EVALUATING THE IMPACT OF THE WISDOMPATH WAY REPARTIVE PARENTING PROGRAM ON THE PARENTAL SELF-EFFICACY OF FOSTER AND ADOPTIVE PARENTS

A Project

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by

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Stephanie Anne Bagley

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Division of Social Work
Abstract

of

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This exploratory study examined the impact of a 15-hour, 5-week training module utilizing the WisdomPath Way Reparative Parenting Approach on the self-efficacy of foster and adoptive parents. The WisdomPath Way Reparative Parenting Approach is a psychoeducational model that consists of four educational components (Relational LifeSpace, Brain-Based Wisdom, Developmental Pathways, Wisdom-Based Coaching) that provides foster and adoptive parents with knowledge and skills to know how to coach their children to develop emotion regulation skills and to accept and surrender to limits/boundaries and directions/rules. This study utilized secondary data from the training module that utilized a pre/post-test design which was originally administered as the TOPSE (Tool to measure Parenting Self-Efficacy), to measure parental self-efficacy. The study began with 21 parents of foster or adopted children from Yolo County, CA.
Study findings are based on a paired sample t-test and revealed a statistically significant positive difference in total pretest and posttest scores \( t (9) =4.697, \ p=.001, \ (p<.05) \). The findings indicate a greater need for more research involving the WisdomPath Way Reparative Parenting Approach with the foster and adoptive community.

________________________________________, Committee Chair
Teiahsha Bankhead, Ph.D.

____________________________
Date
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Chapter 1

INTRODUCTION

In the United States, there are approximately 415,000 children in the foster care system waiting to be reunited with their biological families or adopted (U.S. Department of Health and Human Services (DHHS), 2014). Foster parents and foster-to-adopt families are responsible for the well-being of the children until the legal system determines whether to reinstate or terminate parental rights (U.S. DHHS, 2014). Many foster homes also act as a transition for children waiting to find an adoptive family or age-out of care. This unique responsibility of fostering a child is accompanied with many benefits, but also certain challenges. Minors legally removed from their primary caretakers have typically experienced one or more of substantiated experiences of neglect, abuse, or threats of harm to their wellbeing (U.S. DHHS, 2014). These incidents of maltreatment are known as adverse childhood experiences (ACEs) and can have taxing effects on children’s personal (Simmel, Barth, & Brooks, 2007), mental, and emotional well-being (Copeland, Keeler, Angold, & Costello, 2007; Garland, Boettiger, & Howard, 2011).

Statement of the Problem

Children and adolescents in foster care have disproportionately higher incidents of problematic behaviors at a rate of three to four times that of the general population (Burns et al., 2004), placing foster parents in the critical position of either helping or hindering their foster child’s ability to cope with their lived experiences. Many children in the foster care system continue to experience emotional, psychological, and behavioral
problems (Dworsky & Courtney, 2009; Lehmann, Havik, Havik, & Heiervang, 2013; Pears, Kim, Fisher, & Yoerger, 2013). As a result, foster children end up disproportionately involved with mental health systems of care (Raviv, Taussig, Culhane, & Garrido, 2010; Lehmann et al., 2013; Vinnerljung, Hjern, & Lindblad, 2006), struggle with academic problems (Pears et al., 2013), are often involved in the juvenile justice system (Fagan, 2005; Ryan & Testa, 2005) and are over-represented in the homeless population (Dworsky & Courtney, 2009). These hardships not only appear in childhood but also often persist into adulthood (Fowler, Toro, & Miles, 2009; Vinnerljung et al., 2006). These problems present behavioral, psychological, emotional challenges that exceed the average foster parent’s ability to parent. As a result, foster children frequently lose their placements and experience multiple moves. According to Rubin, O’Reilly, Luan, and Localio (2007), one in five children (20%) fail to achieve placement stability in the first 18 months of foster care, which increased their risk of behavioral problems 36%-63%. This placement instability further exacerbates children’s problematic behavior and experiences of trauma (Rubin et al., 2007; Leathers, Spielfogel, Gleeson, & Rolock, 2012).

It is imperative that more effective parent training models specific to the needs of foster families are developed to support foster parents who are parenting foster children. Although little research has been done thus far on the effects of parental self-efficacy on placement stability, Morgan and Baron (2011) found in a study of 58 foster parents, that the effects of parental self-efficacy on placement stability indeed point to parental self-efficacy as a mitigating factor in reducing the negative effects of a child’s challenging
behaviors. For the purpose of this research project, parental self-efficacy is defined as “beliefs or judgments a parent holds of their capabilities to organize and execute a set of tasks related to parenting a child” (de Montigny & Lacharité, 2005, p. 390). It is the assumption of this project that improving parental self-efficacy would improve the experiences of foster children thus reducing placement instability and providing them with opportunities to heal and recover from early adverse childhood experiences.

**Background of the Problem**

About 255,400 children and adolescents enter the child welfare system each year, referred for allegations of childhood maltreatment (Child Welfare Information Gateway, 2014). The lived experiences of foster children can include a history of neglect and abuse, otherwise known as adverse childhood experiences (ACE’s) (Kalmakis & Chandler, 2013). There is a growing body of research that positively correlates ACE’s with damaging consequences to the well-being of children (Dube, S., Felitti, V., Dong, M., Giles, W., & Anda, R., 2003). Foster children, despite various evidence-based interventions, continue to display behavioral problems at a higher rate than the general population (Simmel *et al.*, 2007). Children and adolescents in foster care have been found to be over-represented in the homeless population (Dworsky & Courtney, 2009; Dworsky, Napolitano, & Courtney, 2013; Fowler *et al.*, 2009), mental health care system (Raviv *et al.*, 2010; Lehmann *et al.*, 2013; Vinnerljung *et al.*, 2006), and in the juvenile justice system (Fagan, 2005; Ryan & Testa, 2005) despite current interventions. They also experience more academic problems (Pears *et al.*, 2013), and those who display more externalizing behaviors are at an even higher risk for multiple placements (Leathers
et al., 2012; Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007; Rubin et al., 2007; Strijker, Knorth, & Knot-Dickscheit, 2008). The youth who experience more placement instability struggle to engage in future relationships (Stott & Gustavsson, 2010) and develop more problematic behaviors (Rubin et al., 2007) than those who have found stability. The more foster youth struggle to cope with ACEs the more chances they have to fall into the negative cycle of instability.

These problem areas have been identified within the mental health field as behavioral, psychological, and emotional problems that range from externalizing/internalizing behaviors, symptoms of post-traumatic stress disorder (PTSD) (Copeland et al., 2007), attachment disorders (Craven & Lee, 2006), and trauma-informed neurodevelopment (Perry, 2009). For instance, the long-range effects of exposure to adverse childhood experiences can negatively impact the brain, changing the size and volume of the prefrontal cortex (Carrion et al., 2009) and causing neuronal damage (Bellis, Keshavan, Spencer, & Hall, 2000). Children in foster care who experienced early adverse experiences are at an increased risk for neurochemical alterations in their brains resulting from exposure to violence and/or neglect that include elevated stress hormones that leave the child vulnerable to mood dysregulation, hyperarousal, and hyper-reactivity. These behavioral and emotional manifestations of PTSD further inhibit a child’s brain from developing normative learning and memory and emotion management ultimately negatively impacting behavior (Fox, Perez, Cass, Baglivio, & Epps, 2015).
Considering the consequences of ACE’s on foster children it is important for foster and foster-to-adopt parents to be equipped with the tools and knowledge to meet the unique needs of these children to reduce the likelihood of placement failure. As previously noted, several parenting models have been developed to respond to the problematic behaviors of children who may already have significant clinical mental health diagnoses (Kaminski, Valle, Filene, & Boyle, 2008); however, there remains a clear imperative to develop further and/or identify parenting models for foster parents. The sheer number of children not only in the foster care system, but who once in the system then endure placement instability, warrants a systemic response that begins by helping foster parents to better manage and reduce problematic behaviors in the home, so that foster children might experience the placement stability necessary to begin healing and recovering from the early adverse experiences they endured.

**Statement of the Research Problem**

According to the U.S. Dept. of Health and Human Services, there are approximately 415,000 children in the foster care system (2014). As previously stated, the majority of these children suffer from adverse childhood experiences that result in significant emotional and psychological problems and external behavior difficulties. All of these areas of difficulty contribute to placement instability for the foster child, which further exacerbates the problems. While various parenting models have been implemented to address the special needs of foster and foster-to-adopt parents; to date, no model has as yet, demonstrated significant success in reversing the national trend of
placement instability and sustained emotional, psychological, and behavioral problems for the foster and adopted child.

**Study Purpose**

This project aims to make a contribution to extant research on parenting programs specifically designed or modified for the unique needs of foster and foster and foster-to-adopt parents. This project will do so through a research study that employs analysis of secondary data initially administered for internal data collection purposes from the WisdomPath Way Institute during a 15-hour training program for foster and foster-to-adopt parents in the wisdompath way (WPW) reparative parenting approach. The WPW reparative parenting approach is a psycho-educational approach that teaches and coaches foster and foster-to-adopt parents to understand and effectively parent foster and adopted children with identified problems in emotion management/regulation and compliance to rules/directions and limits/boundaries. The WPW reparative parenting approach is a psychoeducational model that consists of four educational components (relational lifespace, brain-based wisdom, developmental pathways, wisdom-based coaching) that provides foster and adoptive parents with knowledge and skills to know how to coach their children to develop emotion regulation skills and to accept and surrender to limits/boundaries and directions/rules. This secondary data analysis will measure parental reports of change in feeling/cognitions related to improved parental self-efficacy. For this research project, self-efficacy refers to a parents’ perception that they are capable and skillful regarding parenting foster children with emotional and behavioral problems. This analysis will serve as a preliminary investigation into one parenting approach that might
serve to mitigate placement instability for foster children whose behaviors are typically experienced by foster parents as unmanageable.

**Theoretical Framework**

The needs of foster children and foster parents are complex and far-reaching. The challenges faced by both groups are affected by systems that are etiological or contributory in nature, such as early adverse childhood experiences endured by the children, the structure of the foster care system, and the ancillary systems of mental health, education, juvenile justice to name only a few. The theoretical framework of this research project is Brofenbrenner’s ecological systems theory (1979) that was further adapted for social work by Germain (1979). Within the ecological perspective, there are five identified systems (microsystem, mesosystem, exosystem, macrosystem, chronosystem) that are viewed as interconnected parts, in which the actions taken within or upon any part of a system, or the interactions between systems, yield changes in all parts of the greater whole (Brofenbrenner, 1979; Germain, 1979; Robbins, Chatterjee, & Canda, 2011).

This ecological framework provides a framework for understanding the interconnectedness of foster children, foster parents, and the various systems that have historically impinged, or are currently affecting functioning and adaptation. In particular, Brofenbrenner’s chronosystem identifies transitions within the life course as critical impingements, both positive and negative, on any individual’s life experience. According to Germain (1979), continuous adaptation is a function of survival, and as it pertains to foster children and foster parents, learning to adapt to and manage stress improves the
quality of life for people within the larger social system. Bronfenbrenner (1979) and Germain (1979) both purport that individuals and groups are interdependent on their environments and that a match between the demands and expectations of the environment and the individual constitutes what is known as “goodness of fit.” Foster parents and foster children are clearly in an interdependent relationship within the context of the larger systemic whole. To effectively evaluate the wisdompath way reparative parenting model necessitates broadening the scope of analysis to include the complexity of the dynamic relationships between parent and child; parent-child within the larger foster care system; and the even more micro-analysis of how the parent feels about his or her own knowledge and capacity to parent children with considerable emotional and behavioral problems.

**Definition of Terms**

For the purpose of this project, it is imperative to define key terms that are distributed throughout this paper. Key terms provide definitions essential to conceptualizing the main points and themes of this research project. Key terms are defined below:

**Foster children:** Children that have been formally removed from their legal caretakers and placed in an alternative residence (Lewit, 1993).

**Adopted children:** Children placed with a new permanent family that assumes full legal custody. (Child Welfare Information Gateway, 2016)
Kinship care: “The full-time care, nurturing, and protection of a child by relatives, members of their tribe or clan, godparents, stepparents, or other adults who have a family relationship to a child” (Child Welfare Information Gateway, 2010).

Foster/adopt parents: Adults who are currently responsible for the care of foster children and may legally adopt a child from their biological caretaker and assume permanent legal custody. (Child Welfare Information Gateway, 2016)

Parental self-efficacy: “Beliefs or judgments a parent holds of their capabilities to organize and execute a set of tasks related to parenting a child” (de Montigny & Lacharité, 2005, p. 390).

Adverse Childhood Experiences: (ACEs): Children who experience one or more incidents of physical abuse, sexual abuse, and emotional abuse before the age of 18 (Kalmakis & Chandler, 2013).

Assumptions
This study assumes that the collected secondary data was received from participants who honestly and truthfully answered the pre and post-survey questionnaire. This study believes that the foster/adopt parents have a desire to increase their parental self-efficacy through improving child compliance. The researchers also assume that the parent participants did not have a sense of self-efficacy before their participation in the 15-hour, 5-week, WPW reparative parenting approach.

Study Limitations
There are multiple limitations of this study. The first limitation is that the secondary data taken from the pre/post test that spans five weeks. This time span made it
difficult to ensure attendance for all five sessions due to the possibility of the participant’s unpredictable schedules. Attendance could affect the posttest in accurately measuring the trainings effectiveness if they were not present for the entire training series. The participants also could have a varying degree of previous knowledge in parent education and parenting experience that influenced their test results. As a result of the small sample size the findings cannot be generalized to the larger population of foster/adopt parents. Due to these limitations this study highlights the importance of continued research on the efficacy of the WisdomPath Way reparative program on increasing the parental self-efficacy of foster/adopt parents.

Statement of Collaboration

This study was made possible through the collaboration of Social Work students, Jennifer Rose and Stephanie Bagley. Both authors contributed equally to the research and analysis of this project. The literature review was divided between the authors, each researching topics concerning children in foster care and parenting programs. Stephanie Bagley was responsible for chapter 1 and Jennifer edited and reviewed the chapter before submission. Jennifer Rose wrote chapter 3 and Stephanie Bagley edited and review the chapter before the final submission. Together they analyzed the secondary data through the Statistical Package for the Social Sciences (SPSS) program. Both parties collaborated on and reported the study findings and final summary. The written portion was guided and overseen by the student’s thesis advisor, Dr. Teiahsha Bankhead.
Chapter 2

LITERATURE REVIEW

The purpose of this literature review is to explore current research related to the negative impact of adverse childhood experiences for children subsequently placed in foster care or who are later adopted, as well as to explore and examine current treatment and parenting training models that aim to enhance the caregivers’ skill and capacity to address and meet the needs of this vulnerable population. The first section of this review will provide an overview of contributing adverse factors that result in the removal of children from the home. The following section will examine identified adverse childhood experiences (ACE’s) considered to be causal contributors to child maladjustment. The third section will explore the implications of parenting high-risk children with adverse childhood experiences in foster/adopt homes. The fourth section will conclude with an examination of the systemic responses to the challenges of parenting children with ACE’s in foster/adopt settings.

Overview of Contributing Adverse Factors that Result in the Removal of Children From the Home

In 2013, Child Protective Services (CPS) agencies around the country fielded approximately 3.5 million referrals of alleged child maltreatment (U.S. Department of Health and Human Services (DHHS), 2015). The Child Abuse Prevention and Treatment Act defines child abuse and neglect as “Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk or
serious harm” (Child Welfare Information Gateway, 2014, p. 12). From the substantiated reports of neglect and abuse, 21.2% of the victims were placed into the foster care system; adding to the growing population of foster children in the United States (U.S. DHHS, 2014).

According to the U.S. Department of Health and Human Services, (DHHS) the majority of children in foster care are victims of neglect (2015). Neglect is defined as a failure of the primary caretaker to provide needed food, clothing, shelter, medical care, educational needs, and supervision. Physical abuse is the second most reported incident, and it is defined as any non-accidental physical injury to a minor which includes kicking, burning, striking, biting or any action that results in the physical impairment of a child (Child Welfare Information Gateway, 2014; U.S. DHHS, 2015).

Sexual abuse is either interpreted in general or specific terms depending on the state’s definition but includes sexual exploitation, child prostitution, child pornography and human trafficking. In addition to the other forms of maltreatment, psychological or emotional maltreatment is focusing on injury to a child’s psychological capacity, emotional stability through evidence of observed or substantial change in behavior, emotional response or cognition. Lastly, other types of maltreatment fall into the category of threatened abuse to a child and parental substance use. This includes any exposure of a child to harm, a child witnessing or being present during manufacturing of controlled substances, distributing drugs to a child and use of substances impairing the ability to care for the child (Child Welfare Information Gateway, 2014). The next section explores the effects of the child welfare system on children removed from their homes due to
substantiated reports of child abuse and the difficulties associated with parenting them once placed in the foster care system.

**ACE’s as Causal Contributors to Child Maladjustment**

The most prevalent term used to describe the conceptualization of adverse childhood experiences can be categorized into physical abuse, sexual abuse, and emotional abuse (Kalmakis & Chandler, 2013). The growing body of research of adverse childhood experiences (ACE’s) begins with the collaborative efforts of Kaiser Permanente’s Health Appraisal Center (HAC) and the U.S. Centers for Disease Control and Prevention and the development of the ACE study. The purpose of the study was to examine the relationship between the adverse childhood experiences and the impact of health outcomes. The study is a large-scale study that utilizes a cumulative stressor model to establish the relationship (Dube et al., 2003).

The outcome of the study yielded significant findings related to the negative impact on health for children who had a history of one or more adverse childhood experiences. Early research revealed that the exposure to even one ACE increases the likelihood of an additional one by about 65-93% (Felitti et al., 1998). From this initial exploration, researchers then began to examine further the impact of not only one ACE but as well, the prevalence and effects of multiple adverse childhood experiences. A further review of later research indicates that ACE’s present varied symptoms and psychological, emotional, and behavioral problems for children that carry into adulthood (Dube et al., 2003; Felitti et al., 1998; Dube, Anda, Felitti, Edwards, & Croft, 2002; Anda et al., 2002; Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001). Common
problems highlighted in the research literature include externalizing versus internalizing behaviors disorders, post-traumatic stress disorder, trauma-informed neurodevelopment, and attachment disorders. A brief discussion of these problems will be further discussed in the following section.

**Behavioral (externalizing/internalizing)**

Children enter into the foster care system with a wide range of behavioral problems identified as maladaptive externalizing or internalizing behaviors that result from the adversity experienced in childhood. According to a National Survey (Burns et al., 2004) comprised of a study population of 3,803 children aged 2-14, children within the foster care system display problematic behavior three to four times the rate of the general population. Statistically speaking, 47% of children display externalizing behaviors as identified on the Child Behavioral Checklist (CBCL) within their first year in the system. Externalizing behaviors that children in foster care display range from aggressive behaviors to self-destructive, and maladaptive interpersonal relationships (Kerker and Dore, 2006). Foster care children with a history of neglect also present with internalized behaviors. These children experience feelings of shame, abandonment, guilt, and rejection whether expressed or observed (Gonzalez, 2014). Foster children with a history of sexual abuse, present both internalizing and externalizing behaviors (Gonzalez, 2014). Children with a presenting history of sexual abuse may display behaviors or symptoms ranging from internalizing behaviors such as isolation, thoughts of suicide, and distrust in adults to more aggressive or self-destructive behaviors (Campagna, 2006).
Simmel et al. (2007) conducted a longitudinal research study analyzing a data set collected on behalf of California Long Range Adoption Study. The study illuminated the continued issue of behavioral problems for foster children despite intervention. The study included 293 foster children that had been adopted and 312 foster children that remained in the system. The outcome of the research study resulted in an alarming revelation. Children in foster care for the duration of their childhoods’ demonstrated behavioral problems at higher levels than foster children who were eventually adopted. Nonetheless, children adopted out of foster care still demonstrated behavioral problems at higher rates than the general. The results of these studies are clearly discouraging, as the removal of children from their abusive and/or neglectful homes does not seem to yield the positive effects on children’s overall psychological and emotional health that has historically been hoped for. Despite the results of adoption, children that have been removed from their homes continue to experience behavioral problems at a higher rate than their counterparts.

Post-traumatic Stress Disorder

Children entering into foster care have experienced a traumatic event that resulted in some form of county or state intervention that resulted in the child’s eventual removal from their biological parent(s). Witnessing domestic violence and/or being physically and/or sexually abused, and/or neglected, is a traumatic experience for a child regardless of age (Copeland et al., 2007; Dube et al., 2005). Removal from the environment has been the response by law enforcement and children’s protective services across the United States to ensure the immediate safety of the child. Removal from the biological
parent(s); however, is also typically experienced by children as a traumatic event as well, and as such, children who are removed from parents for their safety suffer greatly. These events can ultimately result in a child having a greater risk for the development of symptoms of post-traumatic stress disorder. Research suggests that roughly 25% of children that have experienced a traumatic event will present with PTSD (Copeland et al., 2007). In a review of the literature, children who have experienced a traumatic event display symptoms of PTSD that range from nightmares, affective dysregulation, intrusive imagery, depression, anxiety, self-destructive tendencies, chronic tension, etc. (Copeland et al., 2007; Dube et al., 2005).

Research efforts conducted by Dubner and Motta (1999) examine the prevalence of PTSD in 150 foster children, 8–19 years old. The results of the study revealed that 64% of children had a history of sexual abuse, 42% of children had a history of physical abuse, and only 18% of the children did not experience sexual or physical abuse but were also diagnosed with PTSD.

Children with a history of maltreatment-related, post-traumatic stress disorder often have corresponding traumatic brain impairment. Through the use of functional, magnetic brain imaging (FMRI), researchers have begun to conclude that children with maltreatment-related PTSD have smaller prefrontal cortex volume (Bellis et al., 2002; Carrion et al., 2009). Additionally, individuals diagnosed with maltreatment-related PTSD, present with lower N-acetylaspartate/creatine ratios in the anterior angulate, that potentially result in neuronal damage or neuronal loss (Bellis et al., 2000).
Trauma-informed neurodevelopment

As previously stated, children who experience abuse, neglect, maltreatment, and subsequent removal from their primary caregivers are eventually placed in the foster care system. These traumatic experiences occur during crucial development of the child’s brain. The impact of these experiences on the organizing and developing brain can be detrimental to the function and structure of the brain (Perry, 2009). Research continues to find evidence that adverse childhood experiences can cause damage to chromosomes and result in structural and functional changes in the developing brain (Fox et al., 2015; Perry, 2009). Exposure to ACE’s can cause the development of a heightened neural state that triggers the brain to excrete adrenal steroids, amino acids, and other stress provoking chemicals known as the allostatic response (Garland et al., 2011). The result of the chronic release of stress neurochemicals causes an allostatic load that may lead to permanent neurochemical elevations that lead to negative behavioral responses associated with stress (Cicchetti and Toth, 2005).

Seventy-five percent of children, ages 12-36 months, entering the foster care system do not yet have a formal mental health diagnosis but have been found to be at medium to high risk for neurodevelopmental problems (Herman-Smith, 2009). Research illuminates that children coming into the foster care system are already arriving at a deficit with regard to significant alterations in neurodevelopment (Perry, 2009; Perry & Pollard, 1998). This early negative impact on the development of the brain is also further exacerbated by the disruptions in the bonding and attachment relationship between the
child and his or her caregiver that is now considered essential for healthy development and maturation.

**Attachment disorders**

Bonding and attachment between child and parent serve to develop for the child, an internalized sense of security, safety, and belonging (Perry, & Dodson, 2010). Children who experience a disruption in this process, either within the biological parent-child relationship itself, or through the subsequent removal from their birth parent, will suffer profound consequences (Ainsworth, 1989; Bowlby, 1980; Karen, 1994; Nelson, 2000; Perry, & Dodson, 2010; Schore, 2000; Siegel, 1999; Solomon & George, 1999).

Recent research has established three critical challenges that infants and young children face when entering into foster care (Dozier, Higley, Albus, & Nutter, 2002). The first challenge for a child is rooted in the initial failure of a previous attachment relationship, that now may leave the child unable to form attachments to his or her new caregiver (Stovall & Dozier, 2000; Tyrrell & Dozier, 1999). The second challenge is that some caregivers do not provide a nurturing sense to infants despite their signal of their needs for reassurance (Stovall, et al., 2000). This is a challenge is reflective of the possibility that the foster parent may not read the signals of the infant/child who is entering the system. The last of the challenges is rooted in the failure of the birth parent for any number of systemic reasons, to establish sufficient experiences of attachment to procure for the child, a sense of safety and security. As a result, the child is often dysregulated behaviorally and physiologically, which sets up a cycle of placement losses.
as the behaviors of the child overwhelm the foster parents capacity to manage the behaviors (Fisher, Gunnar, Chamberlain, & Reid, 2000; Craven & Lee, 2006).

**Parenting High-Risk Children in Foster and Adopt Homes**

Currently, in the United States, there are 415,129 children in foster care with an average of 255,400 children entering care each year (U.S. DHHS, 2014). This rate of entry is at a pace of a child entering the welfare system every two minutes. Over half of the children in foster care have reunification with their parent or principle caretaker as their primary case plan goal. The other 107,918 children are waiting to be adopted. Foster families eventually adopt over half of the foster children waiting for adoption. Many children wait, on average, 32 months for adoption, and close to 12 months for reunification with their parents (U.S. DHHS, 2014).

As children wait for reunification or adoption, foster, and adoptive parents play a significant role in the foster child’s life. As a result of the early childhood experiences of neglect or abuse, these children are a vulnerable population more susceptible to a multitude of social, emotional, and psychological problems. These challenges include placement instability (Fisher, Burraston, Pears, 2005; Leathers *et al.*, 2012; Lewis *et al.*, 2007; Rubin *et al.*, 2007; Stott & Gustavsson, 2010; Strijker *et al.*, 2008), mental health diagnoses (Lehmann *et al.*, 2013; Raviv *et al.*, 2010; Vinnerljung *et al.*, 2006), educational problems (Bernedo, Salas, Garcia-Martín, Fuentes, 2012; Bernedo, Salas, Fuentes & Garica-Martín, 2014; Harden, Duncan, Morrison, Panlilio & Clyman, 2015; Pears, Kim & Fisher, 2008; Pears *et al.*, 2013; Pears, Heywood, Kim, Fisher; 2011), homelessness (Dworsky & Courtney, 2009; Dworsky *et al.*, 2013)(Fowler *et al.*, 2009),
and over-representation in the juvenile justice system (Fagan, 2005; Cusick, Havlicek & Courtney, 2012; Ryan & Testa, 2005; Yampolskaya & Chuang, 2012). These challenges are discussed in greater detail below.

**Multiple foster home placements/placement instability**

Foster children spend a considerable amount of time waiting to be reunified with their biological families or adopted into a new family (U.S. DHHS, 2014). As previously noted, these children present with a multitude of emotional and behavioral challenges that can make sustained placement in one home difficult. Research suggests that on average, children in the foster care system experience one placement per year in care (Striker et al., 2008). Rubin et al. (2007) suggest that placement instability can be related to either a failure within the child welfare system to provide stability or is due to problems within the foster or adoptive family in which there is a poor match between child and family (Leathers et al., 2012). Regardless of the reasons; however, extensive research on the topic of the impact of multiple placements on children points to long-term negative effects on the well-being of foster children, ultimately diminishing their chances of finding permanency with a family in the future (Fisher et al., 2005; Leathers et al, 2012; Lewis et al, 2007; Rubin et al, 2007; Stott & Gustavsson, 2010; Strijker et al, 2008).

Research also suggests that permanency placement is imperative for the healthy development of children in foster care. Fisher et al. (2005) studied 54 preschool age children in the foster care system that were now in potentially permanent placements. The study found that the more placements the children had before the study, the less likely they were to find stability with their new placement. A protective factor that decreased
the number of placements was the implementation of an early intervention foster care program. Another protective factor (Morgan & Baron, 2011) identified in a study of 58 foster parents examining the correlation between parental self-efficacy and placement stability, found that parental self-efficacy is a mitigating factor in reducing the adverse effects of problematic behavior.

Fisher et al., (2005) also found that children who experienced multiple placements were vulnerable to the impact of disrupted relationships, relocation trauma, and uncertainty about the future. Stott & Gustavsson (2010), in a study on the effects of multiple placements on adolescents, lent further support for the negative effects of multiple placements, finding that continued instability throughout childhood into adolescence has a negative outcome in the child’s ability to transition into adulthood. According to Stott & Gustavsson (2010), adolescents especially feel discouraged after multiple placements which then serves to inhibit later efforts to engage in future relationships, limiting their ability to secure stable social networks with an individual or family that are crucial for success during this life stage.

Research studies done within the last 15 years have found that the major predictor of placement instability for children is the presentation of externalizing behavior problems that can include oppositional behaviors, fighting, inability to follow rules, and discord with peers or family members (Leathers et al., 2012; Lewis et al., 2007; Rubin et al., 2007; Strijker et al., 2008). Strijker et al. (2008) examined the placement histories of 419 children ages 0-18 placed in long-term foster and kinship care in North Netherlands. Through examining the files and interviewing caseworkers found that in addition to
externalizing problem behaviors, children’s ages, a diagnosis of attachment disorder, and the breakdown of new foster care placements also negatively affected children’s placement stability. In a similar study, Rubin et al. (2007) found similar findings after examining the first 18 months of placement stability in 729 foster children in out of home care from the National Survey of Child and Adolescent Well-being. Even though many of the children arrived in the child welfare system with behavioral problems, placement instability within the first 18 months resulted in a 63% increase in behavior problems compared with the children who were stabilized early. The longer the children floated between placements the more their behavior was impacted (Rubin et al., 2007).

**High presence in mental health systems**

Given the abuse and neglect they have endured, many children involved in the foster care system are at a higher risk for developing a mental illness with a resultant mental health diagnosis (Raviv et al., 2010; Lehmann et al., 2013; Vinnerljung et al., 2006). Risk factors that contribute to the likelihood of developing a mental illness include experiencing neglect/abuse, multiple placements, and exposure to familial and/or community violence. These factors strongly increase a child’s risk for specifically developing anxiety, depression, post-traumatic stress disorder (PTSD) and disassociation (Raviv et al., 2010). Research suggests that these children are likely to have sustained mental disorders even as they age out of foster care and enter into adulthood (Lehmann et al., 2013; Raviv et al., 2010; Vinnerljung et al., 2006).

In 2006, Vinnerljung et al. conducted a study on former child welfare clients. Their findings demonstrate an increased risk of suicide and psychiatric hospitalization for
a wide range of serious psychiatric disorders for the adolescents and young adults in the study. Raviv et al. (2010) also found that youth exposed to maltreatment and subsequently placed in long-term foster care had higher rates of suicidal risk than their peers who had lived in more stable homes. Vinnerljung et al. (2006) also found that adolescents in foster care are five to eight times more likely than their same-age non-foster care counterparts, and four to six times more likely in young adulthood as compared to same-age non-foster care adults to be hospitalized for psychiatric disorders. In addition, Lehmann et al. (2013) and Raviv et al. (2010) found that foster children are not only at risk for developing one psychiatric disorder but many experience comorbid symptoms with other diagnoses that include problematic externalizing behaviors. For instance, Lehmann et al. (2013) discovered that 30% of the foster children with a mental health diagnosis also had ADHD or other behavioral disorders, such as Conduct Disorder or Oppositional Defiant Disorder. The more early childhood adversity children in foster care experienced, the higher they scored on mental illness diagnoses scales and comorbidity with other diagnoses and behavioral problems (Lehmann et al., 2013; Raviv et al., 2010).

**Academic problems**

Another area that is negatively impacted for children in the foster care system is school behavior and academic learning. While research indicates that positive school engagement in early childhood is a protective factor against negative outcomes in later school performance (Pears et al., 2013) children in foster care who have experienced maltreatment are at an increased risk for a myriad of problems behaviorally, socially, and
academically. Problems include inadequate school engagement (Pears et al., 2013), lower cognitive functioning (Pears et al., 2008), below average pre-reading scores (Pears et al., 2011), and poor school performance (Bernedo et al., 2014) making foster youth one of the most vulnerable populations in the school system (Zetlin, Weinberg, & Shea, 2006).

Pears et al. (2011) also examined the pre-reading skills of 63 kindergarten age children in foster care before and during the school year. The results showed average pre-reading deficits that were in the 30th and 40th percentile. Harden et al. (2015) sampled 47 preschool-aged children by researching their socio-cognitive developmental processes in a study that sought to evaluate compliance and internalization of values and rules. Harden et al. (2015) found that children in foster care who had histories of maltreatment were less likely to display compliance and internalization of parental rules which ultimately lead to more externalizing behaviors within the school setting.

Further research by Pears et al. (2013) suggests that children that fail to engage in school in early elementary are at a greater risk for negative outcomes in later schooling. In 2013, Pears et al. compared a group of maltreated children living in foster care to a group of low SES, non-maltreated children in the community. The longitudinal study investigated school engagement in behavioral, affective and cognitive categories from early elementary to late elementary school. Foster children with maltreatment history displayed lower early school engagement, which subsequently increased the risk of substance use, externalizing behaviors, and deviant peer association in their future academic careers (Pears et al., 2013).
Recent research by Bernedo *et al.* (2012) studied 97 foster children using the Teacher Report Form (TRF) to compare children in foster care with children not in foster care, and discovered that foster children had scores typically closer to the borderline and clinical range for externalizing and internalizing scales. The study also revealed differences in behavior based on the gender of the student finding that male children in foster care display more behavioral problems than their non-foster care peers. Boys in the foster care system also scored higher on impulsivity/inattention than the female students in foster care (Bernedo *et al.*, 2012).

Not only do age and gender play a specific role in foster youth’s success in school but also the type of maltreatment they experienced before entering the child welfare system. Pears *et al.* (2008) analyzed the reports of maltreatment incidents for 117 preschool-aged foster children to investigate if there was a correlation between the type of abuse they experienced and impairment in psychosocial and cognitive functioning. They found that children who displayed the lowest cognitive functioning scores were associated with a history of neglect or physical abuse while children with a history of sexual abuse, physical abuse or emotional maltreatment scored higher in cognitive function but displayed more externalizing behaviors. The participants with the highest profiles in internalizing behaviors were the children who experienced physical or sexual abuse.

**Over-represented in homeless population**

Children in the foster care system clearly struggle with a wide range of emotional, behavioral, and psychological problems; however, they typically endure even more
problems as they “age out” of the child welfare system that often results in the experience of homelessness. Dworsky & Courtney (2009) evaluated the adult functioning of former foster youth by following a sample of 732 foster youth aging out of care from Illinois, Wisconsin, and Iowa. In this longitudinal study known as the Midwest Evaluation of Adult Functioning of Former Foster Youth (MEAFFFY), the participants were interviewed at the age of 17 or 18 and then again at age 19. One in seven youth who were interviewed and had exited care at 19, had experienced homelessness. Over half of these episodes happened within 6 months of leaving care, and the youth who experienced homelessness once were more likely to experience it again in the future. In 2013, Dworsky et al. conducted further research with the data collected from MEAFFFY from Dworsky & Courtney (2009). They found the factors that increased a youth’s likelihood of experiencing homelessness was a history of running away, placement instability, male gender, history of physical abuse, engagement in delinquent behaviors, and having mental health symptoms (Dworsky et al., 2013).

Two strong protective factors against homelessness are a close relationship with one or more adult family members and staying in care until age 21 (Dworsky & Courtney, 2009). According to Fowler et al. (2009), they researched the housing outcomes of 265 adolescents who left the foster care system between 2002 and 2003 in a mid-western metropolitan area. After the two year period they found that over half of youth aging out of foster care found stable housing within two years, However, the MEAFFFY study found that there is still up to a 47% chance that the youth in foster care will experience one episode of homelessness before the age of 26 (Dworsky et al., 2013).
The transition to adulthood is challenging for foster youth, and there is a considerable risk for adolescence to experience homelessness within the first few crucial years of young adulthood (Fowler et al., 2009).

**Juvenile justice system involvement**

A final issue for children who have experienced maltreatment and subsequent foster care placement is the correlation between early maltreatment and placement in foster care with an increased risk for delinquent behaviors in adolescence that results in involvement with the juvenile justice system (Fagan, 2005; Ryan & Testa, 2005). The majority of foster youth have been removed from their primary caregiver because of substantiated evidence of childhood abuse and neglect (U.S. DHHS, 2014). An analysis of the National Youth Survey (NYS) that was taken from 1976 to 1992 with 1,725 adolescents from the United States, ranging in age from 11-17 years old, explored correlations between physical abuse and criminal offending (Fagan, 2005). Through the investigation of the NYS, Fagan (2005) found enduring effects of adolescent physical abuse and the prevalence of offenses including violent and non-violent crimes, drug use, and intimate partner violence. An additional study linking delinquency and childhood maltreatment was conducted by Ryan & Testa (2005), analyzing the data of 18,676 children involved with the Illinois Department of Children and Family Services in Cook county. Ryan & Testa (2005) found that there was a 47% higher delinquency rate in children with maltreatment histories over children without a history of maltreatment. These findings suggested that removal from their homes increased the risk of developing delinquent behaviors as compared to children who stayed with their biological parents.
Surprisingly, two studies found that placing children into the foster care system resulted in an increased risk for involvement with the legal system (Fagan, 2005; Ryan & Testa, 2005).

According to Yampolskaya and Chuang (2012), the presence of a mental health disorder and an absentee parent are predictive factors for foster children’s involvement with the juvenile justice system. The study analyzed a sample of 5,720 children in Florida aged 7-17 who were removed from their homes due to maltreatment. Conduct disorder specifically was a strong predictor of juvenile justice participation. The presence of a mental health disorder also strongly predicted the likelihood of recidivism by 80% (Yampolskaya & Chuang, 2012). Involvement in the legal system does not only exist during a foster youth’s time in care but can have lasting affects into adulthood. A survey conducted in California by McCarthy & Gladstone (2011) revealed that the prison inmate population in 2008 was comprised of 14% of adults who had been placed in the foster care system at some point in their lives. These significant findings provide strong correlations for the link between children in foster care and their increase risk for current and future involvement with the legal system. The following sections will explore in more detail how agencies and the community have responded through the implementation of required parenting programs to address these disparaging outcomes in high-risk foster youth.
Systemic Responses to the Challenges of Parenting Children with ACE’s in Foster and Adoptive Settings

Foster children are disproportionately represented in almost every systemic response to childhood trauma and the negative sequela associated with it. Foster children struggle in almost every arena of their lives and invariably end up in one or all of the systems that respond to these psychological, emotional, and behavioral problems. These systems are vast and include multiple responses from the various systems, mental health, juvenile justice, medical, educational, political, and legislative to name but a few. A review of the literature related to the scope of systemic responses exceeds the limits of this study. Two evidence-based therapeutic responses that have been adapted to the unique of foster and adoptive children and parents and three parent-training programs will be examined. Also, two parent-training models specifically developed for foster parents and a third model adapted for foster parents will be reviewed.

Trauma-focused cognitive behavioral therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy, developed by Cohen, Berliner, and Mannarino, (2010) is an evidence-based practice (Child Welfare Information Gateway, 2007). The model is a psychosocial treatment approach developed to treat traumatized school-aged children and has been adapted for foster parents and their children (Gonzalez, 2014; Weiner, Schneider, & Lyons, 2009; Cohen et al., 2010). TF-CBT is centered on a discrete trauma that helps children to build a narrative of the traumatic experience. Individual therapy with the child attempts to reduce physiological manifestations of stress and symptoms of PTSD through psychoeducation about
biological stress and responses, and relaxation techniques (Weiner et al., 2009). A concomitant parenting component teaches parents standard behavior management and skills training that are implemented within the context of trauma-focused therapy (Cohen et al., 2010).

Weiner et al. (2009) conducted a research study to examine the implementation of the TF-CBT model adapted to foster children. This study examined the application of TF-CBT with a culturally diverse population of foster youth ranging from 3-18 years old. The study consisted of 2434 participants. The study demonstrated cross-cultural efficacy.

**Parent-child interaction therapy (PCIT)**

Parent-Child Interaction Therapy (PCIT) is an evidence-based intervention developed in the 1970's by Sheila Eyberg, Cheryl McNeil, Toni Hembree-Kigin, Anthony Urquiza, Robin Gurwitch, and Beverly Funderburk as a model to help develop healthy parent-child relationships through the use of interventions that target the development of parent skill sets to enable parents to better respond to a child’s disruptive and problematic behaviors (Urquiza & Timmer, 2012; Travis et al., 2013).

The theoretical framework of PCIT is rooted in social learning and attachment theories that inform the 14-20 week intervention (Urquiza & Timmer, 2012). The target population is parents of children that are between the ages of 2-7 years old who display disruptive or externalizing problematic behaviors (Eyberg & Robinson, 1983; Urquiza & Timmer, 2012). PCIT is composed of two dependent phases, Child-Directed Interaction and Parent-Directed Interaction. The therapist coaches the parent behind a one-way mirror through the use of an earpiece. Parents are initially trained to improve the
relationship with their child by learning and then practicing reflective statements that refrain from judgment or direction. They are taught the use of an Active Ignore intervention if the child displays negative behaviors; however, in the first phase, parents are directed to avoid giving directions or consequences. In the second phase, parents are taught to give directions and follow-through consequences. Throughout the sessions, parents are encouraged and supported to build on their skills to better address their children’s problematic behavior by improving the quality of the parent-child relationship and developing the skillful use of consequences (Lyon & Budd, 2010).

Although PCIT was originally developed to improved parent-child interactions for high-risk biological parents; there have been subsequent adaptations for work with foster parents and their children (Weiner et al., 2009). Research efforts conducted by Mersky, Topitzes, Grant-Savela, Brondino, and McNeil (2016), attempted to evaluate the adaptability of PCIT to foster families. The study population was composed of 102 foster children. The results of the study revealed that adaptations of the PCIT training were considered efficacious for foster families.

**Parenting models**

There are a number of studies aimed at researching both parent training models designed specifically for foster parents as well as existing parent training models that have been adapted to meet the needs of foster children with behavioral problems (Linares, Montalto, Li, & Oza, 2006; Nilsen, 2007; Sanders, Cann & Markie-Dadds, 2003).
Keeping foster parents trained and supported (KEEP). The development of Keeping Foster Parents Trained and Supported (KEEP) was developed through the efforts of Patricia Chamberlain as a parenting model to meet the specific needs of foster parents (Leathers, Spielfogel, Mcmeel, & Atkins, 2011). KEEP was established as a preventative intervention for elementary aged foster children. The model is delivered over the length of 16 sessions and provides a group setting training that demonstrates parent management skills while simultaneously providing support along the way (Leathers et al., 2011).

In a pilot study conducted by Leathers et al. (2011), the researchers examined the adaptability of the KEEP model to a diverse population. The study purpose was an analysis of the models efficacy with a target population of African-American foster parents that were caring for children with behavior problems living within an urban environment. The focus of the study was the interventions ability to positively influence the foster child and parent interactions to decrease the problematic behavior. The study population was composed of 25 foster parents and 21 children. The methodology of the study included a control group and an intervention group. The assessment tools utilized in the study consisted of the Alabama Parenting Questionnaire and the Child Behavior Checklist. The study’s findings presented that both externalizing and internalizing behaviors significantly decreased post-intervention. Parents reported an increase in consistent discipline and a decrease in yelling and hitting.

The results from this study reveal the KEEP model’s efficacy working with the specific population of foster parents. The study additionally provides evidence supporting
the adaptability in presenting to a diverse population. The present research illuminates the need for the KEEP model to be implemented in more diverse settings to analyze the effectiveness of the model across cultures (Leathers et al., 2011).

**Incredible years parent training program.** Webster-Stratton developed Incredible Years with the purpose to strengthen parental competencies in their abilities to provide changes for the child to develop social competence, ability to regulate emotions, increase positive characteristics, and success in academics by reducing child’s presenting risk of conduct problems. The model is implemented by two group leaders with groups from 10 to 14 caregivers that meet for two hours each week for 12 to 14 weeks. The program provides the use of modeling social skills, coaching, child-directed play, ignoring, modulating emotions, and increase the capacity of the child to self-regulate. The intervention additionally includes education of developmental abilities and expectations and temperaments (Marcynyszyn, Maher, & Corwin, 2011).

A study conducted through the efforts of Marcynyszyn et al. (2011), aimed to evaluate the implementation and the efficacy of outcomes with the child welfare population of the Incredible Years Parent Training Program. The study population was composed of 41 caregivers. There were five self-reported surveys utilized to measure parenting behaviors, social support, and satisfaction of the caregivers in the program. The tools used to measure were pre and post assessments: the Parenting Stress Index-Short Forms, Multidimensional Scale of Perceived Social Support, Family Support Scale, Strengths-Based Practices Inventory, and Adult-Adolescent Parenting Inventory.
The results from the study showed a significant decrease between the pretest and posttest statistics on levels of parental distress and experiencing child difficulty. Also, caregivers reported experiencing feels of greater support. Overall, the study concluded with statistically significant findings in the decrease of previously problematic behaviors of parent and child but continued research efforts are needed. There has yet to be an establishment of IY as an evidence-based intervention that meets the specific needs of the welfare population (Marcynyszyn, et al., 2011). There continue to be efforts made within the field of research to explore the models efficacy within the welfare population.

**Attachment and biobehavioral catch-up.** Attachment and Biobehavioral Catch-Up is an early parenting intervention developed by Dr. Dozier (Lewis-Morrarty, Dozier, Bernard, Terracciano, & Moore, 2012). The model is composed of 10-sessions developed to increase the child’s ability to self-regulate (Lewis-Morrarty et al., 2012). The intervention is comprised of two components: establishing a nurturing parental response to a child’s distress and attunement of the parent and child relationship (Lewis-Morrarty, et al., 2012). The targeted areas of the program are to work with the caregivers to learn and reinterpret the alienating behaviors of their child, assisting caregivers to manage their issues that may cause interference in their ability to provide nurturing care, providing an environment that allows the children to develop regulatory capabilities (Dozier, Linheim, Lewis, Bick, Bernard, & Peoloso, 2009).

In a follow-up study conducted by Lewis-Morrarty et al. (2012), the aim was to evaluate the change in children’s abilities to self-regulate. The population was comprised of 61 children ages 4 to 6 years old of ethnically diverse backgrounds. The tools of
measurement utilized in the study were the Dimensional Change Card Sort, Peabody Picture Vocabulary test, Brief Symptom Inventory, and parents provided information to evaluate the potential prenatal risk indices. Additionally, the researchers implemented the use of a penny-hiding game to evaluate the child’s theory of mind abilities, which can be understood as the child’s ability to understand the viewpoint of another person.

The results from the study signified a difference between the varying groups, foster care control (FCC), non-foster care (NFC), and the ABC children (ABC). The FCC group scored significantly lower in their performance ability on cognitive tasks than the other two groups. Additionally, children in the ABC groups scored significantly higher than the FCC group measuring their theory of mind abilities. Overall, the study highlights the importance of continued research on an intervention that supports normative executive function development and theory of mind abilities to enhance children’s ability to self-regulate. (Lewis-Morrarty et al., 2012).

The intervention has been effective in working with foster children at a behavioral and biological level (Lewis-Morrarty et al., 2012). This intervention serves as an early intervention parenting approach for foster children to develop healthy functions and capacities as a means to be competent socially and within a school environment.

Summary

As stated, there are 415,129 children within the foster care system that have been removed from the care of their parents due to neglect, physical abuse, sexual abuse, maltreatment, etc. (U.S.DHHS, 2014; Child Welfare Information Gateway, 2014). These children have suffered a range of adverse childhood experiences leading to an impact on
their health, mental health, neurodevelopment, and behavior (Dube et al., 2003; Felitti et al., 1998, 2001; Dube et al., 2002; Anda et al., 2002; Dube et al., 2001; Herman-Smith, 2009). Consequently, foster children exhibiting such symptoms and behaviors are represented disproportionately within multiple systems of their environment.

In an attempt to remediate these issues, therapeutic interventions and parent training programs have been either specifically developed for foster parents/children or adapted from other pre-existing models to meet the unique needs of the population (Weiner et al., 2009; Leathers et al., 2011; Lyon & Budd, 2010; Marcynyszyn et al., 2011; Lewis-Morrarty et al., 2012). Although these studies reveal promising results, high rates of placement failure for the child related to parent’s lack of perceived parental self-efficacy highlight the need for continued parent training program development and research.

**Conclusion**

Currently, there are a number of interventions that have been developed and implemented to address the needs of foster children and foster parents. These interventions target problem areas for the child that present as a range of externalizing and internalizing behavior disorders, PTSD, school problems, involvement in the juvenile justice and mental health systems, and an over-representation in the homeless population. Responses to the systemic issues include therapeutic approaches and parenting programs. Despite these interventions, foster children continue to experience problems that put them at risk for placement instability, loss of placements, and multiple placements. Ongoing research points to the need for more comprehensive approaches that improve parental
self-efficacy, as recent research shows promise for increasing the likelihood of placement stability for foster children when parents report parental self-efficacy.
Chapter 3

METHODOLOGY

The purpose of the chapter is to provide the reader with the methods that were utilized by the researchers to analyze and interpret the collected secondary data to address the research design. The researchers conducted a secondary data analysis that explored the training's efficacy of implementation within the agency's target population. The study is a quantitative, experimental design.

Study Design

The study is an exploratory research design. The researchers were the first to conduct and analyze the efficacy of the WPW reparative parenting approach. Previous research efforts have been made to evaluate parent-training programs and measure changes in the desired outcome of increased parental self-efficacy (Abdille, 2012; Bloomfield & Kendall, 2012; Bloomfield & Kendall 2010; Bloomfield & Kendall, 2007). The aim of the study is to evaluate the efficacy of the WPW reparative parenting approach 15-hour, 5-week training on parental- self-efficacy of foster and adoptive parents. The researchers will analyze secondary data that is composed of pretest and posttest assessments to obtain a baseline score of parental self-efficacy to measure the desired outcome of increased self-efficacy.

Study Population

The population was composed of foster and adoptive parents that participated in the 15-hour, 5-week WPW reparative parenting approach training. The sample consisted of 21 participants that ranged in age from 20-60. Regarding gender, 12 identified as
female and 9 identified as male. The study sample was composed of individuals from different racial backgrounds (White, African American, and other). Their educational level ranged from high school graduate to Ph.D. The number of children in home ranged from 0 to more than 5. Twenty-one participants completed the pretest TOPSE assessment. Eleven participants completed the post-test TOPSE assessment; nine did not complete the entirety of the five week session and assessment.

**Sampling Procedures**

The researchers of this study recruited an outside agency, WisdomPath Way Institute, with the purpose of requesting original data from previously conducted trainings. The database the agency provided to the researchers is composed of self-reported assessments from foster and adoptive parents that have participated in the training. The database was provided by the agency to allow the researchers to analyze, interpret, and report on the efficacy of the training.

**Data Collection Procedures**

The data set was collected from WisdomPath Way Institute, in the form of pretest and posttest assessments. The data was gathered and inputted into an electronic database before being given to the researchers. The researchers were then given the data in an electronic de-identifiable format.

**Instruments**

The participants were given the database composed of self-reported pre and post assessments. The TOPSE assessment was given before the participants took part in the training and administered again at the conclusion of the training. The questionnaire was
comprised of two sections. The first section was composed of the demographic information. The participants filled out demographic information that was in the form of choosing between specific identifiers and fill-in responses. The areas included age, gender, race, ethnicity, level of education, the number of children in the home, and the number of trainings they have previously attended.

The instrument administered by the agency was the Tool to Measure Parenting Self-Efficacy (TOPSE), developed to measure parental self-efficacy and the impact of parent training programs (Kendall & Bloomfield, 2005). (See TOPSE Assessment Appendix A). The TOPSE assessment is composed of 48 statements that are phrased positively and negatively. The assessment is comprised of eight sections: emotion and affection, play and enjoyment, empathy and understanding, control, discipline and setting boundaries, pressures, self-acceptance, and learning and knowledge. The response to each section is in a 0-10 Likert scale format, ranging from completely disagree (0-3), moderately agree (4-6), and completely agree (7-10). High scores represent higher parental self-efficacy in the statement and an increase in score of the section reveals an increase of parental self-efficacy in the section topics. Overall, an increase in the total score of all the sections represents an increase of parental self-efficacy (Kendall & Bloomfield, 2005) (See TOPSE scoring sheet Appendix B).

**Protection of Human Subjects**

An application for the protection of human subjects was submitted to the Division of Social Work, Committee for the Protection of Human Subjects at California State University Sacramento, in February of 2016. There was no direct identifiable
information of the participants in the study. The approval was given on February 16, 2016.

**Data Analysis**

The data set was inputted by the researchers through the utilization of Statistical Package for the Social Sciences (SPSS) computer program. The researchers ran descriptive and frequency statistics to analyze the demographic information of the participants. Paired sample t-tests were run to analyze the changes from pretest to the post-intervention assessment responses to determine if there was an increase in feelings of parental self-efficacy. Tables were developed and utilized to illustrate the initial baseline score of parental self-efficacy and changes presented post-training. The results will be discussed in the upcoming chapter.

**Summary**

The researchers of this study conducted a quantitative, exploratory research design. The researchers were the first to conduct a research design with the purpose of evaluating the WPW reparative parenting approach. The researchers utilized the data set from the original source (WisdomPath Way Institute) that consisted of de-identified data (TOPSE). The researchers input the data set into the SPSS computer program in order to run paired sample t-tests to analyze the relationship between the variable of the WPW reparative parenting approach and the variable of parental self-efficacy.
Chapter 4

STUDY FINDINGS AND DISCUSSION

This exploratory research study examines the relationship that exists between foster and adoptive parents’ participation in the WPW reparative parenting model 15-hour, 5-week training teaching parental self-efficacy. This study is comprised of quantitative secondary data from 21 questionnaires that were completed by a sample group of 21 foster and adoptive parents that had participated in the WPW reparative parenting training. The group demographics of the population are represented in Tables 1-5.

Overall Findings

Descriptive statistics were run to analyze the age of the participants is provided in Table 1. The sample size of the study was 21 participants ranging in ages from 20-60 years. The average age of participants was 44.4 years old. The mode of the population age was 47 and 60 years old with fifteen percent each.

Table 1

<table>
<thead>
<tr>
<th>Identifier</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of Participants</td>
<td>20</td>
<td>20</td>
<td>60</td>
<td>44.40</td>
<td>10.450</td>
</tr>
</tbody>
</table>

Table 2 provides a statistical representation of the identified gender of the participants. Participants were given the option to identify as either female or male. All participants stated one of the two choices. A frequency analysis of gender is shown in
Table 2 which reveals that of the population, 42.9% identified as male and 57.1% identified as female.

**Table 2**

*Participant Gender*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>male</td>
<td>9</td>
<td>42.9</td>
</tr>
<tr>
<td>female</td>
<td>12</td>
<td>57.1</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>100.0</td>
</tr>
</tbody>
</table>

In the Race portion of the questionnaire, participants were offered five categories: Asian, African American, White, Other, and Prefer not to answer, as shown in Table 3 below. Roughly three-quarters or 76.2% of the sample population, identified as ‘White.' Nine and a half percent (9.5%) identified as African American. The remaining sample was comprised roughly 15% and evenly dispersed between the following identifiers: Asian, Other, and Prefer not to answer.

**Table 3**

*Participant Race*

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Black/African American</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>White</td>
<td>16</td>
<td>76.2</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>Total</td>
<td>21</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The participants were given the option to identify the number of children living in their home provided in Table 4. Participants identified the minimum number of children living in the home as 0, and the maximum was more than 5 identified in table 4. The mean was 2.52 %.

**Table 4**

*Number of Children Living in the Home*

<table>
<thead>
<tr>
<th>Identifier</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children living in the home</td>
<td>21</td>
<td>0</td>
<td>5</td>
<td>2.52</td>
<td>1.750</td>
</tr>
</tbody>
</table>

The participants indicated the number of trainings they had previously attended provided in Table 5. Twenty participants reported the number of trainings that they attended. Participants identified the minimum number of trainings they attended as 0 and the maximum number as 100. The participants reported the mean of the number of trainings attended was 17.65.

**Table 5**

*Number of Previous Trainings Attended*

<table>
<thead>
<tr>
<th>Identifier</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of previous trainings attended</td>
<td>20</td>
<td>0</td>
<td>100</td>
<td>17.65</td>
<td>30.747</td>
</tr>
</tbody>
</table>

The measuring tool utilized in the research study was the TOPSE, a pre and post-test assessment tool devised to measure the parental self-efficacy and parental knowledge (Bloomfield & Kendall, 2015). This research study was examining the relationship that
exists between parental self-efficacy and participation in the WPW reparative parenting training.

The format of the TOPSE is composed of 8 sections: emotion and affection, play and enjoyment, empathy and understanding, control, discipline and setting boundaries, pressures, self-acceptance, and learning and knowledge. In each section, the lowest possible score is 0 and the highest score is 60. The lowest total score for all areas is 0 and the highest total score of all areas is 480. An increase of scores identifies an increase of parental self-efficacy in the area. Overall, an increase of the total score identifies an increase of self-efficacy in their capacities to fulfill needed tasks as a parent. The results from the TOPSE were inputted into SPSS and paired sample t-tests were run on each of the sections and the total of all sections. The results from the analyses are discussed in-depth below.

The section labeled “Emotion/Affection” pretest mean and posttest mean scores were run in a paired sample t-test to determine if there was a statistically significant difference represented in Table 6. The pretest mean score was 48.5000 to 51.1667 for the posttest mean score. There was a 2.6667 increase between the scores. There is no statistically significant difference between the pretest score and the posttest score. The results of the test present as, (t)11=1.943  p=.078, p>.05.
The section labeled, “Play/Enjoyment” tests were run in a paired sample t-test to determine whether a statistically significant difference existed between the two mean scores, presented in Table 7. The pretest mean was 46.7500 which increased to 51.0000. There was an increase by 4.25000 from the two scores. The results from the analysis present that there is a statistically significant difference between the pretest and posttest scores within the section of “Play/Enjoyment”. The results present as, t (11) = 2.382, p=.036, p<.05.
### Table 7

**Paired Sample t-Test for Pretest/Posttest for “Play/Enjoyment” Section**

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>Lower</th>
<th>Upper</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 pretest – posttest</td>
<td>-4.25000</td>
<td>6.18098</td>
<td>1.78430</td>
<td>-8.17721</td>
<td>-.32279</td>
<td>-2.382</td>
<td>11</td>
<td>.036</td>
</tr>
</tbody>
</table>

The section labeled “Empathy/Understanding” pretest mean and posttest mean scores were run within a paired sample t-test to establish if there was a statistically significant difference, identified in Table 8. The pretest mean score was 44.6364 which increased to 51.3182. The change in scores revealed a 6.68182 increase. The results from the analysis revealed a statistically significant difference. The results presented as, t (10) = 4.660, p= .001, p< .05

### Table 8

**Paired Sample t-Test for Pretest/Posttest for “Empathy/Understanding” Section**

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>Lower</th>
<th>Upper</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
</table>
The section labeled “Control” pretest and posttest mean scores were run in the form of a paired sample t-test, displayed in Table 9. The pretest mean score was 37.8182 which increased to 46.2273. The posttest mean score increased by 8.40909. There is a statistically significant difference in pretest and posttest scores within the “Control” section. The results reveal $t(10) = 3.983$, $p=.003$, $p<.05$.

Table 9

*Paired Sample t-Test for Pretest/Posttest for “Control” Section*

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of the Difference</th>
<th>Lower</th>
<th>Upper</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
</table>

The section labeled “Discipline/Setting Boundaries” mean scores were inputted and run within a paired sample t-test, presented in Table 10. The pre-test mean score was 41.0909 which increased to 47.0909. There was a 6.00000 increase between the two scores. There is a statistically significant difference between the pretest score and the posttest score within the section of “Discipline/Setting Boundaries” The paired sample t-tests results stated $t(10)= 3.195$, $p=.010$, $p<.05$. 


Table 10

**Paired Sample t-Test for Pretest/Posttest for “Discipline/Setting Boundaries” Section**

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of the Difference</th>
<th>95% Confidence Interval of the Difference</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 pretest-posttest</td>
<td>-6.00000</td>
<td>6.22896</td>
<td>1.87810</td>
<td>-10.18468</td>
<td>-1.81532</td>
<td>-3.195</td>
<td>10</td>
</tr>
</tbody>
</table>

The section labeled “Pressures” pretest and posttest scores were run in a paired sample t-test to determine whether there was a statistically significant difference present between the pretest and posttest scores presented in Table 11. The mean pretest score was 38.2727, which increased to 41.5455. There was a 3.27273 increase between the two scores. There is not a statistically significant difference between the pretest and posttest score of the section labeled, “Pressures”. The results reveal, t(10)=1.227, p=.248, p>.50.

Table 11

**Paired Sample t-Test for Pretest/Posttest for “Pressures” Section**

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of the Difference</th>
<th>95% Confidence Interval of the Difference</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 pretest-posttest</td>
<td>-3.27273</td>
<td>8.84410</td>
<td>2.66660</td>
<td>-9.21428</td>
<td>2.66882</td>
<td>-1.227</td>
<td>10</td>
</tr>
</tbody>
</table>
The section labeled “Self-Acceptance” means scores were inputted and run by the researchers in a paired sample t-test. The pretest mean score was 46.6364 that increased to 49.909 identified in Table 12. There was a 3.2727 increase between the pre-test score and post-test mean score. There is not a statistically significant difference between the pre-test and post-test scores within the section of “Self-Acceptance”. The results from this section fail to reject the null hypothesis, \( t(10)=1.154, p=.275, p>.05 \).

**Table 12**

*Paired Sample t-Test for Pretest/Posttest for “Self-Acceptance” Section*

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of the Difference</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
</table>

The researchers inputted the pretest mean score and the posttest mean score from the section labeled “Learning/Knowledge” and ran a paired sample t-test to determine whether a statistically significant difference existed between the two scores, represented in Table 13. The pretest mean score was 47.0000 that increased to 51.5455 in the posttest score. The posttest mean score increased by 4.54545. There is a statistically significant difference between the pretest score and the posttest score within the section of “Learning/Knowledge” The results from this section reveal, \( t(10)=1.85212, p=.004, p<.05 \).
Table 13

*Paired Sample t-Test for Pretest/Posttest for “Learning/Knowledge” Section*

<table>
<thead>
<tr>
<th>Pair 1</th>
<th>Pretest-posttest</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>-4.54545</td>
<td>4.00908</td>
<td>1.20878</td>
<td>-7.23879</td>
<td>-1.85212</td>
<td>-3.760</td>
<td>10</td>
<td>.004</td>
</tr>
</tbody>
</table>

The total score of all the sections were run in paired sample t-tests presented in Table 14. The mean score of the pretest was 347.3000 increasing to 388.3000. The overall increase between the scores was 41.00000. There is a statistically significant difference between the total of pretest scores and the total of posttest scores. The total score of the sections results reveal $t(9) = 4.697, p = .001, p < .05$. 
Table 14

*Paired Sample t-Test for Pretest/Posttest for Total TOPSE Score*

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>Lower</th>
<th>Upper</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 pretest – posttest</td>
<td>-41.00000</td>
<td>27.60435</td>
<td>8.72926</td>
<td>-60.74696</td>
<td>-21.25304</td>
<td>-4.697</td>
<td>9</td>
<td>.001</td>
</tr>
</tbody>
</table>

**Significant Findings**

Paired sample t-tests were run on each section of the TOPSE to evaluate whether there was a statistically significant difference between the pretest and posttest assessments. There are 8 sections of the TOPSE and of those, 5 revealed a statistically significant difference between the pretest and posttest scores. Concurrently, the total scores of the sections determined a statistically significant difference.

The ‘Play and Enjoyment’ section paired sample t-test demonstrated a statistically significant difference between the two scores suggesting, a significant change in parental self-efficacy in the aspect of play and enjoyment with their child at the conclusion on the training. The results of the analysis presented as, t (11) = 2.382, p=.036, p<.05. These results suggest participation in the WPW reparative parenting training increases parental self- efficacy with the context of parents’ abilities to address the task of playing and enjoying their child.
The results of the paired t-test of the ‘category of Empathy and Understanding,’ revealed a statistically significant difference between the tests. The results of the test were as follows, $t (10) = 4.660, p= .001, p< .05$. These results suggest that participation in the WPW reparative parenting training increases parental self-efficacy in their abilities to provide empathy and understanding to their child.

An analysis of the ‘Control’ section showed a statistically significant difference when a paired t-test was run on the pretest and posttest. The results display the statistically significant difference, $t (10) = 3.983, p=.003, p<.05$. The results of this section propose there is an increase in parental self-efficacy within the context of the parent’s control over their child with participation in the WPW reparative parenting training.

The section labeled ‘Discipline and Boundary Setting’ also revealed statistically significant differences between the tests. The results from the analysis present as, $t (10) = 3.195, p=.010, p<.05$. The interpretations that can be drawn from these results suggest that participation in the WPW reparative parenting approach increase parental self-efficacy with their abilities to discipline and set boundaries with their child.

Lastly, the section labeled ‘Learning and Knowledge’ revealed a statistically significant difference between the pretest and posttest. The results from the analysis are, $t (10)=1.85212, p=.004, p<.05$. These results suggest parental self-efficacy increased in the parents’ learning and knowledge of their child with the participation in the WPW reparative parenting training.
A paired sample t-test was run to compare the overall sum of the pretest sections and the posttest sections. The results revealed a statistically significant difference between the total pretest and posttest scores. The results present as, $t(9) = 4.697$, $p = .001$, $p < .05$. Overall these results suggest that parental self-efficacy and knowledge increased from the beginning of the intervention to the conclusion.

**Interpretations of the Findings**

The TOPSE assessment serves as a tool to measure pretest and posttest scores to evaluate the efficacy and knowledge parents gain 8 areas (emotion and affection, play and enjoyment, empathy and understanding, control, discipline and setting boundaries, pressures, self-acceptance, and learning and knowledge), all considered to be critical aspects of being a parent. There were 5 out of the 8 sections that revealed a statistically significant difference. The results for the section “Play/Enjoyment” reveal $t(11) = 2.382$, $p = .036$, $p < .05$. This suggests that parents’ self-efficacy increased in their abilities to meet the task of playing and enjoying their child. The section “Empathy/Understanding” results presented as, $t(10) = 4.660$, $p = .001$, $p < .05$. These results suggest there is an increase of parental self-efficacy in their abilities to meet the needed task to provide empathy and understanding to their child. The results for the section “Control” reveal $t(10) = 3.983$, $p = .003$, $p < .05$. The statistical significant difference reveals an increase in parent’s abilities to control their child’s behavior. The section of “Discipline/Boundaries” results reveal, $t(10) = 3.195$, $p = .010$, $p < .05$. These results suggest that parental self-efficacy increased in their abilities to discipline and control their child. The last section with a statistically significant difference in mean scores is the
section labeled “Learning/Knowledge” resulting in $t(10)=1.85212$, $p=.004$, $p<.05$. The statistically significant difference suggests that parent’s increased self-efficacy in their capacities of learning and having the knowledge about their child.

An increase in the TOPSE scores signifies an increase in parental self-eficacy and knowledge. The results of this study clearly support improvement in parental feelings of self-efficacy by participants in the study as indicated in the statistically significant difference between pretest and posttest responses. These findings suggest that parents’, who participated in the 15-hour, 5-week training in the WPW reparative parenting approach, experienced a positive shift in their perceptions of parental self-eficacy at the end of the training. Overall, an analysis of the results shows an increase in each of the areas post-attendance.

An analysis of the results further reveal an increase from the total pretest mean of 347.3 to a posttest mean total of 388.3. There was a 41 point increase from the pretest score to the posttest score. The paired sample $t$-test results reveal $t(9)=4.697$, $p=.001$, $p<.05$. This increase is a strong indicator that participation in the WPW reparative parenting approach 15-hour, 5-week training is an effective intervention for increasing parental self-eficacy and knowledge of being a parent.

**Summary**

The intention of this research study was to evaluate the efficacy of the WPW reparative parenting approach on parental self-efficacy for foster and adoptive parents participating in a 15-hour, 5-week training. The results of the data analysis of secondary data originally collected from the primary source (TOPSE) show a statistically significant
relationship between the two variables (WPW reparative parenting approach and improved parental self-efficacy). The TOPSE assessment tool administered in pretest and posttest form is specifically designed to measure the relationship between parent training models and parental efficacy. Data analysis of the secondary data provided to the researchers form the original source reveal an increase of the mean score in majority of section of the analysis, including the total mean of the pretest and posttest scores.

There were 5 out of the 8 sections that revealed a statistically significant difference between the pretest and posttest scores. The “Play/Enjoyment” section reveal $t (11) = 2.382, p=.036, p<.05$. The section labeled “Empathy/Understanding” results presented as, $t (10) = 4.660, p=.001, p<.05$. The results for the section “Control” reveal $t (10) = 3.983, p=.003, p<.05$. The section “Discipline/Boundaries” results reveal, $t (10) = 3.195, p=.010, p<.05$. Lastly, the section “Learning/Knowledge” resulting in $t (10) = 1.85212, p=.004, p<.05$. The total mean scores of the sections results reveal $t (9) =4.697, p=.001, p<.05$. The results from this study suggest that participation in the WPW reparative parenting approach yields a significantly significant improvement in feelings of parental self-efficacy for the foster and adoptive parents who attended the 15-hour 5-week training in the WPW reparative parenting approach.
Chapter 5

SUMMARY AND RECOMMENDATIONS

The major finding from this exploratory study is that there is a statistically significant difference between pre and post-test scores on two identified variables following participation in a 15-hour, 5-week training in the WPW reparative parenting approach, around indicators of parental self-efficacy. The results of this study are consistent with results from other research (Weiner et al., 2009; Leathers et al., 2011; Lewis-Morrarty et al., 2012) previously noted in Chapter 2 we find that when parents are provided with parenting skills and knowledge, they experience and report improvement in perceptions of parental efficacy.

An analysis of the secondary TOPSE data also suggests that when parents perceive that they have relevant knowledge and skills, that there are corresponding positive shifts noted in a parent's emotional connection to their child(ren), the desire to be playful, and the subjective experience of increased enjoyment of their child(ren) in general. Also, parents report an improvement in their "felt" empathy for their child(ren) and feel significantly stronger in their understanding of how to be in control, establish discipline, and set boundaries.

The findings of this study reinforce and highlight the effectiveness of the WPW reparative parenting approach in specific, and the need for other efficacious parenting models in general. In keeping with Morgan and Baron (2011) regarding parental efficacy and reduction in placement instability, the findings of this study endorse the WPW reparative parenting approach as a model that, when learned and applied by parents,
could contribute to a decrease in placement instability. Despite the small sample size, the statistical significance of the success of the WPW reparative parenting approach model on parental self-efficacy is a promising development for foster/adoptive parent training models.

**Summary of Study**

The purpose of this study was to explore the relationship between participation in a 15-hour, 5-week WPW reparative parenting approach training and reported parental efficacy for foster/adopt parents. This study analyzed secondary data (TOPSE) collected from the WisdomPath Way Institute that was initially administered for internal data collection purposes. The researchers conducted an exploratory study to determine if participation in a 15-hour, 5-week training in the WPW reparative parenting approach would affect parental efficacy for the foster/adopt parent attendees.

The de-identified data collected by the primary source was then provided to the researchers in an electronic database in which each of the categories was individually totaled and analyzed. Researchers conducted a paired sample t-test on the secondary data. Analysis of the data revealed a statistically significant difference between participation in the WPW reparative parenting approach and an increase in parental self-efficacy. Data analysis further demonstrates an increase in the overall mean score of parental self-efficacy and is found to have a statistically significant difference between the total pretest and posttest TOPSE scores $t(9) = 4.697$, $p = .001$, ($p < .05$). The findings indicate a statistically significant difference between the two variables of the WPW reparative parenting approach model and increased parental self-efficacy. The sample size was not
large enough to generalize to the larger population; however, the information furthers the existing research (Weiner et al., 2009; Leathers, et al., 2011; Lewis-Morrarty, et al., 2012) on parental self-efficacy and placement stability, and identifies a potentially promising new program.

Additionally, the researchers observed particularly notable findings in the category of “Control” when comparing the eight sections of the TOPSE. The largest statistically significant change was found to be in the category of Control (t (10) = 3.983, p=.003, (p<.05)) in which parents answered six questions about how they felt about their control over their child’s behaviors. The results suggest that parents left the training feeling much more confident post training about their ability to control their child's behaviors. The mean score was 37.8182 in the pretest and increased to 46.2273 in the posttest and was the category with the greatest change. Three sections that did improve in the posttest but did not display a statistically significant scores were the sections on Emotion/Affection (t (11)=1.943, p=.078, (p>.05), Pressures (t (10) = 1.227, p=.248, (p>.05)) and Self-Acceptance (t (10) = 1.154, p=.275, (p>.05)).

As previously stated, the results of this study on the relationship between parental self-efficacy and skill-building parenting models further previously studied parent models that have shown good responses for parents after participation in the various programs (Weiner et al., 2009; Leathers et al., 2011; Lewis-Morrarty et al., 2012). These parenting models include Keep (Leathers et al., 2011), Incredible Years (Marcynszyn et al., 2011), and Attachment and Biobehavioral Catch-Up (Lewis-Morrarty et al., 2012). Trauma-informed cognitive behavioral therapy and PCIT have shown promising results as well,
with some studies identifying the need for more practices that are culturally diverse and conducted outside of a university or hospital setting (Weiner et al., 2009; Gallagher, 2003; Lyon & Budd, 2010). The secondary data analyzed in this study indicated that the participants in the initial training were predominantly Caucasian. Further studies on the WPW reparative parenting approach would also benefit from a more inclusive initial parent sample.

**Implications for Social Work Practice**

The social work profession has a mandate to address the needs of marginalized and disadvantaged populations. Foster children are both marginalized and at a disadvantage as they cannot represent or advocate for themselves nor within the larger society or within the child welfare system which can have both immediate and long-term adverse effects on their wellbeing (Fisher *et al.*, 2005; Leathers *et al.*, 2012; Lewis *et al.*, 2007; Rubin *et al.*, 2007; Stott & Gustavsson, 2010; Strijker *et al.*, 2008). The management of children in foster care and the parents who raise them falls to social workers. Problems, most notably placement instability, results in failed placements in which social workers must typically remove the child because of an array of possible oppositional behaviors, i.e. fighting, inability to follow rules, and general discord with peers or family members (Leathers *et al.*, 2012; Lewis *et al.*, 2007; Rubin *et al.*, 2007; Strijker *et al.*, 2008). With these complex challenges, it is imperative for social workers to educate and equip foster/adopt parents with the tools to meet the needs of this vulnerable population and increase placement stability.
The social work profession has been charged with the responsibility to improve and advocate for the rights of vulnerable populations (National Association of Social Work, 2008) at all levels of micro, mezzo, and macro intervention. Children in foster care continue to have disproportionately higher incidents of problematic behaviors at a rate of three to four times that of the general population (Burns et al., 2004). Further research must be done by the social work community to add to the growing body of research that may be identifying a critical factor in improving the likelihood of placement stability through participation in parenting approaches that target skill building and enhanced knowledge. Clearly, the more empowered and prepared foster/adopt parents feel, the more they will be able to manage and decrease problematic behavior while increasing placement stability for foster children and youth.

This research is also necessary for those entering and currently in the social work field because increasing social worker's knowledge about foster youth and childhood adversity (ACEs) will promote increased understanding and empathy for the struggles of re-parenting children who have experienced traumatic events. Large-scale policy changes are also essential for the success of child welfare programs. The greater the awareness of these problems within local and state Child Welfare Services, the more likely it is that departments will seek to invest in the research, development, and implementation of effective parenting programs to help foster/adopt families ensure placement stability for children. This study encourages social workers working at all levels of government, policy making, or direct service to look critically at, and re-evaluate current policies and their effectiveness in supporting families and youth in the child welfare system. The
issues surrounding youth in foster care are a priority for every community because our children are the foundation for a healthy future.

**Recommendations for Future Research**

Based on the findings of this study, the researchers propose several strategies and recommendations for future research on the emerging WPW reparative parenting approach model. The researchers suggest that the study be conducted with a larger sample size. Even though the study started with n=21 participants, only 12 participants completed the posttest. The larger sample size will increase the reliability of the research findings and allow it to be generalized to the other comparable models. Increasing the sample size will also strengthen the results to determine validity and reliability.

Another recommendation is to study a more diverse population. The majority of the participants were Caucasian, non-Hispanic, and had at least some college education. Future research would benefit from the collection of secondary data that includes other races, ethnicities, and educational backgrounds. This is imperative to establish both validity and reliability of future studies of this approach. It is also important to consider the location of the research and collect data from multiple counties and states within the United States.

Lastly, the researchers would suggest a longer longitudinal study that spanned months instead of weeks. This research would allow for a broader secondary data set to be collected that would include a pre, middle, and post evaluation of the reported parent self-efficacy. The longitudinal study might also then provide a mechanism for evaluating actual behavior change based upon the parent's perceptions of self-efficacy.
Study Limitations

One limitation of this research study was the small sample size (n=21). The results of this study cannot be generalized to the larger population of foster/adopt parents because of the small size. Out of the 21 participants, only 12 completed both the pre and the posttest adding to the limitation in producing comparable data. Some participants also did not assign a numeric value to a few of the questions, affecting the overall score of their measured parental self-efficacy. These constraints could have been affected by the study spanning five weeks and the unpredictable nature of people’s schedules and lives.

A second limitation was the lack of diversity in the data set provided to the researchers. There were an unequal number of men and women, with women making up 57.1 percent of the study, and over 70% of the participants were Caucasian and non-Hispanic. They also all had at least two years of college except for 2 participants who completed the equivalent of a high school diploma. These similar demographics may have affected the results due to the impact of the participant’s race, gender, and educational background. These limitations could influence how the participants received and interpreted the information given during the training.

Lastly, this study was mainly focused on the quantitative results, which limited the ability of the researchers to examine the complex issues of parental self-efficacy in foster/adopt parents. A narrative approach coupled with these results might have helped encapsulate the participant’s feelings about the WPW reparative parenting approach. If the data set given to the researchers had included personal narratives by the participants, it would have provided the researchers with the opportunity to broaden the research to
include pinpointing areas of the WPW reparative parenting approach that profoundly affected self-efficacy vs. other areas that were less instrumental or key.

**Conclusion**

Based on the findings of the study, the following conclusions can be drawn. There is a statistical significance difference between the 15-hours, 5-week WPW reparative parenting approach and an increase in parental self-efficacy. As can be seen throughout this research project, parental self-efficacy is an important measure in assessing the competency for managing the unique needs of foster children. This exploratory study, even with the limitations, produced exciting results for the researchers and added to the growing body of knowledge on parenting programs and their impact on parental self-efficacy. Through the process of analyzing the secondary data, the researchers learned many things about the research experience and the profound significance it can have to add to voices advocating for this very vulnerable population of children and youth in the child welfare system.
Appendix A

Parenting Evaluation Tool To Measure Parenting Self-Efficacy (TOPSE)

When completing this booklet, please focus on the child that has been part of the reason for you to attend a parenting (programme).
Name: ……………………………………………   Date: …………………………..

By completing this booklet, you will help us to evaluate our parenting programmes and enable us to make improvements. There are no right or wrong answers. Your booklet will not be compared with other parents’ and will remain confidential.

The following section is about emotion and affection.
Using the scale below, please enter in the boxes how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree). You may use any number between 0 and 10. Please answer all statements.

0   1   2   3   4   5   6   7   8   9   10

Completely disagree    Moderately agree    Completely agree

   o I am able to show affection towards my child.
   o I can recognize when my child is happy or sad.
   o I am confident my child can come to me if they’re unhappy.
   o When my child is sad I understand why.
   o I have a good relationship with my child.
   o I find it hard to cuddle my child.

The following section is about play and enjoyment. Using the scale below, please enter in the boxes how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree). You may use any number between 0 and 10. Please answer all statements.

0   1   2   3   4   5   6   7   8   9   10

Completely disagree    Moderately agree    Completely agree
- I am able to have fun with my child.
- I am able to enjoy each stage of my child’s development.
- I am able to have nice days with my child.
- I can plan activities that my child will enjoy.
- Playing with my child comes easily to me.
- I am able to help my child reach their full potential.

The following section is about empathy and understanding. Using the scale below, please enter in the boxes how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree). You may use any number between 0 and 10. Please answer all statements.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree  Moderately agree  Completely agree

- I am able to explain things patiently to my child.
- I can get my child to listen to me.
- I am able to comfort my child.
- I am able to listen to my child.
- I am able to put myself in my child’s shoes.
- I understand my child’s needs.

The following section is about control. Using the scale below, please enter in the boxes how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree). You may use any number between 0 and 10. Please answer all statements.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree  Moderately agree  Completely agree
o As a parent I feel I am in control.

o My child will respond to the boundaries I put in place.

o I can get my child to behave well without a battle.

o I can remain calm when facing difficulties.

o I can’t stop my child behaving badly.

o I am able to stay calm when my child is behaving badly.

The following section is about discipline and setting boundaries. Using the scale below, please enter in the boxes how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree). You may use any number between 0 and 10. Please answer all statements.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree Moderately agree Completely agree

o Setting limits and boundaries is easy for me.

o I am able to stick to the rules I set for my child.

o I am able to reason with my child.

o I can find ways to avoid conflict.

o I am consistent in the way I use discipline.

o I am able to discipline my child without feeling guilty.

The following section is about pressures. Using the scale below, please enter in the boxes how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree). You may use any number between 0 and 10. Please answer all statements.

0 1 2 3 4 5 6 7 8 9 10

Completely disagree Moderately agree Completely agree

o It is difficult to cope with other people’s expectations of me as a parent.
I am not able to assert myself when other people tell me what to do with my child.

Listening to other people’s advice makes it hard for me to decide what to do.

I can say ‘no’ to other people if I don’t agree with them.

I can ignore pressure from other people to do things their way.

I do not feel a need to compare myself to other parents.

The following section is about self-acceptance. Using the scale below, please enter in the boxes how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree). You may use any number between 0 and 10. Please answer all statements.

0  1  2  3  4  5  6  7  8  9  10

Completely disagree    Moderately agree    Completely agree

I know I am a good enough parent.

I manage the pressures of parenting as well as other parents do.

I am not doing that well as a parent.

As a parent I can take most things in my stride.

I can be strong for my child.

My child feels safe around me.

The following section is about learning and knowledge. Using the scale below, please enter in the boxes how much you agree with each statement. The scale ranges from 0 (completely disagree) to 10 (completely agree).

0  1  2  3  4  5  6  7  8  9  10

Completely disagree    Moderately agree    Completely agree

I am able to recognize developmental changes in my child.

I can share ideas with other parents.

I am able to learn and use new ways of dealing with my child.
o I am able to make the changes needed to improve my child’s behavior.

o I can overcome most problems with a bit of advice.

o Knowing that other people have similar difficulties with their children makes it easier for me.
Appendix B

TOPSE Scoring Sheet

TOPSE is a tool to measure a change in parenting self-efficacy. It can be used to evaluate the effectiveness of parenting programmes. It can also be used to help identify specific problem areas that individual parents may be experiencing.

TOPSE should be completed prior to or during the first session of the parenting programme. A second booklet should be completed during or following the final session. Booklets may be sent to parents to complete several months following the end of the programme to identify if changes in parenting self-efficacy have been maintained.

It is important to explain to parents that their responses will be used to identify changes in their own perception of their parenting abilities. Its’ purpose is not to compare the scores of one parent with another but to evaluate the effectiveness of the parenting programme.

Scoring
Each statement is scored from 0 – 10 and the total score for each section is a sum of scores. The following statements are phrased negatively and should be reverse scored before summing:

Section 1 Emotion and affection reverse score statement 6
Section 4 Control reverse score statement 5
Section 6 Pressure reverse score statements 1,2,3
Section 7 Self-acceptance reverse score statement 3

To reverse the score subtract the actual score from 10 ((e.g. if the actual score is 3, the reverse score would be 7 (10 – 3))

A change in scores for any section would suggest a change in the parent’s perception of their parenting ability in that particular area of parenting.

If you have any questions or concerns about the TOPSE booklet or the guidelines for scoring please contact:
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References


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