EXPLORATION OF THE EFFECTIVENESS OF TRAUMA SYSTEMS THERAPY FOR FOSTER CARE

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ABSTRACT

Permanency is the desired outcome when a child has been placed into a foster care placement. That permanency outcome can involve a return to their birth family, being adopted by a new family, or guardianship with a relative (Lockwood et al., 2015). Achieving the final goal requires foster parents to understand trauma, dysregulated behaviors, and parenting techniques. The foster parent's attachment and commitment to the foster child is affected by their understanding of those three topics. Trauma training is key to accomplishing that fuller understanding (Patterson et al., 2018). Foster parents' comprehension of the trauma effects on behaviors and the tools to better manage those misbehaviors leads to safe and stable foster care placements, allowing a more rewarding healing process for the foster children. This research study explored the outcomes of foster parent training including Trauma Systems Therapy for Foster Care (TST-FC; Bartlett & Rushovich, 2018), attachment (Ballen et al., 2010), commitment, dysregulation behaviors, and placement stability within the duration of a foster child's placement and the foster parent's skills, support, and training related to the desired goals.

Keywords: trauma, foster parent training, placement stability, dysregulated behaviors

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List of Abbreviations

The Resource Parent Knowledge and Beliefs Survey (RPKBS)

The Kansas Parental Satisfaction Survey (KPS)

Trauma Systems Therapy for Foster Care (TST-FC)

The Incredible Years (IY)

Parent-child interaction therapy (PCIT)

Foster Parent College (FPC)

Attachment and bio-behavioral catch-up (ABC)

Model Approach to Partnerships in Parenting Group Preparation Selection of Foster/Adoptive (MAPP/GPS)

Foster Parent Resources for Information, Development, and Education (PRIDE)

National Child Traumatic Stress Network (NCTSN)

Resource Parent Curriculum (RPC)

Keeping Foster Parents Trained and Supported (KEEP)

Critical On-Going Resource Family Education (CORE)

Attention Deficit Hyperactivity Disorder (ADHD)

Posttraumatic Stress Disorder (PTSD)

Posttraumatic Stress (PTS)

Multidimensional Treatment Foster Care for Preschoolers (MTFC-P)

Executive Functioning (EF)

Adverse Childhood Experiences (ACEs)

The Massachusetts Child Trauma Project (MCTP)

Trauma-informed Leadership Teams (TILTs)

Managing Emotions Guide (MEG)

Trauma-Informed Parenting subscale (TIP)

The Tolerance of Misbehavior (TOM)

Parenting efficacy (EFF)

CHAPTER ONE: INTRODUCTION

Overview

The lack of trauma-informed parenting skills presents a troublesome situation for foster parents who desire to provide a safe, stable home environment for their foster children. This problem is widespread throughout foster care agencies, causing a delay in the foster child's healing process (Patterson et al., 2018). Teaching the foster parents trauma-informed techniques through a comprehensive trauma training approach is the key to reducing placement interruptions, restoring placement stability, mitigating further trauma, and promoting the healing process for a child in care.

Background

Foster parent training is a requirement established by the federal government in the Foster Care Independence Act of 1999 (H.R. 3443). The requirement mandates that states adequately prepare foster and adoptive parents before placing a child in the home to qualify for federal funding (IV-E funding). While foster parent training is federally-mandated, the decisions of type and hourly requirements are determined by each state government. Given the ambiguous nature of this mandate, foster parent training requirements vary from state to state. In the early years of foster parenting, formal training was minimal since adults were assumed to possess adequate parenting skills from raising their biological children. Foster parents were expected to provide room and board and were reimbursed for those services (Cain & Barth, 1991).

A review of the foster parent training from 1970 to 2014 was conducted by Benesh and Cui (2017). Foster parent trainings were divided into two categories, pre-service and in-service. Pre-service training was designed for prospective parents to learn about foster parenting, determine if they were a fit for this work, and for the foster care agency to assess the prospective

parents' skills. In-service training was utilized for building skills and knowledge in approved foster parents. Benesh and Cui's (2017) review of the 22 programs found that seven of these programs contained no research basis.

Prior to this review, there were three other studies outlining the field of foster parent training over the years (Dorsey et al., 2008; Festinger & Baker, 2013; Lee & Holland, 1991). Many of these programs were developed from social workers' experiences in the field, instead of theories and research. "Best practice" was the buzzword used to explain the models of training developed by the many years of work in the social work field (Dorsey et al., 2008). Social workers would rely on their years of experience to shape the training's content and delivery to their foster families. In the early years, the training would cover broad topics surrounding child development education, agency orientation, community services, and support for the family while fostering (Lee & Holland, 1991). Remnants of this mindset can still be seen in the fact that eight states have no specific requirements and 13 other states have a required number of hours of training, but no specified topics for educating the parents.

Parent training was initially focused on understanding the externalizing behaviors displayed by their foster children. According to social learning theory (Tan, 2011), children's development is an outcome of their environment and learning experiences. Changing the negative environment and limited learning experiences can help alter the externalizing behaviors of the foster child. Modeling, positive reinforcement, token economy, natural consequences, shaping, and skill training were all interventions used by behaviorists and the key to some early curricula (Seligman & Reichenberg, 2014).

In addition to behavior management, relationships between the foster child and foster parent were viewed as important factors in moderating the foster child's misbehaviors. The role

of attachment theory became vital in understanding how to improve training for foster parents in the area of relationship building with their placements. Foster children over the age of one showed higher symptoms of avoidance and resistance in forming attachments with their foster parents and this was a concern for serious outcomes later in life with the inability to attach (Dozier et al., 2009). This research highlighted the foster parents' inability to be nurturing toward the foster children in response to the foster children's resistance. Skills in recognizing these behaviors in foster children as a request for help and not a rejection of the foster parents should be added to the foster parent training requirements.

Training for foster parents became more intentional when foster children began exhibiting more extreme behaviors. In the last 20 years, more rigorous studies have been conducted utilizing randomized sample sizes to study programs such as The Incredible Years (IY; Linares et al., 2006), Attachment and bio-behavioral catch-up (ABC; Dozier et al., 2009), Parent-child interaction therapy (PCIT; McNeil et al., 2005), and Foster Parent College (FPC; Pacifici et al., 2005). These curricula are geared more towards training specific skills to foster parents such as interaction skills, interpreting behaviors, dealing with sexual abuse disclosures, and play therapy skills. Social learning theory and behavioral-focused skill acquisition seem to be the preliminary focus for stabilizing foster children in a foster home. Attachment theory and the importance of relationships have proven to be a key starting point for foster parents. Behavioral parent training has been found to increase foster parents' knowledge and improve placement outcomes for the foster child (Franks et al., 2013). These types of trainings and/or interventions are provided once foster children are placed in the foster home. These approaches are focused on the foster child's behaviors and the skills needed to manage those behaviors. IY, ABC, and PCIT require sessions with the foster parent and child to observe and model

interactions and to practice new skills. FPC's approach also allows for foster parent training to be conducted via the Internet to give foster parents more access to training.

Nash and Flynn (2009) noted that finding effective foster parent training programs was very sparse and needed much attention, as it could not be assumed that all curricula had positive outcomes. Two foster parent curricula that emerged as best practices for foster parenting were Model Approach to Partnerships in Parenting Group Preparation and Selection of Foster and/or Adoptive Families (MAPP/GPS) and Foster Parent Resources for Information, Development, and Education (PRIDE). MAPP was the first standardized foster parent curriculum (Mayers-Pastzor, 1987). Child Welfare of America determined a need for another such standardized curriculum for foster parents and developed PRIDE in 1993. These two curricula were widely used throughout United Stated in 2009 with 26 states (Dorsey et al., 2008) listing either MAPP or PRIDE as the required pre-service training for prospective foster parents. Being the first two standardized foster parent curricula, they provided more training on policies and procedures and skill development in five competency areas: protecting and nurturing children, meeting children's developmental needs, supporting children's relationships with their biological families, connecting children to safe, nurturing, lifelong relationships, and working as a member of a professional team. The research was conducted to determine whether the training material increased the knowledge of the foster parents from pretest to posttest in these five areas (Nash & Flynn, 2016). Research on these two extensively-used training curricula has shown very little empirical support (Dorsey et al., 2008) in helping address the skills needed for foster parenting.

The last decade has brought the focus around to trauma-informed practices within the child welfare field, recognizing the experience of abuse on the foster child as a whole can be the cause of the foster child's behaviors. The National Child Traumatic Stress Network (National

Child Traumatic Stress Network, n.d.) conducted a study with 2,251 foster youth and found that 70% had experienced complex trauma (Greeson et al., 2011). Complex trauma is defined as experiencing at least two types of trauma. Types of trauma can include child abuse, mass interpersonal violence, natural disasters, transportation accidents, destructive fires, rape/sexual assault, physical assault, sex trafficking, torture, war, or witnessing violence (Briere & Scott, 2015). As practices and information change in the world of child welfare and research, the training programs for foster parents need to continue to develop (Pacifici et al., 2005). Theories on trauma have helped to converge on the underlying reasons for the behaviors and lack of attachment. The immediate effects of trauma on a child's brain can rewire connections that cause the child to be hypervigilant, unable to emotionally regulate, and untrusting of adult relationships (Hartinger-Saunders et al., 2019). Realizing this fact brings the need for professionals and foster parents to have a greater knowledge of trauma and its effects on the children placed in the system (Bartlett & Rushovich, 2018). Understanding the trauma, the symptoms, and behaviors can be a more effective way of stabilizing the foster child, promoting attachment, and providing a safe environment.

The trauma-informed approach enables helpers to understand the trauma and emotions underneath the behaviors presented. Providing a safe space for the child to sleep, talk, and experience emotions is the end goal. Although there is no nationally supported trauma-informed curriculum, more promising curricula for education and interventions in trauma-informed care have been found in the Resource Parent Curriculum (RPC; Sullivan et al., 2015) and Trauma Systems Therapy for Foster Care (TST-FC; Bartlett & Rushovich, 2018).

RPC was developed through The National Child Traumatic Stress Network (NCTSN) in 2010. Congress created the NCTSN in 2001 to unify collaborative networks to further the

treatment and services for children and families exposed to trauma (Pynoos et al., 2011). RPC was created by a workgroup of 31 experts in child welfare, child traumatized stress, and foster parenting (Sullivan et al., 2015). This workgroup developed nine essential elements of trauma-informed parenting that were developed into eight modules focusing on the developmental age range of 8 months to 15 years old in children. Research has shown RPC's effectiveness to increase knowledge and parenting in trauma-informed practices for foster parents (Konijn et al., 2020; Murray et al., 2019; Strolin-Goltzman et al., 2018; Sullivan et al., 2015).

TST-FC was adapted from Trauma Systems Therapy that was created by Dr. Glenn Saxe and colleagues as a clinical and organizational model for helping children and teenagers with trauma (Saxe et al., 2015). This model recognized the importance of the interaction between the social environment and individual development in the process of healing from trauma effects. The TST was studied in residential programs and child welfare agencies (Brown et al., 2013; Hidalgo et al., 2016; Murphy et al., 2017; Redd et al., 2017). Positive outcomes were found in treating the youth with this trauma-informed approach. With the help of Dr. Saxe and Dr. Brown, Kelly McCauley adapted TST for use with foster parents. TST-FC was implemented in two child welfare agencies with positive results in increasing knowledge of trauma-informed practices for the foster parents and caseworkers (Bartlett & Rushovich, 2018). The TST tools were found to be beneficial interventions in strengthening the communication between the caseworkers and foster parents and determining trauma-informed parenting techniques.

Despite these strides in understanding foster children, the mandated training requirements continue to vary across the 50 states. Pennsylvania, the state of residence for the researcher, only requires six hours of training to be initially approved as foster parents. The required trainings include first aid/CPR, passive restraint, orientation, mandated reporter, and prudent parenting.

Trauma training is not required in Pennsylvania. Only seven out of 50 states require trauma training for foster parents and eight states have no specific requirements (U.S. Department of Health and Human Services, n.d.). With the increase of behaviors in foster children coinciding with the increase of traumatic experiences, trauma-informed parenting training needs to be a requirement for foster parents to have the tools needed to be effective in their work (Fratto, 2016). The importance of further research on the trauma-focused curriculum of Trauma Systems Therapy for Foster Care may help to advance the work in providing stability, safety, attachment, and permanency for foster children and provide some stability in the need for uniformity in required foster parent trainings.

Problem Statement

The federal government (Title IV-E Foster Care and the Fostering Connections Success and Increasing Adoptions Act of 2008), state government, agencies, and foster parents (Hebert & Kulkin, 2018; Rhodes et al., 2001) recognize the need for specialized training for foster parents to equip them with the skills and knowledge to enable success in parenting and forming relationships with the foster children. This training is vital in helping the foster parents provide stability and permanency for the foster children placed in their home (Rock et al., 2015). Curricula come in the form of pre-service and in-service to help the foster parents achieve the level of skills needed. Pre-service trainings help to orient prospective foster parents on what to anticipate in their roles as foster parents with foster children's behaviors, foster parent expectations, agency regulations, and many other topics. This type of training can solidify their choice to foster or convince them to drop the pursuit. In-service trainings are provided after full approval as a foster parent is received and involves more in-depth skills, knowledge, and techniques. While there have been several meta-reviews (Benesh & Cui, 2017; Dorsey et al.,

2008; Festinger & Baker, 2013; Lee & Holland, 1991) regarding the scope of these trainings, few studies target specific curricula and their outcomes.

Over the past 30 years, in-service training has evolved from basic parenting skills to more advanced behavioral modification and attachment techniques. PRIDE (Christenson & McMurtry, 2007, 2009) and KEEP, Keeping Foster Parents Trained and Supported, (Price et al., 2009) were developed to address parenting skills in working with the behaviors of the foster children. Mary Dozier (Bernard et al., 2012; Dozier et al., 2001, 2006, 2009; Stovall-McClough & Dozier, 2004) has worked extensively on the attachment between foster parents and foster children and had been successful in establishing the Attachment bio-behavioral catch-up (ABC). Studies have increased in the last 10 years to examine approaches to trauma-focused interventions (Imrisek et al., 2018; Nash & Flynn, 2009, 2016) for foster children and foster parents with 70% of the foster children experiencing trauma in their young lives (Greeson et al., 2011).

"Understanding the effects of trauma and teaching social-emotional health" is one of the 16 competencies that were found to be important for foster parents in providing stability and permanency for foster children (Vanderwill et al., 2020, p. 23). In the last five years, there has been an explosion of trauma-focused curricula, including the CORE (Critical On-Going Resource Family Education) teen parenting curriculum project (Patterson et al., 2018), Resource Parent Curriculum (RPC+, Strolin-Goltzman et al., 2018; RPC, Sullivan et al., 2015) and Trauma Systems Therapy for Foster Care (TST-FC; Bartlett & Rushovich, 2018). While the trauma-focused work is more recent, it is less researched. The CORE teen curriculum was released nationwide in the Spring of 2020 and has a strong trauma training component within the first couple of modules; however, this curriculum is focused on developing foster parents for parenting adolescents. RPC and RPC+ were developed in 2015 and have several studies (Konijn

et al., 2020; Murray et al., 2019; Strolin-Goltzman et al., 2018; Sullivan et al., 2015) examining the administering of the 8 or 10-session curricula with success. TST-FC (a four-module curriculum) has been available since 2017 and was designed to help increase the foster parents' knowledge of trauma, trauma effects, and available techniques to manage misbehaviors. Until recently, this curriculum has only been explored in a few studies. Redd et al. (2017) studied the implementation of TST system-wide within a large agency that provided care to out-of-home placements in Kansas. This agency worked with Dr. Saxe and Dr. Brown to expand the scope of TST to include trainings and tasks for direct care workers such as caseworkers, therapists, and foster parents. The researchers found increases in positive behaviors and decreases in negative behavior from the foster children. They also discovered the eagerness of the foster parents wanting to learn about trauma, trauma effects on children, and tools to better the foster children. The other study focused on evaluating the revamped TST-FC trainings and their effectiveness with foster parents (Bartlett & Rushovich, 2018). TST-FC was found effective in increasing trauma-informed care and tools to improve the ability of the foster parents to care for their foster children. The problem is the lack of research and evidence demonstrating whether the TST-FC curriculum increases the trauma knowledge of foster parents and provides them the confidence to manage the trauma-related behaviors in their foster children. Before requiring foster parents to complete another training component before certification, the effectiveness of the trainings of TST-FC to increase foster parents' trauma knowledge and their ability to be more effective parents to foster children needs to be explored and tested.

Purpose Statement

The purpose of this study was to measure the level of knowledge of trauma information, parental satisfaction, and tolerance for misbehaviors before and after the administration of the

four modules of the TST-FC curriculum. The target audience were foster parents and kinship parents located in six areas within the western, central, and northeast regions of Pennsylvania. Foster parents met the following parameters: aged 21 and above, any race, single, married, or cohabitating, and any sexual orientation. The training was administered via an online platform.

Significance of the Study

With the importance of understanding childhood trauma and its effects on foster children, research into foster parents' knowledge and training on trauma has been sparse (Miller et al., 2018). Beyerlein and Bloch (2014) supported the urgent need for training foster parents in trauma-informed care as a matter of policy and priority to prevent further traumatic damage to foster children. Only one study examined the outcomes of training foster parents with TST-FC (Bartlett & Rushovich, 2018). Several studies have reviewed the outcomes of the RPC and RPC+ curriculum (Konijn et al., 2020) that administer the trauma information and related topics in 10 sessions in comparison to the 4 sessions of TST-FC. Bartlett and Rushovich (2018) outlined the need for more rigorous studies exploring the TST-FC curriculum and its ability to increase foster parents' knowledge and satisfaction in parenting foster children with trauma. This study examined further the research on TST-FC to provide more information on trauma knowledge for foster parents and, hopefully, strengthen the TST-FC as a viable option along with RPC+.

Research Questions

RQ1: Can the Trauma Systems Therapy for Foster Care curriculum increase knowledge and beliefs surrounding childhood trauma for foster parents?

RQ2: Can the Trauma Systems Therapy for Foster Care curriculum increase the satisfaction in parenting foster children for foster parents?

RQ 3: Can Trauma Systems Therapy for Foster Care curriculum increase foster parents' tolerance for misbehaviors in foster children?

Definitions

1. *Best Practice*- Declarations made by providers, government agencies, and experts of targeted, achievable standards of care and intervention for foster children (Ager & O'May, 2001).
2. *Childhood Trauma*- Trauma experienced by a child within the first 10 years of life can cause multiple or chronic exposures that cause developmental delays, dysregulation, distrust of caregivers, and functional impairment (Steele & Malchiodi, 2012, pp. 8-9).
3. *Externalizing Behaviors* - Behaviors of a foster child that can be described as aggressive, hostile, destructive, or defiant in nature resulting from traumatic experiences (Perry & Price, 2018).
4. *Foster Care*- 24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes (Johnson, 2004).
5. *Foster Parent*- An adult who chooses to become licensed as a provider for children needing an out-of-home placement, providing stability and safety. They must possess skills to handle the needs of children with trauma experiences (Geiger et al., 2017).
6. *Internalizing Behaviors*- Examples of internalized behaviors include lack of control of emotions, demand for attention, feelings of inferiority or worthlessness, and social withdrawal (Perry & Price, 2018).

7. *In-Service Training*- An educational requirement for foster parents to maintain licensure and increase knowledge and skills for parenting the different needs of foster children (Festinger & Baker, 2013).
8. *Parent Self-Efficacy*- Caregiver's confidence in their ability to successfully raise children (Jones & Prinz, 2005).
9. *Pre-Service Training*- An educational requirement for parents pursuing a license as foster parents. This type of training provides initial information to the parents while allowing professionals to assess the parents for suitability for fostering (Festinger & Baker, 2013).
10. *Trauma* - Exposure to actual or threatened death, serious injury, or sexual violence (*Diagnostic and Statistical Manual of Mental Disorders,* 5th edition; American Psychiatric Association, 2013).
11. *Trauma-Informed Care*- An approach to helping children by understanding the history of trauma and its effects on their lives and the resulting symptoms (Steele & Malchiodi, 2012).
12. *Trauma Systems Therapy for Foster Care*- TST-FC uses a research-based, integrative trauma-informed treatment methodology that attends to both the child's individual emotional needs and his or her social environment, including foster parents, birth parents, caseworkers, and clinicians (Bartlett & Rushovich, 2018).

Summary

The importance of educating foster parents about their work with the traumatized foster children placed in their homes cannot be overstated to ensure safety and permanency. As research has developed over the years, the importance of acquiring skills to handle internal and external behaviors was studied but has progressed to focus on the trauma behind those behaviors as being a more effective practice. The research into trauma-informed curricula is in its infancy

and requires further study to determine the best approach that presents the greatest outcomes for foster children and foster parents. Presenting Trauma Systems Therapy for Foster Care to approved foster parents in Pennsylvania may allow gathering data regarding the ability of this curriculum to increase the beliefs and knowledge surrounding the topic for foster parents. This can add to the results of one other study on TST-FC (Bartlett & Rushovich, 2018) to further the progress in the trauma training field.

CHAPTER TWO: LITERATURE REVIEW

Overview

The goal of foster care is to provide a safe, supportive family environment for a child to heal and grow before the child returns to their birth family or is adopted into a new family, thus, achieving permanency (Lockwood et al., 2015). Placement disruptions due to a traumatized foster child's externalized behaviors can do further harm and delay the goal of permanency for the foster child (Chamberlain et al., 2006). These behaviors have greatly affected foster parents' commitments to fostering and confidence in their ability to parent foster children. Trauma training for foster, kinship, and adoptive parents has been emerging as a vital tool in the prevention of these disruptions (Bartlett & Rushovich, 2018; Crum, 2010; Patterson et al., 2018). This new understanding has led to improved parenting skills in recognizing the trauma and parenting behaviors accordingly. Higher commitment from the foster parents results from a decrease in dysregulating behaviors and the foster parents' willingness to give the relationship more time to develop (Jacobsen et al., 2018; Lindhiem & Dozier, 2007). That increase in time allows an attachment with the foster child to improve with this increase in knowledge that the foster child's behaviors are not directed toward the foster parent and are not a reflection of the foster parent. Lastly, creating a trauma-informed community with the foster parents trained in tandem with the foster care staff helps everyone feel supported and work together to achieve the best outcomes for the foster children (Bartlett & Rushovich, 2018).

Foster parenting was once thought to be a fairly, straightforward role if one possessed strong, moral values and skills in raising their own children. The federal government thought it is important to train prospective foster parents before their approval, however, gave the states free rein over any parameters outlining the type, hours, and topic content. These trainings have

developed over the years to address behaviors, attachment struggles, and trauma symptoms. Research has been scant for all the different areas, including trauma trainings. Trauma-informed parenting directs the newest focus in training foster parents. Few states require trauma training and there have been very few studies that have only begun to scratch the surface of this topic. More research can be important in showing empirical evidence for the work and knowledge of trauma-informed practices that can change state policies and increase better outcomes for foster children and their permanency.

Conceptual/Theoretical Framework

A foster parent is a person who has been licensed according to state regulations to provide temporary care to children who have been removed from their birth home due to safety reasons based on abuse and/or neglect (Johnson, 2004). The federal government determines the statutes to follow to be eligible for IV-E federal monies. The Title IV-E of the Social Security Act principally entitles states, tribes, and territories with an approved Title IV-E plan to recoup reimbursement of part of their costs of providing foster care, adoption assistance, or kinship guardianship assistance on behalf of eligible children (Stoltzfus, 2017). These funds help to compensate for the costs of having a child in a foster parent's home such as extra water usage, higher electrical bills, more food consumption, and added clothing expenses. A foster parent can be related to the child or known to the child and be termed a kinship foster parent. Most foster parents are unknown to the child and are sometimes termed traditional foster care. Both kinship and traditional foster parents were the focus of this study.

Foster parents are a necessary component of the child welfare system in caring for foster children who can no longer safely reside in their birth family home. This has become a more prevalent need with the passing of the Family First Act in 2018. Part of the goal of this act is to

provide more community-based services to the nuclear family to keep children with their birth families. However, if a placement is needed, the second goal is to place them in kinship or foster homes and keep children out of congregate care. Helping the foster parent in their efforts to shape and maintain a relationship with a new and unknown child brought into their home is essential in determining the placement's stability and permanency (Blakey et al., 2012). Ideally, foster children remaining in one foster home before being reunited with their birth family or adoptive home helps to minimize any more harm or trauma toward the foster child and is the desired goal for stability (Harden, 2004). Statistics on placement stability track the number of moves to different foster homes that a foster child incurs while placed in foster care. These statistics are important to follow in determining the best outcomes for foster children. The federal government found that 85.9% of children in a foster placement for less than a year were in no more than two foster placements (U.S. Department of Health and Human Services, 2011). Less time in foster care and fewer moves help to achieve better permanency outcomes for the foster child. However, that percentage decreases if a foster child remains in foster care longer. The statistic decreases to 63.4% if the foster child remains in care between 12 and 24 months and 32.8% after two years in care (U.S. Department of Health and Human Services, 2011). These lower placement stability statistics make it essential to determine factors to help prevent placement disruption for foster children.

The majority of the research has focused on the foster children's externalizing behaviors as predictors of placement stability (Chamberlain et al., 2006). This has led to training for foster parents to decrease externalizing behaviors (Cooley & Petren, 2011; Nash & Flynn, 2009, 2016). The foster parents' skills and experiences were found to be protective factors for the foster child's placement stability (Rock et al., 2015). However, the increase in the foster child's

behaviors can affect the foster parent's commitment in a negative way that decreases the possibility of a foster child remaining in the home. A parent's commitment to the relationship with a foster child is a factor in that relationship's success. "Foster parents only" have had lower commitment scores than "adopt only" parents and foster and adoptive parents (Cleary et al., 2018). The foster parent's lower commitment level decreases the opportunity for attachment formation between the foster parents and foster children, decreasing placement stability.

Trauma and its effects on children have become a determining factor underlying the externalizing and internalizing behaviors presented by foster children. Young children between the ages of three and six years of age had increases in trauma symptomology when they had experienced neglect. Additionally, the presence of interpersonal violence (IPV) in the home increased the children's trauma symptoms (Fusco & Cahalane, 2014). Training in trauma concepts and their effects has helped increase commitment, parenting skills, and attachment with foster parents in a child welfare system when implementing TST-FC (Bartlett & Rushovich, 2018). TST-FC also provided the tools and knowledge to help bring together caseworkers and foster parents with the common goals of understanding the effects of trauma on the children, communicating as a team, and how to better help the children (Bartlett & Rushovich, 2018).

Related Literature

Exploration into the literature starts with an understanding of the types of behaviors seen in children with trauma. In moving towards healing, a child needs a safe environment, both emotionally and physically. Training foster parents about the effects of trauma and creating a safe environment can increase the healing process. Understanding the behaviors and the proper parenting techniques has increased foster parent commitment and can lead to increased attachment. These features can also support a foster child's healing process. This study aimed to

demonstrate the benefits of TFT-FC in training the foster parents in understanding the behaviors from trauma, how to parent these children with these behaviors, and be a part of a team involved in the support of these children in a trauma-informed environment.

Children's Behaviors Resulting from Traumatic Experiences

Foster children have experienced trauma in the form of neglect, emotional abuse, physical abuse, and sexual abuse at the hands of their birth family or neighbors. This has created an unsafe environment for the child. In-home and community-based services are implemented to help the family acquire skills to help provide safety and stability for the child (Huhr & Wulczyn, 2022). If those measures fail to ensure the child's safety, removal from their birth home needs to occur adding another traumatic event to the child's life. Trauma has been defined by the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (American Psychiatric Association, 2013, p. 271) as:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend – in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s).

This trauma manifests itself in dysregulation of emotions, externalizing behaviors, and internalizing behaviors. Children exposed to a family-involved traumatic event are at a greater risk of developing social-emotional issues as they try to cultivate relationships (Campbell et al., 2016). These social-emotional issues tend to lead to adjustment problems within the family unit (Lamers-Winkelman et al., 2012). Neglecting a young child can increase trauma symptomology

(Fusco & Cahalane, 2014). These risk factors of neglect, sexual abuse, and multiple placements have increased behaviors (Simmel, 2007). The resulting increase in dysregulation of behaviors observed in foster children tends to be a challenge for their caretakers, be they kinship, foster, or adoptive parents. These caretakers voice that these behaviors are the number one challenge for them to successfully parent foster children (Atkinson & Gonet, 2007). Although externalizing behaviors for older foster youth tended to be less compared to younger foster children placed into kinship homes (Wu et al., 2015). Younger foster children appear to express their reactions to trauma triggers through their external behaviors. Older foster children seem to handle their emotions through internalizing and externalizing means that manifest into health problems, focus issues, hidden self-harming behaviors, and risky behaviors. Pregnancy, suicide attempts, and illicit drug usage are some examples of these increases in risky behaviors to cope with the effects of trauma (Fratto, 2016).

Looking deeper for a root cause for these increased dysregulated behaviors and trauma is found in the Executive Functioning (EF). EF is a neural regulatory system in the brain that oversees the working memory, cognitive flexibility, and inhibitory control that are important in developing self-regulation and adaptability in the areas of social, emotional, and cognitive domains. This is an area in the prefrontal cortex that helps with decision-making and impulse control (Sapolsky, 2004, p. 215). The working memory helps with that function of reasoning and decision making, which involves focusing and processing several pieces of information simultaneously (Diamond & Ling, 2016). Nolin and Ethier (2007) found deficits in EF in children that were physically abused but not neglected. These deficits are the result of higher cortisol levels that are released in the event of a stress-producing occurrence (Fisher et al., 2013). This EF deficit can only be one possibility as not all children entering foster care have these

deficits. The inherent make-up of the child's personality, environment, and experiences all can play a role in the effects of stress on a child's behaviors (Fisher et al., 2005).

Despite thinking that attachment and trauma disorders have similar responses in children and that trauma can affect a child's social development, the two schools of thought are very different in conceptualization and treatment. Within the trauma view, a child is seen as a victim and treated as such. Attachment issues are perceived as dysregulated behaviors of a child due to maltreatment (Owen, 2017). There is value in understanding both perspectives when addressing the needs of the child. Empathy developed for the encounter some children have endured can help a foster parent not to internalize the child's behaviors as being directed toward them, but direct their thoughts toward the root of the issues as the experienced traumatic event in the child's life. This focus shifts the foster parents' perception from "what is wrong with the child" to "what has happened to the child" (McCauley, 2017).

An added complication to the type of behaviors of foster children that foster parents will be asked to deal with in their homes will increase as a result of the Family First Prevention Services Act (FFPSA) of 2018. In this piece of legislation, the goal is to decrease the placement of dependent youth in congregate care. The youth typically placed in these types of settings will then need to be placed into therapeutic foster care to help address their emotional and behavioral needs as the result of trauma (Tullberg et al., 2019). These increases in needs for the foster children can equate to an increase in essentials and support for the foster parents to thrive with these foster children.

Anticipating that children removed from birth homes as the result of abuse and neglect have a greater chance to experience trauma, a screening for symptomology should be administered within the first week of placement. Young, maltreated children need to be

evaluated for their traumatic stress reactions based on their responses and family and environmental factors (Lieberman & Van Horn, 2009). Standardizing the intake process and assessment helps give a baseline of information to caseworkers to develop effective treatment plans and make appropriate therapy referrals. Foster parents can also receive clarifying information regarding the child placed in their home in the beginning. Understanding the child's behaviors and underlying issues in the parent-child interaction can help to institute strategies in the parental approach by the foster parents (Mares & Torres, 2014). Historically, the research focused on the foster children's behaviors and not the fundamental issues at the root of those behaviors. The focus has shifted to more emphasis on the traumatic experience.

Formation of the Relationship between Foster Parent and Foster Child

Attachment is an important factor in the bidirectional ability to form relationships between the foster parent and foster child. Commitment and attachment capability can affect the foster parent's skills in relationship formation. Understanding these concepts would be paramount for a foster parent to forge these new relationships with foster children in their care. Externalizing behaviors and trauma symptoms can affect the foster child's ability to form relationships from their perspective. These two factors can frustrate the foster parent's attempts to engage and attune in the development of the relationship. Experiencing many of these behaviors from foster children at the beginning of their placement will prevent the opportunity for a relationship to form before the placement disrupts. Support for the foster parents from agency workers, court systems, and school systems can encourage the foster parents and form a strong alliance in working together for the common goal of helping the foster child heal and learn to trust in relationships again.

The Commitment of Foster Parents

A parent's commitment to the relationship with a foster child is a factor in that relationship's success. When interviewed, previous foster youth reported that a foster parent's ability to have an established interest and commitment to the relationship with the foster youth was a sign of a better foster parent (Affronti et al., 2015). "Foster parents only" have had lower commitment scores than "adopt only parents" and "foster and adopt parents" (Cleary et al., 2018, p. 209). This study would suggest that foster parents enter into relationships with foster children with lower expectations for the long-term outcome of those relationships than the foster parents seeking to adopt a child or adoptive parents. This commitment from the foster parents can rely on the input from the foster children. Associations between a high commitment with the foster parents and higher functioning in the foster child's social-emotional areas were favorable (Jacobsen et al., 2018). Foster parent commitment was found to be higher when the foster child's externalizing behaviors were lower (Lindhiem & Dozier, 2007).

In a comparison study, the commitment to adolescents was compared between foster parents, shift workers, and cottage workers. The commitment level for foster parents was higher than in the other two. The number of externalizing behaviors in adolescents was much higher for shift workers (Lo et al., 2015). The value in the level of commitment towards the children placed in out-of-home placements can vary with the different roles that adults in the children's lives fulfill in conjunction with the rate of externalizing behaviors displayed by the foster children. The temporary nature of foster care lends itself to less commitment by the foster parents but more commitment than a shift worker in a residential facility. With less commitment, the stability of the foster child's placement could be more precarious.

Cooley et al. (2015) studied the relationship between a foster parent's satisfaction with the fostering experience with the foster child's behaviors and whether the foster parent's resilience can moderate. There were no significant findings that their resilience did moderate within instances of high-rate behaviors from the foster child. Moderation was found in lower frequencies of behaviors. It was questioned whether the foster parents with high resiliency just did not identify more disruptive behaviors from the foster children. The study reported that tangible resources were noted to be a protective factor for the challenges facing foster parents. It is important to question if more factors moderated a foster parent's commitment and satisfaction with fostering and maintaining the foster child's placement within their home.

Foster Parent's Attachment

A foster parent's ability to attach provides a key factor in the attachment formation with a foster child. Foster parents possessing an insecure attachment level can have atypical parenting behaviors toward the foster child at the risk of the foster child developing disorganized attachment (Ballen et al., 2010). Abuse or attachment issues of their own can be the indicator of insecure attachment for these foster parents. Dissociation and fear could be the reactions of these foster parents that have been triggered by a foster child's disruptive behaviors. Forming secure attachments would be the ideal and most effective skill for a successful foster parent to possess. The benefits of a foster parent with these secure attachment skills can promote more psychological development in the foster child (Nowacki & Schoelmerich, 2010) and foster relational healing.

Attachment was one of the 16 themes that were determined to be important in the inclusion of foster parent training for working with teenagers (Patterson et al., 2018). That theme was broken down to include the understanding of routines and consistency by the foster parents

to build an attachment with the foster youth. Behaviors by the foster parents that helped the foster youth to connect were explored as part of the attachment process. The ability of foster parents to identify cues that there were problems in the process of attachment and then identify behaviors on the foster parents' part to strengthen and reinforce forward progress in attachment with the foster youth were all part of that particular theme in the training. These cues manifesting in the foster child can be the inability to reciprocate social skills such as empathy, conversations, and offering to assist or these skills are indiscriminate at best (Tarren-Sweeney, 2013).

Once determined that foster parents can form the secure attachment in other central relationships in their lives, the question was to find out if these skills be applied to their developing relationships with foster children. Foster parents undergoing less stress with their abilities to parent can help with forming more secure attachments with their foster children. Knowing that foster children tend to struggle with strong attachments in their birth families can benefit from the hope of building any positive attachment. Experiencing this new ability to form secure attachments can be a shielding factor for foster children in the future (Gabler et al., 2014). Foster parents, who can commit and model secure attachments, can be more successful in dealing with the externalizing behaviors and provide the foster children in their care with better relational tools to use in their future.

Relationships Development

Relationships between foster parents and foster children that developed into a more attending relationship helped to see improvement in the problematic behaviors of those foster children (Dubois-Comtois et al., 2015). These attending behaviors need to be focused on the foster child and be supportive and harmonious. Foster parents' ability to provide these behaviors for the foster child comes with more training and understanding on the foster parents' part. These

are skills that a foster parent can learn and work on to decrease the foster child's rate of behaviors (Chamberlain et al., 2006; Dozier et al., 2006; Price et al., 2009). Relationships between adolescents and parents that offer affection, communication, and boundaries are effective in helping with the foster child's externalizing behaviors that can occur in stressful situations. However, these same relationships are not endorsed to help with the internalizing behaviors of those adolescents (Oliva et al., 2009). A subsequent study on female adolescents endorses the need for emotional support and healthy relationships with parents as important aspects of better mental health (Shahhosseini et al., 2012). To make lasting results within the lives of foster children, change in their internalizing behaviors is required. Focus beyond just teaching foster parents behavior intervention skills will be needed. Skills in developing relationships with traumatized children are missing in the foster parent training and the research.

Foster parents struggle with the lack of connection formed with a foster child within the first few months. There is an expectation by some that the bond should be instant and reinforce their decision to become a foster parent. Research has shown there is a more significant affective bond between the foster parent and foster child than between the foster child and the biological parent. This allows the foster child to turn to the foster parent for help eventually (Maaskant et al., 2016). The foster parent with this understanding and the knowledge that it will take more time to develop the relationship can benefit from more success in foster parenting.

Children's Attachments

Attachment behavior is demonstrated by a child to gain closeness to the attachment figure (Cassidy, 2016). Preferably, this attachment behavior is formed through the support of the foster child's autonomy (Bovenschen et al., 2016) and increased attentiveness or sensitivity of the foster parent (Stovall-McClough & Dozier, 2004). Higher sensitivity by the foster parent to the

child can result in a more secure attachment (Vaughn & Bost, 1999). This higher sensitivity can provide attention to the foster child's cues for different needs, showing a genuine interest in the foster child's concerns, and helping the foster child voice their need and find a solution when appropriate.

However, attachment can even happen between infants and abusive mothers (Cassidy, 2016). If the parent is not attentive or neglectful, the child can form an avoidant attachment realizing his needs will not be met by the caregiver (Dozier et al., 2001). An increase in placement disruptions for the foster child and the birth mother's mental health can adversely affect the foster child's ability to form secure attachments (Lang et al., 2016). The ability to form secure attachments is a developmental trait learned early in children within the first several years. Young children placed in a stable foster home can form a more secure and organized attachment with age (Jacobsen et al., 2014). The secure attachment formed may help with the formation of emotion regulation for the foster child and placement stability (Cassidy, 2016). A secure attachment between a foster child and foster parent provides a secure base for the foster child to explore and experience the world and then return to a safe relationship with the foster parent (Waters et al., 2010).

Attachment behaviors look different depending on the age of the foster child and the number of placements he or she has experienced. Multiple placements can increase the trauma and anxiety experienced by the foster child, adversely affecting their ability to attach to the foster parents (Tarren-Sweeney, 2013). Stability is important in helping foster children with attachment behaviors. The longer a child remains in an abusive home, the more attachment decreases and instability increases. Removing older children from their birth home can result in longer periods of instability and a lack of opportunities to bond with a parent-figure for the older foster child.

Adoptive children struggled with attachment at a higher rate when placed after the age of four. These adoptive children experienced multiple placements and emotionally abusive care in foster homes (Meakings & Selwyn, 2016).

The age a child is placed into foster care is a significant factor in his or her ability to form attachments and relationships to form with their caregiver. Researchers have found that older foster youth may need more intentional work by the foster parents to help them feel integrated into the family (Waid et al., 2017). Additionally, the number of movements and placements a child experiences can also impact a child's ability to connect and regulate in a foster home. For these reasons, attachment-focused interventions may help more with foster children developing secure attachment than behavior-focused interventions (Bovenschen et al., 2016). Once again, these two schools of thought are examined to discover the ideal approach to working with foster children, whether behavioral or attachment interventions. For years, the focus has been on behavioral interventions in working with foster children. These seem to be short-term solutions to help foster children live day-to-day in a foster home (Price et al., 2009). Helping foster parents focus on the trauma and the attachment to a foster child may be the long-term solution.

Placement Stability for Foster Children

Determining what the research says to this point about placement stability for foster children as it relates to a child's trauma and attachment within the family unit is worth exploring as it relates to the foster child's overall healing. There is more research on associations between externalizing behaviors and disruption of placements (Sattler et al., 2018). This highlights the focus on externalizing behaviors of the foster children as the most important factor in placement stability. Very scarce research examining the effects of a lack of foster parent training, lack of trauma training, and the foster parent-child attachment and its effects on placement stability

(Leathers et al., 2019) can be found. This points to the absence of an emphasis on the importance of the foster parents being trauma-informed in their understanding and parenting techniques as a central element in contributing to the children's stability in their foster care placements. This lack of research regarding trauma effects on a foster child's placement stability is predictable with the focus of this field directed toward externalized behaviors versus traumatic experiences.

Fisher et al. (2013) reviewed 59 sources looking for connections between foster care placement instability and externalizing behaviors in the foster child and treatment interventions to treat those behaviors. These behaviors manifested into the psychopathology of ADHD (Miller & Hinshaw, 2010), disruptive behavioral disorders (Bohlin et al., 2012), PTSD (DePrince et al., 2009), and substance abuse (Narvaez et al., 2012). The researchers found that deficits in Executive Functioning could be linked to this increase in these dysregulated behaviors. The interventions of KEEP (Foster and Kin Parents Skilled and Supported Program) and MTFC-P (Multidimensional Treatment Foster Care for Preschoolers) were found to be effective in assisting with the behaviors and regulation skills of foster children. Both treatments provided foster parents with skills to handle behaviors and aid with improving self-regulation and improvement in EF. The parenting role has shown some ability to buffer the trauma risks and slightly improve the child's ability to control through EF (Lengua et al., 2007). The importance of understanding the detrimental effects of child abuse on a child's Executive Functioning (EF) and the possibilities of parental interactions by the foster parents to improve the child's EF would be significant in the scope of training foster parents. Lengua et al. (2007) noted it was essential to determine if there was a connection between supportive foster parents and the development of EF with placement stability and the need to train foster parents on these effects.

Approaching the subject of supportive foster parents was also explored through the lens of the foster child's insecure attachment and placement stability. This cascading effect was seen by the lack of parental support from the foster parents, which increased the foster children's externalizing behaviors, resulting in placement instability within the foster care system (Pasalich et al., 2016). This study, geared for toddlers, references the child's attachment but not the foster parent's attachment in the process leading to placement instability. The lack of placement stability for the foster child can then increase the emotional dysregulation in the foster child resulting in deficits for the child in the areas of emotional, behavioral, neural, and physiological (Fisher et al., 2013). This becomes a vicious cycle for the foster child who enters the system dysregulated from trauma and becomes more dysregulated when their caregivers cannot be supportive and assist with the dysregulation, resulting in placement instability and more emotional dysregulation.

Adolescents placed into foster care at an older age as a victim of sexual abuse have experienced more unstable placement histories. A high number of adolescents (ages 13-16) were found in the unstable placement pattern characterized by frequent moves in the first 18 months of placement (James et al., 2004). Villodas et al. (2016a) found that unstable placements were associated with higher ACEs and higher levels of PTS (posttraumatic stress) for foster youth aged 14 and above. The researchers found higher levels of problems in mental and physical health for these youth. They concluded that utilizing assessments for trauma, ACEs, and stress, early in the youth's placement within foster care, can help with planning for services to promote stabilization in the placement. These assessments can help prevent further traumatizing a foster youth with multiple placements over a long duration of time in out-of-home placements through foster care (Villodas et al., 2016b). A foster placement void of trauma assessments can have

implications for long-term health issues for the foster child at considerable emotional and financial costs (Fratto, 2016).

Foster youth have experienced a high percentage of trauma through abuse and neglect prior to being placed into foster care with 93% of foster children being affected by trauma (Pecora et al., 2006). Their traumatic experiences did not end there for many of them. Removal from their home, family, friends, and schools were additional traumas suffered. For some, while in foster care, they were additionally abused through physical, emotional, and sexual means at the hands of members of the foster homes (Riebschleger et al., 2015). This had occurred in one-third of the 694 foster youth alumni interviewed by Pecora et al. (2006). This additional trauma can be the result of the foster parents' own traumatic history, their poor coping strategies, or lack of trauma-informed training. The foster parents' inability to provide a safe and secure home for the foster child now forces another move for the foster child and another experienced trauma to be pulled from schools, friends, and neighborhoods. These multiple moves in placement for these foster children are a result of their caregivers and not their behaviors. Foster youth can experience an average of 6.5 moves (Pecora et al., 2006). Each move increases the fear and inability of the foster child to learn to trust foster parents and lessens their chance to experience a safe environment and stable home life. For these reasons, placement stability is an important outcome to monitor and work to improve the lives of foster children.

Trauma-Informed Care Environment

Trauma-informed care is a holistic approach to helping abused children heal (Steele & Malchiodi, 2012). National Child Traumatic Stress Network describes trauma-informed care as "a trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the

system including children, caregivers, and service providers" (n.d.). This includes all members of an agency understanding the concepts and utilizing the steps to create safer communities. However, experienced foster parents have commented on their difficulty in navigating the child welfare system in their efforts to help their foster children (Cooley et al., 2017). This trend needs to change to include the foster parents to encompass the foster child's entire system of care. A systems approach in working with social welfare agencies is important in the dissemination of information regarding the effects of trauma on foster children, foster parents, caseworkers, schools, therapists, and communities. The Massachusetts Child Trauma Project (MCTP) had developed Trauma-Informed Leadership Teams (TILTs) throughout the state bringing all the participants together in increasing an environment of Trauma-Informed Care. The foster parents prove to be vital members of the treatment team in helping the foster children with planning and execution. This support from trauma-informed mental health services helped to increase the foster parents' satisfaction and confidence in fostering (Barnett et al., 2019). Increased involvement and confidence helped foster parents to be significant contributors in training on trauma from their unique perspective (Bartlett et al., 2015).

These efforts in cooperation between the adults in a child's life can only increase the likelihood of positive outcomes. Personal relationships between professionals and children and families can help facilitate trauma-informed care delivery. Trust in a relationship is the key to success in any relationship and is possibly more valuable in these relationships (Brown et al., 2017). Trust leads to a safer, trauma-informed environment for foster children. This all seems to logically be able to provide more positive outcomes for foster children, however, there is a gap in research showing this relationship between trauma-informed care environments and positive outcomes for foster children (Hanson & Lang, 2015). This lack of support for this strategy can

derail well-meaning efforts and costs in providing trauma-informed environments with no data to substantiate this work and efforts within the foster care system.

School programs should be a part of the overall systematic approach to providing safety in all domains of a foster child's life. Educators may not always know which students have experienced trauma in their lives. However, usually, foster children are identified with past trauma from previous discussions as such and this provides the awareness for the school personnel to use a trauma lens when analyzing inappropriate behaviors from the student (Martin et al., 2017). This trauma awareness can be provided through in-service training at school and communication from the trauma-trained foster parent. With the countless number of possible triggers, the specific knowledge that a foster parent could share about their foster child's triggers can provide key pieces of the plan for school success. When schools provide a trauma-sensitive approach in the three tiers of the school counseling program, all children can be served with intervention techniques infused with trauma concepts (Martinez et al., 2019). This helps the schools provide a safe environment for all students without knowing their students' traumatic experiences.

As team members in the trauma-informed care approach, medical personnel are still exploring and working to understand the emerging concept of trauma-informed care and how it relates to their medical practices (Raja et al., 2015). A rudimentary perspective of trauma-informed care can be defined as an approach by a social worker, educator, therapist, or medical staff in treating a client with the understanding of traumatic experiences affecting the client and the approach needed to take in delivering the service. There are two approaches from a medical perspective; universal trauma precautions and specific trauma care (Raja et al., 2015). The universal trauma precautions consist of patient screening, understanding one's own trauma and

reactions, interprofessional collaborations, understanding the health effects of trauma, and patient-centered care and communication. Some medical personnel understand trauma but are not convinced of its effects in relation to the mental health of their patient (Isobel et al., 2020). Understanding the concept of trauma-informed care is still in its infancy and the validity of the concepts is not widely accepted by all members of the medical field. Foster parents would need to be trauma-informed, educated, and ready to advocate for the foster children in their care to receive the best treatment.

The trauma-informed conceptualization would not be complete without the understanding of vicarious trauma or secondary trauma. This type of trauma can occur within helpers (therapists, foster parents, caseworkers, teachers) working with the children with trauma (Jankoski, 2012). To work with children that have been traumatized, a foster parent will need to provide a safe space for the children to begin to heal and experience the negative emotions associated with the trauma. The key here not only will the foster children experience the negative emotions, but the foster parents are in this space as well and will also experience the negative emotions, sometimes daily. Trauma requires relational healing, and this comes by way of a foster parent developing a relationship with the foster child. When the foster child is hurting, then the foster parent can be hurting as well if this relational bond is intimate and empathetic. Foster parents were found to experience secondary trauma (Whitt-Woosley et al., 2020). The dose of exposure to the negative emotions of the foster child's trauma and the support of caregivers were found to be both risk and beneficial factors in the development of secondary trauma for the foster parents.

Understanding and providing a trauma-informed environment and community takes much effort from a large team of helpers in a foster child's life. This teamwork can be

complicated with coordinating several professional schedules and finding a mutually available time slot to devote to the care of one foster child. Leading such a vast group can be intimidating and daunting to manage the expectations and determine the ability to have authority in making decisions that can best help the foster child and foster parent.

Foster Parents: Needs, Supports, and Training

Foster parents are key members of the team in helping foster children thrive and grow to their full potential in an out-of-home placement. Overarching motivators for foster parents include wanting to make a difference in a child's life and having the ability to complete that goal (Baer & Diehl, 2019). They choose to welcome into their home a child that is unknown to them or a child as part of their extended family to provide a home, food, shelter, and love. Expectations of behavioral issues were known but not the extent of daily emotional dysregulation that would disrupt the foster child's life and everyone in the family. Understanding their needs to fulfill the role as foster parents can be quite different than parenting their birth children. These altruistic parents have made the important decision to help society's most vulnerable population and deserve the support of their agency and community along with thorough training in all effective tools and techniques available presently.

One of the needs endorsed by foster parents as being a priority was foster parent training (Patterson et al., 2018). Initially, the purpose of foster parent training was focused on teaching specific skills to help foster parents manage externalizing behaviors in foster children (Puddy & Jackson, 2003). Behaviors most likely to be seen would revolve around staying on task, being disrespectful, and lying. Managing difficult behaviors seen in foster children is an essential tool to learn. Patterson et al. (2018) discovered other valuable topics that needed to be mastered by the foster parents in the areas of trauma-informed parenting, building trusting relationships,

adapting to the unique needs of each foster child, maintaining appropriate relationships with birth families, learning regulation skills, and helping the foster youth with connections. Specific education on trauma and its effects on the foster child regarding their emotional, physical, and social well-being was strongly endorsed by foster parents in the study. Finally, information on the agency's foster parent roles within the agency, as an advocate, and responsibilities for safety, well-being, and permanency for the foster child in their care needs to be conveyed to the foster parents (Hebert & Kulkin, 2018). All these topics appeared to cover the scope of information a foster parent would need to know to effectively parent a foster child and feel successful in completing that mission.

With the importance of foster parent training being identified by foster parents and professionals, there continues to be a lack of substantial evidence for the training programs presently being offered (Festinger & Baker, 2013; Kaasbøll et al., 2019). However, some research has shown that there is a decrease in reported behaviors of foster children with the increased training of foster parents (Solomon et al., 2017). Some trainings provided a valid parenting technique, but foster families were not confident in the use of the technique due to the lack of communication and support from the agency staff (Spielfogel et al., 2011). This confirms the need to have an all-encompassing training and treat foster parents as part of the team in discussing background information, assessing and treatment planning for their foster child's safety, well-being, and permanency.

Foster parents who have no interactions or experience with children with trauma are approaching a task that drives them through selfless motives of providing a loving home without the full knowledge of the possible outcome of their decision. These foster parents have usually felt confident in their ability to attend and interact with their own children, their nieces and

nephews, the neighborhood children, the scouts in the Scout troop, or the children in their Sunday School class. Opportunities to help children problem solve through difficult situations and redirect unproductive behaviors were challenges that were overcome, and they handled these situations because they were invested. Therefore, their ability to be sensitive to a child's thoughts and emotions regarding their situation should not be contingent on the child's behaviors. However, the level of emotional involvement for the foster parent is higher with less behaviors (Koren-Karie & Markman-Gefen, 2016). Helping foster parents to understand the child's thought processes regarding their trauma and how that affects their behaviors may create more tolerance in the foster parent's attitude toward the foster child (Kelly & Salmon, 2014).

Support systems are a crucial resource for foster parents beginning this adventure. Extended family members, neighbors, church family, friends, and co-workers can and will offer advice, solicited or not. Social supports and tangible supports may be associated with foster parents wanting to continue fostering and being able to deal with disruptive behaviors (Cooley et al., 2015). Any person hopes to achieve a challenge when they have friends and family cheering and encouraging them along the way. However, those same supports can offer encouragement to abandon the pursuit of helping the foster children in favor of a more peaceful and safer life. There are many fears in the public, a product of media and negative stories in extreme cases, that can deter good foster parents from continuing down the path of foster parenting. Support from the foster care agencies would be vital to help foster parents when friends and family are unsure and skeptical of the foster child. Foster parents have reported this lack of support from their agencies has been a reason for the lack of commitment to maintaining foster children with high-rate behaviors (Murray et al., 2011).

Foster parents can feel adequately trained following their initial training before approval as foster parents. However, there can be doubts that this training can satisfy all their needs in the actual tasks of foster parenting (Cooley & Petren, 2011). Training foster parents can be examined in a process format, necessitating an ever-evolving approach to meet the current needs of foster parents and foster children (Kaasbøll et al., 2019). There are many topics that could be covered during training with the prospective foster parent. Understanding children's behaviors and personalities are important subjects. Other important topics for foster parents can include attachment, child development, grief, loss, and parenting. Foster parents also have a desire to attend the same trainings as their caseworkers to obtain the same information and be equals on the professional team in helping the foster child (Hebert & Kulkin, 2018). The volume of information that is needed to impart to foster parents can be overwhelming for them to process and sort through as they begin their journey in foster parenting. Foster parents advocated for more interactive trainings to help with different learning styles and to include experienced foster parents, professionals, and foster youth alumni to lend credibility to the information being presented (Patterson et al., 2020). Structured approaches for the content and delivery require a well-planned method to help disseminate the information, process the information, and practice the skills.

Trauma Training

Specific trauma training is needed to help foster parents understand the experiences of foster children and the effects of this trauma on their brain development and behavior development. In 2009, research findings on the outcomes of foster parent training were very sparse. Showing any link between the foster parent training and outcomes with the children served by foster care was a struggle. This was an area that needed much attention for research as

it could not be assumed that all training was effective (Nash & Flynn, 2009). During their research, a link between foster parent training and child outcomes (commitment to learning, positive values, social competencies, and positive identity) could not be found. On a philosophical level, it was felt that the training was important to help orient the foster parents. More research has been conducted on the outcomes of whether the material increased the knowledge of the foster parents from start to finish and foster parent satisfaction. Both outcomes were significantly accomplished (Nash & Flynn, 2016). Since that time, various trauma training approaches have emerged in helping children with trauma and some with helping the foster parents.

Foster parents can be taught to help follow a child's lead and help the child regulate in stressful situations in coaching sessions with ABC-T (Imrisek et al., 2018). In this case, the foster parent acts as a support in regulation for the child by responding to the child in distress with a nurturing approach. A nurturing method such as providing comfort can be more effective than repetitive demands. Children with trauma have the inability to self-soothe and need external control to help them. This method can only be completed with the present caregiver and is an attachment-based intervention. The struggle with using this intervention between foster parents and foster children is when a foster child continues to see their birth parents or is making transitions to an adoptive family. These provide inconsistencies in parenting and are dysregulating to the foster child. Foster parents must possess skills beyond effective parenting in being successful in their endeavors with foster children. These concepts would include creative ways to deal with behaviors, accept birth parents into the family system, and help a completely unknown child feel a sense of belonging in their family and home (Berrick & Skivenes, 2012).

Utilizing qualitative interviews and research review, 215 competencies were determined to be important in parenting adolescents effectively. Sixty-one competencies were chosen from the list of 215. These chosen 61 were included in the training modules representing the protective factors found in research that helped traumatized adolescents enhance their well-being (Patterson et al., 2018). This study by Patterson et al. (2018) was the beginning of a three-year research project to develop a foster parent curriculum for parenting adolescents. This three-year project had been grant funded by the federal government. The work included conducting research into the literature on foster parent training, establishing the foster parent competencies needed, and receiving feedback from experienced foster parents, professionals, and foster youth alumni (Patterson et al., 2020). That curriculum was released nationwide in the Spring of 2020 with a concentration on trauma-informed parenting for foster parents. The curriculum, C.O.R.E. (Critical On-Going Resource Family Education) consisted of seven classroom sessions that involved videos, exercises, and discussions. The very first session revolves completely around the understanding of trauma and its effects on the children's thoughts, behaviors, and emotions. A self-assessment was created which can be completed by the foster parent before, during, and after the curriculum administration. The results of this self-assessment are sent directly to the foster parent and then they have the option to share the results with their agency. The results show areas of strength and areas of challenge in the competencies determined to be significant through the research. Eight "Right Time" topic-specific videos, 20 to 30 minutes in length, are also included and can be used in the classroom or as stand-alone training. Topics included in the videos are trauma parenting (two videos), SOGIE (Sexual Orientation and Gender Identity Expression), parenting techniques, and self-care. Videos have content presented by experts, foster parents, and foster youth with an accompanying discussion guide to explore specific topics

and concepts. The feedback was highly favorable from the pilot groups in providing tools and understanding of the concepts, including trauma information (Salazar et al., 2020).

Trauma Systems Therapy-Foster Care (TST-FC) provided the tools and knowledge to help bring together caseworkers and foster parents with the common goals of understanding the effects of trauma on the children, communicating as a team, and how to better help the children (Bartlett & Rushovich, 2018). TST-FC is a four-module training focusing on the skills and information that foster parents need to be successful parents. TST-FC was adapted from TST that was developed by Dr. Glenn Saxe to help workers in congregate care in the endeavors to meet the needs of the residents and provide a trauma-informed environment. Within TST-FC, 13 tools/exercises can be utilized with foster parents, foster youth, and agency staff to implement the course's concepts. The effects of implementing a trauma-informed care approach, like Trauma Systems Therapy, have helped the entire Kansas welfare system increase the children's well-being and promote placement stability (Murphy et al., 2017). TST-FC focuses on understanding trauma and the foster child, preparing for success in fostering a child, handling challenging behaviors at the moment, and finding energy and hope through self-care. Combining playfulness and TST modules can help build supportive relationships between traumatized youth and residential staff (Hidalgo et al., 2016).

With the exciting development of more trauma-focused training in recent years, there appears to be a consistent trend in the emphasis on relationships within the foster child-foster parent dyad. In many instances, trauma has disrupted the ability of a foster child to develop relationships with their birth parents and this has also prevented them from forming relationships with their foster parents. This points to the importance of comprehending the concept of trauma and its influences on brain development, behaviors, relationships, thoughts, and emotions. An

increase in understanding of trauma and trauma parenting can help foster parents create a safe home and handle the behaviors in a supportive way to help regulate and learn better-coping skills. Attending to the needs of the child can help, in turn, build the trust and relationships that may help the foster child grow and heal from their traumatic experiences.

Summary

Foster children experience abuse and neglect that can cause trauma and symptoms for the children resulting in dysregulation behaviors (Campbell et al., 2016). The increase in these externalizing behaviors and their effects on foster families have been studied sparsely throughout the last 20 years (Kemmis-Riggs et al., 2018). These studies have resulted in a focus on researching foster parent trainings that help to lessen the foster child's behaviors (Cooley & Petren, 2011; Dozier et al., 2006). Lessening the dysregulated behaviors can help stabilize the foster child, maintain the placement, and promote permanency in a safe environment. However, these traumatic experiences have far-reaching effects beyond behaviors and can have negative consequences that affect their placement and relationship with their foster parents.

A foster parent's commitment and attachment can be negatively impacted by these dysregulated behaviors resulting from the foster child's trauma (Ballen et al., 2010; Jacobsen et al., 2018). Without supports and foster parent resiliency, their commitment to continue with the tasks of fostering children with high-rate behaviors can falter and become non-existent. Lack of commitment and poor attachment with the foster children has pushed foster parents to make choices in requesting the removal of foster children from their homes. Multiple moves for a foster child have intensified the trauma they have already experienced in their birth home.

Continued foster parent training has been requested by foster parents with a needed focus to understand trauma, its effects on foster children, and parent techniques for these effects

(Hebert & Kulkin, 2018). Increasing foster parents' confidence by understanding their foster children's behaviors and how to best address their needs can hopefully increase placement stability. Studies have increased in the last 10 years to examine approaches on trauma-focused interventions for foster children and foster parents (Imrisek et al., 2018; Nash & Flynn, 2009, 2016). Foster parents can benefit from trauma information as well as concrete interventions to help create a safe, trauma-informed environment in the foster home and surrounding community. Trauma Systems Therapy for Foster Care (TST-FC) is emerging to show promise for foster parents; however, more research is needed (Bartlett & Rushovich, 2018). This study aims to explore the effects of utilizing TST-FC with foster parents and to determine if the increased knowledge provides placement stability for foster children.

CHAPTER THREE: METHOD

Overview

This section examines the methodology for answering the research questions associated with parenting traumatized foster children, tolerance of misbehavior, and parenting efficacy. The appropriate research design needed for these outcomes is discussed. This includes the type of experiment, how to select the participants, and what procedures helped to conduct the research. Data collection methods are outlined, along with the limitations of this method. Biases of the researcher can be part of the limitations of the data and are important to note. The opportunities for the participants to review the data at several key points are described to assess the quality of data.

Design

A quantitative design research was chosen to explore the effects of trauma training through Trauma Systems Therapy for Foster Care (TST-FC) on foster parents' knowledge and confidence to parent foster children with trauma. The specific design is the interpretable pretest-posttest nonequivalent groups design (Heppner et al., 2016). This design is quasi-experimental and not a true design due to the nonrandom assignment of the group members. There were two groups, one group received the treatment and one was a control group. Foster parents were able to choose to participate in the trainings now or in the future (control group). Pretest and posttest design helps to construct a stronger comparison of the effects of the independent variable of training on the dependent variables of trauma knowledge and foster parent confidence in parenting. The pretest observations allowed for interpretation of the foster parents' pre-treatment knowledge and determine any similarities between the subjects. Conducting the pretest and posttest at the same time for both groups helped to eliminate extraneous variables such as

maturation, outside events, and other similar training curriculums. This type of research affords itself the opportunity to compare the difference between two groups' scores between experiencing the training and not experiencing the training.

Research Questions

RQ 1: Will foster parents' level of knowledge of trauma and its effects on children increase after completing all four training modules of the Trauma Systems Therapy for Foster Care?

RQ 2: Will Trauma Systems Therapy knowledge increase the confidence of the foster parents in their ability to parent their foster child(ren)?

RQ 3: Will foster parents be able to tolerate misbehaviors of a foster child with traumatic experiences after being informed of trauma knowledge and trauma-informed parenting?

Hypothesis(es)

H1: There is a statistically significant difference between pretest and posttest scores on the Resource Parents Knowledge and Beliefs Survey (RPKBS) after the experimental group has completed the four modules of Trauma Systems Therapy for Foster Care (TST-FC). The experimental group reported higher scores as measured by the RPKBS Survey. The control group has no significant change in scores in the Belief Survey from pretest to posttest.

H2: There is a statistically significant difference between pretest and posttest scores for parental satisfaction on the Parent Satisfaction scale as the scores for the experimental group increase. The scores for the control group see no significant difference from pretest to posttest.

H3: There is a statistically significant difference between pretest and posttest scores for the tolerance of misbehavior of foster children as measured by the subscale on the Resource Parents Knowledge and Beliefs Survey.

Participants and Setting

The researcher had access to a pool of foster parents in one large agency with approximately 191 families. This agency covers six offices within the northeast, central, and southwest parts of Pennsylvania and services 10 of the 67 counties in the state. This covers a geographical area representing 20.4% of the square miles of Pennsylvania. This area includes cities, suburban and rural areas. The diversity of the population in these 10 counties is 85% Caucasian, 8% African American, 2% Hispanic, 2.6% Asian, .19% American Indian/Alaska Native, and 1.95% multiracial. This compares closely with the diversity of Pennsylvania; 75.7% Caucasian, 12% African American, 7.8% Hispanic, 3.8% Asian, .40% American Indian/Alaska Native, and 2.1% multiracial (U.S. Census Bureau, n.d.)

The participants were drawn from a convenience sample from the six-office cluster of approved foster parents, either kinship or non-kinship. All foster parents have been trained and vetted to be a safe alternative resource for abused and/or neglected children. The initial training consists of orientation to guidelines and agency policies, child development, parenting techniques, foster children's descriptions, foster parent descriptions, grief and loss issues, attachment issues, sexual abuse issues, and resources. Kinship foster parents are adults the child knows as a relative or friend of the family. Foster parents are someone unfamiliar to the child. The process to be approved is the same for both foster and kinship foster parents. Participants were chosen from this pool of approved foster parents with the criteria of having not participated in any formal trauma training through an established curriculum. Participants were informed regarding the research study, including the requirements of attending the four modules of training, completing pretests and posttests, future trainings for the control after the conclusion of

the study, and confidentiality for all participants. The foster care agency provided a cash payment of $50 for each foster parent that completed all four modules of the TST-FC training.

The opportunity to participate in the TST training and this research study was offered on three occasions: April 2021 (35 participants), June 2021(11 participants), and October 2021 (24 participants). For this research study, the number of participants in the treatment group was 34. This represents the number of people who completed demographic information. The gender make-up of this sample was 35% male (*n*=12) and 65% female (*n*=22). Racial representation included 97% Caucasian (*n*=33) and 3% African American (*n*=1). No other races were represented. A large percentage of the foster parents are heterosexual (*n*=30) and a smaller portion identified as homosexual (*n*=4). The age range of participants was from 25 to 71 and the majority were aged between 41-50 years. The majority of the participants had less than five years of foster parenting experience (*n*=30). Two families had between two and 10 years of foster parenting experience. Two families had over 21 years of foster parenting experience. Five families had fostered between 11-20 foster children and 29 families had 10 or less foster children. The division between kinship and non-kinship was eight kinship and 26 non-kinship foster parents. The family income was below $55,000 for the majority of the foster parents (*n*= 25). Nine foster parents' income was above $56,000. Geographically, all six offices were represented with the majority living in a borough (*n*=24) and the remainder in a township (*n*=8) and in a city (*n*=2).

The control group comprised of 36 participants that were sent the pre and post-tests. Racial representation only included 97% Caucasian (*n*=35) and 3% African American (*n*=1). No other races were represented. All of the foster parents in the control group were heterosexual (*n*=36). The age range of participants was from 31 to 77. The majority landing in the range of 41-

50. The majority of the participants had less than five years of foster parenting experience (n=28). Eight families had between two and 17 years of foster parenting experience. Three families had fostered between 15-18 foster children and 33 families had five or less foster children. The division between kinship and non-kinship was 12 kinship and 24 non-kinship foster parents. The family income was above $56,000 for the majority of the foster parents (n= 23). Foster parents' income below $56,000 was 13. Geographically, only two offices were represented with an even distribution living in a borough (*n*=12), township (*n*=10), and in a city (*n*=14).

Formal trauma training was defined as a specific training curriculum devoted to the topics of trauma information, trauma-informed care, or trauma-informed parenting administered within four modules. Within the training curriculum, 13 tools were presented to help foster parents understand trauma's effects on the foster children, identify triggers, identify emotional dysregulation, plans to help, and self-care for the foster parents. The Child I care About Worksheet helps the foster parent identify the foster child's traumas and make the connection to the behaviors that could be happening in the 4 R behavioral stages; Regulating, Revving, Re-experiencing, and Reconstituting. Family Emergency Information Form provides information needed in a crisis for on-call social workers, school resource officers, local mental health crisis centers, family, and friends. Moment By Moment assessments are used by the foster parents, teachers, coaches, and other adults to identify a child's episode of dysregulation by triggers, behaviors, and calming period. Several of these assessments can shed light on a pattern for the child. Helping a Child Build Self-Control is an exercise to break down the parts of the problem, everyone's strengths, and any emotions that could derail the progress. Managing Emotions Guide (MEG) helps the child and parent examine what he is thinking, doing, and feeling during the four

Rs to build awareness of the emotions being experienced. Meltdown Moments is a tool to help the child label and scale feelings. The Pre-Teaching Worksheet helps to lay out a short plan of expectations between the parent and child before known problem situations such as school, grocery store, or any unstructured time. The Revving Worksheet is used to identify the components of the revving episode to identify and prevent in the future. Avoiding Power Struggles helps the parent to identify times and triggers for their engagement in power struggles with their child and how to prevent them in the future. Centering Plans is a tool to help the child label triggers, body signs, and feelings during an episode and ways to center themselves. Priority Challenge Worksheet is an opportunity to take a more detailed approach to identify triggers, feelings, and behaviors of the child. Practicing Emotional Regulation and Problem-Solving Skills provided specific skills in breathing, mindfulness, and muscle relaxation to help families with emotional regulation skills. The last tool, Self-Care Assessment Plans, is to help foster parents realize the importance of taking care of themselves in working with foster children that have trauma.

The recruitment of this participant pool relied on a convenience sampling method (Sedgwick, 2013). This researcher works for a large foster care agency in Pennsylvania. There are currently 191 foster and kinship families approved through this agency and represent the pool of potential participants. These 191 foster parents were offered training in TST-FC on three separate occasions in 2021 via letter outlining the training and research study. The willing candidates were divided into two groups, the experimental group and the control group. The experimental group was offered the training in April 2021, June 2021, and October 2021. The control group was offered the training after the research was completed after the four sessions of TST-FC and post-tests were received.

A team of trainers from the foster care agency conducted the trainings. A survey was administered before the training to capture the demographics of the participants. The survey included demographics and questions regarding their foster placements and the outcomes. Samples of the survey questions are included in the appendix. Once all demographic information was received, the names associated with the information were discarded to protect the participants' identities. The demographics of the sample were aged between 21 and 65 years. Race was largely Caucasian, some African American, and a few Hispanic foster parents. Marital status was married, single, divorced, or co-habitation. Sexual orientation was either heterosexual or homosexual. Equal opportunity for female or male participants with no candidates for transgender. The educational experience was no GED or high school diploma, GED, high school diploma, trade school, or college degree. Religious affiliation was Christian, Muslim, or no affiliation. The geographic location for the foster parents was six areas throughout Pennsylvania with some urban representation, but mostly suburban and rural areas. While Pittsburgh is partially represented, Philadelphia and Harrisburg were not embodied. Economically, foster parents' income can range from lower middle class to upper class.

Instrumentation

The Resource Parents Knowledge and Beliefs Survey (RPKBS; Sullivan et al., 2015) was developed to help record the beliefs and knowledge of resource parents (foster, kinship, and adoptive parents) through three separate scales within the survey. The RPKBS is a 33-item survey scored on a 6-point Likert scale of strongly disagree, disagree, slightly disagree, slightly agree, agree, and strongly agree. This survey was given as a pretest and posttest to the participants. The three scales within the survey have adequate psychometric properties. They are Trauma-Informed Parenting (TIP), The Tolerance of Misbehavior (TOM), and Parenting efficacy

(EFF). Several other studies have utilized this survey as a measure in determining parent trauma knowledge, tolerance for behaviors, and confidence in parenting as trauma-informed care curriculums were researched (Bartlett & Rushovich, 2018; Lotty et al., 2020; Murray et al., 2019; Sullivan et al., 2015).

The Trauma-Informed Parenting (TIP) scale was initially developed to assess a foster parent's knowledge and beliefs regarding parenting a child with the experience of trauma (Murray et al., 2019). Sullivan et al. (2015) were unable to find a measure to help assess this construct in the newly developed Resource Parent Curriculum (RPC; Sullivan et al., 2015) and created this measure to meet this need. This scale has 24 items and demonstrated adequate internal consistency (Murray et al., 2019).

The next scale within the RPKBS is the Tolerance of Misbehavior (TOM) scale. There are four items on this scale to assess the disposition of foster parents to parent a child with intensive behaviors resulting from traumatic experiences (Murray et al., 2019). The importance of this scale helps to assess the difficulty in managing these types of behaviors (sexual behaviors, aggressive behavior, lying, hoarding, etc.) that can lead to foster parents' request for a foster child's removal from their home and create placement instability for the child. This scale was adapted from *Casey Foster Applicant Inventory-Applicant Version* (Orme et al., 2007).

The last scale within the RPKBS is the Parenting Efficacy (EFF) scale and it consists of five items. The items were taken from an adapted version of the Parenting Self-Agency Measure (PSAM; Dumka, Stoerzinger et al., 1996). This scale measured the confidence level in parenting children with traumatic experiences.

The Kansas Parent Satisfaction Scale (KPS) was also utilized to measure parental satisfaction (James et al., 1985) in their child's behaviors, parenting ability, and relationship with

their child(ren). This measure was given pretest and posttest to compare scores. There are three items rated with a 7-point Likert scale of 1 (extremely dissatisfied), 2 (very dissatisfied), 3 (somewhat dissatisfied), 4 (mixed), 5 (somewhat satisfied), 6 (very satisfied), and 7 (extremely satisfied). This scale was found to be utilized in several studies evaluating single parents' satisfaction (Hand et al., 2013; Yopp et al., 2015).

Procedures

Prospective foster parent subjects were informed by a letter regarding the purpose and details of the research study. They were asked to complete a demographic survey and two measures, both completed at pretest (prior to training) and posttest (after training completion). Participants were informed of the process of utilizing anonymous surveys to protect their identity and keep that confidential and their rights to opt-out at any time (Heppner et al., 2016). Participants were then placed into an experimental group to receive the training and a control group to receive the training after the study is completed. Foster families who did not opt to take the training were also included in the control group and sent the surveys and research information.

Pretests for RPKBS and KPS were administered to the experimental and control groups prior to the training commencing. The training times were varied and offered in the evenings (Tuesday and Thursday) and on Saturday mornings. This varied training schedule provided opportunities for increased participation. Each of the four modules took two and a half to three hours to complete and they were presented for four consecutive weeks. Each module was offered twice within the week, giving the participants a choice that fits the best in their schedule. After the last module, the posttests for RPKBS and KPSS were administered. Staff located in the six

offices helped to distribute and receive the pretests and posttests for the two test groups. The scores were entered into an Excel spreadsheet obtained for RPKBS.

Data Analysis

The initial step was to complete preliminary data screening to determine if the sample is viable for further analysis (Heppner et al., 2016). Data were examined to determine the level of missing data. Missing non-random data (MAR) at 10% or less were considered to be non-consequential and not adversely affect the viability of the data set (Dong & Peng, 2013). The initial analysis included comparing the mean, standard deviation, and variance for each group, as well as a histogram and box plot to determine the viability of data from each group and how the data matches with assumptions made (Warner, 2013). The histogram provides a look at the normality of the distribution curve. The box plots help to determine any outliers.

Once the determination of the data was made, the independent samples *t*-test were used to compare the two groups along their scores in Trauma-Informed Parenting, Tolerance of Misbehavior, Parenting Efficacy, and Parental Satisfaction. The one-way ANOVA can be used to compare the individual pretest scores to the posttest scores when there are differences in the initial scores (Lotty et al., 2020; Warner, 2013).

Summary

With the lack of research on the trauma-informed curriculum for foster parents and specifically the TST-FC curriculum, this research design aimed to further the study into this aspect of preparing foster parents for their task to care for traumatized children. A quasi-experimental approach was selected to train specific foster parents within one large agency in Pennsylvania. The sample was derived from the agency's six-office cluster, spread out through a large section of the state with an effort to select a diverse sampling of age, gender, race/ethnicity,

and socioeconomic status to represent the general population. The measures were selected for their specific topics of testing and use with other trauma-informed research studies in the last decade. An experimental and control group was formed to examine their pretest and posttest scores with *t*-test and ANOVA data analysis processes. The processed data were interpreted and compared to the stated hypotheses of the research study.

CHAPTER FOUR: FINDINGS

Overview

This section provides a deeper examination of the data collected in correspondence to the three hypotheses purposed in this research study on the presentation of four sessions of the Trauma Systems Therapy for Foster Care (TST-FC) and its outcomes. A comprehensive approach is presented in the areas of preliminary data screening, inferential statistics, and the interpretation of the data as it related to the research questions. Graphs and figures are utilized to better present the concepts and accurately portray the data in its entirety. Finally, determinations on the outcome of the hypotheses are made.

Descriptive Statistics

All data analysis were completed with the use of IBM SPSS Statistics, version 27. Comparisons were made on the means between pre-tests and post-tests for the three subscales of the RPKBS (TIP, TOM, and EFF). Comparisons were also made regarding the means of these subscales between the treatment and control groups. The same comparisons were made regarding the second measure, Kansas Parent Satisfaction Scale (KPS). The descriptive statistics for the RPKBS subscales are listed in Table 1. Descriptive statistics for KPS are found in Table 2.

Table 1

Descriptive Statistics for the RPKBS Subscales

Report

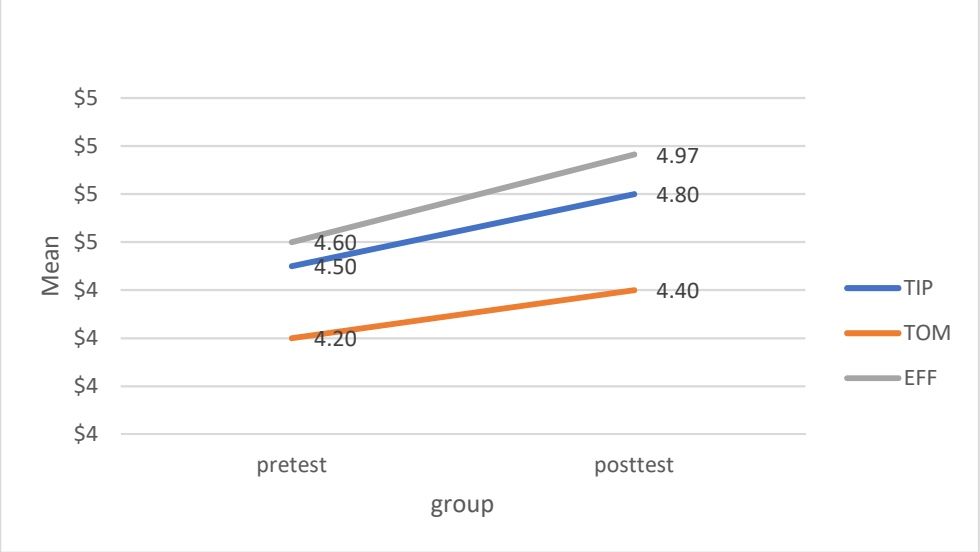
group		pretip	pretom	preeff	posttip	posttom	posteff
treatment	Mean	4.5000	4.2000	4.6000	4.8000	4.4000	4.9650
	N	10	10	10	10	10	10
	Std. Deviation	.52705	.91894	.47140	.78881	.84327	.70948
control	Mean	4.3333	3.8333	4.4333	4.5000	5.0000	4.8333
	N	6	6	6	6	6	6
	Std. Deviation	.51640	.98319	.46332	.54772	.63246	.61210
Total	Mean	4.4375	4.0625	4.5375	4.6875	4.6250	4.9156
	N	16	16	16	16	16	16
	Std. Deviation	.51235	.92871	.46025	.70415	.80623	.65669

TIP= Trauma-informed Parenting; TOM= Tolerance of Misbehavior; EFF=Parenting Efficacy.

The Means of the posttests for the treatment group increased from the Means of the pretest in all three subscales as illustrated in figure 1.

Figure 1

Means of Pretests and Posttests of TIP, TOM, and EFF for Treatment Group



In Figure 2, the Means of the posttests had a different outcome in the control group. EFF and TIP Means had a slight increase from the pretest to the posttest. The TOM Mean had a more significant increase from the pretest to the posttest.

Figure 2

Means of Pretests and Posttests of TIP, TOM, and EFF for Control Group

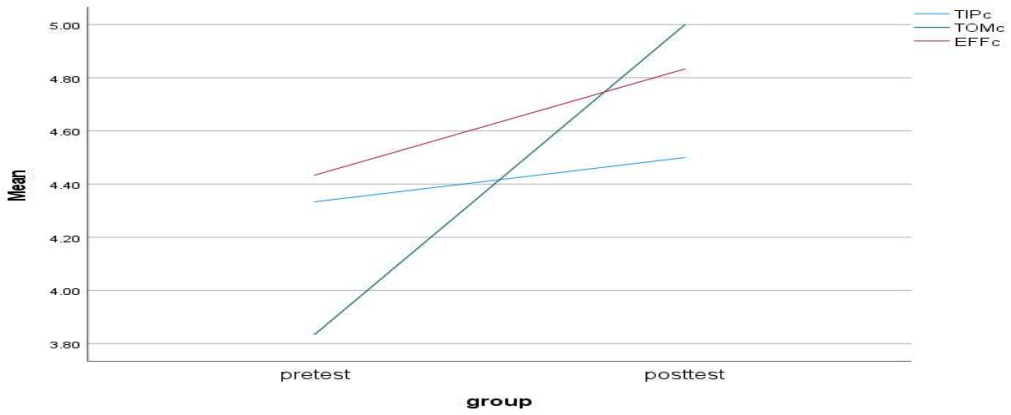


Table 2

Descriptive Statistics for KPS

Report

group		pre1	pre2	pre3	post1	post2	post3
treatment	Mean	4.9000	5.2000	5.9000	5.2000	5.5000	5.7000
	N	10	10	10	10	10	10
	Std. Deviation	1.19722	.91894	.87560	1.22927	1.08012	1.33749
control	Mean	4.6667	5.0000	5.6667	4.8333	5.3333	5.8333
	N	6	6	6	6	6	6
	Std. Deviation	1.36626	1.09545	.81650	1.60208	1.21106	.75277
Total	Mean	4.8125	5.1250	5.8125	5.0625	5.4375	5.7500
	N	16	16	16	16	16	16
	Std. Deviation	1.22304	.95743	.83417	1.34009	1.09354	1.12546

The Mean scores for the three questions from the KPS are illustrated in Figure 3 to show the difference between pretests and posttests in the treatment group as minor differences with a slight decrease in question 3 and very slight increases for the other two questions. The control

group Means between the pretests and posttests are found in Figure 4. There are nominal increases for all three questions.

Figure 3

Means of Pretests and Posttests of KPS for Treatment Group

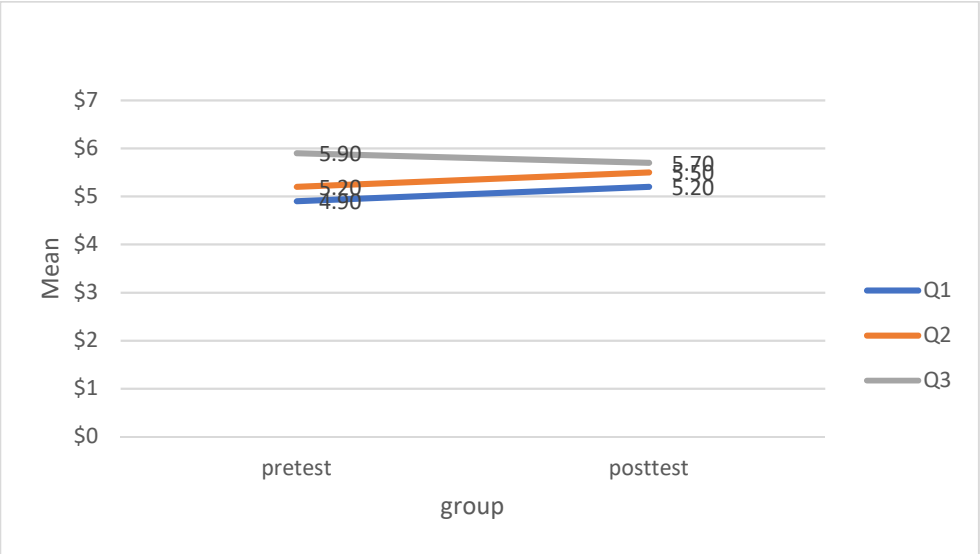
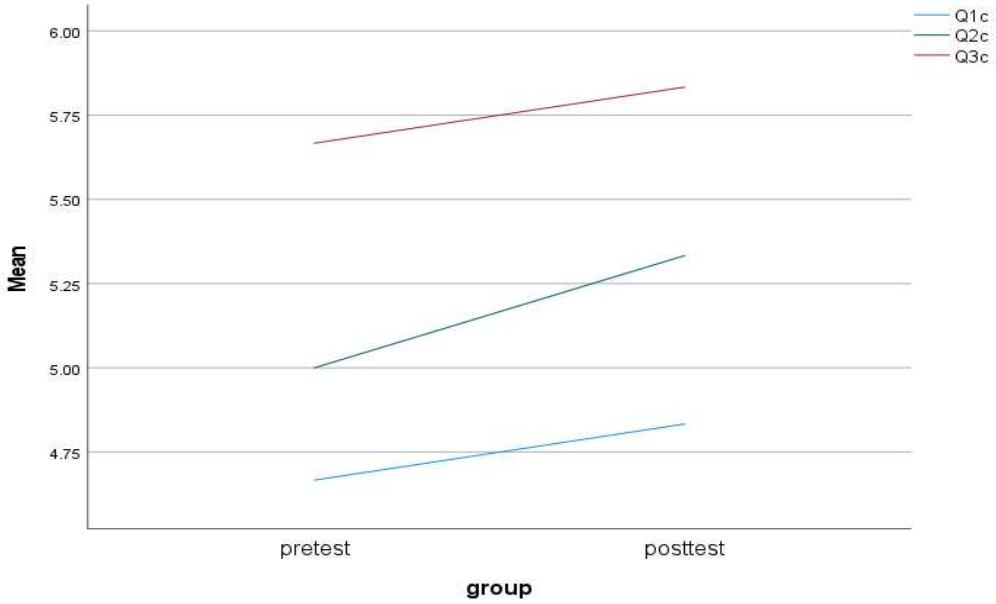


Figure 4

Means of Pretests and Posttests of KPS for Control Group



Results

Hypotheses

H1: There is a statistically significant difference between pretest and posttest scores on the Resource Parents Knowledge and Beliefs Survey (RPKBS) after the experimental group has completed the four modules of Trauma Systems Therapy for Foster Care (TST-FC). The experimental group reported higher scores as measured by the RPKBS Survey. The control group has no significant change in scores in the Belief Survey from pretest to posttest.

Data analysis included preliminary data screening and two inferential statistics. The one-way ANOVA was utilized to compare the pretest scores to the posttest scores for any difference for both groups. The independent samples *t*-test was utilized to compare the two groups along their scores in TIP, TOM, and EFF. There was only one data point missing from all the data. It was determined to place a zero for that data point instead of eliminating the entire data set from that participant. An assumption was made that the participant missed that question and a zero provides no additional computational value to the outcome (Warner, 2013). Histograms were computed for the three subscales in both groups. The histograms for pre-TIP-treatment and post-EFF-treatment had the most normal distribution. Pre-EFF-treatment and post-TIP-treatment histograms were showing a positive skewness. Whereas, a negative skewness was seen in the histograms of pre-TOM-treatment and post-TOM-treatment. The histograms in the control had normal distributions in four of the six; pre-TOM-control, pre-EFF-control, post-TIP-control, and post-TOM-control. A positive skewness was shown in the histograms of pre-TIP-control and post-EFF-control.

Boxplots were completed for the three subscales in both groups. Most of these looked appropriate with no outliers. In the pre-TOM scale, there was one low outlier for the treatment

group and 11 low outliers for the control group. The post-EFF-treatment boxplot showed high and low outliers. As part of the independent *t*-test, the Levene test for homogeneity of variance was used to examine whether there were serious violations of the homogeneity of variance assumption across groups, but no significant violations were found. All values for F and the associated significance (p) values were higher than .05. This confirmed no problems with assumptions.

A one-way between S-ANOVA was done to compare the mean scores on pretests and posttests for the subscale groups (TIP, TOM, and EFF). In the subscale of TIP for the treatment group, $F(1,19) = 1.000$, $p = .331$, and the effect size was .053. For TIP in the control group, $F(1,11) = .294$, $p = .599$, and the effect size was .029. There appeared to be a slight significant difference between the pretests and posttests for the treatment group. There was a slight significant difference in the pretests and posttests for the control group.

For the TOM scale for the treatment group, $F(1,19) = .257$, $p = .618$, and the effect size is .014. Comparing it to the TOM for the control group, between S- ANOVA is $F(1,11) = 5.976$, $p = .035$, and the effect size was .374. In this scale, there appeared to be more significance in the control group scores than the treatment group scores. In the last scale of EFF, the treatment groups scores were $F(1,19) = 1.836$, $p = .192$, and the effect size was .093. For the control group EFF scale, $F(1,11) = 1.629$, $p = .231$, and the effect size was .141. Greater significance is evident in the control EFF scores compared to the treatment EFF scores.

The results of the S-ANOVA tests showed a slight significance in the difference between the pretests of the treatment group to the posttests for the treatment group. As was expected, there were no differences for the control in the TIP and EFF subscales. However, the TOM scale showed a greater difference and, thus, supported the failure to reject the null hypothesis.

An independent samples *t*-test was performed to access whether the mean of the subscales (TIP, TOM, and EFF) differed significantly between the treatment and control groups. The data from these tests for the six subscales are below in Table 3.

Table 3

Results of Independent Sample t-tests

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
pretip	Equal variances assumed	1.094	.313	.617	14	.547	.16667	.27021	-.41289	.74622
	Equal variances not assumed			.620	10.849	.548	.16667	.26874	-.42584	.75917
pretom	Equal variances assumed	.007	.934	.753	14	.464	.36667	.48665	-.67709	1.41042
	Equal variances not assumed			.740	10.077	.476	.36667	.49554	-.73631	1.46965
preeff	Equal variances assumed	.042	.841	.689	14	.502	.16667	.24195	-.35226	.68560
	Equal variances not assumed			.692	10.821	.503	.16667	.24083	-.36447	.69781
posttip	Equal variances assumed	.684	.422	.816	14	.428	.30000	.36775	-.48874	1.08874
	Equal variances not assumed			.896	13.539	.386	.30000	.33500	-.42080	1.02080
posttom	Equal variances assumed	3.079	.101	-1.500	14	.156	-.60000	.40000	-1.45791	.25791
	Equal variances not assumed			-1.616	13.085	.130	-.60000	.37118	-1.40137	.20137
posteff	Equal variances assumed	.000	.986	.377	14	.712	.13167	.34925	-.61739	.88073
	Equal variances not assumed			.392	11.984	.702	.13167	.33583	-.60015	.86348

Table 4

Means of Subscales in the Treatment and Control Groups

Report

group		pretip	pretom	preeff	posttip	posttom	posteff
treatment	Mean	4.5000	4.2000	4.6000	4.8000	4.4000	4.9650
	N	10	10	10	10	10	10
	Std. Deviation	.52705	.91894	.47140	.78881	.84327	.70948
	Minimum	4.00	2.00	4.00	4.00	3.00	3.25
	Maximum	5.00	5.00	5.40	6.00	5.00	6.00
	Std. Error of Mean	.16667	.29059	.14907	.24944	.26667	.22436
control	Mean	4.3333	3.8333	4.4333	4.5000	5.0000	4.8333
	N	6	6	6	6	6	6
	Std. Deviation	.51640	.98319	.46332	.54772	.63246	.61210
	Minimum	4.00	2.00	4.00	4.00	4.00	4.00
	Maximum	5.00	5.00	5.00	5.00	6.00	5.80
	Std. Error of Mean	.21082	.40139	.18915	.22361	.25820	.24989
Total	Mean	4.4375	4.0625	4.5375	4.6875	4.6250	4.9156
	N	16	16	16	16	16	16
	Std. Deviation	.51235	.92871	.46025	.70415	.80623	.65669
	Minimum	4.00	2.00	4.00	4.00	3.00	3.25
	Maximum	5.00	5.00	5.40	6.00	6.00	6.00
	Std. Error of Mean	.12809	.23218	.11506	.17604	.20156	.16417

Table 5

Effect Sizes of the Subscales

Subscale	Pre TIP	Pre TOM	Pre EFF	Post TIP	Post TOM	Post EFF
Effect size	.03	.04	.03	.05	.14	.01

The mean scores for the pretests and posttests between the treatment and control groups did not differ significantly as shown in Table 4. There was a slight increase in means from the

pretests to the posttests in the treatment group. In contrast, the control group showed means decreasing slightly or remaining fairly the same between the pretests and posttests. In the *t*-tests, the effect size as index by *eta square* was calculated with the formula of t squared divided by t squared plus df. These data points were very low in all the pretests comparisons and that was to be expected. There were also some very small significances in all the posttest subscales. This study suggests that there is not any significant difference between the treatment group (TST-FC training) and the control group in the areas of trauma-informed parenting, tolerance of misbehavior, and parent efficacy. Therefore, failure to reject the null hypothesis was the assumed result.

H2: There is a statistically significant difference between pretest and posttest scores for parental satisfaction on the Kansas Parent Satisfaction Scale (KPSS) as the scores for the experimental group increase. The scores for the control group have no significant difference from pretest to posttest.

Data analysis included preliminary data screening and two inferential statistics. The one-way ANOVA was utilized to compare the pretest scores to the posttest scores for any difference for both groups. The independent sample t-test was utilized to compare the two groups along their scores in the three questions on the KPS. There were no missing data points from all the data. Histograms were computed for the three subscales in both groups. The histograms for the 12 subsets (six for the treatment group and six for the control group) were split evenly on showing a normal distribution or negative skewness. Those with a normal distribution were Pre1T, Pre3T, Post1T, Post2T, Post2c, and Post3c. The remaining six (Pre2T, Pst2T, Pre1c, Pre2c, Pre3c, and Post1c) were all showing slight negative skewness.

Boxplots were completed for the three subsets (Q1, Q2, and Q3) in both groups. Most of these looked appropriate with no outliers. The only subset, PreQ2, had outliers for both the treatment and control groups. Both of these incidents of outliers were low. As part of the independent *t*-test, the Levene test for homogeneity of variance was used to examine whether there were serious violations of the homogeneity of variance assumption across groups, but no significant violations were found. All values for F and the associated significance (p) values were higher than .05. This confirms no problems with assumptions.

A one-way between S-ANOVA was done to compare the mean scores on pretests and posttests for the subscale groups (Q1, Q2, and Q3). In the subscale of Q1 for the treatment group, $F(1,19) = .306$, $p = .587$, and the effect size was .017. For Q1 in the control group, $F(1,11) = .038$, $p = .850$, and the effect size was .004. There appeared to be no significant difference between the pretests and posttests for the treatment group. There was no significant difference in the pretests and posttests for the control group.

For the Q2 scale for the treatment group, $F(1,19) = .448$, $p = .512$, and the effect size was .024. Comparing it to the Q2 for the control group, between S-ANOVA was $F(1,11) = .250$, $p = .628$, and the effect size was .024. In this scale, there were no differences in the pretests and posttests of any significance.

In the last scale of Q3, the treatment groups scores were $F(1,18) = .157$, $p = .697$, and the effect size was .009. For the control group Q3 scale, $F(1,11) = .135$, $p = .721$, and the effect size was .013. No significant difference was evident in the treatment EFF scores or the control EFF scores.

Results of the S-ANOVA tests determined no significant difference in the pretests and posttest for the KPS. This evidence supports the failure to reject the null hypothesis.

An independent samples *t*-test was performed to access whether the mean of the subsets (Q1, Q2, and Q3) differed significantly between the treatment and control groups. The data from these tests for the six subscales are below in Table 6.

Table 6

Independent Samples t-test for the Means of Q1, Q2, and Q3 in Both Groups

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
pre1	Equal variances assumed	.043	.838	.359	14	.725	.23333	.65076	-1.16241	1.62908
	Equal variances not assumed			.346	9.543	.737	.23333	.67412	-1.27852	1.74518
pre2	Equal variances assumed	.005	.942	.393	14	.700	.20000	.50897	-.89163	1.29163
	Equal variances not assumed			.375	9.202	.716	.20000	.53333	-1.00245	1.40245
pre3	Equal variances assumed	.063	.806	.529	14	.605	.23333	.44150	-.71359	1.18025
	Equal variances not assumed			.538	11.293	.601	.23333	.43333	-.71741	1.18408
post1	Equal variances assumed	.347	.565	.517	14	.613	.36667	.70957	-1.15521	1.88855
	Equal variances not assumed			.482	8.563	.642	.36667	.76085	-1.36798	2.10131
post2	Equal variances assumed	.141	.713	.286	14	.779	.16667	.58282	-1.08336	1.41670
	Equal variances not assumed			.277	9.686	.787	.16667	.60093	-1.17819	1.51152
post3	Equal variances assumed	1.696	.214	-.222	14	.827	-.13333	.60053	-1.42134	1.15467
	Equal variances not assumed			-.255	13.992	.802	-.13333	.52281	-1.25472	.98805

Table 7

Means of Subsets in the Treatment and Control Groups

Group Statistics

	group	N	Mean	Std. Deviation	Std. Error Mean
pre1	treatment	10	4.9000	1.19722	.37859
	control	6	4.6667	1.36626	.55777
pre2	treatment	10	5.2000	.91894	.29059
	control	6	5.0000	1.09545	.44721
pre3	treatment	10	5.9000	.87560	.27689
	control	6	5.6667	.81650	.33333
post1	treatment	10	5.2000	1.22927	.38873
	control	6	4.8333	1.60208	.65405
post2	treatment	10	5.5000	1.08012	.34157
	control	6	5.3333	1.21106	.49441
post3	treatment	10	5.7000	1.33749	.42295
	control	6	5.8333	.75277	.30732

Table 8

Effect Sizes for the Questions

Subsets	Q1 pre	Q2 pre	Q3 pre	Q1 post	Q2 post	Q3 post
Effect size	.009	.011	.020	.019	.006	.004

The mean scores for the pretests and posttests between the treatment and control groups did not differ significantly as shown in Table 7. The effect size as index by eta square was very low in all the subsets. This study suggests that there is not any significant difference between the treatment group (TST-FC training) and the control group in three questions of the Kansas Parental Satisfaction Scale. Therefore, failure to reject the null hypothesis was the assumed result.

H3: There is a statistically significant difference between pretest and posttest scores for the tolerance of misbehavior of foster children as measured by the subscale on the Resource Parents Knowledge and Beliefs Survey.

Data analysis of the subscale TOM (Tolerance of Misbehavior) included preliminary data screening and two inferential statistics. The one-way ANOVA was utilized to compare the pretest scores to the posttest scores for any difference for both groups.

There were no missing data points for the TOM subscale. Histograms were computed for the TOM subscales in both groups. The histograms were completed for the TOM scales in both groups. A negative skewness was seen in the histograms of pre-TOM-treatment and post-TOM-treatment. The histograms in the control had normal distributions in pre-TOM-control and post-TOM-control. Boxplots were completed for the TOM subscales in both groups. In the pre-TOM scale, there was one low outlier for the treatment group and 11 low outliers for the control group.

As part of the independent *t*-test, the Levene test for homogeneity of variance was used to examine whether there were serious violations of the homogeneity of variance assumption across groups, but no significant violations were found. All values for F and the associated significance (p) values were higher than .05. This confirms no problems with assumptions.

A one-way between S-ANOVA was done to compare the mean scores on pretests and posttests for the TOM subscale groups. For the TOM scale for the treatment group, F (1,19) = .257, p = .618, and the effect size was .014. Comparing it to the TOM for the control group, between S-ANOVA was F (1,11) = 5.976, p = .035, and the effect size was .374. In this scale, there appeared to be more significance in the control group scores than the treatment group scores. Evidence presented supports the rejection of the null hypothesis.

Summary

Foster parent training is critical in the process of approving new foster parents and developing them to be confident in their parenting, be successful in their parenting efforts, and to provide secure stability for the foster children in their care. This type of training has evolved over the last 30 years from a basic course providing some information on the child welfare system, the process of removing a child from their birth home, and expectations as a foster parent to more advanced training in behavioral modification and trauma. The latter was chosen to be the focus of this research study through the curriculum of Trauma Systems Therapy for Foster Care (TST-FC).

Trauma is an event that every foster child experiences through neglect, abuse, and removal from their birth home. These traumatic events have affected the foster children's behaviors and the foster parents' ability to parent them effectively. Information on this topic is a top priority to dispense to foster parents early on in their journey of fostering. Trauma Systems Therapy for Foster Care was chosen to provide the needed trauma information and it included 13 tools that tie the theory into actual practical steps for the foster parents and foster case managers to utilize.

The research study was set up to examine trauma knowledge, tolerance of misbehavior, parent efficacy, and parent satisfaction through two measures: RPBS and KPSS. Pretests and posttests were given in each measure to two groups: treatment and control. Preliminary data screenings were completed through frequencies, histograms, and boxplots. One-way ANOVAs were performed to check for significance between the pretest and posttest groups. Independent samples *t*-test were conducted to check the significance between the treatment and control groups.

The results of this data analysis indicate no significant differences to report and thus, the outcomes do not support that the Trauma Systems Therapy for Foster care training made a significant difference in increasing the trauma knowledge in foster parents, increasing tolerance of the misbehavior of foster children by foster parents, or increasing the parenting efficacy in foster parents. Despite these results, the means of the treatment groups did increase slightly.

CHAPTER FIVE: CONCLUSIONS

Overview

The ability to discuss and explore the outcomes of this study as it compares to other similar research is a focal point in this section. The implication for society and foster care agencies is an important topic to further the purpose of social work and fight the challenge of having healthy families. Although research aims to be all-inclusive in its procedures and methods, there are always limitations that need to be stated and defined. This helps to refine further future research endeavors to get the momentum forward and meaningful.

Discussion

The purpose of this study was to measure the level of knowledge of trauma information, parental satisfaction, and tolerance for misbehaviors before and after the administration of the four modules of the TST-FC curriculum. That purpose was accomplished through the use of two measures, Resource Parent Knowledge and Beliefs Survey (RPKBS) and the Kansas Parent Satisfaction Scale (KPSS), that were administered to foster parents participating in a treatment group or control group over three time periods in 2021. The number of participants in those trainings totaled 69 and were all offered to participate in the study. Demographic surveys were returned by 34 participants and only 10 of those 34 returned pretests and posttests. There were 36 participants offered the opportunity to participate in the control group; 19 returned a pretest and 6 returned a posttest. This was a disappointing return despite many efforts to remind and resubmit the SurveyMonkey for responses.

RQ 1: Will foster parents' level of knowledge of trauma and its effects on children increase after completing all four training modules of the Trauma Systems Therapy for Foster Care?

There was some evidence of the level of trauma knowledge increase occurring with the minimum increase in the mean scores within this research study. Multiple foster parents verbally reported that it was good information and that they thought the training was valuable trauma knowledge. There is only one other research study found on the implementation of TST-FC and examining the outcomes of the training in increasing trauma knowledge for the foster parents. Bartlett and Rushovich (2018) also used the RPKBS measure and had positive results in all three subscales. They tested their participants before the training, after the training, and as a follow-up one month after the training. There was a significant increase in the scores from pretests to posttests. A slight decline was noticed during the one-month period.

With the decline in trauma knowledge seen in the follow-up, trauma could be a topic that needs multiple reviews and trainings to help the participants fully understand the concepts. This idea was reinforced by two studies. Booster trainings in trauma are important to reinforce the concepts and help develop a stronger understanding of the complex effects of the trauma (Redd et al., 2017). When researching competencies for foster parents, trauma was ranked the highest for additional trainings in helping to adequately parent the foster children (Patterson et al., 2018).

An area that needs further training as a result of this research is helping foster parents understand the trauma the birth parents may have experienced in addition to the foster children placed in their home. On the RPKBS, question #16 received many low scores. The question stated “when I think about my child’s birth mother, I feel sorry for her because I bet she had a bad childhood too.” There were 16 out of the 29 pretest respondents that scored that question slightly disagree to strongly disagree. For the posttests respondents, it was eight out of 16 that scored slightly disagree to strongly disagree. No other question had that large number of

disagreeing responses. The curriculum appears to not provide enough trauma knowledge related to the entire birth family and an area that needs more training for the foster parents.

RQ 2: Will Trauma Systems Therapy knowledge increase the confidence of the foster parents in their ability to parent their foster child(ren)?

Although no significant differences, there were increases in parental confidence and efficacy in the outcome data. Several parents enjoyed the tools that were a part of the curriculum. This gave them tangible options to help their foster children manage their behaviors as a result of their trauma. The Moment-by-Moment exercise helped to outline the behavioral episode from beginning to end. These sheets could be given to teachers, Scout leaders, and coaches to describe their experiences. All these incidents would help the foster parent and caseworker see a pattern in behaviors to deal with the behaviors more effectively preemptively. A couple of the foster parents reported feeling empowered by having the tools.

Trauma-informed practices were found to have a positive correlation between children's behavioral health needs and the satisfaction and commitment of foster parents (Barnett et al., 2019). One foster parents that was trained in this research study commented on how valuable the information presented in the training was and how helpful it would have been in parenting their birth child. Many of the other trainees were equally pleased with the information and could see the value the trauma information and techniques had and the need to incorporate it into their parenting.

The training seemed to be more relevant for the foster parents who currently had placements for a couple of reasons. They were able to relate with real-time examples within their foster children to what was being described in the training. Secondly, they had the opportunity to practice the tools shortly after the trainings to help reinforce the concepts taught better. All of

these situations help to increase parent confidence in parenting the trauma behaviors that are presented in their foster children.

RQ 3: Will foster parents be able to tolerate misbehaviors of a foster child with traumatic experiences after being informed of trauma knowledge and trauma-informed parenting?

The subscale for TOM had a slight increase in the mean from pretest to posttest for the control group. Foster parents tend to be more confident in their ability to handle any behaviors that they believe a foster child will present within their home. This was seen in more answers with fives and sixes to the questions associated with tolerance of misbehavior that were agree and strongly agree. However, this tolerance tends to decrease when an actual foster child resides in the foster parents' home and they experience behaviors from trauma firsthand. Placement disruption becomes a greater possibility with this lack of tolerance of the misbehavior.

There is more research on associations between externalizing behaviors and disruption of placements (Sattler et al., 2018). Increasing the foster parent's tolerance through trauma training can play a key role. Knowing the influence of a foster parent's knowledge on the placement stability of a foster child and how to maximize that in the training experience is important (Day et al., 2018). Findings shown in the Bartlett and Rushovich (2018) study that fewer foster parent homes with TST-FC were closing and fewer changes in placements were made in these homes as well.

Implications

This study did not further validate the outcomes of TST-FC training for the greater population. However, it made a large impact in bringing trauma-informed principles to an agency in Pennsylvania. The Pennsylvania governor had in recent years ordered that Pennsylvania become a trauma-informed state by 2029 (PA Council of Children, Youth &

Family Services, 2021) and this TST-FC curriculum helped to fulfill that requirement. This round of trainings have introduced the concepts of trauma, effects of trauma on foster children, tools to manage the behaviors, and the beginning of trauma-informed policies within the agency. Continued work needs to occur to reinforce the concepts with staff and foster parents and continue to have all the foster parents trained in TST-FC and versed in the tools.

Satan roams the earth to kill, steal, and destroy (John 10:10, NLT). His priority in his targeted attacks is the family unit. Destroy the family unit and society will fall apart. The goal of foster care is to provide a safe, healthy, trauma-informed environment for the foster child to heal while the birth family heals and makes changes. Every foster child experiences trauma on a range from a small amount to complex trauma depending on the child's circumstances. Christians do not always understand the extent of the evil in this world and would rather live in denial of the horrors of abuse and neglect of God's innocent children. Relationships are the number one tool for healing trauma. Relationships with a caring, trauma-informed Christian foster parent can fulfill that need and lead a foster child to the ultimate healing relationship with God, our Father.

Limitations

The agency staff were trained with great enthusiasm in February of 2020 with detailed plans to roll out the training of the foster parents in the coming months in the three regions in Pennsylvania. However, the worldwide pandemic with the spread of COVID-19 happened in March, 2020. Plans were put on hold and emergency measures to keep all staff, foster families, and foster children safe and alive were implemented. Families lost jobs and some became very ill. Thankfully, there were no deaths as a result of COVID-19 within the foster agency. The loss of income, sickness, scarce supplies, and quarantining took a mental toll on people. By the end of

2020, individuals were fairly proficient at completing work, school, court, and family visits via an electronic platform such as Zoom, Google Meet, Skype, DoxyME, or Microsoft Teams. The plan for training proceeded via Zoom sessions. This was cumbersome at the time with sharing screens and learning the tools and how to speak to an audience of screens. Despite these obstacles, three trainings were successfully offered in 2021.

Forming the control and treatment groups did not prove to be as easy as hoped. Offering a cash incentive to completing the training helped to form the treatment group. There was no incentive for the control group and there was less willingness. After several attempts, a decent response was received for the pretests but not the posttests. Historical attempts to have foster parents complete a survey required the foster case managers to sit with them in their home and have them complete the survey and hand it back. This was not an acceptable research method as pressuring the foster parents to complete the surveys in the presence of their caseworkers. Trainings conducted in person would have the advantage of allowing the foster parents to complete the surveys at the end of the last session.

Recommendations for Future Research

The TST-FC curriculum comes with 13 tools that are reviewed as part of the training experience. Future studies could include the implementation of these tools and follow-up on the effectiveness of the tools in the areas of Tolerance of Misbehavior and Parent Efficacy. A qualitative experiment may be more appropriate to interview foster families after the training on their understanding of the tools. Several intervals could be explored at three months, six months, and one year to see how the foster family has utilized the tools and the outcome related to their parental confidence and children's behaviors and emotional management.

The subject of trauma is complex to understand and may require repeat trainings or booster trainings. The agency within this study decided to implement a short trauma video at the beginning of a family's journey to become a foster family. There are two small videos (23 minutes and 25 minutes) on trauma parenting that the families will need to view and complete the posttest for approval as a foster parent. Once approved, the new foster parents are required to complete the TST-FC trainings within the first six months. Hopefully, this repeated exposure to the information about trauma may help the concepts to be absorbed and become more second nature in thinking toward a foster child and their birth family. The research study could be formulated to test the three subscales after each of the three phases of trauma training and compare that data. This could allow the opportunity to perform a longitudinal study in regards to training foster parents within the first year of being approved. This approach can provide more significance data numbers to allow for more opportunity to experience positive results in the research. Once those families have been trained, the research can be extended to include their first year of a foster placement to analyze their ability to retain the knowledge of trauma and its effects along with the tools to help with the stability of the placement. This data could be compared to data from foster families who have not had the chance to be trauma trained in the material and tools.

Summary

Foster parent training is critical in the process of approving new foster parents and developing them to be confident in their parenting, be successful in their parenting efforts, and to provide secure stability for the foster children in their care. This type of training has evolved over the last 30 years from a basic course providing some information on the child welfare system, the process of removing a child from their birth home, and expectations as a foster parent

to more advanced training in behavioral modification and trauma. The latter was chosen to be the focus of this research study through the curriculum of Trauma Systems Therapy for Foster Care (TST-FC).

There were high expectations and hopes for implementing this curriculum and transforming the staff and foster parents within this agency into trauma-informed advocates for foster children. Notwithstanding the onslaught of COVID and all its obstacles, there was some success toward this goal a year later. The first two research questions; will foster parents' level of knowledge of trauma and its effects on children increase after completing all four training modules of the Trauma Systems Therapy for Foster Care? and will Trauma Systems Therapy knowledge increase the confidence of the foster parents in their ability to parent their foster child(ren)?, recorded some success through verbal accounts and minimal attainment through data outcomes. The third question, will foster parents be able to tolerate misbehaviors of a foster child with traumatic experiences after being informed of trauma knowledge and trauma-informed parenting?, did not show a positive outcome through the data and remains to be seen if it positively affects placement stability for the foster children.

The importance of this trauma work is evident within Pennsylvania with the governor's goal of becoming a trauma-informed state by 2029. That 10-year goal was established back in 2019 and it was a blessing that it was a time frame of 10 years. COVID derailed the efforts in this study by a year and many initiatives within the state for two years. Resuming many aspects of work life can help to focus on the future and the trauma work needed. As Pennsylvania moves forward with the task of becoming a trauma-informed state, it would be beneficial for all states in this country to adopt plans for training foster parents in trauma-related topics.

Suggestions for future research included examination of the tools within TST-FC and adding booster trainings to reinforce the concepts learned. The healing work in trauma is valuable to children and families and the vision to further the research cannot be lost or stalled if safe and permanent futures are to be attained for foster children.

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Appendix A:

Demographic Survey

1. Gender: M or F
2. Age: 21-30; 31-40; 41-50; 51-60; 61-70; 71-80
3. Race: African American, Caucasian, Hispanic, Asian, American Indian/Alaska Native, Multiracial.
4. Marital status: married, single, divorced, co-habitating
5. Sexual orientation: heterosexual, homosexual.
6. Education completed: GED high school diploma, trade school, undergraduate degree, graduate degree.
7. Religious affiliation: Catholic, Protestant, Christian, Muslim, Hinduism.
8. Years of experience for foster parenting: 0-5; 6-10; 11-15; 16-20; 21 or more.
9. Total number of children fostered: 1-10; 11-20; 21-30; 31-40; 41-50; 51 or more.
10. Number of disruptions: 1, 2, 3, 4, 5 or more
11. City, Borough, or Township.
12. Foster care office: Greensburg, Washington, Altoona, Huntingdon, Williamsport, Towanda.
13. Net income within home: $25,000-$40,000; $41,000-$55,000; $56,000-$70,000; $71,000 or more.
14. Kinship or non-kinship.

Appendix B:

Pre-Workshop Knowledge and Beliefs Survey

Removed to comply with copyright

Murray, K., Lent, M., Tunno, A., Chaplo, S., & Sullivan, K. (2014). Psychometric properties of the resource parent knowledge and beliefs survey. *(Unpublished manuscript). Center for the Child and Family Health, Durham, North Carolina, USA*.

Sullivan, K., Murray, K. Kane, N., & Ake, G. (2014). Resource parents knowledge and beliefs survey. *Center for Child & Family Health, Durham, NC*.

Removed to comply with copyright

Murray, K., Lent, M., Tunno, A., Chaplo, S., & Sullivan, K. (2014). Psychometric properties of the resource parent knowledge and beliefs survey. *(Unpublished manuscript). Center for the Child and Family Health, Durham, North Carolina, USA*.

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Appendix C:

KPS-Kansas Parent Satisfaction

Removed to comply with copyright

James, D.E., Schumm, W.R., Kennedy, C.E., & Grigsby, C.C. (1985). Characteristics of the kansas parental satisfaction scale among two samples of married parents. *Psychological Reports, 57*, 163-169.

Appendix D:

CITI Certificate

CITI PROGRAM

Completion Date 28-Jan-2018
Expiration Date 27-Jan-2021
Record ID 25926977

This is to certify that:

Laura Doran

Has completed the following CITI Program course:

Social & Behavioral Research - Basic/Refresher (Curriculum Group)
Social & Behavioral Researchers (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

Liberty University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wf6346ad3-3aa6-4e26-bbcb-b72eedf579d0-25926977

Appendix E:

Permission Request Letter

November 30, 2020

Robin Klimke
Director of Foster Care and Adoption
Adelphoi Village
[redacted]

Dear Ms. Klimke:

As a graduate student in the, Department of Community Care and Counseling, School of Behavioral Sciences at Liberty University. I am conducting research as part of the requirements for a doctorate degree. The title of my research project is Trauma Systems Therapy for Foster Care: Trauma Training for Foster Parents and the purpose of my research is to administer the Trauma Systems Therapy for Foster Care (TST-FC) curriculum to foster and kinship parents and to examine the effects of the TST-FC training within foster and kinship parents in the areas of trauma knowledge, parent satisfaction, and tolerance for misbehaviors.

I am writing to request your permission to utilize your foster parent/kinship list to recruit participants for my research.

Participants will be presented with informed consent information prior to participating. Taking part in this study is completely voluntary, and participants are welcome to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, please provide a signed statement on official letterhead indicating your approval. A permission letter document is attached for your convenience.]

Sincerely,

Laura Doran
Doctorate Candidate
Department of Community Care and Counseling
School of Behavioral Sciences
Liberty University

Appendix F:

Permission Granted Letter

December 5, 2020

Laura Doran
Doctoral Candidate
Liberty University
[redacted]

Dear Ms. Doran:

After careful review of your research proposal entitled Trauma Systems Therapy for Foster Care: Trauma Training for Foster Parents, we have decided to grant you permission to access our foster parent lists and invite them to participate in your study.

Check the following boxes, as applicable:

☐ [The requested data WILL BE STRIPPED of all identifying information before it is provided to the researcher.]

☐ [The requested data WILL NOT BE STRIPPED of identifying information before it is provided to the researcher.]

☐ [I/We are requesting a copy of the results upon study completion and/or publication.]

Sincerely,

Robin Klimke
Director of Foster Care and Adoption
Adelphoi Village

Appendix G:

Recruitment Letter

December 10, 2020

Name of individual or couple
Foster Parent
Adelphoi Village
[Address 1]
[Address 2]
[Address 3]

Dear [Recipient]:

As a graduate student in the School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctorate degree. The purpose of my research is to explore the effects or trauma training on foster parent's trauma knowledge, parenting confidence, and tolerance of misbehaviors, and I am writing to invite eligible participants to join my study.

Participants must be 21 years of age or older and an approved foster parent. Participants, if willing, will be asked to complete pretests, participate in a 4-module training via Zoom, and complete posttests. It should take approximately 11 hours to complete the procedures listed. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

In order to participate, please contact me at [redacted] or ldoran@liberty.edu to sign up and obtain more information.

A consent document is attached to this letter. The consent document contains additional information about my research. You do not need to sign and return the consent document in the provided envelope.

Sincerely,

Laura Doran
Doctorate Candidate/Researcher
[redacted]/ldoran@liberty.edu

Appendix H:

Short Form Consent to Participate in Research

SHORT FORM CONSENT TO PARTICIPATE IN RESEARCH

Trauma Systems Therapy for Foster Care: Trauma Training for Foster Parents
Laura Doran
Liberty University
Department of Community Care and Counseling/School of Behavioral Sciences

You are being asked to participate in a research study.

Before you agree, the investigator must tell you about (i) the purposes, procedures, and duration of the research; (ii) any procedures which are experimental; (iii) any reasonably foreseeable risks, discomforts, and benefits of the research; (iv) any potentially beneficial alternative procedures or treatments; and (v) how confidentiality will be maintained.

You may contact Laura Doran at [redacted] or ldoran@liberty.edu any time you have questions about the research. The researcher's faculty mentor is Dr. Boone Benton, and you may contact him/her at bbenton3@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd, Green Hall 1887, Lynchburg, VA 24515 or email at irb@liberty.edu.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop.

Signing this document means that the research study, including the above information, has been described to you orally, and that you voluntarily agree to participate.

_____

Signature of Participant Date

_____

Signature of Witness Date

Appendix I:

Consent Form

Consent

Title of the Project: Trauma Systems Therapy for Foster Care: Trauma Training for Foster Parents
Principal Investigator: Laura Doran, Doctoral Candidate, Department of Community Care and Counseling, School of Behavioral Sciences, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be 21 years of age or older, presently an approved foster parent or kinship parent in the state of Pennsylvania. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why is it being done?

The purpose of the study is to administer the Trauma Systems Therapy for Foster Care (TST-FC) curriculum to foster and kinship parents. Next to examine the effects of the TST-FC training within foster and kinship parents in the areas of trauma knowledge, parent satisfaction, and tolerance for misbehaviors.

What will happen if you take part in this study?

If you agree to be in this study, I would ask you to do the following things:

1. Communicate your intent to participate by emailing or calling Laura Doran at ldoran@liberty.edu or [redacted] by December 15, 2020.
2. Complete all pretests by January 4, 2020 and email to Laura Doran, ldoran@liberty.edu.
3. Upon completion of all four training modules, submit all posttests to Laura Doran, ldoran@liberty.edu.
4. Participants will be assigned the experimental or control group by the researcher to form homogenous groups.

How could you or others benefit from this study?

The direct benefits participants should expect to receive from taking part in this study are an increase trauma knowledge in understanding their foster child's trauma experiences. An increase in parenting skills in working with foster children with trauma will help the foster parent report

more confidence in parenting. An increase in knowledge and skills will help to increase the ability for foster parents to tolerate the misbehaviors of traumatized foster children.

Benefits to society include increasing the pool of trauma-informed foster parents to work with foster children. This increase in trained foster parents can help to provide more stability for foster children and increase the chances of successful outcomes for foster children.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

This researcher is a mandated reporter. Any disclosures resulting in child abuse, child neglect, elder abuse, or intent to harm self or others will be reported by this researcher to the state of Pennsylvania.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. Data collected from you may be shared for use in future research studies or with other researchers. If data collected from you is shared, any information that could identify you, if applicable, will be removed before the data is shared.

- Participant responses will be kept confidential through the use of codes.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Confidentiality cannot be guaranteed in group training settings. While discouraged, other members of the group may share what was discussed with persons outside of the group.

Does the researcher have any conflicts of interest?

The researcher serves as a program director at Adelphoi Village Foster Care and Adoption Services. To limit potential or perceived conflicts, an administrative assistant will ensure that all data is stripped of identifiers before the researcher receives it. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate in this study.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or Adelphoi Village. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Laura Doran. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted] and/or ldoran@liberty.edu. You may also contact the researcher's faculty sponsor, Dr. Boone Benton, at bbenton3@liberty.edu.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

_____

Printed Subject Name

_____

Signature & Date