To the Graduate Council:

I am submitting herewith a thesis written by Keith Allen Bailey entitled "Multiple Relocations and Adolescents in Out-of-Home Care." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a Major in Child and Family Studies.

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Cheryl Buehler, Ph.D., Major Professor

We have read this thesis and recommend its acceptance:

Accepted for the Council:

Interim Vice Provost and Dean of the Graduate School

MULTIPLE RELOCATIONS AND ADOLESCENTS IN OUT-OF-HOME CARE

A Thesis
Presented for the
Master of Science
Degree
The University of Tennessee, Knoxville

Keith Allen Bailey
May 2001

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DEDICATION

This study is dedicated to the children in out-of-home placements, who have endured so much and who still must endure what we offer them in the name of "therapeutic care."

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First of all, I would like to thank all the young men who took the time to participate in this study. I am grateful to many of the staff of Holston United Methodist Home for Children who helped me with this study, especially to those case managers who helped to secure so may parental consents. Also, I would like to thank Dr. Cheryl Buehler, my major professor, for her patient guidance through this process. I also very much appreciate the input from the other members of my thesis committee, Dr. John Orme and Dr. Mick Nordquist.

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ABSTRACT

Children in out-of-home care often experience multiple relocations while in the system of care. This study examined the impact of these multiple relocations on the self-esteem, locus of control, sense of safety, and behavioral problems of 60 adolescent males, age 12-18 years, in the treatment programs of a child care agency located in East Tennessee.

The youth were asked how may placements they had been in while in out-of-home care. Hierarchical multiple regression was used to assess the relationship between these numbers of placements and the subjects' scores on the Self-Esteem Inventory, the Self-Esteem Scale, the Nowicki-Strickland Internal-External Control Scale for Children, the Mastery Scale, the Sense of Safety Scale (developed for this study by the author), and the Child Behavior Checklist Youth Self-Report, while controlling for the youths' age, race, present level of care, and time at present placement.

The hypothesis, that adolescents in out-of-home care who have experienced more moves while in out-of-home care will have lower self-esteem, less of an internal locus of control, lower of a sense of safety, and more behavioral problems than adolescents with fewer moves while in out-of-home care, however, was not supported by the findings. Implications for further research and improved practices in the care of children in out-of-home placements are discussed.

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I. Introduction

Children are placed in out-of-home care for a variety of reasons, including abuse and neglect in the home, delinquency, the death of their parents, and the surrendering of parental rights. While in care, the child-care system is supposed to provide a safe, secure, and therapeutic environment. Such an environment should allow them to cope with the stresses and heal from the traumas that they have experienced when taken from their homes. However, the system of care often can circumvent the essential nature of this safe and nurturing environment because of the many factors related to taking care of vast numbers of children and in facing the difficult behaviors that many of these children exhibit. This study will look at one of the factors that can have a negative impact on children in out-of-home care, namely, multiple relocations.

II. Review of Literature

It is estimated that there are almost one million children in the custody of state agencies with as many as 700,000 of these being in out-of-home placements (see Glisson, 1996; Glisson & Hemmelgarn, 1997). Many researchers have used the term "foster care" to denote various forms of out-of-home care. However, "foster care" can be used in a very specific way to indicate various levels of therapeutic and custodial care that take place within family homes, both kin and non-kin. For the purpose of this study, "out-of-home care" will be used to denote various levels of therapeutic and custodial care that take place outside a child's biological home of origin or original adoptive home. These places of care can include: family foster homes, emergency shelters, residential care facilities, group homes, psychiatric hospitals, assessment centers, youth detention centers (short and long term), independent living programs, and wilderness programs.

While in such care, for as little as a few days or for as long as several years, children often are moved from placement to placement. Olsen (1982) found that the average number of moves was 3 with a range of 1 to 21. Information gained in focus groups conducted by this author with 19 adolescents who were in residential treatment or family foster care showed them having experienced an average of 9.5 moves, with a range of 2 to 35. (These data are based solely on the youths' reports.) This follows more closely with Taber and Proch's (1987) study of a sample of 51 youth in out-of-home care who had experienced an average of 9 moves with a range of 1 to 33. Several studies have assessed stability of placement and permanency of placement issues related to children in out-of-home care in order to analyze the factors contributing to the movement of children

between placements (Fein, Davies, & Knight, 1979; Fein, Maluccio, Hamilton, & Ward, 1983; Lahti, 1982; Olsen, 1982; Palmer, 1979; Pardeck, 1984; Staff & Fein, 1995; Tabor & Proch, 1987). Other studies have shown that relocations are stressful for children in general (Donohue & Gullotta, 1983; Newcomb, Huba, & Bentler, 1981, 1986; Raviv, Keinan, Abazon, & Raviv, 1990; and, Vernberg, Ewell, Beery, & Abwender, 1994). However, there is a tremendous lack of information on the impact of multiple relocations on children in out-of-home care.

Lahti (1982), in a program evaluation study of services provided to foster children, found that number of placements and time in care did not negatively effect the children's sense of well-being. However, this study had a limited scope in how "number of placements" was assessed. Although, this study did not specify what it meant by foster care, it appears that the study was conducted with subjects who resided in family foster homes, and the only movement that was tracked during the study was that of changing from one foster home to another and moving from a foster home to a permanent home. The movement histories of the children, all of whom were under 12 years of age, were not considered.

Some studies have talked in general terms about how multiple moves between placements negatively impact children in the areas of mastering developmental tasks, achieving permanency goals (Tabor & Proch, 1987) and developing a sense of belonging (Fein, Davies, & Knight, 1979). However, there is little empirical data on how multiple moves actually affect children in out-of-home care. This study will examine how multiple relocations might have a negative impact on these children by compromising child

adjustment - their self-esteem, internal locus of control, sense of safety, and behavioral and emotional adjustment, all of which are essential attributes for children to benefit from the therapeutic environment and process.

Self-Esteem

Chubb and Fertman (1997) used Harter's definition of self-esteem as being "'how much a person likes, accepts, and respects himself [sic] overall as a person'" (p.114). They cited studies on adolescents that formed a correspondence between adolescent low self-esteem and low life-satisfaction, loneliness, anxiety, resentment, irritability, and depression. High self-esteem correlated positively with academic success, internal locus of control, and a positive sense of self-attractiveness.

In looking at the impact of group psychotherapy as a therapeutic technique in treating children and adolescents in residential treatment, Winek and Faulkner (1994) stated that in addition to the children and adolescents being labeled with psychopathologies ranging from borderline personality, depression, and hyperactive to antisocial and psychotic, all share an impairment to their ego development and low self-esteem. Gardner (1971) believed that all psychopathological symptomology "contain attempts to compensate for low self-esteem" (p. 516) and went so far to say that "'one of the purposes of treatment is to enhance the patient's self esteem because low self-esteem is at the root of practically every psychogenic problem'" (in Winek & Faulkner, 1994, p. 119).

Children in out-of-home care can suffer bouts of depression due to the traumas of abuse and neglect experienced in their homes or from being separated from their families

and familiar environments. In a study comparing 15 clinically depressed adolescents to 15 "somewhat depressed" and 15 "non-depressed" adolescents, it was found that the clinically depressed group had significantly lower self-esteem than did the other two groups (Hammond & Romney, 1995). Kazdin, Mosure, Colbus, and Bell (1985) found that physically abused children showed more depression and lower self-esteem than did non-abused children. Other studies showed that children in out-of-home care have lower self-esteem than do children in comparative groups (Kools, 1997; Maxwell, 1992; Simmons & Weinman, 1991).

Most residential treatment programs have increasing the self-esteem of their residents as either a specific treatment component in its therapeutic milieu or as an underlying theme of its treatment philosophy. However, there have been mixed results in recent findings as to whether these programs and philosophies actually work in a measurable and perceivable way (Fertman & Chubb, 1992; Miller, 1990; Ogier & Hornby, 1996; Valliant, 1993; Winek & Faulkner, 1994).

Locus of Control

Chubb and Fertman (1992) defined locus of control as: "... the generalized expectance of reinforcement as either internal or external to the self. Internal locus of control is defined as the expectation that reinforcement will be the result of one's own effort, ability, characteristics, or behavior. External locus of control is the expectation that reinforcement will be the result of chance, fate, luck, or powerful others" (p.389). They cited studies showing that an internal locus of control correlates with such outcomes as staying in high school, taking responsibility for one's own actions, being more

independent, exhibiting greater self-control, reduced anxiety, the ability to defer gratification, and positive adjustment in relationships. Lefcourt (1982) examined numerous empirical studies and field observations that showed how an internal locus of control, whether real or perceived, moderated the effects of various stressful and adverse experiences by giving people a sense of control over or power within the stressful and adverse situations.

McIntyre (1991) found that adolescents in foster care had a more external locus of control than did those raised in their own homes, when controlling for verbal IQ. In looking at the relation between peer rejection and internalizing problem behaviors for children in foster care, McIntyre, Lounsbury, Berntson, and Steel (1988) suggested that such behaviors "may be an emotional manifestation of vulnerability to events beyond one's (felt) control" (p.135). One study of adolescents in a youth emergency shelter found that they have a more external locus of control when compared to other groups (Simmons & Weinman, 1991). Similarly, another study of clinically depressed adolescents found that they have a more external locus of control than non-depressed and "somewhat depressed" adolescents (Hammond & Romney, 1995). An earlier study of adolescents in a psychiatric residential treatment program showed that internal locus of control and severity of psychiatric illness are negatively correlated, controlling for age and length of treatment (Friedman, Goodrich, & Fullerton, 1985).

A study by Kliewer and Sandler (1992) supported moderating effects of an internal locus of control. It consisted of 238 children (40% girls), aged 8 to 16, and compared a group who had experienced a parental divorce or who had chronic asthma with those who

were considered as a "nonstressed" group. The children were assessed for negative life events, locus of control, self-esteem, and for psychological symptoms. A more internal locus of control moderated the effects of life stressors on psychological symptoms, with children who had more internal locus of control showing higher self-esteem and less psychological symptoms.

One goal of most therapeutic programs is to bring about an increase in a more internal locus of control (Deiker & Matson, 1979). Yet like the findings mentioned above for self-esteem, programs aimed at helping children and adolescents develop a more internal locus of control have had mixed results (Deiker & Matson, 1979; Fertman & Chubb, 1992; Gold & Coghlan, 1976).

Sense of Safety

There is very little information in the literature from any discipline about children's perceived sense of safety. Maslow's (1970) theoretical model of human needs and motivation holds that human beings must have physiological needs and then safety needs met, respectively, if they are to progress up the hierarchy of needs to self-actualization. Gnagey (1980) examined changes in student motivational structure during adolescence and found that the students sampled actually rated safety needs before those of physiological needs. However, the issue of a child's sense of safety is not well addressed in the foster care literature. In one of the only studies to deal with this issue, Berrick (1997), in assessing the quality of kinship and family foster care placements, made a cursory exploration of the safety of the physical environment of 62 homes where children

were placed, yet asked only the foster parents about their own sense of physical safety in the homes.

In caring for children in residential placements, Caldwell and Rejino (1993) stated that the first goal of care is to make sure that "the child will reside in a protected, safe environment" (p.50). They listed the critical factors for a safe environment of care as administrative understanding and commitment, environmental (physical, policy, and protocol) factors, staff attitudes, clinical factors, and investigatory and incidental review process. They conclude that "[o]nce each child is safeguarded, the therapeutic program can focus on other goals that enable a true healing process" (p.57).

Although the physical safety of children's care environments and their sense of physical safety is important, their sense of psychoemotional safety also is important. However, there is little, if any, information in the literature about this specific domain of children's sense of safety. Overall, the concept of "sense of safety" for children in out-of-home care can be defined as a sense of psychoemotional and physical safety that is held both globally and in relating to specific people, places and situations while in an out-of-home care setting.

Behavioral Adjustment/Problems

Children placed in out-of-home care often exhibit behavioral problems and have significant mental health issues. A study by Heflinger, Simpkins, and Combs-Orme (2000) on the use of the Child Behavior Checklist to assess the clinical status of children in state custody found that an estimated 34 percent of children in Tennessee state custody had significant behavior problems. However, they write that these results likely under-

represent the amount of mental health problems in the population of children in state custody. In their review of the literature on the rate of mental health problems for children in out-of-home care, they conclude that "... a number of studies have confirmed that foster children have more mental health problems than the general population based on indications in agency records and clinical judgment and interviews ... service utilization data ... and various standardized measures" (p.56).

Such mental health and behavioral problems can result from family instability, trauma of separation from birth parents, abuse, neglect, reaction to being in out-of –home care, genetic causes, or any combination of these factors (Cantos, Gries, & Slis, 1995; Pugh et al., 1997). Those placed in psychiatric hospitals, residential treatment facilities, and therapeutic foster homes are placed there primarily for the management and treatment of such behavioral problems, including aggression, violence, disruptive and bizarre actions, delinquency, drug abuse, school problems, run-aways, social withdrawal, depression, and other mental health issues (Cantos, Gries, & Slis, 1995; Davis & Boster, 1993; Forand, 1999; Larson, Calamari, West, & Frevert, 1998; Pugh, et al, 1997; Seelow, 1993; Zimmerman, 1990). In short, these children are labeled as having emotional and behavior disturbances (Reddy & Pfeiffer, 1997). Such disturbances also can be the result of trauma caused by the experiences in out-of-home care placement settings, including multiple placements (Cantos, Gries, & Slis, 1996).

III. Hypothesis

Some of the therapeutic goals of having children in out-of -home care include that their self-esteem will be boosted and their locus of control will become more internalized so that they can work through their problems and clinical issues by being enabled to help "heal" themselves. It also is a fundamental goal that these children feel safe, both physically and psychoemotionally. As these and other goals are met, it is expected that their behavioral problems will decrease in number and severity. It is anticipated that multiple moves while in the child-care system will hinder these therapeutic goals, and **it is hypothesized that adolescents in out-of-home care who have experienced more moves while in out-of-home care will have lower self-esteem, less of an internal locus of control, lower of a sense of safety, and more behavioral problems than adolescents with fewer moves while in out-of-home care.**

IV. Method

Sampling

Criteria and Procedures

The sample was a purposive sample of adolescent males who were in out-of-home care in the family foster care, residential, group home, and independent living programs of Holston United Methodist Home for Children (HUMHC) in Greeneville, TN. The use of these subjects for this research was approved by the Institutional Review Board of the University of Tennessee, Knoxville, by the Human Rights Committee of HUMHC, and by Art Masker, President/CEO of HUMHC (Appendix A). Because HUMHC is accredited by the Council on Accreditation of Services for Families and Children, Inc., parental consent had to be obtained to use the data submitted by the subjects who were under the age of 18 years old (Appendix B).

A power analysis was conducted to estimate the number of subjects needed to conduct this study. This analysis indicated that a sample size of 60 was needed given an R^2 of .30 for the control variables and .09 for the number of relocations per year variable (effect sizes approximated). The Type I error was set at $p < .05$.. The power of this test was .81.

The subjects were recruited on a volunteer basis and received a gift of a two-liter soft drink for their participation after completing the study. In small groups of five to ten, and on an individual basis, the youth were briefed on the nature of the research. Each youth who was willing to be a participant was given an "Informed Assent Request" statement that explained the nature of the research. It was read aloud by the researcher,

who responded to any questions raised by the participants having to do with the research. Each participant who agreed to continue with the study was asked to sign the "Informed Assent" form. This form also was signed by a witness (Appendix B).

Sample Characteristics

Seventy-four (74) youth, all males, were asked to participate in this study, and 73 of the youth consented. One youth dropped out of the study. Data were collected on 72 youth. However, parental consent was not obtained for all the subjects who were legal minors, thus the final sample of for which data were used was 60 ($N = 60$). Youth ranged in age from 12 through 18 years ($M = 15.15$, $SD = 1.62$) with 51 (85%) being European American and 9 (15%) being African American (see Table 3).

Data Collection

The various measurement/assessment instruments were administered and background information was collected in the on-campus school and residential houses of HUMHC (Appendix C). In an individual and private session, the subjects were asked the following background information: number of relocations (moves) while in out-of-home care, time in out-of-home care, age, present level of care, and time at present placement. Instructions for filling out the instruments were read aloud to each individual subject or group of subjects, and the individual instruments were read, question by question, if requested (Appendix D). Breaks while filling out the instruments were allowed as needed.

Each instrument was marked with a number to identify each subject so as to protect the identity of the subjects, and a master list of the names of the subjects and their respective identification numbers were kept by the researcher. After completing the

instruments, the subjects placed them in manila envelopes to be returned to the researcher. The gift was given to the participants at this time.

The completed instruments, the recorded background information, and the master list with the subjects' names and identification numbers are in the researcher's home, under lock and key. The master list is separate from the completed instruments and background information. The data will be stored for up to eight years, in case such research could be used to expand into a doctoral dissertation or used for further research that might be published, and then destroyed in the year 2008.

Measurements

Number of Relocations

"Number of relocations" signifies the number of times that a youth has moved to different placements while in out-of-home care. This denotes moves to foster homes (regular, therapeutic, emergency, and state recognized kin care), residential treatment facilities, group homes, psychiatric hospitals, wilderness programs, emergency shelters, run-away shelters, assessment centers, and detention centers. Moves to placements that are considered to be short term and more custodial than treatment oriented in nature, such as emergency shelters, run-away shelters, assessment centers, and detention centers were included because a stay in such a placement for even a day or a week can have an impact on a child's adjustment while in out-of-home care and beyond. (In some treatment facilities, children are moved to different rooms or different wings of a building, however these "moves" were not counted.) This number was assessed by asking the subjects how many different placements they had been in while in out-of-home care.

The "number of relocations" also was assessed by documenting the number of placements notated in each subject's case history. The correlation between self-reported placements and those recorded in case histories was .52 ($p < .01$). This provides evidence of convergent validity for the self-reported number of placements. In the case histories, however, it was found that much of the documentation of placements, when compared to the self-reports, reflected only longer-term placements in residential treatment facilities, psychiatric hospitals, and foster homes. Short term stays in emergency or run-away shelters, foster homes, and detention centers often were not recorded. Thus there appears to be a consistent, systematic bias in the lack of reporting these shorter term, non-treatment oriented placement.

Self-Esteem

Self-esteem was measured by using the Coopersmith Self-Esteem Inventory (SEI) and Rosenberg's Self-Esteem Scale (SES). The SEI was described by Blascovich and Tomaka (1991) as being a 58-item scale with a "like me" or "unlike me" response format to assess self-esteem in the areas of peers, parents, school, and personal interests. Higher scores denote higher self-esteem. An eight-item subscale, called the Lie Scale measures the subject's defensiveness. The original scale was developed using samples of fifth and sixth grade children and another sample of children (no ages specified) in a public school setting.

Reliability coefficients for this instrument have been reported at .90 for split-half reliability, with alphas ranging from .75-.83 (for the 25-item version). Test-retest reliability has was .88 for a five-week span. Convergent validity has been established with

correlations of .44 with self-reports of self-esteem and .50 with interviews and with a range of .41 to .75 for various other scales and measures (see Blascovich & Tomaka, 1991).

Finally, Blascovich and Tomaka commented that there are several problems with this scale. Namely, it correlates highly with social desirability and is negatively skewed, with most people scoring above the mean. Also, it does not account for the multi-dimensionality of self-esteem and lacks face validity for many items. However, several studies on children in out-of-home care have used the SEI, and its use could help in comparing this to other studies. Cronbach's alpha for this sample was .88 ($\underline{n}$ = 56) for the 50 items of the main scale and .55 ($\underline{n}$ = 59) for the 8-item "Lie" subscale.

Blascovich and Tomaka (1991) described the Self-Esteem Scale (SES), developed by Rosenberg (1965) as a measure that assesses adolescents' global feelings of self-worth or self-acceptance. It is a ten-item scale that uses a four-point response format, ranging from "strongly agree" to "strongly disagree." Scores range from 10 to 40, with higher scores representing higher self-esteem. It was originally developed using 5024 high school juniors and seniors from ten New York State high schools.

The reliability for this scale was moderately high, with Cronbach alpha ranging from .77 to .88. Test-retest correlations were .85 for 28 subjects after two weeks and .82 for 259 males and females after one week. Convergent validity has been established at a correlation of .65 with confidence, of .72 with the Lerner Self-Esteem Scale, of .55 with the Coopersmith SEI, and of .78 with general self-regard. Inverse corollary relationships have been found with anxiety at -.64 and with depression at -.54. Discriminant validity

was been established by finding no significant correlations with grade point averages (.10), locus of control (-.04), gender (.10) and age (.01). Blaskovich and Tomaka comment that the SES has had widespread use as a unidimensional measure of self-esteem and often is used to evaluate other measures. However, one drawback is that social desirability is not factored out by this instrument. Cronbach's alpha for this sample was .78 ($\underline{n} = 60$).

Locus of Control

Locus of control was measured by administering two different instruments. The first is the Nowicki-Strickland Internal-External Control Scale for Children (CNSIE), a 40-item test having a "Yes-No" response to measure a child's sense of internal versus external control. A higher score indicates a more internal sense of control and a lower score indicates a more external sense of control.

Lefcourt (1991) stated that internal consistency using the Spearman-Brown split-half reliability correlation ranged from .63 to .81, whereas Cronbach's alpha for various samples ranged from .64 to .91. Test-retest reliabilities ranged from .76 at five weeks and .63 at nine months to .52 over a year. Convergent validity was found by moderate correlation with the Intellectual Achievement Responsibility Questionnaire in the I+ category, with the Bailer-Cromwell Scale, and with achievement, measured by the SAT, CTEB, CAT, and grade point average. Nonsignificant relationships have been found with IQ scores and other measure of intelligence. The CNSIE has been used in several studies of children in out-of-home care and would allow for comparisons with these studies of this population. Cronbach's alpha for this sample was .61 ($\underline{n} = 55$).

The second instrument used to measure locus of control is the Mastery Scale, developed by Pearlin and Schooler (1978). Similar to locus of control, Seeman (1991) defined mastery as the "'extent to which one regards one's life-chances as being under one's own control in contrast be being fatalistically ruled'" (p.304). This instrument is a seven-item scale with a four point answer format ranging from "strongly agree" to "strongly disagree" and ranges in scores from 7 (low mastery) to 28 (high mastery). It was developed over two waves of administrations, the first being to 2300 males and females between the ages of 18 and 25 and the second being to 1106 of the original respondents.

Seeman explained that factor analysis was used to establish unidimensionality, with the correlation between the first and second administrations being .33. LISREL procedures were used to show that relationships between constructs and indicators remained stable over time. Convergent validity was established with pairwise correlations with other variables such as: depression, with a range -.43 to-.16; self-esteem, with a range of .54 to .16; and, age, with correlations of -.15 and -.11. He commented that Pearlin and Schooler used this scale in their research on stress and social strain to show that the lack of a sense of mastery, along with a lack of self-esteem, contribute to depression rather than being merely symptoms of it. Cronbach's alpha for this sample was .71 ($\underline{n} = 60$).

Sense of Safety

There are no known instruments available to measure a child's sense of physical and psychoemotional safety, thus the subjects' sense of safety was measured by the Sense

of Safety Scale developed by the author. This scale originally had twenty-two items that assessed physical and psychoemotional safety both globally and in relation to the unique situations and people in an out-of-home care environment, with responses ranging across "always," "most of the time," "some of the time," and "never."

A question-sort (Q-sort), to establish the content validity of this scale, was conducted with a panel of five experienced service providers in the child-care/mental health care field. They included: a child psychiatrist (MD, Board Certified) with 30 years experience; a therapist (MSW, LCSW) with 10 years experience; a therapist (M.Ed., LPC), with 7 years experience; a therapist/director of community based adolescent group homes (MSW, LCSW) with 12 years experience; and, a director of family service programs (MSW, CMSW) with 9 years experience. There were two males and three females.

Each participant, in an individual session, was given an instruction sheet that directed him/or her to place small index cards, each containing a separate item, under three larger index cards which had the headings "Sense of Safety for Children in Residential Care," "Social Anxiety for Children," and "Other." On the larger card with the heading "Sense of Safety for Children in Residential Care" was a conceptual definition that read: "A sense of psychological and physical safety both globally and in relating to specific people, places, and situations in a residential care setting." Similarly, on the card with the heading "Social Anxiety for Children" was a conceptual definition that read: "The affective, cognitive, and behavioral aspects of the a child's sense of anxiety over both negative evaluation and social avoidance (one's willingness to approach others)" (Leary,

1991). The items on the small cards were to be placed under the heading and conceptual definition with which they best fit, and if an item did not fit with either "Sense of Safety for Children in Residential Care" or "Social Anxiety for Children" it was to be placed under the card with the heading of "Other." There were 39 items on the individual small cards: the 22 that comprise the Sense of Safety Scale, the 10 that comprise the Social Anxiety Scale for Children (LaGreca, Dandes, Wick, Shaw, & Stone, !988), and the 7 that comprise the Mastery Scale (Perlin & Schooler, 1978). After each participant completed sorting the items, the author followed up with questions about why items from their respective original scales were placed under different conceptual definitions or under "Other."

Table 1 shows the percent agreement among the participants in placing the items originally from the Sense of Safety Scale with its conceptual definition. Twelve of the original 22 items received 80 percent or above agreement and were kept for the revised Sense of Safety Scale that was administered to the subjects in this study. This Q-sort helped to support content validity for the items that comprise the revised Sense of Safety Scale and also helped to support discriminant validity between the concepts of a child's sense of safety when in out-of-home care and a child's social anxiety.

It should be noted that the original scale and conceptual definition pertained to children who were specifically in residential care. However, the revised scale includes changes in wording to three items, numbers 15, 1 7, and 19, so that they will be applicable to children in family foster care who participated in this study. See the notation on the bottom of Table 1 for the changes in wording.

Table 1. Percent Agreement on Sense of Safety Scale

Item	Percent agreement
*1. I feel safe when I move to a new place.	80
*2. I feel safe in my bedroom at night.	100
3. I am afraid of my peers.	40
*4. I feel safe in my house/cottage.	100
5. I am afraid of getting my feelings hurt.	0
*6. I feel safe at my school.	100
*7. I am afraid of getting hurt.	100
*8. I feel safe around adults.	100
9. I think that something bad will happen to me.	20
10. I look "over my shoulder".	60
11. I have dreams of bad things happening to me.	40
12. I feel safe when I am by myself.	20
13. I am afraid of dying.	20
14. I get scared easily.	40
*15. I feel safe around staff.[1]	100
16. I won't do anything if there is a risk of getting hurt.	40
*17. I feel safe around my peers in my house/cottage.[2]	100
18. I am afraid of adults.	60
*19. I am afraid of some staff.[3]	100
*20. I feel safe going to sleep at night.	80
*21. I am afraid when I move to a new placement.	80
*22. I don't feel safe when I don't know where I am being moved.	80

* = items with 80% or above agreement used for the revised Sense of Safety Scale.

Note.

[1]For the revised scale, item 15 will read: "I feel safe around staff/my foster parent(s).

[2]For the revised scale, item 17 will read: "I feel safe around my peers/foster brother(s) or sister(s)in my house."

[3]For the revised scale, item 19 will read: " I am afraid of some staff/my foster parent(s).

Cronbach's alpha for this sample was .83 ($\underline{n}$ = 59). The instrument was administered again at an interval of one month to 24 of the original participants. Cronbach's alpha for this retest was .86 ($\underline{n}$ = 24). A correlation for the test-retest scores was .76 ($\underline{p}$ < .01).

Behavioral Problems and Psychopathology

Present behavior problems and psychopathology were measured with Achenbach's (1991) Youth Self Report (YSR), which is compatible with the Child Behavioral Check List (CBCL). Achenbach (1991) described the YSR as an instrument that is designed to obtain 11- to 18- year-old's self reports of their own competencies and problems. The instrument begins with some open-ended questions about the youth's interests and self assessments. These are followed by 112 statements with a response scale of "Not True," "Somewhat or Sometimes True," and "Very True or Often True." Some of these statements also ask for additional information to be written in by the respondent. The YSR assesses problem syndromes, such as Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Aggressive Behavior, Delinquent Behavior, and scores other issues such as Internalizing behavioral/emotional problems, Externalizing behavioral/emotional problems, Total Problems as well as assesses competencies for Activities, Social competencies, and Total Competence.

Achenbach (1991) states that test-retest reliability over seven days for the competence scales was r = .68 for 11- to 14-year-olds and r = .82 for 15- to 18-year-olds (n = 50). Over seven days, the comparison of the problem scales was r = .65 for 11- to

14-year-olds and r = .83 for 15- to 18-year-olds. On the Total Problems scores, reliability was found to be r = .70 for 11- to 14-year-olds and r = .91 for 15- to 18-year-olds. Over seven months, mean stability was found to be r = .50 for competence scales, r = .49 for problem scales, r = .62 for total competence, and r = .56 for total problems in a non-clinical sample of 11- to 14-year-olds. In a clinical samples of 12- to 17-year olds, over six months r = .69 for total problem scores. The alpha for mean scale scores of matched samples of clinically referred and non-referred boys (n = 536) was .95 on Total Problems.

Commenting on the validity of the CBCL, Furlong and Wood (1998) stated that its validity has been correlated with other related instruments, such as the Conners' Parent Rating Scale and the Quay Problem Behavior Checklist. Discriminant validity has been shown in correctly classifying clinically "referred" and "non-referred" groups by using the Total Problems and Social Competence scores 95 percent of the time when Total Problems T-scores are above 75.

Furlong and Wood went on to say that the CBCL scale is one of the most used in the world for assessing children's and adolescents' problem behaviors and is the standard by which other similar scales are compared. However, they cautioned that the Social Competence portion needs some work because it measures low competencies more accurately than high competencies. Cronbach's alpha for this sample was .96 (n = 60).

Control Variables

Age. Each subject's age was obtained by asking the subjects for this information. Age and maturity have been shown to cause a shift from a sense of external locus of control to more of an internal locus of control (Chubb, Fertman, & Ross, 1997;

Friedman, Goodrich, & Fullerton, 1985). Also, in one descriptive study by Taber and Proch (1987) it was found that as youth get older, they tend to have shorter stays in placements and move to more restrictive placements.

Race. The subjects were categorized as being either African American or European American.

Present level of care. The present placement in out-of-home care, such as Level II residential care, Level I group home care, therapeutic family foster care, family foster care, and Independent living, was used to denote the intensity of care that the subject is receiving at the time of this study. The following levels of care have been denoted: family foster care, therapeutic family foster care, independent living, group home (Level 1), residential treatment (Level 2), and intake and stabilization. Less restrictive levels of care in which the youth currently reside might show that they have less severe behavioral or psychological problems or that their behavior or psychological state has improved while in care.

Time at present placement. The variable "time at present placement" was based upon the subject's date of entry for care in the specific programs of HUMHC (as recorded in the subject's case history) and was recorded in number of days. For example, although a subject may have been in the care of HUMHC for one year, but moved from residential care to a foster home only 60 days ago, this number of days will be recorded as the "time at present placement." It could be assumed that the longer a child stays at a placement, the safer he will feel and could develop a greater sense of internal control in that environment.

V. Results

Descriptive Findings

Self-reported moves ranged from 3 to 26 (M = 9.48, SD = 5.78) and moves documented in the subjects' case histories ranged from 2 to 20 (M = 7.32, SD = 4.34) (see Table 2). The length of time subjects spent in their present placements ranged from 1 to 390 days (M = 77.57, SD = 84.10) (see Table 3).

In terms of the number of youths represented in each level of care, there was 1 youth in foster care (1.7%), 2 in therapeutic foster care (3.3%), 3 in independent living (5.0%), 9 in group home care (15.0%), 29 in residential treatment (48.3%), and 16 in intake/stabilization (26.7 %).

Child Adjustment Measures

Raw scores from the instruments used to assess child adjustment indicators were used for all the analyses of data. Missing data on the YSR did not affect the Total Problems Score, thus all the YSR scores were used in the statistical analyses. However, missing data on any of the other instruments caused the score on that instrument to be dropped from the analyses. This resulted in 2.6% of the total instruments being dropped. Table 4 shows the means and standard deviations for each of these measures.

Correlations Among Indicators of Child Adjustment

All correlations in this study were based upon a .05 probability level to indicate statistical significance. As expected, there were several moderate statistically significant correlations between the indicators of child adjustment, which ranged from $r = .28$ ($p < .05$) to $r = .63$ ($p < .001$). The weakest association was between the SOSS and the Lie

Table 2. Self-report and Case History Placements

	Self-report			Case History		
Number	Frequency	Percent	Cumulative Percent	Frequency	Percent	Cumulative Percent
2	-	-	-	3	5.0	5.0
3	3	5.0	5.0	6	10.0	15.0
4	10	16.7	21.7	14	23.3	38.3
5	6	10.0	31.7	4	6.7	45.0
6	7	11.7	43.3	5	8.3	53.3
7	6	10.0	53.3	7	11.7	65.0
8	1	1.7	55.0	1	1.7	66.7
9	3	5.0	60.0	4	6.7	73.3
10	4	6.7	66.7	2	3.3	76.7
11	1	1.7	68.3	3	5.0	81.7
12	4	6.7	75.0	1	1.7	83.3
13	1	1.7	76.7	1	1.7	85.0
14	-	-	-	4	6.7	91.7
15	2	3.3	80.0	2	3.3	95.0
16	2	3.3	83.3	2	3.3	98.3
17	1	1.7	85.0	-	-	-
18	4	6.7	91.7	-	-	-
19	2	3.3	95.0	-	-	-
20	-	-	-	1	1.7	100.0
22	2	3.3	98.3			
26	1	1.7	100.0			

Table 3. Moves, Age, and Time at Present Placement

	M	SD	range
Moves	9.48	5.78	3-26
Age	15.15	1.62	12-18
Time at Present Placement (days)	77.57	84.10	1-390

n = 60 for each variable.

Table 4. Raw Score Means on Measures of Child Adjustment

Scale	M	SD	range	n
Self-Esteem Inventory (SEI)	32.48	8.50	9-46	56
Self-Esteem Scale (SES)	29.28	4.64	15-38	60
Lie Scale	2.03	1.66	0-7	59
Nowicki-Strickland (CNSIE)	15.42	4.60	6-27	55
Mastery Scale	19.60	3.88	11-28	60
Sense of Safety Scale (SOSS)	35.93	6.52	16-47	59
Total Problems (YSR)	68.93	34.29	9-178	60

subscale of the SEI, indicating a significant degree of defensiveness present in high levels of scores on this safety scale. The strongest was a positive association between the measures of self-esteem, the SEI and the SES. Table 5 shows the correlations for all variables.

Correlations Among Background Variables

Among the background variables, which were used as control variables, there were significant correlations between the age of the subjects and the time that they have spent in care, .27 ($p < .05$), and between age and the present level of care, .36 ($p < .01$), for those in independent living and .37 ($p < .01$) group home care. Time at present placement also was positively associated with some of the levels of care, .52 ($p < .001$) for therapeutic foster care and .46 ($p < .001$) for independent living. There was an expected negative correlation between time at present placement and intake/stabilization, -.35 ($p < .01$) (see Table 5).

Hypothesis Testing

In further analysis of the data, age had a moderately high correlation with self-reported number of placements, .49 ($p < .001$), and with the CNSIE score for locus of control, -.34 ($p < .05$). Other significant correlations indicate a negative relationship between being in therapeutic foster care and internal locus of control as indicated by the correlation with the CNSIE score, -.28 ($p < .05$) and a positive relationship with sense of safety scores, .26 ($p < .05$). Finally, there was a significant negative correlation between being in group home care and self-esteem, as indicated with the correlation with the SES scores, -.28 ($p < .05$). (See Table 5.)

Table 5. Correlations Between Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Moves	-															
2. Age	.49	-														
3. Race	-.12	-.10	-													
4. Time at Present Placement	.01	.27*	.04	-												
5. Therapeutic Foster Care	-.05	.04	-.08	.52**	-											
6. Independent Living	-.03	.36**	.12	.46**	-.04	-										
7. Group Home	.23	.37**	-.18	-.02	-.08	-.10	-									
8. Residential Care	-.19	-.24	-.25	-.11	-.18	-.22	-.41**	-								
9. Intake/ Stabilization	.02	-.24	-.15	-.35**	-.11	-.14	-.25	-.58**	-							
10. Self-Esteem Inventory	.15	.06	-.11	-.12	-.02	.15	-.09	.08	-.07	-						
11. Self-Esteem Scale	-.05	-.10	.11	-.17	-.01	.07	-.28**	.04	.14	.63**	-					
12. Lie Scale	-.04	-.21	.02	-.10	-.18	.04	-.21	.10	.13	.18	.19	-				
13. Nowicki-Strickland	-.26	-.36*	-.03	-.05	-.28*	-.02	-.07	.07	.09	-.45**	-.45**	-.13	-			
14. Mastery Scale	.02	.01	.18	.02	-.08	.14	-.10	.21	-.18	.49**	.62**	.21	-.58**	-		
15. Sense of Safety Scale	.06	-.04	-.00	.01	.26*	-.08	.03	.00	-.10	.33*	.35**	.28*	-.16	.19	-	
16. Total Problems (YSR)	.01	-.03	-.02	.15	-.08	-.22	.13	.06	-.02	-.62**	-.53**	-.08	.44**	.40**	-.21	-

*p < .05. **p < .01.

Hierarchical multiple regression was used to test the hypothesis that more relocations are associated with lower self-esteem, less of a sense of an internal locus of control, less of a sense of safety, and more problem behavior. For each dependent variable, the control variables (age, race, level of care, and time at present placement) were entered into Block 1, followed by the entry of the self-reported number of placements. Level of care was originally coded into six categories, but for the regression analysis level of care was dummy coded, with the foster care group serving as the reference group. The hypothesis was not supported. A summary of the statistics of the regression analysis for each of the measures of child adjustment - SEI, SES, CNSIE, Mastery Scale, SOSS, and Total Problems (YSR) - are respectively found in Tables 6, 7, 8, 9, 10, and 11.

Table 6. Summary of Hierarchical Regression Analysis for SEI on Age, Race, Time at Present Placement, Level of Care, and Number of Moves.

Variables	Block 1			Block 2		
	β	t	p (two-tailed)	β	t	p (two-tailed)
Age	.05	.31	.75	-.08	-.43	.67
Race	-.08	-.56	.58	-.08	-.59	.56
Time	-.52	-2.35	.02	-.53	-2.42	.02
Therapeutic foster care	.08	.33	.74	.13	.56	.58
Independent living	.21	.90	.37	.29	1.23	.23
Group Home	-.43	-1.07	.29	-.37	-.92	.36
Residential care	-.39	-.72	.48	-.30	-.55	.59
Intake/ stabilization	-.57	-1.12	.27	-.52	-1.05	.30
Number of moves				.23	1.48	.15

Note. $R^2_{change} = .04$, $F_{change}(1,46) = 2.17$, $p = .15$. Total $R^2 = .19$, $F(9,46) = 1.22$, $p = .31$.

Table 7. Summary of Hierarchical Regression Analysis for SES on Age, Race, Time at Present Placement, Level of Care, and Number of Moves.

Variables	Block 1			Block 2		
	β	t	p (two-tailed)	β	t	p (two-tailed)
Age	.01	.32	.98	-.01	-.04	.98
Race	.08	.57	.57	.08	.57	.57
Time	-.41	-2.05	.05	-.41	-2.04	.05
Therapeutic foster care	.06	.28	.78	.07	.29	.77
Independent living	.07	.26	.79	.08	.29	.78
Group Home	-.51	-1.32	.19	-.51	-1.28	.21
Residential care	-.40	-.75	.46	-.39	-.72	.47
Intake/ stabilization	-.34	-.68	.50	-.33	-.67	.51
Number of moves				.02	.13	.90

Note. $R^2_{change} = .00$, $F_{change}(1,50) = .02$, $p = .90$. Total $R^2 = .16$, $F(9,50) = 1.07$, $p = .40$.

Table 8. Summary of Hierarchical Regression Analysis for CNSIE on Age, Race, Time at Present Placement, Level of Care, and Number of Moves.

Variables	Block 1 β	Block 1 t	Block 1 p (two-tailed)	Block 2 β	Block 2 t	Block 2 p (two-tailed)
Age	- .37	-2.32	.03	-.29	-1.61	.11
Race	-.09	-.65	.52	-.09	-.69	.50
Time	.33	1.55	.13	.33	1.56	.13
Therapeutic foster care	-.33	-1.72	.09	-.35	-1.81	.08
Independent living	.06	.24	.81	.01	.02	.99
Group Home	.20	.50	.62	.16	.40	.69
Residential care	.24	.45	.65	.18	.34	.74
Intake/ stabilization	.26	.53	.60	.23	.47	.64
Number of moves				-.14	-.92	.36

Note. $R^2_{change} = .01$, $F_{change}(1,45) = .85$, $p = .36$. Total $R^2 = .24$, $F(9,45) = 1.57$, $p = .16$.

Table 9. Summary of Hierarchical Regression Analysis for Mastery on Age, Race, Time at Present Placement, Level of Care, and Number of Moves.

Variables	Block 1			Block 2		
	β	t	p (two-tailed)	β	t	p (two-tailed)
Age	.12	.75	.46	.10	.51	.61
Race	.11	.78	.44	.11	.78	.44
Time	-.07	-.34	.73	-.07	-.35	.73
Therapeutic foster care	.02	.10	.92	.03	.14	.89
Independent living	.19	.71	.48	.20	.74	.46
Group Home	.20	.50	.62	.16	.40	.69
Residential care	.27	.49	.62	.29	.52	.61
Intake/ stabilization	.03	.05	.96	.04	.07	.94
Number of moves				.04	.26	.80

Note. $R^2_{change} = .00$, $F_{change}(1,50) = .07$, $p = .80$. Total $R^2 = .11$, $F(9,50) = .66$, $p = .74$.

Table 10. Summary of Hierarchical Regression Analysis for SOSS on Age, Race, Time at Present Placement, Level of Care, and Number of Moves.

Variables	Block 1			Block 2		
	β	t	p (two-tailed)	β	t	p (two-tailed)
Age	-.08	-.48	.64	-.16	-.83	.41
Race	.02	.15	.88	.02	.14	.88
Time	-.30	-1.45	.15	-.30	-1.44	.16
Therapeutic foster care	.27	1.15	.26	.30	1.26	.21
Independent living	-.10	-.36	.72	-.04	-.13	.90
Group Home	-.24	-.61	.55	-.20	-.50	.62
Residential care	-.43	-.79	.44	-.36	-.66	.52
Intake/ stabilization	-.52	-1.04	.30	-.47	-.93	.36
Number of moves				.14	.81	.42

Note. $R^2_{change} = .01$, $F_{change}(1,49) = .66$, $p = .42$. Total $R^2 = .14$, $F(9,49) = .86$, $p = .57$.

Table 11. Summary of Hierarchical Regression Analysis for YSR Total Problems on Age, Race, Time at Present Placement, Level of Care, and Number of Moves.

Variables	Block 1			Block 2		
	β	t	p (two-tailed)	β	t	p (two-tailed)
Age	.01	.08	.93	.04	.27	.79
Race	.00	.03	.98	.00	.03	.98
Time	.73	3.91	.00	.73	3.89	.00
Therapeutic foster care	-.24	1.15	.26	-.25	-1.18	.24
Independent living	-.28	-1.20	.24	-.31	-1.25	.22
Group Home	.53	1.48	.14	.52	1.42	.16
Residential care	.65	1.33	.19	.63	1.26	.21
Intake/ stabilization	.69	1.52	.14	.68	1.48	.15
Number of moves				-.06	-.38	.70

Note. $R^2_{change} = .00$, $F_{change}(1,50) = .15$, $p = .70$. Total $R^2 = .29$, $F(9,50) = 2.24$, $p = .04$.

VI. Discussion

The central hypothesis was not supported by the findings of this particular study. In lieu of these non-significant findings, different configurations of the data and additional statistical analyses were employed: the associations between self-reported moves and each of the dependent variables were assessed for a curvilinear relationship; the control variables were used to assess any moderating effects on the association between the relationship of self-reported moves and the dependent variables; self-reported moves was operationalized as using categories rather than a continuous measure (e.g., by quartiles and by those falling above or below the mean); and finally, the number of moves documented in the case histories was used as the independent variable. Likewise, none of these additional analyses produced any significant findings.

However, there were several significant relationships between many of the established instruments used to indicate child adjustment. As expected, the scores on both self-esteem instruments showed significant relationships to the scores on the locus of control instruments. Both the SEI and the SES correlated positively with the Mastery scale and negatively with the CNSIE, showing that as self-esteem increases a sense of an internal locus of control also increases (or vice versa). The scores on both self-esteem measures also showed negative correlations with Total Problems scores on the YSR, indicating that as self-esteem increases, youth problem behavior decreases.

The scores on the locus of control measures showed significant correlations in the expected way with the Total Problems scores on the YSR. The CNSIE showed a positive

correlation and the Mastery Scale showed a negative correlation, indicating that as locus of control became more internal, there were fewer problem behaviors.

Among the indicators of child adjustment, only the scores on the self-esteem measures showed a significant association with the SOSS. There was a positive relationship, which indicates that as the subjects' self-esteem increases so does their sense of physical and psychological safety. This provides evidence of construct validity for the newly developed Sense of Safety Scale (SOSS) measure. The eight-item Lie sub-scale of the SEI showed a positive correlation with the SOSS. This association indicates that as subjects were more defensive, they also were more apt to say that they felt safe in their out-of-home care environments. This would be a normal reaction for adolescent males, who may feel that they need to show a lack of fear and the capability to take care of themselves in a society that expects such attitudes from its males.

Among the background variables, age was significantly correlated with other variables. As age increased, so did time spent at the present placement. As expected, age also showed a significant association with Group Home and Independent Living levels of care. The agency where the study was conducted traditionally has used its group home as a "step-down" program for older boys and as a transition to the Independent Living Program. Age also correlated significantly with the number of reported placements. This trend was noted in other research (Olsen, 1982; Pardeck, 1984), which found that the longer a child stays in placement, the more moves between placements he will have to make. Finally, the subject's age showed a significant negative relationship with the CNSIE. A study by Chubb, Fertman, and Ross (1997) found that as adolescent males

become older, they tend to develop a more internal sense of control due to the latitude in decision-making and the increase in options that they have before them.

There were the expected directions of association between time at present placement and various levels of care, with those in Therapeutic Foster Care and Independent Living having longer stays while those in the Intake and Stabilization program had shorter stays. The subjects in Therapeutic Foster Care had lower scores on the CNSIE, indicating a more internal sense of control, and higher scores on the SOSS, indicating a higher sense of safety. Although these indications seem as promising support for arguments that children do better in longer-term placements, it must be reminded that there were only two (2) subjects in this group.

Just as this study failed to produce any statistically significant findings related to the hypothesis, similar studies also failed to support the link between the number of moves (or placements) a child experiences while in out-of-home care and indicators of child adjustment. Lahti (1982) found no relationship between number of placements and child well-being, but found that children who had a sense of permanency in the foster homes had a greater sense of well-being. This study, though, was conducted with children under the age of twelve. Proch and Tabor's (1985) review of the literature on placement disruption cites four studies where there have been no statistically significant relationships found between number of placements and measures of well-being and social behavior. Two of these studies, however, included qualitative interviews of adults who had been in out-of-home care as children, in which the adults reflected upon the multiple moves as being painful and unsettling.

There are some studies and literature reviews which have found that children with more behavior problems experience more moves between placements (Palmer, 1979; Pardeck, 1985; Proch & Taber, 1985). However, it is difficult, if not impossible to make causal arguments about the genesis and increase of such behavior. Although problem behavior is a contributing reason as to why children are placed in out-of-home care, it is not known if more severe behaviors cause a child to be moved more or if moving a child more causes an increase in problem behavior. There appears to be a continuous, cyclical influence between these two factors (Pardeck, 1985).

It is counter-intuitive that as the number of moves between placements increase the scores on measures of self-esteem and locus of control do not show the negative impacts of these moves. Fischer and Bersani (1979) posited that the self-esteem of delinquent youth (who often are in out-of-home care programs) is not necessarily low, per se. They argue that because these youth do not "attach" to conventional others and the values held by others, they do not use the same standards by which to assess their own self-worth. From their argument, it follows that as youth continually detach from others as they move from placement to placement, they establish their own criteria for self-worth and self-esteem that are inherent within the culture of the cohort group with whom they are in care. Because this study found a positive relationship between self-esteem and sense of safety, there could be implications about how a child's sense of safety is related to the conventions of others and the environment that they are in.

As adolescent males stay in care longer and become older their sense of control tends to become more internal. A study by Kliewer and Sandler (1992) of 238 children

between ages 8 and 16 years found that the characteristic of a more internal sense of control had a buffering effect on stress. Along these lines, Raviv, Keinna, Abazon, and Raviv (1990), in a study of the impact of moving on the stress levels of Israeli adolescents, concluded that the greater the independence of the adolescent, the less stress there was in a move. Finally, Donohue and Gullotta (1983), in examining the coping behavior of adolescents following a move, stated that number of moves did not prove to be significant. They wrote:

> It may be that there is a survivor effect in moving in that those who do not cope well do not continue to move. Those who do continue to move may be better at it, enjoy it more or at least be more resigned to it than others. Assuming there are some negative consequences to frequent moving ... the survivor effect may obscure these consequences (p.399).

This study has several limitations. The small sample size not only limits the ability to find statistically significant associations between the independent and dependent variables but it also limits the generalizability of findings. This also holds true in that the sample was purposiye, came from the treatment programs of only one agency, and included only adolescent males who were predominantly in higher levels of out-of-home care.

As stated above on the issue of behavioral problems, the use of cross-sectional data excludes the ability to make any causal arguments about the impact of multiple moves on child adjustment. It could be argued that self-esteem issues, locus of control issues, and particularly behavior problems might be the contributor to a child experiencing moves to multiple placements. In all reality, there is probably a cyclical interaction among these variables.

The measure used to assess Sense of Safety is new and in the preliminary stage of development. Although it shows some initial support for validity and for reliability, more work needs to be done to establish the viability of this scale. The use of factor analysis and confirmatory factor analysis would help to further the arguments for the validity of the measure and could help to better dichotomize between the domains of "physical safety" and "psychological safety."

Finally, the relationship of the researcher to the subjects could have had some adverse effects on the honesty of the responses on the various instruments. The researcher works with the subjects on a regular basis as a staff where the subjects are in care. Although the Lie subscale of the SEI was used to detect defensiveness in the subjects answers and showed a significant correlation only with the SOSS, the subjects could have responded in a way that was perceived to be socially desirable to the researcher.

Although this and other studies have found no statistically significant relationships between the number of moves or placements a child experiences while in out-of-home care and their well-being or social adjustment, many researchers and social workers have an intuitive understanding of the negative impact of these multiple moves. Further research should be conducted on this topic that brings to light some of the issues that are pertinent to the practice of moving children several times while in care. As stated above, research the relates number of moves to child well-being and indicators of child adjustment, such as self-esteem and locus of control, have failed to produce statistically viable findings. New approaches to this area of research could begin with focus groups of children in out-of-home care that pertains to some of the specific issues of multiple moves among

placements. In a similar manner, qualitative studies done with children who are in out-of-home care, similar to the ones done with adults who were in out-of-home care as children reviewed by Proch and Taber (1985), might provide more insight into the social significance of this lamented practice in the foster care of children. This method of research could include assessments by the children of each move to see if they perceived the moves to be either "positive" or "negative," "beneficial" or "unbeneficial" for their therapeutic progress and permanency goals (Taber & Proch, 1987).

Longitudinal research would be the ideal way to assess the impact of multiple moves between placements. Both quantitative and qualitative methods could be combined to study such an impact across time. The children's assessments of the moves and measures of well-being or adjustment could be combined to give a broader and deeper understanding of what happens to children who continue to be moved to multiple placements. Growth curve modeling would provide the best methodology for such an analysis.

The greatest implication for more research on this topic is in its application to practice. Some of the goals for the out-of-home care for children are to provide them with a therapeutic environment that includes the children having a sense safety along with the building of positive coping and relational skills. This can only come about through the stability that the children experience while in care. Stability can be conceptualized in terms of the support given the children by their case workers and direct care workers or foster parents. However, stability also must include the stable environments of the children's physical domains.

Staff and Fein (1995) suggested that much of the practice of social work with children is concerned "with change – preparing children for a move, implementing the change, and dealing with the results of the ensuing placement" (p.386). An understanding of how such change impacts children and training in how to prepare children, families, caregivers, and agencies for change would ultimately provide a smoother transition between placements and buffer some of the presumed negative consequences of such transitions.

The ultimate goal, however, is to decrease the number of moves a child has to experience while in out-of-home care. With child care provider agencies becoming more specialized in their scope of care and with fiscal concerns that cause children to be moved too quickly or for the wrong reasons, children who do not fit the particular niche of a treatment milieu or whose care is not monetarily feasible for an agency become further victimized by the very systems which are to care for them. In short, what is done in the name of providing therapeutic care becomes the antithesis of such care. Only advocacy on the behalf of children who are moved too often and for too often the wrong reasons will be able to change the "system" of child care as it exists. However, this advocacy must be supported by research in order to give it more veracity.

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APPENDICES

APPENDIX A

THE UNIVERSITY OF TENNESSEE
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12/10/1999

IRB#: 5777B

TITLE: Multiple Relocations, The Therapeutic Environment, and Adolescents in Out-of-Home Care

Bailey, Keith
Child & Family Studies
420 Holston Dr.
Greeneville, TN 37743

Buehler, Dr. Cheryl
Child & Family Studies
420 Jessie Harris Bldg.
Campus

The points of clarification you submitted to this office regarding the above-captioned project, satisfied the concerns of the reviewers, thus your project has been approved.

This approval is for a period ending one year from the date of this letter. Please make timely submission of renewal or prompt notification of project termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project include the following:

1. To obtain prior approval from the Committee before instituting any changes in the project.
2. To retain signed consent forms from subjects for at least three years following completion of the project.
3. To submit a Form D to report changes in the project or to report termination at 12-month or less intervals.

The Committee wishes you every success in your research endeavor. This office will send you a renewal notice on the anniversary of your approval date.

Sincerely,

Brenda Lawson

Brenda Lawson
Compliances

cc: Ernest Brewer



Holston United Methodist Home for Children
For Children For Families Forever

Memo

To: Institutional Review Board, University of Tennessee

From: Arthur S. Masker, Chief Program Officer

CC: Keith A. Bailey

Date: November 21, 1999

Re: Proposed Research Project (IRB # 5777 B)

Keith Bailey has reviewed with me his proposal to conduct a research project, using Holston Home clients, with said project entitled: "Multiple Relocations, the Therapeutic Environment, and Adolescents in Out-of-Home Care".

It is our understanding the research will include:

- Giving clients, on a voluntary basis, 5 instruments to measure client self-esteem, locus of control, sense of physical and psychological safety; additionally the Child Behavior Checklist-Youth Report Form to measure present levels of psychopathology
- Providing a summary of research findings in a manner that does not violate client confidentiality
- Correlating with other client data such as DSM-IC diagnoses, level of care at Holston Home, and the number of moves while in custody

The agency has given its approval for this research project with conditions as outlined in the proposal. We have requested an opportunity to review the final research report.

If additional information is needed, you may contact me at: 423-787-8702.

P.O. Box 188 • Greeneville, Tennessee 37744 • Phone (423) 638-4171 FAX (423) 638-7171
Email: HolstonH@pop.usit.net • http://www.usit.net/children

APPENDIX B

The research project in which you have been asked to participate is being conducted by Chaplain Keith Bailey for credit toward earning a Masters Degree in Child and Family Studies. The purpose of this study is to find out how moving several times while in out-of-home care is related to your self-esteem, your sense of "who is in control" (called locus of control), and how safe you feel. This could help people to see how moving several times while in out-of-home care can make you and your peers feel about yourselves.

You will be asked to fill out six questionnaires that describe how you feel about yourself, which will take about 45 minutes to one hour. Some of these questions might make you feel uncomfortable or could bring up bad memories. If you would like to talk about any of these feelings or memories, you can talk to your therapist or another staff person whom you choose.

You will also be asked your age, how long you have been in out-of-home care, how many times you have been moved while in care, where you live now, and how long you have been at your present placement. This information will be looked up in your case-history files. This information will help to determine how moving while in out-of-home care effects different people.

If you complete all six of the questionnaires, you will be given a two liter soft drink.

You can withdraw from participating in this research at any time with no negative consequences. If you choose not to participate in this study, it will not change the services you receive from Holston Home. If you chose to withdraw, the questionnaires you filled out will be destroyed immediately.

Your name will not be on any of the questionnaires. All this information will be kept confidential and your name will not be used in this study. The questionnaires will be kept in a locked file cabinet in the Chaplain's home. Only the Chaplain will see these questionnaires. This information will be kept for up to eight years and might possibly be used for other research. This data will be destroyed in the year 2008.

If you would like to ask any more questions about this study or your rights as a participant, you can contact Dr. Cheryl Buehler at the University of Tennessee at 423-974-6271.

INFORMED ASSENT

I have been given an explanation of this research project and have been allowed to ask any questions about it. I understand that I can drop out of the study at any time, with no negative consequences. I understand that this information will be kept confidential and that my participation in this study is totally voluntary.

I agree to participate in this study.

_____

Name Date

_____

Witness Date

PARENTAL/GUARDIAN CONSENT FOR PARTICIPATION IN RESEARCH

Your child volunteered to participate in a research project conducted by Keith Bailey, the Chaplain at Holston Home. The research is on how moving to several different places while in custody effects children. The project consisted of your child filling out six questionnaires: two had to do with self-esteem, two had to do with how much in control he feels, one had to do with how safe he feels while in care, and the other was a general questionnaire about his feelings and actions. **These questionnaires will not be a part of his treatment plan at Holston Home and will not affect his quality or length of care here. Only Chaplain Bailey will see these questionnaires.** Also, he was asked his birth date, where he is in care now, how long he has been in his present placement, how long he has been in out-of-home care, and how many places he has been moved to while in out-of-home care. This information has also been looked up in his case history file. He received a soft drink for participating. Attached is a copy of the form provided for your child that explained the project and asked for his consent.

****Your consent is now needed for the information provided by your child to be used in this research project.**

I agree that the information provided by my child can be used for this project.

_____ _____
Parent's Signature Date

_____ _____
or Guardian's Signature Date

Approval was gained by verbal consent over the phone.

Received by: _____ _____
Signature Date

_____ _____
Witness's Signature Date

APPENDIX C

SELF-ESTEEM INVENTORY

Please mark each statement in the following way:

If the statement describes how you usually feel, circle "*Like Me*."
If the statement does not describe how you usually feel, circle "*Unlike Me*."
There are no right or wrong answers.

1. I spend a lot of time daydreaming.

   Like Me Unlike Me

2. I'm pretty sure of myself.

   Like Me Unlike Me

3. I often wish I were someone else.

   Like Me Unlike Me

4. I'm easy to like.

   Like Me Unlike Me

5. My parents and I have a lot of fun together.

   Like Me Unlike Me

6. I never worry about anything.

   Like Me Unlike Me

7. I find it very hard to talk in front of the class.

   Like Me Unlike Me

8. I wish I were younger.

   Like Me Unlike Me

9. There are lots of things about myself I'd change if I could.

Like Me Unlike Me

10. I can make up my mind without too much trouble.

Like Me Unlike Me

11. I'm a lot of fun to be with.

Like Me Unlike Me

12. I get upset easily at home.

Like Me Unlike Me

13. I always do the right thing.

Like Me Unlike Me

14. I'm proud of my school work.

Like Me Unlike Me

15. Someone always has to tell me what to do.

Like Me Unlike Me

16. It takes me a long time to get used to anything new.

Like Me Unlike Me

17. I'm often sorry for the things I do.

Like Me Unlike Me

18. I'm popular with kids my own age.

Like Me Unlike Me

19. My parents usually consider my feelings.

Like Me Unlike Me

20. I'm never unhappy.

Like Me Unlike Me

21. I'm doing the best work that I can.

Like Me Unlike Me

22. I give in very easily.

Like Me Unlike Me

23. I can usually take care of myself.

Like Me Unlike Me

24. I'm pretty happy.

Like Me Unlike Me

25. I would rather play with children younger than me.

Like Me Unlike Me

26. My parents expect too much of me.

Like Me Unlike Me

27. I like everyone I know.

Like Me Unlike Me

28. I like to be called on in class.

Like Me Unlike Me

29. I understand myself.

Like Me Unlike Me

30. It's pretty tough to be me.

Like Me Unlike Me

31. Things are all mixed up in my life.

Like Me Unlike Me

32. Kids usually follow my ideas.

Like Me Unlike Me

33. No one pays much attention to me at home.

Like Me Unlike Me

34. I never get scolded.

Like Me Unlike Me

35. I'm not doing as well in school as I'd like to.

Like Me Unlike Me

36. I can make up my mind and stick to it.

Like Me Unlike Me

37. I really don't like being a boy.

Like Me Unlike Me

38. I have a low opinion of myself.

Like Me Unlike Me

39. I don't like to be with other people.

Like Me Unlike Me

40. There are many times when I'd like to leave home.

Like Me Unlike Me

41. I'm never shy.

Like Me Unlike Me

42. I often feel upset in school.

Like Me Unlike Me

43. I often feel ashamed of myself.

Like Me Unlike Me

44. I'm not as nice looking as most people.

Like Me Unlike Me

45. If I have something to say, I usually say it.

Like Me Unlike Me

46. Kids pick on me very often.

Like Me Unlike Me

47. My parents understand me.

Like Me Unlike Me

48. I always tell the truth.

Like Me Unlike Me

49. My teacher makes me feel I'm not good enough.

Like Me Unlike Me

50. I don't care what happens to me.

Like Me Unlike Me

51. I'm a failure.

Like Me Unlike Me

52. I get upset easily when I'm scolded.

Like Me Unlike Me

53. Most people are better liked than I am.

Like Me Unlike Me

54. I usually fell as if my parents are pushing me.

Like Me Unlike Me

55. I always know what to say to people.

Like Me Unlike Me

56. I often get discouraged in school.

Like Me Unlike Me

57. Things usually don't bother me.

Like Me Unlike Me

58. I can't be depended on.

Like Me Unlike Me

SELF-ESTEEM SCALE

Mark how strongly you agree or disagree with the following statements.

1. I feel that I am a person of worth, at least on an equal basis with others.

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

2. I feel that I have a number of good qualities.

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

3. All in all, I am inclined to feel that I am a failure.

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

4. I am able to do things as well as most other people.

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

5. I feel I do not have much to be proud of.

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

6. I take a positive attitude toward myself.

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

7. On the whole, I am satisfied with myself.

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

8. I wish I could have more respect for myself.

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

9. I certainly feel useless at times.

   STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

10. At times I think I am no good at all.

    STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

The Nowicki-Strickland Internal-External Control Scale for Children

1. Do you believe that most problems will solve themselves if you just don't fool with them?
   Yes No

2. Do you believe that you can stop yourself from catching a cold?
   Yes No

3. Are some kids just born lucky?
   Yes No

4. Most of the time do you feel that getting good grades means a great deal to you?
   Yes No

5. Are you often blamed for things that just aren't your fault?
   Yes No

6. Do you believe that if somebody studies hard enough he or she can pass any subject?
   Yes No

7. Do you feel that most of the time it doesn't pay to try hard because things never turn out right anyway?
   Yes No

8. Do you feel that if things start out well in the morning that it's going to be a good day no matter what you do?
   Yes No

9. Do you feel that most of the time parents listen to what their children have to say?
   Yes No

10. Do you believe that wishing can make good things happen?
Yes No

11. When you get punished does it usually seem it's for no good reason at all?
Yes No

12. Most of the time do you find it hard to change a friend's mind (opinion)?
Yes No

13. Do you think that cheering more than luck helps a team to win?
Yes No

14. Do you feel that it's nearly impossible to change your parent's mind about anything?
Yes No

15. Do you believe that your parents should allow you to make most of your own decisions?
Yes No

16. Do you feel that when you do something wrong there's very little you can do to make it right?
Yes No

17. Do you believe that most kids are just born good at sports?
Yes No

18. Are most of the other kids your age stronger than you are?
Yes No

19. Do you feel that one of the best ways to handle most problems is just not to think about them?
Yes No

20. Do you feel that you have a lot of choice in deciding who your friends are?
Yes No

21. If you find a four leaf clover do you believe that it might bring you good luck?

Yes No

22. Do you often feel that whether you do your homework has much to do with what kind of grades you get?

Yes No

23. Do you feel that when a kid your age decides to hit you, there's little you can do to stop him or her?

Yes No

24. Have you ever had a good luck charm?

Yes No

25. Do you believe that whether or not people like you depends on how you act?

Yes No

26. Will your parents usually help you if you ask them to?

Yes No

27. Have you felt that when people were mean to you it was usually for no reason at all?

Yes No

28. Most of the time, do you feel that you can change what might happen tomorrow by what you do today?

Yes No

29. Do you believe that when bad things are going to happen they just are going to happen no matter what you try to do to stop them?

Yes No

30. Do you think that kids can get their own way if they just keep trying?

Yes No

31. Most of the time do you find it useless to try to get your own way at home?

Yes No

32. Do you feel that when good things happen they happen because of hard work?

Yes No

33. Do you feel that when somebody your age wants to be your enemy there's little you can do to change matters?

Yes No

34. Do you feel that it's easy to get friends to do what you want them to?

Yes No

35. Do you usually feel that you have little to say about what you get to eat at home?

Yes No

36. Do you feel that when someone doesn't like you there's little you can do about it?

Yes No

37. Do you usually feel that it's almost useless to try in school because most other children are just plain smarter than you are?

Yes No

38. Are you the kind of person who believes that planning ahead makes things turn out better?

Yes No

39. Most of the time, do you feel that you have little to say about what your family decides to do?

Yes No

40. Do you think it's better to be smart than to be lucky?

Yes No

MASTERY SCALE

How strongly do you agree or disagree that:

1. I have little control over that things that happen to me.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

2. There is really no way I can solve some of the problems I have.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

3. There is little I can do to change many of the important things in my life.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

4. I often feel helpless in dealing with the problems of life.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

5. Sometimes I feel that I'm being pushed around in life.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

6. What happens to me in the future mostly depends on me.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

7. I can do just about anything I really set my mind to do.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

SENSE OF SAFETY SCALE

Please mark the answer that best describes how often these things or feelings happen.

1. I feel safe when I move to a new place.

Always Most of the time Some of the time Never

2. I feel safe in my bedroom at night.

Always Most of the time Some of the time Never

3. I feel safe in my house/cottage.

Always Most of the time Some of the time Never

4. I feel safe at my school.

Always Most of the time Some of the time Never

5. I am afraid of getting hurt.

Always Most of the time Some of the time Never

6. I feel safe around adults.

Always Most of the time Some of the time Never

7. I feel safe around staff/my foster parent(s).

Always Most of the time Some of the time Never

8. I feel safe around my peers/foster brother(s) or sister(s) in my house.

Always Most of the time Some of the time Never

9. I am afraid of some staff/my foster parent(s).

Always Most of the time Some of the time Never

10. I feel safe going to sleep at night.

Always Most of the time Some of the time Never

11. I am afraid when I move to a new placement.

Always Most of the time Some of the time Never

12. I don't feel safe when I don't know where I am being moved.

Always Most of the time Some of the time Never

YOUTH SELF-REPORT FOR AGES 11–18

Please Print

For office use only
ID #

YOUR FULL NAME: FIRST MIDDLE LAST

YOUR SEX ☐ Boy ☐ Girl

YOUR AGE

ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Date ____ Yr. ____

YOUR BIRTHDATE Mo. ____ Date ____ Yr. ____

GRADE IN SCHOOL ____

NOT ATTENDING SCHOOL ☐

IF YOU ARE WORKING, PLEASE STATE YOUR TYPE OF WORK:

PARENTS' USUAL TYPE OF WORK, even if not working now *(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK: ____

MOTHER'S TYPE OF WORK ____

Please fill out this form to reflect *your* views, even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on pages 2 and 4.

I. Please list the sports you most like to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of your age, about how much time do you spend in each?			Compared to others of your age, how well do you do each one?		
	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐

II. Please list your favorite hobbies, activities, and games, other than sports. For example: cards, books, piano, cars, crafts, etc. (Do *not* include listening to radio or TV.)

☐ None

	Compared to others of your age, about how much time do you spend in each?			Compared to others of your age, how well do you do each one?		
	Less Than Average	Average	More Than Average	Below Average	Average	Above Average
a. ____	☐	☐	☐	☐	☐	☐
b. ____	☐	☐	☐	☐	☐	☐
c. ____	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams or groups you belong to.

☐ None

	Compared to others of your age, how active are you in each?		
	Less Active	Average	More Active
a. ____	☐	☐	☐
b. ____	☐	☐	☐
c. ____	☐	☐	☐

IV. Please list any jobs or chores you have. For example: paper route, babysitting, making bed, working in store, etc. (Include *both* paid and unpaid jobs and chores.)

☐ None

	Compared to others of your age, how well do you carry them out?		
	Below Average	Average	Above Average
a. ____	☐	☐	☐
b. ____	☐	☐	☐
c. ____	☐	☐	☐

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Please Print

V. 1. About how many close friends do you have? ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more
(Do *not* include brothers & sisters)

2. About how many times a week do you do things with any friends outside of regular school hours?
(Do *not* include brothers & sisters) ☐ less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of your age, how well do you:

	Worse	About Average	Better	
a. Get along with your brothers & sisters?	☐	☐	☐	☐ I have no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Get along with your parents?	☐	☐	☐	
d. Do things by yourself?	☐	☐	☐	

VII. Performance in academic subjects. ☐ I do not attend school because _____

Check a box for each subject that you take		Failing	Below Average	Average	Above Average
	a. English or Language Arts	☐	☐	☐	☐
	b. History or Social Studies	☐	☐	☐	☐
	c. Arithmetic or Math	☐	☐	☐	☐
	d. Science	☐	☐	☐	☐
Other academic subjects – for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., etc.	e. _____	☐	☐	☐	☐
	f. _____	☐	☐	☐	☐
	g. _____	☐	☐	☐	☐

Do you have any illness, disability, or handicap? ☐ No ☐ Yes—please describe:

Please describe any concerns or problems you have about school:

Please describe any other concerns you have:

Please describe the best things about yourself:

Below is a list of items that describe kids. For each item that describes you *now or within the past 6 months*, please circle the *2* if the *very true or often true* of you. Circle the *1* if the item is *somewhat or sometimes true* of you. If the item is *not true* of you, circle the *0*.

Please Print 0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 1. I act too young for my age
0 1 2 2. I have an allergy (describe): _____
_____
_____
0 1 2 3. I argue a lot
0 1 2 4. I have asthma
0 1 2 5. I act like the opposite sex
0 1 2 6. I like animals
0 1 2 7. I brag
0 1 2 8. I have trouble concentrating or paying attention
0 1 2 9. I can't get my mind off certain thoughts (describe): _____
_____
_____
0 1 2 10. I have trouble sitting still
0 1 2 11. I'm too dependent on adults
0 1 2 12. I feel lonely
0 1 2 13. I feel confused or in a fog
0 1 2 14. I cry a lot
0 1 2 15. I am pretty honest
0 1 2 16. I am mean to others
0 1 2 17. I daydream a lot
0 1 2 18. I deliberately try to hurt or kill myself
0 1 2 19. I try to get a lot of attention
0 1 2 20. I destroy my own things
0 1 2 21. I destroy things belonging to others
0 1 2 22. I disobey my parents
0 1 2 23. I disobey at school
0 1 2 24. I don't eat as well as I should
0 1 2 25. I don't get along with other kids
0 1 2 26. I don't feel guilty after doing something I shouldn't
0 1 2 27. I am jealous of others
0 1 2 28. I am willing to help others when they need help
0 1 2 29. I am afraid of certain animals, situations, or places, other than school (describe): _____
_____
_____
0 1 2 30. I am afraid of going to school
0 1 2 31. I am afraid I might think or do something bad
0 1 2 32. I feel that I have to be perfect
0 1 2 33. I feel that no one loves me
0 1 2 34. I feel that others are out to get me
0 1 2 35. I feel worthless or inferior
0 1 2 36. I accidentally get hurt a lot
0 1 2 37. I get in many fights
0 1 2 38. I get teased a lot
0 1 2 39. I hang around with kids who get in trouble
0 1 2 40. I hear sounds or voices that other people think aren't there (describe): _____
_____
_____
0 1 2 41. I act without stopping to think
0 1 2 42. I would rather be alone than with others
0 1 2 43. I lie or cheat
0 1 2 44. I bite my fingernails
0 1 2 45. I am nervous or tense
0 1 2 46. Parts of my body twitch or make nervous movements (describe):
_____
_____
0 1 2 47. I have nightmares
0 1 2 48. I am not liked by other kids
0 1 2 49. I can do certain things better than most kids
0 1 2 50. I am too fearful or anxious
0 1 2 51. I feel dizzy
0 1 2 52. I feel too guilty
0 1 2 53. I eat too much
0 1 2 54. I feel overtired
0 1 2 55. I am overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (*not* stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feel sick
0 1 2 d. Problems with eyes (*not* if corrected by glasses) (describe):
_____
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____
_____
0 1 2 57. I physically attack people
0 1 2 58. I pick my skin or other parts of my body (describe): _____
_____
_____
0 1 2 59. I can be pretty friendly
0 1 2 60. I like to try new things
0 1 2 61. My school work is poor
0 1 2 62. I am poorly coordinated or clumsy
0 1 2 63. I would rather be with older kids than with kids my own age

Please see other side

0 = Not True 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 64. I would rather be with younger kids than with kids my own age
0 1 2 65. I refuse to talk
0 1 2 66. I repeat certain acts over and over (describe): _____
_____
_____
0 1 2 67. I run away from home
0 1 2 68. I scream a lot
0 1 2 69. I am secretive or keep things to myself
0 1 2 70. I see things that other people think aren't there (describe): _____
_____
_____
0 1 2 71. I am self-conscious or easily embarrassed
0 1 2 72. I set fires
0 1 2 73. I can work well with my hands
0 1 2 74. I show off or clown
0 1 2 75. I am shy
0 1 2 76. I sleep less than most kids
0 1 2 77. I sleep more than most kids during day and/or night (describe): _____
_____
_____
0 1 2 78. I have a good imagination
0 1 2 79. I have a speech problem (describe): _____
_____
_____
_____
0 1 2 80. I stand up for my rights
0 1 2 81. I steal at home
0 1 2 82. I steal from places other than home
0 1 2 83. I store up things I don't need (describe):
_____
_____
0 1 2 84. I do things other people think are strange (describe): _____
_____
_____
0 1 2 85. I have thoughts that other people would think are strange (describe): _____
_____
_____
_____
0 1 2 86. I am stubborn
0 1 2 87. My moods or feelings change suddenly
0 1 2 88. I enjoy being with other people
0 1 2 89. I am suspicious
0 1 2 90. I swear or use dirty language
0 1 2 91. I think about killing myself
0 1 2 92. I like to make others laugh
0 1 2 93. I talk too much
0 1 2 94. I tease others a lot
0 1 2 95. I have a hot temper
0 1 2 96. I think about sex too much
0 1 2 97. I threaten to hurt people
0 1 2 98. I like to help others
0 1 2 99. I am too concerned about being neat or clean
0 1 2 100. I have trouble sleeping (describe): _____
_____
_____
0 1 2 101. I cut classes or skip school
0 1 2 102. I don't have much energy
0 1 2 103. I am unhappy, sad, or depressed
0 1 2 104. I am louder than other kids
0 1 2 105. I use alcohol or drugs for nonmedical purposes (describe): _____
_____
_____
_____
0 1 2 106. I try to be fair to others
0 1 2 107. I enjoy a good joke
0 1 2 108. I like to take life easy
0 1 2 109. I try to help other people when I can
0 1 2 110. I wish I were of the opposite sex
0 1 2 111. I keep from getting involved with others
0 1 2 112. I worry a lot

Please write down anything else that describes your feelings, behavior, or interests

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS

APPENDIX D

QUESTIONNAIRE INSTRUCTION SHEET

Take your time in filling out these questionnaires.

Mark an answer for every question.

Please be honest with your answers.

You can take a short break any time that you need to.

I will read any questions or questionnaires to you if you have a hard time understanding them.

If there is question or statement that you don't understand, please raise your hand, and I will try to help you understand the meaning of that question or statement..

Please keep your answers confidential, which means, don't tell anyone in the group or anyone else what answers you marked on your questionnaires.

VITA

Keith A. Bailey was born in Athens, Tennessee on December 25, 1964, the son of Charles A. and Joyce Bailey. He has a younger brother, Kent. Keith graduated from McMinn Central High School, in Englewood, TN, in 1983 and went on to Tennessee Wesleyan College (TWC). While at TWC he was selected to the NAIA 1986 Academic All-America Men's Soccer Team and graduated summa cum laude from TWC in 1987 with a Bachelor of Arts degree in Psychology. Keith went on to attend the Divinity School at Duke University and graduated with a Master of Divinity degree in 1990. He is an ordained minister in the United Methodist Church.

After graduating from Duke, Keith spent two years serving as an Assistant Minister in the Church of Scotland at Newton Mearns Parish Church, Glasgow, Scotland. In September of 1992 he began serving as Chaplain at Holston United Methodist Home for Children in Greeneville, TN and still serves in that capacity.

He is married to Angela (Brown) Bailey and is the father of a daughter, Kaitlyn, and a son, Taylor.