An Autoethnographic Tale of One Louisiana Mother's Personal Journey of Fostering and Adopting: The Impact of the Fostering Process Versus the Fostering Process in Classrooms

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Abstract
The purpose of this ethnographic reflection is to provide an overview of the history of foster care in the United States and compare the foster care classroom training experience to the reality of foster care. It is an attempt to explain the reasons why one South Louisiana mother, scholar, and teacher (and family) would consciously choose foster care and the far reaching and devastating impact the sense of loss and an interrupted childhood has on the placement family and the child in foster care. This richly detailed autoethnographic narrative is both a blue print and a cautionary tale about fostering.

They come through you but not from you,
And though they are with you yet they belong not to you.
-Kahlil Gibran, 1923

The interruption of childhood is emotionally and mentally challenging. An interrupted childhood occurs when affectional bonds are disrupted and normal development is compromised. The psychological and emotional scaring of the placement family and the child in foster care lingers despite the heroic efforts of foster parents, social workers, teachers, and doctors. According to the Committee on Early Childhood, Adoption and Dependent Care for the American Academy of Pediatrics (Miller et al., 2000) consequences of abuse, neglect, and placement into foster care can negatively affect a child's early brain development, ability to attach to care givers, sense of time, and response to stress. An interruption in the continuity of a child's caregiver can be harmful. A child's development and ability to cope are compromised by repeated moves from home to home due to the adverse consequences of stress and inadequate parenting (Health & Services, 2009).
Approximately 422,995 children in the United States (US) were in foster care during the 2017 academic year. At the same time in Louisiana, the number of children in foster care was estimated to be 4,460 (2017). Many of these children, in Louisiana and nationwide, were also enrolled in schools across the US, indicating a need for a myriad school personnel to be versed in the special needs such children can present in educational settings.

The purpose of this manuscript is to describe the impact an unstable childhood – an interrupted childhood – has on the social, emotional, and mental development of a child in foster care and chronical one Louisiana mother's personal journey of fostering and adopting. This is an autoethnographic account of fostering that culminated with adoption. This richly detailed autoethnographic narrative is both a blueprint and a cautionary tale about fostering.

United States History of Foster Care

The US has a history of poor, immigrant populations with extreme needs inhabiting urban areas. This trend continues to be an issue that has not been faced realistically, sufficiently, or satisfactorily. The poverty rate in the US is 14.6%. Neighborhoods with poverty rates of 40% or more are defined as concentrated poverty. Individuals living in these neighborhoods are not only affected personally but also communally. These include higher crime rates, failing schools, and constrained economic opportunity (Stebbins, 2018). It is a documented fact that children in the child welfare system are inordinately attained from families living in poverty (2017).

Due to the Industrial Revolution, New York City (NYC) underwent massive economic transformations from 1830 to 1890. These changes created a new industrial working class that was extremely vulnerable to poverty. During this time, NYC's population was an estimated million and half, and 1/3 of the population lived in poverty, isolated by income as well as by ethnicity, and had scare access to food (Madison, 1971).

In an attempt to improve the conditions for the poor, the New York legislature passed the
County Poorhouse Act in 1824, both acknowledging and mandating each county have at least one poorhouse (Trattner, 2007). The program was funded by tax dollars and poor families were institutionalized. "Almshouses housed males and females, sick and well, sane and insane, juvenile delinquents and hardened criminals, young and old" (Trattner, 1974, p. 60). Children were cared for until they were old enough to be useful, productive laborers (Downs, 2000). The conditions varied among New York county almshouses. In 1850, a New York legislative investigation was conducted and found that beatings, unsanitary conditions, and medical neglect were common in many institutions (Trattner, 1974). However, some institutions provided adequate care. Dissatisfaction with almshouses and public money being awarded to voluntary agencies and church organizations changed the way children of abuse, neglect, and abandonment were being cared for in such entities.

Foster care in the US was started in 1853 by Charles Loring Brace. Brace opposed almshouses and the indenture of children. Brace was extremely concerned with the level of juvenile delinquency and crime among the youth of New York (Trattner, 1974). In the mid-19th century, some 30,000 homeless or neglected immigrant children were sleeping in the streets of New York due to the dire circumstances of poverty. As a minister and the director of the New
York Children's Aid Society, Brace formulated a plan to place these children in homes. He advertised for families in the South and West who would be willing to provide for these children.
Some families took the children out of charity; some took the children as indentured servants. As a result of Brace's actions, state governments and religious social agencies became involved in foster home placements (Madison, 1971).

Historical Overview of Foster Care

Historically, individual states began providing foster families with board payments, passing licensing laws, and providing subsidies to the Children's Home Society in order to continue its work for public childcare. For instance, prior to 1865, Massachusetts was the first state to pay board to families who took care of children too young to be indentured. Similarly, in 1886 Pennsylvania passed the first licensing law that required parents to obtain a license in order to care for two or more unrelated children. In yet another instance, in 1893 South Dakota began providing subsidies to the Children's Home Society for its public child case work (Herman, 2003).

By the early 1900's foster parents were being supervised by social agencies, records were being kept, and children's needs were being considered in many states. Subsequently, the federal government was supporting state inspections of foster homes, and biological families were being provided with services to enable children to return home.

In 1935, Congress passed the Social Security Act (Policy), part of President Roosevelt's New Deal, designed to save the nation from economic ruin. The Social Security Act created Aid to Dependent Children. This act provided millions of dollars to states to support poor families (Herman, 2003). Within the Social Security Act was a provision that authorized the Children's Bureau "to cooperate with state public-welfare agencies in establishing, extending, and strengthening, especially in predominantly real areas, [child welfare services] for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent" (Herman, 2003)

Louisiana: A Local View of Foster Care

In Louisiana, the origins of today's present foster care system can be traced to French civil law and customs. Prior to the French Revolution in 1789, the Roman Catholic Church was responsible for providing poor relief and charity for widows and orphans. After the French Revolution, Napoleon assigned poor relief efforts to the State, and they were administered through the local government. However this did not change the dissemination of poor relief in Louisiana (Wisner, 1976). Prior to the 1900's the state of Louisiana had made little attempt to care for its dependent children. The state provided small amounts of money to private agencies but most agencies depended upon philanthropy and private funds to operate their facilities (Davis, 1960).
Reforms began in the early 1900's when retired ministers, teachers, and nurses were replaced by trained social workers as custodians of welfare agencies. The state of Louisiana recognized the need for qualified

staff to keep sufficient records regarding medical treatment, psychological testing, and behavioral patterns. Trained social workers were also more adept at identifying the needs of individual children and guiding the psychological, physical, and mental development of each child (Slingerland, 1980).

Currently, in Louisiana, foster care is coordinated through the Department of Children and Family Services (2019). Foster care is a service provided to children in the custody of the state due to removal based on abuse, neglect, or sexual victimization. Foster care provides substitute, temporary care for a determined period of time until a child is reunited with his/her family or another permanent living situation is provided. The first goal of foster care is to reunite the child with his or her biological family (Mallon & Hess, 2014).

The Louisiana Department of Children and Family Services' mission statement declares:

> *the provision of foster care services is based on the belief that every child has an urgent need and the right to a safe and permanent family of his own. Therefore, the mission of the foster care program is to maintain the child in a safe environment which is supportive of his development and to assist his parents in resuming responsibility and custody or in attaining an alternative permanent placement for the child as soon as possible* (2019).

Children can be referred to the agency when a concerned person such as a police officer, teacher, family member, doctor, or friend, has concerns about the child's well-being. Anyone can make a referral based on suspicion of abuse or neglect. If the referral meets the stipulations for a report of child abuse or neglect it will be investigated.

The Abuse Prevention and Treatment Act defines child abuse and neglect, at a minimum, as "any recent act or failure on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm" to a person under age 18 (Abuse, 1974). The agency will assess the situation and determine if there is a need for help. This assessment may involve a home visit and interviews with family members and persons outside the family. The assessment allows the agency to identify services that may be needed to provide better care, such as parenting skills or addiction rehabilitation services (Badeau & Gesiriech, 2003). Neglect due to inadequate housing, poor childcare, or insufficient food or medical care is the reason the majority of children enter foster care. A significant percentage of parents with children in foster care require substance abuse treatment (McNichol & Task, 2001).

Once a problem is identified, the agency makes every effort to provide services to assist the family in resolving their problem and avoid removing the children from the home. When reunification efforts fail, the agency obtains court authorization to remove the children from their home. In dire situations, the child may be removed immediately and placed into temporary care until the court order can be obtained. Once a child is removed from the home, the biological parents and the child are assigned a caseworker. The caseworker will develop a plan that determines the types of services the family will receive, reunification goals including scheduled visitations, intended date for the child to return home, and alternative plans for placement if the reunification goals are not met.

Federal law mandates that every state reviews a foster child's case every six months after placement. This allows the court system and the social worker to determine if placement is still necessary and appropriate, if the case plan is being properly and adequately followed, and if progress has been made toward reunification. If the family does not complete the court ordered reunification plan, parental rights will be terminated.
Federal law requires states to initiate termination of parental rights (TPR) proceedings for (1) children who have been in foster care for 15 of the most recent 22 months, (2) infants determined to be abandoned, or (3) cases in which a parent has killed another of his/her children, or (4) certain other egregious situations. States may opt not to initiate TPR if (1) the child is in a relative's care, (2) the child welfare agency has documented a compelling reason that TPR would not be in the child's best interest, or (3) the state has not provided necessary services to the family. 42 U.S.C. 675(1)(5)(E). In the case of an abandoned child, regulations require States to initiate TPR within 60 days of a court determination of abandonment and in the case of a child whose parent has been convicted of a felony specified in the law 60 days of a court determination that reasonable efforts to reunite are not required (Family, 2019).
If the parents successfully compete their court ordered case plan, the child is reunited with her family. Typically, the case is then closed.

Becoming a Foster Parent
In order to be a certified foster parent in Louisiana, individuals must complete four steps of training. The first

step is to attend an orientation meeting. In this meeting, prospective foster parents are given an overview of what to expect and how the agency works. Next the parents fill out an application and complete a criminal background check. Everyone in the household over the age of 18 must have a background check. Applicants then must complete pre-service training, consisting of seven 3-hour sessions. Both parents must complete the training. The final step to being foster parent certified is a completed home study. This process occurs during training. The applicants are assigned a home development worker who periodically inspects the home for appropriate safety measures. During the first home visit the home development worker will conduct a multi-faceted safety inspection including insuring the home is properly prepared to deal with a fire. Oher examples include working toilets, fire extinguishers, window fire escape ladders for two-story homes, all medications and cleaners in locked cabinets, and food in the refrigerator. Additional paperwork will also be completed at this time. For instance, this includes copies of driver's licenses, proof of insurance, license plate numbers, and proof of employment. The home development worker also interviews the foster parents separately about their desire to foster, discipline philosophies, ability to work together as a parental unit, and willingness to adopt. After certification is complete a child or children may be placed in the home. The foster parents can stipulate the ages, gender, and type of children they are willing to foster.

Methodology: Autoethnography

Ethnography is a qualitative research method used in most behavioral sciences with its roots in anthropology. Spindler posits that ethnography "can give fresh insights into perplexing educational problems" (Spindler, 1982, p. iii). Spindler's seminal text, Doing the Ethnography of Schooling, (1982) connects the anthropological method of ethnography to an educational research method. Ethnography is used across many disciplines for its ability to inform by obtaining and ascribing meaning to cultural phenomenon from the perspective of those within the culture. Spradley contends that it is essential that an ethnography consider three core facets of human experiences: "what people do, what people know, and the things people make and use" (Spradley, 1980, p. 5).

Origins and History

Ethnography emphasizes detailed descriptions and discussions of the natural environment and population (Slife & Williams, 1995). The ethnographer observes and investigates the cultural phenomenon from various points of view and employs an intricate and descriptive writing style that communicates the complexity and multidimensionality of the cultural phenomenon. The goal of the ethnographer is to convince his reader that s/he has truly been there and that if the reader had been there as well the reader would also see and feel the same as the writer, therefore drawing the same conclusions (Geertz, 1988). In The Interpretation of Cultures, Geertz defines culture as a set of social norms that govern behavior. He uses ethnography to analyze and search for meaning for the choices and actions of human behavior based on cultural influences.

Malinowski, the father of modern anthropology, is credited with inventing ethnographic fieldwork and coined the phrase "participant observer". This term has become synonymous with ethnography. Malinowski advocated that the researcher must participate in as well as observe the culture in order to explain the behavior of others. It is only through the eyes of others that we can truly know what they know and how they came to know. Malinowski goes on to say that through this knowledge we are able to broaden our own world view and understanding of ourselves (Young, 2004).

During the time of Malinowski, another anthropologist, Boas began shaping the character of anthropology in the United States. Boas employed a systematic investigation of an organism's physiological and psychological state. Boas believed that an organism's actions were an implication of its whole history up to that point in time. Boas was concerned with the influential "surroundings" of an organism. He defined these "surroundings" as the product of "the history of the people, the influence of the regions through which it passed in its migrations and the people whom it came into contact" (Boas, 1989). Boas recognized that in order to understand an organism an anthropologist must see it in relation to its surroundings. Boas also postulated that civilization, the organism which he studied, was not absolute, but implicitly connected to the thoughts and views according to the civilization.

Mead, a student of Boas, further influenced ethnography with her own anthropological research. Mead was taught to contemplate the interconnections of human diversity, advocating that temperament and individualities were formed by cultural conditioning rather than heredity. Mead was the first anthropologist to look at human development with a multicultural lens. As a key influence on military thinking during the Second World War, Mead gained entrance into the world of politics. Mead's knowledge of the world's culture was an advantageous facet in the escalating world war. Expounding the importance and practicality of anthropology in an interdependent world, Mead's success as an ethnographer prompted the hiring of anthropologists in

the postwar years by international agencies created by the United Nations to launch programs in previously ignored countries. These programs included medical, nutritional, and educational studies. This propelled the use of ethnography into the field of education (Mandler, 2013).

Critical Ethnography

Critical ethnography began in the 1960's and 1970's following the civil rights movement. It stems from anthropology and the Chicago School of Sociology. Some ethnographers had become more politically active with their research in order to promote political agendas for change and chose to do their field work in alternative surroundings such as the modern workplace. Other ethnographers focused on marginalized groups to provide new opportunities for dissent and discourse on social transformation. In 1973, the National Institute for Education (NIE) began encouraging ethnographic studies in the evaluation of educational programs and innovative teaching ideas. Studies were conducted on high school student life, student-teacher relations in alternative schools, and life in elementary classrooms (Wilson, 1977).

Ethnographic methods have proven essential for gathering data on human behavior that is impossible to obtain through quantitative methods. The methodological underpinnings of educational ethnography are based on two hypotheses about human behavior. The first, naturalistic ecological hypothesis, states that human behavior is interdependent with the surroundings in which it occurs. Differences among individuals are regulated by social rules and norms that are in place during that moment in time. The second, qualitative-phenomenological hypothesis, theorizes that the researcher cannot understand human behavior without understanding the history of the subject's perspectives of their own thoughts, feelings, and actions. Researchers often devise a strategy of coding and interpreting behaviors in order to ensure that the data remain objective (Wilson, 1977). By 1995 about one-sixth of the published research on learning and teaching was being undertaken using a qualitative methodology and about one half of the published research on teaching utilized a qualitative research methodology (Rose & Church, 1998).

Ethnographers are no longer considered neutral observers and writers, telling the story from their own personal experiences and perspectives (Villenas, 2000). Ethnography is a process and a product of how the researcher came to this actual place and time and how she is living out the research study (Britzman, 1995). The researcher's writing persuades the reader to imagine this world and attempt to understand the constraints of cultural adaptation. It is imperative that the researcher situate herself within the research and clarify the "I" of the researcher and under what conditions the ethnography was written and the impact these factors have on the value of the ethnography (O'Reilly, 2008).

Critical ethnography seeks to identify symbolic structures, to obtain an understanding of the method from the action, and to understand the thought process and behavioral choices of research subjects within historical, cultural, social frameworks typically concerning inequity, and social justice. It is the only method that can be considered in order to comprehend the vast and complicated rhizome of the literacy development of a childhood interrupted. As the mother of the child I am studying, I am intrinsically linked to her and unable to separate from the context of my research. I need to identify and express my own perspective, history, and knowledge, and desired outcomes as it effects and influences my research. It is essential that I describe what is and what could be in order to shift my child's real and perceived social inequalities.

Ethnography researchers study a culture as a "participant observer" (Malinowski, 2002). The culture is foreign to them and they must learn to be part of it in order to understand human behavior and the motivations behind the behavior. Often times multiple participants are studied in order to construct a clear picture of cultural behavior and influences. As an expert on socially correct and acceptable behaviors and expectations I am assisting my child who is ill-equipped to navigate and be successful, how to be social in what may seem foreign. As a parent, you know your child and know how to bring out the best in her. You know what makes her happy, what frightens her, what motivates her, how she learns best, even what food she likes and doesn't like. But these are things I didn't know. I try to understand her thought processes and reasons for her behavior. I am at a deficit. Her childhood has been interrupted just as my parenthood has been interrupted. She has behaviors and routines I know nothing about. She has experiences and memories that I will only know as a second-hand story or an outside observer. She has an established mother-daughter dyad that I can't understand. She is suffering from an interrupted childhood, and I am suffering from an interrupted parenthood. I find myself lacking in knowing how to be the mother I want to be and the mother she needs me to be. Everything I learn about her culture comes directly from her. She must teach me everything there is to know about her world as she strives to function in my world. As Powdermaker implies (1966), I find myself 'stepping in and stepping out' of this developing mother-daughter dyad as I strive to understand it as my child and I are creating it together.

Personal Application of Ethnography
Using ethnographic approaches gives me the opportunity to see both sides of this cultural phenomenon of foster/adopting. It helps me understand my thought processes and behaviors as well as my child's thought processes and behaviors. It allows me to contemplate and make behavior changes for myself and my child in order to create and learn a new culture together that is accepting and nurturing yet still honoring of both our pasts. This mother-daughter dyad is a constantly changing and growing relationship as we are each learning to accept and learn from each other. A key assumption informing ethnography is that by entering into a close and relatively prolonged interaction with people (one's own or other) and their everyday lives, ethnographers engage the best approach to understand the beliefs, motivations, and behaviors of their subjects (Hammersley & Atkinson, 2007).

This autoethnography chronicles the journey of my life as foster-adoptive mother of a special needs child and the steps that I have taken to ensure her happiness and success. It gives a voice to my experience and expands the understanding of sociological knowledge of what is like to be a foster parent when development doesn't follow the standard pattern.

This autoethnography is about describing and understanding my point of view as a parent and educator and understanding my daughter's point of view as a product of her interrupted childhood. We are each learning from each other as we navigate life together.

Writing about my everyday success and battles with Olivia allows me to reflect on situations that lead to a monumental victory or an epic defeat. Conflicts are part of parenthood, but in Olivia's case the frequency and duration of the conflicts combined with her opposition to authority is exhausting. It leaves me feeling depleted and failing parent. This autoethnography affords me the opportunity to meditate on the everyday moments of progress, regression, and stand stills. It allows me to remember and treasure the moments she says, "I love you as big as the sun," as I am reeling from her angry episode that ended with "I hate you and you're not my real mommy". It allows me to separate the child she can be and will be from the child that was created by her past. Reflecting on my experiences helps me make meaning of them and gain an understanding of how to parent, educate, and love my child for who she is. And, my story may assist others who travel the foster-adoptive path. This is my story.

Losing and Choosing to Lose
I became interested in foster care when our second daughter died in utero. I desperately wanted another child but were unable to conceive again, even with infertility interventions. Becoming a foster parent was part of my healing process. It allowed me to be a mother and to work through my sense of loss. But fostering a child is always about loss. As the opening quote by poet, Gibran (1923) selected for this manuscript suggests, these are not my children to keep, but my children to love and nurture through their loss.

The decision to foster is almost as painful as the actual loss of a child. To be the mother to someone else's child - someone who could have children but for some reason or another couldn't or wouldn't put in the work and effort required to be a good mother - made me angry and bitter and feel sorry for the parent all at the same time. The process of having a child placed in your home and then returned to the home situation that she came from is a gut-wrenching experience, not only for my family but for the child as well. Literally, she is ripped from everything she knows and loves. She has lost her home, family, and all things familiar. The emotional and mental strain is overwhelming for the child, but impacts the foster parents, and often the biological parent as well.

Before I Chose to Lose
Before I became a novice foster parent I was an elementary educator. I knew that I wanted to be a teacher when I was 13; nurturing is a big part of my identity. I went to college, graduated with honors, and got a job as a reading specialist - a job I was not qualified for but relished. This is the job that planted the seed. My love for the struggling reader began as I recognized my inadequacies for the job I was hired to do. Realizing I needed more education in order to teach struggling readers, I earned my masters in reading and learning exceptionalities and pursued National Board certification in early childhood education. As I taught kindergarten and then first grade, I grew to love the beginning reader and all the promises that learning to read held for those little minds. Pouring my life into teaching, I taught a multiage class with my two best friends. Patricia was about 7 years older than me, married but with no children. Her rocky childhood with a mentally unbalanced mother had scarred her, and she promised herself she would never subject a child to the possibility of a bi-polar mother. Alice was a friend from college, and we happened to end up teaching in the same county, then the same school, then the same classroom. Alice, like myself, was single and spent

most of her time working on schoolwork. I had been teaching for 10 years when I met my future husband, already 29 years old – a late bloomer some would say. We were married for 2 years when we decided to try to have a baby. We tried for a year with no luck. We consulted doctors and made an infertility plan. Then surprise – without any interventions, we had a beautiful baby girl. Mandy B. is what she likes to go by. She is 13 now and is just about flawless. I like to say she dropped straight from heaven. I sometimes rub her back and tell her I can feel her angel wing bump. She was an easy baby and child: compliant, obedient, helpful, kind, and loving. She has a great work ethic and aims to please others as well as herself. She is everything we could ask for in a daughter and then some. When times get tough I remind her that our family couldn't be a foster family if she weren't so easy.

After having such an easy girl in 2004, my husband and I tried again to have a baby but conception was elusive. I went through several invasive tests and long periods of waiting only for nothing to happen. Then my doctor found a large cyst on my right ovary and recommended that I use birth control for 6 months to shrink the cyst. After 6 months of wasted time, the cyst was still the same size. We sought a second opinion. My new doctor recommended that I take a couple of rounds of Clomid, an infertility drug that would regulate my cycle, shrink my cyst and increase my chances of getting pregnant. It seemed unlikely but I followed his orders because my desperation for a second child was mounting. Three months in and still no success with the cyst – so I elected to have surgery. My doctor recommended that I continue the Clomid and guess what? It worked. I was pregnant with my second child.

The overwhelming sense of joy and relief was beyond measure. Elated, I thought this day would never come and now, we could finally rejoice. But it was a victory that slipped away in the dead of night.
It was a rainy Thursday morning in December around 6 AM; I was 12 weeks along when the spotting started. I prayed that the bleeding would stop, but it only increased and got heavier; the tell-tale signs began to creep in.

Just two days before we would leave for North Carolina to visit my parents and extended family for Christmas that year, disaster struck. Mandy was just 3, and my husband, Thomas, had just graduated with his PhD. We had relocated to Louisiana for his new job. We had no family and had just begun making friends. There was no one to call to babysit or to offer emotional support. So, all 3 of us made our way to the hospital to confirm what I already knew. I sat stoically on the examination table as the unfamiliar doctor read the report and told me what to expect in the next few days. My baby was gone. My heart was broken.
We continued to try to conceive again – this time with more desperation than ever, still with no success. I was getting older and the chances were decreasing, yet my heart continued to ache for the child I would never have. I felt broken, inadequate, and diminished, unable to perform the innate biological function of a female. I had lost my happiness. I was depressed and searching for answers. I was clinging to this prayer:

> *Do not look forward to what may happen tomorrow. The same everlasting Father who cares for you today will take care of you tomorrow and every day. Either he will shield you from suffering or he will give you unfailing strength to bear it. Be at peace, then, put aside all anxious thoughts and imaginations and say continually: "The Lord is my strength and my shield. My heart has trusted in him and I am helped. He is not only with me but in me and I in Him* (De Sales, 1972).

I came to the realization that the only way to help myself was to help someone else.

My husband and I made the decision to become foster parents. In retrospect, I am not exactly sure how we came to this decision. My church is an avid advocate for the foster care system and my dear friend Alice – the one I taught with in North Carolina – had recently adopted a foster child, so I enjoyed a degree of familiarity and knowledge about fostering. I took the classes while my husband stayed home with Mandy, and then he took the classes, and I stayed home with Mandy.

We Must Be Crazy
We had been certified for less than a week when we got the call for our first placement. It was a few days before school started and I was setting up my first-grade classroom, engaged in ritual back-to-school August classroom preparations: making nametags, organizing my closet, and rearranging my desks for the tenth time. My phone rang and it was DCFS. They had a family of 5 girls and needed placement for all of them. I was stunned, shocked, choked up, and scared to death. I said I had to call my husband and that I would call right back.

After a brief discussion with my husband, we agreed to take the two youngest children, a 15-month-old and a

four-week-old. “We must be crazy” is all that I could think. Even now when I look back and reflect on all of it, I still think we must have been crazy. But that night DCFS employees brought us the sweetest baby girls who were so dirty and so in need of someone to love them and care for them. I thought, “this is it.”
These girls are my redemption from the miscarriage. God had answered my prayer. The girls had been taken to the hospital for a mandatory check-up before being placed in a foster home and the nurses cleaned them up the best they could. Ella, the infant, still had dirt on her stomach and caked in her belly button. Sarah, the 15-month-old looked clean but smelled awful. Their clothes were too small and reeked of urine. I stripped their clothes and put them in the tub for a long soak and scrub. I bagged up the clothes they arrived in and tossed them in the trash. My babies would be clean and have clothes that fit. After I bathed them, I fed them and put them to bed.

That night seems a blur now. I remember Thomas and I setting up Mandy’s baby crib and bringing the bassinet down from the attic. We had placed Sarah, the 15-month-old, on our bed while we worked on setting up the crib. Ella, the 4-week old was already sleeping in the bassinet. Sarah couldn’t walk and had difficulty crawling. I recall that I made a mental note to call Early Steps to have her evaluated. Early Steps is an early intervention program that provides services to families with children identified with or at risk for developmental delays. I was working on the crib when I heard a loud thud. Sarah had rolled off the bed into the floor bumping her head on the way down. She didn’t make a sound: not a cry, not a moan, no reaction. It seemed she knew that no one would respond so why bother? My heart ached for this child. At such a young age, it was if she had already learned that she was alone in the world.

Sarah was 15 months old and was already self-sufficient. She could take care of her own emotional needs, even if it was by ignoring them. I am not sure what her home life was like, but when we took her to her pediatrician for a checkup, she told us that the parents left in her in the car seat for hours and hours. I surmised this might be why she couldn’t walk. We only had these girls for seven weeks of loving, caring, and nurturing. At seven weeks, their paternal grandmother agreed to be their legal guardian.

The Loss of Two
Another loss of another child, this time two for our family. Foster care was supposed to be my healing process, but I was still grieving and crying over children I could never have. I convinced myself that the love and care I poured into those girls would impact their lives forever and in the process, heal me and us. I was mostly trying to make myself feel better. Even now, 6 years later in 2019, I still cry for these girls, my first girls. Mandy recently burst into tears when we were checking into church and a new volunteer mistakenly asked who we were checking in, Ella? Sarah? Versus the healing salve I had anticipated, these girls had made a lasting impression on us and had left another hole in our hearts.

No Boys – Except This One
We had stipulated we only wanted girls under the age of 4. This allowed us to use daycare and not be burdened with the difficulty of coordinating my school schedule verses a foster child’s school schedule. Mandy was only 8 and as harsh as it sounds, we wanted to make sure that she could defend herself in case a foster child became aggressive. We once got a call for a 4-year-old boy with a history of violent and aggressive behavior. Mandy asked if she could be locked in cage while he was at our house – we declined this placement. A few weeks after the girls went to live with their grandmother, we received another call from DCFS. They asked if we would take a 6-month old boy – it was a temporary, emergency situation. We said yes. We had KeSan for nine days. His mother had four children and lived in government housing. She would lose her housing for four children if they were in foster care. If she lost her housing for four children she would never have adequate housing, and her children could not be returned. The state returned her children but she was placed on random home inspection to ensure that she was working her plan.

Foster Care Becomes Permanent
Each time a foster child was placed in our home the social worker asked if we were open to adoption. We always said yes knowing that the child always returned home. The goal of foster care is reunification. We lost our hope of adopting when we lost our first placement babies to their grandmother. Family will always trump even the best foster home.

The First Time
Our next placement was one I was not prepared for and ill equipped to handle. Olivia came into state-mandated foster care at thirteen months of age on September 26, 2011. She was a loaded package; we just didn’t know it yet. She was removed from her home when someone reported an incident of domestic violence. Olivia’s mother was being physically abused by her live-in boyfriend. Olivia did not show signs of abuse but

Child Protective Services deemed the situation as unsafe for a child. Both the mother and boyfriend were required to complete a case plan that included psychological evaluations and drug rehabilitation programs. Olivia's mother was using a prescriptive pain medication as well as smoking marijuana. As part of the initial placement into the foster care system Olivia was evaluated by Early Steps. Olivia was assessed for cognitive, motor, vision, hearing, communication, social emotional, and adaptive development. The evaluation indicated that Olivia did not exhibit signs of developmental delays. However, she did have attachment issues, causing socially inappropriate behaviors with adults, such as running away from caregivers and excessive friendliness and inappropriate approaches to strangers.

According to the American Academy of Pediatrics, children between the ages of six months and three years of age who encounter separation from biological family due to family discord and disruption are more likely to suffer from emotional disturbances (Szilagyi, 1998). Olivia was a textbook case of this kind of emotional disturbance. Her childhood had been interrupted. The following sections of this manuscript detail just how disrupted her life was.

We were concerned with stability. As full-time working foster parents, we sought a Class A daycare that was willing to accept the state stipend. We secured a Christian daycare whose mission program supplemented the state stipend allowing foster children to attend. Olivia had difficulty following the rules and staying on task. She was defiant and resisted the authority of her daycare teachers. She also did not have many words and used screaming for most of her communication. She screamed at home and daycare when she was happy, sad, mad, or bored. She had a short attention span for her age and had difficulty following directions.

Grandma's Turn

Olivia had lived in our home for four months when her maternal grandmother decided to be her foster parent. She completed her home study right before Christmas, and Olivia left our home on December 12, 2011, at sixteen months of age. Olivia's social worker reported that

Olivia's grandmother and mother had a volatile relationship. We were told that the grandmother allowed the mother to visit Olivia over the holidays, but they began to argue and the grandmother placed Olivia back into state custody on December 27, 2011, just 15 days after her grandmother gained placement, perhaps to spite her daughter. We had cried tears of sadness when Olivia was taken away from us and now we were crying tears of desperation trying to figure out how to get her back. Olivia's social worker called to inform us that she was back in custody and asked if we would be willing to foster her again. We were out of state, but with the help of the social worker we were able to secure a temporary placement with friends who had gone through the pre-service training with us. Olivia stayed with them for a week until we returned.

The Second Time: Grandma is Not an Option

Olivia was officially placed back into our home on January 2, 2012 almost 17 months old. This time she was with us four months, until May 4, 2012. During this time, Olivia's mother had worked her case plan and was approved for reunification. Again, we went through the heart wrenching process of grieving for a child that would never be ours.

The Third Time: Adderall Ingestion

Five months later on October 1, 2012 we received a call notifying us that Olivia was in state custody once again, her third removal. Olivia was taken to the hospital when she ingested her four-year-old brother's Adderall. All cases of drug misuse in children are reported to the state and since this was not Olivia's first report, she was taken into custody. We agreed to be her foster parents again and began the process of re-acclimating her into our family. This time Olivia lived with us for four months. She was allowed to go home for a week at Christmas and was reunited with her mother on February 1, 2013; she was two years old at the time. Her mother had once again successfully completed her case plan and was approved as an adequate parent.

We had a good relationship with Olivia's mother, and she kept us informed about Olivia's life. She sent us pictures from a Mardi Gras parade in February and met us for a play date in March. Olivia had grown very attached to our biological daughter and had asked to see her again. We also received pictures from a zoo trip in April 2013. However, we did not hear from Olivia's mother again. We sent emails and asked for updates but there was never a reply. We had poured so much into this child's life, we wanted to know that she was safe, happy, and cared for.

The Fourth Time: Escape through a Window

Six months later we received yet another call on August 5, 2013, this time to inform us that Olivia was once

again back in state custody - 10 days before her third birthday. This time her mother was being charged with abandonment. We were informed that Olivia had run away from her house and was found wandering near a busy highway on more than one occasion. Olivia was a clever and determined child. Her mother said that she had stacked boxes and climbed them to reach the window of the trailer and then made the six-foot drop to get out of the house. Another time she used the broom handle to unlatch the chain lock at the top of the door in order to get out. When the sheriff brought Olivia home on August 5, her mother was difficult to wake up and incoherent. The sheriff took the mother to jail; Olivia was sent to DCFS; she was then sent to us. Olivia's mother spent three months in jail but all charges against her were eventually dropped. She had nowhere to live and no money since you cannot receive disability checks while incarcerated. On November 5, 2013, she chose to leave the state to live with her boyfriend. She did not make an appearance at the February 2014 court date, but the judge granted an extension to the case. She did not make an appearance at the June 2014 court date and the social worker petitioned to terminate parental rights. Parental rights were terminated on June 4, 2014. We were elated that Olivia was finally eligible for adoption. We were also terrified because we knew she had psychological and emotional scaring that was already affecting everyone in the family.

Permanent Loss = Permanent Gain

When it became apparent that my 3-year-old foster child was not going to return to her mother, I cautiously took a more vested interest, a more emotional interest in her cognitive development. I had worked with her inconsistently with language – repeating words and phrases correctly, helping her learn her colors, and following a routine but now the stakes had changed. She was no longer a child I was nurturing through a temporary loss; her loss was permanent and so was my gain. She would be part of my family and the expectations had changed, dramatically and emotionally. I was no longer preparing her to re-enter the world she left. I was assimilating her into my world and that meant helping her work through the anger and anxiety issues that were created by the inconsistencies of her formative years. One phase of her life was ending, and it was now my job – and my family's – to assist her to transition to her next phase.

Olivia was finally our child to have and hold forever, except she did not want to be part of this family. She had trust issues and hated anyone who tried to help or console her. She did not seek comfort from others and preferred being alone. We changed our lives to make her a part of it and she only pushed us away. Six years later we are still working through the psychological and emotional scaring and the far-reaching effects that an interrupted childhood has on everyone involved in Olivia's life.

On any given day there are more than 400,000 children in foster care in the US (Disabilities, 2001). These children, who have often been abused and neglected, are undoubtedly also confused. Their story is silenced to protect their privacy. Their foster families are silenced to protect against the ridicule and ignorance of those who do not know what it is like to foster a child who has suffered emotionally, mentally, developmentally, and physically.

The psychological and emotional damage caused by an interrupted childhood can be far more damaging than what a loving home can mitigate and potentially cure. Some foster care children will require more in-depth interventions in order to overcome the deficits created by multiple placements and a dysfunctional home life. The resources needed to facilitate this healing are not always readily available to foster/adoptive parents. In order to heal the damage incurred by an interrupted childhood, parents must be committed advocates for their child and his/her special needs.

The ultimate goal is for all children is to develop appropriate social and emotional skills, enhance their learning, mitigate learning deficits and distractors, and be prepared to live productive adult lives. The odds are stacked against these children. Studies show foster care is a highway to health problems, homelessness, teen pregnancy, arrest, incarceration, and sex trafficking (Nickerson, 2007). More studies similar to this will help develop best practices and hopefully mitigate the negative effects of an interrupted childhood.

I have been thanked for being a foster parent. I have been told that I am a saint. I have been told "I could never do what you do". The truth is, I am not a saint and I am not very good at being a foster parent. I don't have a calling on my life. I am not trying to earn my way into heaven.

I have learned that it takes commitment to the cause, commitment to a child, commitment to making a change. I have learned that anybody could do what I do. It takes all kinds of parents to foster. It takes all kinds of families, families committed to making a difference in a child's life.

If you ever thought about being a foster parent, then do it. Be committed to the children whose parents cannot take care of them. Be committed to the child whose mother loves her and crystal meth. Be committed to the

child whose mother loves him and her abusive boyfriend. Be committed to the child who is scared, defiant, and emotionally scarred. At the time of submission to this journal's 2020 issue, Oliva has been a permanent part of our family since June 2014. Along with my family, I committed to Olivia as my child. As with any child, it has been an arduous journey these past 6 years; she has brought a great deal of joy and many trials to my life. From school to therapy to adjusted medication to assist her, we have folded her into the fabric of our lives.

Implications

Three implications can be derived from this study. First is the urgency for a better system of disseminating resources and information to assist foster parents in order to provide children with the necessary interventions required to combat an interrupted childhood. Another implication is the need for additional quality resources made available to foster care families and children. This extends to schooling, medical issues, and emotional support. Finally, this study has demonstrated that not only do foster-adopted children need healing but so do the foster and adoptive parents.

Systematic Dissemination of Resources and Information to Assist Foster Parents

There are resources available to foster care parents and children. Information is readily accessible; however, the parent must know what to look for and whom to ask. Each foster child is assigned a Court Appointed Special Advocate (CASA) (Calkins & Millar, 1999) to ensure children are placed in permanent, safe, and stable, homes in a timely manner. CASA associations recruit and train volunteers to serve as advocates for abused and neglected children. These volunteers offer to help children adjust to their foster care home and confirm that their basic needs are being met. However, they have little to no training in social-emotional, psychological, and learning deficits that may be affecting the child. These volunteers should be familiar with essential resources and information. This information could be passed on to the foster parent, for example, a list of pediatric dentists that take Medicaid patients, or information on child psychologists who specialize in attachment issues. CASA workers should be required to document responses to basic questions on behavior, academic progress, and developmental milestones. These questions should be connected to resources and information to assist the foster care parent and child. Knowledge is power and without it, the healing process of foster care families is stagnant.

Quality Resources for Foster Care Families

According to the most recent report from the Centers for Medicare and Medicaid Services, over 70.5 million Americans are insured by Medicaid (2012). Medicaid pays the lowest reimbursement rates among health insurance plans (Decker, 2012). According to a study published in Health Affairs, a nationwide survey was conducted and found that doctors willing to accept new Medicaid patients ranged from a low of 40 percent to 99 percent depending on the state (Decker, 2012).

These patients, largely low-income health care consumers, have had a notably difficult time finding doctors to treat them in a reasonable amount of time (Zuckerman, McFeeters, Cunningham, & Nichols, 2004). Recalling the phone conversation with the receptionist who answered the phone as I was attempting to secure Olivia's eye appointment, the receptionist initially confirmed she had an opening for the following week. However, after I gave Olivia's insurance information there wasn't an available appointment for three months. This instance exemplifies the struggles of low-income health care consumers. In the current political climate of 2019, proposed cuts to Medicaid will only exacerbate this issue of timely access.

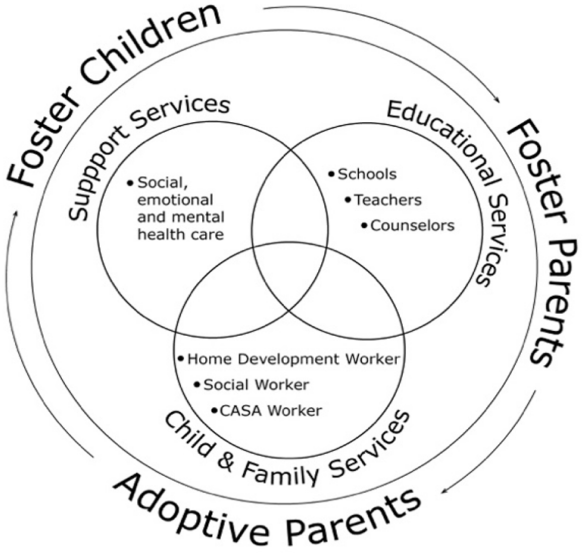
Foster care children are provided with Medicaid Health insurance. Previously stated, children in foster care have extremely high rates of physical, developmental, and mental health problems (Garbarino, Guttmann, & Seeley, 1986; Sedlak & Broadhurst, 1996). When medical treatment is delayed or unable to be obtained it jeopardizes the success of the placement and the mental and physical health of the child. Pediatricians play a key role in assessing and advising foster care parents, social workers, and judges concerning a child's needs, best interests and issues regarding placement. Pediatricians also provide expertise in medical, developmental, and health treatment plans as well as support services to improve the resolve of distressed families (Miller et al., 2000). Foster care alumni are five times more likely to commit suicide and eight times more likely to be hospitalized for a serious psychiatric disorder (Vinnerljung, Hjern, & Lindblad, 2006). A system that prioritizes foster care children and provides quality resources to foster care families is essential in order to mitigate the detrimental effects of an interrupted childhood.

Schools can assist in the mitigation of the effects of being a child in foster care by attempting to match classroom curriculum to the instructional level of the students in foster care, supporting the foster care parents and building a strong relationship, and providing students in foster care the stable foundation they need (Zetlin, MacLeod, & Kimm, 2012)(Zetlin, MacLeod, & Kimm, 2012).

The Need for a Systems Approach for Foster Children Healing and Foster and Adoptive Parents

Systems approach uses all available resources to solve a problem. It is a tool that allows for the examination of an organization's decisions and how each set of decisions effects and influences one another. Systems approach is an analysis of teaching-learning situations that inform decision making. A systems analysis empowers organizations and individuals to consider all components of a system, comprehend their connectivity, decern alternative solutions and measure the impact of those decisions, and modify as needed (Gupta & Gupta, 2013). There are many factors that influence the physical, emotional, and mental well-being of foster care children and foster care parents. Easily accessible healthcare and daycare services, appropriate educational settings, and resources for emotional and mental healthcare are high priorities for foster parents.

A systems approach for the healing of foster children, foster parents, and adoptive parents would establish an interactive structure between foster families where resources could be shared, and experiences could be sympathized and celebrated.



A systems approach emphasizes the interdependent structure and the relationship of internal and external influences on an institution (Von Bertalanffy, 2009). The system would be dependent on external resources as well as internal resources. For example, physicians, psychiatrists, and therapists would offer expert advice and knowledge of available support services. A systems approach would provide practical information such as lists of recommended and discouraged daycare providers that are state approved and foster parent approved. Archives could be generated with information regarding dentists, doctors, and therapists that accept your foster care child's Medicaid insurance, do not have a six to nine month wait list, and are endorsed by other foster care families. Resources, information, and endorsements would be readily available; saving countless hours of wasted time and frustration for the foster care child and parent.

Shared internal experiences would validate concerns, feelings, and best practices. A systems approach would allow the foster care system to function as a unit of community, rather than an entity. A systems approach would provide a structured framework for sharing resources and best practices concerning the social, emotional, mental, and academic well-being of foster children and families.

References

Abuse, C. (1974). Prevention Treatment Act of 1974, Pub: L.

Badeau, S., & Gesiriech, S. (2003). A child's journey through the child welfare system. *The PEW Commission on Children in Foster Care.* [On-line] Retrieved January, 2, 2004.

Calkins, C. A., & Millar, M. (1999). The effectiveness of court appointed special advocates to assist in permanency planning. Child and Adolescent *Social Work Journal, 16*(1), 37-45.

Davis, E. A. (1960). *The Story of Louisiana (Vol. 4*): JF Hyer.

De Sales, F. (1972). *Introduction to the Devout Life (Vol. 5)*: Image.

Decker, S. L. (2012). In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help. *Health Affairs, 31*(8), 1673-1679.

Disabilities, C. o. C. w. (2001). Developmental surveillance and screening of infants and young children. *Pediatrics, 108*(1), 192-195.
Downs, S. (2000). Child welfare and family services: Policies and practice: Longman Publishing Group.
Family, L. D. o. C. a. (2019). *The Foster Parent Handbook for The Foster and Adoptive Families of Louisianna*.
Foundation, A. E. C. (2017). Kids Count Data Center. Retrieved from https://datacenter.kidscount.org/.
Garbarino, J., Guttmann, E., & Seeley, J. W. (1986). T*he Psychologically Battered Child.* Jossey-Bass.
Gibran, K. (2012). The prophet: Oneworld Publications.
Gupta, S., & Gupta, A. (2013). The systems approach in education. *International Journal of Management, 1*(1), 52-55.
Health, U. D. o., & Services, H. (2009). Understanding the effects of maltreatment on brain development. USDHHS.
Herman, E. (2003). The adoption history project.
Madison, C. A. (1971). *Preface to the Dover Edition. How the Other Half Lives*. By Jacob A. Riis. Ed. Charles A. Madison. New York: Dover Publications, Inc, 8.
Mallon, G. P., & Hess, P. M. (2014). *Child welfare for the twenty-first century: A Handbook of Practices, Policies, & Programs*. Columbia University Press.
McKellar, N., & Cowan, K. C. (2011). Supporting students in foster care. *Principal Leadership, 12*(1), 12-16.
McNichol, T., & Task, C. (2001). Parental substance abuse and the development of children in family foster care. *Child Welfare, 80*(2).
Medicaid: Medicaid. (2012). Retrieved October 29, 2020, from https://www.medicaid.gov/medicaid/index.html.
Miller, P., Gorski, P., Borchers, D., Jenista, J., Johnson, C., Kaufman, N., . . . Rezin, J. (2000). Developmental issues for young children in foster care. *Pediatrics, 106*(5), 1145-1150.
Policy, S. Social Security Act (1935). *Political Science Quarterly, 112*.
Sedlak, A. J., & Broadhurst, D. D. (1996). The national incidence study of child abuse and neglect. Washington DC. US Department of Health and Human Services.
Slingerland, W. H. (1980). A constructive program of organized child welfare work for New Orleans and Louisiana (Vol. 30): Benson Print. Co.
Stebbins, S. (2018). Despite overall sustained GDP growth in US, some cities still hit hard by extreme poverty. USA Today.
Szilagyi, M. (1998). The pediatrician and the child in foster care. *Pediatrics in Review, 19*, 39-50.
Trattner, W. I. (1974). *From Poor Law to Welfare State: A History of Social Welfare in America*.
Trattner, W. I. (2007). *From Poor Law to Welfare State: A History of Social Welfare in America*. Simon and Schuster.
Vinnerljung, B., Hjern, A., & Lindblad, F. (2006). Suicide attempts and severe psychiatric morbidity among former child welfare clients–a national cohort study. *Journal of Child Psychology and Psychiatry, 47*(7), 723-733.
Von Bertalanffy, L. (2009). General system theory: foundations, development, applcations.
Wisner, E. (1976). Public welfare administration in Louisiana (Vol. 11): Arno Press.
Zetlin, A., MacLeod, E., & Kimm, C. (2012). Beginning teacher challenges instructing students who are in foster care. *Remedial and Special Education, 33*(1), 4-13.
Zuckerman, S., McFeeters, J., Cunningham, P., & Nichols, L. (2004). Changes In Medicaid Physician Fees, 1998–2003: Implications For Physician Participation: Despite recent gains, the relative attractiveness of Medicaid patients has not improved much over the longer term. *Health Affairs, 23*(Suppl1), W4-374-W374-384.

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