care? Please add up any time lived in any foster home. If you're not sure, please give your closest estimate.  
\_\_\_\_\_ (Years, months, days)
10. Have you lived in any foster homes *before* the one you live in now?
  - No
  - YesIf yes, how many homes? (Please don't count your current home) \_\_\_\_\_

## Appendix B

### INTERVIEW OUTLINE

*“I’m going to ask you tell me about any stressful or distressing problems you’ve had or someone you know like a friend has had over the past six months to one year. I’ll also ask you about how you’ve handled those problems and what that experience was like for you. I would also like to talk about the people in your life, and who has helped you with things, or who might help you if you need it. I’m trying to get a better understanding of how these things are for you, and for other people your age.*

*While we’re talking, remember that you don’t have to tell me anything you’re not comfortable with, and we can stop at any time. Also it’s important for you to know that anything you say will be confidential. The only time that something wouldn’t be confidential is if I feel like your safety or someone else’s safety is at risk. I want to hear about your experiences and how you feel or think about the things I ask you about. There’s no right or wrong answer to anything we talk about today. I want you to make sure you’ve had a chance to say everything you want to say in this conversation. Do you have any questions for me before we get started with the interview?”*

---

--(Rapport building questions; tell me a bit about yourself).

--How did you hear about the study? What did you hear about it? What made you decide to participate?

*Response: “(Give any additional information requested by the participant if it comes up). Those are all great reasons. I really appreciate you taking part in the study and offering your time to talk, this is a huge help. What we learn from you and other people in this study will help us understand what you and other people your age are going through or have gone through and how you’ve dealt with it. This could also help other people your age who might not have had a chance to talk with someone about their experiences, what they’ve been through or how they feel about it, if they’ve had any similar experiences.”*

Many people have experiences or go through periods in their lives that are stressful, upsetting, or difficult to deal with. These could be problems with school, family, friends, feelings, or many other things. It could be something big or small; these things affect different people in different ways.

--I’d like you to imagine a person who having a hard time or any emotional difficulties or is very stressed out. This can be a real person or just an imaginary person. Can you tell

me how you think that person might be feeling? What might they be doing during their usual day? What could they do to feel better?

--Let's say you had a good friend who was going through something, and they were having a hard time with it. How would you help him or her feel better? Why would suggest that? What advice would you give him/her. What would that be, and why would you give that advice?

--I'd like you to think back over the last 6 months to a year of your life. What are some of the more upsetting situations *you've* been through - things that were stressful, hard to deal with, uncomfortable, or emotional for you? You can take a minute to think and you can tell me whatever you're comfortable with. Tell me what this was like for you? (Prompts: How did you feel when you were going through it? How did you deal with it?) (*Ask about each problem if multiple problems are presented*). If you had to go through that again, tell me about what you would do. (Prompts: Would you handle it or cope with it the same way, or would you do something different?)

-How about now? Are you going through anything stressful, or experiencing anything upsetting, or going through any emotional problems that you're having trouble dealing with? What's it like for you? How are you dealing with it right now?

--With all of these problems, did you ask for help? Did you ever think you needed help from someone else, a friend, family member, or another adult? (If they didn't seek help from another person) Did you ever consider talking to anyone, a friend, parent, or another adult? Why or why not?

--Can you think of any time when you think you had a problem that you needed help with? Tell me about it. (If teen can't think of anything, ask for more specifics like how things are going at school) How was that for you? How were you feeling? Did you think you handled this well on your own? Do you think you got the help you needed? Did you ask anyone for help? Who?

--(Ask only if this hasn't been previously covered) People have different ways of dealing with upsetting events, hard times, emotional problems, or stress. If you had a problem, something you were going through that was tough, that you felt you couldn't handle on your own, what would you do? Tell me about it.

--Is that what you usually do (*re: last question*) OR what do you usually do when you have a problem you're struggling with, or feeling very stressed (OR, if no problems: what would you do if...)? What usually helps the most? (OR what would help the most?)

--Sometimes when people are going through something stressful or having emotional problems, they ask another person for some kind of help. Tell me about the people you would go to for help. How do they help you? Why would you go to them? (Ask for each person).

--Where are some of the places you've known people to go, or that you've heard of, where somebody could go if they needed help with a problem? Do you think these are good places to go? How have these people or places been helpful.

--Alright, and how about you? Where are some places *you could* go if you were going through a hard time? How would you feel about going there for help?

-- (If not previously covered in other responses) If you had an issue you needed help with, something you couldn't handle alone, tell me about who you would go to for help? What would this person do to help you? Do you think that would help you? Who else might you go to with a problem? (*Ask about why they would ask each person, or why they wouldn't if they don't feel comfortable discussing things with others.*)

--Is there anything else that helps when you have a problem or you're stressed, besides what we've already talked about?

--Have you ever been to a professional (*give examples if teen is having trouble, like a counselor, doctor, social worker, teacher, therapist*) for help with a problem? How was that for you? Tell me about it.

-- Why did you decide to go talk to this person? How did you find this person? Tell me about it. How did you feel when going there? Tell me about your experience.

-- How do you feel since this experience?

--Would you go again? Was it useful or helpful? How was it helpful? How was it unhelpful?

--(*If not*) Is there any reason why you've never been to a professional?

Tell me about how you think the experience would go, and how you would feel about going to a professional. Do you think you would ever see a professional? Why or why not?

--Without telling me their name, can you think of anyone that you've known who has gone to a professional for help with something?

--If yes: Did you think it was a good idea for them?

--If no: Why do you think people might not want to go to a professional for help?

--If yes/and if no: Do you think people *your age* usually go to professionals with help? Why or why not? How about people of other ages, younger or older? Why, or why not?

--If someone needed help, but they weren't sure about asking someone, what might be some things that would encourage them to get help? How about going to see a professional? What do you think would make people more comfortable, or encourage them to go see a professional if they thought they needed it? Do you have any ideas for how to make people more comfortable going to get help?

--What would be things that might make somebody NOT want to talk to another person? What might be some reasons someone wouldn't want to go to a professional for help?

--What kinds of things might encourage *you* to go to see a professional for help with a problem? (What might make you feel better about going to a professional for help?)

*--Alright, that's all the questions I have for you. Do you have anything else that you would like to add, anything you thought of that you want to say? Do you have any questions for me at all? Thank you so much, again, for coming to talk with me today. This was very helpful to my work and also will hopefully help us to get a better picture of how these issues affect people your age. Here's some information for you, how you can reach me if you have any questions or concerns about the study, and also some places you can go if you feel like you need to talk to someone about any of the issues we talked about today, or anything else.*

Appendix C



University  
of Windsor

**CONSENT FOR AUDIO TAPING**

Research Participant Name:

Title of the Project: Dealing with stressful situations

I consent to the audio-taping of interviews.

I understand this is a voluntary procedure and that I am free to withdraw at any time by requesting that the taping be stopped. I also understand that my name will not be revealed to anyone and that taping will be kept confidential. Tapes are filed by number only and store in a locked cabinet.

The destruction of the audio tapes will be completed after transcription and verification.

I understand that confidentiality will be respected and that the audio tape will be for professional use only.

---

(Signature of Guardian)

---

(Date)

---

(Research Participant)

---

(Date)

## Appendix D



### CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: *Dealing with stressful situations*

You are asked to participate in a research study conducted by Emily Johnson and Dr. Rosanne Menna, from the Psychology department at the University of Windsor. Results of this research study will be used to complete a Master's thesis.

If you have any questions or concerns about the research, please feel to contact Emily Johnson at email address or 519-253-3000 ext. XXXX, or Dr. Rosanne Menna at 519-253-3000, ext. XXXX.

#### PURPOSE OF THE STUDY

The purpose of the study is to examine recent stressful life events, distressing situations, and coping of adolescents living in foster care.

#### PROCEDURES

If you volunteer to participate in this study, you will be asked to:

First, complete a short questionnaire, which asks questions about you and your current and past foster homes. This questionnaire should take no more than 10 minutes to complete.

Second, you will be asked to complete a one-on-one, in-person interview with the researcher. This interview should last between 1 and 1.5 hours. It will include questions about stressful experiences or difficult times you or a friend have had, what you or your friend did to cope during these times, and people who you or your friend talked to during these times. The interview will be audio recorded so that it may be transcribed by the interviewer or a trained research assistant at a later time.

#### POTENTIAL RISKS AND DISCOMFORTS



The questions asked during the interview may be personal in nature, and refer to stressful or difficult times in your life. A risk of this study is the possibility that talking or thinking about these difficult times may cause some emotional discomfort. You have the right to withdraw from this study and discontinue your participation at any time. You also have the right to choose not to answer any questions on the questionnaire or in the interview. Your choice to withdraw or skip any questions will be respected by the researcher. If you have any concerns, you may contact the principal investigator, Emily Johnson, the faculty supervisor, Dr. Rosanne Menna, or any of the resources listed on the information sheet provided at the end of the study.

#### POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Participation in this research will allow you to learn about and be a part of a psychological research study. You may also learn more about yourself, and the way you have dealt with stressful situations in the past, or may deal with them in the future. Participation in this research will also contribute to scientific knowledge about the experiences of youth in foster care.

#### COMPENSATION FOR PARTICIPATION

You will be compensated with a \$20 gift card to Tim Horton's restaurant for your participation.

#### CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. All information that you share will be confidential, with the exception of any information that indicates that there is any risk to you, or to any other person.

Any personal identifying information will be stored separately from the audiotapes and transcriptions of your interview, and your questionnaire data. When interviews are transcribed, all names will be changed. Your data will be kept in a locked cabinet and in a password protected file. Only the primary investigator, faculty supervisor, and trained research assistant will have access to this data. Any quotes from your interview used in reporting the results of the study will not contain any identifying information.

It is your right to review or edit the audio tape of your interview should you wish to do so. Audio tapes of the interviews will be safely destroyed after the completion of this study. Your questionnaire data and the transcription of your interview will be securely destroyed ten years after the completion of the study.

#### PARTICIPATION AND WITHDRAWAL

You may withdraw from this study at any point, without consequence. The investigator may withdraw you from this research if circumstances arise which warrant doing so. Withdrawal from this study will not impact any service you currently receive, or any services that you may receive in the future. Your decision to withdraw from the study will be confidential. You will receive a \$20 gift card to Tim Horton's restaurant, regardless of your decision to complete the entire study.

#### FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

A summary of research findings is anticipated to be available by October 2014. This summary can be found at [www.uwindsor.ca/reb](http://www.uwindsor.ca/reb).

#### SUBSEQUENT USE OF DATA

These data may be used in subsequent studies, in publications and in presentations.

#### RIGHTS OF RESEARCH PARTICIPANTS

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. You may withdraw your consent at any time and discontinue participation without penalty.

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario, N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: [ethics@uwindsor.ca](mailto:ethics@uwindsor.ca)

#### SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I understand the information provided for the study **Dealing with stressful situations** as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

#### SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

## Appendix E



### LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH

Title of Study: **Dealing with stressful situations**

You are asked to participate in a research study conducted by Emily Johnson and Dr. Rosanne Menna, from the Psychology department at the University of Windsor. Results of this research study will be used to complete a Master's thesis.

If you have any questions or concerns about the research, please feel to contact Emily Johnson at email address or 519-253-3000 ext. XXXX, or Dr. Rosanne Menna at 519-253-3000, ext. XXXX.

#### PURPOSE OF THE STUDY

The purpose of the study is to examine recent stressful life events, distressing situations, and coping of adolescents living in foster care.

#### PROCEDURES

If you volunteer to participate in this study, you will be asked to:

First, complete a short questionnaire, which asks questions about you and your current and past foster homes. This questionnaire should take no more than 10 minutes to complete.

Second, you will be asked to complete a one-on-one, in-person interview with the researcher. This interview should last between 1 and 1.5 hours. It will include questions about stressful experiences or difficult times you or a friend have had, what you or your friend did to cope during these times, and people who you or your friend talked to during these times. The interview will be audio recorded so that it may be transcribed by the interviewer or a trained research assistant at a later time.

#### POTENTIAL RISKS AND DISCOMFORTS

The questions asked during the interview may be personal in nature, and refer to stressful or difficult times in your life. A risk of this study is the possibility that talking or thinking about these difficult times may cause some emotional discomfort. You have the right to withdraw from this study and discontinue your participation at any time. You also have the right to choose not to answer any questions on the questionnaire or in the interview. Your choice to withdraw or skip any questions will be respected by the researcher. If you have any concerns, you may contact the principal investigator, Emily Johnson, the faculty supervisor, Dr. Rosanne Menna, or any of the resources listed on the information sheet provided at the end of the study.

#### POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Participation in this research will allow you to learn about and be a part of a psychological research study. You may also learn more about yourself, and the way you have dealt with stressful situations in the past, or may deal with them in the future. Participation in this research will also contribute to scientific knowledge about the experiences of youth in foster care.

#### COMPENSATION FOR PARTICIPATION

You will be compensated with a \$20 gift card to Tim Horton's restaurant for your participation.

#### CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. All information that you share will be confidential, with the exception of any information that indicates that there is any risk to you, or to any other person.

Any personal identifying information will be stored separately from the audiotapes and transcriptions of your interview, and your questionnaire data. When interviews are transcribed, all names will be changed. Your data will be kept in a locked cabinet and in a password protected file. Only the primary investigator, faculty supervisor, and trained research assistant will have access to this data. Any quotes from your interview used in reporting the results of the study will not contain any identifying information.

It is your right to review or edit the audiotape of your interview should you wish to do so. Audiotapes of the interviews will be safely destroyed after the completion of this study. Your questionnaire data and the transcription of your interview will be securely destroyed ten years after the completion of the study.

## PARTICIPATION AND WITHDRAWAL

You may withdraw from this study at any point, without consequence. The investigator may withdraw you from this research if circumstances arise which warrant doing so. Withdrawal from this study will not impact any service you currently receive, or any services that you may receive in the future. Your decision to withdraw from the study will be confidential. You will receive a \$20 gift card to Tim Horton's restaurant, regardless of your decision to complete the entire study.

## FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

A summary of research findings is anticipated to be available by October 2014. This summary can be found at [www.uwindsor.ca/reb](http://www.uwindsor.ca/reb).

## SUBSEQUENT USE OF DATA

These data may be used in subsequent studies, in publications and in presentations.

## RIGHTS OF RESEARCH PARTICIPANTS

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. You may withdraw your consent at any time and discontinue participation without penalty.

If you have questions regarding your rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: [ethics@uwindsor.ca](mailto:ethics@uwindsor.ca)

## SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

---

Signature of Investigator

---

Date

## Appendix F



### CONSENT TO PARTICIPATE IN RESEARCH – GUARDIAN

Title of Study: **Dealing with stressful situations**

A child under your care, \_\_\_\_\_ is asked to participate in a research study conducted by Emily Johnson and Dr. Rosanne Menna, from the Psychology department at the University of Windsor. Results of this research study will be used to complete a Master's thesis.

If you have any questions or concerns about the research, please feel to contact Emily Johnson at email address or 519-253-3000 ext. XXXX, or Dr. Rosanne Menna at 519-253-3000, ext. XXXX.

#### PURPOSE OF THE STUDY

The purpose of the study is to examine recent stressful life events, distressing situations, and coping of adolescents living in foster care.

#### PROCEDURES

If your child volunteers to participate in this study, she or he will be asked to:

First, complete a short questionnaire, which asks questions about the child and his or her current and past foster homes. This questionnaire should take no more than 10 minutes to complete.

Second, your child will be asked to complete a one-on-one, in-person interview with the researcher. This interview should last between 1 and 1.5 hours. It will include questions about stressful experiences or difficult times experienced by your child or a friend, what he or she did to cope during these times, and people who he or she talked to during these times. The interview will be audio recorded so that it may be transcribed by the interviewer at a later time.

#### POTENTIAL RISKS AND DISCOMFORTS

The questions asked during the interview may be personal in nature, and refer to stressful or difficult times in the participant's life. A risk of this study is the possibility that talking or thinking about these difficult times may cause some emotional discomfort. Your child has the right to withdraw from this study and discontinue his or her participation at any time. Your child also has the right to choose not to answer any questions on the questionnaire or in the interview. The choice to withdraw or skip any questions will be respected by the researcher.

If you or your child have any concerns, you may contact the principal investigator, Emily Johnson, the faculty supervisor, Dr. Rosanne Menna, or any of the resources listed on the information sheet provided at the end of the study.

#### POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Participation in this research will allow your child to learn about and be a part of a psychological research study. Your child may also learn more about him or herself, and the way he or she has dealt with stressful situations in the past, or may deal with them in the future. Participation in this research will also contribute to scientific knowledge about the experiences of youth in foster care.

#### COMPENSATION FOR PARTICIPATION

Your child will be compensated with a \$20 gift card to Tim Horton's restaurant for their participation.

#### CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with your child will remain confidential and will be disclosed only with their permission. All information that is shared will be confidential, with the exception of any information that indicates that there is any risk to the child, or to any other person.

Any personal identifying information will be stored separately from the audiotapes and transcriptions of the interviews, and questionnaire data. When interviews are transcribed, all names will be changed. All data will be kept in a locked cabinet and in a password protected file. Only the primary investigator, faculty supervisor, and trained research assistant will have access to this data. Any quotes from interviews used in reporting the results of the study will not contain any identifying information.

It is the participant's right to review or edit the audiotape of his or her interview should they wish to do so. Audiotapes of the interviews will be safely destroyed after the completion of this study. Questionnaire data and the transcription of interviews will be securely destroyed ten years after the completion of the study.

#### PARTICIPATION AND WITHDRAWAL

Your child may withdraw from this study at any point, without consequence. The investigator may withdraw any participant from this research if circumstances arise which warrant doing so. Withdrawal from this study will not impact any service your child currently receives, or any services that he or she may receive in the future. The decision to withdraw from the study will be confidential. All participants will receive a \$20 gift card to Tim Horton's restaurant regardless of their decision to complete the entire study.

#### FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

A summary of research findings is anticipated to be available by October 2014. This summary can be found at [www.uwindsor.ca/reb](http://www.uwindsor.ca/reb).

#### SUBSEQUENT USE OF DATA

These data may be used in subsequent studies, in publications and in presentations.

#### RIGHTS OF RESEARCH PARTICIPANTS

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. You may withdraw your consent at any time and discontinue participation without penalty.

If you or your child have questions regarding rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: [ethics@uwindsor.ca](mailto:ethics@uwindsor.ca)

#### SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I understand the information provided for the study **Dealing with stressful situations** as described herein. My questions have been answered to my satisfaction, and I have been given a copy of this form.

I consent to \_\_\_\_\_'s participation in this study.  
(Name of Child)

\_\_\_\_\_  
Name of Guardian

\_\_\_\_\_  
Signature of Guardian

\_\_\_\_\_  
Date



SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

---

Signature of Investigator

---

Date

## Appendix G



### LETTER OF INFORMATION FOR CONSENT TO PARTICIPATE IN RESEARCH - GUARDIAN

Title of Study: **Dealing with stressful situations**

A child under your care, \_\_\_\_\_ is asked to participate in a research study conducted by Emily Johnson and Dr. Rosanne Menna, from the Psychology department at the University of Windsor. Results of this research study will be used to complete a Master's thesis.

If you have any questions or concerns about the research, please feel to contact Emily Johnson at email address or 519-253-3000 ext. XXXX, or Dr. Rosanne Menna at 519-253-3000, ext. XXXX.

#### PURPOSE OF THE STUDY

The purpose of the study is to examine recent stressful life events, distressing situations, and coping of adolescents living in foster care.

#### PROCEDURES

If your child volunteers to participate in this study, she or he will be asked to:

First, complete a short questionnaire, which asks questions about the child and his or her current and past foster homes. This questionnaire should take no more than 10 minutes to complete.

Second, your child will be asked to complete a one-on-one, in-person interview with the researcher. This interview should last between 1 and 1.5 hours. It will include questions about stressful experiences or difficult times experienced by your child or a friend, what he or she did to cope during these times, and people who he or she talked to during these times. The interview will be audio recorded so that it may be transcribed by the interviewer at a later time.

#### POTENTIAL RISKS AND DISCOMFORTS

The questions asked during the interview may be personal in nature, and refer to stressful or difficult times in the participant's life. A risk of this study is the possibility that talking or thinking about these difficult times may cause some emotional discomfort. Your child has the right to withdraw from this study and discontinue his or her participation at any time. Your child also has the right to choose not to answer any questions on the questionnaire or in the interview. The choice to withdraw or skip any questions will be respected by the researcher.

If you or your child have any concerns, you may contact the principal investigator, Emily Johnson, the faculty supervisor, Dr. Rosanne Menna, or any of the resources listed on the information sheet provided at the end of the study.

#### POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Participation in this research will allow your child to learn about and be a part of a psychological research study. Your child may also learn more about him or herself, and the way he or she has dealt with stressful situations in the past, or may deal with them in the future. Participation in this research will also contribute to scientific knowledge about the experiences of youth in foster care.

#### COMPENSATION FOR PARTICIPATION

Your child will be compensated with a \$20 gift card to Tim Horton's restaurant for your participation.

#### CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with your child will remain confidential and will be disclosed only with their permission. All information that is shared will be confidential, with the exception of any information that indicates that there is any risk to the child, or to any other person.

Any personal identifying information will be stored separately from the audiotapes and transcriptions of the interviews, and questionnaire data. When interviews are transcribed, all names will be changed. All data will be kept in a locked cabinet and in a password protected file. Only the primary investigator, faculty supervisor, and trained research assistant will have access to this data. Any quotes from interviews used in reporting the results of the study will not contain any identifying information.

It is the participant's right to review or edit the audiotape of his or her interview should they wish to do so. Audiotapes of the interviews will be safely destroyed after the

completion of this study. Questionnaire data and the transcription of interviews will be securely destroyed ten years after the completion of the study.

#### PARTICIPATION AND WITHDRAWAL

Your child may withdraw from this study at any point, without consequence. The investigator may withdraw any participant from this research if circumstances arise which warrant doing so. Withdrawal from this study will not impact any service your child currently receives, or any services that he or she may receive in the future. The decision to withdraw from the study will be confidential. Participants will receive a \$20 gift card to Tim Horton's restaurant regardless of their decision to complete the entire study.

#### FEEDBACK OF THE RESULTS OF THIS STUDY TO THE PARTICIPANTS

A summary of research findings is anticipated to be available by October 2014. This summary can be found at [www.uwindsor.ca/reb](http://www.uwindsor.ca/reb).

#### SUBSEQUENT USE OF DATA

These data may be used in subsequent studies, in publications and in presentations.

#### RIGHTS OF RESEARCH PARTICIPANTS

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. You may withdraw your consent at any time and discontinue participation without penalty.

If you or your child have questions regarding rights as a research participant, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario N9B 3P4; Telephone: 519-253-3000, ext. 3948; e-mail: [ethics@uwindsor.ca](mailto:ethics@uwindsor.ca)

#### SIGNATURE OF INVESTIGATOR

These are the terms under which I will conduct research.

---

Signature of Investigator

---

Date

## Appendix H



University  
of Windsor

### POST-STUDY INFORMATION AND RESOURCES

Thank you for participating in this study about dealing with stress. Your time and participation is greatly appreciated!

If you have any questions or concerns about the research, please feel to contact Emily Johnson at [email address](#) or 519-253-3000 ext. XXXX, or Dr. Rosanne Menna at 519-253-3000, ext. XXXX.

If you wish to talk to someone about any of the issues we discussed today, please do not hesitate to contact someone at one of the following places:

#### **Windsor Teen Health Centre**

Telephone: 519-253-8481

Website: <http://windsorsexsex.cioc.ca/record/WIN1304>

#### **Kids Help Phone**

Telephone: 1-800-668-6868

Website: [www.kidshelpphone.ca](http://www.kidshelpphone.ca)

#### **Distress Centre – Windsor-Essex County**

Telephone: 519-256-5000

Website: [www.dcwindsor.com](http://www.dcwindsor.com)

#### **Canadian Mental Health Association, Windsor**

Telephone: 519-255-7440

Website: [www.cmha-wecb.on.ca](http://www.cmha-wecb.on.ca)

#### **The Bulimia Anorexia Nervosa Association, Windsor**

Telephone: 519-969-2112

Website: [www.bana.ca](http://www.bana.ca)

#### **Hiatus House**

Telephone: (519) 252-7781

Website: [www.hiatushouse.com](http://www.hiatushouse.com)

**Sexual Assault Crisis Centre Windsor**

Telephone: 519-253-3000

Website: [www.saccwindsor.net](http://www.saccwindsor.net)

**Windsor Regional Hospital Crisis Line**

Telephone: 519-973-4435 (24 hours)

24 Hour Walk-In Services:

Hotel Dieu Grace Hospital Emergency Department

1030 Ouellette Ave (Goyeau St. Entrance)

**Appendix I**  
Recruitment Flyers



**PARTICIPANTS NEEDED!**

My name is Emily Johnson and I am a student at the University of Windsor. I am looking for participants in my research study on dealing with stressful situations. I would like to interview you about this topic.

If:

You are between 13 and 19 years old and *currently living in a foster home, or you have previously lived in a foster home*, you can participate!

**You will receive a \$20 gift card for your time and efforts!**

If you would like to take part in this study, please contact me at email address OR 519-253-3000 ext. XXXX

THANK YOU for reading this! I look forward to hearing from you!

---

Stress and Coping Study  
Emily:  
Stress and Coping Study  
Emily:  
Stress and Coping Study  
Emily:  
Stress and Coping Study  
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Stress and Coping Study  
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Emily:  
Stress and Coping Study  
Emily:

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This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board.



University  
of Windsor

**PARTICIPANTS NEEDED!**

My name is Emily Johnson and I am a student at the University of Windsor. I am looking for participants in my research study on dealing with stressful situations.

If:

You are between 13 and 19 years old and *currently living in a foster home*, or you *have previously lived in a foster home*, you can participate!

**Youth will receive a \$20 gift card for their time and efforts!**

If you would like to take part in this study, please contact me at email address OR 519-253-3000 ext. XXXX

THANK YOU for your interest! I look forward to hearing from you!

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board.



## Appendix J

### Study Information Emails

Hello,

My name is Emily Johnson, and I am a master's student in the child clinical psychology program at the University of Windsor. For my thesis, I am conducting a study about dealing with stressful situations and help-seeking behaviours in youth who are Crown Wards.

I hope to interview youth who are 13 to 17 years old. I will need to explain the study to you in person and obtain your consent for the youth's participation, in addition to their consent. This means I will need to meet with you before the interview, or you can be present at the interview. Interviews can be confidential between the youth and me - or if they prefer, you can be present during the interview as well. This will take place at the CAS office, and I anticipate the whole process taking 1.5 to 2 hours. The youth will be provided a \$20 gift card for Tim Hortons as a token of my appreciation.

I hope that the results of my study will help us to understand the unique experiences of these youth, and how to work with them through difficult times.

I have attached a script that you can read to any youth who are interested, to give them more information. I have also attached a flyer with study information.

You can reach me at [email](#) or 519-253-3000 ext. XXXX. I am happy to answer any of your questions!

Thank you for your time.

Emily

Hello,

My name is Emily Johnson, and I am a master's student in the child clinical psychology program at the University of Windsor. For my thesis, I am conducting a study about dealing with stressful situations and help-seeking behaviours in youth who are, or were previously, crown wards.

*I am looking to interview individuals who are 18 and 19 years old, who previously had crown ward status. Interviews will take place at the CAS office, and I anticipate the*

*whole process taking 1.5 hours. Participants will be provided a \$20 gift card for Tim Hortons as a token of my appreciation.*

Interviews will be confidential, with parameters for safety. The individuals will be provided full study information and will be asked to sign a consent form prior to the interview. This project has received clearance from the research ethics board at the university and at CAS. I hope that the results of my study will help us to understand the unique experiences of youth in foster care, and how to work with them through difficult times.

**Individuals interested in participating in the study can reach me at email or 519-253-3000 ext. XXXX.**

I am happy to answer any questions!

Thank you for your time.

Emily

## Appendix K

### Recruitment Script for CAS Workers



#### Recruitment Script

A student at the university is looking for participants in her research study. She is a psychology student working on her masters' degree. She is looking to interview people your age about any stressful periods or experiences you may have had in the past six months to one year, and how you dealt with those stressful times. You would meet with her, and fill out a short questionnaire and then do the interview, and this whole meeting would take about 1.5 to 2 hours total. This meeting for the study can be just you and Emily, the researcher, without me in the room, or I can be there. It's up to you. All of your answers to her questions would be confidential, so the only people who would know what you said would be you and Emily, and maybe her research supervisor (and me if I'm there too). The only thing she would potentially tell me, and her research supervisor, is if you disclose to her that you want to hurt yourself or another person, or if someone is currently physically hurting you.

I will have to sign off for your participation, and I can arrange a time for you to meet with Emily.

Emily will meet you at the CAS office, at a time that's easy for you and me. She will give you a \$20 gift card to Tim Horton's as a token of her appreciation for your time. She is doing this study because she is interested in learning about how people your age deal with stressful times. She is hoping to get a better understanding of this, so that more people can learn from this research about the experiences of people your age.

If you are interested in participating, I can contact her to let her know that you are interested and arrange a time. You can think about it and get back to me if you like. It's important that you know that your decision to participate or not to participate won't affect your relationship with me, and it won't change any of the services you currently receive. There is no pressure to participate, I'm just passing along this information, so that you can participate if you wish to.

If you think you might be interested, maybe you could start thinking about some potential times that would work for you to meet with Emily so that a meeting can be arranged.

*(If youth is unsure) If you're not sure, that's alright. If you have more questions before you decide if you want to participate, Emily would be happy to talk to you more about the study to answer any questions. If you think you need some time to think about it, or you think right now isn't a good time, but maybe later might be, that's alright too.*

*(If youth is not interested) That's alright. If you change your mind you can always let me know or contact Emily later on, too.*

Emily's contact information:

email

519-253-3000 ext. XXXX

## VITA AUCTORIS

Emily Marie Johnson was born in 1988 in London, Ontario and raised in Cochrane, Ontario. She graduated from Ecole Secondaire Cochrane High School in 2006. She then attended the University of Western Ontario in London, Ontario, where she obtained a Bachelor of Arts with Honours Specialization in Psychology and a minor in Linguistics in 2011. She is currently an M.A. candidate in the Child Clinical Psychology program at the University of Windsor, and will be graduating in 2014.