Fostering Connections: Group Therapy for Young Women Aging Out of Foster Care

by

Meaghan Elizabeth Pilling

B.A., Colby-Sawyer College, 2008
M.A., Saint Michael’s College, 2010

DISSERTATION

Submitted in partial fulfillment for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2014

Keene, New Hampshire
DISSErTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

FOSTERING CONNECTIONS: GROUP THERAPY FOR YOUNG WOMEN AGING OUT OF FOSTER CARE

presented on July 24, 2014

by

Meaghan Elizabeth Pilling
Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Martha B. Straus, PhD

Dissertation Committee members:
Gina Pasquale, PsyD
William Slammon, PhD

Accepted by the
Department of Clinical Psychology Chairperson
Kathi A. Borden, PhD

on 10/16/14

* Signatures are on file with the Registrar's Office at Antioch University New England.
Acknowledgments

Words are insufficient to describe the tremendous amount of gratitude I feel for having known the following individuals. Each has left imprints on my heart and mind, and I am so thankful for all they’ve done for me. I’ve always found a sort of “home” in school, and in result, I’d like to thank each of you for providing me with a multitude of corrective relational experiences that I will surely carry with me throughout my lifetime.

Dr. Martha Straus, my advisor and mentor, has influenced me in many meaningful ways, for which I am forever grateful. Thank you, Dr. Straus, for providing the context in which the idea for this dissertation was created. The experiences we’ve had together have been invaluable to me, both professionally and personally. Dr. Straus’ unwavering belief in me has helped me developed as a person, and into the soon-to-be psychologist that I am today.

Dr. Bill Slammon, thank you for your continued support and understanding throughout the dissertation process, and my time at Antioch. Dr. Gina Pasquale has been an inspiration to me since the beginning of my time at Antioch. Thank you, Dr. Pasquale, for your feedback and encouragement throughout this process. I’ve learned so much from your depth of knowledge, from your authenticity, and your humble nature.

I also wish to thank Ashley, my partner and best friend, for supporting and guiding me throughout this process. Ashley, your compassionate, brilliant, and hilarious mind is a gift every day. Thank you so much for being you. Thank you also for tolerating my crankiness throughout the countless hours spent working on this dissertation.

To my brothers, Matt and Andrew, thank you for continuing to inspire me every day. You truly are my heroes.
Table of Contents

Acknowledgments.................................................................................................................. iii
List of Figures ........................................................................................................................ viii
Abstract ................................................................................................................................ 1
Chapter 1 ................................................................................................................................ 2
  Statement of the Problem................................................................................................. 2
  Rationale ......................................................................................................................... 3
  Significance for the Field of Professional Psychology............................................... 4
  Theoretical and Conceptual Framework: Relational-Cultural Theory....................... 5
  Major Tenets of Relational-Cultural Theory............................................................... 5
  History .......................................................................................................................... 6
  How Does Relational-Cultural Theory Explain Psychological Health..................... 6
  How Does Relational-Cultural Theory Explain Psychopathology............................ 7
  Relational-Cultural Interventions............................................................................... 7
  What is Relational-Cultural Therapy.......................................................................... 8
  What is Relational-Cultural Mentoring..................................................................... 8
  Mechanisms of Change.............................................................................................. 8
  Rationale for a Mixed Methodological Approach..................................................... 9
  Research Questions ................................................................................................... 10
  How Suitable is the Intervention for the Target Population..................................... 10
  Statement of Intent .................................................................................................. 12
  Statement of Hypotheses......................................................................................... 12
Chapter 2: Literature Review ................................................................................................. 13
  Problem of Study ........................................................................................................ 13
  Emerging Adulthood .................................................................................................. 13
  Female Emerging Adults ............................................................................................ 14
  Growing Up In, and Aging Out of, Foster Care ...................................................... 14
  Risk Factors ............................................................................................................. 14
  Protective factors: The Importance of Connection................................................... 15
  What Works .............................................................................................................. 16
  Relationship-Focused Group Interventions ............................................................. 16
  Group Therapy .......................................................................................................... 18
  Short-Term Group Therapy ...................................................................................... 19
  Co-led Group Therapy .............................................................................................. 19
  Benefits of Co-led Group Therapy.......................................................................... 19
  Providing the Corrective Emotional and Relational Experience............................. 20
  Mentoring and the Co-therapist Relationship ........................................................ 21
  Enhancing the Co-therapist Relationship ............................................................... 22
  Reflective Practice .................................................................................................... 22
  Modifying a Group Therapy Approach for a Unique Population............................ 23
  Relational-Cultural Group Therapy ....................................................................... 23
  Previous Research ................................................................................................... 24
  Goals of Treatment .................................................................................................. 24
  Corrective Emotional and Relational Experience ................................................... 25
  Attempt to Facilitate Within-group, Peer-mentor Relationships............................ 26
<table>
<thead>
<tr>
<th>Content</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 5: Development of the Treatment Manual</td>
<td>48</td>
</tr>
<tr>
<td>Development of the Adapted Manual</td>
<td>48</td>
</tr>
<tr>
<td>Group Format and Outline</td>
<td>48</td>
</tr>
<tr>
<td>Additions to the Manual</td>
<td>49</td>
</tr>
<tr>
<td>Incorporating Mindfulness Practice</td>
<td>49</td>
</tr>
<tr>
<td>Wedding Attachment Theory with RCT</td>
<td>50</td>
</tr>
<tr>
<td>What is Attachment Theory</td>
<td>50</td>
</tr>
<tr>
<td>Identifying Barriers</td>
<td>51</td>
</tr>
<tr>
<td>Developing Collaborative Goals</td>
<td>52</td>
</tr>
<tr>
<td>Requesting Feedback</td>
<td>52</td>
</tr>
<tr>
<td>Tending to Relational Trauma</td>
<td>53</td>
</tr>
<tr>
<td>Termination</td>
<td>53</td>
</tr>
<tr>
<td>Chapter 3: Pilot Study for Evaluating the Intervention</td>
<td>30</td>
</tr>
<tr>
<td>Overview</td>
<td>30</td>
</tr>
<tr>
<td>Research Design</td>
<td>31</td>
</tr>
<tr>
<td>Quantitative</td>
<td>31</td>
</tr>
<tr>
<td>Qualitative: Interpretive Phenomenological Analysis (IPA)</td>
<td>32</td>
</tr>
<tr>
<td>The Researcher’s Role</td>
<td>33</td>
</tr>
<tr>
<td>Intervention Method</td>
<td>34</td>
</tr>
<tr>
<td>Participants</td>
<td>34</td>
</tr>
<tr>
<td>Inclusion Criteria</td>
<td>35</td>
</tr>
<tr>
<td>Rationale for Sample Size</td>
<td>36</td>
</tr>
<tr>
<td>Data Collection Methods and Procedures</td>
<td>36</td>
</tr>
<tr>
<td>Quantitative Data Collection</td>
<td>36</td>
</tr>
<tr>
<td>Relational Health Indices (RHI)</td>
<td>37</td>
</tr>
<tr>
<td>Outcome Questionnaire-45 (OQ-45)</td>
<td>37</td>
</tr>
<tr>
<td>Qualitative Data Collection</td>
<td>37</td>
</tr>
<tr>
<td>Identifying Themes</td>
<td>38</td>
</tr>
<tr>
<td>Quality Control Procedures</td>
<td>38</td>
</tr>
<tr>
<td>Ethical Considerations</td>
<td>40</td>
</tr>
<tr>
<td>Protection of Human Subjects</td>
<td>40</td>
</tr>
<tr>
<td>Dual Roles</td>
<td>40</td>
</tr>
<tr>
<td>Data Analysis: Suitability of the Intervention</td>
<td>41</td>
</tr>
<tr>
<td>Determining Feasibility</td>
<td>41</td>
</tr>
<tr>
<td>Determining Acceptability</td>
<td>41</td>
</tr>
<tr>
<td>Determining Benefit</td>
<td>42</td>
</tr>
<tr>
<td>Exploring the Perceived Value of Mentoring</td>
<td>42</td>
</tr>
<tr>
<td>Chapter 4: Preliminary Findings and Results</td>
<td>44</td>
</tr>
<tr>
<td>Preliminary Findings</td>
<td>44</td>
</tr>
<tr>
<td>Recruitment Process and Outcome</td>
<td>44</td>
</tr>
<tr>
<td>Chapter 3: Pilot Study for Evaluating the Intervention</td>
<td>30</td>
</tr>
<tr>
<td>Overview</td>
<td>30</td>
</tr>
<tr>
<td>Research Design</td>
<td>31</td>
</tr>
<tr>
<td>Quantitative</td>
<td>31</td>
</tr>
<tr>
<td>Qualitative: Interpretive Phenomenological Analysis (IPA)</td>
<td>32</td>
</tr>
<tr>
<td>The Researcher’s Role</td>
<td>33</td>
</tr>
<tr>
<td>Intervention Method</td>
<td>34</td>
</tr>
<tr>
<td>Participants</td>
<td>34</td>
</tr>
<tr>
<td>Inclusion Criteria</td>
<td>35</td>
</tr>
<tr>
<td>Rationale for Sample Size</td>
<td>36</td>
</tr>
<tr>
<td>Data Collection Methods and Procedures</td>
<td>36</td>
</tr>
<tr>
<td>Quantitative Data Collection</td>
<td>36</td>
</tr>
<tr>
<td>Relational Health Indices (RHI)</td>
<td>37</td>
</tr>
<tr>
<td>Outcome Questionnaire-45 (OQ-45)</td>
<td>37</td>
</tr>
<tr>
<td>Qualitative Data Collection</td>
<td>37</td>
</tr>
<tr>
<td>Identifying Themes</td>
<td>38</td>
</tr>
<tr>
<td>Quality Control Procedures</td>
<td>38</td>
</tr>
<tr>
<td>Ethical Considerations</td>
<td>40</td>
</tr>
<tr>
<td>Protection of Human Subjects</td>
<td>40</td>
</tr>
<tr>
<td>Dual Roles</td>
<td>40</td>
</tr>
<tr>
<td>Data Analysis: Suitability of the Intervention</td>
<td>41</td>
</tr>
<tr>
<td>Determining Feasibility</td>
<td>41</td>
</tr>
<tr>
<td>Determining Acceptability</td>
<td>41</td>
</tr>
<tr>
<td>Determining Benefit</td>
<td>42</td>
</tr>
<tr>
<td>Exploring the Perceived Value of Mentoring</td>
<td>42</td>
</tr>
<tr>
<td>Chapter 4: Preliminary Findings and Results</td>
<td>44</td>
</tr>
<tr>
<td>Preliminary Findings</td>
<td>44</td>
</tr>
<tr>
<td>Recruitment Process and Outcome</td>
<td>44</td>
</tr>
<tr>
<td>Chapter 5: Development of the Treatment Manual</td>
<td>48</td>
</tr>
<tr>
<td>Development of the Adapted Manual</td>
<td>48</td>
</tr>
<tr>
<td>Group Format and Outline</td>
<td>48</td>
</tr>
<tr>
<td>Additions to the Manual</td>
<td>49</td>
</tr>
<tr>
<td>Incorporating Mindfulness Practice</td>
<td>49</td>
</tr>
<tr>
<td>Wedding Attachment Theory with RCT</td>
<td>50</td>
</tr>
<tr>
<td>What is Attachment Theory</td>
<td>50</td>
</tr>
<tr>
<td>Identifying Barriers</td>
<td>51</td>
</tr>
<tr>
<td>Developing Collaborative Goals</td>
<td>52</td>
</tr>
<tr>
<td>Requesting Feedback</td>
<td>52</td>
</tr>
<tr>
<td>Tending to Relational Trauma</td>
<td>53</td>
</tr>
<tr>
<td>Termination</td>
<td>53</td>
</tr>
<tr>
<td>Chapter 5: Development of the Treatment Manual</td>
<td>48</td>
</tr>
<tr>
<td>Development of the Adapted Manual</td>
<td>48</td>
</tr>
<tr>
<td>Group Format and Outline</td>
<td>48</td>
</tr>
<tr>
<td>Additions to the Manual</td>
<td>49</td>
</tr>
<tr>
<td>Incorporating Mindfulness Practice</td>
<td>49</td>
</tr>
<tr>
<td>Wedding Attachment Theory with RCT</td>
<td>50</td>
</tr>
<tr>
<td>What is Attachment Theory</td>
<td>50</td>
</tr>
<tr>
<td>Identifying Barriers</td>
<td>51</td>
</tr>
<tr>
<td>Developing Collaborative Goals</td>
<td>52</td>
</tr>
<tr>
<td>Requesting Feedback</td>
<td>52</td>
</tr>
<tr>
<td>Tending to Relational Trauma</td>
<td>53</td>
</tr>
<tr>
<td>Termination</td>
<td>53</td>
</tr>
</tbody>
</table>
List of Figures

Figure 1. Research Questions and Methodology Chart ......................................................... 72
Figure 2. Forms to Demonstrate the Process of Interpretation .............................................. 73
Figure 3. Sample of Forms to be Used for Notes .................................................................. 74
Figure 4. Flowchart of the Corrective Relationship within Relational-Cultural Theory and Attachment Theory .................................................................................................................. 75
Abstract

The following dissertation outlines a group intervention designed to improve the relational and mental health of female emerging adults who have aged out of foster care. It is argued through review of the literature that emerging adulthood is a unique developmental phase in which relational connections are vital to successful transition to adulthood. Female emerging adults who have aged out of foster care frequently lack these social supports; their isolation renders them particularly vulnerable to psychological and interpersonal problems. Therefore, a mentoring component might be valuable to this population and is included in the current intervention. Included in the following is a treatment manual for the proposed intervention, which is adapted to meet the unique needs of young women aging out of foster care. Extensive recruitment efforts did not yield participants for the group, so the following describes the intervention and manual as planned, but not implemented. The treatment manual that is adapted for these young women is offered as the results of the dissertation. A discussion of the limitations and implications for future research is offered. Lastly, the dissertation concludes with a chapter exploring the complexities inherent in serving marginalized populations, as well as recommendations addressing these unique challenges.

*Keywords:* Relational group therapy, emerging adulthood, attachment, relational health, aging out of foster care, co-therapists, mentoring, relational-cultural theory
Chapter 1

Emerging adulthood is a phase of life, spanning the ages of 18 and 25, that poses unique developmental challenges and opportunities (Arnett, 2000). Emerging adults who have been in foster care and then “age out” of the system lose social and institutional support; they are then at a disproportionately high risk for experiencing violence, mental illness, homelessness, substance abuse, and unplanned pregnancy (Casey Family Programs, 2008). Given that relational health is associated with mental health, especially for women (Laing, Tracy, Taylor, et al. 2002), a relational group therapy approach could be beneficial for these young women. The following research project outlines the implementation and assessment of a short-term, relational group therapy intervention pilot and manual, tailored specifically for treating female emerging adults who have aged out of foster care. Though extensive recruitment efforts did not yield participants for the group, the following describes the intervention and manual as it was intended, but not implemented.

Statement of the Problem

Emerging adulthood is a unique, transitional, developmental period distinct from adolescence and young adulthood (Arnett, 2000). Emerging adults are at disproportionately high risk for developing psychiatric disorders (Viner & Tanner, 2009). Familial relationships are essential for emerging adults to effectively maneuver through this developmental phase, as they inform all subsequent relational experiences (Humphrey, 2009). Emerging adults who have emancipated or aged out of foster care often lose this reliable parental support (if they experienced it in the first place) that could aid in the transition to adulthood (Greeson, Usher, & Grinstein-Weiss, 2010). According to the U.S. Department of Health and Human Services, in
2005, 24,407 young people no longer received foster care services solely due to their age (Casey Family Programs, 2008). Emerging adults who age out of foster care face greater risk for experiencing violence, substance abuse, homelessness, incarceration, unemployment, unplanned pregnancy, depression, anxiety, posttraumatic stress disorder (PTSD), and other mental illnesses, compared to their same-aged peers who have family support (Casey Family Programs, 2008). Of related concern are the higher rates of unplanned pregnancy and homelessness in this group; the children of these young women are, in turn more likely to be placed in foster care, thereby perpetuating a cycle of foster care involvement (Casey Family Programs, 2008).

Emerging adults who age out of foster care are an at-risk population for whom there is no current gold standard of treatment. Despite the development of interventions for children and adolescents while still in foster care, emerging adults who age out continue to have poor outcomes, and uncoordinated services (Scannapieco, Connell-Carrick, & Painter, 2007). Young women are particularly vulnerable; they merit unique clinical attention. In this dissertation, I describe a co-led relational group intervention pilot study and manual. The attendant mixed methodology research is intended to help determine the appropriateness and efficacy of the intervention for this underserved and unique target population.

Rationale

A lack of research exists surrounding interventions for foster youth, despite their significant mental health needs (Hughes, 2004); the dearth of documentation of successful interventions for youth who age out of the system is even more pronounced. As described by Casey Family Programs (2008), in this regard, emerging adults who age out of foster care are no different than their age peers with functional families: they benefit from supportive, loving relationships, in their successful transition to adulthood.
From an attachment perspective, the ongoing connection to supportive caregivers is fundamental for understanding the unique developmental needs of emerging adults (Riggs & Han, 2009). Female emerging adults with secure attachment to parents are more likely to have strong peer relationships, and authentic community relationships, all contributing to lower levels of distress and anxiety, compared to those who do not (Frey, Beesley, & Miller, 2006). Early and ongoing relational trauma, common in the experience of foster children, makes connection even more developmentally salient for young women who are aging out of foster care. For these at-risk emerging adults, effective treatment must include a focus on relationships and attachment security (Hughes, 2004). Limited research suggests that group therapy may have particular benefits for this population. For example, Lee and Park (1978) found psychodynamic group therapy to be an effective treatment for female adolescents in foster care, though the approach has not been implemented with emerging adults. The researchers found the familial quality of the group provided healing for female adolescents in foster care (Lee & Park, 1978).

**Significance for the field of professional psychology.** Emerging adulthood is a relatively novel developmental period requiring additional empirical exploration (Arnett, 2000). Further, as described by Arnett, research on emerging adults who do not attend college is vital to a broader understanding of this developmental phase. A developmentally-appropriate treatment adaptation would enhance mental health outcomes for this at risk population. This research study is significant because it seeks to inform clinical practice and research by offering a treatment manual that is tailored to meet the specific needs of young women aging out of foster care. It is also significant because a methodological approach to evaluating the intervention is offered, in the form of an intervention pilot. If deemed appropriate, the intervention pilot could act as the foundation for larger, more controlled research.
Theoretical and Conceptual Framework: Relational-Cultural Theory

Relational-cultural theory (RCT) is the primary theoretical and conceptual framework of this research study. RCT incorporates elements from psychodynamic, developmental, and attachment theories (Jordan, 2010). The central therapeutic perspective of the research study is relational-cultural therapy, which was developed out of RCT. Given the importance of attachment and its influence on social functioning, health behavior, psychological well-being, stress response, and coping among others (Ravits, Maunder, Hunter, Sthankiya, & Lancee, 2010), RCT offers a promising therapeutic approach for emerging adult women who have aged out of foster care, and lack a stable, enduring family.

Major tenets of relational-cultural theory. RCT holds growth-fostering relationships as the essential ingredient to effective psychotherapy; such relationships are defined by increased self-worth, empowerment, interest in relational connection, and clarity between self and other (Jordan, 2010). Growth-fostering relationships are determined by mutual empathy, authenticity, mutual empowerment, and attention to power differences (Jordan, 2010). In RCT, conflict is viewed as crucial to development within therapy, and other growth-fostering relationships; it is particularly beneficial when both parties are open to mutual empathy and responsiveness (Jordan, 2010). Conflict is inevitable within all growth-fostering relationships, and RCT posits that the most profound psychological change occurs through encountering conflict (Jordan, 2010).

History. The primary founders of RCT were trained in psychodynamic psychotherapy, which largely influenced their model (Jordan, 2010). Specifically, RCT incorporates aspects of psychodynamic theories including object relations theory, Freudian psychoanalysis, and self-psychology, as well as the ideas of theorists such as Rogers, Kohut, and Stern (Jordan,
RCT was developed out of the work of Jean Baker Miller, Judith Jordan, Irene Stiver, and Janet Surrey in the 1970s at the Stone Center at Wellesley College (Jordan, 2010). These four feminist psychologists began informally meeting to discuss their reactions to, and alterations of, psychodynamic psychotherapy, thereby forming the base of RCT (Jordan, 2010). Since its inception, RCT has been applied in a variety of therapeutic settings, with various populations internationally, leading to a solid evidence base (Jordan, 2010). As described by Jordan, decades of attachment and neurobiological research on the importance of relational connection further supports the basic premise of RCT.

**How does relational-cultural theory explain psychological health?** Within the relational-cultural framework, it is believed that psychological health parallels relational health, and develops predominantly out of the context of growth-fostering relationships (Jordan, 2010). Growth-fostering relationships derive out of mutual empathy, mutual empowerment, and authenticity, which, in turn, results in relational resilience and competence (Jordan). As indicated by Miller and Stiver, a child whose primary attachments are characterized as growth-fostering will continue to develop positive relational images (RI): internal constructions and expectations of relationships that guide our interactions with others throughout the lifespan (Jordan, 2010). Therefore, psychological health is viewed as a result of growth-fostering relationships that become internal relational images, and subsequently guide strategies for connectedness with others.

**How does relational-cultural theory explain psychopathology?** The relational-cultural approach asserts that psychopathology results from chronic disconnections (Jordan, 2010). Whereas acute disconnections are normative, chronic disconnections result in immobilization, isolation, and increased pain (Jordan, 2010). As indicated by Jordan (2010), “At the extreme,
they result from humiliations, violations, abuse, and emotional neglect” (p. 5). RCT emphasizes how disconnections can occur on individual, group, and societal levels through marginalization and discrimination, thereby creating shame (Jordan, 2010). The cultural portion of RCT involves understanding the controlling images and resulting shame that a person’s culture creates (Jordan, 2010).

As a result of chronic disconnections, negative relational images develop internally, often becoming rigid and overly generalized (Jordan, 2010). Negative relational images in turn influence current relational interactions by stunting authenticity and continuing the chronic cycle of disconnection and isolation (Jordan, 2010). These strategies of disconnection develop to protect the individual from additional harm, given previous attempts to be authentic and vulnerable with significant others have resulted in pain (Jordan, 2010).

Relational-cultural interventions. RCT posits that healing can occur within various sorts of growth-fostering relationships (Jordan, 2010). Given the hierarchical nature of the therapeutic relationship, Jordan (2010) further describes how it is the responsibility of the therapist to both provide a growth-fostering relationship, and encourage the pursuit of additional growth-fostering relationships outside of therapy. In attempt to provide multiple opportunities for such connections, this research project integrates components of relational-cultural group therapy and mentoring.

What is relational-cultural therapy? Relational-cultural therapy is an approach to psychotherapy that is based on the assumption from RCT that all humans yearn for and grow through connections with others, and without which, profound suffering occurs (Jordan, 2010). RCT provides a developmentally-conscious therapeutic model that has a primary focus of enhancing connectedness through relationships (Jordan, 2010). As with all theoretical
approaches, and perhaps with the relational-cultural approach to therapy in particular, the therapeutic alliance is a fundamental element for successful treatment. Once this process has begun, and a sense of safety has developed, the RCT therapist focuses on the healing function of the therapeutic relationship, as well as the cultural factors that influence this process.

What is relational-cultural mentoring? RCT emphasizes the importance of promoting growth-fostering relationships inside and out of therapy (Jordan, 2010). Accordingly, the dissertation project originally included exploration of the utility of a mentor-mentee co-therapist pair for helping and supporting young women who age out of foster care. Essentially, the co-therapist pair would model a growth-fostering mentoring relationship, intended to promote longer-term, within-group peer mentoring.

Preliminary research has indicated effective interventions that focus on mentoring relationships, using RCT for young women in college (Jordan, 2010). As described by Laing, Tracy, Kauh, Taylor, and Williams (2002), mentoring relationships, characterized by providing emotional support, are especially important for women who are transitioning to adulthood.

Mechanisms of change. RCT holds growth-fostering relationships as the essential ingredient to both effective psychotherapy and mentoring. These relationships are characterized by increased self-worth, empowerment, interest in relational connection, and clarity between self and other (Jordan, 2010). Growth-fostering relationships develop through mutual empathy, authenticity, mutual empowerment, and attention to power differences within the relationship (Jordan, 2010). The mechanisms of change in the relational-cultural therapy approach include the therapist providing a corrective relational experience in the context of a growth-fostering relationship, and changes in the client’s internal relational images. Such relationships provide connection, and a corrective relational experience, that results in changes to the negative
relational images that had perpetuated disconnection and caused psychopathology (Jordan, 2010). As a result of experiencing this type of relationship, clients continue to pursue growth-fostering relationships outside of therapy (Jordan, 2010). RCT can be used to conceptualize and intervene to meet the therapeutic needs of young women in foster care.

**Rationale for a Mixed Methodological Approach**

In the following chapters, I describe a mixed methods methodological approach that I planned to employ to evaluate a group intervention for these young women. I had intended to implement a pilot study to use participants’ feedback to inform a larger intervention. As described by Locke, Spirduso, and Silverman (2007), “...the modest pilot study is the best possible basis for making wise decisions in designing research” (p.76). It was postulated that an intervention pilot would function as a foundation for subsequent research on the effectiveness of the proposed treatment. In addition, the pilot would have allowed for feedback obtained from participants to be integrated into the intervention, thereby enhancing its acceptability.

An intervention pilot involving a mixed methods approach was proposed to evaluate and inform the treatment manual. The qualitative portion would have involved interpretive phenomenological analysis (IPA). Within the constructivist paradigm, IPA allows the researcher to explore how participants make sense of their world (Smith & Osborn, 2008). By implementing a double hermeneutic approach, the researcher is provided the opportunity to try understanding the subjective experiences of participants (Smith & Osborn, 2008). Through this approach, I intended to explore and try to understand the subjective experience of my mentor and co-therapist, which would have informed the value of the mentoring focus for this population. Given that the intended methodological approach of the intervention involved attempts to understand the depths of a particular kind of experience, IPA allows for exploration of complex
phenomena and processes (Smith & Osborn, 2008). The planned quantitative element included
pre- and post-intervention scores to be obtained from participants on two assessment measures,
to inform the process of treatment, as well as the benefit for participants.

**Research Questions**

**How suitable is the intervention for the target population?** The research study would
have involved exploration of an intervention that is tailored to meet the unique clinical needs of
female emerging adults who have aged out of foster care. The suitability of the intervention for
the target population would have been determined through assessing feasibility, acceptability,
and benefit of the pilot. Co-therapist perceptions would have informed the value of adding a
mentoring component when working with these women.

Feasibility would have been assessed using observational data. The questions
surrounding intervention feasibility were adapted from Thabane et al. (2010). The acceptability
of the intervention would have been determined through qualitative exploration of participants’
subjective experiences of the intervention pilot. Therefore, research questions were to be directed
toward understanding what the experience of participating in a co-led, short-term, relational
group therapy is like for female emerging adults who have aged out of foster care, as well as the
meanings they attach to their experience. The benefit of the intervention pilot would have been
determined using quantitative assessment measures to be administered before, during, and after
participation. Scores obtained at intervals were to be compared to determine whether the
intervention pilot was beneficial for participants. Please refer to Figure 1 for a chart of the
research questions and methodology of the pilot. The intervention pilot was designed to address
the following questions:

1. How suitable is the proposed intervention for the target population?
2. What is the feasibility of delivering the intervention as designed?

3. How acceptable is the intervention by the target population?
   a. What is it like for female emerging adults who have aged out of foster care to participate in a co-led, short-term, relational group therapy?
   b. What does it mean to a female emerging adult who has aged out of foster care to participate in a co-led, short-term, relational group therapy?
   c. What are the implicit meaning-making processes that occur after participating in a co-led, short-term, relational group therapy?

4. What additional adaptations are needed to meet the clinical needs of the target population?

5. How beneficial is the intervention for the target population?
   a. How do participants score on measures of relational health and mental health before, during, and after the intervention?
   b. What, if any, trends exist within the findings of scores obtained on assessment measures?
   c. How valuable is the inclusion of mentoring as part of the intervention for the target population?

**Statement of intent.** The initial intent of this research study was to explore the suitability of a co-led, short-term, relational therapy approach for female emerging adults who have aged out of foster care. An intervention pilot was planned to determine the feasibility, acceptability, and benefit of the treatment as designed to the target population. The intervention pilot would have allowed me to get a preliminary sense of these factors that will inform future research surrounding treatment effectiveness. It would have also contributed to understanding the value of
integrating a mentoring component into treatment with these young women.

**Statement of hypotheses.** I hypothesized that a co-led, short-term, relational group therapy approach is a feasible, acceptable, and beneficial treatment for female emerging adults who age out of foster care. I further hypothesized that a mentoring approach to group therapy is particularly useful for this population, given their unique relational needs.
Chapter 2: Literature Review

Problem of Study

Emerging adulthood is a developmental phase characterized by unique relational challenges in balancing autonomy and connection with others (Tanner, 2009). For female emerging adults, relational health is associated with mental health (Laing, Tracy, Taylor et al. 2002). By definition, individuals who enter foster care have experienced relational trauma. The majority of children who enter foster care do so because of parental neglect or abuse (Leve, Fisher, & Chamberlain, 2009). The transition to adulthood is particularly difficult for youth who carry with them such a legacy of unstable and unsafe relationships. Group treatment aimed at developing and fortifying connections, at a time when they are losing family and institutional support, may be particularly beneficial for them.

Emerging Adulthood

Emerging adulthood has been characterized by Arnett (2004) as a unique, developmental phase of life, expanding from about 18 to 25 years of age. Emerging adults feel as though they are no longer adolescents, but have not yet achieved adulthood status (Arnett). Emerging adulthood reflects a new developmental period for individuals ranging in age from the late teens through the twenties, and who live in the United States or another industrialized society (Arnett). Arnett describes how shifts in trends of major developmental milestones have contributed to this new phase of life, such as the median rise in age of getting married and having children. However, Arnett speculates that the most significant factor contributing to the development of a new life phase is, “...a profound change in how young people view the meaning and value of becoming an adult and entering the adult roles of spouse and parent” (p. 6). These developmental markers coincide with other social, cultural, and economic shifts that contribute further to
delayed adulthood for many (Settersten & Ray, 2010).

**Female emerging adults.** Just 50 years ago, the developmental tasks of young women in their twenties were to find a husband, and shortly thereafter, have children; in fact, the average age for childbearing has increased significantly (Arnett, 2004). Today, the number of women attending college outnumbers that of men (National Center for Education Statistics, 2002). As described by Arnett (2004), American women have much less pressure from gender roles than they did 50 years ago, allowing for the freedom of identity exploration that characterizes emerging adulthood. Unfortunately for many, this shift has also resulted in economic hardship; most women no longer can hold the expectation that someone will be financially supporting them after they leave home.

**Growing Up In, and Aging Out of, Foster Care**

The developmental stage of emerging adulthood coincides with increased vulnerability to emotional distress. For example, 75% of all adults who have been diagnosed with major mental illness, including psychotic, personality, and mood disorders, experienced the onset of their illness by the time they were 24-years-old (McCloughen, Foster, Huws-Thomas, & Delgado, 2012). A lack of mentor, peer, and community supports is associated with psychological distress for emerging adults of both genders who are transitioning to college (Frey et al. 2006); emerging adults without parental support are particularly at-risk (Settersten & Ray, 2012).

**Risk factors.** Youth who don’t get adopted, or enter into some kind of legal guardianship before they turn 18 years of age are an especially high risk group, compared to same-aged peers within the foster care system (Yates & Grey, 2012). Further, emerging adults who age out of foster care are an at-risk population, significantly less likely than their same-aged peers to have familial support during the transition to adulthood (Greeson et al. 2010). As Yates and Grey
describe, “Emancipated foster youth evidence significant difficulties negotiating the developmental challenges of young adulthood across varied domains, such as education, employment, community engagement, relational well-being, and psychological health” (p. 475). Many fostered youth also attempt to reunite with their biological parents when they reach their 18th birthday; this desire to “go home” seldom results in the stability and safety they hope for, and can cause even more distress (Casey Family Programs, 2008).

**Protective factors: The importance of connection.** The presence of one caring, supportive adult is a normative component of adolescent development, as well as a protective factor for at-risk youth (Greeson et al. 2010). Findings from the National Longitudinal Study of Adolescent Health similarly indicated an association between relationships with caring adults and positive outcomes for both typical emerging adults, as well as emerging adults who were previously involved in foster care (Greeson et al. 2010).

The quality of parental, peer, and community relationships for females during emerging adulthood have been determined to predict distress levels (Frey et al. 2006). In fact, relational health is strongly associated with mental health for female emerging adults (Laing, Tracy, Taylor et al. 2002), underscoring Bowlby’s notion that secure attachments are essential for survival and well-being throughout the lifespan (Mallinckrodt, Porter, & Kivlighan, 2005). Emerging adults’ positive mentor, peer, and group relationships serve as protective factors against psychological distress (Frey et al. 2006). Unfortunately, emancipated emerging adults often lack these vital supports during a critical developmental period (Laing, Tracy, Kauh et al. 2002).

**What Works?**

Psychological development is dependent upon the quality of human relationships, and without high quality relationships, development is compromised (Li & Julian, 2012). It is quite
well established that secure attachments are fundamental to successful overall development (Hughes, 2004). Such relationships foster resilience, emotion regulation, trust, personality, social, and cognitive development, social skills, morality, psychological health, as well as other long-term, positive outcomes (Li & Julian, 2012). Additionally, reciprocal interactions that are characteristic of secure attachment relationships are essential for neuropsychological development (Hughes, 2004).

Li and Julian (2012) recently identified developmental relationships as the essential therapeutic ingredient that is necessary for successful interventions with at-risk youth. Developmental relationships are characterized by interrelated and interdependent factors, including, “…attachment, reciprocity, progressive complexity, and balance of power” (Li & Julian, p. 164). Given such relationships are most influential when they expand over time (Li & Julian), this intervention pilot intended to provide a relational foundation among members, as well as the opportunity for these connections to last beyond the span of the group. Li and Julian describe how developmental interventions should be geared toward fostering developmental relationships, noting, “When developmental relationships are prevalent, development is promoted, and when this type of relationship is not available or is diluted, interventions show limited effects” (p. 159).

**Relationship-focused group interventions.** Given the complex familial and interpersonal challenges foster youth have endured, relational and attachment-focused interventions, “… may serve as the keystone for a treatment for multi-problem foster and adoptive children, who resist more traditional treatment and parenting interventions, including CBT” (Hughes, 2004, p. 264). Group interventions with a relational focus have been implemented for female foster youth (Joseph, 1971; Lee & Park, 1978), and for female emerging
adults who attend college (Johnson, 2009; Kilmann et al. 1999; Levine & Mishna, 2007; Tantillo, 2000), but not for emerging adult women aging out of foster care.

Specifically, Lee and Park (1978) implemented a psychodynamic group therapy approach for adolescent females in foster care who struggled with depression. The group approach appears especially important for foster youth, given the expected disturbances in their familial object relations. As described by Lee and Park, “...perhaps it is the family-like quality of the group that means the most to the girls when all is said and done” (p. 525). Joseph also implemented a group therapy approach with adolescent females in foster care. A group therapy approach was thought to evoke and work-through past feelings of abandonment from members’ birth parents (Joseph, 1971). Joseph (1971) emphasized how a planned ending with the parental group leader provided, “...a corrective emotional experience” (p. 312), while allowing the development of mutual respect and trust amongst members.

Other relationship-focused group interventions have demonstrated effectiveness for emerging adults more generally, though not foster care graduates. These studies report on relational interventions with college students. For example, Kilmann et al. (1999) implemented a relational group approach for insecurely attached female college students, which proved beneficial to their successful transition to dorm life, based on self-reports of improved interpersonal styles and interactions. Similarly, a process-oriented, interpersonal group therapy approach also worked to meet the unique developmental and relational needs of emerging adults in college (Johnson, 2009). Short-term relational group therapy for college females with eating disorders has also demonstrated effectiveness (Tantillo, 2000).

The significant needs of emerging adults not on college campuses have gained scant attention (Arnett, 2000). However, RCT-based, Relational Practice Groups have been effective in
Group Therapy

The premise of all group therapy work is that interpersonal relationships can provide healing (Yalom & Leszcz, 2005). Whereas individual therapy provides a healing relationship with one individual, group therapy provides opportunity for multiple healing relationships (Yalom & Leszcz, 2005). Given the therapeutic potential in relationships, it is notable that group therapy translates psychological symptoms into interpersonal concerns (Yalom & Leszcz, 2005). Although interpersonal and relational group therapy approaches are similar, an interpersonal group therapy approach emphasizes interpersonal distortions and behavioral patterns, whereas a relational group approach places emphasis upon mutually empowering and empathic connections as a way of developing growth-fostering relationships that enhance psychological health (Tantillo, 2000).

Short-term group therapy. In addition to being a cost-effective treatment option, a short-term group therapy approach is preferable in many ways (Hardy & Lewis, 1992). The short-term group therapy model is a useful approach that allows therapists to predict, monitor, and use developmental phenomena that occur within the group (Hardy & Lewis, 1992). The short-term approach is also appealing to individuals who have chaotic lives who might be hesitant to commit to a longer-term treatment modality (Hardy & Lewis, 1992). As described by
Yalom and Leszcz (2005), short-term groups typically have lower dropout rates compared to longer-term groups.

The use of a short-term group approach allows for greater flexibility of therapists to address a variety of clinical needs of a population (Hardy & Lewis, 1992). Homogeneous short-term groups can be of particular benefit. The use of a homogenous short-term group approach allows for quick and easy cohesion among members (Hardy & Lewis, 1992). As described by Rutan, Stone, and Shay (2007), “For individuals who begin with the knowledge that they are similar to others in fundamental ways, the initial, trust-building stage is hastened” (p. 115).

**Co-led group therapy.** Co-therapy is defined as the joining of two therapists in treating a group, couple, or family (Hendrix, Fournier, & Briggs, 2001). Although there have been mixed reviews of the use of co-therapists in group therapy in the past (Hendrix et al. 2001), it was recently discovered that co-led groups are markedly more beneficial than individually-led groups (Kivlighan, London, & Miles, 2012). Therefore, the research study argues the benefits of utilizing a co-led group approach with the target population outweigh potential risks involved.

**Benefits of co-led group therapy.** Utilizing co-therapists in group therapy has various benefits. For instance, co-therapists can model effective communication and problem-solving (Rutan, Stone, & Shay, 2007). When two therapists lead a group, it is likely that a greater amount of clinical material can be addressed compared to when there is only one therapist (Yalom & Leszcz, 2005). Co-therapists are more likely to be able to effectively set limits when working with difficult clients during challenging developmental periods (Rutan et al. 2007). Using a co-led group therapy approach can also be particularly useful in providing corrective emotional and relational experiences, and in facilitating the mentoring process.
Providing the corrective emotional and relational experience. The use of co-therapists in group therapy might be useful in evoking feelings related to early familial relations (Yalom & Leszcz, 2005). The effect of co-led group therapy treatment is enhanced if the model allows for replication of parental figures (Rutan et al. 2007). Parental transference will occur regardless of the gender of the co-therapists in group therapy treatment (Rutan et al. 2007). In fact, the co-therapist pair can provide a corrective re-parenting experience signified by respect and congruence instead of inconsistency and abandonment (Westman, 1996). As identified by Carl Whitaker, co-therapists serve as adult role models that provide in vivo opportunities to experience and observe a healthy relationship between parental-like figures (Hendrix et al. 2001). Similarly, for deeply pained individuals who have suffered disruptions in early familial relations, “...co-therapy constitutes a structural analog to the family constellation and as such provides the opportunity for a corrective emotional experience...” (Berger, 2002, p. 108). In fact, Berger emphasizes how the successful use of co-therapists, whether stated explicitly or not, is one of the most significant curative factors when working through early familial trauma.

Female group therapy leaders allow for identification to more readily occur for female clients (Rutan et al. 2007). Female emerging adults who have aged out of foster care have likely experienced disturbances in familial relations (Casey Family Programs, 2008), and therefore might find it especially beneficial and therapeutic to experience a co-led group therapy. In doing so, co-therapists would represent parental figures working together for their benefit, likely a novel experience for most participants.

According to Yalom and Leszcz (2005), it can be advantageous for clients to observe co-therapists disagreeing during group therapy. When co-therapists disagree during the group, clients experience them as genuine, distinct, and human (Yalom & Leszcz, 2005), and feelings of
parental conflict are evoked (Yalom & Leszcz, 2005). Concurrently, if co-therapists effectively communicate and navigate disagreements during group therapy, clients will have the opportunity to observe healthy adult communication (Yalom & Leszcz, 2005). Co-therapists who effectively negotiate about disagreements can strengthen the effectiveness and honesty of the group” (Yalom & Leszcz, 2005, p. 446).

A visible power differential within a co-therapist team can provide a unique benefit for individuals who struggle with their relationships with authority figures (Tuckman & Finkelstein, 1999). In this scenario, the co-therapist team could model effective relational interactions with authority figures, as one therapist would have had authority over the other (Tuckman & Finkelstein, 1999).

*Mentoring and the co-therapist relationship.* Co-therapists capitalize upon the innate power differences within their relationship when the more experienced therapist serves as a support and role model for the less experienced therapist (Huffman & Fernando, 2012). The experience of observing a more advanced therapist in action is a profound learning experience that can serve as both a model and a mirror for a novice therapist that enhances self-reflection (Tuckman & Finkelstein, 2008).

Mentoring within the co-therapist relationship can also be useful for group members, and perhaps especially for the young women who are aging out of foster care with few supports. The current study describes a mentor-mentee, co-therapist pair. As Yalom (2002) highlights, one of the primary tasks of the group involves the process of members becoming more like the co-leaders. Therefore, it was posited that the mentor-mentee, co-therapist pair will model a healthy mentoring relationship, which in turn would have facilitated peer-mentor relationships among members. Given the lack of attention the topic has received in the literature (Tuckman &
Finkelstein, 2007), the present research study would have expanded the knowledge base about the dynamics of the co-therapist relationship, with a primary focus on mentoring.

Enhancing the co-therapist relationship. Regardless of the stage of development of the relationship, the effectiveness of utilizing a co-led group therapy approach depends upon the quality of the relationship between co-therapists (Rutan et al. 2007). Mutual respect between therapists is essential for effective co-led group therapy, despite differences in clinical abilities (Rutan et al. 2007). Rutan et al. posit that respect, exploration of group processes including the co-therapists’ relationship, and similar theoretical orientation are key ingredients to effective co-led group therapy.

Reflective practice. As postulated by Okech (2008), reflective practice is essential to the effectiveness of co-led group therapy. Reflective practice involves continual critique of ones experiences, beliefs, and choices in interactions in such a way that enhances the intentionality of clinical practice (Okech, 2008). Without reflective practice, the co-therapists jeopardize their effectiveness in group therapy by increasing the likelihood of mistrust, competitiveness, and other power struggles (Okech, 2008). Reflective practice within the co-therapist relationship involves both continual internal self-evaluation and interpersonal processing (Okech, 2008), and is also a consistent practice within qualitative research (Mertens, 2009). The development of intimacy within the co-therapist relationship allows for, “...more effective feedback exchange and peer supervision, which also serves a critical role in the maturation of the co-leader relationship” (Okech, 2008, p. 241). The current research study intended to involve the use of reflective practice within the co-therapist relationship to enhance the effectiveness of the pilot group.

Modifying group therapy for a unique population. Group therapy has been adapted for
adolescent females in foster care (Joseph, 1971; Lee & Park, 1978), and for female emerging adults with eating disorders (Tantillo, 1998), but not yet for treating the unique needs of female emerging adults who have aged out of foster care. Although group treatments have been formulated for college-aged students with depression and anxiety (Seligman, Schulman, & Tryon, 2007), as well as insecurely attached, female college students (Kilmann, et al. 1999), there has been a notable lack of research paid toward emerging adults who do not attend college (Arnett, 2004). Therefore, this dissertation involves the development of a group intervention for young women who are aging out of care.

**Relational-cultural group therapy.** Relational Practice Groups developed out of relational-cultural theory (Jordan & Dooley, 2001). Although they are manualized, Relational Practice Groups are intended to be adapted to meet the unique clinical needs of a given population (Jordan & Dooley). The current research project modifies the Relational Practice Group manual, developed by Jordan and Dooley to meet the unique clinical needs of young women aging out of foster care.

**Previous research.** As Jordan and Dooley (2001) indicate, Relational Practice Groups have demonstrated utility in a variety of clinical and non-clinical settings including: residential treatment facilities for adolescent girls, inpatient and outpatient settings, prisons, businesses, schools, club organizations, and other mental health settings. Relational Practice Groups have also been clinically effective when working with adolescent males and their parents (Jordan & Dooley, 2001). Moreover, Comstock, Duffey, and St. George (2002) use Relational Practice Groups when training graduate counseling students and provide a general framework for implementing relational-cultural group therapy.

**Goals of treatment.** The primary goal of any RCT therapeutic approach involves
developing growth-fostering relationships (Jordan & Dooley, 2001). Growth-fostering relationships provide the avenue required for a corrective emotional and relational experience to occur (Jordan, 2010). In addition, within an RCT framework, it is seen as the therapist’s responsibility to encourage clients to seek growth-fostering relationships outside of therapy (Jordan, 2010). Such relationships lead to what Miller referred to as the five good things (Jordan, 2010; Jordan & Dooley, 2001). Miller’s five good things that occur within growth-fostering relationships include increases in: energy or zest, empowerment, sense of self and other, self-worth, connectedness, and desire for additional connectedness with others (Jordan & Dooley, 2001). Mentoring relationships can be growth-fostering and contribute to relational resilience for female emerging adults (Laing, Tracy, Kauh et al. 2002). Therefore, the secondary goal of treatment for these young women who are aging out of foster care involved facilitating mentoring relationships. A group approach might also be particularly useful when attempting to do so; the mentor-mentee, co-therapist pair can be essential in facilitating this supportive process among group members.

Corrective emotional and relational experience. As previously described, the mechanisms of change within an RCT approach include the corrective emotional and relational experience that leads to internal changes of clients’ negative relational images (Jordan, 2010). A group therapy approach is ideal for this population, as it facilitates the expression of disruptions in early family object relations (Yalom & Leszcz, 2005). The group also acts as a social microcosm, or glimpse into how each person experiences their world and relationships outside the group (Yalom & Leszcz, 2005). The use of co-therapists in group therapy provide additional opportunities for disrupted parental attachment relations to surface (Rutan, et al. 2007). A corrective emotional and relational experience was a primary objective of the proposed
GROUP THERAPY FOR YOUNG WOMEN

intervention, which is obtained by responding to participants in ways that are unexpected (Yalom & Leszcz, 2005). Relational Practice Groups seek to provide connection and relatedness through mutuality and reciprocal empathy (Jordan & Dooley, 2001). Such experiences may be novel for young women who have aged out of foster care.

Yalom and Leszcz (2005) identify two requirements that are necessary for the corrective emotional experience to occur: first, “…members must experience the group as sufficiently safe and supportive so that these tensions may be openly expressed…”; and secondly, “…there must be sufficient engagement and honest feedback to permit effective reality testing” (p. 28). One of the primary mechanisms that facilitate this process is the use of the here-and-now (Yalom & Leszcz, 2005). The use of the here-and-now enhances the effectiveness of the group (Yalom & Leszcz, 2005). Effective use of the here-and-now requires both affect expression, and reflection on that experience (Yalom & Leszcz, 2005). Co-therapists model connectedness by facilitating here-and-now processes for these young women. In doing so, the co-therapist relationship serves as both a model and corrective experience for participants. Ruptures within group relationships are expected, and co-therapists strive to repair such instances to further facilitate the corrective experience (Jordan, 2010). As described by Winnicott (2011), what distinguishes good from bad parents is not the number of mistakes, but how they responded to them. Co-therapists demonstrate empathic attunement that can enhance self and other awareness for group therapy members (Rutan et al. 2007), helping to heal disrupted attachments, and aid in emotion regulation (Hughes, 2004).

Attempt to facilitate within-group, peer-mentor relationships. Developmental relationships, such as those offered with mentors, can facilitate resilience in members of at-risk groups (Li & Julian, 2012). As such, one of the primary goals of Relational Practice Groups
involves the development of growth-fostering relationships among members (Jordan & Dooley, 2001). RCT emphasizes how growth-fostering relationships can occur in a variety of contexts, including between peer-mentors (Jordan, 2010). The co-therapist pair can further facilitate this process by modeling a healthy, growth-fostering, mentor-mentee relationship.

**Foundational interventions.** The interventions involved in group therapy from an RCT approach are geared toward enhancing connectedness with others, and honoring strategies of disconnection (Jordan & Dooley, 2001). The barriers to connection occur on an individual, group, and societal level, and the RCT group is aimed at understanding these barriers. Mutual empathy is another foundational intervention that provides group members with en vivo experiences of connectedness; empathic mentoring and modeling by leaders further supports emotionally corrective experiences.

**Understanding controlling images.** To first provide the client with the essential sense of safety that must exist in order for a growth-fostering relationship to develop, the RCT group therapist must first understand the client’s culture (Jordan, 2010). In doing so, the therapist is able to develop a, “...contextual empathy that helps her or him see the conditions that created this need for self-protection through disconnection” (Jordan, 2010, p. 31). Of particular importance to the RCT group therapist are the controlling images the culture creates, for these societal influences perpetuate cycles of chronic disconnection by becoming internal, negative relational images (Jordan, 2010). Within RCT therapy, the clients and therapists collaboratively understand and address controlling images, and attendant shame (Jordan, 2010). For example, foster children often carry a burden of isolative shame in a culture where the nuclear family is normative; cultural expectations of marginalization and failure may impede development to adulthood.

**Honoring strategies of disconnection.** The RCT group therapist seeks to empathize with
the client’s strategies for avoiding connection, due to the pain experienced in past relationships (Jordan, 2010). Miller and Stiver describe how, “...These strategies are ways of staying out of connection because the only relationship that had been available was, in some fundamental way, disconnecting and violating; in other words, there was good reason to develop the strategies” (Jordan, 2010, p. 104). In doing so, the client holds less shame for having ineffective and sometimes painful coping strategies; she experiences healing validation from the RCT group therapist (Jordan, 2010). Honoring these survival strategies might be of particular benefit to young women aging out of foster care, considering the very high percentage of foster children who develop avoidant styles of attachment (McWey, 2004).

**Mutual empathy.** Mutual empathy is extremely important for relationships to be growth-fostering (Jordan, 2010). Mutual empathy involves relational responsiveness and occurs when a therapist allows herself to be influenced by the client, and for the client to witness their influence in such a way that enhances connection and decreases isolation and loneliness (Jordan, 2010). Within RCT, conflict is viewed as crucial within therapy and other growth-fostering relationships, and beneficial when both parties are open to mutual empathy and responsiveness (Jordan, 2010). As described by Jordan (2010) mutual empathy leads to growth when, “...both people must see, know, and feel that they are being responded to, having an impact, and mattering to one another” (p. 104). The client’s sense of supported vulnerability and mutual respect are essential for mutual empathy (Jordan, 2010).

**Emphasis on the co-therapist relationship.** Co-therapists can facilitate parental transference and the identification process (Rutan et al. 2007), as well as to model growth-fostering mentoring. As described by Roller and Nelson (1991), a re-parenting process occurs when, “...the patient can receive new parenting messages and corrective emotional
experiences in a relationship with two parental figures” (p. 133). Within the model for this study, and consistent with the tenets of IPA, the co-therapist team focuses, between sessions, on the development of their relationship through reflective practice; this involves continual critique of one’s experiences, beliefs, and choices in interactions in such a way that enhances the intentionality of clinical practice (Okech, 2008).

**Summary**

Young women who age out of foster care without a permanent home constitute an at-risk population requiring specified clinical intervention (Casey Family Services, 2008). Developmental relationships are necessary to facilitate resilience for such at-risk individuals (Li & Julian, 2012). Though the research surrounding interventions for such individuals is scarce, the proposed intervention was tailored specifically to meet their unique clinical and developmental needs. A short-term, co-led, relational group therapy approach is posited to be an evidence-based intervention for this at-risk population. Groups can enhance a sense of belonging for these young women, and reduce psychological problems, including anxiety and loneliness (Laing, Tracy, Kauh et al. 2002).
Chapter 3: Pilot Study for Evaluating the Intervention

Overview

The following methodological approach was designed to evaluate the feasibility of implementing the intervention as a pilot, with female emerging adults who have aged out of foster care. The intervention pilot was also designed to determine the suitability of the modified treatment for the target population. Through implementation of the pilot, the feasibility, acceptability, and benefit of the treatment for target population would have been determined. Once deemed suitable for the population, subsequent research could determine the effectiveness of the intervention. In addition, I intended to determine the value of the added focus on mentoring for young women aging out of foster care.

To determine the suitability of the intervention for the target population, I developed evaluation strategies including both quantitative and qualitative methods. Although quantitative measures would not be utilized to make any strong claims about the effectiveness of the treatment, they would help guide the process of treatment, and therefore inform its suitability. By exploring the subjective meaning-making experiences of female emerging adults who have aged out of foster care, clinicians would have gained a deeper understanding of their unique needs. The various themes that would have emerged through qualitative interviews would inform the acceptability of the treatment by the female emerging adults who have aged out of foster care. Quantitative assessment measures would have been utilized to inform how beneficial the intervention is for these young women. Exploration of the co-therapists’ reflective practice journals were intended to inform the value of the added focus on mentoring relationships.

Research Design
Quantitative. A brief self-report instrument, the Outcome Questionnaire (OQ-45), was intended be used to assess overall symptomology of participants to determine overall mental health. As indicated by the Mental Measurements Yearbook (MMY), 16th edition, the OQ-45 is intended to serve as both a screening instrument and outcome assessment scale. Given it was originally designed to be used as a baseline screening tool to aid in treatment planning (MMY, 16th edition), the OQ-45 should be administered at intake to participants. The measure would then be administered again at weekly intervals throughout the intervention. To determine the benefit of the intervention, baseline OQ-45 scores will then be compared to subsequent scores obtained following participating in the intervention pilot. The OQ-45 can be used to screen participants, track intervention progress, and make treatment decisions; it has demonstrated utility with a variety of populations ranging in severity (MMY, 16th edition). The reliability of the OQ-45 has been identified as acceptable within professional standards (MMY, 16th edition). It has also demonstrated evidence of construct validity, criterion-related validity, and convergent validity (MMY, 16th edition).

To assess the relational health of participants, the Relational Health Indices would have been administered at intake to all participants in the intervention. Developed out of RCT, which emphasizes the goal of developing growth-fostering relationships rather than the goal of separation-individuation (Jordan, 2010), the RHI incorporates three scales that assess these relationships in women (Laing, Tracy, Taylor et al. 2002). The three scales of the RHI pertain to mentoring, peer, and community relationships (Laing, Tracy, Taylor et al. 2002). The community scale is particularly useful for the proposed research study, for it is intended to assess group relationships (Laing, Tracy, Taylor et al. 2002). Preliminary research has evidenced the validity, reliability, and utility of the RHI (Laing, Tracy, Taylor et al. 2002).
A single group intervention pilot was proposed to explore the unique clinical needs of female emerging adults who have aged out of foster care. The intervention would have been evaluated quantitatively using two assessment measures to be administered before, during, and after participation to inform the benefit of the treatment. The Relational Health Indices would have been administered to participants to assess changes in relational health among the participants. It was assumed that increased relational health, as measured by increases in RHI scores would be a notable benefit of the group. Further, I intended to administer the Outcome Questionnaire (OQ-45) at weekly intervals to further inform benefit of the intervention; I assumed that decreases in symptomology would also indicate a beneficial treatment.

**Qualitative: Interpretive phenomenological analysis (IPA).** The constructivist paradigm is most closely associated with the methodological approach. The qualitative aim of research study was to determine the appropriateness of the intervention by exploring the subjective realities of participants. The constructivist paradigm embraces the notion that reality is a social construct (Mertens, 2009). Developed out of hermeneutics, or the study of meaning, the constructivist paradigm allows for the emergence of knowledge through research (Mertens, 2009). The constructivist researcher understands that significant information will surface through exploration of participants’ subjective constructions of their realities (Mertens, 2009). The constructivist researcher acknowledges how the interplay between researcher and participant are inseparable from the data collection process (Mertens, 2009). The dialectical and hermeneutical or interactive nature of research involving a constructivist paradigm provides opportunity to, “...obtain multiple perspectives that yield better interpretations of meanings (hermeneutics) that are compared and contrasted through a dialectical interchange involving the juxtaposition of conflicting ideas, forcing reconsideration of previous positions” (Mertens, 2009, p. 19). The
constructivist paradigm suits the current study because the essence of the research would have been directed toward the meanings of individuals who participated in the co-led, short-term, relational group therapy intervention pilot.

The proposed qualitative methodology was interpretive phenomenological analysis (IPA). As described by Smith and Osborn (2008), IPA involves an in-depth exploration of the meanings participants develop. Moreover, IPA seeks to understand and examine participants’ unique perceptions, and the way in which they attribute meaning to their experiences (Smith & Osborn, 2008). IPA also involves interpreting and attempting to understand the ways in which others interpret their experiences (Smith & Osborn, 2008). In doing so, the researcher’s subjective experience always contributes to the data collection process (Smith & Osborn, 2008). As emphasized by the constructivist paradigm that provides the foundation for IPA, no objective reality exists from which to collect data and instead findings arise out of the interactions between researcher and participant (Smith & Osborn, 2008).

**The researcher’s role.** Within the research study, the role of the researcher is both active and interactive, as is characteristic of IPA (Smith & Osborn, 2008). The researcher is constantly aware of how her own subjectivity influences the interpretation of the data (Smith & Osborn, 2008). In this instance, where the researcher would also have been the co-leader of the group, this process would have been especially salient. As the researcher, I would have engaged in reflective practice to continually explore and understand the various ways in which my subjectivity influenced my view of the data.

As in hermeneutics, the researcher in IPA is attempting to understand the participants’ understanding of their experience (Smith & Osborn, 2008). The researcher implementing an IPA methodology is often left to interpret the internal, emotional experiences from the dialogues of
participants (Smith & Osborn, 2008). Therefore, the IPA researcher is continually questioning her (as well as participants’) assumptions, biases, and reactions in attempt to gain deeper understanding of the experience of all parties (Smith & Osborn, 2008). A primary way in which I intended to facilitate this process was through reflective practice journaling. Within the reflective practice journals, co-therapists would have reflected upon their subjectivity, assumptions, biases, and reactions throughout the group process. Particular attention would have been paid toward the co-therapist relationship, participants’ relationships with peers and co-therapists, and toward parallel processes of mentoring within the group.

**Intervention Method**

The intervention involved ongoing modification of Relational Practice Groups by Jordan and Dooley (2001) incorporating gained feedback from these young women. The manual, which is intended to be adapted for any given population, would have been adjusted throughout the intervention with the information learned during each session.

**Participants.** The research study would have included female emerging adults (6-10 women, age range: 18-25) who had aged out of foster care, and met basic criteria for group involvement. Attempts to recruit participants were made through dozens of agencies and sources, including through the Department of Children and Families in New Hampshire, and Vermont, and local therapists working with this population. Please refer to Appendix A for the recruitment letter.

**Inclusion criteria.** Eligible participants for the research study were females, between the ages of 18 and 25 years, who were leaving (or had left) foster care. Given the research study involved an intervention pilot shaped by participant feedback, potential group members would have been assessed to determine the degree to which they were comfortable giving feedback. As
described by Yalom and Leszcz (2005), one of the most important inclusion criterion was motivation. Individuals who are motivated to participate in group therapy typically make good candidates (Yalom & Leszcz, 2005). Another important criterion for inclusion involved the presence of interpersonal difficulties such as difficulties with intimacy and love, feelings of loneliness and isolation, fears of dependency and assertiveness, inability to empathize, and interpersonal aggressiveness, to name a few (Yalom & Leszcz, 2005). When individuals express some motivation to change their interpersonal patterns, and accept some responsibility for the change process, they will likely make good group therapy candidates (Yalom & Leszcz, 2005).

Young women who were unwilling or unable to make the commitment to the full eight weeks, or currently in crisis would not be included. Similarly, young women who were abusing substances, are actively psychotic, homicidal or suicidal, or highly aggressive, would also have been excluded from participation. Group therapy can be difficult when it is the individual’s first experience in therapy (Bernard et al. 2008), therefore, individuals who had been in therapy previously or were currently in individual therapy would have been given priority for inclusion.

Individuals who have external factors that are likely to impede upon their ability to participate in group therapy should be excluded from participating (Bernard et al. 2008). Therefore, eligible participants would have been limited to those who had reliable transportation to get to sessions, sufficiently stable housing, and access to a cell phone for communication purposes (See Appendix B for a full list of participant inclusion criteria).

**Rationale for sample size.** The ideal size of a relational brief therapy group is seven or eight members (Yalom & Leszcz, 2005). However, group therapy continues to be effective when the size of the group ranges from five to ten participants (Yalom & Leszcz, 2005). It is appropriate to start by recruiting nine or ten individuals, as it is likely that one or two will drop
out; any fewer than five members will jeopardize the effectiveness and cohesion of the group (Yalom & Leszcz, 2005). Yalom and Leszcz therefore suggest recruiting nine or ten individuals for a short-term group therapy, so that the group can endure for a couple drop outs, but is not so large that members will feel disconnected or left out.

All participants would have had exit interviews at the end of the group. For the purpose of IPA research, three or four participant would have been asked for more in-depth descriptions of their experience. According to Smith and Osborn (2008), around three participants is reasonable for IPA. Therefore, participants would have been asked if they would be willing to discuss their experiences of participating in the group. Selected participants would be those who were comfortable and willing to discuss and engage in this process.

**Data Collection Methods and Procedures**

**Quantitative data collection measures.** It is necessary to utilize appropriate measures in order to explore the effect of a short-term, relational group therapy approach on the relational health and mental health for female emerging adults who have aged out of foster care. Although the purpose of the intervention pilot did not include determining the effectiveness of the intervention, I would have monitored the progress of participants using outcome measures. The following outcome measures would have functioned as feedback mechanisms for how treatment was proceeding for each individual; qualitative feedback would have helped inform any changes that needed to be made in order to meet the clinical needs of participants, and future research.

**Relational Health Indices.** To assess the relational health of participants, the Relational Health Indices would have been administered at intake to all participants in the intervention pilot. Preliminary research has evidenced the validity, reliability, and utility of the RHI (Laing, Tracy, Taylor et al. 2002).
**Outcome Questionnaire (OQ-45).** A brief self-report instrument, the Outcome Questionnaire (OQ-45), would have been used to assess overall symptomology of participants to determine overall mental health. The measure would have been administered again at weekly intervals throughout the intervention pilot. To determine the benefit of the intervention, baseline OQ-45 scores would have been compared to subsequent scores obtained following participating in the intervention pilot. The reliability of the OQ-45 has been identified as acceptable within professional standards (MMY, 16th edition). It has also demonstrated evidence of construct validity, criterion-related validity, and convergent validity (MMY, 16th edition).

**Qualitative data collection.** A semi-structured interview is a way in which, “IPA researchers wish to analyze in detail how participants perceive and make sense of things which are happening to them” (Smith & Osborn, 2008, p. 57). The semi-structured interview in IPA provides flexibility for the researcher to fully engage in dialogue with the participants and revise questions as needed (Smith & Osborn, 2008). Selected participants in this study would have experienced the semi-structured interview process, which would have had two parts: the first meeting, which would have lasted roughly an hour and a half, included questions from the interview, and the second meeting which would have lasted roughly an hour would have involved any follow-up questions and comments that emerged for the researcher and participants throughout the process. As described by Smith and Osborn, the semi-structured interview provides ample opportunity for participants to share their own stories in an in-depth fashion, with the researcher guiding the process. (see Appendix C for the intended interview schedule).

**Identifying themes.** According to Smith and Osborn (2008), the next step involves identifying themes that arise within the interviews. Once various themes are identified within the transcripts of interviews with participants, the researcher attempts to meaningfully connect the
themes, which will likely be guided by the literature (Smith & Osborn, 2008). Once meaningful themes are identified within the first participant’s interviews, the second participant’s interviews are analyzed in a similar way, but with the knowledge of the themes from the first, which will help guide the process (Smith & Osborn, 2008). The researcher’s role as co-therapist would also have helped guide and inform the process of identifying themes, as moderated by reflective practice. Therefore, the process of identifying similarities and differences between participants’ experiences within the group might have been more easily identifiable. After significant themes are identified and their connections clarified, the researcher would have written up a narrative of the themes and interpreted them, informed by similarities and differences delineated in the literature review (Smith & Osborn, 2008). Please refer to Figure 2 for forms visually summarizing the intended interpretation process.

Quality control procedures. The IPA researcher’s equivalent of obtaining reliability occurs through the process of seeking dependability (Mertens, 2009). Dependability is obtained when the researcher and participant continually revisit assumptions and statements made during the interviews, thereby assessing consistency and clarity (Mertens, 2009).

Credibility is a way in which qualitative researchers obtain validity, which involves thorough engagement in the process, continual observation, and reflections surrounding subjectivity (Mertens, 2009). I would have gained credibly by remaining actively engaged throughout the interviews with participants, intense observation of participants’ expressions that were explicit and implicit, as well as through continual self-reflection.

Qualitative researchers must seek to verify that their interpretations are not products of their imagination, but rather result from engagements with participants (Mertens, 2009). Although I am aware of the influence of authority that I would have had upon participants’
reports, it is important to clarify statements, conclusions, and interpretations that arise through the interview process. In doing so, a participant is able to offer feedback about what she perceives to be occurring within the interviews. Again, I would have continually implemented reflective practice to maintain constant awareness of the influence of my subjectivity on the data.

Whereas quantitative researchers focus on the generalizability of findings, the qualitative researcher is concerned with transferability (Mertens, 2009). Within this framework, qualitative research provides opportunity for rich, context-specific insights to surface from detailed case studies (Mertens, 2009). The current study sought to employ transferability by intensely focusing on the wide array of variables present for the identified participants, and the idiosyncratic details specific to their experience. In doing so, the findings from this study might have been useful in providing insight with depth to clinical experience.

This researcher is also concerned with the authenticity of the proposed research study. A means of evaluating authenticity of qualitative research is through exploration of ontological authenticity (Mertens, 2009). As described by Mertens, ontological authenticity involves the degree to which participants’ experience with the researcher expanded upon their subjective reality in a meaningful way. The researcher would have attempted to gain authenticity of the proposed research study by inquiring about feedback from participants. The researcher would also have asked participants about their experiences throughout the research process and what, if anything, meaningful they obtained by participating.

**Ethical Considerations**

**Protection of human subjects.** As described in Locke et al. (2007), to ensure the protection of humans participating in any research study, the proposal must be reviewed in accordance with ethical guidelines approved by the American Psychological Association (APA).
The current study was reviewed and approved by the Institutional Review Board at Antioch University New England. According to the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010), obtaining informed consent is necessary for protection of participants. The current study attempted to recruit individuals without deception, which is also important according to the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010). After participants would have been recruited, researchers would have reviewed informed consent with participants, as guided by the informed consent document (see Appendix D for the informed consent).

**Dual roles.** A mentor-mentee relationship within a doctoral clinical psychology program poses unique challenges, including those surrounding the ethics of dual relationships (Rosenberg & Heimberg, 2009). Rosenberg and Heimberg further stress, “The mentorship relationship is inherently and practically hierarchical” (p. 181). Given the emphasis of discussion of power differences to enhance connection between individuals, the RCT framework is useful in processing the utility of the mentor-mentee co-therapist pair for young women who age out of foster care. Reflective practice journals would have offered clarity surrounding any challenges that surface regarding dual roles, given the evaluative and participatory role of the dissertation chair in this study. As indicated by Rosenberg and Heimberg, less ethical risk exists when the dual roles share similar goals. For instance, the goal of the dissertation chair and co-therapist are similar in that they pertain to the professional development of the graduate student. In the event the goals of these roles conflict, risk would have been minimized through continual reflective practice. The co-therapist pair would have also received supervision and consultation from a professional colleague throughout the course of the group, which would have aided in managing conflict as it surfaced, thereby further minimizing risk inherent in dual roles.
Data Analysis: Suitability of the Intervention

A method of analyzing collected information involved library scholarship. The feasibility, acceptability, and benefit of the pilot would have informed suitability of the co-led, short-term, group therapy approach for female emerging adults who have aged out of foster care.

Determining feasibility. Participant recruitment and retention rates inform the feasibility of an intervention pilot study (Thabane et al. 2010). The use of participant inclusion criteria also informs feasibility (Thabane et al. 2010). The researcher would have explored whether the inclusion criteria is too inclusive or restrictive to determine feasibility of the intervention being implemented as designed (Thabane et al. 2010).

Determining acceptability. The degree to which the intervention was accepted by the target population would have been assessed using the qualitative method of Interpretive Phenomenological Analysis. All interviews would have been recorded; transcription of the interviews would have occurred after all interviews have been completed. While the transcription would have been read multiple times, I would have documented themes and reflections informed by the literature that seem to be relevant within the interviews (Smith & Osborn, 2008). Please refer to Figure 3 for a sample of prepared forms.

Determining benefit. The degree to which the intervention is considered beneficial would have been determined using quantitative assessment measures. The Relational Health Indices would have been used to assess changes in relational health, and the Outcome Questionnaire would have been used to inform treatment progress and overall mental health. Based on the assumption that increases in relational health and mental health would be experienced as beneficial, trends in participant scores on these quantitative measures would have been utilized to inform benefit.
Exploring the perceived value of mentoring. The value of mentoring would have been explored through reflective practice by the co-therapists, and based upon observations of the mentoring witnessed and experienced by participants, as informed by qualitative interviews. Co-therapists would have been continually reflecting upon their reactions and responses within reflective practice journals, which would have aided in the exploration of the process. As a mentor-mentee pair, co-therapists would have intentionally reflected upon their experiences and how they understand the modeling process of mentoring for group members. Co-therapist perceptions of the mentoring process within the intervention would have been used to explore the perceived benefit of including a mentoring component in a therapy group for this population. I would also have asked participants about their perceptions and experience of the mentor-mentee relationship modeling by the co-therapists, and of any similar relationships that formed between group members. Qualitative interviews would also have been explored for themes of mentoring, and of the co-therapist relationship, to determine the value of the added mentoring element in the pilot group.
Chapter 4: Preliminary Findings and Results

Preliminary Findings

Despite my efforts, the intended pilot study was determined not to be feasible in the context in which it was attempted. Given I was unsuccessful at recruiting a sufficient number of participants to run the group, the pilot study was not considered feasible. The following is a description of the process of my attempts to implement this pilot study; potential contributing factors are explored in the final chapter of this dissertation.

Recruitment Process and Outcome

After receiving approval from my dissertation committee in February 2013, and Antioch University New England’s Human Research Committee (HRC) in June 2013, I started rigorously recruiting participants from July through December (see Appendix E for a copy of the full recruitment resources list). To prepare an extensive list of potential recruitment sources, I searched public listings for therapists in the area working with adolescents and young adults. I printed off the contact information (phone numbers, e-mail addresses, physical addresses) to therapists, private practices, and group practices in the area from Internet searches. I also spoke with my committee, other faculty members at Antioch, and the administrative assistant at the Antioch Psychological Services Center for information about local therapists and agencies that work with this population.

In addition, with the assistance of my dissertation chair, I developed a brochure for the group (see Appendix F for a copy of the brochure) and distributed it to various recruitment sources. I intended on recruiting participants with the help of the Department of Children, Youth, and Families (DCYF) in New Hampshire and the Department of Children and Families (DCF) in Vermont, and through local therapists and agencies working with this population. I was in
contact with DCYF and DCF, and disseminated information about the group to their adolescent program specialists and case workers.

I continued to distribute several brochures, a list of inclusion criteria, and a recruitment letter that includes a description of the intervention pilot to local therapists, group practices, hospitals, schools, homeless shelters, courts, religious institutions, stores, drug and alcohol treatment residential homes, and other appropriate community contacts to help find potential participants. I distributed fliers at the Antioch Psychological Services Center, and sent out a request for recruitment to the entire Antioch community through the university’s list serve. Since I was a practicum student in a local, disenfranchised, middle-high school at the time I was recruiting, I spoke with my supervisor, a school psychologist, who helped identify students and share information and brochures about the group to the other mental health professionals, paraprofessionals, and teachers who work with those students who might benefit from the group.

Given the disproportionate number of former foster youth becoming involved in juvenile justice and other court systems, I distributed information about the group to various courts in the surrounding area. I e-mailed probation and parole officers, as well as vocational rehabilitation and independent living workers to inform them of the group. After meeting several times in my doctoral seminar, my advisor and student colleague helped me think of various other locations in which to recruit, including religious institutions, local stores, community centers, hospitals, women’s health clinics, and soup kitchens, among others.

I attended a conference at Keene State College as a representative of Antioch University where I met with many people from DCYF in New Hampshire who work with this population. I told them about the group, we exchanged information, and were frequently in contact about the group. After agreeing to refer individuals to the group and work together to find potential
participants, I contacted DCYF asking them to write a letter for the Antioch University New England’s Human Research Committee (HRC), describing our collaborative agreement. Unfortunately, after communicating several times with DCYF, I stopped hearing back from them, despite the initial interest they expressed about the group. When contacting DCF in Vermont, they told me that they had a few potential candidates for the group in mind, but they were located too far from Keene, New Hampshire to commute regularly to the group, or they were under 18-years of age.

I also attended the Vermont Foster Care Consortium, where I networked to further disseminate information about the group. In attempt to reach potential participants directly, a colleague and I distributed fliers throughout the Keene area. Together we searched for a local tent community that I had learned about through multiple sources. Unfortunately, we were unsuccessful in our search, and instead distributed fliers to individuals while walking around the Keene area, and on the bike paths in the area.

In response to my recruitment attempts, many professionals expressed interest and excitement in the group. Unfortunately, I was unable to recruit a single participant. One local substance abuse counselor contacted me after receiving my recruitment e-mail and told me that he might have a potential participant, but he did not follow up with me after I responded to him. At the Vermont Foster Care Consortium I asked some of the former foster youth in attendance whether they would find this type of group useful, and they agreed that it would be. Several professionals at the Consortium had leads on participants, but these young women were spread all across Vermont, several hours away from the location of the group in Keene, New Hampshire.

After repeated attempts at recruitment, I finally consulted with my advisor and committee members in January 2014, about how best to proceed. I proposed to my committee that I expand
my inclusion criteria to incorporate any young women who experienced foster care at some point in their lives; however, it was decided that doing this would compromise the integrity of the original intent of the study. Therefore, with the help of my committee members, the pilot study was deemed not feasible in this context. The results of this dissertation now include a supplement to the treatment manual: therapeutic adaptations for young women aging out of foster care.
Chapter 5: Development of the Treatment Manual

As part of this dissertation, I adapted a treatment manual from a relational group intervention to meet the unique needs of young women who have aged out of foster care. Although the complete manual will require feedback directly from group participants, these modifications are supported by research in treatment with similar marginalized populations. The intervention includes a short-term group format, and combines elements of relational, attachment, mindfulness, psychoeducation, and psychodynamic therapy. Refer to Appendix G for a working copy of the adaptations and additions to the treatment manual by Jordan and Dooley (2001), tailored specifically to meet the clinical needs of young women aging out of foster care.

Development of the Adapted Manual

In effort to adapt a treatment manual for young women aging out of foster care, I referred to the literature on group therapy, seeking the gold standards for tailoring a group to a specific population. Additionally, I consulted the attachment literature to help guide the development of these adaptations, given the unique attachment needs of these women. Therefore, the manual is modified specifically to meet the unique clinical needs of young women aging out of foster care. Relational Practice Groups are supposed to be adapted to meet the unique clinical needs of a given population (Jordan & Dooley, 2001); a final treatment manual for this population would, optimally, be informed by their feedback. Since I was not able to include those changes, the group format and outline is based upon the Relational Practice Group manual by Jordan and Dooley (2001), and relevant sources from the literature, constrained by practical limitations.

Group Format and Outline

The group format first includes a relational check-in, lasting approximately 10-15 minutes, followed by a 20-30 minute segment involving a conceptualization process in which
co-leaders and members think of relevant topics and ideas to discuss in the group (Jordan & Dooley, 2001). As Yalom and Leszcz (2005) indicate, one of the initial tasks of group therapy is to translate psychological symptoms into interpersonal challenges, which would occur during this phase. An emphasis is placed upon providing a sense of safety, and promoting empowerment for this unique population by continually checking-in with members for feedback, validating strategies of disconnection, and providing psychoeducation on the effects of interpersonal trauma (Jordan & Dooley, 2001). The third phase of each session of the group involves mutual sharing and reframing concepts in terms of relationships (Jordan & Dooley, 2001). In the last 10-15 minutes of each group session, members are invited to reflect on the experience of the group and process how the session has affected them (Jordan & Dooley, 2001). Within the Relational Practice Group manual, Jordan and Dooley provide weekly handouts and activities that are relationship-focused and aimed toward enhancing growth-fostering relationships between members (e.g., weekly relational check-ins; identifying markers of good connections).

**Additions to the Manual**

In addition to the basic relational framework described in the manual, each session is intended to be tailored specifically to address the clinical needs of young women aging out of foster care. As suggested by Jordan and Dooley (2001), “Leaders are encouraged to creatively adapt the groups to the particular settings and needs of the members” (p. 6). Therefore, the following additions have been suggested based on the relevant literature.

**Incorporating mindfulness practice.** Included in the adapted group manual is a mindfulness exercise at the beginning of each session, and at the end, when time permits. Mindfulness practice can help enhance awareness and tolerance of difficult emotions (Germer, Siegel, & Fulton, 2005). As described in Germer et al. (2005), “Bringing awareness to traumatic
experience can either decrease or increase suffering” (p.126). For those who have experienced chronic stress and trauma, mindfulness can be difficult because so much effort is expended toward keeping painful affective states dissociated from awareness (Germer et al. 2005). Therefore, for trauma survivors, it is recommended that emphasis be placed upon mindfulness activities that direct one’s attention toward the outside, rather than the internal experience (Germer et al. 2005). External awareness of one’s senses is an effective way of practicing mindfulness and grounding (Germer et al. 2005). Metta meditation practices, yoga, and others that involve awareness outside the body are therefore incorporated as an adaptation to the original group manual. To begin each session, one of the co-leaders will begin with a meditation exercise with the group.

**Wedding attachment theory with RCT.** Given the inherent interpersonal trauma experienced by anyone who has been in foster care, integrating an attachment lens into the group intervention is an essential adaptation to the manual. As such, this addition to the manual involves addressing specific topics of trust, security, and safety.

**What is attachment theory?** Attachment is characterized as the lasting emotional bond between a person who is considered wiser and stronger (Bowlby, 1969); a relationship that is especially important when the attachment system is activated (Fitch, Pistole, & Gunn, 2010). As described by Fitch et al., the attachment system inherent within all of us continues to motivate us to seek security by maintaining proximity to attachment figures throughout the lifespan. Within the attachment relationship, the caregiver provides a safety, a secure base, and protection; security is achieved through the sensitivity, responsiveness, and flexibility of the caregiver (Fitch et al. 2010).

This enduring emotional bond has been explored within infant-caregiver, peer, mentor-
mentee, therapist-client, romantic partner, and supervisor-supervisee relationships (Ravitz et al. 2010). Attachment has been demonstrated to influence stress response, coping, psychological wellbeing, physiological health and development, as well as learning (Ravitz et al. 2010). Refer to Figure 4 for a visual depiction of the corrective relationship within a secure attachment relationship, and within a growth-fostering relationship. For a sample of an icebreaker activity, aimed at fostering connections among group members, see Appendix H.

In effort to tend to the topics of trust, security, and safety, co-leaders will maintain a constant, consistent format of the group, with group rituals included. For example, at the end of each group, the co-leaders will share an inspirational quote or poem with the group. For an example of an inspirational poem by Mary Oliver, please visit her site: http://maryoliver.beacon.org/2009/11/new-and-selected-one/. Rituals and consistency are essential to facilitating object constancy for group members.

Identifying barriers. Yalom and Leszcz (2005) have identified some of the basic steps of modifying a group therapy approach to meet the unique clinical needs of a given population. An assessment of the intrinsic and extrinsic limiting factors is essential in the beginning of the group (Yalom & Leszcz, 2005). Specifically, it is crucial to first determine any unchangeable, limiting factors that might make it difficult for participants to attend sessions (intrinsic), and it is important to be able to distinguish such factors from those that are extrinsic or potentially malleable (Yalom & Leszcz, 2005). In terms of this population, it is important to consider, for example, transportation, childcare, housing, means of communication (cell phone, e-mail), and any other factors that might impede the ability of group members to regularly attend sessions. As such, within the first session, the group will discuss these factors to help resolve any potential existing barriers for members.
Developing collaborative goals. Another essential step toward effectively adapting a treatment approach to a particular group involves developing reasonable clinical goals for the therapy group (Yalom & Leszcz, 2005). Yalom and Leszcz emphasize the importance of setting clear and reasonable goals given context and time limitations, as well as how the goals must be made explicit to all clients. In doing so, clients become actively involved in treatment; investment increases when the goals are explicitly linked with the tasks of each group session (Yalom & Leszcz, 2005). Therefore, within the first session (and subsequent sessions, if needed), members will explore their own goals and expectations for the group, and for themselves as individuals. This information will help to shape and mold the group and its process.

Requesting feedback. Group members’ routine feedback is necessary for successful adaptation of the intervention (Yalom & Leszcz, 2005). In order to effectively modify group therapy, it is important to understand the unique clinical needs of the specific population (Yalom & Leszcz, 2005). To help identify the clinical needs of these young women, the group will allow for continual modification of technique based upon participant feedback, which is also an essential and disciplined component of clinical practice (Yalom & Leszcz, 2005). Group members would therefore be asked at the end of each session for feedback about their experience of being in the group. Moreover, co-leaders will attend to inevitable ruptures, requesting feedback from group members about their sense of safety, and, as necessary, initiating repair.

Tending to relational trauma. If deemed appropriate by the co-therapists and group members, the group can incorporate Jordan and Dooley’s (2001) supplement on trauma into the group format. In addition to integrating mindfulness practices into the group, this supplement is especially salient for young women aging out of foster care, given their histories of developmental trauma. Included in this supplement is a psychoeducational segment pertaining to
the neurobiological reactions to trauma, and how trauma often stunts the experience of Miller’s *five good things* (Jordan & Dooley, 2001). Group members are encouraged to speak about their personal traumatic experience of connections and disconnections; the co-leaders are responsible for containing these conversations, such that members do not delve too deeply into their personal trauma narratives (Jordan & Dooley, 2001). Stories surrounding personal trauma can be tied into the larger conversation about relational connection (Jordan & Dooley, 2001). Sharing of personally traumatic experiences that occur on a societal level are also encouraged (Jordan & Dooley, 2001), and might be particularly salient to this marginalized population.

**Termination.** Although Jordan and Dooley (2001) do not appear to tend to the termination process at the start of the group, another adaptation involves co-therapists’ particular attention toward this process throughout the course of the group. Loss and endings are a part of each group members’ lives, and play an important part in the healing process (Mangione, Forti, & Iacuzzi, 2007). Young women who are aging out of foster care are certain to have had some difficult relational transitions; it is therefore essential to tend to their feelings surrounding the length of the group, and to explore any responses to ending they might have as the weeks progress.

In the first session, the co-leaders will bring up the topic of termination. In the fourth session, (or sooner if deemed clinically necessary), termination will be discussed again. Members will be prompted to discuss their cultural and relational ideas surrounding endings and goodbyes. They will also be asked to explore their expectations about this groups’ ending, as well as to begin to think about any rituals they would like to perform as part of the termination session.

In the final group session, Jordan and Dooley (2001) include in their manual a
semi-structured termination session that includes opportunities for the group to reflect upon their experiences and to project into the future. A termination exercise is offered in the final session, during which members will create personal transitional objects that will represent the group experience, so that they can take it with them, facilitating internal integration of the group experience.
Chapter 6: Discussion

This dissertation describes a pilot group intervention that, despite diligent recruitment efforts, proved to be unfeasible. In this discussion, I consider some of the obstacles to getting participants for the group. I then discuss, more generally, challenges delivering mental health services to marginalized populations, as well as implications for future research and social policy.

Recruitment Challenges

Among several possible reasons for difficulty recruiting participants, one contributing factor may have been my lack of experience recruiting in a rural area. Though I initially had the sense that there were many young women who met the criteria for inclusion, I simply couldn’t find them. I eventually attempted to seek participants by exploring the community, and interacting more directly with young adults outside of the institutions that serve them; however, I might have needed to put more effort into engaging directly with the local community earlier on, instead of primarily with professionals and agencies affiliated with the target population.

My indirect strategy of obtaining referrals through referral sources also meant that I did not have full control over how information about the group was conveyed to potential participants. Moreover, as one DCYF worker told me, these young women aging out of foster care are not that motivated seek and accept services. It’s similarly plausible that those agencies serving children and adolescents have less of a mission to engage with these young adults. The young women I sought for the group were not just aging out of their foster homes; they were also aging out of pediatrics, and social services designed for dependent minors.

Complexities Inherent in Serving Marginalized Populations
Although part of my ineffectiveness at recruiting young women who are aging out of foster care might be attributed to my lack of experience and familiarity with the community, there are well-documented obstacles to serving various marginalized populations, including aging-out foster children. It is often difficult for researchers to recruit participants in rural community settings. Moreover, mental health services are underutilized by former foster youth for both obvious and complicated reasons. Finding effective ways to recruit participants is an essential step toward developing useful interventions with this vulnerable population.

**Rural populations.** Recruiting participants in a rural setting proved to be a difficult task. My difficulty in recruiting participants might partly be due to my lack of direct access to them; that is, I was unable to find and speak to potential participants directly, and instead worked through professionals and agencies that worked with these young women. When attempting to recruit from a rural community, degree of contact with potential participants is one of the most significant contributors to successful participant recruitment in research (Asch, Conner, Hamilton, & Fox, 2000). In a study by Asch et al., recruitment rates were extremely low when there was no personal contact between researcher and potential participants, and recruitment rates increased geometrically as the degree of contact became closer. There is a significant need for mental health services in rural areas; over half of foster children in New Hampshire are living in rural areas (Kantor & Blease, 2005). In rural settings, mental health centers are often too far a distance for many people; inadequate public transportation systems available also complicate participant recruitment (Cudney, Craig, Nichols, & Weinert, 2004). Therefore, direct contact with potential participants is essential to successful recruitment, especially in rural community settings.

Rural settings pose several other challenges when attempting to recruit participants for
research. For example, the number of individuals who meet inclusion criteria might be limited (Cudney et al. 2004). The number of foster children living in Cheshire County represents just 8% of the total number of all foster children in New Hampshire (Kantor & Blease, 2005). Indeed, this means that, given the available data, between 2008 and 2012, just 200 or so teens aged out of formal foster care in Cheshire County (National Data Archive on Child Abuse and Neglect, 2014). Therefore, it is likely that, even including young women who lived in kinship care, and had been in foster care at a previous time, I still had a very small number of emerging adults who might meet the inclusion criteria of the attempted study.

Within rural settings, the “insider” versus “outsider” mentality might be especially salient (Cudney et al. 2004). Researchers should be aware of their timing, language, and presentation when attempting to recruit from a rural setting, where they are likely perceived as outsiders (Cudney et al. 2004). Therefore, researchers should make extra effort to reduce their outsider perception to connect with participants (Cudney et al. 2004). The “outsider” perception of the researcher might be especially important when attempting to recruit participants who have been involved in the foster care system. It might be the case that young women aging out of foster care no longer wish to receive services from social service agencies. By recruiting through these realms, I might have been viewed warily by young women eager to be rid of meddling social services.

**Foster youth.** Despite the significant mental health needs of foster youth, barriers to delivering services to this population continue to exist. As described in Staudt (2003), the goal of child protective agencies is to protect these children; that is, there is no requirement to tend to their mental health needs. Although older youth within the foster care system are more likely than their younger counterparts to receive mental health services (Staudt, 2003), as youth age
out, use of mental health services rapidly declines (Havlicek, Garcia, & Smith, 2013). Research indicates nearly 50-80% of older foster youth are utilizing mental health services, whereas just 2-3% of foster youth that have newly aged out are utilizing mental health services (Havlicek et al. 2013).

**Utilization of mental health services among former foster youth.** Despite the high prevalence of mental health disorders among former foster youth, they are not utilizing mental health services (Havlicek et al. 2013). When former foster youth have been asked about this, they report being uninformed about psychological health, and of their mental health treatment options (Havlicek et al. 2013). There are few states that facilitate the connection between transitioned-aged foster youth and adult service agencies (Havlicek et al. 2013). At a time when their mental health needs are peaking, these emerging adults are aging out of reliable access to care (Havlicek et al. 2013).

Fortunately, in New Hampshire, services are becoming increasingly available to former foster youth. In New Hampshire, DCYF offers voluntary aftercare services to help those who qualify, with pursuing education, housing, and employment. Moreover, in New Hampshire, former foster youth are now eligible through Medicaid to receive health insurance under the Affordable Care Act as of January 2014, so utilization rates may gradually improve.

**Insecure-avoidant attachment style.** Attachment theory might also inform our understanding of the barriers keeping former foster youth from utilizing mental health services. Attachment style informs a person’s capacity to rely on others for support and love (McWey, 2004). A disproportionate number of foster youth develop an insecure-avoidant attachment style (McWey, 2004). Foster youth with avoidant attachment styles have difficulty asking and receiving help from, or relying on, others. As described by McWey, “Avoidant attachments are
Avoidant attachment styles appear frequently among foster youth because they have learned that others are not reliable providers of care (McWey, 2004). In turn, individuals with avoidant attachment styles seek to only rely upon themselves for comfort and support (McWey, 2004). Former foster youth with avoidant attachment styles might feel wary of individuals offering care and support because of this protective strategy (McWey, 2004). Therefore, the protective strategies of foster youth with avoidant attachment styles might inhibit them from pursuing and accepting mental health services once they age out of care. Attachment theory suggests that service providers might have to be especially proactive in pursuing those fostered youth who have reason not to seek needed services on their own.

**Implications for Future Exploration**

**Implications for treatment and research.** It is imperative to the well-being and mental health of young women aging out of foster care that future research involves exploration of effective treatment modalities with this population. To begin, the adapted treatment manual offered within this dissertation could be implemented and evaluated, with 3 and 6 month, to 1-year follow-ups to help develop a gold standard of group treatment for this population. Recruitment efforts might be more successful if attempted in a more populated area, or in a school, prison, or residential setting where group recruitment is not as much of an issue.

At a time when their mental health needs are peaking, young adults who age out of foster care have inadequate access to appropriate care, and are not utilizing mental health services even where they exist. Therefore, efforts need to be made to understand the barriers keeping them from accessing mental health services. To enhance the effectiveness of the treatment manual
offered in this dissertation, feedback from young women aging out of foster care is needed, along with changes in social policies that better support high-risk foster youth entering adulthood.

**Social policy implications.** Emerging adults require secure attachments and support to successfully maneuver through this developmental phase. The cultural expectation for emerging adults has shifted drastically in the past several decades, and social policy, particularly for marginalized youth, needs to reflect these changes. As a culture we are no longer expecting 18-year olds with adequate social capital to achieve full independence; however, social policy for those with fewer resources continues to reflect a bygone set of expectations for adult autonomy, that today are often unrealistic and punitive. These expectations have proven to be costly in every way; the long-term consequences of untreated developmental trauma may well be the greatest public health crisis we face in the US today (Anda & Brown, 2010).

Although some argue that extending services would foster unhealthy dependence upon these agencies, there is evidence to suggest this is not the case. For example, a longitudinal study in the Midwest compared the outcomes of emerging adults who aged out of care with those who were granted extended care until age 19. In result, emerging adults who remained in state custody for the extra year were more likely than their aged out counterparts to advance in their education, have stable housing, stay out of the juvenile justice system, receive independent living services, and have access to mental health and other health services (Courtney & Dworsky, 2005). Many states have some transitional supports through 21; this seems to be a step in the right direction. However, the range of services is inadequate to meet the complex needs of these young adults. Further, service utilization rates decline rapidly once foster youth exit care, just at the time when prevalence rates for mental health disorders are peaking (Havlicek et al. 2013). These emerging adults require more – not fewer – transitional services to help them attain adult
functioning as safely and healthily as their age peers.

**Recommendations**

Based on the results of the current dissertation, it is recommended that the group manual be tested and refined in a more urban setting, with a higher density population. Some of the challenges inherent in attempting to recruit and deliver services to marginalized youth in a rural setting could be avoided in a more populated area.

Another consideration involves implementing the group with young women who are aging out of foster care and found within institutional settings, such as schools, prisons, and residential treatment centers. However, doing so brings into question whether the group should be used with “involuntary” clients. The current dissertation involved recruiting voluntary participants; the group curriculum might require additional modifications if attempted with involuntary clients.

Moreover, it might be useful to expand the inclusion criteria of the group. Although it was beyond the scope of this dissertation to do so, it might be useful to try this group with younger women (16-18 years of age) who have not yet aged out of care, and are still within the reach of foster parents and social services. In doing so, potential participants would be more easily identifiable, even in a rural setting. More importantly, members would have the chance to develop meaningful connections that might last beyond the group, providing natural support for when the time comes to age out.

**Conclusions**

Young women aging out of foster care represent a unique population, requiring mental health treatment that is tailored to meet their specific clinical needs. Although there is no current gold standard of treatment for this population, it is posited that a relational group therapy
approach would be a beneficial treatment option for these young women. The current dissertation offers an adapted group manual that is tailored from the literature to meet the unique clinical needs of young women aging out of foster care. Additional research should involve the voices of young women who have aged out of foster care, as their feedback is essential to the development of a group intervention best tailored to their unique needs.
References


York, NY: Guilford Press.


Mangione, L., Forti, R., & Iacuzzi, C. M. (2007). Ethics and endings in group psychotherapy:


## Figure 1: Research Questions and Methodology Chart

<table>
<thead>
<tr>
<th>Research Questions: Intervention Suitability</th>
<th>Method Used to Answer Research Question</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feasibility</strong></td>
<td>Observational data:</td>
</tr>
<tr>
<td>How feasible is the intervention as designed?</td>
<td>1. Recruitment rates</td>
</tr>
<tr>
<td></td>
<td>2. Attendance rates</td>
</tr>
<tr>
<td></td>
<td>3. Participation rates</td>
</tr>
<tr>
<td></td>
<td>4. Utility of inclusion criteria</td>
</tr>
<tr>
<td><strong>Acceptability</strong></td>
<td>Qualitative approach: Interpretive Phenomenological Analysis (IPA)</td>
</tr>
<tr>
<td>How acceptable is the intervention by the population?</td>
<td>Identify themes of acceptability</td>
</tr>
<tr>
<td><strong>Benefit</strong></td>
<td>Quantitative measures (exploring trends):</td>
</tr>
<tr>
<td>How beneficial is the intervention for the population?</td>
<td>1. Relational Health Indices (RHI)</td>
</tr>
<tr>
<td></td>
<td>2. Outcome Questionnaire (OQ-45)</td>
</tr>
<tr>
<td><strong>Perceived Value</strong></td>
<td>Qualitative:</td>
</tr>
<tr>
<td>What is the perceived value of mentoring?</td>
<td>Group members’ feedback &amp; perceptions</td>
</tr>
<tr>
<td></td>
<td>Co-therapists’ perceptions:</td>
</tr>
<tr>
<td></td>
<td>1. Reflective practice journals</td>
</tr>
<tr>
<td></td>
<td>Intentional focus on mentoring</td>
</tr>
<tr>
<td></td>
<td>Explore journals for quotes</td>
</tr>
<tr>
<td></td>
<td>Integrate into findings and discussion</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Figure 2: Forms to demonstrate the process of interpretation**

**Partially-Ordered Matrix of Quotes**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Question 1</th>
<th>Question 2</th>
<th>Question 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Quote</td>
<td>Quote</td>
<td>Quote</td>
</tr>
<tr>
<td>Literature</td>
<td>Interpretation</td>
<td>Interpretation</td>
<td>Interpretation</td>
</tr>
<tr>
<td>#2</td>
<td>Quote</td>
<td>Quote</td>
<td>Quote</td>
</tr>
<tr>
<td>Literature</td>
<td>Interpretation</td>
<td>Interpretation</td>
<td>Interpretation</td>
</tr>
<tr>
<td>#3</td>
<td>Quote</td>
<td>Quote</td>
<td>Quote</td>
</tr>
<tr>
<td>Literature</td>
<td>Interpretation</td>
<td>Interpretation</td>
<td>Interpretation</td>
</tr>
</tbody>
</table>

**Partially-Ordered Matrix of Themes**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Theme #1</th>
<th>Theme #2</th>
<th>Theme #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Theme Summary</td>
<td>Theme Summary</td>
<td>Theme Summary</td>
</tr>
<tr>
<td>Description</td>
<td>Literature</td>
<td>Literature</td>
<td>Literature</td>
</tr>
<tr>
<td>#1</td>
<td>Quote</td>
<td>Quote</td>
<td>Quote</td>
</tr>
<tr>
<td>#2</td>
<td>Quote</td>
<td>Quote</td>
<td>Quote</td>
</tr>
<tr>
<td>#3</td>
<td>Quote</td>
<td>Quote</td>
<td>Quote</td>
</tr>
</tbody>
</table>
Figure 3: Sample of forms to be used for notes

<table>
<thead>
<tr>
<th>Participant</th>
<th>Direct Quotes from Participant</th>
<th>Reflections, speculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1: Description</td>
<td>Quote (include non-verbals)</td>
<td>Researcher’s comments</td>
</tr>
<tr>
<td>#2: Description</td>
<td>Quote</td>
<td>Researcher’s comments</td>
</tr>
<tr>
<td>#3: Description</td>
<td>Quote</td>
<td>Researcher’s comments</td>
</tr>
</tbody>
</table>

IPA – Exploratory Matrices

<table>
<thead>
<tr>
<th>Subordinate Themes</th>
<th>Quotes from Transcript</th>
<th>Exploratory Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme #1</td>
<td>Quote</td>
<td>Interpretation and Reflection</td>
</tr>
<tr>
<td>Theme #2</td>
<td>Quote</td>
<td>Interpretation and Reflection</td>
</tr>
<tr>
<td>Theme #3</td>
<td>Quote</td>
<td>Interpretation and Reflection</td>
</tr>
<tr>
<td>Theme #4</td>
<td>Quote</td>
<td>Interpretation and Reflection</td>
</tr>
</tbody>
</table>
Figure 4: Flowchart of the Corrective Relationship within Relational-Cultural Theory and Attachment Theory

**Relational-Cultural Theory**

Growth-fostering Relationship (GFR)

- Mutual empathy
- Authenticity
- Power recognition

**Attachment Theory**

Secure Attachment

- Safety
- Security
- Flexibility

**Group Member**

↑ Self-worth
↑ Capacity to act
↑ Empowerment
↑ Accurate understanding of self and other
↑ Interest in relational connection

**Attachment Figure**

↑ Learning
↑ Emotion regulation skills
↑ Psychological health
↑ Self-esteem
↑ Self-actualization
Appendix A: Recruitment Letter

To Whom It May Concern:

My name is Meg Pilling and I am a doctoral candidate in the clinical psychology program at Antioch University New England. I am currently in the process of finding young women to be participants in my dissertation project, which is a pilot study involving a (free) short-term, co-led, relational group therapy approach. Specifically, I am looking for young women (ages 18-25) participants who have aged out (or are in the process of aging out) of foster care.

The group will last 8 weeks and will be run by two therapists, Meg Pilling, M.A. (the researcher), and Martha Straus, Ph.D. The purpose of the group is to see if a focus on connectedness in relationships and mentoring is useful for these young women; the group pilot is the focus of my dissertation research. Please feel free to take a look at the enclosed list of inclusion criteria to help you think of anyone who might be a good fit for the group.

Please keep in mind that group therapy can be emotionally activating experience for many people. It is encouraged that participants have either been in individual therapy before, or are attending individual therapy sessions while they participate in the group. If a participant wishes to be in individual therapy, I will provide them with a list of referrals, or help you find a therapist for her.

If you know or work with a young woman who might be a good fit for this group, or if you have any questions, please contact me using the information below. If you do know anyone who would be a good fit for the group, please indicate so in your message, so that we can arrange a brief interview before the start of the group. Thank you for your time. I am very much looking forward to hearing from you.

Sincerely,

Meg Pilling, M.A.

mpilling@antioch.edu
Cell: (XXX) XXX-XXXX

Enclosure
Appendix B: Inclusion Criteria for Recruitment

Inclusion Criteria for Participation in a Short-term, Relational Group Therapy Pilot Study:

- Female
- 18-25 years of age
- Has aged out, or is in the process of aging out, of the foster care system (left foster care due to age)
  - NH: Left DCYF at age 18
  - VT: Left DCF at age 18 or 21
- Is interested in participating
- Might benefit from group therapy (i.e. from peer support, non-parental adult support)
- Can commit and is able to attend 8 weekly sessions
- Is willing to give feedback
- Is open to the idea of being interviewed about their experience in the group
- Has some difficulties in relationships that they would like to work on
- Is not currently in crisis (not actively suicidal, psychotic, or highly aggressive)
- Has access to a cell phone
- Has a residence
- Has been in therapy before, or is willing to attend individual therapy
- Is not currently abusing substances
Appendix C: Interview Schedule

Part A. Group Experiences
Q1. Tell me about what it was like for you in the group (beginning, middle, end).
Q2. What experiences in the group stick out in your mind?
Q3. What would you have liked more/less of in the group?
Q4. If you could do it again with the same people, what would you change?

Part B. Mentoring Component
Q1. Tell me about what it was like for you to be in the group with the co-therapists?
Q2. What do you think of the co-therapists in the group?
Q3. Tell me about how the co-therapists interacted, and how that influenced your experience?
Q4. When thinking about the co-therapists in the group, what worked for you? What didn’t?
Q5. What was it like for you to observe and experience the mentor-mentee, co-therapist pair?
Q6. What, if any, mentoring relationships do you think developed out of the group?
Q7. What was your experience of the focus on mentoring by the co-therapists?

Part C. Follow-up Questions and Clarifications
Q1. Is there anything that you’d like to share in more detail about your experiences in the group?
Q2. Is there anything I haven’t asked that you’d like to tell me about in terms of the group, mentoring, or the co-therapists?
Q3. Is there anything you’d like to share more of?
Appendix D: Informed Consent Form

Title of project: A Co-led Group Intervention Pilot for Females Aging Out of Foster Care

Name of investigator: Meg Pilling  E-mail: mpilling@antioch.edu

If you are a young woman between the ages of 18 and 25, and you aged out of foster care, I am inviting you to learn about an 8-week therapy group. I am a clinical psychology doctoral student, and this project is part of my dissertation research. I will be leading the group with my faculty advisor, who is an experienced clinical psychologist. I am looking for 8 women to be part of this group. If you are not age 18 or older, please do not complete this form or participate.

The purpose of this therapy group is to help you feel more connected within relationships. Difficult life experiences can make it challenging to have successful, meaningful relationships. This group will help you feel better about yourself, and more empowered within relationships. The group will also allow you to share your life stories, when you feel safe enough to do so.

If you are interested in this group, I will meet with you for an hour alone, so we can see if it’s a good fit for you. The group is most likely to be helpful for women who can commit to the full 8 weeks, and who feel supported in talking about their experiences within relationships. If you are in an upset time in your life right now, this group may not be the best choice for you, and I will try to help you find a more appropriate service.

If you become part of the group, we will meet for one hour and a half each week for 8 weeks, at Antioch’s Clinic in Keene, NH. At each group meeting, you will be asked to fill out two short questionnaires. After the 8 weeks are over, I will ask you to talk with me alone about what the group was like for you. I will also ask you if I can record that conversation.

If you are uncomfortable with the group, you can decide to leave at any time. If you choose to stop being part of the group, I will not use your information as part of my research study.

We will take steps to protect your privacy. We will ask all group members not to spread anyone’s information outside of the group. We will promise to keep the information we collect from you private. Any questionnaires you fill out will not have your name on them. Audio recordings will be stored in a locked place. After recordings are transcribed, they will be erased. If anything is going to be published in a journal or presented, your name and information will be kept private. Data will be kept by the investigator in a locked place. A year after the group ends, all data will be erased or destroyed.

If you would like to receive a copy of our research results, please put your initials here: ___.

Risks: Group therapy can sometimes bring up difficult feelings. If you find that you are having a hard time in the group, please bring it up to the co-leaders. That way we can set you up with the help you need. Seeing your own therapist might be helpful, and we can figure that out with you. Crisis services will be sought if you have a really hard time, and you need extra support.
**Benefits:** If you decide to help with this project, you will get 8 weeks of free group therapy. You will also have the chance to meet new people and learn about yourself. Being in the group might help you feeling better about yourself and your relationships. You might learn about how other people see you. You might also feel good about sharing your story with other people. You also might learn something new and meet new people.

**Right to Refuse or Withdraw:** You do not have to answer any questions that you do not want to answer. You can change your mind about being in the group; you can leave at any time.

**Questions:** If you have any questions about the study, you may contact Meg Pilling, Investigator, at telephone # (xxx-xxx-xxxx) to call or text, or via email at mpilling@antioch.edu. If you have any questions about your rights as a research participant, you may contact Dr. Katherine Clarke, Chair of the Antioch University New England IRB at (603-357-3122), or Dr. Stephen Neun, Vice President of Academic Affairs at University New England, at (603-283-2150).

You will get a copy of this form to keep.

*Your signature below means that you want to participate in this project and that you have read and understand the information above.*

Participant’s signature

Date

Participant’s printed name

To my knowledge, this person is choosing to give informed consent to participate.

Investigator’s signature

Date

Investigator’s printed name
Appendix E: Recruitment Source List

1. Contacted:
   a. Local therapists and group practices in Keene, NH and surrounding areas
   b. School counselors
   c. DCYF case workers
   d. Hospitals (primary care and family practice physicians)
   e. Residential treatment centers
   f. Court
   g. Temples, churches, other places of worship
   h. Contact information for:
      i. Amanda Hitchings
      ii. Tom Stearns
      iii. Gina
      iv. Jerry Kaufman
      v. Lorna Watkins Barth

2. Visited appropriate contacts to disperse pamphlets and network
3. Mailed pamphlets and information to contacts
4. E-mailed and called contacts
5. Track down youth development/peer-mentor for foster youth
6. Attempted to identify alternative living situations (tent community in Keene, for example)
7. Local stores, Walmart, individuals on the bike path in Keene

Contacts

- MAPS
- MFS
- Brattleboro Retreat
- DCYF
- Local group practices

Contacts Called and E-mailed

- DCYF Adolescent Workers
- http://therapists.psychologytoday.com/rms/state/NH/Keene.html (e-mail)
- Andrea’s Alumni – Scholarship program for former foster youth
  PO Box 786
  Merrimack, NH 03054

Antioch Psychological Services Center, Keene, New Hampshire
- Clinical psychology student trainee clinic
- Fliers distributed at PSC

Department of Children, Youth, and Families in New Hampshire
- Contacted Jackie Waldvogel (head of adolescent unit in Keene) at DCYF
- E-mailed Robert Rodler (Adolescent Program Specialist) at DCYF
- Patti Carbonara – asked to disseminate info to caseworkers
Lund Family Center; Keene, New Hampshire
  - E-mailed Dannabare@gmail.com (603) 276-0470

Maternal and Child Health at Home Healthcare Hospice and Community Services
  - Penny Vaine 352-2253 x132

Dr. Amanda Hitchings at Cheshire Medical Hospital; Keene, New Hampshire

Antioch Listserv
  - Emailed entire Antioch community with the recruitment letter, inclusion criteria, and brochure for the group

MountainWellness; Keene, New Hampshire
  - Dr. Meghan Estey and her colleagues; she expressed interest in the group and allowed me to disseminate brochures and information about the group to her group practice

Recruited At Vermont Foster Case Consortium
  - Met with members of DCF and other agencies to network about the group
  - Asked for feedback about the group to former foster youth

Amanda Churchill – Youth Development Program in VT

VT DCF Pamela Piper – Pamela.piper@partner.state.vt.us

Bess O’Brien – Kingdom Country Productions

Jessie Amster – AmeriCorps Organization; Youth Development Program

AIDS Services of the Monadnock Region

16 High Street, Gilsum, NH 03448
Phone: (603) 357-6855
AIDS Services for the Monadnock Region, founded in 1989, is a non-profit organization committed to serving people living with HIV/AIDS in Cheshire County, southern Sullivan County and western Hillsborough County. We offer case management, free, anonymous HIV testing in a confidential setting and educational programs.
www.asmronline.org

N.H. Public Health HIV-AIDS Hotline
Toll free: 1-800-752-AIDS (2437)

New Hampshire HIV/AIDS Program
Toll free: 1-800-852-3345, extension 4576

Alcoholics Anonymous
GROUP THERAPY FOR YOUNG WOMEN

Provides time and place of meetings in area or residence.
Toll free: 1-800-593-3330
www.aa.org

Al-Anon and Alateen
Local phone: (603) 228-2542
The Al-Anon Family Groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope in order to solve their common problems.
www.nhal-anon.org

Alcohol and Drug Abuse Help Line and Treatment
Cocaine abuse 24-hour hotline & treatment.
Toll free: 1-800-234-0420

Alcohol Crisis Intervention/Phoenix Health Center Keene
Alcohol and drug treatment center.
Phone: (603) 358-4041

School Districts

School Administrative Unit 24
41 Liberty Hill Road, Bldg 5, Henniker, NH 03242
Phone: (603) 428-3269; www.sau24.org
Includes Stoddard and surrounding towns.

School Administrative Unit 29
34 West Street, Keene, NH 03431
Phone: (603) 357-9002; www.sau29.org
Includes Chesterfield, Harrisville, Keene, Marlborough, Marlow, Nelson, and Westmoreland.

School Administrative Unit 38 600 Old Homestead Highway, Swanzey, NH 03446
Phone: (603) 352-6955; www.mrsd.org
Includes Fitzwilliam, Gilsum, Hinsdale, Richmond, Roxbury, Sullivan, Swanzey, Troy, and Winchester.

New Hampshire Division of Children, Youth and Families
Toll free: 1-800-894-5533
www.dhhs.nh.gov/DHHS/DCYF

Community Services

Adult Learner Services-Community Education
438 Washington Street, Keene, NH 03431
Phone: (603) 357-9041; http://www.keenecommunityed.org/welcome1.html
Provides tutors and classes free of charge for adults who need help with reading or math. Also provides free English classes and tutorials for speakers of other languages.

**American Red Cross, NH West Chapter**  
83 Court Street, Keene, NH 03431  
Phone: (603) 352-3210  
Toll free: 1-800-244-2214

**Catholic Charities**  
161 Main Street, Suite 200, Keene, NH 03431  
Phone: (603) 357-3093; [www.nh-cc.org](http://www.nh-cc.org)  
Offers information and referral, counseling, adoption, NH Food Bank, unemployment support groups, and community outreach.

**Cheshire County Probate Court**  
12 Court Street, Keene, NH 03431  
Phone: (603) 357-7786; [www.co.cheshire.nh.us/Probate/index.html](http://www.co.cheshire.nh.us/Probate/index.html)  
The work of the Probate Court centers on protecting individual rights, particularly for some of the state’s most vulnerable citizens: children, the elderly, and mentally and physically disabled youth and adults. The Probate Court resolves issues involving families as well as property.

**Cheshire Smiles** A service through Cheshire Medical Center with a number of locations in the Keene area  
Phone: (603) 354-5494; [www.cheshire-med.com](http://www.cheshire-med.com)  
Offers dental screenings and education to all children in targeted grades (Preschool to Grade 3) and offers preventative care and referrals to dental offices for those without routine dental care.

**Cheshire YMCA**  
32 Lake St., PO Box 647, Swanzey, NH 03431  
Phone: (603) 352-0447; [www.cheshireymca.org](http://www.cheshireymca.org)  
Offers creative educational and recreational activities including resident and day camping, outdoor education and 7th and 8th grade American history travel programs. Financial assistance is available.

**Community Support Program**  
17 93rd Street, Keene, NH 03431  
Phone: (603) 357-5270

**Consumer Credit Counseling Services of N.H.**  
PO Box 818, Concord, NH 03302  
Phone: (800) 327-6778; [www.cccsnh-vt.org](http://www.cccsnh-vt.org)  
Provides confidential, expert, unbiased individual budgeting, money management, credit, and debt counseling; bankruptcy counseling; housing counseling; and reverse mortgage counseling. With the exception of bankruptcy counseling, all counseling is offered free of charge. CCCS of NH & VT also provides free educational programming to groups covering these same subjects.
Contoocook Housing Trust
PO Box 216, New Ipswich, NH 03071
Phone: (603) 878-1247; www.housingtrust.org
Provides affordable rental and homeownership opportunities for low and moderate income families.

Easter Seals New Hampshire
12 Kingsbury Street, Keene, NH 03431
Vocational Services - Phone: (603) 355-1067
Early Support Services (Early Intervention) - Phone: (603) 352-0165
Foster Family Program - (603) 352-5724
Easter Seals provides exceptional services to ensure that all people with disabilities or special needs and their families have equal opportunities to live, learn, work and play in their communities.

Family Resource Connection
Toll free: 1-800-298-4321; www.nh.gov/nhsl/frc
A statewide phone resource center providing information and resources for families with young children.

Familystrength
206 Roxbury Street, Keene, NH 03431
Phone: (603) 357-8722; www.familystrength.org
Familystrength is a non-profit organization that was built on its passion for helping families and individuals find effective and lasting solutions to life’s most difficult challenges that may involve, severe stress, anxiety, depression, substance abuse, family or sexual violence, child abuse, neglect or mental illness.

Granite State Independent Living
21 Chenell Dr., Concord, NH 03301
Phone: (800) 826-3700, (603) 228-9680; www.gsil.org
A statewide nonprofit, service, and advocacy organization that provides tools for living life on your terms – so you can navigate your own life and participate as fully as you choose in your community, just like everyone else.

Helping Hands
3 Water Street, Troy, NH 03465
Phone: (603) 242-3007

Head Start
63 Community Way, Keene, NH 03431
Phone: (603) 357-0129; www.scshelps.org/headstart.htm
Other locations: Drewsville, (603) 445-2595; Jaffrey, (603) 532-4135; Ashuelot, (603) 239-8228; Swanzey, (603) 352-2574; Claremont, (603) 542-2721; Newport, (603) 863-3112.
Head Start provides a supportive and consistent preschool educational environment for children
and families through open communication, exceptional resources, and positive role modeling to help children and adults become successful and self-sufficient.

**Hillsborough County Probate Court**
30 Spring Street, P.O. Box 387, Nashua, NH 03061
Phone: (603) 882-1231 or 424-7844; [www.courts.state.nh.us/courtllocations/hillsprobdir.htm](http://www.courts.state.nh.us/courtllocations/hillsprobdir.htm)
Has jurisdiction over a variety of issues including all matters related to wills, trusts and estates, guardianships and involuntary commitment proceedings, adoptions, name changes and partition of real estate.

**Juvenile Conference Committee / City of Keene Youth Services**
3 Washington Street, Keene, NH 03431
Phone: (603) 357-9810; [www.ci.keene.nh.us/government/boards-commissions/juvenile-conference](http://www.ci.keene.nh.us/government/boards-commissions/juvenile-conference)
Provides an early intervention, community-based program for first-time young offenders residing in Keene and surrounding towns within the jurisdiction of Keene District Court. This pre-adjudication alternative to formal court proceedings holds youth accountable to the community while minimizes a juvenile’s penetration into the justice system.

**Keene Family YMCA**
38 Roxbury Street, Keene, NH 03431
Phone: (603) 352-6002; [www.keene-ymca.org](http://www.keene-ymca.org)
Provides programs for children and teens, and physical activities for everyone.

**Keene Housing Authority**
831 Court Street, Keene, NH 03431
Phone: (603) 352-6161; [www.kha.org](http://www.kha.org)
Provides decent, safe and affordable housing to residents of the Monadnock Region, while at the same time meeting the needs of family, and elderly households. Toward this end, a vast array of programs and services are offered including Public Housing, Section 8 Voucher Program, Congregate Housing Services Program, Resident Self Reliance Program, and the Housing Assistance Coupon Program.

**Mentor Clinical Care**
32 Washington Street, Keene, NH 03431
Phone: (603) 357-4929

**Monadnock Area Transitional Shelter**
PO Box 3053, Peterborough, NH 03458
Phone: (603) 924-5033; [www.matsnh.org](http://www.matsnh.org)
A transitional shelter run by volunteers from local communities and a part-time Case Manager. MATS serves the towns of the Greater Monadnock Region, and we also accept referrals from other shelters throughout the tri-state area.
**Monadnock Area Housing Coalition**  
Phone: (603) 352-7512  
Provides direct and immediate care to the homeless populations and those in imminent danger of becoming homeless.

**Monadnock Volunteer Center**  
30 Washington Street, Keene, NH 03431  
Phone: (603) 352-2088 or 357-6893; www.monadnockvolunteercenter.org  
Our primary focus is to send volunteers to public and non profit agencies in the Monadnock Area. In order to meet community needs that other agencies are unable to fill.

**N.H. Housing Finance Authority**  
109 Key Road, Keene, NH 03431  
Rental Help: (800) 439-7247  
Home Ownership: (800) 649-0470  
www.nhhfa.org  
Promotes finance and supports affordable housing opportunities and related services for New Hampshire families and individuals through the efficient use of resources and the building of effective partnerships, thereby contributing to the economic and social development of the State and its communities.

**N.H. Legal Assistance**  
Toll Free: (800) 562-3994; www.nhla.org  
A non-profit law firm offering legal services in civil matters to seniors and eligible low-income persons. NHLA provides high quality legal services to vulnerable low-income people, ranging from simple legal information and advice to vigorous and thorough representation in all of New Hampshire’s courts and before many of the local, state and federal agencies which play large roles in the lives of low-income people. In providing legal services to the poor, NHLA helps balance the scales of justice for all citizens.

**N.H. Public Defender**  
1 West Street, Keene, NH 03431  
Phone: (603) 357-4891; www.nhpd.org

**New Hope New Horizons**  
Community Way, Keene, NH 03431  
Phone: (603) 352-7512; www.scshelps.org/NHNH.htm  
New Hope New Horizons (NHNH) provides life enriching services to adults of all abilities so that they may achieve their personal hopes and dreams. These services include employment, day and community outreach, and residential support. A dedicated staff composed of both new and long-term members is committed to the success of the people they support.

**Planned Parenthood of Northern New England**  
8 Middle Street, Keene, NH 03431  
Phone: (603) 352-6898; www.ppnne.org
Provides routine gynecological care, pregnancy testing and testing for sexually transmitted diseases.

**Pregnancy Resource Center**  
100 Washington St., 2nd Floor, Keene, NH 03431  
Phone: (603) 358-6460, 1-800-395-HELP  
[www.PregnancyOptionsKeene.org](http://www.PregnancyOptionsKeene.org)  
All services are free and include: Individual Parenting classes, materials and support provided.  
Pregnancy testing and confirmation through limited obstetrical ultrasound; Information about fetal development, pregnancy options, sexual health, post-abortion small group or individual support.

**Project Share**  
312 Washington Street, Keene, NH 034311  
Phone: (603) 352-8464  
Thrift shop

**St. Vincent DePaul Society**  
161 Main Street, Keene, NH 03431  
Phone: (603) 357-3093; [www.stbernardkeene.com/svdp.html](http://www.stbernardkeene.com/svdp.html)  
The food pantry is open three evenings a week to clients through the generosity of the parish community – their donated, non-perishable food items or monetary donations. Clients may come for food assistance on Monday, Wednesday, and Friday from 7:00—8:00pm in the basement of St. Bernard Church.

**Salvation Army**  
15 Roxbury Plaza, Keene, NH 03431  
Phone: (603) 352-0607  
Provides help with food (food pantry and food voucher system), counseling, information and referral services, social, educational, recreational and religious programs for adults and children.

**Salvation Army Thrift Store:**  
132 Monadnock Highway, Swanzey, NH 03446  
Phone: (603) 357-2207; [www.salvationarmyusa.org](http://www.salvationarmyusa.org)  
Mon.-Sat. 9-5  
Provides clothing and other material assistance.

**Department of Health and Human Services**

**Southwestern Community Services**  
63 Community Way, PO Box 603, Keene, NH 03431  
Phone: (603) 352-7512, extension 4285, 4141, 4284, or 4283  
Toll Free: 1-800-529-0005; [www.scshelps.org](http://www.scshelps.org)  
SCS owns and manages over 200 Senior and Workforce houses and apartments throughout the region. Income limits apply. Applications may be picked up at the Island Street office or can be mailed.
**United Church of Jaffrey Emergency Shelter**  
Phone: (603) 532-7047

**Young Monadnock Cares**  
Phone: (603) 352-2088

### Child Care Centers

**Footsteps Daycare & Learning Center**  
130 Martell Court, Keene, NH 03431  
Phone: (603) 357-1475

**Great Beginnings**  
39 Old Homestead Highway, PO Box 10652, Swanzey, 03446  
Phone: (603) 355-8381  
Offers care for children from 6 weeks through 6 years and a full year preschool program.

**Harrisville Children’s Center**  
66 Main Street, PO Box 128, Harrisville, NH 03450  
Phone: (603) 827-3905; www.harrisvillechildrenscenter.org  
Provides full and part time child care and preschool to children from ages 6 weeks to 6 years old.

**Head Start**  
A program of Southwestern Community Services  
63 Community Way, PO Box 603, Keene, NH 03431  
Phone: (603) 352-7512, extension 4160  
Toll Free: 1-800-529-0005  
www.scshelps.org/headstarthome.htm  
Provides a supportive and consistent preschool educational environment for children and families. Through open communication, exceptional resources and positive role modeling, children and adults become more successful and self-sufficient. Programs in Ashuelot, Claremont, Drewville, Jaffrey, Keene, Newport, and Swanzey.

**Keene Day Care Center**  
86 Wood Street, Keene, NH 03431  
Phone: (603) 352-2129  
School-aged after school program phone: (603) 357-2031; www.keenedaycarecenter.org  
Provides childcare services for children 6 weeks through school age at two sites. Families of all incomes are eligible if they are working, seeking work or attending school. The school-age program is open before and after school as well as during vacation time.

**Keene Family YMCA**  
38 Roxbury Street, Keene, NH 03431  
Phone: (603) 352-6002; www.keene-ymca.org  
Provides childcare services for infants through preschool age, and Before and After School
programs in Keene, Swanzey, Marlborough, Westmoreland and Chesterfield. Please call for additional information.

**Keene State College Child Development Center**  
229 Main Street, Elliot Hall, Suite 2503 Keene State College, Keene, NH 03435  
Phone: (603) 358-2233; [www.keene.edu/cdc](http://www.keene.edu/cdc)  
Provides childcare and educational programs for children 4 months to 4 years, 11 months of the year from late August through mid-June.

**Lily Garden Learning Center**  
867 Route 12, Unit 10, Westmoreland, NH 03467  
Phone: (603) 357-9399; [www.lilygardenlearning.com](http://www.lilygardenlearning.com)  
Provides a nature-based, hands-on early learning experience for infants and young children (3 months to age 5). Offers a curriculum that teaches respect and trust while honoring and valuing differences.

**The Orchard School**  
114 Old Settlers Road, East Alstead, NH 03602  
Phone: (603) 835-2495; [www.orchard.org](http://www.orchard.org)  
Offers childcare services to children ranging from two and a half to six years of age. Summer camps for 2.5 to 14 year olds.

**Rise...For Baby and Family**  
147 Washington Street, Keene, NH 03431  
Phone: (603) 357-1395  
Offers a childcare program for children from infants to age three, which integrates children of different abilities.

**Spofford Children’s House**  
38 Chandler Road, Spofford, NH 03462  
Phone: (603) 363-8498  
Offers childcare to children from two years five months to six years of age.

**Winchester Learning Center**  
5 Michigan Street, Winchester, NH 03470  
Phone: (603) 239-7347  
[www.thewinchesterlearningcenter.org](http://www.thewinchesterlearningcenter.org)  
Offers childcare, preschool and family resources for families with children from one to six years of age.

**Adoptive Families for Children, Inc.**  
26 Fairview Street, Keene, NH 03431  
Phone: (603) 357-4456  
Licensed by the State of New Hampshire to provide complete adoption services for children, birth parents, and adoptive parents.
ARK Supervised Visitation Center  
24 Vernon Street, Keene, NH 03431  
Phone: (603) 357-4661  
Provides a safe, neutral, child-centered environment for supervised visitation and exchange to promote healthy interaction between family members, allowing a child to have safe contact with their non-residential parent in a warm, friendly atmosphere.

Big Brothers - Big Sisters  
166 Emerald Street, Keene, NH 03431  
Phone: (603) 352-9536; www.bbbswnh.org  
Big Brothers Big Sisters helps children reach their potential through professionally supported one-on-one relationships.

Bureau of Special Medical Services  
Division of Public Health  
Department of Health and Human Services  
129 Pleasant Street, Thayer Building, Concord, NH 03301  
Phone: (603) 271-4488  
Toll Free: 1-800-852-3345, extension 4488 www.DHHS.nh.gov/dhhs/specialmedsrvcs  
Health programs for the diagnosis and treatment of children from birth to twenty who have physical disabilities, chronic illnesses, or developmental delays.

Cedarcrest Center for Children with Disabilities  
91 Maple Avenue, Keene, NH 03431  
Phone: (603) 358-3384; www.cedarcrest4kids.org  
Provides comprehensive medical/residential care, special education and outpatient therapy services to children with complex medical and developmental needs. Caregiver training is also offered.

Easter Seals  
12 Kingsbury Street, Keene, NH 03431  
Phone: (603) 352-0165; www.nh.easterseals.com  
Provides early intervention, home-based services for children, from birth to three years of age, and their families.

Monadnock Developmental Services  
121 Railroad Street, Keene, NH 03431  
Phone: (603) 352-1304  
Toll Free: 1-800-469-6082, extension 293 www.mds-nh.org  
Provides advocacy and case management services, family support and respite, along with residential, vocational, recreational and therapeutic services for persons with developmental disorders.

New Hampshire Family Voices  
29 Hazen Drive, Concord, NH 03301
Toll free: 1-800-852-3345, extension 4525  
www.nhfv.org  
Provides families with information on special needs and has a lending library.

**Parent Information Center**  
151-A Manchester Street  
Concord, NH 03301  
Phone: (603) 224-7005  
Toll free: 1-800-947-7005  
www.nhspecialed.org  
Provides information and free training to parents and community agencies regarding special education laws and services provided by schools such as I.E.P.’s for children ages three to twenty-one.

**Parent to Parent**  
12 Flynn Street, Lebanon, NH 03766  
Toll free: 1-800-698-5465; www.p2pnh.org  
Matches parents of children with disabilities with parents of children with similar needs. Also provides information and referral services.

**Partners in Health**  
Phone: (603) 352-1304  
Toll Free: 1-800-469-6082  
www.nhpih.dartmouth.edu  
Help for families of children with chronic health conditions, birth to twenty-one years of age.

**RISE...For Baby and Family**  
147 Washington Street, PO Box 824, Keene, NH 03431  
Phone: (603) 357-1395  
Email: risekeene@worldpath.net  
Provides support and services for infants and toddlers with special needs and their families. Rise also provides an on-site childcare program, which integrates children of different abilities. Serving children with special needs from age three and all students at age five or six.

**Cheshire Medical Center/Dartmouth Hitchcock Keene**  
--For direct emergency patient assessment, go to the Emergency Room and you will be provided with psychiatric consultation and intervention services 24hrs/day, 7 days/week  
--Telephone assessment, intervention, and referral services are also available twenty-four hours. Calls are accepted from throughout the region by licensed professionals.  
Toll free: 800-556-6249  
www.cheshire-med.com

**Monadnock Family Services**  
Immediate help with mental health crises and problems.  
Keene District Office, Children & Families  
64 Main Street, Suite 301
Keene, NH 03431
(603) 357-4400
www.mfs.org

**Monadnock Center for Violence Protection**
--24-Hour help for victims of rape and domestic violence, temporary shelter, and help with police and courts.
(603) 352-3782 or 888-511-MCVP (6287)
www.mcvprevention.org

**Samaritans of New Hampshire**
--Non-denominational, non-profit agency dedicated to the reduction of both incidents and impact of suicide, available 24hrs/day to anyone feeling depressed, lonely, or suicidal.
Confidential, anonymous crisis lines:
Locally: (603) 357-5505 or (603) 924-7000
Teens: (603) 357-5506 and (877) 583-8336
Toll-free: 1-877-583-8336
www.samaritansnh.org

**Adoptive Families for Children, Inc**

26 Fairview Street,
Keene, NH 03431
**Phone:** (603) 357-4456

**Bureau of Special Medical Services Division of Public Health Department of Health and Human Services**

129 Pleasant Street, Thayer Building, Concord, NH 03301
**Phone:** (603) 271-4488
**Toll free:** 1-800-852-3345, extension 4488
www.DHHS.nh.gov/dhhs/specialmedsrvcs

*Health programs for the diagnosis and treatment of children from birth to twenty who have physical disabilities, chronic illnesses, or developmental delays.*

37 Mechanic St., Keene, NH 03431
**Phone:** (603) 352-3200
www.thecommunitykitchen.org

**Community Support Program**

17 93rd Street, Keene, NH 03431
**Phone:** (603) 357-5270
Family Resource Connection

Toll free: 1-800-298-4321  
www.nh.gov/nhsl/frc

Hundred Nights
Cold Weather Shelter & Drop-in Resource Center

17 Lamson Street, Keene, NH 03431  
**Phone:** (603) 352-5197  
www.hundrednights.org

Welfare / Cheshire County

Keene, NH; (603) 357-9809

MAPS Counseling Services

Monadnock Area Psychotherapy and Spirituality Services (MAPS)  
19 Federal Street, Keene, NH 03431  
**Phone:** (603) 355-2244

44 Concord Street, Peterborough, NH 03458  
**Phone:** (603) 355-2240  
www.mapsnh.org

Monadnock Center for Violence Prevention

12 Court Street, Keene, NH 03431  
**Crisis Line:** (603) 352-3782  
**Toll free:** 1-888-511-6287  
www.mcvprevention.org

Monadnock Developmental Services

121 Railroad Street, Keene, NH 03431  
**Phone:** (603) 352-1304  
**Toll free:** 1-800-469-6082, extension 293  
www.mds-nh.org

Monadnock Family Resource Center

30 Washington Street, Keene, NH 03431  
**Phone:** (603) 357-6870  
**Fax:** (603) 357-8394
Monadnock Family Services

**Keene District Office:** 64 Main Street, Suite 301, Keene, NH 03431  
**Phone:** (603) 357-4400 or (603) 357-5270  
[www.mfs.org](http://www.mfs.org)

Jaffrey: (603) 924-6223  
Peterborough: (603) 924-7236  
Walpole: (603) 756-4735  
Winchester: (603) 239-4376

Monadnock Region Substance Abuse Services

**Phone:** (603) 357-3007 or (603) 357-4400

Monadnock United Way

25 Center Street, Keene, NH 03431  
**Local Phone:** (603) 352-4209 or (603) 352-1999  
**Toll free:** 1-800-368-HELP (4357)  
Social Services guide online  
[www.muw.org](http://www.muw.org)

Phoenix House

**Keene Center:** (603) 358-4041  
**Dublin Center:** (603) 563-8501  
[www.phoenixhouse.org/](http://www.phoenixhouse.org/)

Planned Parenthood of Northern New England

8 Middle Street, Keene, NH 03431  
**Toll Free:** 1-800-230-7526  
**Phone:** (603) 352-6898  
[www.ppnne.org](http://www.ppnne.org)

Pregnancy Center/ Abortion Alternative  
Pregnancy Resource Center of the Monadnock Region

100 Washington St., 2nd floor, Keene, NH 03431  
**Phone:** (603) 358-6460, 1-800-395-HELP  
[www.PregnancyOptionsKeene.org](http://www.PregnancyOptionsKeene.org)
Project Share Thrift Shop
Keene Recreation Center

312 Washington Street, Keene, NH 03431
Phone: (603) 352-8464

Saint James Church

44 West Street, Keene, NH 03431
Phone: (603) 352-1019; www.stjameskeene.org
Thrift store hours: Mon.-Fri., 10-4; Sat. 10-2.

Salvation Army

15 Roxbury Plaza, Keene, NH 03431
Phone: (603) 352-0607

Thrift Store:
132 Monadnock Highway
Swanzey, NH 03446
Phone: (603) 357-2207
Mon.-Sat. 9-5
www.salvationarmyusa.org

Southwestern Community Services
63 Community Way, PO Box 603, Keene, NH 03431
Phone: (603) 352-7512, extension 4160 or 4192
Toll free: 1-800-529-0005
www.scshelps.org

WIC Program
A program of Southwestern Community Services

69 Z Island Street, PO Box 603, Keene, NH 03431
Phone: (603) 352-7512, extension 4234
www.scshelps.org

Places of Worship in and around Keene, NH:

- Federated Church of Marlborough
  16 Pleasant Street, Marlborough, NH
- First Baptist Church
  105 Maple Avenue, Keene
- First Church of Christ, Scientist
  74 Washington Street, Keene
• United Church of Christ
  23 Central Square, Keene

Cheshire Mediation
http://cheshiremediation.com/
25 Roxbury Street, Suite C 108 PO Box 340
Keene, NH 03431
(603) 358-3322

The Coalition
Services are available to everyone and we have special programs for women and youth.
Kate McNally, Program Coordinator
tobacco-free@cheshire-med.com
(603) 354-6513

The Samaritans
Suicide prevention and hotline
Business Office: (603) 357-5510
24/7 Hotline: (603) 357-5505 or (603) 924-7000
director@samaritansnh.org
http://www.samaritansnh.org

Big Brothers/Big Sisters
http://bbswnh.org
68 Castle Street
Keene, NH 03431
(603)-352-9536

Court Referral Program
Jdimeglio1@myfairpoint.net
103 Roxbury Street, Suite 206
Keene, NH 03247
Phone: 603-352-0800

City of Keene Youth Services Department
3 Washington Street
Keene, NH 03431
603 357 9811
jsadoski@ci.keene.nh.us
ebrown@ci.keene.nh.us
**Commitment**

If you’re interested, please set up a time to meet with the researcher.

The GIFFT Group runs for 8 weeks. Each session is roughly 1-hour long.

At the end of the group, you’ll be asked to meet with the researcher to talk about your experiences.

---

**Group Times and Location**

The GIFFT Group is offered at Antioch University New England Psychological Services Center
40 Avon Street
Keene, NH 03431

The group meets weekly on….

There is NO FEE for the group.

---

**The GIFFT Group**

Group Intervention for Foster Females in Transition

Psychological Services Center

photo of gift box here
Improving Relational Health

Tasks of the GIFFT Group

1. Create an atmosphere of safety and connection
2. Share stories of relationships involving experiences of connection and disconnection
3. Develop a more accurate picture of yourself and others
4. Develop a greater sense of worth
5. Feel more connected to other people and develop a desire to connect with others outside the group

The GIFFT Group is right for you if:

1. You are a female between 18-25 years old who has aged out (or is about to age out) of foster care
2. You are interested in learning more about yourself and ways to improve your relationships
3. You want to feel less isolated from others
4. You would like to share your personal stories with others, and hear the stories of other young women

Psychological Services Center
40 Avon Street, Keene, NH 03431
603.352.1024
Serving the community for over 20 years
The following is a description of each session in the group manual by Jordan and Dooley (2001), as well as a description of the additions and adaptations for each session, to meet the clinical needs of young women aging out of foster care.

Session One

In the manual by Jordan and Dooley (2001), the first session involves introducing the relational-cultural model to participants. The co-leaders provide psychoeducation about RCT concepts in this session. Participants reflect upon their experiences of connection and their strategies of disconnection, or ways in which we protect ourselves from relational vulnerability.

**Additions and Adaptations**

**Introductions and Purpose of the Group**
- Review timeline of the group, and members’ expectations and hopes for the group
- Have group members’ write down (3) expectations they have about the group (these will be used again in a later session)

**Explore Potential Barriers to Attending the Group**

**Discuss the Concepts of Safety and Trust**
- Explore the meaning of “safety” to the group
- Encourage members to express their safety concerns, if any
- Explore the ways in which we develop safety and how to determine when safety is established

**Icebreaker Activity, “Stand up” (see handout)**

**Mindfulness Discussion and Exercise**
- Describe mindfulness practice
  - Frame mindfulness as an empowerment tool – gaining control and enhancing emotional resiliency
- Mindfulness jars exercise
  - Materials: Small jar, glitter, hot glue gun

**Closing Rituals**
- Group leaders request feedback
- Mindfulness relaxation exercise
  - Focus on the senses; stay external
- Members reflect on the group process
- Close with an inspirational/motivational poem or quote
  - Co-leaders prepare quote, poem or song at first, then offer group members’ to choose
Homework for the Week  
(Optional addition depending upon level of interest expressed by group members)
- Encourage group members to write their reactions and reflections about the group in a journal each week. Members may choose to share or not to share the following week  
- Materials: Journals for each member

Session Two

Jordan and Dooley (2001) address the ebb and flow of connection within relationships, and how movement from disconnection to connection can occur. Participants are encouraged to reflect upon experiences of disconnection, especially times when they felt they successfully maneuvered through an experience of disconnection with someone.

Additions and Adaptations

Mindfulness Exercise
- Mandala exercise
- Materials: Mandala sheets, coloring materials, music (optional)

Focus on Topics of Safety and Trust
- Check-in with members about their experiences and how they are feeling about being in the group

Closing Rituals
- Group leaders request feedback  
- Members reflect on the group process  
- Close with an inspirational quote, poem, or song

Homework for the Week: Mindfulness Exercise
- Pretend to be a camera or a newspaper reporter – each day noticing more and more (of environment and his/her actions)
  - Day 1 – woke up, went to bathroom, got dressed, had breakfast  
  - Day 2 – add steps like washing face, combing hair, brushing teeth  
  - Day 3 – add details of what eaten or smaller steps like pouring milk  
  - Day 4/5 – opening eyes, sitting up and putting feet on floor, walk down hall, feel difference of floor, closing door, going to the bathroom, flushing, turning on water at sink, etc.

Session Three

Within the third session, Jordan and Dooley (2001) suggest discussing the topic of diversity. Participants are encouraged to reflect upon experiences where they have felt particularly advantaged, and disadvantaged. Co-leaders direct a discussion about how differences can become sources of disconnection and connection.
Additions and Adaptations

Mindfulness Exercise
- Mindful eating exercise
- Materials: Small pieces of fruit and chocolate
- Instructions: Have members slowly eat pieces of food while paying attention to their sensory experiences. Encourage members to look at the food and act as if they were from another planet, needing to inspect the food carefully and eating it slowly.

Closing Rituals
- Group leaders request feedback
- Members reflect on the group process
- Close with an inspirational quote, poem, or song

Session Four

In the fourth session, Jordan and Dooley (2001) suggest addressing the topics of shame and isolation, and how they influence our relational and mental health. Participants are encouraged to describe and reflect upon their own experiences of shame and humiliation.

Additions and Adaptations

Mindfulness Exercise
- Mindful walking
  - Instructions: Group members will walk as slowly as possible in a line, paying attention to each moment. If deemed appropriate, co-leaders can play an audio recording of a mindfulness walking script. Co-leaders encourage members to pay attention to their sensory experiences throughout the walk.

Revisit the Topics of Trust and Safety
- Allowing oneself to be vulnerable in a group is difficult for anyone; check-in with group members about their sense of safety surrounding sharing experiences of shame

Revisit the Topic of Termination
- How does the group want to end together?
- Exploration of cultural rituals of “goodbye” and endings
  - Our rituals, families, friends, school

Closing Rituals
- Group leaders request feedback
- Members reflect on the group process
• Close with an inspirational quote, poem, or song

Homework for the Week
• Reflect on the group process in a journal
• Continue practicing mindfulness and reflect upon the process

Session Five

In this session, Jordan and Dooley (2001) propose making the concepts discussed in the first session more personalized. Participants are encouraged to reflect upon the ways in which they protect themselves from vulnerability, and disconnect with other people.

Additions and Adaptations

Mindfulness Exercise
• Time capsule activity
  ▪ Letter to future self
  ▪ Materials: Shoe boxes, magazines, glue, scissors
    • Group members reflect upon their current state and project into the future
    • Members are encouraged to write a letter to themselves in the future

Closing Rituals
• Group leaders request feedback
• Members reflect on the group process
• Close with an inspirational quote, poem, or song

Session Six

Within the sixth session of the manual by Jordan and Dooley (2001), participants discuss and reflect upon the concepts of conflict and growth. Co-leaders provide psychoeducation to participants about how anger is a useful emotion that can lead to constructive or destructive action. Participants learn how dominant groups can stunt authenticity by silencing healthy conflict.

Additions and Adaptations

Mindfulness Exercise
• Mindful drumming activity
• Materials: Drums for each group member
• Instructions: Co-leaders will facilitate a group drumming activity where members are asked to repeat sounds, create their own, and pay attention to the sensory experience of drumming

Closing Rituals
• Group leaders request feedback
• Members reflect on the group process
• Close with an inspirational quote, poem, or song

Homework for the Week:
• Practice mindful walking and reflect in journal

Session Seven

The seventh session by Jordan and Dooley (2001) involves a discussion of the various roles we embody at home, work, and school, for instance. Participants are encouraged to think of concrete ways in which they can use relational values in their interactions with others in their various roles.

Additions and Adaptations

Mindfulness Exercise
• Mindful listening exercise
• Materials: Singing bowl, other music (optional)
• Instructions: Have group members try and hold their attention on the sound of the bowl from the start to the end of its ringing. If preferred, have members listen to a song instead and try to focus on different elements of the song.

Closing Rituals
• Group leaders request feedback
• Members reflect on the group process
• Close with an inspirational quote, poem, or song

Homework for the Week:
• Materials: 3x5 notecards, pens and markers
• Instructions: Have group members write on a card for each member. Include a positive memory from the group, positive feedback, and/or a wish for the member. Group members will give them to each other during the final session.

Session Eight – Final Session

Jordan and Dooley (2001) recommend covering the topics of empowerment and community during the final session of the group. Participants are encouraged to reflect upon their experiences within the group. Co-leaders discuss the importance of networking and facilitating meaningful connections, as well as on relying on others for support.

Additions and Adaptations

Mindfulness Exercise: Transitional Objects Activity
• Materials: Acrylic paint, rocks, paint brushes
Instructions: Have group members paint rocks to take with them as a symbolic representation of the group and group process.

If desired and deemed appropriate, members are encouraged to exchange contact information, practice networking, and utilize social support.

Reminiscing and Re-collecting
- Have group members review their initial list of expectations about the group
- Discussion: How were my expectations accurate or not?

Rituals of Goodbye
- Discussion: What are our ideas about endings? What did we learn about endings and goodbyes growing up?

Closing Rituals
- Group leaders request feedback
- Members reflect on the group process
- Co-leaders close with an inspirational quote, poem, or song
Appendix H: “Stand Up” Icebreaker Activity

Goals:

1. For members to get to know qualities they share and ways in which they differ,
2. To foster group cohesion among group members

Instructions:

Each member is told to stand up from their chair when they hear a statement that is true for them. If deemed appropriate by the co-leaders, members can be encouraged to offer their own statements, as a way to learn more about group members. The depth of the statements can change depending upon the group and co-leaders’ clinical judgment.

List of Sample Statements:

1. Stand up if you’re wearing white socks today.
2. Stand up if you have been to another country.
3. Stand up if cheese is one of your favorite foods.
4. Stand up if you have curly hair.
5. Stand up if you have siblings.