2020

Posttraumatic Stress Disorder Rates Among Children in Foster Versus Family Kinship Care

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Walden University
2020

Abstract

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MS, Walden University

BA, College of New Rochelle

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

February 2020

Abstract

Children in foster care represent a highly traumatized population. However, trauma researchers studying this population have focused primarily on maltreatment rather than the full spectrum of posttraumatic stress disorder (PTSD) attributes and symptoms for children living in nonkinship foster homes versus kinship foster homes. The purpose of this study was to address this gap in the literature, as well as examine the benefits and limitations of children placed in kinship and nonkinship foster homes. Attachment theory was the theoretical framework. The research questions centered on the prevalence of specific types of posttraumatic stress symptoms for a sample of children living in both kinship and nonkinship foster homes, to determine which placement setting was more beneficial for children diagnosed with PTSD. This quasi-experimental study examined 221 foster parents who participated in an online survey. Research findings suggest that there was no significant differences among children in kinship and nonkinship foster homes and reported PTSD symptoms, however there was a significant difference among reported PTSD symptoms and psychotherapy received suggesting children who received mental health treatment services reported less PTSD symptoms Findings may contribute to social change by providing knowledge that Child welfare agencies can use to evaluate childhood PTSD and support foster care children's foster home placement stability, which may ultimately guide child welfare practice and policy.

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Acknowledgements

I would like to express the deepest appreciation to my chair, Dr. Jessica Hart; committee member, Dr. Carolyn King; form and style reviewer Dr. Kachgal, and URR reviewer who have been patient, diligent, and forthcoming with me throughout the research and writing process. Without their guidance and persistent, this dissertation would not have been possible.

I would like to thank my mentors, Dr. Ellen C. Weld; Dr. Angela Lawrence; and Pamela Richburg, LMSW, whose work demonstrated to me that concern for social welfare, supported by an engagement in practices, literature, and modern psychology, should always transcend personal needs for positive social change.

In addition, I would like to extend a personal thank you to Walden PhD alumni and dear friend Dr. Tiesha Scott, who helped me every step of the way when it came to navigating the research process. She is an outstanding psychologist, friend, and colleague. Thank you for your support. Last, but not least, I would like to thank my family for their continued support throughout my educational experiences.

Dedication

This dissertation is dedicated to all youths in foster care, foster parents who provide children with a safe haven, and those who aid in serving children with emotional, behavioral, and cognitive difficulties.

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Chapter 1: Introduction to the Study

Background

For many children globally, foster care serves as a bulwark against abuse and neglect from parental caregivers. Children are placed into foster care primarily based on substantiated physical abuse, sexual abuse, or neglect. However, there are many environmental factors that contribute to children being placed in foster care such as inadequate guardianship, lack of supervision, parent's drug misuse, parent's physical incapability, domestic violence in the home, or parent's mental illness (Casey Family Programs, 2011). Of all these contributing factors, a history of persistent maltreatment is currently the most common reason for referral for children placed in foster care (Oswald, Heil, &Goldbeck, 2010). When children are maltreated by their guardians or biological parents, they are placed into the foster care child welfare system and raised by a state-certified caregiver referred to as a foster parent (Barth, Wildfire, & Green, 2006; Ehrle & Geen, 2002; Veltman, 2016). Children in the United States placed within the child welfare system and into foster care have limited placement options once they enter care. Children are either placed in a kinship foster home or nonkinship foster home. Children in kinship care foster homes, who have been removed from their parents' care, can be raised by anyone the child has a close bond with such as relatives, godparents, grandparents, great-grandparents, a close family friend, or members of a tribe or clan (Child Welfare League of America, 1994; Kang, 2003; McKay, Hollist, & Mayrer, 2016).

Researchers suggest that children in foster care flourish in kinship placements and tend to experience fewer placement disruptions, exhibit fewer behavioral problems, and

report better well-being outcomes than children in nonkinship placements (Andersen & Fallesen, 2015; Barth, Guo, Green, & McCrae, 2007; Koh, 2010, Strozier & Krisman, 2007; Rubin, Springer, Zlotnik, Kang-Yi, & CARE, C. O. F. 2017; Testa, 2002; Winokur et al., 2008; Zinn, DeCoursey, George, & Courtney, 2006). Although kinship foster care providers face more environmental hardships than nonkinship foster care providers, nonkinship providers are more likely to be single and/or older in age, receive less support for parenting, live in improvised communities, and have lower education levels and lower financial income (Ehrle & Geen, 2002; Harden, Clyman, Kriebel, & Lyons, 2004; Owens-Kane, 2007; Ponnert, 2017). Berrick (1998) furthermore suggested that children living in kinship foster homes are less likely to be adopted, and legal custodial permanency placement stability with relatives is often not achieved. Despite some of the disadvantages faced by relative caregivers, research findings suggest that kinship foster homes can promote the child welfare goals of protecting children, supporting families, maintaining connectedness to families, and preserving children's sense of belonging and identity (Hoehn, Foxen-Craft, Pinder, & Dahlquist, 2016; Mosek & Adler, 2001).

During the early 1900s, child welfare officials often believed that children placed in kinship care with relatives were at risk for maltreatment and abuse (U. S Department of Health and Human Services, 2000). It was assumed that the origin of abuse or neglectfulness stemmed from parents who had learned their dysfunctional behaviors from their own parents or family members (Koh, 2010). Therefore, child welfare agencies preferred to place children in nonkinship foster homes, group homes, or institutions rather than kinship foster homes. For most of the last century, kinship care providers were

considered an option only as a last resort (Koh, 2010). However, over the last decade, child welfare agencies have been increasingly turning to relatives as the first option when a foster care home placement is needed. Since the rise of kinship care in the late 1990s, the number of children reported as living in kinship care in the United States has stabilized at around 30% of the foster care population (The Adoption and Foster Care Analysis and Reporting System [AFCARS], 2017; Beeman, Kim, & Bullerdick, 2000).

Although there is a growing body of literature suggesting that kinship foster care is a better alternative for children place in foster care, further research in this area is still needed (Allen, DeVooght, & Geen, 2008; Conway & Hutson, 2007; Lin, 2014; Smithgall, Yang, & Weiner, 2013). Researchers have examined permanency outcomes, safety, well-being, and behavioral problems of children in kinship and nonkinship foster homes (Wu, White, & Coleman, 2015). However, there is limited research on the mental health treatment provided to children in kinship versus nonkinship foster homes. Therefore, an evaluation of kinship care and nonkinship care on foster children's mental health problems is needed to guide child welfare practice and policy.

I sought to address this gap in the literature by conducting this research. My specific focus was on examining children's foster care placement type and mental health service treatment stability of children with posttraumatic stress disorder (PTSD). PTSD is a mental health disorder that develops in some people after experiencing or witnessing a shocking, scary, or dangerous event (National Institute of Mental Health, 2016). For some children, witnessing domestic violence between parents or guardians and their paramours or experiencing a life-threatening event such as combat, a natural disaster, a

car accident, sexual assault, or physical or sexual abuse can be traumatizing (The National Child Stress Network, 2017). Usually when people experience PTSD symptoms, they frequently relive a traumatizing situation, avoid situations that resemble a traumatic experience, are hypervigilant, and have negative beliefs and feelings even months and years after witnessing or experiencing a traumatic event (Children's Bureau, 2012). PTSD can cause children great distress and interfere with school behavior and their ability to have positive relationships with peers, siblings, parents, caregivers, and teachers (American Psychiatric Association, 2013). There are many children living in foster care who suffer from PTSD as a result of being subjected to traumatic experiences (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009; Spinazzola et al., 2017). In addition, there is extensive research that shows the correlation between PTSD and child maltreatment that results in children being placed in foster care (Carlson et al., 2001; Salazar, Keller, Gowen, & Courtney, 2013). However, much less is known about children's foster care placement types and mental health service treatment stability of children with PTSD. In this research study, I examined whether family-based emotional support through kin-related placements is more beneficial for children facing challenges with PTSD in foster care.

Problem Statement

In most U.S. states there are two types of foster care placement arrangements: the traditional nonkinship foster home, where children placed in care are unrelated to the foster parents, and the kinship foster home, which consists of adult extended relatives who have been licensed to board a related child in foster care (Fusco & Cahalane, 2015).

Researchers have found that kinship foster care is a better alternative than nonkinship foster care when children need to be removed from their homes (Fusco & Cahalane, 2002; Lin, 2014). According to research findings, kinship caregivers provide some continuity and connectedness for children removed from their homes, and children are more likely to maintain contact with their families (Ehrle & Geen, 2002; Barth, Barth, & Barth, 2017). Kinship care provides a more stable placement, and there is some evidence that children in kinship care are less likely to re-enter care compared with children in nonkinship foster care placements (Koh, 2010; Wells & Guo, 1999). However, despite the best efforts to place children in family foster care placements with kinship relatives, sometimes children must be placed in substitute care with nonkinship foster parents.

The U.S. Department of Health and Human Services; Administration for Children and Families (ACS); Administration on Children, Youth and Families; and Children's Bureau suggested that there are over 45% of children in nonrelative foster homes versus 32% of children in relative kinship homes in the United States (AFCARS Report, 2017). In their study using the National Survey of Child and Adolescent Well-Being (NSCAW) data, Burns et al. (2004) found that almost one half of all children between age 2 and 14 with completed child welfare investigations demonstrated clinical levels of emotional and behavioral concerns (see also Heneghan, et al., 2013). According to the AFCARS report (2017), over 24,756 of foster children in the United States are placed in care due to emotional or behavioral problems.

PTSD is a prevalent and detrimental disorder among children being placed in foster care (Ko et al., 2008). Symptoms are reported in 19.2% of children referred to

child welfare (Kolko et al., 2010). A study on children in foster care showed that 60% of those sexually abused were diagnosed with PTSD, and 42% of those physically abused were diagnosed with PTSD (Dubner & Motta, 1999; Stovall-McClough & Cloitre, 2006). Other studies demonstrate that children in foster care were diagnosed with PTSD after being exposed to parents' drug abuse; experiencing neglect, domestic violence, community violence, sexual abuse, physical abuse, or verbal abuse; witnessing a life threatening; or experiencing a life altering event (Marsenich, 2002; Margolin, & Vickerman, 2007; Pinto et al., 2017). These statistics and research studies highlight the urgency in further examining the prevalence of PTSD among foster care children and whether kinship foster care home placements provide more emotional stability for children entering the child welfare system. All children age 5 and older with a substantiated child maltreatment case receive routine, standardized screenings to detect socioemotional problems (Child Welfare Education and Research Programs, 2013). In conducting this research study, I wanted to close the gap in the literature by examining the effect of foster care placement type (kinship and nonkinship) and previously reported mental health service treatment on reported PTSD symptoms in foster care children.

Purpose Statement

The purpose of this research study was to examine the effects of foster care placement type (kinship and nonkinship) and previously reported mental health service treatment on reported PTSD symptoms in foster care children. I explored whether children, ages 3-12, in kinship foster homes significantly differ in symptoms of PTSD from children placed in nonkinship foster homes as reported by foster care parents.

Specifically, I explored whether attending previous mental health services within the past three to four months affects PTSD symptoms in foster care children as reported by foster parents. I also examined interactions between kinship and nonkinship care placement type and previous mental health service treatment on PTSD in foster care children as reported by foster parents. For this study, foster parents were asked to measure children's posttraumatic stress (PTS) symptoms, which included intrusive thoughts, sensations, and memories of painful past events; nightmares; fears; and cognitive avoidance of painful feelings, through use of The Trauma Symptoms Checklist for Young Children (TSCYC) (Briere, 1996).The TSCYC is a highly replicable assessment tool used to measure young children's PTS symptoms between ages 3-12 (Briere, 1996).The focus of the mental health treatment service demographic questionnaire, which I developed, was on the types of services received over the past three to four months and the perceptions of the foster parents on the benefits of those services. This comparative research study involved examination of kinship and nonkinship foster children based on their reported PTS symptoms and previously reported mental health service treatment. The benefits of this study include providing foster care agencies with an understanding of how different foster care placement types may affect children's rates of PTSD, as well as help foster care agencies with making informed decisions about children's placement type and stability based on children's PTSD diagnosis.

Research Questions and Hypotheses

RQ1: Do kinship and nonkinship foster parents significantly differ on their reported symptoms of PTSD in their foster care children ages 3-12?

$H_0$1: There is no significant difference in kinship and nonkinship foster parents' reported symptoms of PTSD in their foster care children ages 3-12.

$H_1$1: There is significant difference in kinship and nonkinship foster parents' reported symptoms of PTSD in their foster care children ages 3-12.

RQ2: Does attending previous mental health treatment services within the past three to four months affect PTSD symptoms in foster care children as reported by foster care parents?

$H_0$2: There is no significant difference in previous mental health treatment services within the past three to four months that affect PTSD symptoms in foster care children as reported by foster care parents.

$H_1$2: There is significant difference in previous mental health treatment services within the past three to four months that affect PTSD symptoms in foster care children as reported by foster care parents.

RQ3: Is there an interaction between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents.

$H_0$3: There is no significant difference in interactions between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents.

$H_1$3: There is a significant difference in interactions between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents.

Theoretical Framework

The theoretical framework for this study centers around the attachment theory. Attachment theory is the joint work of John Bowlby and Mary Ainsworth (Ainsworth & Bowlby, 1991). John Bowlby's theory on attachment depicts how children respond to other individuals within relationships when hurt or mistreated, separated, or displaced from loved ones, or when formed or unformed relationships are perceived as a threat (Bowlby, 1969; Ainsworth, Blehar, Waters, & Wall, 2015; Ainsworth, Bell, & Stayton, 1971). In conjunction, Bowlby worked with Mary Ainsworth who was a developmental psychologist known for her work in the development of the Strange Situation procedure which was designed to observe early emotional attachment between a child and their primary caregiver (Ainsworth, Blehar, Waters, & Wall, 2015; Harkness, 2015). Essentially all infants as well as young children become attached if provided any caregiver, but there are individual differences in the qualities of the relationships that sustain a bonding relationship (Hinde, 1991; Burke, 2016). In infants, attachment as a motivational and behavioral system directs the child to seek proximity with a familiar caregiver when they are alarmed (Corcoran & Anafarta, 2005; Duft, Stafford, & Zeanah, 2017). Bolwby (1969) believed that the tendency for primate infants to develop attachments to familiar caregivers was the result of evolutionary pressures, since attachment behavior would facilitate the infant's survival in the face of dangers such as predation or exposure to harm. Researchers have even suggested that humans are innately driven to protect and nurture persons with shared blood linage and pre-existing attachments (Lawler, 2008; Font, 2015). When children are placed into foster care these

same attachment principles apply. Even when children are provided a new caregiver, they will seek proximity with either a close relative or unknown caregiver in order to survive (Turner, 2008; Barbaro, Boutwell, Barnes, & Shackelford, 2017).

Nature of the Study

The research design best suited for this research study was a quantitative research methodology. This quantitative research study explored hypotheses associated with the research question by examining the effect of foster care placement type in kinship and nonkinship foster care placements and previously reported mental health service treatment on reported PTSD symptoms in foster care children through a quasi-experimental design. Through a quasi-experimental design, this research study examined nonrandomized children in both kinship foster care placements and nonkinship foster care placements who were diagnosed with PTSD to determine if prior mental health service treatments show any significant differences within the different foster care placement settings. The quasi-experiment is not a true experiment which places individuals in randomized trials (Wyse, & Torgerson, 2017). However, this method minimizes selection bias when using nonrandomized groups and reduces extensive pre-screening (Lee & Thompson, 2008; Winokur, Holtan, & Valentine, 2009; Steiner, Cook, Li, & Clark, 2015). This researcher collected data to examine causal inferences to the findings within certain groups of foster care children placed in both kinship foster homes and nonkinship foster homes. The study also examined any interactional effects of previously reported mental health treatment services on PTSD rates in children placed

within both placement settings to determine if there were any significant differences in foster parents reported symptoms of PTSD.

Variables

The study focused on two independent variables and one dependent variable. One independent variable examined placement type of children placed in nonkinship foster homes, and children placed in kinship homes. The second independent variable examined previously reported mental health service treatment on reported PTSD symptoms in foster care children. The dependent variable was caregiver rates of children's reported PTS symptoms as measured by the Trauma Symptoms for ages 3-12 (Briere, 2005).

Definitions

Abandonment: Another form of neglect, in which a parent's identity or whereabouts are unknown, and a child has been left by the parent in circumstances in which the child suffers serious harm, or the parent has failed to maintain contact with the child, or to provide adequate support for a period of time (Child Welfare Gateway, 2016).

Attachment theory: A warm, intimate, and continuous relationship with a mother or caregiver over a lifespan (Bowlby & Ainsworth, Bretherton, Bowlby & Ainsworth, 2013). Bowlby described the attachment system as a way to help children seek comfort from their caregiver and develop a sense of security (Goldberg, Muir, & Kerr, J. 2013).

Child Welfare Protective Services: A system comprised of family court and other social services agencies, which stands in the place of a parent taking overall responsibility for children in care and making all legal decisions, while the foster parent is responsible for a child's day-to-day care (Allen & Bissell, 2004).

Educational neglect: A parent's failure to provide for a child with basic school and education. Types of educational neglect include permitted chronic truancy, failure to enroll a child in school, and being inattentive to a child's special education need (Robinson, 2017).

Emigration scheme: widely known today as the orphan trains (The Annals of Iowa, 2005). The emigration program was intended to permanently transport abandoned, homeless, and orphaned children from New York City and Eastern cities to small towns in rural homes and farms in the Midwestern and Western states (Butler, 2014).

Emotional abuse: often a part of physical or sexual abuse (Maguire et al., 2015). Typical language used in defining emotional abuse usually includes injury that causes damage to a child's psychological or emotional stability as evidenced by an observable or substantial change in behavior, emotional response, or cognition (Child Welfare Gateway, 2016). Emotional abuse includes language used towards a child that causes emotional injury anxiety, depression, withdrawal, or aggressive behavior (Child Welfare Gateway, 2016). Threatening to cause someone bodily harm is also considered a form of emotional abuse, especially if threats are routinely systematic causing emotional distress.

Foster parent: provides children with safe and stable homes until they can be reunified with their parents or adopted, if there is no plan for them to return home to their parents (Harden, 2004; Euser, Alink, Tharner, van IJzendoorn, & Bakermans-Kranenburg, 2014). The placement of the child is normally arranged through family court, government, or a child protection social service agency (McGowan, 2017).

Insecure anxious-avoidant attachment: withdrawn and unable to resonate with one's attachment figure (Powell, Cooper, Hoffman, & Marvin, 2013).
Avoidant attachment is characterized by feeling uncomfortable with closeness in relationships and a desire to maintain emotional distance (Edelstein & Shaver, 2004).

Insecure ambivalent/resistant attachment: an ambivalent behavioral style towards the attachment figure (Shilkret & Shilkret, 2008; Atwool, 2006). Clingy, dependent, and rejecting behavior will commonly be exhibited. (Waters, Crowell, Elliott, Corcoran, & Treboux, 2002).

Kinship foster care: defined by the U.S. Department of Health and Human Services (U.S. DHHS) as the full-time care, nurturing, and protection of a child by relatives, members of their Tribe or clan, godparents, stepparents, or other adults who have a relationship to a child (Child Welfare Information Gateway. 2013). A family friend could be considered a next of kin for a child in care if they have an extended relationship through the parents or guardians (Farmer, 2009; Whitbeck, 2017). Relatives are the preferred resource for children who must be removed from their birth parents because it maintains the children's connections with their families (Hegar & Rosenthal, 2009; Farineau, Stevenson Wojciak, & McWey, 2013). Kinship care is often considered a type of family preservation service. According to Hegar and Scannapieco (2002), kinship care did not emerge as a child welfare issue until the late 1980s, and only recently has it become a part of the formalized system for out-of-home care.

Nonkinship foster care: defined by the U.S. Department of Health and Human Services (U.S. DHHS) as the full-time care, nurturing, and protection of a child by non-

relatives (Child Welfare Information Gateway. 2013). Nonkinship foster caregivers have no prior relational ties to a child coming into foster care and they provide children with a temporary place to stay until the child can return home to their own family, move into a longer-term fostering placement, or adoptive care (Ehrle & Geen, 2002; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Andries, 2012). Often this can cause a child distress, especially if attachment is disrupted from a caregiver (Hong, Algood, Chiu, & Lee, 2011). Nonkinship Foster care is temporary out-of-home care service provided by states for children who cannot live safely with their families (Mullin & Morrison 2006). Foster care is a societal intervention system in which a child has been placed into a state's care in an institutional ward, group home, or private home of a state-certified caregiver, referred to as a foster parent (Zeanah, Shauffer, & Dozier, 2012).

Medical neglect: defined as failing to provide any special medical treatment or mental health care needed to a child (US Department of Health and Human Services, Administration for Children and Families, 2005). In addition, medical neglect is also defined as the withholding of medical treatment or nutrition from children with life-threatening conditions (Jenny & the Committee on Child Abuse and Neglect, 2007).

Mental health treatment services: refers to a system of care in which patients are referred in their community to a primary provider who specializes in caring for people with mental illnesses. The goal of community mental health treatment services often includes providing outpatient psychiatric treatment to people with mental health conditions (Olfson, Druss, & 2015). Often psychotherapy can be helpful when individuals are dealing with thoughts, behaviors, symptoms, stresses, goals, past

experiences that causes distress and hinder important areas of functioning (Sue, Sue, Sue, & Sue, 2015; Carkhuff, 2017). For this study the types of mental health treatment services foster parents will be asked if their foster child has attended will include: Cognitive behavior therapy (CBT), Dialetical behavioral therapy (DBT), Interpersonal Therapy (IPT), Mindfulness-based therapies, Psychodynamic therapy, Group therapy, Emotion-focused Therapy (EFT), Family therapy, Play therapy, Art therapy, Trauma-focused cognitive behavioral therapy (TF-CBT).

Neglect: the failure of a parent, or any other person with responsibility for the child, to provide needed food, clothing, a clean living environment, shelter, medical care, or supervision to the degree that the child's health, safety, and well-being are threatened with harm (Child welfare Gateway, 2016; Jones, & Logan Greene, 2016). Neglect also includes leaving a child alone for an extended period of time without proper resources and not providing a child with adequate basic needs as well as medical care (Hussey et al., 2005). Circumstances that are considered abuse or neglect in many states also include prenatal exposure of a child to harm due a parent's use of an illegal drug or other substances (Forkey & Szilagyi, 2014).

Permanency planning: defined in the statutory guidance that accompanies the Children Act 1989 as providing children with a sense of security, continuity, commitment, and identity with a stable and loving family that will support them through childhood and beyond (DCSF, 2010).

Physical abuse: intended use of physical force against another person, which causes or could cause harm (Barnett, Miller-Perrin, & Perrin, 2005). Physical abuse is

leaving a child in a small closet or other enclosed space as a form of punishment (Mash, 2010). Physical abuse involves violent acts towards people such as scratching, biting, pushing, shoving, slapping, kicking, choking, strangling, throwing things at someone, force feeding, denying food, and using weapons or objects that could harm someone (Kemp, et al., 2008). Physical abuse also includes reckless driving, physically restraining someone, such as holding a child in a closed restraining embrace, pinning a child against a wall, floor, or bed, or any other reckless acts that could cause harm (Odhayani, Watson, & Watson, 2013). Often when children are being physically abused, visual bruising maybe left on a child's body (Glick, Lorand, Kristen, & Bilka, 2016).

Posttraumatic stress disorder (PTSD): a mental health disorder that develops in some people after experiencing or witnessing a shocking, scary, or dangerous event (The National Institute of Mental Health, 2016). PTSD is defined as a mental health disorder that develops in some people after experiencing real life exposure or threat of real life exposure to a shocking, scary, dangerous or stressful events such as death, rape, serious injury, abuse, among other distressing situations impact an individual's ability to function (Peterson, Prout, & Schwarz, 2013). According to the DSM-5, posttraumatic stress disorder is classified as exposure to actual or threatened death, serious injury, or sexual violence. Symptoms include involuntary and intrusive distressing memories of a traumatic event, or persistent avoidance of stimuli associated with a traumatic event (American Psychological Association, 2013). The disturbance causes clinical distress such as marked alterations in arousal and reactivity associated with a traumatic event and

negative alterations in cognition and mood associated with a traumatic event (American Psychological Association, 2013)

Secure attachment: an emotional bond between children and caregivers. Securely attached children feel confident that the attachment figure will be available to meet their needs. They use the attachment figure as a safe base to explore the environment and seek the attachment figure in times of distress (Main, & Cassidy, 1988). According to Bowlby (1980), an individual who has experienced a secure attachment is likely to possess a representational model of attachment figures(s) as being available, responsive, and helpful (Ainsworth, Blehar, Waters, & Wall, 2015; Ainsworth, 1985; Belsky & Fearon, 2008).

*Sexual abuse***:** unwanted sexual activity, with perpetrators using force, making threats, fondling, penetration, and taking advantage of victims who do not consent to intimacy (American Psychological Association APA, 2008). In some states, the crime of human trafficking, including trafficking of children for sexual purposes, labor trafficking, involuntary servitude, or trafficking of minors, is included in the definition of child sexual abuse (Institute of Medicine and National Research Council, 2013). Sexual exploitation is also another element of sexual abuse in most jurisdictions (Reid, 2011). Sexual exploitation includes allowing the child to engage in prostitution or in the production of child pornography (Finklea, Fernandes-Alcantara, & Siskin, 2011).

Strange Situation: Ainsworth's observational study of the parent-child bond and interactional relationships during early childhood. Ainsworth identified three main attachment styles, secure (type B), insecure-avoidant (type A), and insecure

ambivalent/resistant (type C) (Bowlby & Ainsworth, 2013; Levy, Ellison, Scott, & Bernecker, 2011).

Trauma: when individuals are exposed to events or situations that overwhelm their ability to cope, and interfere with daily life and their ability to function and interact with others (Figley, & Kiser, 2013; Margolin & Vickerman, 2011; Carver, & Connor-Smith, 2010).

Assumptions

These assumptions are necessary because collecting information was not be possible without the use of the following data. This proposed study was based on the following assumptions.

1. The Trauma Symptoms Checklist for Young Children (TSCYC) parent-report assessment constituted a valid method for collecting data about post-traumatic stress and related psychological symptomatology in children ages 3-12 years who have experienced traumatic events.

2. The mental health service demographic questionnaire constituted a valid method for collecting data about children's previous mental health services.

3. This researcher assumed all foster parents will give honest responses on the Trauma Symptoms Checklist for Young Children (TSCYC) assessment as well as the mental health service demographic questionnaire.

4. A cutoff between 3-12 years of age was be used. Children younger than three years of age will be excluded from the study. In addition, children older than thirteen years of age were excluded from the study.

5. All data for this study was collected from participating foster parents by posting flyers in local community shops near foster care facilities in the Bronx area where foster parents normally congregate and have play dates with their foster children.

6. This researcher assumed that using this data will permit generalizations to children's placement stability in children in foster care, but such generalizations were made with caution.

7. Data assumed to be correct about children's PTSD symptoms were obtained only from the report of foster parents.

Limitations

Limitations center on natural problems which may arise when conducting any research design. The primary issues with non-experimental research are those of external validity and internal validity (Creswell, 2003; Siegmund, Siegmund, & Apel, 2015). Internal validity measures whether research is sound and refers to causal relationships or confounding variables that can jeopardize an experiment and give useless results based on biases (Shadish, Cook, & Campbell, 2002; Brewer, 2000; Campbell, & Stanley, J2015). External validity refers to the ability to generalize results from research findings to other situations and other populations (Aronson, Wilson, Akert, & Fehr, 2007; Creswell, & Creswell, 2017). The following limitations were recognized for this proposed study.

Issues of Internal Validity

The limitations of this study were shared with other research studies that utilize assessments and questionnaires. In this study, the TSCYC reflected the perspectives of a

single informant, the foster parent, who knows the child within a particular context. On the mental health treatment service demographic questionnaire foster parents were asked how long their foster child has been placed in their care, and how long they have known the child. Foster parents were excluded from the study if they had not known the child for more than three to four months. Foster parents were also excluded from the study if their child had not been placed in their care for at least three to four months.

Any differences in reported PTS symptoms on the TSCYC were dependent on the perception of the foster parents rather than directly from the child. A questionnaire approach lacked the specificity and additional depth that more formally structured diagnostic interviews provide; however for this study a mental health treatment service demographic questionnaire was developed by this researcher to gather information related to mental health services, and to see if there were any significant interactions between kinship and nonkinship placement settings and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster parents. The ethnicities of most of the children and foster parents who participated in this research study were predominately Black and Hispanic; however no qualifying participants were excluded from the study in regards to their ethnicity. Similar to most other research studies involving this population, the study design did not control for many experiences of children in foster care in the United States in comparison to children from other countries abroad.

In this study, it was imperative to take caution in the interpretations of results. This study was only limited to children in foster care between ages 3-12, and skewed

towards children who report high rates of PTS symptoms as well as mental health services. As it pertains to the scope of the research, this study did not assess the value of children placed in kinship and nonkinship foster homes, and placement itself was likely to uniquely impact children's cognitive and emotional outcomes. Given that this study was designed as a non-experimental design without any randomized controls, there was a possibility that unknown confounders will bias the results. For this study, it was not known whether there was a particular reason why some children were placed within nonkinship foster care homes versus in kinship foster care homes, but it was assumed that children placed in foster homes were provided with safe environments.

Children's emotional needs were important factors in this study. Often, researchers are hesitant to ask children directly about their own exposure; however researchers suggest that generally children are not negatively impacted by being asked about traumatic events on a questionnaire (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Yule, W., & Williams, 1990; Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). Although, the limitations were many, so were the difficulties associated with emotional and mental stability of children placed in foster care. This may explain why there are so few useful research studies pertaining to children's foster home placement stability and rates of PTSD. For this study, concerns about social stability, behavioral stability, and placement disruption were not assessed, as they were not the focus of the study. Hence, further research may need to be conducted with a focus on these areas.

Issues of External Validity

1. Data for this proposed study consisted of a convenience sample obtained from foster parents. There were no randomization, which may have limited the inferences that had been made from the study and, therefore, there were no generalizability of the results to other groups.

2. All data for this study was collected from participating foster parents by posting flyers in local community shops near foster care facilities in the Bronx area where foster parents normally congregate and have play dates with their foster children. Thus, the majority of the children in this research study presumably resided in the East Coast of the United States. Therefore, location limited the generalizability of the results to foster children who reside in other areas.

3. This proposed study relied on data gathered from one sets of respondents; the foster parent of the foster child(ren). Having multiple respondents may have had different views of the child's functioning, and data about children's functioning gathered from multiple sources may have produced different results.

4. For this proposed study, interested foster parents were asked to follow an electronic link to the TSCYC and mental health treatment service demographic questionnaire and asked a series of questions about their child's PTSD symptoms and previous mental health services within the past three to four months by way of survey. Given that the surveys were completed electronically, generalizability were limited to those foster parents who had access to a computer or mobile device.

Significance

Children in foster care represent a highly traumatized population. However, trauma research on this population has focused primarily on maltreatment rather than the full spectrum of PTSD symptoms for children living in nonkinship foster homes versus kinship foster homes (Salazar et al., 2013). The current study aimed to fill this gap by studying the effect of foster care placement type (kinship and nonkinship) foster care placements and previously reported mental health service treatment on reported PTSD symptoms in foster care children within three to four months. This research study was geared to provide scholars and researchers seeking information on children in foster care with numerical data on PTSD rates among children placed in both kinship foster care homes and nonkinship foster care homes, as well as provide insight on what types of mental health treatment services may be beneficial for children in foster care with PTSD. The benefits of this study were geared also to provide foster care agencies with an understanding of how different types of foster home placements and mental health services may affect children's rates of PTSD.

Summary

There are thousands of children placed in the United States foster care system each year. It is reported that many children in foster care endure all forms of abuse and neglect, but it is also reported that this population suffers from significantly higher rates of PTSD than children in the general population. Although, there are some limitations with the proposed study, the study generally aimed to shed light on the effect of foster care placement type in kinship and nonkinship foster care placements and previously

reported mental health service treatment on reported PTSD symptoms in foster care children. There were a few assumptions which were necessary to conduct this study; however, through data collection and honest respondent answers, this study will be able to guide welfare procedure and policy.

In Chapter 2, this researcher reviewed the relevant research and provided an in-depth discussion of Bowlby's and Ainsworth's attachment theory which was the theoretical basis for the study, as it relates to emotional, social, and behavioral problems (Ainsworth, Blehar, Waters, & Wall, 2015; Bowlby & Ainsworth, 2013). The literature on kinship and nonkinship foster home placements on children's mental health was also reviewed.

Chapter 3 presents the research methods proposed in this study, including research design and approach, setting and sample, instrumentation and materials, data collection and analysis procedures, and measures taken to protect the participants' rights.

Chapter 2: Literature Review

Introduction

PTSD is a disorder that not only affects adult's mental health but has an impact on children's psychological and behavioral health (American Psychological Association, 2008; Nurius, Green, Logan-Greene, & Borja, 2015). PTSD is defined as a mental health disorder that develops in some people after experiencing real-life exposure or threat of real-life exposure to shocking, scary, dangerous, or stressful events such as death, rape, serious injury, and abuse, among other distressing situations, and impacts an individual's ability to function (Peterson et al., 2013; Price & van Stolk-Cooke, 2015). Many children in foster care are affected by symptoms of PTSD due to exposure and endured cases of traumatic experiences. Recent reports support that children in foster care with cognitive, emotional, and behavioral challenges are more emotionally stable with familiar kin relatives versus regular nonkinship foster homes (Bell, & Romano, 2017; Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). Researchers have also documented that kinship foster care placements are a better alternative than nonkinship foster care when children need to be removed from their homes (Fusco & Cahalane, 2002; Lin, 2014). Family-based emotional support through kin-related foster placements shows promising outcomes for children facing challenges with PTSD in foster care despite the benefits of nonkinship foster care placement.

The purpose of this research study was to explore whether children, ages 3-12, in kinship foster homes significantly differ in their reported symptoms of PTSD from children placed in nonkinship foster homes. The study may provide data that help foster

care agency staff with making informed decisions about children's placement type and stability based on children's PTSD diagnosis. The following chapter focuses on literature research, theoretical framework, history and statistics of out of home care, benefits as well as limitations of kinship and nonkinship care, and the effects trauma and PTSD has on children in foster care.

Literature Search Strategy

I primarily conducted the literature search for this study using Walden University's online library resources, focusing on peer-reviewed journals accessed through databases such as Academic Search Premier, Applied Social Science Index and Abstracts, Sociological Abstracts, FirstSearch, Electronic Collections Online, Academic Search Complete, PsycINFO, PsycARTICLES, PsycTESTS, SocINDEX with Full Text, SAGE Journals, Education Source, ERIC, Mental Measurements Yearbook with Tests in Print, and eBook Collection (EBSCOhost). I reviewed all available literature from these databases. Key search terms included *kinship care*, *nonkinship care*, *foster care*, *child abuse*, *posttraumatic stress disorder*, *trauma*, *mental health*, *foster parents*, *truama symptom checklist for young children, TSCYC, PTSD.*

Theoretical Framework

Foster care placement can have serious implications on the emotional and cognitive development of young children (Font, 2014; Pears & Fisher, 2005). The first few years are crucial for early childhood, during which time children develop rapidly. For this reason, out-of-home placement is typically associated with numerous disruptions in attachment relationships (Newton, Litrownik, & Landsverk, 2000; Pasalich, Fleming,

Oxford, Zheng, & Spieker, 2016). Losses and lack of permanence can potentially undermine a child's attempt to form a secure attachment with a primary caregiver (Forsyth, 2017; Ponciano, 2010). The more changes a caregiver's young children in foster care experience, the more likely they are to exhibit oppositional, anxious, depressive, or clinging behavior (Simmel, 2007; Wilkinson, 2016).

The British psychiatrist John Bowlby pioneered attachment theory in the 1940s and used the term *attachment* to describe a warm, intimate, and continuous relationship with a mother (Bowlby & Ainsworth, 2013; Bretherton, 1992). Bowlby described the attachment system as a way to help children seek comfort from their caregiver and develop a sense of security (as cited in Goldberg, Muir, & Kerr, 2013). Bowlby's ethological approach to understanding children's bond to the mother, along with elaborations based on more recent research, suggest that the biological bases of attachment are the evolutionary roots of attachment behavior (Ainsworth, Blehar, Waters & Wall, 2015; Cassidy, 2008). The nature of the child's attachment bond to his or her attachment figures describes how attachments will differ in children when it comes to fostering bonds (Ainsworth et al, 2015). Although Bowlby' s idea that attachment is a lifespan phenomenon was present in his earliest writings, his principal focus was on the tie to the mother during childhood (Bowlby, 1956; Cassidy, 2008).

Mary Ainsworth is best known for her elaborative work on John Bowlby' s attachment theory. Ainsworth, who collaborated with Bowlby on *Child Care and the Birth of Love* (1965), developed a procedure for observing and assessing the quality of attachment in relationships between a caregiver and child (Bowlby & Ainsworth, 2013).

Ainsworth called this procedure the *Strange Situation*, in which she observed parent-child interactional relationships in a controlled setting in order to explore how attachments might vary between children and their caregiver (Chae et al., 2018; Rosmalen, Veer, & Horst, 2015). In 1970, Ainsworth identified three main attachment styles: insecure-avoidant (Type A), secure (Type B), and insecure ambivalent/resistant (Type C). She concluded that these attachment styles were the result of early interactions with a child's birth mother (as cited in Johnson & Anderson, 2016).

Ainsworth first attachment style described Secure attachment as an emotional bond between children and caregivers (Ainsworth, Blehar, Waters, & Wall, 2015; Ainsworth, 1985). Ainsworth reported that children with secure attachments showed minimal distress when their mothers left them alone and sought comfort when their mothers returned (Ainsworth et al., 2015). Additionally, she concluded that caregivers of children with secure attachments responded appropriately and consistently to their children's needs and the children appeared to trust their caregivers (as cited Cassidy & Shaver, 2002). When children feel confident that the attachment figure will be available to meet their needs, they will use the attachment figure as a safe base to explore the environment and seek the attachment figure in times of distress (Bowlby, 2005). A child who has experienced a secure attachment is likely to possess a representational model of attachment figures as being available, responsive, and helpful (Bowlby, 2008; Mesman, Van IJzendoorn, & Sagi-Schwartz, 2016). In contrast, insecure anxious-avoidant children are described as being withdrawn and unable to resonate with their attachment figure (Powell, Cooper, Hoffman, & Marvin, 2013). They are very independent of the

attachment figure both physically and emotionally (Slotter, & Luchies, 2014; Unger, & De Luca, 2014). They do not seek contact with the attachment figure when distressed and are likely to have a caregiver who is insensitive and rejecting of their needs (Ainsworth, 1979; Gross, Stern, Brett, & Cassidy, 2017). The attachment figure may withdraw from helping during difficult tasks and is often unavailable during times of emotional distress (Fujimori, Hayashi, Fujiwara, & Matsusaka, 2017; Stevenson-Hinde & Verschueren, 2002). Individuals with an anxious attachment style fear rejection and abandonment, yet they yearn for closeness and may inadvertently drive others away (Howe, 2005; Tondar, Campos, Shakiba, Dadkhah, & Blatt, 2017).

The second attachment style which is Avoidant attachment is characterized by feeling uncomfortable with closeness in relationships and a desire to maintain emotional distance (Edelstein & Shaver, 2004; Stanton, Campbell, & Pink, 2017). A person who has an insecure anxious-avoidant attachment would find it difficult to trust or depend on others (Collins & Feeney, 2004). Children with avoidant attachment will conceal their feelings, shutting everyone out, and pull away from people both physically and emotionally (Kagan, 2014). Children in foster care with insecure anxious-avoidant attached to their caregivers typically display more fearful, angry, confused, and upsetting behaviors than securely attached children (Gauthier, Fortin, & Jéliu, 2004; Overall, Simpson, & Struthers, 2013).

The third attachment style identified by Ainsworth was Insecure Ambivalent/Resistant attachment where children adopt an ambivalent behavioral style towards the attachment figure (Shilkret & Shilkret, 2008; Atwool, 2006; Tereno et al.,

2017). The child will commonly exhibit clingy and dependent behavior, but will be rejecting of the attachment figure when they attempt to engage in interactions (Waters, Crowell, Elliott, Corcoran, & Treboux, 2002; Alder, Yorgason, Sandberg, & Davis, 2017). The child fails to develop any feelings of security from the attachment figure (Meins, 2013). When distressed they are difficult to soothe and are not comforted by interaction with the attachment figure (Johnson, 2003; Van Wert, Mishna, & Malti, 2016). This behavior results from an inconsistent level of response to a child's needs from the primary caregiver and by the child's feelings of anxiety and preoccupation about the caregiver's availability (Guttmann-Steinmetz & Crowell, 2006; Kerns, & Brumariu, 2014). Children in foster care with an insecure ambivalent/resistant pattern of attachment will typically explore little in the Strange Situation and is often wary of strangers, even when the caregiver is present (Watson, 2005; Sirois, Millings, & Hirsch, 2016). When the parental figure departs, the child is often highly distressed (Johnson, 2003; Verhage, et al., 2016). The child will generally become ambivalent when their caregiver returns, but the anxious-ambivalent strategy is a response to unpredictable responsiveness from their caregiver (Shilkret & Shilkret, 2008; Kennedy & Kennedy, 2004; Brumariu, 2015). In turn, children will display anger (ambivalent-resistant) or helplessness (ambivalent-passiveness) towards the caregiver on reunion and will regard this strategy as a conditional way for maintaining the availability of the caregiver by preemptively taking control of the interaction (Atwool, 2006; Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010). When children do not develop secure attachments they are at risk for subsequent emotional and interpersonal difficulties (Abela, et al., 2005; Zeanah, & Gleason, 2015).

Ainsworth's Strange Situation suggested the caregiver sensitivity hypothesis is an explanation for different attachment types (Dunst & Kassow, 2008). Research suggested a child's attachment style is dependent on the behavior their mother or caregiver shows towards them, and as a result, sensitive foster parents are more likely to have securely attached foster children (Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010; Mennen & O'Keefe, 2005). In contrast, foster parents who are less sensitive towards their child, for example those who respond to the child's needs inappropriately or who are impatient or dismisses a child, are likely to have insecurely attached foster children (Mercer, 2006; Cassibba, Castoro, Costantino, Sette, & Van Ijzendoorn, 2015). The theoretical basis for most of the attachment research is that secure attachment in children will predict good social and emotional outcomes (Sroufe, 2005, Bowlby, 2008; Waldfogel, 2006; Groh, Fearon, IJzendoorn, Bakermans, Kranenburg, & Roisman, 2017). Attachments are best thought of as mutually reinforcing patterns of behavior between a caregiver and a child (Ainsworth, 1964; Ainsworth, Blehar, Waters, & Wall, 2015). Although, children play an active role in developing and maintaining an attachment relationship with caregivers, what motivates a caregiver to respond to a child is important to attachment. Having a foster parent who provides consistent and responsive care helps children to learn and recognize the nature of their own actions, and to regulate their own behavior and emotional states (Stirling & Amaya-Jackson, 2008; Kinniburgh, Blaustein, Spinazzola, & Van der Kolk, 2017).

A child's confidence that a caregiver will be protective also enables the child to explore the world and learn new skills, while using the caregiver as a secure base for

exploration, play or other social behaviors (Becker, Weidman, & Hughes, 2008; Thompson, 2006; Ainsworth, Blehar, Waters, & Wall, 2015; Ainsworth, & Bell, 1970). A child who feels that they are protected by reliable adults is freed from the fear, posttraumatic stress, depression, and anxiety that accompany a sense of being alone or abandoned (Orlans, & Levy, 2014; Cook, et al., 2005; Lee, & Hankin, 2009). The more secure a child feels the more energy and enthusiasm they will have to be curious, to learn, to seek out understanding, be inquisitive, and explorative about the world around them. When a caregiver is sensitive to a child's emotional needs and responds positively, this helps the child to develop a sense of love and being loved (Brazelton, & Greenspan, 2009; Mesman et al., 2016). This is how children learn that they will be able to rely on others for help in times of trouble later in life.

Review of Literature Related to Key Variables and/or Concepts

Foster Parents' Impact on Attachment

Children's attachments may be displayed differently in foster care with other caregivers, depending on the kinds of experiences that they have with those caregivers. When children enter foster care it is expected that caregivers will be nurturing, sensitive, and committed to children placed in their homes (Schofield & Beek, 2005; Hoffman, Cooper, & Powell, 2017). This shift in attachment can be disruptive for some children especially when they are placed in nonkinship homes with unfamiliar people (Jonkman, Oosterman, Schuengel, Bolle, Boer, & Lindauer, 2014).Through experiences with caregivers, children will develop expectations about the dependability of attachment figures to provide comfort, support, nurturance, and protection in times of need (Zeanah,

Shauffer, & Dozier, 2011). These expectations affect how children react and behave in relationships and are related to subsequent psychological and social adaptation both in childhood and adulthood (Sroufe, 2005; Parkes, Stevenson-Hinde, & Marris, 2006). For children in foster care, who are at risk for unhealthy attachments, special efforts may be necessary to facilitate more securely attached relationships with kinship foster parents (Coakley, Cuddeback, Buehler, & Cox, 2007; Winokur, Holtan, & Valentine, 2009; Hegar, & Rosenthal, 2009; Quiroga, & Hamilton-Giachritsis, 2016).

Although there are no easy solutions, it is important that we address the mental health needs of young children in foster care. Children's need for continuity of relationships and their need for sensitive responsive care should be considered foremost in foster care home placement decisions (Rubin, O'Reilly, Luan, & Localio, 2007; Leathers, 2005; Linares, Li, Shrout, Brody, & Pettit, 2007; Barth et al., 2017). When it is necessary for the child to experience an attachment disruption from their primary caregiver, protective service agencies should minimize the possibility of the child experiencing insensitive non-responsive care with an alternative caregiver (Leathers, 2006; McLaughlin, Zeanah, Fox, & Nelson, 2012). These efforts could be made by making all attempts to secure the safest and closest environment that is familiar to the child to minimize children's mere trauma of being displaced from their birth parents (Farmer, 2009; Taussig & Clyman, 2011). Children are better able to cope with traumatic experiences when their foster care placement involves a safe and protected home with someone they know and trust (Barth, Lloyd, Green, James, Leslie & Landsverk, 2007; Messing, 2006; Riebschleger, Day, & Damashek, 2015). Attachment and relationship

bonds established between children and foster parents predict children's later performance in their social lives, partnerships, and relationships with others (Denham, 2007; Negriff, James, & Trickett, 2015). Therefore, it is important to understand the quality of kinship and nonkinship care to see how these types of foster care home placements influence children's symptoms of PTSD.

History of Child Welfare and the Foster Care System

The history of child protection in America is separated by three eras of change and implementation (Myers, 2008). The first era dates back from 1875 colonial times and may be referred to as the era before organized child protection. The second era spans from 1875 to 1962, which was the creation and growth of organized child protection through non-governmental child protection societies. The year 1962 marked the beginning of the third modern era where child welfare non-governmental child protection societies became government-sponsored child protective services (Pimpare, 2008). Before 1875, many children went without child protected services (Myers, 2008). However, there has never been a period of time where children were completely without support services and lawful prosecution has been used to punish individuals who blatantly maltreat or abuse children. For example, in 1735, an orphan girl in Georgia was rescued from a home where she was sexually abused (Buckingham, 1948). In 1809, a New York City merchant was convicted by the courts of brutally assaulting his slave and her three- year-old daughter (Southwich, 1809). Another case was reported in 1810, where a woman was put on trial in Schenectady, New York for murdering her newborn

child (Schermerhorn, 1810). However, in this case, the woman was not convicted due to reported mental insanity.

In 1642, Magistrates in Massachusetts had the authority to remove children from parents who did not rear their children properly (Mullin, 2017). In 1866, Massachusetts was one of the first states to pass a law authorizing judges to intervene in the family affairs when it came to children being maltreated or neglected (Myers, 2006). In the 1800's maltreatment of children was considered abandonment of a child and leaving a child orphaned (Gilbert, Kemp, Thoburn, Sidebotham, Radford, Glaser, & MacMillan, 2009). Neglect by a parent included criminal behavior, drunkenness, or other vices of parents that leaves a child to grow up without education or salutary control, and in circumstances exposing the child to an idle, abusive, and dissolute life (Myers, 2008). Whether or not a law was put in place, judges had authority to stop child abuse way before the establishment of child welfare protective services (Daro & Donnelly, 2002).

Organized child protective services were not established until the end of the nineteenth century (Gordon, 2011). In the nineteenth century, child protection agencies were non-governmental. In the late 1800's, Henry Bergh, who was the influential founder and animal protection advocate of the American Society for the Prevention of Cruelty to Animals, teamed up with his lawyer, Elbridge Gerry, to formalize a legal system to rescue children who were being abused or maltreated by their parents or guardians (Shelman & Lazoritz, 2005; Davis, 2016). In the 1870's, Bergh and Gerry decided to come up with their own non-governmental charitable society entirely devoted to the welfare and protection of children, and created the New York Society for the Prevention

of Cruelty to Children (NYSPCC) (Pleck, 2004; Malousek, Colburn Malousek, & Brown, 2016). The NYSPCC was the world's first founded institution devoted entirely to child protection (LeBowa & Cherney, 2015). The news of NYSPCC spread nationwide by the early1920's, and more than 250 non-governmental child protection organizations were created across America (Myers, 2008).

In the mid-20th century, Societies for Prevention of Cruelty to Children (SPCCs) nationwide shifted from non-government to government-sponsored agency protective services (Herrick & Stuart, 2005; Buffaloe, 2017). In the 1970s, the federal government played a central role in efforts to protect children from abuse and neglect (Ellett & Leighninger, 2006; Shireman, 2015). The federal Children's Bureau, which was established in 1912, followed by the Sheppard-Towner Act, provided federal monies to non-government entities and charitable SPCCs for health services for mothers and their babies (Brown, 2011). In this time, SPCCs were extremely supportive of giving money and providing support services to parents and children in need (Lindenmeyer, 2011). When the Great Depression hit the American economy in the 1930's, that stimulated a change in the federal government's role in social welfare contributions (Marx, 2011). When Congress passed the Social Security Act under President Roosevelt's leadership in 1935as part of the elected proposal to save the nation from economic ruin, this Act provided millions of dollars to states to support impoverished families (Stoltzfus, 2017). Within the Social Security Act was a provision that authorized the Children's Bureau to cooperate with state public-welfare agencies in establishing child welfare services for the protection and care of homeless and neglected children (McGill, 2008). The effects of

The Great Depression in the 1930s and the crash of the economy were the downfall of non-governmental SPCCs (Marx, 2011). Many charitable SPCCs withered away due to lack of government contributions, and only the strongest SPCCs with strong financial support contributors from public sponsors remained open (Brooks-Gunn, Schneider & Waldfogel, 2013)**.** In the early 1900s, many SPCCs merged with other organizations or closed their doors permanently (Ghafoerkhan, 2016). During the period of The Great Depression, 32 states went without child protection services (Fishback, Horrace, & Kantor, 2001; Barth et al., 2017).

Researchers of child abuse also play a role in the history of the child welfare system. Before, there was little research or scholarly articles about child abuse. In 1962, Henry Kempe and his colleagues published a leading article "The Battered Child Syndrome" which brought public, as well as, professional awareness to child abuse (Kempe, 2013). After the publishing of "The Battered child Syndrome" a series of professional articles started to spread across the nation (Krugman & Korbin, 2013; Macmillan et al., 2009; Finkelhor & Jones, 200; Pienheiro, 2006; Donnelly, 2002).

The Battered Child Syndrome, along with other expert articles, streamed headlines from the media, sparking an explosion of child neglect and abuse incidents that shocked the nation (Palusci, 2017). Thus, the nation took interest, and the child protection system started to shift from non-government charitable SPCCs, which were primarily private and religiously funded, to government-sponsored child protective services. The 1962 Social Security Act marked a turning point in the child welfare system. This Act mandated that by 1975, all states had to have child welfare and protective services

(Votruba-Drzal & Dearing, 2017). Before the 1970s, the federal government assumed little involvement in protection of children or child related welfare matters. The Child Abuse Prevention and Treatment Act of 1974 (CAPTA), was the first congressional legislation towards protecting children from physical abuse, sexual abuse, maltreatment, and neglect (Votruba-Drzal & Dearing, 2017). The CAPTA legislation played a leading role in shaping the nation to government-involved child protective services, which are still in effect to this day (Child Welfare Information Gateway, 2011). Although the Act has been amended several times, most recently amended and reauthorized in 2010 by the CAPTA Reauthorization Act, the CAPTAs mission continues to advocate, provide funds, explore, report, research, and demonstrate responsibility for the welfare of abused and neglected children (CAPTA Reauthorization Act of 2010). The CAPTA legislation holds all states responsible for children who are allegedly abused or neglected by their parents, guardians, or caregivers, and it is expected that these states safely remove and place children in protective care of a certified foster home, adoptive home, or institution (Golomb, Sears, Drozd, Kotori, Vera-Hughes, 2017).

History of Out-Of-Home Care

With the establishment of the Children's bureau, and new legislative laws protecting children from harm, many orphaned, neglected, and abused children needed safe placement homes until they were able to return to their parents (Joyce, 2016). In 1853, a philanthropist and social work pioneer named Charles Loring Brace founded the New York Children's Aid Society, which was one of the largest organized government social welfare programs in New York City that survived The Great Depression

(O'Connor, 2001). The Children's Aid Society was a city-based child-welfare institution that provided a variety of programs for impoverished city children (Davis, 2017). Brace was the first person to establish the "Emigration Scheme," which is widely known today as the orphan trains (The Annals of Iowa, 2005). Brace's emigration program was intended to permanently transport abandoned, homeless, and orphaned children from the hustle and bustle of New York City and Eastern cities to small towns in rural homes and farms in the Midwestern and Western states (Butler, 2014).

The mission of Brace's emigration scheme was to ensure homeless, orphaned, abandoned and even voluntarily placed children with better way of living if they were unable to live with their parents (Dummer, 2006; Thompson, 2016). Brace was a former minister and evangelist whose philosophies of child rescue emphasized nurture over nature (Brace, 1929). Brace believed that the Emigration program was a way to rescue and Americanize innocent children from deprived parents and urban surroundings (Chiodo & Meliza, 2014). He believed putting orphaned, homeless, and abandoned children on the orphan train was a way to instill proper work ethics, morals, and values so that children will later become upstanding citizens (Hansan, 2011). According to Brace's philosophy, children must be carefully nurtured in childhood to create healthy adults (Brace 1929). This care, he came to believe, could only be found in family settings. He believed that the idea of fostering a child's care and upbringing was a great way to prevent children from becoming homeless, young thieves, drunkards, and imprisoned criminals (Myers, 2008). In the early 1900s, more than 250,000 children were transported to rural areas to reduce poverty and crime in New York City (Myers, 2008). Some

children were even transported as far as Canada and Mexico (Wendinger, 2009; Davidson, & Howard, 2015). During its seventy-five year history, the program was widely copied by other child welfare organizations and is still viewed as a significant predecessor to the modern foster care system (Myers, 2008).

Brace's ambitious and controversial orphan train project and the relocation of a massive child population was a figurative move toward adoption (Riis, 2001; Frost, 2017). In spite of the trains' stated intention, they did not permanently separate most children, geographically or culturally, from their parents and communities of origin (Kidder, 2004; Dreby, 2015). Well into the twentieth century, impoverished but resourceful parents took advantage of the orphan train services, which included temporary caretaking during periods of economic crisis and apprenticeships that helped children enter the labor market (Wendinger, 2009; Chiodo, J. J., & Meliza, 2014). Reformers like Brace were determined to rescue the civic potential of poor immigrant children by placing them with culturally upstanding families, while simultaneously reducing crime and supplying rural farmers with child laborers (O'Connor, 2001; Cain, 2017; Lynch, 2014). In all efforts to permanently place children in wealthy homes, poor parents had no intention of losing track of their children. The Children's Aid Society records indicated that the largest number of orphan trains that transported children to rural homes and farms in the Midwest and Western states were only temporary (Acierno & Alegria, 2009; Birk, 2015). Brace's emigration scheme became the largest and most influential out-of-home placement program in the United States (Brown, 2011).

In the 19th century, there were no government-sponsored child protection agencies (American Psychological Association, 2008; Preston, & Haines, 2014). After the decline of rural life in the western states, and allegations that the orphan train was a way to dump juveniles on rural towns, the United States government began increasingly formalizing child welfare programs (Goldsmith, 2013). The last orphan train arrived in Texas in 1929, which marked the end of the emigration program (Myers, 2008). By the 1930's, reformed child welfare organizations, such as the Children's Aid Society, started to provide government-sponsored foster care to children who were in need of out-of-home-care (Batista & Johnson, 2016). Today there are over one hundred government-sponsored foster care agencies throughout the United States (Child Welfare Information Gateway, 2017).

Foster Care

Foster care is a temporary out-of-home service provided by states for children who cannot live safely with their families (Mullin & Morrison 2006; Barnow, Buck, O'brien, Pecora, Ellis, & Steiner, 2015). Foster care is a societal intervention system in which a child has been placed into a state's care in an institutional ward, group home, or private home of a state-certified caregiver, referred to as a foster parent (Zeanah, Shauffer, & Dozier, 2012). A foster parent provides children with safe and stable homes until they can be reunified with their parents or adopted, if there is no plan for them to return home to their parents (Harden, 2004; Euser, Alink, Tharner, Van IJzendoorn, & Bakermans-Kranenburg, 2014). The placement of the child is normally arranged through family court, government, or a child protection social service agency. The foster care

protective services system, which comprises the family court and other social services agencies, stands in the place of a parent taking overall responsibility for children in care and making all legal decisions, while the foster parent is responsible for a child's day-to-day care (Allen & Bissell, 2004; Benbenishty, et al., 2015).

Children placed in foster care, which is also known as out-of-home care have two primary foster home placement settings, which include living with relatives in a kinship foster home placement or living with unrelated state certified foster parents in a nonkinship foster home placement (Child Welfare Information Gateway, 2017). Foster care can also refer to placement settings such as group homes, medical facilities, residential care facilities, emergency shelters, and supervised independent living facilities where a child is under the state in which they live (AFCARS, 2017). Foster care is a temporary living situation for children whose parents cannot, for a variety of reasons, take care of them and whose need for care has come to the attention of child welfare agencies (Merritt, 2008; Barbell, & Wright, 2018). The goal for a child in foster care is usually reunification with the birth parents and family, but may be changed to adoption if this is seen to be not in the child's best interest.

Reasons children are placed in foster care. Abuse, whether it is physical or sexual, is probably one of the primary reasons a child enters foster care (Barber & Delfabbro, 2003; Barth, 2017). There are many acts that constitute child maltreatment, such as sexual abuse, physical abuse, witnessing intimate partner violence, medical neglect, educational neglect, parent substance abuse, and abandonment (Herrenkohl, 2005; Van der Kolk, 2017). However, there are other reasons why children come into the

foster care, such as truancy, voluntary placement, or death of a parent or guardian (Ehrle & Geen, 2002; Hill, 2017).

Other reasons children are placed in foster care are due to parent's incarceration, school truancy, death of a parent, and voluntarily placement of a child into care (Arditti, 2005; Shaw, Bright & Sharpe, 2015). Death, although rare, can result in a child being placed in care (Wildeman & Emanuel, 2014). Sometimes a parent's health does not allow them to care for their children. When a parent dies or is incarcerated, all attempts will be made to keep children within the care of their families, but when this is not possible, and there are no family members available to step in, children may enter the foster system (Gleeson, Wesley, Ellis, Seryak, Talley & Robinson, 2009; Turney, & Wildeman, (2017).

We often think of the parent's shortcomings when a child enters foster care, but there are occasions when a child's choices lead them to be placed into the foster care system. Children's high risk behaviors, such as drug use, history of arrest, prostitution, gang affiliation, running away, and truancy can led to children being placed in care (Barth et al.; Cederna-Meko, Koch, & Wall, 2014). Truancy can lead to children being placed in foster care if parents do not ensure that their children are attending school regularly (Zetlin, Weinberg & Shea, 2010; Shubik & Kendall, 2007).

If a child breaks the law, runs away, has truancy concerns, a parent could petition a Persons in Need of Supervision (PINS) or children in need of supervision (CHINS) on their child, and family court will determine if a foster care setting would be best for the child (Baruch Bush, Hershman, Thaler, & Vitkovich, 2009; Consalvo, 2015; Anbalagan, E., & Soulier, M. (2017). Children that are adjudicated juvenile offenders by the court

system and have a series of scrapes with law sometimes find themselves within the child welfare system, especially if there are issues within the home and parents are unable to properly manage the child's behavior (Greenwood, 2008; Hunt, Peters, & Kremling, 2015). In many cases when children break the law, frequently runs away, or have truancy concerns will be referred to group homes or other institutional settings (Baker & Curtis, 2006 Shoemaker, 2017). When children engage in dangerous high-risk behaviors, parents sometimes find it difficult to manage these behaviors alone without help (Consalvo, 2015).

Another rare occurrence is voluntary placement of a child into foster care due to the child's behavior or a parent's health. Some parents can voluntarily and privately place their children into foster care if they are unwell; feeling overwhelmed, or believes that foster care is in the best interest of the child in order for them to thrive (Courtney & Hook, 2012). Rarely, parents may choose to place their children into foster care and relinquish their parental rights leaving their children eligible for adoption if they see it is in their best interest (Carlson, 2010).

Statistics on foster care home placements. In 2015, The Adoption and Foster Care Analysis and Reporting System estimated that over 427,000 children entered the foster care system. (AFCARS, 2017). These children in foster care ranged in age from infants to 21 years old. The AFCARS (2017) federal data from the U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, and Children's Bureau suggests that there are over 45% of children in non-relative foster homes versus 30% of children in relative kinship homes.

In 2015, over 670,000 children spent time in U.S foster care (Coggins, Opiola, & Carnes-Holt, 2017). On average, children remain in state care for nearly two years (Courtney & Heuring, 2005; Barnow, Buck, O'brien, Pecora, Ellis, & Steiner, 2015). Research suggest that twenty-eight percent of children ages 7-9 years old spent one to two years in foster care (Child Welfare Information Gateway, 2017). Despite the common perception that the majority of children in foster care are very young, the average age of children in care is 9-10 years of age (Child Welfare Information Gateway, 2017). In 2015, more than 62,000 children whose parent's rights were legally terminated were waiting to be adopted (LeVezu, 2017). Of the estimated 243,060 children who exited foster care during 2015, only 51 percent were reunited with parent(s) or primary caretaker(s) (Child Welfare Information Gateway, 2017). Twenty-two percent were adopted, nine percent were emancipated, nine percent went to live with a guardian, six percent went to live with another relative, and two percent lived in other placement settings (Child Welfare Information Gateway, 2017). From 2006 to 2015, there were decreases in the percentages of children who left the system to reunite with their parents, primary caregivers, or relatives, which means more children are being raised by nonkinship caregivers (Walker, 2015; Ryan, Perron, Moore, Victor, & Evangelist, 2016).

Differences Between Kinship Care and Nonkinship Care

A support resource parent, also known as a foster parent or kinship parent, are essential to children's healthy development; for foster parents instill basic cultural values and social norms, make sure children are healthy, safe, and equipped with the skills and resources to succeed as adults (Rodger, Cummings & Leschied, 2006; Rivera, &

Sullivan, 2015). Nonkinship and kinship foster parents that become resource parents to children in care who can no longer return to their parents due to termination of parental rights through court action should be able to offer their children love, acceptance, appreciation, encouragement, and guidance over a lifelong period (Vandivere, Chalk, & Moore, 2003; Pokempner, Mordecai, Rosado, & Subrahmanyam, 2015). They should be able to provide the most intimate context for the nurturing and protection of children as they develop their personalities, identities, and mature cognitively, emotionally, and socially (Morris, Silk, Steinberg, Myers & Robinson, 2007; Britto, et al., 2017; Lind, Raby, Caron, Roben, & Dozier, 2017).

Although nonkinship care is important to stability of children in need of out-of-home care, there is a prevalence of kinship care in the United States (Hegar & Rosenthal, 2009; Hong, Algood, Chiu, & Lee, 2011). Kinship foster care is defined by the U.S. Department of Health and Human Services (U.S. DHHS) as the full-time care, nurturing, and protection of a child by relatives, members of their Tribe or clan, godparents, stepparents, or other adults who have a relationship to a child (Child Welfare Information Gateway. 2013). A family friend could be considered a next of kin for a child in care if they have an extended relationship through the parents or guardians (Farmer, 2009). Relatives are the preferred resource for children who must be removed from their birth parents because it maintains the children's connections with their families (Hegar & Rosenthal, 2009; Farineau, Stevenson Wojciak, & McWey, 2013). Kinship care is often considered a type of family preservation service. According to Hegar and Scannapieco (2002), kinship care did not emerge as a child welfare issue until the late 1980s.

The U.S. Department of Health and Human Services (U.S. DHHS) defines nonkinship foster care as the full-time care, nurturing, and protection of a child by non-relatives (Child Welfare Information Gateway. 2013). Nonkinship foster caregivers have no prior relational ties to a child coming into foster care and they provide children with a temporary place to stay until the child can return home to their own family, move into a longer-term fostering placement, or adoptive care (Ehrle & Geen, 2002; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Andries, 2012). Often this can cause a child distress, especially if attachment is disrupted from a caregiver (Hong, Algood, Chiu, & Lee, 2011).

Researchers suggest that the placement of children with kin relatives has emotional benefits for which are attributed to relative care (Rubin, Downes, O'Reilly, Mekonnen, & Localio, 2008; Winokur, Holtan, & Batchelder, 2018).According to Timmer, et al., (2004), children placed with relatives or other kinship caregivers increase children's stability, safety, as well as the ability to maintain family connections and cultural traditions. Research suggest that kinship families that often have a history of support create a more sustainable and stable emotional tie with children, and thus can have improvements on the well-being of both children and families (Billing, Ehrle & Kortenkamp, 2002; León, Jiménez□Morago, & Muñoz□Silva, 2017; Font, 2015).

Benefits and limitations of kinship care. With relative or kinship care becoming the preferred placement for children in out-of-home care, it is important to understand the benefits and limitations of kinship care compared to the benefits and limitations of nonkinship foster care (Farmer, 2009; Blakely, Leon, Fuller, & 2017; Ponnert, 2017). The

differences between relative and non-relative foster care are too significant to ignore. While kinship foster care has the obvious benefit of keeping the children in a familiar environment; nonkinship caregivers may be unprepared to manage the challenges faced by children, particularly if children have special needs as a result of trauma (Cuddeback, 2004; Keagey, & Rall, 2007; McRoy, R.2016). Kinship caregivers often have difficulty balancing appropriate boundaries with the birth parents (Kiraly, & Humphreys, 2015). They are also more likely to be between 41 and 60 years of age (Attar-Schwartz, Tan, Buchanan, Griggs, & Flouri, 2009; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Andries, 2012).). Thus, kinship caregivers are often associated with a high level of strain when playing, caring, and rearing young children (Attar-Schwartz, Tan, Buchanan, Griggs, & Flouri, 2009; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Andries, 2012). Kinship caregivers also have significantly lower levels of education compared to licensed foster parents (O'Brien, 2012; Geen, 2004). Commonly, as a result of the often last minute notification before a placement, most kinship caregivers might lack the economic resources, training, and licensing that nonkinship foster parents are mandated to obtain before becoming a foster parent (Walsh, & Mattingly, 2014). Kinship foster parents have higher rates of living in improvised neighborhoods compared with other family arrangements (Dunifon, 2013).However, kinship care has been proven to reduce the trauma children experience from being placed with strangers, and can help to reinforce their identity and feelings of security (Forkey & Szilagyi, 2014; Blakely, Leon, Fuller, & Bai, 2017).

The benefits of kinship care are considerable and well known. In terms of well-being of children, it is important to help them build up personal and cultural identity. Children in kinship care are placed within a social class and culture familiar to them and have more contact with relatives who reinforce their self-identities, self-esteem, and the sense of belonging with shared family history, routine, and rituals (Holtan, Rønning, Handegård, & Sourander, 2005; Kiraly, & Humphreys, 2016). Also, children in kinship care experience fewer placement disruptions than nonkinship care children, they are able to remain in the community they are familiar with, and are exposed to less risk factors associate with unstable physical and mental environments (Holtan, Rønning, Handegård, & Sourander, 2005; Garcia, O'Reilly, Matone, Kim, Long, & Rubin, 2015). Also, they relatively have more contact with their biological parents than nonkinship care children (Dunifon & Kopko, 2011). Youngsters in kinship care tend to keep in closer contact with siblings (Dunifon & Kopko, 2011).

The philosophy behind kinship care is that children experience better outcomes when they are raised particularly by their own family, and whenever safe for the child that placement in out-of-home care should be temporary, yet does not disrupts a child's family attachment (Font, 2014). Given the importance of stability and the trauma that results from separation from one's parent, it is important to try to utilize kinship care when children cannot remain safely with their parents (Font, 2015; Fraser, et al., 2013). While no one is the perfect parent, there are certain parenting behaviors that can have serious negative effects on children. Children in foster care who have little to no parent or family support to help guide them through life's trials and tribulations are more likely to

be at risk for psychological disorders, low self-esteem, behavioral problems, and problems with the law (Szilagyi, Rosen, Rubin & Zlotnik, 2015). They may also experience poor social adjustment, violent behavior, and depression (Lohr, & Jones, 2016; Healey & Fisher, 2011).

Several laws, including the Indian Child Welfare Act of 1978, and the Adoption Assistance and Child Welfare Act of 1980 support kin as the preferred placement resource for children (Smith & Devore, 2004; Pecora, Whittaker, Maluccio, & Barth, 2012). Kinship offers several benefits, including a familiar caregiver to help reduce the trauma of separation by reinforcing a child's sense of identity and self esteem and offering greater stability in placement and reducing the stigma of foster care (Chipman, Wells, & Johnson, 2002; Walsh, 2015). Ainsworth and Maluccio (1998) noted that a greater use of kinship care should be utilized in foster care, and protection agencies should be more sensitive to family, racial, ethnic, and cultural factors as they are important to family continuity in children's development (Mason, Falloon, Gibbons, Spence, & Scott, 2002; McHugh, 2003; Thoburn, 2017).

Benefits and limitations of nonkinship care. In a perfect world, all children would be loved and nurtured and live in a cozy home with a stable family. Unfortunately, that's not always the case. According to The Adoption and Foster Care Analysis and Reporting System (AFCARS), in 2017, there was an estimate of over 427,910 children in the child welfare foster care system, with more than 200,000 moving in and out of foster homes in a given year (AFCARS, 2017).

One of the most meaningful advantages of nonkinship care is being able to provide children with a safe and stable home. It is so important to have children placed in nurturing foster families. Nonkinship foster parent's goal is to provide children with stability, as well as help with whatever the child may need in terms of medical or psychological treatment (Vostanis, 2010). Nonkinship care does not just benefit children; it can also have a profound impact on foster parents themselves. The most significant benefit to nonkinship foster parenting is making a difference in a child's life. Researchers have found and reported that nonkinship care provides less stability than kin care, a study by Terling□Watts (2001) revealed a substantially lower rate in disruption in nonkinship care (Berrick, 1998; Courtney & Needle, 1997; Lee, Choi, Lee, & Kramer, 2017; Bernedo, García-Martín, Salas, & Fuentes, 2016). It is also documented that children living in nonkinship foster homes were reunified at a much higher rate with their birth parents than children in kinship care, indicating that kin caregivers are less interested in adoption because they already consider the child to be family (Hilliard, 2006; Kang, 2003; Victor, Ryan, Moore, Mowbray, Evangelist, & Perron, 2016). Reunification occurs more frequently when a child is placed in nonkinship foster homes (Kang 2003; Lorkovich, Piccola, Groza, Brindo, & Marks 2004; Leloux-Opmeer, Kuiper, Swaab, & Scholte, 2017).

Mixed results have been found among studies focusing on placement stability in kinship versus nonkinship placements. Researchers found nonkinship caregivers to have less positive perceptions of the children in their care and were also less favorable to physical discipline when tested by the children in their care (Cuddeback, 2004; Gebel

1996; Denby, Testa, Alford, Cross, & Brinson, 2017). Nonkinship caregivers showed less sense of responsibility for their children and indicated significantly weaker feelings of responsibility to maintain the child's contact with their family of origin than kin caregivers (Buehler, Cox, & Cuddeback, 2003; Le Prohn 1994; Bernedo, García-Martín, A., Salas, & Fuentes, 2016). It is documented that nonkinship foster care parents fail to provide foster children with a sense of family support and children have less contact with both birth parents and siblings than children in kinship foster care (Ehrle & Geen, 2002; Boyle, 2017). Also, children placed in nonkinship foster homes were more likely to indicate that they were not satisfied with their placements versus children placed in kinship (Lorkovich, Piccola, Groza, Brindo, & Marks 2004; Vinnerljung, Sallnäs, & Berlin, 2017). The philosophy behind nonkinship care includes the onset of some of the psychological trauma a child experiences upon removal from a parent, decreasing the cultural continuity for a child, and continuing with familial continuity as nonkinship placements are less likely to accept sibling groups of large sizes into their home (Fechter-Leggett & O'Brien, 2010; Meakings, Sebba, & Luke, 2017). Evidence suggests that children who have more behaviorally and emotionally disturbances are more likely to be placed in nonkinship foster homes (Grogan-Kaylor, 2000; Swanke, Yampolskaya, Strozier, & Armstrong, 2016).

Childhood Trauma and PTSD

Children and teens could have PTSD if they have lived through an event that could have caused them or someone else to be traumatized (American Psychiatric Association, 2013). Such events include sexual or physical abuse or other violent crimes

such as witnessing someone being killed or badly hurt (Ehlers, Mayou, & Bryant, 2003; Chu, 2011). Disasters such as floods, school shootings, car crashes, or fires might also cause PTSD (Leaning, & Guha-Sapir, 2013; Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). Other events that can cause PTSD are a friend's suicide or seeing violence in the area they live (Copeland, Keeler, Angold, & Costello, 2007; Finkelhor et al., 2009; Lowe, Sampson, Gruebner, & Galea, 2016). Child protection services in the United States receives around three million reports each year of reported cases of abuse, in which ultimately children will suffer some form of trauma (Fang, Brown, Florence, & Mercy, 2012; Buckingham & Daniolos, 2013). Children and teens that go through the most severe traumas tend to have the highest levels of PTSD symptoms (McLaughlin, Koenen, Hill, Petukhova, Sampson, Zaslavsky, & Kessler, 2013). The more traumas a child goes through, the higher the risk of getting PTSD (Finkelhor, Ormrod, Turner, & Hamby, 2005). The impact of single-incident trauma, such as a car accident or being beaten up, is different from that of chronic trauma such as ongoing child abuse (Habib & Labruna, 2011; La Greca, Taylor, & Herge, 2012).

In addition to the symptoms of PTSD, trauma exposure can have widespread impacts on children's psychological functioning and development (Beers & De Bellis, 2002; Cook, Spinazzola, Ford, Lanktree, Blaustein, & Cloitre, 2005; Hildyard & Wolfe, 2002; Cohen, Mannarino, & Deblinger, 2016). Many children who suffer traumatic events can develop depression or anxiety symptoms along with PTSD (Gabowitz, Zucker, & Cook, 2008; Van Nierop, et al., 2015). Children with a history of having other mental disorders are more likely to develop PTSD following trauma exposure than

children who have never had a mental disorder. In a longitudinal birth cohort study of over 1000 individuals, 93.5 percent of individuals who met criteria for PTSD by early adulthood had met criteria for another mental disorder as a child or adolescent (Koenen, Moffitt, Caspi, Gregory, Harrington & Poulton, 2008). Another study showed a systematic in later adulthood (Debell, Fear, Head, Batt-Rawden, Greenberg, Wessely, & Goodwin, 2014). In particular, children and adolescents with a history of anxiety and mood disorders are more likely to develop PTSD following a traumatic event than youths without a prior mental disorder (McLaughlin, Koenen, Hill, Petukhova, Sampson, Zaslavsky, & Kessler, 2013; Storr, Ialongo, Anthony, & Breslau, 2007; Copeland, Keeler, Angold, & Costello, 2007). PTSD in children usually becomes a chronic disorder (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013). A child's risk for developing PTSD is often affected by the child's proximity and relationship to the trauma, the severity of the trauma, the duration of the traumatic event, the recurrence of the traumatic event, the resiliency of the child, the coping skills of the child, and the support resources available to the child from the family and community following the event(s) (Moore, 2013; Ritter & Lampkin, 2011; Everly & Firestone, 2013). It is reported that PTSD symptoms may be less severe for children who have more family support and if they help children cope and work through the trauma (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012).

Rates of PTSD are higher for certain types of trauma survivors (Cloitre, Stolbach, Herman, Kolk, Pynoos, Wang, & Petkova, 2009). About 4% of children under age 18 are exposed to some form of trauma in their lifetime that leads to post-traumatic stress disorder (Buckingham & Daniolos, 2013; Gradus, 2007). Girls are more likely than boys

to get PTSD (Panda, 2014; Alisic, Zalta, Wesel, Larsen, Hafstad, Hassanpour, & Smid, 2014). Some research shows that minority children have higher levels of PTSD symptoms (Hall-Clark et al., 2017; Weiss, Garvert, & Cloitre, 2015). Researchers show that about 15% to 43% of girls and 14% to 43% of boys go through at least one trauma, and of those children and teens who have had a trauma, 3% to 15% of girls and 1% to 6% of boys develop PTSD (Nadal, 2017; Holmes, Stokes, & Gathright, 2014; U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2012).

The impact of traumatic events on children is often more far reaching than trauma on adults, not simply because children have fewer emotional and intellectual resources to cope, but because children's development is adversely affected (Welsh, 2013; De Bellis, & A.B. 2014; American Academy of Pediatrics, 2016; Child Welfare Information Gateway, 2009). If an adult suffers trauma and deterioration in functioning, after time when the person heals, they can generally go back to their previous state of functioning, assuming that they have not done serious damage to their relationships, studies, and work (Koenen, Moffitt, Caspi, Gregory, Harrington, & Poulton, 2008; Kantor, Knefel, & Lueger-Schuster, 2017). A child will be knocked off of their developmental path and after healing from the trauma will be out of step with their peers and school demands (Kaplow & Widom, 2007; Lubit, Rovine, DeFreancisco, & Eth, 2003; Jackson, Cushing, Gabrielli, Fleming, O'Connor, & Huffhines, 2016). They may therefore suffer ongoing frustration and disappointments even when they have healed from the trauma (Cohen & Mannarino, 2015). Among influential family characteristics, children who do not live

with their both biological parents are at heightened risk for experiencing virtually all forms of trauma, most notably emotional distress (Turner, Finkelhor, & Ormrod, 2007; Riebschleger, Day, & Damashek, 2015). Practitioners and social service agencies therefore need to be aware of children's trauma's and those suffering from PTSD, and place them in appropriate foster homes that will help minimize post-traumatic stress reactions, especially for children in foster care.

Foster care and trauma. Most children in foster care have been exposed to some form of trauma (Moira et al., 2015). The very act of being put in foster care is traumatic for children, because it means the loss of their birth family, friends, schoolmates, teachers, and everything that is familiar. Child traumatic stress occurs when children and adolescents are exposed to events or situations that overwhelm their ability to cope and interfere with daily life and their ability to function and interact with others (Figley, & Kiser, 2013; Margolin & Vickerman, 2011; Carver, & Connor-Smith, 2010). The type of trauma experienced by children in foster care can vary widely from neglect to domestic violence to physical and sexual abuse (Oswald, Heil, & Goldbeck, 2009; Meinck, Cluver, Boyes, & Mhlongo, 2015). Removal from the home may be necessary for the child's safety and well-being, but it is also disruptive and compromises a child's developmental progress (Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009; Pelton, 2015). Many children will be bounced from one foster care placement to another, never knowing when their lives will be disrupted or displaced again (Humphrey, Turnbull & Turnbull, 2006; Chambers, Crutchfield, Willis, Cuza, Otero, & Carmichael, 2017). Foster care children are no different from children who are not in care. They are children who are learning,

growing, socializing, and need the love and stability that a permanent home provides (Rubin, O'Reilly, Luan, & Localio, 2007; Leon, Saucedo, & Jachymiak, 2016).

Trauma and the effect it has on children in foster care. Trauma can affect children's bodily reactions, behavior, and ways in which they think about relationships and attachment (Stirling & Amaya-Jackson, 2008; DeBellis, 2001; Ponciano, 2010, Briggs-Gowan, Carter, Clark, Augustyn, McCarthy, & Ford, 2010). Ongoing trauma often disrupts children's sense of security, safety, and sense of themselves and alters the way they see and respond to people and situations in their lives (Prior & Glaser, 2006; Cohen, Mannarino, Kliethermes, & Murray, 2012). Approximately one in four children in foster care will show signs of post-traumatic stress disorder such as fearing for their lives, believing that they would be injured, will witness or encounter violence, or tragic loss of a loved one (Child Welfare Information Gateway, 2014; Armour, 2007; Teicher, 2002; DePrince, 2001). They may also develop unhealthy behavioral habits and behaviors, including increased aggressive, distrusting behaviors or defiantly disobeying adults (Pecora, White, Jackson, & Wiggins, 2009; Bevilacqua, Carli, Sarchiapone, George, Goldman, Roy, & Enoch, 2012). These behaviors may have helped protect the children from neglect or abuse in the past and may be strongly rooted, however when children are placed in foster care, it will take time, patience, and often therapeutic support to help children overcome PTSD (Cohen, Mannarino, & Deblinger, 2012).

A recent and growing body of research into childhood trauma is shedding new light on the ways that maltreatment changes the structure and chemical activity of the brain and the resulting emotional and behavioral functioning of traumatized children

(Perry, 2009; Watts English, Fortson, Hooper, & De Bellis, 2006; Stien, & Kendall, 2014). Trauma exposure is associated with a range of negative outcomes; in terms of behavioral and emotional functioning that is often the focus of attention for youths in foster care (Copeland, Keeler, Angold & Costello, 2007; Burns, et al., 2004; Cohen, Mannarino & Deblinger, 2016). Emotional difficulties include increased rates of psychiatric disorders and symptoms including posttraumatic stress, anxiety, and depression (Salazar, Keller, & Courtney, 2011). In the area of behavioral difficulties, conduct problems and abuse-specific problems, for example, in the case of sexual abuse, sexualized behavior have been noted (Briggs-Gowan et al., 2010; Hébert, Tremblay, Parent, Daignault, & Piché, 2006). Functional impairments include problems in interpersonal relationships and difficulties in school (Daignault & Hébert, 2009). Researchers also suggest that youth exposed to trauma may have lower self-esteem (Kim & Cicchetti, 2009; Kim & Cicchetti, 2010).

Trauma exposure, particularly exposure to child abuse and neglect, appears to have an impact across the lifespan into adulthood (Ai, Foster, Pecora, Delaney, & Rodriguez, 2013; Norman, Byambaa, De, Butchart, Scott, & Vos, 2012). In a recent study, child maltreatment was associated with a greater likelihood of mental health disorders across the lifetime, including risk for other anxiety disorders, mood disorders, and substance use disorders (Dorsey, Burns, Southerland, Cox, Wagner & Farmer, 2012). Other research has documented that exposure to a wide range of traumatic events such as child abuse and neglect, traumatic death of a loved one, exposure to domestic violence is associated with psychiatric difficulties in adulthood and higher rates of chronic disease,

suicide attempts, and mortality (Greeson et al., & Fairbank, 2011; Graham-Bermann, & Seng, 2005). Up to 80 percent of children in foster care have significant mental health issues compared to approximately 20 percent of the general population (Shin, 2005). Research suggests that mental and behavioral health is the greatest unmet health need for children and teens in foster care (Leslie, Gordon, Lambros, Premji, Peoples & Gist, 2005). Factors contributing to the mental and behavioral health of children and youth in foster care include the history of complex trauma, frequently changing foster homes and having to transition from one setting to another, and lack of consistent family relationships (Unrau, Seita, & Putney, 2008; Bruskas, 2008; Meloy, & Phillips, 2012).

PTSD and Children's Placement Stability

Many children do not have many placement setting options when they enter foster care, however those children with a diagnosis of PTSD may present with more emotional stability if placed in kinship foster homes with relatives (Cohen, Mannarino, & Iyengar, 2011; Weiner, Schneider, & Lyons, 2009). There is a wealth of research attesting to the importance of sustaining placement stability and the ramifications placements can have on children's cognitive and emotional development (Harden, 2004; Munro, & Hardy, 2006). Permanence is defined in the statutory guidance that accompanies the Children Act 1989 as providing children with a sense of security, continuity, commitment, and identity (Boddy, 2013). Permanence is about having a family for life (Sinclair et al., 2007) and a sense of belonging and connectedness (Schofield et al., 2012). Placement stability is an important part of permanence as it creates opportunities for children to

develop secure relationships with a stable and loving family that will support them through childhood and beyond (O'Brien, 2013; DCSF, 2010).

Healthy secure relationships develop when children have placement stability (Leathers, 2002; Bovenschen, Lang, Zimmermann, Förthner, Nowacki, Roland, & Spangler, 2016). Placement stability is important for children with PTSD and serves to reduce the potential stressors that arise from being displaced in foster care (Alisic, Krishna, Groot, & Frederick, 2015). Frequent placement moves in and out of foster homes and children having to adjust to an abrupt move into foster care, not only compounds the issue of being separated from one's parents, but can also result in separation from siblings, relocating to a new geographical area, and experiencing a sense of not belonging (Gauthier, Fortin, & Jéliu, 2004; Withington, Burton, Lonne, & Eviers, 2016). Research suggest that placement stability can lead to less distress and have a profound positive emotional impact on children in kinship care (Selwyn et al., 2013).

Kinship care can be a positive permanency option as it enhances children's sense of belonging through continuity of family identity, which is a key factor in terms of placement stability and emotional well-being (Farmer and Moyers, 2008; Bender, Yang, Ferguson, & Thompson, 2015). A consistent finding is that children placed in kinship care generally do as well as children in unrelated foster care, particularly with regard to the stability of the placement (Hunt & Waterhouse, 2009). In fact, Selwyn et al., (2013) found that overall, kinship children fared significantly better than children in nonkinship foster care (Ford, Goodman, & Meltzer, 2003; Ford, Vostanis, Meltzer, & Goodman, 2007).

Too many children enter a system in which further damage is caused to their social, emotional, and cognitive development through its failure to provide children with caregivers that they know, in a safe place where they have a sense of familiarity and connection to the person that is caring for them (Keller, Wetherbee, Le Prohn, Payne, Sim, & Lamont, 2001; Jackson, & Thomas, 2000; Rubin et al., 2017). Children who are removed from their homes and experience placement disruption may suffer from profound distress and a sense of loss, all of which can lead to PTSD and the forming of insecure relationships (Northern California Training Academy, 2008; Courtney, & Prophet, 2011). Research suggest that youth who experience minimized placement changes and are placed with kinship foster parents are more likely to experience less mental health and behavioral problems, and increased probabilities for experiencing a lasting positive relationship with their kinship foster parent(s) (Gauthier, Fortin, & Jeliu, 2004; Rubin, Alessandrini, Feudtner, Mandell, Localio, & Hadley, 2004; Waid, Kothari, Bank, & McBeath, 2016).

The number of children with PTSD who are in need of placements continues to increase; therefore, it is important to be aware of the potential impact foster home placements may have on a child's mental health. In a study that looked at children's unmet mental health needs in both kinship and nonkinship placements, it was found that children in kinship care reportedly have better mental health outcomes than their nonkinship foster care peers (Hong, Algood, Chiu, & Lee, 2011; Cuddeback, 2004; Smithgall et al., 2013). Since it has been suggested that a large percent of children that are in foster care may experience mental health needs that go unmet, along with knowing

that children in kinship care demonstrate better outcomes than children in nonkinship care, it is important information to consider when working with children, families and agencies that may influence the placement of a child.

Although research is growing about the nature and consequences of trauma and PTSD experienced by older youth in the general population, much less is known about the trauma experiences of youth in foster care (Collin-Vézina, Coleman, Milne, Sell, & Daigneault, 2011; Salazar et al., 2013). To date, the literature addressing trauma exposure among youth in the child welfare system has focused on maltreatment, abuse, and neglect rather than children with PTSD and placement type in kinship and nonkinship foster homes, and how placements may exacerbate or improve PTS symptoms (Klain, & White, 2013; O'Connor, & Elklit, 2008; Fusco, & Cahalane, 2015). The Northwest Foster Care Alumni Study (Pecora et al., 2005) found that child welfare agencies can help prevent PTSD and other negative mental health outcomes for foster children by improving placement stability (Phillips, et al., 2015). To improve placement stability for children with PTSD, child welfare and family support agencies and practitioners might want to consider redoubling their efforts in securing foster children in kinship foster homes where the child feels safe and already has a bond to the caregiver. The purpose of this research study was to create awareness around this topic and to add to the growing amount of research supporting kinship placements for foster children.

Summary

This chapter began with a review and history of child welfare. In addition, foster care in the United States and foster home placement options were discussed to give an

overview of the history of out-of-home care. This chapter primarily focused on the review of literature pertaining to benefits and limitations of placing children in kinship care and nonkinship care with PTSD. Also, trauma, abuse, and attachment theory literature were examined as it pertains to this study on children placed in kinship and nonkinship foster homes.

Based on the literature review, children experience more secure attachments when they trust and secure a solid relationship with their caregiver. In previous research studies on attachment, it was reported by researchers that a caregiver's bond with a child is solidified through the caregiver's sensitivity. Research also suggested that in order for children to build secure attachments to their foster parents it is imperative said the caregivers be sensitive, supportive, nurturing, and invested in the child's personal and emotional needs.

There are mixed reviews on kinship versus nonkinship placement on both caregivers and children's emotional well-being; however kinship care for the past decade has been the primary choice for children placed in out-of-home care for most social service agencies. Being placed in foster care for many children can be traumatizing in itself. Trauma research on this population suggest further research is needed with a primary focus on reported PTSD and whether children living in nonkinship foster homes versus kinship foster homes report lower rates of PTSD. The purpose of this proposed study was to address this gap in knowledge.

The next chapter contains details about the study's research design and methodology, selected to address this gap in the literature by contributing to knowledge

about the rates of reported PTSD for children placed in kinship foster homes in comparison to children placed in nonkinship foster homes.

Chapter 3: Research Method

Introduction

In Chapter 3, I discuss the research methods used in the study along with the setting, sample, and sample size justification, data collection, the purpose, procedures, scoring, and statistical parameters. The data collection and analysis procedures are described, and threats to statistical conclusion validity are discussed. In addition, ethical issues concerning this research are discussed. The purpose of this quantitative study was to study the effect of foster care placement type (kinship and nonkinship) foster care placements and previously reported mental health service treatment on reported PTSD symptoms in foster care children. I used a nonexperimental design.

Research Design and Rationale

This was a quantitative study employing a nonexperimental design. I collected statistical data to examine whether foster children, ages 3-12, in kinship foster homes significantly differ in symptoms of PTSD from children placed in nonkinship foster homes as reported by foster care parents. I also explored whether attending previous mental health services within the past three to four months affect PTSD symptoms in foster care children as reported by foster parents while looking at interactions between kinship and nonkinship care placement type and previous mental health service treatment on PTSD in foster care children as reported by foster parents. For this study, foster parents were asked to measure children's PTS symptoms which included intrusive thoughts, sensations, and memories of painful past events; nightmares; fears; and cognitive avoidance of painful feelings using the TSCYC (Briere, 1996). The TSCYC is

a highly replicable assessment tool used to measure young children's PTS symptoms between ages 3-12 (Briere, 1996). In this study, the TSCYC reflected the perspectives of a single informant, the foster parent, who knew the child within a particular context. Any differences in reported PTS symptoms on the TSCYC are dependent on the perception of the foster parents rather than the child. In addition, I developed a mental health treatment service demographic questionnaire to explore significant interactions between kinship and nonkinship placement settings and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster parents.

The analytical strategy that was used in this study was a 2x2 factorial ANOVA. The dependent variables included children's rates of PTS reported symptoms as measured by the TSCYC. The independent variables included foster care placement type (kinship and nonkinship) and reported mental health treatment services within the last three to four months.

Design Justification

Most of the research cited in this study concerns rates of reported posttraumatic symptomatology and differences between foster care placement types and previously reported mental health treatment services for children in foster care. A review of the research indicates that PTSD is a prevalent and detrimental disorder among children placed in foster care (Kolko et al., 2010) and placement stability can lead to less distress having a profound positive emotional impact on children's mental health (Selwyn et al., 2013). PTSD symptoms are reported in about 19% of children placed in foster care (Kolko et al., 2010). Other research shows that approximately one in four children in

foster care will show signs of PTSD (Armour, 2007; Child Welfare Information Gateway, 2014; DePrince, 2001; Teicher, 2002). According to AFCARS, in 2017, there were an estimated 427,910 children in the U.S. child welfare foster care system, and the number continues to increase (AFCARS, 2017). Little is known about posttraumatic symptomatology, differences in foster care placement type, and mental health services as reported by foster parents, according to my review of the literature.

Nonexperimental research designs are commonly used in the social science fields, including psychology (Miller & Salkind, 2002; Robson & McCartan, 2016). Nonexperimental research involves systematic empirical inquiry where the researcher does not have direct control of independent variables (Gray, 2013). There are three categories of research objectives in nonexperimental research: descriptive, predictive, and explanatory (Johnson, & Christensen, 2008; Leonard, Miller, Christopher, Gleason, & Franklin, 2016). Johnson and Christensen (2008) also listed three time dimensions covered by nonexperimental research designs: retrospective, cross-sectional, and longitudinal. In line with Johnson and Christensen's categorization, this study was a retrospective, explanatory, and nonexperimental study because the intent was to explain how and why a phenomenon operates by identifying the influences, effects, and interactions between independent variables on dependent variables (see Horváth, 2016; Johnson & Waterfield, 2004).

Researchers often use nonexperimental retrospective research designs to make causal inferences with the population of PTSD children in foster care. There are many risk factors in this population for which randomized, controlled trials or laboratory

experiments are neither feasible nor ethical (LoBiondo-Wood, Haber, & Singh, 2014; Johnson, 2017). Within this line of inquiry, a hypothesis-driven examination of the effects of posttraumatic symptomatology, foster care placement type, and reported mental health treatment services is considered informative (Chambers, Saunders, New, Williams, & Stachurska, 2010). Hence, this research study focuses on these many aspects.

I measured posttraumatic symptomatology on a continuous scale using the TSCYC, a PTSD assessment measure (Briere, 1996, 2005). The approach to comparing rates of PTSD among children in foster care for this study required identifying children in care with PTSD in kinship and nonkinship foster home placements and comparing the rates of reported symptoms through use of the TSCYC foster care parent report. The approach to comparing previously reported mental health treatment services among children in foster care for this study required identifying children in care with PTSD in kinship and nonkinship foster home placements and comparing previously reported mental health treatment services through use of the mental health treatment service demographic questionnaire foster care parent report.

Methodology

Sample and Sampling Procedures

Institutional Review Board (10-25-18-0089671) approval was necessary for this study. I obtained the sample data for this research study from four groups of foster parents. For this study the two independent variables focused on foster care placement type (kinship and nNonkinship) and treatment services. The first group concentrated on kinship foster care placement with mental health treatment services. The second group

concentrated on nonkinship with mental health treatment services. The third group concentrated on kinship without mental health treatment services, and the fourth group concentrated on nonkinship without mental health treatment services. This research study, I sought to provide child welfare administration with awareness pertaining to the effects of foster care placement type and how mental health treatment services may have an impact on PTSD symptoms of children in foster care. Table 1 presents information on the four study groups.

Table 1

Description of the Four Study Groups Mental health treatment services (TX)	Foster care placement type: Kinship	Foster care placement type: Nonkinship
TX	Kinship/TX (Group 1)	Nonkinship/TX (Group 3)
No TX	Kinship/No TX (Group 2)	Nonkinship/No TX (Group 4)

For this research study, the sample consisted of information provided by kinship and nonkinship foster parents of children in foster care with PTSD by posting flyers throughout the Bronx, New York regional area. Any foster parent who saw the posted flyer and who were willing to participate in this research study were directed by the flyer to follow a secured electronic survey link to a webpage that would ask them a series of questions about their child's PTSD symptoms and previous mental health services.

Statistical power refers to the probability of accurately rejecting the null hypothesis when it is false (Wetherbee & Achenbach, 2002; Greenland, Senn, Rothman, Carlin, Poole, Goodman, & Altman, 2016). This researcher conducted an A priori power analysis for an F-test ANOVA focusing on fixed effects, special main effects, and

interactions using G-POWER to determine the minimum number of participants needed to achieve sufficient power for this study (VanVoorhis & Morgan, 2007). Based on a power size of .80, which is typical for this type of study, alpha of $p < .05$, a medium effect size of 0.25, numerator df 3, and 4 groups the minimum sample size needed was 179 (Sullivan, & Feinn, 2012). Each participant had a unique identification number to keep their assessments together. This researcher maintained a database that connected all TSCYC assessments and mental health treatment service demographic questionnaires data to this number. This researcher maintained the computer program with the TSCYC data, mental health treatment service demographic questionnaire data, as well as the table that linked all participants.

Procedures for Recruitment, Participation, and Data Collection

I set up an anonymous online survey through Survey Monkey for foster parents to complete. If participants wished to participate, they were asked to check the agree box on the informed consent page to indicate their consent. They were then be asked a series of inclusion questions, including: Are you a kinship or nonkinship foster parent? Do you have a child clinically diagnosed with PTSD? Is your child between the ages 3-12? Has the foster child lived with you for at least three to four months? If participants could not answer all of the four initial inclusion criteria questions they were not able to proceed or move forward to the next page of the survey. This was part of the inclusion and exclusion criteria. If participants could answer all of the initial inclusion criteria questions correctly they were prompted to the next page of the survey where foster parents were then asked to read over the research essentials to participate.

The consent page of the survey informed potential foster parents who planned on participating in the research study that the survey takes about 15-20 minutes to complete. If, participants choose to participate in the study they were asked to either Accept or Decline Consent to participate. Once, participants Accepted to participate they were asked to print or save the consent page to their phone, tablet, or computer for their records. Once foster parents had secured their copy of the consent form they were then able to proceed to the next page of the survey, which consisted of the mental health treatment service demographic questionnaire. After foster parents completed the questionnaire page of the survey they were able to proceed to the next page, which consisted of the TSCYC assessment.

For both the mental health treatment service demographic questionnaires and TSCYC assessments foster parents were asked not to leave any answers blank. This researcher set up the survey webpage in a way that if any of the questions on the survey was left blank, foster parents were prompted to fill in the missing areas. If foster parents do not complete all asterisk questions, they were not be able to proceed to the next page of the survey and/or excluded from the research study. This was part of the inclusion and exclusion criteria. On the mental health treatment service demographic questionnaire foster parents were asked how long have their foster child been placed in their care, and how long have they known the child. Foster parents were excluded from the study if they had not known the child for more than three to four months. Foster parents were also excluded from the study if their child had not been placed with them for at least three to four months.

At the end of the survey, foster parents were prompted to submit the surveys by clicking submit. This researcher kept all participants consents, TSCYC assessments, and mental health treatments service demographic questionnaires confidential. In this researcher's quest to record data, this researcher saved all original data and secured all data through a secure USB flash drive. No names were used to record for this research study and all participants remained anonymous to researcher. When participants reached sample size for the number of participants needed for this research study, this researcher closed the survey link. For this study, this researcher was looking for relatively equal sample sizes between the 4 groups of participants. In addition, this was a closed survey link where only foster parents were able to access. The study was not geared towards the general population; however foster parents who were not affiliated with the participating agency in which flyers were posted were not excluded from completing the online survey or participating in this research study.

Instrumentation an Operationalization of Constructs

Trauma Symptoms Checklist for Young Children (TSCYC). I used the Trauma Symptoms Checklist for Young Children **(**TSCYC) assessment to address research questions and rates of PTSD symptoms in children in kinship care foster home placements in comparison to children placed in nonkinship care foster home placements, and the mental health treatment service demographic questionnaire was used to assess the effects of mental health treatment on foster care children with PTSD in the past three to four months as reported by foster parents.

The Trauma Symptom Checklist for Young Children (TSCYC) is an assessment measure designed to help address the gap in standardized trauma measures for children ages 3-12 (Briere, 2005). The TSCYC is the first fully standardized and normed broadband trauma measure for young children who have been exposed to traumatic events such as child abuse, peer assault, and community violence. The TSCYC parent/caregiver reporting instrument is a measure which consists of 90 items that yield two scales to help determine the validity of caretaker reports (Response Level-RL and Atypical Response-ATR),and eight clinical scales designed to measure the psychological consequences of exposure to trauma (Anxiety-ANX, Depression-DEP, Anger/Aggression-ANG, Posttraumatic Stress-Intrusion-PTS-I, Posttraumatic Stress-Avoidance- PTS-AV, Posttraumatic Stress-Arousal-PTS-AR, Dissociation-DIS, and Sexual concerns-SC) (Briere, 2005; Van der Spuy, 2014).

Mental Health Treatment Service Demographic Questionnaire. I developed a mental health treatment service demographic questionnaire (see Appendix A) to gain information on the effects of foster care placement type in kinship and nonkinship foster care placements and previously reported mental health service treatment within the past three to four months on reported PTSD symptoms in foster care. The mental health treatment service demographic questionnaire asked foster parents a series of questions about their foster child's previous mental health services such as what type of treatment services their child received, how long have their child received treatment services, how long have their foster child been placed in their care, and how long have they known the child. Foster parents were also asked to specify if they received any PTSD training. In

addition, basic demographics such as age, ethnicity, and gender along with a series of mental health questions about their foster child's PTS symptoms through use of the TSCYC assessment was used to gather data and explore whether there are any interactions between kinship and nonkinship foster care placement type and previous mental health treatment service on PTSD symptoms in foster care children as reported by foster care parents.

Instrument for the independent variable. The independent variables (IV) compared whether kinship and nonkinship foster parents reports significantly differ on their reported symptoms of PTSD in their foster care children ages 3-12, and whether pervious mental health treatment services within three to four months has an effect on PTSD symptoms in foster care children as reported by foster care parents.

Procedures. Data from the four groups (kinship with mental health treatment, kinship with no mental health treatment, nonkinship with mental health treatment, and nonkinship with mental health treatment), were obtained from parents and maintained by the researcher. Collected data included TSCYC results, mental health treatment services within the past three to four months; child's confirmed PTSD diagnosis from foster parent, child's placement type, age, and ethnicity. The mental health treatment service demographic questionnaire was developed by this researcher to address the effects of previously reported mental health treatment services, and whether treatment services has an impact on foster children's PTSD symptoms within the past three to four months of the research study. The mental health treatment service demographic questionnaire was designed to ask foster parents a series of questions about their foster child's previous

mental health services such as what type of treatment services their child received, how long have their child received treatment services, and if foster parents themselves received any PTSD training. From these series of mental health questions and the PTSD TSCYC assessment, this researcher was able to explore whether there are any interactions between kinship and nonkinship foster care placement type and previous mental health treatment service on PTSD symptoms in foster care children as reported by foster care parents. Permission was obtained from the TSCYC publishers to use the instrument in this dissertation (see Appendix B).

The data was used to compare each participant based on foster care placement in kinship and nonkinship foster homes with PTSD ages 3-12 and previous mental health services provided in the last three to four months. The comparisons were mutually exclusive, so that a child can only belong to one of the two types of foster care home placements.

Parametrics. No parametric data were available, as this comparison had been created for this proposed study and was based not only on just the TSCYC standardized instrument, but on the literature review as well. Scoring for the mental health treatment service demographic questionnaire was based on foster parents' responses, so that this researcher can look for any significant differences in treatment services within the ANOVA 2x2 between subjects factorial design groups.

Instrument for dependent variables. The Trauma Symptom Checklist for Young Children (TSCYC) ages 3 to 12 years is a standardized, 90-item caretaker-report instrument designed to assist in measuring children's trauma- and abuse-related

symptomatology (Briere, Johnson, Bissada, Damon, Crouch, Gil, Hanson, Ernst, 2001; Salloum, Wang, Robst, Murphy, Scheeringa, Cohen, & Storch, 2016). According to the publisher, the TSCYC is designed to be especially helpful when completed by caregivers, and the instrument is viewed as an acceptable administration method for children in foster care (Briere, 2005; Wherry, & Dunlop, 2017; Wherry, Corson, & Hunsaker, 2013). Caretakers rate each symptom on a 4-point scale from 1 (not at all) to 4 (very often) according to how often it has occurred (Briere, in press). Unlike other parent/caretaker report measures, the TSCYC contains specific scales to ascertain the validity of caretaker reports and evaluates a range of post-traumatic symptoms (Briere, Johnson, Bissada, Damon, Crouch, Gil, Hanson, & Ernst, 2001). In addition, on completion of normative studies, the TSCYC allowed comparison of a given child's caretaker-reported symptoms in a given area to a large, representative sample of caretaker reports from the general population (2001). The TSCYC contains two reporter validity scales (Response Level-RL, Atypical Response-ATR), and eight clinical scales (Post-traumatic Stress-Intrusion-PTS-I, Post-traumatic Stress-Avoidance-PTS-AV, Post-traumatic Stress-Arousal-PTS-AR, Post-traumatic Stress-Total-PTS-TOT, Sexual Concerns-SC, Dissociation-DIS, Anxiety-ANX, Depression-DEP, and Anger/Aggression-ANG), as well as an item assessing how many hours a caretaker is in contact with the child (Briere, et al, 2001). Typical items on the TSCYC consists of: looking sad, exhibiting temper tantrums, having bad dreams or nightmares, living in a fantasy world, frequently thinking or worrying about bad things that happened in the past, being jumping or nervous, experiencing flashbacks, telling lies, being easily scared, experiencing upsetting thoughts

that happened to him or her in the past, getting into fights, throwing or breaking things, and yelling at friends or family members. Caregivers rate each item on a scale of 1 to 4, where 1 equals not at all, 2 equals sometimes, 3 equals often, and 4 equals very often (Briere, 2005). Caregivers were instructed to select the response that most accurately describes how often the child experiences traumatic events (Kolko, Hurlburt, Zhang, Barth, Leslie, & Burns, 2010; Briere, 2005).

The TSCYC purports to encompass a broad, diverse spectrum of acute and chronic posttraumatic symptomatology and other psychological traumatic events in children (Briere, & Spinazzola, 2005; Brown, 2007; Harris, 2016). Tested by clinicians and researchers throughout North America, the TSCYC is a less than 20 minutes caretaker report, with separate norms for males and females in three age groups: 3 to 4 years, 5 to 9 years, and 10 to 12 years (Briere, 2005). Using a 4-point scale (1=Not at All, 2=Sometimes, 3=Often, 4=Very Often), caretakers rate each symptom according to its observed frequency (Briere, 2005). Unlike most other caretaker reports, the TSCYC includes validity scales, Response Level (RL) and Atypical Response (ATR), which can determine if caregivers are over-reporting or under-reporting on TSCYC items based on the standardized sample. The TSCYC also has norm-referenced data on the number of waking hours the caretaker actually spends with the child in an average week (ranging from 0 to 1 hour to over 60 hours). According to the test publisher, a fundamental purpose of the TSCYC is to assist in the identification of children who may need referral to professional help for trauma and/or abuse-related symptomatology (Briere, 2005;

Lanktree, Gilbert, Briere, Taylor, Chen, Maida, & Saltzman, 2008; Crandal, Hazen, & Reutz, 2017).

Procedures. Materials required for administration were the TSCYC Item Booklet and the TSCYC Answer Sheet. The TSCYC is an assessment instrument that was filled out electronically via online survey by foster parents. The TSCYC contained 90-items that request caregivers to rate how often children experience trauma- and stress-related symptomatology (Briere, 2005). The TSCYC was designed to be a caregiver report of children's trauma symptomatology (Balaban, 2009; Ford, 2011). The mental health treatment service demographic questionnaire was developed by this researcher to address the effects of previously reported mental health treatment services, and whether treatment services had an impact on foster children's PTSD symptoms within the past three to four months of the research study.

Scoring. TSCYC responses to individual items were tallied, and several scores were reported. Individual items were grouped into eight clinical scales: Anxiety (ANX), Depression (DEP), Anger/Aggression (ANG), Posttraumatic Stress-Intrusion (PTS-I), Posttraumatic Stress-Avoidance (PTS-AV), Posttraumatic Stress-Arousal (PTS-AR), Dissociation (DIS), and Sexual Concerns (SC). Norms are based on a stratified national standardization sample of 750 children (Briere, 2005)

The clinical scales of the TSCYC measured the extent to which the caretaker endorsed eight different types of potentially trauma-related symptoms in their child. All eight clinical scales were overlapping at the item level. However, the PTS summary scale (i.e., PTS-TOT) was, by definition, the sum of the three PTS scales (i.e., PTS-I, PTS-AV,

PTS-AR) (Briere, 2005). The Anxiety scale evaluated the level of fear and worry observed in each child. The Depression scale tapped into feelings, cognitions, behaviors, and verbalizations associated with sadness, unhappiness, or depression observed in each child. The Anger/Aggression scale evaluated the extent of anger and/or aggressive behavior observed in each child. The Posttraumatic stress-Intrusive scale evaluated the extent of the child's intrusive reliving of posttraumatic memories. The Posttraumatic Stress-Avoidance scale evaluated the extent of Posttraumatic Stress-Avoidance observed in each child. The Posttraumatic Stress-Arousal scale evaluated the extent of sympathetic nervous system hyper-arousal the child was observed to experience. The Dissociation scale tapped into detachment, internal absorption, fantasy, daydreaming, trance-like phenomena, and other potential symptoms of dissociation observed in each child. The Sexual Concerns scale evaluated the amount of sexual distress and preoccupation observed in each child. Finally, all PTS scales were used to compute a Posttraumatic Stress-Total Score. The Posttraumatic Stress-Total was the sum of the PTS-I, PTS-AV, and PTS-AR scales, and thus reflected the total amount of posttraumatic re-experiences, avoidance, and hyper-arousal symptoms seen in each child. Table 1 presents description of the TSCYC validity and clinical scales. The validity scales included two subscales. The Response Level (RL) scale reflects a tendency to underreport even normal problems in children, often due to generalized denial or a need to present the child as psychologically healthy or unusually symptom-free (Briere, 2005, p. 2). The Atypical Response (ATR) scale is a tendency to endorse unusual symptoms in the child, typically

because the caretaker is in a state of being overwhelmed by traumatic stress or based on a need to present the child as especially disturbed or symptomatic (Briere, 2005, p. 2).

The clinical scales included eight subscales. The Anxiety (ANX) scale is generalized anxiety, worry, specific fears (e.g., of being killed); being easily frightened, and a sense of impending danger (Briere, 2005, p. 2). The Depression (DEP) scale is feelings of sadness, unhappiness, and loneliness; episodes of tearfulness, depressed appearance; depressive cognitions such as self-blame and self-denigration; and self-injuriousness (Briere, 2005, p. 2). The Anger/Aggression (ANG) scale is angry feelings and behaviors, including feeling mad, feeling mean, being easily angered, yelling, hitting, fighting, and cruelty to animals (Briere, 2005, p. 2). The Posttraumatic Stress-Intrusion (PTS-I) scale includes nightmares, posttraumatic play, flashbacks, fear in response to trauma-reminiscent events, and being upset by traumatic memories (Briere, 2005, p. 2). The Posttraumatic Stress-Avoidance (PTS-AV) scale includes avoiding people, places, and situations reminiscent of a traumatic event, emotional numbing, unwilling to speak about a traumatic event, and difficulties fully remembering a trauma (Briere, 2005, p. 2). The Posttraumatic Stress-Arousal (PTS-AR) scale includes posttraumatic stress symptoms associated with autonomic hyper-arousal, including jumpiness, tension, attention and concentration problems, and sleep problems (Briere, 2005, p. 2). The Dissociation (DIS) scale includes emotional disengagement, staring into space, living in a fantasy world, absent-mindedness, appearing to be in a trance, and reduced attention to the external environment (Briere, 2005, p. 2). The Sexual Concerns (SC) scale includes sexual knowledge, behaviors, feelings, or preoccupied thoughts that are atypical when

they occur earlier than expected or with greater than normal frequency, and fearful responses to sexual stimuli (Briere, 2005, p. 2).

Two types of scores were generated from TSCYC responses: raw scores and T scores. Raw scores were created by summing the 1, 2, 3, 4 responses endorsed by respondents. To provide a common metric for all scales, to assist with normative comparisons, and for cross-age and gender comparisons, raw scores were transformed into normalized T scores. T scores were created for each scale for each gender at ages 3 to 4 years, 5 to 9 years, and 10 to 12 years. For the clinical scales, lower T scores were truncated at 35, so that scores at or below the 35th percentile of the normative sample were all assigned a T score of 35 or higher (Briere, 2005). TSCYC T scores were used to interpret the child's level of symptomatology. Scores were standardized and derived to have a mean of 50, and a standard deviation of 10. For all the clinical scales except PTS-TOT, T scores less than or equal to 64 were considered normal, T scores between 65 and 69 were deemed potentially problematic, and T scores greater than or equal to 70 were interpreted as clinically significant (Briere, 2005).

Statistical parametric. Norms for the TSCYC were based on a national sample of 750 children, which was acquired using Internet-based sampling technology (Briere, 2005). Participants were enrolled on a first-response basis and the sample was diverse in terms of gender, age, ethnicity, parental education level, and geographical region. To account for possible age and gender differences, separate norms were created for each gender for the age groups 3-4, 5-9, and 10-12 (Briere, 2005).

.....Several types of data on validity were presented in the manual for the TSCYC. Content validity was supported by over two decades of research, consultation, feedback and refinement. In addition, of all the 750 children from the standardized TSCYC sample, 317 were described by their caretaker as having undergone a highly upsetting or traumatic event. A discriminate function analysis and post-hoc univariate ANOVAs indicated that children exposed to traumatic events, regardless of how much time had passed showed significantly higher scores on all the TSCYC clinical scales, as well as the RL scale at the $p < .001$ level (Briere, 2005). The validity of the TSCYC was evaluated in four domains: the intercorrelation between TSCYC scales, the association between TSCYC scales and trauma history, the correlation between TSCYC scales and other similar and dissimilar measures, and the diagnostic utility of the TSCYC in predicting PTSD. The TSCYC clinical scale intercorrelations in the normative sample ranged from .45 and .90 (Briere, 2005). Findings reported on a multi-site analysis suggest good internal reliability with alpha ranging from .81 for sexual concerns to .93 for PTS-Total, with an average of .87 across all scales (Briere et. al, 2001). The authors also reported good construct validity for the scales measuring post-traumatic stress, sexual concerns, and dissociation (Van der Spuy, 2014). Data Analysis Plan

I obtained all data from foster parents via online survey. Participant consent forms, TSCYC assessment, and mental health treatment service demographic questionnaire were completed by foster parents through researcher's webpage survey. All resulting raw scores, consent forms, assessments, and questionnaires were kept secure

and confidential. No names were recorded for this research study and research material gathered from participants were only be accessible to this researcher.

Data analysis was conducted using the computer software program SPSS. Descriptive demographic data was provided for each of the placement types, treatment services as well as for the overall sample. The first assumption was the dependent variable had to be continuous (interval/ratio). The second assumption was the observations were independent of one another. The third assumption was the dependent variable had to be normally distributed, and the fourth assumption was the dependent variable could not contain any outliers. The data was tested against each of these four assumptions, and appropriate adjustments were made if any of the assumptions were violated.

For this study, I conducted a 2x2 factorial ANOVA to examine any significant interactions between kinship and nonkinship foster care placement types and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster parents. All mental health treatment service demographic questionnaires were logged and scored through SPSS. Data obtained from participants included information from the TSCYC, as well as mental health treatment service demographic questionnaires data as reported from foster parents. I sought to answer the following research questions and hypotheses:

RQ1: Do kinship and nonkinship foster parents significantly differ on their reported symptoms of PTSD in their foster care children ages 3-12?

Null Hypothesis (Ho1).: There is no significant difference in kinship and nonkinship foster parents reported symptoms of PTSD in their foster care children ages 3-12.

Null Hypothesis (Ho2): There is a significant difference in kinship and nonkinship foster parents reported symptoms of PTSD in their foster care children ages 3-12.

RQ2: Do attending previous mental health treatment services within the past three to four months affect PTSD symptoms in foster care children as reported by foster care parents?

Null Hypothesis (Ho1).: There is no significant difference in previous mental health treatment services within the past three to four months that affect PTSD symptoms in foster care children as reported by foster care parents

Null Hypothesis (Ho2): There is a significant difference in previous mental health treatment services within the past three to four months that affect PTSD symptoms in foster care children as reported by foster care parents

RQ3: Is there an interaction between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents.

Null Hypothesis (Ho1).: There is no significant differences in interactions between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents.

Null Hypothesis (Ho2): There is a significant difference in interactions between kinship and nonkinship placement types and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents.

Threats to Validity

Creswell (2003) identified several types of threats to validity that can interfere with the ability of a researcher to draw inferences from the data obtained in a study. These threats to validity include internal validity threats, external validity threats, statistical conclusion validity threats, and construct validity threats. This section discussed potential threats to statistical conclusion validity in this study.

Test-retest reliabilities range between .68 and .96 for the clinical scales, with a median coefficient of .88 (Briere, 2001).Validity scales internal consistency for the TSCYC Response Level (RL) scale, as measured by Cronbach's alpha, ranges between .73 and .86, and the Atypical Response (ATR) alpha's were .36 and .46 (Briere, 2005). The TSCYC clinical scales had alphas ranging from .81 and .93.

The statistical parametric of the TSCYC were within acceptable ranges. However, the TSCYC was designed to be one part of a comprehensive, multi-informant assessment system (Nilsson, Gustafsson, & Svedin, 2012). The methodology used by the publisher of the TSCYC to create T scores resulted in a loss of variation at the lower end of the spectrum. Because T scores were used in this study, this loss of variation posed a threat to the validity of interpreting the results. However, because the research focused on reported PTS symptomatology, and the research approach combined scores across genders and age groups, the use of T scores was recommended (Kolko, Hurlburt, Zhang, Barth, Leslie, &

Burns, 2010). The approach of using T scores in this study to compare TSCYC data from different genders and age groups was consistent with the approach used by others in the literature (Milot, Éthier, St-Laurent, & Provost, 2010; Lanktree, Gilbert, Briere, Taylor, Chen, Maida, & Saltzman, 2008; Hunt, Martens, & Belcher, 2011).

The sample used in this proposed study was collected from participating foster parents by posting flyers in local communities shops near foster care facilities in the Bronx, New York City regional area where foster parents normally congregate and have play dates with their foster children. Most of the participants lived in one regional area; a threat was posed to the validity of generalizing results from this study to children who lived in other areas of the country.

Ethical Procedures

Research involving children is subject to a number of ethical hazards. In this proposed study these hazards were mitigated by posting flyers in local community shops near foster care facilities in the Bronx, New York City regional area, and relying on foster parents to complete the consent forms, TSCYC assessment, and mental health treatment service demographic questionnaire via survey. Data collection was used only in the sole purpose of gathering data on foster parents and children's demographics, placement type, mental health treatment services, and PTSD diagnosis. This researcher identified foster parents with children in foster care with a diagnosis of PTSD by posting flyers in local community shops near foster care facilities in the Bronx, New York City regional area. Foster parents who were willing to participate in this study was asked to follow a survey link where they were asked to consent to participate. All participants had

the right to decline participation. When foster parents completed the consent forms, TSCYC assessment, and mental health treatment service demographic questionnaire, the completed documents were sent directly to researcher through researcher webpage survey.

This researcher maintained a database that connected all TSCYC assessments and mental health treatment service demographic questionnaires data to unique identification numbers. This researcher maintained the computer program with the TSCYC data, mental health treatment service demographic questionnaire data, as well as the table that linked all participants identifying number for the one-time surveys to specific caregivers. No names were recorded for this research study and all participants remained anonymous to researcher. This researcher kept all participants consents, TSCYC assessments, and mental health treatments service demographic questionnaires confidential.

Confidentiality was of utmost concern to this researcher and measures were taken to safeguard the privacy and confidentiality of participants' data. Data was reported at the aggregate level, so no identifying information and no information on single cases were reported. In this way it was not possible to identify any participants in the research study. The research study did not include participant's names or any other information that could identify them in the study. Participants' data were entered into this researchers SPSS database with no names or any other identifying information linking participants to the study.

All participating foster parents who consented to participate were able to access the researcher's webpage survey by way of this researcher posting flyers in local

community shops near foster care facilities in the Bronx, New York City regional area. The study did not use personal information for any purposes outside of this research study. Data was kept protected and stored on USB flash drive accessible only to this researcher. Any participant information on computer software was password protected. Data will be kept for a period of at least 5 years, as required by Walden University, and then destroyed for quality assurance. The documents will be destroyed through a computer deletion method. This researcher will maintain the original paper files and computer program.

Summary

A 2x2 factorial analysis of variance ANOVA was used to examine the effect of foster care placement type (kinship and nonkinship) foster care placements and previously reported mental health service treatment on reported PTSD symptoms in foster care children. Statistical differences and interactions were examined between foster care placement types and previously reported mental health service treatment within three to four months in kinship foster care placement in comparison to nonkinship foster care placement on reported Posttraumatic Stress Disorder (PTSD) symptoms in foster children.

The next chapter contains detailed information about the results of the analysis, research findings, and describes the systematic and careful application of the research methods including the presentation of relevant quantitative data related to the research questions and hypothesis.

Chapter 4: Results

Introduction

The purpose of this research study was to examine the effect of foster care placement type (kinship and nonkinship) and previously reported mental health service treatment on reported PTSD symptoms in foster care children. I explored whether children, ages 3-12, in kinship foster homes significantly differed in symptoms of PTSD from children placed in nonkinship foster homes as reported by foster care parents. I explored whether attending previous mental health services within the past three to four months affected PTSD symptoms in foster care children as reported by foster parents. I also examined interactions between kinship and nonkinship care placement type and previous mental health service treatment on PTSD in foster care children as reported by foster parents.

I asked foster parents to measure children's PTS symptoms, which included intrusive thoughts, sensations, and memories of painful past events; nightmares; fears; and cognitive avoidance of painful feelings using the TSCYC (Briere, 1996). The TSCYC is a highly replicable assessment tool used to measure young children's PTS symptoms between ages 3-12. The mental health treatment service demographic questionnaire, which I developed, focused on the types of services children, as well as foster parents, received over the past 3-4 months. I designed this research study to compare kinship and nonkinship foster children based on PTS symptoms reported by foster parents and previously reported mental health service treatment that their child in foster care received. This chapter begins with a description of the participant

characteristics, followed by a detailed analysis of the results. The chapter concludes with a brief summary of the study findings.

Data Collection

I collected all data for this study from participating foster parents by posting flyers (see Appendix D) in local community shops near foster care facilities in the Bronx, New York City, regional area where foster parents normally congregate and have play dates with their foster children. The survey and demographic form were administered via online survey to participants within each group between April and July 2019. All data were obtained from foster parents via an online survey through Survey Monkey, which is a tool that allows users to launch and create any kind of online surveys using question format templates, be it for the purpose of market research, a quick poll, competitive analysis or customer or the employee feedback. This easy to use platform allows users to tailor surveys according to any defined target audience. For this research study the targeted audience, primarily consisted of foster parents with children in foster care. Foster parents who saw the posted flyer within the Bronx community and were interested in participating in this research study were directed by the flyer to follow an electronically secured survey link to a webpage titled "Foster Care or Family Kinship Care: A Comparative Study on Rates of Posttraumatic Stress Disorder." If individuals were willing to participate in the research study, they were asked to read the consent form. If they wanted to proceed and participate in the study, they provided their consent by clicking *OK*. They were then asked a series of questions about their child's PTSD symptoms and previous mental health services. All participant consent forms, TSCYC

assessments, and mental health treatment service demographic questionnaires were anonymously completed by foster parents through the webpage survey; no names were recorded for this research study.

Demographics of Sample

There were no adverse events or circumstances requiring a report to the Institutional Review Board. For this research study, 221 foster parents participated in the online survey. As previously reported in this section, the sample data for this research study were obtained anonymously from four groups of foster parents. The first group concentrated on children placed in kinship foster care placements with mental health treatment services. The second group concentrated on children placed in kinship foster care placements without mental health treatment services. The third group concentrated on children placed in nonkinship foster care placements with mental health treatment services, and the fourth group concentrated on children placed in nonkinship without mental health treatment services.

Thirty-two participant surveys were invalid due to underreporting and overreporting on the TSCYC assessment resulting in a total of 189 participants. The total number of participants from the kinship with mental health treatment group (Group 1) was 48, the total from the kinship without mental health treatment group (Group 2) was 45, the total from the nonkinship with mental health treatment group (Group 3) was 44, and the total from the nonkinship without mental health treatment group (Group 4) was 52. The final sample of 189 participants was equally distributed between female foster children (n = 95, 50.3%) and male foster children (n = 94, 49.7%). Black/African American (n = 81,

42.9%) and Hispanic/Latino (*n* = 90, 47.6%) participants represented the most prominent ethnicity/race followed by White/Caucasian (*n* = 8, 4.2%), American Indian/Native American (*n* =4, 2.1%), and Asian populations (*n* = 6, 3.2%). The most representative age range was children 10 to 12 (*n* = 69, 36.5%), 5 to 9 (*n* = 66, 34.9%), and 3 to 4 (*n* = 54, 28.6%). There was an equal distribution of participants in both kinship (*n* = 93, 49.2%) and nonkinship (*n* = 96, 50.8%) placements. More foster parents reported knowing their foster child for 12 months or longer (*n* = 69, 36.5%) and that their foster child had been living in their home for at least 9-12 months (*n* = 72, 38.1%). There was an equal distribution of participants who received mental health treatment within the last 3-4 months (*n* = 92, 48.7%) and participants who did not receive mental health treatment within the last 3-4 months (*n* = 97, 51.3%). The demographic frequency of children who received psychotherapy within 3-4 months were predominately reported by foster parents with children in their care for at least 5-6 months (*n* =39, 20.6%) and received at least 5-6 psychotherapy sessions per month (*n* = 39, 20.6%). Foster parents reported that their foster child received play therapy (*n* = 33, 17.5%), cognitive behavior therapy (*n* = 30, 15.9%), and trauma-focused therapy (*n* = 17, 9.0%) more than other therapies such as group therapy (*n* = 1, .5) and family therapy (*n* = 9, 4.8). Foster parents were also asked if their foster child participated in any recreational activities within the past 3-4 months, and most foster parents reported high rates for child participation in after-school programs (*n* = 97, 51.3%). In addition, high numbers of foster parents reported that they had received PTSD training themselves (*n* = 115, 60,8%). Information about the 189 participants and the population sample demographic data included in this study are reflected in Table 2.

Results

Assumptions and Data Design

I conducted a 2x2 factorial ANOVA to examine possible significant main effects and interactions between kinship and nonkinship foster care placement types and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster parents

Data analysis was conducted using the computer software program SPSS. The first assumption was the dependent variable must be continuous (interval/ratio). The second assumption was the observations are independent of one another. The third assumption was the dependent variable should be approximately normally distributed, and the fourth assumption was the dependent variable should not contain any outliers (Garson, 2012; Mooi, Sarstedt, & Mooi-Reci, 2018). The data was tested against each of these assumptions, and appropriate adjustments were made to the assumptions that were violated.

The Levene's test was used to assess the normality of variance of all variables. The results of the Levene's test for one of the three variables was significant, which indicated the assumption for one of the observed variables in this research study was not met (Kim, & Cribbie, 2018). The Levene's test suggested that the PTSTOT TSCYC assessment variable showed violations for homogeneity, F (3, 176) = 7.350, with a significant value of P = .000 using a .05 level of significance. The null hypothesis was rejected and the alternative hypothesis was accepted that the population for this variable

was not normally distributed. In addition, the homogeneity of variance was violated and the error of variance on the dependent variable is not equal across groups.

As reported by Garson (2012), the ANOVA test is powerful enough to over-ride violations of the normality assumption under conditions in which there are small to medium sample sizes (n = 2000). Similarly, Nimon (2012) noted that if the normality assumption is violated, researchers may delete outlying cases, transform data, or conduct non-parametric tests. Tabachnick and Fidell, (2013) noted that the F test is potent to issues with normality when the sample size is greater than 40. Based on the noted information from past research, and the medium sample size, the test for normality was not severely violated (Nimon, 2012).

Researchers have found a two-way ANOVA is fairly robust to violating the assumption of homogeneity (Blanca, Alarcón, Arnau, Bono, & Bendayan, 2017; Wang, et al 2017). When Levene's test of normality and homogeneity is violated for two-way ANOVA, a study can still be conducted, however limitations should be noted and the effects of performing heterogeneous ANOVA F test on unequal group means should be documented. (Shieh, 2018; Hatchavanich, 2014). The Q plots show that the PTSTOT TSCYC assessment variable showed violations for homogeneity, so the null hypothesis was rejected and the alternative hypothesis was accepted that the population for this variable was not normally distributed. Figures 1, 2, and 3 are Q plots that show variances of normality for PTS total symptoms, placement type, and mental health treatment services.

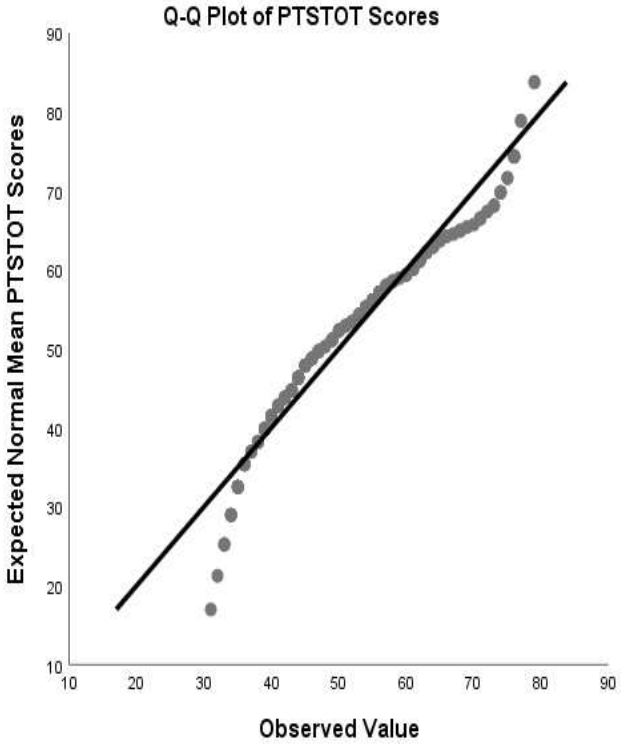

Figure 1. Q plot showing variance of normality for PTS total symptoms.

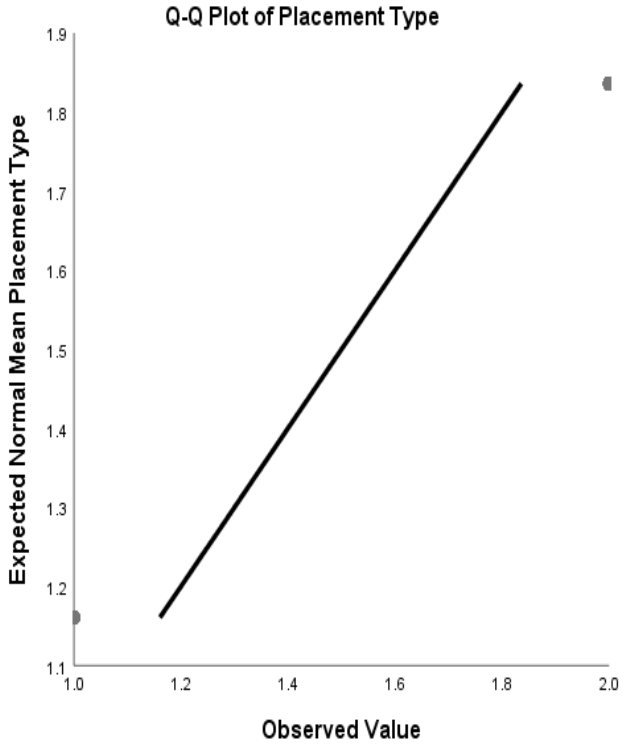

Figure 2. Q plot showing variance in normality for placement type.

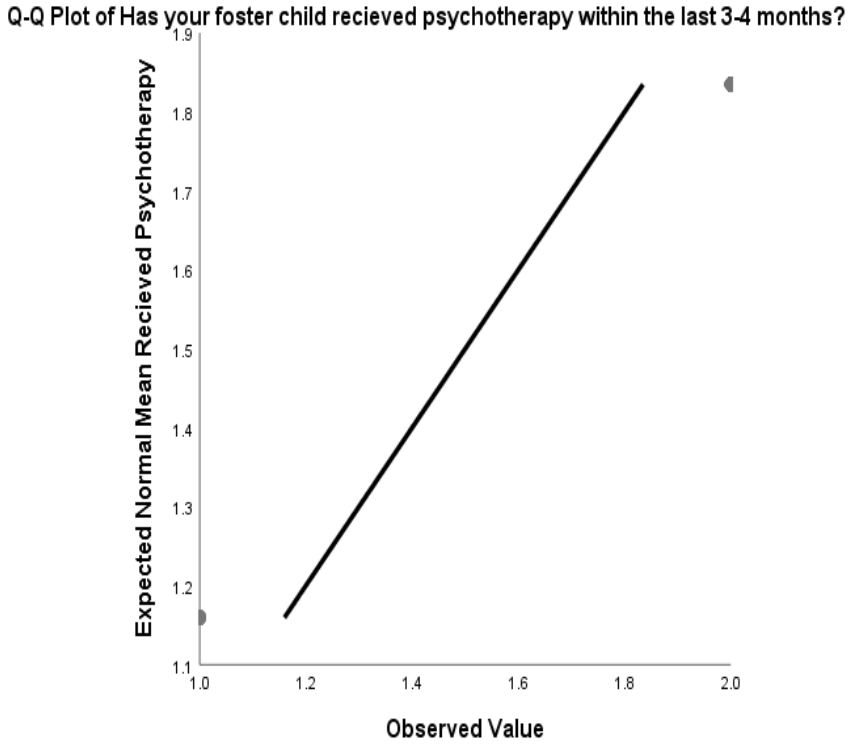

Figure 3, Q plot showing variance in normality for mental health treatment services.

Means and Standard Deviations of Dependent Variable

For this study the TSCYC assessment was used to gather information about children's PTS symptoms as reported by foster parents. The TSCYC contains two reporter validity scales (Response Level-RL Under-reporting, Atypical Response-ATR Over-reporting), and eight clinical scales (Post-traumatic Stress-Intrusion-PTS-I, Post-traumatic Stress-Avoidance-PTS-AV, Post-traumatic Stress-Arousal-PTS-AR, and Post-traumatic Stress-Total-PTS-TOT). For this particular study, only children's PTS scores were calculated by use of the TSCYC. PTS TSCYC score descriptives for children in kinship and nonkinship foster home placements are presented in Table 3. Table 3 shows children's PTSI, PTSAV, PTSAR, PTSTOT, minimum scores, maximum scores, mean

scores and standard deviations for all 189 children in kinship and nonkinship foster home placements.

Table 2. Descriptives for children's PTS symptoms and placement type

	N	*Minimum*	*Maximum*	*Mean*	*Std. Deviation*
PTSI	189	9.00	32.00	15.6138	4.87547
PTSAV	189	9.00	28.00	16.4974	4.87353
PTSAR	189	11.00	32.00	19.7566	4.68974
PTSTOT	189	31.00	79.00	51.6508	12.76276

ANOVA Results

In this section, a detailed analysis for each research question and its corresponding hypotheses are revealed. Research Question 1 was used to help determine whether kinship and nonkinship foster parents significantly differ on their reported symptoms of PTSD in their foster care children ages 3-12. Research Question 2 focused on whether attending previous mental health treatment services within the past three to four months affected PTSD symptoms in foster care children as reported by foster care parents. Research Question 3 looks at whether there was an interaction between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents.

Analysis for Research Question 1

RQ1 was, Do kinship and nonkinship foster parents significantly differ on their reported symptoms of PTSD in their foster care children ages 3-12?

(Ho1).: There is no significant difference in kinship and nonkinship foster parents reported symptoms of PTSD in their foster care children ages 3-12.

(Ho2): There is a significant difference in kinship and nonkinship foster parents reported symptoms of PTSD in their foster care children ages 3-12.

To examine RQ1, this researcher conducted a two-way ANOVA using the SPSS statistical software by IBM to assess whether there were differences in foster parents reported PTSD symptomatology among foster care children ages 3-12 in kinship and nonkinship foster home placements. The ANOVA analysis test of between-subjects effects suggested that there was no statistically significant differences against the PTSTOT and placement type variables F (1, 187) = 12.03, with a significance value of P = .720 using a .05 level of significance, with partial eta-squared η^2 = .001. The null hypothesis was accepted that there is no significant difference in kinship and nonkinship foster parents reported symptoms of PTSD in their foster care children ages 3-12.

Foster parents with children in nonkinship foster homes reported very similar symptoms of PTSD in their foster care children ages 3-12 (n = 96, M = 51.97, SD = 13.38) than foster parents with children in kinship foster homes (n = 93, M = 51.31, SD = 12.14), with differences that were not statistically significant. A post hoc analysis was not performed on the data because there were only two groups being compared. The results indicated that there is no significant difference in kinship and nonkinship foster parents reported symptoms of PTSD in their foster care children ages 3-12. Table 4 presents a summary of the two-way ANOVA findings in favor of the null hypothesis.

Table 3. Hypothesis 1 ANOVA results for children's PTS total symptoms and Placement Type

Placement Type	*N*	*Mean*	*Std. Deviation*	*MS*	*df*	*F*	*P*	*Η²*
Nonkinship	96	51.9792	13.38969					
Kinship	93	51.3118	12.14494					
				21.037	187	129	.720	.001

Analysis for Research Question 2

RQ2 was, Does attending previous mental health treatment services within the past three to four months affect PTSD symptoms in foster care children as reported by foster care parents?

(Ho1): There is no significant difference in previous mental health treatment services within the past three to four months that affect PTSD symptoms in foster care children as reported by foster care parents

(Ho2): There is a significant difference in previous mental health treatment services within the past three to four months that affect PTSD symptoms in foster care children as reported by foster care parents.

To examine RQ2, I assessed whether attending previous mental health treatment services within the past three to four months affected PTSD symptoms in foster care children as reported by foster care parents. The ANOVA test of between-subjects effects suggested that there was a statistically significant differences against the PTSTOT and psychotherapy received variables F (1, 187) = 4958.6, with a significance value of P = .000 using a .05 level of significance, with partial eta-squared η^2 = .162. The null

hypothesis was rejected that there is no significant difference in kinship and nonkinship foster parents reported symptoms of PTSD in their foster care children ages 3-12.

Foster parents with children who did not receive mental health treatment services reported higher symptoms of PTSD (n = 97, M = 56.63, SD = 13.30) than foster parents with children who did receive mental health treatment services (n = 92, M = 46.39, SD = 9.75), with differences that was statistically significant. The results indicated that there is a significant difference in previous mental health treatment services within the past three to four months that affect PTSD symptoms in foster care children as reported by foster care parents. Table 5 presents a summary of the two-way ANOVA findings in favor of the alternative hypothesis.

Table 4. Hypothesis 2 ANOVA results for children's PTS total symptoms and Mental Health Treatment Services.

PTSTOT and Mental Health Treatment Services	*N*	*Mean*	*Std. Deviation*	*MS*	*df*	*F*	*P*	*Ƞ²*
No	97	56.6392	13.30819					
Yes	92	46.3913	9.75632					
				4958.668	187	36.131	.000	162

Analysis for Research Question 3

RQ3 was, Is there an interaction between kinship and nonkinship placement type and previous mental health treatment services within the past three to four months on PTSD symptoms in foster care children as reported by foster care parents?

(Ho1).: There is no significant differences in interactions between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents.

(Ho2): There is a significant difference in interactions between kinship and nonkinship placement types and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents.

To examine RQ3, I assessed whether there were any interactions between kinship and nonkinship placement type and previous mental health treatment services within the past three to four months on PTSD symptoms in foster care children as reported by foster care parents. The ANOVA test of between-subjects effects suggested that there is no statistically significant interactions between placement type and previous mental health treatment, F (1, 185) = 316.8, with a significance value of P = .130 using a .05 level of significance, with partial eta-squared η^2 = .012. The null hypothesis was accepted that there were no significant differences in interactions between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents. Table 6 presents a summary of the two-way ANOVA findings in favor of the null hypothesis.

Table 5. Hypothesis 3 ANOVA results for children's PTS total symptoms on Placement Type and Mental Health Treatment Services.

PTSTOT, Placement Type, and Mental Health Treatment Services	*SS*	*df*	*MS*	*F*	*P*	η^2
	316.894	185	316.894	2.313	.130	.120

Summary

The purpose of this research study was to study the effect of foster care placement type (kinship and nonkinship) foster care placements and previously reported mental health service treatment on reported PTSD symptoms in foster care children. The results of the analysis pertaining to Research Question 1 showed there was no significant difference between kinship and nonkinship foster parents reported symptoms of PTSD in their foster care children ages 3-12. The results of the analysis pertaining to Research Question 2 showed there was a significant difference between foster care children who received mental health treatment services within the last three to four months and those who did not on their reported PTSD symptoms, as reported by foster parents. The results of the analysis pertaining to Research Question 3 showed there were no significant differences in the interaction between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents. The interpretation of the findings, limitations of the study, recommendations, and implications will be discussed in Chapter 5.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

The primary purpose of this study was to examine the effect of foster care placement type (kinship and nonkinship) and previously reported mental health treatment services on reported PTSD symptoms in foster care children. I explored whether children, ages 3-12, in kinship foster homes significantly differed in symptoms of PTSD from children placed in nonkinship foster homes as reported by foster care parents. I explored whether attending previous mental health services within the past three to four months affected PTSD symptoms in foster care children as reported by foster parents. I also examined the interaction between kinship and nonkinship care placement type and previous mental health service treatment on PTSD in foster care children as reported by foster parents. I conducted a 2x2 factorial ANOVA to examine significant main effects and interactions between kinship and nonkinship foster care placement types and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster parents. Data obtained includes information from the TSCYC, as well as mental health treatment service demographic questionnaires, as reported from foster parents. Data analysis was conducted using the computer software program SPSS. In Chapter 5, I further discuss key findings in relation to current and future research and the study's research questions and hypotheses. I also offer recommendations for future research before making final conclusions about the study.

Interpretation of the Findings

I designed the study to address the gap in the literature, as well as examine the benefits and limitations of foster care children with reported PTSD symptoms placed in kinship and nonkinship foster homes. The research questions centered on the prevalence of specific types of posttraumatic stress symptoms for a sample of children living in both kinship and nonkinship foster homes and whether the children had previous mental health treatment services; my goal was to examine which placement setting was more beneficial for children in care who had been diagnosed with PTSD. All data for this study were collected anonymously from participating foster parents via an online survey. I recruited participants by posting flyers in local community shops in the Bronx, New York City, regional area.

Although this research study did not show any significant differences between placement type and reported PTSD symptoms, there were significant differences pertaining to mental health treatment services and reported PTSD symptoms. Foster parents with children who did not receive mental health treatment services reported higher symptoms of PTSD than foster parents with children who did receive mental health treatment services. The null hypothesis was rejected, and the alternate hypothesis was accepted. The results indicated that there was a significant difference in previous mental health treatment services within the past three to four months that affect PTSD symptoms in foster care children as reported by foster care parents. Overall, the study results did replicate the effects of mental health treatment services that have been observed in previous research studies (e.g., Dyregrov & Yule, 2006; Salazar et al., 2013).

This research study aligns with previous research that suggests that mental health services is imperative for children in foster care with PTSD (Bevilacqua et al., 2012 Pecora, White, Jackson, & Wiggins, 2009). This study also aligns with other research studies that suggest more research is needed to provide young children in foster care with reliable mental health services to help decrease problems that are associated with PTSD such as academic, social, and behavioral difficulty (Font, 2014; Pears & Fisher, 2005).

There were no significant differences in interaction effects between kinship and nonkinship placement type and previous mental health treatment services on PTSD symptoms in foster care children as reported by foster care parents. In addition, the results indicated that there is no significant difference in kinship and nonkinship foster parents reported symptoms of PTSD in their foster care children ages 3-12.

There may be several reasons why foster parents with children who did not receive mental health treatment services reported higher symptoms of PTSD than foster parents with children who did receive mental health treatment services. One factor may be overreporting of symptoms by foster parents, which could have skewed TSCYC results. Another reason may be due to placement stability, specifically children being placed in several homes and experiencing placement disruption; this may have led to skewed reports, as well. In addition, higher levels of PTSD symptoms may be due to the lack of training foster parents receive prior or during the time they engaged with a child who exhibited PTSD symptoms. Researchers have shown that PTSD training for foster parents can decrease PTS symptoms in children in foster care (Dorsey et al 2014; Sheperis, Renfro-Michel, & Doggett, 2003). It is reported that foster parents who have

PTSD training can have a better interaction with their foster child (Pecora, 2010). Foster parents who are trained to understand the prevalence of PTSD are better able to relate to their foster child and are more likely able to develop relationship strategies such as empathy, active listening, and healthy emotional bonding (Cusick, Havlicek, & Courtney, 2012).

Interpretation of Findings in Relation to the Theoretical Framework

As discussed in Chapter 1, I based the study on attachment theory (Ainsworth & Bowlby,1991). The theory depicts how children respond to other individuals within relationships when hurt or mistreated, separated, or displaced from loved ones, or when formed or unformed relationships are perceived as a threat (Ainsworth, Bell, & Stayton, 1971; Ainsworth, Blehar, Waters, & Wall, 2015; Bowlby, 1969). Essentially, all infants as well as young children become attached if provided a caregiver, but there are individual differences in the qualities of the relationships that sustain a bonding relationship (Burke, 2016; Hinde, 1991). Bolwby (1969) believed that the tendency for children to develop attachments to familiar caregivers was the result of evolutionary pressures, since attachment behavior would facilitate the child's survival in the face of dangers such as predation or exposure to harm. Researchers have also suggested that humans are innately driven to protect and nurture persons with shared blood lineage and pre-existing attachments (Lawler, 2008; Font, 2015). When children are placed into foster care these same attachment principles apply. Even when children are provided a new caregiver, they will seek proximity with either a close relative or unknown caregiver in order to survive (Barbaro, Boutwell, Barnes, & Shackelford, 2017; Turner, 2008).

Foster care placement can have serious implications on the emotional and cognitive development of young children (Font, 2014; Pears & Fisher, 2005). Out of home placement is typically associated with numerous disruptions in attachment relationships (Newton, Litrownik, & Landsverk, 2000; Pasalich, Fleming, Oxford, Zheng, & Spieker, 2016). Losses and lack of permanence can potentially undermine a child's attempt to form a secure attachment with a primary caregiver (Forsyth, 2017; Ponciano, 2010). The more changes young children in foster care experience, the more likely they are to exhibit oppositional, anxious, depressive, or clinging behavior (Simmel, 2007; Wilkinson, 2016). Results from this study suggest that foster children who were placed in care for at least 5 months or longer with kinship or nonkinship foster parents showed higher rates of receiving mental health treatment services, which may be due to parent-child attachment and PTSD training.

Interpretation of Findings in Relation to PTSD

Child protection services in the United States receives around three million reported cases of abuse each year, which ultimately will result in some form of trauma for children (Buckingham & Daniolos, 2013; Fang, Brown, Florence, & Mercy, 2012). Children and teens that go through the most severe traumas tend to have the highest levels of PTSD symptoms (McLaughlin, Koenen, Hill, Petukhova, Sampson, Zaslavsky, & Kessler, 2013). The more traumas a child goes through, the higher the risk of getting PTSD (Finkelhor, Ormrod, Turner, & Hamby, 2005). Children with a history of having other mental disorders are more likely to develop PTSD following trauma exposure than children who have never had a mental disorder. (Koenen, Moffitt, Caspi, Gregory,

Harrington & Poulton, 2008). This study found that children in foster care who received mental health treatment services exhibited less PTSD symptoms as reported by foster parents. Although there are no easy solutions, it is important that researchers address the mental health needs of young children in foster care. Children's need for continuity of relationships and their need for sensitive responsive care should be considered foremost in foster care home placement decisions (Rubin, O'Reilly, Luan, & Localio, 2007; Leathers, 2005; Linares, Li, Shrout, Brody, & Pettit, 2007; Barth et al., 2017).

Interpretation of Findings in Relation to Mental Health Treatment Services

The results of the study supported much of the literature regarding mental health treatment services and PTSD in foster children. The symptoms of PTSD and trauma exposure can have widespread impacts on children's psychological functioning and development (Beers & De Bellis, 2002; Cook, Spinazzola, Ford, Lanktree, Blaustein, & Cloitre, 2005; Hildyard & Wolfe, 2002; Cohen, Mannarino, & Deblinger, 2016). Many children who suffer traumatic events can develop depression or anxiety symptoms along with PTSD (Gabowitz, Zucker, & Cook, 2008; Van Nierop, et al., 2015). Most children in foster care have been exposed to some form of trauma (Moira et al., 2015). The very act of being put in foster care is traumatic for children, because it means the loss of their birth family, friends, schoolmates, teachers, and everything that is familiar. The type of trauma experienced by children in foster care can vary widely from neglect to domestic violence to physical and sexual abuse (Oswald et al., 2009; Meinck, Cluver, Boyes, & Mhlongo, 2015).

Although there are no easy solutions, it is important that we address the mental health needs of young children in foster care. Children's need for continuity of relationships and their need for sensitive responsive care should be considered foremost in foster care home placement decisions (Rubin, O'Reilly, Luan, & Localio, 2007; Leathers, 2005; Linares, Li, Shrout, Brody, & Pettit, 2007; Barth et al., 2017). A foster parent's goal is to provide children with stability, as well as help with whatever the child may need in terms psychological treatment (Vostanis, 2010). Trauma exposure, particularly exposure to child abuse and neglect, appears to have an impact across the lifespan into adulthood (Ai, Foster, Pecora, Delaney, & Rodriguez, 2013; Norman, Byambaa, De, Butchart, Scott, & Vos, 2012). In a study, child maltreatment was associated with a greater likelihood of mental health disorders across the lifetime, including risk for other anxiety disorders, mood disorders, and substance use disorders (Dorsey, Burns, Southerland, Cox, Wagner & Farmer, 2012). Other research has documented that exposure to a wide range of traumatic events such as child abuse and neglect, traumatic death of a loved one, exposure to domestic violence is associated with psychiatric difficulties in adulthood and higher rates of chronic disease, suicide attempts, and mortality (Greeson et al., & Fairbank, 2011; Graham-Bermann, & Seng, 2005). Up to 80 percent of children in foster care have significant mental health issues compared to approximately 20 percent of the general population (Shin, 2005). Research suggests that mental and behavioral health is the greatest unmet health need for children and teens in foster care that strongly needs to be implemented (Leslie, Gordon, Lambros, Premji, Peoples & Gist, 2005). This research study found a significant difference between

children who had previous mental health services and those who did not, which highlights the need for additional mental health services for foster children.

Limitations of the Study

This researcher was able to collect non-bias reports from foster parents about their children's PTSD symptoms. No participant was chosen for this study, and all participants were anonymous to researcher. In addition, the study was conducted in the state of New York in the Bronx regional area and limits the generalizability of the results to other regions of the country. Another limitation to the study was the survey collection of data from foster parents. Although, there was an online survey available for foster parents to report their children's symptoms, this researcher would have been able to gather more data if partnered with foster agencies to collect pre and post tests of PTS assessments and mental health services after a duration of time looking at changes in symptoms within kinship and nonkinship foster homes and received mental health services. With a larger sample, this research study may have found statistical significances in RQ 1 and RQ3. Another limitation to include is that it was completed online – some foster parents may not have had access to computers, so could not participate. Finally, another limitation is relying on the foster parents to give accurate reported symptoms of their foster child. It is hard to know how someone else thinks and feels.

Recommendations

Several recommendations for further research are warranted based on findings from this study. The first recommendation is for future investigations to assess and consider mental health services for all children in foster care exhibiting PTS symptoms.

The study's findings were consistent with literature suggesting that mental health treatment services, whether children are in kinship or nonkinship foster homes, has an impact on children's psychological and behavioral health (American Psychological Association, 2008; Nurius et al., 2015). Researchers suggest that children who receive mental health treatment services are more likely to experience less mental health and behavioral problems, and increased probabilities for experiencing a lasting positive relationship with their foster parent(s) (Gauthier, Fortin, & Jeliu, 2004; Rubin, Alessandrini, Feudtner, Mandell, Localio, & Hadley, 2004; Waid, Kothari, Bank, & McBeath, 2016). The research findings from this study suggest that further research should be conducted on mental health treatment services provided this study highlights children who did not receive mental treatment services had higher rates of PTSD as reported by foster parents.

Although research is growing about the nature and consequences of trauma and PTSD experienced by older youth in the general population, much less is known about the trauma experiences of children in foster care (Collin-Vézina, Coleman, Milne, Sell, & Daigneault, 2011; Salazar et al., 2013). To date, the literature addressing trauma exposure among youth in the child welfare system has focused on maltreatment, abuse, and neglect rather than children with PTSD and placement type in kinship and nonkinship foster homes, and how placements may exacerbate or improve PTS symptoms (Klain, & White, 2013; O'Connor, & Elklit, 2008; Fusco, & Cahalane, 2015). The Northwest Foster Care Alumni Study (Pecora et al., 2005) found that child welfare agencies can help prevent PTSD and other negative mental health outcomes for foster children by improving

training for foster parents. The purpose of this research study was to create awareness around kinship and nonkinship placements for youths in foster care with PTSD.

The second recommendation is to expand the study to a larger population of foster parents. The study was geared only to a portion of people in a particular region of the United States. If this was a national or longitudinal study, the research results for RQ 1 and RQ 3 may have shown statistical significances. The ethnicities of most of the children and foster parents who participated in this research study were predominately Black and Hispanic. Similar to most other research studies involving this population, the study design did not control for many experiences of children in foster care in the United States in comparison to children from other countries. The study could have been expanded to reflect the whole tri-state area, and in a longitudinal study could be expanded to include the entire United States in which child welfare services are provided.

In this study, it is imperative to take caution in the interpretations of results. This study was only limited to children in foster care between ages 3-12, and skewed towards foster parents with foster children who report high rates of PTS symptoms as well as mental health services. As it pertains to the scope of the research, this study did not assess foster parent training, nor did it assess children placed in other placement settings besides kinship and nonkinship foster homes. In addition, this study did not assess placement stability and how children experiencing placement disruption itself can uniquely impact children's cognitive and emotional outcomes, which may warrant further research.

Implications

There are two significant implications for social change based on the results of this research study. The first implication is that the findings of the current study may add to the body of literature about children in foster care diagnosed with PTSD and how mental health treatment services may have a positive effect on children's emotional and cognitive growth. As an example, it is reported that children in foster care diagnosed with PTSD who receive mental health services regardless of placement type can improve children's well-being and mental health (Dyregrov, Yule, 2006). This study found that children in foster care who received mental health treatment services exhibited less PTSD symptoms as reported by foster parents.

The second implication is that social service welfare agencies will help their clients with PTSD by offering biological parents and children with more options when it comes to placement stability and mental health services. Mental health services as well as parental support is often considered essential for children in foster care to buffer aversive mental health behavior and building positive emotional coping skills (American Psychological Association, 2008; Nurius et al., 2015). Again, this study found that children in foster care who received mental health treatment services exhibited less PTSD symptoms as reported by foster parents.

Conclusion

The purpose of this quantitative research study was to examine the effect of foster care placement type (kinship and nonkinship) and previously reported mental health service treatment on reported PTSD symptoms in foster care children. The study explored

whether children, ages 3-12, in kinship foster homes significantly differed in symptoms of PTSD from children placed in nonkinship foster homes as reported by foster care parents. the research community should continue to study children in foster care diagnosed with PTSD on a national scale. The study results suggested the research community should continue to study children in foster care diagnosed with PTSD on a national scale, and showed that mental health treatment services does have effect on foster children's PTSD symptoms as reported by foster parents, showing a decrease in symptoms for children who received mental health treatment services. While the study did not show any statistical significance on PTSD symptoms due to placement type as reported by foster parents for children in kinship versus nonkinship foster homes, this research study did shed light on the prevalence of mental health services suggesting there is truly an important need for available mental health services to children with PTSD for children in foster care.

References

Abela, J. R., Hankin, B. L., Haigh, E. A., Adams, P., Vinokuroff, T., & Trayhern, L. (2005). Interpersonal vulnerability to depression in high-risk children: The role of insecure attachment and reassurance seeking. *Journal of Clinical Child and Adolescent Psychology, 34*(1), 182-192. doi:10.1017/ S003329179700593X

Ai, A. L., Foster, L. J. J., Pecora, P. J., Delaney, N., & Rodriguez, W. (2013). Reshaping child welfare's response to trauma: Assessment, evidence-based intervention, and new research perspectives. *Research on Social Work Practice, 23*(6), 651-668. doi.org/10.1177/1049731513491835

Ainsworth, M,D., & Maluccio, A. N. (1998). Kinship care: False dawn or new hope? *Australian Social Work, 51*(4), 3-8. doi.org/10.1080/03124079808411238

Ainsworth, M. D. (1964). Patterns of attachment behavior shown by the infant in interaction with his mother. *Merrill-Palmer Quarterly of Behavior and Development,*51-58.

Ainsworth, M. D. (1985). Attachments across the life span. *Bulletin of the New York Academy of Medicine, 61*(9), 792.

Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*, 49-67. doi.org/10.2307/1127388

Ainsworth, M. D. S., Bell, S. M., & Stayton, D. J. (1971). Individual differences in strange-situation behavior of one-year-olds. In H. R. Schaffer (Ed.), *The origins of human social relations* (pp. 17-58). London, England: Academic Press.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. N. (2015). Patterns of attachment: A psychological study of the strange situation (Classic ed.). New York, NY: Psychology Press. doi.org/10.1002/1097-0355(198021)1:1<68::AID-IMHJ2280010110>3.0

Ainsworth, M. D. S., & Bowlby, J. (1991), An ethological approach to personality development. *American Psychologist, 46*, 331-341. doi.org/10.1037/0003-066X.46.4.333

Alder, M. C., Yorgason, J. B., Sandberg, J. G., & Davis, S. (2017). Perceptions of parents' marriage predicting marital satisfaction: The moderating role of attachment behaviors. *Journal of Couple & Relationship Therapy,* 1-19. doi: 10.1177/1069397114552769

Alisic, E., Zalta, A. K., Van Wesel, F., Larsen, S. E., Hafstad, G. S., Hassanpour, K., & Smid, G. E. (2014). Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: meta-analysis. *The British Journal of Psychiatry*, 204(5), 335-340. doi:10.1192/bjp.bp.113.131227

Al Odhayani, A., Watson, W. J., & Watson, L. (2013). Behavioral consequences of child abuse. *Canadian Family Physician*, 59(8), 831–836. doi 10.1186/1471-2431-13-202

Allen, M., & Bissell, M. (2004). Safety and Stability for Foster Children: The Policy Context. *The Future of Children*, 14(1), 49-73. doi:10.2307/1602754

Allen, T., DeVooght, K., & Geen, R. (2008). State kinship care policies for children that come to the attention of child welfare agencies: Findings from the 2007 Casey

Kinship Foster Care Policy Survey. Washington, D.C.: Child Trends.

Alisic, E., Krishna, R. N., Groot, A., & Frederick, J. W. (2015). Children's mental health and well-being after parental intimate partner homicide: A systematic review. *Clinical child and family psychology review*, 18(4), 328-345. doi:10.1177/1088767999003003002

American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Washington, D.C: American Psychiatric Association.

American Academy of Pediatrics. (2016). Adverse events affect children's development, physical health and biology. Science Daily.

American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents. (2008). Disseminating evidence-based practice for children and adolescents: A systems approach to enhancing care. Washington, DC: American Psychological Association.

American Psychological Association Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents (2008). Children and Trauma. Washington, DC: American Psychological Association.

Anbalagan, E., & Soulier, M. (2017). Children In Need of Services (CHINS). *The Encyclopedia of Juvenile Delinquency and Justice*. **doi:**10.1002/9781118524275.ejdj0174

Andersen, S. H., & Fallesen, P. (2015). Family matters? The effect of kinship care on

foster care disruption rates. *Child abuse & neglect*, 48, 68-79. doi:10.1016/j.chiabu.2015.06.005

Arditti, J. (2005) Families and Incarceration: An Ecological Approach. Families in Society. *The Journal of Contemporary Social Services*: Vol. 86, No. 2, pp. 251-260. doi.org/10.1606/1044-3894.2460

Aronson, E., Wilson, T. D., Akert, R. M., & Fehr, B. (2007). Social psychology. (4 ed.). Toronto, ON: Pearson Education.

Attar-Schwartz, S., Tan, J. P., Buchanan, A., Flouri, E., & Griggs, J. (2009). Grand-parenting and adolescent adjustment in two-parent biological, lone-parent, and step-families. *Journal of family psychology*, 23(1), 67. doi:10.1037/a0014383

Attar-Schwartz, S., Tan, J., Buchanan, A., Griggs, J., & Flouri, E. (2009). Grand parenting and adolescent adjustment in two-parent biological, lone-parent, and step-families. *Journal of Family Psychology*, 23(1), 67-75. doi:10.1177/0192513X04265950

Armour, M. (2007). Violent death: Understanding the context of traumatic and stigmatized grief. *Journal of Human Behavior in the social environment*, 14(4), 53-90. doi:10.1177/0011128713505487

Atwool, N. (2006). Attachment and resilience: Implications for children in care. *Child Care in Practice*, 12(4), 315-330. doi:10.1080/13575270600863226

Baker, A. J., & Curtis, P. (2006). Prior placements of youth admitted to therapeutic foster care and residential treatment centers: The odyssey project population. *Child and Adolescent Social Work Journal,* 23(1), 38-60. doi:10.1007/s10560-005-0031-8

Balaban, V. (2009). Assessment of children. Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies, 2, 63-80. doi.org/10.1080/03069885.2010.550798

Barbaro, N., Boutwell, B. B., Barnes, J. C., & Shackelford, T. K. (2017). Rethinking the transmission gap: What behavioral genetics and evolutionary psychology mean for attachment theory. doi:10.1037/bul0000066

Barbell, K., & Wright, L. (2018). Family foster care in the next century. Routledge. doi.org/10.4324/9781351320481

Barber, J. G., & Delfabbro, P. H. (2003). Placement stability and the psychosocial well-being of children in foster care. *Research on Social Work Practice*, 13(4), 415-431. doi.org/10.1177/1049731503013004001

Barnett, O., Miller-Perrin, C. L., & Perrin, R. D. (2005). Family violence across the lifespan: An introduction, 2nd ed. Thousand Oaks, CA: Sage Publications. doi:10.1007/s10964-008-9347-y

Barth, R. P., Lloyd, E. C., Green, R. L., James, S., Leslie, L. K., & Landsverk, J. (2007). Predictors of placement moves among children with and without emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders*, 15(1), 46-55. doi:10.1177/106342660701500 10501

Barth R. P., Guo, S., Green, R., McCrae, J. (2007). Kinship care and nonkinship foster care: Informing the new debate. In: Haskins R, Wulczyn FH, Webb M, editors. Child protection: Using research to improve policy and practice. Brookings Institution; Washington, DC.

Barth, R. P., Wildfire, J., & Green, R.L. (2007). Placement into foster care and the interplay of urbanicity, child behavior problems, and poverty. *American Journal of Orthopsychiatry*, 76 (3), 350-365. doi:10.1037/0002-9432.76.3.358

Barth, R. P., Lloyd, E. C., Green, R. L., James, S., Leslie, L. K., & Landsverk, J. (2007). Predictors of placement moves among children with and without emotional and behavioral disorders. *Journal of Emotional and Behavioral Disorders*, 15(1), 46-55. doi.org/10.1177/10634266070150010501

Barth, R. P. (2017). From child abuse to foster care: Child welfare services pathways and placements. Routledge. doi:10.1080/10437797.2014.856247

Barth, R. P. J, Barth, R. P. K., & Barth, R. P. (2017). The child welfare challenge: Policy, practice, and research. Routledge. doi:10.1007/s10854-017-6461-1

Barnow, B. S., Buck, A., O'brien, K., Pecora, P., Ellis, M. L., & Steiner, E. (2015). Effective services for improving education and employment outcomes for children and alumni of foster care service: correlates and educational and employment outcomes. *Child & Family Social Work*, 20(2), 159-170. doi:10.1111/cfs.12063

Baruch Bush, R. A., Hershman, L., Thaler, R., & Vitkovich, C. (2009). Supporting family strength: the use of transformative mediation in a PINS mediation clinic. *Family Court Review*, 47(1), 148-166. doi.org/10.1111/j.1744-1617.2009.00246.x

Batista, T. & Johnson, A. (2016). The Children's Aid Society: Early Origins of Youth Empowerment in the US Foster Care System or Paternalistic Prevention? *Journal*

of Family History, 42 (1) 67 - 80. doi.org/10.1177/0363199016681608

Becker□Weidman, A., & Hughes, D. (2008). Dyadic developmental psychotherapy: an evidence□based treatment for children with complex trauma and disorders of attachment. *Child & Family Social Work*, 13(3), 329-337. doi:10.1111/j.1365-2206.2008.00557

Beeman, S. K., Kim. H., & Bullerdick, S. K. (2000). Factors affecting placement of children in kinship and nonkinship foster care. *Children and Youth Services Review*, 22, 37-54 DOI: 10.1080/1533256X.2010.521078

Beers, S. R., & De Bellis, M. D. (2002). Neuropsychological Function in Children with Maltreatment-Related Posttraumatic Stress Disorder. American Journal of Psychiatry, 159(3), 483-486. doi:10.1176/appi.ajp.159.3.483 PMID:11870018

Bell, T., & Romano, E. (2017). Permanency and safety among children in foster family and kinship care: A scoping review. Trauma, Violence, & Abuse, 18(3), 268-286. doi.org/10.1177/1524838015611673

Belsky, J., & Fearon, R. M. P. (2008). Precursors of attachment security. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications*, 295–316. The Guilford Press.

Benbenishty, R., Davidson-Arad, B., López, M., Devaney, J., Spratt, T., Koopmans, C., Knorth, E.J., Witteman, C.L., Del Valle, J.F. & Hayes, D., (2015). Decision making in child protection: An international comparative study on maltreatment substantiation, risk assessment and interventions recommendations, and the role of professionals' child welfare attitudes. *Child Abuse & Neglect*, 49, pp.63-75.

doi.org/10.1016/j.chiabu.2015.03.015

Bender, K., Yang, J., Ferguson, K., & Thompson, S. (2015). Experiences and needs of homeless youth with a history of foster care. *Children and Youth Services Review*, 55, 222-231. doi.org/10.1016/j.childyouth.2015.06.007

Berkowitz, S. J., Stover, C. S., & Marans, S. R. (2011). The child and family traumatic stress intervention: Secondary prevention for youth at risk of developing PTSD. *Journal of Child Psychology and Psychiatry*, 52(6), 676-685. doi:10.1111/j.1469-7610.2010.02321.x

Bernard, H. R., Wutich, A., & Ryan, G. W. (2016). Analyzing qualitative data: Systematic approaches. SAGE publications. doi.org/10.1177/1609406917705796

Bernedo, I. M., García-Martín, M. A., Salas, M. D., & Fuentes, M. J. (2016). Placement stability in nonkinship foster care: Variables associated with placement disruption. *European Journal of Social Work*, 19(6), 917-930. doi.org/10.1177/1468017318757399

Berrick, J.D. (1998). When children cannot remain home: Foster family care and kinship care. Protecting Children from Abuse and Neglect, 8(1), 72□87. doi.org/10.1023/A

Berrick, J. D. (1997). Assessing quality of care in kinship and foster family care. *Family Relations*, 46, 273–280. doi:10.1002/psp.437

Bevilacqua, L., Carli, V., Sarchiapone, M., George, D. K., Goldman, D., Roy, A., & Enoch, M. A. (2012). Interaction between FKBP5 and childhood trauma and risk of aggressive behavior. *Archives of general psychiatry*, 69(1), 62-70.

doi:10.1017/s095457941200106

Billing, A., Ehrle, J., & Kortenkamp, K. (2002). Children cared for by relatives: What do we know about their well-being? Washington, DC: Urban Institute. doi.org/10.1080/10502550902717699

Birk, M. (2015). Fostering on the Farm: Child Placement in the Rural Midwest. University of Illinois Press. doi.org/10.1093/ahr/121.3.961

Bisson, J. I., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post□traumatic stress disorder (PTSD) in adults. *The Cochrane Library*. doi:10.1017/S1352465812000793

Blanca, M., Alarcón, R., Arnau, J., Bono, R., & Bendayan, R. (2017). Non-normal data: Is ANOVA still a valid option? *Psicothema*, 29(4), 552-557. doi:10.7334/psicothema2016.383

Blakely, G. L., Leon, S. C., Fuller, A. K., & Bai, G. J. (2017). Foster Care Children's Kinship Involvement and Behavioral Risks: A Longitudinal Study. *Journal of Child and Family Studies*, 1-13. doi.org/10.1038/pr.2015.201

Boddy, J. (2013). Understanding permanence for looked after children: A review of research for the care inquiry. doi:10.1093/bjsw/bct052

Bovenschen, I., Lang, K., Zimmermann, J., Förthner, J., Nowacki, K., Roland, I., & Spangler, G. (2016). Foster children's attachment behavior and representation: Influence of children's pre-placement experiences and foster caregiver's sensitivity. *Child abuse & neglect*, 51, 323-335.

doi.org/10.1016/j.chiabu.2015.08.016

Bowlby, J. (1980). Attachment and Loss Vol 1 (1969). Attachment and loss, 3. doi.org/10.1111/j.1939-0025.1982.tb01456.x

Bowlby, J. (1969), Attachment and loss, Vol. 1: Attachment. New York: Basic Books. doi:10.4236/psych.2017

Bowlby, J., Ainsworth, M., Boston, M., & Rosenbluth, D. (1956). The effects of mother□child separation: a follow□up study. *Psychology and Psychotherapy: Theory, Research and Practice*, 29(3□4), 211-247. doi.org/10.1111/j.2044-8341.1956.tb00915.x

Bowlby, J., Ainsworth, M., & Bretherton, I. (1992). The origins of attachment theory. *Developmental Psychology*, 28, 759–775. doi:10.1037/0012-1649.28.5.759

Bowlby, J. (2005). A secure base: Clinical applications of attachment theory (Vol. 393). Taylor & Francis. doi:10.1046/j.13652648.2003.02857

Bowlby, J. (2008). A secure base: Parent-child attachment and healthy human development. Basic books. **doi**.org/10.1176/ps.41.6.684-a. About.

Bowlby, J., & Ainsworth, M. (2013). The origins of attachment theory. *Attachment Theory: Social, Developmental, and Clinical Perspectives*, 45. doi:10.1080/136918 3X.2012.646417

Boyle, C. (2017). 'What is the impact of birth family contact on children in adoption and long□term foster care? A systematic review. *Child & Family Social*

Work, 22(S1), 22-33. doi.org/10.1111/cfs.12236

Bramlett, M. D., & Radel, L. F. Adverse family experiences among children in non-parental care, 2011-2012. (2014). National Health Statistics Reports, no. 74, 1-8. doi:10.1177/1077559517729486

Brazelton, T. B., & Greenspan, S. I. (2009). The irreducible needs of children: What every child must have to grow, learn, and flourish. Da Capo Press. doi:10.1016/j.ecresq.2006.01.008

Brewer, M. (2000). Research Design and Issues of Validity. In Reis, H. and Judd, C. (eds.) Handbook of Research Methods in Social and Personality Psychology. Cambridge: Cambridge University Press. doi:10.1002/asi.20197

Briere, J. (1996). Trauma Symptom Checklist for Children (TSCC), Professional Manual. Odessa, FL: Psychological Assessment Resources. doi:10.1002/jts.20048

Briere, J., &Lanktree, C.B. (1995) The Trauma Symptom Checklist for Children (TSCC): Preliminary psychometric characteristics. Unpublished manuscript, Dept. of Psychiatry, University of Southern California School of medicine.

Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., Hanson, R. & Ernst, V., (2001). The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study. Child abuse & neglect, 25(8), pp.1001-1014. doi:x.php?id=10.3346/jkms.2015.30.9.1340

Briere, J., & Spinazzola, J. (2005). Phenomenology and psychological assessment of complex posttraumatic states. *Journal of traumatic stress*, 18(5), 401-

412.doi:10.1002/jts.20048

Briggs-Gowan, M. J., Carter, A. S., Clark, R., Augustyn, M., McCarthy, K. J., & Ford, J. D. (2010). Exposure to potentially traumatic events in early childhood: Differential links to emergent psychopathology. *Journal of Child Psychology and Psychiatry*, 51, 1132–1140. doi:10.1111/j.1469-7610.2010.02256.x

Britto, P.R., Lye, S.J., Proulx, K., Yousafzai, A.K., Matthews, S.G., Vaivada, T., Perez-Escamilla, R., Rao, N., Ip, P., Fernald, L.C. & MacMillan, H., (2017). Nurturing care: promoting early childhood development. *The Lancet Journal*, 91-102. doi:10.1016/S0140-6736(16)31390-3

Brooks-Gunn, J., Schneider, W., & Waldfogel, J. (2013). The Great Recession and the risk for child maltreatment. *The Journal of Child Abuse & Neglect*, 37(10), 721-729. doi.org/10.1016/j.chiabu.2013.08.004.

Brown, A. (2011). Orphan trains (1854-1929). Social Welfare History Project. doi.org/10.1080/00377996.2013.859119

Brown, S. D. (2007). An investigation of trauma symptom reduction in a clinical sample of sexually abused children using the trauma symptom checklist for children. Georgia State University. doi.org/10.2307/1132368;

Brumariu, L. E. (2015). Parent–child attachment and emotion regulation. New directions for child and adolescent development, 2015(148), 31-45. doi:10.1002/cad.20098

Bruskas, D. (2008). Children in foster care: A vulnerable population at risk. *Journal of Child and Adolescent Psychiatric Nursing,* 21(2), 70-77. doi.org/10.1111/j.1744-

6171.2008.00134.x

Buckingham, C. E. (1948). Early American Orphanages: Ebenezer and Bethesda Social Forces, 26, (3), 311-321.

Buckingham, E. T., & Daniolos, P. (2013). Longitudinal outcomes for victims of child abuse. *Current psychiatry reports*, 15(2), 342. doi:10.1007/s11920-012-0342-3.

Buehler, C., Cox, M. E., & Cuddeback, G. (2003). Foster parents' perceptions of factors that promote or inhibit successful fostering. *Qualitative Social Work*, 2(1), 61-83. doi:10.1177/1473325003002001281

Buffaloe, M. S. (2017). What's One More Placement: An Exploration of Factors that Impact Placement Stability for Foster Youth in Out-of-Home Care (Doctoral dissertation, Alliant International University).

Burke, L. (2016). Creating Relationships That Heal (Doctoral dissertation, California State University, Northridge).

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(8), 960-970. Ddoi:10.1097/01.chi.0000127590.95585.65

Butcher, F., Kretschmar, J. M., Singer, M. I., & Flannery, D. J. (2015). Confirmatory factor analysis of the Trauma Symptom Checklist for Children in an at-risk sample of youth. *Journal of the Society for Social Work and Research*, 6(2), 251-268. doi:10.1086/681545

Butler, R. W. (2014). A program becomes a home: the Marion County Children's Guardian Home, part 1: the Board of Children's Guardian County, 1889-1936. *The Hoosier Genealogist: Connections*, 54 (1), 229-235.

Cain, C. M. (2017). Child Savers. *The Encyclopedia of Juvenile Delinquency and Justice*. doi:10.1002/9781118517390.wbetc164

Calhoun, S., Conner, E., Miller, M., & Messina, N. (2015). Improving the outcomes of children affected by parental substance abuse: a review of randomized controlled trials. *Substance Abuse and Rehabilitation*, 6, 15–24. doi.org/10.2147/SAR

Campbell, D. T., & Stanley, J. C. (2015). Experimental and quasi-experimental designs for research. *Ravenio Books*. doi:10.4236/health.2013.53055

CAPTA Reauthorization Act of 2010, Pub. L. No. 111-320, 124 Stat. 3459 (2010) (codified as amended at 42 U.S.C. §§ 5101-5106, 5116 (2012)

Carlson, R. (2010). Seeking the better interests of children with a new international law of adoption. NYl Sch. l. rev., 55, 733.

Carlson, E. B., Dalenberg, C., Armstrong, J., Daniels, J. W., Loewenstein, R., & Roth, D. (2001). Multivariate prediction of posttraumatic symptoms in psychiatric inpatients. *Journal of Traumatic Stress*, 14, 549–567. doi.org/10.1023/A:1011164707774

Carver, C. S., & Connor-Smith, J. (2010). Personality and coping. *Annual review of psychology*, 61, 679-704. doi.org/10.1146/annurev.psych.093008.100352

Casey Family Programs. (2011). Foster care by the numbers. doi.org/10.1016/j.childyouth.2012.10.011

Cassibba, R., Castoro, G., Costantino, E., Sette, G., & Van Ijzendoorn, M. H. (2015). Enhancing maternal sensitivity and infant attachment security with video feedback: An exploratory study in Italy. *Infant mental health journal*, 36(1), 53-61. doi:10.1002/imhj.21486 PMID:25445216

Cassidy, J. (2008). The nature of the child's ties. In J. Cassidy & P. R. Shaver (Eds.), Handbook of attachment: Theory, research, and clinical applications, New York: Guilford Press. doi:10.1186/1471-2202-6-37

Cassidy, J., & Shaver, P. R. (Eds.). (2002). Handbook of attachment: Theory, research, and clinical applications. *Rough Guides*. doi.org/10.1002/imhj.21730

Cederna-Meko, C., Koch, S. M., & Wall, J. R. (2014). Youth with oppositional defiant disorder at entry into home-based treatment, foster care, and residential treatment. *Journal of Child and Family Studies*, 23(5), 895-906. doi.org/10.1177/1077559516657637

Cengage Learning Carkhuff, R. (2017). Toward effective counseling and psychotherapy: Training and practice. Routledge. doi.org/10.4324/9781351301480

Chae, Y., Goodman, M., Goodman, G.S., Troxel, N., McWilliams, K., Thompson, R.A., Shaver, P.R. and Widaman, K.F., 2018. How children remember the Strange Situation: The role of attachment. *Journal of Experimental Child Psychology*, 166, 360-379. doi/pdf/10.1111/cdep.12307

Chambers, R. M., Crutchfield, R. M., Willis, T. Y., Cuza, H. A., Otero, A., & Carmichael, H. (2017). Perspectives: Former foster youth refining the definition of placement moves. *Children and Youth Services Review*, 73, 392-397.

doi:10.1080/1550428X.2018.1465875 Brodzinsky, D. (2018).

Chambers, M. F., Saunders, A. M., New, B. D., Williams, C. L., & Stachurska, A. (2010). Assessment of children coming into care: Processes, pitfalls and partnerships. *Clinical child psychology and psychiatry*, 15(4), 511-527. doi:10.1177/1359104510375932

Child Welfare Education and Research Programs. (2013). Developmental screening in Pennsylvania child welfare services: A statewide view of children in child welfare. Pittsburgh, PA: University of Pittsburgh, School of Social Work. doi:10.17226/21868

Child Welfare Information Gateway. (2009). Understanding the effects of maltreatment on brain development. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. **doi**: 10.1016/j

Child Welfare Information Gateway. (2011). Family reunification: What the evidence shows. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. **doi**: 10.1016/j

Child Welfare Information Gateway. (2011). About CAPTA: A Legislative History. U. S. Department of Health and Human Services. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. **doi**: 10.1016/j

Child Welfare Information Gateway. (2013). Out-of-home care. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. **doi**: 10.1016/j

Child Welfare Information Gateway. (2014). Parental substance use and the child welfare system. Washington, DC: U.S. Department of Health and Human Services,

Children's Bureau. **doi**: 10.1016/j

Child Welfare Information Gateway. (2014). Parenting a child who has experienced trauma. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. **doi**: 10.1016/j

Child Welfare Information Gateway. (2016). Definitions of child abuse and neglect. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. **doi**: 10.1016/j

Child Welfare Information Gateway. (2017). Foster care statistics 2015. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau **doi**: 10.1016/j

Child Welfare Information Gateway. (2017). Foster care statistics 2015. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. **doi**: 10.1016/j

Child Welfare League of America. (1994). Kinship care: A natural bridge. Washington, DC: Author. doi:10.1542/peds.2013–0969

Chiodo, J, J. & Meliza, E. (2014). Orphan Trains: Teaching about an Early Twentieth-Century Social Experiment, 145-157. doi.org/10.1080/00377996.2013.859119

Chipman, R., Wells, S., & Johnson, M. (2002). The meaning of quality in kinship foster care: Caregiver, child, and worker perspectives. Families in Society. *The Journal of Contemporary Social Services*, 83(5), 508-520. doi.org/10.1606/1044-3894.51

Chu, J. A. (2011). Rebuilding shattered lives: Treating complex PTSD and dissociative disorders. John Wiley & Sons. doi.org/10.1002/9781118093146

Cloitre, M., Stolbach, B. C., Herman, J. L., Kolk, B. V. D., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of traumatic stress*, 22(5), 399-408. doi: 10.1002/jts.20444

Coakley, T. M., Cuddeback, G., Buehler, C., & Cox, M. E. (2007). Kinship foster parents' perceptions of factors that promote or inhibit successful fostering. *Children and Youth Services Review*, 29(1), 92-109. doi.org/10.1016/j.childyouth.2017.11.026

Coggins, K., Opiola, K., & Carnes-Holt, K. L. (2017). Consultation Strategies for Working with Professionals Supporting Foster Families. In Emerging Research in Play Therapy, Child Counseling, and Consultation, *IGI Global*, 265-287. doi:10.4018/978-1-5225-2224-9.ch015

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child abuse & neglect*, 36(6), 528-541. doi:10.1016/j.chiabu.2012.03.007

Cohen, J. A., Mannarino, A. P., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial. *Archives of pediatrics & adolescent medicine*, 165(1), 16-21. doi:10.1001

Cohen, J. A., & Mannarino, A. P. (2015). Trauma-Focused Cognitive Behavioral Therapy for Traumatized Children and Families. *Child and Adolescent Psychiatric Clinics of North America,* 24(3), 557–570.

doi.org/10.1016/j.chc.2015.02.005

Cohen, J. A., Issues, T. W. G. O. Q., & AACAP Work Group on Quality Issues. (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49(4), 414-430. doi:org/10.1016/j.jaac.2009.12.020

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2016). Treating trauma and traumatic grief in children and adolescents. Guilford Publications doi.org/10.1177

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (Eds.). (2012). Trauma-focused CBT for children and adolescents: Treatment applications. Guilford Press. doi:10.1002/jts/20594

Collin-Vézina, D., Coleman, K., Milne, L., Sell, J., & Daigneault, I. (2011). Trauma experiences, maltreatment-related impairments, and resilience among child welfare youth in residential care. *International Journal of Mental Health and Addiction,* 9(5), 577-589. doi:10.1007/s11469-011-9323-8

Collins, N. L., & Feeney, B. C. (2004). An attachment theory perspective on closeness and intimacy. *Handbook of closeness and intimacy*, 163-187. doi.org/10.1037/0022-3514.78.6.1053;

Conway, T., & Hutson, R. (2007). Is kinship care good for kids? Washington, DC: Center for Law and Social Policy. doi:10.1177/1748895815590201

Cook, A., Spinazzola, J., Ford, J. D., Lanktree, C., Blaustein, M., & Cloitre, M. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390-398. doi. org/10.1111/j.1939-0025.2012.01154.x.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R.,

Hubbard, R., Kagan, R., Liautaud, J. & Mallah, K., (2005) Complex trauma in children and adolescents. *Psychiatric annals*, 35(5), 390. DOI 10.1007, 2017

Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, 64(5), 577-584. doi:10.1001/archpsyc.64.5.577

Courtney, M. E., & Heuring, D. H. (2005). The transition to adulthood for youth "aging out" of the foster care system. On your own without a net: The transition to adulthood for vulnerable populations, 27-67. doi.org/10.1177/1541204012463409

Courtney, J. R., & Prophet, R. (2011). Predictors of placement stability at the state level: The use of logistic regression to inform practice. *Child welfare*, 90(2), 127.

Courtney, M. E., & Hook, J. L. (2012). Evaluation of the impact of enhanced parental legal representation on the timing of permanency outcomes for children in foster care. *Children and Youth Services Review*, 34(7), 1337-1343. doi.org/10.1016/j.childyouth.2012.03.016

Crandal, B. R., Hazen, A. L., & Reutz, J. R. (2017). Identifying Trauma-Related and Mental Health Needs: The Implementation of Screening in California's Child Welfare Systems. *Advances in Social Work*, 18(1), 335-348. doi.org/10.18060/21278

Creswell, J. W. (2003). Research Design: Qualitative, Quantitative, and Mixed Methods Approaches (2nd ed.). Thousand Oaks, CA: Sage. doi: 10.12691/jbms-4-4-1

Creswell, J. W., & Creswell, J. D. (2017). Research design: Qualitative, quantitative, and mixed methods approaches. Sage publications. doi:10.4236/ajc.2015.34011 5,080

Cuddeback, G. S. (2004). Kinship family foster care: A methodological and substantive synthesis of research. *Children and youth services review*, 26(7), 623-639. doi/full/10.1177/1049731515620843

Cusick, G. R., Havlicek, J. R., & Courtney, M. E. (2012). Risk for arrest: The role of social bonds in protecting foster youth making the transition to adulthood. *American Journal of Orthopsychiatry*, 82(1), 19. doi/full/10.1177/1077559517718956

Daignault, I. V., & Hébert, M. (2009). Profiles of school adaptation: Social, behavioral and academic functioning in sexually abused girls. *Child Abuse & Neglect*, 33(2), 102-115. doi.org/10.1007/s12671-017-0759-1

Daro, D., & Donnelly, A. C. (2002). Charting the waves of prevention: Two steps forward, one step back. *Child Abuse & Neglect*, 26, 731–742. doi.org/10.1177/0886260515625908

Davis, J. M. (2016). The Gospel of Kindness: Animal Welfare and the Making of Modern America. Oxford University Press. doi.org/10.1017/

Davis, K. (2017). Perspectives of Professionals on Treatment Foster Care Success.

Davidson, J. O. C., & Howard, N. (2015). Migration and Mobility. doi:10.1016/S2214-109X(15)70016-1

De Bellis, M. D., & A.B., A. Z. (2014). The Biological Effects of Childhood Trauma. *Child and Adolescent Psychiatric Clinics of North America*, 23(2), 185–222. doi:10.1016/j.chc.2014.01.002

DeBellis, M.D. (2001). Developmental traumatology: The psychobiological development

of maltreated children and its implication for research, treatment, and policy. *Development and Psychopathology*, 13, 539–564. doi.org/10.1017/S0954579401003078

Denham, S. A. (2007). Dealing with feelings: how children negotiate the worlds of emotions and social relationships. *Cognitie, Creier, Comportament/Cognition, Brain*, Behavior, 11(1), 196-209.

DePrince, A. P. (2001). Trauma and posttraumatic responses: An examination of fear and betrayal. *Dissertation Abstracts International: Section B: Sciences & Engineering,* 62(6), 2890-2953.

Department for Children, Schools and Families (2010), Support for All: The Families and Relationships Green Paper, London: The Stationery Office. doi/full/10.1080/02673843.2012.709173

Denby, R. W., Testa, M. F., Alford, K. A., Cross, C. L., & Brinson, J. A. (2017). Protective Factors as Mediators and Moderators of Risk Effects on Perceptions of Child Well-Being in Kinship Care. *Child Welfare*, 95(4). doi:10.15405/epsbs.2018.11.02.31

Diaz, J. (1994). The impact of sexual abuse on adolescent females: factors influencing subsequent psychological adjustment and sexual behavior. Unpublished doctoral dissertation. Columbia University, New York. Cited in Briere, J. (1996) Trauma Symptom Checklist for Children: Professional Manual. Florida: Psychological Assessment Resources Inc. doi:10.1177/1077559511403920

Dorsey, S., Burns, B. J., Southerland, D. G., Cox, J. R., Wagner, H. R., & Farmer, E. M.

Z. (2012). Prior Trauma Exposure for Youth in Treatment Foster Care. *Journal of Child and Family Studies*, 21(5), 816–824. doi.org/10.1177/1063426616650166

Dorsey, S., Pullmann, M. D., Berliner, L., Koschmann, E., McKay, M., & Deblinger, E. (2014). Engaging foster parents in treatment: A randomized trial of supplementing trauma-focused cognitive behavioral therapy with evidence-based engagement strategies. *Child abuse & neglect*, 38(9), 1508-1520. doi:10.1016/j.chiabu.2014.03.020

Dreby, J. (2015). US immigration policy and family separation: The consequences for children's well-being. *Social Science & Medicine*, 132, 245-251. doi.org/10.1016/j.socscimed.2014.08.041

Dubowitz, H. (2002). Neglect of children's health care. In: Myers JEB, Berliner L, Briere J, Jenny C, Hendrix CT, Reid T, eds. The APSAC Handbook on Child Maltreatment. Thousand Oaks, CA: Sage Publishing, 269– 292.

Dubner, A. E., & Motta, R. W. (1999). Sexually and physically abused foster care children and posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 67(3), 367-373. doi:10.1177/0146167205277095

Duft, B., Stafford, B. S., & Zeanah, C. H. (2017). Attachment Disorders. Handbook of Preschool Mental Health: Development, Disorders, and Treatment, 219. doi**:**10.3928/00904481-20130326-11

Dummer, S. (2006). The Orphan Train. Holmen, WI: Dummer.

Dunifon, R., & Kopko, K. (2011). Relationship quality and parenting among grandparent caregivers and teens. doi.org/10.1177/0002716214526530

Dunifon, R. (2013). The influence of grandparents on the lives of children and adolescents. *Child Development Perspectives*, 7(1), 55-60. doi.org/10.1177/0002716214526530

Dunst, C. J., & Kassow, D. Z. (2008). Caregiver sensitivity, contingent social responsiveness, and secure infant attachment. *Journal of Early and Intensive Behavior Intervention*, 5(1), 40. doi.org/10.1080/0300443900620106

Dyregrov, A., & Yule, W. (2006). A review of PTSD in children. *Child and Adolescent Mental Health*, 11(4), 176-184. doi.org/10.1111/j.1475-3588.2005.00384.x

Edelstein, R. S., & Shaver, P. R. (2004). Avoidant attachment: Exploration of an oxymoron. Handbook of closeness and intimacy, 39, 7-412. doi.org/10.1037/t03592-000

Ehlers, A., Mayou, R. A., & Bryant, B. (2003). Cognitive predictors of posttraumatic stress disorder in children: Results of a prospective longitudinal study. *Behavior research and therapy*, 41(1), 1-10. doi:10.1016/j.brat.2007.04.009

Ehrle, J., & Geen, R. (2002). Kin and non-kin foster care findings from a national survey. *Children and Youth Services Review*, 24(1-2), 15-35. doi.org/10.1016/S0190-7409(01)00166-9

Elhai, J. D., Layne, C. M., Steinberg, A. S., Vrymer, M. J., Briggs, E. C., Ostrowski, S. A., Pynoos, R. S. (2013). Psychometric properties of the UCLA PTSD Reaction Index. Part 2: Investigating factor structure findings in a national clinic-referred youth sample. *Journal of Traumatic Stress*, 26: 10-18. doi: 10.1002/jts.21780.

Elhai, J. D., Gray, M. J., Kashdan, T. B., & Franklin, C. L. (2005). Which instruments are

most commonly used to assess traumatic event exposure and posttraumatic effects? A survey of traumatic stress professionals. *Journal of traumatic stress*, 18(5), 541-545. doi.org/10.1177/107319110100800408

Ellett, Alberta J.; Leighninger, Leslie (10 August 2006). "What Happened? An historical perspective of the de-professionalization of child welfare practice with implications for policy and practice. *Journal of Public Child Welfare*. 1 (1): 3–34.

Elliot, D. M., &Briere, J. (1994) Forensic Sexual Abuse evaluations in older children: Disclosures and symptomatology. *Behavioral Sciences and the Law*, 12, 261-277. doi.org/10.1002/bsl.2370120306

Euser, S., Alink, L. R., Tharner, A., van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2014). Out of home placement to promote safety? The prevalence of physical abuse in residential and foster care. *Children and Youth Services Review*, 37, 64-70. doi:10.1002/imhj.21751

Evans, J.J., &Briere, J., Boggiano, A.K. & Barrett, M. (1994) Reliability and validity of the Trauma Symptom Checklist for Children in a normative sample. Paper presented at the San Diego Conference on responding to Child Maltreatment. Cited in Briere, J. (1996) Trauma Symptom Checklist for Children: Professional Manual. Florida: Psychological Assessment Resources Inc. doi:abs/10.1177/1524838004272559

Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child*

abuse & neglect, 36(2), 156-165. Ritter & Lampkin, 2011). Community mental health. Jones & Bartlett Publishers. doi:10.1016/j.chiabu.2011.10.006

Farineau, H. M., Stevenson Wojciak, A., & McWey, L. M. (2013). You matter to me: important relationships and self□esteem of adolescents in foster care. *Child & Family Social Work*, 18(2), 129-138. doi/pdf/10.1080/02673843.2018.1564931

Farmer, E. (2009). How do placements in kinship care compare with those in non□kin foster care: placement patterns, progress and outcomes? *Child & Family Social Work*, 14(3), 331-342. doi.org/10.1111/j.1365-2206.2008.00600

Farmer, E., & Moyers, S. (2008). Kinship care: Fostering effective family and friends placements. Jessica Kingsley Publishers. doi.org/10.1177/030857590903300303

Fechter-Leggett, M.O., & O'Brien. K. (2010). The effects of kinship care on adult mental health outcomes of alumni of foster care. *Children and Youth Services Review*, (32), 206–213. doi:10.1111 /cfs.12030

Figley, C. R., & Kiser, L. J. (2013). Helping traumatized families. Routledge. doi.org/10.1111/jmft.12027

Finklea K, Fernandes-Alcantara A, Siskin A. (2011). Sex trafficking of children in the United States: overview and issues for Congress. In: Service CR, editor. DOI: 10.17645/si.v5i2.914

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, 55, 530–541. doi.org/10.1111/j.1939-0025.1985.tb02703.x

Finkelhor, D., Turner, H., Ormrod, R., Hamby, S., & Kracke, K. (2009). Children's

exposure to violence: *A comprehensive national study*. doi:10.1177/1524838000001004002

Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child maltreatment*, 10(1), 5-25. doi:10.1177/1077559504271287

Fishback, P. V., William C. H., and Kantor, S. (2001) Federal Programs in Times of Crisis: The Impact of the New Deal on Local Economies during the Great Depression, National Bureau of Economic Research.

Font, S. A. (2014). Kinship and non-relative foster care: The effect of placement type on child well□being. *Child development*, 85(5), 2074-2090. doi.org/10.1111/cdev.12241

Font, S. A. (2015). Is higher placement stability in kinship foster care by virtue or design? Child abuse & neglect, 42, 99-111. doi: 10.1016/j.chiabu.2015.01.003

Font, S. A. (2015). Are children safer with kin? A comparison of maltreatment risk in out-of-home care. *Children and youth services review*, 54, 20-29. doi.org/10.1177/1077559515597064

Ford, J. D. (2011). Assessing child and adolescent complex traumatic stress reactions. *Journal of Child & Adolescent Trauma*, 4(3), 217-232. doi.org/10.1023/A:1024409817437

Ford, T., Vostanis, P., Meltzer, H., & Goodman, R. (2007). Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. *The British Journal of Psychiatry*, 190(4), 319-325.

doi:10.1192/bjp.bp.106.025023

Ford, T., Goodman, R., & Meltzer, H. (2003). The British child and adolescent mental health survey 1999: the prevalence of DSM-IV disorders. *Journal of the American academy of child & adolescent psychiatry*, 42(10), 1203-1211. doi.org/10.1097/00004583-200310000-00011

Forkey, H., & Szilagyi, M. (2014). Foster care and healing from complex childhood trauma. *Pediatric Clinics*, 61(5), 1059-1072. doi:10.1016/j.pcl.2014.06.015

Forsyth, C. J. (2017). The sociologist as story teller: the broken foster care system used as mitigation at criminal trial. *American journal of criminal justice*, 42(1), 134-147.

Fraser, J.G., Lloyd, S.W., Murphy, R.A., Crowson, M.M., Casanueva, C., Zolotor, A., Coker-Schwimmer, M., Letourneau, K., Gilbert, A., Swinson, E.T. & Crotty, K., (2013). Child exposure to trauma: comparative effectiveness of interventions addressing maltreatment. doi:10.1097/DBP.0b013e31828a7dfc

Frost, N. (2017). Historical themes in child welfare. *The Routledge Handbook of Global Child Welfare,* 19.

Fujimori, A., Hayashi, H., Fujiwara, Y., & Matsusaka, T. (2017). Influences of Attachment Style, Family Functions and Gender Differences on Loneliness in Japanese University Students. *Psychology*, 8(04), 654. doi:10.4236/psych.2017.84042

Fusco, R.A., & Cahalane, H. (2015). Socioemotional Problems among Young Children in Out-of-Home Care: A Comparison of Kinship and Foster Care Placement. *Journal of Family Social Work*, 18:183–201.

doi.org/10.1080/10522158.2015.1005783

Gabowitz, D., Zucker, M., & Cook. A. (2008). Neuropsychological assessment in clinical evaluation of children and adolescents with complex trauma. *Journal of Child and Adolescent Trauma*, 1, 163-178. doi.org/10.1002/jclp.20249

Garcia, A., O'Reilly, A., Matone, M., Kim, M., Long, J., & Rubin, D. M. (2015). The influence of caregiver depression on children in non-relative foster care versus kinship care placements. *Maternal and child health journal*, 19(3), 459-467. doi:10.1007/s10995-014-1525-9

Garson, G. D. (2012). Testing statistical assumptions. Asheboro, NC: Statistical Associates Publishing. doi:10.5121/ijdkp.2018.8601

Gauthier, Y., Fortin, G., & Jéliu, G. (2004). Clinical application of attachment theory in permanency planning for children in foster care: The importance of continuity of care. *Infant Mental Health Journal*, 25(4), 379-396. doi.org/10.1002/imhj.20012

Gebel, T. J. (1996). Kinship care and non-relative family foster care: A comparison of caregiver attributes and attitudes. *Child Welfare*, 75(1), 5.

Geen, R. (2004). The evolution of kinship care policy and practice. *The future of children*, 131-149. doi:10.1093/hsw/25.2.109

Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D., & MacMillan, H. L. (2009). Recognizing and responding to child maltreatment. *Lancet*, 373, 167–80. doi.org/10.1016/S0140-6736(08)61707-9

Gleeson, J. P., Wesley, J. M., Ellis, R., Seryak, C., Talley, G. W., & Robinson, J. (2009). Becoming involved in raising a relative's child: Reasons, caregiver motivations

and pathways to informal kinship care. *Child & Family Social Work*, 14(3), 300-310. doi/10.1177/0093854815613528

Glick, J. C., Lorand, M. A., & Bilka, K. R. (2016). Physical abuse of children. *Pediatrics in review*, 37(4), 146-156. doi:10.1542/pir.2015-0012.

Goldsmith, S. (2013). The Orphan Train Movement: Examining 19th Century Childhood Experiences. doi.org/10.1080/00377996.2013.859119

Golomb, S., Sears, K., Drozd, R., Kotori, J., & Vera-Hughes, M. (2017). Future Mandated Reporters: Understanding the Role. The Practitioner Scholar: *Journal of Counseling and Professional Psychology*, 6(1). doi.org/10.1037/cap0000157

Goldberg, S., Muir, R., & Kerr, J. (Eds.). (2013). Attachment theory: Social, developmental, and clinical perspectives. Routledge.doi.org/10.4324/9780203728017

Goodwin, C. J. (2016). Research in psychology methods and design. John Wiley & Sons. doi:10.1080/02678373.2010.50680

Gordon, L. (2011). Child welfare: A brief history. doi.org/10.1007/s10826-015-0283-7

Gradus, J. L. (2007). Epidemiology of PTSD. National Center for PTSD (United States Department of Veterans Affairs).doi.org/10.1023/A

Graham-Bermann, S. A., & Seng, J. (2005). Violence exposure and traumatic stress symptoms as additional predictors of health problems in high-risk children. The *Journal of pediatrics*, 146(3), 349-354. doi:10.1016/j.jpeds.2004.

Gray, D. E. (2013). Doing research in the real world. Sage. doi:10.1186/s13012-014-0179-8

Greenland, S., Senn, S. J., Rothman, K. J., Carlin, J. B., Poole, C., Goodman, S. N., & Altman, D. G. (2016). Statistical tests, P values, confidence intervals, and power: a guide to misinterpretations. *European journal of epidemiology*, 31(4), 337-350. doi: 10.1007/s10654-016-0149-3

Greenwood, P. (2008). Prevention and intervention programs for juvenile offenders. *The future of Children*, 18(2), 185-210. doi.org/10.1353/foc.0.0018

Greeson, J.K., Briggs, E.C., Kisiel, C.L., Layne, C.M., Ake III, G.S., Ko, S.J., Gerrity, E.T., Steinberg, A.M., Howard, M.L., Pynoos, R.S. & Fairbank, J.A., (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the National Child Traumatic Stress Network. *Child welfare*, 90, (6), 91. doi/pdf/10.2989/17280583.2013.795154

Grogan-Kaylor, A. (2000). Who goes into kinship care? The relationship of child and family characteristics to placement in kinship foster care. *Social Work Research*, 24 (3), 132–141. doi.org/10.1093/swr/24.3.132

Groh, A. M., Fearon, R. M., IJzendoorn, M. H., Bakermans□Kranenburg, M. J., & Roisman, G. I. (2017). Attachment in the early life course: Meta□analytic evidence for its role in socioemotional development. *Child Development Perspectives,* 11(1), 70-76. doi.org/10.1111/cdep.12213

Gross, J. T., Stern, J. A., Brett, B. E., & Cassidy, J. (2017). The multifaceted nature of prosocial behavior in children: Links with attachment theory and research. *Social Development.* doi:10.1111/sode.12242

Guttmann-Steinmetz, S., & Crowell, J. A. (2006). Attachment and externalizing

disorders: A developmental psychopathology perspective. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(4), 440-451. doi:10.1097/01.chi.0000196422.42599.63

Habib, M., & Labruna, V. (2011). Clinical considerations in assessing trauma and PTSD in adolescents. *Journal of Child & Adolescent Trauma*, 4(3), 198-216. doi:10.1080/19361521.2011.597684

Hatchavanich, D. (2014). A comparison of type I error and power of Bartlett's test, Levene's test and O'Brien's test for homogeneity of variance tests. *Southeast Asian Journal of Sciences*, *3*(2), 181-194.

Hall-Clark, B.N., Kaczkurkin, A.N., Asnaani, A., Zhong, J., Peterson, A.L., Yarvis, J.S., Borah, E.V., Dondanville, K.A., Hembree, E.A., Litz, B.T. and Mintz, J., 2017. Ethnoracial differences in PTSD symptoms and trauma-related cognitions in treatment-seeking active duty military personnel for PTSD. *Psychological trauma: theory, research, practice, and policy*, 9(6), p.741. doi:10.1037/tra0000242

Hansan, J.E. (2011). Charles Loring Brace (June 19, 1826 – August 11, 1890): Congregational minister, child welfare advocate, founder of the New York Children's Aid Society and organizer of the Orphan's Train. doi:10.1086/630492

Harden, B. (2004). Safety and Stability for Foster Children: A Developmental Perspective. *The Future of Children*, 14(1), 31-47. doi.org/10.2307/1602753.

Harden, B. J., Clyman, R. B., Kriebel, D. K., & Lyons, M. E. (2004). Kith and kin care: Parental attitudes and resources of foster and relative caregivers. *Children and*

Youth Services Review, 26, 657–671. doi.org/10.1016/j.childyouth.2004.02.001

Harfeld, A., & Marlowe, K. (2017). Making America's Children Safe Again. *Juvenile and Family Court Journal,* 68(1), 115-128. doi:10.1111/jfcj.12089

Harkness, S. (2015). The Strange Situation of Attachment Research: A Review of Three Books. *Reviews in Anthropology*, 44(3), 178-197. doi.org/10.1080/00938157.2015.1088337

Harris, S. E. (2016). Development of the Early Childhood Traumatic Stress Screen (Doctoral dissertation, Marquette University).

Healey, C. V., & Fisher, P. A. (2011). Children in Foster Care and the Development of Favorable Outcomes. *Children and Youth Services Review*, 33(10), 1822–1830. doi:10.1016/j.childyouth.2011.05.007

Hébert, M., Tremblay, C., Parent, N., Daignault, I. V., & Piché, C. (2006). Correlates of behavioral outcomes in sexually abused children. *Journal of Family Violence*, 21(5), 287-299. doi.org/10.1007/s10896-006-9026-2

Hegar, R. L., & Rosenthal, J. A. (2009). Kinship care and sibling placement: Child behavior, family relationships, and school outcomes. *Children and Youth Services Review*, 31(6), 670-679. doi:10.1016/j.childyouth.2009.01.002

Heneghan, A., Stein, R.E., Hurlburt, M.S., Zhang, J., Rolls-Reutz, J., Fisher, E., Landsverk, J. & Herrenkohl RC (2005). "The definition of child maltreatment: from case study to construct". *Child Abuse and Neglect*. 29 (5), 413–24

Herrick, J and Stuart, P.H. (2005) Encyclopedia of Social Welfare History in North America. Thousand Oaks, CA: Sage Publications, 58-62. DOI:

10.1093/obo/9780195389678-0075

Hildyard K. L., Wolfe D. A. (2002). Child neglect: developmental issues and outcomes. *Child Abuse and Neglect*, 26, 679-695. doi.org/10.1016/S0145-2134(02)00341-1

Hinde, R. A. (1991). Relationships, attachment, and culture: A tribute to John Bowlby. *Infant Mental Health Journal*, 12, 154-163. doi.org/10.1002/1097-0355(199123)12:3<154::AID-IMHJ2280120303>3.0.

Hill, K. (2017). Prevalence, experiences, and characteristics of children and youth who enter foster care through voluntary placement agreements. *Children and Youth Services Review*, 74, 62-70. doi:10.1093/cs/cdv016

Ho, C., Bluestein, D., & Jenkins, J. (2008). Cultural differences in the relationship between parenting and children's behavior. *Developmental Psychology*, 44(2), 507–522. doi:10.1037/0012–1649.44.2.507

Hoehn, J., Foxen-Craft, E., Pinder, W., & Dahlquist, L. M. (2016). The role of parents in promoting children's adjustment to chronic illness. *In Child and Adolescent Resilience Within Medical Contexts,* 105-119. Springer, Cham. doi.org/10.1007/978-3-319-32223-0_6

Hoffman, K., Cooper, G., & Powell, B. (2017). Raising a Secure Child: How Circle of Security Parenting Can Help You Nurture Your Child's Attachment, Emotional Resilience, and Freedom to Explore. Guilford Publications. doi.org/10.1007/978-3-319-15877-8_37-1

Holmes, K. J., Stokes, L. D., & Gathright, M. M. (2014). The use of collaborative

problem solving to address challenging behavior among hospitalized children with complex trauma: A case series. *Residential Treatment for Children & Youth*, 31(1), 41-62. doi.org/10.1080/0886571X.2016.1188340

Holtan, A., Rønning, J. A., Handegård, B. H., & Sourander, A. (2005). A comparison of mental health problems in kinship and nonkinship foster care. *European Child & Adolescent Psychiatry,* 14(4), 200-207. doi:10.1007/s00787-005-0445

Hong, J. S., Algood, C. L., Chiu, Y. L., & Lee, S. A. P. (2011). An ecological understanding of kinship foster care in the United States. *Journal of Child and Family Studies*, 20(6), 863-872. doi:10.1007/s10826-011-9454-3

Horwitz, S.M., 2013. Mental health problems in teens explored by US child welfare agencies. *Journal of Adolescent Health*, 52(5), 634-640. doi.org/10.1177/0009922817733740

Horváth, I. (2016). Theory building in experimental design research. *In Experimental Design Research*, 209-231. Springer, Cham. doi>10.1002/sys.21415

Howe, D. (2005). Child abuse and neglect: Attachment, development and intervention. Palgrave Macmillan. .doi.org/10.1016/S0145-2134(02)00538-0

Humphrey, K. R., Turnbull, A. P., & Turnbull, H. R. (2006). Impact of the Adoption and Safe Families Act on youth and their families: Perspectives of foster care providers, youth with emotional disorders, service providers, and judges. *Children and Youth Services Review*, 28(2), 113-132. doi.org/10.1016/j.childyouth.2005.02.011

Hunt, E., Peters, R. H., & Kremling, J. (2015). Behavioral health treatment history among persons in the justice system: Findings from the Arrestee Drug Abuse Monitoring II Program. *Psychiatric rehabilitation journal*, 38(1), 7. doi: 10.1037/prj0000132.

Hunt, K. L., Martens, P. M., & Belcher, H. M. (2011). Risky business: Trauma exposure and rate of posttraumatic stress disorder in African American children and adolescents. *Journal of Traumatic Stress*, 24(3), 365-369. doi:10.1002/jts.20648

Institute of Medicine and National Research Council. (2013) Confronting commercial sexual exploitation and sex trafficking of minors in the United States. Washington, DC: The National Academies Press. doi.org/10.17226/18358.

Jackson, S., & Thomas, N. (2000). What Works in Creating Stability for Looked After Children? Barkingside: Barnardo's. doi:1002/14651858.

Jackson Y, Cushing CC, Gabrielli J, Fleming K, O'Connor BM, Huffhines L.J (2016).Child Maltreatment, Trauma, and Physical Health Outcomes: The Role of Abuse Type and Placement Moves on Health Conditions and Service Use for Youth in Foster Care. *Pediatric Psychology*. 41, (1) 28-36. doi:10.1093/jpepsy/jsv066

Jenny. C and the Committee on Child Abuse and Neglect. (2007). Recognizing and Responding to Medical Neglect. *Pediatrics*, 120 (6). doi.org/10.1542/peds.2007-2903

Johnson, A. L., & Anderson, E. D. (2016). Birth and Infancy: Emotional and Social Development. Human Growth and Development across the Lifespan: Applications for Counselors, 151. doi.org/10.1016/j.childyouth.2005.02.011

Johnson, B., & Christensen, L. (2008). Educational research: Quantitative, qualitative, and mixed approaches. Sage. doi:10.4135/9781506335193.

Johnson, L. V. (2017). Attachment Styles: A Retrospective Study of Commercially Sexually Exploited Female Minors (Doctoral dissertation, The Chicago School of Professional Psychology**.** doi:10.1177/1524838017742168

Johnson, S. M. (2003). Introduction to attachment. *Attachment processes in couple and family therapy*, 3-17. doi.org/10.1093/clipsy/6.1.67

Johnson, R., & Waterfield, J. (2004). Making words count: the value of qualitative research. *Physiotherapy Research International*, 9(3), 121-131. doi10.1080/10528008.2002.11488787

Jones, A. S. & Greene- Logan, P. (2016).Understanding and responding to chronic neglect: A mixed methods case record examination. *Children and Youth Services review,* 67, 212-219. doi:10.1016/j.childyouth.2016.06.011.

Jonkman, C. S., Oosterman, M., Schuengel, C., Bolle, E. A., Boer, F., & Lindauer, R. J. (2014). Disturbances in attachment: inhibited and disinhibited symptoms in foster children. *Child and adolescent psychiatry and mental health*, 8(1), 21. doi/abs/10.1177/1073191118797422

Joyce, K. Save the Children. (2016). Project MUSE, 63 (1), 56-64. doi.org/10.1080/14675986.2015.1109775

Kagan, R. (2014). Rebuilding attachments with traumatized children: Healing from losses, violence, abuse, and neglect. Routledge. doi.org/10.4324/9780203822319

Kagan, R., Henry, J., Richardson, M., Trinkle, J., & LaFrenier, A. (2014). Evaluation of

Real Life Heroes treatment for children with complex PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6(5), 588. doi.org/10.4324/9780203822319

Kaminer, D., Seedat, S., & Stein, D.J. (2005). Post-traumatic stress disorder in children. *World Psychiatry*, 4(2), 121. doi:10.1016/

Kang, H. (2003). Caregiver Environments of Kinship Care Literature Review. *Children and Family Research Center.* doi.org/10.1037/a0020602

Kang, H. (2003). Well□Being Outcomes of Children in Kinship Care Literature Review. *Children and Family Research Center*. doi:10.1002/14651858

Kantor, V., Knefel, M., & Lueger-Schuster, B. (2017). Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review. *Clinical Psychology Review*, 52, 52-68. doi: 10.1016/j.cpr.2016.12.001

Kaplow, J. B., & Widom, C. S. (2007). Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of Abnormal Psychology*, 116(1), 176-187. doi: 10.1037/0021-843X.116.1.176

Keagey, E. J., & Rall, B. A. (2007). The special needs of special-needs adoptees and their families. Handbook of adoption: Implications for researchers, practitioners, and families, 217-227. doi: 10.1016/j.childyouth.2007.05.015.

Keller, T. E., Wetherbee, K., Le Prohn, N. S., Payne, V., Sim, K., & Lamont, E. R. (2001). Competencies and problem behaviors of children in family foster care: Variations by kinship placement status and race. *Children and Youth Services Review,* 23(12), 915-940. doi:10.1016/S0190-7409(01)00175

Kemp, A.M., Dunstan, F., Harrison, S., Morris, S., Mann, M., Rolfe, K., Datta, S., Thomas, D.P., Sibert, J.R. and Maguire, S., 2008. Patterns of skeletal fractures in child abuse: systematic review, 337 (1), 1518. doi.org/10.1136/bmj.a1518

Kennedy, J. H., & Kennedy, C. E. (2004). Attachment theory: Implications for school psychology. *Psychology in the Schools*, 41(2), 247-259. doi.org/10.1002/pits.10153

Kerns, K. A., & Brumariu, L. E. (2014). Is insecure parent–child attachment a risk factor for the development of anxiety in childhood or adolescence?. *Child development perspectives*, 8(1), 12-17. **doi:**10.1111/cdep.12054

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of general psychiatry*, 52(12), 1048-1060. doi.org/10.1001/archpsyc.1995.03950240066012

Kim, J., & Cicchetti, D. (2010). Longitudinal pathways linking child maltreatment, emotion regulation, peer relations, and psychopathology. *Journal of Child Psychology and Psychiatry*, 51(6), 706-716. doi.org/10.1111/j.1469-7610.2009.02202.x

Kim, J., & Cicchetti, D. (2009). Mean-level change and individual variability in self-esteem and depression among high-risk children. *International journal of behavioral development*, 33(3), 202-214.

Kim, Y. J., & Cribbie, R. A. (2018). ANOVA and the variance homogeneity assumption: Exploring a better gatekeeper. *British Journal of Mathematical and Statistical*

Psychology, *71*(1), 1-12. doi: 10.1111/bmsp.12103.

Kinniburgh, K. J., Blaustein, M., Spinazzola, J., & Van der Kolk, B. A. (2017). Attachment, Self-Regulation, and Competency: A comprehensive intervention framework for children with complex trauma. *Psychiatric Annals*, 35(5), 424-430. doi:10.1111/1745-9125.12198

Kiraly, M., & Humphreys, C. (2015). A tangled web: Parental contact with children in kinship care. *Child & Family social work,* 20(1), 106-115. doi:10.1177/0308575916631492

Kiraly, M., & Humphreys, C. (2016). 'It's about the whole family': family contact for children in kinship care. *Child & Family Social Work*, 21(2), 228-239. doi:10.1016

Klain, E. J., & White, A. R. (2013). Implementing trauma-informed practices in child welfare. Doi:10.1111/cfs.12577.

Ko, S.J., Ford, J.D., Kassam-Adams, N., Berkowitz, S.J., Wilson, C., Wong, M., Brymer, M.J. & Layne, C.M., 2008. Creating trauma-informed systems: child welfare, education, first responders, health care, juvenile justice. *Professional Psychology Research and Practice*, 39(4), 396. doi/abs/10.1177/0093854812436957

Koenen, K. C., Moffitt, T. E., Caspi, A., Gregory, A., Harrington, H., & Poulton, R. (2008). The developmental mental-disorder histories of adults with posttraumatic stress disorder: A prospective longitudinal birth cohort study. *Journal of Abnormal Psychology,* 117(2), 460. doi:10.1037/0021-843X.117.2.460

Kolko, D. J., Hurlburt, M. S., Jinjin, Z., Barth, R. P., Leslie, L. K., & Burns, B. J. (2010).

Posttraumatic Stress symptoms in children and adolescents referred for child welfare investigation. *Child Maltreatment*, 15(1), 48-63. doi/10.1177/1524838012447698

Koh, E. (2010). Permanency outcomes of children in kinship and nonkinship foster care: Testing the external validity of kinship effects. *Children and Youth Services Review*, 32(3), 389–398 doi:10.1016/

Kortenkamp, K., and Ehrle, J. (2002). The well-being of children involved with the child welfare system: A national overview, New Federalism, Series B, No. B-43. Washington, D.C.: *The Urban Institute*. doi:10.1111/j.l741-3737.2010.00751.

Krugman, R. D. & Korbin, J. E. (2013). C. Henry Kempe: A 50 Year Legacy to the Field of Child Abuse and Neglect. *Child Maltreatment*, 1, 56-78. Doi:10.1007/978-94-007-4084-6

La Greca, A. M., Taylor, C. J., & Herge, W. M. (2012). Traumatic stress disorders in children and adolescents. *The Oxford handbook of traumatic stress disorders*, 98-118.

Landa, S; Duschinsky, R (2013), Crittenden's dynamic–maturational model of attachment and adaptation, *Review of General Psychology,* 17 (3): 326–338. doi:10.1037/a0032102

Lander, L., Howsare, J., & Byrne, M. (2013). The Impact of Substance Use Disorders on Families and Children: From Theory to Practice. *Social Work in Public Health,* 28(0), 194–205. doi:10.2196/jmir.3261

Lanktree, C. B., Gilbert, A. M., Briere, J., Taylor, N., Chen, K., Maida, C. A., &

Saltzman, W. R. (2008). Multi-informant assessment of maltreated children: Convergent and discriminant validity of the TSCC and TSCYC. *Child Abuse & Neglect,* 32(6), 621-625. doi:10.1.1.467.2638&rep=rep1&type=pdf

Lawler M.J. (2008). Maltreated children's emotional availability with kin and non-kin foster mothers: a sociobiological perspective. *Children and Youth Services Review,* 30(10):1131-43. doi/10.1002/14651858.CD006546.pub3/pdf/CDSR/

Leaning, J., & Guha-Sapir, D. (2013). Natural disasters, armed conflict, and public health. *New England journal of medicine*, 369(19), 1836-1842. DOI: 10.1056/NEJMra1109877

Leathers, S. J. (2005). Separation from siblings: Associations with placement adaptation and outcomes among adolescents in long-term foster care. *Children and Youth Services Review*, 27(7), 793-819. doi:10.1016/j.childyouth

Leathers, S. J. (2006). Placement disruption and negative placement outcomes among adolescents in long-term foster care: The role of behavior problems. *Child abuse & neglect*, 30(3), 307-324. doi. org/10.1111/famp.12134

LeBowa, E. & Cherney, D. J. (2015). The Role of Animal Welfare Legislation in Shaping Child Protection in the United States. *International Journal of Education and Social Science*. 2 (6).

Lee, A., & Hankin, B. L. (2009). Insecure attachment, dysfunctional attitudes, and low self-esteem predicting prospective symptoms of depression and anxiety during adolescence. *Journal of clinical child & Adolescent Psychology*, 38(2), 219-231. DOI: 10.1177/2158244015604695

Lee, B. R. & Thompson, R. (2007) Comparing Outcomes for Youth in Treatment Foster Care and Family-style Group Care. *Child Youth Services*, 30(7): 746–757. doi/10.1177/1049731510386243

Lee, E., Choi, M. J., Lee, Y., & Kramer, C. (2017). Placement Stability of Children in Informal Kinship Care: Age, Poverty, and Involvement in the Child Welfare System. *Child Welfare*, 95(3).

Leech, N. L., Barrett, K. C., & Morgan, G. A. (2005). SPSS for Intermediate Statistics: Use and Interpretation (2nd ed.). Mahwah, NJ: Lawrence Erlbaum Associates. doi:10.1111/j.1944-9720.1991. tb00464

Leloux-Opmeer, H., Kuiper, C. H., Swaab, H. T., & Scholte, E. M. (2017). Children referred to foster care, family-style group care, and residential care: How do they differ?. *Children and Youth Services Review*, 77, 1-9.

Leon, S. C., Saucedo, D. J., & Jachymiak, K. (2016). Keeping it in the family: The impact of a Family Finding intervention on placement, permanency, and well-being outcomes. *Children and Youth Services Review*, 70, 163-170. doi.org/10.1016/j.childyouth.2016.09.020

León, E., Jiménez□Morago, J. M., & Muñoz□Silva, A. (2017). Contact between birth parents and children in kinship care in a sample from Spain. *Child & Family Social Work*, 22(2), 1075-1083. doi:10.1177/1087054716669227

Leonard, A., Miller, S. A., Christopher, R., Gleason, K., & Franklin, R. (2016). Theories in the field of community psychology. *Global Journal of Community Psychology Practice*, 7(2). doi.org/10.7728/0702201601

Leslie, L. K., Gordon, J. N., Lambros, K., Premji, K., Peoples, J., & Gist, K. (2005). Addressing the developmental and mental health needs of young children in foster care. *Journal of developmental and behavioral pediatrics*, 26(2), 140. doi:10.1177/1077559516657637

Le Prohn, N. S. (1994). The role of the kinship foster parent: A comparison of the role conceptions of relative and non-relative foster parents. *Children and Youth Services Review*, 16(1-2), 65-84. doi.org/10.1016/0190-7409(94)90016-7

LeVezu, A. (2017). The Illusion of Appellate Review in Dependency Proceedings. *Juvenile and Family Court Journal*, 68(1), 83-95.

Levy, K. N., Ellison, W. D., Scott, L. N., & Bernecker, S. L. (2011). Attachment style. *Journal of clinical psychology*, 67(2), 193-203. doi.org/10.1002/jclp.20756

Lewis, C. C., Simons, A. D., Nguyen, L. J., Murakami, J. L., Reid, M. W., Silva, S. G., et al. (2010). Impact of childhood trauma on treatment outcome in the Treatment for Adolescents with Depression Study (TADS). *Journal of the American Academy of Child and Adolescent Psychiatry*, 49, 132–140. doi/10.1176/appi.ajp.2011.11020335

Lin, C. H. (2014). Evaluating services for kinship care families: A systematic review. Children and Youth Services Review, 36, 32-41. doi.org/10.1016

Linares, L. O., Li, M., Shrout, P. E., Brody, G. H., & Pettit, G. S. (2007). Placement shift, sibling relationship quality, and child outcomes in foster care: a controlled study. *Journal of Family Psychology*, 21(4), 736. doi.org/10.1037/t06793-000.

Lind, T., Raby, K. L., Caron, E. B., Roben, C. K., & Dozier, M. (2017). Enhancing

executive functioning among toddlers in foster care with an attachment-based intervention. *Development and psychopathology*, 29(2), 575-586. doi:10.1017/S0954579417000190

Lindenmeyer, K. (2011). Children's Bureau. Social Welfare History Project. *Machine learning research*, 1-30.

LoBiondo-Wood, G., Haber, J., & Singh, M. D. (2014). Nonexperimental designs. Nursing Research in Canada-E-Book: Methods, Critical Appraisal, and Utilization, 234.

Lohr, W. D., & Jones, V. F. (2016). Mental health issues in foster care. *Pediatric annals*, 45(10). doi:10.3928/19382359- 20160919-01

Lorkovich, T. W., Piccola, T., Groza, V., Brindo, M. E., & Marks, J. (2004). Kinship care and permanence: Guiding principles for policy and practice. *Families in Society*, 85(2), 159□164. doi.org/10.1606/1044-3894.324

Lubit, R., Rovine, D., Defrancisci, L., & Eth, S. (2003). Impact of trauma on children. *Journal of Psychiatric Practice*, 9(2), 128-138. doi.org/10.1097/00131746-200303000-00004

Lutman, E., Hunt, J., & Waterhouse, S. (2009). Placement stability for children in kinship care: A long-term follow-up of children placed in kinship care through care proceedings. *Adoption & Fostering*, 33(3), 28-39. doi.org/10.1177/030857590903300304

Lynch, G. (2014). Saving the child for the sake of the nation: Moral framing and the civic, moral and religious redemption of children. *American Journal of Cultural*

Sociology, 2(2), 165-196. doi.org/10.1177/0907568218775177

Maaskant, A. M., van Rooij, F. B., & Hermanns, J. M. (2014). Mental health and associated risk factors of Dutch school aged foster children placed in long-term foster care. *Children and Youth Services Review*, 44, 207-216. /doi.org/10.1371

Macmillan, H. K., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Interventions to prevent child maltreatment and associated impairment. *Lancet*, 373(9659), 250–266. doi:10.1016/s0140-6736(08)61708-0

Maguire, S. A., Williams, B., Naughton, A. M., Cowley, L. E., Tempest, V., Mann, M. K., Teague, M., and Kemp, A. M. (2015), A systematic review of the emotional, behavioral and cognitive features exhibited by school-aged children experiencing neglect or emotional abuse. *Child Care Health Development*, 41, 641–653.

Malousek, J. R., Colburn□Malousek, L. K., & Brown, K. S. (2016). Child Abuse in the United States. *The Wiley Blackwell Encyclopedia of Family Studies*. doi:10.1002/9781119085621

Mannarino, A. P., Cohen, J. A., Deblinger, E., Runyon, M., & Steer, R. (in press). Trauma-focused cognitive-behavioral therapy for children: Sustained impact 6 and 12 months later. *Child Maltreatment*. doi:10.1080/15374416.2013.822307

Margolin, G., & Vickerman, K. A. (2011). Posttraumatic stress in children and adolescents exposed to family violence: I. *Overview and issues*. doi:org/10.1023

Margolin, G., & Vickerman, K. A. (2007). Posttraumatic stress in children and adolescents exposed to family violence: I. Overview and issues. Professional

Psychology: *Research and Practice*, 38(6), 613. doi:10.1207

Marsenich, L. (2002). Evidence-based practices in mental health services for foster youth. Sacramento, CA: California Institute for Mental Health. Marx, J.D. (2011). American social policy in the Great Depression and World War II.

Mash, Eric (2010). Abnormal Child Psychology. Belmont, California: Wadsworth Cengage Learning. 427–463. doi:10.1016/j.jaac.2013.12.025

Mason, J., Falloon, J., Gibbons, L., Spence, N., & Scott, E. (2002). Understanding kinship care. doi:org/10.1332/204674314X13898785887043

McElvaney, R., Greene, S., & Hogan, D. (2014). To tell or not to tell? Factors influencing young people's informal disclosures of child sexual abuse. *Journal of interpersonal violence*, 29(5), 928-947. doi:10.1177/0886260513506281

McHugh, M. (2003). A further perspective on kinship care: Indigenous foster care. *Developing Practice: The Child, Youth and Family Work Journal*, (8), 14.

McLaughlin, K. A., Koenen, K. C., Hill, E. D., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(8), 815-830. doi:10.1016/j.jaac.2013.05.011

McLaughlin, K. A., Zeanah, C. H., Fox, N. A., & Nelson, C. A. (2012). Attachment security as a mechanism linking foster care placement to improved mental health outcomes in previously institutionalized children. *Journal of Child Psychology and Psychiatry*, 53(1), 46-55. doi:10.1111/j.1469-7610.2011.02437.x

McKay, P., Hollist, D., & Mayrer, J. (2016). Foster care or group home care for youth on Probation. doi.org/10.1177/1077559517718956

McMillen, J. C., Zima, B. T., Scott, L. D., Auslander, W. F., Munson, M. R., Ollie, M. T., et al. (2005). Prevalence of psychiatric disorders among older youths in the foster care system. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 88–95. doi/pdf/10.1111/ijsw.12323

McRea, Roswell (1971). Societies for the Prevention of Cruelty to Children. In Hart. *Preventive Treatment of Neglected Children,* 4, 51-56. doi:10.1093/acprof:oso/9780195169355.001.0001

McRoy, R. G. (2016). Special needs adoptions: Practice issues. Routledge. doi.org/10.4324/9781315784243

Meakings, S., Sebba, J. C., & Luke, N. (2017). What is known about the placement and outcomes of siblings in foster care? An international literature review. doi.org/10.1080/15548731003799662

Meloy, M. E., & Phillips, D. A. (2012). Foster children and placement stability: The role of child care assistance. *Journal of Applied Developmental Psychology*, 33(5), 252-259. doi.org/10.1007/s13158-018-0212-1

Meinck, F., Cluver, L. D., Boyes, M. E., & Mhlongo, E. L. (2015). Risk and protective factors for physical and sexual abuse of children and adolescents in Africa: a review and implications for practice. *Trauma, Violence, & Abuse*, 16(1), 81-107. doi: 10.1177/1524838014523336

Meins, E. (2013). Security of attachment and the social development of cognition.

Psychology press. doi: 10.1007/ s10802-012-9699-3

Menna, R., Pasiak, C., Johnson, E. M., & Romanchych, E. (2015). Assessment of Posttraumatic Stress, Depression, and Anxiety in School-Aged Children. *Comprehensive Guide to Post-Traumatic Stress Disorder*, 1-13. doi:0.1007/978-3-319-08359-9

Mennen, F. E., & O'Keefe, M. (2005). Informed decisions in child welfare: The use of attachment theory. *Children and Youth Services Review*, 27(6), 577-593. doi.org/10.1016/j.childyouth.2004.11.011

Mercer, J. (2006). Understanding attachment: Parenting, child care, and emotional development. Greenwood Publishing Group. doi.org/10.1177/019251398019002001

Merritt, D. H. (2008). Placement preferences among children living in foster or kinship care: A cluster analysis. *Children and Youth Services Review*, 30 (11), 1336-1344.doi.org/10.1016/j.childyouth.2008.04.002

Mertens, D. M. (2014). Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods. Sage publications. doi/full/10.1177/1609406918821574

Mesman, J., van IJzendoorn, M. H., & Sagi-Schwartz, A. (2016). Cross-cultural patterns of attachment. In Handbook of attachment: Theory, research, and clinical applications. 852-877. Guilford New York, NY. doi:10.1111/cdev.12795

Messing, J. T. (2006). From the child's perspective: A qualitative analysis of kinship care placements. *Children and Youth Services Review*, 28(12), 1415-1434.

doi:10.1016/

Miller, D. C., & Salkind, N. J. (2002). Handbook of research design and social measurement. Sage. DOI: 10.4135/9781412984386

Milot, T., Éthier, L. S., St-Laurent, D., & Provost, M. A. (2010). The role of trauma symptoms in the development of behavioral problems in maltreated preschoolers. *Child abuse & neglect*, 34(4), 225-234. doi:10.1016/j.chiabu.2009.07.006

Mooi, E., Sarstedt, M., & Mooi-Reci, I. (2018). Hypothesis Testing & ANOVA. In Market Research, 153-214. Springer, Singapore.

Moore, J. (2013). Research summary: Resilience and at-risk children and youth. *National Center for Homeless Education*. doi: 10.1111/cdev.12013

Morris, A. S., Silk, J. S., Steinberg, L., Myers, S. S., & Robinson, L. R. (2007). The role of the family context in the development of emotion regulation. *Social development*, 16(2), 361-388. doi:10.1111/j.1467-9507.2007.00389.

Mosek A., Adler L. (2001). The self concept of adolescent girls in non-relative versus kin foster care. *International Social Work*, 44, 149–162. doi.org/10.1177/002087280104400202

Mooi, E., Sarstedt, M., & Mooi-Reci, I. (2018). Hypothesis Testing & ANOVA. *In Market Research*, 153-214. Springer, Singapore. doi.org/10.1161/CIRCULATIONAHA.107.654335

Myers, J. E. B. (2006). Child protection in America: Past, present, and future. New York: Oxford University Press. doi:10.1093/acprof:oso/9780195169355.001.0001

Myers, J. (2008). A Short History of Child Protection in America, Family Law Quarterly, 42, 449-463. doi:10.1111/1745-9133.12232

Nadal, K. L. (Ed.). (2017). The SAGE Encyclopedia of Psychology and Gender. SAGE Publications. doi:10.4135/9781483384269

National Child Traumatic Stress Network. (2016). What Is Child Traumatic Stress? doi.org/10.1037/a0012551

National Institute of Mental Health. (2016). *Post-Traumatic Stress Disorder*. doi:10.1111/j.1755-5949.2008.00049

Negriff, S., James, A., & Trickett, P. K. (2015). Characteristics of the social support networks of maltreated youth: Exploring the effects of maltreatment experience and foster placement. *Social Development*, 24(3), 483-500. doi:10.1111/sode.12102.

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child abuse & neglect*, 24(10), 1363-1374. doi.org/10.1016/S0145-2134(00)00189-7

Nilsson, D., Gustafsson, P. E., & Svedin, C.-G. (2012). The psychometric properties of the Trauma Symptom Checklist for Young Children in a sample of Swedish children. *European Journal of Psychotraumatology*, 3, 10. doi/full/10.1080/10926771.2017.1303012

Nimon, K. F. (2012). Statistical assumptions of substantive analyses across the general linear model: a mini-review. Frontiers in psychology, 3, 322.

doi:10.3389/fpsyg.2012.00322.

Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS medicine*, 9(11). doi:10.1371/journal.pmed.1001349

Northern California Training Academy. (2008). A literature review of placement stability in child welfare services: Issues, concerns, outcomes and future directions. *The Center for Human Services at UC Davis Extension.* doi:10.1017/S135246580001643X

Nurius, P. S., Green, S., Logan-Greene, P., & Borja, S. (2015). Life course pathways of adverse childhood experiences toward adult psychological well-being: A stress process analysis. *Child abuse & neglect*, 45, 143-153. doi:10.1016/j.chiabu.2015.03.008.

O'Brien, V. (2013, June). Children in care and permanency: A comparative perspective. In The Irish Care System and Adoption, IASW, Dublin, 28 June, 2013. *Irish Association of Social Workers*. doi/abs/10.1177/1473325019871607

O'Brien, V. (2012). The benefits and challenges of kinship care. *Child Care in Practice*, 18(2), 127-146. doi:10.1002/14651858

O'Connor, M., & Elklit, A. (2008). Attachment styles, traumatic events, and PTSD: A cross-sectional investigation of adult attachment and trauma. *Attachment & human development*, 10(1), 59-71. doi:10.1080/14616730701868597

O'Connor, S. (2004). Orphan trains: The story of Charles Loring Brace and the children

he saved and failed. University of Chicago Press. doi:10.1097/PSY.0b013e3181d9a104

Olfson, M., Druss, B. G., & Marcus, S. C. (2015). Trends in mental health care among children and adolescents. *New England Journal of Medicine*, 372(21), 2029-2038. doi:10.1056/NEJMsa1413512.

Orlans, M., & Levy, T. M. (2014). Attachment, trauma, and healing: Understanding and treating attachment disorder in children, families and adults. *Jessica Kingsley Publishers*. doi:10.1007/s40653-018-0203-2

Oswald, S. H., Heil, K., & Goldbeck, L. (2009). History of maltreatment and mental health problems in foster children: A review of the literature. *Journal of pediatric psychology*, 35(5), 462-472. doi.org/10.1093/jpepsy

Oswald, S.H., Heil, K., &Goldbeck, L. (2010). History of maltreatment and mental health problems in foster children: A review of the literature. *Journal of Pediatric Psychology,* 35(5), 462-472. doi.org/10.1093/jpepsy/jsp114

Overall, N. C., Simpson, J. A., & Struthers, H. (2013). Buffering attachment-related avoidance: Softening emotional and behavioral defenses during conflict discussions. *Journal of personality and social psychology*, 104(5), 854. doi:10.1037/a0031798

Owens-Kane, S. (2007). Respite care: Outcomes for kinship and nonkinship care-givers. *Journal of Health & Social Policy*, 22(3), 85–99. doi:10.1300/J045v22n03_06

Palusci, V. C. (2017). Child protection and the development of child abuse pediatrics in New York City. *Journal of Forensic and Legal Medicine*. 52,159-167.

doi:10.1016/j.jflm.2017.09.008

Panda, S. (2014). Managing Post Traumatic Stress: The Aftermath of Traumatic Events. *Pedagogy of Learning*, 2(1), 82-87.

Parkes, C. M., Stevenson-Hinde, J., & Marris, P. (Eds.). (2006). Attachment across the life cycle. Routledge. doi:10.1016/0145–2134(83)90033–9

Pasalich, D. S., Fleming, C. B., Oxford, M. L., Zheng, Y., & Spieker, S. J. (2016). Can parenting intervention prevent cascading effects from placement instability to insecure attachment to externalizing problems in maltreated toddlers? *Child maltreatment*, 21(3), 175-185. doi:10.1016/j.childyouth.2014.06.017. PMCID ...

Pears, K., & Fisher, P. A. (2005). Developmental, cognitive, and neuropsychological functioning in preschool-aged foster children: Associations with prior maltreatment and placement history. *Journal of Developmental & Behavioral Pediatrics*, 26(2), 112-122. doi:10.1016/j.childyouth.2014.06.017. PMCID

Pecora, P. J. (2010). Why current and former recipients of foster care need high quality mental health services. Administration and Policy in Mental Health and Mental Health Services Research, 37(1-2), 185-190. doi:10.1007/s10488-010-0295

Pecora PJ, Kessler RC, Williams J, O'Brien K, Downs AC, English D, White J, Hiripi E, Roller White C, Wiggins T, Holmes K. (2005). Improving family foster care: Findings from the northwest foster care alumni study. Seattle, WA: Casey Family Programs.

Pecora, P.J., Kessler, R.C., O'Brien, K., White, C.R., Williams, J., Hiripi, E., English, D., White, J., Herrick, M.A. (2006). Educational and employment outcomes of adults

formerly placed in foster care: Results from the northwest foster care alumni study. *Children and Youth Services Review.* 28:1459–1481. doi:10.1111/j.1465-7287.2008.00136.

Pecora, P. J., Jensen, P. S., Romanelli, L. H., Jackson, L. J., & Ortiz, A. (2009). Mental health services for children placed in foster care: an overview of current challenges. *Child welfare*, 88(1), 5. doi:10.lOOl/archpsyc.6l.6.577.

Pecora, P. J., White, C. R., Jackson, L. J., & Wiggins, T. (2009). Mental health of current and former recipients of foster care: A review of recent studies in the USA. *Child & Family Social Work*, 14(2), 132-146. doi.org/10.1111/j.1365-2206.2009.00618

Pecora, P. J., Whittaker, J. K., Maluccio, A. N., & Barth, R. P. (2012). The child welfare challenge: Policy, practice, and research. doi:10.1111/j.1532

Pelton, L. H. (2015). The continuing role of material factors in child maltreatment and placement. *Child Abuse & Neglect*, 41, 30-39. doi.org/10.1016/j.chiabu.2014.08.001

Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: Clinical applications of the neurosequential model of therapeutics. Journal of Loss and Trauma, 14(4), 240-255. doi.org/10.1080/15325020903004350

Peterson, K. C., Prout, M. F., & Schwarz, R. A. (2013). Post-traumatic stress disorder: A clinician's guide. Springer Science & Business Media.

Phillips, L.A., Powers, L.E., Geenen, S., Schmidt, J., Winges-Yanez, N., McNeely, I.C., Merritt, L., Williamson, C., Turner, S., Zweben, H. & Bodner, C., 2015. Better Futures: A validated model for increasing postsecondary preparation and

participation of youth in foster care with mental health challenges. *Children and Youth Services Review*, 57, 50-59.

Pichini, S., Garcia-Algar, O., Alvarez, A., Gottardi, M., Marchei, E., Svaizer, F., Pellegrini, M., Rotolo, M.C. & Pacifici, R., 2014. Assessment of unsuspected exposure to drugs of abuse in children from a Mediterranean city by hair testing. *International journal of environmental research and public health*, 11(2), 2288-2298.

Pimpare, S. (2011). A People s History of Poverty in America. *The New Press*. doi:10.1515/text-2013-0005

Pinto, R. J., Morgado, D., Reis, S., Monteiro, R., Levendosky, A., & Jongenelen, I. (2017). When social support is not enough: trauma and PTSD symptoms in a risk-sample of adolescents. *Child abuse & neglect*, 72, 110-119. doi:10.1016/j.chiabu.2017.07.01

Pleck, Elizabeth (2004). Domestic Tyranny: The Making of American Social Policy against Family Violence from Colonial Times to the Present. University of Illinois Press.72–75. doi.org/10.2307/1894414

Pokempner, J., Mordecai, K., Rosado, L., & Subrahmanyam, D. (2015). Promoting normalcy for children and youth in foster care. Philadelphia, PA: Juvenile Law Center. doi.org/10.1016/j.childyouth.

Ponciano, L. (2010). Attachment in foster care: The role of maternal sensitivity, adoption, and foster mother experience. *Child and Adolescent Social Work Journal*, 27(2), 97-114. doi:10.1007/s10560-010-0192-y

Ponnert, L. (2017). Emotional kinship care and neutral non□kinship care the struggle between discourses. *Child & Family Social Work*, 22(2), 1084-1093. doi.org/10.1111/cfs.12328

Powell, B., Cooper, G., Hoffman, K., & Marvin, B. (2013). The circle of security intervention: Enhancing attachment in early parent-child relationships. Guilford Publications. doi.org/10.1080/14616730903416955;

Preston, S. H., & Haines, M. R. (2014). Fatal years: Child mortality in late nineteenth-century America. Princeton University Press. doi.org/10.1017/S0963926816000717

Price, M., & van Stolk-Cooke, K. (2015). Examination of the interrelations between the factors of PTSD, major depression, and generalized anxiety disorder in a heterogeneous trauma-exposed sample using DSM 5 criteria. *Journal of affective disorders,* 186, 149-155. doi:10.1016/j.jad.2015.06.012

Prior, V., & Glaser, D. (2006). Understanding attachment and attachment disorders: Theory, evidence and practice. Jessica Kingsley Publishers. doi:10.1080/14733145.2011.6 24839

Quiroga, M. G., & Hamilton-Giachritsis, C. (2016, August). Attachment styles in children living in alternative care: A systematic review of the literature. *In Child & youth care forum*, 45 (4), 625-653. Springer US. doi:10.1007/s10566-015-9342-x

Racusin, R., Maerlender, A. C., Sengupta, A., Isquith, P. K., & Straus, M. B. (2005). Psychosocial treatment of children in foster care: A review. *Community mental*

health journal, 41(2), 199-221. doi.org/10.1177/1359104512458204

Reid, J. (2011). An exploratory model of girl's vulnerability to commercial sexual exploitation in prostitution. *Child Maltreatment*, 16, 146–57. doi:10.1177/1077559511404700

Riebschleger, J., Day, A., & Damashek, A. (2015). Foster care youth share stories of trauma before, during, and after placement: Youth voices for building trauma-informed systems of care. *Journal of Aggression, Maltreatment & Trauma*, 24(4), 339-360. doi/pdf/10.1111/cfs.12579

Riebschleger, J., Day, A., & Damashek, A. (2015). Foster care youth share stories of trauma before, during, and after placement: Youth voices for building trauma-informed systems of care. *Journal of Aggression, Maltreatment & Trauma*, 24(4), 339-360. doi:10.1080/10926771.2015.1079279

Riis, J. A. (2001). How the Other Half Lives: Studies Among the Tenements of New York. New York: Penguin Books.

Ritter, L. A., & Lampkin, S. M. (2011). Community mental health. Jones & Bartlett Publishers. doi:10.1111/psyg.12009

Rivera, M., & Sullivan, R. (2015). Rethinking child welfare to keep families safe and together: Effective housing-based supports to reduce child trauma, maltreatment recidivism, and re-entry to foster care. *Child welfare*, 94(4), 185. doi/10.1177/1077559517702743

Robertson, Stephen (2005). Crimes against children: Sexual Violence and Legal Culture in New York 1860-1960. doi:10.1057/9780230250796

Robinson, D. L. (2017). Neglect and Emotional Abuse. In *Pediatric Forensic Evidence* (pp. 145-159). Springer, Cham. doi.org/10.1007/978-3-319-45337-8

Robson, C., & McCartan, K. (2016). Real world research. John Wiley & Sons. doi:10.4018/javet.2012040104

Rodger, S., Cummings, A., & Leschied, A. W. (2006). Who is caring for our most vulnerable children? The motivation to foster in child welfare. *Child abuse & neglect*, 30(10), 1129-1142. doi.org/10.1177/0308575918799956

Rodriguez, N., Steinberg, A.S., Saltzman, W.S. &Pynoos, R.S. (2001a) PTSD Index: psychometric analyses of the adolescent version. Symposium conducted at the Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans: LA. doi:10.1007/s10896-013-9537-6

Rodriguez, N., Steinberg, A.S., Saltzman, W.S. &Pynoos, R.S. (2001). PTSD Index: preliminary psychometric analyses of child and parent versions. Symposium conducted at the Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA.

Rosmalen, L., Veer, R., & Horst, F. (2015). Ainsworth's strange situation procedure: The origin of an instrument. *Journal of the History of the Behavioral Sciences*, 51(3), 261-284. doi.org/10.1002/jhbs.21729

Rosenthal, J. A., & Curiel, H. (2006). Modeling behavioral problems of children in the child welfare system: Caregiver, youth, and teacher perceptions. *Children and Youth Services Review*, 28, 1391–1408. doi.org/10.1016/j.childyouth.2006.02.007

Roussos, A., Goenjian, A. K., Steinberg, A. M., Sotiropoulou, C., Kakaki, M., Kabakos,

C., Karagianni, S., & Manures, V. (2005). Posttraumatic stress and depressive reactions among children and adolescents after the 1999 earthquake in AnoLiosia, Greece. *American Journal of Psychiatry*, 162, 530-537. doi:10.1176/appi.ajp.162.3.530

Rubin, D. M., O'Reilly, A. L., Luan, X., & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics,* 119(2), 336-344. doi:10.1542/peds.2006-1995

Rubin, D., Springer, S. H., Zlotnik, S., Kang-Yi, C. D., & CARE, C. O. F. (2017). Needs of Kinship Care Families and Pediatric Practice. *Pediatrics*, doi:10.1542/peds.2015-2656.

Rubin, D. M., Downes, K. J., O'reilly, A. L., Mekonnen, R., Luan, X., & Localio, R. (2008). Impact of kinship care on behavioral well-being for children in out-of-home care. *Archives of Pediatrics & Adolescent Medicine*, 162(6), 550-556. doi:10.1001/archpedi.162.6.550.

Rubin, D. M., Alessandrini, E. A., Feudtner, C., Mandell, D. S., Localio, A. R., & Hadley, T. (2004). Placement stability and mental health costs for children in foster care. *Pediatrics*, 113(5), 1336-1341. doi:10.1016/j.pedn.2011.06.003

Runyon, M. K., Deblinger, E., & Steer, R. A. (2014). PTSD symptom cluster profiles of youth who have experienced sexual or physical abuse. *Child abuse & neglect*, 38(1), 84-90. doi:10.1177/0044118X14559916

Ryan, J. P., Perron, B. E., Moore, A., Victor, B., & Evangelist, M. (2016). Foster home placements and the probability of family reunification: Does licensing

matter? *Child abuse & neglect*, 59, 88-99. doi:10.1016/j.chiabu.2016.07.006

Salazar, A. M., Keller, T. E., & Courtney, M. E. (2011). Understanding social support's role in the relationship between maltreatment and depression in youth with foster care experience. *Child maltreatment*, 16(2), 102-113. doi:10.1177/1077559511402985

Salazar, A. M., Keller, T. E., Gowen, L. K., & Courtney, M. E. (2013). Trauma exposure and PTSD among older adolescents in foster care. Social psychiatry and psychiatric epidemiology, 48(4), 545-551. doi:10.1016/ j.chiabu.2005.01.006

Salloum, A., Wang, W., Robst, J., Murphy, T. K., Scheeringa, M. S., Cohen, J. A., & Storch, E. A. (2016). Stepped care versus standard trauma□focused cognitive behavioral therapy for young children. *Journal of Child Psychology and Psychiatry*, 57(5), 614-622. doi/full/10.1080/20008198.2018.1433929

Scannapieco, M., Heger, R. L., & Alpine, C. (1997). Kinship care and foster care: A comparison of characteristics and outcomes. *Families in Society*, 78(5), 480□489.doi:10.1606/1044-3894.817

Scannapieco, M., & Hegar, R. L. (2002). Kinship care providers: Designing an array of supportive services. *Child and Adolescent Social Work Journal*, 19(4), 315-327. doi:10.1023/A:1016305929569

Schermerhorn, R. (1810). Report of the trial of Susanna, a coloured woman at a court held at the city of Schenectady on the 23d October, 1810, on a charge of having murdered her infant male bastard child on the night of the 22d June 1810. Early American Imprints, Troy, NY.

Schimmenti, A., & Bifulco, A. (2015). Linking lack of care in childhood to anxiety disorders in emerging adulthood: the role of attachment styles. *Child and Adolescent Mental Health*, 20(1), 41-48. doi.org/10.1111/camh.12051

Shireman, J. F. (2015). *Critical issues in child welfare*. Columbia University Press.

Schofield, G., Beek, M., & Ward, E. (2012). Part of the family: Planning for permanence in long-term family foster care. *Children and Youth Services Review,* 34(1), 244-253. doi/pdf/10.1177/0308575916681711

Schofield, G., & Beek, M. (2005). Risk and resilience in long-term foster-care. *British Journal of Social Work*, 35(8), 1283-1301. /doi.org/10.1093/bjsw/bch213

Selwyn, J., Farmer, E., Meakings, S., & Vaisey, P. (2013). The Poor Relations? Children and informal kinship carers speak out. University of Bristol in partnership with Buttle UK. doi.org/10.1111/cfs.12423

Shadish, W., Cook, T., & Campbell, D. (2002). Experimental and Quasi-Experimental Designs for Generalized Causal Inference Boston: Houghton Mifflin. doi:pdf/10.1177/109442810472006

Shalonsky, A., & Berrick, J. D. (2001). Assessing and promoting quality in kin and non□ kin foster care. *Social Service Review*, 75(1), 60□83. doi:10.1086/591882

Shaw, T. V., Bright, C. L., & Sharpe, T. L. (2015). Child welfare outcomes for youth in care as a result of parental death or parental incarceration. *Child abuse & neglect*, 42, 112-120. doi.org/10.1016/j.chiabu.2015.01.002

Shelman, E. A., & Lazoritz, S. (2005). The Mary Ellen Wilson child abuse case and the beginning of children's rights in 19th century America. Jefferson, N.C: McFarland

& Co.

Sheperis, C. J., Renfro-Michel, E. L., & Doggett, R. A. (2003). In-home treatment of reactive attachment disorder in a therapeutic foster care system: A case example. *Journal of Mental Health Counseling*, 25(1), 76-88. doi/abs/10.17744/mehc.25.1

Shieh, G. (2018). Sample size determination for examining interaction effects in factorial designs under variance heterogeneity. *Psychological methods*, *23*(1), 113. .doi.org/10.1037/ met0000150

Shilkret, R., & Shilkret, C. (2008). Attachment theory. Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts, 189-203.

Shin, S. H. (2005). Need for and actual use of mental health service by adolescents in the child welfare system. *Children and Youth Services Review*, 27(10), 1071-1083. doi.org/10.1016/j.childyouth.2004.12.027

Shoemaker, d. j. (2017). juvenile delinquency. rowman & littlefield. doi:10.1177/1462474516645688

Shore, N., Sim, K. E., LeProhn, N. S., & Keller, T. E. (2002). Foster parent and teacher assessments of youth in kinship and nonkinship foster care placements: Are behaviors perceived differently across settings? *Children and Youth Services Review*, 24, 109–134. doi:10.1016/S0190-7409(01)00165-7

Shubik, C., & Kendall, J. (2007). Rethinking juvenile status offense laws: Considerations for Congressional review of the Juvenile Justice and Delinquency Prevention

Act. *Family Court Review*, 45(3), 384-398. doi.org/10.1111/j.1744-1617.2007.00154.x

Siegmund, J., Siegmund, N., & Apel, S. (2015, May). Views on internal and external validity in empirical software engineering. In Software Engineering (ICSE), 2015 IEEE/ACM 37th IEEE International Conference on (Vol. 1, pp. 9-19). IEEE.

Simmel, C. (2007). Risk and protective factors contributing to the longitudinal psychosocial well-being of adopted foster children. *Journal of Emotional and Behavioral Disorders*, 15(4), 237-249. doi:10.1080/15562948.2013.827769

Sinclair, I., Baker, C., Lee, J. and Gibbs, I. (2007), The Pursuit of Permanence: A Study of the English Care System, Jessica Kingsley, London. doi.org/10.1016/S2215-0366(17)30127

Singer, M.I., Anglin, T.M., Song, L.Y. & Lunghofer, L. (1995). Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association*, 273, 477-482. doi:10.1001/jama.1995.03520460016008

Sirois, F. M., Millings, A., & Hirsch, J. K. (2016). Insecure attachment orientation and well-being in emerging adults: The roles of perceived social support and fatigue. *Personality and Individual Differences*, 101, 318-321. doi.org/10.1016/j.paid.2016.06.026

Slotter, E. B., & Luchies, L. B. (2014). Relationship quality promotes the desire for closeness among distressed avoidantly attached individuals. *Personal Relationships*, 21(1), 22-34.). doi:10.1177/014616721557905

Siegmund, j., Siegmund, n., & apel, s. (2015, may). views on internal and external validity in empirical software engineering. in software engineering (icse), 2015 ieee/acm 37th ieee international conference on (vol. 1, pp. 9-19). ieee.

Smith, C. J., & Devore, W. (2004). African American children in the child welfare and kinship system: From exclusion to over inclusion. *Children and Youth Services Review,* 26(5), 427-446. doi:10.1.1.597.3577

Smithgall, C., Yang, D., & Weiner, D. (2013). Unmet mental health service needs in kinship care: The importance of assessing and supporting caregivers. *Journal of Family Social Work*, 16(5), 463–479. doi:10.1080/10522158.2013.832460.

Smyke, A. T., Zeanah, C. H., Fox, N. A., Nelson, C. A., & Guthrie, D. (2010). Placement in foster care enhances quality of attachment among young institutionalized children. *Child development*, 81(1), 212-223. doi:10.1111/j.1467-8624.2009.01390.x

Southwich, H.C. (1809). The case against the shopkeeper was sold to the public as a pamphlet. The Trial of Amos Broad and his wife, on several indictments for assaulting and beating Betty, a slave, and her little female child Sarah, aged three years. Had at the court of special sessions of the peace, held in and for the city and county of New- York at the City-Hall of the said city, on Tuesday, the 28th day of February 1809. New York, NY

Spinazzola, J., Ford, J. D., Zucker, M., van der Kolk, B. A., Silva, S., Smith, S. F., & Blaustein, M. (2017). Survey Evaluates: Complex Trauma Exposure, Outcome, and Intervention Among Children and Adolescents. *Psychiatric Annals*, 35(5),

433-439. doi:10.3928/00485713-20050501-09

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & human development*, 7(4), 349-367. doi.org/10.1080/14616730500365928

Stanton, S. C., Campbell, L., & Pink, J. C. (2017). Benefits of positive relationship experiences for avoidantly attached individuals. *Journal of personality and social psychology*, 113(4), 568. doi:10.1037/pspi0000098

Stien, P., & Kendall, J. C. (2014). Psychological trauma and the developing brain: Neurologically based interventions for troubled children. Routledge. doi:10.1080/13552600903335844

Steinberg, A. M., Brymer, M. J., Kim, S., Ghosh, C., Ostrowski, S. A., Gulley, K., Briggs, E. C., Pynoos, R. S. (2013). Psychometric properties of the UCLA PTSD Reaction Index: Part I. *Journal of Traumatic Stress*, 26: 1-9. doi:10.1002/jts.21780

Steiner, P. M., Cook, T. D., Li, W., & Clark, M. H. (2015). Bias reduction in quasi-experiments with little selection theory but many covariates. *Journal of Research on Educational Effectiveness*, 8(4), 552-576. doi.org/10.1080/19345747.2014.978058

Stevenson-Hinde, J., & Verschueren, K. (2002). Attachment in childhood. doi.org/10.1080/14616730701711540

Stirling, J., & Amaya-Jackson, L. (2008). Understanding the behavioral and emotional consequences of child abuse. *Pediatrics*, 122(3), 667-673.

doi:10.1542/peds.2008-1885

Stoltzfus. E. (2017). Child Welfare: An Overview of Federal Programs and Their Current Funding Congressional Research Service.

Storr, C. L., Ialongo, N. S., Anthony, J. C., & Breslau, N. (2007). Childhood antecedents of exposure to traumatic events and posttraumatic stress disorder. *American Journal of Psychiatry*, 164(1), 119-125. doi:1037/0012-1649.37.5.597

Stovall-McClough, K. C., & Cloitre, M. (2006). Unresolved attachment, PTSD, and dissociation in women with childhood abuse histories. *Journal of consulting and clinical psychology*, 74(2), 219. doi:10.1037/0022-006X.74.2.219

Strand, V. C., Sarmiento, T. L., & Pasquale, L. E. (2005). Assessment and screening tools for trauma in children and adolescents: A review: Trauma, Violence, & Abuse, 6(1), 55-78. doi:10.1177/1524838004272559

Strozier, A. L. (2012). The effectiveness of support groups in increasing social support for kinship caregivers. *Children and Youth Services Review*, 34(5), 876-881. doi.org/10.1016/j.childyouth.2012.01.007

Strozier, A. L., & Krisman, K. (2007). Capturing caregiver data: An examination of kinship care custodial arrangement. *Children and Youth Services Review*, 29, 226–246. doi:10.1.1.922.1025

Sue, D., Sue, D. W., Sue, S., & Sue, D. M. (2015). Understanding abnormal behavior. doi.org/10.1037/a0027461

Sullivan, G. M., & Feinn, R. (2012). Using effect size—or why the P value is not enough. *Journal of graduate medical education*, 4(3), 279-282.

doi:10.4300/JGME-D-12-00156.1

Swanke, J. R., Yampolskaya, S., Strozier, A., & Armstrong, M. I. (2016). Mental health service utilization and time to care: A comparison of children in traditional foster care and children in kinship care. *Children and Youth Services Review*, 68, 154-158. doi.org/10.1016/j.childyouth.2016.06.029

Szilagyi, M. A., Rosen, D. S., Rubin, D., & Zlotnik, S. (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*, 136(4), doi: 10.1542/peds.2015-2656

Tabachnick, B. G., & Fidell, L. S. (2013). Using multivariate statistics, 6th edn Boston. Ma: Pearson. doi:10.4236/ijg.2014.55049 18,623

Takazawa, T, (2015). The effectiveness of trauma-focused cognitive behavioral therapy on children and adolescents who suffer from complex trauma and exhibit post-traumatic stress disorder symptoms: A systematic review. *Master of Social Work Clinical Research Papers*, 538.

Tarren-Sweeney, M., & Hazell, P. (2006). The mental health of children in foster and kinship care in New South Wales, Australia. *Journal of Pediatrics and Child Health*, 42, 89-97. doi:10.1111/j.1440-1754.2006.00804.x

Taussig, H. N., & Clyman, R. B. (2011). The relationship between time spent living with kin and adolescent functioning in youth with a history of out-of-home placement. *Child abuse & neglect*, 35(1), 78-86. doi.org/10.1017/S1474746418000179

Teicher, M. H. (2002). Scars that won't heal: The neurobiology of child abuse. *Scientific*

American, 286(3), 68-75. doi.org/10.1177/0886260504269485

Tereno, S., Guedeney, N., Dugravier, R., Greacen, T., Saïas, T., Tubach, F., Ulgen, S., Matos, I. & Guédeney, A. (2017). Infants' attachment security in a vulnerable French sample. L'Encephale, 43,2, 99-103. doi:10.1016/j.encep.2015.11.006

Terling-Watt, T. (2001). Permanency in kinship care: An exploration of disruption rates and factors associated with placement disruption. *Children and Youth Services Review*, 23(2), 111-126. doi:10.1016/s0190-7409(01)00129- 3.

Testa, M. F., & Slack, K. S. (2002). The gift of kinship foster care. *Children and Youth Services Review*, 24, 79–108. doi.org/10.1016/S0190-7409(01)00169-4

The Annals of Iowa (2005). Orphan Trains: The Story of Charles Loring Brace and the Children he saved and failed. The 64, 80-81. doi.org/10.17077/0003- 4827.10875

Thoburn, J. (2017). Children in State Care. Routledge. doi.org/10.4324/9781315260532

Thompson, R. A. (2006). The development of the person: Social understanding, relationships, conscience, self. Handbook of child psychology. doi:10.1080/14616734.2015.

Thompson, G. C. (2016). A phenomenological study: Foster care youth aging out of the system (Doctoral dissertation, Nova Southeastern University).

Timmer, S. G., Sedlar, G., & Urquiza, A. J. (2004). Challenging children in kin versus non-kin foster care: Perceived costs and benefits to caregivers. *Child Maltreatment*, 9(3), 251-262. doi:10.1177/ 1077559504266998.

Tondar, S., Campos, R. C., Shakiba, S., Dadkhah, A., & Blatt, S. J. (2017). The associations between the maladaptive personality dimensions of neediness and

self-criticism, defense styles, self object needs, and attachment styles in an Iranian sample. *Psychoanalytic Psychology*, 34(1), 26. doi.org/10.1037/pap0000097

Trickey, D., Siddaway, A. P., Meiser-Stedman, R., Serpell, L., & Field, A. P. (2012). A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clinical psychology review*, 32(2), 122-138. doi:10.1016/j.cpr.2011.12.001.

Turner, H. A., Finkelhor, D., & Ormrod, R. (2010). The effects of adolescent victimization on self-concept and depressive symptoms. *Child maltreatment*, 15(1), 76-90. doi:10.1177/1077559509349444.

Turner, H. A., Finkelhor, D., & Ormrod, R. (2007). Family structure variations in patterns and predictors of child victimization. *American Journal of Orthopsychiatry*, 77(2), 282. doi:10.1037/0002-9432.77.2.282. 282

Turner, L. 2008. Attachment style of children in foster care and its relationship to interpersonal cognitive complexities. doi:10.5964/ejop.v8i3. 463

Turney, K., & Wildeman, C. (2017). Adverse childhood experiences among children placed in and adopted from foster care: Evidence from a nationally representative survey. *Child abuse & neglect*, 64, 117-129.

Unger, J. A. M., & De Luca, R. V. (2014). The relationship between childhood physical abuse and adult attachment styles. *Journal of family violence*, 29(3), 223-234. doi.org/10.1007/s10896-014- 9588-3

Unrau, Y. A., Seita, J. R., & Putney, K. S. (2008). Former foster youth remember multiple placement moves: A journey of loss and hope. *Children and Youth*

Services Review, 30(11), 1256-1266. doi.org/10.1016/j.childyouth.2008.03.010

US Department of Health and Human Services, Administration for Children and Families. (2005). *Child Maltreatment*. Washington, DC: US Government Printing Office

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2015). The AFCARS Report: Preliminary FY 2017 Estimates as of August 10, No 25.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). Child Maltreatment 2011.

U. S. Department of Health and Human Services. (2000). U. S. Department of Health and Human Services report to congress on kinship foster care Washington, DC: Author.

Vanschoonlandt, F., Vanderfaeillie, J., Van Holen, F., De Maeyer, S., & Andries, C. (2012). Kinship and nonkinship foster care: Differences in contact with parents and foster child's mental health problems. *Children and Youth Services Review*, 34(8), 1533-1539. doi:10.1016/j.childyouth.2012.04.010

Van Der Kolk, B. A. (2017). This Issue: Child Abuse & Victimization. *Psychiatric Annals*, 35(5), 374-378. doi:10.1089/acm.2015.0266,

Van Nierop, M., Viechtbauer, W., Gunther, N., Van Zelst, C., De Graaf, R., Ten Have, M., Van Dorsselaer, S., Bak, M., van Winkel, R. & Outcome of Psychosis

(GROUP) investigators, 2015. Childhood trauma is associated with a specific admixture of affective, anxiety, and psychosis symptoms cutting across traditional diagnostic boundaries. Psychological medicine, 45(6),1277-1288.

Van Wert, M., Mishna, F., & Malti, T. (2016). A conceptual model of the relationship between maltreatment and externalizing, antisocial, and criminal behavior problems, and the intervening role of child welfare service delivery. *Aggression and violent behavior*, 29, 10-19. doi.org/10.1016/j.avb.2016.05.005

Vandivere, S., Chalk, R., and Moore, K.A. (2003). Children in foster homes: How are they faring? Research Brief, Publication, 2003-2023.Washington, DC: Child Trends.

Van der Spuy, C. (2014). Treating Trauma in Early Childhood by Utilising Eye Movement Integration Therapy (Doctoral dissertation, University of Johannesburg).

VanVoorhis, C. W., & Morgan, B. L. (2007). Understanding power and rules of thumb for determining sample sizes. *Tutorials in Quantitative Methods for Psychology*, 3(2), 43-50. doi:10.1093/geroni/igz006

VanVoorhis, C. W., & Morgan, B. L. (2007). Understanding power and rules of thumb for determining sample sizes. *Tutorials in Quantitative Methods for Psychology*, 3(2), 43-50. doi:10.1093/geroni/igz006

Verhage, M.L., Schuengel, C., Madigan, S., Fearon, R.M., Oosterman, M., Cassibba, R., Bakermans-Kranenburg, M.J. & van IJzendoorn, M.H., 2016. Narrowing the

transmission gap: A synthesis of three decades of research on intergenerational transmission of attachment. *Psychological Bulletin*, 142(4), p.337. doi:10.1037/bul0000038.

Veltman, M. A. (2016). Exploring the Experience of Foster Parents as they care for children who are making the Transition from the Hospital into the Foster Home (Doctoral dissertation, The University of New Mexico).

Victor, B. G., Ryan, J. P., Moore, A., Mowbray, O., Evangelist, M., & Perron, B. E. (2016). Foster home licensing and risk of reentry to out-of-home care following family reunification. *Children and Youth Services Review*, 70, 112-119. doi.org/10.1016/j.childyouth.2016.09.015

Vinnerljung, B., Sallnäs, M., & Berlin, M. (2017). Placement breakdowns in long□term foster care–a regional Swedish study. *Child & Family Social Work*, 22(1), 15-25. doi:10.1111/cfs.12189

Vostanis, P. (2010). Mental health services for children in public care and other vulnerable groups: Implications for international collaboration. *Clinical child psychology and psychiatry*, 15(4), 555-571. doi:abs/10.1177/1359104510377715

Votruba-Drzal, E. & Dearing, E. (2017). The Wiley Handbook of Early childhood Programs, Practice, and Policies. Wiley Blackwell Handbooks of Developmental Psychology. John Wiley & Sons, 404-406. doi:10.1002/9781118937334

Waid, J., Kothari, B. H., Bank, L., & McBeath, B. (2016). Foster care placement change: The role of family dynamics and household composition. *Children and youth services review*, 68, 44-50. doi:10.1016/j.childyouth.

Walsh, W. A. & Mattingly, M. J. (2014). Related foster parents less likely to receive support services compared with non-relative foster parents. Casey Research National Issue Brief, 74.

Wang, Y., Rodríguez de Gil, P., Chen, Y. H., Kromrey, J. D., Kim, E. S., Pham, T., ... & Romano, J. L. (2017). Comparing the performance of approaches for testing the homogeneity of variance assumption in one-factor ANOVA models. *Educational and psychological measurement*, 77(2), 305-329. doi.org/10.1177/0013164416645162

Wildeman, C., & Emanuel, N. (2014). Cumulative risks of foster care placement by age 18 for US children, 2000–2011. *PloS one*, 9(3), doi.org/10.1371/journal.pone.0092785

Waldfogel, J. (2006). What do children need? Juncture, 13(1), 26-34.

Walker, M. L. (2015). Kinship care: a look into differing characteristics of children placed in kin and foster placements.

Walsh, F. (2015). Strengthening family resilience. Guilford Publications. doi:10.1111/j.1741-3729.2002.00130

Watts□English, T., Fortson, B. L., Gibler, N., Hooper, S. R., & De Bellis, M. D. (2006). The psychobiology of maltreatment in childhood. *Journal of Social Issues*, 62(4), 717-736. doi:abs/10.1111/j.1540-4560.2006.00484

Waters, E., Crowell, J., Elliott, M., Corcoran, D., & Treboux, D. (2002). Bowlby's secure base theory and the social/personality psychology of attachment styles: Work (s) in progress. Attachment & Human Development, 4(2), 230-242.

doi:10.1177/0265407509345653

Waters, E., Corcoran, D. &Anafarta, M. (2005). Attachment, Other Relationships, and the Theory that All Good Things Go Together' Human Development 48:80–84. *Human Development*. doi.org/10.1159/000083217

Watson, S. (2005). Attachment theory and social work. Social work theories in action, 208-22.

Weiner, D. A., Schneider, A., & Lyons, J. S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. *Children and Youth Services Review*, 31(11),1199-1205. doi:10.1016/j.childyouth.

Weiss, B. J., Garvert, D. W., & Cloitre, M. (2015). PTSD and Trauma□Related Difficulties in Sexual Minority Women: The Impact of Perceived Social Support. *Journal of traumatic stress*, 28(6), 563-571. doi.org/10.1002/jts.22061

Wells, K., & Guo, S. (1999). Reunification and reentry of foster children. *Children and Youth Services Review*, 21(4), 273–294. doi.org/10.1016/S0190-7409(99)00021

Welsh, A. (2013). Effects of Trauma Induced Stress on Attention, Executive Functioning, Processing Speed, and Resilience in Urban Children.

Wendinger, R. (2009). Extra! Extra! The Orphan Trains and Newsboys of New York, Legendary Publications, 11.

Wherry, J. N., & Dunlop, C. E. (2017). TSCC and TSCYC screening forms in a clinical sample: reliability, validity, and creating local clinical norms. *Child maltreatment*, doi:10.1177/1077559517725207.

Wherry, J. N., Corson, K., & Hunsaker, S. (2013). A short form of the Trauma Symptom Checklist for Young Children. *Journal of child sexual abuse*, 22(7), 796-821. doi:10.1080/10538712.2013.830667

Whitbeck, L. B. (2017). Nowhere to grow: Homeless and runaway adolescents and their families. Routledge. doi:org/10.1002/14651858

Wilkinson, I. G. (2016). Why Some Children Come to School with "Baggage": The Effects of Trauma Due to Poverty, Attachment Disruption and Disconnection on Social Skills and Relationships. Canadian Journal of Family and Youth/Le Journal Canadien de Famille et de la Jeunesse, 8(1), 173-203. doi:full/10.1080/19411243.2018.1438327

Winokur, M., Crawford, R., Longobardi, C. & Valentine, D. (2008). Matched comparison of children in kinship care and foster care on child welfare outcomes. *Families in Society*, 89 (3), 338–346. doi.org/10.1606/1044-3894.3759

Winokur, M. A., Holtan, A., & Batchelder, K. E. (2018). Systematic review of kinship care effects on safety, permanency, and well-being outcomes. *Research on Social Work Practice*, 28(1), 19-32. doi.org/10.1177/1049731515620843

Winokur, M., Holtan, A., & Valentine, D. (2009). Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. Oslo: Campbell Collaboration. doi: 10.1002/14651858.CD006546

Withington, T., Burton, J., Lonne, B., & Eviers, A. (2016). Carer perspectives of factors affecting placement trajectories of children in out-of-home care. *Children and Youth Services Review*, 65, 42-50. doi.org/10.1016/j.childyouth.2016.03.006

Wu, Q., White, K. R., & Coleman, K. L. (2015). Effects of kinship care on behavioral problems by child age: A propensity score analysis. Children and Youth Services Review, 57, 1-8. doi.org/10.1177/1078390317730605

Wyse, D., & Torgerson, C. (2017). Experimental trials and what works? in education: The case of grammar for writing. *British Educational Research Journal*, 43(6), 1019-1047. doi:10.1002/berj.3315

Yule, W., & Williams, R. M. (1990). Post□traumatic stress reactions in children. *Journal of Traumatic Stress*, 3(2), 279-295. doi.org/10.1093/jpepsy/15.1.27

Zetlin, A., Weinberg, L., & Shea, N. M. (2010). Caregivers, school liaisons, and agency advocates speak out about the educational needs of children and youths in foster care. *Social work*, 55(3), 245-254. doi:10.1093/sw/55.3.245

Zeanah, C. H., Shauffer, M. C., & Dozier, M. (2011). Foster care for young children: why it must be developmentally informed. *Journal of the American Academy of Child and Adolescent Psychiatry*, 50(12), 1199.

Zeanah, C. H., & Gleason, M. M. (2015). Annual research review: attachment disorders in early childhood–clinical presentation, causes, correlates, and treatment. *Journal of Child Psychology and Psychiatry*, 56(3), 207-222. doi:10.1111/jcpp.12347

Zinn, A. E., DeCoursey, J., Courtney, M. E., & Goerge, R. (2006). Placement stability in Illinois. Chicago, IL: Chapin Hall Center for Children at the University of Chicago.

Appendix A: Mental Health Treatment Service Demographic Questionnaire

Foster Care or Family Kinship Care: A Comparative Study on Rates of Posttraumatic Stress Disorder

Please *Do Not* put any names on this form.

*Please answer all questions as honestly as possible and put a √ check mark next to the appropriate responses.

1. Age
   - 3-5
   - 6-8
   - 9-12

2. Gender
   - Male
   - Female

3. Ethnicity
   - African American
   - Asian
   - Caucasian
   - Hispanic/Latino
   - Other_____
   - Prefer not to say

4. Are you a regular nonkinship foster parent? *(Example: foster parent who is not related to foster child)*
   - Yes
   - No

5. Are you a kinship foster parent? *(Example: foster parent who is related to foster child such as a guardian, a relative, godparents, stepparents, family friend, members of Tribe or clan, or anyone who had a relationship to the child before coming into foster care)*
   - Yes
   - No

6. How long have you known the foster child?
   - o less than 3 months
   - o 4-6 months
   - o 7-9 months
   - o 10-12 months
   - o 12 months or longer

7. How long has the foster child been in your home?
   - o less than 3 months
   - o 4-8 months
   - o 9-12 months
   - o 12 months or longer

8. Has your child or foster child received psychotherapy within the last 3-4 months?
   - o Yes
   - o No

9. How months has your child or foster child received psychotherapy within the last 3-4 months?

o	None
o	1-2 months
o	3-4 months
o	5-6 months
o	7-8 months
o	8 months or more

10. How many number of psychotherapy sessions has your foster child has attended within the past 3-4 months?

o	None
o	1-2 per months
o	3-4 per months
o	5-6 per months
o	7-8 per months
o	8 months or more

11. Has your foster child participated in any recreational activities or sports within the past 3-4 months?
   - o Yes
   - o No

12. Which activities did your foster child participate within the past 3-4 months? (Please check all that apply)

- None
- After-school program
- Summer Camp
- Sports (Basketball, Football, soccer, Tennis, Baseball, Golf, Track)
- Martial Arts
- Yoga
- Swimming
- Gym/Fitness

13. Have you received any PTSD training within the last 3-4 months?

- Yes
- No

14. What type of therapy did your foster child receive within the past 3-4 months? (Please check all that apply)

- Cognitive behavior therapy (CBT)
- Dialectical behavioral therapy (DBT)
- Interpersonal Therapy (IPT)
- Psycho-dynamic therapy
- Group therapy
- Family therapy
- Play therapy
- Art therapy
- Trauma-focused cognitive behavioral therapy (TF-CBT)
- Mindfulness-based therapies
- Not Sure
- None

Appendix B: Permission to Use the Trauma Symptoms Checklist for Young Children

Foster Care or Family Kinship Care:
A Comparative Study on Rates of Posttraumatic Stress Disorder

Greetings PAR Inc,

My name is Rashanda Allen; I am a PhD clinical psychology doctoral candidate at Walden University conducting a research study entitled Foster Care or Family Kinship Care: A Comparative Study on Rates of Posttraumatic Stress Disorder. The purpose of this research study is to investigate whether children, ages 3-12, in kinship foster homes significantly differ in their reported symptoms of PTSD from children placed in nonkinship foster homes.

This study will measure children's Posttraumatic Stress (PTS) symptoms which include: intrusive thoughts, sensations, and memories of painful past events; nightmares, fears; and cognitive avoidance of painful feelings. Through use of the Trauma Symptoms Checklist for Young Children (TSCYC), the researcher will be able to evaluate acute and chronic posttraumatic symptomatology in young children who have been placed in kinship and nonkinship foster homes. The study will assist me in completing my doctorate in clinical psychology from Walden University, will help foster care agencies with making informed decisions about children's placement type, and secure housing stability based on PTSD diagnosis, as well as promote policy and social changes within the child welfare system.

I am writing to request your permission to include the following copyright material in my dissertation:

- Trauma Symptoms Checklist for Young Children (TSCYC), Briere, J. (2005). The Trauma Symptom Checklist for Young Children. *Odessa, FL: Psychological Assessment Resources*.

The TSCYC material will be fully and correctly referenced. There are minimal risks to participate in the study. The study involves biological parents as well as foster parents completing a pre-and-post test of the Trauma Symptoms Checklist for Young Children (TSCYC) to assess children's reported rates of Posttraumatic Stress (PTS) symptomatology after duration of 3-4 months into the study. There will be no changes made to the TSCYC assessment tool if researcher is given permission to use tool, however participants will not be asked to provide any identifying and/or private health information (PHI) for this research study. All participants' information will be kept confidential and protected under The Health Information Privacy Policy Act (HIPPA) law. No participants identifying information will be collected for this research study. All participants will remain confidential. SPSS database as well as TSCYC assessment forms with no names or other identifying information linking participants to the study. On the

TSCYC assessment forms, places where child's name and foster parent's name would go, there would instead be a label covering those spaces with the researchers coding system to protect participants confidential information. A coding system such as 1A and 1B for participant 1 and then 2A and 2B for participant 2, etc will be used to identify and match participants to their pre and post test assessments. Researcher will identify participants through the coding system pre-test and post-test. Data will be reported at the aggregate level, so no identifying information and no information on single cases will be reported. In this way it will not be possible to identify any participants in the final written document or through TSCYC assessment forms.

Your approval to conduct this important research study with the use of the Trauma Symptoms Checklist for Young Children (TSCYC) will be greatly appreciated. If you agree, kindly sign electronically below and return via e-mail to [redacted]. Alternately, if you agree you can also kindly submit a signed letter of cooperation on your institution's letterhead acknowledging your consent and permission for me to conduct this research study with the use of the Trauma Symptoms Checklist for Young Children (TSCYC) and return via e-mail to [redacted]. If you have any questions or concerns about the research study, you may contact researcher at [redacted], or reach my faculty chair or committee members at Walden University at [redacted] [redacted]. I look forward to hearing from you soon.

Thank you in advance for your time and patience,
Rashanda Allen, M.S.
PhD candidate Walden University

Appendix C: Participant Research Flyer

PTSD Research Study

Are you a foster parent with a foster child diagnosed with Post-Traumatic Stress Disorder (PTSD)?
If so, you are invited to participate in a research study

Requirements:

- Are you a Foster Parent or Kinship Foster Parent?
- Do you have a foster child between ages 3-12?
- Has your child been diagnosed with PTSD?

Who to Contact with questions:

- If you have any questions or concerns about the research study, please contact the researcher rashanda.allen@waldenu.edu

How to Participate in Research Study:

- https://www.surveymonkey.com/r/Q2WD2GZ.