Fostering Resilience: A Study of Thriving in Therapeutic Foster Parents

by

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Dedication: This thesis is dedicated to the therapeutic foster parents of CCF, who open their homes to children in need.
Acknowledgments

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Preface

The conceptualization of this piece would not have been possible without the support and generosity of Michele Klimczak, director of Connecting Children and Families. One year ago, Ms. Klimczak appeared as a guest speaker in a Psychology course I took with Professor Charles Barber entitled “The Narratives of Illness and Recovery.” She spoke fervently of her work with children in the welfare system and the impact that past maltreatment and neglect could have on these children’s behaviors and overall development. She captivated the class and inspired my interest in child welfare and treatment for children with complex psychological and behavioral profiles. When I approached Ms. Klimczak and Professor Barber with inquiries about their work and how I might get involved, I was met with a warm welcome and given valuable time from their schedules to discuss and plan a study of therapeutic foster care and the Connecting Children and Families agency in particular.

That summer, I worked as a treatment provider for children with conduct disorder, ADHD or other pediatric psychopathology. I gained first-hand exposure to some of the difficulties of caring for children with complex behavior and a high level of need. A significant aspect of the program’s curriculum involved training for the children’s parents. Through my participation in that training, I became aware of the personal psychological impact that caring for a child with severe mental health challenges can have on parents.

When Ms. Klimczak and I met again to discuss the project later that summer, she shared with me her own experience as a foster parent and the many rewards and
challenges of the job. Based on her insight and passion, it became clear that the focus of the study should be on the foster parents, who not only face the difficult task of caring for children with past trauma and behavioral issues, but choose to do so. From there began the investigation of the therapeutic foster parents of Connecting Children and Families: an investigation of human will and compassion.
Introduction

The number of youth in foster care with behavioral and emotional problems has grown significantly in the last three decades (Chipungu & Bent-Goodley, 2004; Garland et al., 2001). Meanwhile, there is a shortage of foster parents who are willing and able to care for these children (Cox & Orme, 2002; U.S. Department of Health and Human Services [DHHS], 1993), and each year foster parents dropout at a rate as high as 50% (Pasztor & Wynne, 1995; Rhodes, Orme, & Buehler, 2001). The shortage of foster families puts a significant strain on the child welfare system. Caseworkers are often forced to place psychologically and behaviorally complex children with inexperienced foster families, which can lead to placement disruptions, the unplanned removal of a foster child from the home (Strijker, Knorth, & Knot-dickscheit, 2008), as well as foster parent dropout (Sinclair, Gibbs, & Wilson, 2004). When foster parents cease to continue fostering or request removal of a child from the home, there are significant negative consequences for the child’s well-being and development (Leathers, 2006; Oosterman, Schuengel, Wim Slot, Bullens, & Doreleijers, 2007; Rubin, O'Reilly, Luan, & Localio, 2007; Stovall & Dozier, 1998; Zima et al., 2000). Such consequences include decreased academic performance (Zima et al., 2000), exacerbated behavioral issues (Oosterman et al., 2007; Leathers, 2006), and higher risk for future disruptions in placement (Rubin et al., 2007).

Given the adverse consequences of placement disruption and foster parent dropout, there is a need to recruit and retain an increased number of foster parents willing and able to care for children with behavioral and emotional difficulties.
While past research has tended to focus on risk-factors in foster parents that may lead to attrition or requested removal of a child from the home (Oosterman et al., 2007), this study will take a strengths-based approach and examine the unique qualities of therapeutic foster parents—foster parents who specialize in caring for psychologically, behaviorally, or developmentally complex foster children—that contribute to their willingness and ability to foster difficult-to-place children.

**Therapeutic Foster Care**

Therapeutic Foster Care (TFC) is a home-based system of care for youth whose needs exceed those of children in traditional foster care. Children entering TFC homes typically do so for one of two reasons: as an alternative to residential treatment facilities or as a step toward reintegration into normative family life after time spent in a more restrictive setting (Bryant, 1981; Hudson, Nutter, & Galaway, 1994; McClung, 2000). Children in TFC may be of any age from early childhood through 21 years old and often present with a number of difficulties ranging from developmental delays and behavioral and emotional problems to diagnosed psychiatric disorders (Bryant, 1981; Garland et al., 2001). An essential feature of TFC is that the foster parents are considered the primary therapeutic source for the child. Therapeutic foster parents are regarded as professionals who offer ongoing treatment for the child (or children) in their care in a nurturing environment (Bryant, 1981; Dore & Mullin, 2006; Murphy & Callaghan, 1989).

**Challenges of Foster Parenting**

Foster parents face a number of challenges in their day-to-day roles as caregivers for traumatized and abandoned youth. In addition to performing the standard parenting duties of providing meals, clothing, transportation, and emotional support, foster
carers take on tasks specific to foster parenting such as attending court hearings, arranging of the child’s many medical appointments and mental health counseling sessions, seeing that the child gets proper academic attention, and scheduling visits with birth parents, social workers, mentors, and other supports (Chipungu & Bent-Goodley, 2004). When paired with the task of managing their foster children’s cognitive, emotional, and behavioral issues, this constant barrage of logistical demands can cause major disruptions in foster parents’ everyday routines and prior functioning; fostering is not only a significant time commitment, but can be a taxing experience, both emotionally and physically (Sinclair et al., 2004).

**Trouble with the system.** The challenges of foster parenting are not always a direct result of caregiving per se; many of the difficulties foster parents face are posed by the foster care system itself and/or the specific agency from which the foster parent receives services. Simply completing the pre-service training and licensing processes can be stressful and time-consuming, and many foster parents express discomfort with the excessive intrusion of social workers in their lives during initial home evaluations and screenings (Brown & Calder, 1999). Following placement of a foster child in the home, foster carers experience even more frequent intrusions from caseworkers or other agency staff. Some foster parents develop antagonistic relationships with the child’s caseworker, particularly with regard to disagreements about disciplinary strategies or plans for the child’s future (Sinclair et al., 2004). In addition, many foster parents express disappointment that the caseworkers are either very young or without prior parenting experience and that the caseworkers are often unhelpful in difficult situations (Sinclair et al., 2004). Parents also report feeling shut
out of the planning process; they are either bombarded by requests from social
workers to extend the stay of a child who was meant to be only a temporary
placement or, alternatively, are told that a child will be removed from the home
without advance notice. Another complaint concerns the lack of information received
regarding the child’s placement history, behavioral problems or experiences of abuse
(Brown & Calder, 1999). Foster parents receive minimal pay for the job they do and
often have to wait months to be reimbursed for certain expenses that the agency is
meant to cover. In the same vein, many foster parents report feeling undervalued for
the work they do, particularly by the social workers with whom they interact
(Chipungu & Bent-Goodley, 2004).

**Forming a bond.** As a primary caregiver to a foster child, establishing a
trusting relationship can be an arduous task. Virtually all children who enter the foster
care system have experienced some type of trauma in the form of abandonment,
abuse or neglect at the hands of past caregivers (DHHS, 2012), which often leads to
irregular patterns of attachment to subsequent caregivers. Many foster children
exhibit insecure or disorganized attachment styles, manifesting in clinginess and
acute anxiety [because of their concern for] [regarding] the potential for abandonment
or, alternatively, reluctance to seek help from caregivers and a general attitude of
mistrust toward others (McLean, Kettler, Delfabbro, & Riggs, 2012). According to
Bowlby’s (1973, 1980) attachment theory, children form attachments to caregivers in
infancy as an evolutionarily adaptive mechanism for survival. Children with primary
caregivers who are affectionate and available when the child is in need are classified
as “securely attached,” meaning they are confident in their caregiver’s ability to
protect them from harm and are thus able to freely explore their environment without fear (Ainsworth, Blehar, Waters, & Wall, 1978; Stovall & Dozier, 1998).

In the context of a maltreating environment, insecure (anxious) or disorganized (avoidant) patterns of attachment are adaptive; a child with a neglectful parent may need to display an inordinate amount of need by crying or clinging excessively to the caregiver who is otherwise non-responsive. Similarly, a child at risk for abuse may need to display a high amount of variation in his or her behavior toward a caregiver. Such a child will likely avoid the caregiver, thus guarding him or herself from the caregiver’s erratic behavior, but the child may also perform aggressive behaviors as a method of self-protection (Golding, 2003). Though these styles of attachment are highly adaptive in the setting in which they develop, the child’s avoidant, aggressive or overly needy behavior will likely become maladaptive when he or she is removed from the maltreating environment and placed into a foster care setting. In addition to causing the foster parent undue stress, these behaviors may serve to further disrupt the child’s access to a caregiver by giving the foster parent misleading cues regarding the child’s needs (Stovall & Dozier, 1998). A child who is intensely avoidant will likely withdraw from the caregiver when he or she is in need, leading the foster parent to overlook the child’s needs. By contrast, a child who clings incessantly may incite annoyance and stress in the foster parent, leading the parent to reject the child’s constant requests for attention. Thus, part of the challenge for a foster parent attempting to form a secure attachment with a maltreated child is that the child requires a type of responsiveness that is almost the opposite of the instinctual behavior a parent would perform in order to form a secure attachment with a non-
maltreated child (Chisholm, Carter, Ames, & Morison, 1995). While the parent of an overly clingy or demanding child would typically ignore a certain percentage of the child’s requests in order to teach the child to self-soothe, foster parents of insecurely attached, needy children may need to demonstrate to the child that they are a dependable source of care by responding diligently to all of the child’s many requests for attention. Similarly, though the parent of a child who exhibits aggressive or destructive behaviors would likely respond with hostility and punishment in order to teach the child right from wrong, foster parents of children who behave aggressively may need to respond to that behavior with nurturance and warmth, in order to demonstrate that the child is safe (Chisholm et al., 1995; Stovall & Dozier, 1998).

Though forming a bond with a foster child who has endured maltreatment is not an impossible feat, providing a nurturing and sensitive enough environment for a foster child to develop a healthy attachment style may require extraordinary insight, sensitivity, and commitment (Dozier, 2004; Stovall & Dozier, 1998).

**Foster children’s behavioral and emotional problems.** Early experiences of trauma and neglect can lead to the development of significant behavioral and emotional problems that extend beyond the behaviors or thoughts associated with insecure attachment. When children undergo early traumatic experiences in the form of abuse, neglect, or witnessing of domestic or community violence, the trauma triggers a chronic stress response that can negatively alter the child’s neurobiological, emotional, behavioral, cognitive, and interpersonal development (De Bellis, Hooper, & Sapia, 2005). Garland and colleagues (2001) reported that up to 80% of children in foster care exhibit clinically significant behavioral, emotional or developmental
difficulties. Externalizing (outwardly directed) health issues include aggressive behavior, attention problems, sexualized behavior, delinquent behavior, and social behavior problems (McCrae 2009). Internalizing (inwardly directed) mental health concerns include thought problems, depression, and anxious or withdrawn behavior.

A subset of children in foster care also suffer from Posttraumatic Stress Disorder (PTSD), which manifests in any of the aforementioned behavioral, cognitive and emotional problems in addition to high-risk or self-harming behaviors, substance abuse, suicidality, intrusive and recurrent traumatic memories or dreams, and feelings of detachment (Nelson Goff & Schwerdtfeger, 2004). In addition, children may show extreme avoidance of stimuli that serve as reminders of past trauma. For example, a child who was sexually abused in a bathroom may refuse to take showers or to change his or her clothing (Beers & De Bellis, 2002). Thus, not only are foster parents faced with the challenge of forming a bond with their child, but they must also learn to deal sensitively with their child’s past experiences of trauma and all of the ways in which these experiences manifest in their child’s current behavior.

**Retention and Disruption**

Given the highly demanding and challenging nature of foster parenting, it is perhaps unsurprising that the rate at which foster parents discontinue fostering is high, with dropout rates ranging from 30%-50% of foster parents each year (Pasztor & Wynne, 1995; Rhodes, Orme, & Buehler, 2001). The majority of research on placement disruption assesses risk factors for multiple placements or foster parent dropout (Oosterman et al., 2007). Such risk factors include a high number of foster children in the home, low income, or a history of past requests for foster child removal (Hernandez-Mekonnen, 2012). Qualitative studies in the field have found that foster
parents experience significant strain prior to withdrawing from the system or removing a child from the home (Khoo & Skoog, 2013). Sinclair and colleagues (2004) carried out a large-scale study of 944 foster parents documenting the impact of self-perceived strains of fostering on the decision to continue fostering. Foster parents reported strains resulting from a variety of factors related to their child’s behavioral problems as well as more systemic problems such as unavailability of their foster child’s caseworker. Other reported stressors included financial strains when children destroyed things, scheduling constraints when parents were required to stay home if their children were unable to attend school, and personal psychological strains when children were verbally abusive to caregivers or exhibited frequent symptoms of traumatic stress such as nightmares and tantrums. Certain parents also reported feeling useless or defeated, which was associated with the perception of not being able to help their foster child change (Sinclair et al., 2004).

**Strain and placement disruption.** One of the few longitudinal studies of foster parent factors that affect placement disruption examined the role of caregiver’s levels of strain on placement outcomes through assessments both at 3 months after placement and a follow-up interview one-year later. Farmer, Lipscombe, and Moyers (2005) measured foster parent strain by asking foster parents to self-report the level of strain that they perceived themselves to be under in addition to using clinical indicator of psychological strain—the General Health Questionnaire (GHQ). The researchers also used two measures to assess the severity of behavioral and emotional problems exhibited by the caregivers’ foster children. They asked caregivers to rate their child’s behavioral and emotional difficulties and then assessed the foster
children themselves using the same validated scale. One finding was that foster children’s behavioral and emotional problems were not directly associated with caregiver strain; however, foster parents who perceived that their foster children had more behavioral and emotional difficulties were under significantly higher levels of clinical and self-reported strain. The caregivers’ parenting abilities were also assessed both at the 3-month initial assessment and the one-year follow-up. Foster parents who scored in the clinical range on the GHQ showed a significant impairment in parenting abilities such as sensitivity, tolerance, ability to set limits, and willingness to engage and communicate with their child than parents who did not report a significant amount of strain. In addition, parents who reported feeling strain as a result of prior placement disruptions were more likely to feel strain at the start of their current placement, making them less able to employ useful parenting tactics. Higher disruption rates were also associated with the caregivers’ report of prior strain as a result of placement disruption.

Farmer and colleagues’ (2005) results would suggest evidence of a negative feedback cycle by which foster parents’ levels of strain lead to placement disruptions and/or the decision to quit fostering. This negative cycle involves the foster parents’ prior level of strain, employment of less-than-optimal parenting skills during placement, placement disruption, and exacerbated feelings of strain, which, in turn, deplete the parents’ emotional and behavioral resources even further, leading to subsequent negative placement outcomes.

Though the majority of research suggests that foster parents who care for psychologically and behaviorally complex children are under substantial strain and
are considering withdrawing from providing foster care, there is a significant subset of foster parents who are essentially ignored in the research: those who are thriving (Cherry & Orme, 2013). These parents report feeling high levels of satisfaction, personal reward and enjoyment from their work (Sinclair et al., 2004). They tend to feel substantial self-efficacy regarding their ability to manage foster children’s behavioral problems, low levels of psychological strain, and contentment with the support they receive from agency staff (Whenan, Oxlad, & Lushington, 2009).

From the limited research available, these parents appear to be demographically no different from other foster parents, though they are somewhat less likely to work outside of the home (Cherry & Orme, 2013). There is potentially a great deal to be learned from the study of highly effective foster parents—particularly those who foster children with behavioral and emotional difficulties—that could inform retention and recruitment practices.

**Resilience**

Resilience is a multidimensional construct defined by ongoing positive adaptation to adversity (Zautra, Stuart Hall, & Murray, 2010), and is made up of personal characteristics and psychosocial resources that create strengthening effects under stress (Charney, 2004). Resilience is based in the paradigm shift in health research from the “disease model” to the “health model,” implying a shift from the focus on psychosocial problems and illness to strengths and well being (Antonovsky, 1987; Richardson, 2002). Central to the concept of resilience is its separate dimensionality from risk and illness. Resilience is not defined by the absence of stress or negative emotion. Rather, it is the capacity to sustain positivity and purpose in the face of stress or challenge (Zautra et al., 2010).
While the majority of resilience research has focused on the development of resilience in youth and adolescents in particularly challenging environmental circumstances, research on resilience in adults has expanded over the last two decades as well, resulting in a reconceptualization of resilience as an adaptive state, as opposed to a fixed trait developed in childhood (Rutter, 1985).

**Resilience processes.** In order to develop and sustain resilience, an individual must employ what Zautra and colleagues (2010) refer to as “resilience processes,” also referred to as resilience factors (Rutter, 1985), resources (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2003), or qualities (Klumper, 1999). These resilience processes are the cognitive, emotional and behavioral competencies and coping mechanisms utilized in order to sustain improved functioning under stress (Zautra et al., 2010). While part of the make-up of personal resilience stems from genetics and personality factors (McEwan, 2011), many of the processes or characteristics that contribute to resilience can be built through mental effort and awareness (McEwan, 2011; Zautra et al., 2010). Competencies that promote resilience include self-understanding and interpersonal awareness, independence, self-efficacy, problem-solving skills, social skills, emotional control and regulation, sense of humor, empathy, optimism, and a positive orientation toward the future, among others (Klumper, 1999; McEwan, 2011).

**Resilience: cause versus outcome.** Resilience is both a cause and an outcome of positive adaptation to adversity (Zautra et al., 2010). One illustration of this dual cause-outcome effect is the role of positive emotions in building and maintaining resilience. The capacity to sustain positive emotions in the face of stress is a defining
factor of resilience. Frederickson’s (2001) “broaden and build” model of positive emotions posits that positive emotions such as joy, interest, pride and commitment work to broaden momentary thought-action resources, leading an individual to engage more directly with the environment. For example, the experience of joy may broaden attention and willingness to engage with others. This engagement then builds deeper social relationships, and these social relationships may lead to increased feelings of joy in the future or protection from stress (Frederickson, 2001). If resilience is sustained positivity in the face of adversity, then resilience not only acts as a buffer from the negative effects of stress, but actively builds resources that will sustain future positivity and resilience.

**Occupational resilience.** Resilience research has been applied to various professions characterized by demanding, emotionally consuming and/or potentially traumatizing environments such as social work, nursing, and therapy involving severely traumatized populations (Greifer, 2004). Resilience-building interventions for both populations have been developed and have proved effective at reducing job stress (McDonald, Jackson, Wilkes, & Vickers, 2012).

**The Current Study**
Similar to nurses and social workers, therapeutic foster parents also work in a highly dynamic and challenging environment in which they are exposed to the secondary effects of trauma (McClung, 2000); however, resilience in therapeutic foster parents has not been thoroughly investigated. This study sought to remedy the gap in the literature by assessing the applicability of a resilience framework to the study of effective therapeutic foster parents.
Therapeutic foster parents belonging to Connecting Children and Families (CCF)—a therapeutic foster care program in Connecticut—were the primary focus of this study. CCF provides services to roughly 35 therapeutic foster parents, with a total of 37 children currently enrolled in the program (Connecting Children and Families, 2015). The program began in 1993 with the admirable mission to provide long-term care and treatment services to psychologically, behaviorally, and emotionally complex children whose needs exceeded what could be provided by traditional foster homes. All of the children initially enrolled in the program had experienced severe abuse, neglect, and multiple foster home placements prior to CCF, and many had been committed to psychiatric settings (Liddle et al.).

**CCF Children.** In a summary of the therapeutic services offered by CCF, the program’s founders described the clinical profile of the children as follows:

“Behaviorally, the children have long-standing patterns of unacceptable behavior. Socially, the children lack the confidence and skills that would allow them to enter into social situations easily. Emotionally, the children are angry, embarrassed, fearful, guilty and lack self-esteem. They lack the moral development normally acquired during childhood. Cognitively, they have distorted thinking and poor reasoning processes. Educationally, the children lag so far behind their peers that extraordinary supports are necessary for the to be successful in school”(Liddle et al.). In addition to the aforementioned cognitive, behavioral, social and emotional challenges, children referred to CCF are commonly diagnosed with psychiatric disorders such as PTSD, ADHD, depression, general anxiety disorder, and conduct disorder (CCF, 2007). All CCF children have been removed from their birth homes and suffer from the effects
of trauma and neglect. Most have been abandoned not only by their birth families but by previous foster families as well, and many have spent time in psychiatric facilities or institutions (Liddle et al.)

**Theoretical underpinnings of the CCF model.** Underlying the CCF treatment model is the idea that therapy should take place in the context in which it is most useful. CCF differs from traditional foster care and many other TFC programs in that the majority of the child’s therapeutic process takes place in the home rather than a restricted setting such as a healthcare clinic. CCF prescribes to the theory of Social Role Valorization (SRV), which implies that people value themselves as well as others according to the social roles they occupy. According to SRV, children who are routinely placed in restricted settings in order to receive counseling or treatment may begin to view themselves as outsiders (Goodrich et al., 2011). They may internalize the notion that they need to be “cured” of their problems, and feel as though they are of inherently lesser value than children without the same issues. One central tenet of the CCF philosophy is therefore to treat the child within the home setting, by providing the foster parents with the resources and ongoing support to serve as the child’s primary therapeutic source.

The therapeutic framework of CCF is trauma-focused therapy, which involves a process of effecting behavioral, emotional and cognitive change through behavior analysis. Behavior analysis is the practice of examining the historical, emotional, cognitive and thought-based influences on and manifestations of behavior. The emphasis of treatment is on gaining insight into the child’s past to inform the interpretation of the child’s behavior in the present (Liddle et al.).
The role of CCF parents. CCF foster parents are considered to be the primary therapeutic change agents for their foster child. The parents’ role is to support the child through the everyday crises he or she experiences as a result of past trauma. These foster parents are expected to provide behavioral assistance to their foster child in addition to emotional assistance and understanding throughout the child’s process of learning to cope with his or her past and the psychological effects of these experiences (Liddle et al.). Given the heavy burden of responsibility placed on the foster parents in this parent-focused model of care, the CCF program began by recruiting only foster parents with professional experience in helping or human services professions such as social work, teaching or nursing (Goodrich et al., 2011). Now, parents are no longer required to demonstrate professional experience in a social services profession, though many still do. Foster parents’ preparation consists of 12 hours of pre-service (i.e., before foster parenting) training in the P.R.I.D.E. (Parent Resource Information Development Education) curriculum as well as ongoing in-service training each year. CCF also provides an extensive list of supports and services to the foster parents depending on the specific child’s needs, all of which is financed by Connecticut’s Department of Children and Families (DCF). Foster parents are expected to advocate for their child by connecting the child with therapeutic and community resources, as well as manage the child’s many needs in the academic, medical, therapeutic and recreational spheres. CCF typically enlists foster parents who are able to provide a stable home to a foster child, as opposed to a temporary placement, and who will integrate the child into the home either by way of adoption or long-term placement.
Research Questions
This study used a sample of 18 therapeutic foster parents from Connecting Children and Families to investigate the role of resilience in foster parents’ willingness and ability to provide stable placements to emotionally and behaviorally challenging youth. The guiding questions of the study were as follows:

1. Is resilience associated with therapeutic foster parents’ willingness and ability to provide care to children with behavioral and emotional problems?
   
   Hypothesis 1: There is a positive relationship between therapeutic foster parents’ resilience and the willingness to foster children with behavioral and emotional problems.

2. What are the specific qualities of resilience used by therapeutic foster parents to manage the challenges of caring for foster children with emotional and behavioral difficulties?
Methodology

Overview
This study used both quantitative and qualitative methods to examine the relationship between resilience and willingness and ability to foster children with behavioral and emotional difficulties among a sample of 18 therapeutic foster parents. Quantitative measurement consisted of a short demographic survey in addition to two validated measures assessing caregiver resilience and willingness to foster children with behavioral and emotional problems. An explanatory sequential design, in which qualitative analysis is conducted to explore or explain quantitative findings (Chaumba, 2013), was used to guide the qualitative data analysis process. Qualitative analysis was conducted on transcribed interviews from 12 therapeutic foster parents. Texts were analyzed using thematic content analysis—a qualitative methodology involving the coding of texts into meaningful categories.

Immersion in the Field
Prior to formal data collection, several steps were taken to gain a more holistic understanding of CCF foster parents’ experiences: (1) the researcher attended multiple parent-training sessions at the Connecting Children and Families office in New Haven, (2) informational interviews were conducted with CCF staff members and the program director, who doubles as a therapeutic foster parent, and (3) materials documenting the program’s inception and history were collected and examined.

Human Subjects Review
Prior to commencement, the study was approved by Wesleyan University’s Institutional Review Board as well as administrative staff at The Connection. Foster parents were
recruited using IRB-approved scripts and informed of the voluntary nature of the study, as well as their right to withdraw at any time. Participants were required to sign consent forms (see Appendix A) prior to involvement in the study. They were also assured that the information they provided throughout the study would in no way affect their eligibility to serve as a foster caregiver. In addition, they were informed that their individual responses would be kept anonymous and would not be shared with CCF staff members. Confidentiality of the subject data was maintained through use of the following procedures: (1) participants were assigned identification numbers, and all data entered into the computer was coded under the assigned numbers, rather than names, (2) identifying subject information (names, addresses, phone numbers) was kept separate from other data files and destroyed after completion of data collection, (3) names mentioned during the participants’ interviews were removed when interviews were transcribed, and (4) audio recordings of the participants’ interviews were deleted after transcription.

**Participants**
Ultimately, 19 therapeutic foster parents agreed to participate in the study. Participants were chosen using purposive sampling—a criterion-based, non-random sampling method (Lincoln & Guba, 1985, p. 40). The criteria for inclusion in the study was that participants were actively receiving services from CCF as of October 2014 and had at least one foster child living in the home.

**Recruitment.** The researcher recruited participants from a list of 29 therapeutic foster families receiving services from CCF. All 29 families were contacted via telephone, given a description of the study, and asked whether they were interested in participating. If they expressed interest, participants were asked to identify an hour-long
block of time during which would be able to meet for an interview. They were also asked to provide an email addresses in order to receive access to the online surveys.

**Quantitative Data Collection**

Quantitative data were collected via the online survey software Qualtrics (Qualtrics, 2009). Survey links were sent to participants via Qualtrics. Survey data contained no identifying information and were linked only to the participants’ identification numbers, which had been initially entered into Qualtrics to correspond with email addresses. Two validated measures, the Willingness to Foster Scale (Cox, Cherry, & Orme, 2011) and the Connor-Davidson Resilience Scale (Davidson & Connor, 2014) were entered manually into Qualtrics and distributed via email to 16 (84.21%) of the participants. Two (11.11%) of the participants had limited access to email and requested that their surveys be sent via post mail. The battery of surveys (WFS, CD-RISC, and demographic questionnaire) was sent to these two participants with a return envelope and postage included.

**Quantitative Measurement**

Prior to data collection, a questionnaire was developed (see Appendix B) by the researcher to gather information regarding foster parents’ age, sex, martial status, employment status, current occupation, educational background, professional background, and history as a foster parent. Questions related to participants’ history as foster parents measured the following variables: number of years fostering, number of children fostered, number of children adopted, number of biological children living in the home, number of foster/adopted children living in the home, date of most recent foster child’s placement in the home, presence of behavioral/emotional problems in current foster child, presence of behavioral/emotional problems in past foster children, number of children who left the home because they turned 18, number of children who left the home
because of a request by the foster parent, reasons for requesting removal of past foster children, and intent to continue fostering in the next three years. Items on the demographic survey were developed based on the National Survey of Current and Former Foster Parents (National Archive on Child Abuse and Neglect, 1999). The survey was carefully designed so that each question contained all possible answers as well as options “don’t know” or “other.”

**Willingness to Foster Scale—Emotional and Behavioral Problems (WFS-EBP).** The Willingness to Foster Scale—Emotional and Behavioral Problems (WFS-EBP) (see Appendix C) is a 40-item scale developed by Mary Ellen Cox and colleagues (2013) to measure foster parents’ self-reported willingness to foster children with 40 different types of emotional and behavioral problems. Willingness is rated on a four-point scale: (1) would not be willing to foster this child under any circumstances; (2) might be willing to foster this child with a lot of help and support; (3) probably be willing to foster this child with a little extra help and support; and (4) would be willing to foster this child without any extra help or support. Higher scores on the WFS-EBP indicate a greater willingness to foster (potential range from 0 through 100). Scores were calculated based on instructions from the Casey Home Assessment Manual (Orme et al., 2006) using the following equation: WFS-EBP score = (mean item score – 1)*(100 / K – 1), where K=4, or the largest possible value of an item response.

**Content.** Content for the 40-item scale was developed from research and literature on foster parenting, foster parent applicants, foster parent training curricula, and agency assessment practices, and was reviewed extensively by foster care professionals for clarity, comprehensiveness and practical relevance (Cox et al., 2013).
**Reliability and validity.** Validation of the WFS-EBP took place with a nationally representative sample of 298 foster parents from public and private agencies with varying levels of fostering experience. Internal consistency of the scale was high (Cronbach's $\alpha=.96$, SEM=3.79) as was discriminant and construct validity (Cox et al., 2013). Scores on the WFS-EBP were positively and significantly associated with variables related to provision of care such as the number of years fostering, number of children fostered, and the number of children currently in the home. WFS-EBP scores were negatively correlated with the number of children removed from the home at the foster parent’s request. In a test of discriminant validity, demographic variables such as race/ethnic background, highest level of education completed, income, and marital status were not significantly associated with scores on the WFS-EBP (Orme et al., 2006; Cox et al., 2013).

**Measures associated with WFS-EBP scores.** A study sponsored by Casey Family Programs found the WFS-EBP to be correlated with standardized measures assessing greater cultural competence, family resources, time available to foster, perceived responsibility to parent and work with foster care agencies, tendency to like children, personal dedication to fostering, receptivity to foster child’s connections with birth families and ability to handle fostering challenges. In addition, the WFS-EBP accounted for significant variability in the following domains: satisfaction with fostering, greater potential to foster, greater potential to foster challenging children and manage worker-agency challenges (Orme et al., 2006).

**Connor-Davidson Resilience Scale (CD-RISC).** The Connor-Davidson Resilience Scale (CD-RISC) (Davidson & Connor, 2014) is a 25-item self-report measure
designed to assess individual resilience (see Appendix D for content). Resilience is rated on a five-point Likert scale: (0) not true at all, (1) rarely true, (2) sometimes true, (3) often true, (4) and true nearly all of the time. Higher scores indicate higher resilience (scores range from 0-100). CD-RISC scores were calculated following the guidelines of the CD-RISC manual, which prescribed a simple procedure of summing each item to reach a total score (Davidson & Connor, 2014). The CD-RISC was chosen to measure resilience based on its widespread use and demonstration of validity as well as its conceptualization of resilience as both a process and an outcome. The scale measures coping capacity and sense of control as well as positive emotionality and elements of purpose and spirituality. The CD-RISC was obtained through direct contact with the first author via email.

**Content.** The content of the scale was developed based on seminal studies of resilience that have identified cognitive, behavioral, emotional and ecological correlates of resilience (Connor & Davidson, 2003). The scale measures the following core constructs of resilience: personal competence, high standards and tenacity, trust in one’s instinct, tolerance of negative effects, strengthening effects of stress, positive acceptance of change, secure relationships, positive emotionality and spiritual influence. Each item of the scale is worded for sixth grade reading ability and items are worded to exclude gender bias (Smith-Osborne & Whitehill Bolton, 2013).

**Reliability and validity.** The CD-RISC demonstrates satisfactory internal consistency (Cronbach's α=0.89) and high test-retest reliability (intraclass correlation coefficient=0.87) (Connor & Davidson, 2003). The CD-RISC was validated on a sample of 827 participants divided into six distinct groups: general population, primary care,
psychiatric outpatients, GAD, and PTSD (Smith-Osborne & Whitehill Bolton, 2013). The authors found significant differences in the means of the clinically distinct groups. In assessments of divergent validity, the measure was not significantly correlated with demographic variables such as gender, race, or age (Connor & Davidson, 2003). Tests of convergent validity demonstrated CD-RISC scores to be positively correlated with measures of components of resilience such as hardiness, life satisfaction, self-esteem, cognitive functioning, emotional wellbeing, optimism, and social support. Scores were negatively correlated with measures of depression, anxiety, emotion-focused coping (versus active coping), PTSD, occupational burnout, and perceived stress (Davidson & Connor, 2014). The scale has also been validated with Chinese, Korean, Australian and Portuguese populations (Davidson & Connor, 2014).

**Prior use.** Since the initial validation, the CD-RISC has been used in a range of studies with medically vulnerable populations and as a measure of treatment response for psychiatric disorders such as General Anxiety Disorder (GAD) and Post-Traumatic Stress Disorder (PTSD) (Smith-Osborne & Whitehill Bolton, 2013). The CD-RISC has been included in over 30 published studies with samples ranging from children to older adults. The CD-RISC manual (Davidson & Connor, 2014) contains a list of established mean scores for a variety of populations. The mean score of a large-scale study of general population American adults (Lamond et al., 2008) was used as a cutoff point in the current study to determine which foster parents’ interviews would be included in the analysis of qualitative data.
**Qualitative Data Collection**

Qualitative data were collected primarily through face-to-face interviews in the participants’ homes. A total of 19 qualitative interviews were conducted. Following initial phone contact and scheduling, participants were asked to choose a location for the interview that would be most convenient and/or comfortable for them. For the majority (14) of the participants, interviews were conducted in the home. Whenever possible, interviews were conducted in person; however, as a result of transportation challenges and/or scheduling difficulties, four of the interviews took place over the phone. Finally, at the request of the participant, one interview was conducted in a coffee shop.

After a brief conversation and introduction to the study, participants were asked to read the informed consent form and were encouraged to ask questions before signing. Participants were asked to consent both to participation in the study and to allowing I to record the interview on an audio-recording device. Interview length ranged from 25-70 minutes, with a mean length of 38 minutes. Though phone interviews were, on average, 7 minutes shorter than in-person interviews, the collection of qualitative data over the phone allowed the researcher to interview a wider range of participants and typically did not seem to inhibit participants from sharing experiences in a candid and detailed manner.

**Qualitative Measurement**

Qualitative data were collected using a semi-structured interview. The interview consisted of approximately nine open-ended questions designed to elicit the participants’ subjective experiences with therapeutic foster parenting. In addition to the preformed set of interview questions, the researcher practiced reciprocity (Galletta, 2012) in the interviews by using prompts and follow-up questions. The occasional prompts included questions such as “How did you handle that?” or “Can you explain what you mean
by…?” in order to elicit further clarification or elaboration on some component of the participant’s narrative. The following represents a general outline of the semi-structured interview questions:

1. Why did you first become a foster parent?
2. What sort of preparation did you have for foster parenting?
3. Describe some of the challenges you face as a foster parent.
4. What strategies do you use to handle those challenges?
5. What helps you to be a good foster parent?
6. What do you think helps foster children succeed?
7. Have you ever had a foster child leave your care? Can you describe the situation that led up to this child leaving your care?
8. How do you think your relationship with (child’s name) is affecting him/her now?
   Will affect him/her long-term?

**Quantitative Data Analysis**
Quantitative data were analyzed based on the following objectives: (1) to determine the relationship between foster parents’ resilience (CD-RISC scores) and reported willingness to foster (WFS-EBP scores), (2) to assess the predictive value of resilience for determining scores on the WFS-EBP, and (3) to examine the relationship between foster parents’ resilience scores and outcome variables such as the intent to continue fostering, number of years fostered, number of children removed from the home at the foster parent’s request, and number of children fostered.

**Statistical Analyses**
Data were analyzed using the statistical software environment R (R Core Team, 2012).

Descriptive statistics were used to identify frequency distributions of foster parents’
demographic characteristics and CD-RISC scores. Foster parents who scored above the mean for general population adults (M=77) on the CD-RISC were selected as the sample for qualitative analysis. The relationship between foster parents’ resilience and willingness to foster children with behavioral and emotional problems was assessed using a Pearson Product-Moment Correlation. Potential confounding variables were determined based on the literature of willingness to foster as well as that of resilience and included: age, education level, years fostering, marital status, employment status, and employment in a helping profession.

Four of the potential confounding variables (marital status, education level, employment status, employment in a helping profession) were included in four separate bivariate tests of Analysis of Variance (ANOVA) with WFS-EBP score as the response variable and the potential confounders as the explanatory or grouping variables. None of the four categorical variables were significantly associated with WFS-EBP scores, when significance was established as p<.05. Furthermore, none of the four variables approached significance, and all bivariate models had p-values above 0.1. The potential correlation between age as well as years fostering and WFS-EBP scores were assessed using two separate Pearson’s Product-Moment Correlations. A correlation with a p-value of 0.1 or less qualified the variable to be included in the multivariate model. Only one of the potential confounding variables—years fostering—had a significant correlation with WFS-EBP scores. Given that the number of years fostering did not have a significant correlation with CD-RISC scores as well, it was not deemed a potential confounder.

**Qualitative Data Analysis**

**Participants.** Twelve therapeutic foster parents were included in the qualitative analysis process (63.67% of the initial sample). Inclusion criteria were twofold: (1) foster
parents needed to scores above the general population mean (M=77) on the CD-RISC, and (2) foster parents needed to have maintained at least one stable placement with a foster child, where stable was defined based on the literature as a placement lasting a minimum of 9 months (Rubin et al., 2007). Prior to analysis, all participants were assigned pseudonyms. All findings are reported under participants’ pseudonyms in order to protect anonymity.

**Content analysis.** The qualitative portion of this study used a directed, thematic approach to content analysis. The thematic approach to content analysis involves coding texts for content or style to interpret psychosocial, emotional and cognitive characteristics of the sample, and communicating the frequency with which categories occur (Smith, 1992). The approach is “directed” in that coding schemes are predetermined and informed by a particular theory and body of literature (Glaser, 1978). Within these preformed categories, careful attention is paid to the variations within the sample, and sub-codes and themes can be identified that were not expected. This approach was used with the objective of exploring the phenomenon of resilience within the sample while maintaining the subjective nature of the participants’ experiences and narratives.

The thematic approach to content analysis endorses an empiricist/realist approach to the study of reality (as opposed to a social constructionist approach) and recognizes a connection between language and cognitive-affective experience.

As opposed to more traditional forms of qualitative analysis, which establish a concrete unit of analysis such as a sentence or paragraph, thematic content analysis codes the text for shifts in meaning, and may establish more than one code or category per unit.
In this study, thematic content analysis was used to inform the processes of data collection, analysis and presentation.

**Code development and procedure.** Prior to data analysis, an a priori coding scheme was developed (Elo & Kyngäs, 2008) using the conceptual framework and research questions of the study. Various sources on the construct of resilience (Charney, 2004; Connor & Davidson, 2003; Klohnen, 1996; Kumpfer, 1999; Rutter, 1985) were used to form a detailed list of codes and categories that represented a holistic resilience framework, and operational definitions were developed for each code (see Appendix E). As is usual with qualitative analysis, the researcher became immersed in the data through manual transcription of the 12 semi-structured interviews (Miles & Huberman, 1994). The transcripts were uploaded into the qualitative analysis software ATLAS.ti (Muhr, 2009), which enabled enhanced productivity and organization of the data by keeping all documents and codes stored in one easily-accessible project file. Passages that appeared to describe a cognitive, behavioral, emotional, or spiritual component of resilience were highlighted, and the predetermined coding scheme was applied to the highlighted passages. Descriptive sub-categories and codes were given to most passages within the applied framework in order to allow the researcher to return to the specific examples in each category when communicating the results. A total of 39 codes were identified under the 3 main categories of the resilience framework (see Appendix F). Following application of the predetermined coding scheme, the researcher returned to the unmarked portions of the texts and created new codes for these passages. The final code list consisted of 49 codes under 5 categories.
Trustworthiness. To establish reliability of the coding scheme, an undergraduate psychology student was given a copy of the codebook, trained by the researcher and given a seven-page narrative to code. The number of themes coded in the text were by each rater were compared using the percent agreement calculation (Neuendorf, 2002). Percent agreement was 86.67%—an acceptable statistic based on the standards set by Neuendorf (2002).

Use of Mixed Methods
This study utilized both qualitative and quantitative measurement and analysis to gain a holistic understanding of resilience as a process by which therapeutic foster parents persist in their roles as caregivers to behaviorally challenging foster children. Quantitative data were used to guide the selection sample of therapeutic foster parents for qualitative analysis. In addition, qualitative analysis was conducted in order to explore and attempt to explain the correlation between the two measures: the CD-RISC and WFS-EBP. Finally, the use of mixed methods served to triangulate the results of the study. Triangulation refers to the process of utilizing multiple methods in order to increase the credibility or reliability of the results (Chaumba, 2013). Typically, social work research employs mixed methods in order to extend the findings of a qualitative study into an applicable resource for social work practice (Chaumba, 2013). While qualitative data analysis allowed for sensitivity to the unique context of the phenomenon in question, quantitative methods served to increase credibility and validate the findings in a (slightly) larger sample.
Quantitative Results

Demographics
The sample size for statistical analyses consisted of 94.74% of the original sample (n=18). Of the 18 participating foster families, 15 (88.89%) respondents were female. The sample consisted of seven (38.89%) single-parent households in which the participant was either divorced or separated, though the majority (61.11%, n=11) of foster parents were either married or in a domestic partnership/civil union. Foster parents’ ages ranged from 42-68 with a mean of 51.89 years. Participants’ education levels—measured by the highest degree attained—varied from high school/GED (11.11%, n=2) to graduate degree (22.22%, n=4), with the large majority (88.89%, n=16) of participants reporting some form of college education.

Participants were typically full-time employees (61.11%, n=11), though a subset (22.22%, n=4) worked part-time, and three foster parents (16.67%) reported being either unemployed, retired, or disabled and unable to work. The vast majority of foster parents (83.33%, n=15) were currently employed or had, at some point, been employed in a helping profession. Helping professions were defined as occupations in fields that promote physical, intellectual, emotional or psychological well-being including education, healthcare, personal care, mental health, counseling, or social work. Over half (55.56%, n=10) of foster parents had worked in the field of education, and nine (50%) in a healthcare profession. Specific to fostering, the number of years parents fostered ranged from 2-33 (M=8.5, SD=6.18). Parents had fostered anywhere from 1-20 children, with a median of 3 children fostered. Most parents (88.89%, n=16) had biological children, and 12 of the 18 parents (66.67%) had biological children currently living in the home. Only
eight (44.44%) foster parents had ever requested that a child be removed from their home (Table 1).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>11.11%</td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
<td>88.89%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>11</td>
<td>61.11%</td>
</tr>
<tr>
<td>Divorced</td>
<td>6</td>
<td>33.33%</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>5.56%</td>
</tr>
<tr>
<td><strong>Highest degree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS/GED</td>
<td>2</td>
<td>11.11%</td>
</tr>
<tr>
<td>Some College</td>
<td>5</td>
<td>27.78%</td>
</tr>
<tr>
<td>Associate’s Degree</td>
<td>2</td>
<td>11.11%</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>5</td>
<td>27.78%</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td>4</td>
<td>22.22%</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Working</td>
<td>3</td>
<td>16.67%</td>
</tr>
<tr>
<td>Full-Time</td>
<td>10</td>
<td>55.56%</td>
</tr>
<tr>
<td>Part-Time</td>
<td>5</td>
<td>27.78%</td>
</tr>
<tr>
<td><strong>Experience in a Helping Profession</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>11</td>
<td>61.11%</td>
</tr>
<tr>
<td>Healthcare Support</td>
<td>9</td>
<td>50.00%</td>
</tr>
<tr>
<td>Personal Care</td>
<td>4</td>
<td>22.22%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>6</td>
<td>33.33%</td>
</tr>
<tr>
<td>Counseling</td>
<td>4</td>
<td>22.22%</td>
</tr>
<tr>
<td>Social Work</td>
<td>2</td>
<td>11.11%</td>
</tr>
<tr>
<td><strong>Mean (SD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>51.89 (7.13)</td>
<td></td>
</tr>
<tr>
<td>Years Fostering</td>
<td>8.5 (6.18)</td>
<td></td>
</tr>
<tr>
<td>Children Fostered</td>
<td>5 (5.37)</td>
<td></td>
</tr>
</tbody>
</table>
Descriptive Analyses
Participants’ scores on the Connor-Davidson Resilience Scale (CD-RISC) ranged from 60-100 (M=83.11, SD=10.53), and Willingness to Foster Scale-Emotional and Behavioral Problems (WFS-EBP) scores ranged from 24.17-77.50 (M=47.16, SD=16.06).

Years Fostering, Children Fostered, and Willingness to Foster
The correlation between number of years fostering and reported willingness to foster children with behavioral and emotional problems was 0.54 (p=0.021), suggesting that 29% of the variation in WFS-EBP scores is predicted by the number of years fostering.

No significant correlation was found between the number of children fostered and WFS-EBP scores.

Resilience and Willingness to Foster
A statistically significant positive correlation was found to exist between therapeutic foster parents’ CD-RISC and WFS-EBP scores (r=0.49, p=0.037), suggesting that 24% of the variation in foster parents’ willingness to foster children with behavioral and emotional problems can be explained by reported resilience scores.
Qualitative Results

Overview
Under the applied resilience framework, 15 themes were identified in foster parents’ narratives, and 10 of those themes appeared in more than half of the interviews. Eight themes outside of the resilience framework were identified, though none appeared in more than half of the interviews. Significant findings included caregivers’ use of adaptive cognitive and emotional processes to promote their own and their children’s well being and foster parents’ demonstration of sustained engagement and positivity under challenging circumstances.

Sample Characteristics

Inclusion criteria. Ultimately, 12 therapeutic foster parents were included in the qualitative analysis. Foster parents included were those who scored above the general population mean (M=77) on the CD-RISC and had maintained at least one a stable placement with a foster child, where stable was defined as a placement lasting at least 9 months (Rubin et al., 2007).

General demographics. Ages ranged from 46-68 (M=54.42, SD=7.04), and 11 of the 12 foster parents were female. Only seven (58.33%) foster parents were married and living in a two-adult household, while five (41.67%) were divorced or separated and fostering as single parents. The majority (66.67%) of foster parents had attained either a Bachelor’s or Graduate degree, and most (83.33%) had past or current experience working in a helping profession such as education, healthcare support, mental health, personal care, counseling or social work. Five parents (41.67%) were fully employed, and
four (33.33%) were part-time employees, while the remaining three (25%) were unemployed, retired, or unable to work (Table 2).

**Table 2.**
**General Demographics of Foster Parents Included in Qualitative Analysis.**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Overall N=12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>7</td>
</tr>
<tr>
<td>Divorced/ Separated</td>
<td>5</td>
</tr>
<tr>
<td>Highest degree</td>
<td></td>
</tr>
<tr>
<td>HS/GED</td>
<td>2</td>
</tr>
<tr>
<td>Some College</td>
<td>2</td>
</tr>
<tr>
<td>Associate’s Degree</td>
<td>1</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>5</td>
</tr>
<tr>
<td>Graduate Degree</td>
<td>3</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
</tr>
<tr>
<td>Disabled, Not Working</td>
<td>1</td>
</tr>
<tr>
<td>Full-Time</td>
<td>5</td>
</tr>
<tr>
<td>Part-Time</td>
<td>4</td>
</tr>
<tr>
<td>Unemployed</td>
<td>1</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
</tr>
<tr>
<td>Experience in a Helping Profession</td>
<td>10</td>
</tr>
<tr>
<td>Education</td>
<td>8</td>
</tr>
<tr>
<td>Healthcare Support</td>
<td>7</td>
</tr>
<tr>
<td>Personal Care</td>
<td>3</td>
</tr>
<tr>
<td>Mental Health</td>
<td>5</td>
</tr>
<tr>
<td>Counseling</td>
<td>3</td>
</tr>
<tr>
<td>Social Work</td>
<td>2</td>
</tr>
</tbody>
</table>

**Demographics specific to fostering.** On average, foster parents had spent 12 years fostering and had cared for roughly 6 foster children, though significant variation existed within the sample (See Table 2). Ten foster parents (83.33%) had biological children, and eight of the foster parents (66.67%) with biological children still had at least one living in the home. Foster parents were typically only caring for one foster child,
though three parents (25%) had two children in their care (Table 2). Only one foster parent (8.33%) did not intend to continue fostering within the next three years, while ten foster parents (83.33%) answered that they did intend to continue providing foster care, and one foster parent (8.33%) expressed uncertainty. The foster parent who did not intend to continue fostering specified that the reason for this was solely health-related reasons, though the parent who expressed uncertainty cited a lack of financial compensation for fostering as well as a need to return to work full-time.

Table 3. Demographics Specific to Fostering.

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Years Fostering</th>
<th>Children Fostered</th>
<th>Biological Children in the Home</th>
<th>Foster Children in the Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Ashley</td>
<td>16</td>
<td>16</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ms. Braxton</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Ms. Caldwell</td>
<td>18</td>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ms. Fisher</td>
<td>18</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ms. Griffin</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Mr. Holmes</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Ms. Ingram</td>
<td>14</td>
<td>20</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ms. Jones</td>
<td>33</td>
<td>9</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ms. Lewis</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Ms. Palmer</td>
<td>16</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Ms. Mitchell</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ms. Stewart</td>
<td>9</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

Fostering Challenges
The parents of CCF faced a number of challenges in their everyday work as caregivers to difficult-to-place therapeutic foster children. Some of their difficulties reflected the stressors cited in the literature such as difficulty managing the foster child’s behavior, family conflict caused by the presence of a foster child, allegations of abuse and
excessive intrusion of agency staff in the home (Sinclair et al., 2004). Many of the parents cited challenges with the child welfare system such as unmet financial needs, limited experience of the social workers, frequent pleas to take in additional foster children, lack of preparation for fostering, receiving little information on the child and his/her background prior to placement, and challenges navigating the bureaucracy of the child welfare department. All twelve therapeutic foster parents included in the following analysis indicated that their foster child or foster children currently experienced behavioral or emotional problems, and nine (75%) foster parents discussed the behavioral or emotional challenges of past foster children as well. Behaviors included, but were not limited to: fire-setting, running away, lying/manipulation, self-harm and suicidal threats, excessive swearing, sexually inappropriate behaviors, stealing, substance abuse, public urination or defecation, and, most commonly, aggressive or destructive behavior. Five foster parents (41.67%) mentioned conflict with the police as a result of their foster child’s behaviors, and seven parents (58.33%) discussed the financial burden of their child’s complex behavioral or emotional profile, especially the financial costs of the property damages caused by their child’s destructive behavior. Seven foster parents (58.33%) alluded to conflict between their foster child and biological children as a result of the foster child’s behavioral challenges, and two foster parents (16.67%) indicated conflict with members of their neighborhood or community. Eight foster parents (66.67%) described an explicit instance in which their foster child’s behaviors caused the parents marked psychological distress.
Themes in Resilience Framework

**Overview.** Under the applied resilience framework, 17 themes were identified in the interviews. Themes were divided into five categories of resilience processes: self-regulation, cognitive flexibility, interpersonal- and self-awareness, positivity/purpose, and active engagement. Table 3 illustrates the categories, themes, and sub-themes within the resilience framework that appeared most often in foster parents’ narratives. Of the 17 themes, 10 were identified in more than half of the interviews, and are discussed in detail with definitions and narrative examples that elucidate the connections between the foster parents’ language and the resulting interpretation of the phenomenon of resilience.

**Table 4. Categories and Themes in Resilience Framework.**

<table>
<thead>
<tr>
<th>Category/Theme</th>
<th>Occurrences (Total Possible=12)</th>
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<tbody>
<tr>
<td>Interpersonal Awareness</td>
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<tr>
<td>Altruistic Orientation</td>
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<tr>
<td>Insight/Compassion</td>
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<td>Commitment</td>
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<td>Self-Regulation</td>
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<td>Emotional Control</td>
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<td>Patience/Tolerance</td>
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<td>Commitment</td>
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<td>Cognitive Flexibility</td>
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<td>Acceptance</td>
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<td>Positive Reappraisal</td>
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<td>Positivity/Purpose</td>
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<td>Optimism</td>
<td>8</td>
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<tr>
<td>Humor</td>
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<td>Meaningfulness</td>
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**Interpersonal Awareness.** The capacity for interpersonal awareness and skillful communication was essential for therapeutic foster parents’ management of caregiving challenges. All twelve foster parents identified an altruistic commitment to serving others as the primary driving force behind their decision to provide foster care. Once they began
fostering, foster parents’ concern for the well-being of others supported their ability to build a secure relationship with their foster children. Foster parents’ interpersonal awareness was evident through their deep capacity for empathy; they demonstrated empathy for their foster children both through insight and understanding of their foster children’s past and compassion and sensitivity toward their children in everyday interactions.

*Altruistic motivation.* Foster parents attribute their decision to begin fostering to a sense of responsibility and care for others. Ms. Lewis describes her desire to help children as the reason she and her husband began fostering:

Well, we never had our own children. We chose not to because we saw the need that was in the system, and all of the children who needed care. And it started with one child who needed care and we went to the court and we were able to start to take care of that child.

Similarly, Ms. Jones describes being motivated by a desire to “give back” and make a positive impact on a child’s life:

I did work in the group home industry, but then I got a day job and eventually found my way to foster care after awhile, when I realized there was something I wanted to be able to give back. I always enjoyed raising children and teaching them skills and educating them, so to me it seemed like a natural way to make a difference to somebody.

The commitment to serving others continues to motivate foster parents once they have been fostering for some time. Ms. Caldwell, who has provided care for over fifteen years, articulates a sense of personal responsibility for children in therapeutic foster care:

Most other people just think we're crazy. Because why would anybody ever put up with this kind of behavior? But that's it, that's why we do it. Because these kids need some place where they can grow up even though they have these kinds of behaviors.
**Insight and Compassion.** In addition to having a generally altruistic approach to life, most foster parents were skilled with interpersonal interaction; they often revealed deep insight into the motivations behind their foster children’s behaviors. Foster parents tended to use their insight to inform their subsequent parenting tactics.

Ms. Mitchell noticed her foster child’s habit of keeping her stuff packed in bags, and reflected on the behavior in light of her foster child’s past experiences of abandonment:

She kept her stuff in garbage bags for a whole year. I think that came from the fact that every weekend, her mother would just pick her up and drop her off somewhere for the weekend and come back on Sunday—it didn't matter if she called begging to come home or whatever. So I think that abandonment really got to her...It's still taken some time for us to get rid of those bags and convince her, “honey, you're staying here. You don't need a bag set and ready to go. You're home.”

Guided by a deep level of insight into the root of her child’s behavior, Ms. Mitchell uses communication and understanding to establish trust with her foster child. Other foster parents gave similarly insightful accounts of their foster children’s behavior; they demonstrated an ability to interpret disruptive or strange behaviors in light of their children’s past experiences of trauma. Ms. Stewart gives one such example while describing the difficulty she had forming a bond with her foster child:

She really pushes me away. I think she targets me the most because I think she's never really had a mom. Well, she had a foster mom that adopted her very young, and then that mom died. And then she’s been through other families...so in her mind she always wanted a mom, but when she has one she doesn’t know how to handle it.
Rather than feeling defensive or personally targeted by her foster child’s hostility toward her, Ms. Stewart is able to reframe her child’s behavior, taking into account the effects of past neglect or abandonment.

Most foster parents expressed a view of their foster children’s anger or behavioral outbursts as manifestations of emotional damage. Instead of interpreting such actions as overtly malicious or hostile and responding with frustration, foster parents showed compassion for their foster children, even in the most challenging circumstances. Ms. Jones demonstrated an ability to empathize with her foster children and make sense of their destructive behavior:

Even if they act out in ways that you give a consequence for, you understand that there's so much hurt behind that. You understand that they're not purposely breaking your window to be mean, there's something that hurts so bad inside of them that that's how that's coming out.

The compassion and tolerance described by Ms. Jones was in no way a unique sentiment. All twelve foster parents showed profound interpersonal awareness and insight into their children’s behavior.

Overall, foster parents’ empathic nature and sense of responsibility for others, use of sensitive communication, and capacity for deep insight into their children’s behaviors seemed to function in tandem to support a secure emotional bond between foster parent and child.

**Self-Regulation.** Self-regulation—the ability to exercise control over emotional, cognitive, and behavioral processes—was used in order to guide foster parents’ immediate reactions to their foster children’s behaviors as well as orchestrate long-term efforts to help their foster children make positive behavioral and emotional changes. Foster parents used self-regulation to remain calm in response to disruptive behavior,
tolerate long periods of ambiguity when their foster children were unwilling or unable to communicate, and delay immediate reward in pursuit of long-term satisfaction.

**Emotional control.** All twelve foster parents mentioned a need to limit their emotional and behavioral reactions to their children’s disruptive behaviors, even when parents’ initial emotional impulse was to feel angry, upset or agitated. Ms. Fisher described her tactic of lowering her voice and remaining calm when her children were behaving inappropriately:

I’ve learned as a parent, that if you yell at somebody and get upset, and are screaming and yelling and swearing, it just hypes the situation up. It just ups everything. I learned a long, long time ago, that if my kids are doing something they shouldn't be doing, I almost get down to a whisper.

Because that is the only way to bring them back down and get them to listen.

Informed by her past experience as a caregiver, Ms. Fisher is able to regulate her emotional reactions to her children’s behavior and select the response that is most beneficial: composure. By regulating her own emotional response, she is able to elicit a positive emotional state in her child as well.

Similarly, Ms. Palmer described a need to remain calm in response to her foster children’s aggressive behavior by making a conscious effort not to take offense from their actions:

The biggest thing is to not take it personally. It's not about you or your parenting or anything you've done or didn't do. When they're screaming, "fuck you I hate you," you can't crumble and say "oh my god, why do they hate me?" It isn't about you, you can't take that personally—you have to stay calm. So I’ll talk in a low voice, and they’ll see that I’m calm.

By exercising control over her reactions, Ms. Palmer is able to maintain emotional stability and encourage her children to do the same.
The use of self-regulation in the form of emotional control appeared to have a positive influence on caregiver’s ability to elicit calm emotional reactions from their foster children. Repeated successful attempts to regulate their foster children’s behaviors may have given foster parents increased confidence in their ability to manage subsequent behavioral challenges.

**Patience/tolerance.** In order to help their foster children transition into the home or begin to learn to control some of their behaviors, foster parents maintained patience with their foster children over long periods of time and demonstrated tolerance of ambiguity. Though they may not have known the cause of their children’s behaviors or how long their children would continue to act in a certain way, foster parents exercise patience in order to provide their children with the space and time to communicate or to change their behavior.

Ms. Caldwell also described the need to remain patient with her foster child’s difficulty disclosing his emotions. Despite not always knowing the cause of her foster child’s anger or aggression, she accepted the long process of waiting for her foster child to open up:

> Sometimes he doesn't give you enough information. So he's angry, but you don't know why, and they don't tell you because a lot of times they think it's their fault and they don't want you to know, because then they might get in more trouble. But if you don't know what's causing it, it's very hard to get to their level. So you wait. Sometimes you have to wait a whole week before you ask about the money that came out of the bank…you can't want to get things done right away.

Understanding that her child may be reluctant to communicate out of fear of punishment, Ms. Caldwell tolerated long periods of ambiguity, during which she is unsure of the cause of her child’s anger.
Ms. Braxton described the need to maintain patience with her foster child and refrain from asking prying questions about her behavior. Despite receiving a distressing call from the school informing Ms. Braxton that her foster daughter had thrown a tantrum and needed to be restrained by her teacher, Ms. Braxton maintained composure and encouraged communication by making her child feel comfortable, rather than interrogating her foster child or responding with punishment:

She walks into the house and says, “Did you hear what happened?” And I said “Yeah.” And she said, “Do you want to talk about it?” And I said, “After you relax and have something to eat we can talk about it.” So we don’t bother her, we just leave her to calm down. Then, when she’s ready, we can talk. Having that patience with her—she was fine.

By showing patience with her foster child and responding neutrally to news of disruptive behavior, Ms. Braxton encouraged her foster daughter to feel secure and unafraid of retaliation in response to open communication.

Overall, foster parents’ use of patience and tolerance appeared to stem from their insight and understanding of their children’s behavior, and seemed to allow parents to strengthen their relationship with their foster child.

Committment/ability to delay gratification. In addition to short-term control over emotional reactions and the exercise of patience with their foster children, foster parents demonstrated enduring emotional control through their ability to delay gratification. They ignored the lack of immediate reward for their hard work in pursuit of long-term satisfaction and pride in having helped their foster children reach their goals.

Many foster parents acknowledged that the monetary compensation for fostering was minimal, especially when taking into account the fact that their workday was never
officially over. Ms. Braxton demonstrated a willingness to ignore the nominal compensation in pursuit of her foster child’s well-being:

When you think about it, the money isn’t a lot. But sometimes you have to overlook the money, because the goal is success. We want for the child to leave as a different person. We want for them to leave here with a big growth.

Despite the lack of tangible rewards for their work, foster parents demonstrated an ability to keep their long-term goals in sight and construct short-term goals in order to experience reward and keep them committed to their ultimate objective of independence and well-being for their foster children.

Though Ms. Jones’ ultimate goal for her foster children was for them to gain life skills and independence, she described feeling satisfaction when her foster daughter demonstrated an ability to recognize right from wrong:

Even with my daughter there's things I don't approve of. And she'll ask me and then say, "Never mind, don't answer that. I know exactly what you're gonna say." Success! That's exactly what a parent wants a kid to know, and that tells me that she is sensitive to how I feel about what she does. That’s a big piece.

By allowing herself to enjoy successes along the way to her longer-term goals, Ms. Jones is able to maintain positivity and commitment to her work.

Mr. Holmes also expressed feeling gratification through the small accomplishments his foster son made:

He’s a real success story, because he’s a hyper and sort of needy kid, but I do work with him and now he takes the bus. He knows how to take a bus from the library, and different things like that. I
want him to graduate and then maybe move on and sign up for [independent housing], but I feel good about his progress, and he feels good about it.

By constructing short-term rewards for his work, Mr. Holmes maintains positivity and fuels his long-term effort to help his foster son gain independence. When his foster son gains new skills along the way to this ultimate goal of independence, Mr. Holmes feels personally fulfilled, and his commitment to fostering is fortified.

Through commitment to fostering and active relishing in short-term rewards and outcomes, foster parents seemed to promote their own well-being and expression of positive emotions such as pride and general contentment.

**Cognitive Flexibility.** In addition to exercising control over their emotions, foster parents demonstrated an ability to self-regulate their cognitive processes as well. They showed cognitive flexibility—the capacity to modify interpretations of stressors by taking into account the specific context of the situation (Charney, 2004). Foster parents employed processes of cognitive flexibility such as acceptance and positive reappraisal in order to sustain positivity and productivity when faced with challenges.

**Acceptance.** Foster parents practiced acceptance by acknowledging that certain difficult or unwanted situations were out of their control. Ms. Ashley described an overall attitude of acceptance regarding her foster children’s backgrounds:

To me, to a certain extent there’s always going to be the genes of where they came from, and you’re always going to have a harder time when the child comes to you when they’re older and they’re somewhat set in their ways…but that’s the package.

Rather than denying the fact that her foster children were predisposed to certain behaviors based on their past histories of trauma, Ms. Ashley accepted that she was
taking on a major challenge by fostering an older child or a child with a history of maltreatment. Similarly, Ms. Caldwell relinquished feelings of control over how deep of a bond she would be able to establish with her foster children, taking into account her children’s past and their difficulties forming attachments:

Some kids reach out. Others push you back. There's nothing you can do about that. It's their personality and what they've been through, and what they've been through effects different kids differently.

Ms. Caldwell acknowledges that the bonds she forms with her foster children are not solely a reflection of her own efforts to form a relationship, but rather they depend largely on her children’s past experiences and their openness to attachment. This acceptance may prevent Ms. Caldwell from feeling self-blame or distress when she experiences difficulty establishing a relationship with her foster children.

While foster parents acknowledged an inability to control certain realities such as their foster children’s disabling genetic predispositions to mental disorder, personal histories of maltreatment or lasting difficulties with behavioral control, parents’ acceptance skills do not hinder their efforts to support and nurture their foster children. Instead, the use of acceptance worked to inspire foster parents to adapt to their children’s needs and promote their children’s functionality.

Ms. Jones acknowledged her children’s susceptibility to the re-experiencing of traumatic memories, as well as the fact that her own everyday behavior could sometimes trigger these reactions in her children:

These kids have been in an outrageously deficit lifestyle for those early years. And you just don’t know where they’ve come from. And what you think is normal behavior or normal consequence, to them it could destroy their psyche. Because you have to assume the worst all the time and try to
find a way around it so that you can teach them a normal concept without sparking some outrageous memory or something.

Though she accepts the tragic reality that her foster children are perpetually affected by past trauma, Ms. Jones does not give up trying to interact with and teach her children. Instead, she is motivated modify her parenting tactics and teach in a way that will not cause further trauma.

Ms. Fisher also demonstrated acceptance of her foster child’s behavioral issues. She acknowledged her child’s difficulty when he is in small public spaces, as well as his need to be perpetually occupied, and she used this information to plan ahead in order to save herself undue stress:

My [biological] son was in a play that [my foster son] didn’t want to go to. And if he doesn’t want to be somewhere, he wouldn't be containable. He would make enough commotion, enough behavior stuff to get out of there. So there was no way I could take him, because he didn’t want to go. So I had him go to the hardware store for me in town, and then all the way over here to the grocery store, so it would keep him busy while I was at the play.

By identifying her foster child’s needs and accepting his behavioral limitations, Ms. Fisher effectively allows herself to plan ahead and avoid potentially problematic or stressful situations.

Ms. Stewart also demonstrated acceptance of her foster child’s behavioral limitations and an ability to plan ahead to meet her child’s needs:

They were going to get a behaviorist here to deal with some of the issues and we were like, “it’s not going to help, she just needs supervision.” So the reality is, it’s true. She’s a child that just always needs supervision. So that’s what we do.

Rather than continually engage in fruitless efforts to modify her child’s behavior, Ms. Stewart and her husband accept their child’s need for consistent and diligent monitoring
(at least in the short-term). Once they acknowledge that their child requires a high level of care, they are able to adapt to her needs with active problem solving:

The only problem was, she was so needy, that my husband couldn’t work. So we basically said we can’t do it with that ridiculously small of a stipend. So we asked and they did increase that.

After accepting their foster daughter’s need for constant supervision, Mr. and Ms. Stewart actively seek support from the agency and are able to fulfill their needs, allowing them to provide sufficient care for their child.

*Positive reappraisal.* Engaging in positive reappraisal—the process of perceiving challenging situations as opportunities for learning and growth (Lambert, Graham, Fincham, & Stillman, 2009)—allowed foster parents to maintain positivity while processing the difficulties of fostering. Parents tended to view their fostering experiences as growing and learning opportunities, and described their job with terms such as “worthwhile” or “life-changing.” Ms. Jones stated explicitly her view of fostering as a self-improving and spiritual process:

It's a struggle and you wonder sometimes, "What am I doing this for?" But when you put yourself out there for somebody, you grow. They'll teach you another facet of life that I never thought of. Or an emotion that it never occurred to me was tender. It makes you a better person, to be more understanding, to be more confident.

By engaging in positive reflection and reappraisal of her past challenges, Ms. Jones is able to process the highly emotional and difficult nature of her work with appreciation and positivity.

Positive reappraisal was often accompanied by acceptance of hardship as a part of life. Ms. Griffin not only accepted the presence of hardship in fostering, but described looking forward to such experiences as opportunities for growth:
The challenges are always going to be there. As a mother, even with my biological kids. Children challenge you, that’s what they should do. That's how they change, that's how they grow. I look forward to the challenges.

Not only does Ms. Griffin enable herself to remain positive in the face of challenge by accepting difficulties as learning opportunities, but she extends this view to her children’s challenges as well.

Ms. Braxton also acknowledges her children’s difficult behaviors or negative emotional experiences as opportunities to make positive change. She describes communicating this outlook to her children and encouraging them to accept and embrace hardship or negative feelings:

We talk about how there are times when they’re going to be good, and times when they’re going to be angry. That’s the only way for them to understand themselves. By going through anger, we can go through it together, we can talk about it, and we see the peaceful transition at the end. This way, they can move on to the next [thing], because that’s how you grow. Nothing stays the same every day.

By accepting anger and negativity as a natural part of life, Ms. Braxton not only prevents herself from feeling guilt or stress when her children exhibit such emotions, but transfers this positive outlook to her children as well through communication and understanding.

Overall, therapeutic foster parents use of acceptance and positive reappraisal strategies works to maintain positivity and thwart negative feelings of regret, self-blame or rumination on challenges past and present.

**Sustained Positivity and Purpose.** In the midst of exposure to difficult behavior and the effects of post-traumatic stress or abandonment, foster parents exhibited an ability to sustain positivity in the form of optimism, humor, and self-efficacy.
Optimism/hopefulness. The majority of optimistic sentiments expressed by therapeutic foster parents described feelings of hope that their foster child would overcome the behavioral or emotional challenges that he or she currently experienced. Ms. Stewart, whose foster child was exhibiting such extreme behaviors as urinating or defecating in public places, hoarding food and eating inedible substances such as toothpaste or dental floss, expressed hope that her child’s behavior would improve with age:

She’s just so impulsive, and unsupervised, 9 times out of 10 she's going to choose the wrong thing to do. Not that there’s no hope. We think maybe that will change as she gets older. For now, we've already seen a lot of growth. Less tantruming, [sic] less physical outbursts, less aggression.

This statement of optimism for her foster child’s future characterizes the general outlook that these therapeutic foster parents have toward their foster children’s progress: the parents are hopeful for positive change. Ms. Braxton found reason to express a similar feeling of hope for her foster child based on the recent behavioral progress her foster child had made:

When she first came she wouldn’t help with the dishes—now, when I had people over for thanksgiving or my daughters she said, “I’m gonna do the dishes.” If I go do shopping, by the time I put it out there without ringing the bell she comes and she’ll bring over the shopping. So you can see the transition. It’s still a lot of work, I’m not going to change her overnight, but hopefully things will change.

In addition to feeling optimism for their foster child’s behavioral improvement, four of the nine foster parents described a sense of hope in their foster child’s ability to gain life skills, achieve academic success or make meaningful contributions to society. After sharing her foster son’s recent run-in with police and persistent academic challenges, Ms. Palmer nevertheless expressed optimism for her foster child’s future:
He has this really sweet, nurturing side to him, and to give [my foster son] the opportunity to feel safe enough and himself enough for that part of his personality to have an opportunity to flourish, that feels good to me. It gives me hope that he'll be a decent adult who will do kind things and good things in the world.

Other foster parents described a similar faith in their foster child’s ability to contribute to their community or become caring parents to their own children. When asked how she managed the daily challenges of her fostering, Ms. Caldwell made explicit the significant role of hopefulness in her life:

You have to be able to have everything go wrong, go to sleep, wake up and say, "We'll try again. Everything will go okay today.” You basically have to have blind optimism.

For Ms. Caldwell, optimism serves as a motivational force. Hopefulness drives her ability to persist in her efforts as a foster parent, even when confronted with significant challenges. Despite, or perhaps because of, the stressors she faces as a foster parent, Ms. Caldwell demonstrates a powerful capacity to maintain optimism under stress.

**Humor/playfulness.** Foster parents seemed to use humor as a strategy to maintain perspective of their situation. Many of the foster parents were unable to contain their laughter when retelling some of the behavioral incidents they had experienced with their foster children in the past. Ms. Jones expressed a humorous sense of sarcasm while recounting some of her foster children’s past destructive behaviors:

I've had everything happen here between breaking furniture, breaking the kitchen window, pulling doors right off the doorjambs, the showerhead, breaking the pole right out of the wall. How hard do you have to hang on it to break the shower pole? (laughter). It's on the wall for pete's sake!

While retrospective laughter does not necessarily indicate a humorous response to such stressful incidents in real time, two foster parents stated explicitly the role of humor in
their reactionary coping with behavioral outbursts. Ms. Caldwell recounted one such incident that occurred soon after the first foster child moved into the home:

He pulled the bathroom door up off its hinges and threw it down the back stairs, and I just started to laugh. I mean, that's the only response to a child that throws the door down the back stairs!

What can you do?

Rather than responding to stressful incidents with feelings of anger or depression, Ms. Caldwell was able to sustain feelings of positivity by using humor to establish perspective. Similarly, Ms. Palmer described humor as her most significant personal resource for managing her foster children’s difficult behaviors:

Well the biggest, most important thing for me is to have a sense of humor. You have to be able to laugh at the kid peeing out the window, because if you can’t laugh then you’re really going to be miserable.

In a more direct use of humor to manage the behavioral incidents of therapeutic foster children, Ms. Braxton described the implementation of playful, creative strategies to encourage her foster children to change their behavior. When her foster child refused to take showers, Ms. Braxton covertly brushed her child’s leg with makeup in the mornings and looked to see if the mark was still there after her child claimed to have showered.

“These are the things I do to get them to feel good,” Ms. Braxton said, “without being mean and shouting. I do it in a fun way.” In one expertly planned and executed prank, Ms. Braxton enlisted a friend to call the house pretending to be a police officer in order to discourage her foster daughter from smoking. Ms. Braxton described the aftermath of the prank as follows:

I just sat on the back porch laughing, and she said, “I’m sorry officer, I’ll never do it again.” And I just told her last week, “Remember that police officer you were talking to? That was my girlfriend.” We laughed about it then.
By using playfulness and humor in response to some of her foster children’s worrisome behaviors, Ms. Braxton instills her foster children with a sense of comfort and ease while simultaneously fortifying her own feelings of positivity.

Agency/self-efficacy. Most foster parents described feelings of self-efficacy—a belief in one’s own ability to take on challenges and accomplish goals—in relation to the challenges of fostering. Some situated this strong conviction in themselves within the framework of their professional skills as social workers or parent educators. Mr. Holmes articulated a sense of confidence in his ability to handle the behavioral issues presenting in his foster children based on his experience working with special needs populations:

The training I got was really through working with special needs kids. I had done it for years before I became a foster parent, and by working in the field that I work in, it makes my job [as a foster parent] so much easier. Because it is challenging. A lot of people couldn't do it. You have to have a lot of patience, you have to have skills. Fortunately, I have what it takes to diffuse a lot of things, cater to a child's needs.

Citing his past accomplishments while working with special needs children, Mr. Holmes expressed confidence in his ability to provide care to therapeutic foster children. Ms. Fisher also expressed a sense of self-assurance in her work as a foster parent given her professional background:

I'm a parent educator for a living. So I kind of know what I'm doing. I know a lot of strategies because that's my profession as well...So almost nothing stumps me pretty much. I can figure it out.

Though her experience was not working with children per se, Ms. Fisher was able to draw on her career-based knowledge to fuel self-efficacy in the domain of foster parenting. Three parents mentioned both their professional background in a helping
occupation as well as first-hand experience managing the needs of their biological children as factors that instilled the parents with confidence to take on the challenges of foster parenting. Ms. Stewart described feeling qualified for foster parenting based on both her and her husband’s background with special needs populations:

We both have a background dealing with adults with special needs, so in that way we feel very suited to be foster parents in addition to having our own children, and one of them has special needs herself…so, for us, we really know what we’re doing.

The combination of having worked with similar populations prior to foster caregiving as well as managing the needs of her biological daughter seemed to enhance Ms. Stewart’s feelings of competence and self-assurance as a foster parent. Two therapeutic foster parents, neither of whom had never worked in a helping or human services profession, communicated feelings of self-efficacy as foster parents derived from their experiences as parents to their biological children. While discussing the foster parent training she and her husband completed, Ms. Mitchell said the following:

It was basically a refresher course for us, because we brought up three great kids. So we really knew what we were doing as parents. That's one thing I'm really proud to say: we raised three great kids. They're doing great on their own.

Through positive appraisal of her parenting skill with her biological children, Ms. Mitchell demonstrates a strong belief in her and her husband’s ability to be effective foster parents. Ms. Braxton expressed an almost identical sentiment in response to an inquiry about foster parent training:

It was helpful, but it was easy too. I have three of my own, and they are successful children, so it was pretty easy. I never had any issues grooming our kids, they turned out to be really good kids, so I figured we could do the same thing with other kids as well.
Despite differences in professional background and levels of exposure to populations with special needs, each of the therapeutic foster parents who conveyed a sense of parenting self-efficacy implied having reached that state of self-assurance through past experiences and accomplishments.

**Meaningfulness.** All twelve therapeutic foster parents conveyed a sense of meaningfulness achieved through fostering. Statements that reflected meaning were concerned with the attainment of self-actualization—the fulfillment of one’s potential—or the realization of one’s purpose in life through providing foster care. Most often, foster parents indicated a sense of fulfillment by acknowledging the important contribution their work has made to others. Mr. Holmes expressed pride and satisfaction in having been able to offer his foster son the support that he needed:

- Being a foster parent is challenging. You have to have a lot of patience, you have to have skills.
- Fortunately, I have what it takes to diffuse a lot of things, cater to a child's needs. A lot of people couldn't do it, but fortunately there are people like us who do.

By acknowledging his unique ability to provide care to children in need, Mr. Holmes suggests that fostering has give him fulfillment; being a foster parent has allowed him to use his personal strengths to make a lasting contribution to others.

Foster parents also experienced satisfaction in helping their foster children attain their own sense of fulfillment. Ms. Palmer expressed feeling pride in witnessing her foster son strive toward reaching his full potential:

- To give him the opportunity—a life—to feel safe and happy enough to be who he's meant to be—
- I'm very proud of that. I'm happy I could do that for him and help him get there.

For Ms. Palmer, satisfaction and meaning is experienced vicariously through her foster son’s growth and self-actualization.
Some foster parents expressed a sense of meaning attained through enabling their foster child to “give back” to society, or to help others. Ms. Ingram, who fostered 20 children throughout her foster parenting career, described the immense joy she felt when her children not only gained independence but became productive members of society as well:

When they come back and tell you how they're adjusting and some of their experiences and they call you, that's a good moment. When they can call and say, "Guess what I'm doing now? Finishing school. Doing great things. Working. In my own apartment." That's good news—that they've gotten there and that they're going to be an asset to our community. That’s a great feeling.

In addition to experiencing pride in witnessing her foster children gain life skills and independence, Ms. Ingram acknowledges the positive influence of her work beyond the direct effect she has had on her foster children—Ms. Ingram has given her foster children the tools to become “an asset” to the community, or a valuable part of society. Ms. Ingram perceives her work as meaningful not only to herself and her foster child, but to society at large. When facing the everyday challenges of fostering, Ms. Ingram’s feeling that her work has a purpose and value beyond her immediate experience may fuel her ability to sustain satisfaction under stress.

Certain foster parents described foster parenting as a reflection of their true purpose in life or as a task bestowed on them by a higher force. Ms. Ingram referred to foster parenting as “a ministry, not a job,” and Ms. Ashley spoke of her foster children’s achievements and happiness as “blessings.” Ms. Jones viewed her work as a gift from God, and spoke of the spiritual growth both she and her biological children experienced through her work:
I’ve always done [foster care] and my children have always been most capable of being participants. I’ve always believed that God will never give you a gift that the people you care about most can’t tolerate. They have learned a level of compassion that I couldn’t have just taught them.

In addition to viewing foster caregiving as a fulfillment of her own spiritual calling, Ms. Jones recognizes that her work has supported her biological children’s development of empathy and compassion, which may allow them to carry on her legacy and make lasting contributions to others as well.

Ms. Caldwell also expresses a view of her work as a kind of spiritual calling, though she does not explicitly state a belief in a God or higher power:

I'm doing what I want to do—what I think I was supposed to do. I don't know if there's such a thing as that, but if there is then this is it.

Through descriptions of their satisfaction and pride in their work, foster parents demonstrate their capacity for sustained engagement and purposive action, even in the face of major challenges.
Discussion

This study sought to determine the utility of resilience as a framework for conceptualizing of foster parents’ willingness and ability to care for children with emotional and behavioral difficulties. A significant association was found between resilience and willingness to foster children with behavioral and emotional problems. Furthermore, ten specific resilience processes and personal resources used by effective therapeutic foster parents to manage the challenges of their work were identified, and the use of these resources to promote stable placements was explored through qualitative inquiry and analysis.

Resilience and Willingness to Foster

Bivariate analysis indicated a significant positive correlation between resilience and willingness to foster behaviorally and emotionally complex children. Though limited prior research exists on willingness to foster children with emotional and behavioral problems, studies that examine foster parents’ intent to continue fostering may shed light on some of these findings. Whenan and colleagues (2009) found that greater parenting self-efficacy in relation to children’s behavior problems was significantly associated with the intent to continue fostering and with foster parent satisfaction. To the extent that resilience also measures control and self-efficacy (Connor & Davidson, 2003), the association between resilience and willingness to foster may reflect greater parental self-efficacy regarding the ability to exert a positive influence on foster children with emotional and behavioral problems. The nature of the link between resilience and willingness to foster children with behavioral and emotional difficulties was further explored through qualitative investigation.
Resilience Processes
Ten resilience processes were identified through thematic content analysis of 12 interviews with effective therapeutic foster parents. Interpersonal awareness, self-regulation, cognitive flexibility, and sustained positivity and purpose appeared to function in tandem to promote foster parents’ ability to manage the behavioral and emotional difficulties of their foster children and to thrive from the challenges and triumphs of caregiving.

Interpersonal awareness. Qualitative analysis identified interpersonal awareness as a resilience resource used by therapeutic foster parents to manage the challenges of caring for children with emotional and behavioral difficulties. Resilience research suggests that interpersonal skills are used to promote strong relationships and elicit positive reactions from others through empathy and open communication (Skodol, 2010). Foster parents appeared to use their well-developed capacity for interpersonal awareness and insight to form strong, trusting relationships with their foster children. Research shows that a strong foster parent-child relationship has a significant positive effect on the child’s long-term behavioral functioning (Farmer, 2009), and placement stability (Redding, Fried, & Britner, 2000). By engaging in positive parenting tactics, foster parents may have been able to enhance their children’s well-being as well as their own, given the substantial evidence that foster children’s behavioral problems can induce parental strain (E. Farmer, Lipscombe, & Moyers, 2005; McCarthy, Janeway, & Geddes, 2003; Vanschoonlandt, Vanderfaillie, Van Holen, De Maeyer, & Robberechts, 2013).

Self-regulation. Self-regulation may also have functioned to promote a positive relationship between foster parent and child. Through patience, tolerance, and control
over emotional reactivity, parents appeared to be able to reduce their children’s behavioral reactions by modeling tranquility and assimilating them to non-punishing, attentive parenting. This finding is supported by the literature on biological parenting practices, which holds that parental reactivity is associated with the development or exacerbation of child externalizing disorders (Mun, Fitzgerald, Von Eye, Puttler, & Zucker, 2001). Furthermore, parents’ ability to regulate the positive emotions they felt, such as pride and joy, in their foster children [Needs a finish here e.g. may have contributed to the positive relationship.]

**Cognitive flexibility.** Foster parents used positive reappraisal and acceptance—elements of cognitive flexibility—to mediate their interpretations of stressors and challenges and maintain positivity in the face of challenge. Research shows that positive reappraisal, or the process of perceiving a challenge or stressful event as a positive experience (Lambert, Graham, Fincham, & Stillman, 2009), can be used as a cognitive coping mechanism to improve mental health in the face of stressful life circumstances (Florian, Mikulincer, & Taubman, 1995). Of particular interest was the use of positive reappraisal in reference to past placement disruptions. Therapeutic foster parents whose foster children had disrupted and been placed in more restricted settings, such as group homes or psychiatric facilities, appeared to accept the disruption as an occurrence that was out of their control, rather than experiencing thoughts of self-blame or guilt. By contrast, Farmer and colleagues (2005), demonstrated that foster parents who perceived a significant amount of strain after a placement disruption were more likely to continue to be under strain during subsequent placements with a foster child. Strain during placement was also associated with poorer parenting tactics such as lax limit-setting. Poor parenting
tactics have the ability to elicit increased negative behavior from the child, which can lead to placement disruption (Farmer et al., 2005; Vanschoonlandt et al., 2013). Acceptance of the inevitability of at least one experience of placement disruption may have shielded foster parents from feelings of self-blame and strain, thus preventing the negative cycle described by Farmer and colleagues (2005).

**Positive emotions.** Foster parents’ feelings of joy, pride, and delight in their foster children may have allowed them to continually build their capacity for resilience in the face of adversity. In light of the “broaden and build” theory of positive emotions (Frederickson, 2001), the experience of positive emotions does not just provide a momentary break from negativity or strain. Rather, positive emotions inspire one to attend to and engage more actively with the environment. This active engagement has the potential to build personal resources that confer positive emotions in the future. For example, a foster parent who experiences pride and joy in their foster child may engage more actively with the child, thus strengthening the relationship. These positive interactions and the resulting relationship between parent and child may help to reduce a foster child’s behavioral problems (Vanschoonlandt et al., 2013), leading the foster parent to feel accomplished and proud for having helped the child improve. This experience of success may transfer to a feeling of self-efficacy, or confidence in one’s ability to positively influence challenging situations in the future. Foster parents who have higher self-efficacy are more likely to continue to foster, to take in more children, and to foster for longer (Whenan et al., 2009). This sequence of positive emotions and growth of personal resources exemplifies the phenomenon of resilience in effective therapeutic foster parents. They are not just satisfied with their work—they are thriving.
**Resilience model of retention.** Though the findings of this study do not yield causal explanations for why parents quit or continue to foster, the findings support a theoretical model of foster parent retention that is the positive opposite of Farmer and colleagues’ (2005) description of the negative cycle of strain that leads to placement disruption or foster parent dropout. This proposed model has two divergent tracks: one in which the foster parent becomes overwhelmed or feels strain in response to the child’s behavioral and emotional problems, leading to less efficacious parenting practices, and resulting in placement disruption. Based on the findings of Farmer and colleagues (2005), the experience of placement disruption for the highly strained parent may be internalized and lead to greater strain. Negative effects of strain experienced prior to a foster child’s placement have been shown to carry over into the next placement (Farmer et al., 2005), causing the negative cycle to continue until the foster parent eventually gives up fostering.

In this positive model of retention, a parent who possesses resilience resources such as self-efficacy, empathy, and the ability for emotional control and self-regulation may use these resources to build a strong relationship with the child. These resources may be a mixture of personality factors and qualities built upon past experience of success. This therapeutic relationship may serve to ameliorate the child’s emotional and behavioral problems (Farmer, 2009), leading to feelings of pride in having helped the child, increased satisfaction, and joy in parenting. These positive emotions may translate into a feeling of self-efficacy regarding the future ability to care for children with behavioral and emotional problems, leading to the decision to continue taking in foster children (see Figure 1). This proposed model of two separate populations of foster
parents is supported by the work of Cherry and Orme (2013) illustrating the presence of two distinct groups of foster parents: the Vital Few and the Useful Many. The Vital Few represent approximately 20% of foster parents who provide 60-80% of all foster care. They continue to foster for many years, take on more children, adopt more children, and report high levels of satisfaction with fostering. The resilience of the Vital Few is a potential explanation for this finding.

**Figure 1. Conceptual model of resilience-based retention theory**

**Implications**
The implications of this research are of great importance for improving retention and recruitment strategies.
This study echoes the suggestion of others (e.g., Cox, Orme, & Rhodes, 2003) that foster parents who are new to the system or who have not had significant prior experience parenting or working in a helping profession should be matched with children who have a lower level of need. Parents who are able to successfully care for their first child and adapt to the change of lifestyle that foster parenting presents will likely feel more capable of taking in more difficult children in the future. Furthermore, this practice may prevent the process described by Farmer and colleagues (2005) in which parents who are initially unwilling to care for children with behavioral and emotional difficulties experience a stressful placement disruption and resign from foster care.

The demonstration that resilience is in fact correlated with willingness to foster children with behavioral and emotional difficulties merits the development of resilience-based trainings for foster parents in order to ensure the well being of foster parents who take on the noble duty of caring for children with a high level of need. These trainings may be informed by the intervention programs developed for social workers and nurses, which aim to reduce workplace stress, strengthen support systems, and build cognitive competencies (Grant & Kinman, 2012; McDonald et al., 2012). These programs last for roughly 8-11 weeks, and use only 1-2 hours of workers’ time. Thus, the implementation of such strategies in the pre-service and in-service training of foster parents may be feasible.

**Strengths**
This study takes a novel, strengths-based approach to the study of a foster parent’s experiences and influences on willingness to care for children with behavioral and emotional difficulties. The use of a mixed-methods design allowed for contextually
sensitive inferences from qualitative data as well as potential generalizability of such inferences based on the quantitative results. According to Ungar (2003), qualitative methods in resilience research are invaluable, as the manifestation of resilience will differ depending on the particular stressors and risk factors in the environment as well as the psychosocial resources available to support positive adaptation (Ungar, 2003).

**Limitations**
The study had notable limitations. Namely, the use of a cross-sectional design small sample size of 18 therapeutic foster parents limits the confidence in validity and generalizability of the findings. In addition, the use of the WFS-EBP as an outcome measure among a sample of therapeutic foster parents may measure a separate construct from the willingness of regular foster parents to care for such children. Given that therapeutic foster parents are already caring for children with a high level of behavioral and emotional need, the WFS-EBP may be measuring the level of perceived support they need with fostering, as opposed to their overall willingness to care for difficult-to-place children.

**Future Recommendations**
This study merits further investigation of resilience in therapeutic foster parents as a mediator of satisfaction and maintenance of stable placements for foster children with behavioral and emotional problems. Future research should employ a longitudinal design and assess long-term outcomes in foster care for parents who demonstrate high resilience. In addition, future research should examine the role of resilience in foster parents’ ability to take on challenges posed by the foster care system, as opposed to those posed by the children themselves. Various studies (e.g., Brown & Calder, 1999; Sinclair, Gibbs, & Wilson, 2004), have documented the difficulties foster parents have with their foster care
agency and even with specific social workers. Feelings of being undervalued and lacking a clear definition of one’s role in the foster child’s life have been cited as reasons that foster parents give up fostering. One possible explanation for the relatively high overall resilience scores in the sample of CCF therapeutic foster parents may have to do with the workplace environment that is fostered through this particularly supportive and attentive program. Many of the parents interviewed commented on their satisfaction with the CCF staff, many of whom had been foster parents themselves. The potential for supportive staff members who are foster parent peers as well as social workers to support resilience in therapeutic foster parents is a phenomenon that merits further investigation.
Personal Reflection

Prior to meeting Ms. Klimczak, I was under the impression that foster parenting was a task reserved for distant relatives of abandoned children, or for those looking to make extra money by housing a child. What I learned through my contact with Ms. Klimczak and the parents of Connecting Children and Families was that my first impression could not have been further from the truth. These foster parents are hard-working, passionate, and deeply committed to their foster children. They spend time reading about trauma and child development and they are experts at understanding human behavior. They devote themselves to professions outside of foster care but schedule quality time with their children. They strategize and come up with creative ways to teach their foster children life skills, to help them learn to form attachments, and to guide them while they confront past trauma. They are willing to tolerate long periods of adjustment during which their foster children continuously push them away, act out aggressively, lie, steal, or destroy things. They remain committed when this adjustment lasts for years. Finally, these foster parents are not passive hosts to children in need of room and board—they are purposeful and engaged, and they take pride in their work. Foster parenting may be a thankless task in the sense that payment and formal recognition is low, but many of these foster parents are thriving—not in spite of, but because of their work.
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Appendices

Appendix A: Research Disclosure and Informed Consent Form

Dear Participant,

My name is Zoe Feingold. I am a Psychology student at Wesleyan University, and I am conducting a research study on therapeutic foster parents as part of my undergraduate work at Wesleyan. I am being supervised by Charles Barber, a Professor at Wesleyan University and the director of the Connection’s Institute for Innovative Practice.

The general aim of the study is to explore the qualities of therapeutic foster parents that contribute to their ability to create stable homes for foster children. To investigate this question, the study will use three surveys as well as an interview with the parents of Connecting Children and Families. The hope is that the study will provide valuable information regarding qualities of effective therapeutic foster parents and their approach to fostering. In the future, this information may be useful for improving the quality of training and support that therapeutic foster programs provide to parents. In no way will this information be used to determine your eligibility to serve as a caregiver for foster children.

If you agree to participate, you will be asked to complete an in-person interview with me. This interview will include a few predetermined questions that ask about your experience as a foster parent at CCF and in general. The interview process will take approximately 20-40 minutes to complete.

Because it is important to study the exact answers you provide to interview questions, you will be asked for permission to have your interview audiotaped. Following the interview, the audio recording will be uploaded onto a computer and stored in a protected file. The recording will be transcribed onto the computer and the transcription will be stored on a secure computer file accessible only by the researcher. The recording will be deleted after it has been transcribed. You may choose not to have your interview audiotaped without consequences or penalties.

Following the interview, you will be asked to complete three questionnaires. Each survey will take approximately 5-10 minutes. Data from completed questionnaires will be entered into an electronic document and stored in a secure computer file accessible only by the researcher. There will be no identifying information linked to this file.

All information that you share through your answers to the questionnaires and during the interview will be completely anonymous. Your name will not be included on any forms other than the Informed Consent you are reading now. The signed informed consent will be stored in a locked file cabinet accessible only by the researcher. Any
names mentioned in the interview will be removed during transcription to protect the privacy of yourself and your foster children. None of the information provided in this study will be used by CCF to evaluate you in any way.

There is minimal risk associated with your participation in this study; however, some of the topics covered in the interview may be emotionally sensitive. Should you choose not to answer a particular question, you may say “pass” and there will be no consequence of any kind. While there are no direct benefits of participating in this study, the comments you provide will meaningfully contribute to the existing research on foster parenting.

Participation in this study is completely voluntary. You are free to decline to participate, to end participation at any time for any reason, or to refuse to answer any individual question without penalty.

If you have any questions about this study, I encourage you to contact the investigator, Zoe Feingold, by email at zfeingold@wesleyan.edu or by phone at 215-498-1751. You may also contact the faculty supervisor, Professor Charles Barber, at cmbarber@wesleyan.edu or 860-918-6540. If you would like to talk with someone other than the researchers to discuss problems or concerns, or to discuss your rights as a research participant, you may contact the Chair of the Wesleyan University Institutional Review Board, Jennifer Rose, at 860-685-2406 or via e-mail at jrose01@wesleyan.edu.

**Consent to participate:**

Your signature below is an indication of your willingness to participate in this research project and an indication that you have been sufficiently informed of the nature and risks of your participation.

<table>
<thead>
<tr>
<th>Participant’s name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature

**Consent to have interview audio recorded:**

Your signature below is an indication of your willingness to have your interview audio recorded by the researcher.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Demographics Questionnaire

1. What is your age?

________________

2. What is your gender?

○ Male
○ Female
○ Other

3. Which of the following best describes your marital status?

○ Married
○ Widowed
○ Divorced
○ Separated
○ In a domestic partnership or civil union
○ Not married, but cohabiting with a significant other
○ Single, never married

4. What is the highest level of school you have completed or the highest degree you have received?

○ Less than high school degree
○ High school degree or equivalent (e.g., GED)
○ Some college
○ Associate degree
○ Bachelor degree
○ Graduate degree

5. Which of the following categories best describes your current employment status?

○ Employed, working full-time
○ Employed, working part-time
○ Not employed, looking for work
○ Not employed, not looking for work
○ Retired
○ Disabled, not able to work
6. Have you worked in any of the following occupations? (Check all that apply)

- Education
- Healthcare Support
- Personal Care and Service
- Mental Health Occupations
- Counseling
- Social Work Occupations
- None of the above

7. In what year were you first approved as a foster parent?

________________

8. In what year were you first approved as a CCF foster parent?

________________

9. How many children are you licensed to foster?

________________

10. How many children have you fostered?

________________

11. Is there a foster child currently living in your home?

- Yes
- No

12. How many foster children are currently living in your home?

________________

13. Have you adopted any foster children?

- Yes
- No
14. How many foster children have you adopted?

________________

15. Is there an adopted child currently living in your home?

☐ Yes
☐ No

16. Do you have any biological children?

☐ Yes
☐ No

17. How many biological children do you have?

________________

18. How many of your biological children are currently living in your home?

________________

19. How many children (total) are currently living in your home?

________________
20. In what month was the most recent foster child placed in your home?

☐ January
☐ February
☐ March
☐ April
☐ May
☐ June
☐ July
☐ August
☐ September
☐ October
☐ November
☐ December
☐ Don't Know

21. In what year was the most recent foster child placed in your home?

________________

22. Have any of your foster children had behavior or emotional problems?

☐ Yes
☐ No
☐ Don't Know

23. Does your current foster child have behavior or emotional problems?

☐ Yes
☐ No
☐ Don't Know
24. Has any child who was placed in your home ever left your care?

☑ Yes
☑ No

If yes, then please answer the following:

25. How many children who were placed in your home have left your care?

________________

26. Of the children placed in your home who have left your care, how many left because they turned 18 or were legally free to leave?

________________

27. Of the children placed in your home who have left your care, how many left because you requested that they be placed elsewhere?

________________

28. Thinking ahead, over the next three years, do you intend to continue as a foster parent?

☑ Yes
☑ No
☑ Don't know

If No, then please answer:
29. Why do you intend to stop being a foster parent? (check all that apply)

- Conflict between foster child and my own or adopted child
- Child's behavior/discipline problems
- Health problems
- Age--will be too old to care for children
- Divorce, marital problems
- Expect to adopt a child
- Expect to have my own child or more of my own children
- Inadequate reimbursements
- May need to return to work full time
- Cannot get type of child requested
- Poor communication with foster care worker
- Do not have any say in child's future
- Agency insensitive to my needs/lack of support from the agency
- Lack of respite services
- Lack of day care
- Lack of other services
- Health or personal care needs of child will become too difficult to manage
- Problems with child's parent(s)
- Moved, relocated
- Have difficulty seeing child leave
- Other (please specify) ____________________
Appendix C: Willingness to Foster Scale: Emotional and Behavioral Problems

Lots of foster children have emotional or behavioral problems. As you think about what kinds of children would be a good match for your family, it will help to think about what kinds of emotional or behavior problems you can handle. Below is a list of problems that children in foster care might have. Please use the scale provided to indicate what types of children you are willing to foster in your home.

<table>
<thead>
<tr>
<th>SCORE (1-4)</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>1=Would not be willing to foster under any circumstances</td>
<td>1. Child who argues a lot with me</td>
<td>2. Child who is suicidal or wants to hurt himself/herself</td>
</tr>
<tr>
<td></td>
<td>2. Child who steals</td>
<td>3. Child who physically attacks others</td>
</tr>
<tr>
<td>2=Might be willing to foster with a lot of help and support</td>
<td>4. Child who doesn’t obey me</td>
<td>5. Child who gets into trouble at school</td>
</tr>
<tr>
<td></td>
<td>6. Child who threatens others</td>
<td>7. Child who threatens others</td>
</tr>
<tr>
<td>3=Probably be willing to foster with a little extra help and support</td>
<td>8. Child who is disrespectful</td>
<td>9. Child who lies</td>
</tr>
<tr>
<td></td>
<td>10. Child who is very secretive</td>
<td></td>
</tr>
<tr>
<td>4=Would be willing to foster without any extra help or support</td>
<td>11. Child who destroys the property of others</td>
<td>12. Child who masturbates</td>
</tr>
<tr>
<td></td>
<td>13. Child who doesn’t do well in school</td>
<td>14. Child who is restless or cannot sit still</td>
</tr>
<tr>
<td></td>
<td>15. Child who fights with other children</td>
<td>16. Child who rejects me</td>
</tr>
<tr>
<td></td>
<td>17. Child who is cruel or mean to others</td>
<td>18. Child who skips school</td>
</tr>
<tr>
<td></td>
<td>19. Child who cannot concentrate or cannot pay attention for long</td>
<td>20. Child who is very quiet and withdrawn</td>
</tr>
<tr>
<td></td>
<td>21. Child who wet the bed</td>
<td>22. Child who is sexually active</td>
</tr>
<tr>
<td></td>
<td>23. Child who uses drugs or alcohol</td>
<td>24. Child who sets fires</td>
</tr>
<tr>
<td></td>
<td>25. Child who swears or uses foul language</td>
<td>26. Child who is cruel to animals</td>
</tr>
<tr>
<td></td>
<td>27. Child who demands a lot of attention</td>
<td>28. Child who has sudden changes in mood or feelings</td>
</tr>
<tr>
<td></td>
<td>29. Child who doesn’t get along with other children (Child has difficulty making/keeping friends)</td>
<td>30. Child who feels worthless or inferior</td>
</tr>
<tr>
<td></td>
<td>31. Child who threatens to run away</td>
<td>32. Child who affiliates with gangs (e.g. skinheads, cults).</td>
</tr>
<tr>
<td></td>
<td>33. Child who has a bad temper</td>
<td>34. Child who doesn’t feel guilty after misbehaving</td>
</tr>
<tr>
<td></td>
<td>37. Child who has bad table manners</td>
<td>38. Child who is very manipulative</td>
</tr>
<tr>
<td></td>
<td>39. Child who has poor hygiene</td>
<td>40. Child who is a juvenile sex offender</td>
</tr>
</tbody>
</table>
Appendix D: Content Measured Through the Connor-Davidson Resilience Scale (CD-RISC)

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Able to adapt to change</td>
</tr>
<tr>
<td>2</td>
<td>Close and secure relationships</td>
</tr>
<tr>
<td>3</td>
<td>Sometimes fate or God can help</td>
</tr>
<tr>
<td>4</td>
<td>Can deal with whatever comes</td>
</tr>
<tr>
<td>5</td>
<td>Past success gives confidence for new challenge</td>
</tr>
<tr>
<td>6</td>
<td>See the humorous side of things</td>
</tr>
<tr>
<td>7</td>
<td>Coping with stress strengthens</td>
</tr>
<tr>
<td>8</td>
<td>Tend to bounce back after illness or hardship</td>
</tr>
<tr>
<td>9</td>
<td>Things happen for a reason</td>
</tr>
<tr>
<td>10</td>
<td>Best effort no matter what</td>
</tr>
<tr>
<td>11</td>
<td>You can achieve your goals</td>
</tr>
<tr>
<td>12</td>
<td>When things look hopeless, I don’t give up</td>
</tr>
<tr>
<td>13</td>
<td>Know where to turn for help</td>
</tr>
<tr>
<td>14</td>
<td>Under pressure, focus and think clearly</td>
</tr>
<tr>
<td>15</td>
<td>Prefer to take the lead in problem solving</td>
</tr>
<tr>
<td>16</td>
<td>Not easily discouraged by failure</td>
</tr>
<tr>
<td>17</td>
<td>Think of self as strong person</td>
</tr>
<tr>
<td>18</td>
<td>Make unpopular or difficult decisions</td>
</tr>
<tr>
<td>19</td>
<td>Can handle unpleasant feelings</td>
</tr>
<tr>
<td>20</td>
<td>Have to act on a hunch</td>
</tr>
<tr>
<td>21</td>
<td>Strong sense of purpose</td>
</tr>
<tr>
<td>22</td>
<td>In control of your life</td>
</tr>
<tr>
<td>23</td>
<td>I like challenges</td>
</tr>
<tr>
<td>24</td>
<td>You work to attain your goals</td>
</tr>
<tr>
<td>25</td>
<td>Pride in your achievements</td>
</tr>
</tbody>
</table>

(Connor & Davidson, 2003)
Appendix E: A Priori Resilience Codebook

1. **Cognitive Resilience Processes:**
   a. Insight/Compassion: Expressions indicating interpersonal understanding, identification with others, or empathy as a method of coping with challenges, stressors, or vulnerabilities posed by foster caregiving.
   b. Planning ability: Expressions indicating skill in planning/preparing for future challenges posed by foster caregiving.
   c. Positive reframing: Expressions indicating a view of the hardships and stresses of foster caregiving as learning or growing experiences; expressions indicating a non-negative appraisal of past caregiving challenges.
   d. Moral reasoning: Expressions indicating a strong moral compass and commitment to fairness/justice/decenty.
   e. Acceptance: Expressions indicating an acknowledgement of conditions outside of one’s control but without regret/blame/rumination.

2. **Emotional Resilience Processes:**
   a. Hopefulness/optimism: Expressions indicating a positive outlook on present or future life circumstances.
   b. Acceptance: Expressions indicating an acknowledgement of conditions outside of one’s control but without regret/blame/rumination.
   c. Self-regulation: Expressions indicating an ability to exercise cognitive and emotional control, i.e. through the control/suppression of fear, anger, depression or impulses.
   d. Confidence/self-esteem: Expressions indicating positive appraisal of oneself and one’s past achievements.
   e. Humor: Expressions indicating the use of humor as source of positive emotion in the face of difficult circumstances or stressors.
   f. Self-care: Expressions indicating deliberate cultivation/attention to one’s own physical health or mental wellness as a method of managing challenges posed by foster caregiving.

3. **Spiritual/Motivational Resilience Processes:**
   a. Sense of meaning: Expressions indicating an appraisal of life events as valuable, purposive, or existentially significant.
   b. Altruistic orientation: Expressions indicating a desire to help others, a sense of responsibility for others, a desire to “give back” or to make a lasting societal contribution.
   c. Self-efficacy: Expressions indicating confidence in one’s own ability to cope with situational demands and create positive outcomes; willingness/desire to take on challenges.
Appendix F: Coding Scheme After First-Round Coding Process: Deductive and Emergent Themes Combined

Domain: Cognitive Resilience Processes

Code Families, Codes, and Sub Codes

1. Positive Reappraisal
2. Moral Reasoning
   a. Concern with justice/fairness/decency
3. Planning ability
   a. Identification of problems
   b. Generation of solutions to problems
   c. Consideration of consequences of solutions
4. Interpersonal awareness
   a. Attentive observation of others
   b. Active communication/questioning
   c. Listening to others
   d. Encouragement of others
5. Insight/Compassion
   a. Insight into others’ behavior
   b. Finds strengths in others
   c. Empathizes; identifies with others emotions
6. Self-understanding/Self-awareness
   a. Forgiving of own mistakes
   b. Trust in self/trust in instincts
   c. Self-Care
      i. Recognizes own emotional or physical needs
      ii. Able to say no/recognize own limits
7. Acceptance
   a. Flexibility with expectations

Domain: Emotional Resilience Qualities

Code Families, Codes, and Sub Codes

1. Self-Regulation
   a. Emotional Control
   b. Regulates reactions to behavior
   c. Commitment; ability to delay gratification
   d. Composure/tolerance
   e. Able to detach/treat caregiving as job
   f. Not taking child’s behavior personally; perspective
2. Confidence/self-esteem

Domain: Spiritual/Motivational Resilience Qualities

Code Families, Codes, and Sub Codes

1. Hopefulness/optimism
2. Humor/playfulness
a. Uses humor as a tool to resolve challenges
b. Uses humor to establish perspective; humorous reflection on past and current challenges

3. Meaningfulness
   a. Passion/satisfaction for work
   b. Pride in accomplishments/in foster child’s success
   c. Value/purpose in work

4. Self-efficacy
   a. Positive appraisal of future challenges
   b. Belief in ability to influence child’s behavior/future

5. Self-reliance/independence

6. Determination/perseverance
   a. Hard-working
   b. Responsible

Domain: Cognitive and Emotional Processes not in Resilience Framework

Code Families, Codes, Sub Codes

1. Negative Emotionality
   a. Depression
   b. Frustration/anger
   c. Guilt
   d. Disappointment
   e. Self-blame

2. Negative Cognitions
   a. Perceived stress
   b. Victimization
   c. Regret
Appendix G: Categories and Themes in Data

1. Self-Regulation
   a. Emotion control
   b. Patience/tolerance
   c. Commitment/ability to delay gratification
   d. Self-understanding/awareness

2. Cognitive Flexibility
   a. Acceptance
   b. Positive reappraisal

3. Interpersonal Awareness
   a. Altruistic orientation
   b. Insight/compassion

4. Positivity/Purpose
   a. Optimism
   b. Humor/playfulness
   c. Meaningfulness
   d. Self-reliance/independence
   e. Planning ability
   f. Confidence/self-esteem
   g. Self-efficacy

5. Negative Cognitions/Emotions
   a. Depression
   b. Frustration/anger
   c. Guilt
   d. Disappointment
   e. Self-blame
   f. Perceived stress
   g. Victimization
   h. Regret