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**An analysis of the mechanisms of change in an  
intervention for caregivers in New Zealand:  
*The Fostering Security Training Programme.***

A thesis submitted in fulfilment  
of the requirements for the  
degree of Doctor of Philosophy in Psychology  
at Massey University, Wellington, New Zealand

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## ABSTRACT

Effective foster parent training and support is widely recognised as a core intervention to remediate the complex behavioural and mental health problems of foster children, and to prevent foster placement breakdowns which further exacerbate these problems. While generic parent training programmes, largely informed by social learning theory, are beneficial foster parents also need information and training specific to complex foster child attachment and trauma problems. The 10-session Fostering Security group training programme for foster parents in New Zealand provides training and support that integrates theories shown to be effective in meeting the particular needs of foster parents and foster children (i.e., attachment theory, mind-mindedness, social learning theory, neurobiological theories of trauma, abuse, and neglect, attribution theory, and theories about the mechanisms of change). It is facilitated by both mental health and child protection staff to deliver a joint interagency approach and more streamlined service to foster parents and foster children. The current mixed methods study explored the mechanisms of change in the Fostering Security programme. Quantitative findings showed that the programme was associated with positive trends in caregivers' attachment with the foster child, mind-mindedness, caregivers' dysfunctional attributions for the child's misbehaviour, stress and frustration in the caregiver-foster child relationship, and foster child's challenging behaviour at home and at school. Qualitative thematic analysis of participant interviews and evaluation questionnaires indicated six main themes: 1) support, validation, and acknowledgement from facilitators and participants; 2) effectiveness and knowledgeability of group facilitators and positive ethos of the programme; 3) improved understanding of attachment and trauma related child

behaviour problems; 4) learning strategies to manage the behaviours and developing confidence as foster parents; 5) increased participant empathy for and understanding of the foster child and reflection on the child's behaviour; and 6) increased participant reflection on own triggers, behaviour, parenting approach, and self-care. Some caregivers did not progress in the expected manner through the group training programme, and further research is indicated to identify the factors that negatively affect caregiver progress in programmes like the Fostering Security programme. This study's findings further indicated the need for follow-up interventions post-training, to sustain the positive effects of the programme. Limitations of the current study and future directions for research into the Fostering Security training programme are also discussed.

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The children in care and caregivers that I work with are a constant source of inspiration for me. I am continually amazed at how resilient young people who experience great adversity can be, and I have immense admiration for those who give up so much to try to heal these young people. One of the reasons I have found this research project so fulfilling is the fact that I can work with such inspirational people.

Working in the field of complex trauma and attachment disruptions has made me especially grateful for the love, nurturing, guidance, and support of my family. Many of us take our secure attachment relationships for granted. I would therefore like to dedicate this dissertation to my parents who sacrificed much to ensure we had the best they could provide, and to my siblings for the journey we have had together. My sisters and my best friends, Andrea and Cassandra, although so far away give me so much unconditional love, support, encouragement, and guidance. I am so thankful to have such generous, intelligent, and strong women as role models.

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## PREFACE

My interest in the area of the mental health needs of children in care began in Hastings, New Zealand, in January 2005. One of my first clients as a psychologist at the Child, Adolescent and Family Service at the Hawke's Bay District Health Board was a 5-year-old girl, Amy, who was into her sixth placement since being removed from her mother's care at 6 months of age, and was in the legal care of Child, Youth and Family. Like many other children with similar backgrounds, Amy displayed a range of challenging behaviours related to her disrupted attachments, past traumas, neglect, abuse, grief, and loss. My therapeutic work with Amy and many other children like her, and the families caring for them, led me on a journey of information-seeking and supervision to develop my skills in the area of attachment related problems.

It concerned me that the predominant mode of treatment for children with disrupted attachments and experiences of trauma at the time was largely individualised therapeutic or pharmaceutical interventions with the child. It became clear to me that caregivers needed education, support, and capacity building to understand and manage the very challenging foster children in their care, and the literature was also clear about the need to involve caregivers in therapy. It astounded me then, and still does, that as a society we place the most challenging children with caregivers and yet we do not resource, train, and support them appropriately.

I therefore adopted a model of including caregivers in weekly therapy appointments with the children. These sessions focused on helping the child process past experiences, manage present symptoms, and develop new skills in the

context of the current relationship, as well as developing the attachment relationship between caregiver and child. However, it quickly became apparent to me that the caregivers themselves had very specific unmet needs, and that the weekly hour-long therapy sessions gave insufficient time and opportunity to focus on their unique individual needs. It became clear that if the children's placements were to be successful, the caregivers needed specific time and attention to be better educated, informed, supported, and validated than they were being at the time.

Having had a prior 10-year history of facilitating parent training programmes (including the Triple P and Incredible Years parent training programmes), I had experienced the benefits of grouping people with similar needs in a training situation. While caregivers I worked with did attend these generic parent training programmes I facilitated, and found aspects of the training useful, their specific needs around managing their child's behaviours related to attachment problems, trauma abuse and neglect remained unmet. In this context, I developed the Fostering Security training programme for caregivers in 2008. The aims of the programme were to develop the therapeutic capacity of caregivers, to help them understand and manage the challenging behaviours seen in children with adverse early experiences, and to help them reflect on what they bring to the relationship and their responses to the child's behaviour. The long-term aim of the Fostering Security training (alongside individualised therapy) was, naturally, to develop more secure caregiver-child attachment relationships, and to prevent placement breakdowns.

During the first Fostering Security training programme it became clear that caregivers had many issues around Child, Youth and Family policies and practices that the mental health facilitators could not adequately address. A Child, Youth and

Family Practice Leader, Lisa Harrington, was invited to co-facilitate the Fostering Security programme with me, and this proved to be beneficial for caregivers attending the programme as well as for us as facilitators. There had historically been tensions and blame-shifting between mental health and child protection agencies, understandable in the context of professionals dealing with distressing and stressful situations involving children. Working together on the Fostering Security programme meant Lisa and I were able to learn about each other's services and roles, and this led to increased joint discussions, planning and decisions about mutual clients, with flow-on positive benefits for our clients and colleagues in our respective services. In the process of developing and refining the Fostering Security training package, questions arose for me regarding the benefits of specific aspects of the programme, as well as the mechanisms in the programme that led caregivers to change their perceptions and behaviour towards the children in their care. While there is a vast literature on the benefits of behaviourally-based parent training programmes for typical intact families, there is less of a literature on specific programmes for caregivers which incorporates attachment and other theories alongside a behavioural approach. These issues, together with the growing interest in the Fostering Security programme being delivered in other parts of New Zealand, prompted me to undertake this current research study.

The current research follows on from an informal qualitative survey of an earlier Fostering Security group which showed positive feedback from caregivers and improved psychometric outcomes in parenting and child behaviours at programme completion. Given the relatively small number of children in care in Hawke's Bay, the wide range of individual differences and needs of caregivers and the children in their care, and severity of children's behaviour, a traditional

randomised controlled trial was not indicated at this stage of the enquiry, especially as I was more interested in process issues than in outcomes. I was seeing positive results but needed more of a formative rather than a summative evaluation at this early stage. A mixed methods approach was undertaken in this study to ensure that the qualitative information obtained from caregivers about their experiences through the Fostering Security programme and their experiences with their foster children would provide a more in-depth and richer description of the mechanisms of change alongside statistical data.

A large proportion of children in care in Hawke's Bay are Māori (also reflected in national figures). As such, whatever programmes or policies are developed need to take into consideration the values, traditions and social norms of the Māori community. In this thesis I will expand on how the bi-cultural imperative was implemented in the development of the Fostering Security programme and in my research.

Through the thesis I use the term 'caregiver' to refer to foster parent, whether whānau/kin/extended family or non-whānau/non-kin/not extended family. The word whānau, used in this context, is the Māori word for immediate and extended family. For the purposes of this study, I also refer to biological parents currently caring for their children as caregivers. I use the terms 'children in care' and 'foster children' interchangeably, I use the terms 'in care' and 'in out-of-home placements' interchangeably, and the term 'children' refers both to children and young people.

In summary, my 11-year journey to learn more about the effects of trauma, abuse and neglect on young people in care, and to provide more effective and efficient therapeutic interventions to young people in care and their caregivers, has

led me to this point. From my therapeutic experience and reading, it has long been clear that appropriate training and support of caregivers is a vital component in helping young people heal from past traumas and develop more secure attachment patterns. Through my research I hope to show how the Fostering Security training programme for caregivers can help strengthen caregivers' therapeutic capacity, can improve their understanding, and parenting skill and confidence, and can develop their self-reflective capacity.



## **CHAPTER 1: CHILDREN IN CARE**

### **Outline**

This first of two chapters summarising the professional literature outlines the context for the current research study and for the Fostering Security training programme I developed for caregivers, (i.e., the issue of children in the care of the New Zealand government's Child, Youth and Family service). This chapter will discuss the prevalence and demographics of children in care in New Zealand's care and protection system, alongside some of the challenges inherent in this system. It will be shown that foster placement breakdowns and the mental health and behavioural problems that children in care can present with are linked in a negative loop, with dire mental health outcomes for these children more likely if the loop cannot be broken. This chapter will also discuss current mental health treatments for children in care, highlighting gaps with access to effective and evidence-based treatments, and further highlighting the need to look critically at current mental health services for children in care.

Chapter 2 will explore the current literature on mental health interventions for children in care that are focussed on caregivers, that is, dyadic child-caregiver therapies and caregiver training to support them and develop their skills in understanding vulnerable children in their care. Limitations of generic parent training programmes largely developed for parents of generally securely attached children in generally intact families will be discussed. As will be seen, caregivers of children with disrupted attachments and histories of trauma require more specific and focused training and support to help them to understand the foster

child's behaviour, to understand their reactions to the child's behaviour, and to implement the appropriate parenting approaches.

Chapter 3 will provide detail about the Fostering Security training programme for caregivers, outlining the programme's philosophies and aims and its cultural context within New Zealand, giving a description of the training programme, and discussing important factors and theories that need to be incorporated to make caregiver training programmes more effective. The Fostering Security programme differs from typical parent training programmes by incorporating knowledge from different theoretical sources and research areas. This ensures caregivers are not only provided with behaviour management strategies, but are also given an understanding of the following: the nature of the child's attachment difficulties, the effect of the child's traumatic experiences, the effect that the child's behaviour has on their emotions and behaviour, and their responses to the child. The current research will then be presented and discussed in Chapters 4, 5 and 6.

### **Prevalence and Demographics of Children in Care**

In New Zealand as at June 2016, there were 5,312 children (predominantly between the ages of 0 and 17) in the custody of the Chief Executive of the Ministry of Social Development with 4,394 of those in out-of-home placements (Ministry of Social Development, 2016a). Approximately 5 per 1,000 New Zealand children are in care and these figures are generally comparable to the number of children in care in other Western countries. In Australia approximately 7 per 1000 children were in out-of-home care as at June 2015 (Australian Institute of Health and Welfare, 2016). In March 2015 approximately 6 per 1,000 children in Britain were placed in

care (British Association for Adoption and Fostering, 2015). In September 2014 approximately 5.5 per 1,000 American children were in care (U.S. Department of Health and Human Services, 2015).

In Hawke's Bay, as at June 2016, there were 203 children in care, and 255 in the custody of the Chief Executive (Ministry of Social Development, 2016a). Hawke's Bay, on the East Coast of the North Island of New Zealand, accounts for about 5.1% of New Zealand's land area (Hawke's Bay District Health Board, 2016), has a population of approximately 155,000 people, and has approximately 3.6% of New Zealand's population (Statistics New Zealand, 2015).

While there are children from a number of different ethnicities in care in New Zealand, Māori are significantly over-represented. The 2013 New Zealand census statistics show that Māori constitute approximately 15% the population (Statistics New Zealand, 2015). However, of the 5,312 children in custody of the Chief Executive, 3,208 (60%) were Māori and 1,478 (28%) were New Zealand European, and of the 4,394 in out-of-home placements, 2,632 (60%) were Māori and 1,270 (29%) were New Zealand European (Ministry of Social Development, 2016). While the placement types included whānau and non-whānau placements, as well as Child, Youth and Family homes and residences, the vast majority of children were in whānau placements (2,303) and non-whānau placements (1,281) (Ministry of Social Development, 2016a).

For Cram (2012) the over-representation of Māori in negative social statistics (like children in out-of-home care) needs to be understood in the context of the legacy of colonisation, racism, and disenfranchisement. Cram (2012) asserts that New Zealand is similar to other countries that have been colonised, with the indigenous people being left culturally, spiritually and economically bereft. New

Zealand's Expert Advisory Group on Solutions to Child Poverty (2012) further link the over-representation of Māori in negative social statistics to their relative economic poverty and ensuing poorer health outcomes and lower educational achievements, among other factors.

### **New Zealand System of Care and Protection**

Child, Youth and Family is a service within New Zealand's Ministry of Social Development that is tasked with the following:

1. Keep children safe from harm, abuse and neglect and ensure their health and welfare (care and protection practice vision).
2. Ensure children and young people engaged in criminal activities are given opportunities for remediation (youth justice practice vision).
3. Ensure children and young people are adopted into safe and secure homes (adoption practice vision) (Ministry of Social Development, n.d.).

Child, Youth and Family functions predominantly under The Children Young Persons and their Families Act 1989 (Ministry of Social Development, 2013). This Act states that in all decisions about children's welfare their interests are paramount, and stresses the importance of the immediate and wider family groups being involved in decision-making about children. New Zealand is unique amongst Western countries in implementing the Family Group Conference system to ensure families are involved in this decision-making process (Doolan & Connolly, n.d.). Impetus for the introduction of the Family Group Conference also came from the concern about cultural loss when Māori children were placed in out-of-family care.

In addition, the Care of Children Act 2004 promotes the welfare and best interests of children in New Zealand, ensures that the right arrangements are made

for their guardianship and care, and recognises the rights of children (Parliamentary Counsel Office, 2018). The Vulnerable Children Act was introduced in 2014 making the heads of six government departments (i.e., police, health, education, justice, social development and child protection) accountable for improving and protecting the lives of vulnerable children in New Zealand (Parliamentary Counsel Office, 2018). Furthermore, screening and police vetting of people in the central and local government children's workforce is now mandatory and those with serious convictions are prohibited from working with children.

Child welfare systems internationally have generally shifted to keeping children within the care of extended family where possible (Connolly, 2003). This is due to a number of reasons: valuing the family as a resource in the child's life; maintaining the child's family and cultural identity; continuity and familiarity in the child's life; the reduced number of placement changes for children in the care of extended family; and the difficulty finding and keeping caregivers in the community. The Children Young Persons and their Families Act 1989 also states that children should be kept with family or whānau when possible and only removed where there is significant risk of harm (Ministry of Development, 2013). While removing children from significant harm from their parents protects them from further harm, it is usually traumatic for the children and can disconnect them from a range of social connections (i.e., neighbourhood, school, peers, extended family). Child, Youth and Family staff in Hawke's Bay report that children in care tend to seek biological family when they become older teenagers, needing to re-establish family connections.

There is much debate in the literature about the issue of moving children into care or leaving them in abusive and/or neglectful families. Doyle (2007; 2008)

found placement instability was correlated with poorer life outcomes (i.e., juvenile delinquency, adult criminal activities, teenage pregnancy, and unemployment), and that children with problematic placements tended to have better outcomes if they remain in their homes. While Doyle's 2007 and 2008 studies showed methodological problems, (i.e., a small sample size and large size of estimated effects require caution in interpretation of the results), our clinical experience at the Hawke's Bay District Health Board over the last ten years indicates some merit in his statements. Wade, Biehal, Farrelly, and Sinclair (2010), on the other hand, in their three-year follow-up of 3,872 British children in care, found that those who stayed in care fared better behaviourally and educationally. It can be seen that the issue of whether children should remain in adverse home environments or move into care is a contentious one, with evidence supporting both arguments. However, with the multitude of factors within each individual child, family and home environment, it is extremely difficult to predict, consistently and accurately, which children should be left in their adverse home environments and which children should be removed into care.

New Zealand's Ministry of Social Development commissioned the Vulnerable Children Study by the Centre for Applied Research in Economics (University of Auckland), to examine the value in using predictive risk modelling to identify children at risk of child abuse and neglect and to target preventative interventions to their families to reduce the risk (Blank et al., 2015). Predictive risk modelling is a statistical technique which combines demographic and historical data about a child and the family (e.g., mother's mental health history, parents' child protection history, presence of non-biological adult male in the house) from the child protection and welfare benefit systems into an automated algorithm,

which generates risk scores for the probability that the child will be maltreated (Vaithianathan et al., 2012). Welfare benefit data was included as 83% of children maltreated by age 5 were found to have been on the benefit system before the age of 2 (Vaithianathan et al., 2012). The Vulnerable Children Study found that the algorithm applied to children under the age of 2 had “fair, approaching good, strength” in predicting neglect or emotional, physical or sexual abuse by the time the child was 5 (Vaithianathan et al., 2012, p. 3).

There is much controversy about the ethical use of predictive risk modelling to identify children at risk (Blank, et al., 2015; Dare, 2013). Concerns about its use include: (a) privacy and confidentiality issues for families, (b) confusing correlation with causation, (c) concerns that social workers will depend on computer-generated scores instead of their own judgment, (d) Māori being more negatively affected by any negative effects of the algorithm as Māori are over-represented in child abuse statistics, (e) the possibility that identifying families at risk may increase their level of stress and therefore the potential for child abuse, (f) families at risk not on the benefit may not be identified, and (g) the individualising of larger social problems, like child poverty (Blank et al., 2015; Child Poverty Action Group, 2016; Dare, 2013; Keddell, 2015). Despite these concerns, there appear to be potential benefits of the predictive risk modelling tool to forecast those children at risk of abuse and neglect, as well as to identify families so the appropriate level of family support services are provided. At this stage no decisions have yet been made about how the predictive risk modelling tool will be used by New Zealand’s Ministry of Social Development. Blank et al. (2015) and Dare (2013) strongly recommend an ethical framework to guide agencies in the

appropriate use of predictive risk modelling to minimise any potential adverse effects of the tool.

Tarren-Sweeney's Children in Care Study (2008a) examined the mental health of 347 children in care in New South Wales, Australia, over a 15-year period. One of the key predictors for mental health problems in children in care was found to be the age at which the children entered care: children who went into care after age seven months had more problems with attention, aggression, sexual behaviour and attachment than children who went into care before age seven months (Tarren-Sweeney, 2008a). This finding is consistent with attachment theory (discussed in detail in Chapter 3) which states that, by approximately age three, the most important aspects of attachment development are negotiated (Bowlby, 1982). Given this major tenet of attachment theory, and the findings from the Children in Care Study (Tarren-Sweeney, 2008a), it follows that children at risk of abuse and neglect in their original homes need to be identified as early as feasible, and if indicated, need to be removed to secure and stable placements as soon as possible. Predictive risk modelling may be a useful adjunct in early identification of children at risk of maltreatment, providing opportunity to intervene earlier with families (Vaithianathan, 2012). However, if children are removed from the care of their parents, the crucial aspect is whether they are placed into care with caregivers equipped and skilled to cope with their difficult behaviours and provide them with consistent and stable care, or whether they experience many placement breakdowns with exacerbated behavioural and mental health problems. The most important conclusions we can draw from this are that we need to intervene early and equip caregivers to be as capable as possible in understanding the complex behaviour and emotional needs of children in care. This latter conclusion was a major impetus for

the development and initial evaluation of a caregiver training programme that is described in this thesis.

### **Frequency of and Reasons for Placement Breakdowns**

While some children in care experience placement stability, a significant percentage experience multiple placements or ‘placement drift’, and the chances of placements breaking down increase the older the child is and the longer he or she have been in care. Children in care in the United States generally move home at least once, while approximately 25% move home three or more times (Doyle, 2008). Atwool (2010) reported that, in New Zealand in December 2009, 52% of children in care had had one to three caregivers, 26% had had four to six caregivers and 22% had had seven or more caregivers. Children under the age of four who had been in care for more than two years, had an average of approximately three placements, the maximum number of placements being nine (Atwool, 2010). These numbers are deeply concerning in light of attachment theory: the evidence is that by approximately age three the most important aspects of attachment development have been established in the context of stable relationships with a few significant primary attachment figures (Bowlby, 1982). Placement stability is vital in the development of a child’s secure attachment, and this in turn is vital for the child’s cognitive, emotional and social development (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969).

Placement changes for children in care are not always related to placement breakdowns, and may actually be planned due to caregivers retiring or children only needing short periods in care (Munro & Hardy, 2007). However, the complex mental health and behavioural problems of children in care are well-documented as

contributing to placement breakdowns and resulting in unplanned moves between placements (Horwitz, Chamberlain, Landsverk, & Mullican, 2010; Jones et al., 2011; Rankin, 2010; Murray, Tarren-Sweeney, & Frances, 2011). Caregivers often report difficulty with understanding and coping with the difficult behaviours and emotions of children in their care and report that their typical parenting approaches do not appear to be as effective for children with histories of abuse, trauma, neglect, grief and loss (Murray et al., 2011). Caregivers further report high levels of stress and relational frustration with the foster child and find it difficult developing a healthy attachment relationship with a child who from previous experiences is already distrustful, rejecting of affection, avoidant, detached or indiscriminately and superficially affectionate (Atwool, 2010; Horwitz et al., 2010; Murray et al., 2011). Further factors caregivers have reported in surveys to negatively affect placements include: inadequate economic support; poor acknowledgement of the degree of difficulty of caring for children with very challenging behaviours and mental health problems; the negative impact on the caregiver's biological family; problematic relationships with professionals; not feeling valued, consulted, or respected by staff from the various agencies involved with the foster child; not given adequate background information about the foster child and the child's history; and the lack of adequate support and training to understand the range of behaviour and mood problems the foster child displayed (Atwool, 2010; Brown & Bednar, 2006; Murray et al., 2011). All these factors contribute to the destabilisation of the placement, the burnout of the caregivers, placement breakdown, and the movement of children to successive placements.

In addition, children who have unsettled home environments, due to a number of different foster placements, are likely to have problems developing

trusting relationships and secure attachments with others (Newton, Litrownik, & Landsverk, 2000). Placement breakdowns are therefore related to an increase in mental health and behaviour problems in children in care, increasing the chances that future placements will also be at risk of breakdown (Rock, Michelson, Thomson, & Day, 2015; Rubin et al., 2004; Rubin, O'Reilly, Luan, & Localio, 2007; Tarren-Sweeney, 2008b). Thus, a negative loop develops: complex mental health and behaviour problems of children in care prove too challenging for caregivers to manage and result in placements ending; placement breakdowns destabilise children in care further and their mental health and behaviour problems are exacerbated; and this increases the likelihood of future placements breaking down.

### **Mental Health Problems of Children in Care**

The complex mental health and behaviour problems children in care can present with can be understood in the context of the adverse home environments from which the majority of them are removed. In these adverse home environments the children may suffer abuse, maltreatment or neglect, and they may be exposed to transient lifestyles, domestic violence and/or drug and alcohol abuse. They are likely to suffer loss and grief, be repeatedly traumatised by their experiences, and do not obtain the emotional support and appropriate parenting that might mitigate against the effects of their traumatic experiences (Schmid, Petermann, & Fegert, 2013). Such contexts compromise the development of secure and trusting attachment relationships between parent and child (Shipman et al., 2007; Tarren-Sweeney, 2008b).

Early adverse experiences, along with a trajectory of multiple foster care placements, serve to maintain the attachment problems for children in care (Kools & Kennedy, 2003). Briere and Lanktree (2011) highlighted early psychological neglect, disconnected parents, and attachment problems as being among the most predictive issues for psychopathology. Children who are removed into care therefore tend to present with high levels of neurobiological, developmental, emotional, behavioural, and physical difficulties that are severe enough to warrant interventions from mental health and paediatric services (Jones et al., 2011; Murray et al, 2011; Tarren-Sweeney & Vetere, 2014). They tend to have more learning and language problems, and are more likely to underachieve academically than children not in care (Tarren-Sweeney, 2008b). Children in care also present with more physical health problems than children not in care, having been raised in environments that were harmful to their physical health (Meltzer, Corbin, Gatward, Goodman, & Ford, 2003).

In addition, adolescents in care have higher rates of depression and higher rates of suicide attempts than adolescents in the general population (Royal Australian & New Zealand College of Psychiatrists, 2008). Tarren-Sweeney (2010, p. 615) described the cluster of mental health problems seen in children in care under the term “complex attachment- and trauma-related symptomatology”. Such symptomatology can include attachment and social relationship problems, anxiety and stress linked to trauma and insecurity, antisocial and aggressive behaviours, sexual behaviour problems, oppositional and defiant behaviours, problems with attention and hyperactivity, and the less common problems of atypical eating behaviours and self-harm (Tarren-Sweeney, 2006; Tarren-Sweeney, 2010; Tarren-Sweeney, 2013b). Dissociative symptoms in children have also been associated

with traumatic experiences of severe physical and/or sexual abuse, as well as inconsistent, rejecting and neglectful parenting approaches (International Society for the Study of Dissociation Task Force on Child and Adolescents, 2004). The longer-term mental health outcomes for children in care are also dire, with higher risk of developing depression, substance use problems, eating problems, anxiety problems, and personality problems (Wonderlich et al., 2011). A British study found that adults who had been in foster care as children were almost twice as likely to have drug, alcohol, or mental health problems than those who had never been in care (Viner & Taylor, 2005). It follows then that early interventions to address the mental health and behaviour problems of children in care are needed to attempt to prevent these negative longer-term outcomes and associated social problems like incarceration, unemployment and homelessness.

D'Andrea, Ford, Stolbach, Spinazzola, and van der Kolk (2012) also focused on the mental health problems seen in repeatedly traumatised children (a characteristic of many children who end up in out-of-home care). van der Kolk and colleagues (van der Kolk et al., 2012) and van der Kolk et al. (2009) summarised research indicating that repeatedly traumatised and victimised children exhibited a range of problems including inaccurate attributions about themselves and others, social problems, problems with emotional and physiological regulation, attention, aggression and defiance, health, academic development, sensory perception, self-harm and risky behaviours, and inappropriate sexual behaviours. van der Kolk et al. (2012) proposed 'developmental trauma disorder' as a more accurate diagnosis than post-traumatic stress disorder to understand traumatic stress in children. The findings from the longitudinal Children in Care Study (Tarren-Sweeney, 2013b) are consistent with van der Kolk and colleague's findings (2009; 2012), and Tarren-

Sweeney (2013b, p. 739) stated that developmental trauma disorder “provides a more accurate conceptualization of complex attachment- and trauma-related psychopathology than that provided by existing taxonomies”. Clinical experience at the Hawke’s Bay hospital is consistent with these views – we find that young people in care referred to mental health services tend to present with complex (usually interpersonal) trauma characterised by attachment insecurity, behavioural, emotional and physiological dysregulation, and negative beliefs about themselves and others.

The rates of mental health and behavioural problems in children in care are reported in the literature as being high. In the second National Survey of Child and Adolescent Well-Being between 2008 and 2009 in the United States, Casaneuva, Ringeisen, Wilson, Smith, and Dolan (2011) found that one in three children in out-of-home placements and half of children in child protection group homes and residential institutions had behavioural problems which reached a clinical level of severity. Information in this study was derived from interviews or assessments with the child, caregiver and child protection caseworker. Similar rates were found in a recent Dutch study where foster parents’ completed a behavioural questionnaire for 239 foster children, and one third of these children were found to have total difficulty scores in the clinical range (Maaskant, van Rooij, & Hermans, 2014). Whitted, Delavega, and Lennon-Dearing (2013) examined the social, emotional and behavioural problems of 670 children between the ages of 3 and 11 in the south-eastern United States. They found that 84 % of the sample had conduct problems like lying, property destruction, aggression, and bullying behaviours in the borderline to clinical range, approximately 75 % had hyperactivity scores in the borderline to clinical range, and over 50 % had peer relation problems and

emotional difficulties in the borderline to clinical range. However, these concerning high rates may be due to the fact that the information in the study was gathered only from a psychometric measure completed by the child's caregiver, with no independent clinical assessment to verify the level of the problems.

Landsverk et al. (2009) reported that in the American National Survey of Child and Adolescent Well-Being, between half and three-fourths of children going into foster care had behavioural or social difficulties which required mental health interventions. High rates of mental health problems in children in foster care were also found in a British survey which found between 45% and 49% of children in the care of local authorities had mental health, social and behavioural problems (Ford, Vostanis, Meltzer, & Goodman, 2007).

The Children in Care Study in Australia (Tarren-Sweeney, 2013b) confirmed high rates of mental health difficulties in the children in care population: 35% had mental health disorders as viewed within the current systems for classifying mental health disorders, and 20% had a severe and complex psychopathology which could not be adequately conceptualised within these current systems. For example, while some young people in care could be diagnosed with discrete mental health disorders like attention deficit hyperactivity disorder and depression according to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM-5*; American Psychiatric Association, 2013), some young people presented with a range of mood and behaviour problems (e.g., poor emotional and physiological regulation, self-harm and risky behaviours, and inappropriate sexual behaviours) that did not fit diagnostic classification systems in the DSM.

Data on prevalence rates of mental health concerns in children in care in New Zealand is limited as there have been no large-scale national studies on this issue. In 1999 the then-named Department of Child, Youth and Family Services established a mental health database to determine the prevalence and degree of mental health disorder of young people involved with the Department (Wells & Smith, 2000). Analysis of the database indicated that approximately one third of young people involved with the Department of Child, Youth and Family Services had a moderate or severe mental health disorder (this included alcohol and/or drug abuse), and the main mental health disorders diagnosed were attention deficit/hyperactivity disorder, conduct disorder, and disruptive behaviour disorder (Wells & Smith, 2000). A health and education assessment pilot study of 100 children in four regions in New Zealand further emphasised the high prevalence of mental health disorders for young people in care (Rankin, 2010). The study findings indicated that 40% of children in care had a mental health disorder (approximately 36% had depression, approximately 26% had an anxiety disorder, between 17% and 45% had conduct disorder, and between 10% and 30% had attention deficit hyperactivity disorder) (Rankin, 2010).

While there are consistently high rates of mental health and behavioural concerns for children in care, it is important to note not all children who have had adverse early experiences and are subsequently in care will present with these problems (Leve et al., 2012). The concept of resilience helps to outline individual and environmental protective factors that help people effectively manage adverse life experiences (Rutter, 2000). Younger age of placement in foster care protects children in care from the development of mental health problems, while factors that predict mental health problems include the stability and perceived security in the

child's foster placement, the child's intellectual difficulties, and the number and duration of episodes of abuse (Rubin et al., 2007; Rutter, 2000; Tarren-Sweeney, 2008a; Tarren-Sweeney & Vetere, 2014).

Rutter (2000) proposed the following categories of risk for children in care:

1. Genetic factors contributing to social, emotional, behavioural and developmental problems.
2. Physical problems like pre-natal exposure to drugs, alcohol and other toxic substances, and post-natal problems.
3. Adverse home environments characterised by violence, neglect, abuse and poor parenting practices.
4. Foster placement breakdowns which further exacerbate the child's mental health and behavioural problems.
5. Difficulty coping with life circumstances when leaving foster care as an older adolescent.

Leve et al. (2012) further noted the neurobiological risk factors for children in care - chronic stress, abuse and neglect in early childhood have been shown to result in over activated stress response systems and damage to the prefrontal cortex of the developing brain which is associated with higher level cognitive skills.

It can be seen that interacting biological, psychological, social and environmental factors can function as protection or risk in the development of mental health difficulties for children in care (Schofield & Beek, 2005). One of the aims in mental health interventions for children in care is therefore to identify opportunities to develop and promote resilience at both the individual and environmental level for children in care and their caregivers. While it is always preferable that adversity is reduced or eliminated so young people do not suffer

adversity at all, developing their resilience has been shown to be effective in helping to reduce some effects of those adversities. Prince-Embury and Saklofske (2014) outline a range of personal factors, social environment factors, and environmental factors outside the family that have been utilised within programmes to strengthen the mental health of diverse populations (including homeless children and children in care). Nonetheless, the promotion of resilience in individuals and environments should not, as Evans and Nakahara (2015) caution, place the responsibility for change solely on young people in care. Their difficulties tend to be associated with adverse experiences often beyond their control in inadequate home environments, and focusing interventions on them may convey the message that they are the problem.

### **Mental Health Interventions for Children in Care**

While the high rate of mental health problems in children in care has been well documented, there are concerns about the quality of mental health interventions currently available for them (Kerns et al., 2014; Leve et al., 2012; Wonderlich et al., 2011). Bellamy, Gopalan, and Traube (2014), reporting on findings from the National Survey of Child and Adolescent Well-Being in the United States, found that the behavioural problems of children in long-term foster care were not ameliorated by interventions from mental health services. Bellamy et al. (2014) further added that little is known about the mental health services being provided to children in care and that these young people “frequently receive untested treatments with questionable effectiveness” (p. 31). Tarren-Sweeney (2014a) also highlighted problems with many current mental health interventions that have not been developed or adapted to meet the specific needs of children in

care. Therapists who are trained in specific methods of therapy (e.g., play therapy or cognitive behaviour therapy) tend to apply these therapies regardless of the child's presenting difficulties, rather than adapting or changing therapies to meet the needs of individual children. Where there have been interventions specifically developed to address mental health and behaviour problems in children in care, many have not yet been adequately researched (Tarren-Sweeny, 2014a).

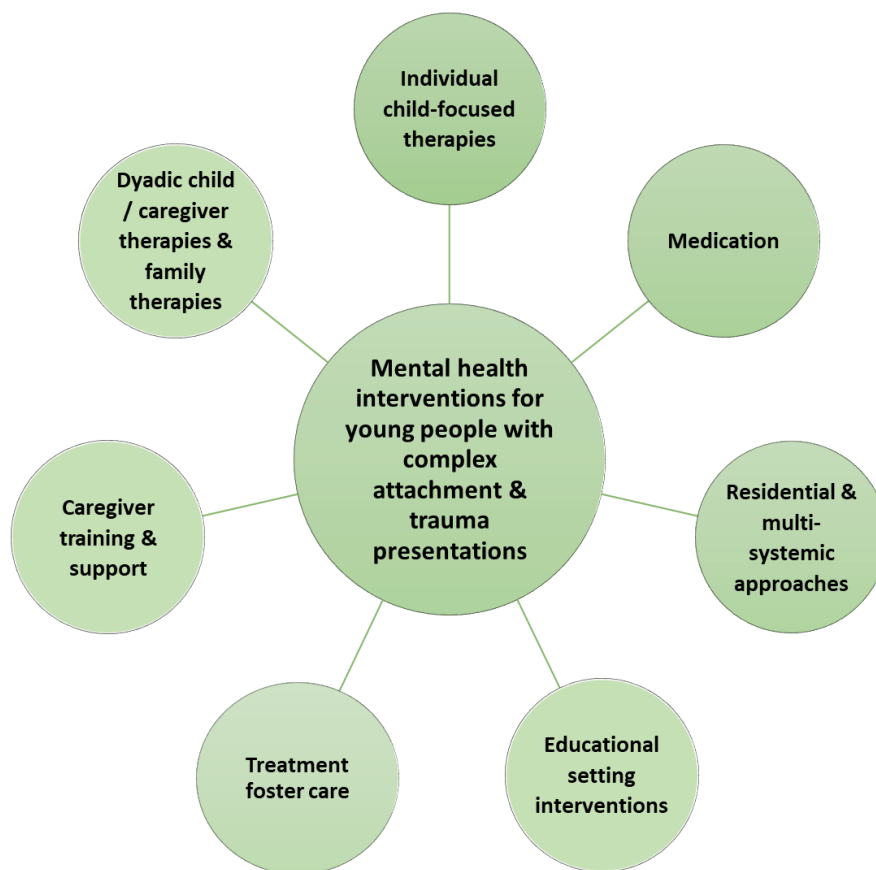
The clinical experience of myself and colleagues at the child and adolescent mental health services in Hawke's Bay supports these limitations. Therapeutic interventions that are currently being delivered by a range of service providers are generally not effective in ameliorating the assortment of emotional and behavioural difficulties children in care exhibit. There are several possible reasons for this, including the pervasive and complex nature of the children's emotional and behavioural difficulties, the fact that progress tends to be slow and characterised by steps forward as well as steps backward, and the resources available in agencies to respond to the needs of children and their families. In addition, while some therapeutic interventions provide support to young people and their caregivers while they are engaged in the interventions, the positive effects are often not maintained once therapy ends. Although there are many variables impacting on the mental health improvements for children in care and the stability of their placements with caregivers (e.g., quality of contact with biological parents; severity of the child's mental health difficulties; quality of the placement), it remains of concern that there is little evidence the therapeutic interventions currently being offered are effective.

The Australian Children in Care Study showed children in care can present in clinically different ways. According to Tarren-Sweeney (2014a), at the very

least, we need to consider the mental health and behavioural problems within two broad clinical categories: mental health and behavioural problems that can be viewed as discrete disorders within the current diagnostic classification systems like the DSM-5 (American Psychiatric Association, 2013) and International Statistical Classification of Diseases and Related Health Problems (10th ed.; *ICD-10*; World Health Organization, 1992), and those attachment- and trauma-related difficulties which do not easily fit into current diagnostic classification systems. While evidence-based interventions for the former category of discrete mental health disorders are well researched and documented in the literature, there are fewer validated interventions specifically developed around the complex mental health needs of children in care (Landsverk et al., 2009; Tarren-Sweeney, 2014a). For example, interventions like trauma-focused cognitive behaviour therapy to address post-traumatic stress disorder in generally securely attached and non-deprived children will include components of psychoeducation, relaxation and affect modulation training, exposure or desensitisation, and cognitive restructuring (Dorsey, Briggs, & Woods, 2011). However, this treatment approach is not easily generalisable to children in care with many consecutive and largely interpersonal developmental traumas, who tend to have accompanying attachment and trust problems, alongside aggressive and defiant behaviours. With children who have experienced a multitude of traumas, it is difficult to know which of those traumas to select for exposure therapy.

Approaches to mental health interventions for children in care can be categorised into seven broad types: individual child-focused therapies, medication, residential and multisystemic approaches, interventions in the educational setting, dyadic child-caregiver therapies, caregiver training and support, and treatment

foster care (see Figure 1). For the purpose of providing a wider context of mental health interventions for children in care, the first four types will be briefly discussed. As the focus of the current research is on interventions directed at caregivers, child/caregiver therapies, caregiver training and support, and treatment foster care will be discussed in detail in Chapter 2.



*Figure 1.* Overview of mental health interventions for children in care

**Individual child-focused therapies.** There is a well-established evidence-base for the efficacy of individual child-focused therapies for specific mental health disorders or problems [e.g., cognitive behaviour therapy for depression, anxiety disorders, anger and aggression (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012), dialectical behaviour therapy for distress tolerance and emotional regulation

training (MacPherson, Cheavens, & Fristad, 2013), and eye movement desensitisation and reprocessing for trauma-related stress (Gomez, 2013)]. However, there is a less established evidence-base for the efficacy of individual child-focused therapies in the treatment of complex biopsychosocial attachment and trauma presentations in children in care (Landsverk et al., 2009; Tarren-Sweeney, 2014a). In isolation of family therapies and interventions in other ecological systems, individualised therapies can inadvertently serve to locate the problems within foster children, rather than highlighting them as having been established in the context of disrupted attachment relationships and highlighting the therapeutic potential of the caregiver-child relationship. Furthermore, individual therapies can place the onus on young people in care to change circumstances they did not create or cannot control (Evans & Nakahara, 2015). In addition, many challenges arise when attempting to generalise manualised therapy protocols for specific mental health disorders (like anxiety and depression), researched in rigorous clinical research studies, to real-world outpatient settings (Blaustein & Kinniburgh, 2010).

Acknowledging this complexity, the need for real-world clinical protocols, and the need to focus interventions on the child *and* significant adults, interventions like the Attachment, Regulation and Competency framework (Blaustein & Kinniburgh, 2010), Integrative Treatment of Complex Trauma (Lanktree et al., 2012), and Trauma-Focused Cognitive Behaviour Therapy (Cohen, Mannarino, Kliethermes, & Murray, 2012) have been developed. These multi-component treatment models offer training, support and education to the child, caregivers, and other significant adults in the child's life. They utilise a range of therapeutic models (e.g., psychoeducation, family therapy, cognitive behaviour therapy, and

dialectical behaviour therapy) and are designed to address a variety of emotional and behavioural problems (e.g., post-traumatic stress, anxiety, depression, anger, and attachment insecurity, grief, dissociation, and self-harm) (Blaustein & Kinniburgh, 2010; Cohen et al., 2012; & Lanktree et al., 2012). Rather than a 'one size fits all' approach, these interventions emphasise customising interventions to fit the child's needs. In randomised controlled trials comparing trauma-focused cognitive behaviour therapy to child-centred therapy models, trauma-focused cognitive behaviour therapy was found to be more useful in reducing symptoms of post-traumatic stress disorder, depression and behavioural problems in children who had been traumatised (Deblinger, Mannarino, Cohen, & Steer, 2006). The Attachment, Regulation and Competency framework is also reported to reduce behavioural problems and post-traumatic stress disorder symptoms (Luke, Sinclair, Woolgar, & Sebba, 2014).

For Lanktree et al. (2012) a problem with studying multi-component therapies is that children do not tend to receive the same treatment. For example, for a child presenting primarily with insecure attachment the focus may be more on attachment therapy, while for a child presenting primarily with anxiety the focus may be on cognitive behaviour therapy. Therefore, while integrative treatment of complex trauma was found to reduce a number of symptoms associated with complex trauma, its model of customised treatment options for different children could mean that the efficacy study was more a test of the benefit of customised interventions than a test of the efficacy of the treatment model (Lanktree et al., 2012).

**Psychotropic medications.** Psychotropic medications (i.e., those that affect mood, thought and behaviour) have been shown to be effective in ameliorating

symptoms of a number of mental health disorders and problems associated with trauma, abuse and neglect in children. Landsverk et al. (2009) reported on several randomised controlled trials demonstrating the significant positive effect of selective serotonin reuptake inhibitors (SSRIs) on depression in children and adolescents. A multisite trial with a sample size of 433 further found that depressed adolescents who received SSRI alone had better improvement in symptoms than those receiving cognitive behaviour therapy alone (TADS Team, 2005). While medication has been found to be less effective in the treatment of conduct disorder, a number of medications have been shown to improve disruptive behaviour in children (Scott, 2008). Mood stabilisers have been successfully used to improve aggression and emotional dysregulation, antipsychotics (e.g., risperidone) are used to reduce disruptive behaviours, clonidine (an antihypertensive) has been shown to reduce restlessness, stress levels and hyperactivity, and stimulants have been demonstrated to reduce behaviour problems, hyperactivity and impulsivity, and improve attention (Landsverk, 2009; Scott, 2008). Although there are some preliminary positive findings for the use of SSRIs on treating post-traumatic stress disorder symptoms in children and adolescents, large-scale placebo-controlled randomised trials are needed to confirm the benefit of SSRIs in reducing post-traumatic stress disorder symptoms in children and adolescents (Bloch & McGuire, 2011).

Despite the reported benefits of psychotropic medication, it is increasingly of concern that children in foster care and those with complex attachment and trauma presentations are prescribed psychotropic medications at significantly higher rates (about 2 to 3 times more likely) than their peers not in foster care (Longhofer, Floersch, & Okpych, 2011). Reasons for unease about this high use of

medication include the shortage of clinical trials for the efficacy of psychotropic medications in children, as well as concern about potential side effects, like weight gain, hormonal disruptions, suicidal behaviours, and behavioural disinhibition (Landsverk et al., 2009; United States Government Accountability Office, 2012). In addition, children in care with complex presentations and many co-morbid conditions can be prescribed combinations of psychotropic medications, which carry increased risk of side effects and increases the likelihood of drug interactions (United States Government Accountability Office, 2012).

While the higher medication rate is likely related to the increased prevalence and severity of mental health disorders and difficulties exhibited by children, it is also likely related to the paucity of evidence-based therapeutic interventions for complex attachment and trauma presentations, alongside a need for medication to quickly control highly disruptive behaviours in children. In addition, if the mental health presentations of children in care are conceptualised as discrete biological mental health disorders rather than complex biopsychosocial problems, there is a tendency for medication to be the main treatment (Waters, 2005). Mental health and paediatric service staff at the Hawke's Bay Hospital working with children in care find that psychotropic medication can be over relied-on, can be difficult to reduce and remove, and changes in the child are sometimes wrongly attributed to changes in the effect of the medication, rather than to the environment. However, the provision of appropriate care usually allows substantial reduction of medication (R. Wills, personal communication, October 11, 2015).

**Residential and multisystemic approaches.** Care and protection residences accommodate children and adolescents in state care who cannot be maintained in the community due to their severe behavioural problems, their

inability to keep themselves safe, and/or their risk of harming others (Ministry of Social Development, 2016b). These residences aim to provide short-term therapeutic interventions, approximately three to six months duration, to get the young people 'back on track' and back into their communities. However, grouping together young people with severe behaviour and mood problems is likely to exacerbate problems, and the loss of family, peers and community resources is a further obstacle to recovery (Landsverk et al., 2009).

Even when residential care has a positive outcome for youth, there is often a lack of sustainability of the positive outcomes once the young person returns to their home, family and community. The Teaching-Family Model is an intervention that attempts to address this issue. The Teaching-Family Model is underpinned by an extensive evidence base, and is based on behavioural and social learning theory (Fixen, Blasé, Timbers, & Wolf, 2007). Teaching-parents live in a home with one or two assistants and up to 7 young people with severe behavioural and emotional problems. The Teaching-Family Model is a highly rigorous model, with intensive training, supervision, certification and regular performance evaluation of staff (Fixen et al., 2007). It is an individualised programme, designed to improve the young person's daily living, relationships and problem solving. The ultimate aim is to support the young person's transition to the family or caregiver at the end of the programme (Fixen et al., 2007). The Teaching-Family Model is currently being trialled with a small group of conduct disordered youth in Hawke's Bay, and while the programme's evidence base is strong, it is a highly costly service for a small number of young people.

Also being implemented in Hawke's Bay are two interventions based on multisystemic therapy. This is a model with an extensive evidence base for

improving conduct-related and substance-abuse problems in young people. Both multisystemic therapy and functional family therapy view adolescent antisocial behaviour problems as influenced by multiple systems, especially the home and school environments, and interventions are focused on the young person and others around them to address difficulties in each system and its impact on the young person (Alexander, Pugh, Parsons, & Sexton, 2000; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). The interventions utilise a range of family, cognitive and behavioural therapeutic approaches, and tend to be two to three months long for functional family therapy and four to six months long for multisystemic therapy (Alexander et al., 2000; Henggeler et al., 2009). Given the complex attachment and trauma symptomology children in care can present with, and the high level of need their caregivers have for training and support, the short therapeutic timeframes of these multisystemic therapies appear to be overly optimistic in providing sustained change for these families.

**Interventions in the educational setting.** In general, young people spend a long period of time in educational settings, and educationally-based programmes to develop their social and emotional well-being can compensate, in part, for the negative influences from other areas of their lives (i.e., individual characteristics, family factors, and peer influences) (Bywater & Sharples, 2012). Furthermore, the positive teacher-child relationship within educational settings has been clearly demonstrated to be associated with academic and behavioural improvements for children and adolescents (Bergin & Bergin, 2009). Given this association, it follows that the relationships children in care have with their teachers and other school staff will be particularly important given the increased likelihood of

attachment disruptions and challenging behaviours in the former (Schmid et al., 2013).

Teacher-child relationships characterised by warmth, respect and trust have been associated with higher grades, better emotional regulation, improved social competence, and less misconduct at school (Bergin & Bergin, 2009; Demanet & Van Houtte, 2012). Research conducted in New Zealand schools further indicated the importance of a warm, positive, and trusting teacher-student relationship (based on the teacher's self-reflective capacity, empathy, and regulation of own emotion) for positive academic and behavioural student outcomes (Andersen, Evans, & Harvey, 2012; Bishop, Berryman, Tiakiwai, & Richardson, 2003; Evans & Harvey, 2012). For these, and other, reasons, comprehensive school-wide positive behavioural interventions and supports have been implemented to prevent and intervene against student behaviour problems in schools (Sugai & Horner, 2009), and to help young people feel a sense of belonging in the school environment. These school-wide interventions aim to alter less effective teaching practices and to develop more positive, trusting and predictable environments to improve academic, social and behavioural outcomes for students (McIntosh, Ty, & Miller, 2014).

In this regard, the New Zealand Ministry of Education's Positive Behaviour for Learning Action Plan includes the following components (Ministry of Education, 2015):

1. Evidence-based training programmes such as the Incredible Years Teacher programme for children aged three to 11, which aims to equip teachers with effective strategies to understand and manage disruptive student behaviours, and to provide a more positive school environment for students (Fergusson, Horwood, & Stanley, 2013).

2. The Positive Behaviour in Schools programme, which comprises three tiers: tier one identifies behaviours of concern, collects data, and teaches behaviours across the school; tier two identifies at-risk students and utilises targeted interventions [e.g., the Check and Connect programme (Cheney et al., 2010) which aims to reduce problematic behaviours at school and promote prosocial behaviours with the help of a trained mentor who works alongside the identified at-risk student daily to set goals, monitor progress, and provide reinforcement]; and tier three involves intensive individualised behavioural and academic supports for high-risk students with severe and challenging behaviours.
3. The Intensive Wraparound Service is an intensive and individualised approach which co-ordinates a number of resources and interventions in the child's different ecological contexts (i.e., home, school and community) to support their highly complex behavioural, social and educational needs. Multiagency collaboration is considered an important aspect of the Intensive Wraparound Service (Bruns et al., 2010).

While the school-wide approaches to improve prosocial behaviours are comprehensive in many regards, they have not been shown to be sufficient in Hawke's Bay to address the complex attachment and trauma symptomatology students can present within the school environment. School-based interventions (except the Intensive Wraparound Service) generally tend to be based predominantly on social learning and behaviour theories, and emphasise modelling and appropriate reinforcement and consequences to promote prosocial behaviour. An identified gap is targeted training for school staff to understand how traumatised students with disrupted attachments present in the school setting, to

reflect on the function of the students' behaviours, to reflect on what negative feelings the students' behaviours elicit in them, to consider the impact of their own actions on the students, and to implement effective behavioural management strategies in the context of a secure environment. For example, a teacher who is able to understand that student counter-controlling behaviours are common in students who have been traumatised will be more likely to remain calm and not get drawn into power battles in the classroom (Evans & Harvey, 2012).

**Dyadic child-caregiver therapies.** Dyadic child and caregiver therapies are considered integral components of mental health interventions for children in care presenting with a complex constellation of behavioural, emotional, and physiological challenges (Leve et al., 2012; Tarren-Sweeney, 2014a). In addition to the multi-component therapies discussed above, a number of dyadic therapies have been shown to be effective in training and supporting caregivers to cope with the child's challenging behaviours and strengthen their relationship with the child. These therapies focus on training the caregivers as co-therapists, aiming to develop their sensitivity and emotional availability to the foster child, helping them reflect on their parenting practices, and supporting the implementation of appropriate behavioural strategies (Boris & Zeanah, 2005; Leve et al., 2012; Scott, 2008). Parent-Child Interaction Therapy (McNeil & Hembree-Kigin, 2010) and Keeping Foster Parents Trained and Supported (KEEP) (Price, Chamberlain, Landsverk, & Reid, 2009) are two dyadic child and caregiver therapies that will be discussed in more detail in Chapter 2.

Dyadic child and caregiver therapies are vital to the development of secure attachment and treatment of trauma responses in children in care for a number of reasons, including: (a) to encourage therapeutic interactions between caregiver and

child, and to develop the caregiver's skills as a co-therapist; (b) to strengthen the attachment relationship between caregiver and child and increase the child's security and sense of well-being in the family; (c) caregivers can offer emotional protection and a secure base for the child to process past traumas, address distressing and challenging behaviours, and help in the healing process; (d) therapists can role model for caregivers how to implement rewards and consequences in relationship-enhancing ways, and how to talk to the child about past traumas in a sensitive manner; (e) to discourage the child bonding with the therapist as this is not usually a long-term sustainable relationship which children in care need to make progress (Lozier, 2013). While the benefits of individual child-focused therapies to help foster children learn skills and process traumas have been clearly demonstrated, I and my mental health colleagues in Hawke's Bay have generally found dyadic child and caregiver therapies to be more useful in addressing complex attachment and trauma presentations in children.

**Caregiver training and support.** Caregiver training and support (including treatment foster care) has also been reported to be a key intervention to improve outcomes for children in care and to sustain their long-term foster care placements (Leve et al., 2012; Modernising Child, Youth and Family Expert Panel, 2015). Consistent and nurturing caregivers with sound parenting skills have been found to be a protective factor in placement stability for children in care (Rock et al., 2015). For many young people in care, mental health improvements occur naturally over years in the permanent and secure care of sensitive, nurturing and dedicated caregivers (Tarren-Sweeney, 2014a). The main therapeutic intervention should therefore be to enable and support caregivers to parent children with complex mental health presentations and to maintain them in a stable home environment. As

the key topic in this thesis is appropriate caregiver training and support as a core intervention to improve outcomes for children in care, this topic will be discussed in further detail in Chapter 2.

There is a range of mental health interventions that can be utilised to ameliorate the complex social, emotional, behavioural and neurobiological problems children in care can present with. However, in Hawke's Bay there has historically been an over-emphasis on interventions focused on the individual foster child (i.e., individual therapies and medication), and an under-emphasis on dyadic child and caregiver therapies, family therapies, caregiver training and support, training and support for wider family members, mentors and minders, and interventions in the educational environments. However, given the complexity of the needs children in care present with, there is an increasing awareness of the need for multiple-levelled interventions which address the young person's behaviour problems, emotional health, self-esteem and identity problems, family relationships, and learning difficulties, in as many ecological systems around the young person as possible, on an ongoing basis (Golding, 2014; Tarren-Sweeney, 2014a). For example, in addition to interventions in a clinical setting involving caregivers and foster children, interventions that support teachers to understand and manage attachment and trauma related problems in the school setting would also be useful.

Furthermore, in addition to utilising social learning and behaviour theories, other psychological and developmental theories (including attachment and systems theories) are vital for improved understanding of the mental health needs of children in care (Scott & Dadds, 2009). It is vital that the interaction between the child's internal biological states and the external environments and contexts are

considered in mental health interventions to obtain improved outcomes for children in care (Gutkin, 2009). It also follows that more emphasis should be placed on caregiver training and support, dyadic caregiver/child and family therapies, and interventions in the educational settings to ensure children in care are able to be adequately supported in their natural environments.

### **Summary**

This chapter has summarised the prevalence and demographic context of children in care, highlighting the over-representation of Māori children in care and suggested reasons for this. The New Zealand system of care and protection was discussed, alongside related ethical and moral challenges within the system. It was also shown that children in care can present with a range of very challenging behavioural and mental health difficulties related to their adverse early experiences, as well as associated neurodevelopmental problems. Their challenging presentations are a significant contributing factor in foster placement breakdowns, and these breakdowns in turn further negatively affect their mental health outcomes. A range of mental health interventions across the various natural settings for children in care was critically discussed, leading to a conclusion that more ecologically and less individually focused interventions were required for improved mental health and behavioural outcomes for children in care. The complex biopsychosocial presentations of children in care require professionals to consider the whole context of the young person, rather than only conceptualising the problems as discrete and separate mental health disorders within the child. A paradigm shift was therefore suggested – from conceptualising symptoms and locating interventions at the individual level, to considering the whole context of children in care, drawing on multiple developmental and psychological theories,

and implementing interventions in multiple naturally-occurring contexts (Gutkin, 2012; Tarren-Sweeney, 2014a). Appropriate caregiver training and support is a core intervention to decrease foster placement breakdowns and to improve mental health outcomes for children in care (Leve et al., 2012; Modernising Child, Youth and Family Expert Panel, 2015; Murray et al., 2011).

## CHAPTER 2: CAREGIVER TRAINING

As discussed in Chapter 1, the adverse early home environments of children in care, their experiences of loss and grief, and their often multiple placements with foster families all contribute to their high rates of neurobiological, developmental, behavioural, emotional, and social difficulties. This complex constellation of biopsychosocial problems means, for caregivers to be effective in parenting and helping the foster child heal from multiple layers of trauma, they will need considerable training and support. Indeed, effective caregiver training and support are widely considered to be essential interventions to facilitate foster placement stability and to improve outcomes for children in care with complex attachment and trauma difficulties (Leve et al., 2012; Modernising Child, Youth and Family Expert Panel, 2015; Rock et al., 2015).

The experience of myself and mental health colleagues in Hawke's Bay is that caregiver training is a vital component of collective interventions to improve outcomes for children in care, but it is not enough on its own to effect the changes needed. Group parenting programmes do not tend to last longer than 18 weeks, and, given the complex and deep-seated nature of the biopsychosocial problems children in care can present with, it is unrealistic to expect a training programme to effect positive changes on its own in such a short time frame. Our experience as professionals working with children in care and caregivers in Hawke's Bay is that progress tends to be slow, over years, and non-linear in nature. As discussed in the previous chapter, there is a need for multiple-levelled interventions which focus on the range of problems children in care can present with, in as many ecological systems as possible, on an ongoing basis (Bruns et al., 2010). If a foster child's

caregiver, teacher, social worker and therapist all had understandings about the child's behaviour and all used similar strategies in their approaches with the child, there would be more consistency in managing the child's challenging behaviours.

As the focus of this thesis is effective caregiver training, this chapter will summarise a number of caregiver training programmes and interventions as well as the related evidence base to provide a context in which to discuss the development and description of the Fostering Security programme. In addition, the need for caregiver training will be discussed, limitations of generic and largely behaviourally-based parent training programmes in meeting the need of caregivers will be explored, and the need for more specific and focused training for caregivers will be proposed. As a reminder, the term 'caregiver' includes kin and non-kin caregivers, the terms 'caregiver' and 'foster parent' are used interchangeably, the terms 'foster children' and 'children in care' are used interchangeably, and 'children' refers both to children and young people.

### **The Need for Caregiver Training**

As discussed in Chapter 1, foster placement stability is critical to help children in care develop healthy and secure attachments, to heal from past traumas, and to develop more prosocial behaviours and appropriate coping strategies. Furthermore, foster parents who have effective parenting skills (i.e., are effective at establishing boundaries, are sensitive to the child's emotional needs, and are child-focused), are protective factors for children in care (Rock et al., 2015). A number of factors have been emphasised as contributing to foster placement breakdowns: caregivers' difficulty understanding and managing the foster child's challenging behaviours with typical parenting approaches; difficulty developing a healthy

attachment relationship with a foster child who is distrustful of adults; the foster child's behaviour negatively affecting the caregiver's biological family; caregivers' difficult relationships with professionals; caregivers' high levels of frustration and stress; poor financial support; poor acknowledgement of caregivers' high burden of care; caregiver feelings of not being valued as an important part of the team; and the lack of adequate training and support around the foster child's complex attachment and trauma problems (Atwool, 2010; Leathers, Spielfogel, McMeel, & Atkins, 2011; Murray et al., 2011; Octoman, 2014).

Analysis of calls to the New Zealand Office of the Children's Commissioner Child's Rights Line during the period 1 April 2009 to 31 March 2010 further indicated that one of the priorities for caregivers was the need for training and support to help them understand and manage the foster child's challenging behaviours (Atwool, 2010). This need is echoed in the literature on mental health interventions for children in care – caregiver training is seen as essential to develop the caregiver's understanding of and responsiveness to the foster child, to develop the caregiver's capacity to reflect on their parenting approaches, to support caregivers in developing secure and healthy attachment relationships with foster children, to provide caregivers with skills and parenting techniques to cope with the foster child's difficult and disruptive behaviours, and to provide caregivers with acknowledgement, validation, and encouragement in the face of a demanding role as a foster parent (Leve et al., 2012; Murray et al, 2011; National Institute for Health & Care Excellence, 2015; Tarren-Sweeney, 2008b). Such training conducted in the context of a group of caregivers has the advantage of capitalising on the knowledge, support, and understanding existing within a

group of caregivers faced with similar parenting situations (Barth, Crea, John, Thoburn, & Quinton, 2005; Leathers et al., 2009).

Grandparents raising their grandchildren form a further sub-group of caregivers who have specific training and support needs (Scarcella, Ehrle, & Geen, 2003). Grandparents attending the Fostering Security training programme in Hawke's Bay have highlighted the changes required in their lifestyles when taking on the care of young children, and the often-accompanying isolation from their peer group as their family circumstances and duties become different from that of their peers. Grandparents also come from an earlier parenting generation and sometimes find it difficult making adjustments to their established parenting approaches. Furthermore, there is an additional dynamic for grandparents in that they are parenting the children of their own children. There are a number of issues arising from this, including loyalties to their children and guilt when reflecting on where they might have gone wrong in their parenting of their own children to result in them having children removed from their care. Training programmes designed for caregivers therefore also need to take into account the more specific needs of grandparents who are raising their grandchildren.

### **A Review of Caregiver Training Programmes**

For many young people in care, permanent and secure parenting from sensitive, nurturing and committed caregivers has the potential to help improve the mental health and behavioural outcomes for children in care (Tarren-Sweeney, 2014a). Four main types of foster parent programmes are described in the literature: introductory training programmes; treatment foster care programmes; programmes based on social learning theory; and programmes based on attachment

theory. These programmes all aim to develop the parenting confidence, competence and therapeutic potential of caregivers as well as prevent placement breakdowns. However, there is a distinction between those programmes that are largely educational in providing information to caregivers (i.e., training) and those programmes that are both educational and function as a targeted therapeutic intervention for caregivers facing challenging foster child behaviours (Tarren-Sweeney, personal communication, July 27, 2017). This chapter will discuss foster parent training programmes in each of the four categories mentioned above, alongside their evidence base.

**Introductory/pre-service training programmes.** Introductory or pre-service training programmes for foster parents tend to be psycho-educational in providing information about attachment difficulties and trauma, keeping children safe, providing information about the role of the foster parent, and orienting them to the child welfare system and fostering agencies (Benesh & Cui, 2017). There is less of a focus on teaching specific skills or parenting approaches in these programmes and foster parents tend to complete the programme before a foster child is placed with them or in the early stages of providing care (Benesh & Cui, 2017). Introductory programmes therefore tend to be educational in nature rather than considered as therapeutic interventions. Two widely-used programmes, Model Approach to Partnerships in Parenting Group Preparation and Selection of Foster and/or Adoptive Families (MAPP) and Foster Parent Resources for Information, Development, and Education (PRIDE), have few studies and little empirical evidence to support them (Dorsey et al., 2008). In spite of this, Dorsey et al. (2008) reported that 26 American states required foster care agencies to use one of these two pre-service training programmes.

A study of MAPP compared 62 foster parents who had completed the training with a control group of 20 and concluded that the former group were no better equipped to manage the challenging behaviour of the foster child than the latter group (Puddy & Jackson, 2003). These results were consistent with those of an evaluation of an earlier version of the programme which indicated that MAPP did not lead to expected outcomes in caregiver knowledge of child development, empathy, and use of physical punishment (Lee & Holland, 1991).

The other commonly used pre-service foster parent training programme, PRIDE, was evaluated by Christenson and McMurtry (2007, 2009). Pre-test and post-test evaluation of 228 foster parents who attended the PRIDE training in 2003 was designed to determine whether foster parents gained the knowledge that the programme imparted (Christenson & McMurtry, 2007). There were statistically significant improvements in many areas of knowledge, as well as maintenance of gains 18 month after the training for a sample of 51 foster parents, 41 of whom were still fostering children (Christenson & McMurtry, 2009). While these results were positive, one commentator noted that there were methodological limitations, including measures with little evidence of validity, the lack of control groups, and a much smaller sample than the original sample at 18 month follow up (Festinger & Baker, 2013).

In summary, in spite of their widespread use to deliver important introductory messages to foster parents, the most commonly used pre-service foster parent training programmes in the United States lack a strong empirical base. Festinger and Baker (2013) make a number of recommendations that could support a stronger evidence base for such programmes, including the use of randomised control groups, standardised measures, more studies on the effect of pre-service

training, and including qualitative research approaches alongside quantitative approaches. In addition, with the generally lesser focus on skills training and meeting the psychological and emotional needs of children in care in current pre-service training it appears that the content may not be adequate to meet the particular needs of foster parents caring for children with challenging problems (Benesh & Cui, 2017).

**Treatment foster care programmes.** Treatment Foster Care is a foster family-based therapeutic intervention that aims to provide children in care, and at times their biological, adoptive or foster families, with an individualised plan to address their emotional, behavioural and psychological difficulties (Turner & Macdonald, 2011). Treatment Foster Care has been viewed as an alternative to residential placements for youth with antisocial behaviour problems who are at risk of multiple foster placements (Webb, 1988) and also appears to be a more cost-effective option (Chamberlain & Weinrott, 1990). Further, youth leaving Treatment Foster Care appear more likely to go on to less restrictive environments (Chamberlain & Weinrott, 1990).

In a review of Treatment Foster Care, Turner, and Macdonald (2011) reported on five randomised control studies of which four evaluated the efficacy of Multi-dimensional Treatment Foster Care. The Multi-dimensional Treatment Foster Care model, recently renamed Treatment Foster Care Oregon for Adolescents, has been researched extensively in randomised controlled trials since 1990, and has been shown to be effective in reducing severe antisocial, criminal and delinquent behaviours for adolescents, and reducing placement breakdowns for younger children (Sinclair et al., 2016; U.S. Department of Health and Human Services, 2011). Multi-dimensional Treatment Foster Care is an intensive 24 hour a

day seven days a week multi-component behaviour-management approach where children and adolescents live for a limited time with a treatment family who are highly trained, supported and supervised to manage severe behavioural and emotional problems (Chamberlain, 2003). This approach is based on the tenets of social learning theory, and focuses among other parenting practices on the increased use of boundaries, positive reinforcement of prosocial behaviours, non-punitive consequences for disruptive behaviour, close caregiver supervision, and attempts to remove the young person from the influence of anti-social peers (Price et al., 2009; Luke et al., 2014). There is also close contact with the child's school staff and with the biological parents, the latter obtaining interventions to prepare for the child's return home (Chamberlain, 2003).

Two randomised control trials in the United States have shown that Multi-dimensional Treatment Foster Care is an effective intervention with male and female adolescent offenders (Chamberlain, Leve, & DeGarmo, 2007; Chamberlain & Reid, 1998). A two-year follow-up evaluation of 81 girls with serious delinquent behaviours compared Multi-dimensional Treatment Foster Care and group care and found that the former intervention was associated with more reductions in delinquency compared with group care (Chamberlain et al., 2007). Furthermore, at 12 and 24-month follow-up the effects found at one year were maintained (Chamberlain et al., 2007). A study of 79 male adolescents with histories of serious delinquent behaviours examined the efficacy of group care with Multi-dimensional Treatment Foster Care and found that the youth participating in the latter intervention had significantly fewer criminal referrals, absconded from their placements less than the youth in group care, spent fewer days in lockup or

detention facilities, and returned to live with their families more often (Chamberlain & Reid, 1998).

Independent replication studies in Sweden and in Britain indicated mixed results. A Swedish study indicated the benefits of Multi-dimensional Treatment Foster Care in improving internalising and externalising behaviours in a sample of youth with conduct problems (Westermarck, Hansson, & Olsson, 2011), but these improvements were not maintained by the follow-up evaluation a year later (Hansson & Olsson, 2012). Similar maintenance issues at follow-up were found in a British study which showed improved outcomes for youth offenders (decrease in offending behaviours and improvements in living with family) after one year in Multi-dimensional Treatment Foster Care, but the effects were not maintained a year after leaving the programme (Biehal, Ellison, & Sinclair, 2011). Green et al. (2014) evaluated the efficacy of Multi-dimensional Treatment Foster Care for Adolescents compared with treatment as usual for young people at risk in foster care and found no evidence that the intervention resulted in better outcomes than usual treatment. They concluded that the intervention may be more efficacious for youth with antisocial behaviour but less useful than treatment as usual for those without antisocial behaviour and with primarily attachment relationship and emotional needs (Green et al., 2014). In spite of these mixed results outside of the United States, analyses support Multi-dimensional Treatment Foster Care as an intervention for young people with high levels of antisocial behaviour, although further research is needed to determine the longer term effects (Sinclair et al., 2016). Derivatives of Multi-dimensional Treatment Foster Care have also been developed for school aged children and pre-schoolers with promising results, and these will be discussed in the next section.

**Programmes based on social learning theory.** As described in Chapter 1, children in care can exhibit a range of emotional, behavioural, and social problems, including conduct problems that include antisocial, aggressive, defiant and disruptive behaviours (Advisory Group on Conduct Problems, 2011). Parent training is well established as the basic intervention for conduct problems in children. Interventions that seem to work best also involve training those in the child's natural environments to implement behavioural changes in the child (Advisory Group on Conduct Problems, 2011; Kazdin, 2011; Scott, 2008; Scott & Dadds, 2009). Social learning theory is a key component of effective parent training for families with children who have conduct problems (National Institute for Health & Care Excellence, 2013; O'Connor, Matias, Futh, Tantam, & Scott, 2013; Scott & Dadds, 2009).

Social learning theory integrates earlier behavioural and cognitive theories of learning, and posits that learning is more complex than just behavioural reinforcement through rewards and negative consequences. Other factors influencing social and emotional development include modelling (imitational learning), cognitive elements of emotion competence such as emotional language skills, and social influences from the peer group and social media on decision-making and group loyalty (Bandura, 1977; Grusec, 1992). Further, social learning theory states that, through reciprocal determinism, an individual's behaviour is influenced by the environment and the environment is also influenced by the individual's behaviour (Bandura, 1977). For example, a foster child who is distrustful of adults may reject the caregiver's affectionate overtures, which may result in the caregiver limiting their affectionate behaviour toward the child, which in turn confirms the child's perception of being unlovable and not important.

A number of well-established and evidence-based parent training interventions are based on social learning theory, and two of these will be discussed in more detail: the Incredible Years parent training programme (Webster-Stratton & Reid, 2010), and Parent-Child Interaction Therapy (Zisser & Eyberg, 2010).

The Incredible Years training programme is a 12-week programme designed for parents, teachers and children aged zero to 13 years old, and the aims of the parent training programme include: reducing the use of punitive discipline strategies; increasing the use of positive strategies such as positive reinforcement, modelling of appropriate behaviours, redirection, and problem solving; improving the parent-child relationship through play; improving parents' confidence, emotional regulation, and positive communication styles; and increasing parental involvement in the child's academic skills (Webster-Stratton & Reid, 2010). The parenting skills are taught through the use of role-play, large and small group discussions, watching and discussing videos, and home tasks (Nilsen, 2007). The effectiveness of the Incredible Years parent training programme has been demonstrated by Webster-Stratton and her colleagues, as well as in independent replication studies in many countries (Baker-Henningham, Scott, Jones, & Walker, 2012; Drugli, Larrsson, Fossum, & Morch, 2010; Reid, Webster-Stratton, & Hammond, 2007; Scott et al, 2010; Webster-Stratton, 1998; Webster-Stratton, Reid, & Hammond, 2004).

The Incredible Years programme has also been used with foster parents but with mixed results (Luke et al., 2014). A randomised control trial in Britain with 29 foster parents found a greater reduction in foster children's problem behaviours compared to the control group of 17 foster parents (Bywater et al., 2010), but

methodological issues included measures reported only by foster parents and a relatively short follow-up at six months from baseline. In an American study of 18 caregivers, 11 in the intervention group and 7 in the control group, caregivers in the former group reported significantly fewer foster child conduct problems than the latter group (Nilsen, 2007). However, no differences in groups were found in foster child aggressive or hyperactive behaviours, nor were differences found in caregiver variables like caregiver-child relationship stress, child development knowledge, or parenting approaches (Nilsen, 2007). As caregivers reported that they experienced the training as helpful and felt more competent in their parenting as a result of the training, it is possible that the measures used in the study were not sensitive enough to assess these changes (Nilsen, 2007). In spite of the positive changes in foster child behaviour and reports of satisfaction from caregivers in this study, its lack of control group, small sample size, and caregiver-only report are methodological limitations affecting conclusions about the programme's efficacy. A further study examining the effect of an alternative version of the Incredible Years programme on both birth and foster parents of 128 neglected children found significant improvements in co-parenting strategies between the birth and foster parents but only marginally significant improvements in the child's externalising behaviours at follow-up (Linares, Montalto, Li, & Oza, 2006).

Parent-Child Interaction Therapy is a two-phase therapeutic intervention (i.e., child-directed interaction and parent-directed interaction) which aims to develop the parenting skills of those with children aged under 8 years old with conduct problems (Thomas & Zimmer-Gembeck, 2011). Parent-Child Interaction Therapy tends to be a more time-consuming programme than others as it takes between 12 to 20 weekly sessions, and it has an attrition rate of approximately 35%

due in part to the challenging nature of some of the families participating (Fonagy et al., 2015; Zisser & Eyberg, 2010). The behaviour management techniques in Parent-Child Interaction Therapy are based on social learning theory, with the emphasis being on clear limit setting, an authoritative parental stance, consistent praise for compliance, and negative consequences like timeout for noncompliance (Zisser & Eyberg, 2010). Training mediums include use of an observation room, one-way mirror, and earphone technology for the therapist to model communication and coach the parent (Zisser & Eyberg, 2010). The therapist teaches, coaches and gives feedback to the caregiver via an ear microphone, and home generalisation skills are also taught (McNeil & Hembree-Kigin, 2010). Parent-Child Interaction Therapy has been shown to be associated with improved child behaviour, less child noncompliance, reduced parental stress, improved parent-child interactions, and improved parental sensitivity for both birth-parent-child and foster parent-foster child dyads (Fonagy et al., 2015; Thomas & Zimmer-Gembeck, 2011; Timmer, Urquizer, & Zebell, 2006; Zisser & Eyberg, 2010).

A more recent American study adapted the programme using group-based training and telephone consultation and randomly assigned 129 caregiver-foster child dyads to either a waitlist control, brief Parent-Child Interaction Therapy or extended Parent-Child Interaction Therapy (Mersky, Topitzes, Janczewski, & McNeil, 2015). The brief programme comprised two-day workshops, the first day focussing on child-directed interaction and the second on parent-directed interaction, followed by brief telephone consultation each week for four weeks then fortnightly for another four weeks (Mersky et al., 2015). The extended programme comprised the two-day training, followed by eight weeks of telephone consultation, another full day training, and a further four telephone consultations over a six-week

period (Mersky et al., 2015). Both the brief and extended versions of Parent-Child Interaction Therapy were found to be associated with a significant decrease in self-reported parenting stress and significant improvements in observed indicators of appropriate and inappropriate parenting approaches. The novel follow-up telephone consultation approach used in this study is a useful way to sustain the effects of the training programme – as discussed above foster parent training programmes in and of themselves are often insufficient to meet the complex needs of foster parents and children in care.

In addition to the two generic parent training programmes described above, there are a several foster parent training programmes that have developed which are based on social learning theory. One of these, Keeping Foster Parents Trained and Supported (KEEP) is based on Multi-dimensional Treatment Foster Care (discussed above) and is a 16-week intervention programme for caregivers of foster children aged 5 to twelve designed to improve the behaviour management skills of foster parents (Price et al., 2008; Price et al., 2009). While Multi-dimensional Treatment Foster Care is an intervention where specially trained foster parents care for one foster child for a period of time, KEEP is designed for foster parents who are already caring for a foster child (Tarren-Sweeney, 2014a). KEEP focuses on teaching caregivers to set behavioural limits, manage difficult child behaviour, support the child with school success and peer relationships, and manage parenting stress (Price et al., 2009).

A large American randomised control study to examine the efficacy of KEEP was conducted with 700 foster and kin families, 359 of whom were in the intervention group and 341 in the control group. The intervention group received 16 weekly 90 minutes training sessions as well as weekly telephone consultations

(Chamberlain et al., 2008; Price et al., 2008). This randomised control study was evaluated in different studies - it was found that the intervention led to significantly reduced foster child behaviour problems (although the effect size was small with a decrease in mean number of daily problem behaviours from 5.9 to 4.4) (Chamberlain et al., 2008), as well as increased the chances of the foster child having a positive exit from the placement, for example, parent-child reunification or move to a permanent placement (Price et al., 2008).

Price, Roesch, Walsh, and Landsverk (2015) studied the effectiveness of KEEP when facilitated by a community agency without the involvement of the programme research and development team. A sample of 335 caregivers were randomly assigned to an intervention or control group, however, they were not blind to the group they were assigned. The programme was found to result in significantly reduced behaviour problems in the intervention group two weeks after the programme (Price et al., 2015). Not only were behavioural improvements found for the foster child but also for other children in the home, leading the authors to surmise that caregivers were able to generalise learned skills to the other children. The study also showed a significant decrease in the intervention group caregiver stress related to the foster child's behaviour problems (Price et al., 2015). Despite these promising results however, it is of concern that caregivers knew which group they were assigned to, and this may have influenced their reporting on the outcomes measures (Luke et al., 2014). A further methodological limitation noted is the lack of longer term follow-up post-study.

Two additional derivatives of the Multi-dimensional Treatment Foster Care programme of promise are Multi-dimensional Treatment Foster Care for Preschoolers (MTFC-P) and a programme developed for school aged children

called Middle School Success (Jonkman et al., 2012; Kim & Leve, 2011). The MTFC-P programme is based on social learning theory, provides foster parents strategies to improve positive behaviours and limit-setting to reduce problem behaviours, and provides foster parents and foster children a wraparound team of therapists, social workers, and behavioural specialists (Jonkman et al., 2012). Foster parents participate in a two-day training, participate in weekly group meetings and receive home visits while the foster children receive training and therapy (Jonkman et al., 2012).

MTFC-P has been extensively studied in the United States with a number of randomised control studies showing significant improvements in the foster child's secure attachment behaviour and decrease in avoidant attachment behaviour, fewer placement disruptions, physiological responses similar to non-fostered peers (Fisher & Kim, 2007; Fisher, Stoolmiller, Mannering, Takahashi, & Chamberlain, 2011; Bruce, Fisher, Pears, & Levine, 2009). However, two studies in the Netherlands showed contradictory results. While Jonkman et al. (2012) found significantly reduced child behaviour problems through the course of the programme, Jonkman et al. (2017) found that children in MTFC-P and children in treatment as usual improved similarly, not demonstrating the same results in earlier studies. They noted that these results needed to be interpreted with caution due to lower than expected power in their study.

Finally, the Middle School Success programme focuses on helping young people set goals, improve relationships, make decisions and problem solve while the caregiver component focuses on teaching behavioural management approaches (Luke et al., 2014). Smith, Leve, and Chamberlain (2011) found that the programme decreased internalising and externalising problems in girls but no

difference in prosocial behaviours were noted in the control and intervention groups. Further studies indicated that the Middle School Success programme was associated with reduced levels of substance use and risk-taking sexualised behaviours (Kim & Leve, 2011; Kim, Pears, Leve, Chamberlain, & Smith, 2013). While Middle School Success seems to be related to improved behaviour in young girls, further studies are needed to provide a stronger evidence base.

As has been shown, there are a number of generic parent training programmes and programmes designed for foster parents based largely on social learning theory which have been shown to be effective in improving positive parenting strategies, decreasing punitive parent approaches, improving parenting confidence, and improving parent-child relationships. However, it is posited that a quarter to a third of families do not benefit from them (Scott & Dadds, 2009).

Reasons for this include:

- While children in care can present with conduct problems, their experiences of trauma, abuse, loss, neglect, disrupted attachments, and multiple placements can result in complex biopsychosocial behaviours and needs which may undermine the effectiveness of parent training programmes designed for generally intact families with children who are mainly securely attached (Leathers et al., 2011; Murray et al, 2011). The challenges of parenting foster children can therefore be seen to go beyond what parent and foster parent training programmes, based predominantly on social learning theory, can address (Leve at al., 2012; Rork & McNeil, 2011). In particular, caregivers in two New Zealand studies have indicated that they would like specific training on the effects of trauma, neglect, and disrupted attachments on the behaviour of foster children, as well as strategies to help

them develop more secure attachment relationships with the foster children (McDonald, 2011; Murray et al., 2011).

- Scott and Dadds (2009) suggest that, while the value of social learning theory in parent training programmes is well-evidenced, families who do not make the expected changes may benefit from a more diverse approach to interventions. In addition to social learning theory, families may also benefit from attachment theory to help parents understand the child's behaviour further, attribution theory to help parents shift their negative beliefs about the child, family systems theory to provide insight into family dynamics, and motivational interviewing approaches and empowerment approaches to provide leverage for families who are resistant to change (Scott & Dadds, 2009).
- Our clinical experience in Hawke's Bay, New Zealand of standard parent training programmes, based predominantly on social learning theory, has shown that these interventions may not be sufficient for foster families. Children in care, with distrustful and negative relationships with adults, feelings of being worthless and unlovable, and who have experienced helplessness in the face of traumatic experiences, tend to be controlling in their interactions in a misguided attempt to protect themselves from future abuse, neglect or loss. The use of parenting strategies like rewarding positive behaviour with praise or reinforcement schedules are likely to be unsuccessful if the intrinsic reward for the child is to remain in control of the situation rather than allow the adult to control it. It is also likely to be unsuccessful if the child does not feel connected to people, places or things, so does not care about tangible rewards.

- Similarly, the implementation of negative consequences is not likely to be threatening to the foster child who has experienced great adversity and deprivation. In addition, consequences like time out (temporarily removing the misbehaving child from the environment where the misbehaviour occurred), can elicit feelings of rejection and abandonment in children who have experienced these feelings before. In contrast, time in strategies (where the consequence for misbehaviour involves close proximity to the caregiver) are useful in helping the caregiver maintain the relationship with the child while still implementing the consequence. Time in also allows for the caregiver to teach and model emotional regulation skills to the child who may have not successfully mastered these skills due to poor early parenting and disrupted attachment relationships. For standard behaviourally-based parenting interventions to be successful for foster children, these need to be based on a positive relationship between the caregiver and the foster child. Evans, Heriot, and Friedman (2002) highlight this when stating that the functional analysis of the child's behaviour is paramount, and if a child's negative behaviour is based on anger and is designed to be hurtful towards others, then negative consequences will likely serve to further anger the child and not be successful. They express concern about the cognitive-behavioural parenting strategies which emphasise rewards and negative consequences over parental sensitivity and emotional availability, which are foundations of a positive attachment relationship (Evans et al., 2002).

**Programmes based on attachment theory.** Cognisant of the limitations of the generic parenting programmes based predominantly on social learning theory,

Rork and McNeil (2011) suggested that, since children in care have been found to show attachment deficits, attachment-based interventions as well as behaviourally-based interventions may be successful with this population group. Further, there is general consensus in the current literature that caregiver training, which includes behavioural management training, self-reflective capacity building, and addresses complex trauma- and attachment-related child mental health difficulties, is an essential component of mental health interventions for children in care (Leathers et al., 2009; Murray et al., 2011, Rankin, 2010; Tarren-Sweeney, 2008b). To this end, a number of training programmes specific to foster parents and based on attachment theory have been designed, three of which are outlined below.

Attachment and Biobehavioral Catch-up is an evidence-based intervention for foster parents of children aged zero to three years old who have experienced early adversity and are at risk for developing attachment problems (Bernard et al., 2012; Dozier, Bick, & Bernard, 2011). An advantage of the Attachment and Biobehavioral Catch-up is that it is based on the home and therefore reaches families who may not be able to attend group training programmes. Being home-based also means that skills learned are more easily generalisable in the home setting. Attachment and Biobehavioral Catch-up aims to develop trusting attachment relationships between parent and child, as well as better emotional and behavioural regulation in the child and foster parent. The intervention comprises 10 interactive sessions with foster parent and child, to help the parent correctly interpret the child's behavioural signals, re-interpret the child's rejecting behaviours and provide comfort when the child is distressed, and follow the child's lead with pleasure when the child is not distressed (Dozier et al., 2011).

Randomised controlled trials of the Attachment and Biobehavioral Catch-up intervention showed significantly higher rates of secure attachment and significantly lower rates of disrupted and avoidant attachment in the experimental groups (Bernard et al., 2012; Dozier et al., 2009). Further, the intervention was associated with significantly lower rates of problem behaviour in older infants as well as significantly more typical cortisol production in foster children than a control group of foster children (the authors drawing a connection between a number of emotional and behavioural problems and higher levels of cortisol production) (Dozier et al., 2006). Dozier et al. (2006) posited that the Attachment and Biobehavioral Catch-up intervention improved children's self-regulatory capacity and changed their physiology to that more closely resembling typical children. While there is good evidence that the Attachment and Biobehavioral Catch-up intervention promotes improved behaviour, stress regulation, and secure attachments in foster children age zero to 3 years old in the short term, there are some limitations about the programme and its evidence. As a foster care intervention that is implemented in homes on an individual basis, Attachment and Biobehavioral Catch-up requires more practitioner time than group-based interventions. Most of the efficacy studies included only short-term follow-up evaluations (Luke et al., 2014), however a study evaluating outcomes six years after the intervention found that foster children involved in the Attachment and Biobehavioral Catch-up had better theory of mind skills and higher cognitive abilities to adapt behaviours in response to changes in the environment (Lewis-Morrarty, Dozier, Bernard, Terracciano, & Moore, 2012).

The next two caregiver training programmes outlined below are the most similar in many ways to the Fostering Security training programme for caregivers.

The Fostering Changes programme, developed at the Maudsley Hospital in London, was originally based on social learning theory and cognitive behavioural therapy (Pallett et al., 2002), and was revised to include attachment theory as understanding of the effects of neglect and abuse developed (Briskman et al., 2012). This intervention aims to facilitate secure attachment and good communication between caregiver and foster child, to help caregivers understand the relationship between thoughts, feelings and behaviour, to develop caregiver's child behavioural management skills, as well as to provide the caregivers with the skills to facilitate improved educational outcomes for the foster child (Briskman et al., 2012). The Fostering Changes program is a 12-session group-based intervention which gives caregivers information about attachment theory and guides them in the use of a range of behavioural interventions like the use of praise, consequences, and limit-setting, the use of positive communication strategies, and the use of strategies to support various aspects of the foster child's learning (Briskman et al., 2012). Caregivers are also supported to reflect on how they interpret the foster child's behaviours, how they respond to the child, and how they communicate with the child (Warman, Pallett, & Scott, 2006). The evidence for the Fostering Changes programme has been conducted in Britain (Briskman et al., 2012; Pallett et al., 2002; Warman et al., 2006).

An early non-controlled study, based on the earlier version of the Fostering Changes programme (informed by social learning and cognitive behavioural theory), involved 60 caregivers participating in ten-weekly three-hour sessions and separated into two groups: those caring for foster children under 12 years old and those caring for foster children over 12 years old (Pallett et al., 2002). Baseline data was collected approximately one month before the training programme and

outcomes data was collected approximately one month after the study (Whitehead, 2015). Ten caregivers completed the Parenting Stress Index (Abidin, 1995) at programme completion and statistically significant decreases were found in the caregiver-child dysfunctional interaction scale and the difficult child scale (Pallett et al., 2002). In addition, a carer defined problems scale and the Strengths and Difficulties Questionnaire (Goodman, 1999), completed by 36 of the caregivers showed statistically significant decreases in the severity of the caregiver's behavioural concerns for the foster children, although no significant difference was found for the children's hyperactivity and conduct problems (Pallett et al., 2002).

A second study, also based on the earlier version of the Fostering Changes programme informed by social learning and cognitive behavioural theory, also used the Parenting Stress Index and Strengths and Difficulties Questionnaire and found significant decreases in caregiver distress and stress levels, caregiver's behavioural concerns for the foster child, and consistent with the first study, no decrease in conduct problems or hyperactivity (Warman et al., 2006). The authors surmised that the Strengths and Difficulties Questionnaire was not sensitive enough to capture behavioural changes as it was designed to be a screening tool.

A more recent randomised controlled trial used the version of the Fostering Changes programme that included attachment theory and comprised a sample of 34 caregivers in the intervention group and 29 caregivers in the control group (Briskman et al., 2012). In addition to the measures used in the two previous studies, a questionnaire that measured the quality of the caregiver-foster child attachment relationship was also completed by caregivers (Briskman et al., 2012). Results from this study showed that the Fostering Changes was associated with significantly reduced caregiver reports of the foster child's problem behaviours,

greater improvements in the attachment relationship as reported by the caregiver, improvements in the foster child's attachment security, and positive changes in caregiver confidence (Briskman et al., 2012). The evaluations of the Fostering Changes programme therefore indicate that it is a promising intervention that has positive outcomes on caregiver as well as foster child variables.

A New Zealand qualitative study investigated the experiences and perceptions of five caregivers 13-15 months following their participation in the Fostering Changes training programme (Whitehead, 2015). Interview analysis indicated that caregivers found the Fostering Changes programme was a well-designed programme that had a positive impact on caregiver's ability to parent their foster children and was highly valued by them (Whitehead, 2015). Specifically, the caregivers reported continued benefits from the programme in their competencies and confidence as caregivers (e.g., improved insight into the foster child's behaviour, more use of praise and focus on positive behaviours, improved caregiver emotional regulation, more acceptance and patience, and reduced stress), as well as improvements in the caregiver-foster child relationship, increased placement stability, and improvements in some of the foster child's behavior (Whitehead, 2015). While the Fostering Changes intervention was found to be beneficial, Whitehead (2015) concluded that caregiving is a stressful and ongoing struggle and caregivers continued to need further professional interventions and additional support in addition to their participation in the time-limited training programme.

Another group caregiver training programme developed in Britain is Fostering Attachments Group (revised and currently renamed Nurturing Attachments Training Resource), which is also based on social learning and

attachment theories (Golding, 2007). This training programme aims to develop caregivers' parenting skills to help them understand the effect of the social environment on the child's behaviour and to support caregivers to manage the child's attachment and trauma difficulties (Gurney-Smith, Granger, Randle, & Fletcher, 2010). Caregivers are provided with psychoeducation on attachment theory and are taught to apply the theory through group discussions, role plays and exercises (Golding & Picken, 2004). The Fostering Attachment Group uses the House Model of Parenting as a framework (Golding, 2008) and emphasises Hughes (1997) attachment-based parenting approach which is based on improving the caregiver-foster child relationship by building a secure and positive family base which provides the child with a sense of safety and belonging.

All the evidence for the Fostering Attachments Group programme comes from studies conducted in Britain. In a pilot study of six caregivers attending 18 two-hour sessions over 18 months Golding and Picken (2004) found significant improvements from baseline to programme end in caregiver ratings for foster child peer difficulties, hyperactivity problems and total difficulties on the Strengths and Difficulties Questionnaire. The authors however acknowledged the methodological limitations of the study, including the small sample size and lack of randomised control trial (Golding & Picken, 2004). Another study with a small sample of seven caregivers, no controlled trial and no follow-up, found no change in the foster child's behaviour, social functioning or emotional wellbeing over an 18-week Fostering Attachments Group programme (Laybourne, Andersen, & Sands, 2008).

An evaluation of the Fostering Attachments Group for 13 caregivers, with measures repeated post-group and at three months follow-up, improvements were found in the caregiver's understanding of the foster child's difficulties, significant

child behavioural improvements were reported by caregivers, and significant improvements were found in caregivers' mind-mindedness, that is, the ability to correctly identify and be sensitive to the child's thoughts and feelings (Gurney-Smith et al., 2010). A further controlled-group evaluation assessed the effect of the Fostering Attachments Group at the end of the programme and at eight months follow-up (Wassall, 2011).

This study found that the programme was associated with increased caregiver confidence and self-efficacy, but did not appear to improve caregiver stress levels, caregiver perception of the foster child, the foster child's emotional and behavioural problems, and the foster child's sense of security with the caregiver (Wassall, 2011). These findings are consistent with our experience as professionals working with foster children in Hawke's Bay – given the complex nature of the biopsychosocial problems foster children can present with, improvements in their attachment relationships and behavioural problems cannot be expected to occur over such a short time period as a 10 to 15-session training programme. Wassall (2011) focused on some methodological limitations which may have moderated the study's conclusions, including the small sample size that could have reduced the generalisability of the study's results, the lack of pertinent psychometric measures that were suitable for children of all ages, and the reliance on self-report assessments that could have led to biased responses. Wassall (2011) concluded that the Fostering Attachments Group appeared to serve as a foundation for a broader package of interventions for foster children, but did not seem enough on its own to meet the substantial needs of foster children and caregivers. This conclusion is consistent with the awareness of the need for multiple-levelled

interventions to address complex attachment and trauma problems children in care can present with (Bruns et al., 2010; Gutkin, 2012; Tarren-Sweeney, 2014a).

**Summary.** In summary, a number of generic parent training programmes and foster parent training programmes have been associated with improvements in the foster child-caregiver attachment relationship and improved emotional and behavioural regulation in the foster child and caregiver. Widely used training programmes that are largely educational in nature are beneficial but are not sufficiently focussed on developing the therapeutic potential of caregivers as are intervention programmes that are educational as well as skills-based. It has also been increasingly recognised that, in addition to behaviour management strategies (i.e., use of reinforcements, consequences, modelling, and limit-setting), caregivers benefit from training programmes which incorporate attachment theories. The insight from the latter theories is beneficial in helping caregivers understand the foster child's attachment and trauma problems, and facilitates the development of more trusting and secure relationships.

### **Methodological Issues**

The methodological limitations of evaluations of foster parent training programmes appear to be a contributing factor to the varied evidence of their effectiveness (Luke et al, 2014; Solomon, Niec, & Schoonover, 2017). Everson-Hock et al. (2011) reported on findings from six American and British studies evaluating the effectiveness of foster parent training programmes. Overall, they found varied evidence of the effectiveness of foster parent training and support on the behavioural and emotional problems of children in their care, and on placement stability (Everson-Hock et al., 2011).

Methodological weaknesses of studies of the effectiveness of foster parent training programmes have been found to include a lack of rigorous randomised controlled trials, small sample sizes, evaluation of the programme by the programme developer and therefore subject to bias, and a reliance on caregiver/parent-only reports of the child's behaviour, which may be biased (Dorsey et al., 2008; Everson-Hock et al., 2011; Wassall, 2011). Everson-Hock et al. (2011) further speculated that, as the benefit of parent training programmes tends to decrease over time, the studies with follow-up timeframes of a longer duration were less likely to have been found to be effective.

While it is acknowledged that the methodological problems seen in foster parent training evaluations contribute to the mixed evidence of their effectiveness, the complexity of problems children in care can present with makes it difficult to study changes in this population group. In particular, there appears to be difficulty in using traditional research designs to evaluate training programmes designed to address complex child mental health and behavioural problems that take long periods of time to ameliorate, if they can be ameliorated. Tarren-Sweeney (2014a) suggested the following as issues likely to affect robust research studies: (a) the difficulty defining and measuring the complex pattern of attachment and trauma problems children in care can present with; (b) the difficulty defining and measuring realistic and meaningful change in this group of children; (c) the diversity among groups of caregivers and foster children; and (d) the number of years it takes before positive outcomes are seen in children in the care of consistent and nurturing foster parents. It is therefore important that future studies into the effectiveness of foster parent training programmes consider other ways to measure successful outcomes of a time-limited group training programme (M. Tarren-

Sweeney, personal communication, July 27, 2017). For example, it may be that foster parent training programmes are evaluated for their contribution as a foundational base for ongoing support and professional intervention.

### **Component Analysis**

Evaluations of caregiver training programmes are also likely to be enhanced by assessing the relative effect of individual training components within the training programmes. It is therefore important to look at the individual components, delivery methods, and processes of change within parent training programmes, rather than just evaluating a manualised and packaged programme in its entirety (Solomon et al., 2017; Westen, Novotny, & Thompson-Brenner, 2004). For example, variables such as teaching caregivers to develop the relationship with the child through play or getting them to practice how to implement time out, could be examined to determine which particular programme components are associated with larger or smaller programme effects (Kaminski, Valle, Filene, & Boyle, 2008). This component-analysis would be valuable in informing what components should be included in parent training programmes to make them more effective, but is very rarely undertaken in evaluations of generic or foster parent training programmes (Everson-Hock et al., 2011; Kaminski et al., 2008; Tarren-Sweeney, 2013a). In a meta-analytic review of the components of 77 parent training programmes, Kaminski et al. (2008) found the following:

- Three components were associated with improved parent behaviours and skills, that is, teaching parents positive emotional communication skills, teaching parents how to interact positively with their child through play and

other activities, and requiring parents to practice skills learned in the programme with their child at home.

- Four components were associated with improved child behavioural outcomes, that is, teaching parents how to use the time out strategy appropriately, requiring parents to practice skills learned in the programme with their child at home, teaching parents to react positively to their child, and teaching parents to be consistent in their responses to the child.
- Less effective programme components included teaching parents how to problem solve about the child's behaviour, teaching parents how to develop the child's academic and cognitive skills, teaching parents how to develop the child's social skills, and providing services beyond what was specific to parenting skills, for example, stress, anger management or substance abuse services.

While this meta-analytic study only included generic parent training programme evaluations published between 1990 and 2002 (Kaminski et al., 2008), the results may be pertinent to all parent training programmes, including foster parent interventions. Studies evaluating the effects of foster parents training programmes may benefit from the inclusion of a component analysis to determine the relative influence of the individual components and methods of programme delivery. This issue of component analysis and the analysis of the mechanisms of change in parent training programmes is discussed later in this chapter. Further, as will be seen in Chapters 3 and 4, the present study of the Fostering Security training programme for foster parents includes an analysis of the different modules of the programme to attempt to determine their relative effects on foster parent and foster child outcomes.

### **The Need for More Specific and Focused Caregiver Training**

As has been shown, the complexity of biopsychosocial problems children in care can present with means that their caregivers require more than just generic and largely behaviourally-based parenting interventions. In New Zealand, the National Caregiver Training Programme is offered to caregivers through the Ministry of Social Development, and comprises 12 one-day workshops which occur at different times through the year (Ministry of Social Development, 2016c). The 12 workshops of the National Caregiver Training Programme are (1) attachment and resilience, (2) child development, (3) understanding and managing behaviour, (4) principles of Māori culture and tradition, (5) maltreatment and family violence, (6) health and wellbeing, (7) safety and prevention, (8) identity and belonging, (9) legal issues, (10) teamwork, (11) carer families, and (12) working with adolescents (Ministry of Social Development, 2016c). While these workshops focus on a range of issues relevant to caregivers and their foster children, anecdotal reports from caregivers indicated that they found the national training too general to address their needs for information and support to understand and manage the specific and challenging attachment- and trauma-related behaviours their foster children displayed.

For Dorsey et al. (2008) training for foster parents needs to be two-pronged – they need information about legal and occupational issues which are important to their roles and jobs as foster parents, but they also require the skills to parent and care for children who have very challenging mental health problems related to their histories of abuse, neglect, trauma, and loss. As will be shown, the Fostering Security training programme has been developed to address both these sets of

issues. The following factors have been suggested as core components of effective foster parent training and support and have guided the development of the Fostering Security programme delivery and content (Bernard & Dozier, 2011; Fuentes, Salas, Bernedo, & Garcia-Martin, 2014; Golding, 2008; Modernising Child, Youth and Family Expert Panel, 2015; National Institute for Health and Care Excellence, 2015; Rock et al., 2015; Schofield & Beek, 2005):

- Developing the caregiver's understanding about the effect of attachment disruptions and traumatic experiences on the child's development, behaviour, and mood.
- Improving the caregiver's understanding of what their child's behaviour means.
- Helping caregivers to be able to reflect on their own and the foster child's thoughts, feeling and behaviours and their parenting approach, to be available, sensitive and responsive to the child's needs, especially when the child is distressed, to help the child understand difficult experiences, and to show acceptance of the child's difficulties and develop the child's strengths.
- Helping caregivers to develop the child's security, self-esteem, sense of trust, sense of well-being, and sense of belonging within a warm, committed, emotionally-involved, nurturing, and permanent family.
- Facilitating caregivers' warmth, tolerance, empathy, emotional regulation, and positive communication patterns in the face of very challenging, distrustful, and rejecting child behaviours.
- Supporting caregivers to implement rules, routines, boundaries, and consequences for inappropriate child behaviours in a positive manner which protects their relationship with the child.

As was discussed in Chapter 1, caregivers reported not feeling valued by professionals and not feeling respected as an integral part of the team around the foster child (Atwool, 2010; Murray et al., 2011). To support caregivers with the very onerous task of parenting children in care with complex biopsychosocial problems, it is vital that they receive the appropriate support, training, acknowledgement, and respect for the critical role they have in improving outcomes for the children in their care. It is also vital that caregivers are viewed by the professionals working with the foster children as valued partners and co-therapists in interventions aimed to improve the mental health and behaviour of the foster children (Modernising Child, Youth and Family Expert Panel, 2015; Murray et al., 2011). Many children in care demonstrate gradual mental health improvement in the care of nurturing, responsive, and consistent foster parents (Tarren-Sweeney, 2014a), and this can occur even in the absence of mental health interventions from services. It therefore follows that mental health interventions for children in care, with complex attachment- and trauma-related difficulties, should support their caregivers to be the types of caregivers these children need to make behavioural, emotional and developmental progress (Rock et al., 2015).

### **Summary**

This chapter has shown that interventions targeted at foster parents are a vital component of mental health interventions for children in care. To develop secure and trusting attachment relationships with their foster children, and to achieve foster placement stability, foster parents require specific and focused training and support to understand and cope with a range of complex attachment- and trauma-related behaviours (Modernising Child, Youth and Family Expert

Panel, 2015; Rock et al., 2015; Tarren-Sweeney, 2014a). It was also argued that generic parent training programmes, while useful to an extent, are limited in meeting the specific needs of foster parents. While learning behavioural principles around rewards, consequences and limit-setting is important for foster parents, this is not enough to help them understand and manage the foster child's complex biopsychosocial problems. They also require support to develop emotional sensitivity to the child, an understanding of the reasons for the child's behaviour, and insight into their own responses to the child so as to better regulate their emotions and responses to the child.

Therefore, while social learning theory remains a core component of foster parent interventions, effective foster parent interventions also need to be underpinned by attachment theory, the concept of mind-mindedness, neurobiological theories of trauma, abuse, and neglect, attribution theory, and theories about the mechanisms of change (Rork & McNeil, 2011; Schofield & Beek, 2005; Scott & Dadds, 2009). The Fostering Security training programme in New Zealand is underpinned by these theories and concepts in recognition of the particular needs of foster parents to understand and cope with the complex attachment and trauma problems of their foster children. The Fostering Security programme and its guiding theories are described in detail in Chapter 3. Finally, a number of methodological limitations have been highlighted as contributing to the mixed evidence regarding the effectiveness of foster parent training programmes.

### **CHAPTER 3: THE FOSTERING SECURITY PROGRAMME**

This chapter provides a description of the essential features of the Fostering Security training programme that I developed in Hawke's Bay, New Zealand in 2008. There are four sections in this chapter. The first section outlines the development of the Fostering Security programme and the current research. The theories guiding the programme are then discussed, that is attachment theory, neurobiological theories of trauma, abuse and neglect, social learning theory, attribution theory, mind-mindedness, and the mechanisms of therapeutic change. Thirdly, a description of the Fostering Security programme is provided alongside its aims and philosophies, the cultural context, and the interagency aspect. Finally a framework for considering the mechanisms of change in the Fostering Security training programme is then suggested, which guided the current research study.

#### **Programme and Research Development**

As discussed in the Preface, the Fostering Security programme for caregivers was the product of my background and interest in the foster care field and many years of working therapeutically with children in care and their caregivers. The Fostering Security training programme for caregivers was developed in 2008 due to my concerns that caregiver-child therapy sessions did not provide the appropriate time and environment needed to address the specific needs of the caregiver - seeing foster children and caregivers therapeutically one hour a week was insufficient time to provide information and support that caregivers needed. In addition, caregivers provided consistent feedback regarding their need for specialised training. In particular, it became clear that caregivers would benefit

from a therapeutic and educational space to reflect on the foster child's attachment- and trauma-related problems, their parenting approaches, and the effect of their own background and experiences on the caregiver-child relationship. At the time of the development of the Fostering Security programme, no other programme designed specifically for foster parents was available in New Zealand.

Given my background of training and experience in generic parent training programmes like the Incredible Years parent programme, and recognition of their benefit in providing sound parenting frameworks, I decided to group foster parents with similar experiences together to capitalise on the collective knowledge they had and to share pertinent information with them as a group. I recognised from clinical experience that caregivers needed more information about attachment and trauma, and targeted interventions to ameliorate the complex problems which children in care often exhibit.

I developed the Fostering Security programme for caregivers, assisted by two intern psychologists at the Child, Adolescent and Family Service at the time. The Fostering Security programme was not developed in competition with any other parent training programme – rather it was seen as complementary in many ways, that is, foster parents will often participate in the Incredible Years programme to obtain core parenting skills before participating in the Fostering Security programme to obtain more specific attachment and trauma related knowledge and skills.

Given that New Zealand delivered the National Caregiver Training Programme to caregivers through the Ministry of Social Development which covered a range of issues relevant to caregivers and their foster children, it was considered important to consult with Child, Youth and Family to discuss the fit

with the national caregiver training. In addition, after the first Fostering Security programme which I facilitated alongside another mental health clinician, it was apparent that the involvement of Child, Youth and Family would be important as many issues were raised by caregivers that related to Child, Youth and Family policies and procedures that we could not adequately address.

Initially the Fostering Security programme consisted of two modules, that is, education about the effects of trauma, abuse and neglect and behaviour management strategies to manage the challenging behaviours most common in foster children. With the benefit of feedback and analysis participants' comments and concerns throughout the course of the next two Fostering Security programmes, further refinement of the curriculum occurred. These modifications were the extension of the original psychoeducation module, the inclusion of the self-care/self-reflection module, the expansion of the behaviour management module so that it was renamed the behaviour management and skills training module, and the creation of a new section outlining Child, Youth and Family policies and procedures pertinent to caregivers.

Following national conference presentations about the Fostering Security programme, it gained some national attention and was the 2010 Werry Centre winner of the Inaugural Werry Centre Innovative Workforce Development and Service Award in the category of innovation in service development benefiting workers, infants, children and adolescents using mental health services. The Fostering Security programme was further supported by Dr. Russell Wills who was at the time the Children's Commissioner and a Hawke's Bay District Health Board paediatrician. Dr. Wills wrote about and advocated for the Fostering Security

programme in several articles and submissions in his role as the Children's Commissioner.

Given the awareness of the Fostering Security programme nationally, there were increased requests for it to be shared in other centres around New Zealand. However, given the early stage of development of the programme, the lack of an evidence base, and a focus on the bottom lines for programme fidelity for the programme, we were uncomfortable sharing the programme too widely. It was therefore decided to pilot the Fostering Security programme in Christchurch and West Auckland as both centres had strong champions for the programme and had dyads of mental health and child welfare practitioners who were willing to be trained together as facilitators. We were also interested in obtaining feedback about the programme from centres other than Hawke's Bay. The issues around robust fidelity measures was important – we wanted to be sure that the Fostering Security programme was being delivered in other centres in a similar way to how it was being delivered in Hawke's Bay. Training manuals and packages were therefore put together for the Christchurch and West Auckland teams, and Lisa Harrington (Child, Youth and Family supervisor at the time and Fostering Security co-facilitator) and I developed the training manuals and packages as a joint mental health and child protection initiative.

An informal survey of two Fostering Security caregiver groups was undertaken in 2010 for feedback about the programme and quality improvement. This preliminary evaluation was not a formal research study, but about evaluating what we had done thus far and from the feedback to further refine the programme. Two caregiver groups participated in semi-structured interviews and the interviews were analysed for over-arching themes. These themes were: caregiver need for

education and training; access with biological parents; issues that grandparents raising grandchildren faced; the resurfacing of historical and intergenerational issues; caregiver need for ongoing support and validation; the more and less useful aspects of the Fostering Security programme (e.g., self-reflective exercises for caregivers, the use of 'time in' versus 'time out', creating a sense of belonging in the family for the foster child). The analysis also provided the opportunity for reflection on the outcomes measures used at the time, that is, the Strengths and Difficulties Questionnaire (Goodman, 1999) and the Parenting Stress Index (Abidin, 1995). While the Strengths and Difficulties Questionnaire was initially used we did not find that it gave enough specific information about the foster child's attachment and trauma related mood and behaviour problems. In addition, the Parenting Stress Index was useful in providing information about the degree of caregiver-foster child relational frustration but it was not a broad enough measure to capture the different domains of the foster parent-foster child relationship (e.g., the attachment relationship) as well as parental stress and frustration.

Interest in the current research grew as a result of a number of factors. Experience and study highlighted the need for foster parent training to be based on social learning theory as well as theories and approaches about attachment and trauma, critical reflection on parenting, and the development of the therapeutic capacity of caregivers. I was particularly interested in the capacity of caregivers to be able to look critically at their parenting approaches and reflect on the foster child's and their own emotions and behaviours. I was also increasingly interested in the mechanisms of change for caregivers on the Fostering Security programme as well as an analysis of the specific components of the ten-session programme. I began reading more about emotional responses to parenting, attributions for

behaviours, how and why people change, and theories about attachment, trauma, mind-mindedness, attributions, and the mechanisms of change in foster parent training programmes.

To increase my opportunities to engage in field research as a practicing clinician, I joined a research group at Massey University, Wellington. This group, entitled the CHERUBS lab, was led by Professor Ian Evans, and their programmatic research focused on the emotional elements of effective parenting and teaching, and the management of challenging behaviour. It was then decided that the Fostering Security programme would be delivered within a quasi-experimental design to the next two eligible groups, to be explored with more detailed quantitative and qualitative measures. These two groups formed the sample for the research described in this doctoral thesis.

The informal qualitative survey of the Fostering Security programme (discussed above) showed a high degree of programme satisfaction for caregivers and improvements in parenting and child outcomes (as subjectively reported by the caregiver). Given the complex nature of the biopsychosocial difficulties for children in care, improved child behavioural outcomes over a ten-session caregiver training programme had not been anticipated in the preliminary evaluation. This led to speculation that the caregivers' reports of child behavioural improvements may have been associated with the caregiver's increased understanding of the child rather than actual improvements in the child's behaviour. The current research therefore also includes teacher information about the foster child's behaviour, in an attempt to provide a more objective measure of child behavioural improvements. The preliminary investigation had also raised questions regarding the relative influence of the different modules of the Fostering Security training programme in

improving foster parent skills and behaviours. The current research is therefore concerned with those factors in the Fostering Security training programme content and process which seem to be associated with improved foster parent skill, self-reflection, and parenting approaches.

This study utilised a mixed methods, pre/post quasi-experimental research design to attempt to more fully explain the mechanisms of change in the Fostering Security programme – alongside the statistical data, caregivers' qualitative information about their experience of the Fostering Security programme, their experiences as a foster parent, and their perceptions of their foster children, were considered important to provide a deeper and more comprehensive description of the factors in the Fostering Security programme which led to change. The benefits of a mixed methods research design are widely acknowledged as providing a robust study of psychological phenomena by combining quantitative and qualitative research methods (Caruth, 2013; Cresswell, 2009). Mixed methods research designs are increasingly used by researchers as a way to triangulate research information to ensure its validity, and to utilise quantitative and qualitative research information to provide more information about each other (Onwuegbuzie & Leech, 2006; Migiro & Magangi, 2011).

### **Guiding Theories**

This section outlines the theories and concepts that underpin the Fostering Security training programme as well as the current research. As was discussed earlier, children in care can present with a range of neurobiological, developmental, emotional, behavioural and social problems, including conduct problems (i.e., defiant, aggressive, noncompliant and disruptive behaviours) due to their adverse

early experiences, inappropriate role modelling, and poor parenting (Maaskant et al., 2014; Tarren-Sweeney, 2013b; van der Kolk et al., 2012). Due to these complex biopsychosocial problems, it is important that caregiver training is underpinned by theories which can meet the range of these needs (Rork and McNeil, 2011; Scott & Dadds, 2009). The guiding theories informing the Fostering Security programme and research are attachment theory, theory of mind-mindedness, social learning theory, neurobiological theories of trauma, abuse, and neglect, attribution theory, and theories about the mechanisms of change. These will be discussed in further detail below. As attachment theory is the main theory underpinning the Fostering Security programme, this section is discussed in more detail than the other theoretical approaches.

**Attachment theory.** Due to the early adverse and traumatic experiences that tend to lead to children being placed in foster care (such as inconsistent parenting, abuse, neglect, transient lifestyles, domestic violence and exposure to drug and alcohol abuse), they can have difficulty developing secure and trusting attachments to others (Schmid et al., 2013; Shipman et al., 2007; Tarren-Sweeney, 2008b). In addition, multiple foster care placements tend to exacerbate these attachment problems, as there are not long enough time periods in placements for children to develop stable relationships with caregivers (Kools & Kennedy, 2003). It is therefore important that caregiver training programmes are informed by attachment theory, so caregivers gain an understanding of the effects of disrupted attachments on the foster children in their care, and to support them to help the children develop healthier and more secure attachments (Bernard & Dozier, 2011; Golding, 2008; National Institute for Health and Care Excellence, 2015).

Discussions about attachment theory typically begin with John Bowlby, a British psychiatrist and psychoanalyst widely recognised as the father of attachment theory. Working in London in the 1930s with children with emotional and behavioural difficulties, Bowlby grew interested in the attachment process between parent and child, its influence on the child's social, emotional and cognitive development, and how disturbances in the attachment process were often intertwined with issues of grief and loss (Holmes, 1993). Bowlby asserted that prolonged separation of a mother and child in the first five years of the child's life was one of the main causes of delinquent behaviour in young people (Bowlby, 1969). Rutter (1972), however, argued that it is the disrupted attachment between the parent and child, rather than just physical separation that can lead to behavioural and developmental problems in young people. This was illustrated in a study which found 52% of children with depressed mothers were insecurely attached (Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985).

Bowlby described attachment as a "psychological connectedness between human beings" (1969, p. 194). This focus on attachment as being of psychological importance in its own right differed from previous psychoanalytic theories of the mother-infant relationship which emphasised infant sexuality and feeding issues (Holmes, 1993). In addition to attachment serving a psychological aim, Bowlby also stressed attachment as being adaptive in the evolutionary context in ensuring the protection and survival of the infant (Holmes, 1993). Highlighting the give-and-take nature of the attachment relationship, James (1994, p. 2), defined attachment as "a reciprocal, enduring, emotional, and physical affiliation between a child and a caregiver". The most important tenet of attachment theory is therefore the infant's need to seek nurturance and protection, especially in stressful situations, from at

least one primary attachment figure (usually the mother), for typical development to occur (Bowlby, 1982).

Infants, from about the age of six months old, typically become securely attached to adults who are sensitive, responsive, and consistent in providing care and affection (Bowlby, 1969). After about six months of age, infants tend to become wary of strangers and protest when separated from their primary attachment figures (Zeanah, Shauffer, & Dozier, 2011). While Bowlby originally suggested a critical period (between six months and two to three years old), during which it was necessary for selective attachments to develop, more recent research indicated that children retain the ability to form secure attachments later in life in stable foster placements (Mercer, 2011; Rutter, 1995). This is particularly important for foster parents to be aware of – if they believe the foster child is able to form positive attachment relationships later in their childhood, they will be more optimistic about their role as positive and stable attachment figures for the child.

Children use their main attachment figures as a secure base from which to explore, develop, and learn (Ainsworth, 1982). Infants develop a range of attachment behaviours designed to keep their caregivers close and use them as a secure base, for example, getting upset or crying if the caregiver leaves, showing pleasure or excitement at the caregiver's return, clinging to the caregiver when afraid, and following the caregiver when able to (Golding, 2008). Secure base behaviour has been suggested as being characteristic of the human species, and Posada et al (1995) found that in seven countries (China, Colombia, Germany, Israel, Japan, Norway, and the United States), children generally used their mothers as a secure base. In a review of the attachment literature from an indigenous Māori perspective in New Zealand, Fleming (2016) concluded that the western concepts

of attachment also applied to Māori, in particular, the interpersonal and nurturing relationship (usually between mother or father and infant) was held to be essential for optimal infant development. However, additional to this crucial interpersonal relationship, Fleming (2016) argued that, given that whānau (or immediate and extended family like grandparents, uncles, aunts, and cousins) is a foundational building block of Māori society, extrapersonal or extended family relationships are also important for Māori when considering attachment relationships.

Another important tenet in the field of attachment theory is that of Bowlby's internal working models (Bowlby, 1973). While the concept arose from Bowlby's psychoanalytic background, the term appears more aligned with cognitive theory (Holmes, 1993). Internal working models are the schema or mental representations the growing child forms of themselves, their relationship with others, and of the general safety and predictability of the environment around them (Bowlby, 1973). Children develop positive internal working models when their primary caregivers are consistently nurturing, responsive and sensitive to their needs. However, those children who experience frequent abuse and neglect, are consistently exposed to trauma and violence, have transient and unsettled home environments, and have parents who are unable to consistently meet their physical, emotional and psychological needs, are more likely to develop negative and distorted perceptions of themselves (as not worthy of being loved and as being to blame for their difficulties), of adults (as inconsistent, hurtful, and untrustworthy), and of their world in general (as being an unsafe place and one in which they must stay in control to keep from being hurt again). Internal working models are believed to be established by age three, but there is evidence to suggest that infants as young as 12 months old are already establishing mental representations

(Johnson, Dweck, & Chen, 2007). Around the age of three years old these mental representations appear to form part of a child's personality and informs their understanding of the world and their social interactions (Schoore, 2000).

While it is possible to alter the negative mental representations children in care can have of themselves, adults and their world, the experience of mental health professionals in Hawke's Bay indicates that it is a very challenging undertaking for caregivers – perspectives that have become ingrained over years are often difficult to change, and require years of consistent, responsive and nurturing parenting and experiences to replace with more positive schema (Schofield & Beek, 2005).

Particularly difficult for caregivers is that their foster children find it difficult to accept and trust these more positive experiences, tending to revert to the established negative internal working models and view good foster care with distrust and suspicion (Schofield & Beek, 2005). Foster parent training therefore needs to support caregivers to understand why their foster children are distrustful of their parenting, and to support caregivers to persevere with providing the foster child with consistent, nurturing and responsive parenting and with alternative perspectives of themselves, others and the world around them, in the face of the child's distrust, fear, challenging behaviours, and need for control.

Ainsworth and her colleagues (1978) provided empirical evidence for Bowlby's attachment theory using the Strange Situation Procedure. This procedure involved observing how children under 18 months old responded when taken into a strange room with their primary attachment figures, when left only with a stranger in the room for a short time, when left alone in the room for a short time, and when the attachment figure returns (Ainsworth et al., 1978). With the Strange Situation Procedure, infants were classified into one of three organised patterns of

attachment, the patterns being 'organised' as the child knows how to behave with each respective type of parent (Ainsworth et al., 1978; Benoit, 2004; Golding, 2008; Holmes, 1993):

1. Infants with a secure attachment experience their primary attachment figures (usually the mother) as warm, consistent, responsive and sensitive. They are able to use their mothers as a secure base from which to explore the environment, and to which to return for comfort. Infants with secure attachments patterns tend to have positive internal working models, for example, they are worthy of love, and will be cared for and protected. Infants with secure attachment patterns are typically distressed by separation from their mother, but are easily comforted by her on her return.
2. When a primary attachment figure is frequently not responsive to the infant's emotional distress, and is often resentful and rejecting of the infant, an insecure avoidant pattern of attachment can develop. The infant learns to minimise their displays of distress in an attempt to maintain closeness to the parent, fails to use the mother as a secure base to explore from, and avoids or approaches the mother indirectly on her return. Internal working models of insecure avoidant children may include perceptions of themselves as being of little worth, and perceptions of others as being inconsistent, not dependable, and emotionally unavailable.
3. Infants with an insecure ambivalent-resistant attachment pattern tend to have primary attachment figures who are frequently inconsistent and insensitive, find it difficult to attune to their child, and are unpredictable in how they respond to the child. The infant tends to be very distressed on separation from the mother in the Strange Situation Procedure, but can

resist being comforted and alternate between anger and clinging behaviour toward the mother. The insecure ambivalent-resistant child tends to have internal working models of self as unlovable and of little worth, and of others as unreliable and inconsistently available.

More recently, a fourth category of attachment has been suggested, namely, the disorganised attachment pattern (Main & Solomon, 1990). When a primary attachment figure is not only inconsistent and insensitive but also frightening and/or abusive, infants feel fear, distress and helplessness, and their attachment behaviours do not bring protection and comfort (Main & Solomon, 1990). The primary attachment figure is therefore both the source of harm and fear but also the potential source of comfort and protection, so when the child is afraid or distressed they cannot organise their attachment behaviour in any predictable manner toward a primary attachment figure and remain distressed and emotionally dysregulated (Golding, 2008). The child with a disorganised attachment pattern tends to have internal working models of themselves as unworthy of love and care, and of others as frightening and unavailable. Under stress, the child with a disorganised attachment pattern perceives others as potential threats, even in benign situations, and may shift between social withdrawal and aggressive and defensive behaviour (Wilkins, 2012). Figure 2 provides an overview of the four patterns of attachment.

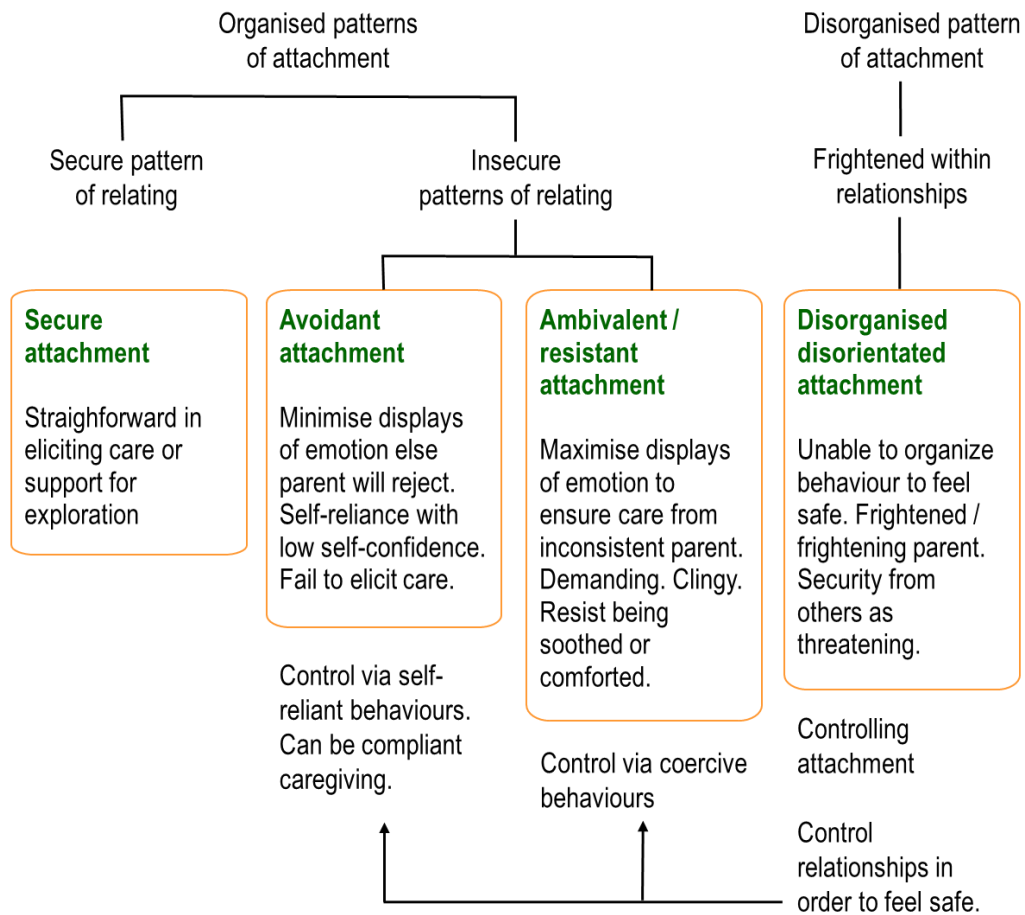


Figure 2. Patterns of attachment (adapted from Golding, 2008, p. 46)

In addition to these patterns of attachment, Golding (2008) suggested a small percentage of children, who have had no experience of an attachment relationship with a primary attachment figure and who have experienced severe neglect, will fail to develop attachment behaviours and show a pattern of non-attachment (e.g., children in very deprived institutions for orphans, and those children who are left alone for long periods of time from very young). These patterns of non-attachment are consistent with DSM-IV (American Psychiatric Association, 2000) diagnostic criteria for reactive attachment disorder. In addition, a dimensional approach to considering patterns of attachment (i.e., the degree to which attachment disruption is present) has been suggested over a categorical

approach (i.e., the presence of attachment disruption or not) (Minde, 2003; Fraley & Spieker, 2003). Zeanah & Gleason (2010) summarised research studies which showed reactive attachment disorder can be identified in children using both the dimensional and categorical approaches, indicating that children who go on to experience good parenting can show improvements in signs of reactive attachment disorder.

With regard to the patterns of attachment behaviours that children in foster care can demonstrate, it is important for foster parents to know that children can have different types of attachment relationships with different people (Zeanah et al., 2011). For example, a child may have a secure attachment with her mother who is consistently warm and responsive, but an insecure avoidant attachment with her father who is unresponsive and rejecting of her displays of emotion. Attachment patterns therefore appear to be related to relationships rather than fixed cognitive models. However, as they grow older, children tend to demonstrate one main and consistent pattern of attachment in relationships with others (Bretherton & Munholland, 2008). Nevertheless, studies into the longitudinal stability of attachment patterns indicated that patterns of attachment can change for young people (in either a positive or negative direction), when they are in relationships with adults who respond differently to them than adults did in the past (Lewis, Feiring, & Rosenthal, 2000; Weinfield, Sroufe, & Egeland, 2000). It is particularly important that caregivers are aware that children and adolescents in care do have the potential to develop more secure attachment relationships in foster care (Joseph et al., 2014).

Attachment theory is not without its criticisms, which include the following: not all children with adverse early experiences will have disrupted and

insecure attachments as a complex interaction of biological, psychological, social and environmental protective factors can protect them from the development of mental health problems (Schofield & Beek, 2005); in adolescence peers have as much influence, or more, on young people (Harris, 1998); there is an overemphasis on the mother-child attachment relationship to the exclusion of other important attachment relationships throughout the child/young person's life (Field, 1996); and under certain environmental conditions there are potential adaptive benefits of insecure attachment styles (Ein-Dor & Hirschberger, 2016). Despite these and other criticisms, the main tenets of attachment theory, have generally been validated (Mercer, 2011). Citing relevant research findings, Mercer (2011) showed that the following tenets of attachment theory have generally been supported by research: attachment involves emotional ties to significant people in one's life for the purpose of security and protection; the attachment relationship is not restricted to biological parents; while long separations from the primary attachment figure can result in grief, new attachments are possible with nurturing and responsive caregivers; attachment is about more than just feeding and physical care, it is based more on the quality of parenting the child receives; the child's early attachment experiences are central in shaping resulting social behaviour; and mental representations or internal working models about the self, others, and the world, are formed on the basis of the quality of attachment relationships, and inform future social interactions and relationships through life.

**Mind-mindedness.** Another important concept that has been associated with secure parent-child attachments is mind-mindedness (Meins et al, 2012). Mind-mindedness describes the parent's ability to understand and respond to their child's thoughts and feelings, as well as to their own thoughts and feelings (Meins,

Fernyhough, Fradley, & Tuckey, 2001). The mind-minded parent is attuned to the child's internal mental states (e.g., beliefs, desires, and intent), and is able to verbalise the child's thoughts, feelings and intentions to them, thereby helping them to understand and regulate their emotions (Howe, 2005). Mind-mindedness is often assessed by analysing parental descriptions of the child – these descriptions might include physical descriptions of the child (“He is very tall for his age”), behavioural descriptions (“He is a very busy boy”), or identify mental states or feelings (“I think she was sad as she didn't have anyone to play with”).

Mind-mindedness draws on the concept of sensitivity, which refers to the parent's ability to perceive things from the child's point of view, to recognise or try to understand what is causing the child's distress, and to respond promptly to attempt to soothe and regulate the child's emotions (Ainsworth et al., 1978). Meins (1997) maintained that parents who are mind-minded are able to interpret their child's psychological experiences, and verbally reflect these feelings back to the child in a clear manner, which helps the child develop an understanding of their and others emotions, and facilitates the development of a secure attachment.

Mind-mindedness can be inaccurate as well, with the parent identifying the child's mental state, but inaccurately (e.g., “I am sure she is deliberately trying to get me angry”, when the child is having a tantrum about not getting a toy she wants) (Evans, 2015). When parents who are able to accurately interpret their child's psychological states, the growing child begins to understand their own and other's behaviour as meaningful and predictable (Howe, 2005). This growing ability to think about one's own mind and the minds of others (i.e., the development of reflective function), is believed to be vital in the development of emotional regulation, and monitoring and controlling one's behaviour (Fonagy &

Target, 1997). Maternal mind-mindedness with infants has also been associated with strong theory of mind performance at age four (Meins et al., 2002; Meins et al., 2013). Theory of mind refers to the ability to understand one's own internal mental states and the mental states of others, the ability to understand that one's own beliefs and intent can be different from others, and the ability to use this knowledge to explain and predict the actions of others (Premack & Woodruff, 1978; Wellman & Liu, 2004). In addition, mother's positive mind-mindedness was found to be associated with decreased parental stress and improved perception of the child as being challenging (Demers, Bernier, Tarabulsy, & Provost, 2010).

Meins (1999) speculated that the parent of a child with an avoidant pattern of attachment does not tend to make many reflective and interpretive comments about the child's internal mental states, and tends to follow their own agenda rather than follow the child's cues. The parent of a child with an ambivalent-resistant pattern of attachment is likely to interpret the child's mental states inaccurately (Meins, 1999), while the parent of the child with a disorganised pattern of attachment tends to be unwilling or unable to correctly interpret the child's mental states (Meins et al., 2012). This latter type of parent (who may be abusive to or neglectful of their child), either does not recognise or acknowledge the child's psychological experiences, or does recognise the child's experiences but is rejecting of them (Howe, 2005). Given their early poor parenting, and experiences of abuse and/or neglect, it follows then that children in care can demonstrate difficulties with understanding their own and others thoughts, feelings and behaviours as meaningful and predictable. A study comparing the theory of mind ability of maltreated children and a non-clinical sample of children (O'Reilly & Peterson, 2015), found that the group of maltreated children had persistent

problems with understanding and interpreting their own and others' mental states. O'Reilly and Peterson (2015) suggested that poor parental involvement, responsiveness, and inadequate communication severely hinders the child's development of theory of mind. It can be seen then, that with poor reflective functioning, theory of mind problems, and poor ability to express and regulate their emotions, children in care can become angry and aggressive, confused, withdrawn, distrustful, dissociative, and socially uneasy (Fonagy, 1999; Howe, 2005; Schofield & Beek, 2005).

A critique of research on mind-mindedness is that it tends to be focused on mothers, much like the broader field of parenting research, in spite of evidence that the father-child relationship is also crucial in child development (McMahon & Bernier, 2017). A further gap in the research on mind-mindedness is the universal applicability of the construct. A study of 241 parent-child dyads found mind-mindedness to be a fairly consistent construct across English, French, Italian, and German speaking parents residing in the United Kingdom, and also found higher mind-mindedness scores in these British-based parents compared to parents in Hong Kong (Hughes, Devine, & Wang, 2017). Hughes and colleagues (2017) speculated that mental state attributions and statements may differ in parents from more collectivist cultures compared to parents from more individualist cultures. However, a vast body of research suggests that the assessment of parental mind-mindedness is an effective way to identify those parents who are able to develop their infant's emotional regulation, secure attachment, and mentalising abilities (McMahon & Bernier, 2017).

It follows then that foster parents taking on the care of children with emotional and behavioural problems will need training and support to help the

children develop their reflective function and theory of mind skills, among other mentalising skills. O'Reilly & Peterson (2015) therefore recommended that therapeutic interventions for maltreated children should include helping them to develop an awareness that people have different thoughts, beliefs and feelings, and supporting their development of the core social skills. Children in care first need their caregivers to understand their thoughts, feelings, intentions and perspectives, and then need their caregivers to help them to appropriately express these mental states. To this end, improving parental mind-mindedness has been suggested as a core component of mental health interventions to improve outcomes for children in care (Walker, Wheatcroft, & Camic, 2012).

In a longitudinal study of children in long-term foster care, sensitive parenting in caregivers was highlighted as a factor in successful foster placements (Schofield & Beek, 2005). Sensitive caregivers were found to provide foster children with a sense of security, were responsive and available to the child, tried to interpret what was happening in the child's mind and reflect this back to child (developing reflective functioning), and reflected critically on their own thoughts, feelings and parenting style (Schofield & Beek, 2005). A mindful approach to parenting has also been suggested to develop secure parent-child attachments, and encompasses the following aspects: parents listening to the children with their full attention, parents being non-judgmental of themselves and the children, parents having a good emotional understanding of their own emotions and the emotions of their children, consistent parental responsiveness to the needs of the children, the ability of the parents to regulate their own emotions, and parental empathy and compassion for themselves and their children (Duncan, Coatsworth, & Greenberg, 2009).

To summarise, mind-mindedness is acknowledged as a core component of secure parent-child attachment relationships, which should be included in interventions designed to support and train foster parents. To this end, it is one of the theories which underpins the Fostering Security training programme, which aims to increase the foster parent's sensitivity and responsiveness to the foster child, help them to reflect on their own attachment histories and past experiences that influence their parenting approach, and develop the foster parent's capacity to reflect on their own and on the foster child's internal mental states. It is certainly the experience of the Fostering Security programme facilitators, after nine years of the programme delivery in New Zealand, that many foster parents can develop their mind-mindedness capacity with the appropriate support, training, and acknowledgement.

**Social learning theory.** Given that social learning theory is considered to be a cornerstone of effective interventions for parents who have children with conduct problems (National Institute for Health & Care Excellence, 2013; O'Connor et al., 2013), and that children in care can present with conduct problems, it follows then that social learning theory should be one of the theories which underpins caregiver training. Parent training programmes, like the Incredible Years parent training programme are predominantly based on social learning theory, and have been shown to be effective in improving positive parenting practices and parenting confidence, and in reducing child behaviour problems (Baker-Henningham et al., 2012; Drugli et al., 2010; Fonagy et al., 2015; Reid et al., 2007).

A fundamental concept underpinning social learning theory is that learning is not purely behavioral but is a cognitive process that takes place in a social

context (Bandura, 1977). Social learning theory therefore emphasises the influence of the social environment on the child's behaviour (Bandura, 1977; O'Connor et al., 2013). As discussed in Chapter 2, the theory combines earlier behavioural and cognitive theories of learning, and states that learning is more complex than just behavioural modification by consequences and rewards, that is, positive reinforcement increasing the likelihood of desirable behaviours and negative reinforcement decreasing the likelihood of undesirable behaviours. Social learning theory also posits that the individual's behaviour is influenced by the environment as well as the environment being influenced by the individual's behaviour (i.e., reciprocal determinism) (Bandura, 1977). As illustration, a foster child who has very challenging behaviour in the classroom may trigger dislike for him amongst his peers who stay away from him, further exacerbating the child's behaviour problems.

Further, social learning theory states that, through reciprocal determinism, an individual's behaviour is influenced by the environment and the environment is also influenced by the individual's behaviour (Bandura, 1977). For example, a foster child who is distrustful of adults may reject the caregiver's affectionate overtures, which may result in the caregiver limiting their affectionate behaviour toward the child, which in turn confirms the child's perception of being unlovable and not important.

In social learning theory, learning is believed to be a cognitive process of observing others' behaviour, making conclusions about their behaviour, and deciding whether to behave similarly (Bandura, 1977; Grusec, 1992). Bandura's (1977) study of the concept of modelled behaviour involved children watching a person punching a Bobo doll (an inflatable and egg-shaped balloon doll with a

weight at the bottom) and then imitating many of the aggressive actions viewed.

Bandura (1977) surmised that negative behaviours occur when a person perceives another's behaviours as desirable or acceptable and therefore models the behaviour.

Parent training is clearly enhanced by supporting parents to positively reinforce the child's appropriate behaviours, maintain firm behavioural limits and boundaries, give clear directions and instructions, and implement consequences for inappropriate behaviours (Webster-Stratton, 2010). It therefore follows that foster parent training will be similarly enhanced by the inclusion of behaviour management skills and strategies informed by social learning theory. However, as discussed earlier, behaviour management skills and strategies are not enough on their own to meet the parenting needs of foster parents who are parenting children with complex attachment and trauma problems.

Social learning theory has been criticised by biological theorists who argue that the theory ignores biological states like autonomic nervous system reactions to experiences, and ignores the contention that some behaviours and responses may not only be learned but also be partly inherited (Burdick, 2014). However, social learning theory is well researched and its concepts are clearly defined and measured in empirical research. As such, it is rightly regarded as a cornerstone of parent and foster parent training programmes (National Institute for Health & Care Excellence, 2013; O'Connor et al., 2013).

**The neurobiology of trauma, abuse, and neglect.** Children in care can exhibit a range of emotional, behavioural, neurological, developmental, and physical problems due to earlier maltreatment, attachment disruptions, and adverse home environments (Murray et al, 2011; Tarren-Sweeney & Vetere, 2014).

Furthermore, children in care may have these problems long after they have been

removed from the abusive or neglectful home and placed into nurturing and consistent foster care (Stirling & Amaya-Jackson, 2008). Neurobiological studies have shown that children who have experienced chronic trauma, abuse, and neglect are more likely than children from typical backgrounds to show disturbances in a number of areas of brain and the wider nervous system development (Feit, Joseph, Petersen, & Council Institute of Medicine and National Research, 2014; Leve et al., 2012). Some of these areas of neurobiological disruptions are summarised below.

Childhood abuse and neglect has been associated with the negative functioning of the hypothalamic-pituitary-adrenocortical axis (Feit et al., 2014; National Scientific Council on the Development Child, 2012). The hypothalamic-pituitary-adrenocortical axis is a major part of the stress system and prepares the body to respond, in either a fight or flight mode, by regulating the release of cortisol (a hormone that modulates many of the body's changes required to deal with stressful situations, such as raising heart rate and blood glucose levels to provide the body with more energy) (Feit et al., 2014). This process can be disrupted in children exposed to chronic stress, due to prolonged activation of the body's stress response system (National Scientific Council on the Developing Child, 2014).

Elevated stress hormones have further been shown to negatively affect the growth and functioning of the amygdala and the hippocampus, two parts of the brain which play important roles in the body's stress response system (National Scientific Council on the Development Child, 2010; Ziegler, 2011). The amygdala is important in emotional regulation and helps the person accurately detect the level of threat in a situation, while the hippocampus helps with memory retrieval and

links the fear response with the context (Feit et al., 2014; National Scientific Council on the Development Child, 2010).

In addition, prolonged stress due to early experiences of neglect and abuse have been shown to impair the development of the prefrontal cortex of the brain (Leve et al., 2012; National Scientific Council on the Developing Child, 2011). The prefrontal cortex has been found to play a key role in the development of executive function skills, for example, planning, organisation, impulse inhibition, attention focus, problem-solving, flexibility of thinking, and the ability to hold and manipulate information in short-term memory at the same time (Leve et al., 2012; National Scientific Council on the Development Child, 2010; National Scientific Council on the Developing Child, 2011). Besides stress due to neglect and abuse, other conditions have been found to negatively affect executive functioning, including prematurity, and prenatal alcohol exposure (National Scientific Council on the Developing Child, 2011).

While there has been significant development in scientific evidence of the neurobiological impact of trauma, it has also been argued that the way brain development in the context of early trauma is publically disseminated may be overstated and over-simplified (Shonkoff & Bales, 2011). An example of this, cited by Shonkoff and Bales (2011), is the overgeneralisation of research on critical periods of learning in infant brain development that led to incorrect beliefs that brain development is largely set by three years of age, despite facts indicating otherwise. Nonetheless there are common findings from the research, as summarised above, that collectively suggest that child brain development is likely to be affected in some way by early experiences of trauma and adversity. However, this neurobiological impact can vary in outcomes as there are so many biological,

psychological, social and environmental factors that interact to impact on outcomes for children (Rutter, Moffitt, & Caspi, 2006).

Given the enduring nature of the neurobiological sequelae of trauma, abuse and neglect, it follows that caregivers may benefit from having an overview of what encompasses typical child brain development, and how adverse early experiences can negatively affect the developing brain and nervous system. In particular, caregivers are likely to benefit from having knowledge about the following:

- Repeated and traumatic life experiences can cause a child to experience a persistent sense of fear, which impairs their capacity to differentiate between benign and threatening situations, thereby impairing their social interactions (Perry, 2001).
- Children who have experienced significant traumatic events can experience flashbacks (intense recollections of memory), as well as states of dissociation (psychological detachment from reality or the immediate surroundings due to the heightened experience or recollection of a significant stressful or traumatic experience) (James, 1994).
- Foster children may show a range of executive function problems, difficulties regulating their emotions in social contexts, and a distrustfulness of adults, and physical and emotional intimacy (James, 1994).
- Children who have experienced trauma, abuse, and neglect need responsive, nurturing, predictable, and secure home environments to help them develop a sense of safety and security (National Scientific Council on the Developing Child, 2010).

- Children in care can present with a range of biopsychosocial problems which require their caregivers and teachers to help them develop social and emotional skills, as well as a range of executive function skills (National Scientific Council on the Developing Child, 2011).
- Recent research findings show that more rapid brain development occurs in adolescence than at any other developmental period, other than in the first three years of life (Coleman et al., 2016). As such foster parents can potentially have much influence on the development of the adolescent in their care during this period.

**Attribution theory.** Attribution theory is concerned with the meaning people attach to their own and others behaviour, and how they arrive at causal explanations for behaviours and events (Heider, 1958; Fiske & Taylor, 1991). Heider (1958) posited that attributions are organised and predictable, based not only on another's behaviour, but also what one thinks the other might be thinking and feeling, as well as what one feels about the person and the behaviour. Internal attributions involve ascribing the cause of behaviour to an internal characteristic, (e.g., shyness as a cause of withdrawn behaviour), while external attribution ascribe the cause of the behaviour to an influence outside a person's control (e.g., poor role modelling as a cause of aggressive behaviour) (Heider, 1958). Abramson, Seligman, and Teasdale (1978) identified the following dimensions of causal attributions:

- Following on from Heider's (1958) distinction between internal and external attributions, people can have an internal locus of control (i.e., they perceive some aspect of themselves as causing an event, for example, "I am so forgetful, I often forget my lunch"), or an external locus of control (i.e.,

they perceive an external factor or force as causing an event, for example, “The family was so demanding of my attention this morning that I forgot my lunch”).

- People may perceive situations to be unchangeable and have stable attribution styles or (e.g., “People see me as boring, I’ll never make friends”), or may perceive situations to be changeable and have unstable attribution styles (e.g., “I’m new to this school, it may take some time but I am sure I can make some friends”).
- People may also perceive an event as specific to a particular situation (e.g., “I don’t understand this new software, it’s going to take me some time to stop making mistakes in my work”), or they may see an event as global and having a larger-scale effect on their lives (e.g., “I don’t understand this new software, I am always going to make mistakes and my work output will suffer).

Abramson et al. (1978) suggested that self-causal attributions for negative events which tended to be internal, stable and global were related to low self-esteem, learned helplessness, and depression.

Attribution theory has been criticised for the absence of empirical evidence linking attributions to behaviour, as much of the attribution research is qualitative in nature (Gough, McFadden, & McDonald, 2013). Attribution theory has also been criticised for being based on what has been referred to as a common sense psychology that draws on our shared ways of looking at social issues, for example, pity for the obviously physically impaired beggar but annoyance at the laziness of a seemingly able-bodied beggar (Graham, 1991). However, attribution theorists hold

that it is important for psychology to make systematic what is known to be common sense beliefs and shared ways of thinking (Graham, 1991).

The explanations parents have about a child's behaviour, and their attributional styles, have been associated with a number of variables related to the way a family functions (Bugental & Johnston, 2000; Miller, 1995). For example, parents who use punitive and harsh parenting approaches tend to view their children as defiant and tend to see themselves as powerless; and parents with low perceived control tend to become more physiologically distressed and reactive to their children than parents in general (Bugental & Johnston, 2000; Miller, 1995). While earlier research into parental attributions showed associations between parental attributional styles and family functioning variables, more recent studies have suggested that dysfunctional parent attributions may play a causal role in parenting problems and child behaviour problems (Snarr, Slep, & Grande, 2009).

Given this relationship between dysfunctional parent cognitions, poor family functioning and child behaviour problems, it follows then that caregiver training interventions should include components which address and attempt to remediate these problems of cognition. Examples of dysfunctional attributions which caregivers may have for the behaviour of foster children include, "He is being oppositional and defiant just to make me angry", and "There is nothing I can do to make this child behave better". Bugental et al. (2002) compared a standard home visitation programme for at-risk families with a programme enhanced with a cognitive training component designed to help parents correctly interpret their child's behavioural cues, correct dysfunctional parent attributions about the behaviours, and problem solve to reach an appropriate response. In the group receiving the programme enhanced with the cognitive training component,

decreased levels of harsh parenting and a lower level of physical abuse were found (Bugental et al., 2002). While problem solving has been found to be a less effective component of parent training programmes (Kaminski et al., 2008), it is likely that the combination of cognitive and attribution training, in addition to the other programme components, led to the positive study outcomes in this reported study. A further study evaluated the effects of including anger management and attributional retraining components to the Triple P – Positive Parenting Program, and found significant improvement in negative parent attributions for the child's challenging behaviour, decreased potential for harsh parenting approaches, and more realistic parent expectations about the child (Sanders et al., 2004).

It therefore appears that caregiver training interventions would be enhanced by supporting caregivers to consider the cognitions and attributions they have about themselves and their behaviours, and the child and the child's behaviours. As discussed earlier in this chapter, internal working models (the schemas/mental representations which people have formed of themselves, others, and their environment), inform their understanding of the world and their social interactions (Bowlby, 1973; Schore, 2000). Supporting caregivers to reflect on their own and their child's internal working models, attachment patterns and attributional styles is likely to enhance positive parental responses to the child's challenging behaviours. As has been shown, a nurturing, sensitive, fair and consistent parenting approach is needed to improve the mental health, behavioural and developmental outcomes for foster children.

**Mechanisms of change.** As the present study is interested in the ways in which the Fostering Security caregiver training programme can affect positive therapeutic change in the way caregivers parent their foster children, a discussion

about the factors involved in effecting positive parenting change is warranted. In the context of mental health interventions, Kazdin and Nock (2003, p. 1117), referred to mechanisms of change as “the processes through which therapeutic change occurs”. They stated that identifying the processes that effect therapeutic change is vital to improve therapeutic practice, rather than merely identifying an association between an intervention and an outcome. In other words, to ensure positive therapeutic results it is more important to try to identify what aspects of the therapeutic intervention (i.e., processes of change) lead to positive change, than just making an association between the intervention and positive change (Evans & Fletcher, 2013; Furlong & McGilloway, 2014; Kazdin & Nock, 2003). It therefore follows that if we can understand what makes foster parent interventions work, it should serve to inform future foster parent interventions and enhance the outcomes for foster parents.

It has been argued that both the therapeutic alliance/relationship between the therapist and client, and the therapeutic procedure which is used, are important for the effectiveness of the therapeutic outcomes (Evans & Fletcher, 2013). Furthermore, Evans (2013, pp. 265-266) suggested a number of over-arching categories underlie the reasons for change in therapeutic interventions, including the following:

- Culture (i.e., the values, norms, rules and morals which govern how people live) and context (i.e., the physical and social environments within which they live) are vital in understanding people’s behaviour as these factors influence behaviour alongside intrinsic personality characteristics.

- The consequences of our behaviour help to shape the behaviours we will repeat, as human beings try to maximise positive feelings and reduce negative feelings.
- We are also motivated by social relationships, and the need for the feeling of connectedness with others may influence our behaviours positively or negatively.

With regard to parent training programmes in particular, (which generally aim to effect change in parenting skills so as to improve behavioural, social, emotional and developmental outcomes for children), a number of factors have been identified as contributing to programme effectiveness. Studies examining parents' experiences resulting in changes in their parenting practices, found that a number of factors influenced positive intervention outcomes (Couch, 2009; Holtrop, Parra-Cardona, & Forgatch, 2014): learning specific behavioural and parenting strategies like the use of clear behavioural direction, limit setting, and the use of positive reinforcement to increase appropriate behaviours; the parent's experience of the group facilitator as knowledgeable, supportive, encouraging, trustworthy, non-judgemental and non-blaming; feeling supported and understood by other parents in the training programme; feeling affirmed, validated and empowered in their roles as parents; gaining a better understanding of the child's behaviours; feeling encouraged by the effect of their newly acquired parenting skills on their child's behaviour as well as their relationship with the child; the use of specific training delivery methods such as the use of role play to practice skills learned, and having home activities to practice skills learned; and receiving information sheets and hand-outs which served as a reference when the programme ended. These factors appeared to further facilitate parents' ability to reflect on their

parenting practices and parenting approaches, decrease their stress levels, increase their parenting confidence, improve the parent-child relationship, and lead to improved child behaviour (Couch, 2009; Couch & Evans, 2011; Holtrop et al., 2014).

There is a lack of studies evaluating the mechanisms of change in foster parent training programmes. However, it is reasonable to assume that the processes influencing positive outcomes in general parent training programmes will be similar to those in foster parent training programmes. Both types of parent training programmes (i.e., generic parent training and foster parent training), have similar aims: to improve parenting self-reflective capacity, confidence, and skills, and to decrease parent stress levels, which will hopefully lead to improved child behaviour and improved parent-child relationships. However, as has been shown earlier in this chapter, foster parent training programmes require more focused attachment and trauma training components to support the foster parent to provide the “therapeutic caregiving” needed to help the foster child heal from negative past experiences (Schofield & Beek, 2005, p. 21). It follows then that, in addition to ensuring the content of foster parent training programmes reflects the specific needs of foster parents and foster children, it is also important to determine the processes or mechanisms within these training programmes which lead to positive foster parent outcomes. These two factors are therefore the focus of the present study.

**Summary.** This section has summarised a number of theories regarded to be important in informing caregiver training programmes to enable caregivers to understand and care for foster children with complex biopsychosocial problems.

These theories are discussed further in the next section as they apply to the context, content and process of the Fostering Security programme.

### **Description of the Fostering Security Caregiver Training Programme**

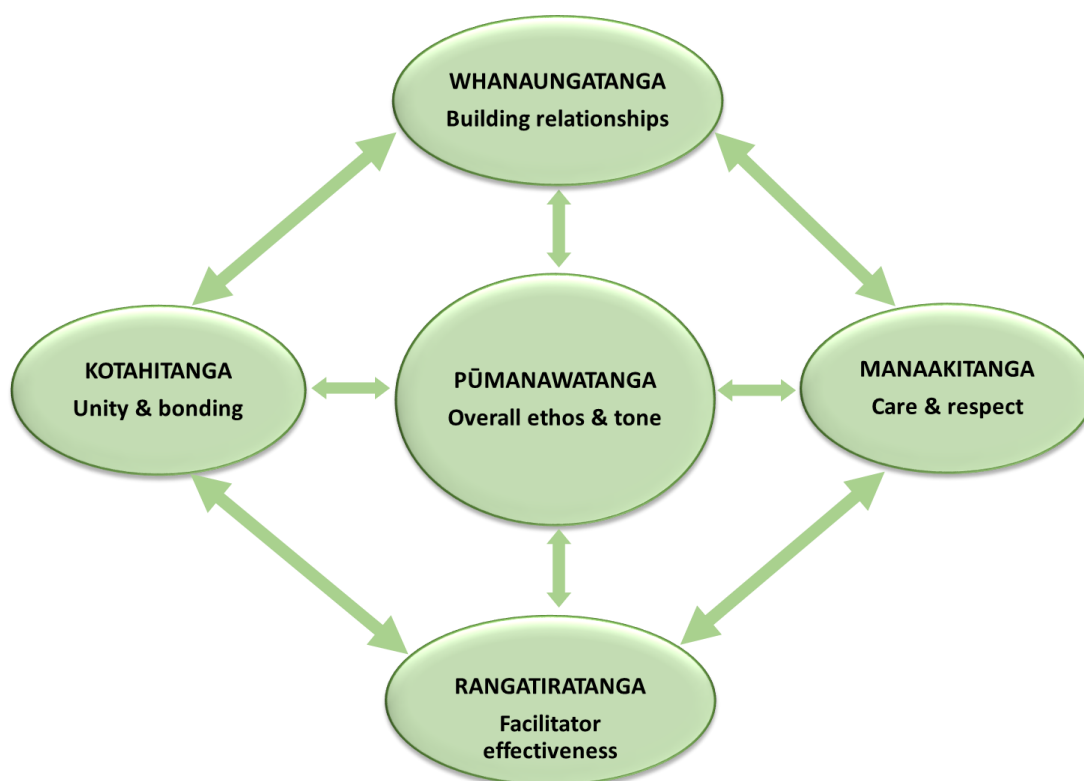
**Aims and philosophies.** The Fostering Security training programme for foster parents aims both to introduce more effective parenting approaches and skills to meet the specific needs of foster parents, as well as to minimise their less effective parenting approaches and strategies. Furthermore, given the focus on education, self-reflection, and skills building, the programme is designed to be a therapeutic intervention for caregivers who are caring for foster children with complex attachment and trauma related difficulties.

A fundamental aim of the Fostering Security training programme is to support, acknowledge, and validate caregivers of foster children. As has been discussed, caregivers frequently reported feeling undervalued by professionals, and poorly acknowledged for their demanding role parenting foster children with complex attachment- and trauma-related mental health problems (Atwool, 2010; Murray et al., 2011). Further, parents' experience of group facilitators as supportive, non-blaming, and validating has frequently been indicated as a mechanism of change leading to positive parenting outcomes (Couch, 2009; Holtrop et al., 2014; Levac, McCay, Merka, & Reddon-D'Arcy, 2008). The ethos of the Fostering Security programme is one of support, encouragement, acknowledgment of caregivers' high burden of care as well as trust and validation issues. The programme facilitators are non-judgemental in their approach and demonstrate an unconditional positive regard for caregivers, accepting and respecting the caregivers without judgement, and attempting to set aside their own

opinions and biases (Rogers, 1951). Caregivers are viewed as the primary agents of therapeutic change for their foster children (Golding, 2014), and as an integral component of the multiple-levelled interventions in a range of ecological settings needed to obtain better outcomes for foster children (Gutkin, 2012). The Fostering Security programme therefore aims to train and support caregivers to become therapeutic caregivers on an ongoing basis in the home environment, to help the child heal from past traumatic experiences and develop more secure attachments with the foster family (Schofield & Beek, 2005).

The Fostering Security programme also aims to empower caregivers by acknowledging their existing in-depth knowledge about their foster children, and work with them to combine their knowledge and the training programme material to jointly construct different ways of perceiving the foster child. As discussed in Chapter 2, the empowerment of parents has been proposed as an important component of positive change in families (Graves & Shelton, 2007). Macfarlane's (2004) Educultural Wheel (developed to provide an understanding of the learning needs and context for Māori people in the educational setting), is a useful model to describe the context of the Fostering Security programme, which emphasises collaboration, building on pre-existing knowledge, and respect for caregivers. The Educultural Wheel (see Figure 3) identifies five key aspects for training to be inclusive and effective for all learners: *whanaungatanga* (bringing people together and building relationships), *manaakitanga* (care, support, and respect), *kotahitanga* (achieving unity by collaborating and bonding as a group), *rangatiratanga* (effectiveness, integrity, and accountability of the teacher or programme facilitator), and *pūmanawatanga* (the overall ethos or tone of the programme

setting) (Macfarlane, 2004). The Fostering Security programme endeavours to incorporate these five aspects in the group process.



*Figure 3.* The Educultural Wheel (Adapted from Macfarlane, 2004)

The known benefit of grouping caregivers facing similar parenting circumstances was a key factor in the development of the Fostering Security programme. Training in the context of such a group means caregivers can benefit from the understanding, experience, and support, of caregivers in similar situations to themselves (Barth et al., 2005; Leathers et al., 2009). This factor has also been shown to be an aspect of parent training programmes which is associated with positive change in parenting outcomes (Couch, 2009; Levac et al., 2008).

As discussed in Chapter 1, a major factor in the breakdown of foster placement breakdowns is the lack of adequate training for caregivers to help them understand, and implement the appropriate parenting strategies for the range of

complex behaviour and mood problems observed in children in care (Atwool, 2010; Murray et al., 2011). Caregivers frequently reported high levels of stress and frustration about their relationship with the foster child, and reported difficulties forming secure attachments with their foster children (Atwool, 2010; Murray et al., 2011). While generic parent training programmes are beneficial to caregivers to an extent, they are limited in providing them with the needed information and behaviour management strategies about attachment- and trauma-related behaviours (Leve et al., 2012; Scott & Dadds, 2009). The Fostering Security training programme therefore integrates behaviour management strategies (e.g., using rewards, consequences, and limit-setting), with information and strategies aimed to develop caregivers' sensitivity and emotional understanding of the foster child.

The Fostering Security programme further aims to meet the specific needs of caregivers by providing them with information to increase their knowledge about: basic child development; basic brain development; attachment theory, attachment problems and related diagnostic issues; and the psychological and neurobiological effects of trauma, abuse and neglect. The programme provides caregivers with information and strategies to effectively manage a range of attachment- and trauma-related problems, as well as training them to teach their foster children needed skills (e.g., emotional regulation skills and relaxation skills). The aim of this information is to help caregivers understand the reasons for the child's behaviour, feel more confident about their parenting ability, reduce their stress levels, and develop their therapeutic parenting strategies.

The Fostering Security training programme also aims to increase caregivers' sensitivity, emotional availability, and responsiveness to their foster children. Caregivers who are attuned to the child's emotional needs, and

demonstrate mind-mindedness (i.e., they are able to accurately interpret their child's internal mental states and respond appropriately), are able to provide foster children with a sense of security, are able to help the children develop their ability to reflect on their own and others' thoughts and feelings, have decreased parental stress, and view their child more positively (Meins et al, 2012; Schofield & Beek, 2005). The Fostering Security programme helps caregivers attempt to understand the child's perspective by reflecting on the possible functions underlying the child's challenging behaviours, and by reflecting on the internal working models or mental representations children form of themselves, others, and their environments based on their past experiences (Bowlby, 1973). Given their understanding of these issues, it is more likely that caregivers will develop more accurate attributions about the foster child's behaviour, and a more positive view of the child.

Also related to a more positive caregiver-foster child relationship is the caregivers' ability to look critically at their parenting approaches, to reflect on their own internal working models, and to identify and alter the dysfunctional attributions they have of their own and the foster child's behaviour (Bugental et al., 2002; Schofield & Beek, 2005). The Fostering Security training programme supports caregivers in these self-reflective activities by encouraging them to consider the influence of their own attachment histories and past experiences on their current parenting approaches. Understandably, this can sometimes be an emotional experience for caregivers who have themselves experienced trauma, abuse and neglect. The Fostering Security programme facilitators therefore ensure that the caregivers receive the appropriate family, peer or professional support they need to safely manage these experiences. Caregivers are also supported to identify the negative emotional responses which the foster child's challenging behaviours

trigger in them, and are taught strategies to control these emotions so that they are able to manage the challenging behaviours calmly and assertively.

A longer-term aim of the Fostering Security training programme is the prevention of foster placement breakdowns, which have been shown to exacerbate the emotional, behavioural and social problems of children in care. It has been well documented that caregivers frequently reported high levels of stress and frustration parenting foster children with complex mental health and behaviour problems who are distrustful, rejecting, avoidant or socially indiscriminate in the social behaviour (Atwool, 2010; Horwitz et al., 2010; Murray et al., 2011). Caregivers also reported that their usual parenting approaches, which may have been successful for them with their biological children, did not tend to work in the same way with their foster children, thereby negatively affecting their parenting confidence and sense of efficacy as parents (Murray et al., 2011). The Fostering Security programme is therefore designed to provide caregivers with the training, support, and validation they need to develop their understanding of the foster child, reflect on what the foster child triggers in them, and develop their parenting skills to respond appropriately and build a more secure attachment with the foster child. It is held that these factors, alongside others inherent in the content and process of the Fostering Security programme, will serve to increase the caregiver's confidence in their abilities to parent their foster children, as well as improve their sense of efficacy as caregivers.

**Programme outline.** The Fostering Security training programme for caregivers is delivered by two facilitators, one from child and adolescent mental health services and one from child protection services, over 10 two-hour weekly sessions. The programme generally occurs in school term-time between 12:30 and

2:30pm, but has also occurred between 4:00 and 6:00pm. Caregivers are assisted with childcare support and/or petrol vouchers if needed to allow them to attend the training. Referrals are largely received from professionals from the child and adolescent mental health service and the child protection service, but self-referrals and referrals from other agencies are also accepted. Participants are referred to the programme if they want to improve the attachment relationship between them and their foster child, to develop their knowledge and skills about the attachment and trauma problems their foster child presents with and/or if they are experiencing their foster child's behaviour as very challenging and need guidance in understanding and managing these problems. Participants in the Fostering Security training programmes tend to have various levels of need, from those who have minor behaviour problems to manage to those who are struggling with their foster child and the placement stability is threatened. Participants also range from those who are in the early stages of fostering to those who have been fostering for many years.

Initial contact with caregivers interested in attending the Fostering Security training programme is by telephone or face-to-face visits. As discussed earlier in this chapter, this initial engagement is considered important to give caregivers information about the programme, answer any questions they may have, and ensure they are aware of the collaborative nature of the programme. The vast majority of caregivers referred to the Fostering Security programme are motivated to attend as they feel the programme might benefit them. Occasionally caregivers are required to attend the programme, for example by the child protection social worker responsible for the foster child. When this has happened the caregivers initially attended the programme grudgingly but the non-threatening and accepting context

of the programme and the useful material positively impacted on their attitudes towards attending.

Inclusion criteria to the Fostering Security training programme and research study are caregivers who are caring for children with past experiences of trauma, abuse and/or neglect. This includes biological parents who are caring for a child who had previously experienced trauma, abuse and/or neglect in the care of the other biological parent. However, this latter group are in the minority of caregivers attending the programme. While it is acknowledged that the non-abusive biological parents are a different target population to kin non-kin caregivers, we decided to include them as participants in the Fostering Security programme due to their level of need for the group intervention. In addition, the partners of the non-abusive biological parent, in the role of step-parent to the foster child, are also deemed in need of the intervention in a group setting.

The Fostering Security programme is not offered to caregivers with ongoing serious mental health, addiction, violence, or other personal issues which needed addressing before they can participate in the programme. This group of caregivers form a very small number of the caregiver population in Hawke's Bay and often have a number of professionals involved to provide support to them and the foster children on a more individual level. The Fostering Security programme is also not deemed suitable for biological parents who had a history of neglect and/or abuse of their child who is due to be returned to their care. This group of parents are held to benefit more from individualised interventions than group interventions. Further, caregivers in the Fostering Security training programme sometimes express anger and frustration towards the biological parents who exposed the foster child to adverse earlier experiences, and it is important that they are able to express

these feelings in the Fostering Security programme. If the previously-abusive biological parent attended the same programme it would considerably change the dynamic of the group.

During the first session of the Fostering Security programme, caregivers are welcomed, introductions are made, and an overview of the programme is given. Group rules and values are generated as a group, to ensure that issues like confidentiality and respect underpin the group process. Caregivers' goals for and expectations of the training are written up and these, alongside the group rules and values, are displayed through the training. Caregivers are also introduced to the Tree of Hope, an activity which commences each training session. The Tree of Hope is an illustration of the bare branches of a tree, and caregivers begin each session by relating a positive experience they had with their foster child over the preceding week, and attaching a green paper leaf onto the branches. This exercise serves as an opening ritual for the caregivers, but also injects positivity into the programme that is dominated by discussions of the foster child's deficits and problems. By the end of the Fostering Security programme, the bare tree is transformed into a healthy leaf-filled tree, symbolising the nurturing and developing caregiver-foster child relationship.

Delivery of the training is via a number of methods: PowerPoint presentations, large and small group discussions, role plays, watching and discussing videos, and reading aspects of the participant handouts. Caregivers are given handouts containing the Fostering Security training material, folders for the handouts, and notebooks for home exercises. Caregivers have home practice sessions which focus on their reflecting on some aspect of their parenting, reflecting on the child's behaviour, practising a particular behaviour management

strategy, or teaching a particular skill to the foster child. Feedback about these home practice sessions are provided by caregivers at the following training session. As caregivers have different levels of educational ability and achievement the facilitation and training materials are presented according to what it is thought the caregivers are likely to understand. A break is provided halfway through each session, and caregivers are provided with light refreshments. In the final training session, caregiver goals and expectations are revisited, caregivers receive certificates of programme completion, and they receive a small house plant which further symbolises the nurturing caregiver-foster child relationship. A shared meal also culminates the caregivers' graduation from the Fostering Security training programme.

Three modules constitute the Fostering Security programme: 1) a psychoeducation module to help caregivers understand their foster child's mental health problems (4 sessions), 2) a self-care and self-reflection module (2 sessions), and 3) a behaviour management and skills training module (4 sessions). See Figure 4. The modules are delivered in this order on the assumption that foundational knowledge in the first module will provide a framework for the discussions, reflections and skills training in the second and third modules. However, this assumption has not been formally tested. For example, the information about attachment disruption and attachment patterns in the psychoeducation module should provide context for the discussion about the caregiver's reflection on their own and their foster child's internal working models. In addition, the psychoeducation module provides a theoretical framework to the parenting strategies discussed in the third module, making them more meaningful to the caregivers.

While the Fostering Security programme modules are presented in this thesis as separate modules, in practice there are at times overlaps across modules that are unavoidable. For example, it is impossible to prevent caregivers from starting to reflect on their own and their foster child's attachment styles when discussing the patterns of attachment and internal working models in the psychoeducation module. Similarly, it is sometimes necessary to discuss behaviour management strategies for caregivers as they arise through the programme rather than waiting till the behaviour management and skills training module. Each of the three modules will be described in further detail below, alongside the theories and concepts which inform them.

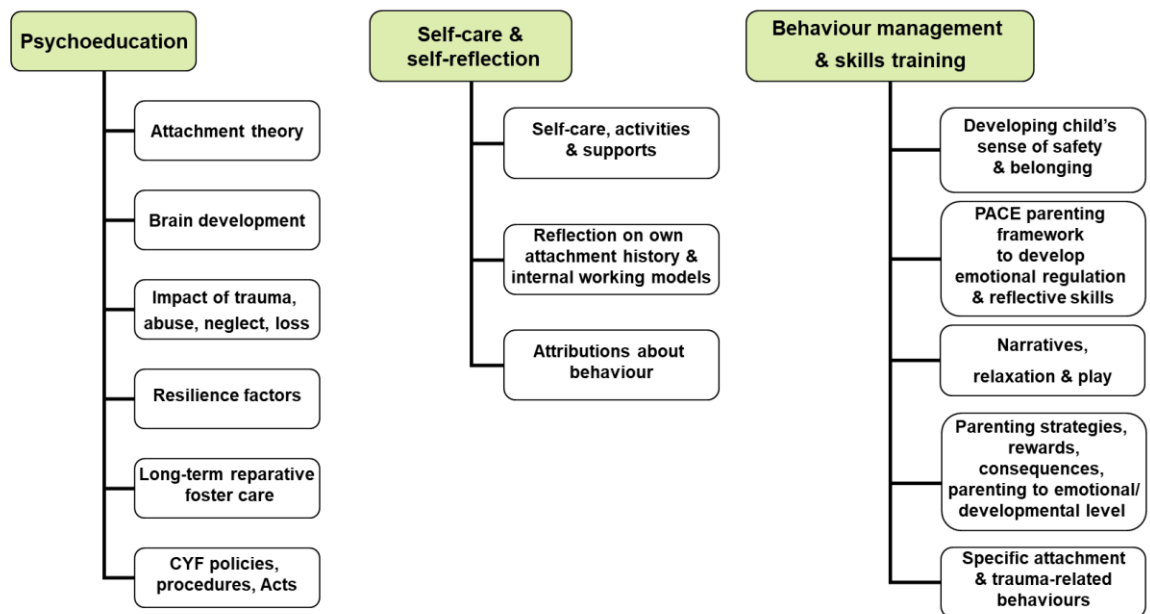


Figure 4. The Fostering Security Training Programme Modules

### 1) *Psychoeducation module.*

- a. The first section of this module is largely informed by attachment theory. Caregivers are provided with information about attachment theory, the typical development of attachment in infants, internal

working models (schemas or mental representations), patterns of attachment, and factors that disrupt attachment. In addition to the main methods of training like PowerPoint presentation, discussion, role play and perusing components of the participant handouts, participants use home activities to reflect on the course of their foster child's early development, the ensuing mental representations the foster child developed of themselves, others and their environments, and the foster child's attachment patterns. For example, after discussion about the four patterns of attachment (see Figure 2) caregivers are asked to think about their foster child's attachment style with regard to these four patterns and whether the attachment style has changed since being in their care. Caregivers also reflect on their own attachment styles and the fit with the attachment styles of their foster children. Caregivers discuss their reflections with the group if they choose to do so. In this module caregivers are also provided with a summary of relevant diagnostic issues, particularly with regard to reactive attachment disorder and disinhibited social engagement disorder (American Psychiatric Association, 2013). This is so that they have an understanding and implications of the clinical diagnoses that their foster children sometimes receive.

- b. The second major section of this module includes an overview of infant brain development, the typical functioning of the stress response system, and the psychological and neurobiological impact of trauma, abuse, neglect and loss. This aspect of the training often results in many moments of insight for caregivers as they realise the extent to which

adverse early childhood experiences can affect children psychologically as well as neurologically. An example of such a moment of insight is when a caregiver made a connection between her foster child's hypervigilant state and his over activated stress response system as an infant and toddler, and this allowed her to implement a less punitive consequence when he was restless and distractible. These neurobiological understandings are therefore crucial to the caregivers developing their empathy and mind-mindedness with regard to the foster child's difficult behaviours. Care is taken in this section of the programme to stress the positive impact predictive, consistent and nurturing care can have on all aspects of the foster child's development so that caregivers realise their own therapeutic potential.

- c. To balance the number of risk factors affecting children in care, caregivers are also provided with information about those resilience factors within the child, the family, and the social environment which have been shown to improve development, behavioural, emotional and social outcomes for children in care (Rutter, 2000; Tarren-Sweeney & Vetere, 2014). For example, when considering a list of resilience factors like optimism, good self-esteem, empathy, and social competence, it is thought-provoking for caregivers when they realise that these are factors they can influence. Again the resilience component is emphasised so that caregivers realise their potential to facilitate positive behavioural and mental health outcomes for foster children.
- d. The psychoeducation module also engages caregivers in discussion about those factors which can contribute to successful foster placements

and the development of secure and healthy caregiver-foster child relationships. Factors that contribute to successful placements include factors in the child (e.g., age when placed in care, severity of difficulties, and nature of contact with biological parents), factors in the foster parents (e.g., ability to reflect on own past experiences, capacity to develop a secure attachment with a foster child, and ability to be empathic and sensitive to what the child has suffered), and factors in the placement (e.g., the foster child, foster parents, and biological parents, acceptance of the child's need for a long-term placement with the foster family) (Single, 2005). This section of the programme often lends itself to lengthy discussions about the foster child's visits with their biological families. Caregivers can find the foster child's contact with their biological families stressful as these contacts can raise the child's anxiety and negatively affect the child's behaviour or mood, even when the visits are positive (Sinclair, Gibbs, & Wilson, 2004). The focus is therefore to allow caregivers the space to express their anger and frustration with the foster child's biological families while talking about the importance of the biological family to the foster child whether contact occurs or not.

This section also provides caregivers with information about the legal system and Child, Youth and Family policies and practices that impact on their day-to-day care of their foster children, for example, the issues around access with the foster child's biological family, the difference between custody and guardianship, and the extent of their authority in day-to-day matters for their foster children.

## 2) *Caregiver self-care and self-reflection module*

- a. The second module begins with a focus on the importance of making time for oneself and the importance of self-care when parenting a child with complex attachment and trauma problems. Caregivers are encouraged to participate in and access a range self-care and self-help activities and supports, for example, developing supportive networks of peers and professionals, maintaining realistic goals about the foster child's progress, making time for relaxation and other stress-reducing activities, as well as making time for reflection on their own and the foster child's behaviour.
- b. This module also supports caregivers to think about their own attachment histories and own internal working models, so they are able to gain an understanding of the origins of their current parenting styles, understand what reactions the foster child triggers in them, and manage these reactions more effectively. One of the ways caregivers are guided through the reflection on their own attachment histories is by asking them to think about the answers to a list of questions about their own histories. The intention is not to find someone to blame for past events that are difficult to address, but rather to simply begin to address them. Examples of questions caregivers reflect on include "How did you get along with your parents early in your childhood?", "How have your childhood experiences influenced your relationships with others as an adult?" and "How did your parents communicate with you when you were happy, excited, distressed or unhappy as a child" (Siegel & Hartzell, 2003). As painful memories can be raised for caregivers

through their reflecting on these questions, they are encouraged to seek support from a trusted friend or family member or a professional if the exercise causes them distress.

- c. In this module, informed by attribution theory, caregivers are encouraged to critically think about their attributional styles, or the explanations they hold for the foster child's behaviour and their own behaviour and responses. Further, they are guided to consider more accurate explanations for the child's mood and behaviour in light of past experiences and thoughts about themselves and others.

The importance of the caregiver's ability to be sensitive, empathic, responsive, and emotionally available to the foster child is also emphasised. Caregivers are supported to develop their empathy and sensitivity to the foster child by thinking about the foster child's adverse early experiences and thinking about how those experiences may have negatively affected the child's development in a number of ways. For example, if a caregiver is aware that the foster child was severely neglected in the first three years of life the caregiver can consider those early milestones that may have negatively affected the child and is more likely to become empathic toward the child.

### **3) *Behaviour management and skills training module***

- a. Drawing on attachment theory and social learning theory, the first section of this module focuses on factors which can help caregivers develop the foster child's sense of safety and belonging in the foster home. Factors for discussion include maintaining predictability with routine and structure, sustaining a positive relationship while

implementing consequences for inappropriate behaviours, planning for changes and separations which may raise the foster child's anxiety, and establishing house rules and family rituals which include the foster child. Caregivers are provided with some ideas to develop the child's feelings of safety and belonging in the home but they also provide ideas as well based on their own experiences about what has worked well for them in the past.

- b. Caregivers are also introduced to the PACE model, a parenting framework described as a warm, open and unconditional attitude or interpersonal stance toward the foster child that nurtures the child and supports the child's development (Hughes, 2009). The PACE model emphasises four main components, that is, playfulness, acceptance, curiosity, and empathy (Hughes, 2009). Playfulness and laughter are seen as important in helping a child feel connected and safe in a relationship. An unconditional acceptance of the child involves perceiving the child beyond their behaviours and ensuring that consequences never involve a threat to the relationship or imply to the child that there are deficiencies in himself or herself. Open, non-judgmental curiosity involves making guesses about the child's thoughts, feelings, and intentions with the child so as to develop their reflective functioning. Finally, with empathy the caregiver is able to understand and share the child's experiences and the child feels understood by the parent. The child is therefore better able to manage difficult situations without being overwhelmed by intense negative emotions (Hughes, 2009).

- c. To further develop the therapeutic potential of caregivers in the foster child's natural everyday environment, they are trained and supported in teaching the foster child a number of skills. The therapeutic use of relationship-based play has been shown to facilitate the attachment and connectedness between parent and child (Jernberg & Booth, 1999; Kaminski et al., 2008), and a number of these play approaches are shared with caregivers. Caregivers are also trained in the use of relaxation strategies both for their own use, as well as to teach to their foster children. Examples of these include deep breathing, progressive muscle relaxation, and visualisation. Relaxation training has been associated with a range of physical and psychological benefits, particularly with regard to stress and anxiety-related problems (Manzoni, Pagnini, Castelnuovo, & Molinari, 2008).

In addition, caregivers are supported to use and develop stories about the child's life to help shift some of the foster child's core negative beliefs about themselves and others, and to provide the child with more balanced and accurate accounts of their past experiences (as opposed to the inaccurate life stories children in care can develop). Such stories can be designed to be about the foster children themselves or they can be about another person or even animals. The use of such narratives has been shown to help the child heal from past experiences and build new secure relationships (Lacher, Nichols, & May, 2005).

Caregivers are therefore assisted with helping develop accurate life stories with and for their foster children. Life story work provides foster children with a narrative describing their life events from birth to their

current placement, it can help them explore their understanding of these events, and it provides an opportunity to correct erroneous perceptions they may have about these events, themselves and others (Rose, 2017). The foster children's life stories are also useful in providing them with a sense of connection and belonging to their family of origin, as well as to the current foster family, and can help them reconcile the range of conflicting emotions they can have about their biological parents. For example, foster children may feel sadness at no longer being with their biological parents, but may also feel anger at having been neglected and rejected. Foster children who have inaccurate perceptions of their past experiences may develop imagined stories of themselves and family members which could lead to erroneous senses of identity as they mature (Smalley & Schooler, 2015).

- d. Social learning, behaviour theory, as well as attachment theory inform the section on day-to-day parenting skills specific to the needs of children with attachment and trauma problems. This section focuses on supporting caregivers to develop the foster child's self-reflective and emotional regulation skills, parent to the child's emotional level, use consequences and rewards effectively, implement behavioural limit-setting, promote healthy sleep routines, understand the importance of positive physical contact in the caregiver-foster child relationship, and communicate effectively with the child. Caregivers get the opportunity to discuss and practice these parenting skills in the group, use them at home, and report back to the group on their experiences of using the skills.

This section also provides caregivers with tools to first attempt to understand what the foster child's behaviour is communicating, that is, undertaking a functional analysis of the behaviour. A number of behaviours and issues associated with attachment and trauma problems are presented alongside the visual of an iceberg, and for each of these caregivers are encouraged to think about the visible behaviour (i.e., the visible part of the iceberg) and possible reasons underlying the behaviour (i.e., part of the iceberg that lies invisible under the water). For example, a caregiver may take the foster child's overeating behaviour at face value and relate it to greediness or disobedience but by considering the child's past experiences may see that it might instead be related to their unmet emotional needs. The caregiver's ability to accurately interpret the foster child's internal thoughts, feelings and intentions (i.e., the caregiver's mind-mindedness ability), is a key focus as mind-mindedness has frequently been associated with secure parent-child attachments (Meins et al., 2012). Examples of other behaviours that caregivers analyse using the iceberg model are the need to stay in control of social situations, socially indiscriminate behaviours, and emotional regulation problems.

**Cultural context.** The New Zealand government recognises Māori as tangata whenua, or indigenous people of New Zealand, and the Treaty of Waitangi/te Tiriti o Waitangi outlines the principles of partnership, protection and participation to ensure culturally competent practice with Māori (New Zealand Psychologists Board, 2011). Partnership involves working together with Māori to improve outcomes for them, participation includes Māori in planning and making decisions about their wellbeing, and protection means safeguarding Māori cultural

concepts and striving to ensure they have equal health outcomes to non-Māori (Ministry of Health, 2015).

As outlined in Chapter 1, Māori are significantly over-represented in the foster child population group (Ministry of Social Development, 2016a). In addition, a significant number of caregivers attending the Fostering Security training programme identify as Māori. It was therefore important that the Fostering Security training programme take into consideration the values, traditions and norms of Māori participants, ensures their cultural safety in the group training context, and engage them in the training process alongside other programme participants. The Fostering Security training programme for caregivers addresses these cultural issues in a number of ways.

From its inception, the training programme has had cultural oversight and input from Hawke's Bay District Health Board Māori Health Unit Kaumātua (elders in the Māori community providing cultural advice, leadership and guidance) (Barlow, 1994). The Kaumātua supporting the Child, Adolescent and Family Service at the time the programme was developed provided specific guidance around the appropriateness of the programme material and resources, and also provided guidance around initial and ongoing engagement with Māori caregivers attending the Fostering Security programme. With the commencement of the current research study a few years subsequently, clinical supervision was obtained from an additional Hawke's Bay District Health Board Māori Health Unit Kaumātua, who was also the Kaumātua at the Massey University School of Psychology (the university at which the current research study is being conducted). Currently, cultural advice and supervision is provided by the Child, Adolescent and Family Service's Pou Ārahi. Cultural supervision with regard to the Fostering

Security programme content and process is also obtained from a Māori clinical psychologist, particularly pertaining to Māori world views, models of parenting, and principles of engagement and training.

To ensure all participants (regardless of their ethnicity, religion, gender identity, age, or socioeconomic status) feel safe and at ease in the Fostering Security training group, Kaumātua provide cultural supervision to support group facilitators with ensuring that Māori tikanga (customs and etiquette) are followed through the course of the programme. The engagement process with caregivers prior to them attending the programme is considered to be a vital first step, as the programme emphasises collaboration and empowerment. Where possible, the first contact with caregivers referred to the Fostering Security training programme is face-to-face or by telephone, to let them know what the group can offer them and how they can contribute to the group. Further, time is allocated at the first meeting of the group participants for appropriate welcome and introductions of all present, and values and rules which will guide the group process are discussed. This process of whanaungatanga (Macfarlane, 2004), is intended to help caregivers make a connection to the group facilitator and other caregivers in the group, allows the facilitator to allay any concerns the caregiver might have about attending a training programme with a group of strangers, and attempts to indicate to the caregivers that their experience and perspectives will be valued in the group. Kaumātua and Pou Ārahi are also available throughout the course of the programme to provide assistance should it be needed to support individual Māori caregivers to access the programme.

As described earlier in this chapter, the ethos or pūmanawatanga of the Fostering Security programme is characterised by support and validation of the

caregivers for their high burden of care, acknowledgement of them as integral in mental health interventions for their foster child, and a non-judgemental and accepting stance by the group facilitators. This stance attempts to ensure that caregivers from all backgrounds feel a sense of inclusion in the process. In addition, through the course of the programme, caregivers are shown care, respect, and nurturing to ensure that they feel a sense of belonging in the group. This process of *manaakitanga* (Macfarlane, 2004), is shown by celebrating the positives which caregivers relate about their relationships with their foster children (the Tree of Hope exercise illustrating this is discussed later in this chapter), providing caregivers with good quality resources (such as colour-printed handouts, folders for their handouts, and home activity notebooks), and providing refreshments at break times.

**Interagency approach.** I facilitated the first Fostering Security training programme for caregivers in Hawke's Bay alongside child and adolescent mental health colleagues. Through the course of that first programme, it became clear that it would be beneficial to have Child, Youth and Family staff co-facilitating the programme with mental health clinicians as many issues arose for caregivers which required the input of Child, Youth and Family social workers. Caregivers needed information about Child, Youth and Family policies and practices as it applied to them as foster parents and to their foster children, for example, understanding the difference between guardianship and custody, and what they did and did not have the authority to do for their foster children in their day-to-day care roles. Caregivers also required a better understanding of the legal system as it applied to their care of the foster child, and needed to discuss their thoughts, concerns and frustrations about the foster child's access visits to their biological families. For

Dorsey et al. (2008) caregiver training needs to develop caregivers' skills to parent foster children with challenging behaviours, as well as provide them with practical legal information and information about their roles as caregivers. The Child, Youth and Family social workers, who subsequently co-facilitated the Fostering Security programme, were able to provide caregivers with the information they required in this regard and to facilitate discussions around Child, Youth and Family policies and practices.

A number of caregivers have had negative previous experiences with Child, Youth and Family social workers. For example, a caregiver attending the Fostering Security programme was tearful when talking about how she felt negatively judged by a social worker. Caregivers reported feeling undervalued and not considered a valuable part of the foster child's team (Atwool, 2010; Murray et al., 2011), and reported being angry and frustrated at Child, Youth and Family social workers for not better preparing them and giving them adequate support around the foster child's challenging behaviours (McDonald, 2011). In addition, some caregivers had themselves had previous negative involvement with Child, Youth and Family staff as children in care themselves or as family members. Given the ethos or *pūmanawatanga* of being supportive, non-blaming, and validating, the Fostering Security training programme provides a safe space for caregivers to voice some of these frustrations and concerns. The Child, Youth and Family social workers are thus afforded a space to listen to caregivers, acknowledge their feelings, and engage in reparative discussions where possible. It has been evidenced, through the course of the Fostering Security training programmes, that many caregivers were able to develop a more positive view of Child, Youth and Family through building positive relationships with the Fostering Security programme facilitators.

A further benefit of mental health and child protection staff co-facilitating the Fostering Security programme is that it offers a more streamlined and integrated approach for families. Given the range of health, educational, and behavioural problems that children in care can be affected by, there are often many agencies and professionals involved with the child and foster family. It therefore follows that joint planning and interventions between the different agencies will benefit families with children who have high and complex needs (Bruns et al., 2010; Golding, 2014). Fostering Security training programme participants have frequently commented positively on the benefit of having two agencies delivering the same information about attachment and trauma together, rather than being given differing information by different professionals in these organisations.

Disagreement has historically been evident between mental health and child protection staff who may have differing views and opinions about client needs and appropriate interventions for children in care and their caregivers (Golding, 2014). The field of interventions for children in care is fraught with agencies' mutual distrust, an unwillingness to work together, poor communication, poor understanding of respective roles, and blame shifting (Conway, 2009; Golding, 2014). This is understandable in the context of professionals dealing daily with stressful and distressing cases of child trauma, abuse and neglect (Conway, 2009). Historically, in Hawke's Bay, mental health clinicians and child protection social workers have generally worked in 'silos', with the roles of each agency not always clearly understood by the other. A further aim in the development of the Fostering Security programme was therefore to facilitate more integrated cross-agency communication, information-sharing, and joint interventions for children in care. The Fostering Security programme is therefore described as a joint initiative

between mental health and child protection services. The benefits of service integration are well documented, including: interagency problem-solving and planning around specific cases; coordinated interventions, improved communication and information-sharing, a holistic understanding of the foster child and family, a greater understanding of the roles of other agencies, more appropriate referrals across agencies, and a streamlined service for families (Golding, 2014; Tarren-Sweeney, 2014). Increased interagency collaboration has further been found to be associated with improved outcomes for young people receiving mental health interventions (Cooper, Evans, & Pybis, 2016). What was evidenced through the Fostering Security training programmes since its development in 2008, is that the mental health and child protection facilitators share information about their respective roles, learn about the roles of each other, and are also able to influence staff perceptions in their respective services. This has led to more joint case discussions, and more joint planning and interventions for foster children, and their biological and foster families. This joint interagency approach is a vital component of a whole of government approach to ensure better outcomes for children in care, rather than it being limited to the role of child care and protection agencies (Cooper et al., 2016; Modernising Child, Youth and Family Expert Panel, 2015; Royal Australian & NZ College of Psychiatrists, 2008).

### **Proposed Framework of Change in the Fostering Security Training**

#### **Programme**

As has been shown, the context, content, and process of the Fostering Security training programme have been designed to facilitate positive parenting outcomes for foster parents as well as their foster children. For Donabedian (1988)

to assess the value or quality of a health care intervention it is necessary to consider the relationship between the intervention's structure, process and outcomes, as good structure increases the probability of good process and good process increases the probability of positive outcomes. Structure refers to the physical as well as interpersonal context of the intervention, process refers to the actions taken and how the intervention is carried out, and the outcome denotes the effects or results of the intervention (Donabedian, 1988).

The Fostering Security programme aims to develop those parenting skills which have been shown to improve parenting practices, child behaviour, and parent-child relationships, for example, through the process of providing psychoeducation around specific mental health and behavioural problems, training in the functional analysis of behaviour, improving parental mind-mindedness or the accurate interpretation of a child's mental states, self-reflection on parenting approaches, limit setting, the appropriate use of rewards and consequences, and teaching emotional regulation skills (Couch, 2009; Couch & Evans, 2011; Holtrop et al., 2014; Meins et al., 2012). The Fostering Security programme also utilises specific training delivery methods which have been associated with positive parenting outcomes, for example, home practice activities, role plays, and visual aids like videos, PowerPoint presentations, and training handouts (Holtrop et al., 2014). The training occurs within a context of validation, care and support by a group of caregivers with similar parenting experiences, as well acknowledgement and support from facilitators who are non-blaming and work collaboratively with caregivers to help them become therapeutic caregivers (Schofield & Beek, 2005). Such a training context, characterised by respect and building on caregivers' pre-existing knowledge, has been emphasised as an important mechanism of change in

parent training programmes (Levac et al., 2008), and for inclusive and effective learning (Macfarlane, 2004).

It is held that the context, process and content of the Fostering Security training programme can lead to positive outcomes, such as improved caregiver confidence in their parenting abilities, decreased stress levels, and the development of more accurate explanations for the foster child's behaviour leading to more appropriate responses to challenging behaviours. It is believed that all these factors will further improve the foster child's behaviour and the attachment between the caregiver and the foster child, hopefully resulting in stability of the foster placement. Figure 5 illustrates this suggested framework of change in the Fostering Security training programme.

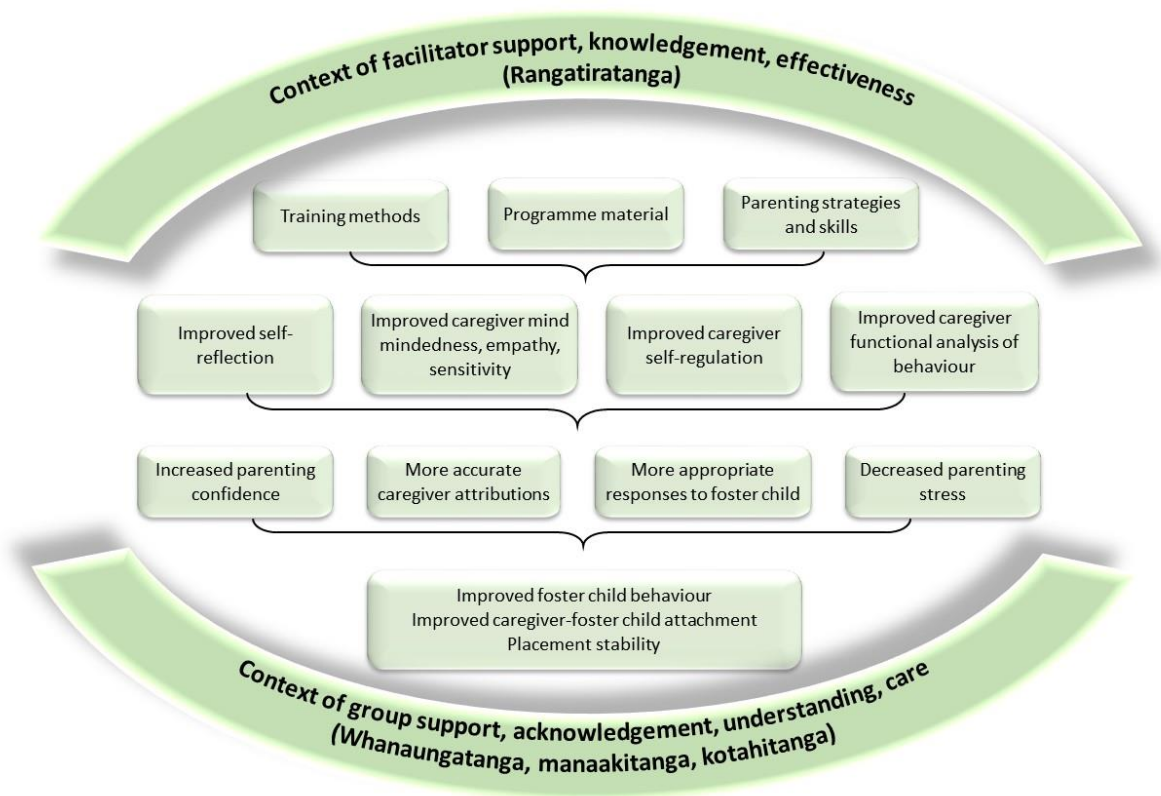


Figure 5. Proposed framework of change in the Fostering Security programme

## **Summary**

This chapter has described the development Fostering Security training programme and the current research study, discussed the theories underpinning the programme, and provided a description of the programme's context, content and process alongside its aims and philosophies. It has been shown that the Fostering Security programme differs from typical parent training programmes by drawing on additional theories and concepts alongside social learning theory (i.e., attachment theory, mind-mindedness, and the neurobiology of trauma, abuse, neglect, and loss). The Fostering Security programme is similar to other foster parent training programmes that combine aspects of social learning theory and attachment theory to address the diverse needs of caregivers. However, the Fostering Security programme differs from other foster parent training programmes in its strong emphasis on the development of caregivers' mind-mindedness and self-reflection, in its consideration of the values and cultural safety of Māori caregivers in the group training context, as well as in the joint mental health and child protection interagency approach to ensure more streamlined mental health interventions for children in care and their caregivers. Finally, a framework was proposed to understand the mechanisms of change in the Fostering Security training programme, and this framework forms the basis for the current research which is described in the next chapter.



## CHAPTER 4: THE CURRENT RESEARCH

### Rationale

The preceding chapters have outlined the complex nature of the mental health and behavioural problems in the foster child population, critically appraised a range of mental health interventions designed to ameliorate these problems, and emphasised the need for effective foster parent training and support as a core component of a collective set of interventions targeting the different ecological systems around the foster child (i.e., home, educational institution, and wider community). The Fostering Security training programme was then described, highlighting how it differs from generic parenting training programmes and other foster parent training programmes, by incorporating theories and concepts shown to be important to improve outcomes for foster parents and foster children (i.e., social learning theory, attachment theory, mind-mindedness, attribution theory, theories of change, and the neurobiology of trauma, abuse and neglect).

The Fostering Security programme was also described in terms of its consideration of the traditions and values of Māori caregivers, and its joint interagency approach between child protection and mental health services. As discussed in Chapter 3, there is a substantial body of research into the effectiveness of parent training programmes and, to a lesser degree, into the effectiveness of foster parent training programmes. However, there is a paucity of research into the process of change in parent and foster parent training programmes, as well as a paucity of research into the component analysis, to understand those aspects of the programmes which work best and are associated with development of positive parenting skills, and those which are not as effective

(Everson-Hock et al., 2011; Kaminski et al., 2008; Tarren-Sweeney, 2013a). In addition, there is a lack of research into parent and foster parent training programmes developed within the New Zealand context. The current research study is therefore concerned with identifying those factors in the Fostering Security training programme context, content, and process which are associated with improvements in foster parents' self-reflection, parenting skill, and parenting practices, as well as improved child behaviour outcomes. At this early stage of research into the Fostering Security programme, the focus is predominantly on process rather than on outcomes, and it is therefore more a formative study (exploratory study of the programme's process) rather than a summative study (evaluation of programme outcomes).

In the analysis of the effects of the different modules in the Fostering Security programme, the first two modules (the psychoeducation and self-care/self-reflection modules) were assessed together as the latter is a smaller module and combining the two would reduce the number of assessments for participants. The psychoeducation and self-care/self-reflection modules were further considered justifiably combined as both are strongly underpinned by attachment theory and self-reflection occurs at a number of points in the psychoeducation module. For example, when discussing the patterns of attachment, caregivers are supported to reflect on their own and their foster child's attachment styles, and when discussing the psychological and physiological impact of abuse and neglect, caregivers consider the effect of their child's adversities on their development and behaviour. The behaviour management and skills training module was assessed on its own.

## Research Objectives

The objectives of this research study were to:

- Identify and analyse the mechanisms of change for caregivers in the Fostering Security training programme context, content and process.
- Investigate whether the order of module delivery had differing effects on the six variables (i.e., caregivers' mind-mindedness, caregiver-child attachment, caregiver-child relationship frustration, dysfunctional child-responsible attributions, child behaviour problems at home, and child behaviour problems at the educational facility). It was speculated that the psychoeducation and self-care/self-reflection modules would be associated with improvement in caregivers' mind-mindedness, caregiver-child attachment, caregiver-child relationship frustration, and dysfunctional child-responsible attributions for the child's misbehaviour. It was also speculated that the behaviour management and skills training module would be associated with reductions in the foster child's noncompliance, defiance, aggressiveness and impulsiveness at home and in the educational facility.
- Explore the influence of the order of module delivery on the effectiveness of the Fostering Security training programme.

## Research Design

The current study utilised a mixed methods research design in order to obtain a deeper understanding of the factors in the Fostering Security programme context, content and process associated with improved foster parent and foster child outcomes. As discussed in Chapter 3, mixed methods research designs are

increasingly used by researchers to obtain more valid and robust information about psychological phenomenon from both quantitative and qualitative research data (Caruth, 2013; Migiro & Magangi, 2011).

A repeated measures design, the crossover study, was employed in the current study as it allowed for an experiment with few participants, allowed for the monitoring of change in participants over time, and allowed for evaluation of the effect of the different modules of the Fostering Security programme. Participants were placed in either Group A or Group B as they were referred to the Fostering Security training programme (i.e., the two experimental groups which were delivered consecutively). All participants in both Groups A and B received the same interventions, although the two groups received the interventions in reversed order (i.e., Group A received the psychoeducation and self-care/self-reflection modules before the behaviour management and skills training module, and Group B received the behaviour management and skills training module before the psychoeducation and self-care/self-reflection modules). As a reminder the first two modules of the Fostering Security programme (the psychoeducation and self-care/self-reflection modules) were assessed together and the third module (the behaviour management and skills training module) was assessed on its own.

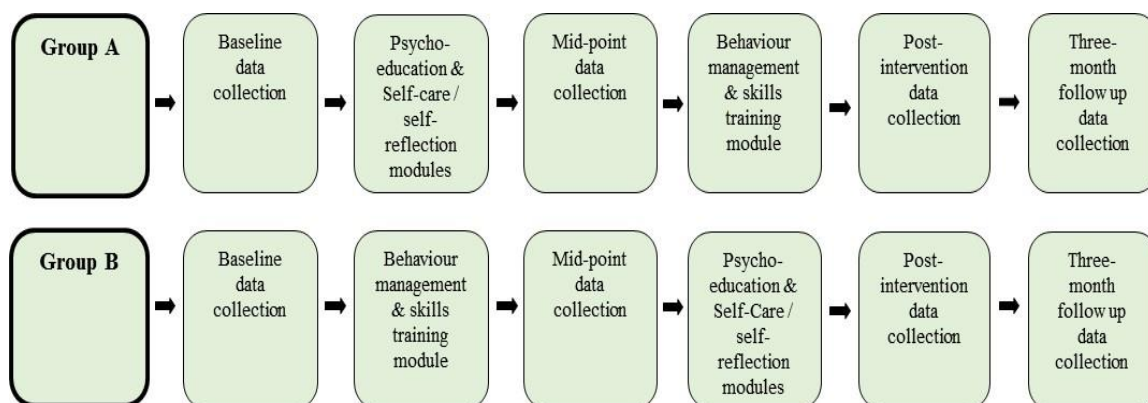


Figure 6. Illustration of current research design

## Method

**Participants.** Participants were caregivers referred to the Fostering Security Programme by their Child, Adolescent and Family or Child, Youth and Family keyworkers, who agreed to participate in the study. All the participants were referred to the programme by their keyworkers from the child and adolescent mental health service or the child protection service who knew what the programme provided. Participants who were referred to the programme wanted to develop a more secure attachment relationship between them and their foster child, wanted to learn more about the attachment and trauma problems their foster child had, and wanted to develop their skills in managing and ameliorating these problems. Inclusion and exclusion criteria as outlined in the Programme Outline section in Chapter 3 applied to the current study.

Participants joined one of two research groups (which ran consecutively) as they were referred. Each of the groups had 11 participants, none of whom exited the training programme or study. None of the participants or their foster children accessed any other mental health interventions during the course of the Fostering Security training programme. Participants were interviewed in their homes by the researcher/facilitator prior to the training, as it was found in previous programmes that home visits led to high rates of attendance at the first session and helped facilitators build rapport, allay concerns, and answer questions for participants before the programme started. Māori participants were offered initial visits alongside a Māori staff member from the Child, Adolescent and Family Service to ensure appropriate engagement and recognition of the cultural values and norms of Māori participants.

In total, 22 caregivers (13 female, 9 male) attended the Fostering Security training programme and participated in the two research groups. The sample comprised seven couples who were counted as individual participants. Where participants were caring for more than one foster child, information was obtained about the child with whom they had the most difficulty. Table 1 summarises the demographic information of the study participants at the point of pre-intervention assessment. As can be seen, the participants ranged in age from 31 to 67 and the vast majority were in relationships with partners. Most of the participants identified as New Zealand European, and the majority also stated no relation to the foster child. One participant was the biological father of a seven-year-old child who had been in his care for a year. There were no foster placement breakdowns through the course of this study, which ended at three-month follow-up after the programme.

This participant cohort is fairly similar in terms of demographic variables to others in previous Fostering Security training groups, although the ethnicity figures tend to vary, with some groups having a larger percentage of Māori participants than the current study did. Given the relatively small number of children in care in Hawke's Bay it was not possible to ensure that the over-representation of Māori children in care was reflected by recruitment of Māori caregivers to this study. The participants in this cohort differed in terms of education, with some having had university education and some not. Again, this is a similar pattern with participants in other training groups, showing the range of people from all walks of life who become foster parents. Within this cohort there was also a range of fostering experience, from less than one year to 17 years experience. Appendix A gives further details about two typical Fostering Security programme participants, with information changed to protect privacy and confidentiality.

*Table 1.* Demographic information of research participants at pre-intervention assessment

<b>Participants (n=22)</b>	<b>Number</b>	<b>Mean or Percent</b>
Gender:		
Female	13	59%
Male	9	41%
Age:		49
Minimum = 31		
Maximum = 67		
Standard deviation = 10		
Marital status:		
Single	3	14%
Married/de facto partnership	18	82%
Divorced/separated	1	4%
Ethnicity:		
New Zealand European	16	73%
Māori	3	14%
New Zealand European & Māori	1	4%
Other European	2	9%
Education:		
Some secondary schooling	8	36%
Completed secondary school	3	14%
Trade or technical school education	3	14%
Undergraduate university degree	7	32%
Postgraduate university degree	1	4%
Employment status:		
Unemployed or homemakers	6	27%
Employed	16	73%
Relation to foster child:		
Kin or whānau	8	36%
No relation	14	64%
Length of time caring for foster child		
Less than six months	8	36%
One to three years	9	41%
Four to six years	5	23%
Length of time as foster parent		
Less than one year	9	41%
Between one and a half to three years	6	27%
Between three and a half to eight years	5	23%
Between 12 to 17 years	2	9%

Table 2 outlines the demographic information of the foster children that behavioural data was collected about for this study. Fifteen children comprised this sample as the some pairs of participants in the study provided information about the same child. The seven-year-old child returned to the care of his biological father is included in the category ‘foster child’ in all statistics.

As can be seen in Table 2, there is a range in terms of age of the foster child, total length of time in care, and the number of placements. While it is preferable that there are participants in the groups with foster children of similar ages, this cannot always be guaranteed given the range of caregivers wanting to attend the training programme. However, through the course of the programme caregivers get to see that even though the children may be of different ages and developmental stages, the core attachment and trauma-related issues are the same, for instance, food maintenance and self-injury issues have similar functions and need similar interventions regardless of the age and stage of the foster child. In the current cohort a caregiver commented on her initial reservation when she realised that her foster child was so much older than the other caregivers’ foster children, and her surprise when she came to see that similar issues affected children in care despite their age or developmental stage.

When there is a range of ages amongst the foster children, care is taken to ensure that examples in the programme relate to these different ages. Group cohesion has not appeared to be negatively affected for participants attending the Fostering Security programmes given the wide age range amongst the caregivers’ foster children.

*Table 2.* Demographic information of foster children in the care of research participants at pre-intervention assessment

<b>Foster Children (n=15)</b>	<b>Number</b>	<b>Mean or Percent</b>
Gender:		
Female	5	33%
Male	10	67%
Age:		7
Minimum = 2		
Maximum = 13		
Standard deviation = 3.6		
Ethnicity:		
New Zealand European	9	60%
Māori	3	20%
New Zealand European & Māori	2	13%
Māori and Pacific Islander	1	7%
Total time in care:		
Less than a year	5	33%
One and a half to two and a half years	5	33%
Three to four years	3	20%
Five to six years.	2	14%
Total number of placements:		
One placement	6	40%
Two placements	4	27%
Four placements	2	13%
Five placements.	3	20%

Participants were asked to name three of their foster child's behaviours that were of most concern to them at the initial interview. These behaviours are listed below with the number of times they were reported by participants in brackets after the behaviour.

- non-compliance, defiance, and argumentativeness (9)
- aggressive behaviour (7)
- manipulative and/or socially indiscriminate behaviour (5)
- attention-seeking behaviour (5)
- lying (4)
- abnormal eating behaviours (4)

- poor attachments with significant others (3)
- controlling behaviour (3)
- inattention and hyperactivity (3)
- anxiety (3)
- sleep problems (3)
- emotional dysregulation, with temper tantrums, screaming, and yelling (2)
- night terrors (2)
- peer interaction problems (2)
- enuresis and/or encopresis (2)
- school refusal (1)
- poor self-esteem (1)
- stealing (1)
- self-harming (head banging) (1)
- lack of emotional expression (1)
- hypervigilance (1)
- psychosomatic complaints (1)
- cruelty towards animals (1)
- poor cause and effect thinking (1)

Foster child mental health and medical diagnoses reported by participants in this cohort included attention deficit hyperactivity disorder, attachment disorder, mild intellectual disability, low muscle tone, epilepsy, and fetal valproate syndrome. The foster child diagnosed with epilepsy was taking prescribed Epilim, and some of the children diagnosed with attention deficit hyperactivity disorder were medicated with Methylphenidate.

**Informed consent.** Informed written consent was sought from all caregiver participants and educators for information they gave about themselves and the foster child (Appendix B). Where the caregiver was not the legal guardian of the foster child, informed consent to obtain demographic information about the child and to collect information about the child's behaviour at school was obtained from the child's legal guardian, that is, the child's biological parent, Child, Youth & Family, or previous caregivers (Appendix B). Participants were offered the opportunity for the consent form to be read to them, in the case of literacy difficulties.

Informed written and/or verbal assent was also sought from all children of verbal age, using language appropriate for their age and developmental stage (Appendix B). While the caregivers, and not the children, were the main focus of this study, assent was obtained from the children as information was collected about them. Assent was taken by the researcher, a registered senior psychologist, experienced in communicating with children of all ages, and familiar with obtaining assent from children. The children had the right to refuse to have information collected about their behaviour from their caregivers or educators. However, they could not refuse for caregivers to give information about themselves (e.g., about the caregivers' beliefs and parenting behaviour). Consent and assent were successfully obtained from and for all caregiver participants, educators, and foster children.

Caregivers, educators, and legal guardians of the foster children were provided with information sheets (Appendix C), given the opportunity to ask questions, given clear statements that participation was voluntary, and given the opportunity to receive a summary of the research findings on completion of the

study. Caregivers and educators teachers were informed that they were able to withdraw from the study at any time without compromising their participation in the Fostering Security training programme or mental health interventions for the child.

**Ethical issues.** As the current research was conducted in a secondary mental health setting, ethical approval was sought and obtained from the Central Regional Health and Disability Ethics Committee, as well as the Hawke's Bay District Health Board's Research Committee. As information was being collected about foster children, some of whom were in the custody of the Chief Executive of the Ministry of Social Development, ethical approval was also sought and obtained from the Ministry of Social Development's Research Access Committee.

Many parent and caregiver training evaluations are undertaken (at least initially) by the developers of the training programmes which implies a potential conflict of interest or the potential for research bias (Eisner, 2009). In particular, ideological conflicts may arise when researchers hold particular views about issues in the field of study, which may conflict with the role of the researcher as the impartial scientist (Eisner, 2009). Cognisant of the potential for conflict of interest or research bias due to my joint role as the Fostering Security programme developer as well as the evaluator of the programme, strategies were implemented in this study to mitigate against researcher bias as far as was possible.

I was aware that my worldview and perspectives as well as the participants' worldviews and perspectives were present in the research, particularly during the qualitative data collection and analysis components. As advised by Fusch and Ness (2015), I was therefore mindful of recognising and bracketing my personal views in these phases of the research so as to more clearly receive and interpret the

participants' views and perspectives. In addition, steps were implemented to verify my analysis of data. A psychologist colleague, blind to the study's research objectives, coded a randomly selected 25% of the Mind-Mindedness Interviews (see Measures section below). Interrater agreement was  $K = .88$  indicating very good agreement. A second psychologist colleague checked the scoring on a quarter of all additional measures administered. In thematic analysis the initial codes and resulting themes were checked by an additional psychologist colleague to reduce the chance of missing any potential themes and to ensure as much inclusivity as possible. The themes were further corroborated by the main academic supervisor in this study.

I was also mindful of the potential for respondent bias given my dual role as the programme facilitator and evaluator. As the programme facilitator position has the potential for the development of therapeutic rapport with participants, I was aware that participants might be inclined to provide responses that they thought would be favourable to me during the interviews and questionnaire completion. Respondent bias can be minimised or eliminated if the interviewer is not involved with the training programme and is blind to the study's purpose (Pannucci & Wilkins, 2010), but this was not a feasible option in this study. In an attempt to mitigate against possible respondent bias participants were given the opportunity to provide anonymous written feedback in the evaluation questionnaires at the end of the programme.

An additional ethical issue which required consideration was the possibility that the Fostering Security programme content and process could raise distressing memories for caregivers of their own past traumatic experiences. Caregivers were

therefore advised that they could request individual support from the group facilitators and/or referral for counselling if required.

**Measures.** A number of measures were used to provide a broad understanding of the factors that changed for the participant caregivers and their foster children through the course of the Fostering Security programme context, content and process. Quantitative and qualitative data were obtained from semi-structured interviews and questionnaires administered to participants and the foster child's educator at four data collection points. Semi-structured interviews were used to allow for flexibility in exploring relevant issues raised by the participants. Participants fostering more than one child were asked to answer questions about and complete questionnaires on the child about whose behaviours they were most concerned. Table 3 outlines the interviews and questionnaires used, and the data collection points at which they were administered. The measures were administered at the start of the Fostering Security programme, after the psychoeducation and self-care/self-reflection modules, after the behaviour management and skills training module, and three months after the Fostering Security programme. As a reminder, study Group A received the psychoeducation and self-care/self-reflection modules before the behaviour management and skills training module, and study Group B received the behaviour management and skills training module before the psychoeducation and self-care/self-reflection modules.

**A) Caregiver measures** (completed by study participants)

*1. Initial interview* (Appendix D). I conducted all initial interviews in the participants' homes prior to the start of the Fostering Security training programmes. In the initial interview, demographic information was obtained about the participants and their foster children, as well as details about the

foster child's behaviour, health, development and schooling. The initial interview also included the Mind-Mindedness Interview, and participants completed the first Parenting Relationship Questionnaire, Parent Cognition Scale, and Eyberg Child Behavior Inventory (summarised below).

2. *Mind-Mindedness Interview* (Appendix E). The Mind-Mindedness Interview (Meins, Fernyhough, Russell, & Clark-Carter, 1998; Meins et al., 2003) was selected for use in this study as it was considered the most appropriate instrument to measure the participant's tendency to identify and describe the child's internal mental states which has been associated with parental mind-mindedness (i.e., the willingness and ability to interpret the child's behaviour with reference to the child's thoughts and feelings which might be underlying the behaviour) (Meins et al., 2001; Meins et al., 2012). The Mind-Mindedness Interview was also selected as it was well suited to being included in the participant interviews at the four data collection points in this study.

The Mind-Mindedness Interview consists of one question: "Can you describe (foster child's name) for me?" Participants were informed there were no right or wrong answers and they could talk about any of the child's characteristics. The participants' descriptions were audiotaped and later transcribed and coded, and each child attribute was placed into one of four exhaustive and exclusive categories:

- a) Mental attributes (e.g., "He gets confused in some situations", "He worries about me a lot", "She loves it when she can help you").

- b) Behavioural attributes (e.g., “He is very active and lively”, “She’s very outgoing but in an indiscriminate way”, “She chews on her clothes a lot”).
- c) Physical attributes (e.g., “She’s an attractive young woman”, “She’s lost her two front teeth”, “He is very tall for his age”).
- d) General attributes that do not fit into any of the other three categories (e.g., “He’s a pleasant young man”, “He’s been good at the moment”, “She can be a typical child sometimes”).

To control for differences in verbosity, each participant received a mind-mindedness score which was the number of mental attributes calculated as a proportion of the total number of attributes (Meins et al., 1998; Meins et al., 2003). Higher scores on the mental category are associated with greater mind-mindedness (Meins et al, 2003). As was demonstrated in this study, the Mind-Mindedness Interview has been shown to have high inter-rater reliability (Meins et al., 2003). Participants’ responses on the Mind-Mindedness Interview were also used in the qualitative data analysis.

*3. Parenting Relationship Questionnaire.* The Parenting Relationship Questionnaire is a self-report questionnaire designed to assess a parent or caregiver’s perspective of the parent-child relationship and includes assessment on the following dimensions: attachment, communication, discipline practices, involvement, parenting confidence, satisfaction with school, and relational frustration (Kamphaus & Reynolds, 2006). The Parenting Relationship Questionnaire was selected as other commonly used brief mental health screening instruments, like the Child

Behaviour Checklist (Achenbach & Rescorla, 2000) and the Strengths and Difficulties Questionnaire (Goodman & Scott, 1999), do not capture the complexity of mental health problems that foster children present with. The Assessment Checklist for Children (Tarren-Sweeney & Vetere, 2014) was also considered for use in this study as it was developed to measure the range of attachment- and trauma-related mental health problems seen in foster children. However, given that the checklist consists of 120 items, and the measures required frequent administration to participants, it was not practical to use this instrument. The Parenting Relationship Questionnaire was thought to be the most appropriate instrument to use as it provided the opportunity to measure the caregiver-foster child attachment relationship as well as parental stress or relational frustration. This was considered preferable to using two separate measures to obtain this data.

The Parenting Relationship Questionnaire has two levels, that is, a preschool level for children ages two to five years old which has 45 items, and a child and adolescent level for children ages 6 to eighteen which has 71 items. Items are rated on a four-point Likert-type scale, and the questionnaire takes between 10 to 15 minutes to complete. Two dimensions of the Parenting Relationship Questionnaire were used in this study: attachment (closeness, empathy, and understanding as reported by the parent for the child) and relational frustration (level of stress or distress in parenting the child). Examples of items relating to the attachment scale are: “I enjoy spending time with my child”, “I know when my child will become upset”, and “I can sense my child’s moods”. Examples of items relating to

the relational frustration scale are: “My child and I get into heated discussions”, “I lose my temper with my child”, and “My child tests my limits”. Kamphaus & Reynolds (2006) reported that reliability coefficients (median values ranging from .82 to .87) showed that the Parenting Relationship Questionnaire scales are reliable estimates of aspects of the parent-child relationship. In addition the Parenting Relationship Questionnaire had good test-retest reliability with the test-retest correlations ranging between .79 and .81 for the majority of the scales. With regard to validity, moderate to high correlations were found between the Parenting Relationship Questionnaire and other commonly used measures of parent-child relationships, and moderate correlations were found between scales in the expected directions (Kamphaus & Reynolds, 2006).

*4. Parent Cognition Scale.* The Parent Cognition Scale is a 30-item self-report measure designed to measure the degree to which parents or caregivers hold dysfunctional child-responsible and parent-causal attributions for the child’s misbehaviour (Snarr et al., 2009). This measure was selected for use in the current study as it was considered to be the most appropriate measure to assess dysfunctional attributions foster parents might have about their foster child’s behaviour and it is a relatively short questionnaire to complete. In addition, it was difficult to find an attributions measure that was not focussed on caregivers for people with disabilities.

The Parent Cognition Scale takes approximately five minutes to complete and requires respondents to think about the child’s misbehaviour over the last two months and to rate various reasons for the behaviour on a six-point Likert scale which ranges from 1 (always true) to 6 (never true).

Ten items relate to child-responsible attributions, that is, the child's wilful intent to misbehave or have a negative effect on the parent (e.g., "My child is headstrong", "My child is very demanding", and "My child tries to get my goat or push my buttons"). Ten further items relate to parent-causal attributions, that is, parent characteristics related to the child's misbehaviour (e.g., "I don't do the right thing", "I don't give my child enough attention", "I'm not able to be clear"). The final 10 items attribute the child's misbehaviour to unintentional child factors (e.g., "My child is in a stage"), or to situational parent factors (e.g., "I was tired at the time"). For the purposes of the current study, only the child-responsible attribution scores were utilised. In terms of psychometric properties, Snarr et al. (2009) reported that the Parent Cognition Scale had adequate internal consistency ( $\alpha = .81-.90$ ), good test-retest reliability (test-retest correlations ranging between .55-.76), and promising convergent and discriminant validity.

5. *Evaluation questionnaire* (completed at programme completion) (Appendix F). The evaluation questionnaires were administered to study participants at the final session of the Fostering Security training programme. Participants were given the opportunity to complete and return these questionnaires anonymously. The questionnaires required them to rate and comment on items relating to the

- quality of the programme, presentation, materials used, and venue;
- achievement of participants' personal learning goals;
- value and order of the different training modules;
- suggestions for programme follow-up and improvement;

- cultural appropriateness of the programme and/or how their needs as Māori participants were taken into consideration.
- Māori cultural appropriateness of the programme; and
- co-facilitation by the Child, Adolescent & Family Service and the Child, Youth and Family Service.

*6. Mid-programme, post-programme, and three-month follow up interviews* (Appendix G). I administered the mid-programme, post-programme, and three-month follow up interviews with participants in their homes. These interviews included the Mind-Mindedness Interview (i.e., “Can you describe [foster child’s name] for me?”). The interviews also obtained information about the participants’ experiences of the Fostering Security programme, the aspects of the programme they found useful and not so useful or the skills or strategies from the programme they remembered and still used, about their experiences as caregivers, and whether the foster child was still in their care.

### ***B) Child behaviour measures***

*1. Eyberg Child Behavior Inventory* (completed by study participants). The Eyberg Child Behavior Inventory is a 36-item behaviour rating scale which assesses the frequency and severity of child behaviour problems in the home setting (Eyberg & Pincus, 1999). The Eyberg Child Behavior Inventory and the Sutter-Eyberg Student Behavior Inventory – Revised (see below) were selected for use in this study as they are commonly used behavioural questionnaires in parent training programme research, they are reliable and valid measures, they are relatively short in length, and there are parent and teacher questionnaires available.

Examples of items on the Eyberg Child Behavior Inventory are: “Has temper tantrums”, “Physically fights with friends own age”, and “Acts defiant when told to do something”. The Eyberg Child Behavior Inventory takes approximately five minutes to complete and has an age range of two to 16 years old. On each item the parent or caregiver rates how often each behaviour occurs on a seven-point Intensity Scale [ranging from 1 (never) to 7 (always)], and whether or not the behaviour is a problem (rating “Yes” or “No” on the Problem Scale). For the purposes of this study, only the Intensity scale was used. The Eyberg Child Behavior Inventory is reported to be a reliable and valid instrument (Eyberg & Pincus, 1999). Internal consistency coefficients were .95 for the Intensity scale and .93 for the Problem scale, test-retest reliability correlations across a three-week period ranged from .86 to .88, inter-rater reliability values ranged from .79 to .86, and acceptable convergent and discriminant validity was found.

2. *Sutter-Eyberg Student Behavior Inventory - Revised* (completed by the foster child’s teacher or early childhood centre staff member). The Sutter-Eyberg Student Behavior Inventory - Revised is a 38-item behaviour rating scale which assesses the frequency and severity of disruptive and conduct problem behaviours in the school setting (Eyberg & Pincus, 1999). It takes approximately five minutes to complete and the age range is 2 to 16 years old. The teachers who completed this inventory were the foster child’s form teachers or the teacher designated to the foster child at the early childhood centre. Most of the teachers spent between about 30 hours a week with the child, with one having contact with the child 20 hours per week and another 9 hours a week.

Examples of items Sutter-Eyberg Student Behavior Inventory - Revised are: “Teases or provokes other students”, “Demands teacher attentions”, and “Argues with teacher about rules or instructions”. The teacher/early childcare staff member indicates how often each behaviour occurs on a seven-point Intensity Scale [ranging from 1 (never) to 7 (always)], and whether or not the behaviour is a problem (rating “Yes” or “No” on the Problem Scale). For the purposes of this study, only the Intensity scale was used. The Sutter-Eyberg Student Behavior Inventory - Revised showed high internal consistency (values ranging from .93 to .98), good test-retest reliability (values ranging from .81 to .84), and acceptable convergent, discriminant and predictive validity (Eyberg & Pincus, 1999).

Table 3. Questionnaires/interviews at four data collection points for Groups A and B

Baseline Data Collection	Post-Psycho-education and Self-care/Self-reflection Modules	Post-Behaviour Management and Skills Training Module	Three-Month Follow-up Data Collection
<p><b><u>Group A caregiver measures:</u></b></p> <ul style="list-style-type: none"> <li>Initial interview including Mind-Mindedness Interview</li> <li>Eyberg Child Behavior Inventory</li> <li>Parenting Relationship Questionnaire</li> <li>Parent Cognition Scale</li> </ul> <p><b><u>Group A educator measures:</u></b></p> <ul style="list-style-type: none"> <li>Sutter-Eyberg Student Behavior Inventory – Revised</li> </ul>	<ul style="list-style-type: none"> <li>Mid-programme interview including Mind-Mindedness Interview</li> <li>Eyberg Child Behavior Inventory</li> <li>Parenting Relationship Questionnaire</li> <li>Parent Cognition Scale</li> <li>Sutter-Eyberg Student Behavior Inventory – Revised</li> </ul>	<ul style="list-style-type: none"> <li>Evaluation Form</li> <li>Post-programme interview including Mind-Mindedness Interview</li> <li>Eyberg Child Behavior Inventory</li> <li>Parenting Relationship Questionnaire</li> <li>Parent Cognition Scale</li> <li>Sutter-Eyberg Student Behavior Inventory – Revised</li> </ul>	<ul style="list-style-type: none"> <li>Follow-up interview including Mind-Mindedness Interview</li> <li>Eyberg Child Behavior Inventory</li> <li>Parenting Relationship Questionnaire</li> <li>Parent Cognition Scale</li> <li>Sutter-Eyberg Student Behavior Inventory – Revised</li> </ul>
Baseline Data Collection	Post-Behaviour Management and Skills Training Module	Post-Psycho-education and Self-care/Self-reflection Modules	Three-Month Follow-up Data Collection
<p><b><u>Group B caregiver measures:</u></b></p> <ul style="list-style-type: none"> <li>Initial interview including Mind-Mindedness Interview</li> <li>Eyberg Child Behavior Inventory</li> <li>Parenting Relationship Questionnaire</li> <li>Parent Cognition Scale</li> </ul> <p><b><u>Group B educator measures:</u></b></p> <ul style="list-style-type: none"> <li>Sutter-Eyberg Student Behavior Inventory – Revised</li> </ul>	<ul style="list-style-type: none"> <li>Mid-programme interview including Mind-Mindedness Interview</li> <li>Eyberg Child Behavior Inventory</li> <li>Parenting Relationship Questionnaire</li> <li>Parent Cognition Scale</li> <li>Sutter-Eyberg Student Behavior Inventory – Revised</li> </ul>	<ul style="list-style-type: none"> <li>Evaluation Form</li> <li>Post-programme interview including Mind-Mindedness Interview</li> <li>Eyberg Child Behavior Inventory</li> <li>Parenting Relationship Questionnaire</li> <li>Parent Cognition Scale</li> <li>Sutter-Eyberg Student Behavior Inventory – Revised</li> </ul>	<ul style="list-style-type: none"> <li>Follow-up interview including Mind-Mindedness Interview</li> <li>Eyberg Child Behavior Inventory</li> <li>Parenting Relationship Questionnaire</li> <li>Parent Cognition Scale</li> <li>Sutter-Eyberg Student Behavior Inventory – Revised</li> </ul>

## Data Analysis

Child home and school behaviour measures and caregiver measures (i.e., attachment relationship with foster child, mind-mindedness, attributions for foster child misbehaviour, and relational frustration), were analysed both quantitatively and qualitatively in this study. The quantitative and qualitative approaches to data analysis are described below. The overall objective of the analysis was to provide an understanding of the factors that changed for the participant caregivers and their foster children through the course of the Fostering Security programme training programme and at three months follow-up.

- 1. Quantitative data analysis.* Data were analysed by Analysis of Variance (ANOVA) with each major outcome measure as a separate dependent variable. The ANOVA design was a 2 between (order of modules) by 4 within (data collection points over time), and effect sizes were reported on. As outlined in Table 3, the four data collections points were: Time 1 (prior to intervention), Time 2 (post first training module), Time 3 (post second training module/completion of intervention, and Time 4 (three-month follow-up). There is not much information about the likely standard error (i.e., measurement of the accuracy with which a sample represents a population) of the measures used, but the repeated measures ANOVA provided some protection for high levels of participant variability. Following procedures described by Murphy, Myors, and Wolach (2009), it was estimated that 11 participants per group would provide adequate power for the F test and for looking at difference between means for which a priori predictions were being made. Random assignment of all

participants to the two groups was not practical, due to as the relatively small number of caregivers and children in care in Hawke's Bay.

Participants were essentially being considered as a series of individual cases. The significance level assumed was  $p = <.05$  as the participant numbers in this study were small and as conclusions were not only being drawn from the quantitative statistical results. The quantitative data were analysed with SPSS version 20.0.

2. ***Qualitative data analysis.*** Participant pre-, mid-, post-, and three-month follow-up semi-structured interviews were audio-recorded and transcribed. I analysed the transcribed interviews and participant comments on the evaluation questionnaire for patterns or themes using thematic analysis (Braun & Clarke, 2006). Thematic analysis was selected as the qualitative methodology as it seemed to be the most suitable method to identify themes and patterns in rich detail and offer some interpretation of the data. Thematic analysis is considered to be a flexible approach particularly suited for qualitative analysis in small research studies (Braun & Clarke, 2006), such as the current study. In addition, thematic analysis was also selected as it is flexible enough to be used to analyse most types of qualitative data (Braun & Clarke, 2006), in the case of the current study participant interviews and evaluation questionnaire comments. As this was an exploratory study, the aim in the interpretation of the data was to explore participants' comments as presented to derive shared themes across the group, and thematic analysis was considered to be the most suitable qualitative method to do so.

Interpretative phenomenological analysis, a qualitative approach which aims to provide in depth and detailed examination of people's lived experiences and the meaning these experiences have for them (Smith & Osborn, 2008), was also considered as a possible methodological option for the current study. Interpretative phenomenological analysis attempts to describe a person's lived experiences in its own terms rather than attempting to describe it in some objective manner, and it acknowledges the researcher's role in trying to make sense of the experiences the participant is trying to make sense of (Smith, Flowers, & Larkin, 2009). Interpretative phenomenological analysis is an idiographic approach in that it examines peoples' experiences in a detailed case-by-case manner before making more general claims, and as such it is suited to studies with smaller samples (Smith & Osborn, 2008). As the current study was interested more in the patterning of meaning across the participants as a group of caregivers and less in the detailed study of the lived experiences of each participant, thematic analysis was considered a more suitable methodological approach.

Another qualitative methodological option considered in this study was narrative analysis which involves exploring what people say, how they say it and why they say it, that is, it is concerned with the content, structure and function of people's narrative (Willig, 2013). Like interpretative phenomenological analysis, narrative analysis is concerned with the lived subjective experience of a person, but it also acknowledges the importance of language, for example, the manner and style of speaking, the psychological and social functions of language, and the influence of broader social and cultural contexts (Willig, 2013). However, as the focus in the

current study was on the content of participants' interview and evaluation questionnaire comments not on how and why they made those comments, thematic analysis was held to be a more suitable methodological option. In addition narrative analysis deals only with verbal material while thematic analysis deals with both verbal and non-verbal material, and the latter was required in this study.

The transcribed interviews and participant comments on the evaluation questionnaire were analysed using the six phases of thematic analysis, as outlined by Braun and Clarke (2006).

1. Becoming familiar with the data. This phase involved the transcription, reading, and re-reading of the transcribed data to familiarise myself with the participants' comments.
2. Generating initial codes. In this phase I coded the data into smaller meaningful segments. As a main aim of this study was to analyse the mechanisms of change for participants attending the Fostering Security programme only data that was relevant to this issue was sorted into initial codes. The failure to reach data saturation in qualitative research, that is, the point at which no additional codes or themes are found, negatively affects content validity (Fusch & Ness, 2015). The initial codes were therefore checked by a psychologist colleague to reduce the chance of missing any potential themes and to ensure as much inclusivity as possible.
3. Searching for themes. The initial codes were collated into main or overarching themes, as well as sub-themes which fitted within these main themes (e.g., within the main theme of 'Participant's self-reflective

capacity and capacity to reflect on child's behaviour', the sub-themes included 'development of reflection on child's behaviour', 'development of understanding, empathy and tolerance', and 'development critical appraisal of parenting approach', and 'awareness of triggers and the need to stay in control of emotions').

4. Reviewing and refining the themes. This phase involved removing themes that either did not have enough data to support them, or the data were too diverse. It also involved consideration of main themes that might need breaking down into more specific themes. The psychologist colleague who checked the initial codes also reviewed the themes in this phase, and the themes were further corroborated by the main academic supervisor in this study. No inconsistencies were noted between my codes and themes and those reviewed by my colleague.
5. Defining and naming themes. In this phase the themes were more clearly defined and named to clearly indicate the nature of the theme. Sub-themes were considered in relation to their interaction with the overarching theme.
6. Reporting and write-up of the analysis. The final phase of the thematic analysis involved the generation of a coherent and logical account of the data, across the main themes and within the sub-themes. Clear verbatim examples of participants' dialogue were captured to demonstrate the main principles of the themes. These main and sub-themes are described in detail in Chapter 6, alongside the quantitative data analysis findings.

**Summary**

This chapter has described the research objectives, research design, and method of the current study (i.e., discussion about participants, informed consent, ethical issues, measures used to collect data, and data analysis methods). Chapter 5 will outline the qualitative and quantitative findings of the study. These findings will be discussed in the final chapter, Chapter 6, alongside the study limitations, implications, suggestions for future research, and directions for further development of the Fostering Security training programme for foster parents.



## CHAPTER 5: RESULTS

This chapter presents the formal results of this research study in three sections. Firstly, the quantitative findings from the psychometric measures administered to participants are reported. Different aspects of the research objectives required comparisons between and within groups at different points of time. For each of the six variables being considered (i.e., attachment relationship with foster child, mind-mindedness, attributions for foster child misbehaviour, relational frustration, child misbehaviour at school, and child misbehaviour at home) the data will first be presented descriptively, either as raw scores or T-scores, in the form of frequency histograms. These will illustrate the values obtained and the distribution of these values across all participants (both groups combined). The estimated marginal mean scores for the two groups across the four time periods are then presented. All analyses of variance met the assumptions of homogeneity of variance. Participants' comments which illustrate changes in the six variables are presented after each of the six quantitative data presentations. These comments were obtained from the semi-structured participant interviews that occurred mid-programme, post-programme, and at three month follow up, in particular from the questions pertaining to participants' experiences of the Fostering Security programme. Secondly, the overarching and sub-themes from the qualitative thematic analysis, related to the mechanisms of change in the Fostering Security training programme, are reported thereafter. Finally, results and comments from participants' evaluation questionnaires (completed at completion of the 10-session training programme), which related to participants' perceptions of the training content, context, and process are also reported.

## Quantitative and Qualitative Analysis Findings by Variable

### A) Caregiver Measures

**Attachment.** The construct of attachment was measured quantitatively by the Attachment Scale of the Parenting Relationship Questionnaire (Kamphaus & Reynolds, 2006), in which higher scores indicate greater levels of positive attachment. The Attachment Scale has three factors: closeness, empathy, and understanding. From these three constructs one overall score for the degree of secure attachment is generated. The frequency distribution for both groups at pre-test (Time 1) is presented in Figure 7.

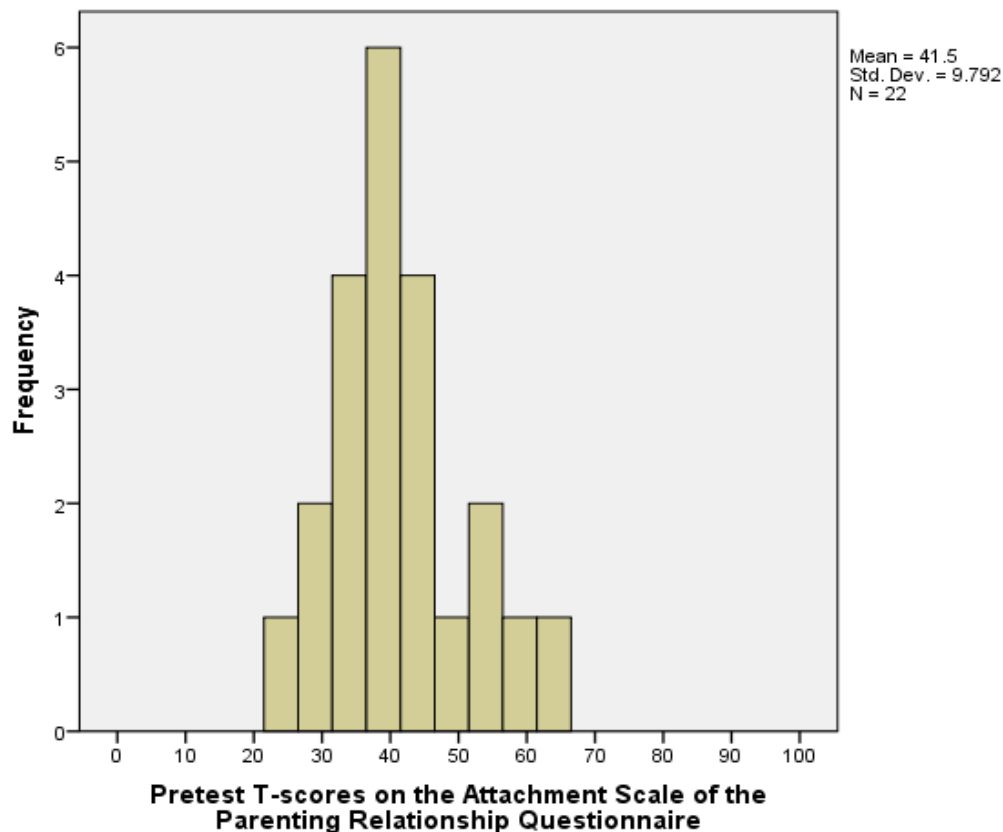


Figure 7. Frequency of T-scores on the Attachment Scale of the Parenting Relationship Questionnaire at pretest

It can be seen that the attachment scores were slightly skewed in the direction of lower scores. The mean T-scores for both groups across all four time periods are depicted graphically in Figure 8.

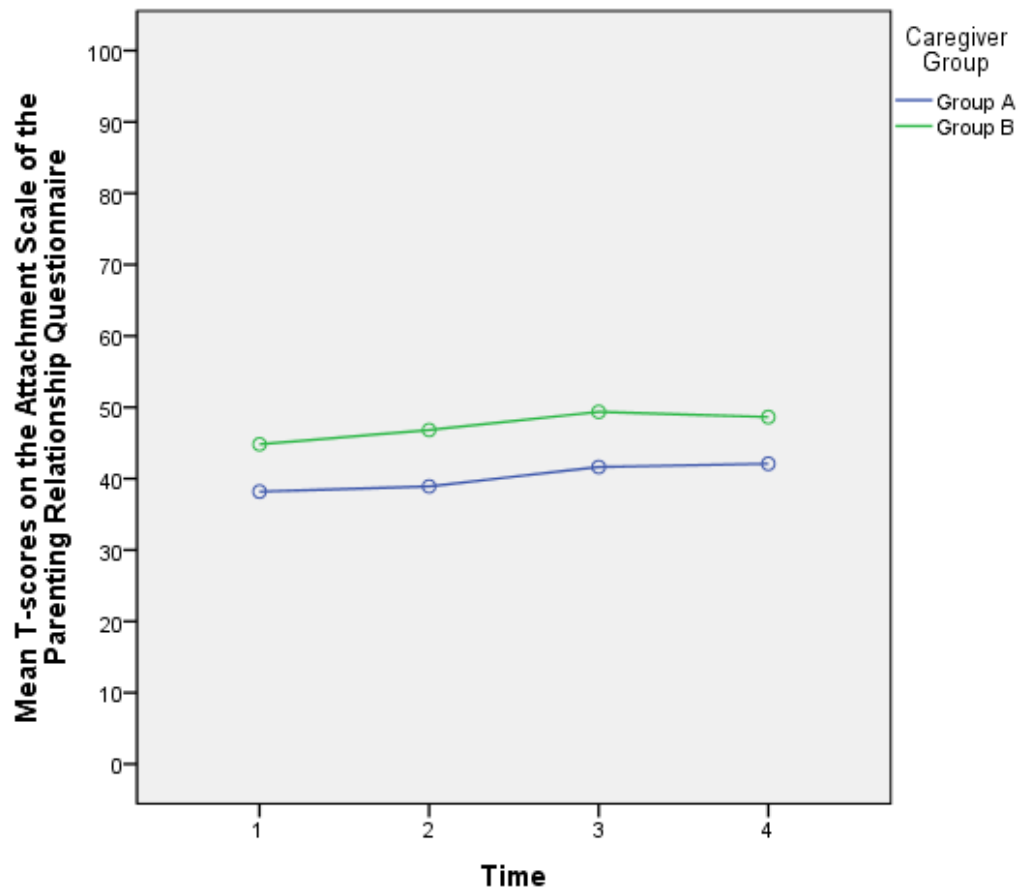


Figure 8. Attachment means by group by time

T-scores below 40 on the Attachment Scale indicate problems with the participant's ability to understand the foster child's mood and feelings, and ability to provide comfort to the child when he or she is upset. Group A started at Time 1 with a mean score below 40 while Group B began with a score above 40. This indicates that Group B participants had a more positive and secure attachment with their foster children than Group A participants had with their foster children. It can be seen from the figure that attachment scores generally increased across the four

time periods for both groups. At the three month follow up point (Time 4), the means for both groups were, as expected, higher than the means at pre-assessment (Time 1). A 2 (Groups) by 4 (Time) mixed between-within analysis of variance found no group by time interaction, indicating that the change in attachment scores was not significantly different for Groups A and B over the four time periods. The main effect for time was not significant,  $F(3, 21) = 2.99, p = .058$ , partial eta squared = .33. The main effect comparing the two types of interventions (i.e., main effect for group), was also not significant,  $F(1, 21) = 2.95, p = .10$ , partial eta squared = .13. This shows that the small increasing trend for attachment over the course of the programme and follow up was close to statistically significant, and no difference in the effectiveness of the order of the Fostering Security training modules on attachment scores was suggested.

This increasing trend in participants' empathy for and understanding of the foster child are supported by many participant statements from the qualitative analysis, some of which are presented below. Participants are coded as C (for caregiver) alongside a number, with A or B representing the research group they were part of.

CA5 (mid-programme interview): "The group is excellent, very good, it's helped me have more understanding so I am more patient...I do this because I love him. And I do love him loads, sometimes it just gets really hard, you know, you don't want to feel like that, but because of the bad things they went through they bring out that awful thing inside us that we don't like sometimes."

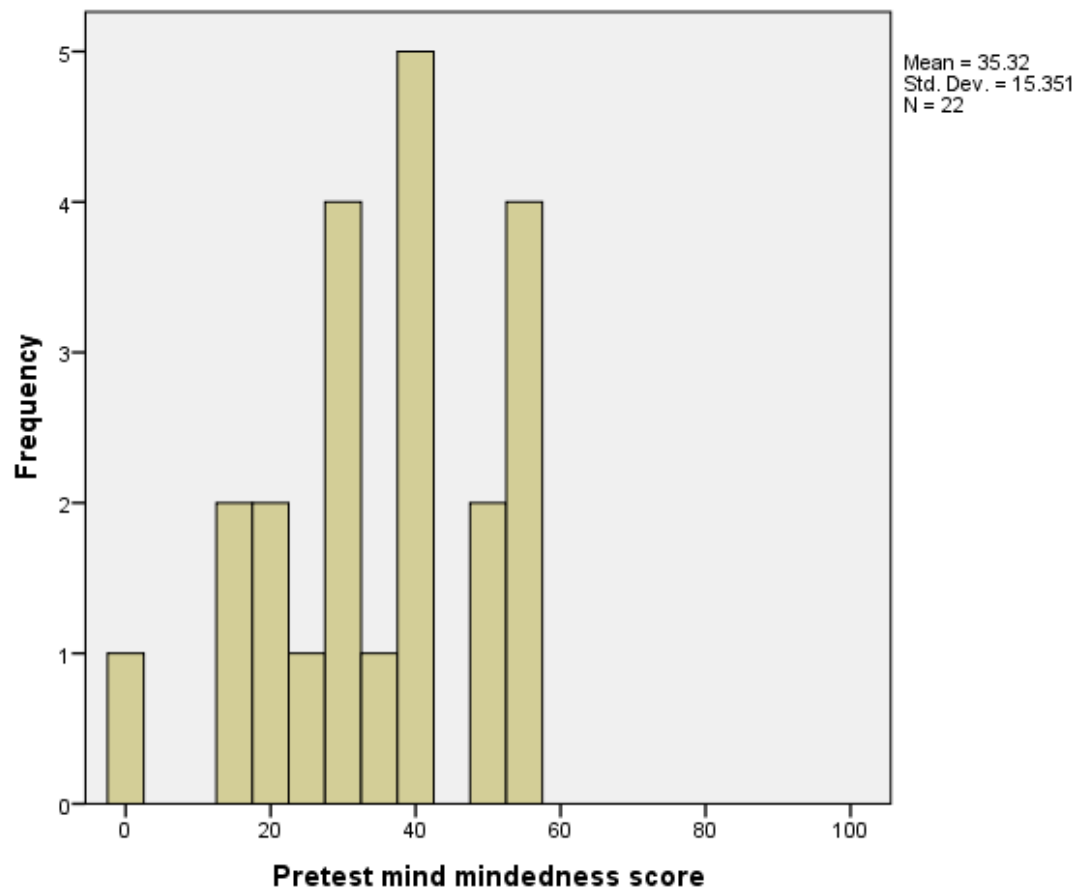
CB1 (mid-programme): The other day when he was on his bed crying, he said he didn't like to have fun, he didn't like fun. Tears were just rolling down his eyes, and I was trying to explain to him, uhm, what fun was all about but he just was not in the mood to listen. So I actually said to him that I loved him and that I was trying to explain the right way about having fun and stuff like that."

CA8: (programme completion): "D didn't allow what I had to say because she didn't want that attention, she didn't let you in. But she is getting there and every now and then she lets you in. Or it might be later, when she is calmer, and we have a cuddle, then she does allow it...we can see changes in her behaviour as well."

These statements illustrate the participant's ability to attempt to understand their foster child's emotions and moods, their closeness to the child, and their provision of comfort to the child when he or she is upset. It can be seen that empathy for and an understanding of the child are crucial aspects to the development of a secure attachment relationship between caregiver and foster child, and these are areas of particular focus in the Fostering Security programme.

***Mind-mindedness.*** Mind-mindedness was measured by scoring the participants' verbatim responses to a single question embedded in the interview protocol: "How would you describe your [foster] child?" (Meins et al., 1998). The mind-mindedness score was calculated as the percentage of mental attributes in relation to the sum of all four attributes, the other three attributes being behavioural, physical and general. A higher percentage of mental attributes in relation to other attributes implies higher levels of participants' mind-mindedness.

The frequency distribution for both groups at pretest (Time 1) is presented in Figure 9.



*Figure 9.* Frequency of mind-mindedness scores at pretest

From Figure 9 it can be seen the scores for mind-mindedness were not normally distributed but that the distribution was slightly skewed in the direction of higher scores.

Mean mind-mindedness scores by group and by time are presented in Figure 10.

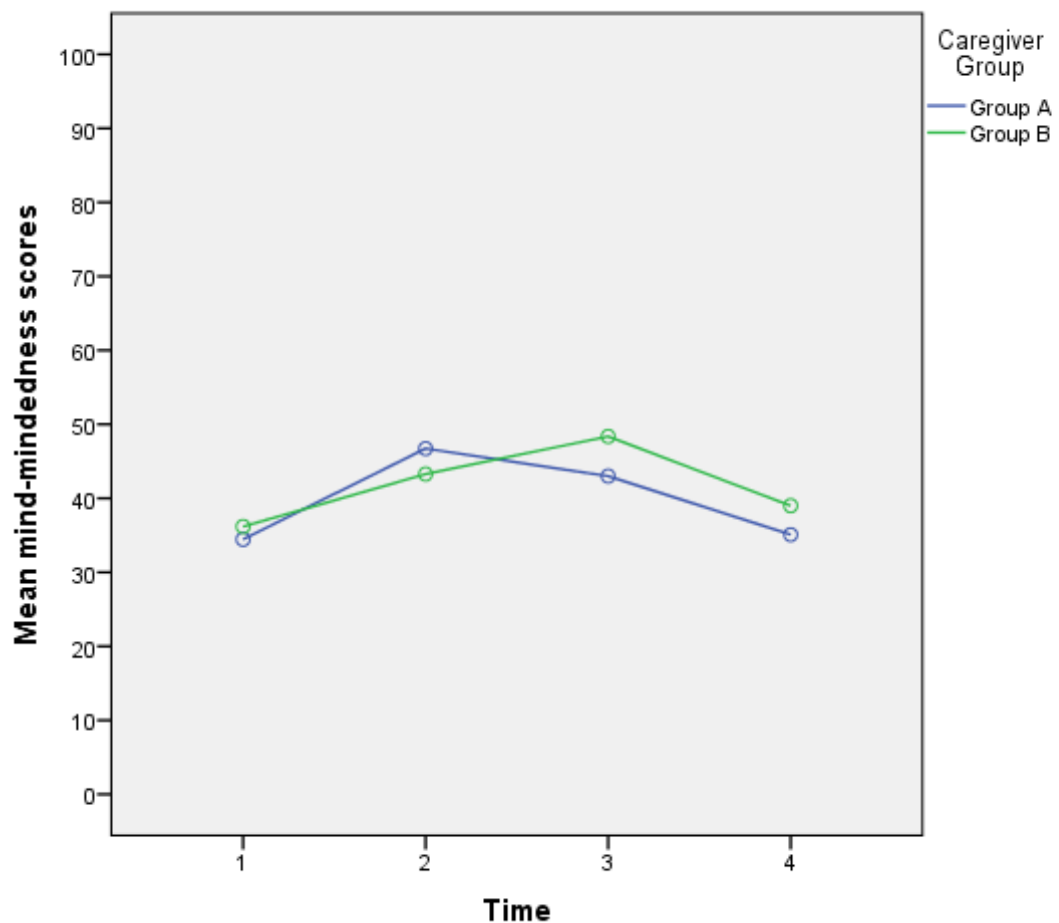


Figure 10. Mind-mindedness means by group by time

Increases in mind-mindedness occurred at different time points. A 2 (Groups) by 4 (Time) mixed between-within analysis of variance found no group by time interaction, indicating that the change in mind-mindedness scores was not significantly different for the two groups over the four time periods. A significant main effect for time was found,  $F(3, 21) = 3.57, p = .035$ , partial eta squared = .37. Quadratic significance for time was also significant ( $F(3, 21) = 11.88, p = .003$ , partial eta squared = .37), showing that participants' mind-mindedness scores increased over time and then fell at the last measurement. The main effect comparing the two types of interventions (i.e., main effect for group), was also not significant,  $F(1, 21) = .21, p = .66$ , partial eta squared = .01.

The expectation based on the presumed effects of the training programme was that the largest increase in mind-mindedness scores would occur following the training modules dealing with psychoeducation and self-care/self-reflection. This implies that for Group A the largest increase would occur between Time 1 and Time 2, and for Group B, the largest increase would occur between Time 1 and Time 3. This pattern can be seen in Figure 10. This indicated that a specific benefit of the psychoeducation and self-care/self-reflection modules was that these had a beneficial effect on mind-mindfulness. This effect was not sustained over time, as by the 3-month follow-up, the level of mind-mindfulness was only slightly higher than the pre-intervention levels. Possible reasons for the drop-off in mind-mindedness scores at three-month follow up will be discussed in Chapter 6.

A number of participants' statements illustrated the improvement in their ability to be sensitive to, understand, and respond to their child's internal mental states, thoughts and feelings. For example, before the Fostering Security programme, three participants' descriptions of their foster children were more negative and had fewer mental state narratives than their later descriptions:

CA13 (pre-programme): "...attention seeker, needs all the attention, good or bad. He's got awesome ball skills. Has no personal boundaries, he loves everybody, doesn't care about stranger danger. He has obsessions, at present its jam sandwiches, even his cereal, it has to be a certain way or it will be a tantrum...He is pedantic about how things are. He is a big eater, a huge eater. He's just started the sexual behaviour, playing with himself and groping another little girl the other day."

CA13 (post-programme): “Very strong-minded, he’s got a beautiful sense of humour, he can be very arrogant, I think he’s come a long way, he tries so hard to be good and wants to do well, and I don’t know, it’s sort of like he’s learning hey...he’s too affectionate, kisses and cuddles, very affectionate, he’s very in your bubble, thrives on it, the more you give him the more he wants, but the better he is, but it can really just do your head in at the same time, it’s such overkill. Very affectionate, challenging, determined, just very frustrating child too. But very adorable at the same time.”

CB13 (pre-programme): “She’s funny, polite, lovable, frustrating, exasperating, helpful, maybe you could say she’s a little mixed up, kind of back to front sometimes, like she’ll put on her best clothes to play around at home in and then to go out she’ll put on her oldest clothes which have got stains, kind of back to front sort of thing.”

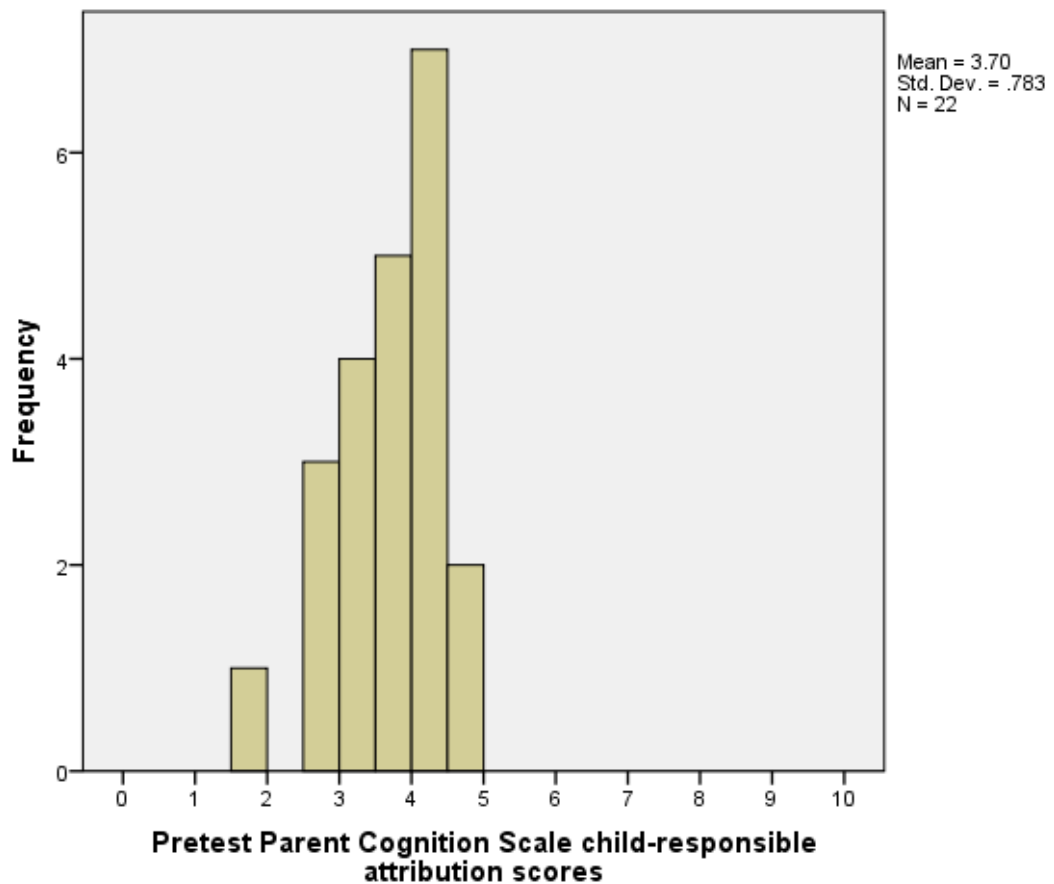
CB13 (post-programme): “Well she’s really lovable, she’s better at taking a joke than she was, she doesn’t quite get when people tease her, she doesn’t understand that and gets quite upset, but she is getting better.”

CA6 (pre-programme): “She’s an attractive young woman, she’s generally happy, very outgoing, but in a very indiscriminate way, she gravitates towards males rather than females, she can talk to people but she wouldn’t initiate conversations, any conversations will be superficial, generally quite self-centred.”

CA6 (mid-programme): “She’s a tall slim redheaded good looking young woman. She likes people, she likes to be around people. She’s actually, this year, she’s like a chrysalis that’s metamorphosing, because she’s actually been given slightly more responsibility for doing things, and she’s coping...she’s managing to find her way around school and that’s building her confidence. She’s a friendly bubbly person who is a little lethargic when it comes to exercise. She likes to be at the centre of attention, but she doesn’t know how to relate to people and she doesn’t read body language, so she might get up people’s faces a bit too much and not realise that they’re getting annoyed with her and she needs to back off.”

As can be seen, through the course of the programme some participants were able to develop their ability to be more sensitive to and understanding of the foster child, be more responsive to their feelings and thoughts, and interpret their behaviour more accurately.

***Child-responsible attributions.*** Dysfunctional child-responsible attributions were measured by the Parent Cognition Scale (Snarr et al., 2009), in which higher scores indicate greater levels of dysfunctional attributions. The frequency distribution for both groups at pretest (Time 1) is presented in Figure 11.



*Figure 11.* Frequency of child-responsible attribution scores on the Parent Cognition Scale at pretest

Figure 11 shows that the scores for child-responsible attributions were not normally distributed and skewed in the direction of higher scores.

The mean T-scores for each group across all four time periods are depicted graphically in Figure 12.

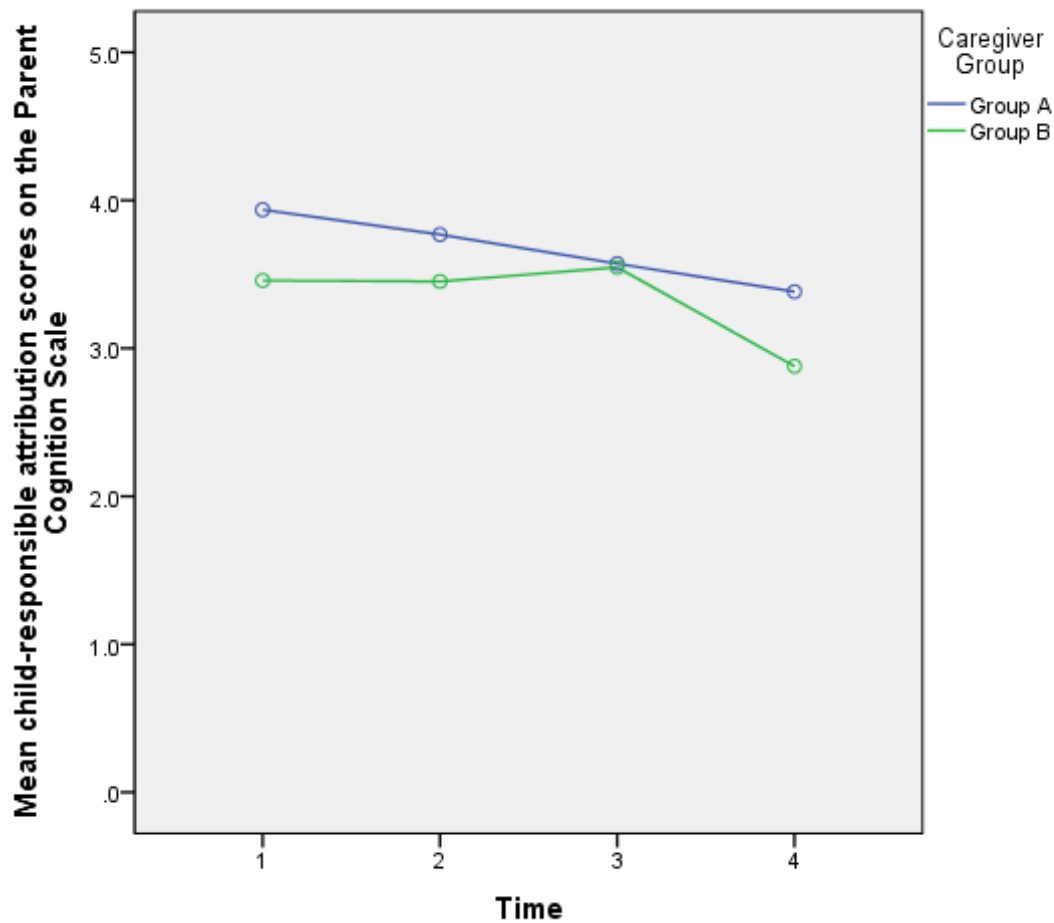


Figure 12. Child-responsible attribution means by group by time

Dysfunctional child-responsible attribution scores decreased across the four time periods for Group A. For Group B, there was a slight increase at Time 3, and a further decrease by three month follow up (Time 4). A 2 (Groups) by 4 (Time) mixed between-within analysis of variance found no group by time interaction, indicating that Groups A and B did not significantly differ in their child-responsible attribution scores over the four time periods. The main effect for time was significant, [ $F(3, 21) = 3.77, p = .029, \text{partial } \eta^2 = .39$ ], with both Groups A and B showing a reduction in the dysfunctional child-responsible attributions they held about the foster child's misbehaviour. The main effect for

group was not significant,  $F(1, 21) = 1.78, p = .20$ , partial eta squared = .082. This suggests no difference in the effectiveness of the order of the Fostering Security training modules on the child-responsible attribution scores.

Qualitative statements from participants also showed their shifting attributions about the foster child's misbehaviour, from more negative to positive attributions. Some examples to illustrate this are reported below:

CA14 (pre-programme): "...he's very persistent and demanding, like every night I cook tea and he'll know I'm cooking tea but he'll still come and ask, are we having tea, when we having tea, are you cooking tea, but I'll be in the kitchen and it's real big thing with him, even though he can see me."

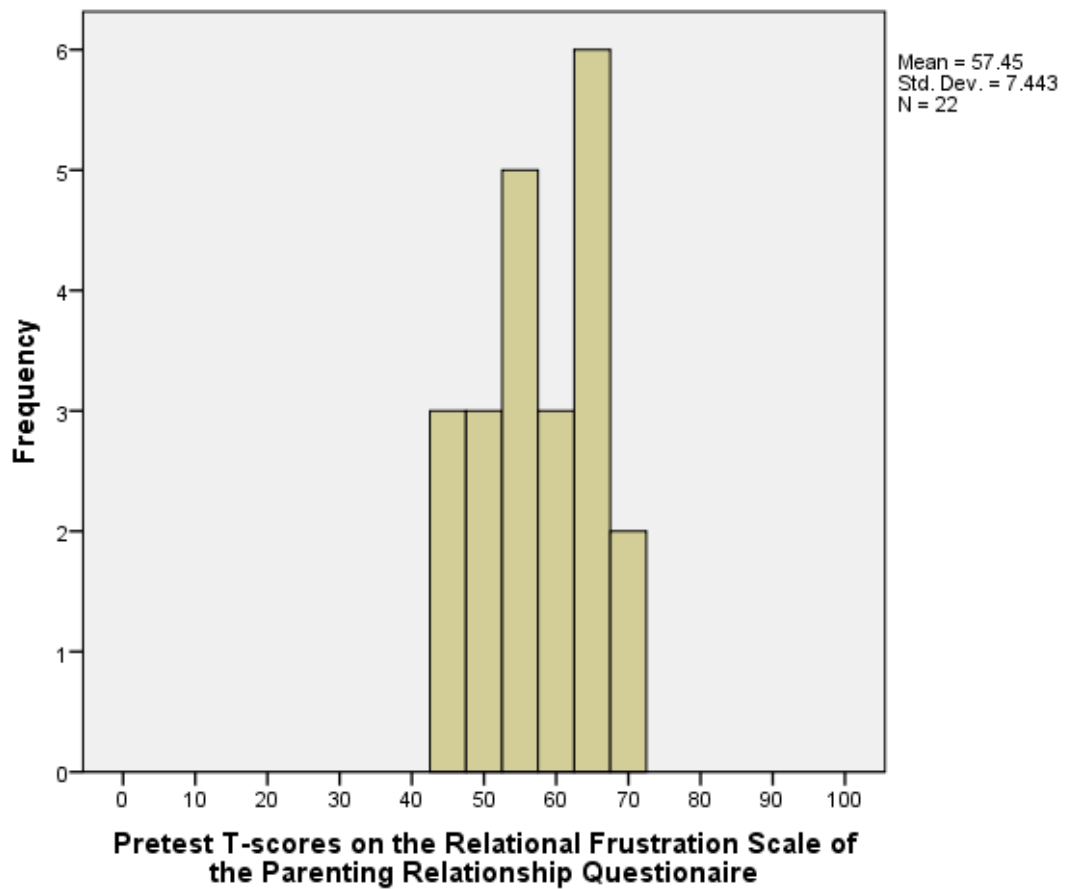
CA14 (post-programme): "...one thing he has trouble coming to grips with is, if I'm cooking tea he'll ask us every night, are we having tea, are we having tea, it's like, I'm cooking it T, wait, it's coming you know. But he wants it now, this is every night, and know I know why he does that, he's needing reassurance that he will be getting food."

CB5 (mid-programme): "I'm getting new insights that I wouldn't have got if I hadn't come to the group. When we talked about the child will play out the trauma they had with their birth parents with the same sex parent, I had a light-bulb moment and thought it's possible that G's yelling and screaming with L (*husband*) is probably about that."

CB12 (post-programme): “He has every intention to be a good and happy boy but his muddled up emotions and actions don’t always go in his favour...if he feels like he’s being treated unfairly, which is probably because he does not understand what’s being asked of him or understand the situation he feels wronged, and when he’s wronged he gets quite angry and a wee bit disruptive at times.”

These examples show that some participants were able to develop their insight and understanding of the foster child’s challenging behaviours and determine the real functions of the behaviours and what they actually communicated, rather than viewing the behaviours at face value. As can be seen, the ability to derive accurate attributions for the child’s behaviour incorporates aspects of the variables already discussed, that is, attachment and mind-mindedness. Having empathy and sensitivity for the child, developing a close relationship with the child, and accurately interpreting the child’s internal mental states are all crucial to being able to correctly determine why the child is behaving the way they are.

***Relational frustration.*** The construct of relational frustration was measured by the Parenting Relationship Questionnaire’s (Kamphaus & Reynolds, 2006) Relational Frustration Scale in which higher scores are related to greater levels of parental stress or distress in relating to and managing the child’s behaviour. The frequency distribution for both groups at pretest (Time 1) is presented in Figure 13.



*Figure 13.* Frequency of T-scores on the Relational Frustration Scale of the Parenting Relationship Questionnaire at pre test

It can be seen that the scores for parental relational frustration were not normally distributed and slightly skewed in the direction of lower scores.

The mean T-scores for each group across all four time periods are depicted graphically in Figure 14.

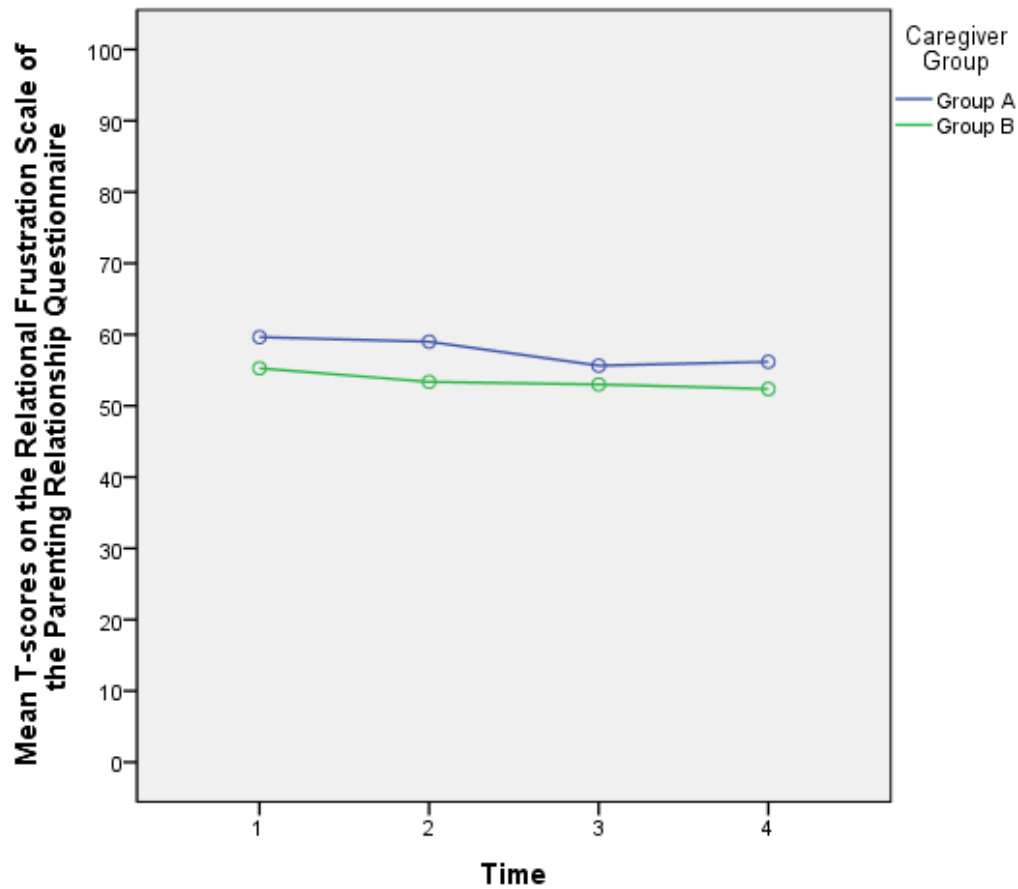


Figure 14. Relational frustration means by group by time

Figure 14 shows that relational frustration scores decreased across the first three time periods for both groups, with Group A scores increasing slightly by time period 4 and group 2 slightly decreasing at period 4. T-scores of 60 or higher indicate concerns about the participants' stress levels in the context of their relationship with their foster children. As can be seen, the mean score for Group B at Time 1 was lower than that of Group A (which was close to 60). At the three month follow up point (Time 4), the means for both groups were lower than the means at pre-assessment (Time 1). A 2 (Groups) by 4 (Time) mixed between-within analysis of variance found no group by time interaction, showing that the

change in relational frustration scores were not significantly different for Groups A and B over the course of the four measurement points. The main effect for time was significant,  $F(3, 21) = 5.39$ ,  $p = .008$ , partial eta squared = .47, with both Groups A and B showing decreased relational frustration scores over the four time periods. No difference in the effectiveness of the order of the training modules was suggested, as the main effect for group was not significant,  $F(1, 21) = 2.13$ ,  $p = .16$ , partial eta squared = .096.

Decreased levels of parental stress or distress about the foster child's behaviour were also reported by participants through the course of, and following the Fostering Security training programme. Participants also reported more positive relationships with their foster children. Three examples are shown below.

CA9 (post-programme): "...in the early stages she starts whining if it didn't work out if she wouldn't so it, and now she, she is asking, can you help me dad, or mum....she's more playing with D and not by herself...an enjoyable kid, yeah, more enjoyable than if you look back to the start, way more enjoyable, and that just makes us feel better and happier."

CA12 (post-programme): "...we see to the behaviour and it's over, I think that's what's good, it's not dragging on, and I actually can see like, before he used to offend me, you know, with some of the stuff that he used to do, but because I've been on the course he can't offend me, I haven't allowed him to offend me with some of his behaviours. So I think if I had a known earlier, then a lot of this stuff I think I wouldn't have taken offense so much, been so annoyed with him..."

CB9 (mid-programme): “I think for me I’m better at understand K from things that I’ve learned, I think I’m not being so impatient, I suppose, for want of a better word, in dealing with him...there’s a lot more patience happening and a lot more giving of time to understand the whole thing, the situation of what’s going on...”

As can be seen, a key aspect of decreased parental stress levels is the ability to understand the child’s behaviour better, regulate their own responses to the behaviour, and respond in a calmer and more measured manner. This in turn assists with the development of a closer and more positive relationship with the foster child.

## **B) Child Behaviour Measures**

*Intensity of child’s misbehaviour at school.* The intensity of the child’s misbehaviour at school was measured by the Sutter-Eyberg Student Behavior Inventory-Revised (Eyberg & Pincus, 1999) completed by the child’s school teacher or early childhood centre educator. Higher scores indicate greater levels of the child’s noncompliance, defiance, aggressiveness and impulsiveness. T-scores of 60 and above indicate that the teacher or educator is significantly concerned about the child’s behaviour problems. The frequency distribution for both groups at pretest (Time 1) is presented in Figure 15.

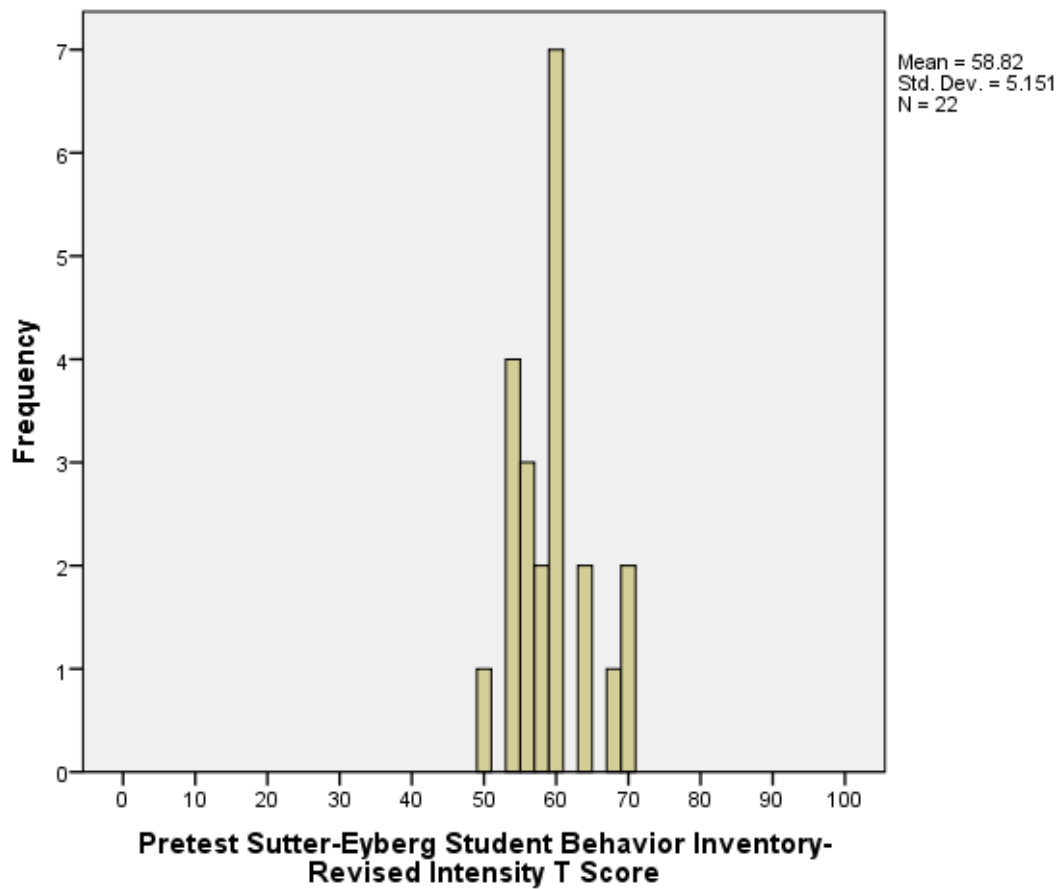


Figure 15. Frequency of child's school misbehaviour intensity T-scores on the Sutter-Eyberg Student Behavior Inventory at pretest

Figure 15 shows the scores for the intensity of the child's misbehaviour at school were not normally distributed and skewed in the direction of lower scores.

The mean T-scores for each group across all four time periods are depicted graphically in Figure 16.

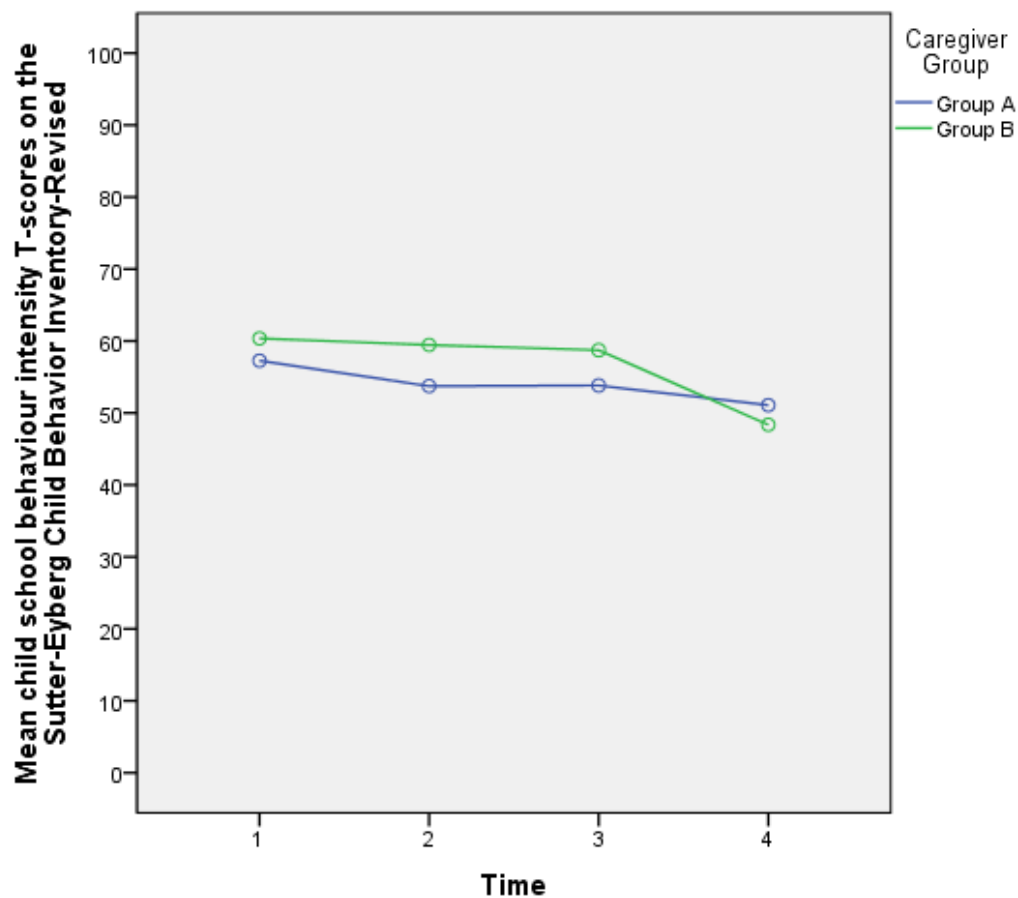


Figure 16. Child's school misbehaviour intensity means by group by time

As seen in Figure 16, the intensity of the child's challenging behaviour at school, as reported by the teacher/educator, decreased over the four time periods for Group B, and generally decreased for Group A across the time periods, except at Time 3 when there was a slight increase. It is important to note that the mean scores for both groups indicated that, in general, the teachers/educators did not consider the children's behaviour to be of significant concern at pretest. A 2 (Groups) by 4 (Time) mixed between-within analysis of variance found no group by time interaction, showing no significant difference in child school misbehaviour for the two groups over time. The main effect for time (i.e., decrease in child

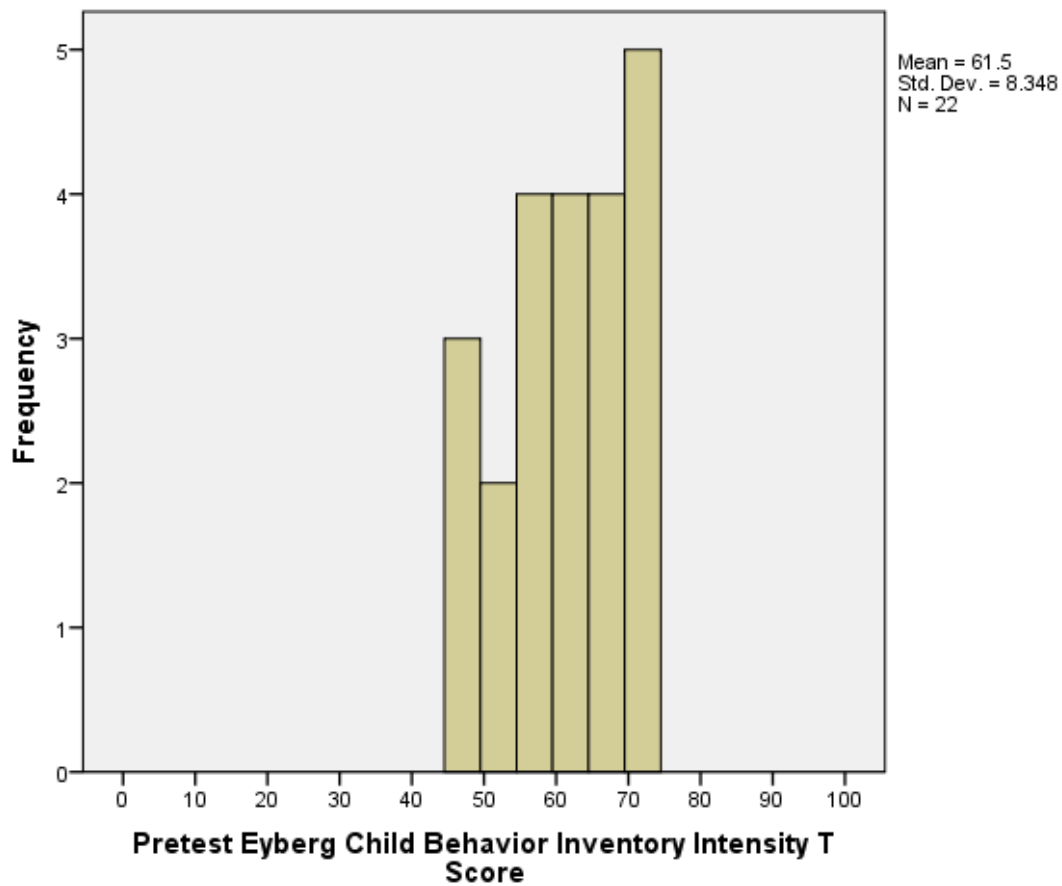
misbehaviour at school over time), was significant,  $F(3, 21) = 17.75, p < .001$ , partial eta squared = .75. As was the case with all the variables discussed above, the order of the Fostering Security modules was not shown to affect the intensity of the child's challenging behaviour at school, as the main effect for group was not significant ( $F(1, 21) = 2.37, p = .14$ , partial eta squared = .11).

Participants' comments about improved behaviour at school were consistent with the observed trend of decreased intensity of challenging behaviour at school, as reported by the teachers and educators. Participants noted a number of improvements in the foster child's prosocial behaviours, including improved compliance and less aggressive behaviour.

CA12 (programme completion): "He's just happier, he's happy, he's settling in at school, he's had a few run-ins with the teacher but they're getting sorted on the spot, and they're not getting dragged out..."

CB9 (mid-programme): "I've noticed with G that he's really really trying in everything that he does, you know he tried in school with the fighting and things that were happening, they're not happening anymore, he's a lot more open and honest whereas sometimes if I've known that he's done something and I've asked him, hoping that he does own up to it, he would just put it off and just keep denying and denying, and he was kind of really good at that. And so now he may do it a couple of times and then the truth follows a lot soon than it really ever did. And a lot more of him just walking away from things."

***Intensity of child's misbehaviour at home.*** The intensity of the child's misbehaviour at home was measured by the Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999) completed by the child's caregiver, in which higher scores signify greater levels of the child's noncompliance, defiance, aggressiveness and impulsiveness. T-scores of 60 and above indicate that the caregiver is significantly concerned about the child's behaviour problems. The frequency distribution for both groups at pretest (Time 1) is presented in Figure 17.



*Figure 17.* Frequency of pretest T-scores of the intensity of child's home misbehaviour on the Eyberg Child Behavior Inventory

Figure 17 shows that the scores for the intensity of the child's challenging behaviour at home were not normally distributed and skewed in the direction of higher scores.

The mean T-scores for each group across all four time periods are depicted graphically in Figure 18.

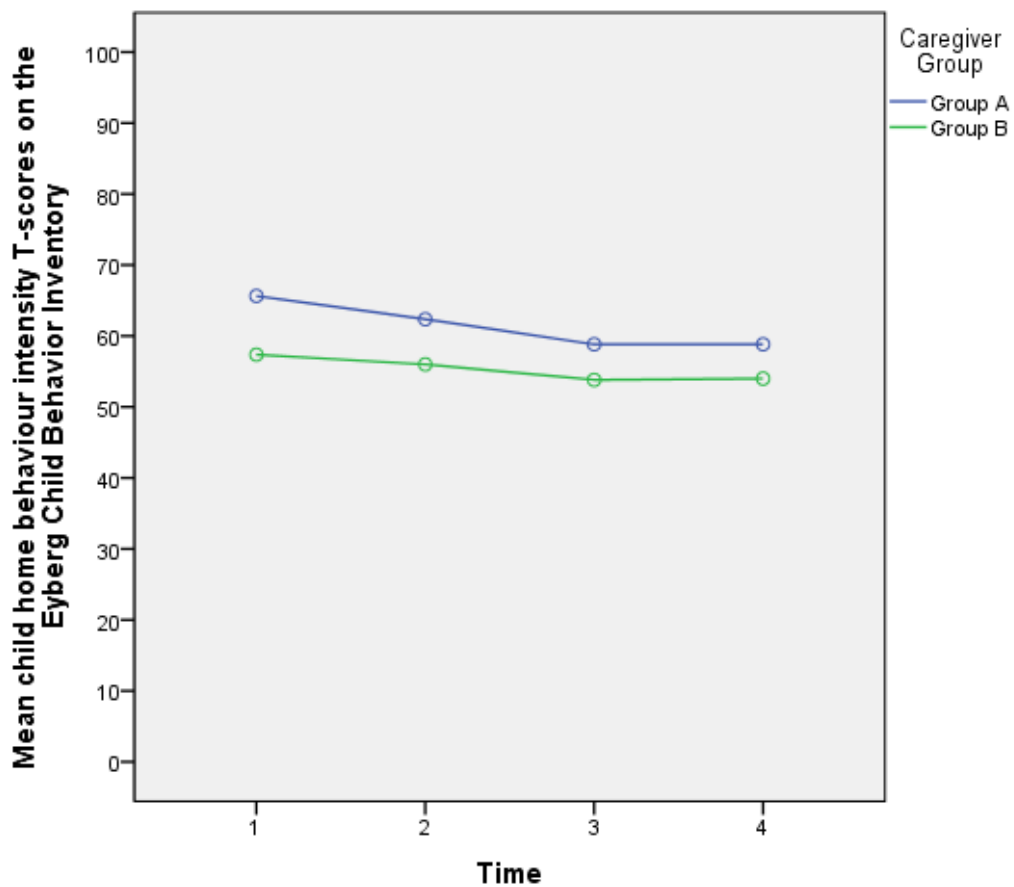


Figure 18. Child's home misbehaviour intensity means by group by time

It can be seen from Figure 18 that the mean scores for Group A at Time 1 are higher than those for Group B, indicating that Group A participants found their foster children's behaviour more challenging than Group B participants. The intensity of the child's misbehaviour at home, as reported by the caregiver,

decreased for both groups over the first three time periods through the training, with a sustained effect at the three month follow-up point for Group A and a slight increase for Group B. A 2 (Groups) by 4 (Time) mixed between-within analysis of variance found no group by time interaction, indicating that the change in child misbehaviour at home scores was not significantly different for Groups A and B over the four time periods. The main effect for time was significant ( $F(3, 21) = 4.7, p = .014, \text{partial eta squared} = .44$ ), with both Group A and Group B showing decreased scores in child misbehaviour at home over the four time periods. In contrast to the other variables discussed above, the main effect for group was significant,  $F(1, 21) = 4.52, p = .046, \text{partial eta squared} = .18$ . This indicated a difference between Groups A and B when looking at all time points.

Qualitative reports from participants also showed improvements in the foster child's behaviour through the course of the Fostering Security training programme.

CA5 (programme completion): "I do think M's changing...when we went down to Masterton these school holidays...my daughter remarked about how good M was, and her husband did, they said to me the last time, oh I don't want him back here again, can't put up with his tantrums and his cheekiness. But she said, this time he was really well behaved, and he was..."

CA12 (programme completion): "...he's behaving, he's behaving and, I'm still on the alert, and I don't think that will go away, so, I think my response to his behaviour though will be different, but he's actually seems a little bit chirpier I suppose. But I don't know it's

because we're looking at him differently now, and understanding him better, or if it's because he feels that way.”

CB11 (mid-programme): “...he's a polite boy, and that's quite often. He's learned to say please, he finds that works quite well and uses manners you know. And yes he does still regress and have his bad times and that happens quickly, just at the snap of an instant, but I'm understanding more now thanks to what we doing as to why that's happening to him and how to deal with it too.”

CB14 (three month follow-up): “...she's starting to spread her wings, she's sort of feeling more comfortable in the family, she's starting to sort of, you know, be like a normal child is, sort of questioning why we are asking her to do something... which I put down to she's sort of feels safe and comfortable so she's starting to spread her wings a little bit.”

As some of these examples show, the behavioural improvements that participants noted in their foster children may also be related to their increased understanding of the child and the behaviour as well as their more accurate attributions for the child's behaviour.

### **Qualitative Analysis Themes Related to the Mechanisms of Change in the Fostering Security Training Programme**

Thematic analysis of participants' mid-, post-, and three-month follow-up semi-structured interviews and the post-programme evaluation questionnaires indicated eight main themes.

1. Support, validation, and acknowledgement from facilitators and participants.
2. Effectiveness and knowledgeability of group facilitators and positive ethos of the programme
3. Improved understanding of attachment and trauma related child behaviour problems
4. Learning strategies to manage the behaviours and developing confidence as foster parents.
5. Increased participant empathy for and understanding of the foster child and reflection on the child's behaviour.
6. Increased participant reflection on own triggers, behaviour, parenting approach, and self-care.
7. Factors that make foster parenting difficult.
8. Factors that help foster parenting.

The first six of these themes relate to the mechanisms of change in the Fostering Security training programme, and are described below, with underlying sub-themes. Themes are discussed in terms of their relation to either the context, content, or process of the programme. For each of the sub-themes, the number of times participants commented on these issues are also reported to show the relative weight of these themes. Examples of participants' verbatim responses are reported to illustrate these themes [again, participants are coded as C (for caregiver) alongside a number, with A or B representing the research group they were part of]. The two remaining themes, that is, factors that make foster parenting difficult and factors that help foster parenting, are not directly related to this section but are

of importance and interest to those supporting and training caregivers and are therefore reported in Appendix H.

## **A) Context of The Fostering Security training programme**

### ***1. Support, validation, and acknowledgement from facilitators and participants***

*Value of group support.* In total, participants commented 29 times about the value of the group support in the programme. They felt supported and understood by others with similar experiences; they felt a sense of relief that they were not alone and were not the only ones having difficulties parenting a foster child, and hearing the difficulties of others put things in perspective for them.

CA7: “It’s nice to see other people going through the same issues and not to have to explain that, so when you say something, they know what you mean, whereas to people that aren’t fostering or don’t have kids with the issues, they just don’t understand.”

CA6: “...it’s quite good being with other people, and just finding that they’re going the same kind of stuff...it helps in as much as it puts things in perspective, it makes me feel like I’m not alone, I’m not the only one that’s having the same hassles with the child, because they experience the same sort of stuff...”

Participants also reported that their learnings were from the programme content as well as from fellow caregivers.

CB9: "...I found that some of the information that came out from the notes but also from other participants helped me with some of the things that I was dealing with here."

This sub-theme further highlights the factors needed to make the training process inclusive and effective for participants, that is, whanaungatanga (bringing people together and building relationships), manaakitanga (care, support, and respect), and kotahitanga (collaborating and bonding as a group) (Macfarlane, 2004). This includes valuing and facilitating the contribution of the knowledge and skills caregivers already have and bring with them to the training.

*Formation of informal participant networks.* Participants commented three times about the friendships and networks they had made with others in the group, even at times providing respite for each other's children. This is an important aspect in ensuring that caregivers develop and continue to have support structures in place once the programme is over.

CA11: "I just felt it was good, we've all sort of gelled together, V bought me those (*flowers*), she said after the group, just stay I've got a little something, and she'll come over to visit me at some stage...she's a grandparent, I'm a great grandparent, but we're actually both the same age...and I can relate to the difficulties she has with her daughter."

*Hope for the future.* Three statements were made by participants about them feeling more positive and hopeful about their future after hearing the stories of others. Empathy and admiration was also expressed

for other caregivers given the difficulties they faced raising their foster children.

CA7: “We are all clearly in the same boat and I feel privileged being with others who are doing such an amazing job. It gives me hope for myself that things will keep improving.”

*Participants as agents of therapeutic change for foster children.* Two participants commented on feeling validated in being acknowledged as therapeutic agents for positive change in their foster children, and in being acknowledged as a vital component of the child’s treatment team.

CB11: “...I’d never really thought about that before, we are the ones that are with these kids most of the time, we know them the best. It makes sense that we’d be the main ones putting in the therapy at home in many many many small ways that all adds up eventually.”

## ***2. Effectiveness and knowledgeability of group facilitators and positive ethos of the programme***

Participants commented positively 32 times on various aspects of the programme facilitation and positive ethos of the programme. Comments were made about the sense of safety in the group and the relaxed, non-judgemental, positive, and friendly atmosphere set by the group facilitators. Comments were also made about the facilitators’ knowledgeability.

CB5: “The group facilitators were great. Approachable, have a sense of humour, good knowledge, able to keep it moving and interesting.”

Participants also remarked favourably on the joint facilitation of the programme by mental health and child protection staff as they found it very beneficial in helping them with particular care and protection issues as well as mental health and behavioural concerns.

CA12: “Excellent having CAFS and CYF working together and assisting each other, and us. There were a lot of questions we had aimed at CYF and Lisa was great, she got us all the relevant information.”

This sub-theme emphasised the importance of the concept of rangatiratanga (the effectiveness, integrity, and knowledgeability of the programme facilitator) for an effective training process. Four participant statements indicated that the training was considered to be culturally sensitive and appropriate to their ethnicity and culture.

CA12: “The programme was definitely culturally sensitive and the goals we laid out in the beginning help keep us on track and address the issues we all face.”

## **B) Content of The Fostering Security Training Programme**

### ***3. Improved understanding of attachment and trauma related child behaviour problems***

*Knowledge about attachment, and the psychological and physiological effects of trauma, abuse, and neglect.* A significant area of learning for participants was the importance of early experiences for children, the impact of attachment disruptions, the effects of trauma, abuse and neglect on foster children, and the expected trajectory of progress. For participants the learning was from the programme

materials as well as group discussions and home activities. There were 20 participant comments related to this sub-theme, and examples are shown below.

CA14: “I found it interesting, especially the bit when you realise that it’s actually about how the brain developed, that they’re not just plain naughty, that it’s set in there, the way they start life...before I went to the course I thought he was just an arrogant naughty little boy but now it’s helped me to understand him.”

CB9: “Learning about how stealing and lying could be about attachment problems was one of the main things I learned, that was really really handy to me.”

CB14: “I think I’m learning to be realistic about progress...like you said, peaks and troughs in improvements, there will be steps forward and steps backward.”

*Understanding misbehaviours in context of developmental stages.* It was also useful for participants to develop an understanding of attachment and trauma related behaviours in the context of typical developmental stages and participants commented on this issue three times. This sub-theme is particularly important as caregivers often found it difficult to identify the behaviours that were to be developmentally expected and those behaviours that were more related to adverse childhood experiences.

CB10: “I think probably for my situation is sorting out what is that teenage age, what is the stage and what is the situation, and I think the group is helping me do that a little bit easier.”

**4. *Learning strategies to manage the behaviours and developing confidence as foster parents.***

*Value of behaviour management skills and strategies.*

Participants commented on this sub-theme 24 times. They found the specific strategies around the management of challenging behaviour useful, including the use of models to understand the function of the child’s behaviour, and to consider the minor, moderate and severe misbehaviours and plan consequences for each of these in advance.

CB9: “...the information that I’m actually gathering is becoming really useful for me at home, so there’ve been some really positives come out for me...pretty much when dealing with the tantrum side of things, and just the communicating, the difference with the time-ins and the timeouts...those sorts of things, and the iceberg one really fascinates me, the underlying reasons, what’s really going on...it’s kinda helping me understand or giving me some ideas to follow, a pathway to follow in dealing with situations.”

CA9: “Helpful, really helpful, more understanding towards the kids, to deal with their issues, tools or strategies to deal with the behaviours, and more understandable. Early on we

were getting grumpier, angry at her cos she didn't want to do something...but now we know where it's coming from and deal with it differently.”

CB1: “Using the iceberg and the behaviour triangle helped me focus on the behaviour, not S...it taught me to manage his behaviour before it got to big tantrum stage.”

*Value of therapeutic skills and strategies in developing parenting confidence and confidence.* Twenty three participant statements focused on the usefulness of the therapeutic skills in the home environment which built their confidence as therapeutic foster parents, such as using relaxation strategies, using play, reflecting aloud on the child's behaviour, and using stories to teach and help their foster child understand their past experiences. They felt that the strategies helped them to understand and manage challenging behaviours more confidently and competently as caregivers.

CA8: “...you feel stronger, more able to rely on yourself...that you are doing things that can help them, and you feel stronger as a parent...”

CB9: “The balloon breathing and the other relaxation techniques are great for the children and for me!”

### **C) Process of The Fostering Security Training Programme**

#### ***5. Increased participant empathy for and understanding of the foster child and reflection on the child's behaviour***

*Development of understanding, empathy, and tolerance.* With growing knowledge of the negative effect of early adversity, disrupted attachments, and traumatic experiences, participants

described greater understanding, patience, and empathy for their foster children, and a more positive caregiver-foster child relationship. Participants commented on this sub-theme 29 times. The following are some examples of caregivers' changing attributions, attitudes, and core beliefs about the foster child.

CA6: "...I kind of felt sorry for her...it was frustrating for me, but it kept going through my mind that she just doesn't get it, she just doesn't understand, that her level of comprehension is too low...so I am more patient."

CB9: "I think for me I'm better at understanding P from things that I've learned...there's a lot more patience and a lot more taking time to understand the whole situation, reflect on why he is doing what he is doing."

CB10: "We're working on, like, I understand more the attention seeking behaviours and I understand a little bit more now than what I did at the beginning of the group...it's made me realise her dramas are real and why she is the way she does. And when I said about being sick all the time and you explained it on Monday, why, it made me step back and go, ah ok then, I can deal with this differently."

*Development of reflection on child's behaviour.* A key mechanism of change in the Fostering Security programme that participants reported was their developing ability to step back, be more objective, and reflect on the

reasons or nature of the child's misbehaviour. There were twenty-five participant statements related to this sub-theme.

CA8: "A lot of recognition as well, things, because they are so close to us, you don't always see things with an objective view. And then when you tell us things, especially with regard to what trauma does to the mind and how things work and, it's so clear..."

CA5: "He has poor concentration, so things, he forgets sometimes...they have poor retention, it's not their fault you know, it's part of the drugs and things I suppose that they ingested as babies."

CB12: "On the other hand if he feels like he's being treated unfairly, which is probably because he does not understand what's being asked of him or understand the situation he feels wronged, and when he's wronged he gets quite angry and a wee bit disruptive at times."

**6. *Increased participant reflection on own triggers, behaviour, parenting approach, and self-care***

*Development of self-reflection and critical appraisal of parenting approach.* In addition to their developing ability to reflect on the child's behaviour, participants also reported an increasing ability, through the course of the Fostering Security programme, to reflect on their own parenting behaviour and their parenting approaches. Participants made 21 comments about this sub-theme. In addition, grandparents raising grandchildren highlighted issues pertinent to them, including their difficulty

adjusting established parenting approaches. This ability to think critically about one's one parenting approach and behaviour is fundamental to the development of caregivers' therapeutic capacity.

CB11: "...I find it quite stimulating, just gaining new knowledge, learning something new is always good and I feel personal growth comes from it. I'm gaining new insights into ways of dealing with children and situations. One of the things that stood out is it helps me see, understand myself a little bit better...and yes, I can certainly see reasons for his behaviour."

CB13: "The programme taught me to self-reflect and think about my parenting ...I realised that I steel boxed everything and needed to be less hard on her..."

CA6: "...it's empowered me to stop sweating the small stuff and to pick my battles, it's given me permission to stop worrying about other people's feelings, the bottom line is what's best for the child..."

Through the Fostering Security training programme, participants also reflected on their guilt and grief, especially when the child in their care was a family member. Grandparents, in particular, talked about their tendency to blame themselves for not having done more to stop their grandchildren from being neglected or abused by their parents. They also raised the intergenerational issues around abuse and neglect in their families.

CA5: "I love my son, I just don't like the way his life is and I feel a lot of guilt. I know a lot of it isn't my fault, but some of it

is, but I didn't know about him then, I didn't understand about attachment...I disliked him and pushed him away..."

CA11: "Now that we know about the intergenerational aspects, and the feeling of failure and guilt, we don't want it to happen in our family again."

*Awareness of triggers, the need to regulate own emotions, and the importance of self-care.* For many participants the ability to self-reflect on their own parenting behaviours and approaches was accompanied by their identification of the negative emotions triggered by the child's challenging behaviours, their attempt to maintain control of those emotions, and their recognition of the importance of self-care. Participants made 20 statements related to this sub-theme.

CB3: "I was beginning to see the awful things H brings out in me, and the course taught me to stay calm. I learned to manage my anger and not try to reason with him when we're both angry."

CB8: "I was so close to losing it and was starting to lose it and came out here...I guess I'd made up my mind that I was going to make him get dressed and he was chopping and changing his mind all over the place and I got frustrated and triggered...I came out here and just went, aarrgghhh ...I pulled myself together, fairly quickly and went back and he, I can't remember whether he was crying at that point but he settled down fairly quickly..."

CB2: “She can be a little bit more defiant with me but it hasn’t made a lot of difference because I just deal with it. Still, I had to do my deep breathing to stay calm!”

The Fostering Security programme stressed the importance of participants ensuring that they make time for relaxation and stress-reducing activities when parenting a child with complex attachment and trauma problems. Participants also acknowledged this aspect as being crucial in managing stress and keeping the caregiver-foster child relationship positive.

CA5: “You know that you need to care properly for yourself to care for the children, but it’s not a priority with everything else happening. The group made it clear, stressed how we had to fill up our own resources before we can give to others...and we have to give so much to these hurt children.”

CA6: “The other thing I’ve found since we’ve been doing this group, we’ve got back some of the laugh, we kinda like, one of the first things that started to slip when we fostered was the humour, we used to laugh all the time. We are caring for ourselves more and it helps us be more positive when she’s being negative.”

### **Participants’ Evaluation of the Fostering Security Training Programme**

At the end of the 10-session Fostering Security training programme, the 22 participants completed evaluation questionnaires (Appendix I), which required them to rate or comment on the following aspects of the programmes context, content, and process:

- The overall programme
- Programme content
- Programme presentation
- The venue
- Participant involvement
- The extent to which their learning goals had been achieved
- The value of the psychoeducation and self-care/self-reflection modules
- The value of the behaviour management and skills training module
- Order of module delivery
- Suggestions for improvement of the programme
- The cultural appropriateness of the programme
- The co-facilitation by mental health and child protection staff

All participants commented favourably on the programme overall, as well as the content, presentation, venue, and participant involvement. No participants commented unfavourably nor had any concerns about any aspects of the training programme. The vast majority felt that their personal learning goals had been fully or mostly achieved, two indicated they had been partially achieved and none said they had not been achieved. The psychoeducation and self-care/self-reflection modules were rated as very valuable by 13 participants, as partially valuable by nine participants, and none rated them as not valuable. All 22 participants rated their knowledge in this area as being increased by these modules. The behaviour management and skills training module was rated as very valuable by 12 participants, as partially valuable by ten participants and none rated it as not valuable. All 22 participants rated their knowledge in this area as being increased by this module.

All but two participants thought that the order of the module delivery was appropriate to their needs. One participant thought it would be useful to have the self-care and self-reflection module first, and another participant thought it would be useful to begin with the behaviour management module. All participants felt that the Fostering Security programme was culturally sensitive and culturally appropriate and two Māori participants reported feeling respected and a sense of inclusion in the group. There were also 13 positive statements about the joint facilitation by mental health and child protection staff, in particular that it worked well, gave participants a more integrated intervention, and helped them see both agencies as approachable and knowledgeable.

Participants were provided with the opportunity at the mid-, post- and three-month follow up interviews to indicate what they were finding helpful and not so helpful in the Fostering Security training programme. While there were numerous comments on the aspects they found helpful, there were no comments on what had not been helpful. It is possible that respondent bias may have been a factor, given my dual role as the programme facilitator as well as the research interviewer – participants may have felt the need to provide desirable responses and/or to please. However, even though they were given the opportunity to provide anonymous written feedback in the evaluation questionnaires at the end of the programme, no negative nor concerning comments were forthcoming from participants. The evaluation questionnaire also gave participants the opportunity to suggest ways that the programme could be followed up or improved and a desire for ongoing support following the Fostering Security programme was expressed in 11 participant comments. Their suggestions in this regard included having follow up meetings which included the foster children, a programme for their biological children to

help them understand the foster child better, a programme for the foster children to help them understand their difficulties, refresher courses, regular follow up meetings every three to six months, and ongoing support and contact with caregivers in the group.

### **Summary**

This chapter has presented the study results in three parts:

- 1) The quantitative analysis described the results descriptively with frequency histograms, then inferentially with mean scores for Groups A and B across the four time periods for the six outcome measures (i.e., attachment, mind-mindedness, child-responsible attributions, relational frustration, intensity of child misbehaviour at school, and intensity of child misbehaviour at home). Participants' comments from the qualitative analysis which illustrated changes in the six outcome measures were presented.
- 2) The qualitative thematic analysis focused on six main themes related to the mechanisms of change in the Fostering Security training programme, and these were discussed in terms of the context, content, and process of the Fostering Security training programme.
- 3) Finally, results and comments from participants' evaluation questionnaires, completed at completion of the 10-session training programme, which relate to participant's perceptions of the training content, context, and process were also reported.

These results will be discussed in the final chapter of this research study, alongside the study's implications, the study's limitations, recommendations for

future research, and ideas for future development of the Fostering Security training programme for caregivers.

## CHAPTER 6: DISCUSSION AND CONCLUSIONS

This thesis has outlined the complexity of behavioural and mental health problems in the foster child population, and the contribution of these problems to foster placement breakdowns which further exacerbate the negative outcomes for foster children. To address the complex biopsychosocial needs foster children can present with requires a paradigm shift, from focusing mental health interventions at the individual child level to implementing interventions in multiple ecological contexts (i.e., at the individual level, within the home environment, in the educational institution, and in the wider community) (Gutkin, 2012; Tarren-Sweeney, 2014). As was shown, a core intervention to improve mental health outcomes for children in care is effective caregiver training and support (Leve et al., 2012; Modernising Child, Youth and Family Expert Panel, 2015; Murray et al., 2011). The Fostering Security training programme was developed in recognition of the need to support, train, and develop the parenting and therapeutic capacity of caregivers so that they could understand and manage very challenging attachment- and trauma-related behaviours in the children they have taken on the care of. The Fostering Security training programme incorporates a number of theories and concepts shown to be effective in meeting the specific parenting needs of caregivers, that is, attachment theory, the concept of mind-mindedness, social learning theory, neurobiological theories of trauma, abuse and neglect, attribution theory, and theories about the mechanisms of change (Rork & McNeil, 2011; Schofield & Beek, 2005; Scott & Dadds, 2009).

While there is a substantial body of research into the effectiveness of generic and largely behaviourally-based parent training programmes, as well as

foster parent training programmes, there is less research in the field regarding the mechanisms of change in these programmes, particularly in foster parent training programmes. Rather than merely making associations between interventions and positive therapeutic outcomes, it is also important to identify the aspects of the intervention which lead to change (Evans & Fletcher, 2013; Furlong & McGilloway, 2014; Kazdin, 2011). The aim of this study was therefore to analyse the process and mechanisms of change in the Fostering Security training programme, and to undertake a component analysis of the different modules of the programme to determine their effect on caregiver's self-reflection, parenting skill, and parenting practices, as well as foster child behaviour outcomes. A crossover design was utilised - participants in both Groups A and B received the same interventions, but the interventions were received in reversed order. Group A received the psychoeducation and self-care/self-reflection modules before the behaviour management and skills training module, and Group B received the behaviour management and skills training module before the psychoeducation and self-care/self-reflection modules. A mixed method research design was utilised to obtain more robust and valid information from both the quantitative and qualitative research data, and data were collected at four time periods, that is, before the start of the Fostering Security program, after the first module, at the end of the programme, and at three-month follow-up. As a reminder, the study's specific objectives were as follows:

- Identify and analyse the mechanisms of change for caregivers in the Fostering Security training programme context, content and process.
- Investigate whether the order of module delivery had differing effects on the six variables, that is, caregivers' mind-mindedness, caregiver-child

attachment, caregiver-child relationship frustration, dysfunctional child-responsible attributions, child behaviour problems at home, and child behaviour problems at the educational facility.

- Explore the influence of the order of module delivery on the effectiveness of the Fostering Security training programme.

## **Summary of Major Findings**

### **The Mechanisms of Change in the Fostering Security Programme.**

Thematic analysis of participants' mid-, post-, and three-month follow-up interviews and their post-programme evaluation questionnaires revealed six main themes related to the mechanisms of change in the Fostering Security programme: 1) support, validation, and acknowledgement from facilitators and participants; 2) effectiveness and knowledgeability of group facilitators and positive ethos of the programme; 3) improved understanding of attachment and trauma related child behaviour problems; 4) learning strategies to manage the behaviours and developing confidence as foster parents; 5) increased participant empathy for and understanding of the foster child and reflection on the child's behaviour; and 6) increased participant reflection on own triggers, behaviour, parenting approach, and self-care. These themes are consistent with the mechanisms of change reported in previous studies of parent training programmes in New Zealand and internationally (Couch, 2009; Couch & Evans, 2011; Holtrop et al., 2014; Levac et al., 2008). While these latter studies are of parent training programmes rather than foster parent training programmes, it is likely that the factors influencing positive parenting outcomes will be similar for both types of parenting programmes. The six

themes are discussed further below, in terms of their relevance to the context, content, or process of the Fostering Security programme.

*A) Context of the Fostering Security programme.* One of the main themes related to the structure and interpersonal context of the programme that emerged was the value caregivers placed on the support from the group facilitators and the other caregivers, as they felt supported, acknowledged, understood, relief in not being alone, and hopeful about change. This feeling of being supported was also reflected in the participant's desire for ongoing post-programme support, in the form of regular refresher sessions, e-mail or letter updates, informal coffee groups, and social gatherings including their foster children. These themes highlight the importance of the Māori concepts of whanaungatanga (bringing people together and building relationships), manaakitanga (care, support, and respect), and kotahitanga (collaborating and bonding as a group), to make the training and learning process effective for participants (Macfarlane, 2004). As outlined in Chapter 3 the ethos of the Fostering Security programme is one of validation, support and encouragement of caregivers in light of the many difficulties they face caring for foster children. Another important theme related to the context of the programme that was highlighted was the participants' experience of the group facilitators as effective, knowledgeable, and culturally sensitive. This concept of rangatiratanga, that is, effectiveness, integrity, and accountability of the teacher or facilitator, has been accentuated as another vital factor in effective learning (Macfarlane, 2004). Further, the facilitator-participant relationship is held to be similar in nature to that of the therapist-client relationship, which alongside the therapeutic procedure, is deemed to be important for effective therapeutic change (Evans & Fletcher, 2013).

**B) Content of the Fostering Security programme.** Participants found the programme materials, discussions, and home activities useful in developing their understanding of the psychological and physiological effects of adverse early experiences on children, developing their understanding of the attachment- and trauma-related behaviour problems, and supporting their utilisation of the appropriate behaviour management skills and strategies. For example, participants developed more accurate attributions about their foster child's challenging behaviours when they developed an understanding that repeated traumatic experiences can result in a persistent fear state which may mean that the child interprets benign situations as threatening. Participants' developed understanding and skills enabled them to feel more competent in their ability to parent children with complex attachment- and trauma-related problems. They also commented on the usefulness and confidence-building aspect of learning how to become therapeutic caregivers. This aspect of capacity- and confidence- building for caregivers, by acknowledging them as the primary agents of therapeutic change for their foster children (Golding, 2014), is a crucial mechanism of change in the Fostering Security training programme. The empowerment of parents and caregivers is thought to be an important aspect of positive change in families (Graves & Shelton, 2007). However, as will be discussed later in this chapter, the drop-off in positive effects of caregiver training programmes poses a challenge to sustaining the effects post-programme.

**C) Process of the Fostering Security programme.** As discussed in Chapter 3, the Fostering Security programme aims to develop those parenting skills which grow more secure and positive caregiver-foster child relationships. This is done through providing psychoeducation to aid the understanding of specific attachment

and trauma problems, training in the functional analysis of behaviour, developing caregiver mind-mindedness, self-reflective capacity, the effective use of rewards and consequences, and teaching emotional regulation skills. Key mechanisms of change reported by participants in this study included their enhanced ability to understand and reflect on the reasons underlying their foster child's behaviour, their enhanced ability to reflect on what the child triggers in them and their responses to the child's behaviour, as well as reflecting on their parenting approaches and strategies. This self-reflective capacity (i.e., being able to think about their own attachment histories and internal working models; the ability to accurately interpret the foster child's internal thoughts, feelings and intentions; and the ability to critically think about their attributional styles, or the explanations they hold for the foster child's behaviour) is held to be a vital aspect of therapeutic caregiving and secure parent-child attachment (Bugental & Johnston, 2000; Meins et al., 2012; Schofield & Beek, 2005).

Participants in this study further reported increased empathy for, and understanding and tolerance of the foster child, through a growing awareness of the negative effect of the adverse earlier experiences on the child's development. Caregivers who are able to provide positive and nurturing responses in the face of negative and distrustful responses from foster children, are more likely influence the development of healthier foster child internal working models or mental representations the child holds about themselves, others and the world (Schofield & Beek, 2005).

With increased understanding of and empathy for the foster child through the course of the Fostering Security programme, participants reported and were observed to change core beliefs they had about the child's challenging behaviour.

They developed more accurate attributions about the child's behaviour, for example, participant CA14 who began to realise his foster child was not being demanding about having his dinner, but merely needed reassurance that he was indeed going to be fed that night. With more positive core beliefs about the foster child and more accurate attributions about their challenging behaviours, participants' implicit attitudes toward the foster children were seen and were reported to improve.

The Fostering Security programme's strong focus on the importance of self-care, time for relaxation, reflection, and stress-reducing activities was also highlighted by participants as an important factor in managing their stress levels and keeping their relationship with the foster child positive. This was especially pertinent for those participants who were caring for family members, for example, grandparents caring for their grandchildren are a sub-group of caregivers with specific training and support needs (Scarcella et al., 2003). Grandparents raising grandchildren face isolation from their peer group, have difficulty adjusting established parenting approaches, and experience guilt and grief around intergenerational issues around abuse and neglect in the family.

**The effect of the Fostering Security programme on caregiver and child behaviour measures.**

A) *The effect on caregivers' attachment relationships with their foster children.* As has been discussed in Chapter 2, a secure attachment relationship or "psychological connectedness" (Bowlby, 1969, p. 194), between caregiver and foster child is a key aspect in helping children heal from past adverse experiences. The Fostering Security programme therefore undertakes to provide caregivers with information about the effects of

disrupted attachment to help them better understand the child's challenging behaviours, and to support them in the development of a more trusting, close, and secure attachment with the child.

Analysis of group means showed that, while participants' attachment scores increased through the course of the Fostering Security programme, the trend was not statistically significant. However, thematic analysis showed that many participants experienced increased empathy for, understanding of, and closeness to the foster child through the course of the programme. It is possible that the measure of attachment used in this study, that is, the Attachment Scale of the Parenting Relationship Questionnaire, was not sensitive enough, and may have successfully been augmented by direct observation of caregiver and foster child at points through the Fostering Security programme. Analysis of participant group means further showed that, while there was a slight drop-off in attachment scores for Group B at three-month follow-up, the three-month follow-up scores for both Groups A and B did not drop lower than the scores at assessment before the start of the programme. This drop-off effect at three-month follow-up will be seen with other measures below, and is consistent with other research findings that the benefit of parent training programmes tends to decrease over time following the training (Everson-Hock et al., 2011). Finding ways to sustain the effects of parent and caregiver training when the programme is complete is a challenge, and will be discussed in more detail later in this chapter.

As described in Chapter 3, the psychoeducation and self-care/self-reflection modules of the Fostering Security programme have strong

focuses on supporting participants to understand the importance of secure attachments, the effects of disrupted attachments in their foster children, and how their own attachment patterns interact with the child's attachment pattern. Given that module content, it was speculated that greater increases in participant attachment scores would be seen following the introduction of the psychoeducation and self-care/self-reflection modules. However, analysis of group means indicated that there was no difference in the effectiveness of the order of the Fostering Security training modules on attachment scores.

On reflection this finding is not surprising - while the Fostering Security programme has three separate modules (i.e., psychoeducation, self-care/self-reflection, and behaviour management and skills training), it is unavoidable that at times content from one module is discussed in another as caregiver needs dictate at that time. For example, when talking about internal working models in the psychoeducation modules, the behaviour management strategy of timeout might be briefly discussed as it relates to its potential to trigger foster children's feelings of abandonment or rejection which can negatively affect the security of the caregiver-foster child attachment.

***B) The effect on caregivers' mind-mindedness.*** The concept of mind-mindedness is associated with secure caregiver-foster child attachments (Gurney-Smith et al., 2010; Meins et al., 2001; Meins et al., 2003). As such, this concept is a strong focus throughout the Fostering Security programme, particularly in the self-care and self-reflection module,

which supports caregivers to reflect on their and their foster child's attachment patterns and mental representation of self, others and the environment, and to be sensitive, empathic, responsive, and emotionally available to the foster child. As such, it was speculated that the largest increase in participants' mind-mindedness scores would be seen after the self-care and self-reflection module, and this pattern was seen in the analysis of group means for both Groups A and B. The improvements in mind-mindedness scores for both groups were found to be significant. This positive effect was not sustained at three-month follow-up, with both groups showing a decrease in mind-mindedness scores at three-month follow-up. However, the scores remained higher than they had been before the start of the programme.

Thematic analysis of participants' interviews and reports further showed improvements in caregivers' sensitivity, understanding, and responsiveness to the foster children's internal mental states through the course of the Fostering Security programme. These findings are promising as sensitive and mind-minded caregivers have been shown to be a significant factor in successful foster placements (Schofield & Beek, 2005).

**C) *The effect on caregivers' dysfunctional child-responsible attributions.*** Given that dysfunctional attributions for child's misbehaviour have been shown to play a causal role in parenting and child behaviour problems (Snarr et al., 2009), the Fostering Security programme supports caregivers to reflect on the thoughts and attributions they have about the foster child's behaviours, as well as their own responses to these behaviours. Group means analysis showed significant decrease in

dysfunctional child-responsible attributions for the child's misbehaviour, and this positive effect was sustained at three-month follow-up. Qualitative analysis of participant interviews and reports further demonstrated their shift from more negative to more positive attributions about the foster child's misbehaviour, for example, from perceiving a child as being wilfully disobedient, to understanding that she is disobedient as she does not trust adults to keep her safe. These findings are consistent with those of other studies which found that caregiver training interventions were enhanced by supporting caregivers to reflect on the attributions they hold about the child's behaviour (Bugental et al., 2002; Sanders et al., 2004).

As was seen with the attachment measure, no difference was indicated in the effectiveness of the order of the Fostering Security training modules on caregiver's dysfunctional child-responsible attribution scores. As discussed above, this is understandable when considering the way that the programme modules are at times unavoidably not delivered as completely separate sections.

*D) The effect on caregivers' relational frustration.* Quantitative analyses of group means showed that the Fostering Security training programme was associated with significantly decreased levels of parental stress or distress in relating to the foster child. While there was an increase in relational frustration for Group A at three-month follow-up, the relational frustration for both groups A and B were lower at three-month follow-up than they had been at the start of the programme. Participants' statements further indicated lowered stress levels as well as the development of a more positive relationship with the foster child. No difference in relational

frustration scores was indicated by the reversed order of the training modules.

There have been varied results regarding caregiver stress levels through the course of group training programmes. Those studies, which found decreased caregiver stress levels speculated that this decrease was associated with the support of peers and group facilitators (Golding & Picken, 2004). Wassall (2011) did not find reduced stress levels in an evaluation of an attachment-based parent training programme for adoptive and foster parents, and speculated this may have been due to the sample's high baseline stress levels as well as the difficulty caring for children with complex needs. It is interesting to note that, in the current study, mean participant relational frustration scores did not start off being very high at baseline (before the start of the programme) (see Figure 13).

**E) *The effect on the foster child's behaviour at home and at school.***

Data were collected about the foster child's challenging behaviour at home as well as at school (i.e., noncompliance, defiance, aggressiveness, and impulsiveness), through the course of the Fostering Security programme and at three-month follow-up. It was speculated that, as caregivers can sometimes have more subjective perceptions of the foster child's behaviour, teacher and early childhood centre staff might give more objective perspectives. While the child's challenging behaviour at school at the start of the programme was not generally considered of significant concern by teachers, there was a significant decrease in child's misbehaviour at school for both Groups A and B. These findings were also corroborated by participant statements regarding the foster child's improved behaviour at

school. At three month-follow-up with teachers, the group analysis of mean scores showed continued child behavioural progress at school for both groups. No group difference in child's misbehaviour at school was found with regard to the reversed order of the Fostering Security training modules.

With regard to the foster child's challenging behaviour at home, significantly decreased scores were found in group analyses for both Groups A and B through the course of the Fostering Security programme, and these findings were consistent with qualitative participant reports. At three-month follow-up the scores appeared to have plateaued since the end of the Fostering Security programme, but were still lower than they had been at the start of the programme. Wassall (2011) did not find significant overall improvement in foster child behaviour as rated by caregivers over the course of a caregiver training programme. Wassall (2011) speculated that, given the complex nature of the foster child's behaviour, it was optimistic to expect significant behavioural change in a short time frame (i.e., the course of a training programme and follow-up). While the current study showed significant foster child behavioural improvements as rated by their caregivers, it is possible that the child's behaviour may not have changed as much as the caregiver's perception of the child's behaviour changed. If it is the perception of the caregiver that has changed rather than the child's actual behaviour, this is still considered to positively impact on the foster child. As illustration, at programme completion participant CA12 stated:

“...he's behaving, he's behaving and, I'm still on the alert,  
and I don't think that will go away, so, I think my response

to his behaviour though will be different, but he's actually seems a little bit chirpier I suppose. But I don't know it's because we're looking at him differently now, and understanding him better, or if it's because he feels that way."

Of interest to note in the group analyses for the foster child's misbehaviour at home and at school is that teachers rated more behaviour problems for the foster children in Group B at baseline while caregivers in Group A rated more behaviour problems at home at baseline. This highlights the fact that there are a number of variables that may affect the behavioural presentation of foster children, for example, their relationship with their teacher, their perception of school, factors in the home environment, and their attachment to the caregiver.

**Summary.** In summary, six main themes relating to the mechanisms of change in the Fostering Security programme were discussed as related to the context, content and process of the programme. While positive group trends over the course of the Fostering Security training programme was generally found for the six outcome measures (i.e., attachment, mind-mindedness, child-responsible attributions, relational frustration, intensity of child misbehaviour at school, and intensity of child misbehaviour at home), not all of these trends were statistically significant. In addition for five out of the six variables the order of module presentation made no difference to the outcome indicating that the particular module was less

important than the general programme effect. Finally, despite the positive group trends for the six variables, not all participants changed in the expected way through the Fostering Security programme. There are numerous variables which may affect how and why participants change in the Fostering Security programme, and indeed other parent and caregiver training programmes. While it is beyond the scope of this thesis to discuss these variables in depth, it is important to raise a few of them here.

Our experience as professionals working with caregivers and foster children in Hawke's Bay is that, given the complexity of the biopsychosocial problems foster children can present with, their progress tends to be slow, over years, and characterised by improvements and deteriorations in behaviour. This is due to a number of individual, interpersonal, and environmental factors, for example, behavioural regression after access with biological parents, and experiencing split loyalties towards biological parents and caregivers. This non-linear trajectory can be mirrored by the caregiver as well, who responds and reacts to the foster child's behaviour as much as the foster child responds and reacts to the individual, interpersonal, and environmental factors. As such, caregivers may also show improvements and deteriorations in aspects such as attachment, mind-mindedness, stress and frustration, and attributions for the child's behaviour. Caregivers have also commented on the 'emotional rollercoaster' they sometimes feel like they are on with regard to their attachment relationship with the foster child. At times they feel connected and close to the child, and at times they feel more distant and insecure in the relationship, for example, when the child rejects their love and care, or when they feel unsure about the permanence of the child's placement with their

family. These feelings are likely to affect the individual participants' pathways through training programmes.

Wassall (2011) reported similar findings in a study evaluating a group training programme for adoptive and foster carers – despite evidence of positive group trends, some participants changed on some measures in the predicted way and some did not. The findings, as well as findings from similar studies, suggest that group training programmes do not effect change for all caregivers in the same way. Further research will be useful to identify those caregivers who find the group interventions less helpful in facilitating change in their parenting skills and approaches, and to identify the factors which negatively affect their progress in training programmes.

### **Interpretations and Implications of Findings**

The qualitative thematic analysis of participants' interviews and evaluation reports, alongside analyses of group means for the six caregiver and child behaviour measures, indicated that the Fostering Security training programme for caregivers was beneficial in facilitating positive parenting outcomes for caregivers and their foster children. In terms of the mechanisms of change, a number of factors were highlighted within the context, content, and process of the programme. Specific training methods, the programme content, and the development of parenting skills and strategies pertinent to the needs of caregivers, within a supportive group context and effective training, was shown to be associated with improvement in a number of areas for many participants (i.e., self-reflective capacity, mind-mindedness, self-regulation, and understanding of reasons for the child's behaviour) (see Figure 5). These

improvements appear to have positively influenced participants' confidence in parenting the foster child, the development of more positive and accurate attributions for the child's misbehaviour, more appropriate responses to the child, and decreased parenting stress and frustration. All these factors, in turn, are posited to lead to improvements in the child's behaviour, and a healthier and more secure caregiver-foster child attachment relationship. The chances of a more stable and permanent foster placement are therefore thought to be enhanced. As all these factors form the core aims of the Fostering Security training programme, the findings in the current study are promising.

While significant positive trends were found for most of the caregiver and child measures, the tendency for a drop-off effect at three-month follow-up was expected, but also of concern. These findings are consistent with previous findings (Everson-Hock, 2011; Wassall, 2011), and indicate that a short-term caregiver training programme is useful to provide foundational learning and support, but not enough on its own, to provide the level and duration of support caregivers need to successfully parent children with complex and well-established attachment- and trauma-related problems. While people can and do change their beliefs and behaviours, change does not always last forever, and people can revert back to previous ways of thinking and acting (Evans & Fletcher, 2013). Caregiver participants in this programme themselves recognised this and expressed a desire and a need for ongoing input and support, for example, through regular refresher sessions, updates by e-mail or newsletter, or informal coffee groups. It follows that what is needed when intervening to improve outcomes for children in care are interventions that are designed to support foster children and caregivers over longer timeframes. How the success

of caregiver training programmes, like the Fostering Security programme, is measured is therefore important – while such programmes have been shown to have a number of benefits as outlined in this thesis, it is the longer-term interventions with foster families that will likely produce the desired positive outcomes.

Further, as discussed in Chapter 2, while caregiver training is a core component of mental health interventions for foster children (Leve et al., 2012; Modernising Child, Youth and Family Expert Panel, 2015; Murray et al., 2011; Rock et al., 2015), it needs to be a part of an encompassing package of interventions which target as many ecological systems around the foster child as possible (i.e., at the individual, interpersonal, and environmental levels) (Bruns et al., 2010). The drop-off effects highlight the need for ongoing support for caregivers post-group training programme. In this regard an ‘in-home’ component to caregiver training, implemented when the group intervention is complete, may provide the ongoing support caregivers needs and may help caregivers to generalise and transfer their understanding, knowledge and skills from the group sessions to the home setting (Wassall, 2011). The benefit of refresher training, ongoing support post-training for more vulnerable families, and relapse-prevention modules have further been suggested in light of the drop-off effects (Everson-Hock et al., 2011; Furlong & McGilloway, 2014).

In further attempts to maintain the effects of the Fostering Security training programme and to continue to provide caregivers with support, training and information after the programme ends, a website and a support group are currently being established. It is envisaged that graduates of the Fostering Security programme will have access to information and resources on the

Fostering Security website, which will also serve as a means to maintain contact with caregivers, for example, through regular newsletters. The support group, occurring a few times a year, will consist of an information or training session, as well as time for caregivers to establish informal and self-sustaining support networks. In addition, child welfare social workers are also being encouraged to attend the Fostering Security training programme, in particular the caregiver liaison social workers, so that they can follow up with caregivers after the group intervention and ensure that the professionals are providing consistent information, strategies and support.

It had been speculated that the Fostering Security training programme would be more effective if the psychoeducation and self-care/self-reflection modules were delivered before the behaviour management and skills training module, and that the specific modules would have specific effects on the caregiver and child measures at different times through the programme. Besides a group effect being found for the foster child's misbehaviour at home, none of the other measures showed group effects. It is thought that these findings might be related to the fact that, while the Fostering Security training programme has separate and distinct modules, there are sometimes unavoidable overlaps between modules as caregiver needs dictate at the time. As such it might be that the overall effect of the programme, combining the different aspects of the programmes content, context and process, is more pertinent than the effects of the separate modules. This has implications for the future delivery of the programme, but the current findings need to be confirmed in further studies.

### **Limitations of Current Research**

This research study was concerned predominantly with process rather than outcomes of the Fostering Security training programme. At this early stage of research into the programme, the study focus was more formative (exploration of processes) than summative (evaluation of outcomes). While randomised controlled trials are considered to be the ‘gold standard’ in programme evaluation (Tarren-Sweeney, 2014a), a randomised controlled trial was not indicated due to this study’s focus on process rather than outcomes, as well as the relatively small number of children in care in Hawke’s Bay. Further, it has been argued that, while the randomised controlled trial methodology is ideal for medical drug trials, it is not the only way to establish the effectiveness of interventions in the social sciences (Evans & Fletcher, 2013). While the two experimental groups were comparable in terms of the demographic variables of caregivers in Hawke’s Bay, who are naturally a diverse group, in this study true random assignment to the groups to balance the groups in terms of demographic variables was not possible. As this study did not include a control group, there is no certainty that the changes in outcomes were not merely a result of the passing of time or a maturational effect with the foster child gradually settling into the placement. However, a strength in this study was the inclusion of quantitative data which provided more in-depth and valid information about the measures being studied.

The crossover repeated measured design utilised in this study is held to have been the most appropriate design for a small participant sample, to monitor participant change over time, and for evaluation of the effect of the different modules of the Fostering Security training programme (Jones & Kenward, 2003; Vonesh & Chinchilli, 1997). While it is important to note that the small sample size

reduces the generalisability of the study's results, this is not considered to be of great concern as the focus is formative rather than summative at this stage of research. However, the small sample size of 22 caregivers is made more problematic by the fact that these include seven couples with both members reporting on the same child.

In future research that might try to address the effectiveness of the programme in terms of its beneficial influence on the foster children themselves, it would be necessary to ensure that for each caregiving parent in such a study there is one independent foster child contributing to the outcome data. It is worth mentioning, however, that the reality of foster care is that typically both adults in a family are involved in caregiving and they support and influence each other, which is something desired. There seems to be little point in only training one member of a family couple who are together providing a foster home for a challenging child. An additional complication is that caregiving families sometimes have more than one foster child and for different lengths of time. In addition, all the children in a family, both biological children, step-children, and foster children, do have influence on each other. Not all permutations of a family structure can be balanced in conventional designs, as I discovered in the present study. This may suggest the possible importance of detailed individual family case studies in which there is opportunity to observe and record day-to-day family interactions.

Ideally a component analysis of the Fostering Security programme would have assessed the relative effect of each of the three modules separately, that is, the psychoeducation, self-care and self-reflection, and behaviour management and skills training modules. However, as the self-care and self-reflection module was a relatively short module spanning two training sessions, compared to the other two

of four sessions each, it was combined with the psychoeducation module so that caregivers would not have to complete all the questionnaires and be interviewed again after only two sessions. In addition, as both these modules are strongly underpinned by attachment theory and self-reflection unavoidably occurs at various times in the psychoeducation modules, the conflation was considered reasonable. However, as this conflation meant the weights of the final two modules that were assessed were unequal in length (i.e., six sessions versus four sessions) this means that the mid-point was not the same for both groups. As this was not controlled for in the analysis it does negatively impact on the component analysis aspect of the study. Given that the psychoeducation and self-care/self-reflection components of the programme are theoretically similar and share a degree of overlap, it may be that a more permanent conflation of these two modules is indicated.

A further limitation of this study was my joint role as the Fostering Security programme developer as well as the evaluator of the programme which has the potential to introduce conflict of interest and research bias as discussed (Eisner, 2009). As outlined in Chapter 4, to mitigate against these potential issues, I was deliberate in recognising and bracketing my own perspectives especially during qualitative data collection and analysis and I obtained the assistance of psychologist colleagues to corroborate scoring and analysis. In addition, as both the research groups in this study had the same facilitators, there is a possibility that the intervention effects could be due to the facilitator variables, rather than only the Fostering Security programme itself. As discussed in the recommendations section below, an independent trial of the Fostering Security programme would be useful in addressing these limitations in the current study.

As well as the potential for research bias, I was also mindful of the potential for respondent bias as I was both the programme evaluator as well as a group facilitator and had therefore developed therapeutic rapport with some participants. To mitigate against the possibility of participants providing favourable responses due to this rapport they were given the opportunity to provide anonymous feedback at the end of the programme. However, ideally, data collection would be conducted by an interviewer blind to the study's purpose (Pannucci & Wilkins, 2010). This point is also raised in the next section as a recommendation for future research.

All participants in the current study were interested in attending the Fostering Security programme as they wanted to develop a more secure attachment relationship with their foster child, wanted to learn more about attachment and trauma problems, and/or wanted to develop their skills in managing and addressing these problems. Given this motivation to attend it implies that the caregivers might be more motivated to make changes as per their learnings in the programme than would caregivers who were less interested in attending and might have had to do so as they were required to. The results in the current study therefore need to be considered with this in mind.

In addition, the strong reliance on caregiver self-report in this study may have been subject to biased and subjective responses. In an attempt to obtain more objective information about the child's behaviour, data was also collected from the teacher or early childhood educator. However, it is known that teachers and educators may also have biased views of the foster child. Observation of the caregiver and foster child would have provided more valid and objective information about the nature of the caregiver-foster child interactions and

relationship, as well as the foster child's behaviour. This method of data collection will be valuable in future research into the Fostering Security programme.

The child behaviour measures used were the Eyberg Child Behavior Inventory, to assess foster child misbehaviour at home, and the Sutter-Eyberg Student Behavior Inventory – Revised, to assess foster child misbehaviour at school. These measures were selected for this study as they are widely used in studies into the effectiveness of parent training programmes, and as they are relatively short with 36 and 38 items respectively. However, these measures were standardised on children from relatively intact families rather than children in care with complex biopsychosocial problems. A measure like the Assessment Checklist for Children (Tarren-Sweeney & Vetere, 2014), developed to measure the range of attachment- and trauma-related mental health problems in foster children, will likely be more suitable for future study of this population group.

While the Mind-Mindedness Interview is widely used in research to assess caregivers' ability to correctly interpret the foster child's mental states, this measure still requires investigation into its psychometric properties. However, it is acknowledged that there are limited accessible, valid, and reliable measures of caregivers' attachment relationships, self-reflective capacity, responsivity, and sensitivity (Gurney-Smith et al., 2010).

When researching complex phenomena, like multifaceted and established attachment and trauma problems, there are reliability issues with using psychometric measures which have not been designed for assessing complex phenomena. Further, given the non-linear trajectory of behavioural improvement in foster children, and the variability in the caregiver-foster child relationship, caregivers may respond differently on the same measures at different

administration times. For these reasons and others, the results obtained from the measures used need to be interpreted with caution. However, having the qualitative findings to corroborate and elaborate on the quantitative data is beneficial.

Given that participants completed psychometric measures and were interviewed at three time periods through the course of the Fostering Security programme and then again at three-month follow-up, there is also a possibility of the occurrence of practice effects. Participants' performance may have been affected in the second and subsequent administration of the measure as they were familiar with completing the measures. However, it is acknowledged that repeated measures designs tend to be affected by practice effects, except in the case of longitudinal studies with long periods of time between the administrations of psychometric measures (Jones & Kenward, 2003; Vonesh & Chinchilli, 1997).

### **Recommendations for Future Research**

As stated above, a larger multi-site study of the effectiveness of the Fostering Security training programme will be useful to investigate a number of issues:

- Explore whether the intervention effects are due to the programme and/or the facilitators and provide an independent trial of the programme.
- Further investigate the effect of the order of the training modules on participants and foster children outcomes in other regions in New Zealand.
- Assess the effect of the self-care/self-reflection module on its own (which would mean expanding that section and ensuring that it had

equal weight to the other two modules), or assess the combined effect of the psychoeducation and self-care/self-reflection modules that is weighted equally to the behaviour management and skills training module.

- Investigate the relationship between the range of historical and demographic caregiver and foster child variables (e.g., socioeconomic status, ethnicity, age of child, number of placements, and severity of abuse and neglect), and the effectiveness of the Fostering Security programme.
- Obtain more detailed information about those caregivers who do not progress in the expected way in the training programme.

Future research into the Fostering Security training programme will also likely benefit from the use of psychometric measures more specific to the complex behaviours of foster children, as well as direct observation of caregiver and foster child to monitor changes in their relationship as well as the foster child's behaviour. It will also be useful to include a measure that is designed to assess family functioning in addition to assessing the relationship between the foster child and caregiver. In addition, detailed individual family case studies may be indicated to provide the opportunity observe and measure day-to-day family interactions given the number of possible family structure permutations in society.

Given the drop-off effect at three-month follow-up, which is also seen in other similar studies, we may need to rethink how we measure success of such interventions. It may be that due to the long-term nature and complexity of difficulties foster children and their caregivers face, it is unrealistic to expect a 10-16 session training programme to effect long-term changes on its own.

Interventions may therefore need an ongoing component to ensure that families are supported a period of time as needed after the training to embed and operationalise the learnings from the training programme. As such, it would follow that the best methodology for studying the effect of foster parent training programmes would be the evaluation of the programme as well as the ongoing interventions and the long term effects (i.e., more secure caregiver and foster child relationships, more stable foster placements, and better foster child mental health and behavioural outcomes).

### **Conclusion**

To improve outcomes for foster children with complex mental health, behavioural, developmental, and physical needs, interventions are more effective when implemented across multiple naturally-occurring contexts around the child, rather than just focused on the individual child. This enables those in the foster child's ecological environments to develop the skills and confidence required to parent, teach, and support foster children on an on-going basis. Effective caregiver training and support is a core intervention, within the wider framework of interventions, to develop the therapeutic parenting capacity of caregivers, to facilitate secure caregiver-foster child relationships, to improve mental health outcomes for foster children, and to decrease foster placement breakdowns.

The Fostering Security training programme for caregivers, developed in recognition of these needs, is informed by a number of theories shown to be effective in meeting the specific needs of foster parents and foster children with attachment- and trauma-related problems (i.e., attachment theory, mind-mindedness, social learning theory, neurobiological theories of trauma, abuse, and neglect, attribution theory, and theories about the mechanisms of change).

Caregivers are not only provided with behaviour management and modification strategies, but are supported to develop their self-reflective capacity, emotional understanding, acceptance, and warmth for the foster child, and supported to develop their parenting problem-solving abilities. This integrated, educative, supportive and nurturing context of the Fostering Security programme aims to facilitate the development of a more secure and loving caregiver-foster child relationship.

One of very few parent or caregiver training programmes developed in New Zealand, the Fostering Security programme is cognisant of the values, traditions and norms of Māori caregivers, and aims to ensure cultural sensitivity and safety for caregivers from all walks of life. The training programme is also jointly facilitated by child and adolescent mental health and child care and protection staff to facilitate a joint interagency approach and more streamlined service to caregivers and foster children. Such an approach is a vital component of a ‘whole of government’ strategy to ensure better outcomes for children in care, rather than it being limited to the role of child care and protection agencies.

This exploratory mixed methods study into the mechanisms of change in the Fostering Security programme has indicated that the programme content, context, and process are associated with positive trends in caregivers’ attachment with the foster child, mind-mindedness, caregivers’ dysfunctional attributions for the child’s misbehaviour, stress and frustration in the caregiver-foster child relationship, and foster child’s challenging behaviour at home and at school. The study’s results further indicate the need for follow-up interventions post-group training programme, to sustain the positive effects found during the course of the programme. Given the complex biopsychosocial problems of foster children,

caregivers need ongoing support and discussion opportunities to reflect on their own and the child's behaviours, and to deliberate parenting strategies. As results in this study also showed that not all caregivers progress in the hoped-for manner through the group intervention, further investigation into this issue, among others, has been highlighted for future research.

Across the world, children in care with adverse early experiences and ensuing mental health, behavioural, and developmental problems are among the most vulnerable groups of children. Caregivers who take foster children into their homes and care need, deserve, and should receive the support, acknowledgement, respect, training, and resources to understand and parent these children as successfully as possible. The Fostering Security training programme for caregivers in New Zealand, developed to address some of these needs, has been shown to be beneficial in strengthening caregivers' behaviour management skills, self-reflective capacity, as well as emotional understanding of and sensitivity for their foster children. With these factors being strengthened, the goals of more secure foster parent and child relationships, more stable foster placements, and better foster child mental health outcomes are more likely to be achieved.



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## APPENDICES

### **Appendix A: Description of Two Fostering Security Programme Participants**

(Information changed to protect privacy and confidentiality)

**Participant A – Amy.** Amy was a 44-year-old woman who lived with her husband and three children in their late teens and early twenties. Amy and her husband, Bill, decided to foster a child as they felt that their family had a lot to offer a child in need. Both Amy and Bill work full-time and their children are students at school and university. Amy and Bill have the day-to-day care of five-year-old Petra who does not have any contact with her biological family. Petra was removed from the care of her biological parents at the age of three due to reported neglect and physical abuse. Petra had a series of failed placements, largely blamed on her challenging behaviours, before going to live with Amy and her family at the age of four and a half.

On arrival, Amy described Petra as being “feral” in her behaviour – she ate very quickly, shovelling food into her mouth with her hands, and she was not toilet trained and had poor hygiene. Petra was extremely non-compliant, very demanding of attention, and manipulative. She would have tantrums that lasted hours and would become physically aggressive and scream very loudly. While Petra’s behaviours had improved a little since being in their care, Amy still felt overwhelmed by her challenging behaviours, and stated that she regularly worried that they had made a mistake taking her into their care and then felt guilty for feeling that way.

Attending the Fostering Security programme helped Amy realise that she was not the only one who at times disliked the foster child, felt that they had made a mistake, and then felt guilty about feeling that way. Amy stated that she found the nurturing quality of the group invaluable. Through the course of the programme she was able to reflect on the negative feelings Petra triggered in her, and she was able to relate these feelings back to her own childhood and relationship with her own mother. Amy was able to develop more realistic expectations of a five-year-old who had attachment and trauma problems. She and Bill spoke at length about needing to provide a consistent parenting approach for Petra, and about the need to share the parenting as it was too difficult for any one of them to manage on their own.

At three-month follow-up Amy stated that, while she sometimes did regret the decision to foster Petra, these times were less frequent and she felt that “there was light at the end of the tunnel”. Amy was grateful for having attended the Fostering Security training programme, but felt strongly that further regular support was needed for foster parents as the challenges and behaviour problems they were faced with were ongoing and longstanding issues.

**Participant B – Beth.** Beth was a 60-year-old New Zealand European woman who lived with her husband and worked part-time in a clothing store. She and her husband were raising their 10-year-old granddaughter, Zara, the daughter of their daughter who had had her four children removed from her care by child protection services due to severe neglect and exposure to domestic violence. Zara went into Beth’s day-to-day guardianship at 8 years of age with a number of developmental, behavioural, and emotional problems. Beth and her husband were

committed to having Zara in their long-term care, but were frustrated and tired by her attention-seeking behaviours, difficulty learning from consequences, temper tantrums, controlling behaviour, socially indiscriminate behaviour with strangers, and poor social skills with peers. Zara has very irregular contact with her mother, largely due to the fact that her mother is not consistent with the planned contact arrangements. When contact does occur, Zara is usually unsettled for a number of days afterwards, and her behaviour problems escalate in that period.

Before the start of the Fostering Security training programme, Beth reported a high intensity of child behaviour problems, and she also reported a high level of frustration with her relationship with Zara. While she felt that her attachment relationship with Zara was slowly developing, she felt that Zara still did not trust them like a 10-year-old girl should trust her grandparents. Beth had a number of negative attributions about Zara's behaviour, including, "She is deliberately trying to wind me up with her temper tantrums", and "She is very demanding and wilful".

Through the course of the Fostering Security training programme, Beth had a number of moments of insight when she began to understand how Zara's experiences with her mother had negatively affected her attachment, development and socialisation, and when she realised that Zara's behaviour problems were manifestations of emotional concerns. Beth was increasingly able to identify and reflect on her own emotional and behavioural triggers, and put in strategies to regulate her emotions so that she stayed in control. Beth was also increasingly able to speculate about the thoughts and feelings that were likely underlying Zara's challenging behaviours (mind-mindedness), and her attributions for Zara's behaviours were less negative. Beth enjoyed attending the Fostering Security training programme as she felt connected to the other participants as they were all

dealing with similar problems. She developed particularly close relationships with the other grandparents in the group and they sometimes met for coffee during the week.

At three-month follow-up, Beth reported continuing improvements in her attachment relationship with Zara and in Zara's behaviour. There were the expected 'peaks and troughs' in Zara's improvement, as there were a number of factors that caused ongoing regression in her behaviour (including access contact with her mother). However, Zara was more realistic about the expected course of improvement.

**Appendix B: Consent Forms****Participant Consent Form****Request for Interpreter**

English	I wish to have an interpreter	Yes	No
Deaf	I wish to have a NZ sign language interpreter	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhaka Māori/kaiwhaka pakeha korero	Ae	Kao
Cook Island Māori	Ka inangaro au i tetai tangata uri reo	Ae	Kare
Fijian	Au gadreva me dua e vakadewa vosa vei au	Io	Sega
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu	E	Nakai
Sāmoan	Ou te mana'o ia i ai se fa'amatala upu	Ioe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	Io	Ikai

**Name of study:**

An analysis of the mechanisms of change in an intervention for caregivers in New Zealand: *The Fostering Security Training Programme*.

I have read and I understand the information sheet dated February 2012 for volunteers taking part in the study designed to evaluate the effectiveness of the Fostering Security training programme for parents and caregivers. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study.

I understand that taking part in this study is voluntary (my choice), that I may withdraw from the study at any time, and this will in no way affect my continuing or future health care.

I have had this project explained to me by Bernice Gabriel, Senior Psychologist at the Hawke's Bay District Health Board.

I understand that my participation in this study is confidential and that no material that could identify me or my foster child will be used in any reports on this study. I understand that the information I provide will not be used for any other purpose or released to others without my written consent.

I have had time to consider whether to take part in the study.



## **Assent Form for Children**

### **Name of study**

An analysis of the mechanisms of change in an intervention for caregivers in New Zealand: *The Fostering Security Training Programme*.

### **Name of researcher**

Bernice Gabriel, Senior Psychologist, Child, Adolescent & Family Service, Hawke's Bay District Health Board

### **What's the study for?**

The Fostering Security programme is a training programme for parents and caregivers to understand themselves and their children better. They learn about how the difficult times their children may have had before they came to live with them may affect their children's behaviour. They learn new ways to manage their own feelings, and they learn new ways to manage their children's behaviour. This study will help us know how the Fostering Security programme works to help the adults learn these new things, and whether this helps with the children's behaviour.

### **How will it help me and other children?**

This programme will help you and other children because it's designed to help parents and caregivers understand themselves and their children better, and to manage their children's behaviour better.

### **What will I have to do?**

You don't have to do anything. I will be collecting information from your teacher and mum/dad/caregiver about your behaviour at different times over the next year. This will be to see if the programme is making any difference in your behaviour, through your parent or caregiver.

### **Who can I ask questions if I want to?**

You can ask your parent or caregiver, or you can ask them if you can ask me questions that they may not be able to answer.

### **Assent**

Signing here means that you have read this paper or that I have read it to you, and you are willing for your teacher and parent/caregiver to give me information about your behaviour over the next year. Being involved in this study is up to you, and no one will be angry if you don't sign this form or change your mind later.

The research has been explained to me and I agree to my mum/dad/caregiver and teacher sharing information about my behaviour.



## Consent Form – Guardian – Release of information

### Request for Interpreter

English	I wish to have an interpreter	Yes	No
Deaf	I wish to have a NZ sign language interpreter	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhaka Māori/kaiwhaka pakeha korero	Ae	Kao
Cook Island Māori	Ka inangaro au i tetai tangata uri reo	Ae	Kare
Fijian	Au gadreva me dua e vakadewa vosa vei au	Io	Sega
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu	E	Nakai
Sāmoan	Ou te mana'o ia i ai se fa'amatala upu	Ioe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	Io	Ikai

### Name of study:

An analysis of the mechanisms of change in an intervention for caregivers in New Zealand: *The Fostering Security Training Programme*.

I have read and I understand the information sheet dated February 2012 to evaluate the effectiveness of the Fostering Security training programme. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study.

I understand that any information from this study is confidential and that no material that could identify me or my child will be used in any reports on this study.

I know who to contact if I have any questions about this study in general (details below).

I \_\_\_\_\_ (*please write your full name*) hereby consent to have information about my child released for the purposes of this study.

Date:

Signature:

Full names of researcher:

Bernice B Gabriel, Senior Psychologist,  
Programme facilitator and project researcher  
Child, Adolescent & Family Service  
Hawke's Bay District Health Board

Contact phone number for researchers:

06 8788109 extension 5770 or 027 2330316

Signature:

Date:

## Consent Form for Teachers/Early Childhood Centre Staff

### Request for Interpreter

English	I wish to have an interpreter	Yes	No
Deaf	I wish to have a NZ sign language interpreter	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhaka Māori/kaiwhaka pakeha korero	Ae	Kao
Cook Island Māori	Ka inangaro au i tetahi tangata uri reo	Ae	Kare
Fijian	Au gadreva me dua e vakadewa vosa vei au	Io	Sega
Niuean	Fia manako au ke fakaaoga e taha tagata fakahokohoko kupu	E	Nakai
Sāmoan	Ou te mana'o ia i ai se fa'amatala upu	Ioe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania ki na gagana o na motu o te Pahefika	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	Io	Ikai

### Name of study:

An analysis of the mechanisms of change in an intervention for caregivers in New Zealand: *The Fostering Security Training Programme*.

I have read and I understand the information sheet dated February 2012 for teachers/early childhood centre staff taking part in the study designed to evaluate the effectiveness of the Fostering Security training programme for parents and caregivers. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice), that I may withdraw from the study at any time, and this will in no way affect my student's of the caregiver's continuing or future health care.

I have had this project explained to me by Bernice Gabriel, Senior Psychologist at the Hawke's Bay District Health Board.

I understand that my participation in this study is confidential and that no material that could identify me or my student will be used in any reports on this study.

I understand that the information I provide will not be used for any other purpose or released to others without my written consent.

I have had time to consider whether to take part in the study.

I know who to contact if I have any negative effects from the study.

I know who to contact if I have any questions about this study in general.

*Please tick one box*

I wish to receive a copy of the results.

yes  no

(please be advised that a significant delay may occur between the information being collected from you and the information being shared with you)

I \_\_\_\_\_ (please write your full name) hereby consent to take part in this study.

Date:

Signature:

Full names of researcher:

Bernice B Gabriel, Senior Psychologist,  
Child, Adolescent & Family Service  
Hawke's Bay District Health Board

Contact phone number for researchers:

06 8788109 extension 5770 or 027  
2330316

Project explained by:

Bernice B. Gabriel

Project role:

Programme facilitator and project  
researcher

Signature:

Date:

## Appendix C: Information Sheets

### Participant Information Sheet

**An analysis of the mechanisms of change in an intervention for caregivers in New Zealand: *The Fostering Security Training Programme*.**

**Researcher:** Bernice B. Gabriel, Senior Psychologist, Child, Adolescent & Family Service, Hawke's Bay District Health Board

You are invited to take part in a research study. Before you decide whether or not to take part in this study, it is important for you to understand why the research is being done and what it will involve. You will have a week or two to decide whether to take part in the study or not, so please take time to read the following information carefully and discuss it with others if you wish. You can choose whether to take part in the study or not. Please contact me if there is anything that is not clear or if you would like more information.

#### **What is the purpose of the study?**

The purpose of the study is to understand how the Fostering Security training programme for caregivers works. The Fostering Security programme was designed to help caregivers raising children who have experienced trauma, abuse and/or neglect, and who often have attachment difficulties. The programme aims to help caregivers better understand and manage the child's behaviours, and understand and manage their own responses to the child's behaviour, with the long-term aim of preventing placement breakdown. The programme provides information about 1) the physical, psychological and developmental impact of trauma, abuse and neglect, 2) caregiver self-care and self-reflection, and 3) behaviour management and skills training. The Fostering Security programme is facilitated by a psychologist from Child, Adolescent & Family Service (CAFS) and a social worker from Child, Youth and Family (CYF).

This study aims to understand how the Fostering Security programme works to help caregivers better understand and manage their foster child's behaviours, and understand and manage their own responses to the child's behaviour. We are also interested in which parts of the programme helped the most with caregiver's parenting skills and the child's behaviour.

#### **Why have I been chosen?**

Participation in the study is offered to all participants of the Fostering Security programme. The Fostering Security programme is offered to caregivers of children in the care of CYF and CAFS clients with attachment and trauma issues. The study will involve two groups of participants, one beginning at the beginning of 2012, and one beginning toward the middle of 2012. We are hoping to get a minimum of 11 participants involved in the study in each group as this will make the results we get more meaningful.

**Do I have to take part?**

Your participation is entirely voluntary (your choice). You do not have to take part in this study, and if you choose not to take part you are still welcome to participate in the Fostering Security training programme. If you do agree to take part in the study, you are free to withdraw from the study at any time, without having to give a reason. This will in no way affect your participation in the Fostering Security programme.

If you wish, you are welcome to attend the Fostering Security programme with a support person (friend, family/whanau), and you can have this person present during the questionnaire completion and during the interviews.

If you need an interpreter, one can be provided.

**Are my children involved in the study?**

The research does not directly involve your foster child or children in any way. We will be asking caregivers and the foster child's teacher or early childhood centre staff to complete a questionnaire about the child's behaviour before, during and after the Fostering Security programme, to see if the programme has made a difference to the behaviour. For this reason, the researcher will talk with your foster child to explain what information will be collected and to get your child's agreement for this to happen.

**What will happen during the study?**

The Fostering Security training programme is a ten-session long programme held once a week on a Monday afternoon from 4 to 6pm at the Hastings Hospital. We will be asking participants to give us information about their parenting and the child's behaviour at 4 points over a year – at baseline before the start of the Fostering Security training programme, halfway through the programme, at the end of the programme, and 3 months after the programme. Information will be collected from you in the form of interviews and questionnaires, and will take about 1.5 hours to complete at each setting.

Your foster child's teacher or early childhood centre staff will also complete a questionnaire about the child's behaviour before, during and after the Fostering Security programme.

The reason for collecting information at all these points is to determine the effect of the Fostering Security programme over time, as well as to determine which modules of the programme are effective to help with parenting and child behaviour management.

With regard to the questionnaires and interviews, you do not have to answer all the questions if you do not want to, and you may stop the interview at any time.

All interviews with you will be audio-taped for accuracy, and these will be transcribed (written up). All transcripts will be treated confidentially and will be securely stored (see section below on confidentiality).

**What will happen at the end of the study?**

As mentioned before, there will be a follow-up visit with you 3 months after the end of the Fostering Security training programme. You will also be invited to join the support group which is made up of previous graduates of the Fostering Security programme. This support group was set up so that caregivers could get ongoing support from other caregivers after the Fostering Security programme ends. Participants will also have access to the Fostering Security website (currently being designed) for resources, information and ongoing support.

**What are the possible disadvantages or risks in taking part in the study?**

As some of the discussions in the Fostering Security training programme are about the trauma, abuse and neglect children suffered by children, it is possible that some participants may become distressed during the programme. This might be because they are upset about what their children suffered or because of their own negative childhood experiences. Should this happen, psychological support for the participant to work through these issues will be provided, either through CAFS, an agency already involved, or another agency. Participants are welcome to discuss their needs with the researcher, who is a registered psychologist, at any stage of the study.

Participation in this study will not cost you anything. If transport costs or babysitting costs are preventing you from attending the programme or being involved in the study, please feel free to discuss this with the researcher as assistance with these issues may be available from CAFS and/or CYF.

**What are the possible benefits of taking part in the study?**

By participating in the Fostering Security training programme, caregivers can gain an increased understanding of their foster child's difficulties and needs, they can reflect further on what they bring to the relationship with their child, they can develop their behaviour management skills, and they can form supportive relationships with other caregivers.

By participating in the study, participants will be helping with improving our understanding of how we can help support caregivers to parent their foster children more effectively. Participants will also be helping with increasing our understanding of how we can help effectively treat the mental health and behaviour problems of children in care.

By participating in this research, participants can have confidence that the Fostering Security programme is continuously improving, and that its effect is being researched.

**Will my taking part in this study be confidential?**

Although, with your permission, your interview will be recorded, only members of the research team (the researcher and her supervisors) will have access to the recording, the transcript of the recording and the questionnaires. These will be kept in a locked cabinet in the CAFS offices and treated with the same confidentiality and privacy as hospital patient records. You are welcome to view these

questionnaires and transcripts of the interviews. Neither your or your foster child's name will be used, and the questionnaires and interviews will be identified by initials and numbers only. No material that could personally identify you will be used in any reports on this study. At the end of the study, questionnaires and transcripts will be filed alongside hospital patient records, and treated with the same degree of privacy and confidentiality.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:

Free phone: 0800 555 050

Free fax: 0800 2 SUPPORT YOU (0800 2787 7678)

E-mail: [advocacy@hdc.org.nz](mailto:advocacy@hdc.org.nz)

### **What will happen to the results of the research study?**

The results of the research study will be collected together and a report written. You or your foster child will not be identified in this report. All participants in the study are welcome to receive a copy of the report. Please be aware that there will be some delay between the time we collect the information from you and when the report is complete and ready to be shared with you.

### **Who has reviewed the study?**

This study has received ethical approval from the New Zealand Central Regional Health and Disability Ethics Committee, ethics reference number **CEN/11/12/077**.

### **Compensation**

In the unlikely event of a physical injury as a result of your participation in this study, you may be covered by ACC under the Injury Prevention, Rehabilitation, and Compensation Act 2001. ACC cover is not automatic, and your case will need to be assessed by ACC according to the provisions of the Injury Prevention, Rehabilitation, and Compensation Act 2001. If your claim is accepted by ACC, you still might not get any compensation. This depends on a number of factors, such as whether you are an earner or non-earner. ACC usually provides only partial reimbursement of costs and expenses, and there may be no lump sum compensation payable. There is no cover for mental injury unless it is a result of physical injury. If you have ACC cover, generally this will affect your right to sue the investigators.

If you have any questions about ACC, contact your nearest ACC office or the investigator.

You are also advised to check whether participation in this study would affect any indemnity cover you have or are considering, such as medical insurance, life insurance and superannuation.

**Contact for further information**

Please feel free to contact the researcher if you have any questions about this study:

**Researcher:** Bernice B. Gabriel, Senior Psychologist

**Address:** McLeod Street, Child, Adolescent & Family Service,  
Hawke's Bay District Health Board, Hastings

**Phone:** 06 8788109 extension 5770 or 027 2330316

Thank you for taking the time to read this information sheet.

Researcher's signature: \_\_\_\_\_

## **Guardian Information Sheet**

**An analysis of the mechanisms of change in an intervention for caregivers in New Zealand: *The Fostering Security Training Programme*.**

**Researcher:** Bernice B. Gabriel, Senior Psychologist, Child, Adolescent & Family Service, Hawke's Bay District Health Board

### **What is the purpose of the study?**

The purpose of the study is to understand how the Fostering Security training programme for caregivers works. The Fostering Security programme was designed to help caregivers raising children who have been removed from the care of their biological parents for various reasons. The programme aims to help caregivers better understand and manage any difficult child behaviours. The Fostering Security programme is facilitated by a psychologist from Child, Adolescent & Family Service (CAFS) and a social worker from Child, Youth and Family (CYF).

### **Are my children involved in the study?**

The research does not directly involve your child or children in any way. We will be asking caregivers and the child's teacher or early childhood centre staff to complete a questionnaire about the child's behaviour before, during and after the Fostering Security programme, to see if the programme has made a difference to the behaviour. For this reason, the researcher will talk with your child to explain what information will be collected and to get your child's agreement for this to happen.

### **Will my child's information be confidential?**

Only members of the research team (the researcher and her supervisors) will have access to the research information. These will be kept in a locked cabinet in the CAFS offices and treated with the same confidentiality and privacy as hospital patient records. Neither your or your child's name will be used, and the information will be identified by initials and numbers only. No material that could personally identify you will be used in any reports on this study. At the end of the study, all information will be filed alongside hospital patient records, and treated with the same degree of privacy and confidentiality.

### **What will happen to the results of the research study?**

The results of the research study will be collected together and a report written. You or your child will not be identified in this report.

### **Who has reviewed the study?**

This study has received ethical approval from the New Zealand Central Regional Health and Disability Ethics Committee, ethics reference number **CEN/11/12/077**.

**Contact for further information**

Please feel free to contact the researcher if you have any questions about this study:

**Researcher:** Bernice B. Gabriel, Senior Psychologist

**Address:** McLeod Street, Child, Adolescent & Family Service,  
Hawke's Bay District Health Board, Hastings

**Phone:** 06 8788109 extension 5770 or 027 2330316

Thank you for taking the time to read this information sheet.

Researcher's signature: \_\_\_\_\_

## **Information Sheet for Teachers/Early Childhood Centre Staff**

### **An analysis of the mechanisms of change in an intervention for caregivers in New Zealand: *The Fostering Security Training Programme*.**

**Researcher:** Bernice B. Gabriel, Senior Psychologist, Child, Adolescent & Family Service, Hawke's Bay District Health Board

We would appreciate your assistance in reporting on the behaviour of the child for the purposes of evaluating the Fostering Security training programme. Please contact me if there is anything that is not clear or if you would like more information.

#### **What is the purpose of the study?**

The purpose of the study is to understand how the Fostering Security training programme for caregivers works. The Fostering Security programme was designed to help caregivers raising children who have experienced trauma, abuse and/or neglect, and who often have attachment difficulties. The programme aims to help caregivers better understand and manage the foster child's behaviours, and understand and manage their own responses to the child's behaviour, with the long-term aim of preventing placement breakdown. The programme provides information about: 1) information about the physical, psychological and developmental impact of trauma, abuse and neglect, 2) caregiver self-care and self-reflection, and 3) behaviour management and skills training. The Fostering Security programme is facilitated by a psychologist from Child, Adolescent & Family Service (CAFS) and a social worker from Child, Youth and Family (CYF).

This study aims to understand how the Fostering Security programme works to help caregivers better understand and manage their child's behaviours, and understand and manage their own responses to the child's behaviour. We are also interested in which parts of the programme helped the most with caregiver's parenting skills and the child's behaviour.

#### **Why am I being asked to share information?**

In addition to obtaining information about the foster child's behaviour in the home and community from the caregiver, we would like to obtain additional information about the child's behaviour at school or early childhood centre.

#### **Do I have to take part?**

Your participation is entirely voluntary and you do not have to take part in this study if you choose not to. If you choose not to take part in the study, this will in no way affect the caregiver or the child involved.

#### **What will my involvement in the study mean?**

We will be asking education personnel to give us information about the child's behaviour at 4 points in the space of a year – at baseline before the start of the Fostering Security training programme, halfway through the programme, at the end of the programme, and 3 months after the programme. Information will be

collected from you in the form of a single questionnaire which comprises 38 items and takes about 5 minutes to complete.

**What are the benefits of taking part in the study?**

By participating in the Fostering Security training programme, you will be helping us improve our understanding of how we can help children in care with their mental health and behaviour problems. In addition, by participating in this research, you are helping us improve the Fostering Security programme.

**Will my taking part in this study be confidential?**

Neither your nor your student's name will be used, and the questionnaires and interviews will be identified by initials and numbers only. No material that could personally identify you will be used in any reports on this study. At the end of the study, questionnaires will be filed alongside hospital patient records, and treated with the same degree of privacy and confidentiality.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:

Free phone: 0800 555 050

Free fax: 0800 2 SUPPORT YOU (0800 2787 7678)

E-mail: [advocacy@hdc.org.nz](mailto:advocacy@hdc.org.nz)

**What will happen to the results of the research study?**

The results of the research study will be collected together and a report written. You or your student will not be identified in this report. All participants in the study are welcome to receive a copy of the report – please let the researcher know if you would like a copy of the results. Please be aware that there will be some delay between the time we collect the information from you and when the report is complete and ready to be shared with you.

**Who has reviewed the study?**

This study has received ethical approval from the New Zealand Central Regional Health and Disability Ethics Committee, ethics reference number CEN/11/12/077.

**Contact for further information**

Please feel free to contact the researcher if you have any questions about this study:

**Researcher:** Bernice B. Gabriel, Senior Psychologist,

**Address:** McLeod Street, Child, Adolescent & Family Service,  
Hawke's Bay District Health Board, Hastings

**Phone:** 06 8788109 extension 5770 or 027 2330316

Thank you for taking the time to read this information sheet.

Researcher's signature: \_\_\_\_\_



**Appendix D: Initial Interview**

**Initial Interview & Demographic Questionnaire**

To allow me to learn more about you and child/children, I would like to ask you some background information about you and your family. This interview will be audio-taped. You can choose not to answer questions if you do not want to, and the interview can be stopped at any point you choose.

1. Background information

Child's DOB: \_\_\_\_\_ Age \_\_\_\_ Gender: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Child's DOB: \_\_\_\_\_ Age \_\_\_\_ Gender: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Child's DOB: \_\_\_\_\_ Age \_\_\_\_ Gender: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Child's DOB: \_\_\_\_\_ Age \_\_\_\_ Gender: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
 Child's DOB: \_\_\_\_\_ Age \_\_\_\_ Gender: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Caregiver's/Parent's DOB: \_\_\_\_\_ Age \_\_\_\_\_ Gender: \_\_\_\_\_  
 Caregiver's/Parent's partner's DOB: \_\_\_\_\_ Age \_\_\_\_\_ Gender: \_\_\_\_\_  
 Partner's relationship to child:  
 \_\_\_\_\_

Primary language spoken at home:  
 \_\_\_\_\_

Ethnicity of caregiver:  
 \_\_\_\_\_

Ethnicity of child/ren:  
 \_\_\_\_\_

Caregiver's marital status:  
 \_\_\_\_\_

Caregiver's highest level of education:  
 \_\_\_\_\_

Caregiver's partner's highest level of education:  
 \_\_\_\_\_

Caregiver's occupation:  
 \_\_\_\_\_

Caregiver's partner's occupation:  
 \_\_\_\_\_

How long you been a foster parent?  
 \_\_\_\_\_

How many children have you fostered?  
 \_\_\_\_\_

How long has/have your current foster child/children been in your care?  
 \_\_\_\_\_

Are the foster children in your care related to each other?  
 \_\_\_\_\_



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**Thank you very much for sharing this information with me so that I can understand you and your child better.**







**Appendix F: Evaluation Questionnaire**

**Evaluation Form (Group A)**

**Fostering Security Training Programme**

It is important that we know how you have found this training programme and we welcome your feedback

**How did you find the programme?** *(Please tick the box(es) that apply).*

	Excellent	Very Good	Good	Poor	Very Poor
The programme overall					
Content					
Presentation					
Venue					
Participant Involvement					

Comments?

.....

.....

.....

**To what extent do you think your personal learning goals have been achieved by this programme?** *(Please circle a number)*

Fully 

5	4	3	2	1
---	---	---	---	---

 Not at all

Comments?

.....

.....

.....

**Thinking about the first module of the programme, on information about attachment problems, the effects of trauma, abuse and neglect, factors affecting long-term foster care, self-care, and self-reflection:**

*(Please circle a number)*

How valuable did you find this module?

Very valuable 

5	4	3	2	1
---	---	---	---	---

 Not at all

Would you say that your knowledge in these areas

decreased	stayed the same	increased
<b>1</b>	<b>2</b>	<b>3</b>

Comments?

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**Thinking about the second module of the programme, on skills and strategies to manage your child’s emotions, mood and behaviour problems:**

*(Please circle a number)*

How valuable did you find this module?

Very valuable 

5	4	3	2	1
---	---	---	---	---

 Not at all

Would you say that your knowledge in these areas

decreased	stayed the same	increased
<b>1</b>	<b>2</b>	<b>3</b>

Comments?

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What did you think of the order in which the modules were presented? Would you have preferred a different order or were you happy with the order?

.....

.....

.....

Suggest a way or ways that this programme could be followed up or improved.

.....

.....

.....

Please comment on the cultural appropriateness of the Fostering Security programme for you, and/or how your needs as a Māori participant were taken into consideration.

.....

.....

.....

.....

Please comment on the co-facilitation of the group by CAFS and CYF staff

.....

.....

.....

Any other comments?

.....

.....

.....

Date: \_\_\_\_\_

Name (optional): \_\_\_\_\_

**Thank You**

**Evaluation Form (Group B)**

**Fostering Security Training Programme**

It is important that we know how you have found this training programme and we welcome your feedback

**How did you find the programme?** *(Please tick the box(es) that apply).*

	Excellent	Very Good	Good	Poor	Very Poor
The programme overall					
Content					
Presentation					
Venue					
Participant Involvement					

Comments?

.....

.....

.....

**To what extent do you think your personal learning goals have been achieved by this programme?** *(Please circle a number)*

Fully 

5	4	3	2	1
---	---	---	---	---

 Not at all

Comments?

.....

.....

.....

**Thinking about the first module of the programme, on skills and strategies to manage your child’s emotions, mood and behaviour problems:**

*(Please circle a number)*

How valuable did you find this module?

Very valuable 

5	4	3	2	1
---	---	---	---	---

 Not at all

Would you say that your knowledge in these areas

decreased	stayed the same	increased
<b>1</b>	<b>2</b>	<b>3</b>

Comments?

.....

.....

.....

**Thinking about the second module of the programme, on information about attachment problems, the effects of trauma, abuse and neglect, factors affecting long-term foster care, self-care, and self-reflection:**

*(Please circle a number)*

How valuable did you find this module?

Very valuable 

5	4	3	2	1
---	---	---	---	---

 Not at all

Would you say that your knowledge in these areas

decreased	stayed the same	increased
<b>1</b>	<b>2</b>	<b>3</b>

Comments?

.....

.....

.....

What did you think of the order in which the modules were presented? Would you have preferred a different order or were you happy with the order?

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Suggest a way or ways that this programme could be followed up or improved.

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Please comment on the cultural appropriateness of the Fostering Security programme for you, and/or how your needs as a Māori participant were taken into consideration.

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Please comment on the co-facilitation of the group by CAFS and CYF staff

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Any other comments?

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Date: \_\_\_\_\_

Name (optional): \_\_\_\_\_

**Thank You**











What, if any, are the things you learned about in the Fostering Security programme that you remember and still think about?

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What, if any, behaviour management strategies or skills to manage you foster child's mood and emotions that you learned about in the Fostering Security programme do you still use?

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What are two things that help you in caring for and parenting your foster child?

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What are two things that make caring for and parenting your foster child more difficult?

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**Thank you very much for sharing this information with me so that I can understand you and your child better.**

## **Appendix H: Remaining Thematic Analysis Themes and Sub-Themes**

- 1) Factors that make foster parenting difficult
  - Difficulties regarding foster child's access with biological family
  - Difficulties with respite
  - System issues with Child, Youth & Family
  - Particular issues affecting grandparents raising grandchildren
  - Financial difficulties related to being a foster parent or whanau caregiver
  - Lack of understanding and negative attitudes of others
  - Caregiver confidence and competence issues
  - Stressful nature of caregiving
  - Difficulties getting help and support
  - Difficulties understanding and managing foster child's behaviour and mood problems
  - Self-care and keeping yourself safe
  
- 2) Factors that help foster parenting
  - Having supportive family, friends and other caregivers
  - Getting the information, support and training needed to understand and manage the foster child
  - Having planned respite
  - Support and acknowledgement from the agencies and services involved
  - Developing an understanding of the foster child's behaviour

- Developing a secure attachment with the foster child
- Regulation of own emotions and behaviour
- Better communication with involvement with the foster child
- Having security about the foster child's permanent placement in the home

**Appendix I: Results from Participants' Evaluation Questionnaires****How did you find the programme?**

	Excellent	Very Good	Good	Poor	Very Poor
Overall	13	9	0	0	0
Content	15	5	2	0	0
Presentation	12	7	3	0	0
Venue	7	7	8	0	0
Participant Involvement	12	6	4	0	0

**To what extent do you think your personal learning goals have been achieved by this programme?**

Fully achieved	8
Mostly achieved	12
Partially achieved	2
Not achieved	0

**How valuable was the psychoeducation and self-care/self-reflection module?**

Very valuable	13
Partially valuable	9
Not valuable	0

**How valuable was the behaviour management and skills training module?**

Very valuable	12
Partially valuable	10
Not valuable	0

