THESIS

EXPLORING FOSTER AND ADOPTIVE PARENT STRESSORS AND RESOURCES: A MIXED METHOD STUDY

Submitted by

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ABSTRACT

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At any given time over half a million children are in foster care and over 50,000 of these children are adopted each year in the United States. The majority of these children have been exposed to trauma. Parents may not have the resources needed to effectively parent their foster/adoptive children and the experience of parenting a child with a significant trauma history may be stressful. In the current study, we conducted 8 focus groups with 25 foster and adoptive families to learn more about the relationship between child behavior and parenting stress and whether resources moderate this relationship. Secondly, we explored parent resources through qualitative analysis.

Results indicated emotion symptoms and conduct problems respectively, resources, and their interaction significantly predicted total parenting stress. Moreover, both emotion symptoms and conduct problems variables significantly predicted total parenting stress but these effects were not moderated by support. Parents reported trainings and social support were generally helpful but that other supports such as respite, positive relationships with schools, and helpful professionals were important. Parents expressed frustration over a lack of resources after initial foster parent training or adoption, negative interactions with professionals, and judgement from friends and family. The current study suggests a need for larger studies on the types of support that would be most helpful to this population, as well as how support fits into the space between child behavior and parent stress in, order to create effective interventions for this population.

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INTRODUCTION

Over 50,000 children are adopted from the foster care system each year (U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2017a). Foster and adoptive parents may face challenges parenting a child who has been involved in foster care and has been exposed to trauma (De Young, Kenardy, & Cobham, 2011; Moyer & Goldberg, 2017; Sullivan, Murray, & Ake, 2016). Better understanding the challenges faced by foster and adoptive parents will allow us to create more targeted interventions to promote positive parent-child relationships, decrease trauma symptoms, minimize parental stress, and maintain placements. In this selective review, findings concerning the manifestation of trauma in this population, the role of long-term foster and adoptive parents, and processes within the parent-child dyad as they relate to parenting challenges as well as questions and hypotheses to be addressed are discussed.

Foster Care

Children are generally placed in foster care when biological caregivers are neglectful or are physically or sexually abusive toward them, with the most common form of maltreatment being neglect (U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2017b). These experiences, as well as being separated from parents, siblings, and other significant people in their lives because of the maltreatment and subsequent entry to foster care may be traumatic. Children may also encounter traumatic situations within the foster care system such as multiple failed placements (Rayburn, Withers, & McWey, 2017).

Foster and adoptive parents tend to rank their child's behavioral and mental health difficulties as their greatest concern (Barnett, Jankowski, Butcher, Meister, Parton, & Drake, 2017). Children with trauma histories may exhibit symptoms such internalizing and externalizing behavior, attachment disorders, mental health disorders, substance use, and suicidality (De Young et al., 2011; Kim & Cicchetti, 2010; Villodas, Litrownik, Newton, & Davis, 2016). Children involved in foster care are at high risk of exhibiting symptoms given their greater likelihood of experiencing trauma (Villodas et al., 2016). These symptoms may vary in number and severity depending on many factors including the nature and duration of the trauma, experience in foster care, experience with attachment, age, temperament, and genetic predispositions (Stoner, Leon, & Fuller, 2015; Villodas et al., 2016). Symptoms may develop over time or may be immediately noticeable, may improve or worsen over time, and may last into adulthood (De Young et al., 2011). Adults with untreated childhood trauma are at risk for maltreating their children as they may have maladaptive parenting schemas and symptoms that may impede their ability to parent (De Young et al., 2011).

The period immediately following adoption is often referred to as the honeymoon period because adoptive parents tend to report few stressors (Canzi, Ranieri, Barni, & Rosnati, 2017). The age of the child at adoption is a salient factor after the honeymoon period but the impact of age may lessen over time (Canzi et al., 2017). Children older than four may be perceived by adoptive parents as more difficult to parent than younger children as this group often displays more trauma symptoms and symptoms of greater severity (Canzi et al., 2017; Nadeem et al., 2017). This may be because older children are more likely to have been removed from their home at an older age and there is a greater likelihood that they experienced maltreatment for a longer period as well as sexual abuse (Villodas et al., 2016). Children younger than four tend to

display fewer trauma symptoms initially but symptoms, especially externalizing behavior, may increase over time (Nadeem et al., 2017). Nadeem et al. (2017) hypothesize that this may be because the children become more comfortable with their adoptive parents over time and may be testing boundaries with this behavior. Challenging behavior in all ages may decrease over time, but there tend to be ups and downs. Additionally, symptoms often remain in a subclinical to clinical range (Nadeem et al., 2017).

The fact that children in foster care are prescribed psychotropic medication at a rate significantly higher than the general population is important to note in the discussion of trauma symptoms (Scozzaro & Janikowski, 2015). This may be in part, related to the higher prevalence of serious mental health and behavioral issues in this population, but may also be related to a culture of quick fixes and a lack of resources (Barnett, Boucher, Neubacher, & Carpenter-Song, 2016). The foster care system is increasingly overburdened, and children may not receive the most appropriate treatment for their diagnoses. These findings highlight the severity of trauma symptoms these children may be experiencing as well as the potential challenges adoptive parents may encounter when navigating treatment.

International Adoption and Unaccompanied Refugee Minors

International adoption may involve unique considerations and challenges. Findings tend to be mixed about what factors may contribute to resilience and parenting challenge within this population. Parents may adopt from a variety cultures, and with a variety of experiences, making it difficult to make comparisons (Harwood, Feng, & Yu, 2013). Cultural differences between the child and their adoptive parents may present some challenges, but findings are mixed (Tan, 2018). Some studies have found that internationally adopted children show poorer school performance, while others have found school performance to be on par with same age peers

raised by biological parents (Harwood et al., 2013; Tan, 2018). Institutionalization in general, as well as institutionalization at a younger age may be a risk factor for behavioral problems in some populations (Lee, Seol, Sung, Miller, Minnesota International Adoption Project Team, 2010). Children adopted internationally tend to display more insecure attachment, with children from Eastern Europe displaying the highest rates of insecure attachment (Barcons et al., 2014).

Unaccompanied refugee minors (URMs) are children who entered the United States without their parents and came from areas affected by traumatic events such as war or natural disaster (Carlson, Cacciatore, & Klimek, 2012). These children often cannot reconnect with their parents and are fostered long-term. The literature on this population is sparse, but a few studies have been conducted to better understand the experiences of these children. URMs may struggle with parental authority, and misunderstandings related to cultural differences may create conflict (Luster et al., 2009). In a study of Sudanese URMs who had been living in peer groups for several years, over half had more than one foster placement and reported having difficulty adjusting to parental decision making initially (Luster et al., 2009). Connection with family and community, a sense of belonging, positive outlook, valuing education, healthy coping mechanisms, religiosity, and connection to home culture may be sources of resilience for URMs (Carlson et al., 2012; Pieloch, McCullough, Marks, 2016).

Role of Adoptive Parents

Adoptive and long-term foster parents may be a source of resilience for these children but they are often unprepared for the symptoms associated with their child's trauma (De Young et al., 2011; Moyer & Goldberg, 2017). Current classes offered by many agencies do not include a trauma-informed parenting component (Sullivan et al., 2016). Additionally, these classes are typically only offered before the adoption, with little support afterward, leaving many adoptive

parents without the necessary understanding and skills to properly parent children who have experienced trauma (Sullivan et al., 2016).

Adoptive parents who are knowledgeable about trauma and its impacts are more likely to respond to their child in a manner that builds healthy coping strategies such as emotion regulation in the child and secure attachment in the parent-child relationship (Santos-Nunes, Narciso, Vieira-Santos, & Roberto, 2017). If adoptive parents are not well-informed about trauma and how it may manifest, they may perceive their child's behavior as disrespectful and disobedient or question their ability to parent.

Foster to adopt or long-term foster parents may have known the child for longer but may also encounter parenting challenges (Barnett et al., 2017). Although the foster parent may be the primary caregiver for the child before the adoption is finalized, officials within the foster care system may have control over many of the decisions a parent usually makes on their own (Barnett et al., 2016). Medical decision making is more likely to be under the control of the child's team within the system. For example, the foster-to-adopt parent may be required to give their child psychotropic medication or bring their child to a specific therapist. Those within foster care may not take the foster-to-adopt parent's views or experience into account when formulating a treatment plan (Barnett et al., 2016). This may be a stressful experience in which the foster-to-adopt parent lacks control. After the adoption, the adoptive parent may need to shift their role and begin to take a larger role in decision making for the needs of their child. Coordinating existing and new resources may also be a stressor (Barnett et al., 2017).

Grief and Loss

It is important to note that grief may be a salient factor in the functioning of both foster and adoptive children and parents (Mitchell, 2016; Mitchell, 2017). Children who have entered

foster care may have experienced the death of a parent and grieve this parent, but more often children have been removed from the home of their parents and away from extended family, friends, and familiar surroundings and must grieve this ambiguous loss (Mitchell, 2017). In the case of refugee children, their parents may be alive but unable to be located or unable to join them in a safe place, another type of ambiguous loss (Pieloch et al., 2016). Children who have experienced sudden and/or ambiguous loss may struggle to make meaning of their experiences and the world around them, which could begin to impact their mental health and ability to interact successfully with others if left untreated (Mitchell, 2016).

Adoptive parents may be grieving losses from before the adoption such as infertility, miscarriage, or the loss of a child that have precipitated their interest in adoption (Lockerbie, 2014). Adoptive parents may also grieve previous adoptions that have fallen through. Long-term foster parents may have similar experiences and may also grieve the fact that they may never be able to formally adopt their child. Unresolved grief on the part of the adoptive parent may contribute to mental health difficulties and could impede relationship formation with their adoptive child (Lockerbie, 2014; Moyer & Goldberg, 2017).

Processes Within the Adoptive Parent-Child Dyad

Two salient processes emerge from the literature concerning the relationship between the adoptive parent and child: the family's response to stressors in the relationship and attachment. Adoption is usually regarded as a positive event, but it has been shown to be a stressful event for the family system (Santos-Nunes et al., 2017). How a family responds to this stress may affect the quality of parent-child attachment (Santos-Nunes et al., 2017).

Family stress theory, particularly the ABC-X and double ABC-X models provide a useful framework for understanding the role stress plays in the relationship, although few researchers

have used these models to conceptualize these processes. Family stress theory posits that a family's response to a stressor can be understood through the ABC-X model that includes (A) the stressor, (B) resources, (C) definition of the situation, and (X) crisis (Smith & Hamon, 2009). If the family is unable to define the situation as manageable, obtain appropriate resources, or both, the family may enter a crisis (Smith & Hamon, 2009).

Adoptive parents may be unaware of the severity and number of their child's trauma symptoms until after the child has been placed in their home (Moyer & Goldberg, 2017; Santos-Nunes et al., 2017). Moyer and Goldberg (2017) found that adopting a child who is experiencing trauma symptoms and attempting to parent without trauma-informed parenting techniques may be stressful for adoptive parents and may impact their ability to parent effectively. Even with the proper skill set, this experience may be stressful. Moyer and Goldberg (2017) utilize the ABC-X model to conceptualize the experience of adopting a child from foster care without full knowledge of the child's trauma symptoms with (A) being the unmet expectations for behavior, (B) insufficient resources to cope with unmet expectations, and (C) parent's negative appraisal of the situation. Building on the ideas of Moyer and Goldberg (2017), (X) may be the manifestation of a larger number and greater severity of trauma symptoms, attachment issues, or failed placement.

Adoptive parents may encounter a variety of other stressors. The sum of stressors could impact the family negatively if the family is unable to cope with successive stressors or multiple stressors at one point in time. The double ABC-X model captures the cascading stressors associated with adopting a child. This model builds upon the ABC-X by showing how stressors repeat and build over time. The initial stressor may be thought of as adopting the child. This stressor may be followed by many others that must be coped with such as unanticipated

symptoms, taking time off work, forming secure attachment, learning how to parent a child with trauma symptoms, etc. It is important to note that the model's resources component posits that coping with the stressor by seeking and utilizing resources may mitigate the stressor, but finding resources may be a stressor in and of itself as many adoptive parents report that there are few resources available (Barnett et al., 2017).

The transactional model of stress and coping may further explain the interplay between stress and coping strategies adoptive parents may employ (Lazarus & Folkman, 1987). The transactional model posits that we must determine whether a stressor is a significant enough threat to the individual's well-being to address it and to decide how to cope with it. An individual or family must first make a primary cognitive appraisal: whether and how to cope with demands, what harm has already happened, what could happen if the individual or family does not address the stressor, and potential for mastery or gain. Secondary appraisal occurs once the individual or family makes a determination that the stressor is significant enough to warrant some action. When in the secondary appraisal step, foster or adoptive parents may determine if an action can be taken to improve the problem and begin to assess which coping strategies may work (Lazarus & Folkman, 1987).

In this model, coping has the power to shift the appraisal of a situation, and thus the quality and intensity of emotional response to a situation (Lazarus & Folkman, 1987). Both coping and appraisal are thought of as mediators of short-term emotional reactions. Coping may be emotion focused or problem focused. Problem-focused coping may be more responsive to contextual factors but emotion focused coping may be more responsive to interpersonal factors.

In exploring foster and adoptive parent coping, understanding thought processes that go into appraisal and coping and how these processes influence parents' emotional reactions may be

particularly useful. Stressors these parents encounter may be of an interpersonal nature and may be ongoing, so emotion-focused coping may a more successful strategy for these parents. Emotional reactions may color future appraisals and could begin to influence processes occurring within the parent-child relationship.

Attachment seems to impact all aspects of the parenting challenges associated with adopting a child who has experienced trauma. Secure attachment forms a base from which the parent-child relationship is built (Dunham, 2017). Children in the foster care system, however, are more likely to have experienced trauma in the form of abuse and neglect perpetrated by their caregiver, making it difficult for them to build this new relationship with a caregiver (Kim & Cicchetti, 2010; Villodas et al., 2016). These children are more likely to display insecure or disorganized attachment. Insecure or disorganized attachment may have emerged as a coping strategy to adapt to a caregiver who was unpredictable or abusive (Kim & Cicchetti, 2010). These coping strategies were useful during that time but may not be useful in the long term or with safe caregivers (Rayburn et al., 2017). The maladaptive coping strategies these children have utilized to survive unsafe situations can hamper the relationship with their adoptive parents; these children may be concerned that their needs will not be met, or that eventually their caregiver may hurt or give up on them (Rayburn et al., 2017).

Issues with the formation of secure attachment may be conceptualized using the double ABC-X model as an initial stressor followed by numerous related stressors. Parenting a child with insecure or disorganized attachment may be viewed as a stressor by the adoptive parent and may impede their ability to parent successfully (Barnett et al., 2017; Moyer & Goldberg, 2017). Santos-Nunes et al. (2017) found that parental emotional warmth and stress were mediated by insecure attachment in adoptive parent-child dyads. Utilizing the model, the initial stressor may

be the child displaying attachment problems. If the parent does not appraise the situation as manageable or bring in additional resources, they may experience stress and cope by displaying lower emotional warmth, reinforcing their child's attachment schema. The reinforcement of their child's attachment schema may cause the child to display additional trauma symptoms to have their needs met, further stressing the parent and perhaps creating additional crises.

Hypotheses

Figure 1 depicts that the relationship between child behavior and parenting stress is moderated by resources. Child behavior may consist of internalizing (emotional problems) and externalizing (conduct problems). Parenting stress is defined as parent-child relational problems and overall stress from parenting the child. Resources may consist of services or assistance parents found to be helpful such as positive experiences with training, supportive friends and family, interactions with similar parents, and helpful professionals. Research questions and hypotheses elaborating on Figure 1 will be discussed below.

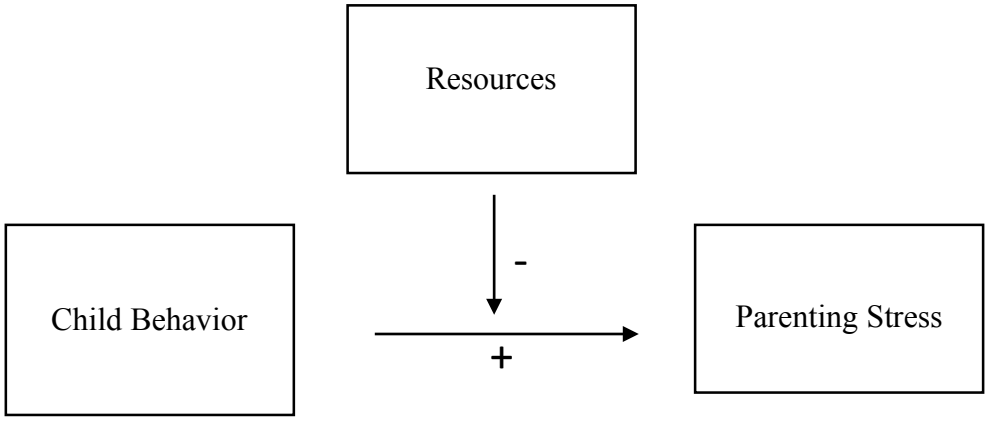

Figure 1. Relationship between child behavior and parenting stress moderated by resources.

Does perceived child behavior predict parenting stress and if so, do resources moderate this relationship (quantitative research question)? Higher parent ratings of child internalizing and externalizing behavior problems (emotional problems and conduct problems, respectively) are

expected to predict higher parent-child relationship dysfunction. These parents may not be prepared for the severity or number of behavior problems their child may display as a result of their trauma (De Young et al., 2011; Moyer & Goldberg, 2017). Even with preparation and training, parenting a child with behavioral problems may be stressful without support (Sullivan et al., 2016). Resources that reduce child behavior problems and provide support to parents may reduce the strength of the relationship between child behavior and parenting stress (Barnett et al., 2017; De Young et al., 2011; Moyer & Goldberg, 2017).

What resources may moderate the relationship between child behavior and parenting stress (qualitative research question)? One goal of this study was to ascertain which resources parents found to be helpful, such as which trainings, which types of social support, and which forms of respite care. We also wanted to find out which resources and trainings were not found to be helpful.

METHOD

Participants

We selected participants through purposive sampling as part of a larger project called Teaching Adoptive Parents Trauma-Informed (TAPT-In) Parenting. We recruited participants through private and public agencies serving foster-to-adopt families in the Rocky Mountain region. Our contacts at these agencies informed potential participants of our study and invited them to participate.

The eligibility criteria for this study were that the participants be current or past foster and/or adoptive parents. We did not exclude any type of foster or adoptive parent to gather information on the full range of experiences of this population. However, we recruited from agencies and organizations that work with foster and foster-to-adopt families.

Eight focus groups were conducted with a total of 44 foster/adoptive parents: 18 parent dyads and 8 parents who were single parents or whose partners were not in attendance. For all quantitative measures, each family was treated as one case, regardless of whether one or two parents responded, and couples were noted in focus group data. Focus group sizes ranged from 3 to 8 participants. Participants were primarily Caucasian and most were highly educated. Socioeconomic Index (SEI) scores, based on the parent with the higher occupational status, ranged from child care worker 30.82 to engineer 87.91 (Entwisle & Astone, 1994). Entwisle and Astone (1994) developed guidelines and a scoring system to give an estimate of socioeconomic status for participants based on their occupation. This system was developed based on Census Bureau data. Participants fostered and/or adopted through 4 agencies in 5 counties. Participants reported on a total of 25 foster or adoptive children (12 boys) who were primarily Caucasian.

Children ranged in age from 1 to 20 with an average age of 7 years. One couple was omitted from analysis because they did not have foster or adoptive children and had not in the past and one couple was omitted because they did not fill out questionnaires. In addition, *n*'s vary because some parents did not complete all questionnaire items. Complete demographic information is provided in Table 1 below. See Appendix B for demographic form.

Table 1. *Demographic Characteristics of the Sample*

Characteristic	Mean (SD)	Min	Max	*n*	%
Child age, years	7.63 (5.25)	1.61	20.72	25	
Children in household	2.95 (1.77)	1	6	23	
Biological children in household	2 (0.00)	2	2	15	
Adoptive/foster/other children in household	1.59 (.71)	1	3	17	
Child gender				24	
Male				12	50
Female				12	50
Other/nonbinary				0	0.00
Child ethnicity				24	
Hispanic/Latinx				4	16.7
African-American/Black				1	4.2
Asian/Asian-American/Pacific Islander				1	4.2
Middle Eastern				0	0.00
Native American/Alaskan Native				1	4.2
European-American/Caucasian				16	66.7
Other				1	4.2
Agency					
In-state Agency 1				7	31.8
In-state Agency 2				13	59.1
In-state Agency 3				1	4.5
Out-of-state Agency 1				1	4.5
County					
In-state County 1				12	57.1
In-state County 2				4	19
In-state County 3				1	4.8
In-state County 4				3	14.3

Out-of-state County 1	1	4.8
Foster/adoptive mother ethnicity	25	
Hispanic/Latinx	2	8.7
African-American/Black	1	4.3
Asian/Asian-American/Pacific Islander	0	0.00
Middle Eastern	0	0.00
Native American/Alaskan Native	0	0.00
European-American/Caucasian	20	87.0
Other	0	0.00
Foster/adoptive father ethnicity	20	
Hispanic/Latinx	2	10
African-American/Black	1	5
Asian/Asian-American/Pacific Islander	0	0.00
Middle Eastern	0	0.00
Native American/Alaskan Native	0	0.00
European-American/Caucasian	20	85
Other	0	0.00
Mother education	23	
High school diploma	3	13
Some college	5	21.7
Associate's degree	1	4.3
Bachelor's degree	8	34.8
Some post-bachelor's education	2	8.7
Master's degree, doctoral degree, or similar	4	17.4
Father education	20	
High school diploma	1	5
Some college	5	25
Associate's degree	2	10
Bachelor's degree	7	35
Some post-bachelor's education	0	0.00
Master's degree, doctoral degree, or similar	5	25

Measures

Behavior problems. Child behavior problems were operationalized as the emotional problems and conduct problems subscales of the Strengths and Difficulties Questionnaire (SDQ) completed by mothers (Goodman, 1997). We used mother report because our sample size was small and the sample size of fathers was significantly smaller. Scores on the SDQ have been shown to be highly correlated with the Child Behavior Checklist (CBCL), an empirically validated and widely-used measure in the mental health field and research contexts, with a systematic review finding a weighted correlation of r (4590) = .76 on average (Goodman & Scott, 1999; Stone, Otten, Engels, Vermulst, Janssen, 2010). The SDQ, however, is significantly shorter, at 25 items, and takes much less time to complete than the CBCL, at about 5 minutes. The SDQ's ability to detect inattention and hyperactivity is significantly better than the CBCL (Goodman & Scott, 1999).

The SDQ appears to be a valid measure for use in this study. The SDQ consists of 5 subscales that measure emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior (Goodman, 1997). This measure asks parents to report whether statements such as "steals from home, school or elsewhere" and "many worries or often seems worried" are not true, somewhat true, or certainly true of their child. The items have face validity for internalizing and externalizing behavioral difficulties (Goodman, 1997). In addition, convergent validity was obtained in 16 studies and, on average, moderate or strong correlations were found between SDQ scales and the other measure, r = .67. Emotional, Conduct, and Hyperactivity subscales were correlated with other relevant measures at acceptable levels, r =.55-.63. The Peer Problems, and Prosocial subscales were unacceptable, r = 0.49 and r = 0.18 respectively, thus we will not be using these scales in our study (Kersten et al., 2016).

Reliability for the SDQ was high in the original psychometric studies (Goodman, 1997). However, in a systematic review of the validity and reliability of the SDQ in children ages 3-5, results were more mixed. It was found that across 26 studies, the weighted average of Cronbach's alpha was .79 for the total problems score, indicating good internal consistency; however, the average reliability of emotional problems and conduct problems were .62 and .56, ranging from .56 to .68 and .5 to .62, respectively, across studies (Kersten et al., 2016). Given the variable reliability across studies, as well as the unique population for the present study, we calculated alphas for our sample. The alphas for emotional problems and conduct problems in our sample were .64, and .58, respectively. These are similar to those in the recent literature, but are lower than optimal.

Parenting stress. Mother report of Abidin's (2012) Parenting Stress Inventory Short Form (PSI-SF) provided measures of Parent-child interaction dysfunction and overall parenting stress. The PSI-SF has three sections: parental distress, dysfunctional parent-child interactions, and difficult child characteristics. The reliability and consistency of this abbreviated version is similar to the original long form PSI (Abidin, 2012). In an evaluation of the PSI-SF in a sample of Head Start families, Reitman, Currier, and Stickle (2002) found similar levels of internal consistency and reliability reported in the original PSI. Even in this diverse and low income sample, results indicated adequate levels of reliability with Cronbach's alpha for parental distress .88, parent-child interaction dysfunction .88, difficult child characteristics .89 and total stress .95. Hickman et al. (2013) also found good to excellent internal consistency within the three subscales of the PSI-SF when used with a sample of parents of children who had experienced lifetime exposure to violence and had trauma symptoms and behavior problems, in other words, a sample similar to the one included in the present study.

The PSI-SF also appears to be a valid measure for use in this study. Barroso, Hungerford, Garcia, Graziano and Bagner (2016) tested the psychometric properties of the PSI-SF in a sample of high risk mothers with infants. They found that in terms of convergent validity, mothers' scores on the PSI-SF were moderately correlated with mothers' scores on the Center for Epidemiological Studies Depression Scale CES-D, a scale testing similar theoretical constructs of parenting stress and depression, r (58) = .53, $p < .001$. Haskett, Ahern, Ward, Caryn, and Allaire (2006) found similar results with the parent distress scale on the PSI-SF correlating with Global Severity Index scores on the Symptom Checklist (SCL), a checklist testing a similar construct of child behavioral problems, r (163) = .23 $p < .01$. Haskett et al. (2006) also found the parent-child dysfunctional interactions scale and difficult child characteristics scale correlated with the Eyberg Child Behavior Inventory (ECBI), an inventory testing similar constructs, r (141) = .61, $p < .001$. Haskett et al. (2006) also tested the predictive validity of the PSI-SF and found that scores on the PSI-SF predicted child adjustment, tested through the ECBI, one year later. The alphas for the PSI-SF total score and PSI-SF dysfunctional parent-child subscale in our sample were .93, and .83, respectively. These are similar to those in the recent literature.

The dependent variable, parenting stress, was operationalized as the dysfunctional parent-child interactions subscale of the Parenting Stress Index Short Form (PSI-SF) as well as the total score (Abidin, 2012). The moderator, resources, was operationalized as a score calculated from the count of distal/family social supports, helpful professional resources, respite provided by organizations/professionals, respite provided by family and friends, supportive school experiences, self-care, and helpful trainings. Resource data were coded from focus group discussion. A note taker was present at each focus group to note which participants (using pseudonyms) were speaking, and which pseudonyms were coupled and these notes were cross

referenced with audio recordings to create transcripts that indicated who said what. Participants identified themselves by pseudonyms on their questionnaires, enabling matching of focus group statements and questionnaire data. The resource score was mean-centered and multiplied by the mean-centered behavior score for that regression, to compute the interaction (moderation) term in the regression.

Qualitative coding of focus group transcripts. The focus groups were recorded using a digital voice recorder and then transcribed for later coding. A code book was developed post hoc using a general inductive approach, and then a qualitative coding software program, Dedoose, was used to associate codes with text from the transcripts (Thomas, 2006). Focus group transcripts were coded for mentions of supports either utilized or needed, as well as other emergent results.

Agreement was calculated using Cohen's Kappa. The author and a graduate assistant coded all data. We coded 25% of cases to assess reliability and then continued to code and assess until training reliability exceeded .7 for all measures except for distal/family social relationships-supportive. There were very few instances of this latter code, so although there was only one discrepancy between coders, reliability was only .67. Given that there was almost complete agreement on this code, we decided to consider it reliable even though it was just below the threshold. We then considered the coding team to be reliable. We continued to code, checking reliability on 25% of the remaining cases. Calculating reliability on coding performed after reaching training reliability is referred to below as drift reliability, as we wanted ensure coders continued to code similarly throughout the process (that coding drift did not occur; see Wilhelm, Rouse, & Jones, 2018). Utilizing Cohen's Kappa is intended to increase the likelihood that the coding reflects systematic coding categories that are not biased views of a single coder, and the

use of an advisory board of experienced foster and adoptive parents to validate the focus group questions, as discussed, may have increased the validity of the measure. See Table 2 below for code list, definitions, and interrater-reliability.

Table 2. *Code list, Definitions, and Interrater-reliability*

Code	Definition	Interrater Reliability (κ)	
		Training	Drift
Distal family/social relationships	Parent discusses how having a foster or adoptive child has affected social life	.93	.95
Supportive	Parent discusses supportive response or interaction with distal family/social group	.73	.96
Unsupportive	Parent discusses unsupportive response or interaction with distal family/social group	.67	.93
Foster/adoption impact on biological children	Parent discusses how having a foster/adopted sibling has impacted their biological children	.92	1.00
Negative	Parent discusses negative response from or interaction with distal family/social group	.91	1.00
Positive	Parent discusses positive response from or interaction with distal family/social group	1.00	1.00
Foster/adoptive child behaviors	Parent discusses foster/adoptive child behavior whether positive or negative	.75	.72
Parental emotional response	Parent describing how they felt or feel using a feeling word	.88	.87
Parenting behaviors	Parent describes engaging in explicit/concrete parenting behaviors	.78	.80
Professional	Parent describes interaction with and service provided by professionals	.96	.93

	Desired	Parent describes professional or service they need or would like but do not currently have access to	.86	.80
	Helpful	Parent describes professional or service that has been helpful	.96	.83
	Unhelpful	Parent describes professional or service that has been unhelpful	.98	1.00
Respite		Parent discusses respite, babysitting, and/or childcare	.96	.87
	Desired	Parent describes type of respite or respite provider need or would like but do not have access to currently	.94	.92
	Organizations/professional	Parent discusses respite provided by a professional or organization	1.00	.80
	Other family member/friends	Parent discusses respite provided by distal family members/friends	.80	1.00
School		Parent discusses experience with school/school professionals	.75	.93
	Supportive	Parent describes school experience or professional that has been supportive	.89	.91
	Unsupportive	Parent describes school experience or professional that has been unsupportive	.80	1.00
Self-care		Parent discusses what they do for self-care	.80	1.00
Training		Parent discusses parenting, fostering, or adoption trainings	.96	.95
	Desired	Parent describes training they need or would like but do not currently have access to	.80	.80
	Helpful	Parent describes training that has been helpful	1.00	.85
	Unhelpful	Parent describes training that has been helpful	.98	.91

Note: See text above for explanation of drift.

Procedure

Each focus group met at a community partner site, or other sites used by partner agencies for parent groups, such as local churches. Participants gave informed consent, and were then assigned a pseudonym to use during the focus groups and to label questionnaires (which were separated from the consents before data entry). Each participant was assigned a pseudonym so that we were able to match data from the focus group to the questionnaires without knowing the participant's identity.

Participants filled out a demographic questionnaire (see Appendix B) as well as the PSI-SF and the SDQ questionnaires (Abidin, 2012; Goodman, 1997). Completing these questionnaires took participants approximately 15-20 minutes. Participants then participated in a focus group led by a trained member of the research team. Each focus group followed the same basic outline of questions developed by the research team based on the literature and an advisory board of foster and adoptive parents (see Appendix A for list of focus group questions). We used the advisory board to provide additional insight but also to increase content validity, as the advisory assessed the representativeness of items for the construct.

Focus groups were audio recorded and at least one live note-taker was present at each focus group, to record which pseudonyms were coupled (co-parents of the same child) and nonverbal expressions, as well as the gist of the conversation. At the end of each focus group, participants were thanked for their participation with a $5 gift card.

ANALYSES

To test the association between perceived child behavior and parenting stress, as well as to find out if resources moderate this relationship, four multiple regressions were utilized. The first set of two regressions was used to predict the first dependent variable, total PSI-SF score, measuring overall parenting stress. The second set of two regressions was used to predict the dependent variable, PSI-SF dysfunctional parent-child interactions, measuring parenting stress from interactions with the target child. For each of these dependent variables, one of the regressions included the mean-centered emotional problems SDQ subscale as the child behavior score, the interaction between this centered variable and the centered total resources score as the moderator, and the centered total resources score as the third predictor. The second regression involved the same approach, but with the centered, conduct problem subscale of the SDQ as the child behavior predictor, its interaction with centered total resources as the moderator, and centered total resources as the other predictor.

The total resources variable was comprised of a count of distal/family social supports, helpful professional resources, respite provided by organizations/professionals, respite provided by family and friends, supportive school experiences, self-care, and helpful trainings. We centered the data on the mean for child behavior and for total resources and then multiplied the two centered predictors to test for moderation. Both child behavior and resources were main effect predictors.

RESULTS

Does perceived child behavior predict parenting stress and if so, do resources moderate this relationship?

We expected higher parent ratings of child internalizing and externalizing behavior problems (emotional problems and conduct problems, respectively) would predict higher parent-child relationship dysfunction. Resources that reduce child behavior problems and provide support to parents would reduce the strength of the relationship between child behavior and parenting stress (Barnett et al., 2017; De Young et al., 2011; Moyer & Goldberg, 2017). See Table 3 below for descriptive statistics. All scales appear to be relatively normally distributed. Each scale appears to have good variability.

Table 3. *Descriptive Statistics*

					Skewness	
Variable	Mean (SD)	Min	Max	*n*	Stat.	SE
Total resources	6.12 (3.73)	1	16	25	.926	.464
SDQ emotion symptoms subscale	3.92 (2.26)	0	9	24	.235	.472
SDQ conduct problems subscale	5.17 (2.18)	2	10	24	.729	.472
PSI-SF dysfunctional parent-child interactions	53.38 (26.64)	22	99	25	.496	.464
PSI-SF total scores	94.24 (4.70)	48	141	25	-.275	.464

The first multiple regression analysis was used to test if SDQ emotion symptoms subscale scores significantly predicted participants' total PSI-SF scores, and whether total resources moderated this relationship. The results indicated emotion symptoms, resources, and their interaction significantly predicted total parenting stress, F (3,20) = 3.60, p = .031. The centered emotion symptoms scale was the only variable that contributed significantly to predicting total parenting stress, although there was a trend of borderline significance for the

interaction to moderate this effect. Next, a second multiple regression analysis was used to test if SDQ conduct problem subscale scores significantly predicted participants' total PSI-SF scores, and whether total resources moderated this relationship. The overall model was significant, F (3,20) = 3.53, p = .034. Moreover, the results indicated conduct problems significantly predicted total parenting stress, but this effect was not moderated by support. See Table 4 below for additional information.

Table 4. *Total PSI-SF Score Multiple Regressions*

Variable	*B*	*SE B*	β	*t*	*p*
Regression 1					
SDQ emotion symptoms subscale	4.789	1.751	.495	2.735	.013*
Total support	.919	1.034	.160	.889	.384
Interaction between total support and SDQ emotion subscale	.977	.525	.337	1.859	.078
Regression 2					
SDQ conduct problems subscale	4.392	1.970	.438	2.229	.037*
Total support	.698	1.076	.122	.649	.524
Interaction between total support and SDQ conduct problems subscale	.410	.354	.234	1.159	.260

Note: Independent variables centered on the mean, * p < .05

Next, a third multiple regression analysis was used to test if SDQ emotion symptoms subscale scores significantly predicted participants' PSI-SF Dysfunctional Parent-Child Interaction scores, and whether total resources moderated this relationship. The results indicated that this model was not significant, F (3,20) = 1.13, p = .363. Emotion problems, support, and their interaction failed to predict Dysfunctional Parent-Child Interaction. A comparable multiple regression analysis was used to test if SDQ conduct problem subscale scores significantly

predicted participants' PSI-SF Dysfunctional Parent-Child Interaction scores, and whether total resources moderated this relationship. This overall model was not significant, although it approached significance, F (3,20) = 2.79, p = .067. In order to explore the basis for this trend, to suggest possible directions for future parenting research, we examined whether any of the independent variables significantly contributed to predicting Dysfunctional Parent-Child Interaction. Interestingly, although neither conduct problems nor support significantly predicted Dysfunctional Parent-Child Interaction, the interaction between these two variables did significantly predict this variable.

In order to explore this interaction, we did a median split on number of supports and graphed the relation between conduct problem scores and Dysfunctional Parent-Child Interaction. Figure 1 suggests that when mothers reported a level of support that was above the median, there was a positive relation between children's conduct problems and mothers' reports of dysfunctional parent-child interaction. However, for mothers reporting a level of support that was below the median, there seemed to be no relation between degree of child conduct problems and mothers' reported dysfunctional interaction patterns between themselves and their child. This finding should be viewed with caution, given the fact that the overall model was not significant, See Table 5 and Figure 1 below for additional information.

Table 5. *PSI-SF Dysfunctional Parent-Child Interactions Multiple Regressions*

Variable	*B*	*SE B*	β	*t*	*p*
Regression 1					
SDQ emotion symptoms subscale	4.084	2.452	.346	1.665	.111
Total support	-.589	1.448	-.084	-.407	.689
Interaction between total support and SDQ emotion symptoms subscale	.609	.736	.172	.828	.417
Regression 2					
SDQ conduct problems subscale	2.061	2.496	.168	.826	.419
Total support	-1.295	1.363	-.185	-.950	.354
Interaction between total support and SDQ conduct problems subscale	.987	.448	.461	2.201	.040*

Note: Independent variables centered on the mean, * p < .05

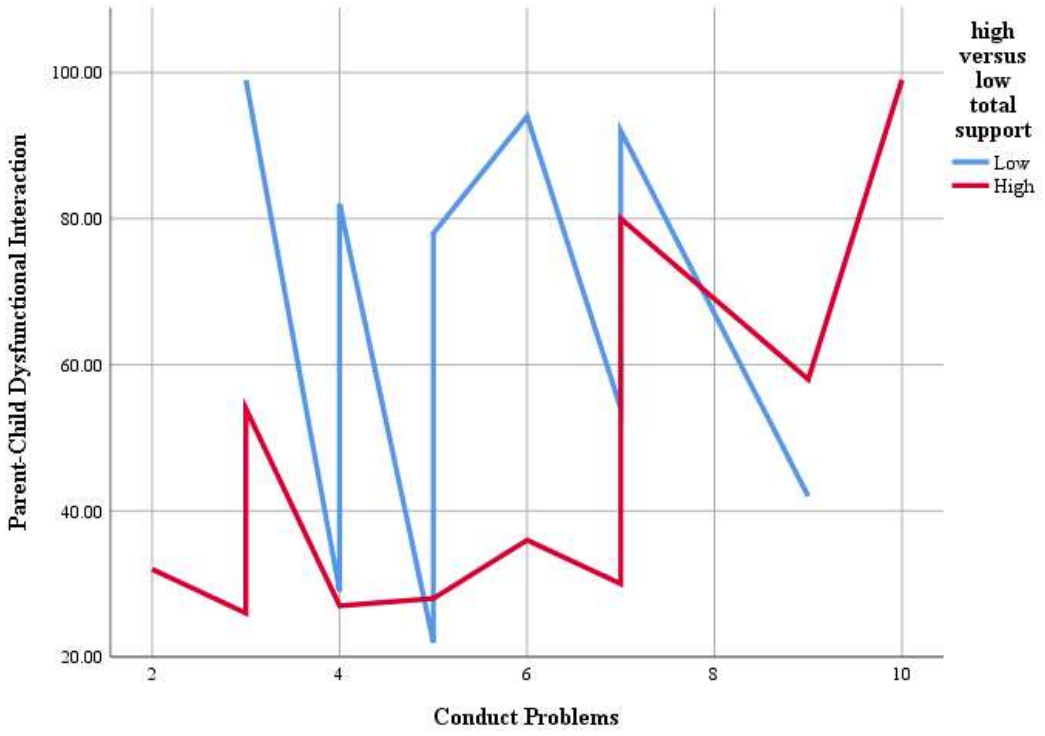

Figure 2. *Parent-Child Dysfunctional Interaction by Conduct Problems by High Versus Low Total Support*

What resources may moderate the relationship between child behavior and parenting stress?

We expected parents to report that trainings, social support, and help locating and coordinating care were helpful (Barnett et al., 2017; De Young et al., 2011; Moyer & Goldberg, 2017). We found parents reported training and social support were helpful but that other supports, such as respite, positive relationships with schools, and helpful professionals were also important to parents. Parents described frustration over negative interactions with professionals, a lack of resources after initial foster parent training or adoption, as well as judgement from friends and family about their choice to be a foster/adoptive parent and their child's behaviors. Parents described needing more respite, training, and many other resources. We calculated percentages to determine the percentage of parents mentioning each theme and means to describe the average number of times each theme was mentioned by each participant. Means and percentages, as well as specific examples from the focus groups are provided to further characterize the data. Please refer to Table 2 for code definitions.

Distal family/social relationships. About 88% discussed distal family/social relationships, *M*=1.72 times mentioned/participant. Approximately 68% reported having at least one supportive distal/family social relationship, *M=1.72.* For example, one participant reported fostering has brought her closer to her family:

> My parents and my sibling. I have a large family. I have three sisters and a brother and my parents. Most of my family has gotten pretty attached to them. We had them for Christmas and 4th of July. They are at every event I'm at. It's brought me closer to my mom and it feels, I don't know something really bonding.

Approximately 60% reported at least one unsupportive distal/family social relationship, *M=.88.* For example, one foster mother reported unsupportive friendships, and changes in her friend group as a result of fostering:

> We haven't had as much with family but more with friends. A good friend said, "Isn't there someone else who would want these kids?". Those types of questions implying maybe you should focus on your own kids. Our friendship group has changed. Instead of people asking to help they would say things like, "Well they've already moved 4 times, a 5th time wouldn't hurt." That was not helpful at the time. Don't tell me to kick my kid out.

Fostering/adoption impact on biological children. About 68% discussed the impact fostering or adopting has had on their biological children, M=1.04. Some 56% reported at least one negative impact on their biological children, *M*=.88. Several parents reported their biological children became 'lost in the shuffle':

> They really felt like they were getting lost in extreme emotions, like me being exhausted and not having enough energy to parent them and enjoy them. It was really like- our kids acted so excited the first time we took it [respite] and they had so much they wanted to do and to share with us. We were like, wow, we really couldn't see what we were doing to them, well, not really doing, cause there are so many positive things.

However, 44% reported one or more positive impacts on their biological children, *M*=.52. For example, this family reported an overall positive experience and working through negative impacts:

> It's been very interesting. The older ones have been absolutely awesome and just adore her [foster daughter]. Our biological 3 year old has been a bit more of a challenge with sharing. The amount of trouble she's been getting into she's increased 10 fold. They love each other and they get along, just some interesting things we have to work through, like sharing and hitting. One of our favorites is when they give each other a big bear hug. That said, they also play together. They

> both have very strong personalities. It's interesting and fun to see, and exhausting too. I think it will get better and has gotten better in most cases.

Foster/adoptive child behavior. Approximately 64% discussed foster/adoptive child behavior, *M*=1.64. Parents described different or challenging behaviors to work through, such as this adoptive parent who described her baby's special feeding needs:

> When he came, he had special feeding needs, and I had a nursing one year old at that time and if he came up to me, and that bottle would fall out, you know, the baby would get very disorganized. We had to, you know, calm down and re-latch. It would take 30 minutes to feed him, and he would eat every 3 hours, so you only had 2.5 hours between feeds.

A foster family describes their foster son's challenging behavior and the impact it had on their relationship:

> First couple of weeks it was nice, but then it got very manipulative. Tested the waters with everyone. Not only with us but with his classmates and his teachers. It did drive a wedge between her (other parent) and I. You don't realize. When we took a step back, he built a wedge between us where we weren't communicating.

Parental emotional response. About 64% discussed emotions they had felt or were currently feeling about fostering/adopting or their child, *M*=1.68. Several families described grief over foster children returning to their biological family. One foster to adopt family described the heartbreak of losing a child they thought would stay with them:

> As we've said goodbye to one little boy that we had hoped would be a forever child, our whole family experienced heartbreak that, we I think, hurt more than anything we've been through…It was the worst heartbreak I've felt.

Parenting behaviors. Some 52% of families discussed parenting behaviors they had or were currently engaged in, *M*=1.32. Several parents described concrete parenting behaviors they use

regularly, “I use his name more often, greet him. When I say, “knock that off” or “we don’t do that here”, I’ve already said 4 positives. Positives.”

Professional resources. A full 96% discussed a need for professional resources, *M*=3.88. Approximately 60% reported desiring one or more professional resources, *M*=1.60. Parents identified a range of professional resources that would be helpful. Many parents discussed wishing helping professionals were not so overwhelmed:

> I don’t think they know it all. They come once every other month. One GAL [Guardian Ad Litem] may be representing 50 kids. They’re probably numb and get these stories mixed up. They pretend to know it all. They’re overwhelmed. I wish they weren’t because maybe we would get more positive feedback and help kids better.

Still, 68% reported one or more helpful professionals or professional resources, *M*=1.40. Some parents discussed the difference between a helpful professional and an unhelpful one being accessibility:

> Heard stories, but good professional support. We got so much information and had people to call. I think we had 3 GALs and two case workers, and an adoption caseworker. I feel like they were very accessible.

However, 64% reported at least one unhelpful professional or professional resource, *M*=1.64. Many families expressed frustration around bureaucracy and hierarchy:

> She (child) wanted to go skiing. Big deal, couldn’t do any of those things without all this advance notice. We told them in plenty of advance but it wasn’t enough. Honestly, you’re getting the same notice as us. [Agency] was like “uuuugh”, [Other provider] helpful. I’m sorry she wants to be a normal kid. She wants to ride in her friend’s car. You have to have a this and a that and a this. It’s easier to tell them no but it’s heart breaking.

Respite. Approximately 84% discussed respite, *M*=1.40. A full 48% reported desiring respite, M=.72. Some 44% reported using respite provided by organizations or professionals, M=.52 and 24% reported using respite provided by family members and/or friends, *M*=.32. Several parent dyads reported needing childcare to attend trainings, being unable to find childcare workers with sufficient training, and being unable to afford childcare:

> We need two college age or older you know. It's asking a lot of them and it could be disastrous. It's a lot to ask in a lot of ways. We can't afford to pay them. And let's say we go to this training for a couple hours, we come home and the house is a disaster. You know, no blood, the kids aren't bleeding…but it's stress on you. Now this training was more stressful than useful. And that's the thing, if training is stressful, then you forget everything at the training. Like I'm stressed out at the training and forget everything.

School. Approximately 68% discussed school, M=1.16. 48% reported supportive experiences with school, *M*=.72. For example, these foster parents reported their child's teacher was responsive and helpful:

> Had a tour and we exchanged emails. We were new to the school system. The teacher helped us cause he was behind. They gave us programs online, the portals. If I had problems I would just email the teacher. Two way street. Told them we've never had foster kid in our home. We need some guidance so we can help him succeed.

Yet, 44% reported unsupportive experiences with school, *M*=.60. Several foster parents reported it was difficult to get additional assistance at school, such as IEPs:

> We tried to get things through school but didn't come to anything. We were pushing for things because he had behavior issues. We didn't want him to get kicked out of school. And ever since that our casework said we don't have educational rights, you can't do

> that. The parents still have educational rights. Any advocating was difficult. You could feel tension when they came into the home. We tried to reach out to them [school].

Self-care. About 64% of parents reported engaging in one or more self-care activities, M=.88. Parents reported engaging in mindful activities on their own as well as social activities with friends and family for self-care, "…Long walks and talking to other people and having friends who are walking with you. The ones who see the beautiful vision and see your family."

Training. Approximately 96% discussed trainings, *M*=2.0. Some 72% reported there were trainings they desired or would like access to, *M*=1.20. Parents reported desiring training on a range of topics from the legal system, parenting with trauma in mind, having a healthy relationship with biological families, and the effects of substance use on brain development, and learning from a mentor who has done foster care or adoption. A full 72% reported trainings they had attended were helpful, *M*=1.08. Many parents reported having positive experiences with a training called Trust-Based Relational Intervention (TBRI):

> TBRI, we did it with the county, our caseworker's boss…What I think would be beneficial, it's called flipping the lid with the hand motions. That helped a lot. Basically when they are going through trauma, their brains are closed. But if you can get them to open up, that helped a lot. He's flipped his lid. We need to help him calm down, breathing techniques, maybe a squishy ball, fidget spinner. Get down to their level, that helped us a lot…

However, 28% reported having attended one or more unhelpful trainings, *M*=.32. Some parents reported training videos and online training were not as helpful, as well as trainings that did not have a trauma component.

DISCUSSION

Key Findings

Quantitative. This paper presented preliminary findings from an ongoing study. Our multiple regression analysis using emotion symptoms, resources, and their interaction to predict total parenting stress was significant. However, mother report of emotion symptoms was the only variable that contributed significantly to predicting total parenting stress in this regression. Similarly, a multiple regression using conduct problems, resources, and their interaction to predict total parenting stress was significant, and mother report of conduct problems was the only variable that significantly predicted total parenting stress. These findings affirm previous findings concerning the significant stressors foster and adoptive parents face in terms of child behavior and parenting (De Young, Kenardy, & Cobham, 2011; Moyer & Goldberg, 2017; Sullivan, Murray, & Ake, 2016). Additionally, these findings are consistent with existing literature regarding the heightened emotional and behavioral symptoms in this population of children (Nadeem et al., 2017).

Surprisingly, however, having more resources did not seem to reduce parenting stress; nor did it significantly moderate the effect of either child behavior problem on parenting stress. We are unsure why this might be, but it could be that parents who have children with more serious behavior problems might feel less stress if they are able to obtain more resources, but having children with serious behavior problems might reduce their ability to avail themselves of resources.

Although, conduct or emotional problems and resources failed to predict Dysfunctional Parent-Child Interaction, the interaction between conduct problems and resources significantly

predicted Dysfunctional-Parent Child Interaction. Interestingly, when mothers reported a level of support above the median, there was a positive relationship between child conduct problems and mother report of parent-child interaction difficulties. We are uncertain why this may be the case, and the overall model was not significant so it is important to be cautious, however we will offer some speculation. Given that most of these children seem to have at least some conduct difficulties, parents who have less support may find any level of conduct problems difficult, and their level of stress from their interaction with their child may have more to do with their skills at parenting the child than the absolute level of conduct problems the child has. In contrast, for those with more support, higher levels of conduct problems are, as one would expect, associated with more problems in the interaction.

Qualitative. Our multiple regression analysis indicated it is unclear that simply having more resources impacts the relationship between child behavior and stress. Thus, it is important to assess further what resources are more and less helpful. Our qualitative findings may shed light on what foster and adoptive parents find helpful and unhelpful, and what else they desire in resources. Our qualitative analysis also uncovered other important findings.

Most foster and adoptive parents reported having at least one supportive distal/family social relationship but a full 60% reported they had at least one unsupportive social relationship. Many foster and adoptive parents reported feeling judged by friends, relatives, and strangers concerning their parenting, their child's behavior, and even their child's race or ethnicity. Most parents reported having one or more helpful professionals or professional resources yet 60% reported desiring more professional resources. Consistent with previous research, many of the 64% of parents that reported unhelpful professionals, reported they felt the professionals were judgmental, lacked necessary experiences, or were overwhelmed (Barnett et al, 2017). Parents

reported helpful school professionals provided open communication and had a basic understanding of trauma. In contrast, parents reported unhelpful school professionals were slow to implement IEPs and did not understand their child's behaviors or how to work with them. Many parents reported they would like professionals, school staff, and social supports who would take the time to listen, validate, and be present for their family; providing tangible resources seemed to be secondary.

Most parents reported trainings they had attended were helpful. Parents reported that trainings that were particularly helpful, such as TBRI, focused on the impact of trauma and building relationships, consistent with previous literature (Sullivan et al., 2016). Several parents provided examples of how TBRI and other trauma informed trainings had helped them develop a parenting philosophy and given them concrete steps to take in difficult situations.

Most parents reported engaging in self-care and it seemed respite was a large part of self-care for many parents. Parents reported needing time to themselves and to spend with social supports to help them recharge. Parents reported they also used respite care to be able to attend trainings. Parents reported barriers to respite care were being unable to find childcare workers with sufficient training and being unable to afford quality childcare.

Parents reported fostering and adoption had an impact on them and their biological children. Most parents reported their biological children grew and learned from the experience but some also reported their biological children felt left out, or learned inappropriate coping behaviors from their foster/adoptive siblings. Consistent with the literature, many reported the experience of fostering or adopting was taxing emotionally and described grief at foster children returning to their biological relatives' home, and frustration around others not understanding how

their child's behavior results from trauma (Mitchell, 2016; Moyer & Goldberg, 2017). Most parents reported fostering and adopting are difficult, but also rewarding.

Strengths and Limitations

A goal of this study was to honor and learn from parents' lived experience. We feel the mixed methods, focus group design utilized in this study was the best way of hearing the voices of foster and adoptive parents. In keeping with the spirit of qualitative research, our coding was done a posteriori because we wanted to delve into the kinds of resources parents were availing themselves of and the strengths and limitations of these. Parents also reported to us that they enjoyed participating in focus groups and that found the experience to be rewarding and validating of their experiences.

Generalizability of this study may be limited. Purposive sampling from multiple sites contributed to the representativeness of the sample, with families representing 4 agencies and 5 counties, but most participants were recruited from the Northern Colorado and Denver metro areas, and the sample was small. The sample obtained from the agencies we are working with may not be representative of all foster and adoptive parents. We were transparent about why the study was being conducted: to learn more about what difficulties foster and adoptive parents face in parenting and to build an intervention from this data. Thus, the large number of children who displayed mental and behavioral difficulties and other problems may be an overrepresentation as the foster and adoptive parents of these children may have an interest in the outcome of the study. On the other hand, it is possible that parents of children with very severe behavior problems were less likely to attend because they felt they could not leave the child. We know of one family that cancelled their planned participation at the last minute because of this issue.

Each focus group involved non-independent participants, which could also be a limitation. However, we did several things to minimize this. First, we established "group norms", emphasizing that we wanted to hear all participants' voices and there are no right or wrong answers. Second, we held 8 separate focus groups, and found very similar themes across them. However, the nesting of responses in specific focus groups still could have affected results. In terms of data analysis, it may be possible for a larger study to utilize a hierarchical linear model in order to get at nesting in focus groups but we did not have enough data to perform this analysis in our study. Given the significant results as well as results approaching significance, it may be possible that with a larger sample size, more significant results could be obtained as well.

Although data from the SDQ scales were normally distributed, reliability for the SDQ scales were lower than optimal. We had considered using the total problems score of the SDQ as well but were not able to because of extremely low reliability. We think this may be because standard deviations were quite low and the sample lacked variability. The families in our sample rated behavior problems as very high in general, which is an important finding, but did restrict reliability. It is also important to note alphas were calculated on a smaller *n* because the calculation requires all items be completed, and some questionnaires were missing one or more items. Therefore, it is possible reliability in the sample was higher than reported.

Finally, although the interaction between conduct problems and support significantly predicted dysfunctional parent-child interaction this finding should be viewed with caution, given that the overall model was not significant by conventional standards. This model should be tested further with larger samples.

Future Directions

Research on the experiences and needs of foster and adoptive parents is incomplete. Few studies examine the parent perspective directly. While this study is a step in the right direction, more research, with larger and more diverse samples, will need to be done to support and expand on the findings of this study.

The TAPT-in project is in the process of conducting additional focus groups, which will yield a larger sample that will provide more information. The quantitative portion of this study was based on mother report as we have been more successful in recruiting mothers than fathers, but hopefully with a larger *n*, we will be able to study father perceptions as well. Collecting data on a larger sample may also increase representativeness. The sample used in this study was mostly adopted children through a private agency. Our larger sample will include county Department of Human Services adoptions as well.

Describing the relationship between child behavior and parenting stress, as well as what resources may be helpful for these families are the first steps in creating effective parenting interventions for this population. Based on our findings, our team as well as other researchers and community agencies will be able to create more targeted interventions to promote positive parent-child relationships, decrease trauma symptoms, minimize parental stress, and maintain placements.

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APPENDIX A

Tapt-In Parenting Focus Group Questions

1. Tell us about your family.
    a. How many kids are adopted? How many biological children?
        i. Impact on biological children? What are their perceptions and experiences?
2. How have the interactions and relationships among members of your family changed since you adopted/began fostering?
    a. Are there ways it has changed for the worse? How?
    b. Are there ways it has changed for the better? How?
    c. What kinds of challenges have members of your family had in dealing with one another?
    d. What challenges have you faced as a parent?
3. What aspects of parenting do you wish you had more education/training about?
    a. Do you regularly attend any foster/adopt support groups or trainings?
    b. Were your expectations met in trainings you have attended?
    c. What trainings were helpful and what weren't?
4. Who are your main supports, both within and outside of your family?
    a. How have interactions and relationships with friends changed since you adopted/began fostering?
    b. What type of support would your family benefit the most from? Support groups, social groups, play groups for your children?
    c. Would you as parents benefit from a mentoring program with other parents? For instance, being introduced to veteran adoptive parents who may be able to provide support, advice and guidance?
    d. What does self care look like for you? What things do you do?
    e. What type of therapeutic support does your child receive, if any? What kind of therapeutic support do you or other members of the family receive? Has the cost of therapy ever been a factor in being able to provide the best therapy for your child or family?
    f. What does respite look like for you? Are there factors that prevent you from seeking respite care for your child? If so, what are they?
5. Was there a time point after your adoption/foster placement when you felt that the amount of support you received decreased or you felt that more was needed? If so, when?
6. What challenges have you faced within the school system? Is it trauma informed? Have schools offered resources or help for your child? If not, what are specific ways in which schools could support children with traumatic histories?
7. What else should we know about your life with your adoptive/foster child and the kinds of supports or training you think would be helpful?

8. Question about cost as a factor/ stipend for foster care

APPENDIX B

Participant pseudonym(s) _____

Today's Date: _____

Dear parents: Could you please give us the following information about your family?

1. How many adults and children under 18 live in your household?

Adults (18 or over) _____(number) _____(genders of each)

Children (under 18) _____(number)

2. Ethnicity of Mother/parent 1 (check all that apply) (If parent 1: please also specify gender)_____:

____Hispanic/Latinx)

____African-American/African/Black

____Asian-American/Asian/Pacific Islander _

____Middle Eastern

____Native American/American Indian/Alaskan Native

____ European-American/European/Caucasian

3. Ethnicity of Father/parent 2 (check all that apply) (If parent 2: please also specify gender)_____:

____Hispanic/Latinx

____African-American/African/Black

____Asian-American/Asian/Pacific Islander _

____Middle Eastern

____Native American/American Indian/Alaskan Native

____ European-American/European/Caucasian

4. Mother/Parent 1: occupation_____

5. Father/Parent 2: occupation_____

6. Mother/parent 1 education level: _____ less than high school education

_____ high school diploma or GED

_____ some college (no degree)

_____ Associate's degree

_____ Bachelor's degree

_____ Some post-bachelor's education

_____ Master's degree, doctoral degree, or similar

7. Father/parent 2 education level: _____ less than high school education

_____ high school diploma or GED

_____ some college(no degree)

_____ Associate's degree

_____ Bachelor's degree

_____ Some post-bachelor's education

_____ Master's degree, doctoral degree, or similar

8. Please list your adopted children first, then your non-adopted (or not-yet-adopted) foster children and then your biological children.

Child 1 (**THIS IS THE ONE YOU ARE REPORTING ON IN YOUR OTHER SURVEYS—THE ONE WHO IS ADOPTED, IF YOU HAVE AN ADOPTED CHILD; THE ADOPTED/FOSTERED CHILD WHO HAS BEEN IN YOUR FAMILY LONGEST IF YOU HAVE MORE THAN ONE ADOPTED CHILD OR ONLY FOSTER CHILDREN**)

a. Is this child the biological offspring of the parent(s) in the household? Yes/No (**If yes, skip to c. (age**))

b. Is the child adopted?: _____ Fostered_____ Other (specify) _____

Start date of placement (MM/DD/YYYY): _____

Agency: _____

County: _____

c. This child's age is:_____

d. This child identifies as a: Boy/Girl/Other (specify)_____

e. This child's ethnicity is (check all that apply):

____Hispanic/Latino(a)

____African-American/African/Black

____Asian-American/Asian/Pacific Islander _

____Middle Eastern

____Native American/American Indian/Alaskan Native

____ European-American/European/Caucasian

Child 2 (THIS IS NOT THE ONE YOU ARE REPORTING ON IN YOUR OTHER SURVEYS)

a. Is this child the biological offspring of the parent(s) in the household? Yes/No (**If yes, skip to c. (age**))

b. Is the child adopted?: _____ Fostered_____ Other (specify) _____

Start date of placement (MM/DD/YYYY): _____

Agency: _____

County: _____

c. This child's age is:_____

d. This child identifies as a: Boy/Girl/Other (specify)_____

e. This child's ethnicity is (check all that apply):

____Hispanic/Latino(a)

____African-American/African/Black

____Asian-American/Asian/Pacific Islander _

____Middle Eastern

____Native American/American Indian/Alaskan Native

____ European-American/European/Caucasian

Child 3 (THIS IS NOT THE ONE YOU ARE REPORTING ON IN YOUR OTHER SURVEYS))

a. Is this child the biological offspring of the parent(s) in the household? Yes/No (**If yes, skip to c. (age**))

b. Is the child adopted?: _____ Fostered_____ Other (specify) _____

Start date of placement (MM/DD/YYYY): _____

Agency: _____

County: _____

c. This child's age is:_____

d. This child identifies as a: Boy/Girl/Other (specify)_____

e. This child's ethnicity is (check all that apply):

____Hispanic/Latino(a)

____African-American/African/Black

____Asian-American/Asian/Pacific Islander _

____Middle Eastern

____Native American/American Indian/Alaskan Native

____ European-American/European/Caucasian

Child 4 (THIS IS NOT THE ONE YOU ARE REPORTING ON IN YOUR OTHER SURVEYS))

a. Is this child the biological offspring of the parent(s) in the household? Yes/No (**If yes, skip to c. (age**))

b. Is the child adopted?: _____ Fostered_____ Other (specify) _____

Start date of placement (MM/DD/YYYY): _____

Agency: _____

County: _____

c. This child's age is:_____

d. This child identifies as a: Boy/Girl/Other (specify)_____

e. This child's ethnicity is (check all that apply):

____Hispanic/Latino(a)

____African-American/African/Black

____Asian-American/Asian/Pacific Islander _

____Middle Eastern

____Native American/American Indian/Alaskan Native

____ European-American/European/Caucasian