The Prevalence of ACEs Among Foster Parents in Alabama

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The Prevalence of ACEs Among Foster Parents in Alabama

by

Levonna S. Davis

A Dissertation

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the School of Social Work in partial fulfilment

of the requirements

for the Degree of Doctor of Social Work

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Abstract

Highlights: Adverse Childhood Experiences (ACEs) affect 63.9% of the U.S. population, slated to cause detrimental impact on physical health, mental health, and social outcomes to include parenting behaviors; however, a thorough assessment of its impact on foster parents is minimal. Foster parents are subject to ACEs, which in turn, may impact foster care placement outcomes.

Objectives: To examine the prevalence of ACEs among foster parents in Alabama and the relationship between ACEs, foster parent characteristics, and some foster care placement outcomes such as length of placement and number of placements per foster parent. Participants included 52 licensed foster parents who reside in Alabama, United States.

Methods: Univariate and bivariate statistical analyses, including ANOVA, Independent samples t-test, and Pearson correlation models, were conducted to investigate the relationship between the demographic characteristics of foster parents, ACEs, and number and length of foster care placements.

Results: The study showed that 60% of the sample population reported encountering one or more ACEs, while 23.1% reported encountering 4 or more ACEs, an indication of important trauma levels. The study concluded that there is an association between the number of placements which a foster parent has had over their service and the number of ACEs foster parents have experienced, but no other variables were significant.

Conclusions: These findings may suggest that an increase in foster care placements may be seen when ACEs are present among people serving as foster parents, which has potentially important implications for the wounded healer phenomenon, suggesting that foster parents who have experienced trauma have a greater desire to help children in difficult situations. Though ACEs are prevalent among the foster parent population and may have a connection with foster care
placements, there appears to be a need to look at additional factors that can contribute to foster parents’ skills and abilities. There is an indication for the necessity of effective foster parent training and support to enhance trauma awareness and its effect on work with children in foster care and with strengthening resiliency attributes in foster parents.

**Key Words:** Adverse Childhood Experiences (ACEs), foster parents, foster care, trauma
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Introduction

This work’s interest is to understand the prevalence of ACE among foster parents and its influences in child welfare. Child welfare examines allegations of abuse and neglect against children, provides direct care to families, and consists of recruitment of foster parents, foster parent training, licensing of foster homes and foster care placements. There continues to be ongoing discussion in the foster care system regarding challenges among foster parents and foster care placements, sparking an interest in understanding foster parents’ barriers and strengths, along with advocating for trainings to enhance foster parents’ skills and abilities. This research seeks to explore efforts to stabilize foster care placements and minimize disruptions.

In the foster care system, there have been challenges with foster parents maintaining placements with youth who presented with challenges that the foster parent struggled to work through, yet persisted because the foster parent was unwilling to accept failure when helping children in their care. The foster parent’s intent was to produce a successful outcome though it did not occur. It is observed that these foster parents seek to provide a nurturing home and become active participants in helping foster children make improvements in behavior, health, and outlook on life. According to Browning (2020), caring for children who enter foster care with significant trauma can present challenges for foster parents; however, the aim of the foster parent is to create a nurturing home for the child regardless. While there are situations in which improvements occur in working with foster children with challenging behaviors or needs, there are also times which the foster parent experiences strong and unwanted emotions of dislike for the child, as opposed to seeking solutions to improve and promote desired behaviors and emotions (Browning, 2020). It was indicated that foster parents who exhibit certain behaviors
such as undesirable emotions and responses may have been subjected to ACEs themselves as children (Lange et al., 2019).

There presents instances that suggested foster parents were working through their own personal issues, to include childhood experiences. Literature states that though some foster parents are driven by a desire to be loving caregivers and to protect foster children (Rodger et al., 2006; Cooley et al., 2021), there may be barriers arising from their own past that prevent the occurrence of a positive outcome. Foster parents are to be aware of their needs and abilities as it can be hampered by unrecognized or unexamined countertransference (Reidbord, S., 2010). As a result, if their issues are ignored, foster parents can run the risk of projecting their issues onto their foster children, which could have a detrimental effect on the child and/or foster care results, if they fail to appropriately address their trauma.

Despite the challenges that may exist, foster parents express many reasons for wanting to open their homes to foster youth. As previously mentioned, a stated reason is the feeling of relatedness via identification with underprivileged kids as a result of unpleasant childhood experiences (Dando & Minty, 1987). Another reason is that foster parents feel it is good for them to provide care for a child who has been removed from their caregivers (Sebba, 2012). Some individuals choose to foster to establish companionship for their own child (Sebba, 2012). There are also those who may experience infertility and desire to foster as a way to become a parent (Cooley et al., 2021; Dando & Minty, 1987). These are just a few of the many reasons that individuals seek to become foster parents. Whatever the motivation, it is important that those aspiring to foster and who currently foster are aware of their abilities and needs. It is also important that they are aware of personal experiences that may influence their parenting practices.
A study by Adkins et al. (2020) revealed that foster parents themselves exhibit trauma and have ACE histories just as the general population. This knowledge is helpful in exploring what foster parents’ parenting needs may be and aid in developing ways to support them. Knowing how foster parent’s own prior experiences have shaped their current behaviors is crucial as experiences can determine the way people parent. Carlson (2017) states that early life experiences have long-lasting impacts on the way people behave. Assessing foster parents’ trauma experiences raises awareness of parenting behaviors and histories as well as creates the ability to advocate for adequate training, support, and education. By doing so, this also enhances efforts in building healthier foster home environments. Though, more research is needed about the effects of ACEs among foster parents, what is known is that foster care agencies and the child welfare field can provide services or training needed to address any parenting limitations of foster parents to enhance their abilities to provide sufficient parenting to children and youth they serve.

Training is an important component in preparing individuals to become foster parents; however, Herbert & Kulkin (2018) found that identifying the most effective foster parent training program has been a challenge for those who work in the child welfare arena. In continuing to further explore training needs for foster parents, Herbert & Kulkin (2018) uncovered that foster parents felt that it was crucial that they acquire knowledge on how to handle difficult behaviors and assist foster children in adjusting to their new environment. Foster parents most often express their desire for training in the area of trauma and agency expectations. The need for adequate support and training of foster parents is evident (Denby et al., 1999). It is apparent that training on trauma and the effect of trauma is beneficial in working with parents who have
identified their own ordeal and have become aware of how their experiences are at play in their relationships with foster youth.

**Background and Significance**

Many children in foster care are placed into foster home settings. Licensing agencies are to ensure that these children are placed with foster parents who are recruited to provide a nurturing environment and adequate care needed for the child to flourish. Foster parents are utilized to teach basic living skills and independent living skills to foster youth. They are to create an environment that displays healthy interactions, support, safety, and security. When there is an interference in the parent acquiring skills needed to produce this setting, it can inhibit healthy outcomes. A factor that has been introduced to influence parenting skills and influences the relationship between the child and parent is Adverse Childhood Experiences (ACE) (Lange et al., 2019).

In reviewing previous research, many studies explored the influence of ACEs experiences of the natural parent. These studies indicated that those parents who reported encounters with ACEs exhibited parental stress (Lange et al., 2019) which affected children’s behaviors (Schickedanz et al., 2018; Wang et al., 2022). Research showed that these children displayed insecure attachment and disorganized attachment (van Ee et al., 2016), and additionally, concerns in child development were acknowledged (Miccoli, 2022). Attachment concerns appeared to be a major outcome influenced by parent’s trauma experience. ACEs has also been shown to cause a display in negative parental attitudes and practices (Morris et al., 2021). These studies of the parent-child ACE relationships can guide in work with foster parent-child ACE relationships. Knowing what is required to strengthen ties between the foster parent and child requires awareness of the foster parent’s transference of beliefs and behaviors. It is necessary to
recognize that understanding foster parents' experiences will help with assessing strengths and needs.

**A Look at Adverse Childhood Experiences**

Adverse childhood experiences (ACEs) are traumatic incidents endured prior to age 18. It is an encounter with violence, abuse or neglect, witnessing violence in the community and home, and family suicide attempts or deaths (Jones, et al., 2020). The Center for Disease Control and Prevention (2022), also states that ACEs includes residing in an environment where there are substance abuse issues, mental health concerns and where children are separated from parents or other household members due to incarceration or imprisonment. In the U.S., 63.9% of the adult population has had an encounter with ACEs (Swedo et al., 2023).

As it has been identified what life factors trigger ACEs, vast studies are also shedding light on how these life situations can establish the blueprint for future health issues in adulthood. ACEs are associated with presenting a high risk of unfavorable outcomes that affect individuals and extend beyond a timeframe, individual, or generation (Ports et al., 2019). The health of adolescents and adults is adversely affected over time by instances of such traumatic experiences (Goddard, 2020). ACEs have been slated to increase risk of enduring poor health consequences (MacMillan et al., 2020; Port et al., 2019), social consequences (Port et al., 2019), and is connected to mental health risks (Bomysoad et al., 2020).

ACEs have been found to cause alterations in brain chemistry (Kalmakis et al., 2015). A modification of such can cause an individual to become more likely to participate in high-risk behaviors like alcohol and cigarette use, which are linked to physical health concerns involving cancer and cardiovascular disease (Baylor University, 2019). Even when people with ACEs
refrain from high-risk behaviors, the effects ACEs have on brain development can still result in physiological changes that lead to a decline in health according to Baylor University (2019).

**Why Foster Parent ACEs**

There is little research on ACEs among the foster parent population, though it is known that they exist. The knowledge of foster parents ACEs can be impactful in addressing work with foster children. Research is needed in order to better understand the association. Slade & Cohen (1996) informs that a person’s integration of previous relationships has a significant impact on how they provide care for their children. Looking at the relationships between ACEs and parenting can help to better understand its association to foster parenting and how it can affect foster care outcomes. The University of California - Los Angeles Health Sciences (2018), states that childhood traumas that parents experienced led to increased behavioral health problems. Additionally, parents who underwent negative childhood experiences were more likely to report feeling more frustrated as parents and struggle with mental health issues (UCLA, 2018).

Other research that looked at the relationship of ACEs on parenting identified that attachment was significantly related to ACEs. Research conducted revealed that more experienced foster parents exhibited a lack of secure attachment to their foster children (Ponciano, 2010; Quiroga & Hamilton & Giachritsis, 2017 cited by West et al., 2020); however, it was not assessed during their study whether ACEs was a factor to the foster parents’ attachment. Conversely, Reisz (2023) asserts that there is a correlation between ACEs and attachment with foster parents. Reisz et al. (2023), stated that foster parents with higher ACEs had increased likelihood of attachment avoidance. When looking at forming secure relationships, foster parents’ traits are frequently cited as being more crucial than those of the foster child and placement status. When foster parents demonstrated encouraging, sensitive
parenting styles, there was a positive connection of a stable attachment between the foster children, and their foster parents received high agreement (West et al., 2020).

Attachment is important for a child and is necessary for child protection (Rees, 2007). If a youth is struggling with attachment in response to a past trauma experience and the foster parent is challenged with displaying sufficient attachment abilities, this can affect the placement and influence the outlook of the foster youth’s development within the home. The discussion of ACEs among foster parents should not be ignored, rather it should indicate the necessity of ensuring and promoting healthy outcomes for foster parents and foster youth.

**The Importance of Addressing Trauma**

Traumatic situations may cause significant changes in an individual’s psychological make-up, especially if posttraumatic stress disorder arises (Simmen-Janevska et al, 2012). According to van Ee et al. (2016), parents who experience Post Traumatic Stress symptoms produce children that have unorganized and insecure attachments. Children who enter foster care are already at risk for social-emotional challenges in adjustment as a result of possibly experiencing abuse and neglect prior to entering into foster care (Jacobsen et al., 2020). Also, for many children, being taken away from their relatives and familiar surroundings is a traumatic experience in and of itself (Bowlby, 1980; Lee et al., 2007). Therefore, dealing with the effects of these traumatic experiences on children and their foster parents may present challenges (Greeson et al., 2011). This helps demonstrate the need for caregivers who are trauma-informed, aware of their own personal experiences, and who are able to provide interventions to help children thrive while in foster care. It is suggested that when recruiting foster parents, sensitivity, traumatic experiences, and attachment of foster parents should be assessed (Stovall-McClough & Dozier, 2000).
Increasing understanding of trauma caused by ACEs can alter the way that individuals perceive what causes ACEs and aid in prevention development and strategies. It can minimize the stigma associated with getting assistance for parental difficulties. Also, understanding trauma caused by ACEs can encourage nurturing, stable, and secure interactions, and surroundings for kids to live, learn, and play. Lastly, it changes the emphasis from personal accountability to collective action (Center for Disease Control and Prevention, 2021).

Ports et al. (2019) proposed that addressing trauma related to ACEs necessitates describing the issue, measuring it, and then using the information to guide action. The lack in knowledge regarding foster parent trauma can hinder the development and implementation of policies, practices and interventions that support increase in foster parent skills and bolster healthy foster care outcomes. Once aware, agencies can address this lack by enacting effective screening and assessment protocols for foster parents. Agencies can also provide support and training to aid identified foster parents in becoming trauma informed and aware when providing appropriate and effective services to foster children.

**Problem Statement**

ACEs are common trauma experiences that are present in 63.9% of the adult population in the U.S. (Swedo et al., 2023). In the U.S., approximately 2 out of 3 adults had an encounter with one ACE, and 1 out of 6 adults reported encounters with 4 or more ACEs (Swedo et al, 2023). According to Adkins et al. (2020), adults who have experienced trauma are more likely to become foster parents. In the foster care system, foster parents provide a crucial role (Rosenwald & Bronstein, 2008). They become temporary caregivers to children in foster care without becoming the child’s legal guardian (Collins COBUILD, n.d.), and are responsible for supplying a child a safe, secure, caring, and loving home environment for as long as necessary to support
the child (Vista Del Mar, 2015). In the area of foster care, there is an array of research dedicated to the needs of foster youth who are challenged with different concerns of varying degrees, including risk from trauma exposure. However, the traumatic experiences of foster parents as a result of ACEs, which can affect parenting, are rarely acknowledged. This is important to explore because research on ACEs of biological parents suggests difficulties with parenting and attachment skills (Lange et al., 2019), as well as interference with parenting practices and parenting outcomes (Haynes et al., 2020; Azhari et al., 2020; Lange et al., 2019). Foster care outcomes may be impacted if the foster parent lacks adequate attachment skills as a result of ACEs influences. For a child to thrive and for child protection, attachment is vital (Rees, 2007). This can contribute to placement and future outlook of the foster youth.

The purpose of this study is to examine the prevalence of ACEs among foster parents in Alabama, and to assess the association between demographic factors and other foster parent characteristics. Foster parents are a part of the adult population that has been affected by ACEs, yet there is little research that investigates this stance. This dissertation contends that there is ACE prevalence among foster parents and that its examination is necessary due to the identification of ACEs being named as a contributor to adverse adult outcomes and effecting parenting behaviors.

The researcher reviewed existing knowledge in the area of bio-parents, foster parents and ACEs based on current literature. The researcher explored the prevalence of ACEs among foster parents in Alabama along with demographic factors and foster parent characteristics. The researcher evaluated literature regarding trauma theory, positive psychology, and the Wounded Healer phenomenon as they may provide considerations to addressing ACEs and foster parent circumstances.
Chapter 1: Literature Review

The Foster Care System

Foster care is an approach that provides placement for children and youth who have been removed from their home as a result of being dependent or neglected by a caregiver (Schor, 1982). It is intended to be temporary (Child Welfare Information Gateway, n.d.). For foster care consideration, there is an investigation of a report involving abuse or neglect of a child and then a determination made regarding whether the child is at risk when residing with its caregiver. If the child’s safety and wellbeing is compromised by remaining in the caregiver’s home and no kin or relative caregiver is identified, the child may be placed into foster care. The placement and custody of children, safety and permanency planning, and proceedings for the termination of parental rights are all decisions made by the courts regarding children after they enter into foster care. Judges are required to consider whether a decision will be in the "best interests" of the child whenever a court makes one of these decisions (Child Welfare Information Gateway, 2024).

The foster care system is responsible for providing the safest and nurturing placement option for children in the least restrictive and most family-oriented manner (Watson, 2016). Each state oversees how it runs its own foster care system; however, it must adhere to federal guidelines (Font & Gershoff, 2020). Children can reside in various types of foster care placements. These placement types can include placement into residential facilities, group homes and specific types of foster homes (traditional or therapeutic). While in these placements, foster children can receive services to address trauma from abuse and neglect, acquire academic recovery, learn basic living skills, develop independent living skills, and additional services depending on their level of need. When placing foster children into a foster home, the placement agency is responsible for ensuring that the foster parent can support the child’s needs.
History

In the 1900’s care for dependent and neglected children evolved into what is known today as the foster care system. The government became more involved in child welfare causing a shift away from indenture, placing-out and institutional care to a system called “boarding-out” which consisted of paying individuals to care for children who were orphaned or on the streets (Hacsi, 2017). Child placing agencies were then established to help locate families that would take children into their homes who had been removed from their parents or taken off the streets; however, these agencies were not adequately screening families sought to care for these children (Hacsi, 2017). Also, minimal contact was made with the child and the family after the child was placed in the family’s home. Agencies that were able to make contact with families that had received a child found that the placements were not working well (Hacsi, 2017).

Later in the 19th century, changes occurred to the method in which boarding homes were located. In response to recognizing that there were homes that were not good homes, for some agencies, investigation of foster homes became more in-depth (Hacsi, 2017). This is also around the time when the classification of dependent, neglect and juvenile offenders became identified as classes of children needing out of home placements. By the 1930s, boarding homes became a more utilized form of care for children. These homes consisted of children who were dependent due to the child’s family being impoverished causing them to be unable to provide adequate care for the child, due to the child’s family being able but not willing to care for the child, or as a result of child committing a juvenile offense (Hacsi, 2017). The number of children entering foster care versus institutions tripled by 1968 and by 1970 reached a peak due to the “rediscovery” of child abuse via research that was conducted about child abuse during this time.
(Hacsi, 2017). With the increase of children entering into foster care, federal legislation sought to establish policies and provide funding for the child welfare system.

In 1980, the U. S. Congress enacted into law PL 96-272, the Adoption Assistance and Child Welfare Act, which provided provision of payment for foster care and adoption assistance, and child welfare services (Avery, 1998). It determined the amount that states would be allocated for various child welfare related social service needs such as funds for training, emergency shelters, day care needs, and many other service areas (Avery, 1998). The government also became involved in inspecting foster homes. Each state was responsible for keeping a record of foster care placements and ensuring that foster children’s needs were being met in foster homes, as still occurs today. States later became responsible for the recruitment and training of specialized foster families to care for children with severe emotional, behavioral, or medical issues. There following, improved support for families in distress were among state’s initiatives to assure appropriate placements (Watson, 2016).

Now, states were not only responsible to simply work with foster parents in the foster care system, but each state became accountable for the development of resources to aid birth parents and caregivers with addressing issues necessary for them to reunify with their children in order to remove them out of the foster care system (Findlaw, 2018). Intensive family-based interventions were frequently mentioned as being a vital part of successful reunification initiatives. The primary goal of intensive in-home assistance for reunification is to ensure that families can provide the fundamental needs of their children. Parents were to receive practical instruction in areas where they are having difficulties, such as meal planning, grocery shopping, meal preparation, or housekeeping chores. However, there have been challenges with paying for extensive in-home care services which created difficulties and reduced birth families obtaining
what they needed to reunify with their children in foster care (Dougherty, 2004). This issue demonstrates why the foster care census remains consistently high. As the number of children entering foster care increases, foster homes continue to be a more utilized placement option for children removed from their parent or caregiver’s home (Children’s Bureau, 2021).

The foster care system faces numerous challenges as a result of the volume of children who enter care annually. Issues involve lack in uniformity of care across states, retention of foster parents, and instability of foster care placements. An additional concern is the problem surrounding addressing health matters of foster youth. It is documented that children and teenagers in foster care have the greatest unmet health need of mental and behavioral health. It has been reported that up to 80% of children in foster care have serious mental health problems which is four to five times greater than the general population (UMPC Health Beat, 2023). Minorities are disproportionately represented among this population. It was revealed that Native American/Alaskan Native persons reported suffering from severe psychological anguish 2.5 times more frequently than the overall population (Mental Health America, n.d.). Also, those who identify as LGBTQIA2S+ are six times as likely than those who do not to have depressive symptoms (Mental Health America, n.d.), and African Americans are less likely than the overall population to receive evidence-based psychotherapy or medication (American Psychiatric Association, 2017). Nearly 90% of Latinx/Hispanic adults with substance use disorders over the age of 12 did not obtain treatment (Mental Health America, n.d.). Finding healthcare and other services can be challenging for this population due to language barriers in that 32.6 percent of Asian Americans as a whole struggle with their English fluency (Mental Health America, n.d.).

This data indicates the need for foster care providers that are culturally aware and trauma informed so that the needs of youth in these populations can be met. As foster care is an avenue
by which dependent and neglected youth are cared for, it is therefore accountable for finding children the safest, most loving, family-oriented placement possible that is least restrictive. It has undergone numerous changes since its inception over a century ago, yet it still encounters challenges today with issues such as managing the number of children in care which has continuously grown over time, maintaining appropriate foster homes for these children, and meeting the needs of the children in the system.

**Foster Parents**

Foster parents are individuals who offer their homes to children who have been placed in the foster care system; they play a crucial role in providing services and taking care of these less fortunate children. (Ahn et al., 2017). Their role is closely related to that of a biological parent though it is not intended to be long term. It includes but is not limited to taking children to and from visits, school events, and medical appointments (Vista Del Mar, 2015). Foster parents are usually recruited, screened, and trained via the agency with which they foster. Factors that account for foster parents’ characteristics usually include demographics, age, income, career, and foster care experience (Ahn et al, 2017), as well as biological children, gender, ethnicity, marriage, education and whether the foster parent has ever been in foster care (Crum, 2010). According to Craft (2020), foster parents should possess skills to include conducting honest self-evaluations, engage in effective communication, be able to embrace the challenge that may come, be able to implement positive disciplinary skills and utilize conflict resolution, possess compassion and are able to collaborate as team members on behalf of the foster child (Craft, 2020).

Foster parents care for children with a variety of needs, with some to include responding to trauma reactions. According to Konijn et al. (2020), a child being taken away from his/her birth
family is traumatic in itself for the child. The foster parent works to stabilize the child and minimize placement disruptions within the foster home that can result from behavior responses. A foster parent may at any time need to confront or deal with a foster child who exhibits self-harming behaviors, runs away, engages in risky conduct like substance use or promiscuity, shows lack of bonding, or other concerns. Foster parents are viewed as key determinants when foster care moves occur (Leathers et al., 2019). To minimize the interruptions of foster home placements, effective skills are required. Papovich (2020), suggests that people who work with foster children or come into contact with them frequently should demonstrate their grasp of trauma-informed care.

**Types of Foster Care Placements**

Foster care placements are state governed and can range in placement types. These placement types can include residential facilities, group homes and specific types of foster homes (traditional or therapeutic) (Children’s Bureau, 2021). With the larger number of children in foster care residing in a non-relative foster home placement opposed to any other placement setting (Children’s Bureau, 2021), this indicates the volume of the use of foster parents. Many children are placed into foster homes of caregivers whom they are unaware of, and some foster children are even separated from their siblings upon entering into foster care. Foster children also frequently experience long-term physical issues, educational disadvantages, and severe emotional impairment (Schor, 1982). These may contribute to a foster child’s behavior and affect placement type.

Among the foster care population, numerous disruptions can occur, causing foster children to be moved from foster home to foster home. Disruptions may happen due to the foster youth displaying behavior problems that the foster parent is challenged with resolving and foster
parents lacking support (Leathers et al., 2019), and when there are allegations of abuse or neglect by the foster parent. A foster child's behavior may be misunderstood by foster parents who are unaware of the effects of trauma and attempts to address the child's negative behavior may be ineffective or even harmful.

When children are in foster homes that are unable to meet their needs and they begin to move around to multiple placements, these moves interrupt their education due to them having to change schools (Gypen et al., 2017). Their medical and medication services may get delayed due to changes in providers, and their behaviors may regress (Gypen et al., 2017). It is reflected that when compared to their peers from the general community, children who exit foster care continue to struggle with education, employment, income, housing, health, substance addiction, and criminal activity; hence, stressing the importance of stable foster care placements with knowledgeable, healthy and supported foster parents as paramount to having a consistent adult guide who cares for these adolescents which appears to be crucial in improving outcomes (Gypen et al., 2017).

Federal laws mandate that each State must create a permanency plan containing the exit strategy for each child in foster care (Information Gateway, 2016). The desired permanency plan goal is that the foster child will eventually exit the foster care system to reside in a more permanent living arrangement, mainly reunification with family (Carnochan et al., 2013). However, some children exit via other methods to include aging out (Reilly, 2003), guardianship or through adoption (Akin, 2011). Reunification involves the youth exiting foster care to return home to family or relatives. According to recent data from The Annie E. Case Foundation (2022), 214,542 children and teens left foster care in 2021, and less than half (47%) of them were reunited with their parents or primary caregiver, which is a decrease from 57% in 2000.
Guardianship is most commonly used when family caregivers want to provide a child a permanent home while continuing the child's interactions with other family members (The Annie E. Casey Foundation, 2024). Adults who take on guardianship of a youth have the authority to decide what is best for the child's educational, medical, and personal requirements though the parent still has legal rights to remain involved in their child's life (The Annie E. Casey Foundation, 2024). Twelve percent (12%) of all children who left foster care in 2021, were placed under guardianship which is a significant surge from the 3% of children in 2000 (The Annie E. Casey Foundation, 2024). Aging out varies by state and is according to that state’s age of emancipation (Findlaw, 2023). It is usually when the individual obtains legal rights as an adult, the age of 18 (Findlaw, 2023). However, in the state of Alabama, youth may remain in foster care until the age of 21 and does not age out prior to the age of 19 (Ala Admin. Code § 660-5-48-.05(1)). Youth who age out of foster care are likely unprepared for adulthood and society and have an increased risk of reentering circumstances that lead to them entering into foster care to begin with (Spigner, 2021). States are to implement initiatives to ensure that youth are prepared to age out of foster care if this is the youth’s path to permanency. Until a permanency goal is reached, States are responsible for establishing guidelines for care of children within placement settings that include the foster home setting while the foster parent is enlisted as the primary caregiver to ensure that the foster child is aided mentally, physically, and emotionally, and that all the child’s needs are met.

Youth can reside in foster care or foster homes for varying amounts of time. The duration may be viewed as short term or long term. There is no universally defined timeframe for short term foster care; however, some agencies view it as being a week to a few months (Benchmark Family Services, Inc., n.d.). Short term foster care is considered “temporary” care for a youth.
with the anticipation of them returning to their caregiver. It is seen as a moment to provide brief relief to “hard pressed” parents (Sellick, 1996). It can be viewed as a short period to afford the parent time to work on addressing risks that created the unsafe environment and caused the child to be removed from the home. The hope is that this occurs so that the out of home placement is short lived. There is also no precise definition for long-term foster care placement; however, it references children who reside in foster care through their childhood or adolescence, and children who remain in foster care until they reach adulthood (Ward & Schofield, 2011). It also classifies youth who have been in foster care for over six months. Although there are many reasons why a child's parent’s rights may be terminated, the length of time a youth spends in foster care is factored because the intention is for foster care to be a temporary rather than a long-term arrangement for the child.

In the state of Alabama, termination of parental rights can be pursued if the child has been in foster care for “12 cumulative months of the most of recent 22 months” unless a statutory exception is met (Alabama DHR, n.d.). Termination of parental rights is considered a last resort for children in foster care as a result of their parent(s) being accused of abuse and/or neglect and not meeting requirements to be reunified with their child(ren). Across the US, around 327,000 parents lost their rights to their children from 2015 - 2019 (Philip et al., 2022). Termination of parental rights has been heavily utilized over the past 25 years in response to federal policies during the Clinton era that supported foster adoption (Philip et al., 2022). According to the report, one in every 100 American children—a disproportionate number of whom are Black and Native American—have their parental rights terminated by the child welfare system before they turn 18 (Philip et al, 2022). Tens of thousands of these children have been in foster care for
months or years after being separated from their parents despite intentions to increase adoptions as an exit for children in foster care (Philip et al., 2022).

**Criterion to Foster in the U.S.**

In order to become a foster parent in the United States, individuals must go through a licensure process. Each state has a standard set of requirements that individuals must adhere to in order to achieve full licensure status (Child Welfare Information Gateway, n.d.). The general steps that are required by all states include background checks and a home study process; however, some states may require varying actions. For example, the Tennessee Department of Children’s Services’ (https://www.tn.gov) additional requirements include being at least 21 years of age, complete a health examination, provide proof of sufficient income as well as attend informational meetings. Conversely, California Department of Social Services (https://www.cdss.ca.gov) identifies additional requirements for licensure to include an orientation meeting, twelve hours of Trauma Informed Training, a family evaluation to include interviews of children and adults in the home to be licensed, and a home environment assessment among other obligations. Each state uses its own home study tools. Some states use the Structured Analysis Family Evaluation also known as the SAFE Home Study in order to ascertain a comprehensive overview and assessment of the prospective foster parent (Crea et al., 2009). Also, the number of placements at a time varies by state. In Alabama, foster parents can provide care for as many as one up to six children at one time depending on the child’s level of needs (Alabama Department of Human Resources, n.d.). Per governmental standards, any adult may apply to become a foster parent, regardless of their age, gender, race, religion, color, political views, national origin, disability, marital status, gender identity, gender expression,
actual or perceived sexual orientation, physical or mental health, genetic information, citizenship, first language, immigration status, or ancestry.

Training criteria in the U.S. for foster parents beyond the initial certification is not standardized. It differs by state. Although the Foster Care Independence Act of 1999 (H.R. 3443) stipulates that prospective foster parents must receive training, it only offers broad guidelines for the program's subject matter (Herbert & Kulkin, 2018). Therefore, it is undefined what additional training foster parents acquire after becoming certified and whether states require trauma training during the ongoing training process. Chamberlian et al., (2008), reported that minimal knowledge is also known about the effectiveness of foster parent training that is provided.

**High Need and Viability**

The number of children and teenagers in foster care is still considerably high today, and finding suitable placements for these youth has become more difficult (Barbell & Freundlich, 2001). In 2020, there were 407, 493 children in foster care in the U.S. (Children’s Bureau, 2021). They were 52% male and 48% female. The number of children residing in foster homes of relatives was 32% and the number of children residing in foster homes of non-relatives was 46% (Children’s Bureau, 2021). With more children residing in non-relative foster homes, viable and appropriate foster homes are needed quicker.

The majority of youth remain in foster care between 1 to 2 years before exiting (Children’s Bureau, 2021). Many of these youth need care and services to address trauma responses, and concerns involving mental, physical and special medical needs. It is indicated that adolescents who have had adverse childhood experiences have special developmental requirements that must be met by the systems that support them as they are at risk for suicidal
ideation, as well as at a higher risk for behavioral and learning deficits (Soleimanpour, et al., 2017).

A great number of foster children with high needs are being placed in home-based therapeutic foster care settings due to the shift away from relying on residential programs for children with complex emotional and behavioral issues per the 2018 Family First Prevention Services Act (The City University of New York, 2019). Residential care is the most intensive and costly form of youth care (Gutterswijk et al., 2020). Youth in residential care receive round-the-clock mental health care to treat serious emotional and/or behavioral issues (Gutterswijk et al., 2020). Many residential placements are court ordered and involuntary (Gutterswijk et al., 2020). Care in these settings is delivered in a carefully supervised, organized living group environment, with the option of individual therapy being provided if needed (Gutterswijk et al., 2020). Children in therapeutic foster homes are those with serious emotional, behavioral, or social problems or medical needs (Child Welfare Information Gateway, n.d.). They can include youth who have stepped down from being placed at a residential facility. Once placed into a therapeutic foster home, the foster parent is to provide services and interventions to address the youth’s therapeutic needs and help teach and restore the youth’s basic living skills. With these circumstances, there is a great need for therapeutic foster parents who have the ability to care for these children and youth. Therapeutic foster youth need quality, supportive and trained foster homes to reside in that can cater to their treatment needs.

**Challenges in Foster Care**

The foster care system faces many challenges. To note, there is a large population of children placed into the foster care system annually, and obtaining and retaining suitable foster homes has become more complicated (Chipungu et al., 2004). There are difficulties placing
adolescents especially those who exhibit behavior concerns. It becomes challenging to reunify them with family or caregivers due to the family becoming used to the adolescent being out of the home (Dougherty, 2004). Other concerns in foster care include obtaining services for foster youth who present with mental health needs. Literature indicated that up to 80% of children in foster care have serious mental health problems which is four to five times greater than the general population (UMPC Health Beat, 2023). Some mental health diagnosis comprise of emotional disorder, behavioral disorders or attention-deficit/hyperactivity disorder (ADHD) (Lehmann et. al., 2013). Emotional and behavioral disorders may include disruptive, depressive, anxious, and pervasive developmental (autism) disorders, which can be either internalizing or externalizing in nature and are examples of mental health issues that affect children and adolescents (Ogundele, 2018). Attention-deficit/hyperactivity disorder (ADHD) is a persistent neurodevelopmental disorder that affects 5% of children and adolescents and 2.5% worldwide. ADHD can increase the risk of other psychiatric disorders, educational and occupational failure, accidents, criminality, social disability and addictions. No single risk factor is necessary or sufficient to cause ADHD (Faraone et al., 2015).

Foster care alumni reported posttraumatic stress disorder at a rate approximately five times greater than the general adult population (National Conference of State Legislatures, 2019). Research is unclear as to why, but it indicates that psychotropic drugs are provided to adolescents in foster care at a rate that is significantly higher varying from 13 to 52 percent than the rate for all youth at 4 percent (Leslie et al., 2013). Youth in foster care also display concerns regarding attachment issues that may interfere with the foster parent and child relationship (Stovall & Dozier, 2000). Dozier (2005) indicated that foster parents were inclined to ignore and respond angrily to foster children when avoidant behaviors were displayed towards them by the
foster child. Many foster parents give up their role as foster parents within the first year due to stress, frustration, and lack of support (Chipungu, & Bent-Goodley, 2004). The presence of trauma adds to the dynamic of the foster care system as it affects behaviors, parenting, and influences physical and mental health, and there is a lack in trauma-informed care within the system that often leads to additional trauma events (Beyerlein, & Bloch, 2014).

Over the years, there have been challenges that have necessitated reform and changes in policy of the foster care system. Between 2003 to 2016, there was a higher mortality rate for children in foster care than with children in the general population (Chaiyachati et al., 2020). The risk of death was 42% higher and the difference was mainly unaffected by race or age. Lawsuits involving child abuse, neglect, and even death after placement in foster care have been frequent. In the Florida foster care system it was reported that nearly 170 children were placed into foster homes with suspected evidence of abuse (Beall et al., 2020). In Oregon, a 40-million-dollar lawsuit settlement involved abuse and neglect of foster care youth in which a 30-year prison sentence was granted to the foster parent alleged in the incident (Botkin, 2023). In 2020 an Alabama foster home was brought up on allegations of sexual, physical, emotional, and mental abuse. One of the suspects is serving a 25-year sentence in connection with the allegation while the other suspect is awaiting trial (Remkus, 2020). In Texas, concerns with the foster care system forced the state to face decades of mistakes when U.S. District Judge Janis Graham Jack announced in 2015 that foster children in the state were coming out of it worse off than when they came in, stating that children were being exposed to “unreasonable risk of harm” (Dey, 2023). Therefore, Judge Janis Graham Jack has pressed for reform of the foster care system.
Trauma and Foster Care

Trauma

Trauma as defined by the American Psychiatric Association (2013), involves the occurrence of a traumatic event that threatened or caused a major injury, death, or caused other threats to an individual. It encompasses having a response of dread, helplessness, or fear. Individuals who have encountered traumatic events may experience intrusive thoughts regarding the incidents, have distressing dreams of the event, exhibit physiological response and may be distressed by current reminders of the traumatic event.

Types of Trauma Exposure

Trauma can be experienced in many types of ways. It can be imposed directly or indirectly, also called vicarious trauma (May & Wisco, 2016). Direct exposure encompasses going through a traumatic event firsthand or seeing one happen to someone else (May & Wisco, 2016). On the other hand, indirect exposure might happen when one learns of the violent or unintentional death of a close friend, through secondary narrative accounts (for instance, in service-related professions), or through media coverage pertaining to one's place of employment (May & Wisco, 2016). Trauma that may occur one-time, repeatedly, or is long-lasting has a different impact on each person (Center for Substance Abuse Treatment, 2014). A traumatized individual may experience a variety of feelings both instantly and years later. Some individuals may struggle to process their response to the incident and feel overpowered, helpless, stunned, or overwhelmed (Leonard, 2020). Responses to trauma can be psychological and physical. Psychological responses can include feelings of anxiety, being hypervigilant, having sleep disturbances, encountering intrusive memories, experiencing feelings of guilt, shame, embarrassment, sadness, irritability and anger, and also, emotional numbness, withdrawal,
disappointment and mental avoidance (Regel & Joseph, 2017). Physical reactions include shakiness, trembling, tension, muscle aches, sleeplessness, poor concentration, palpitation, shallow rapid breathing, dizziness, gastrointestinal symptoms such as nausea, diarrhea and vomiting (Regel & Joseph, 2017).

There are ranges of trauma exposure which can extend in severity from acute, chronic to complex (Leonard, 2020). Acute trauma is common in children and adolescents (Kassam-Adams, 2014). This type of trauma happens as a result of a single tense or hazardous circumstance (Leonard, 2020) and can involve such events as violence, traffic accidents, unintentional injuries, fires, natural disasters, and man-made calamities (Kassam-Adams, 2014). Chronic trauma is the result of exposure to extremely stressful situations over an extended period of time. Cases of child abuse, bullying, or domestic violence are a few examples (Leonard, 2020). Complex trauma are incidents that occur frequently and progress over time (Courtois, 2004). Domestic violence and child abuse are examples of it within families. A single catastrophic traumatic incident or an acute or chronic illness that necessitates severe medical treatment are also examples of complex trauma (Courtois, 2004). Trauma varies and produces different outcomes for different individuals.

**Adverse Childhood Experiences (ACE) Effects**

Adverse trauma in childhood is linked to adverse health outcomes in adulthood. Felitti et al., 1998 discovered that childhood trauma had an association with increased risk for heart disease, chronic long conditions and cancer in adulthood. In relation to children, after an acute trauma such as ACEs, posttraumatic stress reactions can continue to have ongoing effects on a child and adolescents’ development and wellbeing (Kassam-Adams, 2014). This can involve a significant lifetime co-occurrence of other psychiatric disorders, with anxiety and depressive
disorders showing the highest prevalence (Copeland et al., 2007). Children’s immune systems, stress-response systems, and brain development can all be adversely impacted by toxic stress from ACEs. Children's learning, decision-making, and attention spans may similarly be impacted by these changes. Moreover, it may be difficult for youth who are exposed to such toxic stress to develop secure and healthy connections (Fratto, 2016).

In observing youth in the foster care system, post-traumatic stress disorder (PTSD) is a serious mental health issue for adolescents in foster care. Compared to 11% of those who were living with their parents, 20% of abused children in foster care presented with post-traumatic stress symptoms (Papovich, 2020). Many foster care youth have likely gone through at least one traumatic event, and they may exhibit post-traumatic stress symptoms as a result. Thus, the degree to which foster parents are sensitive to their foster child's PTSS symptoms has a significant impact on the foster child's development (Teculeasa et al., 2023). Foster parents who are unfamiliar with the effects of trauma may incorrectly calculate a child’s behavior response, and as a result, they may be ineffective in dealing with a child's problematic behaviors or run the risk of causing harm, because it may be harmful or ineffective to try to change what is being viewed as a bad behavior versus a trauma response (Papovich, 2020).

Trauma-Informed Care (TIC) should be understood by those who interact closely with foster children or foster children themselves. In order to lessen long-term harm, TIC is a psychological approach that emphasizes the prevalence of trauma, the detrimental effects that trauma can have on a person's life, and the use of a range of services. The pervasiveness of trauma and how it may impact mental health practices are topics that professionals need to be aware of (Papovich, 2019). Conversely, foster parents should also understand how their own
ACEs may show up in foster parenting abilities when addressing behaviors of foster children as previous research has indicated that ACEs can impact parent-child bonding.

**Adverse Childhood Experiences (ACEs)**

**Background**

Adverse childhood experiences, exemplified as a concept of trauma, have been circulating throughout research over recent years. The ACE categories are of specified negative encounters that occur at the age of 18 or younger (Lange et al., 2019). ACEs is a term first used by researchers Vincent Felitti, Robert Anda, and associates in their groundbreaking study carried out between 1995 and 1997. The seven kinds of childhood adversities that the researchers questioned adults about included being abused physically, sexually, or emotionally; having a violent mother; living with a mentally ill person; living with someone who misused drugs or alcohol; and having a household member incarcerated (Bartlett & Sacks, 2019). Since then, several lists of other types of adversities have been referred to as ACEs. For example, parental divorce or separation and physical and emotional neglect are included in the current ACEs study supported by the Centers for Disease Control and Prevention (Bartlett & Sacks, 2019).

The concept has since grown even more to include additional terms such as "the most intensive and frequently occurring sources of stress that children may suffer early in life," as well as alcohol and substance abuse, being exposed to violence by peers and in the community (WHO, 2020), living in challenging conditions where there is interpersonal or group violence, and residing with a person who is mentally ill (Wang et al., 2022). It involves traumatic events that have a long-term negative impact on adults' and adolescents' health (Goddard, 2020). ACEs produces toxic stress (Shern et al., 2014) and is associated with behavior concerns, parenting issues, poor mental health and can compromise physical health.
The ten ACE questions involve the following: 1) Did a parent or other adult in the household often or very often…Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? 2) Did a parent or other adult in the household often or very often…Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? 3) Did an adult or person at least 5 years older than you ever…Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you? 4) Did you often or very often feel that …No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other? 5) Did you often or very often feel that …You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? 6) Was a biological parent ever lost to you through divorced, abandonment, or other reason? 7) Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife? 8) Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? 9) Was a household member depressed or mentally ill? or Did a household member attempt suicide? 10) Did a household member go to prison? Participants marked “yes” for every ACE encounter and “no” if they did not encounter, then they tallied the number for all the “yes” ACE encounters in order to acquire their final ACE score (Felitti et al., 1998). These incidents become traumatic when the individual struggles to cope with stress and induced fear or anxiety as a result of exposure. Trauma is a subjective experience and is defined by the one who experiences it (Giller, 1999).
ACEs is widespread in the U.S. and has been identified as a contributor to risks that produce negative adulthood outcomes (Daines et al., 2021). Given the evidence of their long-term effects on health, adverse childhood experiences are a major public health concern (Boullier & Blair, 2018). ACEs Aware (2020) indicates that an ACE score of more than 4 places an individual at high risk for toxic stress and a score between 0-3 places the individual at low risk for developing toxic stress. This has led to the continued growing interest and research regarding ACEs’ impact on human development, health, mental health and life choices, and for this research foster parent factors and foster care outcomes.

**ACE Prevalence and Foster Care**

ACEs are prevalent among youth in foster care and affect placement stability. According to Liming et al. (2021), children in foster care who had been exposed to more ACEs over time had a much higher risk of experiencing placement instability. Their study indicated that when accounting for all other factors and compared to youth with 1 to 5 ACEs exposures, foster children with 10 ACEs had a 31% increase of experiencing placement instability and foster children who had experienced 6 to 9 ACEs had a 52% higher possibility of placement disruption Liming et al. (2021). ACEs experienced by youth in foster care can also greatly decrease the likelihood of the child reuniting with family and lengthen the period for reunification. The greater the ACEs, the less likely reunification was to occur (Liming et al., 2021); therefore, extending the life of the child in foster care.

Not only does ACE affect foster care youth, but it is also evident that it impacts foster parents as well. Research conducted by Adkins et al., (2020) discovered that 40% of foster parent participants reported being exposed to 2+ ACE and 20% reported encounters with 4+ ACEs. The study also indicated that adults of trauma experiences are more likely to become foster parents.
and that foster parents’ ACEs exposure was associated with foster youth behavior difficulties (Adkins et al., 2020). Cooley et al. (2020), conducted research in which 68% of their foster parent participants reported experiencing one or more ACE. Their study reported no relationship between ACEs and foster parent outcomes, rather it measured ACEs in connection to parent resilience, parent stress and foster parent satisfaction. Their study inferred exploring how resiliency factors should be considered in addressing work with foster parents. Due to limited studies on this topic, more research is needed to determine how the prevalence of ACEs among foster parents impacts foster care outcomes, as well as to promote the need for the right kind of support and interventions.

Assessing for Trauma

It is important to assess trauma in order to understand the role it plays in the life of the individual who has experienced it (Center for Substance Abuse Treatment, 2014). Trauma is linked to poor behavioral and physical health outcomes especially when experienced during childhood (Center for Substance Abuse Treatment, 2024). It also impacts the ability to maintain healthy relationships (Fratto, 2016). Proper assessments for trauma can also show how trauma impacts individuals and relationships, and also aid in the development and/or administration of services, supports and resources to address the need associated with response to trauma experiences. Because of the many ways that trauma can negatively impact an individual to include foster parents and youth in foster care, sufficient assessment are necessary. For this to occur, adequate screening tools must be utilized to ascertain knowledge of an individual’s exposure to or impact from trauma. There are various types of screening tools used to assess for trauma exposure and impact.
The Original ACE questionnaire was used in this research (See Appendix A). It was initially utilized to determine how the relationship of exposure to childhood emotional, physical, or sexual abuse and dysfunctional families affects health risk behavior and disease in adults (Felitti et al., 1998). The assessment has evolved to be widely used in evaluating for many outcomes in research to include parenting studies (Murphy et al., 2014; Lange et al., 2019; Treat et al., 2019), foster parent studies (Adkins et al., 2020), use in child welfare to address various needs and issues such as child well-being in policy and practice (Bethell et al., 2017), assess work-stress management among those who work in the child welfare field (Lee et al., 2017), and in addressing needs of adolescents (Soleimanpour et al., 2017). The questionnaire consists of 10 questions for respondents to indicate their encounter with the described ACE. If a respondent checked "yes" to one or more of the questions in a category (childhood emotional, physical, or sexual abuse and household dysfunction), they were considered exposed to that category.

**Intervening Trauma**

Interventions for trauma include psychological (Bisson et al., 2007) and pharmacological treatments (American Psychological Association, 2017; Bisson, 2022; Sonne et al., 2017) which may be used independently or together. Some psychological and therapeutic methods of interventions for addressing trauma include trauma-focused cognitive behavior therapy, exposure-based therapies, coping skills therapy, psychoeducation and normalizing to name a few. There are also new interventions to addressing trauma that involve methods using mindfulness and mind/body therapies (Ringel & Brandell, 2019).

Pharmacological interventions are usually prescribed when there is a trauma diagnosis and are based on additional factors of the individual as individuals have varying responses and tolerance levels to treatment (American Psychological Association, 2017). Prior to starting
medication, a clinician diagnosing a patient with posttraumatic stress disorder should take into account the patient's present symptomatology, co-occurring conditions, and the data supporting the effectiveness of various treatments (Ehret, 2019). Medication treatments involve serotonin reuptake inhibitors that are used to alter mood. Though these treatments are evident approaches to addressing trauma; however, there is no vast identifiable public data of the percentage of adults or foster youth who are prescribed pharamological treatment for the use of trauma related diagnoses.

While psychological and pharamological methods are identified as common treatment methods for trauma, protective factors (Crouch et al., 2018) and resiliency factors (Luthar et al., 2000) have also been acknowledged as preventing and mitigating trauma outcomes. Then, there is the concept of the Wounded Healer phenomenon which has been argued to mitigate negative responses to trauma experiences also. Resiliency is the ability to continue doing well despite having encountered trauma or significant adversity (Luthar et. al, 2000) IT is argued that two circumstances must exist for resiliency to occur: 1) Being exposed to a serious threat or adversity 2) the accomplishment of favorable adaptation in spite of significant attacks on the process of development (Luthar et al., 2000). Protective factors can be support from the community, family and friends (Luthar et al., 2000). They are conditions or characteristics that, when present in communities and families, improve children's and families' well-being, and lessen the probability of abuse. In looking at the Wounded Healer, it asserts that an individual’s own trauma experiences allow them to help others. These individuals possess the ability to be resourceful, sympathetic, welcoming, and good listeners (Rabb, 2022). It is cautioned that when working with injured individuals, the healer may experience countertransference because in some circumstances, their own scars may reappear when implanted (Luton, 2010).
Finding tools, support, or coping mechanisms that enable parents to parent well even in stressful situations is made easier by identifying protective factors (Child Welfare Information Gateway, 2020). Being trauma informed and understanding protective and resiliency factors are necessary to aid in recognizing how people may be affected by trauma and how it may present when these influences are involved in an individual’s life. It is also important to understand the possibility of the Wounded Healer characteristic in an individual. Being aware of methods and factors for intervening impacts of trauma can aid in promoting parenting abilities of foster parents who have ACEs experiences.

**ACEs Prevalence among Foster Parents and Impact**

It is to be noted that there are limited studies that explore the prevalence of ACEs among foster parents. There appear to be only four studies that assessed ACEs among foster parents in order to look at its association with foster parent satisfaction, resiliency and coping (Adkins et al., 2020; Cooley et al., 2020; Reisz et al., 2023). Cooley (2020) found that 68% of the foster parents who participated in the study had one or more ACE. Along with identifying the commonness of ACE among the foster parent in their study, the researcher concluded that the greatest issue among this population of foster parents was more so challenges with the foster care system. Adkins et al. (2020) also found that 40% of foster parents had 2 or greater ACEs and 20% reported encounters with 4 or more ACEs. The researcher indicated that it appears the foster parent population consisted of individuals who are most impacted by ACEs and trauma experiences (Adkins et al., 2020). This study also acknowledged an association between foster parent's ACEs and foster children’s challenging behaviors. There is not much information concerning foster parents’ experiences prior to them becoming foster parents especially in regard
to ACEs (Cooley et al., 2020). Additional studies are needed to assess these incidences among foster parents.

In exploring how ACEs show up in parenting depends on the trauma background, the individual’s response to the trauma, and whether interventions are needed or utilized. In adults, ACEs can result in the development of posttraumatic stress (Herzog & Schmahl, 2018). It has been discovered that parental posttraumatic stress is linked to impaired functioning across several parenting domains to include having higher stress levels and less favorable parent-child bonding (Christie et al., 2019). Findings also indicated that trauma in parenting can cause parenting concerns and affect the bond between the foster youth and foster parent (Reiz et al., 2023). It was further revealed from a study of 55 participants, that attachment avoidance and overall parenting stress were more likely to be reported by foster parents who had higher total ACEs (Reiz et al., 2023). Foster parents with a history of emotional abuse as children experienced greater levels of attachment anxiety and foster parents who had more attachment anxiety also expressed more parental discomfort and defensive behavior (Reiz et al., 2023).

ACEs does not have to impact parenting practices, yet there is a possibility that it has the ability to do so, if necessary, blockers such as protective factors, interventions and supports are not incorporated. While studies have shown that foster parent ACEs is related to difficult behaviors exhibited by the foster child, there is limited research on this association which is why additional studies are needed to understand its impact.

**Looking at Parental ACEs Impact to Shed Light on ACEs in Foster Parenting**

As a result of limited research on foster parent ACEs, examining parental trauma can help understand its relationship in parenting practices and surrounding factors. Parental trauma influences have been reviewed across many studies to examine its connection within parenting.
Azhari et al. (2020), reported that parents who had experienced trauma presented indicators of its effect on parenting styles. Morris et al. (2021), found evidence linking ACEs to poor parental attitudes and behaviors. Lange et al. (2019), revealed that mothers with more ACEs had an association with increased parenting stress which affected parenting styles and behaviors to include the presence of insecure parent-child attachment.

In discussion of children of caregivers who had post-traumatic stress disorder symptoms as a result of having experienced trauma, these children were shown to have unorganized and insecure attachments (van Ee et al., 2016). In literature discussing mother–child attachment, it was noted that the impact of the maternal factors in the mother–child attachment relationship appeared more essential than the impact of the child characteristics (van IJzendoorn & Bakermans-Kranenburg, 2004; van IJzendoorn et al., 1992 cited by West et al., 2020). Along with attachment deficiencies, effects of parental trauma experiences of the mother are seen to impact children's risk for poor behavioral outcomes (Schekcendanz et al., 2018; Cooke et al., 2019), create risk to children of problematic parenting (Murphy et al., 2014), effect developmental concerns (Folger et al., 2018), along with many other problems.

A child’s need to thrive is established by their types of interaction and relationships formed as seen with parental involvement. This can be translated to the needs of children in foster care. An essential element in a child's growth is their attachment to their significant others (West et al., 2020). With children who enter foster care being at notable risk for social-emotional challenges in adjustment due to experiencing abuse and neglect prior to entering into foster care (Jacobsen et al., 2020), their caregivers need to be equipped with the skills to address challenging behaviors of foster children, and to ensure that a nurturing environment is provided to the foster child. As made evident, attachment is paramount in establishing these healthy relationships. Analyzing
foster parents’ trauma experiences to understand how trauma response plays a role in attachment

Thus, in doing so, can enhance efforts in creating healthier foster home environments for both

the foster child and foster parent.

**Research Questions**

1. What was the prevalence of ACEs among foster parents in Alabama?

2. Was there an association between ACE score and demographic characteristics among foster parents in Alabama?

3. Was there an association between ACE score and number of placements and length of time fostering among foster parents in Alabama?

**Summary**

Looking at the connection between parenting practices with the presence of parental ACEs allows us to view how foster parent outcomes may be influenced if ACE factors are present. Studies indicate that parental trauma histories may come with parenting stress which influenced parenting styles and behaviors to include the presence of insecure parent-child attachment. Researching foster parent’s histories of impactful past relationships can help assess their need to address past trauma in connection with promoting healthy parenting skills for children in foster care.

Next, the author examined factors of ACEs connections with foster parenting outcomes to explore its process in foster parenting. These factors, resilience (Luthar et al., 2000) and protective factors (Crouch et al., 2018) have been recognized as preventing and minimizing trauma consequences. The author looked at a framework that hypothesizes that demographic
variables coupled with ACEs, the Wounded Healer Phenomenon and positive psychology can influence the trajectory of foster parent and foster care outcomes.
Chapter 2: Theoretical and Conceptual Framework

In looking at trauma and its relation to foster parents, the author discussed principles from the trauma theory to understand trauma, but also integrate positive psychology and the Wounded Healer phenomenon. This theoretical framework provides a background of the aforementioned thoughts and helps to explain how some individuals exposed to trauma seek to produce positive outcomes despite research indicating that trauma produces lasting negative effects. Trauma theory seeks to understand the various ways that traumatic events are depicted, dealt with, exposed, and repressed. Positive psychology evaluates circumstances and procedures that promote successful or desirable functioning of individuals (Gable & Haidt, 2005). Zerubavel et al. (2012) explains that the wounded healer model implies that "healing powers" arise from healer's own woundedness (Guggenbuhl-Craig, 1971; Nouwen, 1972; Sedgwick, 1994 as cited in Zerubavel & Wright, 2012). This relatedness to sharing a common wound motivates the individual to help others.

Trauma Theory

The origins of trauma theory can be traced back to the 1800's from observations that inferred that traumatic experiences evoke great and protracted pain (Sütterlin, 2020). Around 1866, physician John Erichsen attributed trauma to organic life experiences while a surgeon named Herbert Page attributed trauma to neurological and emotional factors like being in fright and having "nervous shock" (Sütterlin, 2020). A neurologist named Herman Oppenheim would develop the term "traumatic neurosis" to describe victims of trauma type experiences who appeared to be unharmed physically; however, they reported experiencing motor and sensory concerns (Sütterlin, 2020). This led to Oppenheim's introducing into the field of psychiatry the use of "wound" and "injury" in relation to mental health matters, establishing that traumatic life
experiences can contribute to psychological as well as neurological wounds (Sütterlin, 2020). Conversely, neuropsychiatrist Jean-Martin Charcot linked what he termed as "traumatic hysteria" to incidents with physical encounters. He would later acknowledge that the incident of emotional factors and "nervous shock" created a psychological condition (Sütterlin, 2020). However, it would be Charcot's student Pierre Janet, to receive the credit for identifying dissociation, found to be a crucial component of psychological trauma. Dissociation is the absence of association or integration between two or more mental processes or items (Cardeñia, 1994). It is a coping mechanism that can help someone endure stressful events like accidents, disasters, or being the victim of a crime when it would otherwise be too much for them to handle (American Psychiatric Association, 2022). Dissociation is impactful in trauma science today as its toxic implications gives rise to posttraumatic stress. A person who experiences dissociation loses touch with their ideas, memories, feelings, behaviors, and sense of self (American Psychiatric Association, 2022).

Sigmund Freud, a psychoanalytic arrived on the scene positing that traumatic neuroses originated from childhood sexual assault then later claimed that it derived from drives present at infancy as sexual abuse was prevalent during this time (Sütterlin, 2020). He and neurophysicians would later allege trauma as a breach of the psyche's protective defense in assessing how soldiers exposed to war presented with nervous disorders attributed to the effect from extreme fear (Sütterlin, 2020). In the 1960’s studies regarding trauma involved a number of social issues that included the recognition of the prevalence of violence against women and children (rape, battering, and incest), the discovery of post-traumatic stress disorder in (Vietnam) war veterans, and the realization of the psychological scars incurred (Mambrol, 2017). In looking at responses to traumatic experiences, American psychoanalyst, Abram Kardiner observed a breach in the
protective barrier on the psyche as a result to trauma. This generated additional developments to trauma responses which led to the introduction of post-traumatic stress by The American Psychological Association in 1980 via the Diagnostic Statistical Manual of Mental Disorders (DSM) (Sütterlin, 2020).

The criteria for PTSD have retained the same basic components since it was first introduced in DSM-III in 1980. This is exposure to a traumatic stressor which acts as the gatekeeper criterion (Levin et al, 2014). Changes to the criteria were noted in the DSM-III-R to include the addition of symptoms centered around three aspects of the stress response: physiological arousal, avoidance and numbing, and reliving the stress. It also included child-specific symptoms (Brett et al., 1988). The newer version of the DSM - the DSM 5 describes the criteria for posttraumatic stress in adults, adolescents and children older than 6 years (Center for Substance Abuse Treatment (2014). The criteria state the following:

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic
media, television, movies, or pictures, unless this exposure is work related (Center for Substance Abuse Treatment, 2014).

Research surrounding trauma theory continues to be robust and multifaceted and trauma can be a complex term to objectify as it varies from person to person. Its concepts have generated great debates and an extensive body of work (Sütterlin, 2020). As it relates to foster care, trauma can present in many forms and be present in foster children and foster parents. As Oppenheim introduced "wound" to the field of psychiatry, this can relate to the woundedness of the foster parent who seeks to utilize their traumatic life experiences to help others such as youth in foster care. As knowledge surrounding trauma and trauma-informed care continues to be explored, this will advance research and knowledge on how to address the barriers and effects of trauma in the foster care system.

**Principles of Adverse Childhood Experiences**

The theory of adverse childhood experiences is complex and include a wide range of in-family and social-environmental sources (Kalmakis et. al, 2014). Originally, ACEs referenced childhood adversities in the home involving physical and emotional abuse, neglect, and household dysfunction (Felitti et al., 1998). However, they have been expounded over time to include, child abuse, living in challenging conditions where there is interpersonal or group violence, and residing with a person who is mentally ill (Wang et al., 2022). ACEs are also reported as "the most intensive and frequently occurring sources of stress that children may suffer early in life," and can include household issues to involving alcohol and substance abuse as well as being exposed to violence by peers and in the community (World Health Organization, 2020). Conclusively, ACEs are a facet of the child's environment that can impede on their sense of security, stability, and bonding (Center for Disease Control and Prevention, 2021). They have
been found to be attributed to developing unhealthy consequences over the lifespan (Schickedanz et al., 2018).

These traumatic events may have long-lasting social and health ramifications that transcend particular generations, individuals, or historical periods (Ports et al., 2019). They manifest in human development, mental health, physical health, and can influence lifestyle decisions and parenting practices. Toxic stress that is derived from ACEs negatively impacts a child’s brain development, response to stress, affects the immune system, and produces difficulty in forming stable and healthy relationships (Center for Disease Control and Prevention, 2022). In adulthood, stress that results from ACE can lead to major issues including alcoholism, depression, eating disorders, unsafe sex, HIV/AIDS, heart disease, cancer, and other chronic diseases (World Health Organization, 2020). ACEs can interfere with parenting behaviors and parenting outcomes (Haynes et al., 2020). A study with UCLA (2018) indicated that there is a correlation between parental trauma early in life and their child’s behavior.

Toxicity from ACE exposure can be restricted with efficient support to counteract them. Factors that can positively offset the effects of ACEs include treatment interventions and resiliency factors as was discussed in the previous chapter. A foster parent who has been challenged with such toxic exposure can acquire healthy parenting skills to aid foster children who have experienced trauma to build resiliency and reduce stress that result from traumatic experiences by allowing the youth to obtain help in talking with a caring and trusting adult; thus, helping the youth learn coping techniques that are aimed at reducing stress (Frederiksen, 2019).

**Positive Psychology**

Though life may bring instances of trauma and grief, it also presents times of joy that people seek to make life fulfilling and wholesome. One would prefer not to focus on negative
encounters that produce stress and anxiety. Rather, search for the good things in life, the things that cause empowerment and self-actualization. The elements of the emphasis on good life experiences and influences can be found in the study of positive psychology. The ideology of positive psychology helps to create the understanding of how a person who has faced traumas and adverse experiences can negate its negative effects.

Positive psychology is the study of the situations and processes that promote the flourishing or ideal operation of individuals, communities, and organizations (Gable & Haidt, 2005). It was founded by researcher Martin Seligman who began his quest towards this school of thought while establishing the groundwork for the psychological theory of “learned helplessness” (Ackerman, 2018). Learned helplessness provided rationale for how it is possible for individuals to develop a sense of helplessness and loss of control over their circumstances. However, in shifting focus from attention being given to negative attributes of life such as pain, suffering and trauma, Seligman saw the need to shed light on people’s strengths, happiness, and wellbeing (Ackerman, 2018).

Initially labeled as the “science of happiness” (Compton & Hoffman, 2020), positive psychology was also known as “the scientific study of what makes life most worth living” (Peterson, 2008, as cited by Ackerman, 2018). Gable and Haidt (2005) coined the definition to indicate their study of the “optimal functioning” of not only people, but groups and institutions as well. Howbeit, Seligman’s mission for positive psychology is to study the strength and virtue of the individual, not to just focus on mending what is broken within the individual. It seeks to understand the fulfilling components of human behavior and studies what allows individuals and communities to thrive (Compton & Hoffman, 2020).
Though, immense attention is drawn to negative impacts in life, causes of adverse situations and how adversity can create long term issues for the developing human, it is acknowledged that there is power in resiliency, the motivation to do great things and to be a great individual despite the challenges, adversities, and hard times. This aspect of life is what positive psychology wants to highlight. This can be impactful in addressing foster parent ACEs when exploring its relationship with foster care outcomes.

**Wounded Healer Phenomenon**

Carl Jung (1963) describes the wounded healer as a prototype in which he conveys the importance of suffering to human healing. Wounded healers are considered individuals who are able to help others as a result of their own personal painful experiences. They have the capacity to be good listeners, empathic, accepting, and resourceful (Rabb, 2022). In working with wounded individuals, the healer’s own wounds can be resurfaced when implanted in certain situations; hence, this can create the rise of countertransference (Luton, 2010).

Countertransference occurs when the therapist, in this case, the wounded healer, holds the emotions conjured up by interaction with the wounded individual. The analysis and use of countertransference by the healer can pose risks or advantages (Holmes & Perrin, 1997). Unexamined or undetected countertransference can obstruct the effectiveness of treatment or services (Reidbord, S., 2010). Therefore, if a person does not address his own issues and conflicts, he may risk negatively impacting those in his care. According to this philosophy, if a foster parent does not properly address their trauma, they risk projecting their conflicts onto the foster child which may negatively impact the child and/or foster care outcomes. The individual who has experienced trauma and abuse, manages through life to help others who have endured similar situations, or who are at risk of encountering the same circumstances can be explained as
the “wounded healer” characteristic. This archetype has been widely referenced in viewing physician’s relatedness to his patients. Explained by Zerubavel et al. (2012), the wounded healer model implies that "healing powers" arise from healer's own woundedness (Guggenbuhl-Craig, 1971; Nouwen, 1972; Sedgwick, 1994 as cited in Zerubavel, N. & Wright, M. O., 2012). Healers of traumatic experiences are empowered to help others by use of knowledge and association acquired from their own trauma encounters, but Zerubavel et al. (2012), advised that this is not a simple process. The researcher stated that recovering from a traumatic experience is ongoing. The process should be monitored. How a healer approaches the desire to help others can be impactful or detrimental.

The wounded healer phenomenon parallels the relationship of the foster parent with ACEs experiences and the foster child with childhood trauma experiences. Foster parents who have had adverse childhood experiences may want to help foster children with whom they share similar experiences. However, these encounters can go wrong if the foster parent cannot connect or is retraumatized while working with the foster youth. If the foster parent is not healed from his own woundedness, he can risk not successfully helping a foster child.

**Foster Parents, Trauma, and Positive Psychology Connections**

Foster parents seek to care for children who need stable placements; however, some foster parents have trauma in which the residual, if not addressed, can be exhibited in parenting behaviors when working with the foster child. On the contrary, theories suggest that effects of trauma can be mitigated via encounters with positive factors and positive thoughts. For example, a foster parent may be motivated to help a foster youth out of his own woundedness. The parent may have experiences similar incidents as the foster child and want to help the foster youth therefore, promoting a safe and nurturing environment for the child. Conversely, the foster
parent may still not have worked through emotions and thoughts from his own trauma which can influence behaviors towards the foster youth. Some individuals may feel they have worked through their adverse experiences and are able to teach skills and provide care to foster youth. This can be so according to positive psychology; however, this will be unknown if not assessed.

According to Center for Substance Abuse Treatment (2014), immediate responses of trauma survivors are complicated and are influenced by a variety of factors, including the individual’s own experiences, the availability of natural supports and healers, their coping mechanisms, the coping mechanisms of their immediate family, and the reactions of the larger community in which they live. Being that trauma responses are not simplistic and can vary, there is a duty to understand whether a potential foster parent has worked through past traumas as to not expose the foster child to the unhealthy effects of it. Pulling out the strengths and positive attributes of the foster parent appears to be imperative in building effective parenting practices of a foster parent who has experienced ACEs.

The present study stages a model for exploring the research questions pertaining to foster experiences, characteristics, and outcomes in association with ACEs histories. It asserts how the Wounded Healer phenomenon may intercept negative response to ACEs experiences of foster parents. This model considers encounters of adverse events and the potential moderating factor that is correlated with outcomes. In this study, foster parent ACEs were identified as potential factors that have a connection with foster care outcomes.

Figure 1 displays the conceptual model for this study created to explore what factors are associated with the development of foster parent characteristics and foster care outcomes. On the right side of the model, foster parents’ factors were conceptualized via sociodemographic characteristics and ACEs being in the center. The model demonstrates the buffer for the adverse
output of ACEs with the Wounded Healer phenomenon, citing that the foster parent with ACEs encounters is able to avoid its impact and enact his own wounded experiences to help foster children due to relatedness, and that this can also create a path of healing for the foster parent himself.

Figure 1. Conceptual Model

Summary

The author examined ACEs, their connection to foster parents, and how trauma theory, positive psychology, and the wounded healer phenomena can be attributed. As research has indicated that ACEs have been found to affect the bond that exists between parents and their children, it can be utilized ways to counteract it. ACEs' negative impacts can be effectively offset by resilience and therapy interventions and other positive influential moderators. Positive psychology illustrates how foster parents’ toxic response to ACEs can be overshadowed by looking at the parents’ positive qualities. The wounded healer phenomenon asserts that
individuals can present as an aid to others as a result of their own difficult experiences. However, if the foster parent ignores his own problems, improper support is implemented and conflicts occur, there becomes the risk of having an undesirable outcome on the people they are responsible for, such as the foster youth.

**Current Study**

While ACE scores have been associated with foster parent attachment and parenting stress (Reisz, et al., 2023), and with foster children’s challenging behaviors (Adkins et al., 2020), this study aims to look at the association between foster parent ACE encounters in relation to additional foster parent factors. The potential benefits of characteristics to include domains such as placement types and fostering history of foster parents warrant further attention in attempts to identify risk and other factors that may attribute to foster care outcomes.

The following research questions guided this data analysis:

1. What was the prevalence of ACEs among foster parents in Alabama?
2. Was there an association between ACE score and demographic characteristics among foster parents in Alabama?
3. Was there an association between ACE score and number of placements and length of time fostering among foster parents in Alabama?
Chapter 3: Methods

The present study was a cross-sectional study which utilized secondary data. Wickham (2019) states that a secondary analysis involves a research method of investigating a new research question employing data collected by another researcher. The use of secondary data for this study allowed the ability to generate a greater depth of focus on newly identified issues and aspects that were not completely or sufficiently addressed in the initial research, which is also acknowledged as supplemental analysis (Tripathy, 2013).

The following section explains how data was collected and analyzed, and provides the procedure and processes utilized to conduct this study (Jalongo & Saracho, 2016). This study was performed using ACE scores, demographic information and foster parent characteristics of foster parents provided by an Alabama foster care agency with divisions in Huntsville, Birmingham and Montgomery which assessed the prevalence of ACEs among the population. The primary goal of this study was to gain insight regarding whether the ACE score of foster parents had a relationship with foster care outcomes, as previous studies have indicated that a relationship existed between ACEs and parenting behaviors and outcomes. This study uncovered the existence of ACEs among foster parents and whether there were associations.

Data Collection

The study utilized secondary data that was collected by a foster care agency’s divisions in Huntsville, Birmingham and Montgomery. Data collection was conducted between October 2022 and September 2023 with licensed foster parents and with foster parents who were engaged in the licensing process who attended training classes. The data collection process involved agency staff administering ACEs questionnaires to foster parents at the end of foster parent ACE training classes as part of the agency’s requirement. The ACE training was provided in the
training segment called “therapeutic foster care” training hours. It was required for all foster parents at the agency and was administered several months of the year for current foster parents and foster parents in the licensure process. The number of foster parents who attended the training classes varied depending on which foster parents had previously taken the class and which had not and whether there were foster parents going through the certification process.

Each division, Huntsville, Birmingham, and Montgomery conducted its own training sessions in which the questionnaires were presented to foster parents at the end of their training class. The questionnaire consisted of the following questions: 1) 10 Original ACEs questions (Felitti, 1998), 2) characteristics of foster parents and 3) sociodemographic information to include gender, age, race, income, marital status and education.

In seeking to utilize the agency’s data, the foster care agency was contacted by email to determine its willingness to provide data regarding ACE scores of foster parents they administered ACE questionnaires to as a part of their training curriculum. Following the email submission to the agency’s executive director, a meeting was conducted to discuss the purpose, benefits, and risk of the research project. The agency’s director provided a data sharing agreement discussing the use and limitations of the data to be shared with the researcher. The Institutional Review Board granted approval for the research to be conducted.

Divisional supervisors then granted permission to provide the researcher with de-identified ACEs questionnaire scores, sociodemographic information, and foster parent characteristic responses. The sociodemographic information entailed the foster parents’ age, location, race, gender, income, marital status, and education level. The foster parent characteristics included responses to the number of foster care placements of the foster parent, the average age of placements accepted, the number of years the parent had fostered and the
foster parents’ age at licensure/certification. The data was transmitted to the researcher from the agency’s supervisors via secure electronic format that was protected by a security wall and passwords. Data were obtained from October 2022 through September 2023, by the researcher from the agency supervisors. The researcher received data with missing information to include ACEs score from 1 participant, income from 2 participants, marital status from 1 participant and educational level from 4 participants, but with all other information. The data was charted and analyzed by the researcher.

Study Sample

The study sample represented (N=52) licensed foster parents from three of the agency’s locations in Alabama, Huntsville, Birmingham, and Montgomery, with the majority participants being represented from Montgomery (n=24, 46.2%). Huntsville had the fewer participants (n=12, 23.1%). The remaining participants came from Birmingham (n=16, 30.8%). The foster parents were recruited by the foster care agency to become licensed foster parents in Alabama. Participants were included in this study according to an established inclusion and exclusion criteria (Setia, 2016). The final number of participants included in this study (n = 52) encompassed foster parents who were currently licensed opposed to being in the licensing process. Data inclusion factors for this study were that individuals had to be 26 years or older, a licensed foster parent, and reside in Alabama. Exclusion factors included individuals who were under the age of 26, those who were not currently licensed foster parents and those not residing in Alabama.
Measures

Instruments

In this study, the researcher used the ACE Questionnaire scores obtained by the agency. The ACE questionnaire was a 10-item self-report used to recognize adverse childhood experiences to include abuse and neglect. The 10 questions allowed for respondents to indicate their encounter with the described ACE. If a respondent checked "yes" to one or more of the questions in a category (childhood emotional, physical, or sexual abuse and household dysfunction), they were considered exposed to that category. However, for this research, the researcher was provided with the total ACE score and not each specific response to each specific question. The second part of the instrument included self-report of the participants’ gender, race, marital status, education, income, number of placements, average age of placements, length of time fostered and the foster parent’s age at certification/licensure.

Variables

For this study, the variables consisted of the following placement outcome characteristics when assessing for ACE relationships: the number of placements had by the foster parent, average age of placements, length of time fostered, and age at certification. The variables also consisted of the following demographic characteristics of the foster parents when assessing for ACE relationships: gender, race, marital status, education, income.

Operationalization of Variables

Number of Placements. The number of placements is measured via scale and evaluated for the number of children a foster parent had fostered since becoming a foster parent. The range was from 0 to 10, with 0 being the lowest and 10 being the highest number of placements. No foster parent in this study had received more than 10 placements.
**Average Age of Foster Child at Placement.** The average age of placements accounted for the age of the foster child at the time of placement. The average age was measured via scale and ranged from 1 to 15 years.

**Duration of Foster Care.** The length of time fostered was evaluated by the number of years the participant had been a licensed foster parent. This was measured via a scale ranging from 0 to 23 whole years, with 0 being the lowest range reported and 23 being the highest range reported.

**Age at Certification.** The age at certification is a scale measurement of the years of life a person had lived when they obtained their licensure as a foster parent. The age range was from 0 to 79. The age was charted in increments of 10 to include 0-39, 40-49, 50-59, 60-69, 70-79.

**ACEs.** ACEs is defined as adverse childhood experiences encountered prior to age 18 (Felitti et al., 1998). The ACE variable was a continuous variable ranging from 0 to 10. The ACE score is the total number of adverse childhood experiences encountered by an individual prior and up to age 18 according to the 10-question ACE questionnaire (Felitti et al., 1998). Participants marked “yes” for every ACE encounter and “no” if they did not encounter, then they tallied the number for all the “yes” ACE encounters in order to acquire their final ACE score. The secondary data from the foster care agency provided the researcher with only the total ACE score from each foster parent participant. The foster parent’s individual score to each specific ACE question was not provided; therefore, the researcher was not able to measure specific ACE contributions to specific outcomes.

**Gender.** Gender was assessed as to whether the participant self-identified as a male or female and defined as 0 for male and 1 for female.
Age. Age was measured using a scale and indicated the age of the participant at the time they completed the questionnaire. The age range was from 0 to 79. The age was charted in increments of 10 to include 0-39, 40-49, 50-59, 60-69, 70-79.

Race. Race was assessed as the participant’s affiliation with a shared origin, culture, or historical affiliation. For this study, race was recoded and measured as 0 for non-African American and 1 for African American.

Income. Income was identified as the total amount of money a household received on a yearly basis from work, investments or benefits. This was measured on a scale of 1 to 6 depending on income ranges from < 20,000 to 70,000 +.

Marital Status. Marital status assessed whether a foster parent was married or not married (single, separated, widowed, divorced). For this study, marital status was re-coded to indicate 0 for not married and 1 for married.

Education level. Education level assessed the academic attainment of the foster parent. This was recoded to exclude elementary school as being an option as one of the highest levels completed due to it being reported that a foster parent must have completed a general education program; therefore, the recoding indicated 0 for high school or GED and 1 for college.

Statistical Analysis

Data analysis was performed using SPSS Statistics 29.0.1.0 software. Descriptive statistics was used to calculate the study variables. A Point-biserial correlation analysis was conducted for all binary independent variables (gender, race, marital status, education) with the continuous ACEs score (Kornbrot, 2014). A Pearson correlation analyzed age and income with ACEs score to look at connections between the study variables (Ghodrati et al., 2022), and an ANOVA was conducted to look at the relationship between groups of three or more (Knapp,
2013) which included the foster parents’ location and ACEs data. Visual examination of boxplots was utilized to examine the data for outliers. There was one significant outlier found for ACEs score. The decision was concluded to include the outlier in the data.

Supportive of Research Question 1

To answer research question 1 regarding the ACEs prevalence among foster parents in Alabama, descriptive statistics was used to identify its prevalence by gender, race, education, marital status, and location. The researcher ran a descriptive statistical analysis in SPSS 29.0.1.0 using the measure of frequency in order to ascertain the incidence of each variable.

Supportive of Research Question 2

To answer research question 2 regarding the association between ACE score and demographic characteristics among foster parents in Alabama. The demographic variables were the independent variables while ACEs score was the dependent variable. The researcher conducted a bivariate analysis using SPSS 29.0.1.0. A Point-biserial correlation analysis was conducted for all binary independent variables (gender, race, marital status, education) with the continuous ACEs score (Kombrot, 2014). A Pearson correlation analyzed age and income with ACEs score to look at connections between the study variables (Ghodrati et al., 2022). An ANOVA test was conducted to examine the relationship between groups.

Supportive of Research Question 3

To answer research question 3 regarding whether there was an association between ACE score and foster parents in Alabama related experiences/characteristics, the number of placements had by the foster parent, average age of placements, length of time fostered, and age at certification were the dependent variables while ACEs score was the independent variable.
The researcher conducted a Pearson correlation between the continuous “foster related experiences” variables with ACE scores analysis using SPSS 29.0.1.0.

**Summary**

In summary, for this study, the researcher used a cross-sectional design consisting of secondary data to analyze the relationship between ACEs and foster parent characteristics. The participants consisted of foster parent participants from a child welfare agency with 3 divisions: Huntsville, Birmingham, and Montgomery. ACEs scores, foster parent demographic information and foster parent characteristics were obtained and analyzed. Data was analyzed using SPSS Software 29.0.1.0. In order to assess ACEs relationship with foster parent demographic, demographic characteristics were the independent variables while the ACE score was the dependent variable. In ascertaining the relationship between foster parent characteristics, foster parent characteristics were the independent variables while the ACE score was the dependent variable. The next section outlines the outcome of the analysis and report results.
Chapter 4: Results

Descriptive Statistics

Table 1 Demographic Description of the Sample

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</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Table 1 presents data on the demographic distribution of foster parent participants in this study. The participant data consisted largely of female foster parents. It was observed that, there were 5 male foster parents, accounting for 9.6% of the participants. Similarly, female foster
parents made up the majority, with 47 individuals, representing 90.4% of the total participants. This implied that the majority of foster parents in this study were female, comprising a significant proportion of the total, consequently, highlighting the gender imbalance, with a greater representation of females as foster parents compared to males. The table indicated that the majority of foster parent participants (38.5%) fell within the 50 – 59 years age range, with the least (7.7%) falling within the 70 – 79 age range. In regard to race, Non-Black/Non-African American foster parent participants accounted for 5 individuals, representing 9.6%; Black or African American foster parents made up the majority with 47 individuals, constituting 90.4%. This indicated that the majority of foster parent participants were Black or African American.

It was also demonstrated that regarding income, 7.7% of the foster parent participants had an income of less than $20,000. Similarly, the largest income bracket was $20,000 - $39,000, which represented 38.5% of foster parent participants, and 26.9% of foster parents fell within the income range of $40,000 - $49,000. Moreover, another 7.7% of foster parents had an income in the range of $50,000 - $59,000. Only 3.8% of foster parents had an income in the range of $60,000 - $69,000. Similarly, 11.5% of foster parents had an income of $70,000 or more. The majority of foster parent participants fell within the lower to mid income range of $20,000 - $49,000, which accounted for 65.4%. It is worth noting that there is a relatively small percentage of foster parents with higher incomes, as only 15.3% earned $60,000 or more annually.

The marital status of the participants included 35 non-married participants, accounting for 67.3%, with a small sample of 16 constituting married participants, thus accounting for 30.8% of the foster parent participants. This indicated that the larger number of the sample are unmarried individuals. Lastly, the education level of the participants indicated that 11 foster parent
participants (21.2%) obtained a high school diploma or GED while the majority of the participants had some college attrition to tally at 37 participants, accounting for 71.2%. This is an indication that the majority of the foster parent participants had pursued higher education after high school whether attending or completing a college education program.

Table 2 Description of Location

<table>
<thead>
<tr>
<th>Location</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>16</td>
<td>30.8</td>
</tr>
<tr>
<td>Huntsville</td>
<td>12</td>
<td>23.1</td>
</tr>
<tr>
<td>Montgomery</td>
<td>24</td>
<td>46.2</td>
</tr>
</tbody>
</table>

The sample represented 52 licensed foster parents from three of the agency’s locations in Alabama, Huntsville, Birmingham, and Montgomery with the majority participants being represented from Montgomery accounting for 24 which is 46.2% of the participants. Huntsville had the fewer participants at 12, consisting of 23.1% and Birmingham being in the middle with 16, accounting for 30.8% of the participants (See Table 2).

Table 3 Descriptive Statistics of Foster Parent Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Placements</td>
<td>51</td>
<td>5.18</td>
<td>4.10</td>
</tr>
<tr>
<td>Avg. Age of Placements</td>
<td>52</td>
<td>11.01</td>
<td>3.88</td>
</tr>
<tr>
<td>Length of time Fostered</td>
<td>52</td>
<td>6.89</td>
<td>7.56</td>
</tr>
<tr>
<td>Age at Certification</td>
<td>52</td>
<td>47.37</td>
<td>10.03</td>
</tr>
</tbody>
</table>

Table 3 shows the descriptive analysis of foster parent characteristics regarding the mean and standard deviation of the number of foster care placements, average age of accepted foster placements, length of time fostered was assessed and age at certification. The mean number of placements had by a foster parent was 5.18 with a standard deviation of 4.102. The
mean for the average age of placements was 11.01 with a standard deviation of 3.8862. The mean for the length of time a parent has fostered was 6.894 with a standard deviation of 7.5637. Lastly, the mean age at which the individual completed the foster parent certification process was 47.375 with the standard deviation of 10.0352.

**Prevalence of ACEs Among Participants**

Table 4 represents data regarding the percentage of foster parent participants with ACE encounters. Of the participants, 38.5% reported 0 ACE. Those who reported 1 ACE were 11.5%. Participants with 2 ACEs were 21.2% while 3.8% reported 3 ACE encounters. Conversely, those with 4 ACE encounters were 9.6%, and those with 5 were 5.8%. Also, participants with 6 ACEs were 3.8% and those reporting 7 and 10 ACEs were 1.9%. There was 1 missing score in the sample. In conclusion, a larger number of participants (59%) reported having encountered 1 or more ACEs, while 48% reported experiencing at least 2 or more ACEs. However, 23.1% reported having experienced 4 or more ACEs. The mean prevalence of ACE among the sample population was 1.92 (Table 5).

<table>
<thead>
<tr>
<th>ACE Score</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>20</td>
<td>38.5%</td>
</tr>
<tr>
<td>1</td>
<td>6</td>
<td>11.5%</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>21.2%</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>9.6%</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>5.8%</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1.9%</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>1.9%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>1.9%</td>
</tr>
</tbody>
</table>
Table 5 Mean ACE Prevalence of the Sample

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEScore</td>
<td>51</td>
<td>0</td>
<td>10</td>
<td>1.92</td>
<td>2.261</td>
</tr>
<tr>
<td>Valid N</td>
<td>51</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The range of scores, means and standard deviation for ACE among foster parents is presented in Table 6. The group statistics table illustrates that among male foster parents (N=5), the mean ACE Score was 1.80, with a standard deviation of 1.48. Among female foster parents (N=46), the mean ACE Score was 1.93, with a higher standard deviation of 2.34. The results revealed that the mean ACE scores were slightly higher among female foster parents (1.93) compared to male foster parents (1.80). The statistics for race showed that among Non-Black/non-African American foster parents (N=5), the mean ACE score was 2.60, with a standard deviation of 2.41. Comparatively, the ACE score for Black or African American (N=46) was lower with a mean score of 1.85 and a standard deviation of 2.26. This indicated that non-Black/Non-African American foster parent participants had slightly higher ACE score than Black/African American foster parents. Foster parents with some college education (N=36) had slightly higher ACE scores with a mean of 1.97 and a standard deviation of 2.37, as opposed to foster parents with high school education or GED (N=11) who possessed a mean score of 1.91 with a standard deviation of 1.76. This indicated that there was a slightly higher ACE presence (1.97) among foster parents with college education. Among non-married foster parents (N=35), the mean ACE score was 2.17 with a standard deviation of 2.48, while the mean score among married foster parents (N=16) was 1.38 with a standard deviation of 1.63. This information showed that parents who were not married possessed a slightly higher mean ACE score (2.17) over married foster parents mean ACE score of 1.38. Lastly, regarding the location of foster
parents, those in Huntsville (N=12) showed a mean ACE score of 1.33 with a standard deviation of 2.15, in Birmingham (N=15), mean ACE score was 2.13 with a standard deviation of 2.92, and Montgomery participants (N=24) possessing a mean score of 2.08 and a standard deviation of 1.86. The findings demonstrated that Birmingham foster parent participants held a slightly higher mean ACE score (2.13) than foster parents in Huntsville (1.33) and Montgomery (2.08).

Table 6: Descriptive of ACE Score and Demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEScore</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>1.8</td>
<td>1.48</td>
</tr>
<tr>
<td>Female</td>
<td>46</td>
<td>1.93</td>
<td>2.34</td>
</tr>
<tr>
<td>ACEScore</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Black/Non African American</td>
<td>5</td>
<td>2.6</td>
<td>2.41</td>
</tr>
<tr>
<td>Black/African American</td>
<td>46</td>
<td>1.85</td>
<td>2.26</td>
</tr>
<tr>
<td>ACEScore</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highschool or GED</td>
<td>11</td>
<td>1.91</td>
<td>1.76</td>
</tr>
<tr>
<td>College</td>
<td>36</td>
<td>1.97</td>
<td>2.37</td>
</tr>
<tr>
<td>ACEScore</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Married</td>
<td>35</td>
<td>2.17</td>
<td>2.48</td>
</tr>
<tr>
<td>Married</td>
<td>16</td>
<td>1.38</td>
<td>1.63</td>
</tr>
<tr>
<td>ACEScore</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HUN</td>
<td>12</td>
<td>1.33</td>
<td>2.15</td>
</tr>
<tr>
<td>BHAM</td>
<td>15</td>
<td>2.13</td>
<td>2.92</td>
</tr>
<tr>
<td>MTG</td>
<td>24</td>
<td>2.08</td>
<td>1.86</td>
</tr>
</tbody>
</table>

The Association between Demographic Characteristics and ACEs

An analysis conducted demonstrated the relationships between each of the independent variables (gender, race, marital status, education) and ACE score via the use of Point-biserial correlations (Cheng et al., 2016) and a Pearson correlation for age and income with ACEs score. The results indicated that there was no statistically significant relation between gender, age, race, and marital status, education, or income in connection with ACE score. For gender ($r = 0.018$, p
= 0.901), age ($r = -0.245$, p = 0.084), race ($r = -0.1$, p = 0.486), marital status ($r = -0.165$, p = 0.247), education ($r = 0.012$, p = 0.935), and income ($r = -0.092$, p = 0.53).

An Independent sample test was conducted to look at the difference between marital status, race, and ACE scores. There was no significant difference in the reported ACE score when marital status was assessed $t(49) = 1.17$, $p = .247$. Also, there was no significant difference in the reported ACE score when race status was assessed $t(49) = .703$, $p = .486$.

An ANOVA test was conducted to examine the relationship between the three different foster parent participant locations and ACE scores. An ANOVA was conducted due to there being three locations to compare with ACE scores (Knapp, 2013), thus a bivariate analysis would not be sufficient. The ANOVA revealed that there was no statistically significant differences identified between three participant locations and ACE scores [$F(8, 42) = 1.15$, $p = .352$]. Also, there was no statistically significant difference between foster parents’ income and ACE scores [$F(8, 40) = .781$, $p = .621$].

The Association between ACEs and Foster Parent Related Characteristics

In analyzing ACE relationship with foster parent characteristics, a Pearson correlation was conducted between the continuous “foster related experiences” variables with ACE scores. Results indicated that there was a significant association between the number of placements by the foster parent and the foster parent’s ACE score. Number of placements ($r = .298$, p = 0.036) indicated an association between foster parents’ number of placements and ACE score. This indicated that the higher the ACEs score, the more placements the foster parents had.

Summary

Descriptive statistics of the foster parent distribution indicated that female foster parents made up the majority of the foster parent participants. A larger number of foster parent
participants (38.5%) fell within the 50 – 59 years age range. African American foster parents made up the majority with 47 individuals, constituting 90.4%. The largest income bracket was $20,000 - $39,000, which represented 38.5% of foster parent participants, and 67.3% of participants were unmarried. Most of the participants had some college attrition (71.2%), and Montgomery represented the largest amount of foster parent participants (46.2%). ACE prevalence among foster parent participants was 1.92 and more prevalent among foster parents that were female, African American, college educated, unmarried, and resided in Birmingham. In analyzing the relationships between ACEs and foster care characteristics, results indicated that there was a significant, positive association between the number of ACEs and number of placements by the foster parent.
Chapter 5: Discussion

Literature acknowledges ACEs experiences among foster parents (Cooley et al, 2020; Adkins et al., 2020). This study sought to determine the ACE prevalence among foster parents in Alabama and whether there was an association among foster parent demographics, foster parent characteristics and ACEs in order to further explore ways to address parenting needs and foster care outcomes. This study confirmed that there is an ACE prevalence among foster parent participants in Alabama. It was also concluded from the test conducted that the only association that existed was between the number of placements had by a foster parent and foster parent ACEs. All other comparisons showed no significant association.

Around 60% of the study participants reported exhibiting 1 or more ACE. Females presented with more ACE encounters than males. The majority of this study’s population was African American which may have played a role in response to the ACEs questionnaire. Though, the sample of non-African Americans was smaller (n=5), they had a higher ACE prevalence than African Americans (n=47). This can be attributed to the Original ACE questionnaire not being culturally sensitive or aware, and not fully capturing African American ACE related experiences. The Original ACEs questionnaire conducted by Felitti et al. (1998) comprised of respondents who were mostly Caucasian male college students. The Philadelphia Urban ACE Survey noticed this difference in the Original ACE study and included 5 additional questions to their ACE study which assessed for community-level stressors experienced by African Americans in an urban community. The additional questions addressed witnessing violence, ever feeling discriminated against, encountering adverse neighborhood experiences, being bullied by a peer or classmate and ever residing in foster care as was developed in the 2021
Philadelphia ACE Project. This information indicates the importance of awareness of the use of culturally responsive assessments and understanding of the target population.

Another factor to note, it has been revealed that African Americans view trauma and mental health as taboo and have negative views regarding it (National Alliance on Mental Health, 2020). Ward et al. (2013) discussed that African Americans appear to not be particularly open to accepting psychological issues, are very concerned about the stigma associated with mental illness and prefer religious coping. According to The Rape, Abuse & Incest National Network (RAINN, 2020), many African American females as young as age 12 do not report encounters with sexual assault due to feeling they will not be believed. This ideology may also influence African American responses to ACEs questions as they may not be comfortable with sharing their experiences even in confidence.

The results of this study indicated that foster parent ACE encounters did not have a significant relation to the age of placements accepted, the length of time fostered or the foster parent’s age at certification. However, foster parents’ average age of placements accepted were youth between the ages of 11-14 years with instances of 53%. The youth fell within the category of adolescents. As indicated in this paper, post-traumatic stress disorder (PTSD) is a serious mental health issue for the adolescent population in foster care. Post-traumatic stress reactions can have lasting impacts on these adolescents even after an immediate trauma. Adolescents who had adverse childhood experiences have unique developmental needs that must be met by the systems that support them due to the likelihood of them displaying suicidal ideation as well as behavioral and learning issues. Foster parents who care for these youth out of relativity or care and concern, need the knowledge and support to do so.
The average length of time individuals fostered was 0-3 years which accounted for 50% of the foster parent population in this sample. It was reported that in some states foster parents’ length of service was between 8 and 14 months (Gibbs & Wildfire 2007). Foster parent turnover increases the need for agencies to continuously recruit, evaluate and train new foster parents for licensure to care for youth. Though the majority of foster parents in this study had not fostered longer than 3 years, it was indicated that 38% of the foster parent participants had been fostering for more than 8 years. Gibbs and Wildfire (2007) identified that long-term foster parents are more likely to be older, take care of more newborns, teenagers, or children with special needs, but when addressing their ACEs history, more studies are needed as there is limited data. It can be explored how this population defines and views ACEs. There is not enough information to draw a firm conclusion about its impact on the length of time an individual fosters. Yet, it is known that retaining foster parents has an impact on the wellbeing of both the children served and child welfare organizations (Gibbs & Wildfire, 2007).

The average age of foster parents in this study was individuals in their 50s, and the minimum age at certification of foster parents in the sample was 32, while the maximum age was 75. The mean age at certification was 52.66. This may account for 38% of long stayers that was previously mentioned, yet there is no correlation between these ages and ACEs histories. Foster parents who had incomes between 20,000 and 39,000 had a mean ACE score of 3.5 and single foster parents had an average ACE score of 3.15. According to ACEs Aware (2020), an individual is at moderate risk of toxic stress if their ACE score is between 0 and 3 which is less than being at high risk. Moderate risk is not viewed as necessarily harmful; however, stress response is dependent upon the individual. Accounting for the information gathered during this study, there has been additional attention presented on the possibility of ACEs influences in the
lives of foster parents and its potential for unhealthy as well as positive consequences of its encounter depending on various different factors.

A key finding in this study was that the number of placements ($r = .298, p = 0.036$) indicated an association between foster parents’ number of placements and ACE score. This indicated that the higher ACEs that foster parents have, the more foster care placements they experience. However, more information is needed to draw conclusions as to the reason for this association. It could be that foster parents who have ACEs have the ability to provide care to foster youth due to the Wounded Healer concept which states that healers of traumatic experiences are empowered to help others by use of knowledge and association acquired from their own trauma encounters (Zerubavel et al., 2012), or the increased placements may account for the many disruptions had by the foster child.

Research asserts that parenting behaviors play an intricate role in placement disruptions. Placement disruptions can occur when the foster youth is displaying behavior problems that cannot be mitigated by the foster parent (Weiner et al., 2011). Foster parents can have problems with addressing foster youth behaviors due to the need of being trauma informed. Trauma informed parenting improves the foster parent’s knowledge on how trauma impacts an individual (Konijn et al., 2020) to include themselves and the foster child. Trauma informed training also promotes secure attachment (Konijn et al., 2020) which is important to the foster parent child relationship and contributes to minimizing disruptions. Another key finding in this study was that 23% of the foster parent participants had an ACEs score of 4 or more which was 33% above the general population. A score of 4 or more is considered high and increase the risks of impact on adult health, behavior and life outcomes. Behavior outcomes may include foster parents’ parenting behavior, skills and abilities.
The dynamic and complex environment of foster care highlights the need for comprehensive support and intervention due to the experience of trauma by both foster parents and children. Foster parents also endure trauma, and foster children enter into foster care with trauma. Foster parents may encounter additional trauma from their interactions with their foster children as well as secondary trauma while managing the emotional and behavioral problems of their foster children. In addition, foster parents may experience extra trauma reactions as a result of their encounters and parenting responsibilities in the foster care relationship. This may result from the emotionally taxing nature of managing difficult behaviors, tending to the needs of kids with complicated trauma histories. Acknowledging and addressing trauma experienced by both the foster child and foster parent is essential to promoting positive outcomes within the foster care system.

**Relation to conceptual framework**

The conceptual framework illustrated how ACEs can be factored into the foster parents’ life. It asserts how the Wounded Healer phenomenon may contribute to why foster parents who have ACE histories desire to become foster parents. The framework also discussed how positive influences may intercept negative response to ACEs experiences of foster parents and considers encounters of adverse events and the potential moderating factor that is correlated with outcomes.

Key findings of this study uncovered that foster parents who had ACEs exhibited a greater percentage of encounters with 4 or more ACEs (23%) than the general population (17.3%). Having more ACEs increase the risk of parenting, health and life outcomes of the foster parent. Though ACEs are known to impact parenting skills and abilities, yet, with mitigating factors such as resiliency, the effects of ACEs may be combatted. From this research, it is
presumed that foster parents with high ACE scores are perceived as wounded healers due to their wanting to help others because of their own personal “wounded” experiences.

However, there is a need to know more about how it impacts foster parents’ caring for foster children in order to understand ways to address this concept in the field of child welfare. There were limitations to this study that may not have allowed the researcher to fully capture this issue; therefore, continued research is needed. The following section discusses the limitations and provide future implications for advancing this area of study.

Limitations

The most notable limitation of this study is the small sample size. Though generalizable conclusions cannot be made with 52 participants, the findings provided will allow for exploration of future studies that can be examined using a larger sample size. However, it cannot be assumed that the study's findings accurately captured foster parents' experiences in this or other foster care systems across the United States. The sample of respondents represented only a fraction of the foster parents of one foster care agency in one state. This study had greater representation from one division over the other two.

There was a lack of diversity in the sample population. This sample consisted of majority African American, female foster parents. This is not a total representation of the ethnicity and cultural identity of all foster parents. Secondly, the researcher was unable to measure specific ACEs to specific characteristics due to obtaining secondary data that provided the total ACE score and not the specific ACE the participant identified with. For example, it could not be determined whether physical abuse was more prevalent in older versus younger foster parents or if divorce attributed to more ACEs than neglect. Generally, the phenomena of ACE needs more clear, consistent interpretation (Kalmakis et al., 2014). There could have been additional trauma
related experiences that were not captured on the ACE questionnaire used such as race related trauma or poverty related trauma. There are other questionnaires that assess for additional types of ACEs across culture such as the Philadelphia Urban ACE Survey. Obtaining foster parents’ narrative via a qualitative study would have allowed the researcher to acquire the foster parent’s perspective of their childhood ACEs histories. This study relied on self-reported short answer measures which was viewed as a limitation. There was one outlier in this study in which only one participant had an ACEs score of 10.

In asserting the wounded healer phenomenon, resiliency was not addressed among the foster parent participants. Literature reports that resiliency is a beneficial component to helping individuals work through trauma. This in turn, allows the “healed” individual to provide help to other wounded individuals. This was not able to be explored during this study and should be included in future research to look at ways that trauma is addressed by individuals and what factors provide individuals the ability to help others after they have endured a traumatic experience.

**Implications for Future Research**

The implication for future research should include conducting mixed methods research as individual’s perspective of trauma and its impression on their lives vary by individual. As Carlson (1997) indicated, trauma exposure differs depending on the methods employed to describe and inquire about the experiences. Though the sample size was appropriate for this study, the researcher suggests utilizing a larger sample size in order to try to obtain diversity in participants, if possible, in order to provide results that are more generalizable as well as assess for additional characteristics to include resiliency questions.
More research needs to be conducted to better understand ACE in foster parents. Proper assessments for measuring ACE should be explored in order to ensure trauma is being accurately captured. Also, looking at the success and failures of foster care placements can provide a better demonstration of why placements terminate or why foster parents have a certain number of placements. The lack of knowledge in this area may hinder the development and implementation of policies, practices and interventions needed to support the development of foster parent skills and increase healthy foster care outcomes. Social services agencies can address this lack by enacting effective screening and assessment protocols for foster parents. Agencies can also provide support and training to help identified foster parents become trauma informed and aware when providing appropriate and effective services to foster children. Being aware of the effects of ACEs on foster parenting, it must be must acknowledged that understanding foster parents’ life experiences can be beneficial to the development of parenting supports. It can be argued that there is ACE prevalence among foster parents and that its examination is necessary as foster parents are needed for the foster care system (Rosenwald & Bronstein, 2008).

**Implications for Social Work**

Due to this study implicating that the prevalence of 4 or more ACEs encounters was high in foster parents, social workers need to be able to appropriately assess for ACEs in foster parents. Informing the field of social work on the importance of educating child welfare providers to include staff and foster parents on understanding trauma along with incorporating specialized training that is trauma-informed can strengthen awareness, skills, and abilities. Herbert and Kulkin (2018) evaluated the training needs of foster parents and found that foster parents believed it was essential for them to learn how to deal with challenging behaviors. This can be advanced by helping them understand the background of behaviors.
Due to findings indicating that the increase in ACEs score was associated with the increase in foster placements, more research is needed to ascertain the cause. There is a need to know if this association was due to the success of placements, causing foster parents to be used more often, or whether this was connected to placement failure. There is also a need to assess whether success was connected to the Wounded Healer concept or if other factors are at play, as well as determine if failure was due to foster parent parenting skills and abilities. In foster parents possessing the wounded healer syndrome they desire to care for foster youth who have experienced similar encounters as theirs to keep them safe, they may have had protective factors to redress or divert negative impacts of ACEs, or they may have active resiliency capacity. This highlights the need for understanding recovery of adverse experiences via resilience and the motivation to do good. Foster parents' resilience becoming the focal point of foster parent education and support (Cooley et al., 2020), but assessing for what needs to be attached to the resilience can be a role of the ACE questionnaire opposed to ACEs being solely utilized as an indication of parenting abilities. Whatever the cause, it is beneficial to provide trauma informed training to foster parents and social workers to ensure that knowledge and awareness are raised as trauma is prevalent in the foster care population. Proper ACE assessments should proceed training in order to ensure the appropriate guidance is provided. Assessments for ACEs should contain additional ACEs categories that contribute to ACEs and effects of its encounters across cultures and individuals as was pointed out by the 2021 Philadelphia ACE Project. Lastly, appropriate tools and interventions need to be developed that include targeted trauma informed training and education on ACEs and trauma in the field of child welfare and foster care.
Implications for Policy

Child welfare is a field that carries a system of trauma. Though not discussed in depth in this study, all are impacted in some facet, by trauma in child welfare, from the foster youth who enters foster care, the foster parent who may have a trauma history, to the child welfare worker who may endure secondary trauma while working with individuals affected by trauma. According to research, people with ACEs who work in child welfare frequently experience high levels of stress and have trouble using coping mechanisms (Lee et al., 2017). There needs to be a mandate for appropriate assessments that are culturally sensitive and capture specific ACE encounters. There needs to be advocacy for states to provide appropriate assessments and evidence-based training to foster care workers, staff and foster parents who may be affected by trauma. They can develop skills to help them better cope and provide the best service to foster youth in their care. Per Wylie et al. (2018), complex trauma, can make it challenging for practitioners with little background in transcultural or trauma-informed treatment to conduct meaningful assessments. Lastly, in looking at outcomes, state programs should ensure they have protocols to appropriately measure success and non-success of foster care placements as the number of placements was identified as an association with foster parent ACE presence.

Conclusion

This study provides some insight into assessing ACEs among foster parents, and it can serve as a starting point for researching foster parent experiences and implications but it does not capture all that needs to be captured. It does not capture the degree of ACEs, the attributes of specific ACEs on a foster parent. However, with there also being evidence that there is a presence of ACEs among foster parents and knowledge regarding how ACEs influences parenting abilities, and the challenges present with foster care placements, there establishes for
the need to provide more emphasis on efficient trauma-informed training and foster parents’ positive and resiliency factors for foster parents with ACE histories. This study showed that placement number increases correlated with foster parent’s ACE presence. Research also, indicates that foster parents have more ACE than the general population and that their ACEs histories may have an impact on the foster parent’s abilities. Data developed during this research indicated that there was one relation between foster parents having ACEs and foster parent characteristics; though it may be presumed there would be more relationship presence.

According to research, trauma is relative and impacts individuals differently. Theory states that resiliency factors and other positive life experiences can develop as mediating factors to the negative impact of adverse childhood experiences.

It is recommended that a larger sample is gathered to reproduce this study and that this study be conducted using a mixed-methods including qualitative analysis approach in order to get narratives of foster parent’s ACE encounters. It is also worthy to note that ACEs may not be the pressing subject matter of exploration regarding foster parents and parenting abilities, rather added focus be placed on consistent, efficient trainings such as trauma-informed care and in cultivating foster parents’ positive attributes. Given the information gathered during this study, it is important that future assessments, interventions, and policy initiatives are implemented to focus on ways to promote positive foster care outcomes and to encourage the enhancement of sufficient supports for foster parents to promote success in foster care.
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Appendix A

ACE Questionnaire

1. Did a parent or other adult in the household often or very often…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ________

2. Did a parent or other adult in the household often or very often…
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you ever…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?
   Yes No If yes enter 1 ________

4. Did you often or very often feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn’t look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ________

5. Did you often or very often feel that …
   You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ________

6. Were your parents ever separated or divorced?
   Yes No If yes enter 1 ________

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ________

8. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 ________

9. Did a household member go to prison?
   Yes No If yes enter 1 ________

Now add up your “Yes” answers: ________  This is your ACE Score

Felliti, et al. (1998)