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## Promoting Mental Health: The Experiences of Youth in Residential Care Promouvoir la santé mentale : Les expériences de jeunes en centre d'hébergement

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### ABSTRACT

This qualitative study used the enhanced critical incident technique to explore the experiences of youth who are living in residential childcare facilities and identified key influences on their mental health during the transition into adult life. Participants were 8 youth (aged 16 to 18; 6 European Canadian, 2 Aboriginal Canadian) who engaged in individual semistructured interviews. Analyses of transcribed interview transcripts revealed that numerous themes in the areas of internal processes, interpersonal relationships, and impact of social contexts have the potential to influence in unique ways the mental health of youth who are living in residential care.

### RÉSUMÉ

Pour mener cette étude qualitative, on a eu recours à la technique améliorée d'analyse d'incident critique pour explorer les expériences vécues par des jeunes vivant dans des centres d'hébergement et de soins pour enfants, ce qui servit à définir les facteurs-clés influençant leur santé mentale durant leur transition vers la vie adulte. Les participants étaient 8 jeunes (de 16 à 18 ans; 6 Canadiens d'origine européenne, 2 Canadiens d'origine autochtone) qui se sont prêtés à des entrevues individuelles semi-dirigées. Les analyses des transcriptions d'entrevues révèlent que de nombreux thèmes touchant les processus internes, les relations interpersonnelles et les effets des contextes sociaux peuvent influencer considérablement la santé mentale des jeunes qui vivent en centre d'hébergement.

Experiences during the transition into adulthood can have an enormous impact on future life trajectories and well-being (Arnett, 2000; Crocetti et al., 2016). The presence of mental health issues can substantially hinder this transition (O'Connor, Sanson, Toumbourou, Norrish, & Olsson, 2017). Youth living in residential childcare centres experience a particularly high prevalence of mental-health-related difficulties (Deutsch et al., 2015). Consequently, Deutsch and colleagues (2015), together with the Office of the Child and Youth Advocate, Alberta ([OCYAA], 2013) have reported that during their transition into adulthood, this population is increasingly vulnerable to and experiences poorer life outcomes compared to their peers. Guided by Arnett's (2000, 2004) theory of emerging adulthood, in this qualitative study we explored factors that youth living in residential childcare

centres in Atlantic Canada perceive to be important influences regarding their mental health during a key period in their lives: the transition out of residential care and into adulthood.

#### THEORETICAL FRAMEWORK: ARNETT'S "EMERGING ADULTHOOD" PERSPECTIVE

The transition into adult life signifies a key developmental period for people in industrialized societies across the world, including Canada (Arnett, 2000, 2004). In Western societies, the transition into adulthood has undergone a major transformation over the past 50 years (Furstenberg, 2010; Osgood, Foster, Flanagan, & Ruth, 2005; Representative for Children and Youth, 2014; Settersten, Furstenberg, & Rumbaut, 2005). For much of the 20th century, this transition was relatively quick and straightforward: Young people typically left high school during their teenage years and then entered immediately into adult roles such as full-time employment and marriage (Furstenberg, 2010; Settersten et al., 2005). Although much of Canadian social policy continues to view the transition into adult life from this perspective and defines adulthood as beginning once youth reach 18 to 19 years of age, such rapid transitions into adulthood are no longer the norm in Canada, according to the Representative for Children and Youth (2014). Instead, young people now face an increasingly challenging and complex transition into adulthood that extends over a longer duration. Achieving independent adulthood, which was often accomplished by young people during their early 20s, is now often delayed close to a decade (Furstenberg, 2010; Settersten et al., 2005). Arnett (2000) and other researchers (Salvatore, 2017; Suárez-Orozco, 2015; Swanson, 2016) who have built on his work argue that this extended and complex transition period represents a distinct period of psychological development between adolescence and adulthood.

Arnett (2000) coined the phrase *emerging adulthood* to characterize this developmental period, which he conceptualizes as distinct from adolescence and adulthood. He stated that emerging adulthood, which is typically defined as ranging from the late teenage years into the early 20s, encompasses several significant transitions, such as completing postsecondary education, entering the workforce, and moving out of the parental household. This period also commonly involves young people entering more serious and committed personal relationships with romantic partners (Arnett, 2004; Young et al., 2011). According to Arnett (2000, 2004), during emerging adulthood, young people also move progressively toward psychological and practical independence and autonomy, needing to become increasingly self-reliant while discovering how to manage their own lives independently from their families. Additionally, Arnett characterized emerging adulthood as a significant period of self-examination during which youth explore who they are and how they wish to live their lives, as well as search out potential opportunities and investigate their own ideas, beliefs, and values. For these reasons, the transition into adult life is an important time of growth, maturity, and self-discovery (Crocetti et al., 2016).

The research evidence for Arnett's (2000) theory that has accumulated over the past decade has led to an increasing recognition within the developmental literature of the value of examining the transition out of adolescence through the lens of emerging adulthood (Salvatore, 2017; Suárez-Orozco, 2015; Swanson, 2016). Indeed, although the theory remains contested within the literature, Suárez-Orozco (2015) has claimed that Arnett's work has led to a "paradigm shift" (p. 535) within the field. Moreover, the disconnect between social policy, which assumes a straightforward transition between adolescence and adulthood (Representative for Children and Youth, 2014), and the growing body of research evidence that young people in industrialized societies do experience this extended transition period (Suárez-Orozco, 2015) has made Arnett's theory particularly salient for researchers exploring the experiences of youth in care. When the transition out of adolescence is artificially accelerated and compressed (Biehal & Wade, 1996), as is the case for youth in residential childcare centres and other forms of government care (Berzin, Singer, & Hokanson, 2014), they are not allowed the opportunity to fully engage in the emerging adulthood developmental process. This may lead to deleterious consequences (Arnett, 2004; Stein & Munro, 2008).

#### CHALLENGES FOR YOUTH LEAVING CARE

Across Canada, there are approximately 62,428 children residing in out-of-home care (Jones, Sinha, & Trocmé, 2015). Some of these individuals live in residential childcare centres, which are typically defined as a care service for youth up to the age of 18 who experience a variety of issues including behavioural and emotional difficulties (Canadian Mental Health Association, 2017). Many youth who enter residential childcare centres originate from high-risk community and family backgrounds (Okpych & Courtney, 2017). Okpych and Courtney (2017) explained that most of these youth have experienced adverse situations that have negatively affected their well-being in a variety of ways. These adverse experiences include various forms of abuse, neglect, traumatic experiences, addiction, and trouble with the law (Altschuler, Strangler, Berkley, & Burton, 2009; OCYAA, 2013; Osgood et al., 2005). Youth who have experienced such significant struggles are often hindered in terms of their development and face many challenges throughout emerging adulthood (Representative for Children and Youth, 2014; Scannapieco, Smith, & Blakeney-Strong, 2016).

The struggle to successfully transition into adulthood may be exacerbated by various issues associated with living in care. Specifically, the services provided by childcare settings are time-limited and are often terminated once youth reach legal adulthood status, often at the ages of 18 or 19 (Canadian Mental Health Association, 2017; Representative for Children and Youth, 2014). Due to the termination of residential care services at age 19, these youth face a transition into adulthood that is both accelerated and compressed; they are often propelled into adulthood much earlier than their noncare peers and do not have the opportunity to transi-

tion gradually (Arnett, 2000; Biehal & Wade, 1996; Settersten et al., 2005; Stein & Munro, 2008). Furthermore, for many of these individuals a return to their parents is not possible once leaving care due to negative past experiences or the unwillingness of their families to offer support (Dworsky & Courtney, 2009; Shah et al., 2016).

According to the OCYAA (2013), youth leaving care have reported being unprepared for the transition into adulthood and feel that unrealistic expectations are placed upon them to achieve independence, and many are lacking the appropriate skills and supports necessary to make a successful transition into adult life. They often also lack transitional support services such as mental health, career, or financial services (Jaudes, 2012; Scannapieco et al., 2016). This is especially problematic given that youth who have lived in out-of-home care settings often have a history of negative experiences and will likely require additional assistance compared to their noncare peers (Altschuler et al., 2009; OCYAA, 2013). Furthermore, barriers resulting from stigmatization and negative stereotypes, which link being in care to delinquency and psychological instability, are also quite common among this population (Representative for Children and Youth, 2014).

#### MENTAL HEALTH AND LEAVING CARE

One challenge faced by this population that is particularly salient for counsellors and psychotherapists is their experience with mental health. The Public Health Agency of Canada ([PHAC], 2006) defines mental health as

the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections, and personal dignity. (p. 2)

A report completed by the Canadian Institute for Health Information ([CIHI], 2009) operationalized the PHAC definition of mental health and broke it down into five suggested components: “ability to enjoy life,” “dealing with life’s challenges,” “emotional well-being,” “spiritual well-being,” and “social connections and respect for culture, equity, social justice and personal dignity” (pp. 10–16).

The CIHI (2009) report defined the first component as the ability to enjoy life. This is commonly assessed in terms such as happiness, life-satisfaction, and subjective well-being (Diener, 2000; Lyubomirsky, Sheldon, & Schkade, 2005; Suldo & Heubner, 2006). According to the CIHI, this form of enjoyment is often linked to variables including genetics, personality types or traits, specific life circumstances, family/social characteristics, and personal behaviours. The second component within the definition described in the CIHI report, dealing with life’s challenges, refers to an individual’s ability to cope and grow from the hurdles faced in life. Emotional well-being includes an individual’s ability to experience positive emotions, but also the ability to regulate these emotions so that they may serve the individual in a beneficial way.

Spiritual well-being, the fourth component of mental health, is described as an individual's feeling of connectedness to something larger than themselves. Spiritual well-being is also recognized by the CIHI (2009) report as experiencing a sense of purpose or meaning in life. The final component identified within this definition of mental health refers to environmental processes that promote positive social connection, safety, equity, equality, and personal respect. Together, these five components represent a comprehensive review of what mental health is and how it is incorporated through all aspects of life.

Youth living in care are up to four times more likely to experience mental-health-related issues throughout their lifetime compared to their noncare peers (Jaudes, 2012; Okpych & Courtney, 2017). Consequently, these young people are at an increased risk of experiencing markedly poor transitional outcomes, including negative educational trajectories, unemployment, underemployment, poverty, homelessness, criminality, early parenthood, and poor quality intimate relationships (Deutsch et al., 2015; Dworsky & Courtney, 2009; Pecora et al., 2006; Scannapieco et al., 2016). Additionally, the OCYAA (2013) and the Representative for Children and Youth (2014) report that youth exiting the residential childcare system have been found to experience persistent mental health difficulties well into adulthood, including significantly high rates of substance abuse.

#### THE PRESENT STUDY

As described previously, existing research reveals that youth in care often experience mental health difficulties and simultaneously lack many important transitional supports as they move into adulthood. Much of the existing literature on this subject has been deficit-oriented (Deutsch et al., 2015; Dworsky & Courtney, 2009; Garrido, Patricio, Calheiros, & Lopes, 2016; OCYAA, 2013; Okpych & Courtney, 2017). That is, relatively little research has focused on methods of improving the transitional success of youth leaving residential care settings, especially with reference to the promotion of positive mental health (Lopez & Allen, 2007). Additionally, mental health has been shown to play an important role during this crucial transition.

Bachmann, Znoj, and Haemmerli (2014) found that mental health status during emerging adulthood is a predictive factor of well-being years later, with positive mental health during this time serving as a protective factor regarding basic need satisfaction. Therefore, the mental health challenges experienced by youth in residential care, combined with the central tenets of Arnett's theory (2000, 2004) and government policies related to this population, lead to the conclusion that it is particularly important for researchers, policy makers, and practitioners to understand what influences the mental health of these youth during the transition out of government care. Unfortunately, there is little existing research on this subject, and no published studies have been conducted within a Canadian residential care context. Researchers within the field of counselling and psychotherapy are particularly well positioned to go beyond the medical-model, deficit-oriented

approaches that have dominated the existing body of scholarly work, given our discipline's emphasis on attending to and promoting client strengths in both our practice and our research (Bedi et al., 2011; Domene & Bedi, 2013; Gazzola, Buchanan, Sutherland, & Nuttgens, 2016).

Addressing this lack of research, the present study was designed to explore experiences with mental health of youth in residential care, with the aim of discovering ways that positive mental health can be effectively promoted among this largely disadvantaged population. Although this study is an open, qualitative exploration of the phenomenon, it is broadly grounded in Arnett's (2000, 2004) theory of emerging adulthood, which suggests that the transition to adulthood is a distinct developmental period, and that individuals at this stage of life engage in substantial reflection about themselves and their futures. In addition, conducting research in this area has important implications for counsellors working with young people who are transitioning out of residential childcare settings and into adult life. This research provides valuable insight into effective ways of supporting these individuals and promoting their positive mental health, which will help to foster their resilience in the future.

Using the enhanced critical incident technique (ECIT) approach to qualitative research and the PHAC (2006) conceptualization of mental health (elaborated by the CIHI, 2009, report) as a way to frame our topic to participants, the present study addressed the central research question: *What do youth who live in residential childcare centres perceive as important in promoting their mental health as they transition into adult life?* Following the standard format of the ECIT method, our overarching research question was divided into three specific components:

1. What do youth perceive as helping the promotion of their mental health?
2. What do youth perceive as hindering the promotion of their mental health?
3. What do youth wish had been present in the promotion of their mental health?

## METHOD

### *Participants and Recruitment*

The sample consisted of 8 participants (6 European Canadians, 2 Aboriginal Canadian; 6 males, 2 females) between the ages of 16 and 18, living in a residential childcare setting at the time of the initial interview. The average length of time in care for participants was 4.5 years, with 7 participants in care under guardianship status and 1 under custody care. Seven of the participants anticipated that their time in care would end when they were between 18 and 19 years of age, before the termination of childcare services. Six participants were registered in high school, while the remaining 2 attended an alternative education program. Seven participants indicated that they had received a mental health diagnosis, and 5 reported co-occurring diagnoses. They self-reported their diagnoses to include attention deficit hyperactivity disorder (50%), depression (37.5%), oppositional defiant

disorder (25%), attention deficit disorder (25%), anxiety (25%), gender dysphoria (12.5%), Asperger's syndrome (12.5%), and bipolar disorder (12.5%). Seven participants reported taking prescribed medication for mental-health-related issues, which they reported as including fluoxetine (25%), lisdexamfetamine (12.5%), aripiprazole (12.5%), lithium (12.5%), olanzapine (12.5%), methylphenidate (12.5%), and risperidone (12.5%).

After a research ethics board review was completed, recruitment for the study commenced. A combination of snowball and purposive sampling were used throughout the recruitment process. Participants were recruited through the social workers responsible for the youth in four group homes and one residential treatment facility in Atlantic Canada. All residents in the social workers' caseloads who met the eligibility criteria were invited to participate. Ten youth were approached regarding participation; 2 declined. A \$10 gift card for a restaurant chain was offered as an incentive in the initial interview, and an additional \$10 restaurant gift card was offered for participating in the follow-up interview. The incentive was offered in recognition of the time and effort that the participant volunteers devoted to the study, and to encourage them to return for the follow-up interview.

### *Procedure*

*Research design.* Butterfield, Borgen, Maglio, and Amundson's (2009) ECIT method was selected because (a) it has a well-recognized status as a counselling research method in Canada (Butterfield, Borgen, Amundson, & Maglio, 2005; Domene, Buchanan, Hiebert, & Buhr, 2015; Leclerc, Bourassa, & Filteau, 2010; Woolsey, 1986), and (b) its structured format and focus on concrete examples were judged to be developmentally appropriate for the age of the participants. ECIT is grounded in a constructivist approach and is designed to distinguish what is contributing to and preventing the success of particular goals or experiences, along with the identification of "wish-list items"; that is, factors absent from participants' experiences that they believe would have contributed to their success. As such, the method allows for a thorough exploration of an experience that not only explores both the positive and negative aspects of the experience, but also allows participants to speculate about things that have not happened but that they believe should have happened. This aspect of the method fits particularly well with the field of counselling as it explicitly invites participants to think about what could be different and to make suggestions for change.

*Data collection.* Data were collected using individual, audio-recorded, semistructured interviews that averaged 42 minutes in length (range = 18 to 95 minutes). Each interview began with preliminary questions to identify personal goals for the future and to consider how the experience of living in care might influence these goals. Preliminary questions also allowed the researcher to build rapport with the participants before beginning the interview and to provide a relevant context from which their experiences could be understood (Butterfield et al., 2009). Participants were then provided with a handout showing the PHAC's (2006) definition of mental health and the five suggested components of the definition identified by

the CIHI (2009), followed by a discussion and clarification that, in this context, mental health encompassed a much broader concept than any diagnoses that the participants may have received.

Participants were then invited to discuss specific incidents that they perceived to be influential (i.e., helping or hindering) in promoting mental health. For example, participants were asked “When looking at the definition and categories of mental health on the sheet I’ve given you, what is one important thing that you do or that is in your life that helps to promote your mental health?” or “What is one important thing that you do or that is in your life that has interfered with or has had a negative effect on your mental health?” Follow-up probes were also used to elicit maximum information from the participants. Examples of the follow-up probes include

1. “When you say (name the factor that they describe), can you tell me a bit more about that or what it means to you?”
2. “How does (name the factor) help to promote/hinder your mental health? What is helpful/not helpful about (name the factor)?”
3. “Please tell me an example of a specific time when (name the factor) was helpful/not helpful. What was the result or outcome in terms of what you did/felt/thought/etcetera?”

Finally, participants were asked to identify and describe additional factors that they believed would have been helpful in promoting their mental health had those factors been present or available (i.e., their “wish list”). They were also asked to explain how these wish list items would have been helpful, prompted by questions such as “Can you tell me specific kinds of situations or circumstances where (name the factor) would have been helpful?”

Follow-up interviews (lasting 20–45 minutes) were conducted with participants following the initial data analysis. These interviews allowed the researcher to clarify any confusion arising from the initial interviews, determine participants’ agreement with initial interpretations, and invite participants to review how their incidents and wish list items had been categorized. Although Butterfield and colleagues (2009) did not use the label “member-checking” in describing this part of the ECIT protocol, these follow-up interviews can be conceptualized as a form of participant validation.

*Data analysis.* Interviews were transcribed verbatim by the researcher, who then extracted critical incidents (CIs)—both helping CIs and hindering CIs—and wish list items (WLIs) using Butterfield and colleagues’ (2009) protocols for ECIT analysis. Once all CIs and WLIs had been extracted from the first three transcripts, they were inductively grouped into categories based on existing patterns of similarities and differences in meaning (Butterfield et al., 2009). This process was then repeated for the next three interview transcripts and so on. Categories were modified (i.e., new categories added, other categories merged or removed) on an ongoing basis, based on the information obtained from each set of three transcripts.



*Credibility.* Eight credibility checks, proposed by Butterfield and colleagues (2005, 2009), were used to establish the rigour and validity of the findings. First, audio-recording the interviews improved the accuracy of the data and allowed the researcher to be more precise during analysis. Second, an external auditor who is a licenced psychologist with more than a decade of experience using qualitative methods to conduct counselling research (including ECIT) examined two randomly selected recordings to assess interview fidelity. The auditor concluded that the researcher followed established ECIT protocols appropriately.

Third, another reviewer, who was a student in a graduate-level counsellor education program, conducted a confirmatory extraction of the CIs and WLIs, which yielded 100% agreement with the original analysis. Fourth, data collection continued until exhaustiveness—that is, the point at which no new categories emerged—occurred. No new categories emerged in the seventh or eighth interviews, indicating that exhaustiveness had been achieved after the sixth interview and no further data collection was required. Fifth, categories were only considered valid if they maintained a 25% participation rate (Borgen & Amundson, 1984). The participation rate was calculated by adding up the number of participants who identified CIs or WLIs in a particular category and then dividing that number by the total number of participants in the study (Butterfield et al., 2009).

Sixth, 25% of the CIs and WLIs were independently placed into the existing categories by the reviewer who conducted the confirmatory extraction. This credibility check yielded a 97% agreement rate. Seventh, 6 participants reviewed the findings during the follow-up interviews. They all endorsed the identified CIs, WLIs, and categories. Lastly, an expert in the field, with more than 20 years of experience working with at-risk youth, examined the identified categories to determine their usefulness and validity. He stated that the findings resonated with his experience as a practitioner in the field of mental health for youth in care.

## FINDINGS

When asked about their goals or plans for the future, all participants identified specific career interests. Six participants described careers that require postsecondary education (e.g., veterinarian, graphic designer, therapist). In addition, most participants (75%) believed that living in care provided them with many of the skills and supports necessary to achieve their future goals. For example, 1 participant indicated that living in care prepared him for a successful transition by teaching skills such as saving money, cleaning, and completing chores. Others stated that residential care provided support, stability, and security in knowing that they would have a place to live. In contrast, 2 participants believed their time in care had hindered the development of their sense of independence, while another youth reported not living with family members to be damaging to career development.

As a group, the participants identified 120 CIs and WLIs. There were 55 helping CIs, organized into 8 categories (see Table 1); 37 hindering CIs, organized into 8 categories (see Table 2); and 28 WLIs, organized into 7 categories (see Table 3).

Table 1.  
*Categories of Critical Incidents That Were Perceived to Be Beneficial in Promoting Mental Health*

Category	PA	IN	%
<b>Peer Relationships</b> – Positive relationships with friends and romantic partners.	7	9	<b>88</b>
<b>Personal Coping Strategies/Self-Care</b> – Specific activities/resources used to manage or resolve negative emotions.	7	20	<b>88</b>
<b>Residential Staff</b> – Positive interpersonal relationships with residential staff members.	5	6	<b>63</b>
<b>Activities/Resources Outside of the Residential Setting</b> – Involvement in activities that are outside of the residential childcare environment.	4	7	<b>50</b>
<b>Family Connections</b> – Positive interpersonal relationships with family members.	4	4	<b>50</b>
<b>Freedom/Independence</b> – Engaging in activities that promote a sense of autonomy.	3	5	<b>38</b>
<b>School</b> – Participation in the school environment.	3	3	<b>38</b>
<i>Connection to Culture</i> – <i>Feeling connected to one's specific culture.</i>	1	1	13

PA = number of participants ( $N = 8$ ); IN = number of incidents ( $N = 120$ ); % = Percentage of participation rate. Italicized type indicates categories that failed to meet the 25% participation rate validity threshold.

Table 2.  
*Categories of Critical Incidents That Were Perceived to Interfere with the Promotion of Mental Health*

Category	PA	IN	%
<b>Challenging Personal Experiences</b> – Experiencing adverse circumstances.	4	6	<b>50</b>
<b>Feeling Constrained (Within the Residential Setting)</b> – Feeling an absence of freedom, independence and/or autonomy.	4	9	<b>50</b>
<b>Conduct of Residential Staff</b> – Unfavorable behaviours and characteristics of residential staff members.	3	5	<b>38</b>
<b>Feeling Disrespected/Undervalued</b> – Feeling as though they are not being valued and respected.	3	5	<b>38</b>
<b>Family Disconnection</b> – Perceived absence of interpersonal family relationships and connections.	3	4	<b>38</b>
<b>Tumultuous Living Environment (Within the Residential Setting)</b> – Residing in a hectic living environment.	3	4	<b>38</b>
<i>Feeling Different</i> – <i>Feeling as though the specific experience of residing in residential care sets them apart from their same-age peers.</i>	1	3	13
<i>Music</i> – <i>Music that intensifies negative emotions.</i>	1	1	13

PA = number of participants ( $N = 8$ ); IN = number of incidents ( $N = 120$ ); % = Percentage of participation rate. Italicized type indicates categories that failed to meet the 25% participation rate validity threshold.

Categories were only considered valid and worthy of further interpretation if they maintained a participation rate of at least 25% (Borgen & Amundson, 1984). Pseudonyms are used throughout the findings section to protect the anonymity of the participants.

### *Helping Critical Incident Categories*

*Peer relationships.* One of the two categories with the highest participation rate (88%) was *peer relationships*. These relationships included friendships and romantic relationships. These particular peer relationships were characterized by supportive interactions that assisted in the promotion of mental health, such as being available to talk about personal issues and acting as a positive distraction from troubling emotions. One participant, Eric, described helpful peer relationships as “friends that give you good advice and they’re always there for you and you’re there for them. So, it’s a mutual thing.” Participants also described how friendships with coresidents provide support. For example, Max stated:

I got mad at group home workers and we got to screaming and then I went down to my room and ... one of my friends was there and he helped calm me down because I was really mad and hitting things and he came in and helped. He talked to me, told me it’s all right, I don’t need to do this and I got calmed down.

Table 3.  
*Categories of Factors That Participants Believed Would Have Been Helpful in Promoting Mental Health*

Category	PA	IN	%
<b>More Family Connections</b> – Desire to experience more positive interpersonal relationships with family members.	6	6	75
<b>Freedom/Independence</b> – Desire for an increased sense of autonomy.	6	6	75
<b>Additional Coping Resources</b> – Access to desired coping activities and resources.	4	4	50
<b>Employment/Financial Control</b> – Desire to be employed and have control over their own money.	4	4	50
<b>Residential Staff/Policy</b> – Suggested improvements concerning the conduct of residential staff members and residential policy.	2	3	25
<b>Stability</b> – Desire for increased stability in living and educational settings.	2	2	25
<i>Additional Peer Relationships</i> – <i>Additional relationships with individuals other than staff and family members.</i>	1	2	13

PA = number of participants ( $N = 8$ ); IN = number of incidents ( $N = 120$ ); % = Percentage of participation rate. Italicized type indicates categories that failed to meet the 25% participation rate validity threshold.

*Personal coping strategies/self-care.* This category also had an 88% participation rate and was defined as engagement in activities that help to manage or resolve negative emotions. Specific coping activities included physical activity (e.g., biking, walking, bowling, curling), playing video or board games, reading, and spending time with animals. Participants described many of these activities as mental distractions from negative emotions. Max stated:

I did bowl and curl and those were helpful because those were things that would get my mind off of the different things that were happening ... Really, I just, I go bowling and I just drop all the things that are around me and focus on that only.

Some youth reported a need to have space and time for themselves when experiencing negative emotions. Specific coping/relaxation strategies, such as deep breathing, were also identified. The most prevalent coping strategy, identified by 5 participants, was music, which included playing music, writing song lyrics, or simply listening. Participants indicated that music promoted their mental health in a number of ways, including serving as an emotional outlet and calming or resolving adverse emotions. For example, Savannah disclosed:

When I'm in a fight with somebody or, like, something is just happening that's putting me in a really bad mood, I just listen to music and I rethink, like, what I'm saying and stuff. So, it calms me down and it puts me in a better state of mind to talk about it ... if I'm in an argument with my boyfriend, I just leave and I listen to music and then I come back and just everything is cooled down and I can actually talk to him instead of freaking out.

*Residential staff.* This thematic category was defined as positive interpersonal relationships with employees at the residential setting. The 5 participants who mentioned incidents within this category described feeling truly cared for and understood by staff members. Possessing a calm demeanour and maintaining a sense of humour were identified as positive staff characteristics. Participants also indicated that it was beneficial to their mental health when they felt that staff members made an effort to connect with them on a personal level. When positive staff relationships existed, participants reported feeling supported and as though they had someone they could talk to about personal issues. Jasper recounted:

I can talk to them about how I'm feeling or I can talk to them about different things. Especially the ones that say they're going to be in my life after. It's like well, then I don't have to worry, well if I'm getting too close to them ... hear people saying I can stay in contact when I leave out of different ways, it's like it helps because then I don't fear the whole "not being able to see or contact them very easily" ... It feels very reassuring. It helps me want to move on and get into my life.

Another quote from Jasper depicts the influence positive relationships with staff members can have on youths' mental health:

I used to cut myself so like if I would come out of my room in long sleeves all of a sudden, even if I was in there for hours or something, he [primary staff member] would notice and he would be like “you’re a bad liar” and it like just like, he wouldn’t pretend like there was nothing wrong and he would just, even if I didn’t want him to, he would notice and I might have not liked it at the time, but then I’m thankful for it ... I don’t think I would have ever gotten to the point of stability I’m at now without people doing that.

*Activities/resources outside of the residential setting.* This category was defined as activities that allowed participants to distance themselves from the residential environment and engage with other individuals in the community. This category included organized activities, such as youth groups, and unstructured activities, such as spending time at a coffee shop. The following quotation describes Jasper’s experience of participating in a transgender support group:

I’ve made a lot of friends there that I even talk to on Facebook and stuff and it’s just like, it’s when I go there, I go there weekly and ... it’s just like it’s a safe environment to talk to them and like the people ... they’ve both helped me out a lot and by bringing me to the hospital when I was suicidal and stuff.

*Family connections.* The family connections category involved positive interpersonal relationships and interactions with family members. Youth who reported CIs in this category discussed love and support received from family members, and having individuals in their family with whom they could talk to or spend time. For example, Savannah stated:

There’s not a lot of people that you know and that know you. Like family knows you and like, they give you more love and support than people that don’t know you. And [staff] people when you live in a group home, they go home at night and it’s just their job.

*Freedom/independence.* This category was defined as experiencing a sense of autonomy. The 3 youth who identified CIs in this category described freedom as feeling in control and being able to make their own decisions. They reported that experiencing a sense of independence was stress relieving and also helped prepare them for the upcoming transition into adult life. Jordan discussed free time (i.e., scheduled time that youth could use independently in the community) and how he believed it promoted independence: “I have to follow the rules [in the residential setting] and I can make my own rules when I’m out [on free time].”

*School.* School was considered a helping category by 3 participants. However, this category is not defined by its educational value. Instead, participants indicated that school was beneficial to mental health by allowing them to spend time with friends and experience freedom away from life in care. Mira described her experience:

If you go to my school, you’d see me jumping all over the place. I have so many friends because I’m always—first thing I do, bell rings, cafeteria.... So, I just go

down, see if I see anybody that are getting lunch or whatever. I look around, I'm upstairs, middle floor, and then if I don't see anybody there I go outside and then I'd be out front and in every spot there's different groups, there's actual groups and I mean groups the size of eight people, ten people. They all smile when they see me. They all joke with me.

### *Hindering Critical Incident Categories*

*Challenging personal experiences.* This was one of two hindering categories with the highest participations rate (50%). This category was defined as adverse personal circumstances, either past or present, experienced by participants. Incidents placed into this category included experiences of bullying, harmful romantic relationships, family problems, and trouble with the law. The focus of this category was on life events and experiences other than the circumstance of living in residential care. Although they may also have been challenging, incidents related to living in care were judged to be sufficiently conceptually distinct from the other personal circumstances described by participants as to require their own thematic categories. Jasper described being rejected after disclosing that he was transgender:

My dad says he'll never see me as a son. He'll call me his son and stuff, he'll call me by [name] and all that stuff, but he will never see me as a male ... it's hard because like that's why so many times I was like okay, I'm just gender fluid, which means you're both, so I would just dress up as a female in front of my parents type thing ... I've been disowned by two of my older brothers. They're in their late twenties. I have a nephew by one of them and I'm not allowed to have contact because of my gender identity.

*Feeling constrained (within the residential setting).* The other most frequently cited hindering category was feeling constrained, defined as an overall subjective sense of lacking independence and autonomy due to specific rules and regulations imposed by the residential care setting. This category included incidents in which participants perceived that they were not being allowed to make their own decisions, and incidents in which limitations were imposed on the time they were allowed to spend with friends and family. Rules regarding staff supervision of activities and approved contact lists were among the more commonly described circumstances that participants identified as imposing a constraint upon them. Many participants reported feeling "trapped" or as if they were "in jail." Savannah linked feeling constrained by living in care to a fear of losing friendships:

When I first came it was like I was stuck here constantly and it was like I missed a lot of things that I shouldn't have had to miss like going to a birthday party or something or like just hanging out with someone or going out for like dinner and you just can't do that ... [Friends] don't really understand that you're not ditching them, you just can't; and you lose touch with your friends and you lose friends that way, not hanging out with them and stuff. So, I just felt like I was going to lose all my friends being stuck here all the time.

Mira addressed how the constraints imposed by living in care could have a negative effect on her transition into adult life:

I feel like my independence is getting sucked out of me like everyday even more because I'm treated like a little kid ... I think it's more interfering with like the future. Like how am I supposed to be independent in the future if I wasn't independent going into it? Like you need to learn independence at a young age to be more independent when you're not living with people.

*Conduct of residential staff.* This category was defined as unfavourable behaviour and characteristics of staff members who worked in the residential settings. This category included incidents where staff members were disorganized or confused, lacked knowledge and expertise in working with relevant issues, failed to make an effort to engage with residents, acted as if they did not care about the youth, ignored problems that were present within the residential setting, and did not make an effort to understand youths' experiences. For example, Savannah stated:

Staff members should talk to you more and treat it more than just a job. It should be more like if you're going to work with kids you need to have like a heart and not just be like this is my job, these are the rules type deal ... If you're not going to be caring, then you shouldn't be in this job. Like, you have to think about other kids' feelings. Like, you don't know what they're living through and stuff.

*Feeling disrespected/undervalued.* This category involved youth feeling as though they were not being valued as individuals or respected. The category included incidents such as feeling ignored, showing no respect for personal belongings, and being compared to others. For example, Eric described his reaction to feeling ignored, after trying to ask staff a question:

When I'm angry and I'm being ignored, like I go over the top and it just really makes me angry a lot ... me not being as important as them. If they're ignoring me, it makes me feel less important.

*Family disconnection.* The family disconnection category was defined as participants having no connections to family members, or being unable to contact or spend time with family as much as they would like. For example, Jordan reported that being unable to see his uncle "makes me feel angry and sad and builds my anxiety up because that's the only person that I can trust."

*Tumultuous living environment (within the residential setting).* This category was defined as living in a chaotic environment characterized by commotion, yelling, negative energy, and personal crises. Incidents in this category included conflict with other residents, living among residents of varying ages and maturity levels, and disruptive behaviours. Incidents related to tumultuous living environments that participants experienced prior to moving into residential care were excluded from this category and, instead, were coded as falling within the challenging per-

sonal experiences category. Living in such environments was described as stressful. Savannah offered her perception of the residential care environment:

There's the attention seekers and they're always in group homes, attentions seekers, and when you live with attention seekers they'll do anything to get attention. They'll cut themselves, they'll just flip out, run away, anything and it's kind of hard to live in that situation when there's cops coming to your house a bunch and stuff like that. I've had one time I came home ... and found out that there was cops that went through my window and onto the roof to get another kid and I was like, "Seriously?"

### *Wish List Item Categories*

*More family connections.* The wish list category with the highest participation rate (75%) was more family connections. It was defined as a longing to experience a greater sense of family and ability to have contact with family members more often. Eric speculated:

I ran away ... to my mom's and I was there for like 17 days and the whole time I was happy there and, like, since I got back I haven't gotten in trouble. I might have got, like, a few timeouts, but before I would get, like, I'd always be in trouble and be grounded and stuff and I haven't been grounded since I've been back and stuff, so I feel like that helped my mental health ... there's not a lot of love here because it's professional here.

*Freedom/independence.* Freedom/independence was defined as the desire to experience a greater sense of autonomy and to be allowed additional opportunities to develop independence. Participants who reported items in this category identified a desire to spend more time with friends and family outside of the residential setting and to take time away from the residence when they felt it was needed. They also reported a yearning to make their own decisions throughout the course of their day as opposed to feeling as though they were always following orders. Participants believed this would allow them to feel an increased sense of control over their own lives:

I think definitely feeling like you're more in a normal life like everybody else. Like that you can just hang out with your family or friends whenever ... It's like just living here, like, it's awkward. Like, none of my friends live in a group home or foster home, none of them, so they all have, like, normal family lives.

*Additional coping resources.* This category was defined as a desire to access additional coping activities and resources, such as musical instruments at the residence, participation in music lessons, being able to have a pet, and easier access to counselling services. Savannah described the potential benefits of having access to pets:

I find animals really help. Like, when you're just feeling low or lonely they're there.... a lot of the times when I used to get into arguments with my Nan's boyfriend and stuff I used to have my cat and I'd just pet my cat or play with



her and she used to sleep with me every night in my bed. So, I just really didn't feel that lonely when she was around.

*Employment/financial control.* The category of employment/financial control was defined as participants' desire to obtain employment and earn/manage their own money, which related closely to participants' desire for independence. However, this category also included a desire for a sense of pride and ownership. For example, Max stated, "Having money to get things and stuff. Like, being able to, I guess, support myself, to get my own money, and be able to buy things myself once in a while."

*Residential staff/policy.* The residential staff/policy category involved youths' suggested improvements for residential policy and the conduct of staff. Items identified in this category included the desire for staff members to take the time to talk to youth and attempt to truly understand their experiences, staff members and residential settings being better prepared to work with various personal challenges, and residential policies being more inclusive in acknowledging diverse groups of individuals. For example, Jasper discussed his experience of being transgender within the residential childcare environment:

I couldn't talk to them about things I'm going through like gender dysphoria because they really didn't know what that kind of stuff was ... staff are good now, but when I was there, there were certain staff that were older and they were, like, "I can't respect this." And they have [policy statement] things about sex, religion, race, but they have nothing on gender.

*Stability.* This category was defined as a desire for increased consistency within educational and residential settings. Participants indicated that they had been moved around to a variety of different living situations throughout their youth, which disrupted their education. Shifting living situations involved living with different family members, moving into foster care, and moving among different residential childcare centres. As Mira explained:

Just not have to go through being taken out of my home, put into some random person's house and tell you "Oh you're just going to be staying here for a little bit." That little bit turns into a couple months and that turns into "Oh you can't stay here any longer, you're going to go somewhere else" and then they tell you you're not going back home and then you stay there for a couple months, and I've been in like at least eight different elementaries, middle schools, and high schools.... I'm a molder. I mold into whatever my friends want me to be. I have no idea who I am.

## DISCUSSION

The participants identified many factors that they perceived to have an influence on their mental health during the transition into adulthood, some of which provide further support for the existing literature. First, the OCYAA (2013) as-

serted that all youth in care have a desire to feel valued and respected as individuals who have unique experiences and challenges. The present study provides research evidence for this assertion, as 3 participants reported negative evaluations of their current situations and indicated that they often felt disrespected or undervalued. This is potentially detrimental to their mental health and underscores the importance of counsellors being involved with these youth. Specifically, core aspects of counselling and psychotherapy (e.g., empathy, unconditional positive regard, and genuineness) are likely to be effective in addressing these issues. As Polvere (2011) suggested, when youth in care feel disregarded and unappreciated, they are left feeling fearful, frustrated, and powerless. In contrast, when youth receive counselling, they may regain a sense of appreciation and power even if they remain in a problematic situation.

Participants also reported the importance of experiencing a sense of freedom and independence in relation to mental health. The maturation of independence and autonomy are primary components of adolescent development (McLaren, 2002; Savard, Joussemet, Emond-Pelletier, & Mageau, 2013; Steinberg, 2011). McLaren (2002) and Savard and colleagues (2013) elaborated that achieving a sense of autonomy and independence has been found to be associated with aspects of positive mental health, including increased feelings of self-worth and self-competence. They further explained that increased perceptions of autonomy and independence can also serve as a buffer against mental health problems such as depression and anxiety.

Participants' desire for freedom and independence was also connected to their desire to obtain employment and experience financial control, which they perceived to be beneficial to their mental health. Although there is support for their belief within the existing research, it is equivocal. Research has shown that adolescent employment is often associated with increased leadership skills, better time management, and higher career motivation, all of which could significantly benefit the transition into adulthood (Mortimer, 2010; Staff, Messersmith, & Schulenberg, 2009). Additionally, a report conducted by the CIHI (2009) suggested that adolescent employment encourages greater community engagement, which has been associated with the promotion of mental health. However, research has also demonstrated negative impacts of adolescent employment, at least when youth are working excessively: Youth who work over 20 hours per week experience higher levels of emotional distress (Resnick et al., 1997), and working a high number of hours per week may also increase delinquent behaviours and substance use (Carrière, 2005; Steinberg, 2011).

Many participants described a history of personal challenges, which they perceived to be detrimental to their mental health. Based on existing literature of the residential childcare system, it is not surprising that participants reported histories of adverse experiences. Common experiences faced by this population include high-risk family environments, abuse, negative relationships, trouble with the law, and addiction (Courtney, Terao, & Bost, 2004; OCYAA, 2013; Osgood et al., 2005; Representative for Children and Youth, 2014). Youth who have been

exposed to such personal challenges have been found to be hindered in terms of their well-being (Okpych & Courtney, 2017).

Participants described numerous strategies they used to resolve or manage negative internal experiences. Previous research has demonstrated the importance of positive coping strategies for mental health. Barendregt, Van der Laan, Bongers, and Van Nieuwenhuizen (2015) found that active coping strategies, defined as intentional ways of managing a problem and seeking social support, are beneficial to the well-being of youth living in residential care.

A particular contribution of the present study is the use of music as a coping strategy. Participants indicated that listening to, writing, and playing music were beneficial to their mental health. This finding extends previous research on counselling high-risk youth, which has found that music can be beneficial to the therapeutic process and can increase youth engagement (Evans, 2010; Olson-McBride & Page, 2012). The present findings suggest that music may also be a beneficial self-regulatory strategy for at least some youth living in residential care. In addition, for some participants, music may have served as an effective distraction from distressing situations, consistent with previous research indicating that distraction can be an effective way of coping for adolescents (Ayers, Sandler, West, & Roosa, 1996; Zimmer-Gembeck & Skinner, 2011).

Numerous findings spoke to the importance of interpersonal relationships—youths' connections with significant others who they believed had the potential to positively or negatively influence their mental health. The importance of interpersonal relationships is well documented within the literature. Family connections have been found to be a fundamental component of the successful transition into adulthood due to the practical and emotional support these relationships can provide (Osgood et al., 2005; Representative for Children and Youth, 2014). The literature also reveals that family relationships are essential to one's mental health. Helliwell and Putnam (2004) found that individuals who maintain regular, positive contact with family members experience higher levels of life enjoyment and well-being. Similarly, family stability, defined as security and consistency in the family, and parental attachment were found to have a significant positive influence on adolescents' life satisfaction (Preston et al., 2016; Rask, Astedt-Kurki, Paavilainen, & Laippala, 2003; Williams & Anthony, 2015). Research by Williams and Anthony (2015) and McLaren (2002) has also revealed that positive peer connections are associated with reduced emotional problems and can assist in developing social and emotional skills.

Relationships with residential staff members were also identified as influential within the present study. There is little previous research on the impact of these specific relationships. Nonetheless, one study in this area is by Polvere (2011), which addressed several hindering aspects associated with negative youth-staff relationships. Consistent with the present research, Polvere's results included factors such as frequent conflict, staff members lacking knowledge and training, and excessive power assertion. These relationships were associated with frustration, hostility, and negative emotional experiences. In contrast, the OCYAA (2013) found

that youth in care who reported positive relationships with workers experienced a greater sense of support and were more likely to establish healthy interpersonal relationships with others.

Although participants believed the school environment to be beneficial to their mental health, they perceived the primary benefits to be social rather than educational. Previous research reveals that educational attainment is one of the best indicators of success in adult life (Hankivsky, 2008; Representative for Children and Youth, 2014). The present study, however, suggests that schools can also contribute to the promotion of mental health by providing opportunities for social interactions with peers outside of the residential care environment.

Participants made a connection between incidents such as conflict with coresidents or a high prevalence of disruptive behaviours, and their own feelings of stress and frustration. Supporting this perspective, Polvere (2011) found that conflict among coresidents is common within residential childcare settings and can lead to youth in care experiencing adverse emotions. Instability of home, residential care, and school environments was another factor found to be influential on participants' mental health. Placement disruptions are frequent among youth in care (Berzin et al., 2014; Sunseri, 2005), and studies have established links between placement instability and both emotional and behavioural problems as well as high rates of psychiatric hospitalization (Fawley-King & Snowden, 2012; Northern California Training Academy, 2009; Rubin, O'Reilly, Luan, & Localio, 2007; Sunseri, 2005). The present study confirmed and expanded upon this literature, with 1 participant suggesting that placement instability also hindered her sense of identity, which is recognized as a primary component of development (Representative for Children and Youth, 2014; Steinberg, 2011).

### *Implications for Counselling*

In the present study, family connections were perceived to be one of the most significant factors with respect to the mental health of youth living in residential care. This finding suggests that encouraging positive family relationships should be considered a priority when working with this population, a recommendation also made by Williams and Anthony (2015). However, given the volatile nature of familial relationships for many of these youth, in some circumstances it may be necessary to assist them in establishing appropriate boundaries regarding their connections with certain family members. In addition to assisting youth with parental relationships, counsellors can promote positive connections by assisting youth to establish long-term interpersonal supports elsewhere through siblings, extended family members, or community-based mentoring programs (Biehal & Wade, 1996; OCYAA, 2013; Representative for Children and Youth, 2014).

Peer relationships were also reported by participants to be an important determinant of positive mental health. Therefore, it is essential for counsellors to acknowledge the perceived importance of these relationships and to promote more positive and supportive peer connections. For example, counsellors could work with these youth on how to identify and critically evaluate their existing peer

relationships, including romantic relationships. This, in turn, may assist youth in becoming increasingly aware of which types of relationships are beneficial and which are detrimental when considering their own well-being. Establishing and renegotiating boundaries is a distinct characteristic of Arnett's (2000, 2004) theory of emerging adulthood, a phase of life that typically includes exploring and renegotiating peer and romantic relationships.

Results of the present study suggest that time away from the residential setting is also perceived to be beneficial to the mental health of youth in care. Counsellors working with this population may make use of this finding by encouraging youth to become involved in extracurricular activities through their schools or communities. Similarly, freedom and independence were perceived as primary promoters of mental health by most participants through fostering the development of their autonomy. Allowing these individuals an appropriate level of freedom and independence will benefit their personal development and encourage them to experience a greater sense of control as well as ownership over their own lives (Steinberg, 2011). The importance of autonomy is also consistent with the definition of emerging adulthood, which Arnett (2000, 2004) describes as being characterized by increasing freedom and independence from one's family.

Findings from the present study also suggest that employment and greater financial control may benefit the promotion of mental health for youth who are living in residential care. In addition, consistent with Arnett's emerging adulthood theory, employment and obtaining greater control over one's finances are characteristics of moving toward adulthood. When appropriate, counsellors should encourage youth to seek suitable part-time employment and assist them with the application process. These efforts may work best when combined with psychoeducation about budgeting and time management skills, as well as workplace etiquette.

Many youth who enter residential care have a history of negative past experiences and continue to face challenging personal situations that have an adverse impact on their mental health (OCYAA, 2013; Osgood et al., 2005). The OCYAA (2013) advocated that it is essential that counsellors acknowledge the existence of difficult personal situations that exist in the life of individual youth in care, work to facilitate access to relevant support services, and apply appropriate forms of therapy. In a similar way, the present study also revealed stability as a factor that youth in residential care believed would have been beneficial to their mental health, had it been possible. Participants indicated that instability in their lives included frequently moving between different living environments and schools. It is important for counsellors to remain cognizant that many clients who are living in care have experienced frequent instability in their lives and remain sensitive to this fact throughout their interactions, including preparing these clients for eventual termination from the very beginning and throughout the course of therapy.

Participants described a variety of coping strategies that assisted them in maintaining positive mental health. Counsellors can implement this finding by assisting youth to discover specific coping activities that work for them and focusing

interventions to encourage these specific behaviours (Barendregt et al., 2015). The coping strategies identified by the present set of participants were quite individualized, which is consistent with the propositions of Arnett's (2000, 2004) theory of emerging adulthood. Nonetheless, most participants reported that music was a fundamental source of coping used to maintain their mental health. Counsellors might improve their practice with this population by explicitly asking about the role of music in their lives and, if appropriate, focusing on the use of music to help clients process emotional experiences and increase therapeutic engagement.

### *Limitations*

There are several limitations that must be taken into consideration in understanding the findings that have emerged in the present study. One of the specific limitations of the ECIT method is that both the interview protocol and the method of analysis are quite highly structured, relative to most other qualitative approaches. Although this structure is well suited to conducting research with adolescents, it does impose a particular structure on the kinds of findings that can emerge (i.e., things that are helping, hindering, and wished for). There can be little room for participants to go "off script" or for analysts to code experiences that are not CIs or WLIs. Using a different kind of qualitative method (e.g., narrative inquiry, phenomenology, thematic content analysis) is likely to have yielded a different understanding of mental health promotion during the transition out of residential care.

It should also be noted that 2 participants did not complete the follow-up interviews that are part of ECIT's approach to establishing credibility. At the time of the follow-up, 1 youth had moved out of the residential childcare system without leaving contact information, and another had run away from her care home. As a result, participant validation of the researchers' interpretations of their experiences and the structure of the categories was only partially completed. Nonetheless, the information that was obtained from the follow-up interviews with the remaining participants revealed general agreement with the initial analysis and did not yield any objections or concerns.

As a qualitative study, this study was not designed to achieve generalizability. Instead, the findings reflect the experiences of the youth who chose to participate, which may differ from the experiences of other kinds of youths. Counsellors and researchers will need to actively consider the degree to which these findings can be transferred to other settings. For example, all but 1 participant were under full legal guardianship of their province. Therefore, results of this study may better reflect the experiences of youth who do not have any legal ties to members of their family. Other participant characteristics that need to be attended to in assessing the transferability of these findings include the participants' ethnicity (i.e., 6 European Canadians, 2 Aboriginal Canadians) and the fact that all but 1 participant had been diagnosed with mental health disorders and were receiving medication.

Similarly, any research conducted on phenomena related to the policies and practices of governments and social service agencies will reflect, to some degree,

the specific circumstances of those governments and agencies. In this study, data collection occurred within one specific province within Atlantic Canada. Consequently, counsellors and researchers working in other jurisdictions will need to evaluate the degree to which the experiences described here reflect the laws and social services practices of their own settings (i.e., the transferability of the findings). Nonetheless, it is our assessment that many of the findings that emerged may be transferrable beyond the specific research context because they reflect circumstances and experiences that are likely to occur across provinces and even in different countries.

Finally, this research used a qualitative design to explore individuals' perceptions of things that are helping, hindering, and missing in promoting their mental health. As such, this research was not designed to establish a causal link between living in residential care and any of the themes that emerged, nor to determine whether the categories of incidents that emerged have a statistically significant effect on mental health outcomes after the transition out of care. Follow-up studies utilizing different methodologies (e.g., longitudinal quantitative methods with mechanisms to control for the influence of extraneous variables) are required to establish the strength and direction of the connections between the categories that emerged and the mental health of youth in care.

#### *Future Directions*

Building on this study, future qualitative research could explore factors that influence the mental health of youth living in residential care in greater depth by replicating this study, but using purposive sampling to explore the experiences of other kinds of youth in care (e.g., youth living under custody care arrangements, youth living in other jurisdictions). Additionally, given the importance of social relationships within the findings, follow-up research could be conducted to further explore the social relationships of this population, including potential ways to foster positive social connections and improve the quality of the peer relationships of youth in care.

This research could be conducted in a variety of ways, such as using ECIT with a research question specifically focused on social relationships, using anthropological field research methods focused on observation, or program evaluation research where interventions designed to promote social connections are implemented and assessed in terms of their ability to improve the peer relationships of youth in care. Given the present findings, it may also be useful to conduct mixed-method research to examine how and why music and pets could serve as coping resources in residential care settings: What kinds of youth would benefit from these resources? Are they effective? Are there any uses of music or pets that could hinder mental health? Finally, building on the findings of the present study, it may also be useful to conduct a qualitative study focused on individuals who have completed the transition to adulthood, to explore their retrospective perspectives on factors that have promoted their mental health after they have completed their transition into adult life.

## CONCLUSION

Although youth who have experienced life in residential childcare face several distinct challenges as they transition into adulthood (Representative for Children and Youth, 2014), the present study has focused on a particularly challenging component of this transition by addressing 8 participants' experience with mental health. We hope that the insights provided here are helpful in improving the practice of both residential staff members and counsellors in their work with similar youth.

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