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A STUDY OF OUT-OF-HOME CARE.

WHAT ABOUT THE CAREGIVERS?

A thesis presented in partial fulfillment of
the requirements for the degree of
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ABSTRACT

The primary aim of the present study was twofold. The first was to examine caregivers' perceptions of their caregiving experiences: that is, how well their professional needs were met, their job satisfaction, and how well the children in their care were functioning. The second was to determine if these factors were related to caregivers' psychological wellbeing. The study also investigated relationships between caregivers' parenting practices, the behaviour, needs, and progress of children in their care, and psychological wellbeing. The final aim of the study was to examine caregivers' motives in having sought caregiving work, to determine if more altruistic or more egoistic motives played a role in caregivers' work-related experiences and psychological wellbeing. One hundred and fourteen caregivers completed a battery of measures which assessed demographic information, perceptions of caregiving experiences, motives for caregiving, levels of psychological wellbeing, and preferred parenting practices. Results indicated that higher levels of total support (i.e. formal and informal support), social work support, job satisfaction, improved functioning of children in care, and positive parenting practices were positively related to higher levels of psychological wellbeing. Positive parenting practices were also related to the improved functioning of children in care. Multiple regression analyses showed that positive parenting practices were the most important predictor of psychological wellbeing, and also that higher levels of total support best predicted caregiver satisfaction. Psychological wellbeing was not related to perceptions of professional status, effects of caregiving on caregivers' own families, or to caregivers' relationships with the natural families of foster children. It was found that almost all respondents endorsed altruistic motives but it was not determined whether more altruistic motives enhance caregiver functioning and wellbeing. The overall implication drawn from the findings is that support and training which assists caregivers with parenting skills may be particularly useful for fostering their wellbeing and satisfaction, and also for the improved functioning of children in their care. Further research and methods for studying factors related to caregiver wellbeing, and the improved functioning of children in out-of-home care are discussed.

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1.0 Aims

This thesis examines the experiences of a number of caregivers who provide out-of-home care for children who are in need of care and protection. Most research in the area of out-of-home care has focused on the needs and experiences of the children themselves, with caregivers' experiences being afforded less interest. However, caregivers' experiences may be one of a number of variables that affect children in care. This study treats caregivers and their work experiences as an issue that is worthy of research in its own right, as the demands of such work can have major repercussions on caregivers, their families, and also on the children for whom they provide care.

More specifically, the study seeks to identify caregivers' perceptions of how well their professional needs are met, how well supported they feel in their work, and their job satisfaction. The primary aim of the study was twofold: (a) to examine the difficulties and demands of the caregiving task and to determine whether caregivers feel sufficiently supported in these aspects of their work, and (b) to examine whether there is any relationship between these factors and caregivers' psychological wellbeing or general happiness.

Although the main focus of this study is caregivers' perceptions of their caregiving experiences and their hypothesized relationship with psychological wellbeing, a further aim is to determine if there is a link between caregivers' wellbeing, their preferred parenting practices, and their perceptions of the children's behaviour while in their care. Parenting is an aspect of caregiver behaviour which is likely to have a direct effect on the behaviour and stability of children in their care. While the ethical limitations imposed on this study did not permit the children themselves to be assessed directly, an investigation of caregivers' preferred parenting practices gives

some indication of the quality and nature of caregiving that they provide. Furthermore, an additional brief assessment of childrens' behaviour by caregivers enabled the study to determine if there was any association between caregivers' parenting practices and childrens' behaviour while in out-of-home care.

Finally, this study sought to examine caregivers' motives in seeking caregiving work to determine whether more altruistic or more egoistic motives affect the caregivers' experiences of caregiving, their job satisfaction or their psychological wellbeing. Some of the research has suggested that caregivers with altruistic motives tend to have more "successful" placements of children in out-of-home care (for example, Hampson & Tavormina, 1980; Dando & Minty, 1987). Therefore, altruistic motives may play a role in the enhancement of caregivers' job satisfaction and wellbeing even if caregivers perceive that they are not adequately supported in their work. Thus, it was hypothesized that more altruistic motives may provide a protective factor in the challenging and difficult work that caregiving requires.

Through the responses of caregivers themselves, the study sought to determine if they feel sufficiently prepared, supported, consulted, and valued in their efforts to provide therapeutic care for children and young people in need of care and protection. It is intended that the outcomes of this study will have some "real life" benefits by identifying some of the caregiving-related indicators which are related to psychological wellbeing, and ultimately contribute to more stable, successful, out-of-home placements for children. By having access to the results of this research, the agencies, social workers, and current and potential caregivers may be assisted to evaluate their own practices and to implement changes that are likely to benefit caregivers, their families, and children in their care.

1.1 Rationale for Survey Methodology

Moser and Kalton (1971) suggest that “if one wants to find out what people think” about certain issues, “then one must ask them and rely on what they say” (p.256). Hence, it was decided that the research question would be approached by questioning caregivers themselves about their caregiving-related experiences. While it must be noted that the responses recorded in this survey are representative of only the respondents (Gilligan, 1996), it must also be acknowledged that it is important to invite feedback from caregivers in a research context, as they hold personal and specialized knowledge of caregiving that is not available elsewhere (Worrall, 1996). Owing to the dearth of research in this area, the findings of this study are intended to provide an initial contribution within the New Zealand context and to detect and clarify possible areas for further investigation. Greater understanding of caregivers’ perspectives may also lead to more successful recruitment, support, and retention of caregivers in the future.

The ideas and facts that emerged from reviewing the literature and my exploratory talks with social workers, agency administrators, and caregivers provided the basis for the formation of the research questions, and, ultimately shaped the data collection process (Bryman, 1988; Worrall, 1996). The only major New Zealand study of caregiving to date is Worrall’s (1996) in-depth, qualitative study of five kin-caregivers and their families. The advantage of using a quantitative approach in the current study is that it makes it possible to measure statistically the views of many participants, thus providing a broader strategy for investigating the research questions (Patton, 1986; Bryman, 1988). Therefore, the decision was made to assess a wide range of caregiving experiences, across a number of agencies, geographical areas, and caregiving categories (e.g., stranger and kin caregiving; long-term, short-term and respite care). The selection of participants from a variety of agencies was designed to reduce any bias which may be caused by the utilization of

different policies and practices within each agency, and would also enable a comparison of inter-agency differences.

It was decided that a postal survey would provide the most efficient and economical method for eliciting information from a large number of caregivers in a variety of agency and geographical settings (Bryman, 1988). The main advantage of being able to use a postal, survey-based methodology was that it enabled access to a sufficiently large sample for a statistical analysis of the results (Moser & Kalton, 1971). The mail questionnaire avoids problems associated with interviewer error which may affect the reliability and validity of the study (Oppenheim, 1986). There is also evidence that respondents tend to answer questions of a personal or sensitive nature more truthfully and willingly on a mail questionnaire than when confronted by an interviewer (Moser & Kalton, 1971).

1.2 Brief Overview

The following two chapters of this thesis comprise a description of the current context of caregiving and a review of the literature. Before examining the literature on caregivers' experiences it is necessary to become acquainted with the context within which out-of-home care has been shaped and is being practised today. Thus, caregiving in New Zealand is placed in context in Chapter Two (Worrall, 1996). Some of the recent political and social factors that have contributed to policies for children in need of care and protection since the implementation of The Children, Young Persons and their Families Act (CYPF Act, 1989) are discussed. This includes a brief overview of the current philosophical trends in New Zealand and overseas. It also covers trends in out-of-home care that have emerged from the ideological and political shift from State control to family responsibility, the increase in deinstitutionalisation, the new economic climate based on economic determinism, and the resulting decrease in resources for social welfare.

The literature examining the primary issues of concern in caregiving is reviewed in Chapter Three. These appear to be the following: the quality and availability of formal and informal support for caregivers; preparation and training; caregivers' job satisfaction; the behaviour and needs of children in out-of-home care; caregivers' attitudes to their relationship with the biological parents; volunteerism and the question of professional status; and the effects of caregiving on the caregiver's own family. The lack of New Zealand-based research on caregivers' needs and experiences became obvious in the literature search. However, Worrall's (1996) qualitative study of the experiences of kin caregivers provides New Zealand-based research that is most pertinent to contemporary caregiving and will be examined in the following review. There is also increasing interest and attention from professionals who are beginning to voice their concerns about the problems they have witnessed in the practice of out-of-home care.

Issues related to out-of-home care have been more extensively researched overseas. Overall findings reveal that placement in care can be unstable and unsatisfactory for significant numbers of children. There is also research which examines specific factors that affect caregivers, although earlier studies tended to emphasise the demographic features of caregiver samples and their association with the success or failure of placements. However, in more recent years, with increasing pressure on out-of-home care through more stringent economic policies, deinstitutionalisation, and escalating numbers of children with special needs and behavioural problems, the research literature on caregiving has focused on issues that characterise these contemporary problems.

One issue not yet adequately addressed in the literature is the issue of caregiver psychological wellbeing and its possible relationship to caregiver functioning and work-related experiences. Only one study (Gilligan, 1996)

appears to have examined issues relating to general wellbeing, including caregiver morale and commitment. In addition to examining that study, the review will include an examination of the construct of psychological wellbeing as generally discussed in the literature. It also identifies factors that are relevant to a more focused discussion on caregiver wellbeing.

Although the issue of parenting practices and their effects on child behaviour and stability has been well researched within the context of biological families, it has received scant attention in regard to out-of-home caregiver/child parenting. However, the review will examine the limited material available which indicates how parenting practices relate to placement stability for children.

The review also examines available evidence concerning how caregivers' motives affect their perceptions of their caregiving experiences, their satisfaction with their work, and their psychological wellbeing.

2.0 The Interests and Rights of the Child

"In reality a foster parent's role ... is always a combination of caretaker, therapist, compensatory parent and substitute parent".

(Rowe, 1980, cited in Hudson and Galaway, 1989, p.84).

While it is usually within the best interests of children to live with their natural families, sometimes families are unable to provide the care that children need. In fact, out-of-home care happens for many children in New Zealand for a variety of reasons, and today, much of it occurs as part of the process of preparing the natural family for the return of the child (Kenny & Foster, 1997). Laurensen (1997) maintains that ideal foster care practice aims at assisting the natural family through difficulties with the primary aim being the return of the child when the family is once again able to provide suitable care on a permanent basis. Thus, caregivers often fill the role of "substitute parents". However, they are also expected to perform the difficult job of caring for the child as if it were a member of their own family. At some time in the future they must often be prepared for the return of the child to its natural family (Hudson & Galaway, 1989; Kenny & Foster, 1997; Laurensen, 1997).

However, when abuse, neglect, or other parental inadequacy has occurred in the natural family, the safe and successful return of the child is highly questionable and unlikely (Kenny & Foster, 1997). The goal then becomes one of providing an alternative family who will commit themselves to providing a permanent home in which the child is able to experience more stability and is able to develop a sense of belonging and attachment (Or, 1995). Thus, the child is offered a chance to be part of a family unit and, ideally, to have "an alternative experience of family life with loving parental figures" (Hudson & Galaway, 1989, p.84). A United Nations Expert Group Meeting on Adoption and Foster Placement of Children held in 1978 recommended that when parents were not able to rear their children, "the children's right to security,

affection and continuing care should be of greatest importance”, and that “every child has a right to a family” (Adoption and Foster Placement of Children, 1980, cited in Or, 1995, p.5). Moreover, the United Nations Convention on The Rights of the Child (1989), ratified by New Zealand in 1993, obligates the State to act in the best interests of children who are not living with their families (O’Reilly, 1997).

Similar principles which ensure stability for children out of their family of origin are operationalized in New Zealand’s own legislation, as established in Section 13(h) of the CYPF Act (1989): “Where a child or young person cannot remain with, or be returned to, his or her family, whanau, hapu, iwi, and family group, ... the child or young person should be given an opportunity to develop a significant psychological attachment to the person in whose care the child or young person is placed, and where the child can develop a sense of belonging” (p.23). Furthermore, the wellbeing of children is ensured by clause 6 (CYPF Act, 1989) which establishes that “where any conflict of ... interests arises, the welfare and interest of the child or young person shall be the deciding factor” (p. 17). However, despite the universal recognition of the importance of ensuring children’s welfare and stability, there is a strong body of opinion which argues that in its current state, out-of-home care in New Zealand is not able to guarantee this for a considerable number of children (Or, 1995; Worrall, 1996; O’Reilly, 1997; Smith, 1997a).

2.1 Current Trends In Out-of-home Care

“Some of the ideology which led into the Children, Young Persons and their Families Act created a belief that foster care would not be needed, which was an unrealistic belief.”

(Or, 1995, p.18).

The implementation of the CYPF Act (1989) saw an ideological shift from state responsibility for children and young persons in need of care and protection to “family” responsibility (Mason, Kirby & Wray, 1992; Laurensen, 1993/4;

Worrall, 1997). Thus, section 13 (CYPF Act, 1989) established that whenever possible, a child was to be placed with members of his/her family/whanau, hapu or iwi and was to return home as soon as possible, once it was ensured that the environment was safe. However, in their Review of the CYPF Act (1989), Mason et al. (1992) made the criticism that in their enthusiasm to maintain children within the family/whanau unit, some Department of Social Welfare (DSW) workers allowed children to remain with family/whanau when clearly circumstances called for a placement outside the family.

Although placement with family members is considered to be less disruptive than out-of-home care provided by strangers, and gives greater assurance that children will not be separated from family systems, certain risk factors have been identified (Worrall, 1996). For example, there is some evidence for an intergenerational inadequacy of parenting skills (Dubowitz, 1994, cited in Worrall, 1996), children are likely to remain longer in kinship care than in non-kinship care, and kin-based care is cheaper than "stranger" care with kin-caregivers receiving substantially less financial reimbursement for board and other expenses simply because "they are family" (Worrall, 1996). Furthermore, Or (1995) states that caregivers, irrespective of kin/stranger status, have received less support, both financially and in terms of social work support, since the implementation of the Act (1989). Thus, although the Act (1989) has the potential of responding effectively to care and protection issues in a way which empowers families, protects young people, and encourages sound social work and foster care practice, its effectiveness is undermined by lack of adequate resources and funding (Laurensen, 1993/4; O'Reilly, 1997).

In spite of the disparities that exist between the policies and practice of stranger and kin caregiving, there will be no differentiation made between the two groups in the course of this study in terms of the need for support. It is strongly argued in the literature that there is a place for state and society

support of all caregivers of children who require care and protection, irrespective of the caregiver's biological relationship to the child (Klee & Halfon, 1987; Laurensen, 1993/4; Kenny & Foster, 1997; Smith, 1997a). However, this study did seek demographic information regarding caregiver status (stranger vs. kin) in order to ascertain the relative numbers of kin and stranger caregivers participating in the study.

At a national symposium in Christchurch in 1996 on Quality and Safety for Children Living Away from Home, Professor A. Smith (1997c) reported that many of the conference participants felt there was "a crisis in foster care" in New Zealand (p.8). An increasing need for the provision of family-based care for children with relatively high levels of needs and problems has led to new and more stressful demands of caregivers (Or, 1995; Worrall, 1996; Kenny & Foster, 1997). Kenny and Foster (1997) also suggest that a number of children who would have once come into care because of difficulties at home are now staying at home, ideally with support for the family. Those that do come into care tend to do so later, often after quite prolonged maltreatment.

Furthermore, the ideological and political shift towards deinstitutionalization over the last two decades has resulted in an increased proportion of disturbed and hard-to-manage children receiving home-based, rather than institutional care (Horner, 1981; Klee & Halfon, 1987; Or, 1995). This trend has been exacerbated by the situation described earlier in which children coming into foster care later tend to be more disturbed. In fact, some caregivers, extended family members, and social agencies have reported that they are unable to handle the behaviour of many of the children and young people who would formerly have been placed in a DSW home (Mason et al., 1992).

An approach being taken in some other countries (e.g. Canada, USA, and Great Britain) with children who exhibit serious behaviour or emotional problems is known as "treatment" or "specialist" care, and makes use of

screened and specially trained caregivers (Hudson & Galaway, 1989; Thomlison, 1995; Swift & Longclaws, 1995). This approach is showing promising results (Thomlison 1995). However, such an approach, in which the role of caregivers is clarified and developed in a more specialized and professional sense, is yet to be utilized by New Zealand's state-provided foster care system.

The more stringent social-spending policies of recent governments have resulted in a reduction in the New Zealand Children, Young Persons and their Families Service (NZCYPFS) budget which has affected social work practice in out-of-home care in many ways (Laurensen, 1993/94; Or, 1995). It is common for social workers to have excessive caseloads and to have to work in "crisis management mode" much of the time (Smith, 1997a). Furthermore, the concept of out-of-home care being a service that is done for no financial reward still prevails, with caregivers only being reimbursed for out-of-pocket expenses (Laurensen, 1993/94; Kenny & Foster, 1997; Smith, 1997a). Financial pressure and lack of material resources is a problem for increasing numbers of caregiving families, with the result that some caregivers have been forced to withdraw in order to seek paid work (Or, 1995; Smith 1996, cited in Smith, 1997a). This, in turn, places more pressure on the social workers and caregivers who remain in the system.

The CYPF Act (1989) promotes the family in its widest sense, maintaining that the best place for a child to grow up is within a family, preferably their own, or within a family as much like their own as possible (Laurensen, 1993/4). It also establishes that the goal for children in out-of-home care is their return to the family of origin once it has been strengthened and is functioning better. Although the return home is an optimal goal for the child, it has proved distressing for some caregivers (Or, 1995). Furthermore, there is still a considerable number of children for whom reunification is not a realistic goal

(Smith 1997a; 1997b). However, a crucial factor in the identity development and self worth of some of these children is the preservation of connections with their families of origin (Salahu-Din & Bollman, 1994; Or, 1995). Inevitably, much of the effort of ensuring such contact falls on caregivers (Laurenson, 1993/4). Laurenson suggests that this is a "huge expectation of caregivers" but also points out "that acceptance and affirmation of the biological family is important, and these days caregivers must be prepared for that to happen from the start" (personal communication, May 1997).

2.2 The Expectations Being Placed on Caregivers

"It is reasonable to ask how much stress a foster family can be expected to cope with".

(Eastman, 1979, p.568).

There is now more evidence reported in the literature of the difficulties being experienced by caregivers and their families (Mason et al., 1992; Or, 1995; Worrall, 1996; 1997). It is also recognised that placing children in out-of-home care in no way precludes their abuse, neglect or exploitation in their new environment. This reinforces the idea that making the provision of quality and safety is a prime objective for professionals in this field (McFadden, 1984; Dawson, 1989; O'Reilly, 1995, cited in Smith 1997a). While the reasons underlying abuse and neglect in foster care may be complex and diverse, there are "good" practice principles which serve to protect both children and their caregivers from the trauma of abuse (Worrall, 1996).

Given the state and societal obligations established under a United Nations' mandate and government legislation to uphold the safety and wellbeing of children living away from home, it seems that state agencies, social workers and other professionals, as well as the general public, expect a high level of care for children in out-of-home placements (Dawson, 1989; Kenny & Foster, 1997). With such expectations, caregivers are now asked to deliver a high

level of skill in supporting children with special needs and behaviour problems. In addition, caregivers are also often expected to work with the natural families and social workers for the eventual return of the child to the family, or to another permanent placement (Kenny & Foster, 1997).

The children being entrusted to out-of-home care are increasingly likely to be from environments in which they have been underprivileged, deprived, neglected or abused, and are frequently suffering from concomitant emotional trauma, and exhibiting behavioural, health, and social adjustment problems (personal communication, Juliette Scott, Senior Social Worker, NZCYPFS, Palmerston North, May, 1997). Despite their negative experiences, there is often a highly intense tie between such children and their parents.

Consequently, they may experience grief and loss when they are removed (Black, 1994; Shealy, 1995). Smith (1997b) stresses that one of the most difficult tasks for a caregiver is to attempt to make an emotional connection with the child and to stabilise his/her life "when the child may bring feelings of resentment, mistrust, and lowered self-esteem from early maltreatment or insecure attachments" (p.24). Thus, caregivers have considerable expectations and demands placed on them, and the question that must be asked is: "Are caregivers receiving the training, preparation, support, resources, and recognition that they need to carry out the work effectively?"

3.0 Introduction

Over the last two and a half decades much has been learned from out-of-home care research about the child's need for stability, and the inability of out-of-home care to guarantee that; the importance of maintaining contact with the child's natural family; and the relationship between the child's parental contact and his/her return home (Worrall,1996). Furthermore, research indicates that there are special difficulties for caregivers in caring for children who have suffered abuse and neglect, and that training, assessment, and preparation are essential prerequisites for the task (Smith, 1997a; 1997b).

However, there has been less systematic research on caregivers' own needs and experiences with regard to their professional development, their general wellbeing in their work, and how their motives might be related to these factors. Moreover, there has been no investigation of the relationships that may exist between these caregiver variables and the caregiver's ability to function in the caregiving role.

The issues that have emerged from the literature that are pertinent to this study are: caregiver support and training; the needs and behaviours of children in out-of-home care; the caregiver's relationship with the child's family of origin; professionalisation issues; caregiver job satisfaction; effects of caregiving on the caregiver's own family; abuse in out-of-home care; parenting practices; and motives for caregiving. As there is no literature that relates directly to "caregiver wellbeing", the construct of wellbeing will be discussed within the context of the general literature on that subject.

3.1 Support

"It is a huge commitment by a family, and for them to be able to maintain the commitment they need ongoing skilled and available social work, support and adequate financial resources"

(Laurensen, 1993/4, p.4).

Much of the caregiving literature emphasizes the role of support as a solid basis for both the quality and continuity of the placement, and the retention of caregivers (Ramsay, 1996; Worrall, 1996; Pithouse & Parry, 1997). The major source of support discussed in the literature is formal support from social workers, and to a less extent support offered by social service agencies and other professionals. Informal sources of support, such as family and friends, are also discussed briefly. The literature focuses on the different categories of support available from these sources: general support, both formal and informal; financial support; and training.

3.1.1 Social Worker/Liaison Worker Support

Several studies of out-of-home care breakdown have revealed that placements are more vulnerable in the early stages, with caregivers reporting an often prolonged period of adjustment after children are placed in the home, and that adequate support and supervision in the early stages are vital (Hampson & Tavormina, 1980; Berridge & Cleaver, 1987). Furthermore, it is suggested that rapport and long-term visiting patterns are established in the first few weeks of a placement (Berridge & Cleaver, 1987). Berridge & Cleaver (1987) suggest that the main reason for lack of social worker support is that social workers restricted their involvement to placements that were experiencing particular problems, or to requests for assistance from caregivers. In addition, some social workers perceived that their involvement would be unwelcome. Keane (1983) also found that social workers sometimes find it difficult to offer the practical advice or assistance that caregivers are wanting, particularly with regard to children's behaviour problems.

Consequently, a degree of incongruence may develop between social workers' and foster parents' perspectives (Berridge & Cleaver, 1987).

In contrast, a survey (Gilligan, 1996) of caregivers in Ireland indicated that 83% of the respondents thought that social workers maintained "good contact" and 89% found the social worker's advice and support "helpful". In addition, Sellick (1996) cites a number of out-of-home care studies in which accounts of the provision and quality of social work support contrast sharply. There are indications that caregivers who work for more recently established "professional" agencies report high satisfaction with the caregiver social workers, although they report dissatisfaction with the children's social workers/caseworkers (Ramsay, 1996; Sellick, 1996). Sellick (1996) suggests that inadequate training, inexperience, frequent exposure to distressing cases, and high job turnover of children's caseworkers impair the quality of caseworker support for children and caregivers. It is evident, therefore, that there are wide variations in the quality and amount of social work support. A marked characteristic of caregivers in some studies is one of isolation from social work support, with many caregivers stating that they would seek guidance from their extended family, or other caregivers, rather than from the social services (Berridge & Cleaver, 1987; Worrall, 1996).

The severe behaviour problems exhibited by some children in out-of-home care can also be a source of tension in the social worker/caregiver relationship (HMSO, 1990). A number of studies reveal that lack of effective and practical help with the children's behavior is the greatest source of frustration and dissatisfaction for some caregivers, and that behaviour-associated problems have a strong relationship with placement breakdown (Rowe, Cain, Hundleby, & Keane, 1984; Aldgate & Hawley, 1986; Berridge & Cleaver, 1987). Gilligan (1996) agrees that without constructive support for caregivers the child's needs may remain unmet, and the caregiver's morale

may be damaged to the point that the placement breaks down. Gilligan's (1996) comments are supported by the findings from a national survey of foster homes in England (Bebbington & Miles, 1990) which indicate that many caregivers leave caregiving because they feel "unsupported" and "undervalued" in their work .

Caregivers may also feel ambivalent about seeking social worker assistance in managing children's behaviour, and may refrain from discussing such problems with their social workers. They may prefer to deal with the difficulties alone or seek help from other sources (Stone & Stone, 1983; Berridge & Cleaver, 1987). This may contribute to the low social worker involvement reported in some studies. The main reason cited for low social worker consultation is that social workers were not providing what caregivers wanted: "practical advice, and a certain amount of sympathetic recognition of the difficulties they were faced with" (Keane, 1983, p.61). Furthermore, alternative practical options, such as respite care for children when caregivers need relief may not be well developed (Bebbington & Miles, 1990; Aldgate, 1993, cited in Worrall, 1996). Research shows that social workers tend to be more reactive than proactive, especially in long-term placements (Berridge & Cleaver, 1987). The findings of Rowe et al. (1984), however, indicate that one of the main difficulties for social workers is to decide how active a part to play, and when to become involved in a situation, so that they are not perceived as intrusive by caregivers.

The need to develop strong and supportive links between social workers and caregivers has long been strongly advocated in the caregiving literature (McWhinnie, 1983; Berridge & Cleaver, 1987; HMSO, 1990; Sellick, 1996). The more recent literature suggests that this relationship is ideally based on "partnership" principles, which may enable social workers and caregivers to identify together, problem areas which they may solve collaboratively, or for

which they may seek help from other sources (Aldgate & Hawley, 1986; Berridge, 1994). Caregivers in Bradley & Aldgate's (1994) study defined a "good working partnership" with social workers as one in which there is: reasonable accessibility, especially at difficult times; reflective listening by the social worker; and appropriate advice given by the social worker. However, the incorporation of such principles into agencies' policies does not guarantee their application through practice (Sellick, 1996; Pithouse & Parry, 1997). This is especially true when social welfare systems are under-resourced (Smith, 1997c).

A recurring theme in the literature is one of complaints by caregivers that they are given inadequate information about the children in their care. This includes basic information about the child's health history, his/her previous life, and specific behaviour problems (Berridge & Cleaver, 1987; Gilligan, 1996). Berridge (1994) also reports that caregivers are frequently excluded from care and planning reviews. Furthermore, Ramsay's (1996) study of caregivers in a professional service found that the most frequent requests from caregivers were for more social worker visits, increased caregiver involvement in care-planning, and better information on the background and pre-placement lifestyle of the children. In contrast, however, over two thirds of the short-term caregivers in Bradley and Aldgate's (1994) study felt that they had made an "informed and significant contribution" to placement planning and had attended reviews regularly (p.28).

When a placement breaks down, if a child leaves care unexpectedly, or even at the natural ending of a placement, caregivers are frequently deeply affected by the child's departure and the events preceding it (McFadden, 1990; Strover, 1997). Planned management of a placement ending is helpful for the child's and the caregiver's adjustment to their separation. However, research indicates that caregivers generally receive inadequate support from social

workers when placements end, particularly when they break down prematurely (Aldgate & Hawley, 1986; Berridge & Cleaver, 1987; Strover, 1997). Consequently, caregivers may be left with painful and unresolved feelings of guilt and inadequacy (Aldgate & Hawley, 1986; Berridge & Cleaver, 1987). Caregivers' family members may also be left with "a similar residue of feelings" so that they too often need assistance (Aldgate & Hawley, 1986, p.47). Strover (1997) suggests that placement breakdowns may have better outcomes for both caregivers and children if the social worker actively follows up the breakdown with constructive feedback for the caregiver and the child, and by organising and supporting continued contact between them.

To summarise, research suggests that the level and quantity of social work support available to caregivers varies significantly, but that caregivers have frequently received insufficient social work support to enable them to carry out their work effectively. However, current attempts in some countries to transform traditional "foster-care" services into "professionalised" community services with improved "support infrastructures", appears to be providing a more supportive base for caregivers (Ramsay, 1996; Sellick, 1996; Pithouse & Parry, 1997). Currently, New Zealand has made no such attempt.

3.1.2 The Agency

Very few studies have addressed the organizational role of the social service agencies that provide out-of-home care, apart from the agencies' role in reimbursing caregivers (payment of caregivers will be dealt with later as a separate issue). The social worker, who liaises between the agency and the caregiver, fulfills many of the agency functions simultaneously with his/her work with caregivers. Jones, Flynn and Kelloway (1996) maintain that the supervisor (social worker) is for most work groups, the "immediate representative of the organization and the most powerful individual when it comes to transmitting the values of organizational culture. Hence, ... the

supervisor is the organization” (p.49).

Rowe et al. (1984) note that in spite of the many problems and criticisms reported by caregivers in their study, there was a feeling of “considerable” loyalty to the social service agency, although there was a positive relationship between criticism of the agency and fewer social worker visits. This may indicate that the caregivers in Rowe et al’s (1984) study tended to perceive the agency and social workers as one entity. As with social work support, caregiver rapport with the agency is associated with more successful placements - that is, placements that do not end prematurely (Stone & Stone, 1983). There is also evidence from the literature that caregivers need and appreciate some form of recognition by the agency of the value of their work, apart from any monetary reimbursement or payment that is made (McWhinnie, 1978; McFadden, 1990; Strover, 1997).

3.1.3 Additional Professional Support

Research shows that an increasing proportion of children in out-of-home care have major educational, psychological, and health needs which caregivers cannot manage unless additional, effective, professional help is available (Smith, 1997a; Klee & Halfon, 1987; Fanshel, Finch, & Grundy, 1989).

However, research also shows that special needs are often not attended to due to “systemic” problems such as, poor co-ordination of services, funding shortages within agencies, lack of appropriate services for children, and high social worker caseloads (Klee & Halfon, 1987; Worrall, 1996). For example, Frank (1980, cited in Klee & Halfon, 1987) found that trained social workers rated only two children out of 227 as having received adequate treatment for their psychological problems while in care. Furthermore, the need to integrate services, to include caregivers in joint planning, and to exchange information within all involved services, has only recently begun to be seriously considered (Klee & Halfon, 1987).

3.1.4 Support from Friends, Family, and Peers

There is evidence in the literature that caregivers regard the informal support provided by their family, friends, and neighbours as indispensable (Gilligan, 1996; Minkler & Roe, 1993, cited in Worrall, 1996). However, a minority of caregivers in Gilligan's (1996) study reported that they sometimes experienced inadequate informal support, such as having difficulty in finding babysitters. Research by Minkler and Roe (1993, cited in Worrall, 1996) shows that kin caregivers rarely call an agency for assistance if they can turn to their extended families for support.

In addition, the mutual support that caregivers can give each other through their common understanding and experience of caregiving work is often valued (Aldgate & Hawley, 1986; Gilligan, 1996). While this may occur through formal membership in national foster-care associations (Pithouse & Parry, 1997), it also takes the form of informally organised caregiver support groups (Bradley & Aldgate, 1994). Steinhauer, Johnston, Hornick, et al.'s (1989) study showed that caregivers who were members of a support group felt consistently more supported, satisfied, and valued, and that fewer placements with these caregivers broke down. In some places, the development of "self-help" groups is beginning to be seen as essential to caregiver support, and appears to be promoted and supported by some agencies (Pithouse & Parry, 1997). Many caregivers in less progressive settings, however, choose not to belong to support groups, and some regard them critically as "grumbling groups" (Minkler & Roe, 1993, cited in Worrall, 1996).

3.1.5 Financial Support

The issue of caregiver remuneration is a complex one, and has strong historical and social traditions that have been further reinforced by current economic ideologies. Historically, foster care was "firmly embedded in the

values of volunteerism and charity, and is seen as an extension of the natural role of mothering in the family" (Smith, 1988, p.36). Consequently, payment for the work was, and often still is, regarded as inappropriate, irrespective of the caregiver's skills and commitment (Rhodes, 1993; Ramsay, 1996).

Payment to caregivers in New Zealand is still officially regarded as reimbursement for costs incurred, and is not seen as a wage or salary (Inland Revenue Department, 1992, cited in Worrall, 1996). It does not take into account the services rendered, or the personal cost to caregivers and their families, even though these may be great (Smith, 1988; Rhodes, 1993; Worrall, 1996). However, a number of overseas schemes pay higher rates to "specialist" caregivers who provide care for difficult placements or children with special needs (Pithouse & Parry, 1997). As mentioned in Chapter One, the Welfare State in New Zealand has recently undergone economic reform, with accompanying decreases in funding to social services (Laurensen, 1993/94; Or, 1995). Both government and state-funded agencies, therefore, have a strong interest in upholding the concept of out-of-home care as a charitable deed "that is done for love, not money" (Rhodes, 1993, p.8). Contemporary New Zealand writers are critical of this stance and view out-of-home care, and particularly kin-based care, as "cheap options" for children needing care and protection (Laurensen, 1993/94; Or, 1995; Worrall, 1996).

A number of studies have attempted to estimate the real economic cost of out-of-home care and indicate that a "fair wage" would exceed reimbursement amounts, and that levels of reimbursement do not reflect the true monetary value of the work and skill involved (Van Name, Settles, & Culley, 1977; de Jongh, 1985, cited in Smith, 1988; Schlosser, 1985, cited in Smith, 1988).

The relationship between caring and money is also a complex one for many caregivers. The literature indicates that caregivers express considerable ambivalence about the issue of caregiving for money. On the one hand, many

do not want to appear "mercenary", but also do not want their goodwill to be taken for granted or exploited (Smith, 1991; Ramsay, 1996). In spite of this, the changing nature of caregiving has begun to stimulate caregiver demands for the recognition of caregiving as a professional job, with the appropriate payments and conditions (Rhodes, 1993). However, critics of payment schemes have argued that the introduction of financial gain would attract people to caregiving for ulterior reasons, although this has thus far proved unfounded (Chamberlain, Moreland, & Reid, 1992; Ramsay, 1996). Research shows that payment of a professional fee has a number of benefits for caregivers: increased satisfaction in their work; recognition and enhancement of their professional status; providing a tangible incentive to persevere at difficult times, thus retaining caregivers; and increasing agencies' accountability to caregivers (Chamberlain et al., 1992; Berridge, 1994; Ramsay, 1996). Payment of a fee also enables agencies to make explicit their expectations, and to clarify the obligations of caregivers, so that attendance at training, on-going development, and provision of a professional service can be expected (Maclean, 1989; Smith, 1997a).

A number of studies report that lack of material resources is a problem for some caregiving families, and that a disproportionately high number of caregivers fall into lower income categories (Heath, Colton, & Aldgate, 1989; Smith, 1991; Worall, 1996). Having adequate financial resources enables such families to provide more than just the basic necessities for children in their care (Heath et al., 1989). Ramsay (1996) found that payment of a professional fee, plus maintenance allowances, enabled caregivers to contribute to the care of the children" (p.46). Furthermore, reimbursement disparities may occur, as in the widely differing rates paid to "stranger" and "kin" caregivers in New Zealand, with the latter being substantially financially disadvantaged (Or, 1995; Worrall, 1996).

A major source of discontent for caregivers is the process by which reimbursements are made (Gilligan, 1996; Worrall, 1996). For example, the New Zealand system requires that caregivers must produce evidence of a purchase, for which they are then reimbursed, or alternately, a purchase order is sent to the agency by the caregiver, and the purchase transaction is completed by the agency (Personal communication with J. Pepworth, Caregiver Liaison Worker, NZCYPFS, March, 1998). This method of reimbursement for clothing and other items appears to be unpopular with many caregivers because of the inconvenience and the time delays in reimbursement payments (Personal communication with caregivers at the New Zealand Family and Foster Care Federation Meeting, Palmerston North, May, 1997). Half of the respondents in Gilligan's (1996) survey complained that they were disadvantaged by the health board administration in terms of punctuality of payments; courtesy of staff when dealing with reimbursement claims; and calculation of their full entitlements. Research also shows that caregivers frequently feel that they are "begging" for entitlements, and that they are made to appear "money-grabbing" (Rhodes, 1993; Gilligan, 1996).

As discussed in Chapter One the aims, and consequently the practice of contemporary caregiving, have changed: the principles of "carer partnership" and "primacy of family of origin" require a more inclusive approach, involving caregivers, social workers, and natural parents, which places increased expectations and demands on caregivers (Maclean, 1989; Pithouse & Parry, 1997). Furthermore, the growing need for out-of home care for children and young people with increasingly severe problems, such as violence, sexualised behaviour, and sexual offending, requires a high level of skill and commitment from caregivers (Maclean, 1989; Kenny & Foster, 1997). In recognition of such challenges, and, in some cases, to find caregivers for "unfosterable" children (such as children with physical or mental disabilities, or difficult adolescents), a number of agencies have initiated professional

caregiving schemes which offer, along with specialised training and support, financial incentives (Ramsay, 1996; Kenny & Foster, 1997). There is a need, evident in the New Zealand literature, for the introduction of such schemes here (Laurensen, 1993/94; Kenny & Foster, 1997; Smith, 1997a; Worrall, 1997).

3.1.6 Training

Training for caregivers has been identified in the literature as an essential component in the quality and success of out-of-home care for children and young people (Lee & Holland, 1991). However, placement breakdown has been the criterion most examined in relation to the effects of caregiver training. There has been limited research on the direct effects of training on caregiver-related variables, such as work satisfaction, increased child-management skills, or caregiver commitment and morale.

As previously discussed, caregivers are currently subjected to an increasing amount of work-related stress. Research shows that caregivers are dropping out at "alarming rates" (Chamberlain et al., 1992, p.388). According to Worrall (1993, cited in Or, 1995), "It is arguable that foster parents are a diminishing resource" (p.20). The reasons most often cited by caregivers for their withdrawal are: lack of appropriate training; inadequate support (including access to respite care); and the severity of problems being presented by children requiring care (Chamberlain et al., 1992; Smith, 1996).

Children who require out-of-home care and protection are at greater risk for psychological, behavioural, developmental, social, and educational problems (Klee & Halfon, 1987). These children are also more likely to have suffered physical and sexual abuse, which, as research has shown, places them at higher risk of suffering abuse in out-of-home care (McFadden, 1984). Daly and Dowd (1992) maintain that tired caregivers suffering from burn-out may abuse children, but also that caregiver burnout can be reduced by effective training,

regular respite relief, and “responsive” supervision. Thus, caregivers may require specialized training to learn about the consequences of child maltreatment, how to manage the resulting behaviour, and how to recognise and manage their own tolerance thresholds regarding difficult and disturbed behaviours (Cicchetti, Toth, & Hennessy, 1989; Daly & Dowd, 1992). Furthermore, being equipped to cope with any resulting changes in family dynamics, plus reactive behaviour problems in their own children, may necessitate further training for caregivers and their families (Berridge & Cleaver, 1987).

Caregivers are now expected, whenever possible, to have an on-going relationship with the child’s natural family, and to actively foster on-going contact between the child and its family (Or, 1995). However, it is argued that involvement with the family of origin should not be a routine expectation of caregivers unless training is provided. In addition, advanced training needs to be provided for caregivers who are working directly with the child’s natural parents (Ryan, McFadden, & Warren, 1981).

It has been established that when children have been removed from their families and placed in out-of-home care, they inevitably suffer feelings of grief, loss, and sometimes guilt (Duclos, 1987; Urquhart, 1989). It is essential for caregivers to receive training to help them to understand issues of grief over loss and separation, and also the child’s expression of it through his/her behaviour (Duclos, 1987; Shealy, 1995). Urquhart (1989) also emphasises the need for such training to include the caregiver’s own issues of separation and loss, and to extend this into preparation for the eventual separation from the child/children for whom they provide care.

Few studies have been carried out to investigate the impact of training in terms of “measurable” improvements on caregivers’ experiences of caregiving or their provision of care (Lee & Holland, 1991). However, Boyd & Remy

(1978) found that there were significant differences between trained and untrained caregivers, with the former having more successful placements (i.e., less breakdown) and increased retention. A more recent study (Chamberlain et al., 1992), also demonstrated the positive effects of “enhanced” training on caregivers themselves, as well as on caregiver retention, when compared with controls who received no training. Caregivers reported that they felt more satisfied and skilled in their work, and more appreciated as “professional people” after participating in the programme. There was also a significant effect on the caregivers’ ability to discipline children and adolescents in their care (Chamberlain et al., 1992). In contrast, Lee and Holland (1991) found no significant difference between trained and untrained caregivers in their study which used a training approach based on several currently used programmes.

Lee and Holland’s (1991) findings raise a number of research implications regarding the content and implementation of training programmes. It is suggested that social workers examine carefully the content and processes of programmes, and note information regarding demonstrated benefits to caregivers and children before implementing them (Lee & Holland, 1991; Smith, 1994). Caregivers report that they learn more from personal experience and the observations of other caregivers, than from formally-run programmes (Hampson & Tavormina, 1980; Smith, 1994). They appear to value most the opportunity to learn about the children and their families, and how to cope with the children’s behavioural and emotional problems (Bradley & Aldgate, 1994).

Polaschek (1997) reports that basic mandatory training for prospective caregivers in New Zealand is conducted during the recruitment phase with a 13-hour programme developed by the New Zealand Children, Young Persons, and their Families Service (NZCYPFS). The training modules include introductory material on: working as a caregiver in the NZCYPFS; values, culture, and difference; the characteristics and needs of children who

require care and protection; child maltreatment and its effects; and the legal rights and responsibilities of caregivers (Polashek, 1997). Agencies other than the NZCYPFS may have their own variations of this approach (Personal communication, A. Henare, Social Worker, Anglican, Catholic Resourced Organization of Social Services, ACROSS, Palmerston North, 1997). The New Zealand Family and Foster Care Association (NZFFCA) has produced a number of publications which have been used by some agencies to assist in caregiver training (Laurensen, personal communication, May, 1997).

Bensley (1997) is critical that there is no compulsion for caregivers to attend training, and that because of a shortage of available caregivers, placements are sometimes started before mandatory training is completed. It is also reported that minimal numbers of caregivers attend post-introductory training courses which offer more in-depth training in specific areas, such as caregiving for children who have been sexually abused (Personal communication, J. Pepworth, Caregiver Liaison Worker, NZCYPFS, Palmerston North, May, 1997). Moreover, training is not expected of kin-caregivers who inevitably have similar, and sometimes more extreme needs for guidance, skills, and support than stranger caregivers (Worrall, 1996).

Given the current state of caregiver training in New Zealand, Smith (1997a) and Worrall (1996; 1997) argue that the pressures and demands of contemporary caregiving necessitate on-going, intensive training and supervision for caregivers. However, the question remains as to what sort of training is most effective and useful for caregivers and the children for whom they provide care? Concern is expressed in the New Zealand literature that, as yet, there has been no research conducted into the effectiveness of training programmes, or any other aspect of out-of-home care being implemented under the CYPF Act (1989) (Or, 1995; O'Reilly, 1997; Smith, 1997c).

3.2 The Caregiver's View of the Child's Behaviour and Needs

"In the past, things like stealing, telling habitual lies etc. were not admitted to us ... and relationships were strained, to say the least, when a teenage foster child stole from our own family".

(Gilligan, 1996, p.89).

The extensive literature examining the health needs of children in out-of-home care reports that such children are disproportionately affected by psychological problems, especially emotional and behaviour problems (McIntyre & Keesler, 1986; Lee & Halfon, 1987; Hulseley & White, 1989). The psychological problems common to children placed in care include aggression, anxiety, low self-esteem, depression, hostility, and feelings of rejection and abandonment (Smith, 1994; Trocme & Counce, 1995). These children also tend to have difficulties with interpersonal relationships, typically manifested by withdrawal or aggression, and also exhibit higher rates of educational problems and developmental delay (Klee & Halfon, 1987; Trocme & Counce, 1995). The current trends of deinstitutionalization, increased public awareness of physical and sexual abuse of children, and increasing social and economic pressures which contribute to family instability are contributing to an escalation in the incidence and rates of dysfunctional behaviour among children in out-of-home care (McIntyre & Keesler, 1986; Hulseley & White, 1989). A number of studies have shown that placement failure is strongly associated with child behaviour problems that caregivers feel incapable of handling (Berridge & Cleaver, 1987; Cooper, Peterson, & Meier, 1987, cited in Smith, 1994; Kelly, 1995). Conversely, Cautley and Aldridge (1975) and Rowe et al. (1984) found that caregivers' ability to manage common problem behaviour, and aggressive and withdrawn behaviour, is more predictive of successful outcomes. Stone and Stone (1983) also found that less aggressive, better socialized children were more likely to remain in their placements.

In spite of all the research that shows the characteristics and prevalence of behaviour problems of children in care, and their association with placement

breakdown, there has been very little systematic research on caregivers' own perceptions and experiences of children's behaviour problems, or on their ability to respond appropriately to foster children's special needs. However, Rowe et al.'s (1984) study sought information about behavioural difficulties as described by caregivers themselves, as a means of understanding how they perceived their experiences. Rowe et al. (1984) note that caregivers vary greatly in their tolerance of different behaviours; this is determined by their standards of what constitutes acceptable and unacceptable behaviour, their behaviour management skills, and their understanding of child development and the consequences of maltreatment. Rowe et al. (1984) concluded that the caregiver's perceptions of "the seriousness of the problem ... are all important with regard to the management of" and survival of a placement (p. 71).

The majority of caregivers in Rowe et al.'s (1984) study reported having to deal with one or more of a wide range of problems, and the children with more disturbed behaviours were rated by interviewers as "markedly" less well integrated into their caregiving families than less disturbed children. A significantly higher proportion of caregivers of children with disturbed behaviour were rated as more critical of their children, and as having difficulty tolerating their behaviour. One in four of these caregivers indicated that at some point they had thought the child "would have to go" (Rowe et al., 1984).

Gilligan (1996) also attempted to elicit information directly from caregivers regarding their awareness of, and views on the needs of the children in their care, and of their ability to respond appropriately to such needs. Over a quarter of caregivers expressed difficulty in knowing how to respond to the child's difficult behaviour, and almost half felt inadequate in helping a child deal with "past issues", or in being "able to make sense of what was going on inside the child's mind" (Gilligan, 1996, p.38). Gilligan (1996) reiterated Rowe et al.'s (1984) conclusion that caregivers' perceptions of the child's behaviour

are central to their attitudes to the placement, and are predictive of eventual placement breakdown.

Although the majority of respondents in Gilligan's (1996) survey indicated that they took "the child's behaviour in their stride" (p.88), there were substantial minorities who reported concerns about behaviour problems. Such concerns were held mainly with regard to the impact of the child's behaviour problems on the caregivers' own children, and, to a less extent, on their relationships with neighbours and friends (Kelly, 1995; Gilligan, 1996). Thus, Gilligan's (1996) study indicates that some caregivers experience difficulty in coping with children's emotional and behavioural needs. It also illustrates the importance of ongoing support and training in enabling caregivers to meet foster children's needs more effectively.

3.3 The Effects of Caregiving on the Caregiver's Own Children

It is not only the foster children who are at risk in the caregiving family".

(Aldgate, 1989, p.25).

A number of "landmark" studies of out-of-home care have indicated the relevance of the caregiver's own children to placement breakdown (Berridge & Cleaver, 1987). Trasler (1960, cited in Prasad, 1975), Parker (1966), George (1970), and Berridge and Cleaver (1987) found that placements where there were no birth children present were significantly more successful than those in which one or more birth children were present. Additionally, the rate of placement breakdown increases if the caregiver has a very young child (less than 5 years) or a child of similar age to the child in care. It was concluded that "perceived competition in the form of caregivers' own children presents a destabilizing influence" on placements (Berridge & Cleaver, 1987, p.125).

While the effects of the presence of birth children on the success of placements has been well researched and documented, the impact of

caregiving on the caregivers' own children is often overlooked (Aldgate, 1989). It is important to note that the caregiving relationship occurs within the context of the whole family system, involving both parents and children, and that considerable flexibility and adjustment is required when a new member is admitted (Eastman, 1979). Consequently, when birth children and their foster siblings have incompatible and competing needs and demands, the caregiving relationships within the family system may be threatened (Eastman, 1979; Aldgate, 1989).

Smith (1997a) notes, however, that there are both rewards and difficulties for birth children in caregiving families. Positive effects are more likely to occur if the birth children are well prepared for the arrival of foster siblings so that they have more realistic expectations and a better understanding of the situation. Poland and Groze's (1993) survey of caregivers' birth children revealed that the majority liked having foster siblings, felt that their parents loved them as much as their foster siblings, and that having foster siblings helped them to appreciate their own families more. However, a majority also stated that they would have liked more preparation before placements, particularly with regard to their foster siblings' behaviour, and to how much their home life would change as a result of caregiving (Poland & Groze, 1993)

The presence of foster siblings may act as a stressor for birth children who "have to be more than unusually patient and understanding to live with and assist foster siblings" (Smith, 1997b, p.24). Birth children may perceive the foster sibling's arrival as causing changes in their home and family that they do not like: stricter discipline and discrepancies in discipline; decreased parental time and attention; increased responsibilities and expectations of them by parents; and an increase in family arguments (Poland & Groze, 1993; Smith, 1997a). They may consequently experience feelings of guilt and resentment as they try to love and accept the foster sibling/s, while also

contending with negative feelings towards them (Poland & Groze, 1993).

Caregiving families are also required to make adjustments to children moving in and out of their home both unexpectedly and frequently, as short-term, emergency, and respite care are commonly sought (Horner, 1981). Thus, separation from foster siblings may provide another source of stress, with the birth children having to make emotional adjustments, often without adequate support or time to deal with their feelings (Horner, 1981; Aldgate, 1989). It can be concluded therefore, that caregivers' "own children may suffer" when a placement disrupts the "close child centered dynamics of nuclear family life" (Aldgate 1989, p.25).

3.4 Caregivers' Perceptions of their Relationship with the Natural Family of the Child in Care

"... the hardest thing is not to judge the parents"

(Smith, 1991, p.179).

Historically, concern for the stability of the caregiving relationship usually resulted in the exclusion of the child's natural family, with the notion that the intervention consisted of the placement of the child in a substitute family (Bluml, Gudat, Langreuter, et al., 1989). However, as discussed, a major philosophical change in out-of-home care in recent years favours "inclusive" care, in which relationships between the child and its natural family are maintained, with the aim being the child's eventual return home (Kufeldt, 1993; Pithouse & Parry, 1996). Irrespective of whether such a reunion occurs, however, there is clear evidence that in the majority of cases better outcomes are achieved when relationships with the child's biological family are encouraged and "emotional cut-offs" are prevented (Salahu-Din & Bollman, 1994). When children can establish identity and understand their family and cultural heritage, they are better able to form new attachments in the caregiving family (Prasad, 1988; Begun, 1995). For most children, therefore,

maintaining connection with their origins appears necessary for their healthy development as well as their adjustment to being in care. However, the role that the caregiver plays in this difficult process also appears to be pivotal to its success (McWhinnie, 1978; Bluml et al., 1989).

A major factor which determines whether children have an ongoing relationship with, and positive view of their natural parents and family, is the attitude of the caregiver to the family (Gilligan, 1996). Caregivers are now encouraged to see themselves as “part of a team” who are providing a service to families rather than as a “substitute for families” (Fein & Maluccio, 1992, cited in Gilligan, 1996). However, there is often a gap between theory and practice in this regard (E. Laurensen, personal communication, May, 1997). The needs of the child, the rights of the birth family, and the wishes of the caregiver may be at odds, resulting in the caregiver feeling an ambivalence toward the family and its involvement with the child (Rowe et al., 1984; Gilligan, 1996). Gilligan (1996) found that the majority of caregivers saw themselves as working in an inclusive role. Eighty seven percent of those who maintained contact with parents reported that they got on well with them. On the other hand, two out of three long-term caregivers questioned whether contact with the natural parents was “worth all the effort” (p.93). By contrast, Kelly’s (1995) study showed that “most” of the caregivers held negative attitudes towards the natural parents, but at the same time recognised that the children’s parents and families were important to them. Bradley and Aldgate’s (1994) study also found that ambivalence between caregivers and natural parents was a strong feature in all of the caregiving relationships which broke down prematurely.

Ryan et al. (1981) suggest that where “antipathy” toward the children’s families does exist, it is perhaps a natural outcome of caregivers’ concern for the children, their “outrage” at neglect and maltreatment children may have

received, and their apprehension that children may be returned home innapropriately. In some cases, reunification with family is not in the child's best interests. Yet, if the expectation for contact remains, great demands may be placed on the emotions and skills of caregivers in maintaining contact (Pithouse & Parry, 1996). Furthermore, caregivers may be inconvenienced if their home is used for parental or family visits, which they may have to organize and monitor, or if they are called on to provide transport (Hess, 1988). Contact with natural parents may also result in negative behavioural and emotional reactions from the child (Hess, 1988), and caregivers may experience difficulty in accepting the way parents behave towards their children during contact (Bradley & Aldgate, 1994).

3.5 Caregiver Job Satisfaction

"When I see the kids looking happy, that's when it's well worth it".

(Prasad, 1984, p.126).

Job satisfaction is defined as "a multidimensional positive affective response to one's job" (Locke, 1976, cited in Jones et al., 1996, p.43), and "to the extent that the work environment fulfills the needs of the worker, the worker is satisfied" (Dawis, Lofquist, & Weiss, 1968, cited in McClelland, 1988, p.82). Variables associated with general job satisfaction include occupational status, complexity and variety of job tasks, autonomy and control, pay and other economic rewards, feelings of competence, and relationships among fellow workers (Mortimer, 1979, cited in McClelland, 1986). Unfortunately, investigation of caregivers' job satisfaction has received little attention, so that specific predictors of job satisfaction among caregivers have not yet been adequately established. However, it would seem that theoretically, caregivers' levels of job satisfaction are related to how well their professional needs are met, through training, support, financial remuneration, and recognition of professional status.

Caregivers who work in specialized and professional schemes report that high levels of social work support, full caregiver involvement in the processes of consultation, exchange of information, and case planning, and an element of financial reward contribute to their satisfaction with their work (Bradley & Aldgate, 1994; Ramsay, 1996). However, such out-of-home care research has tended to interpret the retention of caregivers and the "success" of placements (i.e. not ending prematurely) as indicators of caregiver satisfaction, rather than measuring caregiver job satisfaction directly. Furthermore, the relationship between caregiver retention, success of placements and caregiver job satisfaction does not yet appear to have been empirically established.

However, studies show that satisfaction gained from a meaningful relationship with the child, the child's progress while in care, and the knowledge that their work has made a difference, does play a role in caregiver job satisfaction (Bradley & Aldgate, 1994; Kelly, 1995; Gilligan, 1996). Wilkinson (1988, cited in Triseliotis, 1989) found that caregivers became increasingly "disillusioned" if no child-based progress was made within 12 months of the placement. It would seem, therefore, that caregivers' job satisfaction is enhanced by evidence of their effectiveness, by their social relationship with the child, and perhaps by the amount of autonomy and control that they are able to exert. Studies of job satisfaction among child day-care workers, a group which has many work features in common with caregivers, show that positive interaction and knowledge of success with children are important sources of reward to staff and enhance performance and satisfaction (McClelland, 1987; Kingsley & Cook-Hatala, 1988). Furthermore, Kingsley and Cook-Hatala (1988) found that awareness of child success while in care was the greatest predictor of child care workers' job satisfaction.

The findings from several studies suggest that although caregivers may experience frustrations, difficulties, and disappointments in their work,

compensation may be found in seeing the child in their care respond and improve (Rowe et al., 1984; Kelly, 1995; Gilligan, 1996). Gilligan (1996) also found that a very high proportion of respondents registered "definite" job satisfaction, and that caregiving on the whole, had been a positive experience for the families, although there were also many factors with which caregivers were dissatisfied. These included: problems with administrative matters and professional and financial support; a possible parting from the child; and inadequate training and assessment (Gilligan, 1996). However, almost all respondents felt that the child had made "real progress" since being placed in their care (Gilligan, 1996), which would support the suggestion that the child's progress while in care provides a potential moderating factor when caregivers experience dissatisfaction in other aspects of their work.

3.6 Abuse Issues in Out-of-home Care

"All caregivers are at risk of having an abuse allegation brought against them".
(Worrall, 1997, p.19).

It has been generally established in the literature that caregiving is a difficult and demanding job, and that it brings stresses which affect not only the child placed in care, but also the wellbeing of the entire caregiving family (McFadden, 1984). Unfortunately, abuse, neglect, and the provision of less than adequate care does occur, although the real extent of abuse is unknown (Doelling & Johnson, 1990). The extent of abuse in out-of-home care in New Zealand may be indicated by a newspaper report that in 1996-97 a total of 79 allegations were made against 52 caregivers working for NZCYPFS, and that 19 were substantiated (New Zealand Herald, 12.4.97). The reasons underlying abuse and neglect in out-of-home care are diverse and complex, and are likely to be exacerbated by inadequate support, preparation, and training, caregiver isolation, caregiver/child mismatching, an authoritarian approach to discipline, and external stressors such as marital discord or

financial problems (McFadden, 1984; McKenzie, 1993).

The issue of abuse in out-of-home care involves two aspects: abuse perpetrated by older children on other children in the home, and the abuse of children by their caregivers (McKenzie, 1993). It is recognised that some of the children who are victims of abuse become perpetrators themselves, which again raises the issue of caregivers being adequately informed, trained and supported when such placements commence (McKenzie, 1993). McFadden (1989) advises that all children in a caregiving household should be included in sexual abuse awareness and prevention training. Sexualized and aggressive behaviours from foster children and adolescents can provoke physical abuse from caregivers as they "struggle to control this unacceptable behaviour" (McFadden & Ryan, 1986, cited in McFadden, 1989, p.92). Thus, placing abused (especially sexually) children with inadequately informed and poorly prepared caregivers, creates the risk that abuse may reoccur.

Increased awareness about child abuse and the growing number of children in care who have been abused has focused attention on the issue of abuse in out-of-home care (McKenzie, 1993). Although the wellbeing of children in care is of primary importance, reports and allegations of child maltreatment can nevertheless have damaging consequences for caregivers and their families (Carbino, 1991). Many allegations are unsubstantiated: for example, in the report cited above (New Zealand Herald, 12.4.97), 60 of the 79 allegations were unsubstantiated. Additionally, Rosenthal, Matz, Edmonson, and Groze (1991, cited in McKenzie, 1993) reported that of 500 allegations of abuse in out-of-home placements over a five-year period, only 29% were confirmed. When allegations occur, the agency's allegiance is primarily to the child. Caregivers are inevitably forced to turn to whatever support is available from other sources, such as other caregivers, or caregiver associations (Carbino, 1991). Caregivers are increasingly affected by the fear of abuse allegations,

and are concerned about the lack of support services available to them under such circumstances (McKenzie, 1993).

3.7 Caregivers' Professional Status

"It means that professional child care tasks can become an expected part of the job, and not be seen as a special favour. It means that caregivers are more accountable".

(McColgan, 1989, p. 28).

Traditionally, out-of-home care has been regarded as a substitute family environment, with little recognition from authorities that the work warranted extensive training, support, payment, and professional recognition for caregivers. This is reflected in the "lingering adherence to the volunteer, charitable model of service" which is still present in out-of-home care, in spite of the fact that it is "out-of-date" (McKenzie, 1993, p.4). However, escalation in the psychological problems of children requiring care has been accompanied by an increase in the expectations made of caregivers. These include managing serious behaviour problems, being involved with the child's family, and working with the social worker and other professionals in case management (Dawson, 1989). In brief, a more professionalized and accountable model of care is now expected. As previously discussed in Section 3.2.5, caregiver payment is a major issue in the growing movement for the professional recognition of caregivers. However, increased demands for improved levels of care and higher standards are generally not accompanied by either remuneration or recognition of caregivers' increased professional status.

An investigation of the current "professional" status of caregivers reveals a number of anomalies which result from the difficulties that agencies and caregivers have in understanding the caregiving role (Meadowcroft, 1989). Caregivers are encouraged to provide an experience of family life with "loving parental figures" yet they are also expected to assume the role of therapist or

caretaker; caregivers occupy a parental role yet they have no parental rights, and must often be prepared to lose the child; caring for more difficult and disturbed children and youth necessitates extensive and ongoing training, yet there is no obligation for caregivers to pursue this after they have completed introductory training; and caregivers are expected to work in an inclusive style with social workers, the children, and their biological families, albeit in a sometimes tense and ambivalent relationship (McColgan, 1989; McKenzie, 1993; Pithouse & Parry, 1996). The relationship between caregivers and social workers may also be characterized by ambiguity. McColgan (1989) suggests that many social workers have not yet resolved the issue of whether caregivers are “clients “ or “partners” in the caregiving relationship, and that this difficulty arises from the “peculiarly dual nature of caregivers initially requesting, but later providing, a specific kind of service” (p.86).

Thus, the caregiver role can vary at times between caring parent, therapeutic worker, agency employee, and client. Prasad (1988) suggests that “role clarity” is a most important consideration for caregivers. Furthermore, role clarity is suggested as being fundamental to job satisfaction (George, 1970). Jones et al. (1996) describe a social-psychological model of work stress which shows that role conflict, role ambiguity, and role overload cause lower job satisfaction, unfavourable attitudes toward others, and increased anxiety. However, there does not appear to be any caregiving-related research which examines these suggestions.

Nevertheless, research does show that caregivers recognise the importance of the more “open” model of care, which promotes “partnership” between caregivers, agency staff, and birth parents, and the greater involvement of caregivers in consultation and decision-making processes, with a concomitant recognition and enhancement of their professional status (Gilligan, 1996; Ramsay, 1996; Sellick, 1996). Some more recent studies indicate that social

workers, caregivers, other professionals, and sometimes the natural parent/s are now working more collaboratively within the “team” approach (Berridge, 1994; Bradley & Aldgate, 1994; Ramsay, 1996). However, Pithouse and Parry (1996) report that while both caregivers and agencies generally support the concept of partnership, many are still struggling with it in practice.

3.8 Motives for Caregiving

“The importance of motives ultimately lies in their influence on behaviour”.
(Hoffman, 1976, p.137).

Studies of out-of-home care have tended to concentrate on the physical and social characteristics of caregivers rather than on their “psychological make-up” and their motives for doing the work (Triseliotis, 1989). Nevertheless, a major issue in the recruitment of caregivers in New Zealand is assessing why they want to do the work, and whether they have a “desire” to work with children and young people rather than to meet their “own needs” (Polaschek, 1997). However, it has been noted that there are limitations to the disclosure of motives by caregivers as “professed motives often operate as partial masks”, so that underlying, and often less understood motives may not be made known (Dando & Minty, 1987, p.385). Rowe et al. (1984) also added that large-scale, retrospective studies “could not hope to uncover the all-important unconscious needs that bring people into this special parenting role” (p.63).

Reported reasons for caregiving can be broken into two broad categories: (a) altruistic motives, which include a desire to help under-privileged children and families, knowing a child who needs a home, identification with deprived children through a caregiver’s own experiences; and (b) egoistic motives, which include childlessness, the need for more children or companionship for a caregiver’s own child, wanting to nurture children, or wanting a job at home (Rowe et al., 1984; Dando & Minty, 1987). Kay (1966) and Dando & Minty (1987) found that a high standard of caregiving is associated with motives

which are based on strong personal needs, whether altruistic or egoistic. By contrast, Kraus (1971) and Hampson and Tavormina (1980) found clear associations between altruistic motives and successful outcomes; egoistic motives and less successful outcomes. Nevertheless, it is essential that caregivers who identify with children because of their own unhappy or deprived childhoods have come to terms with those experiences, so that they have the emotional maturity and the capacity to fill a caregiving role (Dando & Minty, 1987).

Rowe et al. (1984) found in their comprehensive study of 133 “foster” mothers and 93 “foster” fathers that 52% of mothers and 60% of fathers gave altruistic reasons as their main motives for caregiving. However, there were no clear-cut associations between motives for caregiving and placements being rated as “good” or “excellent” (Rowe et al., 1984). Both Gilligan’s (1996) and Kelly’s (1995) findings suggest high levels of altruism among respondents, although a possible relationship between motives and placement outcome was not examined. Gilligan (1996) suggests that the high proportion of caregivers with altruistic motives in his study of predominantly Roman Catholic, rural communities in Ireland, may be due to religious or other cultural factors.

In view of the numerous findings cited in this review, it is evident that many factors are associated with caregiver satisfaction and more successful care outcomes. Consequently, a caregiver’s motivation cannot be examined in isolation, but must be viewed in the context of other factors in the caregiver’s life, and in the lives of others within the caregiving context (Kraus, 1971).

3.9 Caregiving and Parenting Practices

“Children grow into the intellectual and social life around them and they do this by being stimulated, guided, challenged, and supported by others who have a warm relationship with them”.

(Bronfenbrenner, 1979, cited in Smith, 1997, p.23).

Research shows that children in out-of-home care are at greater risk for the

development of psychological problems than children living with their biological parents (Klee & Halfon, 1987). Shealy (1995) points out that it is essential that children who have experienced abusive, neglectful or unsafe treatment from parents should not be exposed to similar harmful treatment when placed in care. Furthermore, the greatest challenge for caregivers lies in forming a relationship with these children early enough to “foster in them the positive feelings of self-esteem and competence that they so desperately lack” (Cicchetti, Toth, & Hennessy, 1989, p.44).

Child behaviour problems that caregivers feel incapable of handling are one of the major factors contributing to placement breakdown (Smith, 1994). Although caregivers have reported a need for more specific training regarding behaviour management, very little research has examined the child-rearing attitudes and practices of caregivers (Klee & Halfon, 1987; Smith, 1994). However, studies of parents and their biological children demonstrate that there is a relationship between parental child-rearing practices and child psychological outcomes (Arnold, O’Leary, Wolff, & Acker, 1993; Shelton, Frick & Wootton, 1996). Specifically, inconsistent use of discipline, failure to use positive change strategies (for example, positive reinforcement for appropriate behaviour), and excessive use of corporal punishment are linked with child conduct problems (Frick, Christian, & Wootton, in press).

When such findings are extrapolated to the field of out-of-home care, it can be argued that caregiver child-rearing practices may be associated with placement outcome, and also with the social, emotional, and cognitive functioning of children in care (Smith, 1994). Smith’s (1994) study indicates that better developmental outcomes for children in care are associated with “higher quality” child-rearing environments. Authoritative parenting by caregivers was associated with greater pro-social behaviour, and fewer internalizing and externalizing problems in children (Smith, 1994). In addition,

a greater variety of stimulating activities, including language stimulation, were significantly associated with less aggressive behaviour and more positive interaction by children (Smith, 1994).

Doelling and Johnson's (1990) study of caregiver/child mismatching, showed that when a child's behaviour does not meet the caregiver's expectations, and when the caregiver is described as "authoritarian", the placement is likely to fail. Research also shows that children who feel more secure with caregivers, develop positive attachments with them, and receive physical affection are psychologically better adjusted (Marcus, 1991). Thus, these few studies that have examined caregivers' parenting practices and their impact on children in out-of-home care, indicate comparable outcomes to the findings from research on parenting practices in biological families.

3.10 Psychological Wellbeing

"Families who are under stress themselves are not likely to be able to provide appropriate care for the children of others"

(Vadasy, 1989, p.15, cited in Smith, 1997b).

There is abundant evidence to show that caregivers who are well trained, supported, and motivated can provide safe and effective environments for children and young people. However, Urquhart (1989) says that caregivers are a "critical component" in the current context of challenging placements, and that "the wellbeing of caregivers is directly related to the wellbeing of children in their care" (p.207). Unfortunately, Urquhart (1989) does not support this statement with evidence from research. As discussed earlier, studies of out-of-home care have used placement outcomes or measures of child adjustment as indicators of "successful" caregiving, while variables such as the psychological wellbeing of caregivers have been ignored. As yet, there has been no research into caregivers' subjective wellbeing and whether it relates to effective caregiving, the improvement and progress of children in care, or to other key factors in the caregiving process.

Social psychological research has shown increasing interest in the processes which enable successful functioning; in particular, the development of social skills, parenting and work skills, and stress management skills (Maxwell, Flett, & Colhoun, 1990). This has led to the emergence of the concept of “psychological wellbeing” (Maxwell et al., 1990). In many fields, including social psychology, the terms psychological wellbeing, subjective wellbeing, morale, general happiness, quality of life and life satisfaction are all used to mean essentially the same thing, with little distinction often being made between them in broad terms (Ryff, 1989).

These terms have been used, to a greater or lesser extent, to describe the individual’s perception of overall life quality and inner experience (Lawton, 1996, cited in Bailey, 1998). However, there are many different approaches to an exact definition of psychological wellbeing. For example, Huebner and Dew (1996, cited in Bailey, 1998) argue that psychological wellbeing consists of three factors: positive affect, reduced negative affect and life satisfaction. Another approach (Ryff 1989) suggests that global psychological wellbeing is made up of a number of positive dimensions: self-acceptance, a sense of purpose in life, positive relations, mastery, personal growth, and autonomy. Kamman and Flett (1986), on the other hand, define psychological wellbeing as a predominance of positive feelings, and a “complete and lasting satisfaction with life as a whole which imply feelings of cheerfulness, energy, freedom, a sense of purpose and control, and the feeling that life is meaningful” (p.10).

Research shows that psychological health is particularly affected by satisfaction with oneself and with one’s work (McIntosh, 1985, cited in Maxwell et al., 1990). In addition, effective social support is considered an intrinsic part of psychological wellbeing, although the “satisfaction” derived from the quality of social support plays a more important role than the amount of contact

(Maxwell et al., 1990) Finally, wellbeing is positively related to physical health and energy, while it is negatively related to stressful life events such as major failure, loss of social support, marital breakup, and life changes (Flett, 1986, cited in Maxwell et al., 1990; Maxwell & Robertson, 1988). Therefore, it can be conjectured that an examination of caregivers' wellbeing is particularly relevant in relation to other key factors which caregivers require, such as support, training, work satisfaction, role definition, and professional status. The present study will look at psychological wellbeing as an overall construct that includes confluence, optimism, self-esteem, self-efficacy, close social relationships, freedom, energy, and thought clarity (Kamman & Flett, 1986).

3.11 Conclusion

The literature review has revealed that family-based care is now regarded internationally as the placement of choice for children and young people who require out-of-home care. This is particularly relevant to the policy and practice of out-of-home care in New Zealand, given the challenge to agencies of finding placements for children with increasingly complex needs in a climate of politically-driven financial stringency. However, the New Zealand literature and media reports indicate that caregiving is a service under considerable stress, with the likelihood of severe social implications for future generations unless certain issues are addressed and funding is increased (Smith, 1997c). Given this climate, it is important to address pertinent issues that include the experiences and wellbeing of not only the children in care but also the caregivers themselves.

3.12 The Research Questions

There is still a scarcity of research which examines caregivers' own experiences, perceptions, skills, and motivation, and how these relate to the wellbeing of the caregivers themselves, their families, and the children in their care. Therefore, the current study investigates the relationship between how

well caregivers' work-related needs are met (i.e. positive caregiving experiences) and psychological wellbeing from several different perspectives: social work and other support; job satisfaction; professional status; relationship with the foster child's natural family; effects of caregiving on the caregiver's own family; and the behaviour and needs of the child in care. The following hypotheses were proposed:

- 1) More positive caregiving experiences would be associated with higher levels of psychological wellbeing.
 - 1a) Higher levels of social work support would be associated with higher levels of psychological wellbeing.
 - 1b) Higher levels of total support (formal and informal) would be associated with higher levels of psychological wellbeing.
 - 1c) Higher levels of job satisfaction would be associated with higher levels of psychological wellbeing.
 - 1d) Higher levels of perceived professional status would be associated with higher levels of psychological wellbeing
 - 1e) More positive relationships with the natural families of children in care would be associated with higher levels of psychological wellbeing.
 - 1f) More positive perceptions of the effects of caregiving on caregivers' families would be associated with higher levels of psychological wellbeing.

Child behaviour problems that caregivers feel incapable of handling are one of the major contributors to placement breakdown (as discussed in Section 3.3). An examination of child-rearing practices in biological families demonstrates a relationship between positive parenting practices and positive child psychological and behavioural outcomes. From this, the second set of hypotheses were developed:

- 2a) Higher levels of positive parenting practices would be associated with more positive assessments of the behaviour, needs and progress of

the children in care.

2b) Higher levels of positive parenting practices would be associated with higher levels of caregiver psychological wellbeing.

Altruistic motives have been associated with a higher standard of caregiving and better placement outcomes in some studies but not in others. The current study investigates whether caregivers' motives are associated with their perceptions of caregiving needs being met, their job satisfaction, and their psychological wellbeing. The third hypothesis proposes that:

3) Caregivers with altruistic motives will have more positive experiences of their professional needs being met, higher job satisfaction, and higher psychological wellbeing than caregivers with egoistic motives.

There were no formal hypotheses about differences between agencies on how well caregivers' work-related needs were met, caregivers' psychological wellbeing, their parenting practices, or their motives for caregiving. However, it is anticipated that there may be some differences between caregivers within the five agencies as a result of their varying philosophies, and administrative and social work practices.

There were also no formal hypotheses about how the study variables were related to the demographic variables. Previous research indicates that caregivers who are older, are more experienced at caregiving, have fewer biological children at home, and more than one child currently in care, are more likely to experience "successful" placements. There is also some evidence that the socio-economic status of caregivers and placement outcomes may be positively related. In view of the above findings, the decision was made that the present study would also examine caregiver age, work experience (time caregiving and total number of children cared for), number of caregiver's birth children in the household, and household income in relation to caregiver wellbeing and job satisfaction.

4.1 Sample

Consent from the Human Ethics Committee at Massey University was sought and received prior to the researcher inviting caregivers to participate in the present study. Five major agencies were approached and asked for access to caregivers as possible respondents in the survey. All of the agencies agreed to participate. The targetted agencies were: the Children and Young Person's Service (CYPS) in Palmerston North (including Feilding); The Open Home Foundation (OHF) in both Palmerston North and Wellington; The Anglican, Catholic Resourced Organization of Social Services (ACROSS) in Palmerston North; and Presbyterian Support Services (PSS) in Gisborne. The ethnicity of the current caregiver populations of the five agencies are as follows:

- (a) OHF (Wellington): 109 Pakeha/European; 14 Maori; and 8 Pacific Island.
- (b) OHF (P. Nth.): 56 Pakeha/European; 10 Maori; and 1 Pacific Island.
- (c) CYPS: 48 Pakeha/European; 19 Maori; and 3 Pacific Island.
- (d) PSS: 11 Pakeha/European; and 17 Maori.
- (e) ACROSS: (not available).

With the exception of CYPS, the other agencies are overtly based on a Christian philosophy, although all are dependent on State funding for carrying out their work.

4.1.1 Sample Reliability

The sample consisted of a total of 294 currently active caregivers. Response rates to questionnaires usually do not exceed 50%, with the return rate for postal questionnaires being even lower, usually below 35% (Miller, 1991). There is a likelihood that non-respondents differ significantly from those who answer the questionnaire, so that estimates based on the latter are biased (Moser & Kalton, 1971). Gilligan (1996) points out, however, that the problem

lies in interpreting the meaning of non-response, and suggests that it is not within the scope of such studies to interpret the reasons for response or non-response. Gilligan (1996) concludes that there is generally no means of determining whether the bias is excessively positive or negative.

4.2 Data Collection

The survey was conducted by means of a battery of written structured questionnaires (Appendix C). The battery consisted of five parts including: demographic information; caregivers' ratings of their perceptions of certain key caregiving issues and experiences; an indication of motives for becoming a caregiver; caregivers' assessment of recent feelings of wellbeing; and caregivers' indications of preferred parenting practices. The questions seeking demographic data were presented at the beginning of each questionnaire but the remaining four parts were counterbalanced to prevent order effects (Oppenheim, 1986). The rotation of questionnaires occurred in each agency's allotment of surveys.

A recruitment letter (Appendix A) was sent to all currently active caregivers introducing the researcher, outlining the nature of the research, and inviting caregivers to participate in the study. Moser and Kalton (1971) suggest that the recruitment letter fulfills the role of the interview opening, and as such it must try to overcome any prejudice the respondent may have against surveys, and also clarify what it is hoped to be gained from the survey. An Information Sheet (Appendix B) and a copy of the Questionnaire were also included in this posting to save further cost and time of subsequent mailouts. The recruitment letter and the Information Sheet were designed to help increase the response rate by stressing the importance of the investigation to caregivers themselves, and the social usefulness of the study. Miller (1991) suggests that questionnaires are more likely to be returned if they are judged as salient to the respondent.

The posting-out was done by the respective agencies in order to ensure caregiver anonymity and also to comply with the requirements of the Privacy Act (1993). Each Questionnaire package included a stamped, return-address envelope for the return of completed questionnaires to the researcher, thus ensuring that the respondents' identities were also unknown to agencies' staff members. The prospect of total anonymity was intended to increase the caregivers' willingness to respond, and also to promote the likelihood of their answering accurately and honestly (Oppenheim, 1986).

4.2.1 Questionnaire Return Follow-Up

The use of questionnaire return follow-ups can increase the response rate by as much as 20% (Moser & Kalton, 1971; Miller, 1991). As anonymity was guaranteed in this survey, it was not possible to identify non-respondents through a follow-up letter. Instead, a reminder notice was circulated to all caregivers via their respective agencies' newsletters. It was accompanied by a notice of acknowledgement and thanks to those caregivers who had already completed and returned their questionnaires.

4.2.2 Respondents

A total of 114 valid questionnaires (38.8% of the overall total) were returned in time for analysis. Of these 114 respondents, 93 (80.7%) were female and 21 (19.3%) were male, with a total of 99 (95.6%) currently having one or more children in their care. The age range of the sample was from 20-29 (value label =1) years to 70-79 (value label = 6) years ($M = 2.63$, $SD = 1.11$). A total of 61 (53.50%) respondents described themselves as providing long-term and permanent care with the remainder engaged in short-term or varied forms of care. Fifty three (46.5%) respondents had been caregiving for more than five years, 25 (21.9%) for two to five years, 18 (15.8%) for one to two years, and 13 (11.4%) for less than one year. Only 8.8% ($n=10$) of the sample were kin-

caregivers with the remainder (n=94, 91.2%) being “stranger” caregivers. More demographic data are presented in the Results section.

4.3 The Caregiver Questionnaire

The battery which was constructed for the survey comprised five sections containing questions seeking demographic information, a questionnaire which elicited caregivers’ perceptions and opinions of their caregiving experiences, a questionnaire on motives for caregiving, an assessment of current wellbeing, and an assessment of parenting practices. The preliminary version of the caregiving experience section of the battery was composed and edited in consultation with the literature (e.g. Gilligan, 1996), my supervisor, and key informants, and was then viewed and accepted by the Massey University Human Ethics Committee.

4.3.1 Demographic Information

Respondents were requested to give demographic details on their, and their partners’ (if applicable) age, number of natural children living at home, family income, and usual occupation to establish the relationship between client socio-economic states and the areas addressed on the survey. Such data provided an indication of the socio-economic range from which the sample was drawn and it would also enable possible inter-agency comparisons to be made. Questions addressing the length of time caregiving, caregiving status, possible child/caregiver kinship, and the number and ages of both children in care and natural children were included on the basis of these factors being associated with specific outcomes in previous research.

4.3.2 Caregiver Experience Questionnaire

A major component of the Questionnaire dealt with the respondents’ perceptions of key caregiving issues that had become evident through the

literature search and through the researcher's discussions with key informants. Gilligan's (1996) postal questionnaire had included a number of the same key issues. It was decided, therefore to incorporate or adapt those questions from Gilligan's (1996) survey that were pertinent to the present research: 15 questions were taken directly from Gilligan's (1996) questionnaire, and a further 9 items were adapted from it. The remaining 12 questions were developed on the basis of the pilot work conducted by the researcher. The key issues covered by the questionnaire (see Appendix C) were: the quality of, and access to sources of formal and informal support (Q 2; Q 5; Q 7; Q 8; Q's 10a & 10b; Q 11; Q 12; Q 13; Q 17; Q 19; Q 23; Q's 25a - 25 f; Q 28; Q 35); perceptions of professional status (Q 15; Q 18; Q 20; Q 30; Q 34); perceptions of the child's behaviour and responding to the child's presenting needs (Q 9; Q 14; Q 22; Q 27; Q's 33 a & b); the perceived effect of caregiving on the caregiver's family (Q 1; Q 6; Q 31); the caregiver's view of his/her relationship with the child's family of origin (Q 3; Q 20; Q 36); and the caregiver's satisfaction and morale in relation to the caregiving role and tasks (Q 4; Q 16; Q 21; Q 24; Q 26; Q 29; Q 30).

Information was sought on these issues by way of 36 statements to which responses were sought on a Likert scale consisting of five points from "*agree strongly*" to "*disagree strongly*". The statements were presented in random order rather than within the five underlying themes (subscales). As certain key questions were repeated with slightly different wording, they were scattered randomly to minimize the effects of repetition. Random placement of questions also ensured that the same subscale/s would not be repeatedly omitted if the questionnaire was not completed by a number of respondents. Gilligan (1996) also suggested that the total number of valid responses would vary according to two factors; firstly, whether the respondent chose to make any response to the given statement, and secondly, whether the statement was relevant to the respondent's circumstances (for example, a caregiver who had no natural

children could not address questions assessing the impact of caregiving on his/her child/ren).

4.3.3 Reliability of the Caregiver Experience Questionnaire (CGQ):

A reliability analysis was conducted in order to help assess the reliability of the CGQ. The analysis showed a Cronbach's alpha of .86 indicating that the measure had high reliability. The alphas for each subscale of the CGQ indicate a range of high, moderate and low reliabilities: Total Support (TOTS) = .86; Social Work Support (SWS) = .83; Caregiver Job Satisfaction (CGS) = .65; Child's Behaviour and Needs (CHB) = .55; Caregiver Professional Status (CGP) = .50; Effects of Caregiving on Caregiver's Family (CGF) = .33; Caregiver's Relationship with Foster Child's Family (CHF) = .44. The lower reliability of the last three subscales is likely to be largely due to the subscales having only five, three and three items respectively.

4.3.4 Motives for Caregiving

In order to determine the respondents' motives for becoming caregivers, a brief measure developed by Rowe et al. (1984) was used. Gilligan (1996) also incorporated this instrument in his study. The measure consisted of eight hypothetical statements regarding reasons for becoming a caregiver: "*I wanted to help under-privileged children*"; "*I wanted a child/more children*"; "*I knew of a child who needed a home*"; "*Because of my own childhood experiences*"; "*I knew other people who were caregivers*"; "*I wanted to adopt but couldn't*"; "*I/my partner wanted a job at home*"; "*Our own children were grown up*". A ninth item, "*Other reasons*", was also included. Respondents could indicate an unlimited number of reasons out of the total number, but were asked also to indicate the most important, or primary reason.

4.4 The Affectometer 2

The assessment of caregivers' psychological wellbeing was conducted through the use of the Affectometer 2 (AFF II) (Kamman & Flett, 1983a), a scale which measures a person's current level of general happiness or sense of wellbeing. Affectometer 2 is a 40-item self-report inventory concerned with positive and negative feelings arising in the course of everyday living. The scale has been developed through several stages of systematic testing and refinement based on responses of randomly sampled New Zealand adults (Kamman & Flett, 1983b).

There are two separate items for measuring positive and negative affect (PA and NA), with the overall level of wellbeing conceptualised as the extent to which good feelings predominate over bad feelings. The participants are asked to report their feelings "over the past few weeks", which achieves a compromise between measuring a sense of global wellbeing and the choice of a time period which allows reasonably accurate recall (Kamman & Flett, 1983a). The 40 items consist of either sentences or adjectives which "describe different feelings about yourself and your life", to which the participant responds according to "how often" the feeling is present on a four point scale: "not at all/ occasionally/ some of the time/ often/ all the time " (Kamman & Flett, 1983a, p.81).

4.4.1 Reliability of Affectometer 2

The Affectometer 2 has high cited reliability estimates indicating that it possesses a high degree of internal consistency. Kamman and Flett (1983a) report that in a sample of 110 random Dunedin adults, the Affectometer 2 had an alpha of .95, which is comparable with earlier results obtained for Affectometer 1 (an earlier 96-item prototype version). The stability of the Affectometer 2 over a period of two weeks is indicated by a test-retest

correlation of .83, which is an average of results obtained in three studies by Christie and Gilmore (1977, cited in Kamman & Flett, 1983a) for a total of 91 subjects. In addition Cramb and Hills (1982, cited in Kamman & Flett, 1983b) observed a test-retest reliability of .72 on 45 control group subjects on a 24-item short form of Affectometer 1, over a period of 13 weeks. In the current sample, the alpha reliability was found to be .87.

4.4.2 Validity of Affectometer 2

Affectometer 1 has been compared with 12 other wellbeing and related scales on a national random sample of 118 New Zealand adults (Kamman, Farry, & Herbison, Unpublished Manuscript, cited in Kamman & Flett, 1983a). The Affectometer yielded substantial correlations in a range of .68 to .75 with the majority of other measures. Furthermore, in another study on 57 randomly selected New Zealand adults the Affectometer 1 correlated with Dupuy's (1978, cited in Kamman & Flett, 1983a) General Wellbeing Schedule ($r=.74$). This latter scale in turn has been found to be highly and negatively correlated with standard scales of anxiety and depression (Fazio, 1977, cited in Kamman & Flett, 1983a).

4.4.3 Selection of Items for Affectometer 2

Kamman & Flett (1983b) report that a variety of factor and cluster analyses on the 96 items in Affectometer 1 failed to produce any reliably distinct groups of items. The high degree of item homogeneity as measured by alpha indicated that any random selection of items could be used to form a reliable shorter version. Consequently, Affectometer 2 was constructed with its 40 items being correlated with the total PA-NA balance score from the remaining 39 items. The results of these item to total remainder correlations showed that all items were valid with r 's ranging from .33 to .76, with a median of .57, all significant beyond the .001 level (Kamman & Flett, 1983b).

4.4.4 Subscales of Affectometer 2

Kamman and Flett (1983a) found that the mean r between the PA and NA subscales of Affectometer 2 was $-.66$ on 112 adult participants. An identical mean r of $-.66$ had been found between the subscales of Affectometer 1 with a total N of 501 adult subjects (Kamman, Farry, & Herbison, 1981, cited in Kamman & Flett, 1983a).

4.5 The Alabama Parenting Questionnaire

The Alabama Parenting Questionnaire (APQ; Frick, 1991) is a multi-informant (parent and child), multi-method (endorsement and telephone interview) technique for assessing parenting practices in school-aged children and adolescents. For the purposes of the present study, however, only the parent endorsement method was used.

The parent report measure includes 35 items assessing five parenting practices that research has most consistently linked to child behaviour problems (Wootton, Frick, Shelton, & Silverthorn, 1997). The parenting practices are grouped within the following sub-scales: a Parental Involvement (IN) scale (10 items); a Positive Parenting (PP) Scale (6 items); a Poor Monitoring/Supervision (MS) scale (9 items); an Inconsistent Discipline (ID) scale (6 items); and a Corporal Punishment (CP) scale (3 items) (Wootton et al., 1997). Items assessing the first two constructs are worded in the positive direction (indicating more positive parenting), and the items assessing the latter three constructs are worded in the negative direction (Frick, Christian, & Wootton, in press). Also included are 7 additional items measuring specific discipline practices other than corporal punishment, so that the latter items are not asked in isolation from other forms of discipline which could place an implicit negative bias toward these items (Frick et al., in press; Frick, personal communication, 1998). Endorsement items are rated on a 5-point frequency

scale (1=*never* to 5=*always*) to represent the "typical" frequency of the parenting behaviour (Frick et al., In press).

4.5.1 Reliability of the APQ

Shelton, Frick, & Wootton (1996) estimate that internal consistencies for the 5 subscales, in a sample of 160, are as follows: IN, .80; PP, .80; MS, .67; ID, .67; and CP .46. The CP scale's low internal consistency is likely to be largely due to the scale only having three items, and its reliability, therefore, may have been underestimated (Shelton et al., 1996). Test-retest reliability was established only for the interview format of the APQ (1991): interviews were conducted at least 3 days apart across a 2- to 4-week time period, with scores being highly consistent across the interview times, ranging from .69 to .89 for the 5 scales (Shelton et al., 1996). In the current sample, a reliability analysis of the APQ showed a Cronbach's alpha of .81, indicating that the measure had adequate reliability. The alphas for each subscale of the APQ indicate a range of reliabilities: IN, .78; PP, .70; MS, .73; ID, .74; CP, .55. The lower reliability of the last subscale is likely to be largely due to the subscale having only three items.

4.5.2 Validity of the APQ

Adequate convergent validity of APQ scores across informant and assessment methods for each parenting construct has been demonstrated (Shelton et al., 1996). Across the five subscales, the highest correlations, all of which are statistically significant, tended to be within each informant but across methods: for parents, the correlations for a construct across endorsement and interview formats ranged from .30 to .55 (Shelton et al, 1996). The correlations among APQ scales within each assessment format were calculated as a test of the scales's divergent T validity, with the MS scale, ID scale, and CP scale showing good divergent validity. The average intercorrelations for these three

scales within the parent endorsement format was .19 (Shelton et al., 1996). In contrast, the PP and IN scales were highly correlated across informant and assessment formats (.41-.85; $M=.67$), suggesting that these may be measuring a more singular dimension of parenting (Shelton et al., 1996).

Shelton et al. (1996) report that both the endorsement and interview formats were "highly useful" for obtaining parental reports of parenting practice. They note, however, that the reliability and validity data were based largely on a moderately sized ($N=160$) sample, consisting of a clinic-referred sample ($N=124$) and a small volunteer sample ($N=36$) (Shelton et al., 1996). Mothers or other female caretakers made up 95% of the clinic sample and 100% of the volunteer sample, thus requiring further testing of the APQ for a generalization to more diverse samples (Shelton et al., 1996). Although its psychometric properties are in the early stages of development, Frick et al. (in press) propose that the APQ is able to be used at this stage for research purposes. For example, in their study of the moderating role of child callous-unemotional traits in the development of child conduct problems Wootton et al. (1997) successfully used the APQ (Frick, 1991) to assess the dimensions of parenting practices most frequently associated with child conduct problems. Frick et al. (in press) also used the APQ (Frick, 1991) to assess parenting practices in their study of age-related (child) variations in the association between parenting practices and conduct problems.

The APQ was selected for use in the present study because of the ability of the Parent endorsement to assess parenting practices in families of school-age children across a broad age-range of 6 to 17 years. Although the research literature cites several standardized questionnaires for assessing family functioning, these measure parenting "style" rather than parenting "practice" (Roberts, Block, & Block, 1984, cited in Shelton et al., 1996). Being able to use a single measure to assess caregivers of a wide age range of children was

another advantage in using the APQ. Furthermore, similar to the parent sample used in the development of the APQ, the majority of caregiver respondents in the present study were females.

4.6 Data Analysis

Analysis of data was conducted using the Statistical Package for Social Sciences SPSSPC+ computer programme. Descriptive statistics, correlations, chi-square tests, independent *t*-tests, and multiple regressions were used in the analysis of results.

- (1) Descriptive statistics summarising the demographic information, the CGQ, the AFF II, and the APQ item responses were computed. This included percentages, means, and standard deviations.
- (2) Reliability analyses were conducted on the CGQ, the CGQ subscales, the Affectometer II, and the APQ to determine the Cronbach's alphas.
- (3) Correlations using Pearson's *r* were used to determine the strength of the relationships between the demographic data, scores of the CGQ, the CGQ subscales, the Affectometer II, and the APQ.
- (4) The Chi-square Test for Goodness of Fit was conducted to compare the frequencies of scores falling into the "agreed" versus "other" ("uncertain", "disagree", or "disagree strongly") categories for scores in the CGQ.
- (5) Independent sample *t*-tests were used to test the differences between the altruistic motives group and the egoistic motives group scores for the CGQ, the Caregiver Satisfaction subscale of the CGQ and the AFF II. Independent sample *t*-tests were also used to test the differences between the five agencies' scores for the CGQ, the CGQ subscales, the AFF II, and the APQ.
- (6) Multiple regression analyses were used to assess for possible moderating variables in relation to psychological wellbeing, and caregiver job satisfaction.

5.1 Demographic Information

The total number of returned questionnaires was 114/294, thus showing an overall return rate of 39%.

There was a high percentage of female respondents with 93 females (81.6%) and 21 males (18.4%) participating.

Only 10 respondents (8.8%) indicated kinship ties with the children in their care whereas 97 respondents (85.1%) indicated that the children in their care were non-kin, with 7 (6.1%) giving no indication of "kin/stranger" status.

Figure 1 shows the percentage of caregivers according to the type of care they provided. The two largest groups comprised caregivers who provided permanent care (n=37, 32.5%), and those who provided short term care (n=36, 31.6%). A total of 24 (21.1%) caregivers provided long-term care and 17 (14.9%) caregivers provided both short and long term care.

Figure 1. Percentage of Caregivers providing short term, long term and permanent care.

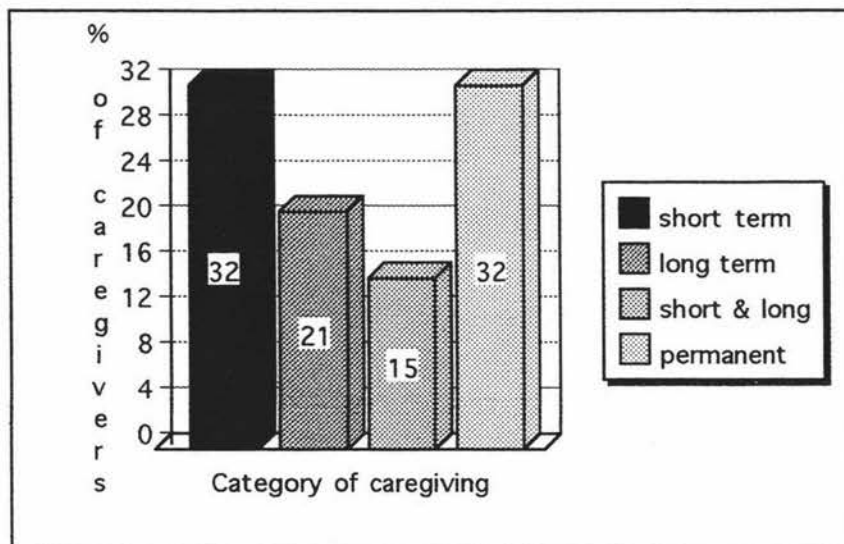


Figure 2 shows that the largest number of respondents ($n=52$, 45.6%) in the sample have been working as caregivers for more than 5 years whereas the lowest number of respondents ($n=13$, 11.4%) have been providing care for less than a year. The mean number of years was 2.96 ($SD=1.23$).

Figure 2. Number of years spent working as a caregiver.

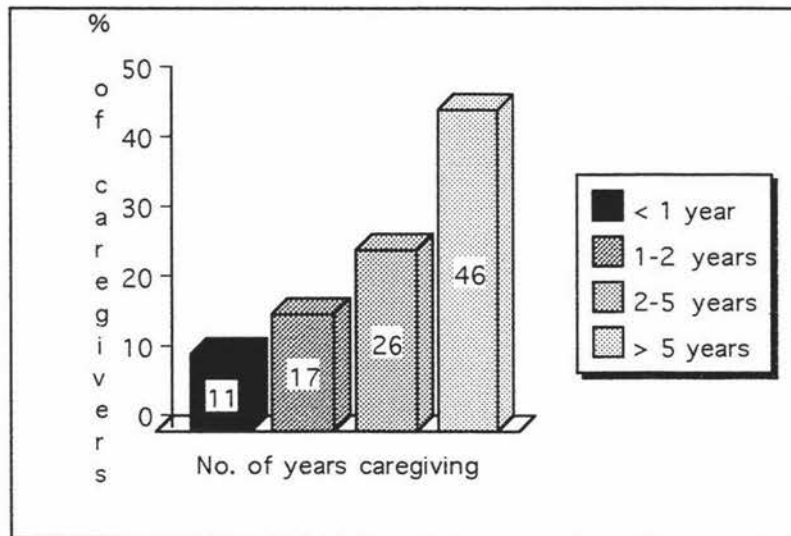


Figure 3 shows the total numbers of foster children for whom respondents ($N=111$) have provided care. It can be seen from this graph that the largest number of caregivers ($n=36$, 32.4%) have provided care for fewer than 6 children, followed closely by 6-10 children ($n=33$, 29.7%), and 11-29 children ($n=31$, 27.9%), with a sharp decline to the number of caregivers who have provided care for 30 or more children ($n=11$, 9.9%). The mean total number of children in care was 2.16 ($SD=1.12$).

Figure 3. The total number of foster children cared for by caregivers.

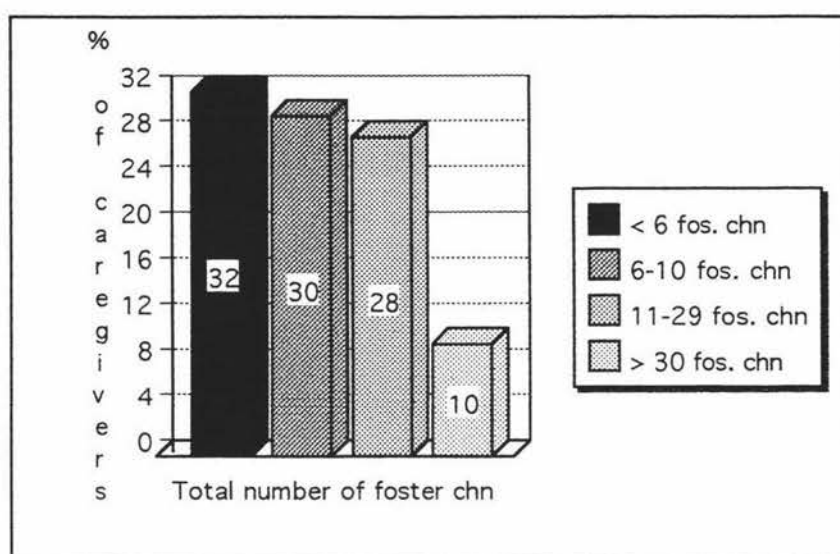
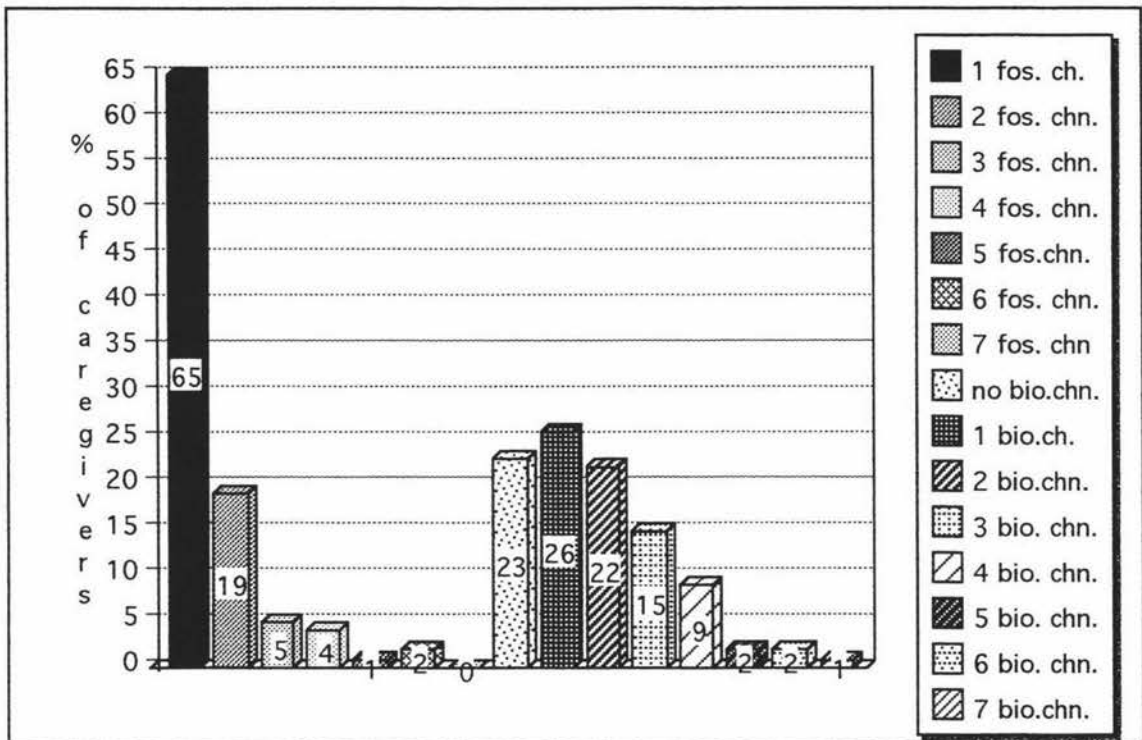


Figure 4 shows that a total of 26 caregivers (22.8%) had no biological children living at home and that five (4.4%) caregivers had no children currently in care. The graph indicates that the majority of caregivers ($n=74$, 64.9%) were providing care for one child, with the numbers of children in the care of one caregiver concurrently decreasing sharply after two children. The numbers of biological children per caregiver were spread more evenly, with most respondents ($n=30$, 26.3%) having one biological child living at home, down to one (.9%) respondent who had seven of her own children at home. The mean number of biological children was 1.81 ($SD=1.57$, Mode = 1); the mean number of children currently in care was 1.50 ($SD=1.08$, Mode = 1).

Figure 4. Numbers of children in care compared to caregivers' children.



A total of 111 respondents indicated their age on the questionnaire. Figure 5 shows that caregivers' ages ranged from 20-29 years (n=10, 9.0%) to 70-79 years (n=2, 1.8%), with the majority falling between 30-39 years (n=40, 36.3%) and 40-49 years (n=42, 37.8%).

Figure 5. The percentage of caregivers in each age group.

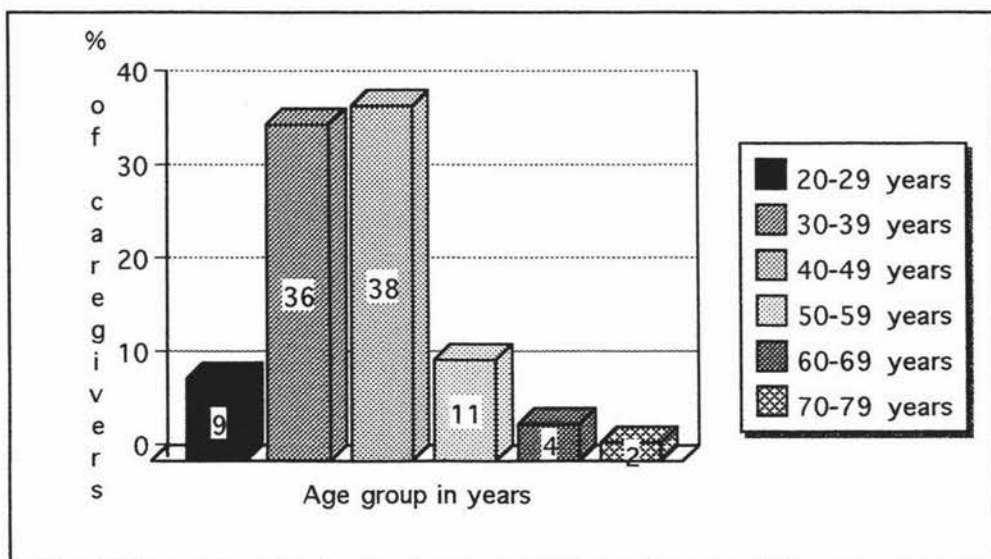
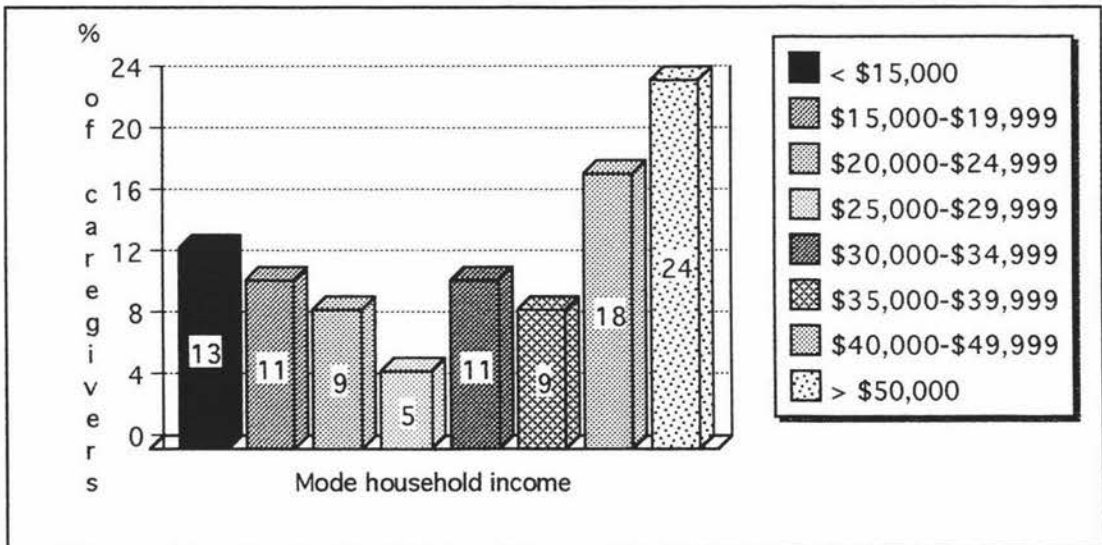


Figure 6 indicates the categories of household incomes and the percentage of respondents that are in each category. A total of 110 (96.5%) respondents indicated their household income category. It can be seen from this graph that the the highest percentage of caregivers (24.5%, n=27) have a household income of \$50,000 or more. This is followed by the \$40,000 to \$49,999 category with 18.2% (n=20) caregivers, the \$15,000 or less category with a percentage of 13.6% (n=15), and the \$15,000 to \$19,999 category with a percentage of 10.9% (n=12).

Figure 6. The percentage of caregivers according to household income.



5.1.1 Correlations involving Demographic Variables

There were no formal hypotheses linking the demographic data with the study variables. However, it was anticipated that caregiver age, time caregiving and the total number of children cared for (work experience), the presence of biological children, and level of household income would be correlated with caregiver wellbeing and satisfaction.

Pearson's correlations were carried out between the study variables and the following demographic variables: caregiver age (CG Age), caregiver gender

(CG Gen), time spent caregiving (Time CG), total number of foster children (Tot Fos), the number of current foster children (Fos Chn), the number of biological children (Bio Chn), and household income (HHI). The results are presented in Appendix D.

The suggestion that caregiver age would be associated with job satisfaction and wellbeing was not upheld. However, caregiver age (CG Age) was positively associated with the caregivers' positive perceptions of children's behaviour and needs (CHB) ($r = .24, p < .01$). That is, the older the caregiver, the more positively he/she perceived the behaviour and needs of the child in care.

The suggestion that the total number of children cared for (Tot Fos) would be associated with psychological wellbeing (AFFII) was upheld ($r = .22, p < .01$). That is, respondents with greater caregiving experience were more likely to experience higher levels of psychological wellbeing.

The number of caregivers' biological children (Bio Chn) was positively correlated with the positive effects of caregiving on the caregiver's own family (CGF) ($r = .38, p < .001$), and also with psychological wellbeing (AFFII) ($r = .26, p < .01$).

Other correlations were nonsignificant.

5.2 Descriptive Statistics for the Study Variables

Means and standard deviations for the CGQ, the CGQ subscales, the AFF II, and the APQ are presented in Table 1. As there are no normative group scores available for the CGQ or the parent endorsement section of the APQ no comparisons can be made with the present means and standard deviations for those measures. However, a comparison of the AFF II scores with those of the Flett-Power (Kamman & Flett, 1983) sample ($M=1.43, SD=1.08$) indicates that

the present sample displayed a high level of positive psychological wellbeing.

Table 1. Means and standard deviations of the major study variables.

	Mean	Std dev
Caregiver Experience Questionnaire (CGQ)	142.85	19.10
Psychological Wellbeing (AFF II)	2.25	.84
Parenting Practices (> 6yrs old) (APQ)	146.76	11.77
Foster Child's Behaviour and Needs (CHB)	19.23	3.74
CGQ Subscales:		
Total Support (TOTS)	68.24	13.05
Social work support (SWS)	38.28	8.79
Caregiver Job Satisfaction (CGS)	31.51	3.74
Relationship with Foster Child's Natural Family (CHF)	10.39	2.47
Effect of Caregiving on Caregiver's Family (CGF)	9.96	2.40
Caregiver Professional Status	17.25	3.29

5.3 Caregivers' Perceptions of their Caregiving Experiences

Frequencies and chi-square statistics on raw item scores for the Caregiving Experience Questionnaire (CGQ) are shown in Tables 2-7. In instances of negatively worded items in the CGQ, the primary variable of interest was how many respondents disagreed with it; that is, how many respondents had positive caregiving experiences with regard to those items. Therefore, in Tables 2-7, the negatively worded items are reworded in the positive so that all responses to the affirmative can be indicated by the "agree/agree strongly" category.

Chi-square tests for independent samples compared the frequencies of

caregivers in categories of those who "agree/agree strongly" with the item statements versus "others" (uncertain, disagree, or disagree strongly). The Questionnaire items are grouped according to the following subscales: Total Caregiver Support (TOTS); Social Work Support (SWS); Caregiver's Perception of Foster Child's Behaviour and Needs (CHB); Caregiver Job Satisfaction (CGS); Caregiver's Relationship with the Foster Child's Natural Family (CHF); Effects of Caregiving on the Caregiver's Own Family (CGF); and Caregiver's Professional Status (CGP).

The percentages of male and female respondents according to their primary motive for caregiving are presented with comparative findings from other studies (Rowe et al., 1984; Gilligan, 1996) in Table 8.

5.3.1 Total Caregiver Support

As can be seen in Table 2, respondents generally reported that they felt supported by the various sources of formal and informal support that were available to them, although there were some specific areas in which large minorities of caregivers reported that they would have liked more support.

Overall, respondents felt supported by their social workers in that their advice was perceived as helpful and supportive (n=77, 67.5%) (Q.2), they could be contacted by phone when their assistance was needed (n=85, 74.6%) (Q.8), and they were receptive to caregivers discussing their work-related needs with them (n=82, 71.9%) (Q.12). A majority (n=70, 61.4%) of respondents found that there was someone "neutral and qualified" there to listen when they felt the need to "let off steam about caregiving" (Q.23), with 73 (64.1%) respondents reporting that their social workers understood how difficult the caregiver's task really is (Q.19). A very high number (n=96, 84.2%) of respondents felt that their skill and commitment as caregivers were recognised and valued by their respective agencies (including social workers) (Q.18).

Table 2. Comparison of frequencies of responses to Total Caregiver Support (N = 104 to 114).

Total Caregiver Support	Agree/ Agree strongly %	Others * %	X ² (df = 1)	p
Q.2. Helpful support & advice from social worker.	67.5	32.5	14.035	.007
Q.5. Satisfied with amount of background information.	19.3	80.7	42.982	.000
Q.7. Training prepared me .	62.3	37.7	6.877	.009
Q.8. Social worker is available when needed.	74.6	25.4	27.509	.000
Q. 10a. Support from relatives.	68.4	31.6	15.474	.000
Q.10b. Friends & neighbours support me.	77.2	22.8	33.719	.000
Q.12. Can talk to social worker about my needs.	71.9	28.1	21.930	.000
Q.13. Can get suitable babysitters.	53.5	46.5	1.309	.253
Q. 17. Lack of parental rights does not make the work more difficult.	45.6	54.4	.877	.349
Q.18. My caregiving skills are valued by the agency.	84.2	15.8	53.368	.000
Q. 19. Social workers understand how hard caregiving is.	64.1	35.9	8.982	.003
Q. 23. There is somebody neutral & qualified there to listen.	61.4	38.6	5.930	.015
Q. 25a. Satisfied with social work support re foster child's behaviour	49.1	50.9	.035	.851
Q. 25b. Satisfied with social work support re my own child/children.	50.0	50.0	.000	1.000
Q.25d. Satisfied with social work support re the child's natural family.	47.4	52.6	.221	.638
Q. 25e. Satisfied with social work support re a child's return home.	39.5	60.5	2.143	.143
Q. 28. There are other sources of support I find helpful.	65.0	35.0	10.140	.001
Q. 32. Respite care is available if I need it.	60.5	36.0	7.127	.008
Q. 35. Caregiving work assisted by contributions of multi disciplinary team.	39.5	60.5	4.681	.030

* uncertain/disagree/disagree strongly

Relatively low numbers of respondents were satisfied with the amount of social work support they actually received in some areas, particularly assistance with management of the foster child's behaviour and needs (n=56, 49.1%) (Q.25a), with management of their own child/children (n=52, 50%) (Q.25b), with their relationship with the child's natural family (n=54, 47.4%) (Q.25d), and with a child's return to its natural family (n=45, 39.5%) (Q.25e). Furthermore, 69 (60.5%) respondents were confident that respite care would be available if they really needed it (Q.32).

The support available to caregivers through training and preparation was not perceived as adequate by all of the respondents. Although a majority (n=71, 62.3%) of caregivers reported that their formal training had prepared them sufficiently for caregiving work (Q. 7), only 22 (19.3%) respondents indicated that they had received sufficient background information regarding the foster child at the beginning of the placement (Q.5). In addition, fewer than half of the respondents (n=52, 45.6%) thought that their lack of parental rights had not made the caregiving task more difficult (Q.17).

A number of respondents reported receiving additional support from sources other than social workers; these ranged from informal sources such as other caregivers, church and prayer groups, and extended family, through to more formal sources such as the Family and Foster Parents Association, the Special Education Service, the Maori Mental Health Team, psychologists, and counsellors. A majority (n=74, 65.0%) of caregivers indicated that they received support from such sources (Q.28) although only 45 (39.5%) felt that their caregiving work was consistently assisted by the contributions of a multidisciplinary team (Q.35).

The majority of the respondents reported that they received social support in relation to their work, with a high number (n=88, 77.2%) experiencing the support of friends and neighbours (Q.10b), and slightly fewer (n=78, 68.4%)

reporting support from relatives (Q.10a). In spite of the high levels of social support reported, just over half (n=61, 53.5%) the caregivers found that they could get a suitable babysitter who could “cope with the child.” (Q.13).

5.3.2 Caregiver Job Satisfaction

Table 3 shows the respondents' perceptions with regard to their satisfaction with caregiving work.

Table 3. Comparison of frequencies of responses to Caregiver Job Satisfaction (N = 113 to 114).

Job Satisfaction	Agree/ Agree strongly %	Others*	X ² (df =1)	p
Q. 4. Caregiving is more or less what I expected.	80.7	19.3	42.982	.000
Q. 16. My caregiving skills enable me to provide good childcare.	97.4	2.6	102.316	.000
Q. 21. My morale is not lowered by abuse allegations being made against caregivers.	63.2	36.8	7.895	.005
Q. 24. I would definitely do it again.	83.3	16.7	50.667	.000
Q. 26. I get a great deal of satisfaction from caregiving.	90.3	9.7	74.246	.000
Q. 29. The demands & stresses of caregiving do not make me feel dissatisfied.	71.0	29.0	20.211	.000
Q. 30. I feel as though I am a valued member of a team.	73.7	26.3	25.579	.000
Q. 34. My ability as a caregiver improves the longer I do this work.	85.0	15.0	55.230	.000

* uncertain/ disagree/ disagree strongly

Overall, a very high proportion (n=103, 90.3%) of caregivers derived “a great deal of satisfaction” from their work (Q.26), with 95 (83.3%) indicating that they would “definitely” want to do the work again (Q.24). Almost all

(n=111, 97.4%) of the respondents were confident in their competency as caregivers (Q.16), in the continuing improvement of their skills (n=96, 85.0%) (Q.34), and in their contribution to the child-care process being valued by the “team” (n=84, 73.7%) (Q.30). On the whole, the respondents reported that their job satisfaction and morale were not affected by the “demands and stresses” of caregiving (n=81, 71.0%) (Q.29), although fewer, but still well over half (n=72, 63.2%) (Q.21) said they were not affected by the escalation of abuse complaints and allegations.

5.3.3 Caregiver’s Perception of Foster Child’s Behavior and Needs

Table 4. Comparison of frequencies of responses to Caregiver’s Perception of Child’s Behaviour and Needs (106 to 114).

Children’s Behaviour and Needs	Agree/ Agree strongly %	Others* %	χ^2 (df = 1)	p
Q. 9. Feel sure of how to respond to foster child’s difficult behaviour.	44.8	55.2	1.263	.261
Q. 14. Foster child has a realistic view of why he/she is in care and is comfortable about this.	56.1	43.9	2.286	.131
Q. 22. Can see progress foster child has made.	81.2	18.8	43.750	.000
Q. 27. Usually understand what is going on in foster child’s head.	30.7	69.3	16.982	.851
Q. 33a. Foster child has emotional &/or behavioural difficulties.	71.0	29.0	18.925	.000
Q. 33b. Foster child’s behaviour & emotional functioning has improved while in my care.	70.8	29.2	18.264	.000

* uncertain/ disagree/ disagree strongly

Table 4 indicates the respondents’ perceptions of the foster child’s behaviour and needs. A majority (n=76, 71.0%) of caregivers had children in their care

whom they considered to have behavioural and emotional difficulties (Q.33a). A notable feature of the data on the respondents' views of children's functioning is the large proportion (n=91, 81.2%) of respondents who reported that the children had made "real progress" (Q. 22), and that the children's functioning had improved since coming into their care (n=75, 70.8%) (Q.33b).

The respondents indicated that the management of the children in their care was not without its difficulties: less than half the respondents (n=51, 44.8%) felt sure of how to respond to "something difficult the child" had "said or done" (Q.9), and only 35 (30.7%) were "often" able to understand what was "going on in the child's mind" (Q.27). Sixty four (56.1%) respondents were confident that the children in their care had a "realistic view of why they were in care" and were "comfortable about this" (Q.14).

5.3.4 The Caregiver's Relationship with the Foster Child's Natural Family

Table 5 indicates the respondents' perceptions of their relationship with the foster children's natural families.

Table 5. Comparison of frequencies of responses to Caregiver's Relationship with Foster Child's Natural Family (N =109 to 114).

Caregiver's Relationship with child's Natural Family	Agree/ Agree strongly %	Others* %	X ² (df =1)	p
Q.3. I think that contact with the foster child's natural family is worth the effort.	34.2	65.8	8.817	.003
Q. 20. I see myself as part of a team which holds the child in trust for its parents.	83.3	16.6	50.667	.000
Q. 36. On the whole I get on well with the foster child's natural parents.	75.2	24.8	27.752	.000

* uncertain/ disagree/ disagree strongly

Overall, the respondents (n=82, 75.2%) felt that they got on well with the children's natural parents (Q.36), and a large proportion (n=95, 83.3%) saw themselves as holding the children "in trust for their parents" (Q.20). Only 39 (34.2%) respondents consistently thought that their contact with the natural family was "worth all the effort" (Q.3).

5.3.5 The Effects of Caregiving on Caregivers' Own Families

Table 6 indicates respondents' perceptions of how their caregiving work affects their own families. A very high number (n=104, 91.2%) of respondents reported that "overall", caregiving had been a "worthwhile experience for everyone" in their families (Q.6).

Table 6. Comparison of frequencies of responses to the Effects of Caregiving on Caregiver's Own Family (N =99-114).

Effects of Caregiving on Caregiver's Own Family	Agree/ Agree strongly %	Others* %	χ^2 (df = 1)	p
Q.1. I am not concerned that my own children may suffer because of my caregiving work.	49.5	50.5	.010	.920
Q. 6. Caregiving has been a worthwhile experience for everyone in my family.	91.2	8.8	77.509	.000
Q. 13. I am able to get a babysitter who can manage our foster child.	53.5	46.5	1.309	.253
Q. 31. My foster child's behaviour can lead to life being awkward or uncomfortable for our family.	40.3	59.7	3.252	.071

* uncertain/ disagree/ disagree strongly

Nevertheless, there were some specific concerns about the effects on families: only half (n=49, 49.49%) of the respondents were not concerned that their children "may suffer" as a result of their caregiving (Q.1); 46 (40.3%)

respondents thought that the foster child's behaviour did not make life "awkward or uncomfortable" for their families (Q.31); and 61 (53.5%) respondents indicated that they had access to suitable babysitters (Q.13).

5.3.6 Caregivers' Professional Status

Table 7 indicates respondents' perceptions of their professional status as caregivers. Overall, respondents had a positive view of their professional status with a total of 96 (84.2%) caregivers feeling that their professional skills were recognised by their agencies (Q.18), and 84 (73.7%) seeing themselves as part of a team in which their contributions to the child-care process were valued (Q.30). Fewer respondents had positive attitudes about the financial and administrative aspects of out-of-home care: 64 (56.1%) respondents thought that caregivers should receive a professional wage (Q.15), and only 48 (42.1%) were satisfied with the current system of board payments (Q.11).

Table 7. Comparison of frequencies of responses to Caregiver's Professional Status (N = 113 to 114).

Perceptions of Caregiver Professional Status	Agree/ Agree strongly %	Others* %	X ² (df = 1)	p
Q. 11. I am satisfied with the amount and method of payment of board allowances.	42.1	57.9	2.558	.110
Q. 15. Caregivers should be paid a wage over and above the cost of board.	56.1	43.9	1.719	.190
Q. 18. My caregiving skill and commitment are valued by the agency I work for.	84.2	15.8	53.368	.000
Q. 30. I feel as though I am a member of a team which values my contribution to the decision-making processes regarding the foster child.	73.7	26.3	25.579	.000

* uncertain/ disagree/ disagree strongly

5.3.7 Motives for Caregiving

Table 8 presents the percentages of male and female caregivers and their spouses according to their professed single most important motive for caregiving.

Table 8. Primary motive for becoming a caregiver.

	Female Caregivers			Male Caregivers		
	This study (n=107)	Gilligan* (n=61)	Rowe** (n=133)	This study (n=57)	Gilligan* (n=49)	Rowe** (n=93)
	%	%	%	%	%	%
I wanted to help under privileged children.	56.0	67.2	36.0	56.1	77.5	44.0
I wanted a child//more children.	4.7	11.5	29.0	5.3	4.1	16.0
I knew of a child who needed a home.	8.4	9.8	11.0	8.8	4.1	9.0
Because of my childhood experiences.	6.5	0	5.0	5.3	2.0	7.0
I knew of others who were caregivers.	0	0	0	1.7	0	0
I wanted to adopt but couldn't.	.9	3.3	2.0	0	0	3.0
I/my spouse wanted a job at home.	.9	1.6	2.0	3.5	2.0	1.0
Our own children were grown up.	0	0	3.0	0	0	0
Other reasons***	22.4	6.5	12.0	19.3	10.2	15.0

* Data reproduced from an Irish study, Gilligan (1996), Table 1, p.95.

** Data reproduced from an English study, J.Rowe et al. (1984), Table 4.3, p.64.

*** Other reasons from this study include:

- I felt called by God to foster
- To offer Christian compassion and to serve others
- We wanted to share the good things we had
- We felt we had something to offer
- It was important to my spouse

The percentages were calculated separately for male (n=57) and female (n=107) caregivers who were either respondents, or spouses/partners of respondents who responded to Item 37, Reasons for Becoming a Caregiver. The findings from the present study are presented with comparative findings from the two other studies (Rowe et al., 1984; Gilligan, 1996) which used the same instrument (Rowe et al., 1984).

A total of 76 (76/107, 71.02%) female caregivers and a total of 40 (40/57, 70.17%) male caregivers selected altruistic items which included the following: "I wanted to help underprivileged children" (female n=60/107, 56.0%; male n=32/57, 56.1%); "I knew of a child who needed a home" (female n=98/107, 91.6%; male n=5/57, 8.8%); and "because of my own childhood experiences" (female n=7/107, 6.5%; male n=3/57, 5.3%). A total of 24 (24/107, 22.4%) female caregivers and 11 (11/57, 19.3%) male caregivers selected "other" reasons which included items such as: "I felt called by God to foster" (female n=6/107, 5.6%; male n=3/57, 5.3%); "to offer Christian compassion and to serve others" (female n=3/107, 2.8%; male n=1/57, 1.75%); or "to share the things we had" (female n=4/107, 3.74%; male n=1/57, 1.75%).

A total of 7 (7/107, 6.54%) female caregivers and 6 (6/57, 10.53%) male caregivers selected egoistic items which included the following: "I wanted a child/more children" (female n=5/107, 4.7%; male n=3/57, 5.3%); "I knew of others who were caregivers" (female n=0/107; male n=1/57, 1.7%); "I wanted to adopt but couldn't" (female n=1/107, .9%; male n=0/57); "I/my spouse wanted a job at home" (female n= 1/107, .9%; male n= 2/57, 3.5%); "Our own children were grown up" (female n=0/107; male n=0/57).

5.4 Hypothesis One: Relationships between Perceptions of Caregiving Experiences and Psychological Wellbeing

Pearson's product moment correlations were conducted and an indication of

the relationships between caregivers' perceptions of their positive caregiving experiences, psychological wellbeing, and parenting practices are shown in Table 9. Table 9 shows the correlation matrix involving the CGQ, the CGQ subscales (Caregiver Job Satisfaction (CGS), Social Work Support (SWS), Total Support (TOTS), Caregiver Professional Status (CGP), Effects of Caregiving on the Caregiver's Family (CGF), and the Caregiver's Relationship with the Foster Child's Natural Family (CHF), the Caregiver's Assessment of the Foster Child's Behaviour and Needs (CHB)), the Affectometer 2 (AFF II), and the Alabama Parenting Questionnaire (APQ).

5.4.1 Relationships Involving Caregivers' Job Satisfaction (CGS)

The data shows significant positive relationships between caregivers' job satisfaction (CGS) and: perceptions of total support (TOTS) ($r = .5790$, $p < .001$), perceptions of social work support (SWS) ($r = .5006$, $p < .001$), perceptions of professional status (CGP) ($r = .5222$, $p < 0.001$), perceptions of the positive effects of caregiving on their own families (CGF) ($r = .3665$, $p < 0.001$), perceptions of a positive relationship with the foster child's natural family (CHF) ($r = .3690$, $p < 0.001$), and a positive assessment of the foster child's behaviour, needs, and progress ($r = .2479$, $p < .01$). Caregivers' job satisfaction (CGS) was also significantly related to their psychological wellbeing (AFF II) ($r = .2789$, $p < .01$). Other correlations were nonsignificant.

5.4.2 Relationships Involving Social Work Support (SWS)

Respondents' perceptions of received social work support (SWS) was also significantly positively correlated with: perceptions of their professional status (CGP) ($r = .6149$, $p < 0.001$), perceptions of the positive effects of caregiving on their own families (CGF) ($r = .2524$, $p < 0.001$), perceptions of a positive relationship with the foster child's natural family (CHF) ($r = .3760$, $p < 0.001$), and psychological wellbeing (AFF II) ($r = .2301$, $p < .01$).

Table 9. Pearson's Product Moment Correlations between the Caregiver Experience Questionnaire (CGQ), the CGQ subscales, the Affectometer 2, and the Alabama Parenting Questionnaire.

	CGQ	CGS	SWS	TOTS	CGP	CGF	CHF	CHB	AFFII	APQ
CGQ	1.0000									
CGS	.7126**	1.0000								
SWS	.8709**	.5006**	1.0000							
TOTS	.9456**	.5790**	.9477**	1.0000						
CGP	.7137**	.5222**	.6194**	.7099**	1.0000					
CGF	.4466**	.3665**	.2524**	.2791*	.1646	1.0000				
CHF	.5871**	.3690**	.3760**	.4845**	.5189**	.3171**	1.0000			
CHB	.1622	.2479*	-.0025	.0025	-.1464	-.0050	-.1402	1.0000		
AFF II	.2905**	.2789*	.2301*	.2451*	.1676	.1397	.1686	.1368	1.0000	
APQ	.0858	.2104	.0049	-.0263	-.0003	.1597	.0481	.3110**	.4425**	1.0000

Key:

CGQ - Caregiver Experience
Questionnaire
AFFII - Affectometer 2
APQ - Alabama Parenting Questionnaire

CGQ Subscales:

CGS - Caregiver Job Satisfaction
SWS - Social Work Support
TOTS - Total Support
CGP - Caregiver Professional Status
CGF - Effects of Caregiving on Caregiver's
Family
CHF - Relationship with Foster Child's
Natural Family
CHB - Foster Child's Behaviour and Needs

* $p < .01$

** $p < .001$

Other correlations were non-significant.

5.4.3 Relationships Involving Total Support (TOTS)

Respondents' perceptions of the total support (TOTS) they received in their caregiving work was significantly positively correlated with: job satisfaction (CGS) ($r = .5790, p < 0.001$), perceptions of caregiver professional status (CGP) ($r = .7099, p < 0.001$), perceptions of a positive relationship with their foster child's natural family (CHF) ($r = .4845, p < 0.001$), and perceptions of the positive effects of caregiving on their own families (CGF) ($r = .2791, p < 0.01$). Caregivers' total support (TOTS) was also significantly related to psychological wellbeing (AFF II) ($r = .2451, p < .01$). Other correlations were nonsignificant.

5.4.4 Relationships Involving the Caregiver's Relationship with the Foster Child's Natural Family (CHF)

There were significant positive correlations between caregivers' positive perceptions of their relationship with the foster child's natural family (CHF) and: (a) their perceptions of professional status (CGP) ($r = .5189, p < 0.001$), and (b) their perceptions of the positive effects of caregiving on their families (CGF) ($r = .3171, p < 0.001$). Other correlations were nonsignificant.

5.4.5. Relationships Involving Caregivers' Psychological Wellbeing (AFFII)

Respondents' perceptions of how happy they had felt (AFF II) were significantly positively correlated with their perceptions of their overall caregiving experiences (CGQ) ($r = .2905, p < 0.001$). More specifically, there were significant positive correlations between respondents' psychological wellbeing (AFF II) and: job satisfaction (CGS) ($r = .2789, p < 0.01$), perceptions of total support (TOTS) ($r = .2451, p < 0.01$), and perceptions of social work support (SWS) ($r = .2301, p < 0.01$). The levels of psychological wellbeing (AFF II) experienced by caregivers was also positively correlated

with their positive parenting practices (APQ) ($r = .4425, p < 0.001$). Other correlations were nonsignificant.

5.5 Hypothesis Two: Relationships Involving the Parenting Practices of Caregivers

The data shows a significant positive relationship between positive parenting practices of caregivers (APQ) and a positive assessment of the foster child's behaviour, needs, and progress (CHB) ($r = .3110, p < 0.001$). The use of positive parenting practices (APQ) was also positively related with respondents' psychological wellbeing (AFF II) ($r = .4425, p < 0.001$). Other correlations were nonsignificant.

5.6 Multiple Regression Analyses

In summary, the correlations described above provide partial support for hypotheses 1 and 2. A significant association was found between caregivers' experiences of their professional needs being met and psychological wellbeing; more specifically, positive relationships were found between higher levels of (a) total support, (b) social work support, (c) job satisfaction, and higher levels of psychological wellbeing. However, there were no other significant associations to support subsections (d), (e), and (f) of hypothesis 1. Significant associations were also found between caregivers' psychological wellbeing, foster children's behaviour and needs and caregivers' parenting practices.

Multiple regression analysis was used to identify the most salient predictors for psychological wellbeing, taking into account all of the variables that were significantly correlated (including demographic variables) with psychological wellbeing. Similarly, multiple regression analysis was also used to identify the variables that were most likely to contribute to job satisfaction.

5.6.1 Predictors of Psychological Wellbeing

To identify the most salient predictors of caregiver psychological wellbeing, a multiple stepwise regression analysis was performed in which psychological wellbeing (AFF II) was regressed onto social work support (SWS), total support (TOTS), job satisfaction (CGS), the child's behaviour and needs while in care (CHB), parenting practices (APQ), the total number of foster children since commencing caregiving (TOTFOS), and the total number of biological children in the household (BIOCHN). Residual analysis revealed that all of the assumptions required for multiple regression were met. Results, including beta coefficients, their *t* values, the total variance explained by the equation (adjusted R^2), and the *F* values are presented in Table 10.

Table 10. Multiple Regressions of Psychological Wellbeing on Social Work Support, Total Support, Job Satisfaction, the Child's Behaviour and Needs, Parenting Practices, Total Number of Foster Children, and Number of Biological Children in the Household.

Variable	Beta	<i>t</i>
Social Work Support	.17	1.16
Total Support	.19	1.35
Job Satisfaction	.08	.54
Foster Child's Behaviour and Needs	.03	.27
Parenting Practices	.41	3.51**
Total Number of Foster Children	.25	2.27*
Number of Biological Children in Home	.24	2.07*

Adjusted $R^2 = .25$, $F = 3.28^{**}$

* $p < .05$; ** $p < .01$; *** $p < .001$

The regression results in Table 10 show that three variables were contributing significantly to the variance of psychological wellbeing. Caregivers' parenting practices, with a beta coefficient of .41, $p < .01$, was the most salient predictor of psychological wellbeing, followed by the total number of foster children since commencing caregiving (beta coefficient of .25, $p < .05$), and the number of caregiver's biological children in the home (beta coefficient of .24, $p < .05$).

5.6.2 Predictors of Job Satisfaction

To identify the most salient predictors of caregivers' job satisfaction, a multiple stepwise regression analysis was performed in which job satisfaction (CGS) was regressed onto psychological wellbeing (AFF II), social work support (SWS), total support (TOTS), effects of caregiving on the caregiver's family (CGF), professional status (CGP), the caregiver's relationship with the child's natural family (CHF), and the child's behaviour and needs while in care (CHB). Residual analysis revealed that all of the assumptions required for multiple regression were met. Results, including beta coefficients, their t values, the total variance explained by the equation (adjusted R^2), and the F values are presented in Table 11.

The regression results in Table 11 show that four variables were contributing significantly to the variance of job satisfaction. The main contributor was perceived total support received (beta coefficient of .39, $p < .01$), followed by the caregivers' perceptions of professional status (beta coefficient of .35, $p < .01$), the positive effects of caregiving on the caregiver's family (beta coefficient of .21, $p < .05$), and caregivers' positive perceptions of the children's behaviour, needs, and progress (beta coefficient of .20, $p < .05$).

Table 11. Multiple regressions of Job Satisfaction on Psychological Wellbeing, Social Work Support, Total Support, the Effects of Caregiving on the Caregiver's Family, Professional Status, Relationship with the Child's Natural Family, and the Foster Child's Behaviour and Needs.

Variable	Beta	<i>t</i>
Psychological Wellbeing	.04	.36
Social Work Support	.19	1.59
Total Support	.39	3.21**
Effects of Caregiving on Caregiver's Own Family	.21	2.10*
Caregiver's Professional Status	.35	2.78**
Relationship with Foster Child's Natural Family	-.00	-.02
Foster Child's Behaviour and Needs	.20	1.18*

Adjusted R² = .40, F = 6.89***
 * $p < .05$; ** $p < .01$; *** $p < .001$

5.7 Hypothesis Three: Differences between Caregivers with Altruistic and Egoistic Motives

A high number of caregivers (n=104, 91.2%) from the total number of CGQ respondents (not including spouses/partners) indicated that their primary motive for caregiving was of an altruistic nature, while only 10 (8.8%) caregivers held more egoistic motives. A high proportion (n=76, 73.1%) of the former group cited "wanting to help less fortunate and under-privileged families and children" as their main motive for caregiving, with smaller numbers maintaining that they were doing it because of their "own childhood experiences" (n=13, 12.5%), or for "other" reasons such as: "God called me to foster" or "we wanted to share the good things we had" (n=15, 14.4%). The group with egoistic motives was divided evenly between those "who wanted to

work at home" ($n=5$, 4.38%) or who "wanted a child/more children" ($n=5$, 4.38%).

Between groups t -tests were conducted to test for differences between the mean scores of caregivers with altruistic motives and caregivers with egoistic motives on the CGQ, the Job Satisfaction subscale (CGS), and the Affectometer 2 (AFF II). There was no significant difference between the mean scores of the altruistic group ($M = 143.86$, $SD = 18.31$, $n = 104$) and the egoistic group ($M = 132.30$, $SD = 24.68$, $n = 10$; $t(112) = 1.85$, $p > .05$) on the CGQ. No significant difference was found between the mean scores of the two groups on caregiver job satisfaction (CGS) (altruistic group mean = 31.57, $SD = 3.65$, $n = 104$; egoistic group mean = 31.00, $SD = 4.77$, $n = 10$; $t(112) = .54$, $p > .05$). There was also no significant difference between the mean scores of the two groups on psychological wellbeing (AFFII) (altruistic group mean = 2.26, $SD = .83$, $n = 104$; egoistic group mean = 2.14, $SD = .94$, $n = 10$; $t(112) = .43$, $p > .05$).

5.8 Differences Between the Agencies:

Planned comparisons were conducted to test for differences between the mean scores of the five agencies on the following measures: the CGQ; the Job Satisfaction subscale (CGS); the Professional Status subscale (CGP); the Affectometer 2 (AFF II); the APQ. The alpha level was adjusted to .005 reflecting the number of comparisons per variable (i.e.10).

The results revealed that there was a trend towards a difference between the mean scores of the OHF (Wellington) group and the ACROSS group in their perceptions of their professional status (CGP): OHF caregivers tended to hold more positive perceptions of their professional status (CGP) ($M = 18.37$, $SD = 3.21$, $n = 54$) than the ACROSS caregivers ($M = 13.60$, $SD = 3.29$, $n = 5$; $t(57) = 3.17$, $p < .01$).

The results also indicated that there was a significant difference between the mean scores of the OHF (Wellington) group and the CYPS group in their perceptions of their professional status (CGP). The OHF group was found to hold significantly more positive perceptions of professional status (CGP) ($M = 18.37$, $SD = 3.21$, $n = 54$) than the CYPS group ($M = 15.57$, $SD = 2.69$, $n = 30$; $t(82) = -4.06$, $p < .001$). Other comparisons were nonsignificant.

6.1 Summary of the Major Findings

The main objective of the present study was to examine caregivers' perceptions of their caregiving experiences: how well supported they feel in their work, how well their professional needs are met, and their job satisfaction, and to investigate the relationship between these factors and caregivers' psychological wellbeing.

Overall, caregivers endorsed high levels of support, job satisfaction and commitment to their work, of feeling valued by their agencies, and of the children in their care showing signs of improvement and progress. Given the current trends in out-of-home care in New Zealand, as outlined in the Introduction, these findings provide somewhat unexpected and encouraging evidence that caregivers rate many of their caregiving experiences positively. The increasing trends toward more disturbed children requiring out-of-home care (Or, 1995; Worrall, 1996; Kenny & Foster, 1997), the reduction of State responsibility and spending in social services and the subsequent effects on social work practice (Laurensen, 1994; Worrall, 1996; Kenny & Foster, 1997), and the increasing demands and expectations made of caregivers (Laurensen, 1994; Or, 199; Smith, 1997c), have led out-of-home care in New Zealand to be described as being in "crisis" (Smith, 1997a).

Notwithstanding these national trends, and the fact that 71% of the current respondents assessed the children in their care as having behavioural and emotional difficulties, the present findings showed that approximately seven out of ten respondents felt supported by their social workers and other sources of support, and eight out of ten felt valued by their agencies. Perhaps even more surprising is that nine out of ten viewed caregiving as highly satisfying and considered the experience as being worthwhile for their families.

Furthermore, these high levels of support and job satisfaction were positively related to higher levels of psychological wellbeing. These findings are indirectly supported by research which shows that the level of support afforded to caregivers is related to successful placement outcomes, caregiver retention, and in some cases, their satisfaction (Berridge & Cleaver, 1987; Klee & Halfon, 1987; Steinhauer et al., 1989; Chamberlain et al., 1992; Berridge, 1994; Bradley & Aldgate, 1994; Ramsay, 1996; Sellick, 1996).

However, perhaps more importantly, regression analysis revealed the most important predictor of psychological wellbeing to be positive parenting practices. In addition, the support and job satisfaction variables were less important in this multiple regression, whereas the total number of children a caregiver had fostered, and the number of biological children living in the home were found to be more important predictors of caregiver wellbeing. In light of the present findings, it is possible to suggest that positive parenting skills provide a buffer against some of the stresses and demands of caregiving, and that the associated wellbeing may provide caregivers with a resilience which better equips them to rear larger families and provide care for more children.

The present findings suggest that support and training which aims at assisting caregivers with developing parenting strategies may be particularly useful. Whether caregivers' parenting skills are learned through formal training, self-education, vicariously, or a combination of these, research shows that behaviour management training can accelerate skill development to displace experience (Chamberlain et al., 1992). Therefore, the wider implication of the present findings is that caregivers, the children placed in their care, and their biological children, are all likely to benefit from the provision of training and support for positive parenting practices.

The present findings are supported indirectly by other research The ability of

caregivers to manage common behaviour problems, and withdrawn and aggressive behaviour, has been shown to be more predictive of successful outcomes for children in care (Cautley & Aldridge, 1975; Stone & Stone, 1983; Rowe et al., 1984), and the use of positive parenting practices is associated with benefits for children's functioning (Arnold et al., 1993; Smith, 1994; Shelton et al., 1996). Parker (1966), George (1970), and Berridge and Cleaver (1987) also found that better placement outcomes were associated with caregivers having more caregiving experience. However, these articles found that the presence of caregivers' biological children in the household had a destabilizing influence on placements.

The present study also found that support may be most fruitful in assisting the development of caregiver satisfaction. Multiple regression analysis revealed perceptions of total support to be the most important predictor of job satisfaction, followed by caregivers' perceptions of their professional status, positive effects of caregiving on their families, and positive perceptions of children's behaviour, needs, and progress. Thus, areas where support, particularly social work and agency-based support, may be beneficial include: (a) treating caregivers as professionals, (b) alerting caregivers to the effects of caregiving on their own families, (c) assisting caregivers to respond appropriately and effectively to the behaviour and special needs that often characterize children who come into care.

Support for this set of findings is provided by research which has found that high levels of social work support, and full caregiver involvement in case discussions and the exchange of relevant information contributed to caregiver satisfaction (Bradley & Aldgate, 1994; Ramsay, 1996), and that foster children's improved functioning played a role in caregiver satisfaction (Gilligan, 1996). Thus, support and training that focuses on assisting caregivers with parenting skills, how to seek support, how to help their own

families anticipate and cope with the arrival of a foster child, and promoting caregivers' professional status may assist caregivers in feeling more satisfied and committed in their work.

When the multiple regression findings are considered jointly, formal and informal support (including training) for caregivers' work-related needs becomes a more salient factor, not only for caregivers' increased wellbeing and satisfaction, but also for ensuring that the foster children's behavioural and psychological needs may be better met, and for minimizing any negative effects of caregiving on caregivers' own children and families. The high rate of children's behavioural and emotional problems in out-of-home care, and the associated difficulties experienced by some of the respondents in the present study illustrate the challenges faced in caregiving work, and they also underlie the importance of support and training if caregivers are to carry out their work effectively.

Overall, the respondents felt supported in their work by social workers, agencies, and informal sources of support. Approximately seven out of ten caregivers felt that they received helpful advice and support from social workers, that their social workers were accessible when they needed assistance, and that they felt comfortable talking to them about their needs as caregivers. Furthermore, more than four out of five felt that their skills were valued by their agencies. These findings are consistent with similar findings in some of the research (Rowe et al., 1984; Bradley & Aldgate, 1994; Gilligan, 1996; Ramsay, 1996; Sellick, 1996), although other research shows that social workers are not perceived as being readily available, supportive, or helpful (Keane, 1983; Berridge & Cleaver, 1987; Bebbington & Miles, 1990; Worrall, 1996). Large proportions of respondents also reported several additional sources of support that were available to them which they found helpful (such as neighbours, friends, family, church, and professional groups).

The respondents' perceptions regarding job satisfaction were also generally very positive. More than four out of five respondents agreed that they got a "great deal of satisfaction" from their work, that caregiving had fulfilled their expectations, and, knowing what they know now, "would definitely do it again". More than seven out ten expressed satisfaction with caregiving in spite of the "demands and stresses" involved, and almost two thirds indicated that their morale was not affected by the currently escalating abuse allegations against caregivers. A point of interest that has emerged from the current research is that in spite of caregivers' responses to items regarding job satisfaction reaching uniformly high levels, large minorities also reported that they would have liked more support in some specific aspects of their work. The present findings suggest, therefore, that even in the face of work-related dissatisfactions, there are a number of protective factors whose presence is predictive of increased levels of wellbeing and satisfaction in caregivers.

Although the findings discussed thus far constitute the major findings of the present study, they do not preclude the fact that some caregivers also had serious concerns. In fact, there were a number of specific areas in which respondents' levels of responses were less than ideal, although in most cases over 50% continued to hold positive perceptions. In particular, large minorities expressed concern about the wellbeing of their own children, and about their inability to always respond appropriately to difficulties with their foster children. A majority (two thirds) expressed doubts as to whether contact with the children's natural families was worthwhile, and a similar high proportion felt that their work had been hampered by being given insufficient preplacement information about the child. It is not surprising, therefore, that half of all the respondents reported that they would have liked more social work support in these aspects of their work. Approximately one half also indicated their dissatisfaction with the financial aspects of caregiving. The present findings are consistent with a large number of studies which revealed that some

caregivers are dissatisfied with the quality of some aspects of social work support, particularly with providing help in these areas: managing the foster child's behaviour, assisting in meeting their own children's needs, receiving adequate preparation and background information prior to the child's placement, and with a child's leaving the placement and returning home (Rowe et al., 1984; Berridge & Cleaver, 1987; Bebbington & Miles, 1990; Gilligan, 1996; Worrall, 1996; Pithouse & Parry, 1997; Strover, 1997)..

6.2 Hypothesis One: Caregiving Experiences and Psychological Wellbeing

Findings provided mixed support for the hypothesis that caregivers' perceptions of positive caregiving experiences are associated with higher levels of psychological wellbeing. The total CGQ measure and the following CGQ subscales were significantly related to psychological wellbeing: Caregiver Job Satisfaction, Social Work Support, and Total Support. However, the subscales of Professional Status, (Positive) Effects on the Caregiver's Family, (Positive) Relationship with the Child's Natural Family, and (Positive Perceptions of) the Child's Behaviour and Needs were not significantly related to psychological wellbeing. A possible reason for the lack of relationship may have been the low number of items in each of the non-correlated subscales, whereas the CGQ measure overall, and the subscales which showed positive relationships contained more items. In order to investigate further the possibility of relationships between these variables, a more extensive examination of the constructs of caregivers' professional status, their relationships with the children's natural families, and the effects of caregiving on caregivers' families is required. The use of more comprehensive measures may help. On the other hand, these constructs may not be as strongly related to wellbeing when compared with other factors.

As previously noted, the issue of caregivers' psychological wellbeing has not

been addressed in the research literature. Hence it was not possible to directly relate the present findings to other research. However, it has been established that there are benefits for children in out-of-home care when caregivers are adequately trained, prepared, and supported in their work, (Smith, 1997a; 1997b), and when they apply positive parenting skills (Smith, 1994). The present findings provide support for the hypothesis that there may also be some benefits for caregivers when these factors are present.

As discussed in Section 6.1, an unexpected finding of the present study was that psychological wellbeing is best predicted by parenting practices, and also by greater caregiving experience, and the number of caregivers' own children in the household. Notwithstanding these results, the current findings also indicate that there were positive relationships between respondents' total support, social work support, job satisfaction, and psychological wellbeing. This suggests that caregivers' wellbeing is more likely to be elevated if they are well supported from a number of sources, and experience job satisfaction.

These findings are indirectly supported by studies focusing on general psychological wellbeing, which suggest that wellbeing is related to frequency of contact and availability of both emotional and tangible assistance, and that the quality of interpersonal relationships has often been found to be the single most important predictor of wellbeing (George & Fillenbaum, 1985, cited in Maxwell et al., 1990; Maxwell et al., 1990). In such studies the "quality" of support rather than "amount" of contact has been emphasized (George & Fillenbaum, 1985, cited in Maxwell et al., 1990; Maxwell et al., 1990). In addition, caregiving-related studies have found that when support is practical and helpful, and takes the caregiver's needs into account, it is associated with more successful placement outcomes (Rowe et al., 1984; Gilligan, 1996; Ramsay, 1996). Therefore, it is also likely that caregivers' psychological wellbeing may be related to the "success" (i.e. if stable and full-term) of the

placement, when “quality” support is available.

Furthermore, if caregivers perceive that they have a good working relationship with their social workers and other support systems (e.g. fellow-caregivers), so that the supporter is regarded as a “fellow team member”, confidante, or friend, then the quality of the support is likely to be more conducive to the recipient’s psychological wellbeing (Bailey, 1998). Research shows that the “collaborative” approach, in which a good working partnership is developed between the caregiver, the social worker, the agency, and sometimes other professionals, is associated with more successful placements (Stone & Stone, 1983; Aldgate & Hawley, 1986; HMSO, 1991; Bradley & Aldgate, 1994; Berridge, 1996). More than seven out of ten respondents in the present study reported that they found it “easy” to talk to their social workers, that their caregiving skills were appreciated, and that they felt like a valued member of the professional team, which suggests that a “friendly”, “collaborative” style of social work support was experienced by many of the respondents.

Job satisfaction and psychological wellbeing were positively related, with those caregivers who experience satisfaction with their work also enjoying higher levels of wellbeing. This relationship was expected to occur, as a number of studies have established that satisfaction with work impacts on both self-esteem and wellbeing (McIntosh, 1985, cited in Maxwell, 1990). However, as previously discussed in Section 6.1, while the overall perception of general job satisfaction by respondents was high, there were also relatively large minorities which expressed dissatisfaction with some aspects. The present results are not consistent with research which has shown that when caregivers feel inadequately supported, trained, informed, and consulted, it is more likely that they will become disillusioned, and that the placements will break down (Keane, 1983; Rowe et al., 1984; Berridge & Cleaver, 1987; Berridge, 1994). Instead, the findings are consistent with Gilligan’s (1996) which show that one

in three caregivers identified similar areas in which their professional needs were not adequately met, yet nine out of ten in that study registered definite job satisfaction.

Notwithstanding some dissatisfaction, it was found that a significant number of respondents perceived that they received high levels of general support, that their professional competence was valued by their agencies, that caregiving had been worthwhile for their families, and that their foster children had made progress, all of which acted as moderators for satisfaction. These findings are supported by research which shows that occupational status, autonomy and control, feelings of competence, and relationships among fellow workers are variables associated with job satisfaction (Mortimer, 1979, cited in McClelland, 1986). Caregivers in specialized and professional schemes also report that high levels of support and full caregiver involvement in the process of consultation and case planning contribute to their job satisfaction (Bradley & Aldgate, 1994; Ramsay, 1996). Furthermore, Gilligan (1996) suggests that a meaningful relationship between the caregiver and the child in care, the child's progress, and the caregiver's perception that his/her contribution has helped, may play a role in caregiver satisfaction. It can also be argued that if the factors contributing to caregivers' dissatisfaction are addressed, such as sharing relevant pre-placement information, providing specialized training for behaviour management, or improving methods of allowance payments (McClelland, 1986), caregivers may also experience a concomitant increase in their psychological wellbeing.

6.3 Hypothesis Two: Parenting Practices, Children's Behaviour and Needs while in Care, and Psychological Wellbeing.

As hypothesized, positive relationships were found between higher levels of positive parenting practices and caregivers' more positive assessments of the behaviour and needs of the children in their care, and also with higher levels

of psychological wellbeing. The Alabama Parenting Questionnaire was significantly related to the Child's Behaviour and Needs subscale, and also to the Affectometer 2. Increasing scores on the Child's Behaviour and Needs subscale indicated caregivers' more positive perceptions of the children's progress and improved functioning, and the caregivers' ability to relate appropriately to the children. Indirect support for the present findings is provided by research which shows that caregiver inability to manage behaviour problems is strongly associated with placement breakdown (Rowe et al., 1984; Aldgate & Hawley, 1986; Berridge & Cleaver, 1987; Smith, 1994), and that better outcomes for children in care are associated with more functional child-rearing practices (Doelling & Johnson, 1990; Smith, 1994).

Studies show that the psychological and behavioural problems of children who have been placed in care are particularly demanding for caregivers (Berridge & Cleaver, 1987; Smith, 1994; Worrall, 1996). However, with the exception of Smith's (1994) study, there is a lack of research on the parenting practices of caregivers and the implications for children in their care. Thus, the current findings were also compared to findings from research on parents and their biological children. Such studies support the present findings by showing that there is a relationship between child-rearing practices and child emotional and behavioural outcomes (Arnold et al., 1993; Shelton et al., 1996).

Inconsistent use of discipline, failure to use positive change strategies, and excessive use of corporal punishment have all been associated with child conduct problems (Frick et al., in press). Smith's (1994) study of parenting practices in out-of-home care found that authoritative parenting was associated with greater pro-social behaviour and fewer internalizing and externalizing problems in children. Thus, the use of positive parenting practices by caregivers is to be fostered, to assist in children's improved psychological, cognitive, and behavioural functioning, to enable them to benefit from their placement in out-of-home care, and to assist caregivers in

feeling better about themselves and their work.

Related to this last point, it would be expected that the use of positive parenting practices, which is consistently associated with children's improved functioning, would also be related to caregivers' psychological wellbeing, which incorporates feelings of self-esteem, positive affect, self-efficacy, and a sense of intimacy with others (Kamman & Flett, 1983). Research shows that psychological health is particularly affected by satisfaction with oneself and with one's work (McIntosh, 1985, cited in Maxwell et al., 1990). Thus, caregivers who use positive parenting strategies with children are likely to increase their feelings of self-efficacy, self-esteem, and positive affect by effecting control (i.e. increased mastery) over their immediate environment (i.e. over the behaviour of children in the household), and by seeing evidence for its effectiveness over the longer term in the children's improved behaviour and social relationships.

On the other hand, Flett (1986, cited in Maxwell et al., 1990) found that psychological wellbeing is negatively correlated with stressful life events, such as major failures, loss of social support and "tense times". Such events could well include the experiences of caregivers who are unable to manage conduct problems of children in their care. This may result in the caregivers (and their families) feeling frustrated, stressed, and with negative feelings about themselves, the child, and the placement (Rowe et al., 1984). While this is likely to occur as a result of a complex interplay of events (including factors such as increasingly disturbed children being in care), the current results suggest that inadequate parenting practices are likely to be a major contributing factor to increasing stress.

The present findings are preliminary and point to a need for further examination of this important aspect of caregiving. Given that the use of positive parenting practices is significantly related to the improved behaviour

of children in care, and further, that it is the most salient predictor of caregivers' psychological wellbeing, it is evident that parenting practices play a pivotal role in positive outcomes for both caregivers and children in caregiving relationships. The present finding thus has important implications for the training and support of caregivers, for their job satisfaction and commitment to their work, and indirectly, for the benefit of all members of the caregiving family.

6.4 Hypothesis Three: Differences between Groups with Altruistic or Egoistic Motives

The present study did not support the hypothesis that caregivers with altruistic motives would be more likely to have more positive caregiving experiences, higher job satisfaction, and higher psychological wellbeing than caregivers with egoistic motives. Hence, there were no differences between the groups of caregivers with altruistic or egoistic motives on any of the selected variables. However, while no support was evident for the hypothesis, it must also be stated that almost all respondents reported altruistic motives, and very few (i.e. less than 10%) reported egoistic motives.

Seven out of ten respondents in the present study reported an altruistic motive as their main reason for caregiving which is higher than the findings of Rowe et al., (1984) (six out of ten respondents), and lower than Gilligan's (1996) (eight out of ten respondents). This relatively high level of altruistic motivation was based on the following responses: "I wanted to help underprivileged children", "I knew of a child who needed a home", or "Because of my own childhood experiences". One in five respondents in the present study endorsed the "other" category as their main motive for caregiving. Interestingly, all of the items in this category were "altruistic" in nature: "I felt called by God to do this work"; "To offer Christian compassion and to serve others"; "We felt we had something to offer families who were in need"; "We

wanted to share the good things we had”; and “It was important to my spouse”. When these responses are included in the overall findings, the level of altruistic motives becomes extremely high, with nine out of ten males and more than nine out of ten females professing such motives. Unfortunately Rowe et al., (1984) and Gilligan (1996) do not describe the content of caregivers’ responses to the “other reasons” category in their studies, thus preventing further comparisons with the present findings being made. Gilligan (1996) suggests that the predominance of the Roman Catholic faith and the rural nature of the sample of caregivers in his study may explain that study’s high rates of altruism. It can also be hypothesized that the affiliation of a high number (n=84, 73.68%) of caregivers in the present study with Christian-based agencies may have similarly contributed to the high degree of altruism, particularly when one considers the religious nature of the “other” items.

There is a noticeable difference between the findings of Rowe et al. (1984) and the present study regarding caregivers’ responses to the item “I wanted a child/more children”, which is considered an egoistic motive. Rowe et al. (1984) found that 29% of female and 16% of male respondents professed this item as their main reason, whereas only 4.7% of females and 5.3% of males from the current study did so. This contrast may reflect different recruitment criteria for selecting caregivers between agencies in Rowe et al.’s (1984) study and the current study. Gilligan’s (1996) findings (11.5% female and 4.1% male) for this item are closer to the present findings, which suggests that contemporary caregiver selection criteria may be more successful in excluding potential caregivers who view caregiving as a means of fulfilling their need for a child. However, other reasons are also possible (e.g. sampling bias).

Motivation is seen by agencies and social workers as a key issue in caregiving (Rowe et al., 1984; Dando & Minty, 1987; Polaschek, 1997). A

major focus in the recruitment of caregivers in New Zealand is assessing their primary reasons for wanting to do caregiving work, with the desire to assist children and young people being viewed as preferable to more self-serving needs (Polaschek, 1997). The rationale for this preference is that more altruistic motives are believed to be related to more positive placement outcomes. However, Rowe et al. (1984) point out that it is unlikely that the “all-important unconscious needs” of caregivers can be uncovered in recruitment interviews (p. 63). Furthermore, a relationship between motives and placement outcomes has not yet been demonstrated convincingly in the literature. While some studies (Kraus, 1971; Hampson & Tavormina, 1980) show an association between altruistic motives and “successful” outcomes, and egoistic motives and less “successful” outcomes, others (Kay, 1966; Rowe et al., 1984; Dando & Minty, 1987) show no clear association between types of motives and placement outcomes. Although the present study was not able to examine respondents’ motives in relation to placement ratings or outcomes, it lends indirect support to Kay’s (1966), Rowe et al.’s (1984), and Dando and Minty’s (1987) findings by showing that no significant differences exist between the groups with altruistic and egoistic motives on any of the selected variables.

However, there is a major limitation of the present findings concerning the size ($n=10/114$, 8.8%) of the group with egoistic motives: the group may not have been large enough to achieve the power required to reach significance in the present statistical analyses. Although the mean scores of the altruistic group were greater than those of the egoistic group on each of the tested variables, there may not have been a sufficient number in the egoistic group for the results to reach statistical significance. Thus, a replication of the present study would achieve more reliable results by using a sample which included more respondents with egoistic motives.

6.5 Caregivers' Perceptions of their Caregiving Experiences

The findings from the CGQ offer an indication of how respondents view their caregiving experiences in terms of the following: formal and informal support; training and preparation; professional status; job satisfaction and commitment; effects of caregiving on their own families; and relationships with the natural families of the children in care. The findings also reveal the caregivers' perceptions of the progress and current functioning of children in their care, and whether they feel able to respond appropriately to the children's behaviour and needs.

6.5.1 Formal and Informal Support

As previously discussed in Sections 6.1 and 6.2, the major finding was that caregivers in the current study generally felt supported by their social workers and agencies. However, there were large minorities, and in a few cases majorities of respondents, reporting that some specific needs were not well met. Sellick's (1996) review of a number of out-of-home care studies found that the provision and quality of social work support varied considerably within studies. A consistent finding across studies has been dissatisfaction voiced about the following areas: inadequate preplacement information, inadequate training and support in behavioural management, and in meeting their own children's needs, and inadequate support when a foster child returns home.

Additional sources of support were considered to be accessible to two thirds of the respondents in the present study, and ranged widely from prayer and church groups to specialist services such as the Special Education Service and the Maori Mental Health Team. Nevertheless, three out of five respondents felt that their work was made "more difficult" by the efforts of the "multidisciplinary team". This is upheld by other research which shows that increasing numbers of children in care require special interventions, but that

many cases are dealt with inadequately, or not at all, due to insufficient resources, and a lack of joint-planning and exchange of information with all involved services, including caregivers (Klee & Halfon, 1987; Worrall, 1996).

The mutual support that caregivers can give each other through professional organizations such as the New Zealand Family and Foster Care Association (NZFFCA), was valued by fewer than one in six respondents in the current study. By contrast, Gilligan (1996) found that almost two thirds of all respondents valued the opportunity to meet with other caregivers, and that four out of five were members of the Irish Foster Care Association. This contrast in findings may be due to the rural and more community-focused nature of the former group, or to other factors relating to the respective professional organizations such as their perceived usefulness and effectiveness. It is worth noting that a number of the current respondents reported feeling supported in their caregiving needs by church and prayer groups, which may have precluded their need to seek group support from other sources, such as the NZFFCA.

More than three quarters of all respondents reported relying on the understanding and support of friends and neighbours, with slightly fewer receiving similar support from relatives. These findings are consistent with research which shows that caregivers regard informal support provided by friends, neighbours and relatives as important (Bradley & Aldgate, 1994; Gilligan, 1996; Worrall, 1996). However, Gilligan's (1996) study of caregivers in rural Ireland found that a greater proportion of respondents felt supported by relatives, family, and babysitters compared to current study participants, which may also be explained by the greater levels of mutual supportiveness that may be present in such rural communities.

6.5.2 Caregivers' Job Satisfaction

It was pointed out in the literature review in Chapter Three that caregiver job satisfaction has tended to be interpreted through indicators such as caregiver retention, and stability and/or length of placements, rather than through the caregivers' "positive affective response" to their job as assessed directly in the present study (Locke, 1976, cited in Jones et al., 1996). This anomaly in the definition of caregiver job satisfaction poses some difficulty in relating the present findings to much of the research.

The present study revealed high levels of job satisfaction, morale, perceived self-competency, and professionalism. Almost all of the respondents were highly satisfied with and committed to their work, were confident in their caregiving skills, and perceived that their professional skills were improving over time. More than eight out of ten felt that their skills were valued by their agencies, and three quarters felt that they were regarded as "valued members of a team". A slightly lower proportion, almost two thirds, reported that their morale was not affected by abuse allegations against caregivers. While positive, this also indicates that a third of the respondents felt affected by such allegations.

It is of interest that almost half the present sample have been caregivers for more than five years, and over two thirds for more than two years. This supports the likelihood that the majority of respondents were experienced, committed to their work, and perhaps had developed a resilience, which caregivers who experience lower levels of satisfaction do not have. This is consistent with research which found that placements are more "vulnerable" during a caregiver's first year of work, and that caregivers are more likely to leave at this stage through lack of support and high dissatisfaction (Hampson & Tavormina, 1980; Berridge & Cleaver 1986; Aldgate & Hawley, 1986).

6.5.3 Caregivers' Professional Status

There were mixed findings regarding respondents' views of their professional status. On the one hand, more than seven out of ten respondents endorsed high levels of feeling professionally involved in a "partnership" role in which they were valued by their social workers and agencies. However, on the other hand, more than half were not satisfied with the amount and method of board and clothing allowance payments, and a similar proportion disagreed with the current system of non-payment of caregivers for their services. Meadowcroft (1989) found a similar discrepancy when investigating the professional aspects of caregiving.

The recent research literature indicates a growing trend toward a more accountable and professionalized model of out-of-home care. Caregivers are now expected to manage serious behaviour problems, to be more involved with children's families, and to work with social workers and other professionals in case management (Dawson, 1989; McKenzie, 1993; Kenny & Foster, 1997). The present findings appear to endorse this model of caregiver professionalism, and are also consistent with the findings of Bradley and Aldgate (1994) which revealed that over two thirds of caregivers felt that they had made a significant contribution to the planning of placements. On the other hand, more respondents express ambivalence concerning remuneration.

The present findings also suggest that the majority of respondents have made, or are making, the transition from the concept of the "family substitute" model of care to a more "open" model which promotes a professional partnership between the caregiver, the agency, and the child's parents/family. However, the general conclusion drawn from the literature is that the "partnership" model remains a theoretical "ideal" rather than the general practice (Pithouse & Parry, 1996; Ramsay, 1996; Laurensen, 1997). The current findings run

counter to this conclusion. However, it must be noted that the present research did not investigate, using objective criteria, whether the children's families are actually included in various aspects of the consultation and decision-making processes, as in the true partnership model.

Nevertheless, Smith (1994) and McKenzie (1993) argue that the traditional connotation of caregiving being seen as "women's charitable work" is still present, occurring alongside the newer expectations of professional standards and accountability. Support for this view is clearly provided by the current findings in which the respondents indicate high levels of regard for their "professional" involvement, but more than half report dissatisfaction with their financial status. Respondents were clearly divided over the issue of payment. In addition, the large percentage (75%) of respondents from Christian-based agencies may have inflated the number of respondents who did not support the issue of "payment", as some may have viewed caregiving as a Christian responsibility (i.e. based on altruism) which did not justify payment. An equally contentious issue was that of board and allowance payments. Gilligan's (1996) findings were comparable, with almost half of the respondents reporting dissatisfaction with the administration of financial allowances for the support of children in care.

The overall levels of household income in the present study may also have affected some respondents' opinions regarding payment and board allowances, with higher-income respondents not experiencing the same financial burden as others. The majority of respondents had a household income of over \$30,000, with almost one in four being in the over-\$50,000 category, and the same proportion being in the under-\$20,000 category. The present findings did not support other findings that a disproportionately high number of caregiving families fall into low income categories and also experience concomitant financial hardship (Heath et al., 1989; Smith, 1991).

6.5.4 Caregivers' Relationships with the Natural Family of the Child in Care

The present findings suggest, as did Gilligan's (1996), that a large majority of respondents are moving away from the traditional model of care in which caregivers were seen as a "substitute" family, toward the ideal of providing a "service to families" (Fein & Maluccio, 1992, p.334). However, in spite of the respondents' more enlightened and positive attitudes toward the purpose of caregiving, there was also evidence of some concern about ongoing contact with the natural families of the children in their care.

In terms of movement toward the ideal, more than four out of five respondents saw themselves as working in the interests of the child and his/her family by holding the child "in trust for its parents", and three out of four felt that on the whole, they got on well with the child's natural parents. The current findings are consistent with comparable findings in Gilligan's (1996) study. On a wider scale, the present findings are in keeping with the recent philosophical movement of out-of-home care toward "inclusive" care, in which the children's relationships with their natural families are, where possible, maintained (Kufeldt, 1993; Pithouse & Parry, 1996). Research shows that better outcomes are achieved for children when relationships are encouraged with their natural families (Begun, 1985; Prasad, 1988; Salahu-Din & Bollman, 1994). The current research does not provide direct support for these findings, but does reveal positive associations between caregivers' perceptions of their relationships with children's natural families and job satisfaction and professional status. Thus, when caregivers hold more positive views toward an "inclusive" approach, they also enjoy higher levels of job satisfaction and better regard for their professional status.

However, the present study also found that many caregivers held ambivalent attitudes toward contact with the children's families. Two out of three respondents questioned whether contact "is worth all the effort", and almost

half would have liked more support from social workers in dealing with this issue. Comparable findings from other studies (Rowe et al., 1984; Kelly, 1995; Gilligan, 1996) support the present findings. Such attitudes are more likely to be an outcome of caregivers' concerns for the children, who may be upset and react negatively after family contact, although there are other more practical inconveniences for caregivers as well (Ryan et al., 1981; Bradley & Aldgate, 1994; Gilligan, 1996). Laurensen (1997) maintains that there is often a "gap" between the theory and the practice of the inclusive model, and it is possible that the present findings may be an indication of this. However, the current study also found that when caregivers are well supported, they are more likely to feel positive about contact with the children's families. This suggests that while there are difficulties for caregivers which may be inherent in the contact process, these may improve when good support and training are provided.

6.5.5 The Effect of Caregiving on Caregivers' Own Families

Almost all of the respondents viewed caregiving as a worthwhile experience for their own families, but half also expressed concern about some adverse effects, and wanted more social work support to help them deal with their children's needs. These levels of concern are high compared to Gilligan's (1996) findings which showed that only one in five respondents expressed these same concerns.

As would be expected, the current results showed a positive association between caregivers perceiving the benefits of caregiving for their families and higher levels of satisfaction, social work support, and total support. Poland and Groze (1993) found that there are both rewards and difficulties for the biological children in caregiving families, and that the benefits are more likely to be maximized by thorough pre-placement preparation. These findings tend to buttress the present findings by showing that the biological children can both benefit and be disadvantaged by being in a caregiving family, and that

social work support may be a crucial element in assisting the family's adjustment to a new placement.

6.5.6 Caregivers' Views of the Behaviour and Needs of the Children in Care.

The present findings reveal that many of the placements were affected by difficulties: 71% of the respondents assessed that the children in their care had behavioural and/or emotional problems, and half of the respondents considered that the children understood why they were in care. (However, approximately one in four respondents were caring for children under the age of five and did not expect such young children to appreciate why they were in care). In addition, half of the respondents reported that they were "sometimes" unsure as to how to deal with particular difficulties with the children, and also wanted more social work support to assist with the children's behaviour and needs.

However, a high proportion of respondents felt that the children's functioning had improved, and four out of five could see that they had made "real progress" since coming into care. In spite of the reported high levels of behavioural difficulties, indirect evidence of the stability and duration of the majority of placements in the present study is provided by the very high levels of perceptions of children's progress and caregiver job satisfaction, plus the fact that three quarters of the placements were described as either permanent or long-term.

The present findings are consistent with those of Gilligan (1996) which found that a very high proportion of caregivers noted the children's progress and the stability of placements. Wilkinson (1988, cited in Triseliotis, 1989) found that caregivers are likely to become "disillusioned", and placements to break down if no progress in children is observed within the first 12 months. In fact, it is suggested that the caregivers' perceptions and management of the children's

behaviour are central to their attitudes toward the placement, and ultimately to its stability and duration (Rowe et al., 1984; Kelly, 1995; Gilligan, 1996).

Although there is no direct evidence for this in the present findings, there were high levels of perceived progress. In addition, almost all of the respondents were confident that they provided a “good” standard of care, and felt that their skills were valued by their agencies. The apparent stability of the long-term arrangements is also an indication of how well the caregivers were coping with their respective placements in spite of the difficulties being incurred.

It must be noted that the large proportion of respondents who reported children’s progress while in their care may be an indication of the particular group of caregivers who chose to participate in the present study, and therefore may not be a representative sample of the whole caregiver population. It is possible that a preponderance of those caregivers who experienced “success” in helping the children in their care chose also to volunteer for the present study. Therefore, in order to pursue further examination of the possible effects of children’s progress or lack of progress on their caregivers, it would be essential to gain access to a broader sample.

6.6 Differences between the Agencies

In order to maximise the representativeness of the sample, the present study sought respondents from five different agencies. The study investigated possible differences between the agencies on respondents’ perceptions of total caregiving experiences, job satisfaction, professional status, psychological wellbeing, and parenting practices. It was surmised that different social work and organizational and practices within the agencies may result in varying caregiving experiences for the respondents.

In general, no differences were found between agencies with the exception of the variable, Caregiver’s Professional Status. A trend indicated a significant

difference between the OHF (Wellington) respondents and the CYPS respondents in their perceptions of their professional status, with the OHF caregivers holding more positive perceptions than the CYPS caregivers. A significant difference between the OHF (Wellington) respondents and the ACROSS respondents was found on the same variable, with the OHF caregivers again having more positive perceptions. It must be noted, however, that the ACROSS group contained a very small number (n=5) of respondents, and that this particular finding may have been limited by the size of this group.

Nevertheless, it appears, albeit tentatively, that the OHF respondents had more favourable perceptions of their professional status and of the financial aspects of caregiving. The different attitudes of the OHF and the CYPS respondents may be a reflection of the agencies' different approaches toward the development of caregivers' professional skills, the inclusion of caregivers in casework and planning meetings, more efficient financial administration, and appreciation of the respondents' skills, and commitment. It may also be a reflection of the Christian philosophy of the OHF caregivers, who may be inclined to follow the more traditional model of "serving" in the Christian sense. It is also possible that the OHF respondents feel compensated in other positive ways for their lack of remuneration (e.g. spiritual support from church groups).

6.7 Relationships involving some of the Demographic Variables

The suggestion that selected demographic variables may be associated with job satisfaction and wellbeing was partially upheld by the current findings. However, other relationships were also found between some of the demographic variables and the study variables. An association was found between caregivers' increased age and their positive assessment of the children's behaviour, needs, and progress. Thus, when caregivers were older, they were more likely to view the children's behaviour, needs, and progress more positively. This may be a function of the increased parenting and

caregiving experience that may be expected to occur with older caregivers. Furthermore, a higher level of fostering experience (i.e. higher total number of children fostered) was found to be a significant predictor of caregiver wellbeing. Thus, if foster children's progress and caregivers' wellbeing are interpreted as indicators of placement "success", the present findings are consistent with those of Berridge & Cleaver (1987), who found that older and more experienced caregivers were associated with more successful placements.

An unexpected finding was that the number of biological children in the household was both associated with, and a significant predictor of higher levels of psychological wellbeing. The implications of these findings have been discussed within the Major findings of the Study (6.1).

6.8 Limitations of the Study

There are a number of factors which may have placed limitations on the present study.

Attempts to generalize the present findings to caregivers throughout New Zealand may be problematic because of the nature of the sample used in the study. The respondents were volunteers, which may have contributed to a biased response. It has previously been acknowledged in this thesis that a self-selection bias may have occurred in which respondents who had more positive caregiving experiences and enjoyed higher job satisfaction may have chosen to respond. As the study was dependent on voluntary participation, it was not possible to use more structured means to gain access to a sample that was representative of all caregivers. In spite of this limitation, however, the postal questionnaire method was considered appropriate because it provided access to caregivers from a variety of agencies, across several geographical areas, and assured respondents of anonymity.

Another limitation of the present study is that the data are cross-sectional and correlational. Consequently, the temporal ordering and the causality is not able to be determined. For example, it could not be established whether respondents' positive perceptions of caregiving experiences preceded an elevation in psychological wellbeing, whether psychological wellbeing occurred first, or whether either of these variables contributed to the elevation of the other. The same limitations apply to the relationships between parenting practices, job satisfaction and psychological wellbeing, or any other relationships investigated in the present study.

The caregiving experience section of the CGQ was an adaptation of Gilligan's (1996) Caregiving Questionnaire from which a number of items were excluded for the purposes of the present study, and a number of additional questions devised by the researcher were included. It was not, therefore, an a priori empirically tested psychometric instrument in which the validity had been previously tested in any comprehensive way, other than Gilligan's supportive findings. However, a Cronbach's alpha of .86 indicates that its internal reliability is quite adequate. Gilligan's (1996) measure appeared to be the only available questionnaire devised for research into caregivers' experiences; thus, it was able to provide a suitable "blueprint" for the present questionnaire as it tapped into the major constructs of interest of the present research. However, some modifications were necessary due to differences between the Irish and New Zealand out-of-home care systems, and also due to some additional emphases of interest in the present study (such as respondents' attitudes to payment).

Furthermore, a single reliable measure could not be found which was able to elicit information on the parenting practices of respondents who were currently caring for children and young people across the age range of 3 months to 17 years. As a result, the APQ (Frick, 1991) was selected on the basis that it could

be used with caregivers of children across a relatively wide age range (6-17 years), and also because it tapped the most important aspects of parenting practices rather than “dysfunctional” parenting practices or parenting styles (Shelton et al., 1996). Consequently, it was only possible to examine the parenting practices of approximately three quarters (72.80%, 83/114) of respondents (those caring for children aged 6 to 17 years). Thus, relative to other variables, analyses involving the APQ had reduced statistical power.

The present research regarding respondents’ parenting practices would also have been enhanced by the assessment of parenting practices across informants (caregiver and child in care). In fact, the APQ was designed to allow for a comparison across multiple informants and across multiple assessment modalities (Shelton et al., 1996). Such information may have provided a more comprehensive assessment of respondents’ parenting practices. In addition, the present study relies on caregivers’ own perceptions of the impact of caregiving on their own families, and does not examine the attitudes and perceptions of the children themselves. However, ethical constraints (due to opposition by the agencies on account of the amount of “intrusion” already experienced by the majority of the children in care) prevented children from being available for participation in the study. Finally, restrictions on the scope of this study, due to ethical considerations, prevented any formal assessments of the children’s functioning and adjustment to care, so that the respondents’ perceptions are to be solely relied upon. However, the present findings are supported by research which shows that children in out-of-home care are disproportionately affected by psychological, emotional and behavioural problems when compared with rates for children in the general community (Klee & Halfon, 1987; Hulsey & White, 1989; Trocme & Cauce, 1995). It must also be acknowledged that the use of self-reports does present some problems: for example, Achenbach (1991) notes that parents, teachers and children will differ on ratings of the

severity of emotional and behaviour problems. Notwithstanding, such additional information would have provided comparative material for the respondents' assessments of the children's behaviour and progress, and would also have provided an additional perspective on the respondents' perspectives in relation to the children's behaviour and needs.

6.9 Implications for Future Research

The present study provided evidence to support the potential of a sound and well-resourced development and support service for caregivers.

Consequently, more specific research is now needed to determine how caregivers' professional development and needs can be best met, so that both their wellbeing and their professional competence are fostered. As outlined in the literature review, the expectations and demands being made on the entire out-of-home child-care system are escalating rapidly at a time of increasing social and economic difficulties for families. It is essential, therefore, that research is able to inform the policy-makers and providers of out-of-home care services of the appropriate requirements of the children who need out-of-home care, of the agencies and social workers who implement and oversee the care, and not least, of the caregivers who provide the care.

More specifically, research of a longitudinal nature is required to determine relationships between key variables over time. Such longitudinal studies would be particularly useful in clarifying whether positive caregiving experiences precede enhanced psychological wellbeing, whether caregivers with more enhanced psychological wellbeing are more able to access and benefit from positive caregiving experiences, or whether it is a non-linear combination of these factors that underlies the present findings. Furthermore, given the relationship between parenting practices, caregiver wellbeing and children's progress while in care, further research now needs to examine how

caregivers best acquire these skills and whether they play a causal role in the above relationships.

The present findings have highlighted several other areas which warrant further examination. Within-New Zealand, experimentally-based research is needed to examine the specific effects of caregiver training (including “specialized” training) and support services, particularly with caregivers of more dysfunctional children and children with “special” needs. Furthermore, given the present levels of reported dissatisfaction with the financial aspects of caregiving, further research is needed to replicate the few findings that demonstrate the benefits for caregivers of payment for their work (Chamberlain et al., 1992; Berridge, 1994; Ramsay, 1996). It would also be of value to determine to what extent children in care have ongoing and satisfactory relationships with their natural families, the caregivers’ attitudes to and involvement in this process, and the special support and training that are needed by all concerned. Finally, an examination of the specific needs of the biological children of caregivers, and how these can be best met through preparation and ongoing support of the whole caregiving family, is warranted.

Research into many aspects of out-of-home care practice in New Zealand is urgently needed (Or, 1995; Worrall, 1996; Smith, 1997a, 1997c), particularly in relation to the working of the CYPF Act (1989). The present study has provided an initial attempt at assessing some of the more pertinent issues affecting caregivers, so that these in turn may be further investigated and clarified. However, while a broad range of issues was examined, the constraints set by the design of this study precluded any in-depth examination being carried out. Although quantitative research has a number of features which justify its use, it generally describes groups, not individuals, with much “detail being lost in the translation from individuals to group” (Bailey, 1998, p.53). Although the researcher was aware that the current respondents were a heterogeneous

group, made up of individuals with a wide range of experiences, skills and attitudes, only limited efforts could be made to give voice to the individual variations which emerged within the group. More research is needed, therefore, not only to determine caregiver majority views, but also to seek out the opinions of minority groups, and to examine critically the issues over which their views differ from those of other caregivers, and how these might impact on caregiving practices.

Thus, as a closing comment, there are a number of issues that warrant further consideration. There is a need for more focused, in-depth research (both quantitative and qualitative) in order to understand the interplay between caregivers' professional needs being well met and their psychological wellbeing, and between their psychological wellbeing, their parenting practices, and the improved functioning of children in their care. It is hoped that such research will result in more effective outcomes for caregivers themselves, the agencies that support them, and ultimately for the children who have been entrusted to their care.

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APPENDIX A

A Study of Out-of-family Care. What about the Caregivers?

9th March 1998

Dear Caregivers

My name is Christine Murphy. I am a student in the School of Psychology at Massey University and I am currently undertaking research in order to complete a Masters degree in Psychology.

The topic of my research is the experience of caregivers who are providing out-of-home care for children.

My interest in the topic comes from my awareness of media reports of current foster-care issues in New Zealand, and from my past experience of working with caregivers in Barnardos and with children receiving care in a local social service agency. As a parent of 4 children I also have a strong personal interest in the parenting experiences of others. Finally, I am interested in how current government policies affect families caring for children who require out-of-home care.

I am approaching you as a caregiver to ask if you would be willing to take part in this study. Attached to this letter is an Information Sheet explaining the proposed research. Also enclosed is a questionnaire which has been posted to all caregivers with current placements. If, after reading this letter and the Information Sheet, you are willing to be a participant, you are invited to fill out the questionnaire. A stamped envelope is provided for you to post the completed questionnaire back to the researcher. Your participation would be completely anonymous.

As I am including caregivers from a number of different agencies it would be useful to be able to compare the findings. In order to do this I will need to mark the front page of each questionnaire with an identifying letter (A,B,C, D, or E) to indicate which agency the caregiver works for.

Thank you.

Yours sincerely,

Christine Murphy.

APPENDIX B**CAREGIVER RESEARCH PROJECT****Information Sheet**

- The Researcher:** Christine Murphy
c/- School of Psychology
Massey University
Private Bag 11222
Palmerston North. Ph: (06) 356 9099.
- The Supervisor:** Dr Kevin Ronan
Lecturer
School of Psychology
Massey University. Ph: (06) 356 9099.

What is this study about?

This research is being undertaken for my MA thesis. The study aims to examine the professional needs of caregivers and how well they perceive themselves to be supported in their work. More specifically, it aims to find out if there is a relationship between the wellbeing of caregivers and their perceptions of the formal and informal support they receive. Also, whether or not there is any relationship between caregiver wellbeing and parenting style. Finally, it aims to gain an understanding of the role played by caregivers' motives for caregiving in these processes.

There is much research which focuses on factors relating to the stability and adjustment of children in care but there is a noticeable lack of research relating to the needs and wellbeing of caregivers. Hopefully, this study will help to identify some of the factors which contribute to the professional development and wellbeing of caregivers, and ultimately may contribute to more effective foster-care practice.

What would you have to do?

If you agree to take part, simply filling out the questionnaire will imply your consent to this research project. Participation is voluntary and you will not be asked to identify yourself in any way. The questionnaire should take approximately 40 minutes to complete.

If you take part in the study you have the right to:

- Refuse to answer any particular question, or withdraw from the study at any time.
- Expect complete anonymity throughout the course of this study.
- Expect that the researcher has no access at any time to the identity of any participant.
- Provide information on the understanding that it is strictly confidential and will be used for the research and subsequent professional publication only.
- Be given access to a summary of the findings from the study when it is concluded.
- Ask any questions about the study that occur to you (see contact numbers above).

Christine Murphy

APPENDIX C

Caregiver Research Project

Questionnaire

This questionnaire is strictly confidential.

It should take 30-40 minutes to complete.

In Part 1 we wish to get some basic background information on you and your family.

Your name and address are not required, thus ensuring your complete anonymity.

Part 2 of this questionnaire asks you to describe your caregiving experience by rating your feelings towards certain issues.

Part 3 of this questionnaire asks you to indicate your reasons for becoming a caregiver.

Part 4 is a questionnaire which indicates your preferred style of parenting.

Part 5 is a questionnaire for assessing your recent feelings of well-being.

Please return by the 24th April in the addressed freepost envelope provided.

Christine Murphy, School of Psychology, Massey University, Palmerston North

Thank You for Your Co-operation in this Project

Background Information:

1. Please tick who is completing this questionnaire?
 1. Mother
 2. Father

2. Please tick your status as a Caregiving Family:
 1. Short term (up to 2 mths):
 2. Long term (over 2mths):
 3. Permanent:

3. How many children have you provided out-of-home care for to date?

4. Please give the date you first started caregiving:

5. How many children are currently placed in your care?

(5a) Please list their age/s:

Child 1	<input type="checkbox"/> <input type="checkbox"/>	Child 2	<input type="checkbox"/> <input type="checkbox"/>	Child 3	<input type="checkbox"/> <input type="checkbox"/>
Child 4	<input type="checkbox"/> <input type="checkbox"/>	Child 5	<input type="checkbox"/> <input type="checkbox"/>	Child 6	<input type="checkbox"/> <input type="checkbox"/>

6. If you currently have more than one child placed with you please indicate their relationships to each other.
 1. Siblings
 2. Other
 3. Not related

7. How many, if any of your natural children are living in your home currently?

(7a) If you have natural children who are living at home, please list their ages:

Child 1	<input type="checkbox"/> <input type="checkbox"/>	Child 2	<input type="checkbox"/> <input type="checkbox"/>	Child 3	<input type="checkbox"/> <input type="checkbox"/>
Child 4	<input type="checkbox"/> <input type="checkbox"/>	Child 5	<input type="checkbox"/> <input type="checkbox"/>	Child 6	<input type="checkbox"/> <input type="checkbox"/>

Please turn to the other side of this page:

8. Is the child/children in the current placement related to you or your spouse/partner?

Yes:

No:

9(a). If yes, how is the child/children related to you? _____

9. Tick age of Father:

1 20-29 2 30-39 3 40-49 4 50-59 5 60-69 6 70-79

10. Usual job of Father (give full title): _____

11. Tick age of Mother:

1 20-29 2 30-39 3 40-49 4 50-59 5 60-69 6 70-79

12. Usual job of Mother (give full title): _____

13. How many adults in your household are in paid employment?

13(a). Indicate the range of your family income:

Under \$15,000:

\$15,000 to \$19,999:

\$20,000 to \$24,999:

\$25,000 to \$29,999:

\$30,000 to \$34,999:

\$35,000 to \$39,999:

\$40,000 to \$49,999:

\$50,000 or more:

The following pages contain a number of statements about life as a caregiver. Please tick the box that most closely represents your feelings on each issue.

If you are currently providing out-of-home care for more than one child, please answer any child-related questions with regard to the child you find most challenging to care for.

When did the current placement commence? _____

1. I am concerned that our own children may suffer because of our caregiving work.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

6 Not applicable

2. In general, I find my social worker/liaison worker helpful in terms of advice and support.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

3. I sometimes wonder if contact with the child's natural family is worth all the effort.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

6 Not applicable

4. I find caregiving is more or less what I expected.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

5. It would have been easier to care for the child in our care if we had been given all the background information at the beginning.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

6. Overall, caregiving has been a worthwhile experience for everyone in our family.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

7. The assessment process and quality of training did not prepare me sufficiently for what caregiving is really like.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

8. I know that my social worker/liaison worker is only a phone call away and is there if I need assistance.
- 1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree
9. Sometimes I'm not sure how to respond to something difficult the child in our care has said or done.
- 1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree
10. (a). Overall, I find that our relatives really understand and support what I do as a caregiver.
- 1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree
- (b). Overall, I find that our friends and neighbours really understand and support what I do as a caregiver.
- 1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree
11. On the whole, I am not satisfied with the amount and the method of payment of the clothing and other allowances.
- 1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree
12. I find it easy to talk to the social/liaison worker about my own needs as a caregiver.
- 1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree
13. We often find it hard to get out socially because it is difficult to get a babysitter who can cope with the child in our care.
- 1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree
14. I think that the child has a realistic view of why s/he is in care and is comfortable about this.
1. Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree
-

15. Caregivers should be paid an amount over and above the cost of board to acknowledge the time, commitment, skill, and work involved in caregiving.
- 1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree
16. I feel confident that my skill as a caregiver enables me to provide good care for the child in our care.
- 1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree
17. My work as a caregiver is made more difficult by my lack of parental rights in regard to the child in my care.
- 1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree
18. I feel that my skill and commitment as a caregiver is recognised and valued by the agency I work for.
- 1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree
19. Social workers/liaison workers have no idea how hard being a caregiver really is.
- 1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree
20. I really see myself as part of a team who holds this child in trust for its parents.
- 1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree
21. My morale as a caregiver has been lowered as a result of the complaints and allegations of abuse being made against caregivers these days.
- 1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree
22. I can see real progress that the child in our care has made since s/he came to live with us.
- 1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree

23. I often feel the need to let off steam about caregiving, but there's really nobody neutral and qualified there to listen.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

24. Knowing what I know now, I would definitely do it all over again.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

25. I would have liked more support from my social/liaison worker to help me deal with:

	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
(a) foster child's behaviour and needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) my own child's/children's feelings and behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) emergencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) foster child's natural family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) a foster child's return home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. Generally, I get a great deal of job satisfaction from caregiving.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

27. I find I am often at a loss to understand what is going on inside our foster child's mind.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

28. Apart from the social/liaison worker, I find that there are other sources of support available which I find helpful. For example: _____

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

29. The demands and stresses involved in caregiving are causing me to feel somewhat dissatisfied with caregiving as a job.

1 Strongly agree 2 Agree 3 Uncertain 4 Disagree 5 Strongly disagree

30. I feel as though I am a member of a team which values my contribution to the decision-making processes regarding the child in our care.

1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree

31. I often think that the way the child in our care behaves, leads to life being awkward or uncomfortable for our family.

1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree

32. I know that if I felt I really needed a break, I could ask for respite care and it would be provided.

1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree

33. (a) The child in our care has emotional and behavioural difficulties.

1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree

(b) During his/her time with us his/her emotional and behavioural functioning has:

1. Got worse 2. Stayed same 3. Improved

34. I have found that my ability as a caregiver has improved the longer I have been involved in caregiving work.

1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree

35. Sometimes I find that my work as a caregiver is made more difficult by the contributions of other members of the multi-disciplinary team working with the child.

1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree

36. I find that on the whole I get on well with the foster child's natural parents .

1 Strongly agree 2. Agree 3. Uncertain 4. Disagree 5. Strongly disagree

37. **Reasons for Becoming a Caregiver:**

Please tick any of the reasons which apply in your own case:

	Mother	Father
I wanted to help under-privileged children	<input type="checkbox"/>	<input type="checkbox"/>
I wanted a child/more children	<input type="checkbox"/>	<input type="checkbox"/>
I knew of a child who needed a home	<input type="checkbox"/>	<input type="checkbox"/>
Because of my own childhood experiences	<input type="checkbox"/>	<input type="checkbox"/>
I knew other people who were caregivers	<input type="checkbox"/>	<input type="checkbox"/>
I wanted to adopt but couldn't	<input type="checkbox"/>	<input type="checkbox"/>
I/my wife wanted a job at home	<input type="checkbox"/>	<input type="checkbox"/>
Our own children were grown up	<input type="checkbox"/>	<input type="checkbox"/>
Other reasons: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

Which one of the above reasons in the whole list was the most important for you:

Mother: _____

Father: _____

Please continue ...

PARENTING QUESTIONNAIRE

To be completed by caregivers of children aged 7 years or over.

Please rate each of the following statements according to how often it typically occurs in your home by ticking one of the boxes beside each statement.

	Never	Almost Never	Sometimes	Often	Always
1. You have a friendly talk with your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. You let your child know when he/she is doing a good job with something	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. You threaten to punish your child and then do not actually punish him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. You volunteer to help with special activities that your child is involved in e.g. sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. You reward or give something extra to your child for obeying you or behaving well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Your child fails to leave a note or to let you know where he/she is going	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. You play games or do other fun things with your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Your child talks you out of being punished after he/she has done something wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. You ask your child about his/her day at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Your child stays out in the evening past the time he/she is supposed to be home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. You help your child with his/her homework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. You feel that getting your child to obey you is more trouble than it's worth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. You compliment your child when he/she does something well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. You ask your child what his/her plans are for the coming day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. You drive your child to a special activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Almost Never	Sometimes	Often	Always
16. You praise your child if he/she behaves well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Your child is out with friends you do not know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. You hug or kiss your child when he/she has done something well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Your child goes out without a set time to be home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. You talk to your child about his/her friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Your child is out after dark without an adult with him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. You let your child out of a punishment early e.g. lift restrictions earlier than you originally said	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Your child helps plan family activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. You get so busy that you forget where your child is and what he/she is doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Your child is not punished when he/she has done something wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. You attend parent/teacher meetings or other meetings at your child's school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. You tell your child that you like it when he/she helps around the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. You don't check that your child comes home at the appointed time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. You don't tell your child where you are going	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Your child comes home from school more than an hour past the time you expect him/ her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. The punishment you give your child depends on your mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Your child is at home without supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. You spank your child with your hand when he/she has done something wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Almost Never	Sometimes	Often	Always
34. You ignore your child when he/she is misbehaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. You slap your child when he/she has done something wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. You take away privileges or money from your child as a punishment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. You send your child to his/her room as a punishment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. You hit your child with a belt, switch, or other object when he/she has done something wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. You yell or scream at your child when he/she has done something wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. You calmly explain to your child why his/her behaviour was wrong when he/she misbehaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. You use time out as a punishment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. You give your child extra chores or jobs as a punishment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank You Very Much for Your Co-Operation.

AFFECTOMETER 2

A RAPID INVENTORY OF SUBJECTIVE WELL-BEING

Affectometer 2 is a questionnaire for reporting how often you have certain general feelings which are related to your emotional satisfaction and life fulfilment.

There is no point in filling out this questionnaire unless you describe your own honest feelings as best you can.

The items are either sentences or adjectives which describe different feelings about yourself and your life. For each item, please check how often you have had that feeling over the past few weeks.

You have five choices for how often you have each feeling.
These are:

- not at all
- occasionally
- some of the time
- often
- all of the time

Please make a small checkmark (✓) in the box which shows how often the item applies to you. You may wish that you could choose a phrase which is in-between one of the choices given, but if you choose the one which comes closest to your experiences, your results will still be very accurate. You do not need to spend a long time on the items.

Please turn to the other side of this page...

Affectometer 2

Form B-1

Feeling	Not at all	Occasion-ally	Some of the time	Often	All the time	For Office Use
1. Satisfied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Free-and-easy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Clear-headed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Helpless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Impatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Loving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	

Form B-2

Feeling	Not at all	Occasion-ally	Some of the time	Often	All the time	For Office Use
1. Optimistic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Enthusiastic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Good-natured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Discontented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Confused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Confident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Understood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Insignificant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	

Please turn to the other side of this page...

RECENT HAPPINESS

Taking all things together, how happy would you say you have been in the past few weeks. Place a checkmark (✓) by the phrase which best describes how you have felt.

(Put ✓ by one)

- very happy _____
- happy _____
- somewhat happy _____
- mixed (about equally happy and unhappy) .. _____
- somewhat unhappy _____
- unhappy _____
- very unhappy _____

Please proceed to the next part of the questionnaire ...

Table 12. Pearson's Product Moment Correlations between the Demographic Variables and the Main Study Variables.

	CGQ	CGS	SWS	TOTS	CGP	CGF	CHF	CHB	AFFII	APQ
Time CG	-.1193	-.1384	-.2319	-.1803	-.0480	.0474	.0530	-.0107	.1743	.0400
Age CG	-.0715	-.0520	-.1661	-.0840	-.0940	-.1550	-.1260	.2440*	-.1708	-.0591
Tot Fos	-.0309	.0383	-.0359	-.0976	-.0570	.0098	.0192	.1370	.2243*	.1383
Curr Fos	.1224	.2200	.0187	.0566	.1008	.2037	.2517	.0592	-.0377	.0328
Bio Chn	.1320	.0075	.1097	.0837	.0668	.3787**	.1728	-.0988	.2641*	.0673
H/hold Inc	-.0108	-.0674	.0432	-.0123	-.0677	.1130	-.1857	.0069	.0912	.0735

Key:

* $p < .01$ ** $p < .001$

Time CG - Total length of time caregiving

Age CG - Age of caregiver

Tot Fos - Total number of foster children cared for

Curr Fos - Number of current foster children

Bio Chn - Number of caregiver's biological children at home

H/hold Inc - Caregiver's household income

CGQ - Caregiver Experience Questionnaire

CGS - Caregiver Job Satisfaction

SWS - Social Work Support

TOTS - Total Support

CGP - Caregiver Professional Status

CGF - Effect on Caregiver's Family

CHF - Relationship with Foster Child's Family

CHB - Foster Child's Behaviour and Needs

AFFII - Affectometer 2

APQ - Alabama Parenting Questionnaire