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THROUGH THE WIRES OF CONNECTION: THE ROLE OF EMPOWERED TO CONNECT PARENT EDUCATION IN TRAUMA-INFORMED PARENTING AND PARENT-CHILD RELATIONSHIPS

by

Nicole D. West

A Dissertation

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Abstract

This repeated measure design evaluates the effectiveness of the trauma-informed parent education course known as Empowered to Connect. This research used a quantitative method to investigate whether caregivers who are exposed to trauma-informed material improve their trauma-informed parenting skills and their parent-child relationship with their biological, foster, adoptive, and/or kinship children. Trauma-informed parenting is defined as a caregiver's understanding of the impact of trauma on development and his or her ability to parent a child who has experienced a disruption in attachment and connection. A One-Way Repeated Measures Analysis of Variance (ANOVA), descriptive statistics, and a Wilcoxon Signed-Rank Test were used to determine improvement in caregiver scores. The Resource Parent Knowledge and Beliefs Survey (RPKBS) as well as the Behavioral Assessment for Children Parent Relationship Questionnaire (BASC-PRQ) were given at pre and post time points. The sample consisted of 36 caregivers, all of whom completed the RPKBS; 20 of whom completed the BASC-PRQ. The findings for RPKBS were statistically significant, suggesting a need for continued research, as this study did not utilize a control group for comparison purposes. Although BASC-PRQ scores improved from pre to posttest, the improvements were not found to be statistically significant.

Dedication

To my late Mother, Debra (Debbie) Dudley – You taught me everything that I would ever need to know; about life, about love, and about living. It saddens me that you were called away before you could get to witness this accomplishment and so much more of my journey, but I know you are smiling down on me and I know you couldn't be more proud! Thank you for making me strong, thank you for making me wise, thank you for making me determined. Without you, I don't know where I would be. You made so many sacrifices in order for me to succeed and I could never thank you quite enough. You taught me through your determination, your grit, your strength, how to one day be the mother I'd be so lucky to become. Words can't express how much I miss and thank you for being all that you were to me. I love you forever and you will always be "my favorite girl!"

To my father, Lawrence Campbell – Talk about one of a kind! Thank you for your insurmountable support. You have taught me so much about how to stand up for what I believe in, how to be selfless, and how to be determined and laser focused. It is not without your dedication that I stand here today on the verge of three degrees. Your encouragement to "go all the way" did not fall on deaf ears. I couldn't have asked for a better father and I am forever grateful for your love and unwavering devotion to helping me be the best that I could ever imagine myself to be. Thank you for also sharing my Step Mother (Judy) with us. She has truly been a blessing. Thank you Judy for picking up where my Mom had to unfortunately leave off. We are beyond blessed to have you.

To my siblings - You all are loved and appreciated immensely. You have taught me things about life in ways only siblings could. I recall all of our fun times and hard times, as well

as our times of uncontrollable laughter and uncontrollable crying. You have been there through it all and I thank you for that.

To my husband, Shawn – I couldn't have been more blessed to have met you, to have loved you, to have created a family with you. Your love and support is truly unmatched. Thank you for taking on the responsibility of leading this family and thank you for allowing me to take a few years to continue to "find myself professionally." I will never forget the sacrifices you have made for us. No matter what we go through, I will love you forever and will always be grateful for what we created and shared together.

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Lastly, to my cohort – I can't think of better people to have gone through this experience with. Thank you for answering my crazy questions, letting me vent, and being the most supportive people on the planet. Darius, Frances, William, and Amanda - I wish you all the very best!

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Dr. William Hunter, thank you for agreeing to be part of my committee and for offering your expertise on all things related to education. Thank you for always considering and trusting me to be a part of your Service Learning project. Dr. Chi Li, thank you for agreeing last minute to be a part of this effort as well. I am aware that these things take a lot of your time as faculty and your willingness to participate is greatly appreciated! Lastly, thank you Dr. Todd Zoblotsky, for so generously answering all of my statistics related questions. Your willingness to act as my "statistician" in the absence of a core statistics faculty member is an absolute testament to your dedication to students and undoubtedly, one of the main reasons I was able to complete this project. I am grateful for all offers of help and support throughout this process.

Table of Contents

List of Tables

The Role of Empowered To Connect Parent Education in Trauma-informed Parenting and

Parent-child Relationships

Chapter I: Introduction

 "The potential space between baby and mother, between child and family, between individual and society or the world, depends on experience which leads to trust. It can be looked upon as sacred to the individual in that it is here that the individual experiences creative living."
–D. W. Winnicott

Parent education equips caregivers with an in-depth understanding of child development and effective practices for addressing challenging behaviors. Parent education has historically involved caregivers participating in a set number of classes designed to enhance skills related to communication and discipline (Croak & Glover, 1977). Traditional parent education programs do not address challenging behaviors in the context of trauma or its impact on development. However, recent literature suggests that trauma-informed parent education is valuable for both foster parents and children (Myers, 2019). Understanding and implementing effective parenting practices is especially important for caregivers whose children have been exposed to trauma (Myers, 2019). Although newly published research on the topic of trauma-informed parent education exists, studies related to the efficacy of trauma-informed parent education are limited in number (Bass, 2017).

This quantitative study examines the relationship between caregivers' participation in a nine-week trauma-informed parent education course and scores on trauma-informed parenting and parent-child relationship measures. For the purposes of this research, "caregivers" refers to foster, adoptive, or kinship families. Using a pre and posttest design, this research investigates whether caregivers report improvements in trauma-informed parenting and evaluates their ability

to relate to and connect with their children. "Trauma-informed parenting" is defined as a caregiver's understanding of the impact of trauma on development and his or her ability to parent a child who has experienced a disruption in attachment and connection (Purvis, et al., 2015). "The parent-child relationship" is defined in terms of the degree to which caregivers are involved and are responsive to the child. A strong parent-child relationship is vital to reversing the adverse effects of early stress on the brain, reducing stress-related behavior, and improving psychosocial functioning (Purvis, Cross, Danserau, & Parris, 2013).

Although many children experience trauma, this study focuses on children who were placed in foster care as a result of their experiences. Foster children have typically endured multiple traumas, including the one which led to their initial removal and the additional trauma of being disconnected from their family of origin. Participant focus is on single or married caregivers who are the legal guardians of a foster, kinship, or adoptive child who has been exposed to trauma. Focusing on these distinct populations allows for evaluation of the impact of trauma-informed parenting on parent-child cohesion and knowledge of the traumatic impact on development.

The introductory section of this dissertation explains the history of parent education; describes the trauma-informed parent education program Empowered to Connect (ETC); and reviews significance, limitations, and areas for future research.

History of Parent Education

Parent education dates back to the early 1900s when theorists like Benedek (1938) emphasized the importance of parent-child dynamics. Benedek suggested that parents should promote growth in their children, which in turn would stimulate the parent to reconcile any developmental conflicts not addressed during their own childhood. This reconciliation would

create further psychological integration for the parent. In simpler terms, through the parent-child attachment, the parent teaches the child, and the child inadvertently teaches the parent.

There are currently many different models of parent education, including Love and Logic; Safe, Secure and Loved (SSL); and Parents as Teachers. Most of these programs consist of weekly two-hour sessions over a period of 8 and 12 weeks (Collins & Fetsch, 2012). However, none of these programs specifically addresses trauma or attachment difficulties as catalysts for behavior or emotional challenges. Conversely, The Parenting Process (TPP) emphasizes bonding, mirroring, differentiation, and a child-centered listening perspective. The Parenting Process disrupts the transmission of intergenerational trauma by enhancing the emotional development of both the parent and the child. The program is based on the premise that the parent-child relationship is essential in creating positive outcomes in the child's self-esteem as well as in his or her ability to navigate his world independently and successfully (Paris, 2012). Paris (2012) asserts that providing psychoanalytically informed parent education promotes the development of new, more adaptive patterns of relating to a child, thus providing a more conducive space for connection. This connection between a parent and child can often make the difference between a confident child who can deal with potential setbacks and a traumatized child who is unable to function appropriately in his or her social environment.

Safe, Secure, and Loved is another parent education program that addresses trauma. This program is based on clinical psychology as well as resilience and child development research. Safe, Secure, and Loved educates parents on "habits of resilience" (practicing mindfulness and self-compassion) to establish a pattern of nurturing behaviors and to promote self-care, healthy parenting goals, and practices that foster resilience in children. Facilitators educate parents on

ways to incorporate self-regulation and the use of executive functioning skills into their daily lives as a means of cultivating the parent-child attachment (Burns, Merritt, & Chyu, 2019).

Parent education has evolved from providing the basics in communication and discipline to offering a more in-depth understanding of the root of communication and discipline issues (Bass, 2017). Comparable to SSL and TPP, the ETC curriculum provides caregivers an understanding of behavior through the lens of trauma and attachment. This understanding, and the implementation of skills through a trauma-informed approach, provides healing and restoration for children and their families (Purvis, et al., 2015).

Development of Trauma-informed Curriculum

In 2007, the National Child Traumatic Stress Network (NCTSN), a project of the Substance Abuse and Mental Health Services Administration (SAMHSA), developed training materials related to childhood trauma. These trainings included 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families (Layne, Pynoos, & the Core Curriculum on Childhood Trauma Task Force, 2013). These principles were intended to promote an understanding of trauma-informed principles among systems that many children are often involved in, including child welfare, education, and criminal justice systems (Myers, 2019).

In 2014, SAMHSA identified four primary assumptions that organizations should adopt when developing a trauma-informed approach. In order to promote safety for those who have experienced maltreatment, organizations should engage in *realizing*, *recognizing*, *responding*, and *resisting retraumatization*. Realizing allows organizations to understand the widespread impact of trauma as well as the potential for recovery. Organizations are encouraged to see an individual's behavior as possible coping mechanisms used as attempts to maintain safety. Recognize refers to being familiar and noticing the signs of trauma in others. Respond

encourages a system to integrate knowledge about trauma's impact into company policies, procedures, and practices to ensure that all involved within the system are working from a trauma-informed lens. Resist refers to having an awareness of interactions with individuals who may have trauma histories as to reduce the possibility of retraumatization to those individuals (Kuhn, et al., 2019).

More recently Dublin, Abramovitz, Layne, & Katz, (2019) developed eight core child trauma skills including a) identifying relevant trauma information, b) understanding the complexity of trauma impacts, c) using clinical reasoning to process client information, d) using facts to formulate hypotheses, e) weighing evidence both for and against hypotheses, f) using trauma-related concepts to work with caregiving systems, g) using self-care strategies to reduce secondary trauma, and h) working effectively with traumatized children and adolescents.

According to the most recent review of trauma-informed literature, essential elements in trauma-informed parenting should include a) recognizing the impact trauma has had on your child, b) helping the child to feel safe, c) helping your child understand and manage overwhelming emotions, d) helping he child to understand and modify problem behaviors, e) respecting and supporting positive, stable, and enduring relationships in the child's life, f)helping the child develop a strength-based understanding of their life story, g) being an advocate for the child, h) promoting and supporting trauma-focused assessment and treatment for the child, and i) taking care of yourself as the caregiver (Sullivan et al., 2019).

In a 2014 review, Strolin-Goltzman, McCrae, and Emery, (2017) found that the number of required foster care training hours differed from state to state, and ranged from 6 to 36 hours. Although most states required training on child behavior management, child development, and attachment, separation and loss issues, only three states required an actual trauma-informed

curriculum. Consequently, it is likely that most foster caregivers across the lack the critical understanding of the way in which trauma shapes a child's worldview and alters their development (Strolin-Goltzman, McCrae, & Emery, 2017). This is evidence that more trauma-informed parent education is necessary for the treatment and health of the many children connected to the child welfare system.

Trauma-informed programs such as the Empowered to Connect curriculum have adopted many of the aforementioned concepts when developing trauma-informed material. The ETC curriculum, which will be detailed below incorporates some of these aspects in modules titiled, Building a Foundation of Connection, Understanding Your Child's History, Examining What You Bring to the Relationship (Part I), Examining What You Bring to the Relationship (Part 2), Exploring the Heart of Connection, Focusing on the Needs of the Whole Child, Putting It All Together: Connecting While Correcting (Parts 1, 2, and 3).

Empowered to Connect (ETC) Curriculum

Empowered to Connect is a nine-week trauma-informed parent education program offered both nationally and internationally. Approximately 113 trained instructors currently facilitate ETC, which differs from traditional frameworks due to its foundation in the Trust-Based Relational Intervention (TBRI) model. Developed by Dr. Karyn Purvis of Texas Christian University, TBRI is a trauma-informed, attachment-based curriculum that trains caregivers to provide support and treatment for children exposed to trauma. The basics of brain development and complex trauma are taught through the use of play, in-class activities, and homework. The nine modules of ETC help caregivers master the skills necessary to empower, connect, and correct children who have previous trauma exposure (Purvis, et al., 2015). It is imperative to

evaluate and develop evidence-based programs that promote trust and aid in the healing of youth who have extensive experience of the types of trauma that lead to out of home placement.

When formulating a program to treat complex trauma, the following constructs should be integrated: a) development of safety, b) promotion of healing relationships and c) teaching of emotional regulation skills (van der Kolk, 2005). These constructs align with the core principles of TBRI, which include empowering, connecting, and correcting. These core principles (each with two aligning strategies) facilitate felt safety, self-regulation, and connection.

The empowering principles include ecological and physiological strategies that address the fundamental physical and physiological needs of the child. Meeting their necessary hydration and nutritional needs help children make use of their prefrontal cortex and perform higher-level tasks successfully (Purvis, Cross, and Pennings, 2009). Examples of ecological strategies include establishing rituals that facilitate structure and connection and considering the impact transitions can have on a child's ability to regulate his or her emotions. Physiological strategies focus on providing physical and sensory experiences. Applying these strategies promotes the child's capacity to build self-regulation skills, increasing the likelihood of successful connection (Purvis, et al., 2015).

The connecting principles are grounded in attachment theory and focus on gaining the child's trust. The material in this module promotes mindful awareness (of child, self, and environment), and engagement (valuing eye contact, playful interaction, and healthy touch). The connecting principles include recognizing behavior as a form of communication, active listening, and intentionality in body positions and voice inflection (Purvis, Cross, and Pennings, 2009). These principles are essential for building trusting relationships and are the driving force that allows for empowering and correcting principles to create change (Purvis, et al., 2015).

Lastly, the correcting principles are based on interactions that work to empower the child. Intended to shape challenging behaviors, the correcting principles consist of proactive and responsive strategies. Proactive strategies (such as teaching emotional regulation skills) provide positive alternatives to practice when the child is feeling dysregulated (Purvis, Cross, and Pennings, 2009). Proactive strategies include knowledge of behavioral scripts to use during playful interactions, while responsive strategies teach caregivers to use the IDEAL response when addressing challenging behaviors. The IDEAL response stands for "Immediate," "Direct," "Efficient," "Action-based," and "Leveled at the behavior." Successful application of the correcting principles ultimately relies on a firm foundation in the former principles (Purvis, et al., 2015). Unless the child has developed the ability to trust (connect) and feels empowered, correction will likely feel to the caregiver like a repeated defeat.

How ETC Differs from Other Parent Education

Empowered to Connect is a trauma-informed, attachment-based, community-focused program designed to support, resource, and educate caregivers whose children have experienced adverse childhood experiences (ACEs) and toxic stress. The fundamental premise of ETC is that every child has the capacity to grow and overcome hardship in the context of supported, connected, and nurturing spaces. The modules of ETC include "Balancing Nurture and Structure"; "Responding to Fear With Connection"; "Connect First, Then Correct"; "Regulate Your Emotional State"; "Give Your Child Voice"; "Encourage Feelings"; "Use Time-In, Instead of Out"; "Think Before You Consequence"; and " Offer Choices." All modules are facilitated through the lens of attachment and connection (Empowered to Connect Course, 2013).

The ETC program is premised on the idea that attachment is merely about connection and is a way to understand the quality of the relationship between the parent and child. The

attachment relationship is the most formative one in a child's life, as it becomes the template for core beliefs and future relationships. Attachment influences a child's worldview and also provides the foundation for emotional regulation, trust, and self-esteem (Empowered to Connect Course, 2013). According to Weir (2006), elements of attachment theory have been seen as critical to the treatment of attachment-related issues among adoptive and foster children; however, there is a need for additional research related to children with histories of trauma who continue to display attachment-related difficulties following adoption (Prather & Golden, 2009).

Empowered to Connect addresses the biological effects of trauma and informs caregivers' understanding of the behavioral, academic, social, and emotional consequences. As an integrative model, ETC provides a foundation for caregivers to develop an awareness of self in relation to connecting with their child (Empowered to Connect Course, 2013). Trauma-informed parent education understands that when under stress, caregivers are less likely to inquire about the possible meaning behind a child's behavior (Purvis, et al., 2015). Consequently, ETC modules teach the fight, flight, or freeze response to stress and push caregivers to learn about their response to challenging behaviors in addition to the stress patterns their child typically practices (Empowered to Connect Course, 2013). This conscious awareness and reflection allows caregivers to respond proactively in more productive and meaningful ways (Paris, 2012).

Empowered to Connect modules also focus on the consequences of trauma that result in a child feeling unsafe, unseen, and unable to attach. According to Purvis, et al. (2015), the loss of control that stems from a traumatic experience disrupts a child's ability to feel secure and protected. Purvis et al. (2015) refer to feeling safe enough to attach as "felt safety." The internalization of "felt safety" ultimately nurtures the very development that was derailed as a

9

result of a child's trauma. Empowered to Connect encourages caregivers to restore this sense of safety by providing consistent connection and attuned nurturing.

To address feeling "unseen," ETC modules emphasize the importance of mirroring. Mirroring is the process of hearing and reflecting a child's communication of his or her needs. This practice demonstrates that the child's needs can be understood and regulated by the caregiver, which fosters the child's confidence in his or her world (Paris, 2012). Another ETC strategy to help validate a child's experience is offering choices or compromises. Experts in ETC believe choices and compromises allow children to feel that their voices matter.

According to Arnwine (2019), the most common reaction to trauma is emotional and social isolation. While traditional parent education programs focus on communication and discipline, ETC modules incorporate methods to properly connect with children while providing the tools to repair children's tendency to disconnect. Connection forms the necessary empathic bond, which decreases a child's sense of isolation and restores the ability to attach and connect (Arnwine, 2019).

Researching trauma-informed programs like ETC is essential because trauma is a pervasive part of our society. Trauma impacts millions of families and has been linked to physical and mental health issues that ramify into adulthood. According to the Adverse Childhood Experiences (ACE) study, the amount of exposure to ACEs (childhood abuse or household dysfunction) has a strong relationship to the onset of physical and mental health issues in adulthood. Participants who reported four or more ACEs had a four to twelve times chance in risk for drug abuse, suicide attempts, and alcoholism; a two to fourfold increase in risk of sexually transmitted diseases or smoking; and 1.4 to 1.6 times the risk of severe obesity. The number of ACEs reported also bore a relationship to adult diseases such as cancer, heart disease,

chronic lung disease, and liver disease (Felitti et al., 1998). With research into interventions that support children who have been exposed to traumatic environments, we can help children heal and reduce the impact that trauma will ultimately have on their lives.

Statement of the Problem

Trauma causes a multitude of consequences among children, specifically those who have experienced out-of-home placement (Greeson et al., 2011). Millions of children are subjects of child abuse reports each year, and hundreds of thousands are placed in out-of-home care due to substantiated allegations. Unfortunately, thousands of children's injuries end in fatalities (Sufna, Brandt, Secrist, & Mesman, 2019). Children exposed to trauma are at risk of developmental, emotional, social, and academic difficulties. These difficulties are likely to transition into the foster/adoptive home if not addressed and appropriately treated (Razuri et al., 2016).

Parent education courses are one way to provide caregivers with the tools to care for children with trauma exposure. To date, however, traditional programs neither include a specific component to address trauma nor incorporate attachment issues and the struggles traumatized children have with their ability to connect with caregivers. Studies of trauma-informed parent education have demonstrated positive outcomes related to improving behavioral patterns and the emotional functionality of children with traumatic experiences. Increased awareness of the prevalence and consequences of trauma sheds light on the need for trauma-informed initiatives; however, more research is necessary (Beyerlein & Bloch, 2014) to support children in the foster care system.

In Dovran and colleagues' (2012) twenty-five-year review of empirical research on children placed out of the home due to trauma exposure, only one study relies on trauma-informed care. Purvis, et al. (2015) suggest that successful interventions not only need to address

behavioral difficulties exhibited by children exposed to trauma but also must recognize trauma as the underlying issue. Arnwine (2019) states that effective psychological interventions that address symptoms of trauma can alleviate long-term effects of trauma exposure.

It may be nearly impossible to eradicate all circumstances that cause trauma; however, we as mental health professionals owe it to future generations to provide interventions that mitigate the effects (Arnwine, 2019). Ignoring the problem is irresponsible and creates continuous negative consequences for generations to come. As the ACES study demonstrates, the well-being of thousands of children and families depends on how we care for them today. By educating families in relational environments, we can teach families to cultivate similar spaces in their own homes (Paris, 2012). Families struggling with the emotional and behavioral needs of trauma-exposed children can experience extreme healing and great comfort from a trauma-informed parent training curriculum such as ETC.

Purpose of the Study

The purpose of this study is to investigate the effectiveness of ETC parent education curriculum to determine any impact on caregivers' trauma-informed parenting skills and their parent-child relationships. This researcher hypothesizes that participation in the nine-week program will increase caregivers' ability to connect, attach, and assist their children in the recovery from symptoms of trauma. This study will benefit caregivers of adopted and foster children by providing evidence of ETC's impact. It is my hope that this research will prompt other child-based agencies to implement a more trauma-informed curriculum with caregivers of children who come from traumatic backgrounds.

Significance of the Study

Childhood trauma affects not only the children but also their families, communities, and classrooms (Gelles & Perlman, 2012). Unaddressed trauma often leads to poverty, addiction, crime, and mental and physical health issues, which ultimately result in billions of dollars being spent to address the consequences of trauma (Beyerlein & Bloch, 2014). Research has demonstrated the link between trauma exposure and subsequent maladaptive behaviors in foster and adoptive children; however, there are very few empirical studies investigating specific traumas in these populations (Razuri, et al., 2016). While there have been a handful of studies conducted on TBRI's framework, to date there have been no studies specifically focused on the ETC curriculum, and there is as yet no evidence to indicate that the nine-week course has any impact on caregivers and children. Investigating ETC's impact on children's ability to recover from trauma and on caregivers' ability to connect and attach with their children may prove to be extremely valuable in the recovery from childhood trauma. This study will provide new knowledge related to the efficacy of ETC, which is a topic that has yet to be considered.

Operational Definitions

Attachment – Innate system in the brain that influences and organizes motivational, emotional, and memory processes as they relate to caregivers (Empowered to Connect Course, 2013).

Bonding - Lifelong process of attachment and connection, which infuses the organization of safety and trust (Bowlby 1988).

Complex trauma - The dual problem of exposure to traumatic events and the impact of this exposure on immediate and long-term outcomes (Arnwine, 2019).

Disruption- Circumstances that lead to a child leaving his or her current foster home and being placed with new caregivers (Bass, 2017).

Caregiver – An adult (over the age of 18) who is legally responsible for a person under the age of 18 and is participating in the ETC course.

Parent-child relationship - The degree to which parents are involved and are responsive to the child.

Parent education – Courses intended to teach new methods by which to interact with, engage with, and discipline children (Croake & Glover, 1977).

Resource parent - Caregivers who provide out-of-home care for children in foster care (Bass, 2017).

Trauma – A single, repetitive, or enduring experience that overwhelms one's capacity.

Trauma-informed care - An approach which a) acknowledges the prevalence and influence trauma has on all parts of a family system, b) responds with trauma-sensitive practices, and c) actively works to eliminate the experience of re-traumatization (NCTIC, 2013).

Research Questions

The following research questions were defined for the study:

1. Does participation in a nine-week ETC parent training course improve caregivers' parent-child relationships?

2. Does participation in a nine-week ETC parent training course improve caregivers' trauma-informed parenting?

3. Does a caregiver's gender impact the parent-child relationship or trauma-informed parenting outcomes?

4. What is the relationship between the number of children residing in the home and scores on the BASC-PRQ and trauma questionnaire?

5. What is the relationship between disruptions in placements and caregivers' scores on the BASC-PRQ and the trauma questionnaire?

6. What is the relationship between the type of parent (foster, adoptive, or kinship) and scores on the BASC-PRQ and the trauma questionnaire?

Independent Variables

-Time (pre and post)

-Gender of caregiver, number of other children in the home, total number of disruptions

Dependent Variables

-Scores on the BASC-PRQ and Resource Parent Knowledge and Beliefs inventories

The study's hypothesis states that caregivers enrolled in an ETC course will report increased trauma-informed parenting and higher levels of improvement in their parent-child relationship than caregivers who are not enrolled in an ETC course. This study will also examine any correlation between the parent-child relationship and the caregiver's gender, the number of other children in the home, and the number of previous disruptions.

Limitations of the Study

Participants will include caregivers who possess the time and means to volunteer in a nine-week parenting course. This sample may not represent the population as a whole. Additionally, the use of parent-report measures may not accurately reflect true outcomes. It is possible that the parent-child relationship may improve following treatment because caregivers desire or expect that outcome. Limitations related to the selection of participants include the lack of diversity in the population, as the majority of the sample is likely to consist of white upper-middle-class families. An additional limitation includes the inability to determine causal effects of ETC on intended outcomes as randomization methods with a control group were not utilized.

Without a control group, this research lacks the ability to determine whether changes from pre to post are due to the treatment, or additional factors.

Future Research

Trainers follow a train-the-trainer method, which may result in trainer differences. An important direction for future research will be to examine the impact of trainer qualifications on the outcome of individual class groups. Some of those trainer qualifications including the length of time trained, the number of classes taught, and how closely trainers stick to the training material.

Assumptions

This research study assumes the following: a) participants will respond to measurement items accurately and indicate accurate perceptions, (b) participants will understand the language and concepts associated with trauma and the parent-child relationship measures, (c) the data collected will measure the knowledge, skills, and perceptions of the participants, and (d) the interpretation of the data will accurately reflect the perceptions of the respondents.

Organization of the Study

This dissertation consists of five chapters. Chapter I includes the overview, purpose, and significance of the study, as well as the definition of terms. Chapter II provides a review of current and previous parent education literature. Chapter III includes methodology, including the selection of participants, proposed data collection and analysis, and survey instruments. Chapter 4 presents the statistical analysis used and the results of the data analysis. Discussion of findings, implications, recommendations for further research, and conclusions are presented in Chapter 5.

Chapter II: Literature Review

Introduction

This literature review examines recent studies in which trauma-informed approaches have been used in parent education programs. Studies have demonstrated an increase in trauma-informed parenting and a decrease in mental health symptoms among participants in programs with a trauma-informed or an attachment-related curriculum. This review also provides an in-depth explanation of the impact of trauma on foster children and their caregivers and makes a case for the ability of trauma-informed parenting to improve those dynamics.

Definition and Symptoms of Trauma

The most recent edition of the Diagnostic Statistical Manual (DSM-5) defines trauma as

exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend—in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (DSM-5; American Psychiatric Association [APA], 2013)

DSM-5 excludes emotional abuse, significant loss, or separation and does not make mention of non-life-threatening events as traumatic. Although emotional abuse, loss, or separation may not cause life-threatening damage, they are associated with the development of acute stress and posttraumatic stress disorder (Briere & Scott, 2014). Perhaps in an attempt to be more inclusive of potentially traumatic experiences, the Substance Abuse and Mental Health Administration (SAMHA) defines trauma as

an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. (SAMHA, 2014, para. 2)

SAMHA's definition takes into account one's experiences of the event leading to the perception of trauma (Bass, 2019). For the purposes of this study, trauma will be defined using SAMHA's criteria.

Childhood Trauma

Childhood trauma causes harm to general functioning and developmental abilities, leading to deficits in a child's skills. Trauma can be acute or chronic, with chronic trauma developing into complex trauma if the exposure is long-lasting or pervasive. Long-lasting chronic trauma includes exposure to multiple types of trauma, making experiences more harmful (Myers, 2019). Reactions to trauma involve an inability to control intense emotions; somatic complaints; and academic, behavioral, or social difficulties. Trauma can also result in feelings of hopelessness, persistent fear, difficulties in eating or sleeping, nightmares, flashbacks, hypervigilance, concentration issues, and bed-wetting (Beyerlein & Bloch, 2014). Many of these symptoms will be discussed throughout this literature review.

Types of Childhood Trauma

The American Psychological Association (APA) Presidential Task Force on Posttraumatic Stress Disorder (PTSD) (2008) classifies traumatic events as including domestic/community violence, neglect, abuse, suicides and other deaths or losses, medical trauma, experiences of war, vehicular accidents, and natural or manmade disasters (Buss, Jeffrey & Horton, 2015).

Prevalence of Trauma

According to Razuri et al. (2016), 68% of Americans have experienced some form of childhood trauma and 25% of the general public has experienced some form of abuse or violence (Bass, 2017). These types of experiences are likely more common among children who live in

poverty, as daily stressors are often extensive and lend themselves to potentially traumatic conditions (Bass, 2017). Experience of these conditions frequently leads to reports of child abuse and neglect. According to the U.S. Department of Health and Human Services Administration for Children and Families, nearly 3.2 million child abuse reports involving 7.4 million children were made during 2016. Substantiated cases of abuse or neglect affected approximately 683,000 children (9.1 per 1,000 children) during that same year. The most prevalent type of abuse is neglect (76.9%), followed by physical abuse (18.2%), and sexual abuse (8.5%).

In fairly recent studies, McLean (2004) finds that 81% of all children studied report histories of significant childhood trauma. McLean's (2004) findings are similar to those of Dorsey et al. (2012), who examined 229 foster care children for trauma exposure and emotional and behavioral problems. Approximately 93% reported exposure to at least one trauma, and nearly half reported exposure to four or more types of trauma. The types of trauma reported included emotional abuse (85%), witnessing domestic violence (65.4%), sexual abuse (52.7%), neglect (51.5%), and physical abuse (49.5%).

Highest Risk

Younger children experience a higher level of dependence on caregivers, which may put children from birth to age five at a particularly high risk of exposure to potentially traumatic events (Lieberman & Van Horn, 2009). This supports recent studies indicating that approximately half of all substantiated reports involved children under six years of age. Likewise, the Child Welfare Information Gateway (2014) has found that 88% of child abuse and neglect fatalities involved children seven years of age and younger.

Consequences of Trauma

Higher rates of traumatic experiences are linked with higher rates of behavioral, emotional, social, neurological, and academic deficits that leave children in foster care vulnerable to additional negative consequences (Beyerlein & Bloch, 2014). Behavioral and social challenges for trauma-exposed youth can include poor coping skills; dating violence; and engagement in risky, delinquent, or violent behaviors (Bass, 2019). They are also at risk for mental and physical health issues and dysfunctional interpersonal relationships. These youths can also experience attachment disorders, emotional regulation challenges, dissociation, self-concept issues, and fear or hyperarousal that persists long after the threat has subsided (Razuri et al., 2016).

Trauma exposure can also result in neurobiological changes, depending on the stage of development at which the trauma occurs. Exposure to trauma during early developmental periods disrupts brain development and functioning in several key areas. One of these areas is the amygdala, which acts as our body's "security guard" and alerts us to potential danger. For most people, the amygdala responds when we are threatened and then deactivates when the threat is no longer relevant. For children with histories of trauma, however, the amygdala remains on high alert and becomes unable to distinguish a real threat from a perceived one. Children who are always on high alert may be more likely to engage in unhealthy behaviors as a means of attempting to protect themselves (Bremner, 2006).

Neurocognitive delays in children exposed to trauma are also a concern. Pears and Fisher (2005) demonstrate that maltreated children have increased issues with visuospatial processing, memory skills, and language ability compared to children not involved in the child welfare system. Razuri et al. (2016) offer evidence of sensory processing disorders in children who have

trauma backgrounds. These children may over- or under-react to sensory input, leading to potential behavioral, social, and academic problems.

Another critical area impacted by trauma is the hippocampus, which is the brain's center for emotion and memory. During a frightening event, the hippocampus stops filing memories, making details of the event difficult to recall. During times of fear, the hippocampus pumps cortisol to prevent the experience of pain so the body can focus on the necessary survival tactics (Perry, 2006). When this occurs, a child's ability to remember spelling words or math facts in the classroom is significantly impacted.

Trauma exposure also inhibits prefrontal cortex functioning, making higher-level thinking (such as planning, impulse control, and appropriate decision making) difficult. The cortex, which is responsible for language and reasoning, experiences deficits in language production and comprehension (Perry, 2006). The brainstem, where stress-regulation, survival, and metabolism are regulated, and the limbic system, responsible for emotion, attachment, mood, and pleasure, are also negatively impacted by trauma. The depletion of serotonin levels in these areas ultimately hinders a child's ability to regulate emotions. A decreased capacity for emotional regulation can make appropriate reactions to situations problematic (Bremner, 2006).

Motor activity, sleep, and appetite are the responsibilities of the midbrain. Trauma can cause damage to this part of the brain, resulting in deficits in motor activity, as well as under- or overeating or sleeping. Lastly, trauma exposure decreases developing connections, equating to brain shrinkage, an effect demonstrated in scans of children who have experienced extreme neglect (Bremner, 2006).

According to van der Kolk (2014), trauma survivors experience trauma corporally, meaning that the body relives and replays events as if still under threat. This response stores

traumatic, emotional memories in the brain's implicit memory, producing blueprints of the traumatic experience that are often difficult to access through verbal means. Children remain on high alert in attempts to proactively defend themselves from additional negative experiences (Razuri et al., 2016). This type of reaction may present itself in behaviors such as suddenly fleeing the classroom or becoming aggressive with a peer for no apparent reason.

Although these changes have an impact during early childhood development phases, the deficits have been shown to continue into adulthood. The Adverse Childhood Experiences (ACE) study demonstrates a link between childhood maltreatment and subsequent physical and mental health issues in adulthood (Felitti et al., 1998). Likewise, longitudinal studies have indicated that childhood trauma is positively linked with behavior problems as a child ages into adulthood (Beyerlein & Bloch, 2014). Such findings confirm the lifelong consequences of childhood trauma even when the child is removed from the traumatic environment (Purvis et al., 2015).

Impact on Behavior

Children with histories of trauma often experience behavioral difficulties that persist long after the initial trauma took place. These include challenges with impulse control and emotional regulation, including frustration tolerance, understanding emotional needs, self-soothing ability, and complying with directions. Following trauma, children are at risk of developing emotional and behavioral dysregulation, which manifests in internalizing and externalizing behaviors such as depression, anxiety, behavioral disorders, and substance abuse (Sufna, Brandt, Secrist, & Mesman, 2019). These maladaptive behaviors develop as coping mechanisms to address the child's need for survival (van der Kolk, 2005) but are often seen as noncompliant challenges and can lead to negative consequences.

Impact on School Achievement

Foster youth experience academic deficits that contribute to the likelihood of academic failure. In comparison to their peers, youth who have experienced trauma generally demonstrate lower academic progress, more problems with school behavior, and a higher rate of special education referrals (30–50% as compared to 10% in the general population) (Bass, 2017). Foster care youth, specifically, are three times as likely to be placed in special education classes. Special education referrals have been associated with truancy and foster care instability (Bass, 2017).

Trout et al. (2008) have found that youth in foster care are at higher risk of academic failure, perform below grade level on standardized tests, and are required to repeat grades at higher rates than non-foster youth. Burley & Halpern (2001) analyzed 60,000 statewide achievement tests and found that non-foster youth outperform foster youth by 15 to 20 percentile points. Results also show that twice as many foster care youth are retained as non–foster care youth. Similarly, a Smithgall et al. (2004) study shows Chicago's public school foster youth to be two times as likely to be retained and to have reading scores lower than the 25th percentile.

Foster youth experience additional circumstances that hinder academic progress. Approximately half of all foster youth change schools four or more times between kindergarten and 12th grade (Powers & Stotland, 2002). When a child experiences a school move, it can take him or her four to six months to catch up with his or her peers. Disruptions in foster placements and, therefore, in the school environment have been associated with absenteeism; potential issues for foster youth, who are often highly transient, appear inevitable (Bass, 2017).

Childhood trauma can severely hinder a child's ability to perform well by damaging the physiology of the child's developing brain and ingraining neurobiological responses that work

against a child's ability to concentrate, comprehend, organize, and regulate his or her emotions in the classroom (Bremner, 2006; Bass, 2017). The hippocampus, the brain's center for learning and memory formation, is vital for adequate academic progression. Trauma increases cortisol levels in the hippocampus, leading to a decrease in its volume. Traumatized children have also been shown to have a smaller prefrontal cortex, which is a brain structure that allows a child to regulate emotions, plan, make decisions, and control impulses. When these brain structures are decreased, skills required to promote academic abilities may also be decreased (Perry, 2006).

Studies have shown that children exposed to violence demonstrate decreased grade point averages, reading ability, and comprehension and are less likely to graduate high school as they experience more absences. Children who have experienced three or more traumatic events are two and a half times as likely to have severe attendance issues (Arnwine, 2019). Exposure to two or more traumatic events makes students almost three times as likely to fail a grade.

Although youth in the Myers (2019) study earned a high school diploma, they are among the small percentage of youth with trauma history and involvement in the foster care system who successfully graduate. Despite their ability to graduate, the majority of participants reported that being in foster care impacted their learning and academic success.
According to Myers (2019), academic progress is adversely impacted by changes in home and school placements as a result of foster care. Repeated changes in schools can lead to missing vital curriculum, thus causing the youth to be delayed in instruction as compared to their peers.

Impact on Attachment

Attachment theory describes attachment as the security or insecurity of the early child-parent bond, which impacts interpersonal relationships into adulthood. Care perceived as inconsistent or frightening impedes a child's ability to experience secure attachment. Research on

foster children and attachment has shown that a history of abuse can manifest itself in emotional and behavioral deficiencies and make it difficult for children to securely attach with their caregivers (Prather & Golden, 2009). Consequently, caregivers indicate that one of the most difficult aspects of caring for children who have been exposed to trauma is their inability to experience trusting relationships (Schofield and Beek, 2005). Other difficulties include a distorted sense of safety, often demonstrated in a child's difficulty with interpersonal relationships.

Foster children often develop disorganized attachments resulting in a need to control their environment. Because these children have learned to adapt to inconsistent or fear-inducing caregiving, it becomes difficult to perceive caregivers (including new foster parents) as safe or trustworthy. Children may act out in attempts to keep themselves safe, inadvertently hindering their ability to securely attach to caregivers. They may appear to be manipulative or disingenuous due to their perception of a need to rely on themselves rather than their caregivers to meet their needs (Prather & Golden, 2009). Attachment difficulties can also appear in the form of a lack of impulse control, impaired moral development, and a general inability or lack of desire to be connected to others (Termini & Golden, 2007).

Supportive Relationships

Safety, connection, and access to meaningful relationships are fundamental to the recovery from trauma. Supportive relationships function as a protective mechanism and can help improve cognitive functioning of children exposed to trauma as well as their psychological outcomes (Perry, 2006). Additional protective factors for foster children include participation in extra-curricular activities, which provides an opportunity for them to make additional connections with peers and adults who may act as role models or support systems. Connections

with supportive peers and adults also aid in the development of self-identity and self-esteem (Bass, 2017).

According to Myers (2019), a key protective factor for students in foster care during K-12 education is supportive relationships. Myers (2019) findings demonstrated consistency with other studies stressing the importance of supportive and healing relationships with adults and peers. The entire sample of youth reported believing that their connections with peers and trusted adults were critical in their trauma recovery in the Myers (2019) study. Additionally, the majority of participants indicated that trusting relationships with peers and adults continues to be a protective factor for them. These findings are also consistent with Perry (2006) who asserted that social health was essential for trauma recovery for adolescents placed in foster care (Myers, 2019).

Foster Care and Trauma

According to Greeson et al. (2011), children placed in foster care have the most exposure to trauma due to high instances of chronic stress. These children typically come into care due to at least one caregiver-related trauma such as abuse or neglect and have likely faced additional trauma such as domestic or community violence. The vast majority of foster children have experienced multiple traumas.

Greeson et al. (2011) studied 2,251 foster children between 2004 and 2011 and indicate that 70% of foster children have experienced complex trauma. Complex trauma is defined as a history of chronic interpersonal caregiver-related trauma consisting of at least two interpersonal trauma types (i.e., physical abuse, sexual abuse, emotional abuse, domestic violence, and neglect). Similarly, Ford and Courtois (2009) define complex trauma as repeated or prolonged

exposure that occurs during early childhood and involves direct harm, abandonment, or neglect by caregivers and poses a severe threat to a child's development.

In addition to the abuse or neglect that caused the initial trauma, children also endure other consequences, such as separation from parents, siblings, the school environment, and other adults that may have been a support for the child. Children may also suffer from mistreatment in foster care, feelings of guilt about reporting the abuse, fear related to their future stability, and a longing for their biological families. This type of chronic trauma, if untreated, can lead to challenging relationships between the children and their foster care providers (Beyerlein & Bloch, 2014).

Behavioral difficulties can result in multiple disruptions, causing additional traumatic experiences. Disruptions occur when caregivers feel they can no longer care for a youth because of their behavioral, emotional, or physical needs (Beyerlein & Bloch, 2014). According to Bass (2017), school-aged foster care youth relocate at twice the rate of their peers. Repeated disruptions further complicate the existing chronic stress symptoms, opening the door for additional internalizing and externalizing symptoms (Conradi et al., 2011).

Children exposed to complex trauma are often placed with foster families, and in some cases, these become adoptive families. In 2016, the Adoption and Foster Care Analysis Reporting System estimated that approximately 437,465 children had been placed in foster care, with more than half being placed for over a year (Sufna, Brandt, Secrist, & Mesman, 2019). According to the U.S. Department of State, there have been over 240,000 international adoptions since 1999. Another 50,000 children are adopted annually from domestic child welfare agencies (Purvis et al., 2015). According to the Child Welfare Information Gateway (2004), there were at that time approximately 127,000 adoptions annually, with 15% being international adoptions.

Although many of these children are adopted into loving and stable homes, previous trauma causes them to experience attachment, behavioral, and social issues (Purvis et al., 2015).

Mental Health and Foster Care

Numerous studies indicate a link between trauma exposure and subsequent mental health issues. According to Purvis, Cross, and Pennings (2009), children who experience abuse or neglect are more likely to develop pervasive behavioral disorders. Many of these children are at risk for social or relational disturbances resulting from their histories of trauma. Juffer and van Ijzendoorn (2005) find adopted children to display more internalizing and externalizing behavior problems than non-adopted children. Adopted children are also overrepresented in this study among those seeking mental health services.

Exposure to trauma can decrease the ability to tolerate painful internal states and to reduce stress without avoidant or dissociative behaviors. Oftentimes, trauma survivors attempt to regulate emotions by using substances, being impulsive, engaging in self-injurious behaviors, or taking steps to seriously harm themselves (Briere & Scott, 2014). Foster children with internalizing and externalizing behaviors are at risk for long-term mental and behavioral health challenges (Myers, 2019). Likewise, children with low self-esteem have an increased likelihood of externalizing behaviors and experience more psychological trauma than children in the general population. Conversely, high self-esteem has been linked with positive psychological well-being and decreased incidence of depression and anxiety (Bass, 2017).

The study by Greeson et al. (2011) mentioned above finds not only that 83% of foster children have been diagnosed with at least one mental health disorder but also that they experience a 20% higher rate of PTSD than children in the general population. Likewise, Purvis et al. (2015) find that foster care children demonstrate PTSD symptoms at a rate twice that of

combat veterans. Similar studies include that by Burns (2004), which analyzes data from the National Survey of Child and Adolescent Well-Being (NSCAW). Of the nearly 4,000 2- to 14-year-olds studied, half experienced behavioral and/or emotional problems that were considered clinically significant.

Children placed in foster care generally experience higher levels of behavioral and emotional clinical distress. Foster care youth are 2.5 times as likely to require mental health resources as the general population. Dorsey and colleagues (2012) examined 229 foster care children for trauma exposure and emotional and behavioral problems and found that increased exposure to child abuse and neglect was linked to decreased emotional and behavioral functioning.

Traditional Foster Parent Education Training

Federal guidelines require foster parents to be trained in relationship building, behavior management, methods for fostering social and emotional skills, and parenting practices that are developmentally appropriate. Although foster parent training is federally mandated, states use a variety of different programs with varying objectives. Expectations vary across the United States, and only 36 states mandate that foster parents participate in a training course (Festinger & Baker, 2013).

Foster parent training should include the four foundational features of empathy and relationship building, knowledge and self-efficacy related to the youth's education, awareness of developmentally appropriate expectations for the youth, and social-emotional development and behavior management (Bass, 2017). These skills are taught to improve outcomes for foster youth by decreasing the potential for disruptions and improving foster parent retention. When foster parents are trained, foster children have a higher likelihood of being successful in the home and

foster parents feel more equipped to care for their children. Both effects lead to increased foster parent retention and successful foster care youth (Bass, 2017).

Buehler et al. (2006) have investigated state and federal laws related to foster care training guidelines and find that participation in foster care training does, in fact, improve youth's educational outcomes. Satisfaction and retention among foster parents also improve in association with training participation. Satisfaction can be gained when foster parents are successful in meeting the needs of their youth, thus increasing their self-efficacy in meeting the requirements of such a demanding position.

Retention of foster parents is vital to the advancement of foster children but is difficult to maintain, with close to half of all foster parents resigning following their first year (Pasztor & Wynne, 1995). Reasons for resigning include unclear role expectations (Le Prohn, 1994), perceived difficulty managing behavior (Buehler, Cox, & Cuddeback, 2003), high burnout, and feeling undervalued (Heller et al., 2002). Bass et al. (2004) note foster parents reporting high levels of stress and feeling overwhelmed. Conversely, feeling supported, exercising a consistent routine, and tolerance for behaviors are associated with foster parents who are more satisfied in their roles (Buehler et al., 2003). Foster parents also acknowledged that routine and structure provide necessary feelings of safety for foster youth and establish ways to prevent and respond to challenging behaviors (Bass, 2017). Incorporating ways of promoting the safety of foster youth helps them to flourish and helps foster parents to manage stress-provoking behaviors, again promoting improved outcomes for youth and retention of foster parents.

In Kriener & Kazmerzak (1994), foster parents indicate a need for improved training that addresses the socioemotional and behavioral development of foster youth to better manage the stress that accompanies fostering youth. This training can equip foster parents with a clear

understanding of their role, help to prevent burnout, and empower foster parents to meet the unique demands of their foster placements. Proper training can decrease disruptions and ultimately work in the youths' favor. This is especially critical for a population of youth who have already experienced traumatic circumstances and may ultimately have more negative outcomes than other children their age (Bass, 2017).

Foster parent trainings teach essential skills that prepare foster parents with the knowledge to address challenging behaviors and, according to Barlow & Stewart-Brown (2000), produce long-term effects. For example, research indicates that Behavior Parent Training (BPT) improves parenting strategies, reduces stress in foster parents, and improves home and classroom behavior of foster youth (Chronis et al., 2004).

Although research suggests that foster parent training is vital to decreasing disruptions and increasing the academic success of foster youth, there is a lack of research to confirm the effectiveness of the most widely used parent training models. Dorsey et al. (2008) have conducted a comprehensive review of foster care training models, including two of the most commonly used models, Parent Resources for Information Development and Education (PRIDE) and Model Approach to Partnerships in Parenting (MAPP). Neither program generated sufficient evidence to indicate its benefits to foster parents (Dorsey et al., 2008). Also included in the comprehensive review is a study by Lee and Holland (1991) in which pre- and posttest measures find no significant difference in foster parent skills or attitudes. Conversely, the Incredible Years and Cognitive Behavioral Parent programs, for example, have been shown to generate improvements in foster parents' skills and a reduction in foster youths' externalizing behavior (Bass, 2017).

The Dorsey et al. (2008) review notes the discrepancy between goals and measurement of those goals as they differ from one program to the next. This disparity highlights an area in which training program competencies should be evaluated and improved to include evidence-based practices known to increase retention and improve foster youth outcomes (Bass, 2017).

Trauma-informed Care

The National Child Traumatic Stress Network (NCTSN) defines trauma-informed care as an approach which a) acknowledges the prevalence and influence trauma has on all parts of a family system, b) responds with trauma-sensitive practices, and c) actively works to eliminate the experience of re-traumatization (NCTIC, 2013). Beyerlein and Bloch (2014) similarly suggest that trauma-informed awareness should result in the practice of enacting appropriate and beneficial programs, providing adequate training, and implementing well-thought-out policies and procedures that decrease the potential for re-traumatization.

Trauma-informed programs should (a) utilize culturally competent evidence-based treatments, (b) assess for trauma exposure, (c) consider how trauma affects the entire system, (d) educate clients on the impact of trauma, (e) provide resources that work to facilitate resilience, (f) collaborate with other involved systems of care, and (g) work to decrease secondary traumatic stress. Trauma-informed care promotes a sense of understanding from the trauma survivor's perspective and considers best practices to help individuals heal, while not judging or blaming individuals for their current coping mechanisms (Beyerlein & Bloch, 2014).

Trust-Based Relational Intervention

Trust-Based Relational Intervention (TBRI) is different from traditional parenting frameworks in that it prioritizes trauma as the underlying cause of behavior problems among adopted children (Razuri et al., 2016). The trauma-informed care principles of the TBRI

framework helps caregivers learn to mitigate the consequences of trauma using concepts traditional programs tend not to include. For example, Bath (2008) suggests that felt safety, self-regulation, and connection are the three pillars of trauma-informed care required to help children heal from the experience of complex trauma. The teaching of TBRI is based on these three pillars.

According to the founder of TBRI, trauma-informed interventions should consider the importance of the parent-child relationship, as connection lays the groundwork for felt safety and self-regulation. Felt safety develops from trusting interactions, and self-regulation develops from repeated and attuned caregiver attachment (Purvis et al., 2015). Increasing a child's ability to experience felt safety, self-regulation, and connection with caregivers ultimately improves the parent-child relationship, thus improving the child's behavioral, social, and emotional development (Hawk and McCall, 2010).

Increasing caregiver empathy and sensitivity has also been shown to improve children's behavior and attachment capabilities (Woolgar, 2013). Improved parent-child relationships can provide opportunities to safeguard children from the adverse outcomes they may experience as a result of their trauma. Trust-Based Relational Intervention provides intervention in the context of attachment and promotes the idea of seeing the need behind the behavior while educating caregivers on specific practices to meet those needs (Purvis et al., 2015).

Successful trauma-informed interventions, specifically TBRI and ETC, are beneficial in providing the type of support and resources necessary for adoptive families struggling to care for children with histories of trauma. By attending to connection as an essential pillar of healing, empathic bonds can be formed, resulting in a decrease in the sense of isolation and mistrust and an increase in felt safety (Purvis et al., 2015).

Parent Education Studies

Murray, Sullivan, Lent, Chaplo, and Tuno (2019) investigated the effectiveness of a parent education curriculum entitled Resource Parent Curriculum (RPC). This program was designed to promote trauma-informed parenting skills among foster, adoptive, and kinship caregivers. Goals included improving placement stability and promoting healing from traumatic experiences in foster children. Similar to the ETC curriculum, the RPC offers the following trauma-informed modules: Trauma 101, Understanding Trauma's Effects, Building a Safe Space, Dealing with Feelings and Behaviors, Connections and Healing, Becoming an Advocate, and Taking Care of Yourself.

This study used a multisite sample with a pre and posttest assessment to measure 314 resource parents' improvement on trauma-informed parenting, perceived self-efficacy, tolerance of child misbehavior, and whether parent characteristics moderated the impact of RPC on these outcomes. Parent age, gender, race/ethnicity, and type of resource parenting were evaluated as between-subjects variables, and trauma-informed parenting, tolerance of misbehavior, and parenting efficacy were evaluated as within-subjects variables. Between 2014 and 2017, participants completed an RPC course offered in five states. Each class enrolled between 3 and 33 participants. A total of 314 resource parents were selected from 542 eligible participants who completed any part of the RPC workshops.

Although there was no established measure of fidelity to the RPC, facilitators across all sites reported RPC workshops to be delivered in accordance with the implementation standards used by NCTSN. Measures utilized include the Resource Parent Knowledge and Beliefs Survey (RPKBS), which assesses beliefs and attitudes related to caring for children who have experienced trauma. This measure yields three scales: Trauma-Informed Parenting, Tolerance of

Misbehavior, and Parenting Efficacy. The Trauma-Informed Parenting Scale contains 24 items assessing the impact of knowledge of trauma as well as beliefs and attitudes about parenting a child who has experienced trauma. The Parenting Efficacy Scale, a five-item questionnaire, assesses parents' confidence in their ability to parent a child who has experienced trauma. Lastly, the Tolerance of Misbehavior Scale describes the extent to which caregivers tend to be annoyed by child misbehavior. Items were developed from an adapted version of the Parenting Self-Agency Measure (PSAM; Dumka, Stoerzinger, Jackson, & Roosa, 1996), which has been determined to have adequate psychometric properties. This measure uses a 6-point Likert scale, where 1 indicates "Strongly Disagree," 2 indicates "Disagree," 3 indicates "Slightly Disagree," 4 indicates "Slightly Agree," 5 indicates "Agree," and 6 indicates "Strongly Agree." The 33 item measure has a score range of 33-198. As this measure was not normed, there were no interpretations of each individual score, thus pre and post scores were used to determine improvement.

Researchers completed an attrition analysis to examine whether participants included in the final sample (n = 314) differed significantly from those excluded from the study (n = 228) in terms of demographic characteristics or pretest scores. Chi-square analyses compared the two groups on categorical variables (parent race, gender, foster parent status, kinship status, and adoptive parent status). An analysis of variance (ANOVA) compared the two groups on continuous variables (pretest trauma-informed parenting, tolerance of misbehavior, efficacy, parent age, and years as a resource parent). Results showed no significant differences between the group excluded from the study and the final sample included in the study except that kinship caregivers and adoptive parents were more likely to be excluded from the study than parents who did not identify as kinship or adoptive. Results for this study can be found in the table below.

Table 1

Resource Parent Results

Parent characteristic	Trauma-informed parenting (TIP)			Tolerance of misbehavior (TOM)			Parenting efficacy (EFF)		
	N	Pre-TIP M (SD)	Post-TIP M (SD)	n	Pre-TOM M (SD)	Post-TOM M (SD)	n	Pre-EFF M (SD)	Post-EFF M (SD)
Full sample	303	4.59 (.57)	5.14 (.47)	303	4.02 (1.04)	4.57 (.89)	302	4.57 (.75)	5.14 (.60)
Gender									
Female	203	4.64 (.57)[a]	5.18 (.47)[a]	204	4.01 (1.04)	4.55 (.94)	203	4.62 (.74)	5.21 (.58)[a]
Male	96	4.49 (.56)[b]	5.05 (.47)[b]	95	4.06 (1.03)	5.62 (.79)	95	4.46 (.76)	5.03 (.61)[b]
Race/ethnicity									
Caucasian	171	4.54 (.57)[a]	5.14 (.48)	171	3.97 (.99)	4.59 (.81)	168	4.46 (.74)	5.15 (.59)
African American	86	4.58 (.56)[a]	5.14 (.46)	85	4.05 (1.15)	4.51 (1.11)	90	4.73 (.72)	5.18 (.63)
Other	36	4.83 (.61)[b]	5.18 (.47)	37	4.20 (1.03)	4.72 (.86)	36	5.17 (.58)	5.17 (.60)
Parent type									
Foster	232	4.58 (.53)	5.14 (.45)	230	3.94 (1.03)[a]	4.56 (.90)	230	4.57 (.73)	5.17 (.58)
Nonfoster	71	4.62 (.68)	5.13 (.51)	72	4.26 (1.01)[b]	4.62 (.87)	69	4.55 (.82)	5.10 (.66)
Adoptive	106	4.57 (.60)	5.13 (.51)	107	3.91 (1.11)	4.43 (1.07)[a]	108	4.45 (.82)[a]	5.03 (.68)[a]
Nonadoptive	195	4.60 (.55)	5.15 (.45)	195	4.08 (.99)	4.65 (.79)[b]	202	4.62 (.71)[b]	5.22 (.54)[b]
Kinship	22	4.51 (.54)	5.15 (.47)	24	4.22 (.87)	4.60 (.78)	22	4.74 (.67)	5.41 (.53)[a]
Nonkinship	281	4.59 (.57)	5.07 (.48)	279	4.00 (1.05)	4.57 (.91)	280	4.55 (.76)	5.13 (.60)[b]
Therapeutic foster	38	4.81 (.56)[a]	5.19 (.44)	39	4.47 (.92)[a]	4.71 (.74)	39	4.83 (.66)[a]	5.19 (.56)
Nontherapeutic foster	264	4.55 (.57)[b]	5.13 (.47)	264	3.95 (1.04)[b]	4.55 (.92)	263	4.53 (.76)[b]	5.14 (.61)

Note. Within each parent characteristic category for each outcome, superscripts indicated significantly different scores ($p \leq .05$) based on independent samples t-tests. For table clarity, superscripts are only displayed for parent characteristics that demonstrated significant differences. Regarding parent type, four comparisons were made between foster and nonfoster parents; adoptive and nonadoptive parents; kinship and nonkinship parents; and therapeutic versus nontherapeutic foster parents. These categories were not mutually exclusive.

Overall, resource parents reported relatively high preworkshop trauma-informed parenting, tolerance of misbehavior, and parenting efficacy scores. The findings of this study replicate those from previous studies, indicating that RPC improves the trauma-informed perspective of resource parents (Sullivan et al., 2016). The RPC study did not include a control group; therefore, inferences cannot be made about causality. Nonetheless, previous research has linked trauma-informed parenting, tolerance of misbehavior, and parenting efficacy with positive parent and child outcomes, such as reduced foster parent burnout, increased foster parent retention, and increased placement stability (Sullivan et al., 2016).

Gigengack, Hein, Lindeboom, and Lindauer (2017) have studied resource parents' perceived stress and knowledge of posttraumatic stress syndrome (PTSS) prior to engaging in the RPC, following completion, and six months after. This study was conducted in Amsterdam with a population of mostly women whose children were an average age of nine. Age and race of

caregivers were not specified. Measures included demographic questionnaires, the Burden of Upbringing Questionnaire, and the Children's Revised Impact of Event Scale (CRIES) parental version. Findings demonstrated resource parents' increased identification of their child's PTSS as well as a decrease in experienced stress (related to the upbringing of the child). Limitations include a lack of randomization of participants, no use of a control group, and small sample size.

TBRI Studies

Trust-Based Relational Intervention is the framework in which this study's ETC curriculum is based. Studies assessing the TBRI framework have been conducted with youth of all ages, from all risk levels and in various settings, including schools, residential facilities, orphanages, courts, churches, and adoptive/foster homes (Purvis, Cross, Danserau, & Parris, 2013). Unfortunately, only a few studies have been conducted on TBRI, while no studies have been conducted on ETC.

Purvis et al. (2015) conducted the first randomized study which used a control group to investigate the effectiveness of TBRI. Researchers hypothesized that trauma symptoms would improve for children whose caregivers participated in the program. Criteria for participation included being a parent of an adopted child between the ages of 5 and 12 who had been in the home for at least one year. The treatment group intervention was conducted over a four-day period, with each day lasting 6 hours. Modules included the TBRI overview and empowering, connecting, and correcting principles, designed to help participants understand and improve behavioral patterns.

Participants (n = 85) were randomly assigned to the treatment group's four-day in-person training. The remaining 82 were randomly assigned to either an online treatment or a control group, with the control and treatment group being matched on gender, child's age, adoption age,

and adoption type. Participants completed pre- and posttest Strengths and Difficulties Questionnaire (SDQ; Goodman 2001) and Trauma Symptoms Checklist for Young Children (TSCYC; Briere 2001).

The SDQ is a self-report caregiver/teacher/adolescent scale measuring behavior in children 3 to 16. This 25-item scale assesses prosocial behavior, emotional symptoms, conduct problems, hyperactivity/inattention, and peer problems. The TSCYC is a caregiver self-report scale measuring posttraumatic symptoms in children between 3 and 12. This 90-item scale yields clinical subscales which include anxiety, depression, anger/aggression, posttraumatic stress symptoms, sexual concerns, and dissociation.

Using a repeated measures Multivariate Analysis of Covariance (MANCOVA) with pre- and post-times as within-subjects factor, treatment and control group as between-subjects factor, and sex/current age of the child as covariates, researchers found the control groups' reporting of behaviors remained the same from pre- to posttest. The treatment group saw a decrease in conduct problems, hyperactivity, inattention, and emotional problems and a significant increase in prosocial behavior following the intervention. Treatment group participants also reported a significant decrease in depression, anger, anxiety, and posttraumatic stress symptoms following the intervention. The control groups' reports remained the same.

Results indicating significant decreases in trauma symptoms and significant increases in prosocial behaviors suggest the positive implications of considering trauma with caregiver-child relationships among adopted children. This study confirms that a trauma-informed approach such as TBRI can be effective in improving outcomes for severely traumatized children and their families (Purvis et al., 2015). Findings replicate those of previous studies, including Dozier et al. (2002), demonstrating trauma-informed, attachment-based interventions to be effective in

improving behavioral challenges among at-risk children. Findings were also consistent with Milot et al. (2010), which finds trauma symptoms to be the cause of relationship issues between at-risk children and their caregivers.

A similar study by Razuri et al. (2016) utilizes a web-based TBRI intervention treatment group. The same design is used as in the previous study, randomly assigning 128 caregivers to an online treatment group and 128 to a control group. The treatment group were provided with 18 online modules. The treatment groups' findings indicate significant decreases in emotional and conduct problems, with control group behaviors remaining the same. The treatment group trauma results demonstrate a significant decrease in anger, posttraumatic stress symptoms, and disassociation following the intervention, with the control groups' results remaining consistent. Results suggest that educating caregivers in TBRI principles creates a reduction in behavioral problems and trauma symptoms among adopted children (Razuri et al., 2016). A decrease in behavioral symptoms can also improve caregivers' stress levels, making it less likely that a child will disrupt from the home. Maintaining a child in the home provides greater opportunity for felt safety and successful connection and less opportunity for additional exposure to traumatic experiences (Razuri et al., 2016).

Parris, Dozier, Purvis, Whitney, Grisham, and Cross (2014) have conducted a qualitative study to evaluate TBRI on behavioral outcomes in a residential charter school. Of the 138 students enrolled, 49% were White, 35% were African-American, 12% were Hispanic, and 4% reported belonging to other ethnicities. All students were from low socio-economic backgrounds. School staff were trained in TBRI principles and encouraged to implement them throughout the day. Researchers conducted focus groups three times during the intervention period. First-year results found students to be more likely to discuss problems with staff and less likely to use

profanity, engage in physical altercations (33% decrease in referrals), or be restrained than prior to the intervention. During the second year of implementation, school staff reported 13 TBRI components to be in place. Results showed improved school culture and mood among staff and students. Physical aggression continued to decrease (68% decrease from year one), as did referrals for verbal aggression (down 88%) and disruptive behavior (down 95%). These results indicate the TBRI framework to be effective in addressing behavioral outcomes for students (Parris, Dozier, Purvis, Whitney, Grisham, and Cross, 2014).

Summary

The research presented in this literature review addresses components instrumental in the shaping of connected, attachment-rich relationships among foster and adopted children. Although only a limited number of studies have been conducted on TBRI principles, they have demonstrated positive results for caregivers whose children have experienced trauma. Conversely, no study to date has been conducted on the ETC framework. The current study will contribute to knowledge of the effect of trauma-informed interventions on children's ability to connect and experience safety after being exposed to complex trauma. Confirming the effectiveness of such interventions will help to promote additional healing opportunities for millions of children and families.

Chapter III: Method

Overview

This study utilized a quantitative method to investigate the impact of the ETC curriculum on caregivers' trauma-informed parenting and parent-child relationships. Data consists of the secondary analysis of self-report measures derived from a previous ETC study. This previous study invited participants who were enrolled in a 2019 ETC course to complete pre and post inventories to assess improvements in trauma-informed parenting as well as their parent-child relationship. Trauma-informed parenting was measured by the Resource Parent Knowledge and Beliefs Survey (RCKBS) and was defined as a caregiver's understanding of the impact of trauma on a child's brain development; feelings of safety; and academic, social, and behavioral outcomes (Murray, Sullivan, Lent, Chaplo, & Tuno, 2019). The parent-child relationship was measured with the Behavior Assessment System for Children-Parent Child Relationship (BASC-PRQ) and was defined as the unique and enduring bond between a caregiver and his or her child (Purvis, et al., 2015).

Participants

Participants included 36 biological, foster, adoptive, and kinship caregivers who were enrolled in a 2019 ETC course facilitated through a local agency in a midsize southern city. All participants received the same lectures, instruction, and assignments from the same instructor throughout the nine-week timeframe. Criteria for participation required each caregiver to be the legal guardian of a youth under the age of 18, who has resided in their home for at least a year. Caregivers who did not have a child residing in the home at the time of the study were excluded from participation. The majority of caregivers who complete this course are married, Caucasian, and Christian couples, which may have affected the sample.

Procedure

Archival data was provided directly to the researcher from the agency which offers the nine-week ETC course. Data obtained included responses to demographic questions, as well as pre and post results from the Resource Parent Knowledge and Beliefs Survey and the BASC-PRQ assessments. Participants were asked to complete both assessments on the first night of the class, prior to beginning class instruction. This offered a baseline for participant's knowledge of trauma and trauma-informed practices in parenting.

Instruments

Participants completed a demographics questionnaire and two self-report inventories including the Behavioral Assessment System for Children-Parent Relationship Questionnaire (BASC-PRQ) and the Resource Parent Knowledge and Beliefs Survey (RPKBS). All instruments were completed online and distributed to participants via the researcher.

Demographics Questionnaire. Participants were asked to provide information on their caregiver classification (biological, adoptive, foster, or kinship), their child's age and gender, and whether they have taken ETC before.

Resource Parent Knowledge and Beliefs Survey (RPKBS). The Resource Parent Knowledge and Beliefs Survey was adapted by Sullivan et al. (2016) and developed on a 6-point Likert scale. This survey assesses a caregiver's belief and attitude related to their ability to care for a child who has experienced trauma. This instrument is a 33 item self-report measure that yields three scales, including Trauma-informed Parenting, Tolerance of Misbehavior, and Parenting Efficacy scales.

Trauma-informed Parenting Scale. The Trauma-Informed Parenting Scale consists of 24 items that assess a caregiver's knowledge of the impact of trauma on child development. The

validity of this instrument was assessed by a) polling the NCTSN RPC experts who determined the scale to be inclusive of essential information taught in the RPC curriculum, b) comparing correlations to similar scales, and c) conducting an exploratory factor analysis. Validity assessments of this scale have demonstrated an internal consistency (Cronbach's.90) among the RPC participants. Example items from the subscale include, "I understand how traumatic events can impact the way my child's brain works," "I routinely think about how my child is physically safe in my home, but might not feel safe," and "An important role as a parent is to identify trauma reminders in my child's life."

Tolerance of Misbehavior Scale. The Tolerance of Misbehavior Scale consists of four items that measure a caregiver's willingness to care for a child with behaviors that may lead to parental stress and placement disruptions. Items were adapted from the Casey Foster Application Inventory-Applicant Version, which demonstrates psychometrically sound properties. When applied to the RPC study participants, this scale yielded internal consistency (Cronbach's.90). Example questions from this subscale include, "I can care for a child who lies about everything," "I can care for a child who curses at me or says mean and hurtful things to me," and "I can care for a child who rejects me."

Parenting Efficacy Scale. The five-item Parenting Efficacy Scale evaluates the perception of confidence as it relates to a caregiver's ability to parent a child with trauma exposure. Items were developed from an adapted version of the psychometrically sound Parenting Self-Agency Measure (PSAM; Dumka, Stoerzinger, Jackson, & Roosa, 1996). Cronbach's internal consistency for the Parenting Efficacy Scale was .84 in the RPC study. Items from this subscale include, "I feel sure of myself as a parent of a child who has experienced

trauma," "I can solve most problems between y child and me," and "When things are going badly between my child and me, I keep trying until things begin to change."

Behavioral Assessment System for Children-Parent Relationship Questionnaire (BASC-PRQ). The BASC-PRQ indicates a caregiver's perception of the parent-child relationship. The parent-child relationship can explain differences between mother and father ratings and can account for self-esteem, social competence, affect, and academic outcomes. The BASC-PRQ is useful when implementing behavioral and emotional interventions that involve parental participation. The BASC-PRQ has both male and female normative samples that closely match the 2013 U.S Census population approximations, and has validity indexes which can identify threats to validity such as misunderstanding or careless survey responses (PRQ; Kamphaus & Reynolds, 2006). The 87 item scale is measured on a Likert scale where responses are "Never," "Sometimes," "Often," and "Almost Always." The BASC-PRQ has several scales that assess attachment, communication, discipline practices, involvement, parenting confidence, satisfaction with school, and relational frustration.

Attachment questions include, "I enjoy spending time with my child," "I know what my child is thinking," "I know how my child will react in most situations," and "I feel close to my child." Items from the communication scale consist of, "My child tells me about his/her day," "My child likes to talk to me," "My child tells me, I love you," and "My child tells me about his/her problems." The discipline practice questions include, "It is important for a child to follow family rules," "I insist that my child follow the rules of the house," "I respond immediately to my child's misbehavior," and "I set limits with my child for acceptable behavior." Parental involvement addresses questions such as, "My child and I go on outings together," "My child and I play games together," and "I spend my free time helping my child do things." Parental

44

confidence is assessed with questions such as, "I make good parenting decisions," "I am afraid of making mistakes in decision making about my child," "Being a parent scares me," and "I am a good parent to my child." The satisfaction with school scale asks for participants to respond to, "My child's school meets his/her educational needs," "I am happy with the services my child's school offers," and "My child's school is run well." Lastly, the Relational frustration scale yields questions such as, "My child is hard for me to handle," "I feel overwhelmed being a parent," "My child tests limits," and "I feel like parenting is harder than it should be."

Data Analysis

Archival data including participant's individual assessment scores were entered into a data sheet on SPSS. Participants with missing data from one of the two instruments were removed from analysis for that particular assessment. Independent variables included time (pre and post measures) and parent characteristics such as gender, number of children in the home, and disruptions (the number of times a child has been removed from the home). Dependent variables include scores on the RPKBS and BASC-PRQ instruments.

A Repeated Measures Analysis of Variance (ANOVA) was used to analyze pre and post scores on the RPKBS to determine whether results improve following completion of an ETC course. In order to determine effect size, ranges established by Scruggs & Mastropieri (2001) were utilized. Effect sizes include $\geq$ .90 which indicates very effective treatment; .70-.89 indicating moderately effective; $\leq$ .69 demonstrates debatable; and $\leq$ .49 suggests that the treatment was not effective.

A smaller portion of the sample (N=20) completed the BASC-PRQ assessment. Demographics for this group are represented in Table 3. A Non-parametric Wilcoxon Signed

45

Rank Test was used to analyze results and determine whether improvements occurred from pre to posttest. A non-parametric test was chosen due to the small sample size within this population.

Summary

This chapter introduced the quantitative methods used to investigate the relationship between participating in a trauma-informed parent education course and scores on trauma-informed parenting and parent-child relationship inventories. Additionally, an introduction to the population, the study instruments, and data collection procedures were discussed. Chapter 4 will describe and summarize the data analysis used to evaluate the research questions and hypotheses.

Chapter IV: Results

Introduction

This chapter introduces the sample demographics and results on both the BASC-PRQ and RPKBS measurements. Descriptive statistics, repeated measure one-way analysis of variance (ANOVA), and Wilcoxon Signed Rank Test results will be detailed, in attempts to address each research question. Each participant's pre and post scores will be compared to determine changes in their performance and then compared to that of the larger sample. These results will demonstrate the statistically significant change caregivers experienced over the nine-week course.

Participant Demographics

Resource Parent Knowledge and Beliefs Survey (RPKBS) Sample. A total of 36 participants completed the RPKBS pre and post measure (20 of these participants also completed pre and post BASC-PRQ questionnaires). The racial makeup of the larger sample included 97.2% Caucasian and 2.8% Hispanic participants, all of whom were completing the ETC course for the first time. The sample's 61% female and 39% male caregivers had an average of 2.6 children with an average age of 6.2 years. The largest percentage of the sample (44.4%) represented caregivers who had both biological and foster/kinship/adoptive children in the home at the time of the study. The remaining sample consisted of "bio only" and "foster/adoptive/kinship only" caregivers (both groups equaling 27.8% each).

Of those caregivers with foster/adoptive/kinship children in their home, 23.5% reported experiencing a disruption (having a child removed from the home for any number of reasons) within the past year. The reported disruptions were specifically due to unmanageable behaviors the child experienced while in the caregiver's home.

Table 2

RPKBS Sample Demographics

	N	Percentage
Gender		
Male	14	38.9
Female	22	61.1
Race/Ethnicity		
Caucasian	35	97.2
Hispanic	1	2.78
Caregiver Type		
Bio Only	10	27.80
Foster/Adoptive/Kinship Only	16	44.44
Bio and Foster/Adoptive/Kinship	10	27.80
Disruption History Children	8.46	23.5
Mean Between Caregivers	2.6	
Mean Age	6.2	

Behavioral Assessment for Children Parent Relationship Questionnaire (BASC-PRQ)

Sample. This sample included 20 caregivers who completed pre and post BASC-PRQ assessments. There were 35% male and 65% female participants, all of whom were of Caucasian background. Caregivers had an average of 2.5 children with an average age of 8.2 years. Half of this sample consisted of "foster/adoptive/kinship only" caregivers, and the other half included "bio only" (25%) and "bio and foster/adoptive/kinship" (25%) caregivers. While 80% reported having no disruption history, the remaining 20% reported experiencing three or more disruptions from their home over the past year. The average number of disruptions experienced by this group was .75 with a standard deviation of 1.59.

Table 3

BASC-PRQ Sample Demographics

Participant Demographics	N	Percentage
Gender		
Male	7	35
Female	13	65

Participant Demographics	N	Percentage
Race/Ethnicity		
Caucasian	20	100
Caregiver Type		
Bio Only	5	25
Foster/Adoptive/Kinship Only	10	50
Bio and	5	25
Foster/Adoptive/Kinship		
Disruption History	4	20
Children		
Mean Between Caregivers	2.5	
Mean Age	8.2	

Descriptive Statistics

RPKBS Survey. The RPKBS is scored on a Likert scale of 1-6, where 1 is "Strongly

Disagree," 2 is "Disagree," 3 is "Slightly Disagree," 4 is "Slightly Agree," 5 is "Agree," and 6 is

"Strongly Agree." The RPKBS has a total of 33 items for a score range of 33- 231. Higher scores

indicate a more in-depth understanding of trauma-informed parenting skills. As noted in Chapter

II, this measure was developed and utilized in the Sullivan et al. (2016) study. One adaptation for

the use of this instrument in the current study includes adding a "neutral" option, which

increased the Likert scale to 1-7. Interpretations of each individual score are not available as this

measure was not normed during use in the Sullivan et al. (2019) study. For the purposes of this

research, pre and post scores were used to determine improvement.

Participants' overall RPKBS scores increased from ($M = 146.02$, $SD = 24.47$) at pretest to

($M = 172.71$, $SD = 20.19$) following the posttest. Subscale scores also demonstrated

improvements in caregivers' acquired skills. Participants demonstrated gains in all three subscale

areas including (a) trauma-informed parenting, (b) tolerance of misbehavior, and (c) parental

efficacy. These improvements are detailed in Table 6.

Gender

Male participants received higher scores on both the pre ($M = 147.40$, $SD = 20.42$) and posttest ($M = 178.02$, $SD = 18.13$) when compared to females' pre ($M = 145.30$, $SD = 26.90$) and posttest ($M = 169.72$, $SD = 21.04$) scores. Results indicate that male participants had a higher initial and ending understanding of trauma-informed parenting skills. It is important to note that the number of male participants was 39%, compared to females at 61%.

Caregiver Type

"Bio only" caregivers scored the lowest on both pre ($M = 127.53$, $SD = 31.30$) and post ($M = 155.61$, $SD = 16.7$) tests, indicating less of an understanding of trauma-informed parenting skills at both time points. Caregivers with biological and foster children in the home scored just above "bio only" caregivers on pretest ($M = 144.62$, $SD = 16.42$) and posttest ($M = 173.80$, $SD = 15.70$), while "Foster/adoptive/kinship only" caregivers scored the highest of all groups on pre ($M = 158.50$, $SD = 16.00$) and posttests ($M = 182.75$, $SD = 18.23$).

Disruption History

As noted above, 23.5% of caregivers with a foster/adoptive/kinship child in their home reported experiencing a disruption within the past year. When asked about disruptions specifically due to unmanageable behaviors, over three-quarters of the sample (76.5%) reported no experience in the past year, while 5.9% reported one, 8.8% reported three, and 8.8% reported experiencing four to five disruptions over the past year. Caregivers who experienced five or more disruptions received similar scores on the pretest ($M = 145.00$, $SD = 1.41$) to caregivers' with no disruption history ($M = 145.91$, $SD = 26.29$). Although pretest scores were similar, caregivers with five or more disruptions showed much higher scores on the posttest ($M = 178.00$, $SD = 13.30$) when compared with that same group ($M = 171.30$, $SD = 21.54$). This indicates that

although caregivers with more disruptions showed a similar understanding prior to completing

the course, they increased their understanding at higher levels than caregivers with no disruption

history.

Number of Children in the Home

Results demonstrated that scores for participants with 1-3 children decreased as the number

of children increased. For example, participants with one child scored (M =151.61, SD = 22.19)

on the pretest and (M =175.21, SD = 23.88) on the posttest, while those with two children scored

lower (M =143.05, SD = 31.48) on both the pretest and on the posttest (M=171.18, SD = 22.90).

There continued to be a decrease for participants with three children scoring (M =139.62, SD =

18.30) on the pretest and (M =159.58, SD = 9.93) on the posttest. Although this trend

demonstrated a consistent decrease for parents with 1-3 children, scores began to increase for

caregivers with four children but decreased once again for those with 5 or more children (M

=149.73, SD = 8.26 for pre; M =179.73, SD = 9.87 on the post).

Table 4

Pre and Post Scores for RPKBS Survey

Demographics		Resource Parent Knowledge and Beliefs Survey (RPKBS)	
	N	Pre RPKBS (SD)	Post RPKBS (SD)
Gender			
Male	13	147.38 (20.42)	178.02 (18.13)
Female	23	145.25 (26.90)	169.72 (21.04)
Caregiver Type			
Bio Only	10	127.53 (31.30)	155.61 (16.7)
Bio and Foster/Adoptive/Kinship	10	144.62 (16.42)	173.80 (15.70)
Foster/Adoptive/Kinship Only	16	158.50 (16.00)	182.75 (18.23)
Disruption History			
None	28	145.92 (26.30)	171.30 (21.54)
One	2	161.00 (2.83)	180.00 (9.90)
Three	3	147.97 (21.03)	184.45 (13.94)
Four	1	145.91 (26.29)	171.30(21.54)
Five	2	145.00 (1.41)	178.00 (13.30)

Demographics		Resource Parent Knowledge and Beliefs Survey (RPKBS)	
Number of Children			
One Child	6	151.61 (22.19)	175.21 (23.88)
Two Children	16	143.05 (31.48)	171.18 (22.90)
Three Children	5	139.62(18.30)	159.58 (9.93)
Four Children	6		
Five or More Children	3	149.73 (8.26)	179.73 (9.87)
Entire Sample	36	146.02 (24.47)	172.71 (20.18)

BASC-PRQ. A total of 20 participants completed the BASC-PRQ, 35% of which were male and 65% female. As noted in Chapter II, responses are measured on a Likert scale of "Never," "Sometimes," "Often," and "Almost Always." *T-scores* of 50 indicate an average range, while 30-40 denotes below average, and 0-30 indicates the lower extreme range. Significantly above average scores falls into the 60-70 range, while the upper extreme range fall between a score of 70-100. Overall *T-scores* on the BASC-PRQ assessment increased from pre (M=47.90, SD= 5.50) to posttest (M=50.37, SD = 4.49). Participant's average subscale scores also increased from pre to posttest and are detailed in Table 6.

Gender

Female participants performed slightly better on the pretest (M=48.44, SD = 6.05) compared to male participants (M=46.89, SD =4.55), and slightly better on the posttest (M=50.41, SD = 4.84) than their male counterparts (M = 50.30, SD=4.11).

Caregiver Type

All caregiver types demonstrated an increased knowledge from pre to posttest. **"Bio only" caregivers** (N = 5) scored the **highest** at pretest (M = 48.58, SD = 6.46), and **"Foster/Adoptive/Kinship Only"** (N = 10) caregivers scored the **highest** at posttest (M = 51.03, SD = 4.91). Caregivers from the **"Bio and Foster/Adoptive/Kinship"** (N = 5) group scored the **lowest** on both pre (M = 47.44, SD = 6.26), and posttest (M = 49.20, SD = 3.69).

Disruption history was reported for 20% of caregivers with foster/adoptive/kinship children in the home. Within this group, those caregivers (*N* = 2) who experienced **four to five disruptions** within the past year scored the **lowest** on both the pre (*M* = 46.40) and posttest (*M* = 44.70). Caregivers with **no disruption history** (*N* = 16) scored the **highest** on both the pre (*M* = 48.08, *SD* = 5.95) and posttest (*M* = 51.03, *SD* = 4.15) measures.

Number of Children In The Home

Participants with **one child** in the home (*N* = 3) scored the **lowest** on both pre (*M* = 43.60, *SD* = 2.18) and posttests (*M* = 48.93, *SD* = 4.40), while those (*N* = 4) with the **median number of children** (*Mdn* = 3) scored the **highest** on both pre (*M* = 50.45, *SD* = 8.57) and posttests (*M* = 51.10, *SD* = 4.74).

Table 5

Pre and Post BASC-PRQ Scores

Demographics		Behavioral Assessment For Children Parent Relationship Questionnaire (BASC-PRQ)	
	N	Pre BASC-PRQ M (SD)	Pre BASC-PRQ M (SD)
Gender			
Male	7	46.89 (4.55)	50.30 (4.11)
Female	13	48.43 (6.05)	50.42 (4.84)
Disruption History			
None	16	48.08 (5.95	51.03 (4.15)
Three	2	47.90 (6.22)	50.75 (7.28)
Four	1	46.40	44.70
Five or More	1	46.4	44.70
Caregiver Type			
Bio Only	5	48.58 (6.455)	50.24 (5.02)
Bio and Foster/Adoptive/Kinship	5	47.44 (6.26)	49.20 (3.69)
Foster/Adoptive/Kinship Only	10	47.78 (5.20)	51.03 (4.91)
Number of Children			
One	3	43.60 (2.18)	48.93 (4.40)
Two	9	48.98 (4.77)	50.50 (4.42)
Three	4	50.45 (8.57)	51.10 (4.74)
Four	2	42.90 (.849)	50.60 (7.07)
Five or More	2	49.35 (4.17)	50.30 (7.92)

Demographics		Behavioral Assessment For Children Parent Relationship Questionnaire (BASC-PRQ)	
Entire Sample	20	47.86 (5.50)	50.38(4.49)

Results

Resource Parent Knowledge and Beliefs Survey (RPKBS). The RPKBS yields three

subscales, all of which were measured with separate One-Way Repeated Measure ANOVAs.

These subscales include (a) Trauma-informed parenting, (b) Tolerance of Misbehavior, and (c)

Parental Efficacy. The one-way repeated measures ANOVA was used to evaluate the change in

participant's total and subscale RPKBS scores when measured before and after participating in

an ETC course. Hypothesized, was that participants would increase trauma-informed knowledge

from pre to post time points. Consistent with the hypothesis, participant increased their scores on

the overall RPKBS, as well as the subscale scores. Pretest RPKBS subscale scores ranged from

4.10 to 4.84 on a 7 point Likert-scale, while posttest scores ranged from 5.10 to 5.68. The means

and standard deviations for pre and post RPKBS scores are presented in Table 4. Those for the

RPKBS subscales are detailed in Table 6.

One way ANOVA results of the **overall scores** on the RPKBS scale indicated a

statistically significant time effect, Wilks' Λ=.24, $F(1, 35) = 110.50$, $p < .00$, n^2= .76. ETC

demonstrated a significant main effect on caregivers' **overall trauma-informed parenting**

scores $F(1, 35) = 110.50$, $p < .001$, n^2 =.76. This improvement in scores was statistically

significant ($p <.001$). These results suggest that participation in ETC does, in fact, improve

participants' trauma-informed knowledge, ability, and efficacy in their parenting. According to

effect sizes established by Scruggs & Mastropieri (2001), a moderate effect was observed.

Trauma-informed parenting subscale. The results from the Trauma-informed Parenting

subscale indicated a significant time effect, Wilks'Λ=.33, $F (1, 35) = 72.60$, $p <.01$, n^2=.68. The

trauma-informed subscale demonstrated a significant main effect on caregivers' trauma-informed parenting $F(1, 35) = 72.52$, $p < .001$, $n^2 = .68$. This improvement in scores was also statistically significant ($p < .001$) and suggests that participation in ETC improves participants' trauma-informed parenting skills. This suggests significant evidence to reject the null hypothesis. The effect size in this case according to Scruggs & Mastropieri (2001) was debatable.

Tolerance of Misbehavior subscale. The results from the Tolerance of Misbehavior subscale indicated a significant time effect, Wilks' $\Lambda = .55$, $F (1, 35) = 28.64$, $p < .01$, $n^2 = .45$. The tolerance of misbehavior subscale demonstrated a significant main effect on caregivers' ability to withstand frustrating behaviors $F(1, 35) = 28.64$, $p < .001$, $n^2 = .45$. This improvement in scores was statistically significant ($p < .001$) and suggests that participation in ETC improves participants' ability to tolerate misbehavior. The effect size indicates that the treatment was not effective.

Parental Efficacy subscale. The results of the Parental Efficacy subscale also indicated a significant time effect, Wilks' $\Lambda = .54$, $F (1, 35) = 29.74$, $p < .01$, $n^2 = .46$. The Parental Efficacy subscale demonstrated a significant main effect on caregivers' parenting confidence $F(1, 35) = 29.74$, $p < .001$, $n^2 = .46$. Significant increases in scores over time suggest that participation in ETC increases caregivers' parental efficacy. The effect size indicates that the treatment was not effective.

Table 6

RPKBS Subscale Scores

		Trauma-informed Parenting (TIP)		Tolerance of Misbehavior (TOM)		Parental Efficacy (PEE)	
Demographics	N	Pre TIP (SD)	Post TIP (SD)	Pre TOM (SD)	Post TOM (SD)	Pre PEE (SD)	Post PEE (SD)

		Trauma-informed Parenting (TIP)		Tolerance of Misbehavior (TOM)		Parental Efficacy (PEE)	
Demographics	N	Pre TIP (SD)	Post TIP (SD)	Pre TOM (SD)	Post TOM (SD)	Pre PEE (SD)	Post PEE (SD)
Gender							
Male	13	4.75 (.57)	5.70 (.60)	4.47 (.75)	5.28 (.87)	4.50 (.85)	5.61 (.70)
Female	23	4.90 (.60)	5.67 (.62)	3.90 (1.39)	5.00 (.90)	4.41 (.87)	5.19 (1.02)
Caregiver Type							
Bio Only	10	5.14 (.66)	6.13 (.52)	3.71 (1.56)	5.17 (.98)	4.12 (1.21)	5.30 (1.37)
Bio and Foster/Adoptive/Kinship	10	4.50 (.62)	5.36 (.48)	3.86 (.91)	4.60 (.94)	4.40 (.52)	5.36 (.54)
Foster/Adoptive/Kinship Only	16	4.88 (.42)	5.60 (.59)	4.51 (1.08)	5.38 (.69)	4.67 (.73)	5.36 (.84)
Entire Sample	36	4.84 (.59)	5.68 (.61)	4.10 (1.21)	5.10 (.89)	4.44 (.85)	5.34 (.93)

Table 7

RPKBS Statistical Values

	Overall RPKBS Scores	Trauma-informed Parenting Subscale	Tolerance of Misbehavior Subscale	Parental Efficacy Subscale
n^2	.76	.68	.45	.46
F	110.50	72.60	28.64	29.74
p-value	<.001	<.01	<.01	<.01

BASC-PRQ.

The BASC-PRQ yields subscales including Attachment, Communication, Discipline Practices, Involvement, Parenting Confidence, Satisfaction With School, Relational Frustration. Scale classifications are based on *T scores* obtained using either female or male rater norms. Scores that fall in the lower extreme range (or upper extreme for Relational Frustration) indicate significant issues in which an intervention is necessary, while scores in the below average range

(or above average for Relational Frustration) indicate the need for continued monitoring. Due to low sample size (*N* =20), a Wilcoxon signed-rank tests was used to analyze the results.

Overall BASC-PRQ scores were compared before and after participating in the ETC course. On average, participants' overall BASC-PRQ scores improved from (*M* =47.90, *SD* = 5.50) prior to completing the course, to (*M* =50.38, *SD* = 4.49) following completion of the course. A Wilcoxon signed-rank test (used due to having a smaller sample size) indicated that there was no statistically significant difference between the two timepoints, *T*=155, z = -1.87, *p* = .062. Similar results were indicated for the BASC-PRQ subscales. No significant difference could be concluded for all seven subscales. Results for subscale scores are detailed in Table 8.

Attachment Subscale. Participant's pre and posttest scores for the attachment subscale improved from (*M* = 45.30, *SD* =9.57) prior to completing the course, to (*M* = 49.80, *SD* = 7.16) following completion of the course. A Wilcoxon signed-rank test indicated that there was no statistically significant difference between the two timepoints, T=130, z = -21.94, *p* = .052. No effect on participant's parent-child relationship could be determined based on results.

Communication Subscale. Pre and post communication scores improved from (*M* = 47.65, *SD* =10.15) prior to completing the course, to (*M* = 49.90, *SD* =8.76) following completion of the course. A Wilcoxon signed-rank test indicated no statistically significant difference between the two timepoints, T=119.50, z = -.99, *p* = .32. This may, however, be due to the small sample size. Results did not demonstrate improvement in participants' communication with their child following the ETC course.

Discipline Practices Subscale. Discipline practices improved from (*M* = 43.30, *SD* = 12.43) prior to completing the course, to (*M* = 43.65, *SD* =9.93) at posttest. Results from the Wilcoxon signed-rank test indicated no statistically significant difference between the two timepoints,

T=67.00, z = -0.52, *p* = .96. These improvements are not evidence of ETC's effect on participants' discipline practices. It is important to note, that the sample size may have had an effect on the findings.

Involvement Subscale. Involvement pre and posttest scores improved from (*M* = 55.55, *SD* =12.12) to (*M* = 57.45, *SD* =9.22) following completion of the course. A Wilcoxon signed-rank tests did not indicate a statistically significant difference between the two timepoints, T=113.00, z = -1.20, *p* = .23. Results failed to demonstrate that ETC improves participants' involvement with their child.

Parenting Confidence Subscale. Parenting confidence pre and posttest scores improved from (*M* = 45.65, *SD* = 10.99) prior to completing the course, to (*M* = 38.35, *SD* = 11.65) following completion of the course. A Wilcoxon signed-rank tests was not able to detect a statistically significant difference between pre and posttest, T=117.50, z = -1.40, *p* = .16. Possibly due to the small sample size, results were not able to conclude that ETC demonstrated a positive effect on caregivers' parenting confidence.

Satisfaction With School Subscale. Participant's pre and posttest scores for the attachment subscale improved from (*M* = 45.30, *SD* = 8.54prior to completing the course, to (*M* = 49.60 *SD* =9.04) following completion of the course. A Wilcoxon signed-rank tests indicated no statistically significant difference between the two timepoints, T=154.00, z = -1.85, *p* = .06. Results did not indicate that ETC improves participants' attachment with their child. As with previous results, these are possibly influenced by the small sample size.

Relational Frustration Subscale. Participant's relational frustration scores improved from (*M* = 63.05, *SD* =9.77) to (*M* = 63.75, *SD* = 11.77) at the posttest. A Wilcoxon signed-rank tests did

not indicate a statistically significant difference between pre and post, T=101.50, z = -.26, *p* = .79. Results did not demonstrated improvements with participant's relational frustration scores.

Table 8

Pre and Post BASC-PRQ Subscales

Demographics	Behavioral Assessment For Children Parent Relationship Questionnaire (BASC-PRQ)	
	Pre BASC-PRQ (SD)	Post BASC-PRQ (SD)
Attachment	45.30 (9.57)	49.80 (7.16)
Communication	47.65 (10.15)	49.90 (8.76)
Discipline	43.30 (12.44)	43.65 (9.93)
Involvement	55.55 (12.13)	57.45 (9.22)
Parental Confidence	35.65 (10.99)	38.35 (11.65)
School Satisfaction	45.30 (8.54)	49.60 (9.04)
Relational Frustration	63.05 (9.77)	63.75 (11.77)

Table 9

BASC-PRQ Statistical Values

	T	z	p-value
Overall BASC-PRQ	155.00	-1.87	.06
Attention	130.00	-1.94	.052
Communication	119.50	-.99	.32
Discipline Practices	67.00	-.52	.96
Involvement	113.00	-1.20	.23
Parental Confidence	117.50	-1.40	.16
School Satisfaction	154.50	-1.85	.064
Relational Frustration	101.50	-.26	.79

Conclusion

The purpose of this quantitative study was to explore the relationship between participation in the trauma-informed ETC course and participants' scores on the Resource Parent Knowledge and Beliefs (RPKBS) survey and the BASC-PRQ. The results of Chapter 4 were obtained from the use of multiple statistical analyses: A repeated measures ANOVA and a Wilcoxon signed-rank test. The ANOVA results demonstrated a statistically significant difference in participants' pre and post scores. These results indicate that the sample population

experienced a level of improvement in both their trauma-informed parenting skills. A Wilcoxon signed-rank test did not demonstrate a statistically significant change in participants' pre and post BASC-PRQ scores, nor the subscale scores. Results from this analysis cannot determine that ETC had any impact on participants' parent-child relationships.

Although results for one instrument were statistically significant, there were limitations that are important to note. The sample size for the BASC-PRQ results was smaller than the sample size for the RPKBS making it difficult to equally compare each group. This also leads to issues with statistical power as well as with generalizability. Other issues related to generalizability include the sample size being mostly white and mostly female. These results may only generalize to similar groups of people.

These findings add to existing literature related to the implications of providing trauma-informed parent education and considerations of the impact of childhood trauma. Results of the current study support previous findings such as Sullivan et al. (2019) which indicated the effectiveness of trauma-informed parent education on caregiver's tolerance of misbehavior, parental efficacy, and trauma-informed parenting. The final chapter will consist of a discussion on how these results can be contextualized and fit within the greater context of existing literature.

Chapter V: Discussion

Introduction

Chapter 5 provides a brief explanation of the purpose and significance of the study. Next, the chapter will provide an interpretation of the findings, explore the study limitations, suggests for future research, and discuss implications for social change. Each research question will be addressed in the context of the study's results as well in attempts to demonstrate the ETC's impact on caregivers' experience with the trauma-informed curriculum. Through a discussion of these results, I will contextualize the findings within the existing literature on trauma-informed parent education. Study limitations and recommendations for future research will also be addressed in this section.

There is a significant need for trauma-informed parent education for those responsible for raising children with trauma histories (Sullivan et al., 2019). Evaluating the most effective trauma-informed interventions for children with child welfare contact is critical. Although there has been an increased awareness of the importance of trauma-informed care, little research has investigated many of the different trauma-informed curricula provided to foster parents (Sullivan et al., 2019). The current study provides the first evaluation of the ETC curriculum, a program offered to national biological, foster, adoptive, and kinship parents. The findings of this study are consistent with previous studies including Gigengack et al. (2017); Strolin- Goltzman et al. (2018) and Sullivan et al. (2016), which indicate that trauma-informed programs such as the Resource Parent Curriculum improves caregivers' trauma-informed knowledge (Sullivan et al., 2019).

The purpose of this quantitative study was to investigate the impact ETC would have on caregivers' trauma-informed parenting and parent-child relationships. In order to assess

improvements, participants were asked to complete pre and post BASC-PRQ and RPKBS

measurements at the beginning of a nine-week parent education course, and once again at the

end. Scores were analyzed with a one-way ANOVA and a Wilcoxon signed-rank test to

determine whether any significant difference occurred between pre and post timeframes.

Summary of Findings

Thirty-six caregivers participated in this research. The sample consisted of mostly women

(61%) and mostly Caucasian (99%) participants. The majority of the sample (44.4%) were

caregivers of foster, adoptive, or kinship children, while the remainder of the sample were

caregivers of either biological children (27.8%) or biological and foster/adoptive/kinship

children (27.8%). Approximately 23.5% of the foster/adoptive/kinship caregivers reported

experiencing at least one disruption within the past year. All participants were married and

attended the class with their respective spouses, with the exception of one caregiver.

Results indicated a statistically significant change in participants' pre and post scores for

the Resource Parent Knowledge and Beliefs Survey. Participants also showed statistically

significant improvements on all RPKBS subscales including Trauma-informed Parenting (TIP),

Tolerance of Misbehavior (TOM), and Parental Efficacy (PEE) subscales. The effect sizes for

the RPKBS overall scores were moderate. According to effect sizes established by Scruggs &

Mastropieri (2001), the TIP subscale effect size was debatable. TOM and PEE subscale effect

sizes indicated that the treatment was not effective.

Overall BASC-PRQ scores were not found to be significant, nor were the questionnaire's

subscale scores (including Attention, Communication, Discipline, Parental Confidence, Parental

Involvement, Relational Frustration, and School Satisfaction). Due to these results, a conclusion

about ETC's impact on caregiver's improved parent-child relationship cannot be inferred. A

description of both instruments' effect size and significance can be found below in Tables 7 and 9.

Table 10

RPKBS and BASC-PRQ Statistical Significance/Effect Size

Measurement	Statistically Significant	Effect Size
Resource Parent Knowledge and Beliefs Survey (RPKBS)	Yes	Moderate
Trauma-informed Parenting Subscale (TIP)	Yes	Debatable
Tolerance of Misbehavior Subscale (TOM)	Yes	Treatment not effective
Parental Efficacy Subscale (PEE)	Yes	Treatment not effective
Behavioral Assessment For Children Parent-Child Relationship Questionnaire (BASC-PRQ)	No	
Attachment Subscale	No	
Communication Subscale	No	
Discipline Practices Subscale	No	
Involvement Subscale	No	
Parental Confidence Subscale	No	
School Satisfaction Subscale	No	
Relational Frustration Subscale	No	

Research Questions

Research question one: Does participation in a nine-week ETC parent training course improve caregivers' parent-child relationships? The data shows that both overall and subscale BASC-PRQ scores increased from pre to posttest. However, those improvements were not found to be statistically significant. Based on these results, suggestions about ETC's impact on caregivers' improved parent-child relationship cannot be made.

Research question two: Does participation in a nine-week ETC parent training course improve caregivers' trauma-informed parenting? Participants' overall RPKBS scores increased and indicated a moderate effect size. Caregivers' subscale scores also increased, although none

indicated a higher effect size than debatable. All scores were found to be statistically significant, demonstrating an increase in knowledge of trauma-informed parenting skills. Research has shown that when foster parents are trained with trauma-informed principles, they report higher confidence in their ability to provide care for their children (Bass, 2017). The current study results replicate those findings as overall scores and scores from the Parental Efficacy subscale increased significantly.

Research question three: Does a caregiver's gender impact the parent-child relationship or trauma-informed parenting outcomes? Pre and post results indicated that male participants typically performed better as female participants. Male participants also performed better on all RPKBS pre and post subscales with the exception of the Tolerance of Misbehavior subscale.

Research question four: What is the relationship between the number of children residing in the home and scores on the BASC-PRQ and trauma questionnaire? Results on the BASC-PRQ demonstrated that caregivers with four children made the most improvement from pre to posttest (increasing eight points). Caregivers with one child scored the lowest on both pre and posttests, although they increased their scores by more than five points. More research is necessary to determine the potential implications for this finding. RPKBS results indicate that caregivers with five or more children showed the most improvement from pre to post (increasing their score 30 points). This group also received the highest posttest scores demonstrating the highest understanding of trauma-informed parenting skills.

Research question five: What is the relationship between disruptions and caregivers' scores on the BASC-PRQ and the trauma questionnaire?

As noted in Chapter III, 23.5% of caregivers with a foster/adoptive/kinship child in their home reported experiencing a disruption within the past year. On the RPKBS, caregivers with

three disruptions made the most progress between pre and post (increasing 37 points). This group also scored higher than the overall sample on both the pre and posttest. On the BASC-PRQ, caregivers with no disruption history performed the best on both the pre and posttests. They also outperformed the sample as a whole on both tests. According to Bass (2017), two main goals of foster parent education include decreasing the circumstances that ultimately lead to foster youth disruptions and improving foster parent retention. With foster parent training, not only are foster children typically more successful in the home, but foster parents also report higher levels of preparedness to care for their children (Bass, 2017).

Research question six: What is the relationship between the type of parent (foster, adoptive, or kinship) and scores on the BASC-PRQ and the trauma questionnaire? Results indicate that foster/adoptive/kinship parents performed the highest on both pre and post RPKBS measures, while "bio only" caregivers scored the lowest. These results may indicate that caregivers with "only biological" children may have less initial trauma-informed knowledge or understanding than those with children who have histories in the child welfare system. Conversely, "bio only" caregivers scored the highest on both pre and post BASC-PRQ measures, while caregivers with biological and foster children in the home scored the lowest on both the pre and posttest. More research is needed to investigate this occurrence.

The findings of this study replicate those from previous studies, indicating that ETC improves the trauma-informed knowledge and skills of caregivers. This study did not include a control group and therefore, no inferences about causality can be made. However, previous research has linked trauma-informed parenting, tolerance of misbehavior, and parenting efficacy with positive parent and child outcomes, including reduced foster parent burnout, increased foster parent retention and increased placement stability (Sullivan et al., 2016). These studies

65

have shown what the impact of trauma-informed parenting can produce among caregivers tasked with raising children exposed to trauma.

Purvis et al. (2015) indicated significant decreases in trauma symptoms and significant increases in prosocial behaviors when caregivers are trained with trauma-informed principles. Likewise, the results of the current study suggest the positive implications of considering trauma with caregiver-child relationships. Similar to Purvis et. al (2015), this study demonstrated that a trauma-informed approach such as ETC can be effective in improving outcomes for traumatized children and their caregivers.

Implications

The implications of this study are intended to inform the current iterations of non-trauma-informed parent education programs. The results of this study suggest that there is a significant link between caregiver participation in ETC and improvement in trauma-informed parenting as well as parent-child relationships. The implications of this finding may suggest that caregivers are more likely to exercise patience and understanding when their child with a trauma background is having difficulty. This may also suggest that caregivers through the understanding of the way trauma impacts brain development, are more likely to choose connection overcorrection in a more meaningful way, thus drawing the child and caregiver closer.

A second implication of the study is that caregiver participation may allow for higher quality communication between caregiver and child. This level of communication may provide an environment in which open dialogue and positive expressions of emotions are elicited between the caregiver and the child. Caregivers may be more likely to be open to their child's needs, while the child may be more likely to discuss their needs. Both may ultimately help improve family cohesion. Caregivers may feel more comfortable expressing their expectations,

66

and the child may be more willing to meet those demands. Additionally, this level of communication may help prevent confusion and misunderstandings between caregivers and the child.

Limitations and Future Research

Although thorough methodological and analytical procedures were used during the implementation of this study, limitations do exist. The limitations in this study include the volunteer basis of the study, the self-report model, lack of diversity among the participants, and the short term evaluation timeframe. The population included those interested in learning strategies to improve outcomes in their children, possibly leading to a more motivated group of participants, which may or may not represent the general population of caregivers.

Self-report model results may be skewed due to participants having the desire to "perform better" than they previously had. The study participants spent two hours for nine consecutive weeks participating in a course that was intended to improve their parenting skills. Their hope to be successful at that task may influence their responses, which could lead to participant's scores increasing unknowingly. While this study's pre and post results were encouraging, future research should assess long-term follow-up of outcomes following the intervention to examine whether improvements continue over an extended period of time. This study should also be replicated with caregivers in additional locations to assess any comparable results.

Limitations of Participant Demographics

There was a clear overrepresentation of participants from higher socioeconomic status. Having a less diverse sample in terms of economic and educational backgrounds limited the ability to gain information from participants with differing experiences. Additionally, the small

sample size consisted of mostly females (24 females and 13 males). A larger sample size and a group with a more balanced distribution among gender would be ideal. Future research should aim for a larger sample size of more diverse participants representing varying backgrounds.

Conclusion

Through a quantitative exploration of caregiver's experiences prior to and following engagement in a trauma-informed curriculum, the study investigated the impact that ETC would have on the sample population. The results of this study suggest that trauma-informed parent education does, in fact, promote caregivers' ability to practice trauma-informed parenting, improve their parent-child relationship, parental efficacy, and ability to tolerate misbehavior. Limitations include small sample size, a homogenous sample, no long term follow up, and highly motivated participants, which may not generalize to the public. Areas for future research include follow up assessments to determine whether participants retain and continue to utilize the principles taught during the course. This would also provide a sense of whether caregiver's trauma-informed parenting skills and their parent-child relationships have endured through time. This study provides similar findings as other trauma-informed studies, confirming the benefit for families touched by trauma. The research also provides insight into areas for which non-trauma-informed programs can improve by providing an opportunity to conceptualize how the absence of a trauma curriculum ultimately impacts caregivers, youth, and families.

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Behavioral Assessment For Children, Parent Relationship Questionnaire

1. I enjoy spending time with my child

2. My child tells me about his/her day

3. It is important for a child to follow family rules

4. My child and I go on outings together

5. Our family eats together at the dinner table

6. My child likes to talk to me

7. I know what my child is thinking

8. I make good parenting decisions

9. I insist that my child follow the rules of the house

10. My child and I play games together

11. My child is hard for me to handle

12. My child's school meets his/her educational needs

13. I am scared of making mistakes in decisions about my child

14. I feel overwhelmed being a parent

15. I know how my child will react in most situations

16. I teach my child new things

17. My child tests my limits

18. My child's school is run well

19. I feel close to my child

20. My child tell me, "I love you."

21. My child knows the house rules

22. I feel like parenting is harder than it should be

23. My child is getting a good education at school

24. I know hen my child will become upset

25. I punish my child so he/she learns the proper respect for others

26. I talk to my child's teachers(s)

27. Children should do what parents tell them to do

28. My child tells me about his/her problems

29. Teachers seem to understand my child's needs

30. I am able to make my child smile

31. I respond immediately to my child's misbehavior

32. During the last year, my child has been difficult to take care of

33. I am happy with the services my child's school offers

34. When my child is upset, I can calm him/her

35. My child's opinions are important to me

36. When upset, my child comes to me for comfort

37. My child tells me about the things that he/she is doing with friends

38. My child and I plan things to do together

39. I am confident in my parenting ability

40. My child's school meets his/her emotional needs

41. I feel close to my child emotionally

42. My child frustrates me

43. I punish my child if he/she shows disrespect to an adult

44. I know when my child wants to be left alone

45. My child and I work on projects together

46. I allow my child to use the internet without supervision

47. I spend my free time helping my child do things

48. I set limits with my child for acceptable behavior

49. I lose my patience with my child

50. My child's school does a good job of controlling its students

51. I tell my child, "I love you."

52. My child enjoys spending time with me

53. I remain calm when dealing with my child's misbehavior

54. I can sense my child's moods

55. My child and I do things together outdoors

56. I am a good at balancing my parenting roles with my other responsibilities

57. I listen to what my child has to say

58. My child and I argue

59. The classes offered by my child's school meet his/her needs

60. I feel others know my child better than I do

61. I punish my child when he/she misbehaves

62. I teach my child how to play new games

63. I am proud of my relationship with my child

64. I know what to say to calm down my child

65. I overreact when my child misbehaves

66. My child tells me about activities at school

67. My child and I get into heated discussions

68. My child tells me who his/her friends are

69. My child complains about how I treat him/her

70. I am in control of my household

71. My child makes me angry

72. I am a good parent to my child

73. I have confidence in my child's school principal

74. My child does not listen to me

75. My child and I take walks together

76. I have the energy that I need to cope with my child

77. My child's school seems to spend its money wisely

78. I lose my temper with my child

79. The responsibility of being a parent seems like too much for me

80. My child is honest with me

81. I regret how I treat my child

82. I know what my child is feeling

83. It is my responsibility as a parent to punish all of my child's misbehavior

84. Being a parent scares me

85. My child tell me what he/she has learned that day

86. I react the wrong way to my child's misbehavior

87. I know all of my child's close friends

Appendix B

<u>Resource Parent Knowledge Beliefs Survey</u>

1. I understand how traumatic events can impact the way my child's brain works.

2. Almost all children who have been in foster care or institutions have experienced trauma.

3. I routinely think about how my child is physically safe in my home, but might not feel safe.

4. I routinely tell others (teachers, caseworkers, etc.) about my child's traumatic stress symptoms so they can respond more effectively to my child.

5. An important part of my role as a parent is to identify trauma reminders in my child's life.

6. My child's past experiences impact how I respond to his or her misbehavior.

7. Doing things for myself is an important part of being a good parent.

8. Praises and rewards should outnumber commands and consequences.

9. It is important for me to have a relationship with my child's therapist.

10. There is always a reason for misbehavior.

11. I feel confident talking with my child about his/her feelings about his/her biological parent(s).

12. Bedtimes and mealtimes are stressful for children who have been in foster care.

13. When I think about my child's birth mother, I feel sorry for her because I bet she had a bad childhood too.

14. I feel confident about my ability to handle challenging behaviors.

15. I think defiant kids need to be praised more.

16. I feel confident speaking up for my child's trauma- specific needs with my child's school or daycare.

17. If my child brings up the bad things that happened to him/her in the past, I feel like it's a good idea to praise him/her or her for bringing it up.

18. I feel like I have the skills to help my child heal.

19. I know strategies to help my child express a variety of emotions.

20. It is easy for me to think about the strengths my child has gained from his or her birth family.

21. When my child has intense feelings that don't seem to make sense, I understand how those feelings might be related to his/her past.

22. I know the kinds of questions to ask a therapist to determine if he or she is trauma- informed.

23. I know the warning signs of problems that can come from caring too much for others and not enough for myself.

24. I know what I should look for in a trauma- informed assessment for my child.

25. I can care for a child who lies about everything.

26. I can care for a child who rejects me.

27. I can care for a child who curses at me or says mean and hurtful things to me.

28. I can care for a child with inappropriate sexual behavior.

29. I feel sure of myself as a parent of a child who has experienced trauma.

30. I know I am doing a good job as a resource parent.

31. I know things about being a resource parent that would be helpful to other parents.

32. I can solve most problems between my child and me.

33. When things are going badly between my child and me, I keep trying until things begin to change.