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The Lived Experience of Family in Biological Children Living in Therapeutic Foster Homes

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Abstract

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MS, Capella University, 2010

BS, Empire State College/SUNY Albany, 2008

Dissertation Submitted in Partial Fulfillment

Of the Requirements for the Degree of

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Abstract

Therapeutic-level foster homes provide housing and care for special needs children removed from their own homes. The addition of a special needs child can lead to increased family stress. However, recent reviews of the literature show that there is very little literature aimed at understanding what the biological children in these homes experience. The purpose of this phenomenological study was to explore the experience of family in adults who, as children, were these biological children. The family stress and coping model was used as a conceptual framework of understanding. Data were obtained from participants in Upstate New York from both county and private foster care agencies using a nonprobabilistic, purposive criterion sampling of biological children between the ages of 18 and 21 who had been raised in this type of home environment. Data was transcribed using voice recordings and then entered into NVivo for categorization with follow up review for accuracy. Results found that several of the participants felt that they were not properly prepared for the challenges that the foster care experience brought. Many participants also felt that there was an impact to their own health or well-being during the time their family provided foster care. Nearly all participants expressed being exposed to the foster child's maladaptive behaviors. The results of this study contribute to a better understanding of the biological children's experience with regard to what aspects of fostering they find concerning, more preparation prior fostering, and how they feel their meaning of family differs from those families that do not provide foster care. These results may be used to improve the foster care experience of this target population and case management of these families while contributing to positive social change by identifying areas that could contribute to foster placement disruption.

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Chapter 1: Introduction

Therapeutic-level foster homes provide housing and care for special needs children removed from their own homes until they are able to reunite with members of their biological families, are adopted, or age out of the foster care system. It is common for therapeutic foster parents to have their own biological children living in the home (Felder, 2013). The addition of a special needs child can lead to increased family stress (Saban & Arikan, 2013) and foster child placement disruptions (Hewitt, 2013).

Current research has focused on therapeutic foster care training, descriptions of family units that provide foster homes (Thompson et al., 2014), therapeutic foster child challenges leading to child placement disruptions (Bruce et al., 2013; Crum, 2010; Hewitt, 2013) and the importance of stability in foster placements (Dworsky et al., 2013). Duffy (2013) and Höjer et al. (2013) both pointed out that most research focuses on how to improve case management of foster children and the training of caregivers. These researcers additionally suggested that more research is needed to highlight the roles of these biological children within the families, their needs, and their abilities to influence recruitment and retention of foster families. In this study, I reviewed what is already known about behavioral concerns that therapeutic foster children present, what current training offers for potential therapeutic foster parents, factors that often lead to foster placement disruption, and knowledge involving how stress impacts families. I contributed to this knowledge by connecting how these aspects play a role in the stress experienced by the biological children of the therapeutic foster parents and concerns with the unaddressed stress for these children. I examined how researchers have shown that the

stress between foster and biological children in the home is at times associated with multiple foster placement disruptions. I discussed how previous data show that as the foster child who experienced multiple placements ages out of foster care, there is a correlation of multiple placements with a higher dependency on community resources (Hewitt, 2013; Zlotnick, 2010), implying a need for social change as identified by Walden University's 2014 Social Change Impact Report. In this study, I focused on the change in family dynamics as experienced by the biological child living in the therapeutic foster home. I provided a discussion of future research as possible avenues for how to address the perceived stress that the biological children experience in therapeutic foster homes.

Background

Several researchers have addressed and examined multiple aspects of therapeutic foster care and therapeutic foster children's needs, but not much has been written about foster care from the biological children's point of view (Höjer et al., 2013). The researcher may find inferences in various international studies about how biological children perceive the foster care experience (Höjer et al., 2013; Megahead & Lee, 2012). I reviewed articles for this study regarding stressors that may be found among therapeutic foster children (Bruce et al., 2013; Gabrielli et al., 2015; Lohr & Jones, 2016), current foster parent training (Delaney et al., 2012; Dorsey et al., 2008; Esaki et al., 2012; Orme et al., 2013), changes in family dynamics that occur in foster care (Blythe et al., 2012; Duffy, 2013; Hojer et al., 2013; Thompson et al., 2014; Twigg, 1994; Williams, 2017),

and disruptions in foster child placement (Crum, 2010; Dworsky et al., 2013; Fisher et al., 2011; Hewitt, 2013 Linares et al., 2007; Stott, 2010; Unrau et al., 2011).

Höjer et al.'s (2013) study of how fostering impacts the biological children of foster care providers is a key source for understanding the importance of this often overlooked component of foster care. Thompson et al. (2014) discussed relationship changes between foster parents and their birth children, focusing on the changes in psychology and relationships that can manifest with the foster care experience.

Fisher et al. (2011) examined the relationship between the stressful behaviors of the therapeutic foster child and placement disruptions. In this study, there was evidence that there is a link between foster child problem behavior and placement disruptions, especially when foster parents report concerns within the first 3 months of placement into therapeutic-level foster care (Fisher et al., 2011). Dorsey et al. (2008) not only discussed the factors that therapeutic foster parents may consider as acceptable levels of problematic behavior in their home, such as lying and anger outbursts; they also discussed the specialized training currently utilized in the United States. Bruce et al. (2013) examined the patterns of brain activation in foster children compared to nonmaltreated children during an inhibitory control task, providing data indicating that some therapeutic foster children bring with them to the foster home innate behavioral complications that can create or contribute to stressful environments. Researchers such as Pace et al. (2013) examined the biological changes that take place in the child who experiences early trauma. Lohr and Jones (2016) expanded this information by identifying the biological changes that take place in the child's brain due to heightened

activity in the hypothalamic–pituitary–adrenal axis when exposed to higher levels of stress and trauma. Crum (2010) discussed the characteristics of foster children who are likely to experience placement disruption. Readers of this study should consider the possibility that the biological children in the home may experience similar changes in the brain when they are exposed to stressful or traumatic situations related to the foster children placed in their home. Dworsky et al. (2013) discussed the importance of providing a stable foster care environment and reducing the number of placement disruptions for children in foster care.

Families caring for children with special needs tend to experience changes to the family system as well as to their well-being. Research shows that families that care for special needs children have a greater likelihood to engage in risky behavior, such as smoking or unhealthy sleep (Meen et al., 2017). Additionally, studies indicate that a child with physical disabilities reduces the physical activity levels of the family unit, including nondisabled, healthy siblings (Çelik et al., 2018). For example, a family may not participate in a certain sport or physical activity if it is likely that the disabled child would not be able to participate in that activity. Researchers have also noted that families of disabled children tend to have less social participation than families that do not have disabled children, often feeling that people will not understand the child's disability or fearful of behavioral concerns occurring in the community (Caicedo, 2014).

Johnson and Pryce (2013) presented information corroborating the focus of this study and indicating that there should be multidimensional training for foster families in reducing the stress associated with therapeutic foster children in the home, contributing to

reducing the impact of trauma for foster youth. Furthermore, previous research has suggested that examining for effectiveness in the supports that the foster parents identify as assisting them in overcoming difficulties could lead to a better determination predicting foster parent retention (Esaki et al., 2012). There are many factors involved in the difficulty of fostering therapeutic foster children, and there are problems contributing to placement disruptions. Hewitt (2013) pointed out that placement disruptions often result from stressful relationships between therapeutic foster children and the foster family, which can lead to long-term problems for foster children as they age out of foster care.

Delaney et al. (2012) examined the effectiveness of the current training materials used in the United States that are presented both virtually and in person for effectiveness, empathy, and knowledge enhancement. In these training programs, there is very little discussion of how to support the needs of biological children who live in the home and will experience family changes as a result of their homes becoming foster homes for therapeutic children (Esaki et al., 2012; Twigg, 1994). The current training indirectly supports the need for more information about the fostering experience to be shared with prospective foster families about how the foster care experience can play a key role in the increase of family stress.

By understanding the stress that the biological children in this environment experience, steps can be taken to address this concern adequately. This can reduce the social problem of foster placement disruptions leading to increased dependency on community resources as foster children age out of foster care.

Problem Statement

It is common that therapeutic foster parents have their own biological children living in the home (Felder, 2013). The addition of a special-needs child can lead to increased family stress and disruptions in foster child placement (Saban &Arikan, 2013). Available research often focuses on how to improve case management for foster children and the training of caregivers, yet very little is available to address the needs of biological children in these environments (Noble-Carr et al., 2014; Thompson et al., 2014). Noble-Carr et al. (2014) explored the needs and experiences of the biological children for foster carers and found that these children have unrecognized needs that must be incorporated into family-centered case management. There is a need to provide more focus on the roles of these biological children within the families, their needs, and their abilities to influence the recruitment and retention of foster families.

Purpose of the Study

Given the lack of research aimed at understanding the stress and coping that biological children experience during their time living in therapeutic foster homes, the purpose of this phenomenological study is to explore and describe the experience of family in adults who, as children, were the biological children of therapeutic foster care families. If researchers understand these experiences, future research can focus on aspects of providing therapeutic foster care that could prevent significant stress within families who choose to provide this level of foster care.

Research Questions

I used the following research questions to guide this study:

- What is the meaning of family for adult children who were the biological children in therapeutic foster homes?
- What are the skills that adult children of therapeutic foster parents feel they developed to manage stress from the experience of being a biological child in a home that provided therapeutic foster care?
- Did the biological children in therapeutic foster homes feel they experienced any changes to their own health or well being with the addition of a foster child into their home?

Theoretical Framework

The theoretical framework for this study was the family stress and coping model (Hill, 1949). This theory suggests that when there are changes in the daily routines of a family, they are at increased risk of experiencing stress and crises due to stress (Hill, 1949). Hill speculated that there are two complex variables acting to shield the family from significant stressors and reduce the relationship between multiple stressors and family crisis. Hill called this the ABCX theory of family stress. Each factor plays a role in how one perceives a circumstance (Hill, 1949). A refers to the family unit, B refers to internal and external resources and supports, C refers to perception and self –efficacy, and X stands for family crisis. B and C are the two protective factors that determine how a family handles stress adaptively or in a maladaptive manner.

An update of this theory is the transactional model of stress and coping (Lazarus & Cohen 1977). This model, which I used for this study, evaluates the processes of individuals in coping with stressful events, as well as the complex interactive process

between an individual and his or her environment (Marks et al., 2011). I used the transactional model of stress and coping to examine how stressful experiences are understood as a person–environment transaction, dependent on the impact of the external stressor through appraisal processes. When an individual confronts a stressor, the primary appraisal process evaluates the threat. There is a physical component to this reaction as the nervous system responds with the *fight or flight* response. Researchers have noted that there is a decrease in the efficiency of the flow of information within the brain when an individual is exposed to psychosocial stressors (Wheelock et al., 2018). This was found to be especially true concerning decreased emotional regulation of the functioning of the hippocampus, ventral prefrontal cortex, and cingulate cortex during exposure to stress (Wheelock et al., 2018). In this study, the threats that I considered and examined were from therapeutic foster children. These threats included exposure to behavioral concerns from the therapeutic foster children such as aggression, a threat to parental time available for the biological children, a threat to the safety of the biological children's home environment, or other related concerns. The primary appraisal is the evaluation of the event as being stressful, positive, controllable, challenging, or irrelevant (Lazarus & Cohen, 1977). After the primary appraisal, there is a secondary appraisal providing an assessment of a person's coping resources and options in relation to the stressor. For the purposes of this study, I presented coping resources and options in relation to the stressor as skills that the biological children have developed for addressing stress or conflict in relation to the fostering experience. People use coping efforts to mediate the primary and secondary appraisals (Lazarus & Cohen, 1977). In this study, the coping efforts I

examined were problem management, including what the biological child feels they can do about the stressor, and emotion regulation such as understanding that the foster child's problematic behavior may not be specifically targeted at them. The biological child's coping style also played a key role in the outcome of addressing the stressor. Coping efforts include optimism in which the biological child felt they could effectively address the stressor for a positive outcome, and information seeking in which the biological child may monitor the foster child's behaviors so they can proactively identify future similar concerns. Coping styles that are avoidant in nature may allow the biological child to avoid problematic behaviors of therapeutic foster children, but do not allow the healthy building of coping skills that may be necessary to address similar stressors.

Murray Bowen developed the family systems theory (Good Therapy, LLC, 2015) in the 1950s and introduced it to the field in the 1960s. Bowen (1978) explored family constructs and the constructs of those families caring for children with schizophrenia. Bowen suggested that individuals are part of the larger whole of the family unit. The actions of one family member affect the whole family. Birth order and the position in the family construct affect the behavior of individual members, subject to emotional cut off or triangulation (Bowen, 1978). In this study, I used this theory in relation to the biological child's exposure to therapeutic foster children brought into the home. The biological children of the therapeutic foster parents may experience a possible disruption of birth order and position in the family construction. The biological children of the therapeutic foster parents may also experience the lack of a natural development of emotional coping for the foster child's disabilities that would normally take place in the

family unit. Family roles, rules, and boundaries, which are all important aspects of Bowen's family systems theory (Bowen, 1978), are exposed to change and disruption with the addition of a therapeutic foster child. The ability of family members, including the biological children of the foster parents, to adapt to the members of their family and their environment may not be as secure as in the case where the disabled child was not a foster child. In this study, I considered the sudden addition of a disabled foster child or multiple disabled foster children over time, and possible concerns with which therapeutic foster children often come into care. The addition of the foster children can create changes in the family system that would lean more towards nonnormative stresses rather than a balance of both predictable life cycle changes and nonnormative or crisis stresses. Chapter 2 will provide further information about these theoretical frameworks.

Nature of the Study

For this study, I used an interpretivist qualitative phenomenological design as described by Moustakas (1994) and by Frankfort-Nachmias & Nachmias (2008). According to this design, reality is socially constructed and fluid and negotiated within cultures and relationships to develop meaning (Moustakas, 1994). I used this qualitative design because I searched for meanings and themes from participants who experienced the phenomenon of living as a biological child in a therapeutic foster home. I collected interview data from participants aged 18 through 21 who were biological children of therapeutic foster parents to capture their retrospective lived experiences. I chose therapeutic level foster care for this study as this is the level of foster care in which the foster child has had one or more diagnoses of a medical, emotional, or behavioral

disability as identified by Hewitt (2013) and Johnson and Pryce (2013), yet do not have the individualized care of exceptional-level foster children.

I used the interviews as a rich source of data to derive theme development. I used a phenomenological design to examine how biological children typically perceived growing up in a therapeutic foster home. I also identified the factors that participants perceived as supports or barriers.

Definition of Terms

Basic Foster Care

An initial level of foster care. The state will have custody of the foster children, provide case management, and makes recommendations on what is needed to allow the child to move toward permanency (Child Welfare Information Gateway [CWIG], 2014).

Certified Foster Home

A home in which the adults have completed the training, background clearance, and paperwork necessary to foster children in their home. The certifying agency will determine what level of care this home is able to provide and grant licensing for a specific number of children. This certification may end voluntarily or be discontinued by the foster care agency (CWIG, 2014)

Foster Child

The term used to identify youth through at least age 18—but can be up to age 21 depending on the specific needs of the child—who have been removed from their current living situation and placed in foster care. Foster children can be placed with relatives, which is kinship care, unrelated adults who provide foster care, or in residential and

mental health facilities (Felder, 2013). In this study, foster placements are those residing in the home of unrelated adults.

MAPP

Acronym for the model approach to partnerships in parenting, a foster parent training program that is often used in the United States. MAPP training provides the underpinnings of foster care and focuses on the importance of building a relationship with the biological parents for a well-rounded approach to caring for the child (Dorsey et al., 2008).

Special Needs Child

A child diagnosed with a medical, mental health, developmental or other impairment requiring a heightened level of care (CWIG, 2019).

Permanency

The long-term goal that is set for the foster child pertaining to the outcome of foster care. This goal may include, but is not limited to, returning to the biological home, adoption, placement with alternative family members, or discharged to self-care after aging out of being eligible for foster care (Stott & Gustavsson, 2010).

Placement Disruption

When placement of the foster child in a home is discontinued, causing a move that may be sudden, unexpected, or with advanced notice (Hewitt, 2013).

Therapeutic Foster Care (TFC)

A higher level of foster care designed to accommodate foster children who have a mental health or medical diagnosis, have experienced significant trauma, and/or require a

higher level of supervision such as probation. Therapeutic foster care requires additional training as the children are not stable enough to step down to basic foster care (CWIG, 2014).

There are various levels of foster care available depending on the child's specific needs. While the specifics for each level's qualifications may vary slightly from state to state, or even county to county, the overall determinations are often similar (Megahead & Lee, 2012). Basic foster care is the most common under which children enter the foster care system. The state has custody of the foster child, provides case management, and makes recommendations about what is needed to allow the child to move toward permanency (CWIG, 2014). Exceptional foster care often occurs when the child is diagnosed as being terminally ill or as having ailments such as Leukemia or HIV (CWIG, 2014). These foster homes are often limited to no more than one child in the home, with some agencies requiring that at least one adult in the home be specifically trained to care for medical or fragile children (CWIG, 2014). Therapeutic foster care is a higher level of care than basic, designed to accommodate foster children who have mental health or medical diagnoses, may have experienced significant trauma, and/or require a higher level of supervision such as probation (Gabrielli et al., 2015). In this study, I focused on therapeutic foster homes. A therapeutic foster home is required for caregivers with additional training as the children are often not stable enough to step down to *basic foster care* (CWIG, 2014; Gabrielli et al., 2015). Therapeutic foster parents often have more regulations to adhere to such as the ways in which they interact with the foster children,

and they must work with foster care teams to try to stabilize the child so that they can step down to *basic foster care.*

I used the family stress and coping model to provide a conceptual framework for predicting, examining, and understanding the instability within families due to stressors. I used this model to examine foster families and to determine how living in a home with a therapeutic foster child can change the family system.

Assumptions

I reviewed research that has been previously published about the changes in both family dynamics and the effect that living with disabled siblings has upon youthful family members (Gianinazzi et al., 2014; Saban & Arikan, 2013;). I assumed that I could apply these findings to children whose parents become therapeutic foster care providers with special needs children maintained within their home. I also assumed that the biological children living in foster homes would be exposed to concerns regarding behavior (Smyke et al., 2012; Höjer et al., 2013).

Scope and Delimitations

For this study, I chose participants through a response to advertisements within both private and state-supported foster care programs located in Upstate New York. I provided an informed consent in which I explained that I was looking to explore the perspectives of change in family dynamics and a reflection of coping skills as experienced by those adult children ages 18 through 21 who lived in a home in which their parents provided therapeutic foster care.

The scope and delimitations on which I based this study were that the foster home must have housed at least one full time placement for at least six weeks while the adult child still lived in the home. All of the foster homes I utilized for the study were located in Upstate New York, within a two-hour radius of Fulton County, New York. The adult children interviewed were 18 through 21 years of age, which allowed me to explore a current reflection of the experience of being a biological child raised in a therapeutic foster home. All participants were to have completed MAPP training as previously described, as this is the current model used, within the same geographical area. Additionally, any respondents who had a primary language other than English were not included to avoid language barriers or misinterpretations.

I found that some elements limited transferability of the study, such as that a single source was not providing foster parent training, that the interview was only available in English, and that the sample size was not anticipated to be large. There are delimitations within this study. First, all participants were fluent in the language of the interviewer. There were no translations for this study. Second, I did not collect the names of participants; rather, I issued numbers for identification. I limited the study to one geographical area of New York as foster care regulations vary state to state and can differ region to region. Finally, I limited the participants to ages 18 through 21 to allow for a recent reflection.

Significance of the Study

The significance of this study was that I could identify a better understanding of the biological children's lived experience. Previous researchers have pointed out that

more research is needed to highlight the roles of the biological children within the families, their needs, and their abilities to influence recruitment and retention of foster families. In this study, I referred to previously identified information about behavioral concerns that therapeutic foster children present. I identified factors often leading to disruption in foster placement, and I acknowledged how stressful situations impact families. I included a discussion of how having a special needs child in the home can contribute to stress and may potentially harm the well-being of other family members. I presented information on how behavioral aspects play a role in the stress experienced by the biological children of the therapeutic foster parents. I included a review of related studies on how the stress between foster and biological children in the home is associated with multiple disruptions in foster placement. I mentioned how these placement disruptions are correlated with a higher dependency on community resources as the child ages out of foster care. I also discussed the importance of improving foster parent training and improving the experience for the biological children in the home. I provided information in this study that implies a need for social change. Strong therapeutic foster homes are limited in availability, (KPBS, NPR staff, 2013; Esaki et al., 2012), and current foster parent training is often void of crucial elements related to an increase in family stress (Delaney et al, 2012).

Summary

There are a limited number of therapeutic foster homes available in the United States that provide housing and care for children with special needs who have been removed from their own homes. It is common for these therapeutic foster parents to have

their own biological children living in the home who will experience the various stressors that the addition of a therapeutic foster child can bring into the home. Researchers have linked increased family stress to disruptions in foster child placement that can increase the likelihood that as these foster children age out of foster care, they will experience a higher need for dependency on community resources. Although available research often focuses on how to improve the experience of foster children and the training of caregivers, there is limited research and significant gaps in research addressing the experience as perceived by the biological children living in therapeutic foster homes. The purpose of this phenomenological study was to explore the experience of family in adults who, as children, were the biological children of therapeutic foster care families.

Chapter 2: Literature Review

In this review of the literature, I identified a need to understand better the experience of family in adults who, as children, were the biological children of therapeutic foster care families. Foster parenting is a much needed but challenging undertaking for all family members involved. While the focus is primarily on providing a safe, stable, nurturing environment for the foster child (U.S. Department of Health and Human Services, 2017), very little information is available to determine how this change in the home affects the biological children of the therapeutic foster parents. Research has identified an abundant range of issues that are evident within the context of providing therapeutic foster care. Studies conducted in the last 10 years reveal numerous concerns that the foster family may face when providing this level of foster care including, but not limited to violence, deviant behavior, mental health concerns, and trauma-based behaviors (Crum, 2010; Duffy 2013; Esaki et al., 2012; Fisher et al., 2011). While many of these studies provide significant information regarding what to expect and common concerns, there is very little information about how exposure to these issues can affect the biological children.

There is currently a lack of available research to assist in understanding the stress that biological children of therapeutic foster parents experience during their time living in a therapeutic foster home. The purpose of this phenomenological study was to explore and describe the lived experiences of being a biological child growing up in a home in which the parents provided therapeutic foster care.

I used three strategies to identify the most current and significant literature to review. First, I used multidisciplinary databases. I used EBSCOhost, ERIC, ProQuest, PsychARTICLES, and Sage in searching for peer reviewed journals with the following terms: *foster parent training, common behaviors of children in foster care, foster parent qualifications, foster parent concerns, foster parent training, biological children of foster parents, stress of disabled siblings, causes for foster placement disruption, MAPP, stress of providing foster care, foster parent support, positive foster care, foster care families, therapeutic versus basic foster care, special need children in foster care, and the effects of foster care for biological families.* I also searched for data concerning foster child outcomes, statistical information, and child welfare trends, policies, and focus areas using the government database Children's Bureau (Administration for Children and Families [ACH], 2017). Finally, I conducted a review of various legislative conference proceedings for data pertaining to foster care that was relevant to this study (National Conference of State Legislatures, 2011).

I reviewed data from studies involving behavioral or other special needs that therapeutic foster children bring into the home, as well as the elements of foster parent training material used in the United States. I reviewed Erikson's stages of development during the young adult phase, considering the implications of the effects of changes in family dynamics during this time. I explored data which identified how children are affected by the addition of a special needs sibling into the family and by continuous exposure to a stressful home environment for a child.

I found that most of the articles produced from the years 2010 through 2017 continued to focus on the aspects of fostering pertaining to the needs of the foster child and the behavioral or trauma-based behaviors they bring with them into foster care homes. I found approximately 30 articles that contained useful information for this study pertaining to the foster care experience.

Next, I reviewed Walden dissertations published 2010 through 2017 that included many of these same terms to determine what other similar or related research may currently be conducted or available. By doing this, I secured new sources of information. The collected sources were full text only, completed after 2010 and written in English. Additionally, I conducted routine reviews of the Child Welfare Information Gateway (CWIG), as well as official federal and state websites for additional information pertaining to public data, statistics, and foster care training. By doing this, I achieved a mastery of the available literature.

Theoretical Framework

The family stress and coping model is often used as the conceptual framework for predicting, examining, and understanding instability within families due to stressors. When I extended this model to consider foster families, I concurred that the stress related to providing care to a therapeutic foster child can change the family system. The original framework that Hill (1949) discussed, implies that when there are changes in the daily routines of a family, they are at increased risk for experiencing stress based on their available resources and support. In a revised version, the transactional model of stress and coping (Lazarus & Cohen, 1977), there is a discussion of the evaluation of the

processes of coping with stressful events, and the complex interactive process that occurs between an individual and his or her environment (Marks et al., 2011). One may use the transactional model of stress and coping to examine how an individual perceives stressful experiences based on the impact of the external stressor. When an individual faces a stressor, their primary appraisal process evaluates the threat. For my study, I considered this threat to be exposure to behavioral concerns from the therapeutic foster children such as aggression, a threat to parental time available for the biological children, a threat to the safety of the biological children's home environment, and other related concerns (Höjer et al., 2013). The primary appraisal event causes the person to consider how the stressor may affect their own well-being (Lazarus & Cohen, 1977).

Following the primary appraisal evaluating the event, a secondary appraisal follows. The secondary appraisal provides an assessment of one's coping resources in relation to the stressor (Lazarus & Cohen, 1977). I used support that has been provided to the biological children for addressing stress or conflict in relation to the fostering experience, and the perceived ability to utilize those resources as the participants' coping resources.

In one study I reviewed, which focused on the ability of children who had been exposed to stressful or traumatic situations to cope with what is considered typical daily stress, I found that although the study indicated higher levels of depression in the subjects when facing stressful situations, they often utilized various coping techniques they had previously developed to face new or current stressors (Smith & Somhlaba, 2015). I found that researchers suggested that since the children were able to access the skills they had

previously developed, they presented with better psychological and social well-being (Smith & Somhlaba, 2015). I reviewed another study that focused on how children develop coping techniques when there is someone in the family with a chronic illness or disability such as mental illness or diabetes (Ciudin & Turliuc, 2016). The impact on a child, in respect to the illness or disability of the household member, is influenced by the perceived internal and external sources of support available to them, and their ability to utilize these sources of support in a manner that is not maladaptive (Ciudin & Turliuc, 2016). Ciudin and Turliuc (2016) found that chronic conditions could have a negative impact on a household member's emotional well-being due to changes in the family dynamics, experiencing symptoms such as anxiety or depression, creating an effect on family goals or plans, and the development of physical or emotional isolation.

Previous research has determined that anxiety and stress have an impact on individuals' overall health. Physical symptoms of anxiety include but are not limited to the following: muscle tension, frequent fatigue, nausea, restlessness, heart palpitations, excessive sweating, shaking, difficulty breathing, and difficulty sleeping (National Institute of Mental Health, 2018). Children with anxiety commonly report physical symptoms such as stomachaches, headaches, difficulty breathing, and troubled sleep patterns (Chiracu, 2016).

I reviewed research in which the findings were consistent with previous similar studies that found that children who experience anxiety or exposure to heightened stress had deficits in information processing, especially regarding the inhibition of emotional information, with more attention given to information that caused fear (Gindt et al.,

2016). These findings suggest that some children are unable to block out certain information when necessary, leading to possible emotional distress such as anger or fear, as well as denial or detachment behaviors and. for some, increased risk of developing posttraumatic stress symptoms or disorder (Gindt et al., 2016). Elevated anxiety symptoms during childhood are associated with increased risk for anxiety disorders and depression in later years (Barendse et al., 2018) .

George Engel proposed what is now known as the biopsychosocial model, connecting mind, body, and emotions (Engel, 1977, 1980). The biopsychosocial model evaluates the complex interactions of biological, psychological, and social factors with regard to health and illness. This model embraces both reductionism, in which complex phenomena are derived from a single primary principle, as well as mind–body dualism (Engel, 1977, 1980). The two disorders exemplified within the description of the model are diabetes mellitus and schizophrenia as they are characterized by both somatic and biochemical abnormalities (Engel, 1980). Engel stated that experiences, and their interaction with biological vulnerability, can either promote or prevent susceptibility to certain disorders.

I reviewed research based in the biopsychosocial model and focused on how some children internalize anxiety rather than expressing their distress outwardly, such as through behaviors, and found that some children experienced diminished well-being and physical health (Hastings, 2015). Due to an identified lack of commitment on the part of social/case workers to involve biological children in the foster home or consider their thoughts regarding the foster care experience, biological children sometimes expressed

feeling uncomfortable discussing concerns or anxiety they had regarding the foster care placement (Williams, 2017). This suggests that biological children in therapeutic foster homes can internalize their anxiety associated with caring for special needs foster children. While I considered the biopsychosocial model for the framework of this study, I felt that Erikson's theory of psychosocial development was more appropriate for examining the experiences of biological children raised in a home where the parents provided therapeutic foster care.

Erik Erikson proposed a psychoanalytical theory that identifies the series of stages he believed a healthy individual passes through from infancy through late adulthood (Santrock, 2012). McLeod (2017) summarized the stages of development in Erikson's theory as the following: trust versus mistrust, autonomy versus shame and doubt, industry versus inferiority, identity versus identity confusion, intimacy versus isolation, generativity versus stagnation, and integrity versus despair. Experiences in the individual's life can have a positive or negative impact on that person's development. According to Erikson's epigenetic principle, a person's personality develops in a predetermined order and is based on successes or failures in each stage prior, based on socialization and their sense of self (Santrock, 2012).

For the purposes of this study, I focused on those who fall between the stage of identity versus identity confusion (ages 12–18) and intimacy versus isolation (ages 18–40). I did not, however, exclude the impact on the biological child's development should they be subjected to trauma and maladaptive experiences from the placement of therapeutic foster children in their home prior to age 18.

Erikson considered the progression from childhood to adulthood one of the most important stages as individuals tends to want to become part of society and fit in (McLeod, 2017). In this stage of development, the individual develops a sense of identity and considers their potential direction in life. Negative impacts to the development of fidelity during this stage can alter their acceptance of others when there are ideological differences, as experiences play a large role in the development of perspective. Negative experiences between therapeutic foster children and biological children can affect assumptions, premises, conclusions, and prejudices of others are examples of elements that can be impacted by. If, for example, the biological child in the foster home is a young woman and the home tends to foster aggressive boys prone to violence and property destruction, the young woman might develop the perspective that all boys tend to be violent as she has experienced a physical reaction to the stressor. This perspective is reinforced the more the person is exposed to the stressor. Beliefs developed during this developmental stage and reinforced through experiences can form the root of a person's thinking in future experiences.

The next stage I considered for my study was intimacy versus isolation. Erikson proposed that success during this stage can lead to better relationships and a sense of commitment, safety, and care in a relationship, while negative experiences during this stage can lead to avoidance of intimacy and commitment and the development of isolation and even depression (Santrock, 2012). Erikson believed it was important to a person's psychosocial development to develop relationships with others, and that those

who are successful in resolving conflict with others during this stage go on to have longer lasting and more meaningful relationships (McLeod, 2017).

The turnover of foster child placements within a home can greatly affect this stage of development not only for the therapeutic foster child but also for any biological children in the home they may interact with. Multiple studies found that foster children may experience placement disruption many times during their time in foster care, affecting their ability to develop meaningful relationships (Crum, 2010; Fisher et al., 2011; Hewitt, 2013). What is often forgotten during this turnover however, is the bearing on the biological children in these therapeutic foster homes who also experience disruption in their relationship development and a lack of conflict resolution.

A 2013 study focusing on friendship characteristics, psychosocial development, and adolescent identity formation suggested that conflict within friendships was positively related to moratorium on and diffusion of future relationships (Jones et al., 2014). This study considered the changes in family systems, educational components, societal norms, and even technology that have occurred since Erikson first proposed his theory in the 1950s. The study reported that important factors such as conflict resolution during adolescent and young adult stages greatly influenced later decisions such as the intimacy of adult friendships, delayed marriage, and consideration of parenthood (Jones et al., 2014).This study supports Erikson's view that the strength of peer influence is undeniable, providing examples such as smoking, alcohol use, sexual behavior, negative body image and delinquent behavior that continued to have negative effects on identity formation (Jones et al., 2014). I considered this perspective when reviewing other

literature that discussed the maladaptive behaviors that therapeutic foster children are likely bring into the home (Fisher et al., 2011). I also reviewed research that discussed information that reinforces the perception that providing therapeutic foster care can have a negative impact on biological children in the home (Höjer et al., 2013).

Previous researchers (Duffy, 2013; Höjer et al., 2013) have pointed out that more research is needed to investigate the roles of these biological children within the families, their needs, and their abilities to influence recruitment and retention of foster families. I reviewed studies that addressed and examined multiple aspects of therapeutic foster care and therapeutic foster children's needs; however I found very little written about foster care from the biological child's point of view (Esaki et al., 2012; Höjer et al., 2013).

I found a significant amount of available information associated with aspects of the foster child's experience, such as understanding trauma and the expectations of the foster parents. The current training materials used in the United States that are presented both virtually and face to face, such as *MAPP* training, focus primarily on foster parents building skills in the nature of effectiveness, empathy, and knowledge enhancement to support the foster child (Child Welfare Information Gatewa. 2014; Johnson & Pryce, 2013). Foster parents have stated that training that inadequately prepared them for the real situations they encountered while fostering was a significant factor in their decision to remain active foster parents (Esaki et al., 2012). In my review of the current foster parent training, I found a gap in available knowledge of how the foster care experience can play a key role in the increase of stress in a family.

Levels of Care

There are various levels of foster care available depending on the child's specific needs. While the specific qualifications for each level vary slightly from state to state, or even from county to county within a particular state, the overall requirements are similar (Dorsey et al., 2008). Training also differs between state and agency foster care programs and required training hours differ by levels of care. Therapeutic foster parents are required to have more hours of training to maintain certification and follow more regulations about the ways in which they interact with the foster children. They also work more closely with the foster care team while trying to stabilize the child so that they can step down to *basic* foster care.

Foster homes are defined as temporary housing for children who have been removed from their homes and placed with foster families. Foster parents are required to receive training in caring for these children (Felder, 2013; Gabrielli et al., 2015). While kinship foster care, where the child is placed with a relative that has been approved to provide care for the child in a foster care setting, is sometimes available, my study focused on children who had been placed with unrelated adults licensed to care for foster children.

What to Expect When a Therapeutic Foster Child Enters the Home

Based on my review of the research, common concerns of those children placed in therapeutic foster care include attachment disorders; aggression; maladaptive behaviors including sexual, criminal, and self-injurious behaviors; mental health disorders; developmental disabilities; and physical ailments (Johnson & Pryce, 2013; Scozzaro &

Janikowski, 2015; Smyke et al., 2012; Thompson et al., 2014; Twigg, 1994). Some therapeutic foster children present with multiple psychological complications and trauma experiences, which they bring with them to the therapeutic setting where the biological child of the foster parents is ultimately exposed to (Hewitt, 2013; Noble-Carr et al., 2014; Scozzaro & Janikowski, 2015; Smyke et al., 2012).

Preparedness of Foster Families

Biological children of therapeutic foster parents may experience changes in family dynamics, including the addition of a special-needs household member, which can lead to increased family stress (Ciudin & Turliuc, 2016; Gianinazzi et al., 2014; Saban & Arikan, 2013). Therapeutic foster children can pose a threat to themselves or others, and the biological children of therapeutic foster parents may be ill-equipped to positively adapt to the resulting experiences (Gabrielli et al., 2015; Höjer et al., 2013; Noble-Carr et al., 2014; Twigg, 1994). I found that the current training does not include adequate information for foster parents to prepare their biological children for experiences they may encounter with therapeutic foster children living in the home (Esaki et al., 2012; Linares et al., 2014; Megahead & Lee, 2012; Twigg, 1994).

The research I reviewed indicated the following factors cound have impacts on biological children with therapeutic foster children in the home: exposure to behavioral concerns from the foster children such as aggression, reduction in available parental time, threats to the safety of the home environment or family members including pets, and a sense of loss when a favored foster child is suddenly moved unexpectedly (Hewitt, 2013; Noble-Carr et al., 2014; Scozzaro & Janikowski, 2015; Smyke et al., 2012).

The biological children of therapeutic foster parents interviewed in the research stated that their concerns often went unaddressed, and foster parents discussed the lack of adequate training related to the changes the foster family might experience (Duffy, 2013; Höjer et al., 2013). The relationship and family dynamics between therapeutic foster parents and their birth children can change with the foster care experience (Thompson et al., 2014).

Expectations for Foster Families

As children in therapeutic foster care often have standing medical or mental health diagnoses, therapeutic foster parents are often required to take foster children for more medical visits than are required for children not in foster care (Landers et al., 2013). Children in therapeutic foster care are more likely to have experienced more intense physical, sexual, or emotional abuse requiring repeated follow up care than are children in basic foster care (Bair Foundation, 2016; Orme et al., 2013; Scozzaro & Janikowski, 2015). Children in therapeutic foster care are up to 80% more likely than nonfostered children to have higher rates of mental and behavioral health challenges requiring therapy (Gabrielli et al., 2015; Lohr & Jones, 2016). Therapeutic foster children are likely to have chronic disabilities or developmental delays that require time and management on the part of the foster parents (Landers et al., 2013; Scozzaro & Janikowski, 2015). These factors contribute to increased levels of shared parenting time and attention between the biological and therapeutic foster children (Saban & Arikan, 2013).

Exposure to Psychiatric Concerns

Existing research reports that children in foster care are much more likely to require medication regimes and trials (Landers et al., 2013; Leslie et al., 2011; Lohr & Jones, 2016), which indicates that there may be more side effects experienced by foster children and caregivers. Foster parents reported not feeling adequately trained for the changes their families would experience (Duffy, 2013; Höjer et al., 2013). Many psychotropic medications used to address mental health and behavioral concerns have side effects that may include insomnia, sexual urges, suicidal tendencies, agitation, aggression, violence, mania, nightmares, anxiety, increased impulsiveness, incontinence, mood instability, and abnormal thoughts (National Institure of Mental Health, n.d.; Scozzaro & Janikowski, 2015). Scozzaro & Janikowski (2015) suggested that while the foster parents may have a general understanding of why a foster child experiencing these side effects might behave in a maladaptive manner, others in the home may not. Additionally, if the biological children share a bedroom with the foster children, which commonly occurs according to Felder (2013), they could be directly exposed to these and other maladaptive behaviors.

Therapeutic foster homes are often overcrowded due to shortages in availability (Felder, 2013; Orme et al., 2013), which can result in biological children sharing a bedroom with someone who is a stranger to them. This means that biological children are increasingly exposed to medical ailments and maladaptive or dangerous behavior the foster child may have, including concealed behaviors, the likelihood of subjection increases for the biological child. If the foster child experiences nocturnal seizure

activity, which are more likely to be restricted to sleeping hours according to Langoor (2017), the biological children could become frightened or sleep deprived.

The research reports that some foster child have concerns such as self-harm, aggression, and sexual trauma (Mentalhealth.gov, 2017). Foster children who have been sexually abused may demonstrate behaviors that are sexually expressive or aggressive (Mentalhealth.gov, 2017). The research indicates that fostering a sexually abused child increases the chances of other children in the home being exposed to the effects of this experience and also increases stress in relationships and marital problems (ACH, 2017).

Self-harm is the action of intentionally inflicting injury to oneself. According to the ACH (2017), approximately one out of every one hundred people harm themselves in this manner. Adolescents, primarily female, are the most likely to engage in this dangerous behavior (ACH, 2017). While the intention is often not to die, the behavior can be very difficult to stop and very frightening to others involved in that person's life. One longitudinal study stated the rate of self-harm among children in foster care may be as high as 24%, beginning as young as age eight (Gabrielli et al., 2015). The study discussed a decrease in self-harm talk as foster children aged, but the risk was still present (Gabrielli et al., 2015). Gabrielli et al., (2015) report an approximately 3% discrepancy between foster parent reporting and child self-reporting across the span of the study. This rate increased the likelihood that a biological child of the foster parents was likely to have been exposed to such maladaptive behavior.

Inadequate Preparation

Due to exposure to behavioral challenges foster children may have, biological children may experience increased anxiety and worry, as the biological children may fear not only for their own safety but also the safety of their family members and the home (Duffy, 2013; Höjer et al., 2013; Noble-Carr et al., 2014). In the research I found there were few to no programs in place that promote healthy sibling interactions for children in foster care or for the biological children in the homes (Linares et al., 2014). Children entering foster care may be equally unprepared for the change in family dynamics that take place. Foster children who are accustomed to using verbal aggression or threats of harm to have their needs met have learned that this behavior is effective. Biological children in the home may be unaccustomed to expressions of needs presented in this manner and may become frightened or anxious to experience this behavior towards themselves or their family members.

I found that although studies conducted from a prevention standpoint with a focus on promoting family collaboration and skills development in the foster home yielded positive results, this focus and development has not yet become part of any formal foster parent training (Linares et al., 2014). Encouraging family collaboration and skill development for the foster family can reduce frustration, verbal or physical aggression, and child behavior problems (Linares et al., 2014).Research suggests that the conflict resolution skill development of children placed in foster care was often deficient in emotion regulation, leading to increased sibling conflict and aggression (Linares et al., 2007).

Foster parents expressed various reasons for why they did not engage in further training after they had foster children placed with them (Linares et al., 2014). Common reasons included a lack of time since the foster children were already in their home, the ongoing utilization of too many services due to the special needs of the foster children in their home, and concerns with the length of time needed to complete effective training in this area (Linares et al., 2014). Studies such as the one by Linares (2014) support the need for skill development in the initial foster parent training prior a child's placement in the home, especially if the foster parents will be caring for children with disabilities or mental health complications.

Foster Placement Disruption

In the research I reviewed, increased stress between the biological children and foster children in a therapeutic foster home was a leading cause for foster placement disruption (Crum, 2010; Fisher et al., 2011; Hewitt, 2013). Research suggests that traditional foster parent training and foster homes may not offer enough support for special needs children (Orme et al., 2013). I reviewed studies that focused on the behavior, developmental or medical problems that are typically experienced with fostering therapeutic needs children. One study reports that therapeutic foster parents are least likely to foster those children who have been diagnosed with HIV/AIDS, are pregnant, or have been diagnosed with a terminal illness but were most likely to foster those who had been diagnosed with minor ailments such as communication disabilities, allergies, and learning disabilities (Orme et al., 2013). Additionally, these foster parents stated that with significant support and help, they would be willing to foster children with

physical handicaps, eating disorders, attachment disorders, and seizure disorders and medically fragile infants (Orme et al., 2013). I was surprised to discover that over 48% of the foster parents in this study were willing to foster children who had been physically or sexually abused (Orme et al., 2013). This same research reported that race and education were not significant factors, however, limiting the number of children typically fostered was. Orme et al., (2013) also stated that the length of time as experienced foster parents was an indicator of reduced likelihood that a foster placement disruption would occur. One limitation to this study is that while a majority of the participants in this study reporte being married and a small portion having stepchildren, the presence of biological children living in the home at the time of fostering was not addressed (Orme et al., 2013). These studies indicate that the boundaries and limitations identified by the foster family as being accetable can be key factors in limiting foster placement disruptions.

How foster placement disruptions are perceived by the foster child may differ from the perspective of the foster family. I reviewed studies that state multiple foster placement moves contribute to the foster child developing an increased sense of mistrust for others, a number of behavior problems, and a strained ability to develop relationships with others as they age (Fisher et al., 2011; Hewitt, 2013; Smyke et al., 2012; Stott & Gustavsson, 2010; Zlotnick, 2010). Foster families expressed a sense of stress upon the removal of a foster child from the home in a study by Unrau et al., (2011). This study reported that foster families expressed a sense of grief and loss when a foster placement moved, even if they knew that the placement was temporary (Unrau et al., 2011). It can be a very difficult balance fully embracing the foster child and maintaining a seperated

relationship knowing they will leave one day. When foster parents fully embrace the foster child as a member of the family, placement disruption can lead to a greater sense of emotional loss, anger, emotional instability, denial, and even somatic symptoms (Unrau et al., 2011). Foster family with separated relationships can be hesitent to interact, bond, and relate to the child, knowing that their stay may be temporary (Unrau et al., 2011). Gaining a better understanding of this emotional component of fostering could lead to the development of a resource of support to those biologcal children. I found that having identifiable or perceived sources of support to address stressors can reduce the perceived stress (Lazarus & Cohen, 1977).

Why the Move?

The shortage of foster homes available in the United States decreases the likelihood that therapeutic foster families can limit foster placements to only one or two children. Multiple studies examined the dwindling number of foster homes and the overcrowding this shortage creates (Esaki et al., 2012; Felder, 2013). One study indicated that the lack of adequate preparedness and perceived support resources was a contributing factors in the families asking for foster placements to be removed choosing to cease fostering (Esaki et al., 2012). Up to 50% of these foster famlies discontinued fostering within the first year (Esaki et al., 2012). This was also true for those who were liscensed to provide therapeutic foster care to children who have mental, physical, or behavior disabilites (Esaki et al., 2012). Esaki et al., (2012) additionally states that other factors were noted as contributing to the decision to cease fostering, such as the overwhelming

expectations from the foster care agency, a lack of adequate financial support or daycare, and unstable caseworker coverage. Various studies indicated that the behavior challenges foster children brought into the home and the impact this had on their own biological children were primary factors in the decision to no longer act as therapeutic foster parents (Crum, 2010; Duffy, 2013; Esaki et al., 2012; Fisher et al., 2011; Hewitt, 2013; Höjer et al., 2013; Noble-Carr et al., 2014; Thompson et al., 2014; Twigg, 1994; Unrau et al., 2011).

Chapter 3: Research Methodology

Various international studies have addressed how the phenomenon of the foster care experience is perceived by the biological children in the home of therapeutic foster parents; however I found few studies from the United States dedicated to this topic (Höjer et al., 2013; Megahead & Lee, 2012). Current foster parent trainings do not adequately address the perspective of the biological children of the foster parents, even though increased stress in the home between the foster child and biological family members is considered a primary reason for foster child placement disruption (Hewitt, 2013; Stott & Gustavsson, 2010; Thompson et al., 2014; Twigg, 1994).

Research Design and Rationale

Selecting a research design that allows the researcher to best answer the question through the data collected is crucial for the effectiveness of the study (Leedy & Ormrod, 2010). Multiple studies address the implications of how the foster care experience is perceived by biological children in the home, suggesting that further research should consider this phenomenon (Höjer et al., 2013; Megahead & Lee, 2012; Thompson et al., 2014).

Initially I considered a quantitative survey, which could be replicated; however the subjective nature of what might be stressful in the foster care experience could yield invalid data as it would be based on the experience of that person being interviewed. For example, some children might not report room sharing as a stressful component because they did not have to share a room; however other participants, may have been significantly affected by sharing a bedroom with a therapuetic foster child. Additionally,

while some homes may have had therapeutic foster children who posed no significant concerns, others may have had foster children who were prone to violence, theft, sexual aggression, combativeness, or other concerning behaviors. As I did a deeper review of the available literature concerning biological children in therapeutic foster homes, I developed an overall theme of future research that is needed. As I examined how the experience of foster care is perceived by the biological children of the home, I found that a qualitative approach versus a quantitative approach best fit the needs of this study. I used a qualitative study to focus on natural real-world settings in all their complexity, recognizing that issues often have multiple dimensions or layers that need to be presented in their entirety (Leedy & Ormrod, 2010). I used a qualitative phenomenological research design explored the lived experiences of adult children of therapeutic foster parents, aged 18–21, in order to capture their retrospective experience of living with therapeutic foster children in the home. Using this design, I was able to conduct in-depth analysis of the phenomenon using data I collected through the interviews with chosen participants. I chose this data collection method because it offered the opportunity to expand on or develop new themes when they surfaced.

I considered several qualitative methods including ethnography, grounded theory study, and phenomenological research. I had to consider confidentiality and the undetermined length of stay for foster children in foster homes. I found that using an ethnography approach was not feasible, and the biological children could not be studied over a long period of time in their homes. If I had used this method and then the foster child moved from the home, the data would also become invalid. I also considered that

the variety of foster children possible and the various levels of problematic behavior among foster children could greatly differ. I did not use grounded theory, as there was not a theory to be developed based on the perspectives of the interviewees, nor any comparisons made. Finally, recalling the writing of Moustaks (1993), I decided that a qualitative phenomenological research design would best meet the objective of this study. I reviewed the experiences of adult biological children who were raised in homes in which their parents were therapeutic foster parents, drawn from both state and private therapeutic foster homes in the upstate New York area.

Role of the Researcher

My role within this study was that of the researcher. I actively recruited participants and conducted and recorded the interviews. I entered the data I collected into a program called NVivo where it could be coded and analyzed. None of the participants had a personal or professional relationship with me, and I did not share any personal biases or perspectives with the participants. I did not conduct this research at or with anyone from my place of employment, and I did not act in a supervisory role over the participants. Before the outbreak of the COVID-19 pandemic, I provided 10-dollar Walmart gift cards in exchange for all participation, regardless of completion of the interview. During the COVID-19 pandemic, I provided Walmart ecards in the same amount.

Population and Sampling

The target population consisted of adult children of therapeutic foster parents, aged 18–21. I used nonprobabilistic, purposive criterion sampling, and all participants I

interviewed met the criteria. The criteria I used required that the participants be English-speaking biological children now between the ages of 18 and 21. I required that the participants had been raised in a home environment in which their parent or parents were therapeutic-level MAPP-trained foster parents with foster child placements of at least 6 weeks that had occurred within the last 5 years. I recruited participants from Upstate New York with advertising through web-based foster parent support groups as well as advertising through county and private foster care agencies in the Upstate New York area. I identified the web-based support groups from New York State's Adoptive and Foster Family Coalition, which lists contacts for private support groups for all Upstate New York counties, as well as the National Foster Care and Adoption Directory, which also lists contacts for support groups by state. I did not identify any groups in which information was posted in the study report. I advertised through these websites using the flyer attached in Appendix A. I did not share the identities of individual participants or the sources for those participants. A copy of this advertising and a release for images used on the advertisement are included in Appendix A. I tested interview questions on a non-sample pilot participant for any clarity revisions needed and determined that none were needed. Questions were simple to understand and open ended, allowing for participant elaboration within reason. I limited the study to the geographic location of Upstate New York, without New York City; foster care regulations and allowable placements can differ not only country to country and state to state but also between distant counties within a state (CWIG, 2014; Megahead & Lee, 2012). I limited the

recruitment area to a 2-hour driving radius from my location of Fulton County New York.

The sample size I considered included what sample size would reach saturation, in which there were no new concepts revealed as identified by Guest et al. (2006). Typically, phenomenological studies yield enough data to reach saturation with between six and 20 interviews (Guest et al., 2006; Moustakas, 1994). I believed that a smaller sample size of eight to 10 was more desireable for this study, as it allows time for recruitment as well as interviews that are data rich and in depth. The final total of participants was 14. Interviews continued until no new relevant themes emerged. Since new relevant themes continued to emerge after 10 interviews, I increased the sample size until saturation was reached.

Data Collection

I used an interview protocol that consisted of open-ended questions addressing the research questions in Appendix B. I finalized these questions after determining that no revisions were needed based on the pilot participant review, as identified in the Sampling section. This protocol allowed for flexibility in the ordering and wording of questions based on responses, allowing for a flow of thought and conversation. I audio recorded these interviews, with consent, for accuracy of information. I found that the relevance of the experience was determined by the relationship of the responses to the research questions. Prior to the interview, I told the participants what questions to expect and that the interview would take approximately 1 hour with 15 to 20 minutes for follow up questions if needed. I explained that I would be audio recording the interviews for clarity;

how I would analyze store and use the information to create a typical description of this lived experience; and approximately when they could expect results to be available. Prior to the COVID-19 pandemic, I ensured participants privacy by meeting with interviewees in a private meeting room at the interviewee's local library. During the COVID-19 pandemic, I used video sessions as described below. I asked the interviewees not to verbalize any identifying information during the recorded session. The consent form included the participant's name, but I did not release or use this information in any portion of the interview or study. Although I originally expected time frame for data collection to be less than 3 months, and recruitment was not too low, I had to extend the data collection time frame due to the COVID-19 pandemic until enough participants were obtained. The final data collection time frame was just over 3 months.

Instrumentation

I obtained the data through audio recorded interviews, which were organized in a password-protected computer database, using number-assigned participant identification. I documented and reviewed all steps in the data collection process with my chair and dissertation team. I analyzed the data using the program NVivo. NVivo is time- and work-efficient software that supports qualitative and mixed methods research by organizing, analyzing, and supporting insights into the data. NVivo has been used quite often in qualitative research involving foster care studies as a sufficient and reliable method (Thompson, 2015). I used this program to categorize the data into meaning units,

reflecting various aspects of the phenomenon as it was experienced. I organized larger bodies of text by breaking them down into smaller units based on similar stories or specific words to develop categories or themes as well as subthemes. Through integration and summarization of the data, I was able to describe the typical experience of being a biological child living in a therapeutic foster home.

A sample of interview questions included:

- Recalling a time before your home provided foster care to special needs children, how do you feel your family has changed since providing this care?
- What do you think would have been different in your life if your home did not provide foster care?
- What are some experiences from growing up in a home providing foster care?
- Do you feel there were any changes to your health or well-being as a result of providing foster care?
- How has foster care shaped your perspective and beliefs now that you are an adult?
- What skills do you feel you have developed from the experience of your family providing foster care?

Not only is the researcher who is properly immersed in their study likely to feel strong emotions when ending the research relationship, but participants may also experience a sense of loss or even anger if the exit is not accomplished in a gradual and

meaningful way (Leedy & Ormrod, 2010). In order to avoid this, I built time for properly ending the relationship into the research timeline. I thanked the participant, provided the identified gift card or link to the E card, offered available resources, and voiced my sincere appreciation for their participation.

Factors beyond data saturation can cause the end of a study. Outside of the participant choosing to end their involvement in a study, other possibilities include, but are not limited to, completion of the research agenda, the topic investigated no longer being of concern, researcher exhaustion or personal factors, and funding problems (Morrison et al., 2012). I ensured that participants were given the option to discontinue their involvement in the study at any time, as noted in the consent form; however no participants chose to leave the study early. It is not uncommon for the researcher to present a small token of appreciation such as a gift card to the participant (Morrison et al., 2012). I provided an incentive of a $10 gift card, which I distributed at the conclusion of the interview and would have made available even if a participant had decided to withdraw. While I did not desire an early exit, the criteria for participation in the study included a provision for new participants to enter into the study at any point.

Trustworthiness, Credibility, Transferability, and Dependability

Trustworthiness within a qualitative study is dependent on four key areas of focus: credibility, transferability, dependability, and confirmability. Data saturation is imperative to the trustworthiness of a study (Leedy & Ormrod, 2010). I reached data saturation when there was enough information to allow replication of the study, when no new information surfaced, and when further coding did not appear to be practical. I did

not consider the data to be saturated when resources ran out but when continued interviewing did not yield any new data.

Credibility contributes to trustworthiness through triangulation and member checks (Moustakas, 1994). Triangulation refers to all participants being asked the same interview questions consistently. Member checks refer to the researcher reviewing the data collected and the interpretation of that data with the participant for accuracy and clarity. I conducted member checks, which allowed information to be verified by participants, and provided a chance for any information gaps to be filled. I did not need a confidentiality agreement as no identifying information was transcribed or collected for review. I achieved transferability of the results to other contexts. The results can be applied to other situations and studies. I used purposive sampling, which contributes to the transferability of the study by obtaining specific, similar information from the participants, regardless of whether their foster care experiences are currently occurring or have occurred within the last 5 years. For this study, the results are transferrable regardless of participants' individualized differences.

Dependability in research speaks to the data's ability to remain stable over time and the conditions (Leedy & Ormrod, 2010). I documented the processes involved in this study so that the study could be replicated. To ensure dependability, I carefully documented all of the steps involved in the research. I included the research design and implementation, the operations of data collection, including those during the COVID-19 pandemic, and a reflective assessment of the data analysis and interpretation.

Ethical Considerations

I believed it was important to establish a relationship with participants prior to the data collection, as well as during the study, and ensure a healthy exit from that relationship after the study's publication. By choosing this research topic, I searched for a reflection of a personally lived experience. I understood that the possibility of reflecting on the lived experiences could allow emotions to emerge that are connected with that experience. I included the following for possible concern: feelings of loss, anger, fear, or other strong emotions connected with the lived experiences. I offered resources available to all participants (see Appendix C) that could be utilized should a participant become distressed about reflecting on the topic following the interview or at a later time.

I sought institutional review board (IRB) approval to conduct this study. I submitted all documents for review by the IRB members, determining that the criteria were met for the IRB's approval of the research. My IRB approval number is #01-03-20-0393869. This approval included the following: proper informed consent obtained, consideration of any participants' vulnerability, reviewing the researcher's qualifications, date determination for initial approval and research period, reviewing of the possible risks to participants, recommended revisions to be completed prior to conducting the research, and the allowance of technology to be used during the COVID-19 pandemic. I did not knowingly include any participants who would be considered vulnerable. I provided all participants the same emotional support resources. I will maintain for a minimum of 5 years the research records, which will be maintained electronically using password-protected, nonidentifying coding for participants. After that time, if no further

need for the data exists, I will erase the electronic files so that the information cannot be read or reconstructed. I will not donate or recycle the device that stored the information, and it will be professionally disposed of in time. I communicated this storage and disposal information to the participants.

I provided participants the option of being notified once the writing has been published via a web resource they can check periodically to inquire about results, so I eliminated the need to collect personal contact information. I included resources if the participants wanted to further explore their feelings or thoughts on the topic, regardless of their completion of the research. All participants completed the interview process.

Chapter 4: Results

The purpose of this qualitative, phenomenological study was to gain insight into the lived experiences of the biological children living in therapeutic foster homes. In Chapter 4, I provide the results of the phenomenological analysis to answer the following research question: What is the meaning of family for those biological children living in therapeutic foster homes?

In Chapter 4, I offer a description of the settings, including those affected by the COVID-19 pandemic, as well as a description of demographics, data collection, data analysis, and trustworthiness. This chapter includes a discussion of the resulting categories and themes that emerged as a result of the interviews with qualified participants. A review of the findings, any discrepancies, and the summarized results will complete this chapter.

Settings

Each participant engaged in a private interview that was held in a public library space of their choosing. In April, due to the COVID-19 pandemic, I held the remainder of the private interviews via Zoom in which the participants were asked to remove any identifying screen names. All participants expressed feeling comfortable being interviewed by both methods. The lack of engaging interactions for the first two Zoom interviews led me to speak with the following participants prior to the interview so as to again review the expectations, requesting that they choose a quiet setting free from distractions.

Demographics

Participants in this study consisted of five male and nine female adult biological children of therapeutic foster parents, for a total of 14 participants. All participants were between the ages of 18 through 21, with the average age being tied at 19 and 20. All participants identified English as their primary language and lived in homes in which their parent(s) were therapeutic foster parents for foster children considered to have special needs and were MAPP trained. All participants had lived with foster child placements of at least 6 weeks in the last 5 years.

Data Collection

This research included a pilot study to verify clarity and flexibility with regard to the ordering and wording of questions based on responses, which would allow for a smooth flow of thoughts during the conversation. The pilot study did not yield any required changes. In this study, I collected data regarding the perceptions of family in the adult children of therapeutic foster parents. I distributed flyer-based invitations to participate in this study through web-based foster parent support groups, as well as advertising through county and private foster care agencies in the Upstate New York area. I obtained the support groups from New York State's Adoptive and Foster Family Coalition, which listed contacts for private support groups for all Upstate New York counties. The invitations informed potential participants about the focus of the study and the qualifications required of them. Additionally, I included in the invitations information regarding the interview's approximate length of time, sample interview questions, my name, the school's name, and how to contact me. I informed possible participants that

participation was voluntary, the interview could be stopped at any time, the incentive being offered to the participant (described below), the IRB approval number (i.e., 01-03-20-0393869), and the phone number in which they could contact me.

Duration of Data Collection

All participants reached out to me via phone. Before the COVID-19 pandemic, participants stated which public library they would like to meet in for the interviews, located within a two-hour radius of Fulton County, New York. During the COVID-19 pandemic, I provided a Zoom meeting ID and password with each participant for a specified date and time. For those interviews held via Zoom, I read the participants the consent agreement, and they gave verbal consent agreeing to be recorded and to participate in the interview. Although the interviews were expected to last approximately 1 h, the interview time frame was between 23 and 72 min, with an average interview time of 40 min. The consent agreement included the background information of the study, procedures, sample questions, voluntary nature of the study, risks and benefits, payment for volunteering, privacy policy, contact information for Walden University, and IRB approval number 01-03-20-0393869 for the study.

All participants received a $10 Walmart gift card. Before the COVID-19 pandemic, I distributed these gift cards directly to the first 11 participants following the interview. During the COVID-19 pandemic, I provided a $10 Walmart e-card and pin number to the last three participants' email addresses.

I used a scripted interview to question the participants and gather answers from each of them. When completed, I asked if there were any questions, areas that needed

clarification, or concerns. I reminded the participants of the available resources and thanked them for their time and participation.

Data Recording and Transcription

Prior to the interview process, I developed a unique code for each participant. I did not collect names or identifying information in this study. I used a unique code consisting of each participant's age, number of years their family had fostered (with the letters *UK* being entered for those who had been fostering for longer than the participant could remember), and the chronological number of their interview. I used these identifiers to create a unique code for each participant and to maintain anonymity. I entered each participant identification code into NVivo Transcription.

I used the Google ASR Voice Recorder application to record each interview. All participants were made aware that they were being recorded, and they continued with the interview once I informed them the recording was about to begin. Sometimes the participant or I requested clarification. I used an interview template that included all of the interview questions, and I assigned individual participants' unique identification code to each interview. I used the template to create the transcribed document.

By listening to and typing out each interview, I was able to transcribe the 14 recorded interviews from the Google ASR Voice Recorder application to a Microsoft Word document. So that I could eliminate any errors, I wrote out and replayed the conversations as many times as needed to ensure I made any needed edits until all transcriptions were correct. The Google ASR recordings and all transcribed data received from the interviews will be electronically stored and password protected for 5 years.

Data Analysis

Bracketing

I used the bracketing method prior to data collection. I considered any biases by reviewing the interview questions each time I was waiting for the participant to arrive at the interview in person or via Zoom. Creswell (2013) offered a simplified version of the Stevick-Colaizzi-Keen method discussed by Moustakas (1994) as a description of coding to inquire into the data collected. Based on my personal experiences as a 21-year veteran foster parent for therapeutic children, as well as the concerns expressed by my own biological children, my preconceived notion was that the biological children were impacted by the foster care experience. I was able to set this bias aside, and by withdrawing any emotions or experiences, I was able to focus on the participants' experiences and conduct the interview without bias.

Thematic Analysis

I developed a list of significant statements about how the topic was being experienced by the participants. I grouped the significant statements into themes by associating interview questions with participant responses. By manually transcribing the interviews, I became familiar with the data collected, thus developing a deeper understanding of possible emerging themes. After I transcribed all 14 interviews, I then transferred them into the NVivo Transcription software application. I provided a textural description of what the participants experienced, including verbatim examples, with a structural description of how the phenomenon was experienced, including the settings for the participants. The program coded and classified common and similar responses, and

then I reviewed them for relationship verification. I refined the themes with regard to one theme (i.e., *sharing sexual information*) to be categorized under behavioral concerns. Finally, I wrote a passage describing the essence of the experience so as to provide clear insight into the potential story that the information provides.

During analysis of the comments made by the adult biological children being interviewed, I discovered differences with regard to the length of fostering in the home, the ages of children being fostered, the type of perceived health impaction, and the type of family changes being experienced. I described all information captured in the Interpretation of Findings section of this research study.

Evidence of Trustworthiness

To maintain trustworthiness in this study, I implemented steps to ensure credibility, transferability, dependability, and confirmability. To maintain trustworthiness throughout the process, I used tools such as bracketing, reflexivity, and saturation and maintained a detailed log of all steps taken during the process.

Credibility

I established credibility through the use of triangulation and member checks. I ensured that triangulation occurred by asking all participants the same interview questions consistently. I performed member checks by reviewing the data collected and interpreting those data with each participant for accuracy and clarity. Because I used member checks, I could verify information by participants and fill any information gaps. I used interview questions requesting participants to express their lived experiences so that I could obtain the actual experiences of therapeutic foster parents' adult biological

children. I used reflexivity through the interviews, analyses, and result processes to prevent any assumptions and preconceptions from affecting the outcomes. I achieved saturation during data collection to implement internal validity. I established credibility by reviewing the manually transcribed recordings of the interviews multiple times for accuracy.

Transferability

I established transferability by using thick descriptions of the participants. I narrowed the geographical area of each participant to a 2-h driving radius from Fulton County, New York. Additionally, I identified the limited age of the participant group as 18 through 21, the type of training received by the foster family, and the minimum length of time fostering so as to allow for future studies to accurately replicate this study. I explained the details of the methodology steps, as well as the transcribing, coding, and theme-development processes. I included the steps of analysis and results to additionally account for transferability. I included how data saturation was achieved and direct quotes from the participants to support transferability.

Dependability

The replication of this study's results will verify dependability. Maintaining notes allowed me to track the research process. I consistently presented interview questions to each participant in an identical manner so that possible responses could be replicated. The participants' responses created the themes, further supporting the credibility of dependability that replicated studies would produce similar results.

Confirmability

I validated this study's confirmability using reflexivity and the NVivo Transcription program. Rather than using preconceived notions, there is evidence of the participants' actual experience. I established confirmability through interviews, which produced consistent emergent themes, and established further confirmation through consistencies of the coded information.

Results

The purpose of this phenomenological study was to explore and describe the experience of family in adults who, as children, were the biological children of therapeutic foster care families. I used the family stress and coping model as the conceptual framework for predicting, examining, and understanding the instability within families due to stressors. Stress and coping examine how stressful experiences are understood as a person–environment transaction (Lazarus & Cohen, 1977). When an individual is faced with a stressor, their primary appraisal process evaluates the threat. I asked the participants open-ended, yet identical questions that allow for the emergence of themes in what was considered concerning, including an impact on health. After a person's primary appraisal, their secondary appraisal follows, providing an assessment of their coping skills in relation to the stressor. For the purposes of this study, I considered the coping skills developed by the biological children so as to address concerns in relation to the fostering experiences, which I then used to further categorize experiences into themes. Through the themes, I was able to conceptualize the experience of family in adults who, as children, were the biological children of therapeutic foster care families.

After conducting a comprehensive literature review and developing interview questions guided by elements of the stress and coping model, I identified basic themes during the data collection and analysis process. By continuing to compare experiences and themes, I was able to understand the lived experiences and perspectives of the adult biological children of therapeutic foster parents. I maintained continued reflexivity to avoid personal presumptions and assumptions of preferred results.

I began the analysis by questioning each participant about their experiences with family changes since fostering. I then asked for perspectives on how life may have been different without the foster care experience, and I requested them to share specific experiences growing up in a foster care home. I inquired about their thoughts of any changes to their health or well-being as a result of the family fostering children. I ended by asking about their current perspectives or development of coping skills based on the foster care experience. I used the guidance of the stress and coping model's primary and secondary coping model to frame interview questions and to gather informative responses. From those responses, I found that five themes and multiple subthemes were developed. The themes included the characteristics of the children being fostered, differences in family as compared to families that do not foster, health impacts, changes in lifestyle, and the development of beliefs and skills. I next discuss the themes and responses.

Theme 1: Changes in the Family Unit

The first category I analyzed for themes was the changes experienced in the family due to the foster care experience. Through the interview questions, I gathered a

deep understanding of the experiences of being a biological child growing up in a therapeutic foster home. By gaining insight into these experiences of how they felt the foster care experience changed their family, I was additionally able to develop several subthemes.

During the data collection process, I asked participants to compare their family before and after providing foster care. Five participants stated they had families that had been fostering since either before they were born or from a time they were too young to recall. The first subtheme was participants' described experiences (e.g., changes in the home's atmosphere), as Participant 19152 described: "Sometimes I would wake up, and then there is someone new in the house that I don't know, who maybe came in the middle of the night or something." Participant 19UK9 stated, "Every time someone moves in or out, you have to find a new normal, yeah," which was further supported by a similar statement from Participant 18614, who stated, "Fostering is a great way to care for others, but it's really hard to deal with the coming and going sometimes." Participant 2081 shared that their parents "are definitely busy because they get a lot of little kids," and "maybe it was quieter." This association with increased noise as a change in the home's atmosphere is further supported by Participant 20187, who shared that it was "too noisy" and "It's just really loud." Similarly, Participant 2068 stated that when his parents "get little kids—like babies—then it really sucks because they are, you know, crying all the time." This subtheme was further supported by Participant 20UK12, who shared that although their family had been foster care providers for "all my life," they assumed that, prior to foster kids living in the home, "It must have been quieter."

The next subtheme was experiences with changes in the family's social interactions. Participant 191510 expressed that "Sometimes when we get new kids, the neighbors are chill with it, you know, like bringing over clothes and toys and stuff." Participant 211011 shared the following:

> Our church is always giving my family stuff, like clothes and food—it's a little weird. We have a lot of kids with us when we go, so, you know, people are always coming over to see what we need or to help and stuff. (Participant 211011)

Participant 18126, however, shared,

> It's embarrassing sometimes when the kid makes it a point to show off in front of your friends. I don't really bring too many people home, you know? You never know how the kid is going to act or something. (Participant 18126)

Participant 19152 offered, "I can't really have many friends over because sometimes the fosters have issues, you know?" Additionally, in making references to plans being cancelled when caseworkers were late or when counselors or social workers often visited the home wanting to know the family's personal business, Participant 20187 shared that "the caseworkers kind of sucked."

Another subtheme noted was changes in several of the family's routine activities, as revealed by Participant 211011: "It seems like we went more places when I was younger, like Great Escape and stuff, but not so much anymore." This also included similar changes in routine activities, such as what Participant 18614 discussed: "I think we did more things like visiting my gram a lot more than what we do now" as well as "sometimes even becoming their babysitters while my parents were busy with work."

The last subtheme that emerged during the interviews was changes in family members' state of mind or interactions with each other. Various participants made statements that supported this subtheme. Participant 2081 offered, "Sometimes I feel my mom bonds more with them than she does with me because they have that in common, you know? My mom was a foster kid growing up, so she knows what it feels like." Participant 1964 stated, "I can tell sometimes when my mom is stressed about stuff, like whether there is enough food and stuff." Participant 21UK5 had this to say about their parents: "They get pretty happy when a good kid who is pretty chill comes, you know, but sometimes they get kids that are just bad, too, you know what I mean? Then they are pretty upset most of the time." This participant also shared, "Sharing my family is hard sometimes, even now when I really need their help with something and they can't." Participant 19UK9 said, "My parents always seem to not have patience . . . like they were just done with it, and we had to figure it out." Participant 20UK12 responded with, "My parents are often torn in many different directions." One participant expressed that they believed the foster care experience brought joy to their mother. Participant 191510 stated, "She grew up with a lot of brothers and sisters, so I think it makes her happy."

Theme 2: Experiences Growing Up

I offered the participants the opportunity to share experiences they had as the biological children growing up in therapeutic foster homes. They shared various experiences that often fell into other themes or subthemes, such as the experience of contracting lice, a foster child's emotional distress, large groupings of young children

living in the home, changes to one's health, and a sudden loss of a child from the family unit. Participant 20UK12 expressed one unique experience:

> One of the clearest memories of my entire life is from one of the first nights we had a 3-year-old. I had just heard my parents tuck her in for the night from down the hall, and about 3 seconds later, she started crying. She just kept repeating "I want my mommy, I want my mommy." That was really sad. I just wasn't sure what to do. (Participant 20UK12)

Participant 1964 shared another unique experience:

> We eat weird meals sometimes because either some kids in the house have allergies or can only eat certain things. I try to just do my own thing. I remember that I couldn't wait to get a job so I could buy my own snacks and stuff. Like, I really hate spaghetti and pasta because my mom makes it all the time. (Participant 1964)

Other participants shared similar experiences. The experience of growing up in a large family with many children is one example of this shared similarity. Participant 211011 stated, "We're probably the only people I know of who take so many little kids." However, Participant 20123 also shared this experience, stating "Our house looks like that show where they have like 10 kids," and Participant 1964 said, "Sometimes we've had so many kids in the house."

Another experience in which I found shared similarities between participants was that of learning how to care for younger children. Four participants shared their experiences of learning to care for younger foster siblings. Participant 20UK12 recalled,

"Growing up, I feel we were encouraged to take care of the younger fosters more than ourselves. They needed love, they needed fun." Participant 2068 remembered, "I am always helping out my parents with feeding the younger foster kids, reading to them, and playing with them." In addition, Participant 19152 shared, "I learned how to make baby bottles and stuff to help my mom out."

I identified an additional shared experience that became an unexpected theme in the interviews—that is, some participants were required to register with the foster care agency in their own home once they turned 18 years old. Four participants made reference to this experience. Participant 18614 stated, "Once you turn 18, the social worker sees you as another adult in the house, so you have to fill out paperwork." Similarly, Participant 20187 stated, "When I turned 18, I had to sign up like I was a foster parent or something. I had to get fingerprinted."

The final participant shared an experience that was universally mentioned by all 14 participants, with 10 of them going into lengthy detail—that is, they were exposed to concerning behavior from the foster children living in their home. Examples included living with foster children who stole others' belongings, displayed aggression, discussed topics such as sexual experiences, practiced verbal aggression, used foul language, and displayed manipulation. Participant 20123 shared their perspective that "Some kids are pretty fake. They pretend to be all sweet and really they are tough." Participant 18126 additionally explained, "Each foster kid affected me in a different way, but I was exposed to things I shouldn't have been at a young age."

Theme 3: Changes to Physical Health or Well-Being

I explored the perceptions, beliefs, and attitudes of how a biological child's physical health or well-being is affected as they grow up in a therapeutic foster home. One participant asked for clarity to this question. Participant 19152 asked, "Do you mean in general or like a specific thing?" I replied, "It's whatever physical health or well-being means to you," so as to ensure that they responded from their perspective. Participant 20123 felt that having therapeutic foster kids in the home increased their physical activity, stating "I usually had someone to hang out with and do things with," whereas Participants 19UK9 and 2081 did not feel there was a change to their health or well-being. The other 11 participants expressed some type of change. The 11 responses fell within two subthemes. The first subtheme was effects to physical health or well-being, as in a condition such as a cold or lice, or physical harm by the therapeutic foster children in the home. Participant 2068 expressed, "I think I'm constantly catching colds and stuff from them. I swear every kid that came to stay with us was always sick at first or soon after they moved in." With regard to physical health and well-being, participants were also concerned that they had contracted lice. Both Participants 19152 and 191510 discussed catching lice from foster children in the home. Participant 191510 explained,

> Oh my God, they are always bringing in things like lice and stuff. I mean, they can't help it, but Jesus, I can't tell you the number of times I've treated my head because we had lice in the house. (Participant 191510)

On the subject of their physical health or well-being, Participants 21UK5 and 19513 identified the threat of physical harm from therapeutic foster children. Participant 19513

identified that some foster children in the home "can be violent. I've had my share of things thrown at me."

The next subtheme to emerge was that of becoming less physically active with therapeutic foster children in the home. Five participants responded they had experienced reduced physical activity when therapeutic foster children were placed in the home. Although the subtheme of reduced physical activity emerged, the reasons for this reduction varied among participants. They mentioned ample room in the family's vehicle. Participant 1964 expressed that "We really don't go and do much; we don't all fit in the van." Participant 18126 believed that the foster child's poor behavior was the reason for reduced physical activity: "You never really know how they are going to act. I think other families go out and do more things than we do." In addition, Participant 18614 explained, "I think there's times we don't go and do certain things because my parents are worried the kid is going to start screaming in public," additionally offering, "we definitely don't go outside as much as a family anymore. One of the kids living with us had roaches or something—they freak out whenever they see a bug." Limitations set on the foster children by caseworkers were associated with a reduction in Participant 20187's physical activity:

> If the foster kids can't do it, then we don't do it. Sometimes there are caseworkers that won't let them do things like ride dirt bikes or horses and stuff. Because why? Because they're in foster care? That kind of sucks. (Participant 20187)

Concerning a change in physical health and well-being, the last subtheme that emerged appears to be associated more with stress, worry, and anxiety. Eight participants shared

feelings of this concept. Participant 20123 stated, “I think it’s kind of scary at first,” whereas Participant 19152 offered, “I used to feel a little nervous, sometimes still do . . . I had a lot of anxiety as a kid, and some kids scared me in the past.” Participant 1964 recalled times when there were foster children with concerning behavior in the home: “It was really stressful and confusing most of the time.”

In this subtheme, I also categorized feelings of emotional well-being with regard to loss or sadness as participants expressed feelings of loss and sadness when a foster child they were fond of moved out of the home, at times without much notice. From the data, I gathered seven participants who expressed feelings of loss when this occurred. Participant 191510 recalled one of these moments when a young foster child who had been living in the home was removed suddenly. They stated,

> One day when I was at school, the social worker came and took them from our home. The parents had gotten clean. I didn’t even get to say goodbye. My heart was broken so many times when my foster brothers and sisters were taken away without any warning. It really felt as though they had died, but we weren’t allowed to mourn the loss or anything. Nope, we were expected to go on as if nothing had happened. (Participant 191510)

Participant 19513 shared a similar perspective:

> Sometimes they just leave and you didn’t even know it, you know? You might think they’re on a visit or something, and then my mom tells me they aren’t coming back, like never. It makes you feel like they died or something. (Participant 19513)

Theme 4: The Shaping of Perspectives and Beliefs

The final theme from the interview process was how the foster care experience shaped the participants' perspectives and beliefs now that they are adults. The first subtheme that developed through the interviews was that multiple participants expressed that, despite concerns, difficulties, or changes in their lives due to the foster care experience, they developed the belief and perspective that what their family was doing was for the greater good. Participant 2081 shared, "Sometimes I felt invisible or still do, but I know these kids need help." Similarly, Participant 19152 expressed the following:

> I don't think it was until I got older that I realized what a good thing my family does, you know? I haven't always liked it and still may not like some of the kids that stay with us, but it's still better than people who do nothing. (Participant 19152)

The next subtheme that developed was that some participants expressed that the foster care experience helped them develop skills they use now that they are older. Participant 19152 felt that the foster care experience taught them to be "more patient with other people," and Participant 21UK5 said, "You have to give some people—kids included—space." Participant 20187 stated, "I learned not to take my parents or the privileges I have for granted. I also learned that the world isn't a perfect place, but it is what you make it."

The next subtheme that formed from the interviews was what the participants believed about society based on their experiences of having therapeutic foster children in the home. Four participants expressed that they developed perspectives about their

communities and society based on what they had learned through the foster care experience. Participant 20123 shared,

> There are things that I don't think people realize are out there, like sex offenders and people who really abuse their kids, you know, right in our own area. I have kids that lived with us that already lived in my city and went to my school but still had to come into foster care. (Participant 20123)

Participant 18126 communicated, "You don't realize how many terrible people are really out there until you hear some of what [these foster children] have been through," whereas Participant 211011 disclosed, "Emergency foster care means you're getting kids right from the crime, like molestation or physical abuse, and every other evil you can think of," adding, "I never knew our city had so much crime."

Although they were not asked, five participants shared their beliefs about whether they would consider fostering in the future; thus another subtheme developed. Three participants stated they would not foster in the future, as seen by Participant 19UK9, who claimed, when discussing their family's choice to foster, "It's not for me, though. I totally do not want to be a foster parent." Alternatively, when discussing their family's choice to foster, two participants believed they would. Participant 1964 stated, "God chose our family to help others; it's the right thing to do. I'll probably be a foster parent too if they need it, but I would be careful about who lives with me."

The final subtheme that developed through this last theme was the participants' perspective on being ill prepared for or having support for the foster child living with them. When asked about their perspectives shaped by the foster care experience, four

participants expressed a lack of support or information. Participant 2068 stated, “There’s counseling for the foster kids, but never for us,” whereas Participant 19UK9 shared, “When I was young, I was told many scary, unbelievable things about some of the horrors [foster siblings] had gone through. I had no idea how to deal with this information.” Additionally, Participant 20UK12 shared that, with regard to understanding the different needs of foster children, “I feel I had to teach myself—that it wasn’t something my parents or social workers taught us; it just came because I had to do it.”

Looking to explore the lived experiences of therapeutic foster parents’ biological children, participants identified similar experiences in each of the themes or subthemes that developed, but some perspectives also varied greatly. Additionally, some themes developed that were outliers of the questions asked.

Chapter 5: Recommendations, Implications, and Conclusion

The purpose of this qualitative, phenomenological study was to capture the lived experiences of the adult biological children of therapeutic foster parents. I conducted this research to explore the meaning of family and the perspective of the foster care experience from foster parents' biological children. By exploring these experiences, I was able to identify common experiences, concerns, and perceptions of what it was like to grow up in a home that provided therapeutic foster care.

During each interview, the participants described their experiences prompted by the previously identified questions. Many participants identified similar experiences in each of the themes or subthemes that developed. I found there were some themes in which perspectives varied greatly or themes that developed that were outside of the questions asked. At the beginning of each interview, I asked the participants to describe the changes that occurred in the family during the foster care experience and, if possible, to compare their family before and after providing foster care. Multiple participants described changes in the home environment. These changes included unexpected or sudden arrivals of foster children, as well as loud or noisy environments. Various participants experienced changes in social interactions, such as connecting with their friends and neighbors, or community involvement of their home life. Some participants went on to discuss concerns with a foster child's behavior in the presence of people who did not live in the home, as well as a disruption of the family's plans or routine due to caseworker involvement. Some participants discussed how their own responsibilities in the family unit changed with the addition of therapeutic foster children, whereas nearly

all participants discussed changes in their state of mind or family members' emotional well-being.

I went on to explore memorable experiences growing up in a therapeutic foster home to discover if there were shared experiences that were similar. Whereas some participants' described experiences were believed to be unique, when compared to others' responses, the subthemes that developed were indeed common among some of the participants. An example of this included living in a home that housed many children. This experience was shared by multiple participants, yet each thought this experience was unique to their family.

Multiple participants discussed learning how to care for younger children, especially as a result of helping their parents out, but some expressed they felt at a loss for dealing with the foster child's emotional or behavioral concerns. Some participants also shared the requirement to register with the foster care agency as they turned 18, which they felt was an unusual experience. All participants expressed that they had been exposed to a foster child's behaviors, including situations such as theft, aggression, sexual discussions, and manipulation. While some participants expressed feeling as if they did not know how to handle these concerns, others said they retreated to locations such as their bedrooms or out of the house completely.

Changes to health were discussed as part of the foster care experience by nearly all participants. While some participants did not feel there was a change to their own health, there were various definitions of what health meant. Some participants discussed exposure to ailments such as illnesses or lice, and some other participants viewed health

as changes to emotional well-being and possible physical danger, such as that resulting from an aggressive foster child. While one participant shared an increase in physical health as a result of having therapeutic foster children in the home, multiple participants expressed that their physical activity decreased for various reasons such as concerns about the foster child's behavior, limited vehicle space, or the affordability of activities in the community. Emotional well-being was discussed by many participants under the subject of changes in health. Many participants experienced increased worry, stress, and anxiety as a result of the placement of therapeutic foster children in their homes. Additionally, some participants expressed feelings of grief, sadness, or loss when a child who had been placed with them for some time was suddenly removed with no or limited prior communication.

Finally, I asked participants how the foster care experience shaped their perspectives and beliefs now that they are adults. Multiple participants believed that the care their families provided was for the greater good. The development of various interpersonal skills were attributed to the foster care experience, such as having patience, being caring, being aware of the needs of others, appreciating their own families more, and being more accepting of or having experience with people's differences.

Some participants discussed the development of beliefs about their communities or society as a whole based on their experience of caring for therapeutic foster children. Participants attributed a greater understanding of the dangers of society, such as the presence of sex offenders or child abusers in their own communities, to the foster care experience as well. Some participants stated they did not feel prepared or equipped to

handle the emotional or behavioral concerns that the foster care experience presented, believing they had no support available that would have helped. One unexpected theme that developed, as it was not asked in the questions, was that participants often volunteered whether they would provide foster care in the future. Some participants shared that they would not provide foster care in the future, while a couple shared that they would. Since this question was not asked, but volunteered by multiple participants, this theme's development suggested that the consideration of future fostering is naturally part of the experience shared by the biological children of therapeutic foster parents.

Interpretation of Findings

The literature I reviewed over the last several years points out numerous concerns that a foster family may face while providing therapeutic foster care. MAPP training is used in New York State to prepare foster families to care for therapeutic foster children (CWIG, 2014). This training provides very little preparation on potential concerns. I found only two passages in the MAPP training guide addressing foster families' preparedness: First, "Know your own family. Assess your individual and family strengths and needs; build on strengths and meet needs;" and second, "Assess impact. Assess the ways fostering and/or adopting may affect your family" (ACH, 2017). These are the only two statements that reference how providing foster care may impact the family unit. When I recall that the literature found that foster parents identified inadequate training about the real situations they encountered while fostering as a significant factor in their decision to remain active foster parents (Esaki et al., 2012), the findings of my study support that this concern is still present and unmet. Understanding potential concerns or

identifying training needs prior to placement would better allow a prospective foster family to assess whether they can adequately meet the child's needs or if the placement would be a good match for their family unit. Various participants identified not feeling adequately prepared for the challenges they experienced with foster children in the home.

Applying Erikson's stages of development to participants' responses, there are two stages that should be considered when describing the lived experience of biological children living in therapeutic foster homes. In the first stage, identity versus confusion, a child develops a sense of self and identifies beliefs, goals, and values (McLeod, 2017). A child's experiences and interactions mold their ideals. This psychosocial conflict can become compounded when we consider the experience of living with foster children in the home. I explored the development of beliefs and values during the interview process. Participants expressed the development of the value of providing foster care for the greater good, and the belief that their families were going above other families' efforts. Participants discussed developing the abilities to care for others, to be aware of different people's needs or capabilities, to appreciate what they had, and to help the family as a whole. Participants mentioned how they learned that criminal activity was present in their own neighborhoods. Participants believed that their families were very different from other families. Participants believed that at times, their health and ability to have typical experiences were impacted by the potential behavioral problems of foster children, and that they were exposed to dangerous behavior in their own homes. Adolescents who move forward during challenging situations may come away with a strong sense of

identity, while those who do not may not develop a strong sense of self and clear goals for the future (McLeod, 2017).

Another stage of development discussed by Erikson is that of intimacy versus isolation. This is the stage when people develop a commitment and investment in others, building long-term relationships (McLeod, 2017). Some participants discussed symptoms of withdrawing from the family unit by retreating to their rooms, leaving the home, or attempting to distance themselves from family dynamics. Other participants expressed feeling isolated from friends, extended family, and activities in the community due to the behavioral challenges presented by some foster children. Multiple participants expressed feeling grief and loss at the sudden and unexpected removal of foster children from their homes. There is an implication that progressing in a healthy manner through the intimacy versus isolation stage of development can be impacted by this lived experience.

I included the transactional model of stress and coping in the literature review as it examines how stressful experiences are perceived based on the impact of the external stressor (Marks et al., 2011). A person's primary appraisal process is when they evaluate the threat to their wellness. Then, their secondary appraisal process evaluates coping resources in relation to the stressor. Discussing what they found challenging, upsetting, or concerning about situations they experienced in their families while providing therapeutic foster care can be considered a trigger initiating the primary appraisal process. Some participants primarily appraised the threat as "concerning," such as the participant who described feeling that there was a physical danger to their own wellness when a foster child became aggressive. In the secondary appraisal process, a person evaluates their

ability to cope with the threat. The person determines whether they feel they have the resources (or access to the resources) needed to address the concern. Some participants felt that they had the skills to manage the situations that concerned them, such as understanding that when others are upset, it may be best to give them time and space to calm down. Other participants felt they did not have the skills to adequately manage a concerning situation, such as one person who felt at a loss for what to do when a young foster child was crying inconsolably, or the participant who verbally expressed being upset that they were not taught how to handle specific behaviors. Participants also expressed a deficit in not knowing how to handle concerning information foster children shared with them. Participants indicated they lacked support and had to teach themselves how to cope with various concerns, as neither their parents nor the foster child's social worker had given them the tools to handle the situations. With this information, I reflect back on the literature review, which also revealed that current foster parent training does not adequately prepare foster families for the challenges they may experience (Delaney et al., 2012; Esaki et al., 2012). I reviewed literature in which researchers found that children developed coping skills with repeated exposure to stressors such as behavioral or medical challenges (Ciudin & Turliuc, 2016; Smith & Somhlaba, 2015). Most participants indicated that they had exposure to numerous foster children, many of them with behavioral concerns, over a few years' span, indicating the development of skills to cope with stressors or threats from repeated exposure.

I reviewed the literature regarding the biopsychosocial model discussing how heightened anxiety can contribute to depression, as well as diminished wellness and

physical health (Hastings, 2015). People who experience anxiety or who are exposed to heightened stress have been found to have deficits in information processing, especially regarding the inhibition of emotional information, with more attention given to fearful information (Gindt et al., 2016). Multiple participants expressed feeling symptoms of anxiety, nervousness, and worry with regard to different aspects of the lived foster care experience. As all participants experienced several years of living with foster children, this implies that the biological children likely experienced repeated anxiety. In the literature, biological children were found to not always feel comfortable expressing concerns or anxieties they had regarding the foster care placement (Williams, 2017). I found this accurate—one participant expressed not wanting to upset their parents with their concerns, and another expressed that their parents did not want to hear about their concerns regarding the foster children in the home.

Limitations of the Study

In this study, I focused on the experiences of 14 adult biological children who grew up in homes whose MAPP-trained families provided therapeutic foster care to children with special needs. All participants were between the ages of 18 and 21, had had a foster placement in their homes for at least 6 weeks within the last 5 years, spoke English, and were located within a two-hour driving radius of Fulton County, New York in the United States. The restricted requirements and the use of anonymity for this study limit its transferability. Additionally, while anonymity provided participants the opportunity to speak freely, due to the sensitive nature of this study, some participants may have been hesitant or guarded in sharing some information. Initially, the interviews

moved along well and took approximately the anticipated amount of time (1 hour) to conduct. The COVID-19 quarantine restricted face-to-face interviews during the data collection process, so the remainder of the interviews were held on Zoom. The first few interviews held in this manner were shorter than the face-to-face interviews, and participants presented as distracted, narrower in their conversations, and brief in their responses. After consultation with two professors at Walden University about these concerns, it was suggested that I speak with each participant ahead of their interview to request they be free from distractions during the interviews and share expectations for the interview. The approach worked well, and I again conducted the remainder of the interviews successfully, yielding lengthy responses. For comparison, future studies may find it beneficial to limit participants to adult biological children with the same types of qualifications presented in this study.

Recommendations

In this study, I captured the experiences of adult biological children who grew up in homes whose families provided therapeutic foster care. By articulating these lived experiences, the participants shared their insights into the perceptions of and beliefs about this experience. To better understand this experience, I recommend that future studies explore building and nurturing the relationship between the biological child and foster child, as well as between the biological child and their family regarding how the foster care experience affects foster parents' biological children in the home.

Additionally, future focus should be placed on how the number of children being fostered affects the biological child's perspective of the foster care experience. Several

participants mentioned within their lived experience that fostering multiple children had affected various areas of their lives compared to families that did not provide foster care. This perspective surfaced within multiple themes and subthemes, including whether the participants would consider fostering in the future. I recommend that a future study compare the lived experience among those who provide foster care for multiple children versus those providing foster care for only a single or a small number of children.

Furthermore, I recommend further exploration of the impacts of fostering on biological children's physical and emotional well-being. A number of subthemes developed under this theme, yielding results that varied based on each participant's perspectives on the meanings of physical health and well-being. Possible considerations should include the biological child being the target of physical aggression by a foster child, a reduction of physical activity in the family unit dependent on the foster child, the biological child's exposure to the foster child's mental health symptoms, and the emotional disconnect for the biological child when a foster child leaves the home abruptly.

Finally, exploring alternative training programs for foster families to prepare the biological children for the experiences that they are likely to encounter during fostering warrants further consideration. MAPP training is one of the most common training methods used to prepare foster families for the care a foster child will need (Dorsey et al., 2008), yet the majority of results from the interviews of biological children I conducted suggest that this program does not meet the challenge of providing therapeutic foster care. Stressful relationships between the foster family and foster child are associated with

placement disruption for the foster child (Hewitt, 2013). Foster families feeling unprepared for the behavioral challenges that a foster child may present was an additional cause for placement disruption, as discussed by Fisher et al. (2011). I recommend exploring alternative training programs for enhanced effectiveness and support for the entire family unit.

Implications

I can apply social change implications to the social services, clinical, and foster care communities. Social services, social/case workers, foster care agencies, and foster families will find the results of this study to be an important tool for understanding gaps in the currently available foster parent trainings and supports. The findings in this study can be applied to the development of training and psychoeducational programs for foster care providers who need to better understand how fostering may affect their family units and what challenges their biological children might face. Social/case workers should consider these findings in the supports that they provide to foster families they oversee, determining whether additional supports to the families themselves would be beneficial. By gaining a better understanding of the foster care experience and the meaning of family as perceived by the biological children in the home, proactive measures can be considered to prevent and address various concerns. Such measures can serve as a means to prevent foster placement disruptions—which, as discussed earlier, correlate with a greater pull on community resources as the foster child ages out of foster care. Considering the shortage of available foster families, professionals should explore how

educational and training materials could successfully encourage biological children of therapeutic foster parents to one day become foster parents themselves.

Conclusion

Growing up as a biological child in a therapeutic foster home uniquely influences the development of one's perspectives and beliefs about foster care, foster children, the meaning of family, family differences, impacts on health due to providing foster care, the development of skills, and even thoughts about one's community based on knowledge gained from the foster care experience. With the increase of children entering into the foster care system and an identified shortage of available foster homes, it is increasingly likely that the available foster homes will house multiple children, as identified by many of the participants in this study. It is important for foster care providers and social/case workers to recognize the areas of concern identified within this study to understand the meaning of family for the biological children growing up in therapeutic foster homes and determine what proactive or supportive measures could be taken to address concerns expressed by the participants. Foster care providers and social/case workers can build upon the positive aspects of growing up in a home that provides therapeutic foster care to strengthen the relationships between biological and foster children, decreasing the likelihood that placement disruption will occur.

I conducted this research study to capture the lived experiences of biological children who grew up in households that provided therapeutic foster care. I used the transactional model of stress and coping theory to focuses on providing a conceptual framework for predicting, examining, and understanding the instability within families

due to stressors (Lazarus & Cohen, 1977). By using this model, I explored how stressful experiences are understood as a person–environment transaction, dependent on the impact of the external stressor. When an individual is faced with a stressor in a foster home, such as the addition of a foster child with behavioral concerns, changes in the family dynamics, contracting an ailment such as an illness or lice, or the sudden removal of a foster child from the home, a primary appraisal process evaluates the threat as stressful, positive, controllable, challenging, or irrelevant (Lazarus & Cohen, 1977). In this study, participants did experience several of these primary appraisals.

After the primary appraisal is experienced, a person's secondary appraisal follows. This provides them an assessment of their coping resources and options in relation to the stressor. In this study, multiple participants did not feel that they had resources, support, or options to address the stressors they experienced as biological children growing up in therapeutic foster homes. Some participants felt that they were not well prepared for the experiences that they had, nor did they feel that they had resources available to them from parents or social/case workers to assist with the stressors resulting from their experiences.

Coping efforts, which are used to mediate the primary and secondary appraisals, varied by participant in this study (see Lazarus & Cohen, 1977). While some participants felt they could find balance between a given stressor and their own emotional regulation—such as understanding that a foster child's problematic behavior may be linked to traumatic experiences, giving an upset child space to calm down, or removing themselves from a stressful environment—each interviewee's coping style also played a

key role in the outcome of addressing each stressor. Although some participants remained optimistic in feeling they could effectively address the stressors related to the foster care experience, several participants shared coping styles that were avoidant in nature, such as retreating to or spending an increased amount of time in their bedrooms or refraining from being at home as much as possible. By using this type of avoidant coping effort, an adult biological child may not be able to address problematic behaviors of future therapeutic foster children or allow for the healthy building of coping skills that may be necessary to address similar stressors in other areas of life.

I recommend further research focus on how to provide additional supports to the biological children in therapeutic foster homes while enhancing the relationships between those biological children and foster children. I also suggest future research focus on techniques to support the relationships between foster parents and their biological children in regard to providing foster care. If these areas of concern were addressed, biological children in therapeutic foster homes would more likely have positive perspectives of the foster care experience, develop positive coping efforts in areas they consider stressful, and be less likely to experience placement disruptions based on poor relationships and increased stress.

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Appendix A: Recruitment Advertisement

Does Your Home Provide Foster Care?

Being a Biological Child in a Therapeutic Foster Home

Principal Researcher: Maria Betts for a Walden University Dissertation

The purpose of this research study is to determine what the experience is like to grow up being the biological child of parents who provide therapeutic foster care.

<u>To participate in this research you must:</u>

-Be between the ages of 18 and 21 living in or recently living in a home in which your parents provided therapeutic foster care in upstate New York

-The foster home should be familiar with MAPP training and have had at least one placement for a minimum of six weeks in the last five years.

-English should be the primary language spoken in the home

<u>Participation in this study involves:</u>

An approximately one-hour interview of your experiences, with brief follow-up questions as needed at the end of the interview.

You will receive a Walmart gift card for your participation

<u>Contact Information:</u>

Maria Betts

IRB # 01-03-20-0393869

Appendix B: Interview Questions

- How long has your home provided foster care to special needs children?
- Recalling a time before your home provided foster care to special needs children, how do you feel your family has changed since providing this care?
- What do you think would have been different in your life if your home did not provide foster care?
- Do you feel your physical health or well-being was affected by the foster care experience?
- What are some experiences from growing up in a home providing foster care?
- How has foster care shaped your perspective and beliefs now that you are an adult?
- What coping skills do you feel you developed as a result of your experiences?

Appendix C: List of Emotional Support Resources

1-800-LIFENET: Free professional help with an emotional crisis. Also online at www.800LIFENET.org. Available 24 hours per day/7 days a week; 1-800-543-3638.

National Suicide Prevention Hotline: 1-800-273-8255

Capital District Psychiatric Center: 24-hour emergency support for emotional distress and mental health support: (518) 447-9650

The Samaritans: Free, immediately accessible 24-hour emotional support in complete confidence. 24 hours a day, 7 days a week (212) 673-3000 or Emotional & crisis support via E-mail @ https://www.befrienders.org

New York State Office of Mental Health Crisis Support: Text "Got5" to 741741 to start a conversation