

# Building a Trauma-Informed Foster Care System:

## Giving Foster Parents the Tools to Help Children Heal

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## **Abstract**

The Adverse Childhood Experiences Study, which shows a correlation between exposure to childhood adversity and negative health outcomes such as heart disease, cancer, and lower life expectancy, makes a compelling argument for why we need to pay attention to childhood trauma. Despite the fact that all children in foster care have had at least one adverse childhood experience, the emerging scientific body of knowledge on childhood trauma has not yet produced major changes in the policies and practices of state foster care systems. One of the reasons that key actors in state foster care systems have not yet acted on recent information about trauma is they lack concrete skills on how to use this information to help children. This thesis seeks to address the gap between information and action amongst foster parents, who spend the most time with children and therefore have many opportunities to use trauma information to help children heal.

Through a qualitative analysis of interviews with and survey responses from foster parents and staff at child welfare agencies in four counties in North Carolina, this study provides insight on the strengths and shortcomings of current foster parent training in North Carolina, essential skills foster parents need to work with children who have experienced trauma, and barriers to equipping foster parents with these tools. The results demonstrate that child welfare agencies in North Carolina must equip foster parents with a skill set of communication skills, sensory-based regulation strategies, and discipline techniques, and, above all, treat foster parents as critical actors in children's healing processes.

## **I. Introduction**

More than two decades ago, a four-year-old boy named Robert was placed in foster care because his mother's boyfriend punished him by putting his hands over the flames of a gas stove. Robert remained in foster care for more than seventeen years. While his social workers noted he had a bad temper, he grew up to be a kind-hearted young man. He finished high school and went to college. He wanted to be a social worker to help future generations of children in foster care. Robert left foster care when he turned twenty-one years old. Just a year later, he took his own life.

Robert took his own life almost fifteen years ago, and his social workers now see his suicide as a manifestation of the trauma that never stopped affecting him. According to the Substance Abuse and Mental Health Service Administration:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. ("Trauma," n.d.)

While Robert's social workers only focused on the physical manifestations of his trauma, his burnt hands, Robert's internal pain recurrently affected him. Social worker Gerald Mallon, reflecting on his past work with Robert, wishes he had known more about the impact of trauma-related events and trauma-related symptoms when he was in practice (Mallon, 2011). He wishes he had spent less time focusing on Robert's hands and more time focusing on his internal trauma.

More recently, in January 2017, fourteen-year-old Naika Venant hanged herself in the bathroom of a foster home in southeastern Florida. Naika had been in foster care for eight years and had moved between foster homes, group homes, and shelters more than a dozen times. According to a state report, Naika was, "failed by a foster care system that was unable to meet the needs of a severely traumatized child" (Phillips, 2017). Even though Robert was in foster care more than twenty years before Naika, their stories have chilling parallels. Naika's social

workers and therapists focused primarily on the visible symptoms of Naika's trauma, such as her destructive behavior in foster homes, but they failed to address the internal trauma that Naika endured from the abuse and neglect of her mother.

When Robert was in foster care, social workers did not know about trauma, but today, there is an emerging scientific body of knowledge on childhood trauma and its long-term effects. The Adverse Childhood Experiences Study shows a correlation between exposure to childhood adversity and negative health outcomes such as heart disease, cancer, and lower life expectancy. All children in foster care have had at least one adverse childhood experience, meaning that they are at an increased risk for negative health outcomes. *Given that there is now a scientific study that describes the impact of trauma-related events and trauma-related symptoms on children in foster care, why did Naika's social workers still fail to address Naika's deep, internal pain?*

The answer to this question appears to be the normative practice in systems of foster care in the U.S., managed by state agencies, places priority on the physical safety of children. The social and emotional well-being of children, while important, is not typically what social workers in child welfare services are trained to address or have the organizational capacity to address. The continued narrow focus of the foster care system failed Robert and Naika, and coupled with the Adverse Childhood Experiences Study, this shows focusing on the physical safety of children is not enough.

In the first part of this paper, I discuss how trauma-informed care can broaden the focus of the foster care system to include addressing the impacts of trauma so that children's social and emotional healing can begin, as well as why adopting a trauma-informed approach in the foster care system is imperative. Trauma-informed care is an approach that recognizes that people's behaviors are a direct result of coping with adverse experiences. In doing so, it takes measures to help people recover through policies, procedures and practices - such as reinterpreting "bad"

behaviors as consequences of trauma and increasing staff training on trauma theory. I begin by showing the seriousness of childhood trauma, and the consequences that people who experience it face later in life. Next, I show how trauma impacts children and families who interact with the foster care system, and ways current practices in the foster care system can add to the traumatic experiences of children. I then explore how these practices can be changed.

I note how, on the surface, the problems preventing social workers and foster parents from shifting their priorities from the physical safety of children to the social and emotional well-being of children appear to be the lack of training on how trauma affects children in foster care and the time constraints that social workers face due to high caseloads. The underlying challenge, however, is that social workers and foster parents must change their fundamental attitudes about children's behavior.

In the second part of this paper, I delve into this challenge, arguing that there is not only a need for social workers and foster parents to understand trauma information but also to have concrete skills on how to use this information to help children. Focusing on the population of foster parents in four counties in North Carolina, I answer the question: What concrete skills, informed by current findings on childhood trauma, do foster parents need to help children heal from past traumatic experiences? I conclude by making recommendations on how child welfare agencies can help give foster parents the tools they need to help children heal.

## **II. Part 1: Building a Trauma-Informed Foster Care System**

### **Part A: The Seriousness of Childhood Trauma and its Impact on Children and Youth in Foster Care**

In this section, I discuss the seriousness of childhood trauma and the resulting consequences faced later in life. To set the stage for my argument that a trauma-informed approach in the foster care system is of vital importance, I discuss the findings of the Adverse

Childhood Experiences Study, the impact of trauma on neurodevelopmental processes, and the issue of overmedication of children who have experienced trauma.

### ***The Adverse Childhood Experiences Study***

The Adverse Childhood Experiences Study (ACE Study), based at Kaiser Permanente's San Diego Health Appraisal Clinic, shows a correlation between exposure to childhood adversity and negative health outcomes such as heart disease, cancer, and lower life expectancy (Anda et al., 2006, 2007; Felitti et al., 1998). Adverse Childhood Experiences (ACEs) include abuse (emotional, physical, and sexual), witnessing domestic violence, growing up with substance abusing, mentally ill, or criminal household members, and parental separation or divorce. The number of ACEs a person has experienced is essentially a measure of cumulative traumatic stress during childhood (Anda et al., 2007). Given that, in most state systems of foster care, children are removed from their homes for abuse, neglect, or dependence, it is reasonable to conclude that all children in foster care have had at least one adverse childhood experience. Adverse childhood experiences also meet the definition of trauma according to the Substance Abuse and Mental Health Service Administration, which says that:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. ("Trauma," n.d.)

Therefore, adverse childhood experiences can also be referred to as traumatic experiences.

The ACE Study found a graded relationship between the number of categories of childhood adversity a person had been exposed to, referred to as a person's ACE score, and behavioral risk factors for the leading causes of death in adults, such as alcoholism, drug abuse, depression, anxiety, and suicide attempts (Anda et al., 2006, 2007; Felitti et al., 1998). These risk factors are associated with diseases such as ischemic heart disease, cancer, chronic lung disease, and liver disease, showing that adverse childhood experiences have an impact on adult health



status and causes of early death, which makes addressing the effects of ACEs before children reach adulthood imperative (Felitti et al., 1998). Researchers have also found a graded relationship between ACE score and utilization of psychotropic medications amongst younger, middle-aged, and older adults (Anda et al., 2007). This correlation shows that ACEs also have a significant economic cost, which serves as another compelling reason to address the psychological impacts of ACEs on foster children, especially when combined with the risks of using psychotropic medications and the increased possibility of early death.

### ***The Neurodevelopmental Impact of Childhood Trauma***

Supporting the ACE Study, psychology and neuroscience explain how childhood trauma impacts children's development. Bruce Perry, Senior Fellow at the ChildTrauma Academy, has done extensive work studying the neurobiological impact of childhood trauma and its implications on children's behaviors. According to Perry (2008), "Trauma, from a neurobiological perspective, is an experience or pattern of experiences which activate the stress response systems in such an extreme or prolonged fashion as to cause alterations in the regulation and functioning of these systems" (p. 2).

He concludes two major neuronal response patterns for children who have experienced trauma exist: the hyperarousal continuum and the dissociative continuum (Perry, 2008; Perry & Pollard, 1998; Perry, Pollard, Blakley, Baker, & Vigilante, 1995). The hyperarousal continuum, more commonly known as "fight or flight," refers to defensive responses. When children experience trauma, their brain reacts to feeling threatened through arousal, vigilance, and irritability. As a result, when children are exposed to reminders of the traumatic event in the future, or even when they think about or have dreams about the traumatic event, the previously aroused brain systems are reactivated, leading to motor hyperactivity, behavioral impulsivity, sleep problems, tachycardia, hypertension, and neuroendocrine abnormalities (Perry & Pollard,

1998; Perry, Pollard, Blakley, Baker, & Vigilante, 1995). The dissociative continuum refers to freeze mechanisms, meaning children exposed to traumatic events disengage from the external world (Perry & Pollard, 1998; Perry, Pollard, Blakley, Baker, & Vigilante, 1995). When children dissociate, they are essentially pretending they are far away from where the event is occurring, so they feel less threatened (Perry & Pollard, 1998). Recognizing both hyperarousal and dissociative behaviors as responses to trauma is important because, unless actions are taken to help children recover, traumatic experiences fundamentally change brain structures and distort cognitive development (Perry & Pollard, 1998; Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Therefore, child welfare workers and foster parents both recognizing these behaviors in foster children and attributing trauma as their root cause is crucial.

Additionally, Perry has found that, due to trauma, the higher parts of the brain develop abnormally, since the development of higher parts of the brain, which control cognitive and relational interactions, depends on the development of lower parts of the brain, which control self-regulation and motor activity (Perry, 2008, 2009; Perry & Pollard, 1998). According to Perry, interventions must start with the functions of the lower brain before addressing the functions of the higher brain (Perry, 2009). This key clinical implication of his findings on the impact of traumatic experiences on children's brain development also applies to children who are victims of neglect, another reason that children enter foster care.

### ***The Overmedication of Children Who Have Experienced Trauma***

Another reason it is important for child welfare workers and foster parents to understand the effects of trauma on children's brain development is that current psychiatric diagnoses often lead to the overtreatment or undertreatment of children who have experienced trauma (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Spinazzola, van der Kolk, & Ford, 2018; van der Kolk, 2005). D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk (2012)

argue, “No single current psychiatric diagnosis accounts for the cluster of symptoms that research has shown frequently to occur in children exposed to interpersonal trauma” (p. 188), asserting that the fourth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) puts them in the category of posttraumatic stress disorder (PTSD), but this category does not fully account for the range of symptoms. Bessel van der Kolk (2005) warns that diagnosing the symptoms of persistent childhood trauma as PTSD results in the application of treatments and interventions that are not helpful. Van der Kolk (2005) explains that this improper diagnosis results in the overmedication of children, stating:

Unfortunately, all too often, medications take the place of helping children acquire the skills necessary to deal with and master their uncomfortable physical sensations. To “process” their traumatic experiences, these children first need to develop a safe space where they can “look at” their traumas without repeating them and making them real once again. (p. 408)

Thus, it is crucial for child welfare workers and foster parents to recognize the problems in self-regulation, emotional reactivity, and impulse control that children experience due to past traumatic experiences and understand that medication is insufficient in their healing processes.

***How Trauma Impacts Children and Families that Interact with the Foster Care System & Ways That Current Practices in the Foster Care System Can Add to the Traumatic Experiences of Children***

As aforementioned, it is reasonable to conclude that all children in foster care have had at least one traumatic experience, and the stories of Robert and Naika make this reality especially clear. In addition to the trauma resulting from their initial placement in foster care, children are also affected by the ways that current practices in the foster care system can add to their traumatic experiences. Goldsmith, Martin, & Smith (2014) explain that trauma is more complex than extreme stressors and individual responses. They introduce “systemic trauma,” defined as, “the contextual features of environments and institutions that give rise to trauma, maintain it, and impact posttraumatic responses” (Goldsmith, Martin, & Smith, 2014, p. 118).

Showing how the abstract concept of “systemic trauma” pertains to the foster care system, Riebschleger, Day, & Damashek (2015) carried out a study that examined the testimony of 43 foster children to a panel of state legislators, child welfare professionals, and university educators to analyze how foster youth describe their trauma experiences before, during, and after foster care placement. The study found that youth in foster care do not experience stand-alone traumatic events but rather enduring and cumulative trauma (Riebschleger, Day, & Damashek, 2015). In general, the study found that the youth were critical of the system because it does not address, “what we’ve been through,” meaning the foster care system did not address their adverse childhood experiences, leading to subsequent behavioral problems (Riebschleger, Day, & Damashek, 2015).

A study by Chapin Hall shows the tragic effects of trauma on foster youth at age 17 (Courtney & Charles, 2015). Chapin Hall examined the prevalence of mental health and substance use problems of foster youth at age 17 using the Mini International Neuropsychiatric Interview for Children and Adolescents and assessed suicidal ideation and attempts amongst this population using the Composite International Diagnostic Interview (Courtney & Charles, 2015). After finding major depression and dysthymia, mania and hypomania, psychotic disorders, substance abuse and dependence, and alcohol dependence the most prevalent mental and behavioral health disorders, the study recommended child welfare agencies pay special attention to the needs of this population (Courtney & Charles, 2015). Moreover, over 30% of the youth said they do not believe the good things about the medication outweigh the bad (Courtney & Charles, 2015). This study shows how childhood trauma, comprehensively explained in the previous section, impacts the mental health outcomes of children and youth in the foster care system and why interventions beyond medication are needed to help children heal, as consistent with van der Kolk’s core argument (van der Kolk, 2005).

## **Part B: How These Practices Can Be Changed: Trauma-Informed Care**

In this section, I discuss how the current practices in the foster care system that add to the traumatic experiences of children can be changed. I discuss the Sanctuary Model, a systemic model of trauma-informed care in-depth because using it as a case study sheds light on the key challenges that human service delivery organizations face when trying to implement a trauma-informed approach to their work.

### ***Trauma-Informed Care: An Introduction***

A report by the Children's Bureau, an office under the United States Department of Health and Human Services' Administration for Children and Families, shows the child welfare system can become a place of healing that helps children recover from trauma with the knowledge of how to treat children with trauma histories and the hard work of building trauma-informed practice into the day-to-day work of the system (Children's Bureau, 2015). Trauma-informed care is an approach that recognizes that people's behaviors are a direct result of coping with adverse experiences, and it takes measures to help people recover through policies, procedures and practices - such as reinterpreting "bad" behaviors as consequences of trauma and increasing staff training on trauma theory. To implement trauma-informed practice in child welfare systems, the Children's Bureau recommends strategies such as reinterpreting behaviors exhibited by a "bad kid" as consequences of trauma, collaborating with other service systems, recognizing that trauma is intergenerational and that children's families have experienced their own trauma, acknowledging secondary trauma, and providing staff training that goes beyond single workshops (Children's Bureau, 2015). Several other studies reiterate this call for trauma-informed practice within the foster care system by highlighting the need for training on trauma for foster caregivers, strategies of supervision to help practitioners and organizations follow trauma-informed practice, and the use of trauma assessment tools to help professionals make

appropriate referral and treatment decisions (Agosti, Conradi, Halladay Goldman, & Langan, 2013; Berger & Quiros, 2014; Beyerlein & Bloch, 2014; Conradi et al., 2011; Igelman et al., 2007). An approach to integrating trauma-informed care into the foster care system is the Sanctuary Model.

### ***The Sanctuary Model***

*Restoring Sanctuary* introduces the Sanctuary Model, a specific model created by Sandra Bloom that uses trauma-informed care to make human service delivery organizations “sanctuaries,” or places where injured people can heal (Bloom & Farragher, 2013). The essence of the Sanctuary Model is that in order to become a trauma-informed organization, the practitioners within the organization must stop asking clients with severe behavioral issues, “What’s wrong with you?” and start asking, “What happened to you?” The clients are not bad people, but they are coping with adverse experiences and need help and support (Bloom & Farragher, 2013).

The Sanctuary Model also recognizes that when organizations come into contact with a large amount of trauma and fail to acknowledge the effects that this has on their own work, they themselves can become severely traumatized. Organizations that have experienced trauma can lose sight of their purpose and lack a clear and consistent service-delivery model (Bloom & Farragher, 2013). This proves true with the foster care system, which has come into contact with a severe amount of trauma. Over time, the tendency has been for it to lose a clear sense of purpose, which impacts the quality of its service delivery. The Sanctuary Model provides strategies on an organizational level that can help child welfare agencies fulfill their purposes of helping children heal from past traumatic experiences.

The Sanctuary Model was first implemented at Andrus Children’s Center in New York, a treatment, education, and research facility that provides services to vulnerable children and

families (Yanosy, 2011). After going through the implementation process, the organization observed many positive outcomes such as a decrease in physical restraints to control children who were acting out and a decrease in critical incidents, or incidents in which a person's physical safety is threatened (Yanosy, 2011). This report shows there are proven benefits of adopting a trauma-informed intervention strategy, such as the Sanctuary Model, at the organizational level.

### ***Resistance to Trauma-Informed Care***

The Sanctuary Model contains innovative strategies for integrating trauma-informed care at a systemic level, emphasizing change requires all actors involved in the child welfare system to change their daily procedures and practices. Bloom highlights that, although some people may agree change is necessary and work hard to alter their work habits, others will be reluctant to stray from their longstanding routines.

In her report for the Trauma Task Force in Philadelphia, PA, Sandra Bloom discusses barriers to using scientific research on childhood trauma to transform Philadelphia's mental health system (Bloom, 2006). Although her analysis should not be taken out of context, it still provides insight on barriers to transforming the child welfare system in a similar way, as it further explains "systemic trauma."<sup>1</sup> Bloom explains systems that are meant to help people who have undergone traumatic experiences can become traumatized themselves, or as mentioned previously, suffer from "systemic trauma"<sup>2</sup> (Bloom, 2006). These systems become chronically stressed, and, instead of solving problems carefully and thoughtfully, they revert to old ways of doing things. As a result, those who try to bring about change face social denial of the need for change, collective fear, and social resistance (Bloom, 2006). A trauma-informed approach can be adopted at a systemic level, but whether it is the mental health system or the child welfare

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<sup>1</sup> See p. 11

<sup>2</sup> See p. 11

system, people who want to bring about change must be prepared to face a great deal of pushback and resistance.

Therefore, understanding how trauma-informed care can broaden the focus of the foster care system requires analyzing why resistance to change persists. Specifically, my analysis will focus on social workers and foster parents, which are arguably the most important groups in state foster care systems because they directly interact with children.

On the surface, the problems that are preventing social workers and foster parents from shifting their priorities from the physical safety of children to the social and emotional well-being of children appear to be the lack of training on how trauma affects children in foster care and the time constraints that social workers face due to high caseloads. The underlying challenge, however, is that social workers and foster parents must change their fundamental attitudes about children's behavior. Usually, when children misbehave, they are punished so they learn they are accountable for their behavior and have a deterrent from acting out again. A trauma-informed perspective emphasizes that children in foster care cannot be held accountable for their behavior in the same way as other children. When children in foster care act out, social workers and foster parents must recognize the roots of their behavior are their past traumatic experiences. They cannot punish children and tell them that their behavior was unacceptable, but instead must show children how to deal with their trauma in more productive and acceptable ways. For example, foster parents could help children identify their triggers and help them develop techniques to manage triggers, such as deep breathing exercising, listening to music, or physical activity. After children act out, foster parents could have conversations with them to help them identify what set them off, furthering their ability to recognize and adapt their behavior. Strategies like these are trauma-informed because they do not punish children for behaving wrongly but acknowledge that the trauma they experience drives their current behavior.



### **III. Part 2: Giving Foster Parents the Tools to Help Children Heal**

Sandra Bloom, who developed the Sanctuary Model, identifies that building a trauma-informed system inevitably comes with social resistance from actors within the system who do not see the necessity of the hard work involved in changing their policies and practices (Bloom, 2006). In analyzing why this resistance to change persists, I identify the integral action-step for building a trauma-informed foster care system is that social workers and foster parents must change their fundamental attitudes about children's behavior. In other words, they must understand that children in foster care cannot be held accountable for their behavior in the same way as other children. To ground this understanding, we must acknowledge it is difficult to *tell* foster parents, who often do not have technical knowledge about trauma and its effects on children's brain development, to accept this seemingly abstract concept. Rather, it is essential to *show* foster parents that they can use this information to help children in a concrete way, which is the focus of this part of the paper.

#### **Part A: Trauma-Informed Care in the Child Welfare System: A Review of the Literature**

This aforementioned focus on foster parents, however, is not reflected in current literature. Rather, current literature regarding trauma-informed foster care focuses on the positive effects of incorporating trauma-informed care into state child welfare systems while also discussing systemic barriers to change. Additional themes in current literature are the increased use of evidence-based treatments for children and youth in foster care, engaging caregivers in children's healing processes, and including non-clinical staff and foster parents in trauma-informed interventions. Addressing current literature, I highlight a need for more research specifically on engaging foster parents as critical actors in children's healing processes.

### ***Statewide Initiatives: Positive Effects and Systemic Barriers to Change***

Evaluations of statewide initiatives to integrate trauma-informed care into state policies, procedures, and practices, specifically highlighting their positive effects, serve as the majority of the literature on trauma-informed care in state child welfare systems. For example, a 2016 evaluation of a statewide initiative in Connecticut evaluated changes in system readiness and capacity to deliver trauma-informed care using the *Trauma System Readiness Tool* (Lang, Campbell, Shanley, Crusto, & Connell, 2016). The study evaluated changes that took place in a 2-year period such as the implementation of trauma-informed pre-service or in-service training for the full child welfare workforce, efforts to address worker wellness and secondary traumatic stress, increased trauma screening, the creation of a workgroup to incorporate trauma-informed principles into policies and practices, and the increased use of evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy. The evaluation found significant improvements in trauma-informed knowledge, practice, and collaboration amongst actors in Connecticut's child welfare system (Lang, Campbell, Shanley, Crusto, & Connell, 2016). Similarly, the Massachusetts Child Trauma Project, funded by the Children's Bureau of the Administration of Children and Families and implemented from 2011 to 2016, focused on increasing child welfare workers' and caregivers' knowledge of how to recognize and appropriately respond to children who have experienced trauma (Barto et al., 2018). It also aimed to increase statewide service provider capacity for trauma-focused evidenced-based therapies, showing that practice changes are important at both the clinician and agency level (Barto et al., 2018).

Existing literature also discusses the barriers to implementing trauma-informed care into the child welfare system. An evaluation of the initial stages of a trauma-informed training program for the Arkansas Division of Child and Family Services (DCFS) found significant improvements in participants' knowledge of trauma-informed practices but also emphasized

barriers such as time constraints, heavy caseloads, and limited resources (Kramer, Sigel, Conners-Burrow, Savary, & Tempel, 2013). Other studies similarly discuss systemic barriers to change. An evaluation of three federally-funded statewide demonstration sites that aimed to implement trauma and evidence-informed initiatives in the Northeast, South, and Midwest discusses successes and challenges common to all three initiatives (Akin, Strolin-Goltzman, & Collins-Camargo, 2017). It highlights engagement and collaboration, flexibility, and use of data as successes but also discusses challenges such as getting staff to buy into new initiatives, competing initiatives and priorities, and sustaining momentum over time (Akin, Strolin-Goltzman, & Collins-Camargo, 2017).

### ***Engaging Foster Parents in Trauma-Informed Interventions***

While much has been written on implementing trauma-informed care into the child welfare system at the systemic level and increasing the provision of evidence-based clinical therapies, the topic of engaging foster parents in trauma-informed interventions is largely unexplored. The statewide initiatives in Connecticut and Massachusetts focused on system readiness to implement trauma-informed care, but foster parents were only one small piece of these interventions (Barto et al., 2018; Lang, Campbell, Shanley, Crusto, & Connell, 2016). Sullivan, Murray, & Ake (2016) acknowledge this gap, suggesting future research examining the impact of training foster parents in the National Child Traumatic Stress Network's curriculum in combination with other strategies at a systemic level and deeming the education and empowerment of foster, adoptive, and kinship caregivers to use a trauma-informed parenting perspective "essential but often overlooked" (p. 147).

Furthermore, a study of foster parents in a southwestern state discusses the importance of improving relationships between child welfare workers and foster parents in order to improve child well-being (Geiger, Piel, & Julien-chinn, 2017). It explains foster parents need to feel

valued, respected, and like they are part of the child's "team" and that foster parents also need skills to help children heal from past trauma (Geiger, Piel, & Julien-chinn, 2017). When foster parents have the ability to work with children who have experienced trauma and when foster parents feel respected and part of a team, they are less likely to disrupt placements, and children are consequently less likely to be re-traumatized by disruptions (Geiger, Piel, & Julien-chinn, 2017).

Despite the lack of research on engaging foster parents in the healing processes of children in foster care, this is a promising area for further research. Geiger, Piel, & Julien-chinn (2017) demonstrate further research in this area is worth pursuing given its potential to decrease the likelihood of placement disruptions and re-traumatization for children in foster care. Another body of research, that on trauma-informed evidence-based treatments used to help children and youth in foster care heal from trauma in clinical settings, reveals the need for further research on engaging foster parents in children's healing processes.

### ***Trauma-Informed, Evidence-Based Interventions for Children Who Have Experienced Trauma***

Next, I review evidence-based treatments for children who have experienced trauma as current literature calls for an increased use of evidence-based treatments in the field of child welfare (Barto et al., 2018; Lang, Campbell, Shanley, Crusto, & Connell, 2016; Weiner, Schneider, & Lyons, 2009). According to the American Psychological Association (APA) Council of Representatives (2005):

Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences...The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention.

In other words, trauma-informed interventions described as "evidence-based" are those whose positive effects are supported by research. These interventions are typically carried out by people

with degrees in social work or psychology who have clinical licenses. Examples of evidence-based interventions include the Neurosequential Model of Therapeutics, Attachment Regulation, and Competency, Intensive Permanence Services, Trust-Based Relational Intervention, Parent-Child Interaction Therapy, and Trauma Systems Therapy.

### *The Neurosequential Model of Therapeutics*

One clinical intervention for children who have experienced trauma is the Neurosequential Model of Therapeutics (NMT), developed by Bruce Perry (Perry, 2008, 2009). As mentioned in the first part of the paper, the key clinical implication of Perry's findings on the impact of traumatic experiences on children's brain development is that interventions must start with the functions of the lower brain before addressing the functions of the higher brain (Perry, 2009). Based on this premise, Perry developed NMT, a neurodevelopmentally-informed approach to therapeutic work with maltreated and traumatized children and youth (Perry, 2009). NMT consists of the identification of systems and areas in the brain which have been altered by adverse experiences during development so therapies and interventions can appropriately target these specific areas (Perry, 2008, 2009). Sequence matters, starting with the problems occurring lowest in the brain and moving up in the brain as improvements occur (Perry, 2008, 2009). Therefore, this intervention begins by focusing on the parts of the lower brain that contribute to self-regulation, attention, arousal, and impulsivity (Perry, 2008, 2009). When improvements in these lower-brain structures occur, the focus moves to relational-related problems and then to cognitive-behavioral interventions (Perry, 2008, 2009).

Perry (2009) urges clinicians to change their perspective on appropriate interventions for childhood trauma stating:

Even when targeting the appropriate systems in the brain, we rarely provide the repetitions necessary to modify organized neural networks; 1 hour of therapy a week is insufficient to alter the accumulated impact of years of chaos, threat, loss, and humiliation. (p. 244)

In other words, weekly therapy is not enough to help children heal from past traumatic experiences (Perry, 2009; Perry & Hambrick, 2008). Given that children’s neural systems have been altered through repetition, their healing processes need to take place through repetition as well (Perry, 2009; Perry & Hambrick, 2008). Therefore, while the implementation of the Neurosequential Model of Therapeutics requires a clinician, child welfare workers and foster parents must also engage in this work to assure the repetition necessary to correct dysregulated lower neural networks.

*Attachment, Self-Regulation, and Competency & Intensive Permanence Services*

Two other clinical interventions are the Attachment, Self-Regulation, and Competency (ARC) model and Intensive Permanence Services (IPS) (Fratto, 2016; Hall & Semanchin Jones, 2018). ARC is a, “flexible, comprehensive, evidence-based intervention framework, empirically supported for the treatment of adolescents with a history of maltreatment in childhood” (Fratto, 2016, p. 443). Developed in association with The National Child Traumatic Stress Network, ARC consists of three core domains: attachment, self-regulation, and developmental competencies (Fratto, 2016). The attachment domain addresses adolescents’ ability to cultivate secure relationships with caregivers<sup>3</sup>; the self-regulation domain addresses adolescents’ ability to identify and control emotions and cope with distress; and the developmental competencies domain addresses adolescents’ ability to obtain skills for age-appropriate development (Fratto, 2016). ARC incorporates a variety of treatment methods, including psychodynamic, cognitive, behavioral, relaxation, art/expressive, and movement techniques (Fratto, 2016).

Anu Family Services, a treatment foster care agency that serves youth in Wisconsin and Minnesota, developed IPS for youth in out-of-home placements (Hall & Semanchin Jones,

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<sup>3</sup> The category of caregivers includes foster parents, kinship parents, and adoptive parents.

2018). Informed by the works of Bruce Perry and Bessel van der Kolk, IPS is typically delivered by staff who hold degrees in social work, counseling, or psychology and clinical licenses (Hall & Semanchin Jones, 2018). It is delivered in four phases - the Trusting Phase, the Healing Phase, the Connecting Phase, and the Supporting Phase - that, on average, take 24 months (Hall & Semanchin Jones, 2018).

Both ARC and IPS require consistency and repetition as key components. For example, efforts made by children's caregivers to meet children's needs are at the core of the attachment domain of ARC and the Trusting Phase of IPS. Furthermore, the findings of the qualitative study by Hall and Semanchin Jones (2018) on the key components of IPS illuminate a need for foster parents to be engaged in trauma-informed interventions in order to maximize effectiveness, as they found consistency and transparency in order to break patterns of relational trauma that severed youth's ability to trust adults amongst the critical components of IPS. Hall & Semanchin Jones (2018) conclude that:

To help youth progress in their healing and work toward permanency, all stakeholders in the youth's life, including caregivers, service providers, mental health professionals, county agencies, and schools might benefit from adopting these trauma-informed practices and maintaining consistency across systems. (p. 597)

This further suggests interventions delivered by clinicians alone are insufficient in achieving the consistency and repetition necessary to help children heal from past trauma. Therefore, while it is helpful for IPS workers to do this work, foster parents, as the ones who spend the most time with youth, must play a role in maintaining consistency and transparency.

### *Trust-Based Relational Intervention & Parent-Child Interaction Therapy*

Trust-Based Relational Intervention (TBRI) and Parent-Child Interaction Therapy (PCIT) are unique in that they are administered by a clinician yet engage caregivers in order to help them learn how to interact with children who have experienced trauma and appropriately respond to behaviors. Karyn Purvis at the Texas Christian University Institute of Child Development for

at-risk children and youth developed TBRI (Purvis, Cross, Dansereau, & Parris, 2013).

Consistent with Perry's conclusion on the importance of repetition, Purvis, Cross, Dansereau, & Parris (2013) say:

While children may spend an hour a week in a professional's office, they spend vast hours in the care of their parents or caregivers. In particular it has been noted that relationship-based trauma can only be resolved through loving, stable, relationships, such as can be offered by nurturing caregivers. (p. 361)

Given that TBRI directly involves caregivers, it is arguably more effective at engaging foster parents than clinical models such as NMT, ARC, and IPS. TBRI helps both the caregiver and the child learn healthy ways of interacting, which ultimately helps children heal. Additionally, TBRI achieves positive outcomes such as decreases in children's psychiatric problems, decreases in parents' stress levels, decreases in behavioral problems on the Strengths and Difficulties Questionnaire, and decreases in trauma symptoms on the Trauma Symptoms Checklist for Young Children (Howard et al., 2014; Purvis et al., 2015).

Like TBRI, PCIT includes both children and caregivers. PCIT is an evidence-based treatment for children ages 2-7 with externalizing problems that consists of 12-14 weekly sessions with a therapist (Mersky, Topitzes, & Blair, 2017). The role of the therapist is to help caregivers develop specific parenting skills through psychoeducation, coaching, modeling, and role-play (Mersky, Topitzes, & Blair, 2017; Topitzes, Mersky, & McNeil, 2015). PCIT improves the caregiving of foster parents and the mental health of their foster children (Mersky, Topitzes, & Blair, 2017). Like TBRI, PCIT shows foster parents how to effectively parent children who have experienced trauma, teaching them skills and parenting techniques they can use on a daily basis. These interventions address the need for consistency in children's healing processes, but barriers still remain, since these interventions are not always accessible to foster parents. Both TBRI and PCIT require trained practitioners to lead the sessions, and not all foster parents have the ability to participate in such interventions due to time and funding constraints as well as lack



of awareness that these types of interventions exist. Nonetheless, these interventions show engaging foster parents in trauma-informed interventions has positive effects for both children and foster parents and should, therefore, be further explored.

### Trauma Systems Therapy

The limitations of clinical models such as the Neurosequential Model of Therapeutics (NMT), Attachment, Self-Regulation, and Competency (ARC), and Intensive Permanence Services (IPS), combined with the promising outcomes associated with caregiver-engaging models such as Trust-Based Relational Intervention and Parent-Child Interaction Therapy demonstrate a cogent need for further research on engaging foster parents in children's healing processes. Such a study, exhibiting the promise of this area of research, is an evaluation of the effectiveness of the system-wide implementation of Trauma Systems Therapy (TST) in KVC Kansas, a branch of KVC Health Systems, Inc., a private child welfare and behavioral health organization in Kansas (Murphy, Moore, Redd, & Malm, 2017). Using administrative data to analyze the association between KVC's implementation of TST and children's outcomes, the study found that increases in children's exposure to TST correlate with greater improvements in functioning and behavioral regulation (Murphy, Moore, Redd, & Malm, 2017). This particular implementation of TST was unique because, while TST was initially developed for clinical staff members, KVC incorporated all members of the child serving team rather than just clinical staff. Incorporating all members provided staff and foster parents with the knowledge and tools necessary to better care for children who have experienced trauma (Murphy, Moore, Redd, & Malm, 2017; Redd, Malm, Moore, Murphy, & Beltz, 2017). The evaluation on KVC's implementation of TST found that no one caregiver is central to providing trauma-informed care, which suggests, "implementing interventions with non-clinical staff and foster parents show promise" (Murphy, Moore, Redd, & Malm, 2017, p. 32).

Redd, Malm, Moore, Murphy, & Beltz (2017) further stress the importance of including non-clinical staff and foster parents in trauma-informed interventions, arguing, “Foster parents, in particular, need to be viewed as integral partners on a child’s care team as well as open and willing adult learners” (p. 178). Their reasoning is, “Children in foster care would only be able to realize better outcomes from a trauma-informed system, if the tools were put into the hands of those caring for them on a daily basis” (Redd, Malm, Moore, Murphy, & Beltz, 2017, p. 180). This is consistent with other literature on the topic emphasizing the importance of consistency and repetition in children’s healing processes, highlighting the limitations of interventions consisting of only weekly therapy sessions with clinicians, and underscoring the need for all actors in children’s lives to help children heal (Hall & Semanchin Jones, 2018; Perry, 2009; Perry & Hambrick, 2008).

The literature on trauma-informed, evidence-based interventions for children who have experienced trauma shows that most of these interventions require clinical staff for implementation, yet interventions delivered in weekly therapy sessions are insufficient in achieving consistency and repetition, which are essential to the healing processes of children who have experienced trauma. Interventions that include caregivers, such as Trust-Based Relational Intervention and Parent-Child Interaction Therapy, demonstrate engaging foster parents in trauma-informed interventions is a promising area of research, which KVC’s system-wide implementation of Trauma Systems Therapy furthers by suggesting foster parents can and should be incorporated into interventions traditionally carried out in clinical settings.

## **Part B: Methods**

### ***Research Question***

Given the need for research on engaging foster parents in the healing processes of children in their care, the central research question I address in the remainder of the paper is:

What concrete skills, informed by current findings on childhood trauma, do foster parents need to help children in foster care heal from past traumatic experiences?

### ***Research Methods***

To engage this question, I asked foster parents and mid-to-upper level professionals at foster care and adoption agencies in Durham County, Orange County, Wake County, and Person County, North Carolina for either an in-person interview, a phone interview, or to fill out a survey. I chose to focus on the population of foster parents in these four North Carolina counties to give my research a clear scope, and, given that I had prior relationships with certain child welfare agencies in this area, I knew foster parents and staff at these agencies would be receptive to my project and more willing to participate in my research. In order to conduct an exploratory qualitative analysis, I identified semi-structured interviews as the most suitable method for my study. Given that foster parents balance parenting tasks with meetings and appointments with all other members of the child-serving team, however, I knew that time constraints would be a barrier to foster parents' ability to participate in a half-hour interview. For this reason, coupled with the busyness of foster care staff, I created qualitative survey instruments with questions similar to those in my semi-structured interview guides, enabling me to provide a less time-consuming option than participating in an interview.

Before starting my research, I had a point of contact at the Children's Home Society (CHS) of North Carolina, who indicated their willingness to introduce my research to CHS. To recruit foster parents and staff for in-person and phone interviews, I asked this point of contact to send an email introducing my research to foster parents and staff to gauge interest in interviews with the option of instead completing an online survey. If they preferred, participants also had the option to obtain a hard copy of the survey. After participants indicated their initial interest in an interview, I worked with them to set-up a time for a half-hour interview, either in-person or

over the phone. After starting my research, I continued to contact other foster care and adoption agencies in Durham County, Orange County, Wake County, and Person County, asking if they would be willing to introduce my research to their agencies. I worked with the following child welfare organizations to recruit participants for my research: Children's Home Society (CHS) of North Carolina, Durham County Social Services, Orange County Social Services, Orange County Guardian Ad Litem, Person County Social Services, and Triangle Foster Parents Association. I continued recruiting foster parents and staff to participate in my research through snowball sampling<sup>4</sup>, asking participants to introduce my research to their networks of other foster parents and foster care staff if they felt comfortable.

I conducted semi-structured interviews with three foster parents and four staff at foster care programs. The three foster parents attained their licenses through Orange County Department of Social Services. Three of the foster care staff work at CHS, and one of the foster care staff works at Orange County Department of Social Services. I conducted six interviews over the phone and one interview in-person, respecting the most convenient format for the respective participants. I also collected qualitative survey data from one foster parent who attained their license through Person County Department of Social Services, one foster parent through Durham County Department of Social Services, and two foster care staff who work at CHS.

During the semi-structured interviews, I asked foster parents and foster care staff a set of open-ended questions.<sup>5</sup> I began the interviews with foster parents by asking general questions about themselves and the foster children they have had in their care. I then asked them questions about their motivations for becoming foster parents and their experience with the foster parent

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<sup>4</sup> Snowball sampling is when research participants recruit other participants for a study.

<sup>5</sup> See Appendix A for the in-person/phone interview questions for foster parents. See Appendix B for the in-person/phone interview questions for foster care staff.

training classes. I then moved to the hardest set of questions: those on foster parents' understandings of trauma and how their understandings of trauma impact their parenting practices. I ended the interviews by asking more broadly about which parts of their experiences as foster parents they did and did not feel prepared for and, finally, if there was anything else they would like to add. Thanks to the semi-structured interview format, I asked probing questions to encourage participants to speak further on aspects of their responses I found interesting and relevant to my research question.

Likewise, I began the interviews with foster care staff asking general questions about their jobs and their roles in their positions. I then complemented the set of questions I asked foster parents by asking questions in the following categories: 1) Questions About Foster Parent Training, 2) Questions About Foster Parents' Understandings of Trauma and Trauma-Informed Care, and 3) Questions About Foster Parents' Preparedness. It was important for me to ask questions in these categories because, while foster parents cannot identify what they don't know, foster care staff can help fill in this gap, speaking on their experiences training and supporting foster parents in their work with children in foster care. The qualitative surveys were structured similarly to the semi-structured interview guides.<sup>6</sup>

Interviews were recorded and transcribed using the services of Rev.com<sup>7</sup>. I used NVivo<sup>8</sup> to conduct a thematic analysis with the interview transcripts and survey responses. I developed a set of codes that reflected the key themes in my data in order to compare and explore participants' thoughts on common subjects. After refining my themes through an iterative coding process, I wrote my results and discussion sections, which first provide background on the North

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<sup>6</sup> See Appendix C for the survey questions for foster parents. See Appendix D for the survey questions for foster care staff.

<sup>7</sup> Rev.com allows users to upload audio files and creates transcripts which can then be exported as Microsoft Word files.

<sup>8</sup> NVivo is a software for qualitative research that allows users to store, organize, and code qualitative data.

Carolina child welfare and foster care systems. Finally, I used my findings to make recommendations for child welfare agencies.

## **Part C: Results**

### ***Background: A Summary of the North Carolina Child Welfare System***

The term “child welfare,” although not defined in North Carolina law, refers to child protective, foster care placement, and adoption services (DePasquale & Simmons, 2017). Foster care refers to children removed from their homes and cared for outside of their families. State child welfare systems follow a variety of models, and North Carolina in particular has a state-supervised, county-administered child welfare system (DePasquale & Simmons, 2017). This means that county-run departments of social services (DSS) are responsible for providing child welfare services, including removing children from their homes and placing them in foster care when necessary. According to North Carolina law, government intervention into private homes is only warranted in three circumstances: abuse, neglect, and dependence<sup>9</sup> (DePasquale & Simmons, 2017).

The stages of a child welfare case in North Carolina go as follows: After a county DSS receives a report, they decide whether or not to conduct an assessment. If, when the assessment is conducted, DSS finds evidence of abuse, neglect, or dependency, they decide whether to provide protective services to the family while keeping the child in the home or file a petition for the court to become involved. DSS also decides whether removal of the child is immediately necessary and, if so, can take a child into temporary custody for up to twelve hours. By the end of the twelve hours, DSS must have obtained a “nonsecure custody order” (DePasquale & Simmons, 2017). After a judge issues a nonsecure custody order, a hearing on the need for

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<sup>9</sup> According to the North Carolina Judicial Branch, “A dependent child is one who needs assistance or placement because the child does not have a parent, guardian, or custodian who is taking responsibility for the child’s care or supervision.”

continued nonsecure custody, or, the adjudicatory hearing, heard in a district court by a judge, occurs within seven days. At the adjudicatory hearing, the judge determines whether the allegations stated in the petition are true. The burden of proof is on DSS with a standard of clear and convincing evidence. Following the adjudicatory hearing is the dispositional hearing, during which the court identifies the needs of the child, discusses how the needs will be met, and develops a plan. The initial dispositional hearing must take place within thirty days of the adjudicatory hearing. After the initial dispositional hearing, a review hearing must take place within 90 days and a permanency planning hearing must take place within 12 months after the date of the initial order removing the child from their home. A case remains open until a court issues an order that ends its jurisdiction, a final order of adoption is issued, or the child/youth legally becomes an adult (DePasquale & Simmons, 2017).

***Background: A Profile of the North Carolina Foster Care System***

A fact sheet by Child Trends, a nonprofit research organization, uses data from the federal Adoption and Foster Care Analysis and Reporting System (AFCARS) to report on the profiles of state foster care systems during Federal Fiscal Year (FY) 2015, from October 1, 2014 to September 30, 2015. According to the North Carolina fact sheet, there were 10,324 children in foster care in North Carolina on September 30, 2015 (Child Trends, 2017). 5% of these children were in foster care for five or more years, 5,597 children entered foster care during FY 2015, and the average length of time in foster care was 19 months (Child Trends, 2017). In FY 2015, 80% of children in foster care in North Carolina entered the system partially due to neglect. The reason for foster care entry with the next highest percentage of cases was parental substance abuse (Child Trends, 2017).

During the FY 2015 reporting period, the two racial groups with the highest percentages of children in foster care in North Carolina were white and African American: 49% of children in

the N.C. foster care system were white, and white children comprised 53% of the general child population in N.C. (Child Trends, 2017). While 33% of children in the N.C. foster care system were African American, African American children comprised only 23% of the general child population in N.C., indicating a disproportionately high percentage of African American children in North Carolina's foster care system in comparison (Child Trends, 2017). Moreover, 48% of children in foster care in N.C. were female, and 52% were male (Child Trends, 2017). This gender breakdown remained the same in FY 2016 (The Annie E. Casey Foundation, 2019).

The KIDS COUNT Data Center, a project by the Annie E. Casey Foundation, provides a more recent figure for the number of children in foster care in North Carolina, reporting that there were 10,425 children in FY 2016 and 5,587 children entered foster care (The Annie E. Casey Foundation, 2019). In FY 2016, the breakdown of foster care placement types was as follows: 53% in non-relative family foster homes, 27% in relative family foster homes, 12% in group homes or institutions, 4% in trial home visits, 3% in pre-adoptive homes, 1% of runaways, and <.5% in supervised independent living (see *Figure 1*) (The Annie E. Casey Foundation, 2019). The breakdown of reasons why children exited foster care in FY 2016 was: 42% reunified with parent or primary caretaker, 26% adopted, 19% transfer of guardianship, 10% emancipated<sup>10</sup>, 3% living with other relatives, 1% transferred to another agency, <.5% runaways, and <.5% death (see *Figure 2*) (The Annie E. Casey Foundation, 2019).

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<sup>10</sup> Emancipation means that the child/youth exited foster care because they were legally considered an adult due to their age, marital status, or another reason (Child Trends, 2017).



## Placement Type (FY 2016)

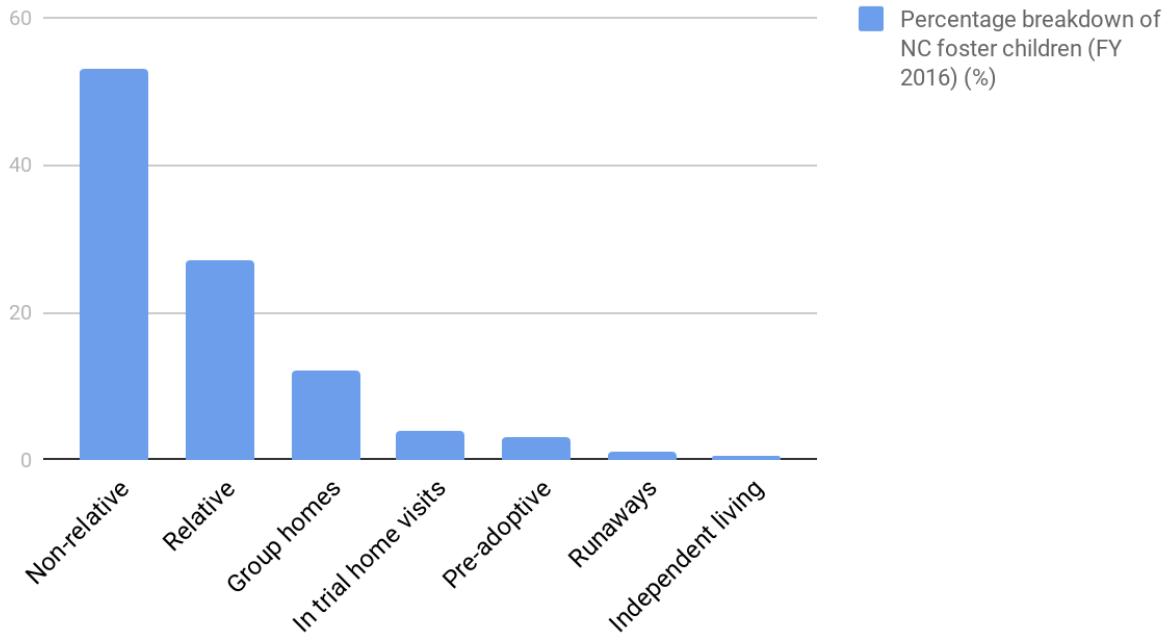


Figure 1 - Breakdown of foster care placement types in FY 2016

## Exit Reason (FY 2016)

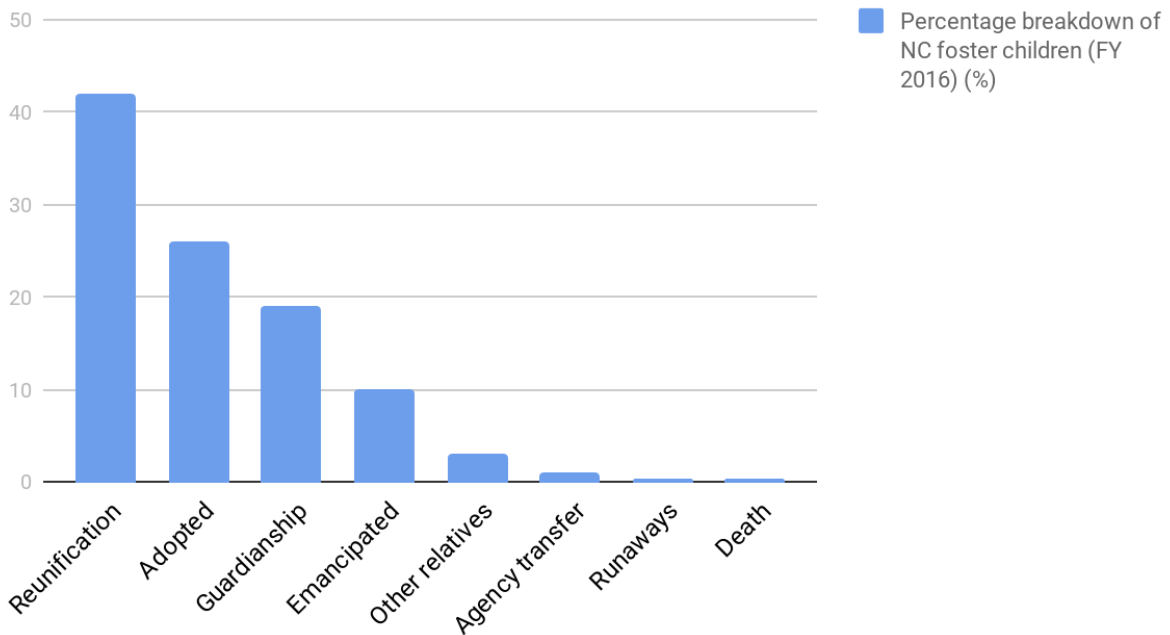
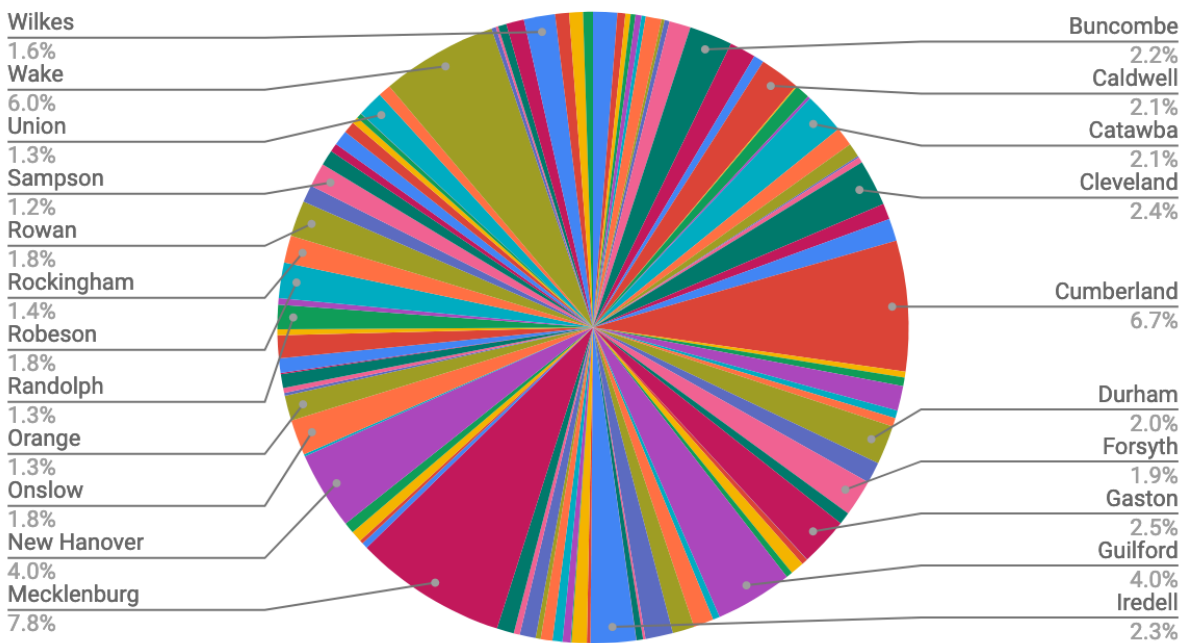


Figure 2 - Breakdown of reasons why children exited foster care in FY 2016

The KIDS COUNT Data Center provides a breakdown of the number of children in foster care per county with the most recent set of data from FY 2011. In FY 2011, out of the 14,329 children in foster care in North Carolina, 285 children were in foster care in Durham County, 184 children were in foster care in Orange County, 106 children were in foster care in Person County, and 853 children were in foster care in Wake County (The Annie E. Casey Foundation, 2019). As shown in *Figure 3*, in FY 2011, 2.0% of children in foster care in North Carolina were in Durham County, 1.3% were in Orange County, 0.7% were in Person County, and 6.0% were in Wake County.

**Children in foster care in North Carolina per county (FY 2011)**



*Figure 3 - Percentage breakdown of children in foster care in North Carolina in FY 2011*

**Description of Participants**

Five participants are foster parents in Orange County, Person County, and Durham County, North Carolina. The foster parents will be referred to as Foster Parent A, Foster Parent

B, Foster Parent C, Foster Parent D, and Foster Parent E. Below are brief descriptions of the five foster parents:

Foster Parent A	Licensed by Orange County Department of Social Services, trained with TIPS-MAPP <sup>11</sup> curriculum, she/her/hers pronouns, participated in an interview
Foster Parent B	Licensed by Orange County Department of Social Services, trained with MAPP <sup>12</sup> curriculum, he/him/his pronouns, participated in an interview
Foster Parent C	Licensed by Orange County Department of Social Services, trained with MAPP curriculum, she/her/hers pronouns, participated in an interview
Foster Parent D	Licensed by Person County Department of Social Services, trained with TIPS-MAPP curriculum, did not indicate gender <sup>13</sup> , participated in a survey
Foster Parent E	Licensed by Durham County Department of Social Services, trained with TIPS-MAPP curriculum, did not indicate gender <sup>14</sup> , participated in a survey

Six participants are staff at child welfare agencies in North Carolina. The staff will be referred to as Foster Care Staff 1, Foster Care Staff 2, Foster Care Staff 3, Foster Care Staff 4, Foster Care Staff 5, and Foster Care Staff 6. Below are brief descriptions of the six staff:

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<sup>11</sup> TIPS-MAPP is a training curriculum for foster parents. It will be discussed further in a subsequent section (see p. 39).

<sup>12</sup> MAPP is a training curriculum for foster parents. It will be discussed further in a subsequent section (see p. 39).

<sup>13</sup> Foster Parent D will be referred to using they/them/their pronouns.

<sup>14</sup> Foster Parent E will be referred to using they/them/their pronouns.

Foster Care Staff 1	Children’s Home Society of North Carolina, she/her/hers pronouns, participated in an interview
Foster Care Staff 2	Children’s Home Society of North Carolina, she/her/hers pronouns, participated in an interview
Foster Care Staff 3	Children’s Home Society of North Carolina, she/her/hers pronouns, participated in an interview
Foster Care Staff 4	Children’s Home Society of North Carolina, did not indicate gender <sup>15</sup> , participated in a survey
Foster Care Staff 5	Children’s Home Society of North Carolina, did not indicate gender <sup>16</sup> , participated in a survey
Foster Care Staff 6	Orange County Department of Social Services, she/her/hers pronouns, participated in an interview

***Foster Parents’ Lack of Concrete Skills***

Both foster parents and child welfare agency staff discussed foster parents’ lack of concrete skills to work with children who have experienced trauma. When asked about specific topics she would have liked to learn more about during training classes, Foster Parent A said she would have liked to learn more about trauma, not necessarily in a theoretical sense, but, “how it manifests and then what to do.” She followed-up this comment with an example to further illustrate her point that, while she has a good understanding of trauma and its effects, she lacks practical strategies to use as a parent. She said:

Let’s say you have a 13-year-old, and she’s sexually active and sneaks out of the house. Seriously, what do you do? I don’t know exactly. I have ideas of what I would probably try, but you’re thrown in this situation and what does that look like?

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<sup>15</sup> Foster Care Staff 4 will be referred to using they/them/their pronouns.

<sup>16</sup> Foster Care Staff 5 will be referred to using they/them/their pronouns.

Similarly, Foster Parent B referred to his lack of “specific tools” to work with children who have experienced trauma. Furthermore, he discussed how it is upsetting to him that, as a result of his unpreparedness, he may not only have failed to help children heal from past traumatic experiences but inadvertently hampered their healing processes. He explains this by saying:

But what’s really horrifying to me - sometimes I have thought about that I could’ve been doing some actual damage, not even staying in neutral. But doing things that actually somewhere in their heads made something worse, obviously inadvertently. So, I don’t think it’s just a matter of not proactively helping. I think lack of training in this stuff could result in negative implications.

Foster parents’ lack of concrete skills was also cited by child welfare agency staff. Staff 1 summarizes this theme by saying:

My overall impression of foster parent training is that we do a good job with theory and with big concepts. I don't feel like we do a very good job, not just Children's Home Society, like any training curriculum, on specific interventions, equipping parents with a toolkit for providing trauma-informed care to children.

This idea was echoed by Staff 4 and Staff 5. Staff 4 described a shortcoming of the pre-service training as not giving foster parents parenting tools, and, in the same vein, Staff 5 said, “if the only training that a foster parent had on trauma was TIPS-MAPP<sup>17</sup>, they would not have the concrete skills to manage an extremely dysregulated child.”

### ***Foster Parents’ Motivations***

Four out of the five foster parents expressed they had genuine intentions to help children but were also hoping to personally get something out of fostering. Foster Parent A expressed she became interested in foster parenting because, as a single, divorced parent, she wanted her biological child to have a sibling. She cited the value that she places on her relationship with her younger sibling as a reason that her child growing up with a sibling was important to her. She

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<sup>17</sup> TIPS-MAPP is a training curriculum for foster parents. It will be discussed further in a subsequent section (see p. 39).

explained it became increasingly clear that foster parenting would give her the ability to both enable her child to have a sibling and serve children and families. She summarized this two-pronged motivation by saying:

I think initially I did this because I wanted a sibling for my child and didn't see that happening biologically through me and thought this was a great way to do it as well as helping a family and helping a child in the meantime.

In similar fashion, Foster Parent B described how he and his ex-husband became foster parents because his ex-husband always wanted to have kids, and he told him he would support him. He discussed how he and his ex-husband discussed their options and decided on foster parenting because they considered themselves “relatively advantaged people” with the capacity to help children who needed homes.

Foster Parent C and her husband also had personal stake in becoming foster parents. Foster Parent C explained she and her husband became foster parents because they wanted to have a second child (they already had one biological child), but, due to the negative effects of overpopulation, they wanted to provide a home for a child who needed one rather than have another child biologically. The fact that fostering is a clear and tangible way to make a difference in the lives of children and families further contributed to their motivation. Similarly, Foster Parent E reported their motivation was:

To have kids while also helping out kids in need - we did not feel a strong need/desire to birth our own children so fostering seemed like a good option. We also considered traditional adoption but decided we could do that after if we still wanted kids and fostering did not work out, but it would be hard/impossible to do it in the other direction (adopt then foster).

Foster Parent D’s response was, “To give children who needed it love, stability and a home,” but this response is too short to assess whether it fits into the same pattern.

### ***Foster Parent Training***

Due to the time they underwent the licensing process, Foster Parents B and C were trained with the “Partnering for Safety and Permanence - Model Approach to Partnerships in Parenting” (MAPP) curriculum and Foster Parents A, D, and E were trained with the “Trauma Informed Partnering for Safety and Permanence - Model Approach to Partnerships in Parenting” (TIPS-MAPP) curriculum. The state of North Carolina requires that foster parents are trained with this 30-hour “pre-service” curriculum before they are eligible to become licensed foster parents. The MAPP curriculum was developed following the passage of the Adoption and Safe Families Act in 1997 (The California Evidence-Based Clearinghouse for Child Welfare, 2019). The TIPS-MAPP curriculum updated the MAPP curriculum to include trauma-informed practice methods in 2013, with guidance from the National Child Traumatic Stress Network (The California Evidence-Based Clearinghouse for Child Welfare, 2019). Foster parents spoke on both positive aspects of the training curriculum and negative aspects of the training curriculum, and many of their main points were echoed by foster care staff.

#### *MAPP - Positive Aspects*

Foster Parent B described the MAPP training as “good training.” He said a lot of the training was around navigating the foster care system, describing this as “the nuts and bolts of DSS.” He also noted some of the training involved “general communication skills,” which was particularly aimed at people who had never worked with children before. He applauded the aspects of the training on navigating the system, communicating with children, and working with school systems. Another positive aspect of the training Foster Parent B noted was what he referred to as “diversity training.” He explained the trainers prepared foster parents to have a child of a different race and encouraged them to be aware of other differences such as religion, diet, and materialistic values.

### TIPS-MAPP - Positive Aspects

Foster Parent A commended the training classes for taking foster parents through a substantial amount of information. She appreciated how the training went over technical information as well as “life experience around the work.” She also appreciated how the training included scenarios for foster parents to work through. She described the TIPS-MAPP training as “incredibly thorough.”

Staff 2 also cited the supplementary scenarios as positive components of the TIPS-MAPP training. Specifically, she noted the supplementary scenarios help cultivate empathy in foster parents, encouraging them to think from the perspective of biological parents and children. She said the following on this point:

I think there's a lot of activities that engage the parents to really think about things and see things from the perspective of a birth parent or a child in foster care and not necessarily just the way they're looking at it from their position. Kind of being in the child's shoes.

She brought up the supplementary scenarios again when she spoke about how TIPS-MAPP teaches foster parents to understand trauma:

There's a lot of good definitions in there [on trauma] but, like I said, the supplemental materials like videos and the activities really help people to understand it. They can read it in words and say, "I understand what that means," but to get those feelings that come with it and to empathize with the person that's been through the things that our foster children have been through, the activities like the Invisible Suitcase, for instance, or the one with the yarn where everyone is together, the birth parents and everyone on the team are connected with the yarn and how that looks when different people step away that had a part. Those kind of things, I think, are the most effective for helping people understand the trauma and how that impacts the children and feeling what that might feel like even though you haven't experienced it yourself.

This quote further expresses her view that one of TIPS-MAPP's strengths is its ability to teach foster parents to be empathetic, especially when thinking about how trauma impacts the children in their care. Staff 5 echoed this point by saying, “TIPS-MAPP is great for cultivating understanding and sensitivity to what foster children and families in the child welfare system



experience.” Foster Parent E also said TIPS-MAPP helped them develop, “an understanding of and an empathy for what the kids are going through.”

### Connection to Foster Parents’ Preparedness

The positive aspects of the TIPS-MAPP curriculum cited by foster parents and foster care staff connected to their perceptions on foster parents’ preparedness. Foster Parent A’s experiences as well as those of a foster parent Staff 2 has worked with reflect the theme of empathy<sup>18</sup>, as Staff 2 and 5 emphasized about TIPS-MAPP. Foster Parent A said the TIPS-MAPP training encouraged her to think about trauma from multiple perspectives, which she appreciated. On thinking about trauma from the biological parents’ perspective, she said:

I think we also try to think about it from the parents' perspective of how they're experiencing the whole piece, and that's something I try to still constantly do is try to think about it from the little one's mom's perspective or dad's perspective on how this is happening.

Analogously, Staff 2 gave an example of a good experience she had with foster parents she trained involving empathy. She thinks the exercises in the TIPS-MAPP curriculum that teach foster parents to put themselves in other people’s shoes translate into foster parents “being kind and open with the birth family.” She gave an example of a foster parent she works with who does this well:

I have a foster parent who goes into the supervised visits and just treats Mom like any other person. Recently Mom's had a lot of struggles, and her visits were reduced, but she still goes to talk to her and brings her things that the kids made at school, tells her how they're doing. DSS allows it, so she still does a weekly phone call when Mom remembers and has minutes on her phone. She gave her her personal number, so she calls her, and the kids are able to talk to her on speaker phone.

Furthermore, Foster Parent E reported she has felt prepared for being understanding of and offering empathy to children.

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<sup>18</sup> Empathy is defined as the ability to understand another person’s experience from their point of view.

### MAPP - Negative Aspects

Even given its positive aspects, Foster Parent B described the MAPP training as “simplistic and superficial” overall. Describing the lack of depth of the training curriculum, he said, “But it was all pretty what I would consider simplistic and superficial. Nothing sticks out to me as having been wrong or bad or harmful. It just wasn't very in-depth.” He found the training was insufficient in preparing him for the experiences he would face as a foster parent. As aforementioned, Foster Parent B found that the MAPP training was insufficient with providing him “specific tools” to work with children who have experienced trauma.

### TIPS-MAPP - Negative Aspects

Foster Parents A and E cited what they see as gaps in the TIPS-MAPP curriculum. As previously mentioned, Foster Parent A stated she would have like to learn more about the manifestations of trauma in children’s behavior and what to do in these situations. She also discussed the need for additional training on bias, privilege, and racial sensitivity. She indicated the importance this need to her by saying:

But relating to and being able to see your own biases and how they play out both for your child and for the child's parents, particularly when we're in a situation knowing the fact that the parents have done something to lose their child, so you already are on a heightened possibly[sic] judgment. To then look at race and do some more unpacking of folks' privilege and bias I think would be helpful. Again, I think we scratched the surface of it but given the fact that the majority of people in my class, and I think this is a majority true of Orange County, I don't have the stats with me, are white, and the majority of kids that are in the foster system are not white, there could be some room for that.

Foster Parent E stated it would have been helpful to be prepared with a better understanding of the mental health system and types of therapies that are available and appropriate for children in foster care.

Many of the foster care staff spoke on the negative implications of the fact that pre-service training can be abstract when the child isn't in the home yet. Staff 3 summarizes this shortcoming by saying:

[TIPS-MAPP] is a really thorough, intensive training. However, people that are in it have not fostered before. So that particular piece of training sometimes needs to be reiterated because I think people are so excited at the beginning that I'm not sure it is necessarily all relevant at that time.

Staff 4 echoed this sentiment, expressing, "It feels like a lot of information up front that isn't applicable without specific required training after a child has been placed in the home."

Staff 4 went on to say, because the pre-service training happens upfront, when a child is actually placed in the home, foster parents often forget what they learned about trauma and struggle with applying what they learned in the training to their everyday experiences. Along the same lines, Staff 5 said, "It is hard to really understand what it takes to parent a child affected by trauma unless you are living it!" Staff 6 elaborated on this shortcoming, discussing how, because the foster care system as a whole is so new to foster parents when they are in the TIPS-MAPP classes and the curriculum covers a lot of material, foster parents tend to forget information later on.

#### *Connection to Foster Parents' Unpreparedness*

Staff 2 spoke about an example of foster parents she worked with who struggled because they did not understand that the child's behaviors were manifestations of trauma rather than personal attacks. This example of foster parents' unpreparedness connects to the point made by Staff 3, 4, and 5 that training can be abstract when the child isn't in the home yet. When asked to describe why Staff 2 thought the foster parents were struggling to parent the child in their care, she said:

I think because they had never done anything like this before. And had not been around children who had been exposed to trauma or weren't with children at all, so it was just completely foreign to them and they just needed a little more to understand it.

Foster Parent B also expressed he felt unprepared to work with children who had experienced trauma and lack of training contributed to this feeling. The following sections describe more specifically what foster parents and foster care staff had to say about how training addresses trauma and its impact on children in foster care.

### ***Foster Parent Training on Trauma***

Both the MAPP and TIPS-MAPP training curriculums address trauma in some capacity. Both foster parents and foster care staff commented on how trauma is addressed in training classes and cited positive and negative aspects of these discussions.

### **MAPP Training on Trauma**

When he went through the MAPP training in 1999, Foster Parent B remembered trauma being mentioned as an adjective used to describe what children had been through but not thoroughly explained or parsed out. He described the portrayal of trauma as a “layperson’s take on it.” When asked if the MAPP training classes mentioned trauma, he said:

I mean, yes in that it was just like an adjective added to kind of the list of troubles these kids have. I don't think there was even a whole hour or ... Certainly there wasn't like a guest speaker on ramifications of traumatized children in foster care. I'm sure there was nothing like that. But they would say, "Remember these kids are traumatized." But it was just an adjective. It wasn't fleshed out at all.

Likewise, when asked if the MAPP training classes mentioned trauma, Foster Parent C said, “I don’t think our training really covered this very much,” but qualified that she was remembering back almost 16 years to answer the question.

Moreover, Foster Parents B and C both remarked that trauma was addressed in conversations surrounding corporal punishment. The MAPP curriculum taught foster parents not to use corporal punishment with children in foster care because they had experienced trauma. However, trainers did not thoroughly explain to foster parents why corporal punishment is

ineffective and detrimental to children who have experienced trauma. Foster Parent B described the conversations surrounding trauma and corporal punishment, stating:

You know, they said, "Well, first of all it's shown that corporal punishment does not work." So that was one thing. But they said, "And it's not good for any children. But in particular not traumatized children." So, they did make that connection. Again, not super thoroughly or anything.

Foster Parent C also referenced the fact that trauma was brought up in the context of discussions on corporal punishment. She said:

I remember it covering why you shouldn't hit a child, and that being a very controversial discussion amongst the foster parents. That some people really being in favor, and there'd be a lot of discussion about, well if I'm hitting my biological children, and I set this one child apart? This foster child apart. Their rationale, that I do think resonated to a lot of people is yes, because of their trauma.

#### TIPS-MAPP Training on Trauma

Foster Parent A came into the pre-service training classes with a baseline understanding of trauma from her prior work experience. She expressed that, notwithstanding her background, the training classes still taught her new concepts related to trauma. She said that the TIPS-MAPP classes taught her that trauma can describe either a specific event or a cumulative experience, referring to the general experience of living in uncertainty and precarity. She learned that trauma is much more than abuse or neglect and can be more "subtle." She described what she learned about trauma in the training classes by saying:

What I think of is trauma can be one of any different types of things. The trauma could be specifically something that happened directly to a child, right? Whether it was in utero, whether it was as a child, whether it was abuse, whether it was neglect, whether it was whatever that specific trauma was. But then I also think we have to think about trauma in the sense of just even disruption. Of just the fact of being put in somebody else's home. That's trauma and the unknown and then having that possibly happen again or changing schools could be trauma.

She also noted the TIPS-MAPP training classes addressed the concept of "triggers" by explaining that children can be reminded of past traumatic experiences in various ways and experience stress responses as a result. She said thinking through things that could trigger

children's recollections of trauma was helpful because so many aspects of foster families' daily lives could potentially trigger children in foster care. She described what she learned about triggers and retraumatization, stating:

Then also thinking through what could trigger somebody's recollection for trauma and I think that was helpful to think through around ... We talked a lot about how bath time could be a trigger because you don't know what happened in bath times. There's just so many things that could happen. Or food being a trigger for remembering trauma. All of that can manifest in so many different ways with different kids and at different age levels or just even how you say goodnight. Are you a touchy family? Are you not? All of that can trigger trauma.

Furthermore, as mentioned in the previous section, Foster Parent A commented on how discussions about trauma in the pre-service training classes encouraged her to consider the effects of trauma from multiple perspectives, including that of the child and biological family.

Foster Parent E discussed how the pre-service training classes taught them the difference between chronological age and developmental age, noting how children who have experienced trauma can be at a less mature developmental age than chronological age. They noted that this reminds them to be patient when the children in their home act younger than their chronological ages.

Foster care staff similarly commented on the TIPS-MAPP curriculum's ability to provide foster parents with a baseline understanding of trauma and how it affects children in foster care. Staff 1 said that foster parent pre-service training does a "good job with theory and with big concepts." She also noted TIPS-MAPP teaches about the neurobiological responses to trauma such as hypervigilance and fight/flight/freeze, identifying this as a positive component of the curriculum. Staff 4 similarly noted TIPS-MAPP "gives a basic framework" for understanding trauma. Moreover, as mentioned in the previous section, both Staff 2 and Staff 5 discussed how TIPS-MAPP does a good job preparing foster parents to be empathetic when considering how

trauma affects the children and biological families involved in the child welfare system. Staff 6, like Foster Parent A, mentioned TIPS-MAPP discusses trauma triggers.

However, as previously mentioned, Staff 1, 4, and 5 were highly critical of TIPS-MAPP's failure to equip foster parents with the concrete skills they need to act on this information about trauma and incorporate it into their parenting strategies. Staff 6 also mentioned TIPS-MAPP does not always go in-depth about trauma. Staff 5 summarized the positive and negative aspects of how TIPS-MAPP helps foster parents understand trauma and how it affects the children in their case by saying:

In my opinion, TIPS-MAPP is great for cultivating understanding and sensitivity to what foster children and families in the child welfare system experience, but it doesn't delve very far into trauma-related needs and behaviors and how to respond to those (the concrete skills part).

Foster Parent E expressed a similar thought on the TIPS-MAPP training classes. When asked in the survey if they can give specific examples of how they have used their training in their experience as a foster parent, they said, "I don't really have any concrete examples - it is more just developing an understanding of and an empathy for what the kids are going through."

Furthermore, Staff 4 criticized TIPS-MAPP's use of "sensationalized stories of trauma to teach foster parents about the effects of trauma" because it makes it more difficult for foster parents to understand the effects of trauma in situations other than the specific ones they are taught. She said:

This is a disservice to foster parents because the effects of trauma manifest with all children in care in some way. It seems that foster parents have a healthy understanding how physical abuse or sexual abuse could be traumatic and have an obvious impact; it's harder for them to understand that the effects are just as present in neglect situations, in fact, often more pronounced.

### ***Foster Parents' Understandings of Trauma***

Both foster parents and foster care staff discussed foster parents' understandings of trauma and gave examples of how their understandings translate into their parenting.

### Foster Parents' Comments

As discussed in the previous section on how the concept of trauma is taught to foster parents in the pre-service training curriculums, Foster Parent A said she understands trauma as either a specific event or a cumulative experience. She also gave examples of how her understanding of trauma translates into the parenting decisions she makes as a foster parent. She spoke about how she was concerned when, at age two, her foster child's language had not developed to the degree she expected it to. She recognized that it may or may not have been a manifestation of trauma. She explained:

I was slightly concerned when [they were] around [their] two-year birthday<sup>19</sup> that [their] language hadn't developed in the way that I would want to see a two-year-old have language. I had [them] tested, and could that have been a manifestation of some sort of trauma? Yeah, it could have been. Could it also have been that [they] were in a bilingual school until that point, so language hadn't been developed? Yep. Could it also have been that [their] parents didn't have as many of the tools that I have at my disposal being a former educator of how to develop language at that age? Could be. Could it be all of the above? Absolutely. Guess what? [They're] three now and I can't get [them] to stop talking, so we're fine.

She also said that her understanding of trauma reminds her to be more patient, which was also mentioned by Foster Parent E. Foster Parent A explained she reminds herself that, when her foster child is acting out after visits, it is not simply because they're testing her boundaries. She expressed that she realizes that she will need to constantly remind herself of this for the rest of her life, saying:

But I think I'm gonna need to constantly remind myself if things happen that are off, could this be because of [trauma]... Even just being put in foster care, even just having to come live with us? Even though I think consciously, [they] probably won't remember.

Beyond reminding her to be more patient, she said her understanding of trauma drives her decisions to maintain open lines of communication, be conscious of the importance of emotional validation for her foster child, engage in shared parenting, and establish boundaries.

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<sup>19</sup> [their second birthday]



Foster Parent E also expressed an understanding that trauma is more than just abuse or neglect. They noted, “Being separated from their family in and of itself is traumatic.”

Foster Parent B expressed he did not have a thorough understanding of trauma when he began fostering. He explained he broadly understood children in the foster care system are “traumatized” because they had been abused or neglected and had to constantly move homes. From the MAPP training classes, he also generally understood corporal punishment should not be used with children in foster care because it is ineffective and detrimental to “traumatized” children. He candidly spoke about feeling completely unprepared for his experiences as a foster parent as a result of his lack of understanding of trauma and how it affects children in foster care, expressing:

When I think about it, yeah, I was really ill-prepared. And I can't really ... I don't even know what ... I can only think of examples where I was totally unprepared. I can't really think of anything more positive to say.

Moreover, at the end of the interview, he shared that it upsets him to think about how unprepared he was for parenting children who have experienced trauma, saying, “It's a little depressing. [It] makes me realize how ill-prepared I was for a major aspect really of all the kids.”

### *Foster Care Staff's Comments*

Foster care staff all discussed foster parents' understandings of trauma but, given their different positions, they spoke on this topic in distinct ways.

#### *Neurobiological Definition of Trauma*

Foster Care Staff 1 develops training curriculums for foster parents as well as professionals and mentioned that she and her colleagues recently created a curriculum called Understanding and Managing Difficult Behaviors, developed with the purpose of giving foster parents specific tools they can use to work with children who have experienced trauma. Staff 1 explained it teaches foster parents a neurobiological, rather than a clinical, definition of trauma,

which she believes is more productive. She explained the difference between clinical and neurobiological definitions of trauma, saying:

Steve Porges teaches, and Peter Levine teach that really there's one set of responses that any individual has to stress. Stress could be positive stress all the way into traumatic stress. Really what trauma is, is not about the bigness of the event but about the response to the stressor. So, a child who's in a car accident may be stuck in that stress response, the fight/flight/freeze/submit/collapse stress response and never move beyond that and be stuck in that and then be traumatized. And then you have somebody who's experienced long-term abuse or neglect, but if they're in a supportive environment, even though they've experienced such trauma they may not be traumatized. They may be able to move beyond the stress response and overcome that experience. So, it's not about the experience as much as about the response. So, we try to teach that.

She explained how Understanding and Managing Difficult Behaviors seeks to normalize the concept of stress responses and has observed that foster parents are receptive to its teachings on trauma. Staff 1 expressed that she thinks the lessons on trauma in this curriculum help foster parents understand how trauma affects the foster children in their care because it helps them visualize trauma's effects on the brain and understand that, at times, they experience the same stress responses. She gave the following example to demonstrate the effectiveness of how trauma is taught in this curriculum:

The sequence that we teach is we teach the hand brain model, and then we teach the gas pedal/brake pedal of the autonomic nervous system - the sympathetic and parasympathetic nerve system in terms of you get the gas to move you to fight or flight, you get the brake to bring you back to rest - and then we teach the hierarchy of survival responses as outlined by Steve Porges. So those three things done in that sequence, I've done it so many times that by the end people are like, "Oh, so this is what happens when I'm in traffic." I'm like, "Yeah, this is you in traffic." Or this is what's happening when, "We were fine and then it's bath time." Yeah, so sensation has triggered this kid, maybe it's running water, maybe it's the steam of the bath, and we teach that the language of the amygdala is sensations. So, like, how would your body and brain know that you were in a house fire? You'd smell the fire, you'd hear the alarm, you'd feel the heat, you'd smell the smoke. That's how the body becomes aware that there's a crisis and responds to that.

In Staff 1's opinion, while TIPS-MAPP *does* teach about neurobiological responses to trauma, it *does not* do enough to normalize the corresponding stress responses. Staff 4, who also develops curriculum for foster parents and professionals, echoed Staff 1's comments on the

Understanding and Managing Difficult Behaviors curriculum and its fruitfulness for teaching foster parents to understand trauma. She said the following on this new curriculum:

In a new curriculum that the training team teaches (has only been delivered a few times to foster parents), the foster parents really begin to see how behaviors are due to unmet need. We teach the "Hand Brain Model" by Dan Siegel and survival responses by Stephen Porges. These concepts really resonate with parents. We give permission to put the "rules" on hold and spend time building a relationship with children, really meeting their needs. Since this training, parents have been heard describing children as being "dysregulated" verses misbehaving and that the children (or their birth parents) are "offline"-term from Hand Brain Model-which is so much less judgmental, and trauma informed. It's easier for parents to empathize and engage in a nurturing fashion with children verses [seeing] behaviors as "what is wrong with you."

Foster Care Staff 6 similarly emphasized the importance of educating foster parents on the effects of trauma on the developing brain. She noted how some foster parents have trouble understanding that removing a child from a traumatic situation does not address the effects that the trauma has had on that child's brain.

#### *Cultivating Empathy*

As discussed in the previous sections on foster parent training and the way it addresses trauma, Foster Care Staff 2 and Foster Care Staff 5 discussed foster parents' understandings of trauma in the context of how it prompts foster parents to be empathetic, which Staff 2 followed with an example of a foster parent who applied their understanding of trauma to effectively engage in shared parenting.

#### *Misinterpreting Behaviors as Personal Attacks*

Staff 2 also gave an example of foster parents she worked with who struggled to understand trauma. She said these foster parents struggled to interpret the child's behaviors as manifestations of trauma rather than personal attacks, explaining:

We had a case just recently where the foster parents were good people and wanted to do good, loved the child, quickly fell in love with him, and cared and were protective of him, but could not understand that some of the behavioral issues that he struggled with were not personal attacks. It was an effect of the trauma. We utilized our family education services program with families that struggle like that, when we can, to kind of get more

education on understanding the trauma-affected brain of a child and why the reactions, just to get a little more in-depth with that sometimes and just provide that extra support.

Staff 6 also spoke extensively on how foster parents struggle to re-frame behaviors as effects of trauma instead of personal attacks. In a similar manner as Staff 2, Staff 6 said:

I think frequently you have situations where people might take behaviors personally rather than being able to think about the big picture of why is this behavior occurring and how can I react in a way that actually helps decrease the anxiety or the trauma response the child is having rather than increase it.

#### *Removing Yourself from the Situation*

Staff 3 discussed foster parents' understandings of trauma and gave examples of foster parents with whom she worked in the past who had good and bad understandings of trauma. When asked about an experience with foster parents who are particularly effective in using their knowledge of trauma as parents, she said effective foster parents are able to remove themselves from the heat of the moment in order to process why children are behaving the way they are. She said these foster parents are also more open to processing the situations with their case managers. Staff 6 made a similar comment, saying, "I think some of the biggest and most helpful pieces are when you have a foster parent who's able to just take a step back from the situation and think through why what is happening is happening." Staff 6 reiterated the importance of foster parents staying calm, thinking rationally, and processing the situation with their social workers throughout the interview.

#### *Understanding Children's Lack of Control*

A yoga teacher who practices trauma-informed yoga and works with both children and adults, Staff 3 mentioned foster parents' understandings of trauma when asked how she sees yoga and mindfulness interventions becoming more institutionalized in the child welfare system. She said people need to better understand trauma before these interventions can be more

established. She explained how she thinks foster parents need to understand children who have experienced trauma are not in control of all of their behaviors, saying:

I think they need to understand that these children don't yet have control of this. It's not something that they are choosing to do. I think that's a really difficult shift to make that people find. The science helps because it's not just a concept. It's actually like it's black and white, that they don't right now, have control, but also, I think they need to understand that there is research showing that the ability to change that is there.

### ***Foster Parents' Concrete Skills Related to Trauma***

As aforementioned, both foster parents and child welfare agency staff discussed foster parents' lack of concrete skills to work with children who have experienced trauma. Foster Parent B expanded on specific skills that he thinks would have been helpful. He expressed he did not know how to communicate with the children in his care about the trauma they were experiencing and would have benefitted from specific communication skills, saying:

I think very specific communication skills. And I mean everything from body language to tone of voice to touching and of course actual words. Or through art or drawing or play reenactment or whatever. Just skills to have whatever was going on in their head come out more. Just so you would know the child better and they would feel safer just knowing you knew more. Even if it wasn't super conscious.

Foster care staff had more to say on foster parents' concrete skills than foster parents themselves. Staff 1 and Staff 4, who develop training curriculums for foster parents and professionals, referenced this theme the most. They both spoke about the Understanding and Managing Difficult Behaviors curriculum and the concrete tools it teaches foster parents. Staff 1 summarizes why this curriculum was developed, saying:

We do a good job of understanding what trauma is, we do a fairly good job of helping to provide a trauma lens. I feel like we miss out on, here are specific strategies that you can use with kids.

She went on to explain how Understanding and Managing Difficult Behaviors fills this gap. She said the curriculum teaches foster parents the following skills: grounding (5-4-3-2-1 strategy); changing the rules at any time to meet basic needs; rhythm, dancing, and music;

having fun to build connection; natural and logical consequences; and using a sensory lens.

Grounding is a sensory-based strategy that foster parents can use when children are acting out to help both themselves and their children calm down and self-regulate. Staff 1 explained grounding and gave an example by saying:

So, 5-4-3-2-1. Five things that you can see, four things you can touch, three things you can hear, two things you can smell, one thing that you can taste. So that's a grounding strategy. If you're in the mall and the kid is screaming in the middle of the mall, you can use that for yourself. We also teach about mirror neurons for co-regulation, so you can use that strategy for yourself, or you can walk to the child and use grounding things like "Wow, this floor is really shiny. Do you hear how loud your voice is in here? Can you hear the echo? This floor is cold." You know, putting something out for them like, "Here's something sweet," that sort of thing, we teach that. So how to get kids to really sense into their bodies in a moment of crisis, that can be regulating.

Staff 1 said another key component of Understanding and Managing Difficult Behaviors is teaching foster parents it's okay to change the rules sometimes. She described this as one of the most empowering aspects of the training because it teaches foster parents that they are not being inconsistent or bad parents by changing the rules sometimes. She also connected this strategy to the way trauma is taught, describing how the "Hand Brain Model" demonstrates children cannot learn when their brain isn't online. She explained this strategy by saying:

We teach that parents have the authority to change the rules at any time. So, it's not a sign of weakness, like, if a kid is screaming for applesauce and you've said, "No applesauce," and the kid is throwing a fit about applesauce, that it's okay to recognize that the child is hungry and cannot regulate. It's okay to give them the applesauce, and when they're calm say, "This is how we're gonna ask for applesauce next time." I think that's really relieving to foster parents. I'm like, "You're not giving in to choose to give them applesauce. You're choosing to meet the need in the moment of crisis." We're not talking about buying them a \$300 TV or anything. We're talking about meeting basic needs that kids can't articulate in the moment and giving parents permission to try that.

Furthermore, Staff 1 emphasized the importance of teaching appropriate consequences. She described consequences must be given with a choice, so children can learn to understand the effects of their choices. Staff 4 discussed many of the same concrete skills. When asked what concrete skills they think foster parents need to use trauma information to parent the children in

their care, they listed the following: sensory regulation skills such as rocking, rhythm, dancing, and weighted blankets; relationship-building and relaxing on the rules until the relationship is built; knowing how to attune to a child's needs; the skills of "serve and return" and "validation" in response to big emotions; not to take anything personally; self-care and how to ask for help; natural and logical consequences; giving choices; admitting when they are wrong; and changing the rules without feeling like they're "giving in." They made a similar point to Staff 1 on the importance of foster parents learning that changing the rules isn't a sign of weakness, saying:

It's important to know that it's not "giving in" if you make the choice to change the rules. Say a child is having a tantrum because you told them they couldn't have another juice box. It's okay to give the child the juice box which meets the immediate need, then practice a different response-this isn't "caving" to a child, it's making a choice to meet the need. There is authority in that.

Staff 1 also stated, according to foster parents' case workers, the Understanding and Managing Difficult Behaviors curriculum has increased their effectiveness. She summarized what a case worker had to say as follows:

She said that it has really shifted thinking, the foster parents who sat through it, and that they reported feeling much more supported, like they had options of things that they could do in the moment, which is what we're trying to accomplish is really being very tool driven or skills driven.

Similarly, Staff 5 mentioned, "Foster parents need practical skills for helping children regulate their nervous systems when they are dysregulated or 'offline.' They also need practical strategies for nurturing attachment," but they did not go as in-depth on the topic as Staff 1 and 4.

Given her experience as a yoga instructor, Staff 3 spoke extensively on mind-body interventions like yoga and mindfulness as concrete skills foster parents can use to both take care of themselves and show the children in their care how to deal with their trauma in more productive and acceptable ways. She explained yoga and mindfulness can help children who have experienced trauma feel safe in their bodies so they can then "be in a better position to build relationships with the people that are trying to help them." She said she thinks these types of

interventions start with foster parents having their own practices and acting as positive examples for children. She also discussed the positive effects of parent-child partner activities during yoga, stating:

It's fun to watch some parent to child partner type things because it puts the child in a position where the parent is relying on them which can really be very impactful because a lot of times our kids feel so out of control and so many people telling them what to do for them to be in charge of something and the parents to be vulnerable in that way can really help that relationship.

At the end of the interview, Staff 3 indicated she is hopeful for the advancement of yoga and mindfulness interventions in the field of child welfare saying, "I think that we've got a lot of work to do, but I think everybody is getting onboard and moving in the right direction."

Staff 6 gave examples of two foster parents she has worked with who were particularly effective at using their skills to parent children who have experienced trauma. She noted positive changes in the children and youth in their care. One foster parent had teenagers in their care and was effective at setting expectations and then talking with the youth when the expectations weren't met, rather than becoming angry or reactive. Staff 6 commended this foster parent's ability to stay calm in heated situations, maintain open communication, and consistently validate the teenagers' feelings. The other successful foster parent was effective in using a coping skills chart to guide their foster child when their behaviors started to escalate. She noted how in both of these examples, consistency on the part of foster parents was key.

### ***Self-reflection/Self-realization***

A common theme Foster Parent A, Foster Parent B, Staff 1, and Staff 3 spoke on was the idea of self-reflection/self-realization for foster parents. In other words, foster parents often realize the trauma they have experienced in their own pasts and engage in self-reflection. Another component of this theme is foster parents realizing they can experience the same responses to stress as the children in their care. Foster Parent A acknowledged she and her



biological child have both experienced trauma, and she remains conscious of it when making parenting decisions. Foster Parent B also spoke on past trauma he has experienced and recognized it inhibited him from helping his foster children heal, stating:

And for myself even, now that I think about it, I had significant trauma in my past that was not addressed appropriately, or in a healthy way. So, if I didn't address it for myself, I can't imagine I was anywhere close to being equipped to alleviate problems in somebody else's situation.

Staff 3 spoke on this same theme, acknowledging that some parents choose to foster because of experiences they have had and emphasizing the importance of these parents having the ability to recognize and manage their own stress responses. She noted training and licensing processes address this idea to some extent, but, unfortunately, sometimes people's diverse experiences can be lumped into the same category. She gave the example of how, if you've lost a child within a certain period of time, you're not eligible to become a licensed foster parent. She acknowledged this can be positive, but she does not think foster parents' experiences can be placed in a "one size fits all box" because it can take people different amounts of time to recover from the same traumatic experience.

Staff 3 also spoke on the theme of foster parents' self-reflection/self-realization in the sense that foster parents experience similar stress responses to children when they are in frustrating parenting situations. In other words, foster parents can also go into "fight or flight mode" when their children are acting out. When asked why she thinks parents struggle when children are acting out due to trauma, she explained:

For the same reason that the child's having a response, I think. I think from we're in the middle of crisis, we get into a fight or flight mode and aren't being so rational. So, when they have those frequently, they may not be able to use their coping skills or step away and realize this isn't something that the child's meaning to do. It's biologically happening. So, I really think a lot of times too, if they have the mind-body connection, the ability to get themselves back in the rightful place and then they're going to be more effective. But if they are in crisis themselves because the child has been up every night for five nights possibly doing things around the house they shouldn't be doing, then they're more likely to not be involved as well.

In the same vein, Staff 1 referenced self-reflection/self-realization when discussing the effectiveness of the way the Understanding and Managing Difficult Behaviors curriculum teaches trauma. As mentioned in the ‘Foster Parents’ Understandings of Trauma’ subsection, she noted a reason why this way of teaching is so effective is because foster parents are able to see they too are impacted by these stress responses. She said the following about how teachings on trauma in this curriculum enable foster parents to connect it to their everyday lives:

So, it's just really simplifying neurobiology and really just basically teaching that life is a sensory experience and that you can really use that science to help regulate kids and grownups. That's why weighted blankets work. That's why aromatherapy works. That's why going for a walk or drinking a cold glass of water works, is because those are all positive or neutral sensations put into the body that help bring us back to nervous system regulation.

### ***Key Challenges***

Staff 1, Staff 2, Staff 3, and Staff 6 spoke on key challenges that foster parents face, one of which was cited by Foster Parent C. Staff 1 mentioned that foster parents who have biological children can have trouble understanding they must use different parenting strategies for children who have experienced trauma, explaining, “there’s this idea that, you know, what works for my kids is gonna work for everybody.” Staff 2 discussed this challenge as well, noting the difficulty for foster parents to understand punitive discipline is not always effective with children who have been exposed to trauma. She cited an example of foster parents saying to her and her staff, “I took away everything they have, and they still don’t care, they’re still getting in trouble every day.” She said that, in response, staff try to get these parents to understand that these children may be more responsive to positive reinforcement techniques such as reward charts.

Staff 3 also commented on this challenge. She said parents who remain close-minded and unwilling to learn throughout the training process are often those with the attitude that they

already know how to parent, having already raised their biological children. She said close-mindedness is rarely an issue with foster parents who have not parented before.

Staff 3 also brought up another key challenge while speaking about how people's understandings of trauma need to improve before yoga and mindfulness interventions can become more institutionalized in the child welfare system. She identified a challenge for foster parents is to understand children who have experienced trauma are not in control of all of their behaviors. When probed why she thinks this is so difficult for people to understand, she said:

I just think it's been the mindset for so long that people have control and I need to learn how to. Kids need to learn how to behave. And they're doing this on purpose. They know better because they did that for yesterday or whenever.

She also said some foster parents think this way of reframing children's behaviors is an excuse for children to be disobedient. She discussed how navigating which behaviors children have control over is incredibly difficult, especially in the moment. She summarized this struggle, saying:

How do you separate being lenient all the time and navigating out what they do and do not have control over yet? Which things need a consequence or a punishment; which things need a processing time and a way to put something in place for next time? It's a tough situation when you're in the home.

Staff 6 also discussed how foster parents need to understand children are not in control of all of their behaviors because, if not, they misinterpret children's behaviors as personal attacks rather than manifestations of trauma. The foster parents in one of Staff 2's examples were facing this challenge<sup>20</sup>. Staff 6 said that, despite foster parents having empathy for children's situations, they often express confusion as to why children aren't "grateful" for what they're providing them. They also struggle to understand how everything can be calm one second and the next

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<sup>20</sup> See p. 43

second the child can start acting out. She cited this challenge as a “mental shift” that foster parents need to make, saying:

It's like feeling like you are personally being attacked or someone is upset with you is really unhelpful in those scenarios. I think that piece is where people have a hard time of like, "But like we have this great bond, or we have a really good connection, or I really care about this child." It was like that is all great. But in that moment, it's just not a thing. You just need to take these actions to make sure that the child is safe and to make sure that you're doing what they need.

Staff 6 also mentioned this challenge can be even more difficult with teenagers because it can be hard to remember that, although these youth are older, their behaviors can still manifest from trauma and may reflect a younger developmental age.

Staff 2 identified another difficult challenge for foster parents: loving, protecting, and supporting the children in their care, while remembering that the children may only be in their home temporarily. She noted this is a unique dynamic and, therefore, foster parents must be, “very careful and very thoughtful and very purposeful about the things that [they] do.” She said foster parents need to be open-minded to grapple with this complexity, expanding:

It's also very important, and this is something we find ourselves re-addressing with people a lot of times, because it's not natural, the whole situation is not natural. Even though you want to be inclusive and you want to give that child a caring attitude and you want to comfort them and offer empathy, you also have to remember that they don't belong to you. They are not yours. I think that's a really key thing for foster parents a lot of times is to remember I'm gonna love this child, I'm gonna help this child, I'm gonna do all of the tasks that can make parenting challenging. Sometimes medical appointments, and then you're gonna add therapy appointments, and I'm gonna take this child to visits, and I'm gonna make sure everything's going well with school and help with homework and attend meetings. But in addition to that, I always have to remember, if I'm fostering, that this is not my child. I need to be inclusive and loving, but this is someone else's child.

Foster Parent C mentioned this challenge was something she and her husband grappled with. She said when she was new to fostering, she struggled to navigate how to treat the child in her care as her own child while also recognizing that, legally, they weren't.

Staff 1 and Staff 3 provided their thoughts on how to address some of these challenges. On the subject of parents hesitant to accept parenting strategies different from their own with their biological children, Staff 1 emphasized the importance of teaching in a non-judgmental, neurobiological way, allowing people to come to their own conclusions. She also cited the effectiveness of a video they use in the Understanding and Managing Difficult Behaviors curriculum that helps people understand how the brain is shaped differently as a result of childhood trauma. She said this can be effective because it helps parents realize how children in foster care's brains have developed differently as a result of the trauma they have experienced, adding:

We use this great video from Harvard Center for Developing Child called the Science of Neglect. It really helps people understand how the brain is shaped differently when you don't get what you need in early childhood. So, then it's much easier for them to be like, "Oh, this kid's brain is different than my kid's." We even sometimes say if that were to come up, we say, "What are experiences that you gave your child that helped you parent them later?" They're like, "This, this, this." I'm like, "Do you think your kid got that?" "No." "Okay." This is all about giving a lot of information and allowing people to come to their own conclusions as well.

On the subject of foster parents recognizing how children who have experienced trauma do not have control of some of their behaviors, Staff 3 emphasized the importance of establishing strong relationships with foster parents as a caseworker and educating parents before encountering the situation. When asked how she, as a caseworker, helped foster parents change their mindset around trauma, she responded:

I think it helped where I had a really strong relationship with the foster parents because then they were more likely to trust this new concept that I'm giving them. I also think it's important to talk about these things and to educate the parents when they're not in the thick of it. That they have an idea, so when we start to use this language again - well do you think that it's possible that this triggered that child in a way that their brain not necessarily knowing, felt like it might be a threat because that was similar to this? If we'd talked about it when they weren't in the middle of crisis, it really helped them think, "oh, this is not new."

On this same challenge, Staff 6 mentioned it can be addressed by educating foster parents on trauma's effects on the developing brain.

### *Suggestions*

In addition to recommendations for addressing the key challenges reported in the previous sections, both foster parents and staff made other suggestions. Both Foster Parent A and Foster Parent B spoke of the difficulty in preparing for such a wide range of experiences since all children have unique behaviors depending on different factors. To improve this, Foster Parent A suggested differentiating training classes based on age groups of children foster parents are considering fostering. She said she understands why the training classes cover all age groups, but thinks differentiating the classes could enable the trainers to go deeper into certain topics, explaining:

There was some of us in there that knew at the moment we weren't taking any kids that were over five, right? What that looks like for them could look very different than the people who are saying I want only teenagers. I get why they do it though because who knows? At some point, you might change your mind and do something, and it needs to be a comprehensive training versus a specific training because of the needs of the kids.

When probed which particular topics she remembered wanting to have gone deeper into, she said practical strategies to deal with behaviors that manifest from trauma as well as bias, privilege, and racial sensitivity training.

Staff 1 suggested providing concrete strategies to help foster parents work with children who have experienced trauma and cited the capacity of the Understanding and Managing Difficult Behaviors curriculum to do this, saying:

So, we're hoping that we can change that, that we can start providing some ... You know, here's like 800 things you can try, you know, because that is severely lacking. We do a good job of understanding what trauma is, we do a fairly good job of helping to provide a trauma lens. I feel like we miss out on: here are specific strategies that you can use with kids.

Staff 4 suggested making pre-service training half as long and then mandating another training once a child is placed in the home. She said the following on why this would be helpful:

It would be great if pre-service was half as long before a child is placed, then mandatory second half once a child is placed in the home. This way foster parents would have the ability to apply what they have learned in real time.

Staff 5 echoed this viewpoint, saying, “I think that trauma training offered as in-service training and support, after parents have a child placed in their home, is more effective than training offered before it becomes ‘real.’” Staff 5 also suggested ways to support and encourage foster parents to attend trainings such as having the agency offer child care and providing dinner or refreshments.

Staff 6 suggested investing time into training social workers on how they can support foster parents in understanding the impact of trauma on children. She said this is important because many opportunities to educate foster parents on trauma, triggers, and reframing situations using a trauma-informed lens arise when social workers visit their homes. Staff 6 also suggested investing time and resources into training foster parents with more trauma-focused curriculums, such as Resource Parent Curriculum, which Orange County Social Services has recently received funding to carry out.

#### **Part D: Discussion of Results**

This exploratory study of the concrete skills that foster parents need to help children in foster care heal from past traumatic experiences provides insight into how foster parent training has improved in the past twenty years, as well as the current strengths and shortcomings of foster parent preparation. Foster parents and foster care staff who participated in this study expressed foster parents need communication skills, sensory-based strategies to help them manage their own stress responses, and discipline techniques. The most interesting finding, however, is that curriculums and interventions to help foster parents cultivate these skills have already been

developed. This shows child welfare agencies need to focus their attention on addressing the barriers to equipping foster parents with these existing tools.

### ***Need for Research***

Both foster parents and child welfare agency staff established a clear need for research on the concrete skills foster parents need to work with children who have experienced trauma. The comments made by foster parents and staff on foster parents' lack of concrete skills demonstrate a consensus around the gap between *telling* foster parents about trauma and actually *showing* them how to use information about trauma in a concrete way. Foster Parent B's point that foster parents who do not have a clear understanding of trauma not only fail to help children heal but inadvertently set back their healing processes is especially important. Coupled with the lack of research on engaging foster parents in children's healing processes established in the literature review, the common theme of foster parents' lack of concrete skills indicates a clear need for research on this topic.

### ***Foster Parents' Motivations***

Foster parents' motivations support the need for comprehensive foster parent training on parenting children who have experienced trauma. Foster Parents A, B, C, and E's indications that they had personal stake in fostering when they decided to become foster parents establishes a need for training that prepares foster parents for the challenges that they will face working with children who have experienced trauma. Given that some of the foster parents decided to foster because they did not have an option to have biological children, they need to understand that their preexisting expectations for parenting may not be met. They also need to recognize children in foster care need to be parented differently from other children, which is often more challenging and time-consuming. Therefore, thorough training and support from child welfare agencies to prepare foster parents for these challenges is imperative. If foster parents are not



equipped with the concrete skills to parent children who have experienced trauma, they are more likely to be disappointed by their experiences as foster parents for not meeting their initial expectations.

### ***Foster Parent Training***

The contrast between the comments on the MAPP training classes and the TIPS-MAPP training classes show the integration of trauma information into the MAPP training curriculum led to huge improvements in foster parents' understandings of trauma and preparedness for their roles. The neurobiological definition of trauma provided in the TIPS-MAPP curriculum shows foster parents how and why children who have experienced trauma develop differently than other children and includes imperative discussions on potential triggers that come up during everyday life. Absent from the MAPP curriculum, this scientific discussion of trauma enhanced the quality of foster parent training. Participants' comments on TIPS-MAPP also established the strengths of the curriculum: TIPS-MAPP should be lauded for its overview of the foster care system and the many actors involved, as well as its success in cultivating empathy in foster parents. TIPS-MAPP encourages foster parents to think from the biological family's perspective as well as the child's - an extremely important point for the practice of shared parenting - or building a collaborative relationship with a child's biological family. Given that the idea of having a relationship with a child's biological family can be a difficult concept for foster parents to grasp, the elements of TIPS-MAPP that promote empathy, such as the scenarios and role play activities, are incredibly valuable.

Participants' observations and opinions on the TIPS-MAPP training classes, however, also suggest areas in need of improvement. One such area is concrete skills foster parents can use when the children in their care are acting out or misbehaving. In the TIPS-MAPP training curriculum, discipline is only covered in one class (Children's Alliance, 2014). The class on

“Helping Children Learn Healthy Behaviors” includes important and useful information on the patterns of stress responses, the differences between discipline and punishment, positive reinforcement, and specific strategies foster parents can use for challenging behaviors (Children’s Alliance, 2014). Given that the subject of discipline appears to be something that foster parents struggle with, more time should be spent on this topic to enable trainers to provide foster parents useful strategies. As stated by Foster Care Staff 3, navigating which behaviors children who have experienced trauma have control over is incredibly difficult, and foster parents would benefit from this additional training and support from child welfare agencies.

Another area of improvement for TIPS-MAPP this study identifies is the abstract quality of the training since it occurs before foster parents have a placement. Including more current foster parents as guest speakers is a potential way to improve this. Prospective foster parents should learn how abstract concepts such as “trauma triggers” and “shared parenting” apply to the lives of foster parents with children in their homes. Staff 4 suggested another potential improvement by making pre-service training half as long and then mandating another training once a child is placed in the home, so foster parents can see the relevance of the concepts they are learning and apply them to their daily lives. Overall, participants reported the pre-service training classes are currently insufficient and opportunities for further training are necessary.

### ***Foster Parent Training on Trauma***

TIPS-MAPP teaches foster parents a neurobiological definition of trauma, explaining the effects of trauma stem from stress responses in the brain and nervous system. TIPS-MAPP’s major strength is how it teaches trauma as the stress responses to a distressing experience rather than the distressing experience itself. Furthermore, by teaching trauma as not only abuse and neglect but a range of experiences and emphasizing how there are many potential triggers, TIPS-MAPP successfully cultivates empathy, encourages patience, and ensures foster parents’

awareness and sensitivity to the trauma the children in their care have experienced. Moreover, TIPS-MAPP shows foster parents that trauma is not necessarily a stand-alone event and can be cumulative. This is essential given an aforementioned study by Riebschleger, Day, & Damashek (2015) found that youth in foster care experience enduring and cumulative trauma that impacts their everyday lives.

Nonetheless, this study also indicates ways in which the teaching on trauma in the TIPS-MAPP training classes could be improved. Beyond providing tangible skills, as already mentioned, the training classes could spend more time teaching about dissociative responses to trauma. As discussed in the first part of this paper, Bruce Perry discusses both the hyperarousal continuum and the dissociative continuum as neuronal response patterns for children who have experienced trauma (Perry, 2008; Perry & Pollard, 1998; Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Given that the hyperarousal response of “fight or flight” is easier to visualize than that of dissociation, foster parents could use additional support in understanding the dissociative continuum so they can adequately help children recover.

Understanding the dissociative continuum can also be difficult for foster parents because, as mentioned, foster parents often foster to meet one of their own needs. It can be hard for foster parents to provide love and care for a child who does not seem to be loving or appreciative back. Foster parents need to understand they should not take this personally as it is a response to trauma, not their parenting efforts. In a similar vein, the training classes could spend more time teaching about neglect and its effects on children’s brain development. While foster parents tend to understand that abuse is trauma, the concept of neglect as a traumatic experience can be more abstract. Therefore, foster parents could benefit from additional training on this topic.

### ***Foster Parents' Understandings of Trauma***

Another key finding is foster parents need to understand the neurobiological definition of trauma as well as its connection to their own lives. Both the comments of foster parents and foster care staff on the theme of self-reflection/self-realization revealed the ability of foster parents to recognize and manage their own stress responses as essential because it helps them understand what the children in their care are going through when triggered. It also helps them realize the importance of self-care because, if they become dysregulated in stressful situations, they lose the ability to help children calm down. This self-awareness is essential because only when foster parents realize they, too, are vulnerable to the same stress responses as the children in their care will they be able to learn to remove themselves from the heat of the moment to process why children behave how they do. They need to understand they need to think calmly and rationally in order to manage a difficult behavioral situation. This self-awareness also helps foster parents understand that children who have experienced trauma are not in control of all of their behaviors and, therefore, need to be parented differently than other children. When foster parents understand the concepts that they are learning about trauma apply to their own lives, they can more easily understand how trauma affects the children in their care and manifests in these children's behaviors.

### ***Foster Parents' Concrete Skills Related to Trauma***

This study demonstrates foster parents clearly have a need for concrete skills they can use to help children recover from past traumatic experiences. The primary skills identified by foster parents and foster care staff include communicating and interacting with children, sensory-based strategies that help both foster parents calm down and children self-regulate, and productive discipline techniques. The Understanding and Managing Difficult Behaviors curriculum, developed by the Professional Training Team at the Children's Home Society, seems to be

promising in equipping foster parents with this skill set. It teaches about how trauma and stress responses affect the brain and includes strategies for communication, sensory input, and discipline. Furthermore, it takes place when foster parents have a child in their home, which enables them to apply what they learn in real time. Yoga and mindfulness interventions also appear to be valuable sensory-based strategies that can aid in foster parents' self-care and children's self-regulation.

The most interesting finding from this study, however, is that the skills that foster parents need to work with children who have experienced trauma and help them heal from past traumatic experiences already exist. In other words, there are curriculums, such as the Understanding and Managing Difficult Behaviors curriculum, and interventions, such as Trust-Based Relational Intervention and Parent-Child Interaction Therapy, that teach foster parents the skills the foster parents and foster care staff who participated in this study believe to be essential. Furthermore, there is an emerging body of research on mindfulness interventions for children and youth who have experienced trauma. A randomized control trial of a population of urban youth in a low-income environment, middle-school age male children found that mindfulness instruction benefits individuals with a known trauma or ACE (Ortiz & Sibinga, 2017). Moreover, a study in an urban area in the Rocky Mountains region of the U.S. explored the intervention of teaching mindfulness to substance-misusing families in the child welfare system as a trauma-informed approach (Brown & Bellamy, 2017).

Given the existence of these tools, I argue there is a two-fold reason for foster parents' lack of concrete skills. First, actors in the child welfare system need to accept foster parents as critical partners in children's healing processes. This is consistent with the finding of Redd, Malm, Moore, Murphy, & Beltz (2017) that foster parents should be viewed as "integral partners on a child's care team" (p. 178). It is also compatible with current literature highlighting the need

for consistency in children's healing processes and the engagement of all actors in children's lives, including foster parents (Hall & Semanchin Jones, 2018; Perry, 2009; Perry & Hambrick, 2008). Second, child welfare agency staff need to help foster parents overcome the counter-intuitive challenges of foster parenting. The 'key challenges' identified by foster care staff in this study provide valuable insight into the latter. In order to ensure foster parents are equipped with the tools they need to effectively parent the children in their care, we must think critically about how to address these challenges.

### ***Key Challenges***

The staff at child welfare agencies who participated in this study cited the following three key challenges that foster parents face in their work: 1) Foster parents who have biological children must use different parenting strategies for children who have experienced trauma; 2) Foster parents must understand children who have experienced trauma are not in control of all of their behaviors; and 3) Foster parents must adapt to the unique dynamic of caring for children who may only be in their home temporarily. A commonality between these three challenges is they are all counter-intuitive. In other words, they require foster parents to change their fundamental beliefs about parenting.

As discussed by Staff 1, 3, and 6, these challenges can be addressed by teaching in a non-judgmental way: showing foster parents the science behind trauma, emphasizing how the stress responses are applicable in their own lives, and allowing them to realize for themselves that they need to shift their perspectives on parenting and children's behavior. Staff supporting foster parents could share aspects of their own experiences that changed their perspectives, but foster parents need to come to their own conclusions. Additionally, establishing a relationship with foster parents before addressing these difficult topics helps.

## ***Limitations***

The findings of this study are not generalizable to any larger population of foster parents or foster care staff. When my initial points of contact at child welfare agencies introduced my research via email, participants self-selected, and it is very likely that only those who were interested in the topic of trauma-informed care responded. Furthermore, snowball sampling was used to continue recruiting participants. The time constraints foster parents and staff at child welfare agencies face severely limited my ability to recruit participants for this study. Knowing time constraints would be a barrier for participants, I included the option to participate in a qualitative survey rather than an interview. Using a combination of semi-structured interviews and qualitative surveys further limited my data collection and analysis.

Moreover, the majority of the foster parents who participated in this study were licensed through public agencies, namely county-run departments of social services, while the majority of the staff worked at Children's Home Society, a private agency. Although no major differences between comments by staff at private and public agencies were apparent in this study, it is possible that foster parents' needs and staff's perceptions of foster parents' needs differ between public and private agencies. Future studies should attempt to recruit a larger, more diverse pool of foster parents and staff from both public and private agencies.

## **IV. Conclusion and Recommendations**

Despite its limitations, this study explores the engagement of foster parents as critical actors in children's healing processes, which lacks in current literature on incorporating trauma-informed care into the child welfare system. In conclusion, the foster parents and foster care staff who participated in this study revealed that, while the current pre-service training classes in North Carolina have many strengths, they prove insufficient in providing foster parents with a

toolkit to use when working with children who have experienced trauma. The material taught in the pre-service classes appears too abstract because foster parents do not yet have a placement. Therefore, child welfare agencies must think critically about how they can equip foster parents with a skill set consisting of communication skills, sensory-based regulation strategies, and discipline techniques, when children are actually placed in their homes. I recommend the following for child welfare agencies that train, license, and support foster parents:

**1) Treat foster parents as critical actors in children's healing processes and teach foster parents to view themselves as such.**

In order for child welfare agencies to see the importance of equipping foster parents with a concrete skill set for working with children who have experienced trauma, they must acknowledge foster parents play a central role in children's healing. Foster parents also need to recognize their value in helping children in foster care recover from past trauma.

**2) Clarify foster parents' initial expectations may not be met.**

Many foster parents decide to foster to meet a need they have, expecting to love and care for a child and receive love and appreciation in return. Therefore, it is essential for child welfare agencies to teach foster parents to view their role as something outside of traditional parenting and to be clear and up front about the challenges foster parents will face.

**3) Seek out and utilize curriculums that include specific tools and strategies that foster parents can use, such as the Understanding and Managing Difficult Behaviors curriculum.**

The Understanding and Managing Difficult Behaviors curriculum addresses the gap between information about trauma and concrete skills to utilize the information to be an effective foster parent. Child welfare agencies should seek out curriculums with specific tools to provide in-service training for foster parents.

**4) Teach foster parents they can use yoga and mindfulness interventions to manage their own stress responses and show children how to deal with their responses to trauma more productively.**



According to Bruce Perry, the development of higher parts of the brain, which control cognitive and relational interactions, depends on the development of lower parts of the brain, which control self-regulation and motor activity (Perry, 2008, 2009). Foster parents must understand children who have been exposed to trauma will not be able to communicate about their experiences or build healthy relationships if they are struggling with self-regulation or are unable to control their bodily reactions. Yoga and mindfulness interventions can help children feel safe and in control of their bodies and better regulate their emotions so that they can start to build healthy relationships. An additional benefit of these interventions is they also help foster parents manage their emotions in challenging situations.

**5) Consider adopting organizational models of trauma-informed care used in residential group care programs, such as the Sanctuary Model.**

Child welfare agencies should recognize trauma not only affects people but organizations and consider adopting organizational models of trauma-informed care. Such models, including the Sanctuary Model and the Teaching Family Model, are employed in residential group care programs (Boel-Studt, 2015). However, these models are promising for foster care programs as well.

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## **VI. Appendices**

### **Appendix A: In-Person/Phone Interview Questions for Foster Parents**

*\*The interviews were semi-structured. The questions below served as conversation starters.*

#### **General Questions**

- Tell me about yourself.
- How long have you been foster parents?
- Tell me about the foster children you've had in your care.
  - Age
  - Gender
  - Racial/ethnic backgrounds

#### **Questions About Motivations**

- Why did you want to become foster parents?
- Has your motivation for becoming foster parents changed over time? How?

#### **Questions About Training and License**

- When did you receive your license?
- What kind of foster care are you licensed for? (traditional or therapeutic?; how many children?)
- What curriculum(s) were you trained in?
- Can you give specific examples of how you have used your training in your experience as a foster parent?
  - Tell me about that.
- How have the training classes helped you understand trauma?
- How have the training classes helped you understand how trauma affects the children in your care?

#### **Questions About Understanding of Trauma and Trauma-Informed Care**

- What is your understanding of trauma? (if not answered above)
- What is your understanding of how trauma affects the children in your care? (if not answered above)
- How has your understanding of trauma impacted your parenting, if at all?
  - Do you think it's helped you be more effective?
  - Why? How?
- Do you have any specific practices you use to show the children in your care how to deal with the effects of trauma in productive and acceptable ways?
  - Tell me more about them.

#### **Questions About Experiences as a Foster Parent**

- Which parts of your experience as a foster parent have you felt prepared for?
  - Why? How?
- Which parts of your experience as a foster parent have you *not* felt prepared for?
  - Why?
- Anything else you would like to add?

## **Appendix B: In-Person/Phone Interview Questions for Staff**

*\*The interviews were semi-structured. The questions below served as conversation starters.*

### **General Questions**

- What is your job title?
- What is your role in this position?
- How long have you had this position?

### **Questions About Foster Parent Training**

- Describe foster parent training at your agency.
- What is your overall impression of foster parent training at your agency?
  - Why do you think that?
- How do the foster parent training classes help foster parents understand trauma?
- How do the foster parent training classes help foster parents understand how trauma affects the children in their care?
- How do the foster parent training classes help foster parents provide trauma-informed care to their foster children?

### **Questions About Foster Parents' Understandings of Trauma and Trauma-Informed Care**

- Have you seen foster parents use their understandings of trauma to be effective parents for the children in their care?
  - How?
- Have you observed foster parents show children in their care how to deal with the effects of trauma in productive and acceptable ways?
  - How?
- Have you worked with foster parents who have trouble understanding trauma and how it affects the children in their care?
  - If so, why do you think that they struggled?
- Have you worked with foster parents who have a good understanding of trauma but have trouble applying their knowledge to parent the children in their care?
  - If so, why do you think that they struggled?
- What concrete skills do you think foster parents need to use trauma information to parent the children in their care?
  - Why?

### **Questions About Foster Parents' Preparedness**

- Which parts of their experiences do you think foster parents are well-prepared for?
  - Why?
- Which parts of their experiences do you think foster parents are ill-prepared for?
  - Why?
  - How do you think that could be improved?
- How can foster parents be better prepared to use information about trauma to guide their actions and decisions?
- Anything else you would like to add?



## Appendix C: Survey Questions for Foster Parents

*\*The survey was created online using Qualtrics, a software for survey data collection and analysis.*

### General Questions

- How long have you been foster parents?
- Can you tell me the ages, genders, and racial/ethnic backgrounds of foster children you have had in your care?

### Questions About Motivations

- Why did you want to become foster parents?
- Has your motivation for becoming foster parents changed? How?

### Questions About Training and License

- When did you receive your license?
- What kind of foster care are you licensed for? (traditional or therapeutic?; how many children?)
- What curriculum(s) were you trained in?
- Can you give specific examples of how you have used your training in your experience as a foster parent?
- How have the training classes helped you understand trauma and how it affects the children in your care?

### Questions About Understanding of Trauma and Trauma-Informed Care

- Have you ever thought about the impact of traumatic experiences on your foster children?
  - Yes
  - No
- How often do you think about the impact of traumatic experiences on your foster children?
- Have the children in your care ever had a traumatic experience, based on your own definition of the term, “traumatic experience”?
  - Yes
    - Please explain: \_\_\_\_\_
  - No
- The following events have been determined cause to cause people stress. They come from the Life Events Checklist, which is used to diagnose PTSD, and the Adverse Childhood Experience (ACE) Questionnaire. Please select any events that have impacted your foster children.
  - Physical abuse (for example being hit, slapped, kicked, beaten up)
  - Inappropriate touching
  - Domestic violence in the home
  - Alcoholism and/or drug abuse in the home
  - Mental illness in the home
  - A household member going to prison
  - Feeling like they didn’t have enough to eat, had to wear dirty clothes, and/or had no one to protect them
- Have your foster children ever worked with a therapist/other professional?

- How does trauma affect the children in your care?
- How do you use your understanding of trauma to be an effective parent for the children in your care?
- How do you show the children in your care how to deal with the effects of trauma in productive and acceptable ways?
- Do you have any **specific practices** you use to show the children in your care how to deal with the effects of trauma in productive and acceptable ways?

### **Questions About Experiences as a Foster Parent**

- Which parts of your experience as a foster parent have you felt prepared for?
- Which parts of your experience as a foster parent have you *not* felt prepared for?

## **Appendix D: Survey Questions for Staff**

*\*The survey was created online using Qualtrics, a software for survey data collection and analysis.*

### **General Questions**

- What is your job title?
- What is your role in this position?
- How long have you had this position?

### **Questions About Foster Parent Training**

- What is your overall impression of foster parent training at your agency?
- How do the foster parent training classes help foster parents understand trauma and how it affects the children in their care?
- How do the foster parent training classes help foster parents provide trauma-informed care to their foster children?

### **Questions About Foster Parents' Understandings of Trauma and Trauma-Informed Care**

- How have you seen foster parents use their understandings of trauma to be effective parents for the children in their care?
- How have you observed foster parents show children in their care how to deal with the effects of trauma in productive and acceptable ways?
- Have you worked with foster parents who have trouble understanding trauma and how it affects the children in their care? If so, why do you think that they struggled?
- Have you worked with foster parents who have a good understanding of trauma but have trouble applying their knowledge to parent the children in their care? If so, why do you think that they struggled?
- What concrete skills do you think foster parents need to use trauma information to parent the children in their care?

### **Questions About Foster Parents' Preparedness**

- Which parts of their experiences do you think foster parents are well-prepared for?
- Which parts of their experiences do you think foster parents are ill-prepared for?
- How can foster parents be better prepared to use information about trauma to guide their actions and decisions?