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Improving trauma-informed education and parenting for resource parents at a foster care agency.

Courtney Albers
University of Louisville, courtney.albers1@gmail.com

Improving Trauma-Informed Education and Parenting for Resource Parents at a Foster Care Agency

by

Courtney Alicia Albers

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Sarah Schriner DNP, MEd, APRN, PMHNP 7/14/2022
Signature DNP Project Chair Date

Rudy Clark EdD, MSN, RN 7/18/2022
Signature DNP Project Committee Member Date

Signature DNP Program Director Date

Signature Associate Dean for Academic Affairs Date

Dedication

This project is dedicated to all my patients, past, present, and future. I promise to always advocate for high quality research, evidence-based practices, and the implementation of quality improvement measures.

Acknowledgements

I would like to thank my parents for supporting me through this journey to my DNP. They have gone above and beyond to ensure I succeed and have always believed in me.

Additionally, I would like to thank all School of Nursing faculty and staff who have helped me throughout my time as a nursing student. It is an honor to be a cardinal nurse!

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Contents

Abstract

Background: 675,000 children nationwide were involved with the foster care system in 2019, and nearly all children within the foster care system are actively suffering from the effects of trauma. Resource parent trauma-informed trainings, such as Resource Parenting Curriculum (RPC) developed by The National Child Traumatic Stress Network, are associated with improved parental perceptions towards trauma-informed care, improved child outcomes, and placement stability. Foster care agencies have trauma-informed state-based curriculum, but it does not meet the needs of resource parents, specifically those caring for children with developmental delays or disorders.

Purpose: The project was implemented at a therapeutic foster care agency for resource parents to improve knowledge, beliefs, and attitudes surrounding trauma-informed parenting, tolerance of misbehavior and parenting efficacy.

Methods: Resource parents participated in a two-hour workshop consisting of a condensed version of RPC, which was adapted to meet the needs of parents caring for a child with a developmental delay or disorder. Resource parents completed a pre- and post-workshop knowledge test and Resource Parent Knowledge and Beliefs Survey (RPKBS). Qualitative measures identified resource parent satisfaction with workshop.

Results: Resource parent knowledge ($p=0.108$) and all three scales from the RPKBS: trauma-informed parenting ($p=0.074$), tolerance of misbehavior ($p=0.500$), and parenting efficacy ($p=0.293$) improved from pre- to post-workshop but were not statistically significant.

Discussion: The project will have sustained outcomes as the project site has adopted a trauma-informed curriculum to implement into their program as a tool for resource parents. Future implementation of this intervention should focus on improving response rates, studying the

relationship of collaborative trainings and the development of staff specific trauma-informed assessments and the impact of trauma-informed workshops on parenting behaviors and outcomes, specifically placement stability.

Keywords: child trauma, child welfare, foster care, resource parent training, placement stability

Improving Trauma-Informed Education and Parenting for Resource Parents at a Foster Care Agency

The Department for Community Based Services (DCBS) maintains the Foster Adoptive Caregiver Exchange System (FACES) to relieve children and adolescents, ages 0 to 18 years-old, from unsafe circumstances (DCBS, 2017). DCBS and more specifically, the foster care system, has greatly contributed to the protection of children by providing placements and safety during times of need. Unfortunately, of the children involved with the foster care system, nearly 70% have experienced three or more adverse childhood experiences (ACEs) (Freeman, 2014). The current literature indicates ACEs can have long-term effects that follow children into adulthood (Boparai et al., 2018; CDC, 2019; Chang et al., 2019; Crouch et al., 2018). ACEs have been associated with the development of physical and mental illnesses (Boparai et al., 2018; CDC, 2019; Chang et al., 2019; Crouch et al., 2018). The state of Kentucky ranks in the top ten states for ACEs and has ranked the number one state in rates of child abuse for the past three years (Health Resources and Services Administration, n.d; Yetter, 2021). Resource parents play an influential role in a child's trauma recovery and thus, resource parents require specific training to adequately understand and manage trauma-related complexities (Bartlett & Smith, 2019; Brodzinsky, 2013; Hardwood et al., 2013; Henry et al., 2007; Sullivan et al., 2016; Wojciak et al., 2017).

Background

Children are resilient, and some may experience only brief symptoms following a traumatic experience; however, some children may experience lasting effects (Children's Bureau, 2020; Tlapek et al., 2017). Trauma causes toxic stress which dysregulates hormone production within the hypothalamic-pituitary-adrenal (HPA) and the sympathetic-adrenal-

medullary (SAM) axes causing a physiological imbalance, which can alter a child's brain during sensitive periods of development (Boparai et al., 2018; Child Welfare Information Gateway, 2015). A child's presentation of trauma symptoms is dependent on the part of the brain affected (Child Welfare Information Gateway, 2015). Childhood trauma may hinder brain development, both structure and functioning, and disrupted neurodevelopment can lead to developmental delays or developmental disorders (Bartlett & Smith, 2019; Child Welfare Information Gateway, 2015; Hughes et al., 2017).

A needs assessment was conducted at the project site, a therapeutic foster care agency located in two different cities in a southeastern US state, and a gap in knowledge among resource parents regarding trauma and its effects on child development was identified. The vice president of the foster care program requested the project focus on trauma-informed parenting with an emphasis on developmental delays or disorders. While there is a state required curriculum from DCBS for trauma-informed parenting training, the vice president expressed the need for more extensive training. Precise estimates of prevalence of developmental delays and disorders in foster care are often difficult to determine due to the ambiguous presentation (Bartlett & Smith, 2019; Boparai et al., 2018; Child Welfare Information Gateway, 2015; Hughes et al., 2017; Putnam, 2006). However, there's an estimated 40% to 60% of children in the foster care system with diagnosed with either a developmental delay or disorder (Leslie et al., 2005; Weiss, 2013). The project site reported they do not currently track the number of children with a diagnosed developmental delay or disorder. The clinical director stated, "it's hard to know exactly how many children, as not all children are psychologically tested; though, many children we serve show signs of a developmental delay or disorder."

Discussions with key stakeholders, including program supervisors and social workers, identified the need for improved relations between resource parents and their children, noting the continuous mission to improve placement stability. Without an understanding of the effects of trauma, resource parents can misinterpret behaviors, and their attempts to address behaviors can be unsuccessful. The National Child Traumatic Stress Network (2010) explains children may react to trauma reminders such as sights, smells, tastes, sounds, sensations, people, places, colors, textures, words, or emotions. Often, this isn't a conscious process, and the child may be unaware of the connection lending to their inability to express the reasoning for their reaction. A trauma reminder may prompt a child to experience intrusions, physiological arousal, avoidance, or dissociation. When a response to trauma occurs, resource parents may not understand the cause and may not react with a therapeutic approach leading to strain on the parent-child relationship, which can potentially result in resource parents requesting for the child to be removed from their home (Child Welfare Information Gateway, 2014; Henry et al., 2007). Jones et al. (2016) found placement stability was able to be maintained when families felt "feelings of closeness." When resource parents respond therapeutically to a child's response to a trauma reminder, it can prompt healing. Conversely, disruptions in a child's placement can further traumatize and potentiate their feelings of instability (Child Welfare Information Gateway, 2015).

Brown et al. (2020) states development and behavior are intricately related. Development can inform behavior, and children with developmental delays and disorders are at an increased risk for disruptions in foster placement due to problem behavior (Fisher et al., 2011). According to the foster care agency, many resource parents reported children's behavioral needs as their most difficult challenge in the home. "Maintaining and maximizing placement stability is one of

the key desired outcomes for children and youth involved with the foster care system" (Child Welfare Information Gateway, n.d.). Jones et al. (2016) deemed the goal for children in foster care to be placed in two or fewer different placements throughout their time in care, and The Casey Family Programs, a foster care foundation, reiterated this goal. Yet, less than 40% of foster care agencies are meeting this goal (Jones et al., 2016). The national average is over three different foster home placements within a 15-month period (Children's Bureau, 2020; Children's Bureau, 2008). Parallel to the national level, in 2018, children in Kentucky had on average three different placements within the year (Cabinet for Health and Family Services, 2020). The project site was seeing disruptions in placement every four months and sometimes, more than once a month. The literature supports the correlation between trauma-informed parenting and improved placement stability (Bartlett & Rushovich, 2018; Strolin-Goltzman et al., 2018).

Population

The target population for this project was resource parents at a therapeutic foster care agency located in two different cities in a southeastern US state. Resource parents were invited to participate in the workshop whether they are currently caring for a child or not. Resource parents at the site care for youths from age zero to 21 years old; however, most referrals are for children ages 6 and older.

Problem

Caring for a child within the foster care system is challenging; however, caring for a child within the foster care system with a developmental delay or disorder adds an additional layer of complexity to an already demanding task. A problem was identified as resource parents' state-based curriculum training does not equip them to fully understand and manage complexities associated with trauma.

Purpose and Specific Aims

The purpose of this project was to implement a trauma-informed parenting training for those resource parents caring for a child who has a trauma related developmental delay or disorder. The specialized trauma-informed parenting training aimed to improve knowledge, beliefs, and attitudes towards trauma-informed parenting.

Definition of Terms

Adoption. The action of legally accepting responsibility of another individual's child.

Developmental delay. Refers to a child who is gaining developmental skills later than expected. Delays can be present in various skills including cognitive, social, and emotional, speech and language, fine and gross motor, and daily living activities.

Developmental disorder. Refers to a child who has not gained the developmental skills expected of him or her, and this impairment can last throughout a person's lifetime. Disorders can be present in various skills including cognitive, social, and emotional, speech and language, fine and gross motor, and daily living activities.

Foster care. State-funded program that provides temporary care for a child in necessary times.

Kinship care. The care of a child is provided by relatives.

Placement. A living arrangement for a child who is within the FACES program. Placements can include residential, foster home, adoptive home, or independent living.

Placement stability. A living arrangement for a child with limited disruptions.

Resource parents. Individual(s) who become trained and certified to serve as a foster parent or adoptive parent.

Therapeutic foster care. Foster care settings designed for children that need extra support, including greater structure and intensity of therapeutic services, due to trauma histories.

Trauma-informed. An approach based on knowledge of the impact of trauma that aims to ensure a secure environment.

Trauma-informed parenting. A parenting style approach based on knowledge of the impact of trauma that aims to ensure a secure environment.

Literature Review

A review of the literature supports the provision of trauma-informed parenting education to adequately equip resource parents with necessary understanding and application of learned skills (Bartlett & Smith, 2019; Sullivan et al., 2016). While many states and foster care agencies have standard education requirements, current research supports the need for additional parenting education for individuals caring for a child who has experienced trauma (Bartlett & Smith, 2019; Brodzinsky, 2013; Hardwood et al., 2013; Henry et al., 2007; Sullivan et al., 2016; Wojciak et al., 2017). A needs assessment at the project site revealed a gap in resource parent knowledge. The site requested for a more in-depth trauma-informed training with an emphasis on the ability of childhood trauma to imprint in the form of a developmental delay or disorder.

For this project, the Resource Parenting Curriculum (RPC), developed by The National Child Traumatic Stress Network, was utilized. The “RPC aims to increase resource parents’ knowledge of trauma exposure and its effects, parents’ willingness to tolerate difficult behaviors that stem from trauma exposure, and to ultimately empower resource parents to feel effective in their ability to parent a child with a trauma history” (Murray et al., 2019, p. 164). The research regarding RPC yielded favorable results indicating RPC increases trauma-informed parenting,

tolerance of misbehavior and parenting self-efficacy. RPC best meets the needs of the project site, and while no curricula from the literature review explicitly addresses trauma-informed parenting for the resource parent caring for a child with a developmental delay or disability, RPC addresses how trauma impacts development. Additionally, RPC can be adapted to incorporate supplemental information to resource parents caring for a child with a developmental delay or disability. Four empirical published studies provide evidence of RPC's effectiveness (Gigengack et al., 2017; Murray et al., 2019; Strolin-Goltzmann et al., 2018; Sullivan et al., 2016).

While all articles in the literature review focused on components to improve parental knowledge, a common barrier noted throughout the literature was the lack of assessment of application of trauma-informed parenting skills inside the foster care home (Bartlett and Rushovich, 2018; Murray et al. 2019). Sullivan et al. (2016) stated resource parents were more knowledgeable about essential elements of trauma-informed parenting; though Murray et al. (2019) asks if improved knowledge leads to parenting changes, and if these changes impact child outcomes. The literature supports the correlation between trauma-informed parenting and improved placement stability; however, specific causation is unknown (Bartlett & Rushovich, 2018; Strolin-Goltzman et al., 2018). A goal of this project was to bridge parental trauma-informed knowledge with application to an in-home setting. Dorsey et al. (2008) explains individualized support and guidance throughout parenting workshops can promote trauma-informed parenting skills. The RPC promotes individualization through "My Child" activities. The "My Child" activities allowed resource parents the opportunity to apply concepts learned throughout the workshop to an actual child in their care.

In-person and online trauma-informed parenting workshops showed promising results. Though, Razuri et al. (2016) expressed the goal of online parent training was to overcome

prohibitive barriers brought about by in-person delivery such as space limitations, expenses, and time restraints. Conversely, Forehand et al. (2019) expressed the most cited benefit of the intervention, beyond increased knowledge and parenting skills, was benefits of in-person training sessions. Participants identified benefits such as the class provided a "safe space on a weekly basis for resource parents to raise challenging caregiving issues, receive feedback, and identify with other resource parents who were facing similar issues" (p. 377). Sullivan et al. (2016) echoed the benefits for face-to-face training, declaring it promotes a support network for resource parents. While there are benefits of in-person training, for this project, in-person training was not feasible due to limitations brought about by the COVID-19 pandemic.

A gap noted within the literature was lack of follow-up results to determine lasting effects of the interventions (Murray et al., 2019; Razuri et al., 2016). Without post-intervention follow-ups to establish effects of the interventions, researchers are limited in understanding the overall impacts of the trainings. Knowing the long-term follow-up results will allow for researchers to alter aspects of curriculum to achieve maximum effects in the future. The principal investigator worked to close this gap by sustaining outcomes of RPC through reinforcing learning post-intervention and evaluating those outcomes with follow up assessments.

Current research supports the need for additional parenting education for individuals caring for a child involved with the foster care system (Bartlett & Smith, 2019; Brodzinsky, 2013; Hardwood et al., 2013; Henry et al., 2007; Sullivan et al., 2016; Wojciak et al., 2017). By studying the relationship between trauma, placement stability, and developmental delays in children within the foster care system, it became clear: to break the cycle of trauma (Appendix A) foster parents would benefit from intentional trauma-informed training. A previous resource parent who attended RPC discussed the benefits stating, "when we became familiar with the

RPC and started parenting through a trauma lens, where we weren't thinking about having punitive consequences but instead, how we can heal them and help them grow and develop… it changed [our home]… and our kids with challenging behaviors were able to stay in our home long-term instead of us needing to terminate placement" (National Child Traumatic Stress Network, 2017).

Conceptual Framework

Rosswurm and Larabee's (1999) Theory for Change to Evidence-Based Practice Model guided this project (Appendix B). This model endorses the utilization of evidence-based practice. The project sought to change the current practice to an evidence-based practice. This model serves as a systematic process for health care professionals to implement evidence-based practice change to ultimately improve patient outcomes. The model includes six steps: assessing need, linking the intervention and outcomes, synthesizing the best evidence, designing a practice change, implementing, and evaluating change, and integrating and maintaining change.

Ethical Considerations

This project was submitted to the University of Louisville Institutional Review Board (IRB) and the IRB classified as non-human subject research. The project site's Quality Improvement and Corporate Compliance Chief Officer and Project Manager provided support and approval for the project implementation (Appendix C).

Measures

This project measured two outcomes: resource parents' knowledge of trauma-informed parenting and resource parents' beliefs and attitudes toward trauma-informed parenting. The purpose of the workshop was to improve knowledge, beliefs, and attitudes surrounding trauma-informed parenting, increase resource parent's ability to tolerate challenging behaviors, and grow

resource parent's confidence in caring for a child with a traumatic history. Involved stakeholders were hopeful that this project would yield similar results of improving parent-child relations and placement stability overtime; however, this aim is outside the timeframe and scope of the project and was not measured (Bartlett & Rushovich, 2018; Conn et al., 2018; Murray et al., 2019; Sullivan et al., 2016).

To measure knowledge, a 10-question multiple choice knowledge test was administered (Appendix D). The knowledge test was developed by the principal investigator and is aligned with the learning objectives of the educational workshop. No other instrument existed to measure knowledge specific to this intervention. The knowledge test was administered at three different time intervals: pre-, post-, and at one-month follow up.

To measure the resource parent's beliefs and attitudes to trauma-informed parenting, the Resource Parent Knowledge and Beliefs Survey (RPKBS), developed by Murray (2014), was utilized. The RPKBS is a 33-item questionnaire that assesses three domains: trauma-informed parenting knowledge, tolerance of misbehavior and parenting efficacy. The items were scored on a six-point Likert scale (strongly disagree, disagree, slightly disagree, slightly agree, agree, and strongly agree). The RPKBS was chosen as the survey for this project because it's widely used in the literature, and it measures the specific objectives for this project. Each item correlates to one of the three main objectives: trauma-informed knowledge, tolerance of misbehavior and parenting efficacy. Additionally, the RPKBS was deemed to have good psychometric properties: Cronbach's alpha coefficient yielded good to excellent reliability ($\alpha = 0.84$ to 0.90) on each domain, and validity was reported as moderate to large association ($r = 0.48$ to 0.66) by means of Pearson's correlations (Murray et al., 2019). The RPKBS was administered at three different time intervals: pre-, post-, and at one-month follow up. Previous studies measured follow up

results at one-month post-intervention, therefore the project also measured at one-month to be comparative (Akin et al., 2018; Bartlett and Rushovich, 2018; Maaskant et al., 2016). Permission for use was granted by developer (Appendix E).

Methods

For this quality improvement project, a trauma-informed parenting workshop was implemented. The trauma-informed workshop was held virtually on January 18th, 2022, and January 20th, 2022. Attendees were given the option to choose the date that worked best for their schedule. Resource parents at the foster care agency were sent an invitation to participate via email from the clinical director. The email included information pertaining to the educational workshop: date and time of workshop, zoom link, and materials and instructions for the workshop. Workshop materials included a preamble (Appendix F), workshop slides (Appendix G), and "My Child" worksheets (Appendix H). The one-day workshop was programed during a regularly scheduled resource parent support group and lasted approximately two hours. Participation was voluntary.

During the intervention, resource parents received a condensed and adapted version of the RPC delivered by the principal investigator. RPC was condensed and adapted to meet the site's needs, specifically related to caring for a child who has experienced trauma with a developmental delay or disability. Permission to use and edit curriculum was granted by The National Child Traumatic Stress Network (NCTSN; Appendix I). The condensed version of RPC addressed six of the 21 learning objectives for the program (Appendix J). The learning objectives were identified by key stakeholders and deemed most beneficial for the site. The evidence-based educational workshop was delivered virtually via Zoom software due to COVID. To participate in this project, resource parents needed access to an electronic device such as a cell phone, tablet,

laptop, or desktop computer with internet connection. The project site confirmed resource parents' access to these resources.

At the beginning of the workshop, resource parents were asked to complete a brief demographic survey (Appendix K). The demographic survey included age, gender, race/ethnicity, length of time spent as a resource parent, type of resource parent, number of children in home over the past year, number of children who could not be maintained in home due to behavior, and information on current birth and non-birth children in home such as age, gender, and placement status. Additionally, the resource parents completed the trauma-informed pre-knowledge test and the pre-workshop RPKBS (Appendix L).

Immediately following the workshop, resource parents completed the post-knowledge test and post-workshop RPKBS (Appendix M). Resource parents were asked to reflect over workshop participation. Resource parents were prompted with the question, "What went well during the workshop or what would you like to see improved?" The qualitative responses were recorded.

In order to promote lasting effects of the intervention, at two-weeks post-workshop, resource parents were sent booster education including a one-page summary of learned concepts via email by the vice president of the foster care program (Appendix N). At one-month post-workshop, resource parents completed a follow-up knowledge test and follow-up RPKBS. Resource parents were incentivized with continuing education credit for their complete participation.

Staff members from the project site attended the workshop and completed the pre-, post- and follow-up materials including the demographic survey, knowledge test, and RPKBS.

Data Collection and Privacy

Data was collected from January 19th, 2022, until February 17th, 2022. It was a high priority for the site to maintain privacy of resource parents and children; therefore, throughout the project, the principal investigator was blinded from all participant information including name and email. The principal investigator signed a pledge of confidentiality form from site (Appendix O). Resource parents completed the demographic questionnaire, knowledge test and RPKBS on JotForm, an online database. All data was stored on a password protected laptop. Resource parents used a unique identifier code consisting of their favorite color and birth year (i.e., RED1989). Resource parents input their unique identifier code for each form completed. The unique identifier code also served as their name on Zoom to de-identify participants during the workshop. Participant confidentiality and anonymity was maintained throughout the project.

Data Analysis

Data analysis was completed using Jamovi version 2.3.2. A pretest, posttest, and follow-up design with quantitative data analysis was performed to evaluate the effectiveness of the educational workshop on resource parents' knowledge, beliefs, and attitudes towards trauma-informed parenting. Descriptive statistics, including frequencies, central tendencies, and standard deviation, were used to describe characteristics of participants and pre-, post-, and follow up data.

The Shapiro-Wilk test determined normality within the knowledge test and RPKBS data sets. The knowledge test was normally distributed; therefore, a parametric test, a paired t-test, was performed to compare pretest, posttest, and follow-up results for significance. The RPKBS data set deviated from normal distribution; therefore, a non-parametric test, the Wilxocon signed rank, was employed. The Cohens d statistic was calculated to determine the effect size, or extent of differences between pre- and post-workshop.

Results

The DNP project was intended for resource parents; though, staff within the organization were invited to attend. Key stakeholders identified staff work closely with children who have experienced trauma and would likely benefit from the curriculum, even if the curriculum was not developed for staff. Staff training on trauma-informed approaches can decrease potential traumatic reactions and distress and encourage emotional support and positive coping throughout the recovery process (Marsac et al., 2016). The decision to include staff within the organization occurred approximately two weeks prior to the implementation date; therefore, no accommodations were made to the curriculum, knowledge test, or survey.

Pre-Workshop Data

Seventeen participants attended the workshop including resource parents (*n*=9) and staff members (*n*=8). Resource parent demographic data is listed in Table 1. Staff demographic data is listed in Table 2.

Four resource parents completed the post-workshop material; therefore, the knowledge test and RPKBS data reflects those responses (*n*=4). Resource parents scored a mean of 9.00 (SD=1.15) for the pre-workshop knowledge test. The RPKBS was scored on a six-point Likert scale in which certain items score three categories: trauma-informed parenting, tolerance of misbehavior, and parenting efficacy. Resource parents scored a mean of 5.00 (SD=0.00) for the RPKBS trauma-informed parenting items. Resource parents scored a mean of 4.75 (SD=0.50) for the RPKBS tolerance of misbehavior items. Resource parents scored a mean of 5.15 (SD=0.59) for the RPKBS parenting efficacy items.

Six of the foster care agency staff completed pre-workshop materials; however, only four completed the post-workshop material. Four staff member's data was analyzed (*n*=4). Staff

scored a mean of 10.00 (SD=0.00) for the pre-workshop knowledge test. Staff scored a mean of 5.5 (SD=0.57) for the RPKBS trauma-informed parenting items. Resource parents scored a mean of 4.75 (SD=0.95) for the RPKBS tolerance of misbehavior items. Resource parents scored a mean of 4.5 (SD=1.11) for the RPKBS parenting efficacy items. The RPKBS was not intended for staff evaluation; however, there was no other measure available to measure staff's knowledge and beliefs toward trauma-informed practices specific to the RPC. This baseline data may be useful for the development of a staff-specific trauma-informed assessment.

Post-Workshop Data

Resource parents scored a mean of 9.75 (SD=5.00) for the post-workshop knowledge test. Resource parents scored a mean of 5.75 (SD=0.50) for the RPKBS trauma-informed parenting items. Resource parents scored a mean of 5.25 (SD=0.50) for the RPKBS tolerance of misbehavior items. Resource parents scored a mean of 5.50 (SD=0.60) for the RPKBS parenting efficacy items.

Staff scored a mean of 10.00 (SD=0.00) for the pre-workshop knowledge test. Staff scored a mean of 5.75 (SD=0.50) for the RPKBS trauma-informed parenting items. Resource parents scored a mean of 5.25 (SD=0.50) for the RPKBS tolerance of misbehavior items. Resource parents scored a mean of 5.31 (SD=0.57) for the RPKBS parenting efficacy items.

Follow-Up Workshop Data

Follow-up materials were sent out at four weeks post-workshop. No resource parents participated in the follow-up data collection. It is hypothesized that virtual instruction due to COVID-19 posed a barrier on engagement and data collection throughout the project. Two staff members completed follow-up materials; however, the unique identifier codes did not correlate to previous submissions. The follow-up data was voided.

Pre-Post Workshop Data

Due to the small sample size, determining the distribution of the data sets was essential for choosing the appropriate statistical method. Resource parent knowledge was normally distributed according to the Shapiro-Wilk test (W=0.863, p=0.272). A paired t-test compared resource parent knowledge pre- and post-workshop (p=0.108). Resource parent trauma-informed parenting deviated from normal distribution according to the Shapiro-Wilk test (W=0.630, p=0.001). A Wilcoxon signed-rank test compared resource parent trauma-informed parenting pre- and post-workshop (p=0.074). Resource parent tolerance of misbehavior deviated from normal distribution according to the Shapiro-Wilk test (W=0.630, p=0.001). A Wilcoxon signed-rank test compared resource parent tolerance of misbehavior pre- and post-workshop (p=0.500). Resource parenting efficacy deviated from normal distribution according to the Shapiro-Wilk test (W=0.828, p=0.163). A Wilcoxon signed-rank test compared resource parenting efficacy pre- and post-workshop (p=0.293). Resource parent statistical data is reported in table 3.

Staff knowledge did not contain enough observations for the Shapiro-Wilk test to be performed. The staff knowledge data set did not change from pre- to post-workshop. A Wilcoxon signed-rank test compared staff knowledge pre- and post-workshop (p=1.000). Staff trauma-informed parenting deviated from normal distribution according to the Shapiro-Wilk test (W=0.630, p=0.001). A Wilcoxon signed-rank test compared staff trauma-informed parenting pre- and post-workshop (p=0.500). Staff tolerance of misbehavior deviated from normal distribution according to the Shapiro-Wilk test (W=0.729, p=0.024). A Wilcoxon signed-rank test compared staff tolerance of misbehavior pre- and post-workshop (p=0.173). Staff parenting efficacy deviated from normal distribution according to the Shapiro-Wilk test (W=0.939,

p=0.650). A Wilcoxon signed-rank test compared staff parenting efficacy pre- and post-workshop (*p*=0.091). Staff statistical data is reported in table 4.

Discussion

The purpose of this project was to improve knowledge, beliefs, and attitudes towards trauma-informed parenting for resource parents. There were improved scores from pre- to post-workshop; however, the data was not statistically significant. Despite the results, the current project was meaningful, impacting resource parents, foster children, and staff. Resource parent knowledge (*d*=0.78), trauma-informed parenting (*d*=1.50), and tolerance of misbehavior (*d*=1.00) had a large effect size indicating practical significance. Parenting efficacy (*d*=0.49) had a medium effect size which also indicates some practical significance. At the conclusion of the workshop, resource parents were asked "What went well?" and "What would you like to see improved?" and one participant expressed, "this workshop was very helpful…it helps us…it reminds us of things to consider," and another participant added, "thank you for this…the activities were very practical…this was one of the most useful sessions." Feedback included themes of appreciation, stating the workshop was highly practical with tangible ways to implement trauma-informed parenting in the home.

The findings of this project are consistent with the overall findings of four previously published studies indicating RPC improves the trauma-informed perspective of resource parents (Gigengack et al., 2017; Strolin-Goltzman et al., 2018; Murray et al., 2019; Sullivan et al., 2016). Resource parent knowledge (*p*=0.108), and all three scales from the RPKBS: trauma-informed parenting (*p*=0.074), tolerance of misbehavior (*p*=0.500), and parenting efficacy (*p*=0.293) improved from pre- to post-workshop. No findings were statistically significant. The previously published studies adhered to high standards of fidelity including the delivery of all eight

modules, in-person, with a NCTSN-trained facilitators. The basis of the current project did not allow for the provision of eight, in-person modules due to time restrictions and the COVID-19 pandemic.

The current project has limitations. First, resource parents had low engagement toward data collection. Future research should focus on interventions to improve response rates; however, it is hypothesized that lack of completion was accredited to online collection of data due to COVID-19. Other common causes for limited resource parent responses may include the non-mandatory nature of the workshop and the competing demands of resource parents including family and child-related obligations (Murray et al., 2019). Current research supports the provision of individualized and personal aspects of training programs to improve engagement and outcomes (Dorsey et al., 2008; Jackson et al., 2012;). At approximately two weeks post-workshop, resource parents, key stakeholders, and staff were given hand-written thank you notes and a small gift of appreciation for their time and participation. Additionally, throughout the workshop, the facilitator promoted individualization using the "My Child" worksheets and provided realistic and tangible trauma-informed strategies including identification and management of emotional "hot spots," safety message planning, and the SOS coping skill. Unfortunately, even with the provision of these recommendations, responses to pre-, post-, and follow up knowledge tests and surveys was still low. The resource parent sample size remained small (n=4). Previous research used the completion of the knowledge test and survey as exit tickets (Murray et al., 2019). Future workshops could implement the exit ticket strategy by dismissing resource parents from the virtual workshop once materials are received. This may require additional planning with workflow design, but this method could improve the amount of data collected. Fleming et al. (2016) evaluated predictors of engagement and found child

attendance at workshops resulted in higher engagement. Future research and workshops should explore the impacts of child-parent workshops and focus on data collection, specifically follow-up data to determine lasting effects of RPC.

Next, it was outside of the scope for the current project to measure RPC's impact on placement stability. The literature supports the correlation between trauma-informed parenting trainings and improved placement stability (Bartlett & Rushovich, 2018; Strolin-Goltzman et al., 2018). When a child is moved from placement to placement, it can further traumatize and potentiate a child's feelings of instability, halting the recovery process (Child Welfare Information Gateway, 2015). Children with multiple placements experience more delinquency, aggression, depression, and trauma symptoms compared to those with fewer placements (Mishra et al., 2020). Additionally, when asked about the effects of placement instability, foster care alumni reported feeling unwanted by caregivers and subsequent difficulties with relationships (Chambers et al., 2018). Future research should focus on understanding the correlation between the RPC and placement stability.

Lastly, the RPKBS was not an appropriate assessment of staff perceptions of trauma-informed care. The RPKBS was developed with resource parents as the intended audience, and for example, one statement is "I know I am doing a good job as a resource parent," which explicitly does not apply to staff. Conversely, another statement on the RPKBS is "I feel confident about my ability to handle challenging behaviors," which could be accurately answered by a staff member. Therefore, the staff results from this project are not conclusive, but serve as a starting point for the development of staff-specific assessments. In 2020, a NCTSN-based training program, the Child Welfare Trauma Training Toolkit (CWTTT), was developed for staff members at various levels and roles to improve trauma-informed care delivery (NCTSN,

2020). There is limited research on this specific training, and no correlated tools have been established. The NCTSN has developed the Trauma-Informed Organizational Assessment (TIOA), which aims to measure trauma-informed care at the organizational level (NCTSN, 2021). However, currently, the NCTSN does not have a tool to measure staff perceptions, knowledge, beliefs, or attitudes towards trauma-informed care. The current literature evaluates staff perceptions, knowledge, beliefs, and attitudes towards trauma-informed care using qualitative assessments (i.e., interviews and focus groups; Galvin, 2021). Future research should consider the development of a tool to measure staff perceptions of trauma-informed care (i.e., staff interaction with child with trauma history) and staff perceptions of trauma-informed parenting (i.e., usefulness of resource parent education and training of trauma-informed practices).

Despite these limitations, the current project has several important implications for trauma-informed parenting for resource parents. First, each measure improved from pre- to post-workshop, indicating RPC can improve resource parent knowledge, beliefs, and attitudes toward trauma-informed parenting, tolerance of misbehavior, and parenting efficacy. These improvements, though not significant, have practical implications toward improving outcomes for the child. Resource parents have greater ability to care for children who have experienced trauma. Improved resource parent trauma-informed parenting has been correlated with improved trauma-informed strategies inside the home, parent-child relations, and placement stability, all of which can promote trauma recovery (Bartlett & Rushovich, 2018; Strolin-Goltzman et al., 2018). While further research is needed to determine if RPC and self-reported parental perceptions are related to changes in parenting styles, the results are encouraging.

Second, this project goes beyond previous research and implementation of RPC, incorporating staff. This project serves as a starting point for the development of staff-specific trauma-informed trainings and self-reported assessments. There is limited research for staff-specific trauma-informed trainings and assessments. Current research is using qualitative assessments such as interviews and focus groups to explore staff perceptions of trauma-informed care. While RPC is not an ideal curriculum to use with staff, it did offer a common language to use when discussing trauma. The use of a common language among resource parents, therapists, social workers, and other health care providers has been associated with better collaboration and outcomes (Bartlett and Rushovich, 2018). Future research should explore the impact of collaborative trainings, and the development of staff-specific trauma-informed assessments.

Third, this project was deemed highly valuable and effective by the organization. The organization has adopted a trauma-informed curriculum to sustain the results of this project. The site's new trauma-informed curriculum was evaluated for use for this project, however, was deemed not feasible due to the high price of the curriculum. The project site's allocation of money toward this trauma-informed curriculum reveals the reported benefits of trauma-informed trainings as a tool for resource parents.

Conclusions

The high prevalence of trauma throughout the country indicates the need for further attention for post-traumatic interventions, especially within the foster care system (Bartlett & Smith, 2019). The trauma-informed parenting workshop was well-received by resource parents and had reported benefits on resource parents' knowledge and beliefs of trauma-informed parenting, tolerance of misbehavior, and parenting efficacy. Future implementation of this intervention should focus on improving response rates by exploring additional options for

individualized components, implementing the exit ticket strategy, and studying the relationship of collaborative trainings including the resource parents, staff, and children. Additionally, future implementation of this intervention should consider the development of staff specific trauma-informed assessments and the impact of trauma-informed workshops on parenting behaviors and outcomes, specifically placement stability.

References

Adverse Childhood Experiences (ACEs). (2019). https://www.cdc.gov/vitalsigns/aces/index.html#:~:text=ACEs%20can%20include%20violence%2C%20abuseand%20substance%20misuse%20in%20adulthood.

Akin, B. A., Lang, K., Yan, Y., & McDonald, T. P. (2018). Randomized trial of PMTO in foster care: 12-month child well-being, parenting, and caregiver functioning outcomes. *Children and Youth Services Review*, *95*, 49–63. https://doi.org/10.1016/j.childyouth.2018.10.018

Bartlett, J. D., & Rushovich, B. (2018). Implementation of Trauma Systems Therapy-Foster Care in child welfare. *Children and Youth Services Review*, *91*, 30–38. https://doi.org/10.1016/j.childyouth.2018.05.021

Bartlett, J. D., & Smith, S. (2019). The role of early care and education in addressing early childhood trauma. *American Journal of Community Psychology*. http://dx.doi.org/10.1002/ajcp.12380

Boparai, S. K. P., Au, V., Koita, K., Oh, D. L., Briner, S., Harris, N. B., & Bucci, M. (2018). Ameliorating the biological impacts of childhood adversity: A review of intervention programs. *Child Abuse & Neglect*, *81*, 82–105. https://doi.org/10.1016/j.chiabu.2018.04.014

Brodzinsky, D. M. (2013). A need to know: Enhancing adoption competence among mental health professionals. Policy Perspective. New York, NY: Donaldson Adoption Institute.

Brown, K. A., Parikh, S., & Patel, D. R. (2020). Understanding basic concepts of developmental diagnosis in children. *Translational Pediatrics, 9*(S1). https://doi.org/10.21037/tp.2019.11.04

Cabinet for Health and Family Services. (2022). Jefferson foster care FACTS. https://chfs.ky.gov/agencies/dcbs/dpp/Documents/Jefferson.pdf

Chambers, R. M., Crutchfield, R. M., Willis, T. Y., Cuza, H. A., Otero, A., Harper, S. G. G., & Carmichael, H. (2018). "It's just not right to move a kid that many times:" A qualitative study of how foster care alumni perceive placement moves. Children and Youth Services Review, 86, 76–83. https://doi. org/10.1016/j.childyouth.2018.01.028

Chang, X., Jiang, X., Mkandarwire, T., & Shen, M. (2019). Associations between adverse childhood experiences and health outcomes in adults aged 18–59 years. *PLOS ONE*, *14*(2). https://doi.org/10.1371/journal.pone.0211850

Children's Bureau. (2008). The AFCARS report. https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport16.pdf

Children's Bureau. (2020). *The AFCARS report.* https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport27.pdf

Child Welfare Gateway. (n.d.). Maintaining/maximizing placement stability. https://www.childwelfare.gov/topics/adoption/postplacement/stability/

Child Welfare Information Gateway. (2015). *Understanding the effects of maltreatment on brain development.* https://www.childwelfare.gov/pubPDFs/brain_development.pdf

Child Welfare Information Gateway. (2014). *Parenting a child who has experienced trauma.* https://www.childwelfare.gov/pubPDFs/child-trauma.pdf

Conn, A.-M., Szilagyi, M. A., Alpert-Gillis, L., Webster-Stratton, C., Manly, J. T., Goldstein, N., & Jee, S. H. (2018). Pilot randomized controlled trial of foster parent training: A mixed-methods evaluation of parent and child outcomes. *Children and Youth Services Review*, *89*, 188–197. https://doi.org/10.1016/j.childyouth.2018.04.035

Crouch, E., Strompolis, M., Radcliff, E., & Srivastav, A. (2018). Examining exposure to adverse childhood experiences and later outcomes of poor physical and mental health among South Carolina adults. Children and Youth Services Review, 84, 193–197. https://doi.org/10.1016/j.childyouth.2017.11.031

Department for Community Based Services. (2017). Retrieved October 02, 2020, from https://chfs.ky.gov/agencies/dcbs/Pages/default.aspx

Dorsey, S., Farmer, E. M., Barth, R. P., Greene, K. M., Reid, J., & Landsverk, J. (2008). Current status and evidence base of training for foster and treatment foster parents. *Children and Youth Services Review*, *30*(12), 1403–1416. https://doi.org/10.1016/j.childyouth.2008.04.008

Fisher, P. A., Stoolmiller, M., Mannering, A. M., Takahashi, A., & Chamberlain, P. (2011). Foster placement disruptions associated with problem behavior: Mitigating a threshold effect. Journal of Consulting and Clinical Psychology, 79(4), 481–487. https://doi.org/10.1037/a0024313

Freeman, P. (2014). Prevalence and relationship between adverse childhood experiences and child behavior among young children. *Infant Mental Health Journal*, *35*(6). https://doi.org/10.1002/imhj.21460

Forehand, G. L., Schisler-Blizzard, A. D., Deaver, A. H., Strolin-Goltzman, J., Breslend, N., Sullivan, A. D. W., Mendoza, G. S., Bielawski-Branch, J., Jorgenson, J., & Forehand, R. (2019). Triangulating perspectives to inform the development of a smartphone application for foster, kinship, and adoptive parents. *Journal of Technology in Human Services*, *37*(4), 362–394. https://doi.org/10.1080/15228835.2019.1666781

Gigengack, M. R., Hein, I. M., Lindeboom, R., & Lindauer, R. J. (2017). Increasing resource parents' sensitivity towards child posttraumatic stress symptoms: A descriptive study on a trauma-informed resource parent training. *Journal of Child & Adolescent Trauma*, *12*(1), 23 – 29. https://doi.org/10.1007/s40652-017-0162-z

Harwood, R., Feng, X., & Yu, S. (2013). Preadoption adversities and postadoption mediators of mental health and school outcomes among international, foster, and private adoptees in the United States. *Journal of Family Psychology*, *27*, 409 – 420. http://dx.doi.org/10.1037/a0032908

Health Resources and Services Administration. (n.d.). *Maternal and Child Health Bureau*. https://mchb.hrsa.gov/

Henry, J., Sloane, M., & Black-Pond, C. (2007). Neurobiology and neurodevelopmental impact of childhood traumatic stress and prenatal alcohol exposure. *Language, Speech, and Hearing Services in Schools, 38*, 99–108. http://dx.doi.org/10.1044/0161-1461(2007/010)

Hughes, N., Williams, H., & Chitsabesan, P. (2017). Chapter 5 The Influence of Neurodevelopmental Impairment on Youth Crime. In *Forensic child and adolescent mental health: meeting the needs of young offenders*. essay, Cambridge University Press.

Jackson, Y., Gabrielli, J., Tunno, A. M., & Hambrick, E. P. (2012). Strategies for longitudinal research with youth in Foster Care: A Demonstration of methods, barriers, and Innovations. *Children and Youth Services Review*, *34*(7), 1208–1213. https://doi.org/10.1016/j.childyouth.2012.02.007

Jones, A. S., Rittner, B., & Affronti, M. (2016). Foster parent strategies to support the functional Adaptation of foster youth. Journal of Public Child Welfare, 10:3, 255-273. https://doi.org/10.1080/15548732.2016.1148092

Leslie, L. K., Gordon, J. N., Lambros, K., Premji, K., Peoples, J., & Gist, K. (2005). Addressing the Developmental and Mental Health Needs of Young Children in Foster Care. Journal of Developmental & Behavioral Pediatrics, 26(2), 140–151. https://doi.org/10.1097/00004703-200504000-00011

Maaskant, A. M., Rooij, F. B. V., Overbeek, G. J., Oort, F. J., & Hermanns, J. M. (2016). Parent training in foster families with children with behavior problems: Follow-up results from a randomized controlled trial. *Children and Youth Services Review*, *70*, 84–94. https://doi.org/10.1016/j.childyouth.2016.09.005

Marsac, M. L., Kassam-Adams, N., Hildenbrand, A. K., Nicholls, E., Winston, F. K., Leff, S. S., & Fein, J. (2016). Implementing a trauma-informed approach in Pediatric Health Care Networks. *JAMA Pediatrics*, *170*(1), 70. https://doi.org/10.1001/jamapediatrics.2015.2206

Mishra, A. A., Schwab-Reese, L. M., & Murfree, L. V. (2020). Adverse childhood experiences associated with children's patterns of out of home placement over time and subsequent negative outcomes during adolescence. Child & Youth Care Forum, 49, 247–263. https://www.doi.org/10.1007/ s10566-019-09526-4

Murray, K. (2014). *Psychometric Properties of the resource parent knowledge and beliefs survey* (Unpublished manuscript). Center for Child and Family Health, Durham, NC.

Murray, K. J., Sullivan, K. M., Lent, M. C., Chaplo, S. D., & Tunno, A. M. (2019). Promoting trauma-informed parenting of children in out-of-home care: An effectiveness study of the resource parent curriculum. *Psychological Services*, *16*(1), 162–169. https://doi.org/10.1037/ser0000324

The National Child Traumatic Stress Network. (2021). *Trauma-informed Organizational Assessment*. Retrieved from https://www.nctsn.org/trauma-informed-care/nctsn-trauma-informed-organizational-assessment

The National Child Traumatic Stress Network. (2020). *Child welfare trauma training toolkit*. Retrieved from https://www.nctsn.org/resources/child-welfare-trauma-training-toolkit

The National Child Traumatic Stress Network. (2010). *Resource Parenting Curriculum.* Retrieved from https://learn.nctsn.org/course/view.php?id=67§ion=1.

Putnam, F. W. (2006). *Impact of Trauma on Early Brain Development*. Lecture presented at National Child Traumatic Stress Network.

Razuri, E. B., Howard, A. R. H., Parris, S. R., Call, C. D., Deluna, J. H., Hall, J. S., Purvis, K. B., Cross, D. R. (2015). Decrease in Behavioral Problems and Trauma Symptoms Among At-Risk Adopted Children Following Web-Based Trauma-Informed Parent Training Intervention. *Journal of Evidence-Informed Social Work*, *13*(2), 165–178. https://doi.org/10.1080/23761407.2015.1014123

Rosswurm, M. A., & Larrabee, J. H. (1999). A model for change to evidence-based practice. Image: the Journal of Nursing Scholarship, 31(4), 317–322. https://doi.org/10.1111/j.1547-5069.1999.tb00510.x

Strolin-Goltzman, J., Mccrae, J., & Emery, T. (2018). Trauma-Informed Resource Parent Training and the Impact on Knowledge Acquisition, Parenting Self-Efficacy, and Child Behavior Outcomes: A Pilot of the Resource Parent Curriculum Parent Management Training (RPC+). Journal of Public Child Welfare, 12(2), 136–152. https://doi.org/10.1080/15548732.2017.1352555

Sullivan, K. M., Murray, K. J., & Ake, G. S., III. (2016). Trauma-informed care for children in the child welfare system: An initial evaluation of a trauma-informed parenting workshop. *Child Maltreatment, 21*, 147–155. http://dx.doi.org/10.1177/1077559515615961

The National Child Traumatic Stress Network (Organization Website). (2017). *Introduction to the Resource Parent Curriculum* [Film].

Tlapek, S. M., Auslander, W., Edmond, T., Gerke, D., Schrag, R. V., & Threlfall, J. (2017). The moderating role of resiliency on the negative effects of childhood abuse for adolescent girls involved in child welfare. *Children and Youth Services Review, 73*, 437–444. https://doi.org/10.1016/j.childyouth.2016.11.026

Weiss, T. C. (2013). Children with disabilities and foster care. Disabled World. https://www.disabled-world.com/disability/children/foster.php

Wojciak, A. S., Thompson, H. M., & Cooley, M. E. (2017). The relation- ship between caregivers and youth in foster care: Examining the relationship for mediation and moderation effects on youth behaviors. *Journal of Emotional and Behavioral Disorders, 25*, 96–106. http://dx.doi.org/10.1177/1063426616628816

Yetter, D. (2021, February 2). *Kentucky leads in child abuse for third year straight as poverty, drugs take toll on families*. Journal. Retrieved November 18, 2021, from https://www.courier-journal.com/story/news/local/2021/02/02/kentucky-leads-in-rate-of-child-abuse-third-straight-year/4311228001/.

Table 1

Resource Parent Demographic Data

Characteristic (*n*=4)	***n* (%)**
Age in years (mean)	52.75
Sex	
Male	1 (25%)
Female	3 (75%)
Race	
White/Caucasian	4 (100%)
Black/African American	0 (0%)
Asian	0 (0%)
Hispanic	0 (0%)
Native American	0 (0%)
Pacific Islander	0 (0%)
Length of time spent as a resource parent in years (mean)	6.47
Type of resource parents	
Therapeutic Foster Care Parent	4 (100%)
Adoptive Parent	0 (0%)
Kinship Caregiver	0 (0%)
Specialization with Medically Fragile Children	1 (25%)
Pre-licensed foster parent (no placements yet)	1 (25%)
# of children in home over the past year (mean)	2.5
# of children who could not be maintained in home due to behavior (mean)	1.25
# of current birth and non-birth children in the home (mean)	3

Table 2

Staff Demographic Data

Characteristic (*n*=4)	***n* (%)**
Age in years (mean)	38.5
Sex	
Male	1 (25%)
Female	3 (75%)
Race	
White/Caucasian	4 (100%)
Black/African American	0 (0%)
Asian	0 (0%)
Hispanic	0 (0%)
Native American	0 (0%)
Pacific Islander	0 (0%)
Length of time spent as a resource parent in years (mean)	N/A
Type of resource parents	
Therapeutic Foster Care Parent	N/A
Adoptive Parent	N/A
Kinship Caregiver	N/A
Specialization with Medically Fragile Children	N/A
Pre-licensed foster parent (no placements yet)	N/A
# of children in home over the past year (mean)	N/A
# of children who could not be maintained in home due to behavior (mean)	N/A
# of current birth and non-birth children in the home (mean)	N/A

Table 3

Resource Parent Statistical Data

Resource Parents (*n=4*)	Pre-Workshop Mean (*SD*)	Post-Workshop Mean (*SD*)	*t*	Sig. (*2-tailed*)	Cohen's D
Knowledge	9.00 *(1.15)*	9.75 *(.50)*	1.57	0.108	0.78
Trauma-Informed Parenting	5.00 *(0)*	5.75 *(.50)*	0.00	0.074	1.50
Tolerance of Misbehavior	4.75 *(.50)*	5.00 *(.81)*	0.00	0.500	1.00
Parenting Efficacy	5.15 *(.59)*	5.50 *(.60)*	1.50	0.293	0.48

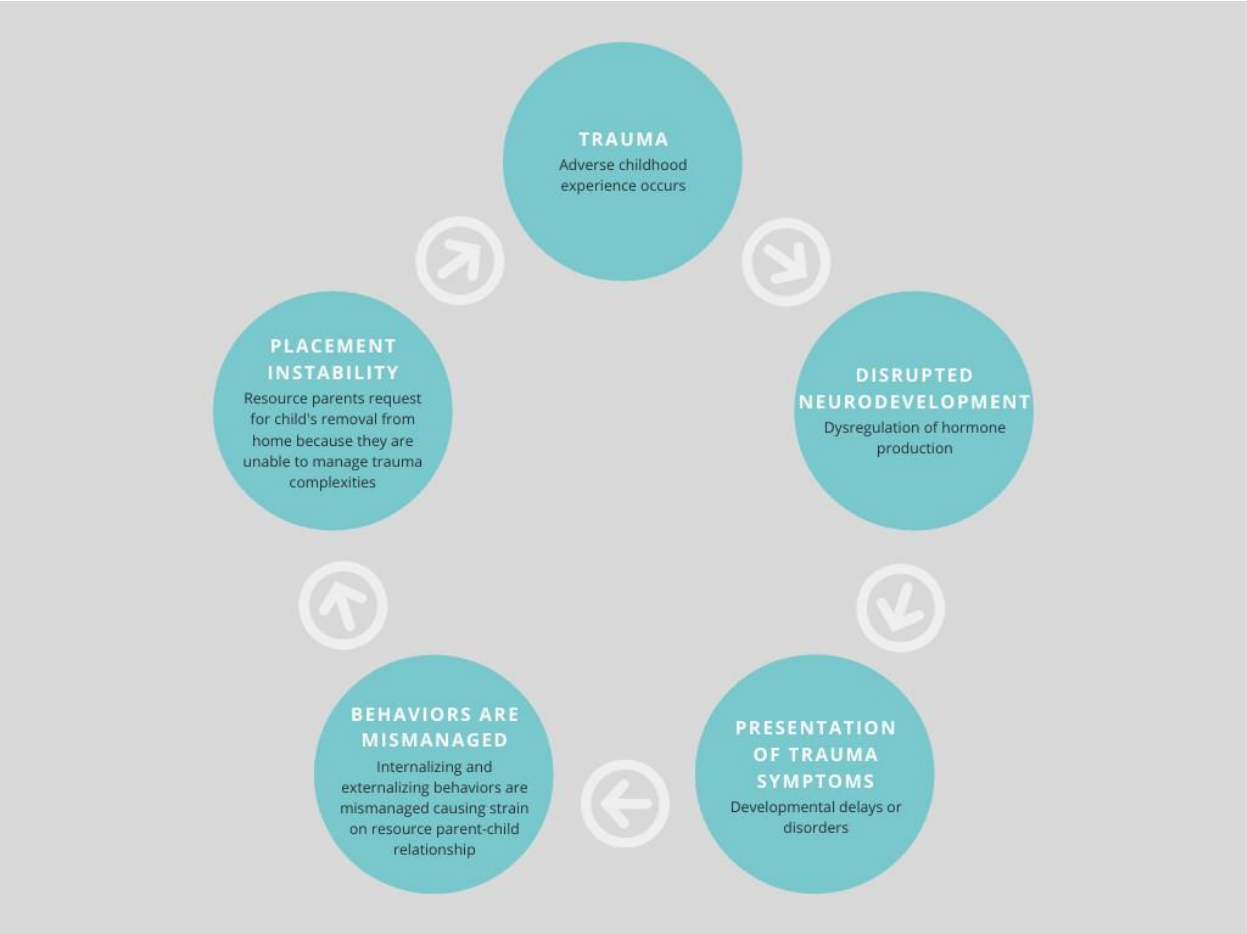
Table 4

Staff Statistical Data

Staff (*n=4*)	Pre-Workshop Mean (*SD*)	Post-Workshop Mean (*SD*)	*t*	Sig. (*2-tailed*)	Cohen's D
Knowledge	10 *(0)*	10 *(0)*	0.00	1.00	NaN
Trauma-Informed Parenting	5.50 *(.57)*	5.75 *(.50)*	0.00	0.500	.50
Tolerance of Misbehavior	4.75 *(.95)*	5.25 *(.50)*	0.00	0.173	0.86
Parenting Efficacy	4.50 *(1.11)*	5.31 *(.57)*	0.00	0.091	1.29

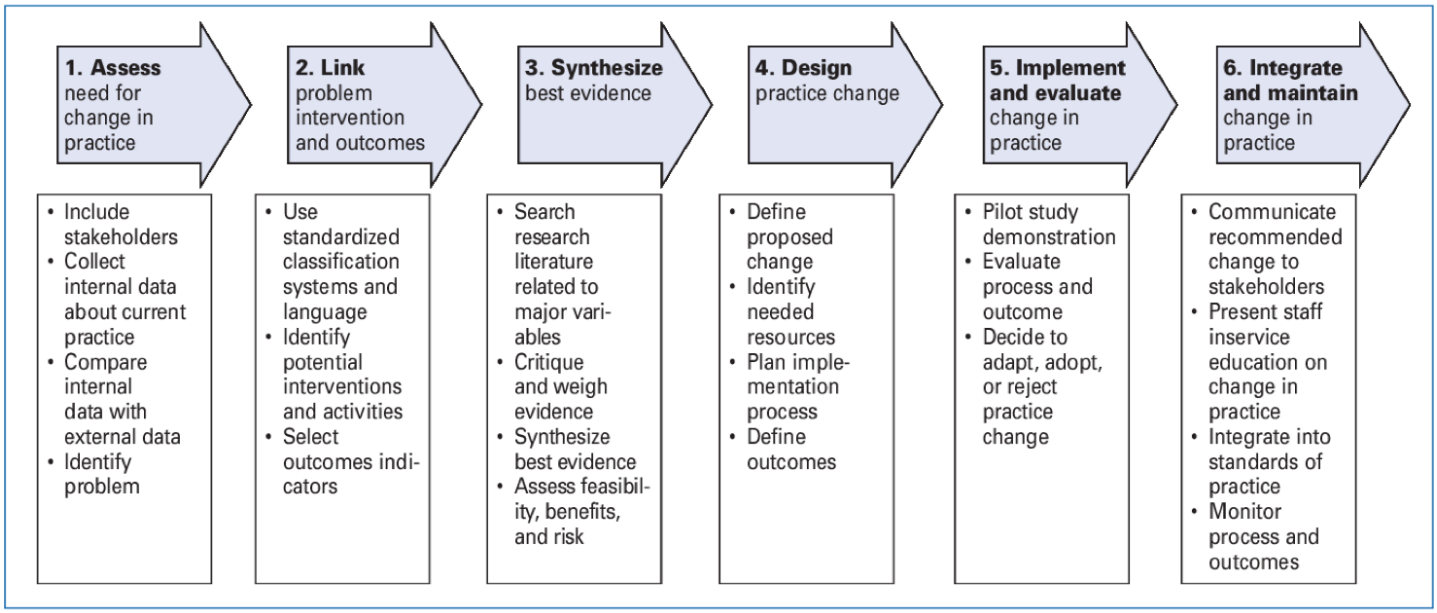
Appendix A

Cycle of Trauma in the Foster Care System



Appendix B

Rosswurm and Larabee's Theory for Change to Evidence-Based Practice Model



Appendix C

Letter of Approval

home of the innocents

October 19, 2021

Re: Courtney Albers, BSN, RN
Doctor of Nursing Practice Project

University of Louisville: School of Nursing,

Home of the Innocents is in support of the Doctor of Nursing Practice (DNP) project to improve trauma-informed parenting that will be completed at Home of the Innocents Therapeutic Loving Foster Care by University of Louisville School of Nursing DNP student Courtney Albers, BSN, RN. This letter is to provide permission for Courtney Albers to complete her DNP project, analyze the data, and present the findings using deidentified data. I understand that the DNP project proposal will be reviewed as a quality improvement project by the University of Louisville Institutional Review Board (IRB) prior to data collection.

Sincerely,

Claire Farabee

Claire Farabee, B.A.

QICC Project Manager, HIPAA Privacy Officer

Quality Improvement & Corporate Compliance

Gloria Berry

Gloria Berry, M.A., LMFT

Chief Quality & Compliance Officer

Quality Improvement & Corporate Compliance

1100 East Market Street | Louisville, KY 40206 | 502.596.1000 | homeoftheinnocents.org

Appendix D

Resource Parent Curriculum Knowledge Test

1. When is brain development complete?
   A. 4 – 5 years old
   B. 12 – 14 years old
   C. 18 years old
   D. Mid-20s

2. Which description best describes trauma in children?
   A. an emotional response to an adverse childhood experience
   B. affects 0.9% of the childhood population
   C. an event that likely did not occur as the child remembers it
   D. affects many children but does not impact/influence life

3. A child's reaction to trauma will vary depending on:
   A. age and development
   B. temperament
   C. trauma history
   D. all of the above

4. A response to trauma can include:
   A. Intrusions
   B. Avoidance
   C. Dissociation
   D. Physiological arousal
   E. All of the above

5. All children removed from their families have experienced some form of:
   A. physical abuse
   B. trauma
   C. starvation
   D. sexual abuse

6. Trauma can lead to:
   A. Developmental delays and disabilities
   B. Confusion about what is dangerous and who to go to for protection
   C. Difficulty imagining or planning the future
   D. all of the above

7. Resource parents can promote resilience by:
   A. Telling the child their trauma wasn't real
   B. Forcing the child to talk about trauma/trauma history
   C. Asking the child what he/she needs to feel safe
   D. Ignoring the child's conversations surrounding trauma

8. One way to cope with trauma reminders is to use the SOS skills. What does SOS stand for?
   A. **Stop (and take deep breaths), Orient (note physical responses), Seek help (using stress busters)**
   B. **S**tay away from any trauma reminders, remain **O**ptimistic, **S**cream at anyone or anything that reminds you of trauma
   C. **S**peak up, take an **O**ath not to be **S**cared anymore
   C. D. **S**eek attention (from caregiver), display **O**ppositional behaviors, **S**eek help (using stress busters)

9. Trauma shapes children's beliefs and expectations about:
   A. Themselves
   B. Adults who care for them
   C. The world in general
   D. all of the above

10. Resource parents must _____ in order to take care of their foster/adoptive child[ren].
    A. have experienced abuse previously
    B. take care of themselves (i.e., self-care)
    C. have the same background (i.e., race, sexual orientation, religion, etc.) as the child
    D. model perfect behavior

Appendix E

Resource Parent Knowledge and Beliefs Survey Permission for Use

Albers,Courtney Alicia
Tue 9/14/2021 5:30 PM
To: george.ake@duke.edu

Hello,

My name is Courtney Albers, and I am a Doctor of Nursing Practice (DNP) student at the University of Louisville. I am working on a quality improvement project to improve trauma-informed parenting for resource parents at foster care agencies in Louisville, KY. I plan to use the Resource Parent Curriculum (RPC) provided by the National Child Traumatic Stress Network and wanted to utilize the Resource Parent Knowledge and Beliefs survey (RPKBS). I noticed in some of your published literature that the survey is unpublished. I was wondering if I could obtain the RPKBS, and request permission to use it as a measurement tool in my project?

Thank you for your time,
Courtney Albers, BSN, RN
University of Louisville
School of Nursing DNP Student
Graduate Teaching Assistant
caalbe02@louisville.edu | (502)386-4488

KP

Kate Murray, Ph.D. <kate.murray@duke.edu>
Thu 9/16/2021 2:55 PM
To: Albers,Courtney Alicia
Cc: George Ake III, Ph.D. <george.ake@duke.edu>; Kelly Sullivan, Ph.D. <kelly.sullivan@duke.edu>

You don't often get email from kate.murray@duke.edu. Learn why this is important

CAUTION: This email originated from outside of our organization. Do not click links, open attachments, or respond unless you recognize the sender's email address and know the contents are safe.

Hi Courtney,
Tripp Ake passed along your request.
All of our measures are available through the Qualtrics link below. The survey asks you a few brief questions, and on the last page there are brief descriptions and pdfs of all of our measures. Here is the link:
https://duke.qualtrics.com/jfe/form/SV_8nUw8WaXXiE8flj

The data supporting the psychometrics of the most recent version is actually all in our most recent published article:
Murray, K. J., Sullivan, K. M., Lent, M. C., Chaplo, S. D., & Tunno, A. M. (2019). Promoting trauma-informed parenting of children in out-of-home care: An effectiveness study of the resource parent curriculum. *Psychological Services, 16*(1), 162–169. https://doi.org/10.1037/ser0000324

Please let us know if there is anything else we can be helpful with!
-Kate

--

Kate Murray, Ph.D.

Consulting Associate
Duke University Medical Center
Department of Psychiatry and Behavioral Sciences

Director of Post Adoption Support
Center for Child and Family Health
Phone: (919) 385-0781
Fax: (919) 419-9353
www.ccfhnc.org

Appendix F

Preamble

Improving Trauma-Informed Education and Parenting for Resource Parents at a Foster Care Agency

Dear Participant:

You are being invited to participate in a quality improvement project about improving trauma-informed education and parenting by answering questions in the attached surveys. The purpose of this project is improving knowledge, beliefs, and attitudes towards trauma-informed parenting through the implementation of a trauma-informed parenting educational workshop. This quality improvement project is conducted by Dr. Schirmer, Dr. Clark, and Courtney Albers of the University of Louisville. There are no known risks for your participation in this quality improvement project. The information collected may not benefit you directly. The information learned in this project may be helpful to others. The information you provide will be internally reviewed by the University of Louisville and Home of the Innocents. Your completed survey will be stored on Jotform or REDCap. The surveys will take approximately 30 minutes to complete.

Individuals from the School of Nursing, the Institutional Review Board (IRB), the Human Subjects Protection Program Office (HSPPO), and other regulatory agencies may inspect these records. In all other respects, however, the data will be held in confidence to the extent permitted by law. Should the data be published, your identity will not be disclosed.

Taking part in this quality improvement project is voluntary. By answering survey questions, you agree to take part in this quality improvement project. You do not have to answer any questions that make you uncomfortable. You may choose not to take part at all. If you decide to be in this quality improvement project you may stop taking part at any time. If you decide not to be in this project or if you stop taking part at any time, you will not lose any benefits for which you may qualify.

If you have any questions about your rights as a participant in a quality improvement project, you may call the Human Subjects Protection Program Office at (502) 852-5188. You can discuss any questions about your rights as a participant in a quality improvement project, in private, with a member of the Institutional Review Board (IRB). The IRB is an independent committee made up of people from the University community, staff of the institutions, as well as people from the community not connected with these institutions. The IRB has reviewed this quality improvement project.

If you have any questions, concerns, or complaints about the quality improvement project, please contact: Courtney Albers at (502)386-4488.

If you have concerns or complaints about the quality improvement project and you do not wish to give your name, you may call 1-877-852-1167. This is a 24-hour hot line answered by people who do not work at the University of Louisville.

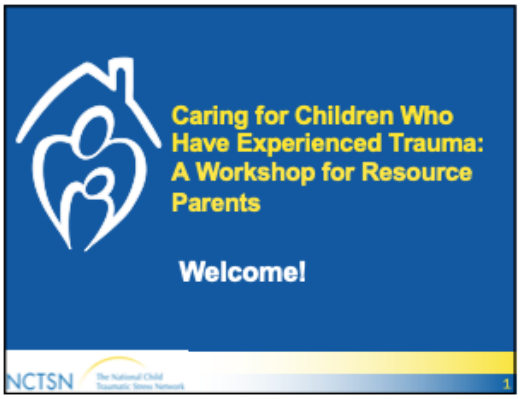
Sincerely,

Courtney Albers, BSN, RN

Version Date: 11-20-21

Appendix G

Workshop PowerPoint Slides



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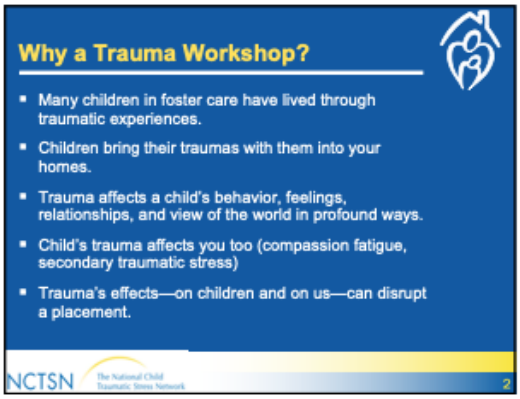

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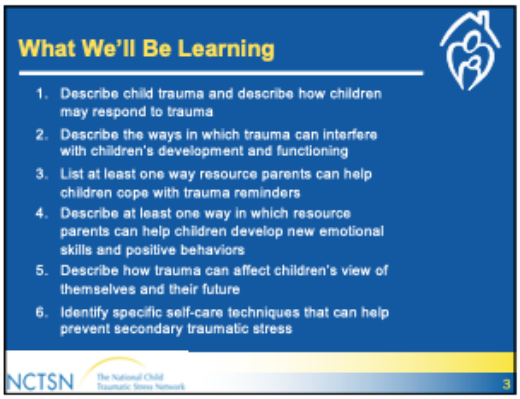

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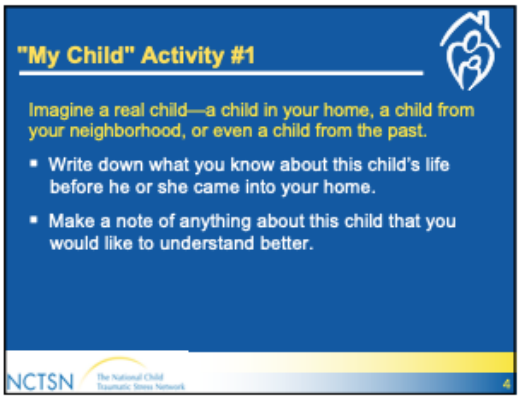

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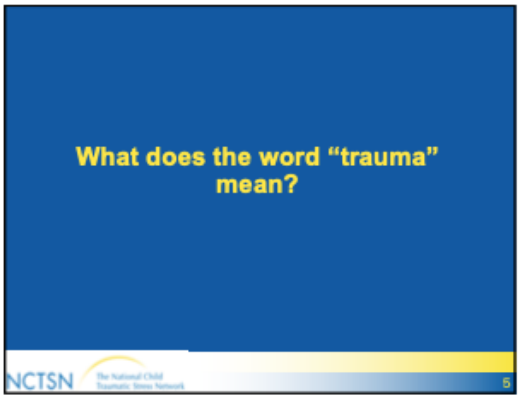

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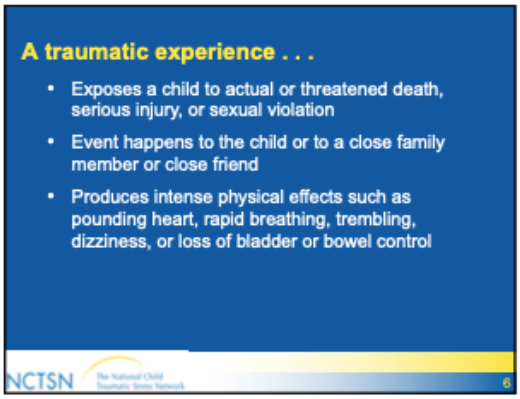

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Types of Trauma
Acute trauma: A single event that lasts for a limited time
Chronic trauma: The experience of multiple traumatic events, often over a long period of time
Complex trauma: Multiple traumatic events that begin at a very young age caused by adults who should have been caring for and protecting the child
NCTSN
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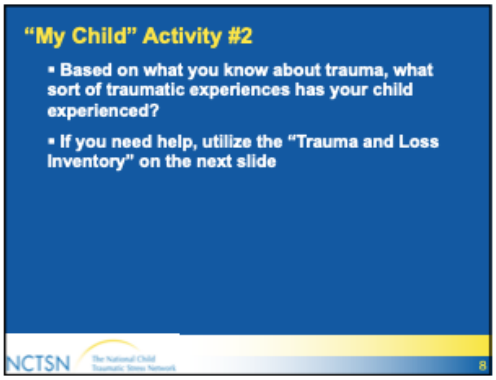
"My Child" Activity #2
Based on what you know about trauma, what sort of traumatic experiences has your child experienced?
If you need help, utilize the "Trauma and Loss Inventory" on the next slide
NCTSN
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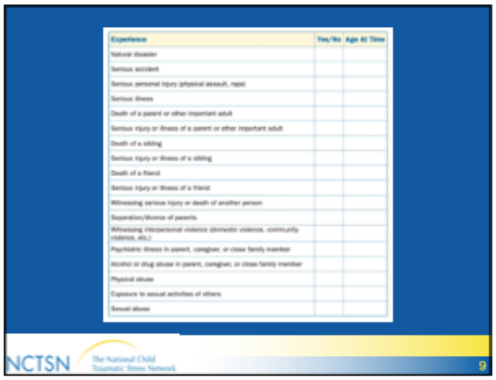
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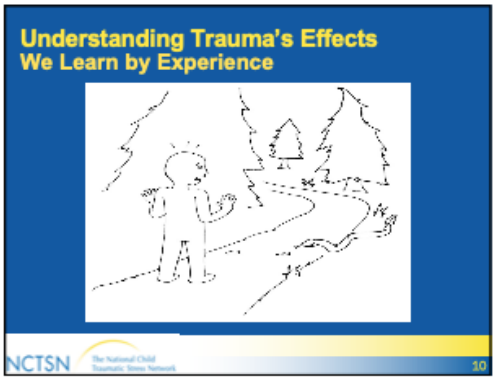
Understanding Trauma's Effects
We Learn by Experience
NCTSN
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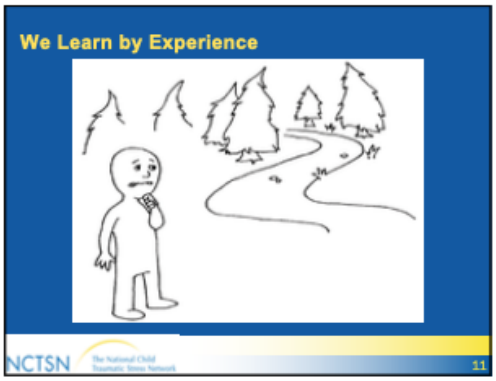
We Learn by Experience
NCTSN
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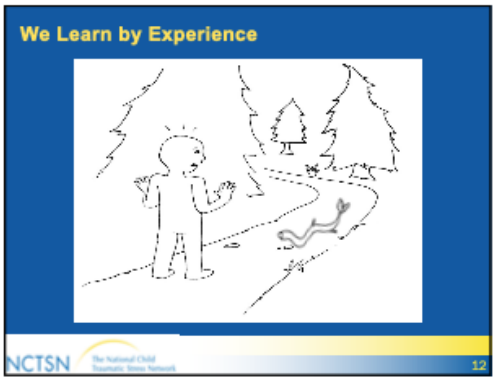
We Learn by Experience
NCTSN
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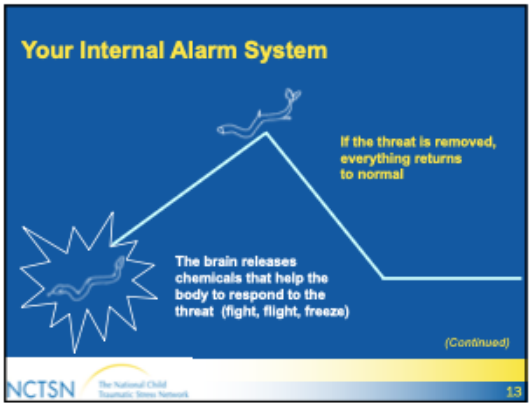

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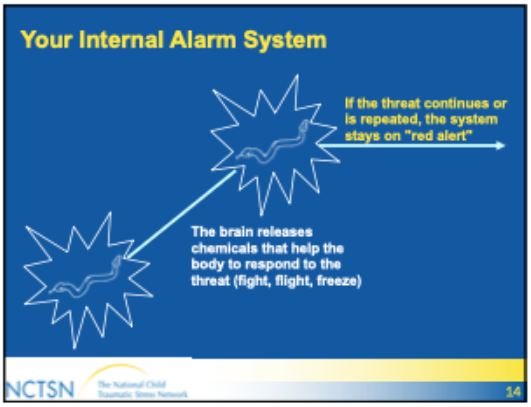

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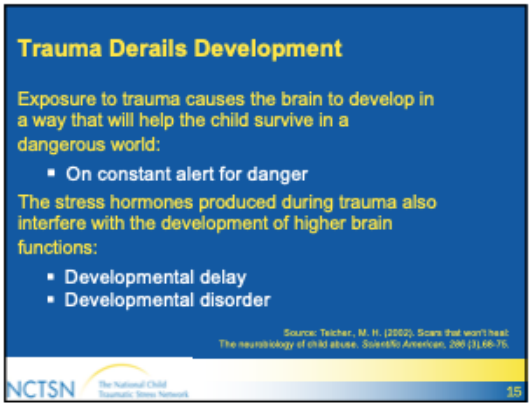

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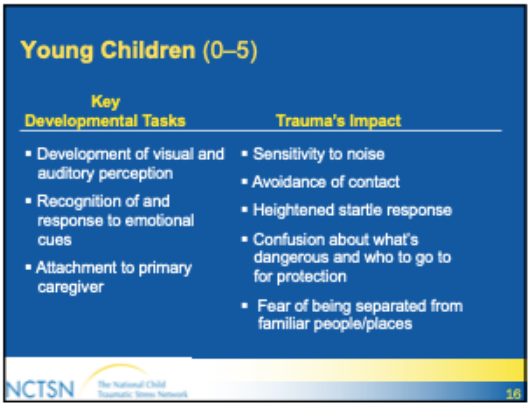

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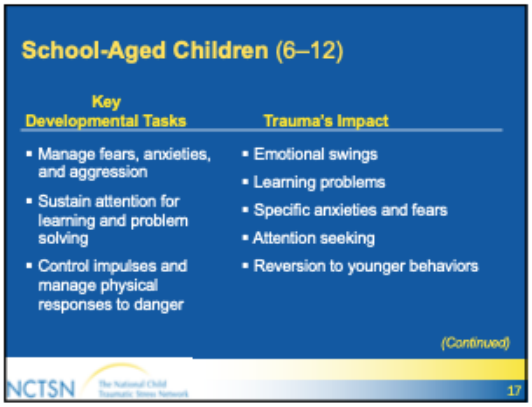

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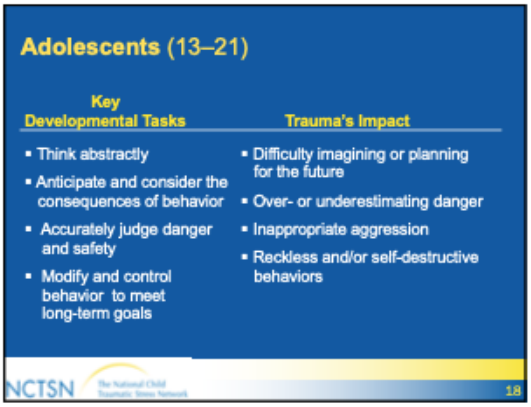

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Trauma Reminders & Responses

Trauma reminders:

- Things, events, situations, places, sensations, and even people that a child connects with a traumatic event

NCTSN 19

19

"My Child" Activity #2 (continued)

- Reflect on your child's trauma and losses
- Think about some possible trauma reminders for your child.
- If you can't identify any right now, the next time your child has a reaction, make note of when, where, and to what
  - These may be useful observations to share with child's caseworker and/or therapist

NCTSN 20

20

A child's reactions to trauma will vary depending on:

- Age and developmental stage
- Temperament
- Perception of the danger faced
- Trauma history (cumulative effects)
- Adversities faced following the trauma
- Availability of adults who can offer help, reassurance, and protection

NCTSN 21

21

How Children Respond to Trauma

Changes in physiological arousal level and reactivity:

- On alert for danger
- Quickness to startle
- Irritability/anger
- Reckless & self-destructive behavior
- Sleep or concentration problems
- In young children, more intense and/or more frequent temper tantrums

NCTSN 22

22

How Children Respond to Trauma

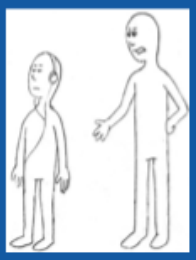
Intrusions in Daily Life:

- Intrusive images, sensations, dreams
- Intrusive memories of the traumatic event or events
- In young children, repetitive or re-enactment in play

NCTSN 23

23

How Children Respond to Trauma



Avoidance:

- Avoiding people, places, or things that prompt memories of the trauma
- Trying not to have thoughts, feelings, or memories about the trauma

NCTSN 24

24

How Children Respond to Trauma

Dissociation:

- Disconnecting from present surroundings and appears to withdraw internally or completely "space out"

NCTSN 25

25

I don't think there was a time when I wasn't abused as a child. In order to survive the abuse, I made believe that the real me was separate from my body. That way, the abuse was happening not really to me, but just this skin I'm in.

—C. M.

My body betrayed me. *Represent*. Sept/Oct. 2003. Available at http://www.youthcomm.org/FCYU-Features/SeptOct2003/FCYU-2003-09-24.htm

NCTSN 26

26

What you might see:

- Changes in thoughts and mood
  - Emotional instability (moody, sad, or angry and aggressive)
  - Trouble remembering
  - Pulling away from activities and relationships, including play
  - Problems concentrating, learning, or taking in new information
- Age-inappropriate behaviors (reacting like a much younger child)
- Traumatic Play
- Difficulty going to sleep or staying asleep, nightmares

NCTSN 27

27

My Child Activity #2 (continued)

- Describe the reactions you've observed from your child during a trauma reminder. What reaction do you see?

NCTSN 28

28

Coping with Trauma Reminders: What Children Can Do

- Stop
  - Stop and take several long, deep breaths
- Orient
  - Look around and take in immediate surroundings
  - Make note of physical reactions
- Seek Help
  - Use a "stress buster" to help calm down
  - If needed, call a trusted friend or reliable adult

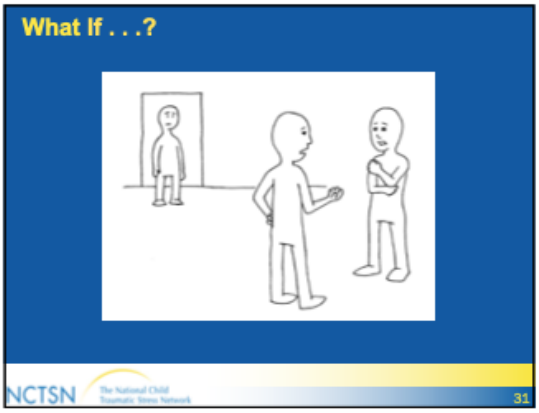
NCTSN 29

29

Let's take a break!

NCTSN 30

30



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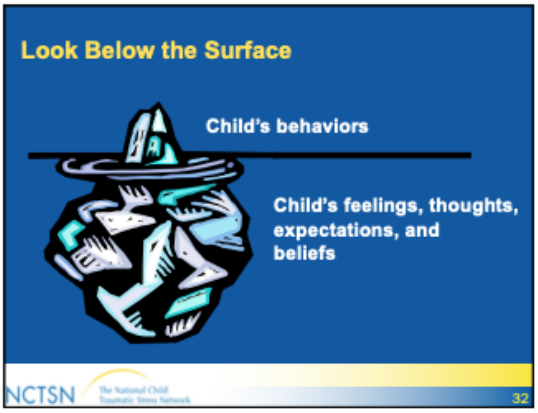

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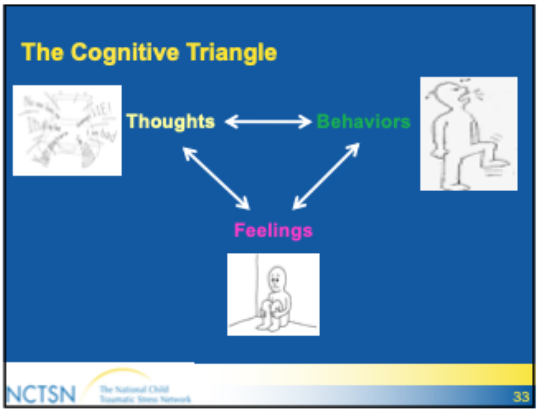

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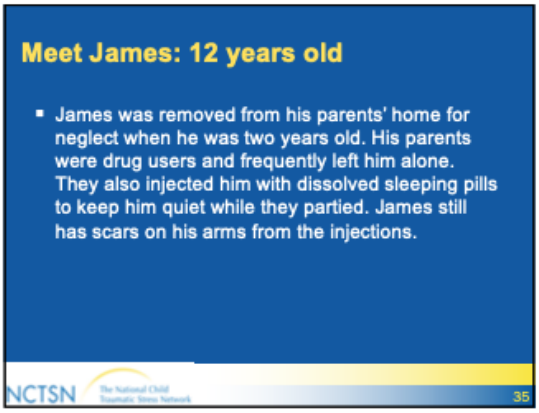

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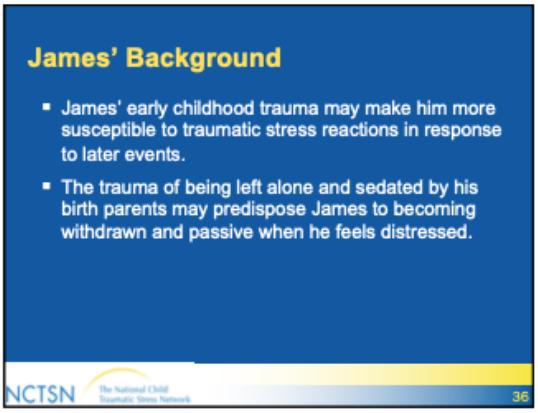

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The Invisible Suitcase

Trauma shapes children's beliefs and expectations:

- About themselves
- About the adults who care for them
- About the world in general

NCTSN 37

37

The Invisible Suitcase: James (12 years old)

NCTSN 38

38

My Child Worksheet #3

What's in the Suitcase?

- Write down what you think might be in your child's "invisible suitcase." Be sure to include:
  - Beliefs and expectations about him- or herself
  - Beliefs and expectations about you and other caregivers
  - Beliefs and expectations about the world

NCTSN 39

39

When supper was over, I saw that there were many biscuits piled high upon the bread platter, an astonishing and unbelievable sight to me. . . .

I was afraid that somehow the biscuits might disappear during the night, while I was sleeping. I did not want to wake up in the morning, . . . feeling hungry and knowing that there was no food in the house. So, surreptitiously I took some of the biscuits from the platter and slipped them into my pocket, not to eat, but to keep as a bulwark against any possible attack of hunger. . .

I did not break the habit of stealing and hoarding bread until my faith that food would be forthcoming at each meal had been somewhat established.

—Richard Wright

Wright, R. (1945). *Black boy*. NY: HarperCollins Publishers, Inc.

NCTSN 40

40

I woke up in a panic. I couldn't stay asleep. [My foster mother] came into my room. "Honey, what's wrong?"

I couldn't even tell her how I felt. I couldn't get the words out to say what was the matter.

—A. M.

Learning to love again. *Represent* July/Aug 2006. Available at http://www.youthcomm.org/FCYU-Features/JulyAug2006/2006-07-04b.htm

NCTSN 41

41

Trauma and the Triangle

Children may act out as a way of:

- Reenacting patterns or relationships from the past
- Increasing interaction, even if the interactions are negative
- Keeping caregivers at a physical or emotional distance
- "Proving" the beliefs in their Invisible Suitcase
- Venting frustration, anger, or anxiety
- Protecting themselves

NCTSN 42

42

Recovering from Trauma:

- Resilience is the ability to recover from traumatic events.
- Children who are resilient see themselves as:
  - Safe
  - Capable
  - Lovable

NCTSN 43

43

Just as despair can come to one only from other human beings, hope, too, can be given to one only by other human beings.

—Elie Wiesel
Author, activist, and Holocaust survivor

NCTSN 44

44

What Trauma-Informed Parenting Can Do:

When we protect them from harm. . .

. . . children learn that the world is safe.

When we support, nurture, and respond to them. . .

. . . children learn that they are capable.

When we give them affection and love . . .

. . . children learn that they are lovable.

NCTSN 45

45

"Repacking" the Suitcase

- How can we "repack" this suitcase with positive experiences and beliefs?
- How can we promote resilience in this child by making him or her feel:
  - Safe?
  - Capable?
  - Lovable?

NCTSN 46

46

My Child Activity #4

Safety Message

- "I want you to feel safe. What do you need to feel safe?"

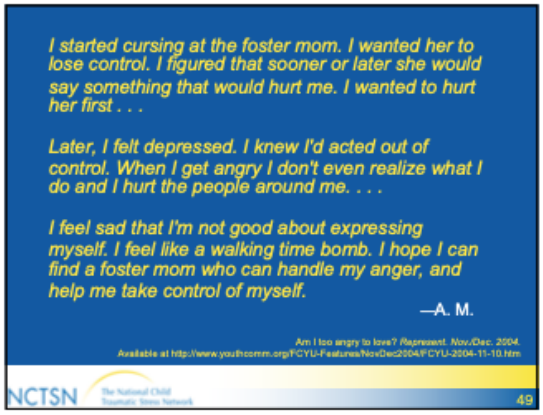
NCTSN 47

47

Be an "Emotional Container"

NCTSN 48

48



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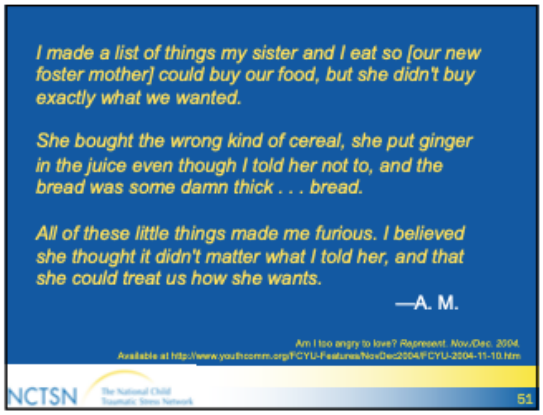

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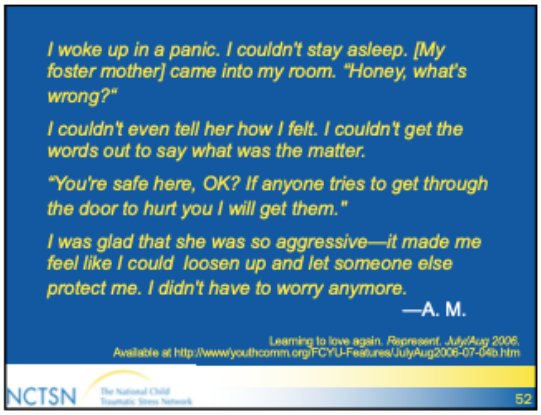

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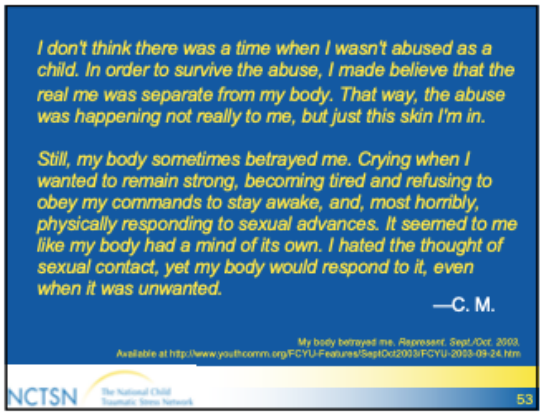

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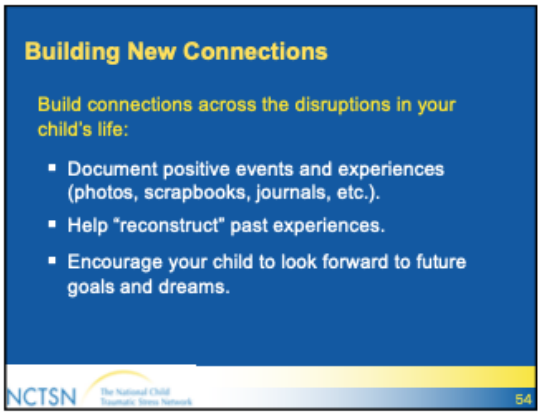

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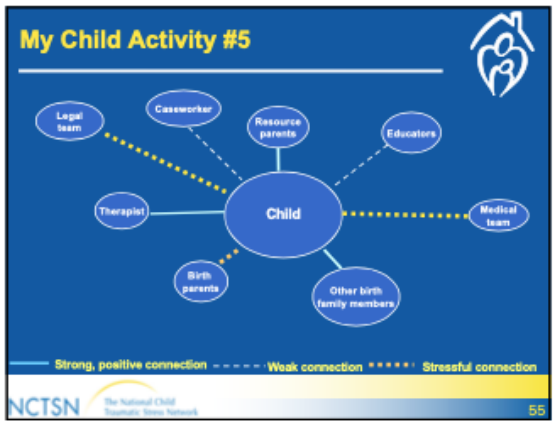

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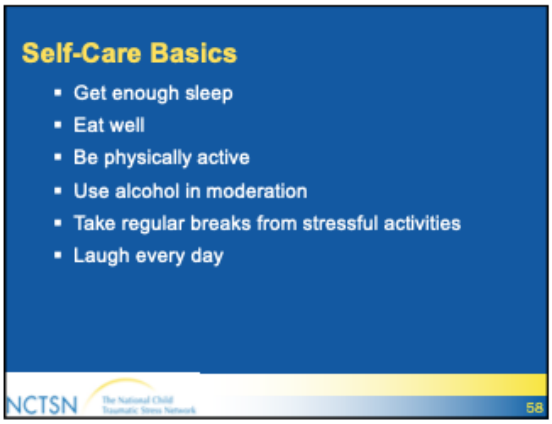

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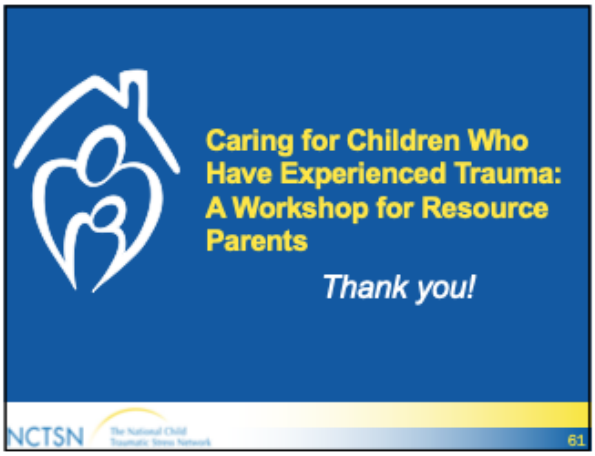

Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents
Thank you!
NCTSN
61

61

Appendix H

"My Child" Activity Worksheets

1

NCTSN The National Child Traumatic Stress Network

"My Child" Worksheet

2

"My Child" Activity #1
What I know about my child's life before coming into my home
What I'd like to know

3

"My Child" Activity #2
My child's traumas and losses (use "trauma and loss inventory")
My child's trauma reminders
My child's trauma reactions

4

"My Child" Activity #3
My child's "invisible suitcase"
Beliefs about self Beliefs about caregivers Beliefs about the world

5

"My Child" Activity #4
Repacking my child's "invisible suitcase"
My safety message to my child My child's emotional hot spots Ways I can manage my child's emotional hot spots by being an "emotional container"

6

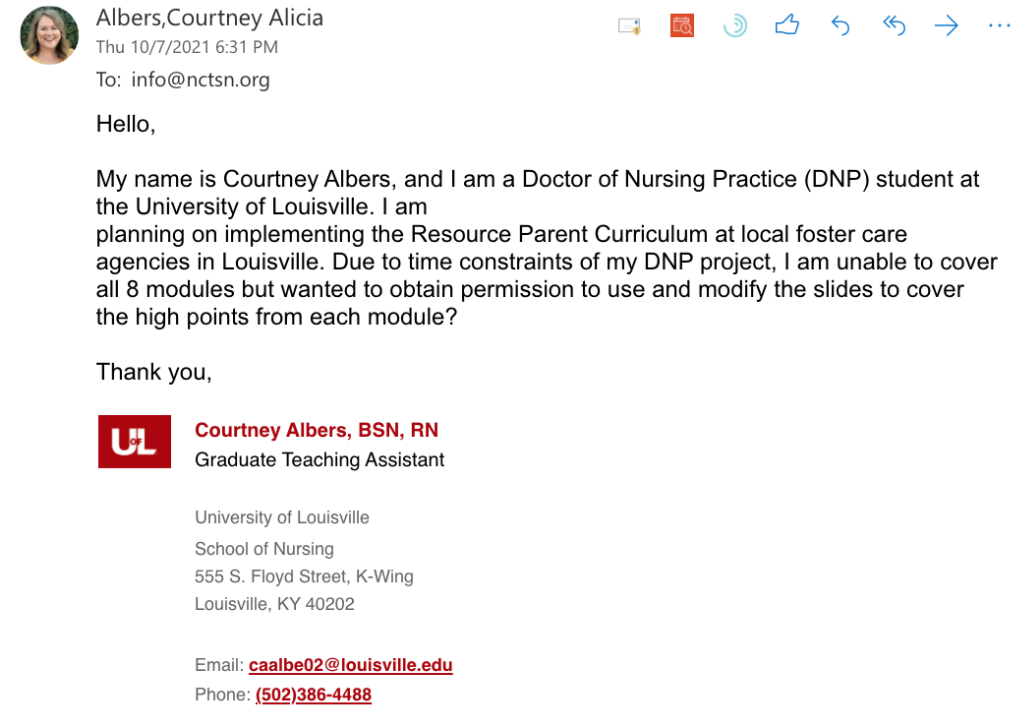
My Child Activity #5		
My child's connections		
Name	Role in my child's life	Type of connection
Steps I can take to help my child build connections across the disruptions in his or her life		

7

"My Child" Activity #6
Implement trauma-informed parenting

Appendix I

Resource Parent Curriculum Permission for Use and Modification



Albers,Courtney Alicia
Thu 10/7/2021 6:31 PM
To: info@nctsn.org

Hello,

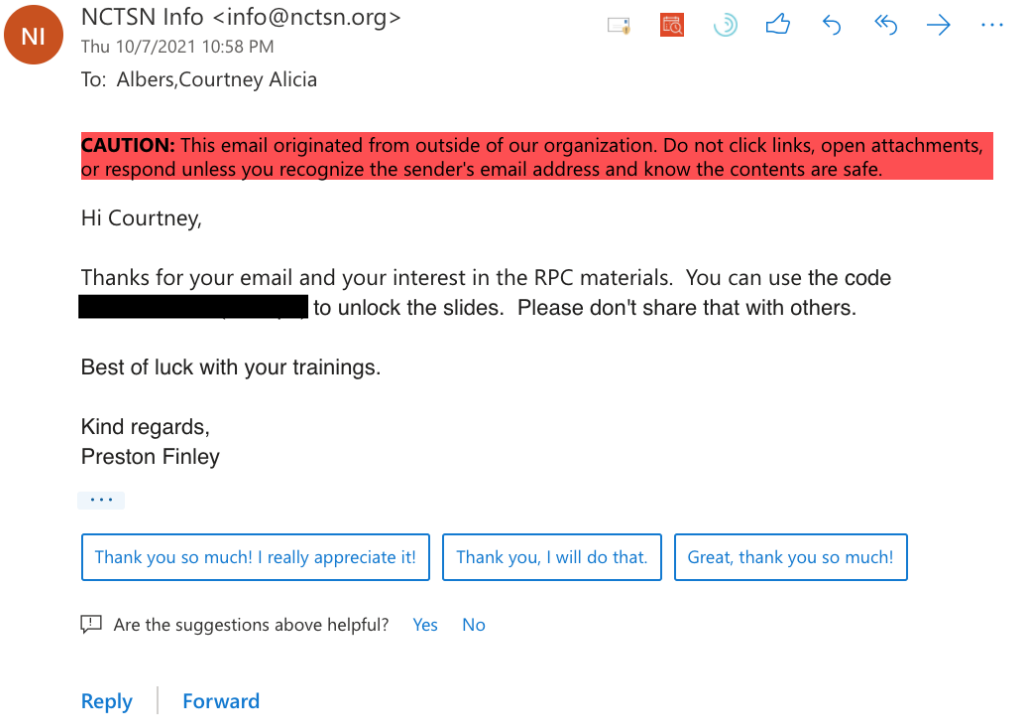
My name is Courtney Albers, and I am a Doctor of Nursing Practice (DNP) student at the University of Louisville. I am
planning on implementing the Resource Parent Curriculum at local foster care agencies in Louisville. Due to time constraints of my DNP project, I am unable to cover all 8 modules but wanted to obtain permission to use and modify the slides to cover the high points from each module?

Thank you,

Courtney Albers, BSN, RN
Graduate Teaching Assistant

University of Louisville
School of Nursing
555 S. Floyd Street, K-Wing
Louisville, KY 40202

Email: caalbe02@louisville.edu
Phone: (502)386-4488



NCTSN Info <info@nctsn.org>
Thu 10/7/2021 10:58 PM
To: Albers,Courtney Alicia

CAUTION: This email originated from outside of our organization. Do not click links, open attachments, or respond unless you recognize the sender's email address and know the contents are safe.

Hi Courtney,

Thanks for your email and your interest in the RPC materials. You can use the code [redacted] to unlock the slides. Please don't share that with others.

Best of luck with your trainings.

Kind regards,
Preston Finley

Thank you so much! I really appreciate it! | Thank you, I will do that. | Great, thank you so much!

Are the suggestions above helpful? Yes No

Reply | Forward

Appendix J

Learning Objectives

1. Describe child trauma and describe how children may respond to trauma
2. Describe the ways in which trauma can interfere with children's development and functioning
3. List at least one way resource parents can help children cope with trauma reminders
4. Describe at least one way in which resource parents can help children develop new emotional skills and positive behaviors
5. Describe how trauma can affect children's view of themselves and their future
6. Identify specific self-care techniques that can help prevent secondary traumatic stress

Appendix K

Demographics Survey

Age	_____
Gender	Male Female Transgender Other, specify _____ I prefer not to say
Race/Ethnicity	White/Caucasian African American/Black Asian Hispanic Native American Pacific Islander Other, specify _____
Length of time spent as a resource parent	_____ days/weeks/months/years
Type of Resource Parent (select all that apply)	Therapeutic Foster Care Parent Adoptive Parent Kinship Caregiver Pre-licensed foster parent (child has not been placed in home yet) Specialization with Medically Fragile Children Other, specify _____
Number of children in home over the past year	_____
Number of children who could not be maintained in home due to behavior	_____
Information on current birth and non-birth children in the home	**Age _____** **Gender:** Male Female Transgender Other, specify _____ I prefer not to say **Race/Ethnicity:** White/Caucasian African American/Black Asian Hispanic Native American Pacific Islander Other, specify _____

	Placement Status: Foster Adoptive Kinship Other, specify _____

Appendix L

Resource Parent Knowledge and Beliefs Pre-Workshop Survey

NCTSN The National Child Traumatic Stress Network

Caring for Children Who Have Experienced Trauma:
A Workshop for Resource Parents

Pre-Workshop Knowledge and Beliefs Survey:

We'd like to know a little about your experiences being a parent of non-biological children (adoptive, foster, or born to a relative, also known as a "resource parent"). There are no right answers; we are only interested in your honest thoughts and feelings.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. I understand how traumatic events can impact the way my child's brain works.	1	2	3	4	5	6
2. Almost all children who have been in foster care or institutions have experienced trauma.	1	2	3	4	5	6
3. I routinely think about how my child is physically safe in my home, but might not feel safe.	1	2	3	4	5	6
4. I routinely tell others (teachers, caseworkers, etc.) about my child's traumatic stress symptoms so they can respond more effectively to my child.	1	2	3	4	5	6
5. An important part of my role as a parent is to identify trauma reminders in my child's life.	1	2	3	4	5	6
6. My child's past experiences impact how I respond to his or her misbehavior.	1	2	3	4	5	6
7. Doing things for myself is an important part of being a good parent.	1	2	3	4	5	6
8. Praises and rewards should outnumber commands and consequences.	1	2	3	4	5	6
9. It is important for me to have a relationship with my child's therapist.	1	2	3	4	5	6
10. There is always a reason for misbehavior.	1	2	3	4	5	6
11. I feel confident talking with my child about his/her feelings about his/her biological parent(s).	1	2	3	4	5	6
12. Bedtimes and mealtimes are stressful for children who have been in foster care.	1	2	3	4	5	6
13. When I think about my child's birth mother, I feel sorry for her because I bet she had a bad childhood too.	1	2	3	4	5	6
14. I feel confident about my ability to handle challenging behaviors.	1	2	3	4	5	6
15. I think defiant kids need to be praised more.	1	2	3	4	5	6

Updated 5/12/2014 Sullivan, K., Murray, K., Kane, N., & Ake, G. (2014).

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
16. I feel confident speaking up for my child's trauma-specific needs with my child's school or daycare.	1	2	3	4	5	6
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.	1	2	3	4	5	6
18. I feel like I have the skills to help my child heal.	1	2	3	4	5	6
19. I know strategies to help my child express a variety of emotions.	1	2	3	4	5	6
20. It is easy for me to think about the strengths my child has gained from his or her birth family.	1	2	3	4	5	6
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.	1	2	3	4	5	6
22. I know the kinds of questions to ask a therapist to determine if he or she is trauma-informed.	1	2	3	4	5	6
23. I know the warning signs of problems that can come from caring too much for others and not enough for myself.	1	2	3	4	5	6
24. I know what I should look for in a trauma-informed assessment for my child.	1	2	3	4	5	6
25. I can care for a child who lies about everything.	1	2	3	4	5	6
26. I can care for a child who rejects me.	1	2	3	4	5	6
27. I can care for a child who curses at me or says mean and hurtful things to me.	1	2	3	4	5	6
28. I can care for a child with inappropriate sexual behavior.	1	2	3	4	5	6
29. I feel sure of myself as a parent of a child who has experienced trauma.	1	2	3	4	5	6
30. I know I am doing a good job as a resource parent.	1	2	3	4	5	6
31. I know things about being a resource parent that would be helpful to other parents.	1	2	3	4	5	6
32. I can solve most problems between my child and me.	1	2	3	4	5	6
33. When things are going badly between my child and me, I keep trying until things begin to change.	1	2	3	4	5	6

Appendix M

Resource Parent Knowledge and Beliefs Post-Workshop Survey

NCTSN The National Child Traumatic Stress Network

Caring for Children Who Have Experienced Trauma:
A Workshop for Resource Parents

Post-Workshop Knowledge and Beliefs Survey:

We'd like to know a little about your experiences being a parent of non-biological children (adoptive, foster, or born to a relative, also known as a "resource parent"). There are no right answers; we are only interested in your honest thoughts and feelings.

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1. I understand how traumatic events can impact the way my child's brain works.	1	2	3	4	5	6
2. Almost all children who have been in foster care or institutions have experienced trauma.	1	2	3	4	5	6
3. I routinely think about how my child is physically safe in my home, but might not feel safe.	1	2	3	4	5	6
4. I routinely tell others (teachers, caseworkers, etc.) about my child's traumatic stress symptoms so they can respond more effectively to my child.	1	2	3	4	5	6
5. An important part of my role as a parent is to identify trauma reminders in my child's life.	1	2	3	4	5	6
6. My child's past experiences impact how I respond to his or her misbehavior.	1	2	3	4	5	6
7. Doing things for myself is an important part of being a good parent.	1	2	3	4	5	6
8. Praises and rewards should outnumber commands and consequences.	1	2	3	4	5	6
9. It is important for me to have a relationship with my child's therapist.	1	2	3	4	5	6
10. There is always a reason for misbehavior.	1	2	3	4	5	6
11. I feel confident talking with my child about his/her feelings about his/her biological parent(s).	1	2	3	4	5	6
12. Bedtimes and mealtimes are stressful for children who have been in foster care.	1	2	3	4	5	6
13. When I think about my child's birth mother, I feel sorry for her because I bet she had a bad childhood too.	1	2	3	4	5	6
14. I feel confident about my ability to handle challenging behaviors.	1	2	3	4	5	6
15. I think defiant kids need to be praised more.	1	2	3	4	5	6

Updated 5/12/2014 Sullivan, K., Murray, K., Kane, N., & Ake, G. (2014).

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
16. I feel confident speaking up for my child's trauma-specific needs with my child's school or daycare.	1	2	3	4	5	6
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.	1	2	3	4	5	6
18. I feel like I have the skills to help my child heal.	1	2	3	4	5	6
19. I know strategies to help my child express a variety of emotions.	1	2	3	4	5	6
20. It is easy for me to think about the strengths my child has gained from his or her birth family.	1	2	3	4	5	6
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.	1	2	3	4	5	6
22. I know the kinds of questions to ask a therapist to determine if he or she is trauma-informed.	1	2	3	4	5	6
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24. I know what I should look for in a trauma-informed assessment for my child.	1	2	3	4	5	6
25. I can care for a child who lies about everything.	1	2	3	4	5	6
26. I can care for a child who rejects me.	1	2	3	4	5	6
27. I can care for a child who curses at me or says mean and hurtful things to me.	1	2	3	4	5	6
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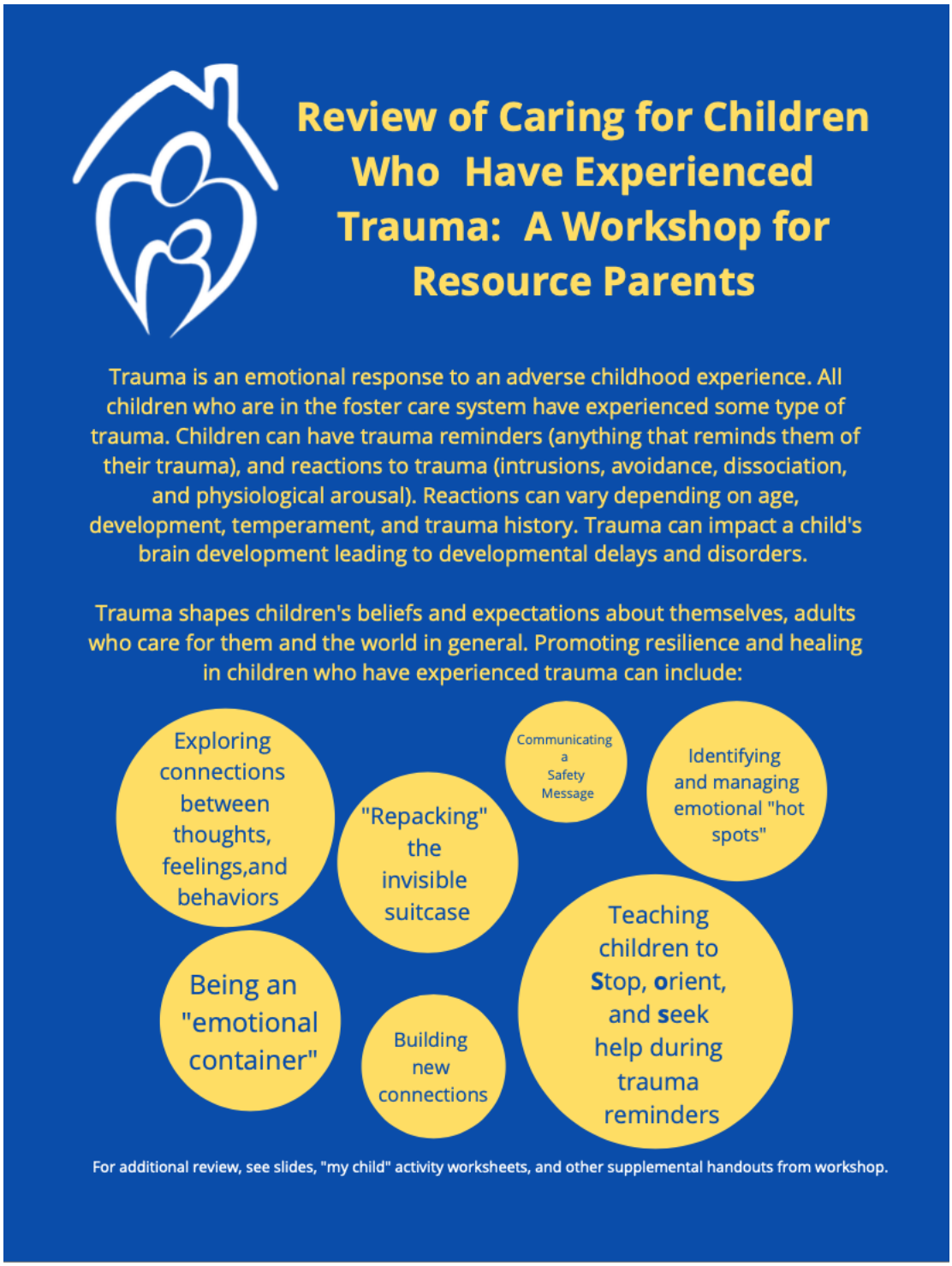
29. I feel sure of myself as a parent of a child who has experienced trauma.	1	2	3	4	5	6
30. I know I am doing a good job as a resource parent.	1	2	3	4	5	6
31. I know things about being a resource parent that would be helpful to other parents.	1	2	3	4	5	6
32. I can solve most problems between my child and me.	1	2	3	4	5	6
33. When things are going badly between my child and me, I keep trying until things begin to change.	1	2	3	4	5	6

Updated 5/12/2014 Sullivan, K., Murray, K., Kane, N., & Ake, G. (2014).

Appendix N

Booster Education Handout



Appendix O

Pledge of Confidentiality

home of the innocents

Home of the Innocents
Pledge of Confidentiality

I hereby pledge that I shall safeguard and treat as confidential all information (whether acquired through verbal communication, written record, electronic record, or observation) pertaining to any service recipient, relative or friend of any service recipient, staff member, any donor or volunteer of the Home of the Innocents, which I may, through my affiliation with Home of the Innocents, so acquire.

I pledge that I will not use any information relative to Home of the Innocents in a manner that would be damaging to the Home. I understand that this pledge of confidentiality extends beyond the term of employment and that should I improperly use confidential information obtained at the Home of the Innocents, the Home may take legal action against the misuse of confidential information.

I have read and understand the foregoing pledge of confidentiality.

Courtney Albers
Print Your Name

Courtney albers
Sign Your Name

10/19/2021
Today's Date