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Development of an Intervention for Foster Parents of Young Foster Children with Externalizing Behavior: Theoretical Basis and Program Description

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Abstract Foster parents are often faced with serious externalizing behaviors of their foster child. These behavioral problems may induce family stress and are related to less effective parenting and often increase. Foster children with behavioral problems are also more at risk of placement breakdown. An intervention to support foster parents of young foster children with externalizing behaviors is necessary to improve the effectiveness of foster placements. Based on research on effective parenting interventions and special needs of foster children, a treatment protocol was developed. This paper describes theoretical foundations for the content and form of the intervention and gives an overview of the modular treatment protocol. Preliminary outcomes of this intervention as well as challenges and future developments and research activities are discussed.

Keywords Foster care · Problem behavior · Intervention · Foster parent

Introduction

In the US as well as in different European countries, interventions to support foster parents of foster children with behavioral problems are being implemented. Reasons for this are the high prevalence of behavioral problems in foster children (Sawyer et al. 2007), the association of foster child's behavioral problems with an increased level of parenting stress (Bastiaensen 2001; McCarthy et al. 2003), a reduced sense of well-being (Whenan et al. 2009) and less effective parenting behavior (Vanderfaeillie et al. 2012b) in foster parents, and breakdown (Oosterman et al. 2007). Breakdown refers to "an unfavorably and prematurely terminated foster care placement" (Strijker and Zandberg 2005, p. 77) and is often detrimental for foster child and foster parents as well as the child welfare system (Vanderfaeillie et al. 2008). In order to prevent placement breakdown, foster parents should be well-prepared and adequately supported. Adequate support has a positive impact on the satisfaction and retention of foster parents (Brown and Calder 1999; Hudson and Levasseur 2002) and can contribute to a decrease in the problem behavior of the foster child (Chamberlain et al. 1992; Fisher et al. 2000b). In this manuscript, we first give a brief overview of the functioning of the foster care system in Flanders (i.e., the Dutch speaking part of Belgium) and argue the need for the development of an intervention for foster parents of foster children with externalizing behaviors. Next, we give a brief overview of internationally existing interventions for foster parents and describe the development of a modified foster parent intervention in Flanders. After the program description, we present some preliminary data about the effects of the intervention. We conclude with some critical remarks and recommendations for further development and research of this intervention.

Need for a Foster Parent Intervention in Flanders?

In Flanders, three governmental agencies subsidize family foster care for minors. In this article, we only focus on foster care, subsidized by the Special Youth Care Agency (SYCA). This is the majority type of foster care (77 %) in Flanders (Pleegzorg Vlaanderen 2011). The children are

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placed either by a Committee for Special Youth Care (voluntary placements) or by court order (compulsory placements) due to a problematic parenting situation in which parents are not capable of guaranteeing the child's safety and well-being. The foster placements aim to protect these children from further harm. The number of placements subsidized by the SYCA increased from 3,781 in 2005 to 4,758 in 2010 (Pleegzorg Vlaanderen 2011), and the proportion of foster children, compared to the total number of children in out-of-home care, increased from 36.5 % in 2005 to 40.7 % in 2010 (Agentschap Jongerenwelzijn 2011). Kinship placements (i.e., placement within the family or social network of the parents or child) are more common (54 %) than non-kinship placements (Pleegzorg Vlaanderen 2011).

An analysis of the influx in Flemish foster care (Vanschoonlandt et al. 2012) showed that children were mostly placed because of circumstances of their parents (79 %, e.g., financial problems, death of a parent) and/or parenting problems (69 %, e.g., limited parenting skills, neglect, maltreatment). Moreover, 45 % of the foster children were not living with their parents at the time of the foster care placement and thus had at least one previous out-of-home placement. Behavioral problems were seldom (11 %) a reason for placement, but were prevalent. However, more than half (51.5 %) of the foster children had internalizing and/or externalizing problems (defined as a borderline or clinical score on the broad-band Child Behavior Checklist scales): 21.6 % had both internalizing and externalizing problems, 16 % merely internalizing, and 13.9 % merely externalizing. This prevalence of behavioral problems is within the range found in international studies (Heflinger et al. 2000; Sawyer et al. 2007).

Foster families are mostly two-parent families (71 %), only 29 % are single foster parents. Slightly more foster mothers (56 %) than foster fathers (44 %) are registered. Foster parents are on average 49 years old (Bronselaer et al. 2011). There are only a very limited number of legal requirements for foster parents: they have to be older than 18 years, have to be in good health, and have a Police Clearance Certificate (Verreth 2009). Foster care agencies have a lot of autonomy in the additional skills/competencies they expect from foster parents. Openness and clearness in communication, collaborating as a team and sharing of parenthood, helping children in changing their behaviors and in developing a positive self-image, and being aware of the impact that fostering might have on their own family life are competencies that are evaluated during selection of non-kinship foster parents in all foster care agencies (De Maeyer et al. 2012). Less is known about the requirements for kinship foster parents. Non-kinship foster parents are also obliged to complete a pre-service training (Verreth 2009). In most foster care agencies, a modified version of the Samenwerking Teamgeest Aspirant Pleegouder (STAP) program[1] [which is similar to the Model Approach to Partnerships in Parenting (MAPP) (Mayers-Pasztor 1987)] is used. In a combination of individual and group sessions, several topics are discussed: motivation to foster, collaboration in foster care, attachment, difficult behavior of foster children, parenting skills, and the impact of foster care on the foster family. Kinship foster parents are not obliged to complete this pre-service training. Foster care agencies screen kinship foster parents before the placement or evaluate kinship placements during the first months of the placement. The criteria for this screening or evaluation are not clearly defined and differ between the different agencies.

Besides the recruitment, selection/screening, and matching of foster child and foster family, the foster care agencies are also responsible for the monitoring of the foster care placements. They organize support for the foster child, optimize contacts with birthparents and family, and coach and train foster parents (Verreth 2009). The only legal criterion is that foster care workers have seven personal contacts a year with the parties involved (foster child, foster parents, and birthparents). A foster care worker is on average responsible for the monitoring of 25 foster care placements (Sprangers 2009). It is thus not surprising that foster care workers do not have more than the, by law, seven contacts with the foster parents, foster child, and biologic parents they monitor. Bronselaer et al. (2011) found that only 40 % of the foster parents had contact at least once a month with their foster care worker. Besides individual counseling, most foster care agencies also offer group training to foster parents (it is not mandatory). Foster care agencies organize, on average, four collective training sessions a year. Bronselaer et al. (2011), however, found that 79 % of the foster parents did not attend any group training during the past 5 years. Flemish foster care agencies thus have limited resources to intensively support their foster parents through their regular casework.

There are, however, indications that more intensive support is necessary in some cases. Firstly, a recent study (Vanderfaeillie et al. 2012b) showed that a considerable group of Flemish foster mothers (10–25 %) were less positively involved with the foster child, taught the child fewer rules, disciplined the child less, and punished the child more inconsistently. Moreover, these authors found that foster mothers, confronted with externalizing behavior of their foster child, became less supportive and used more negative discipline practices. In non-foster children, it has been shown that such negative interactions between child and parent may escalate and generalize to other systems (school, peers), hinder the child from learning adaptive

[1] Collaboration and team spirit for foster parent candidates.

problem-solving skills (Patterson 2002), and lead to anti-social behavior in adolescence (Patterson 2002; Scaramella and Leve 2004). A Flemish study (Vanderfaeillie et al. 2012a) found the same pathways in the foster parent–foster child interaction: foster children's behavioral problems increased when foster parents used more negative control and foster parents had a less supportive relationship with the foster child. On the other hand, foster children's social and emotional adjustment is associated with an authoritative parenting style (Smith 1994). Being positively involved with foster children, teaching them rules and stimulating their autonomy are associated with a decrease in foster children's behavioral problems (Vanderfaeillie et al. 2012a). Supporting foster parents in the parenting of their foster child and in preventing negative interactions with their foster child might thus be a crucial factor in the prevention of foster children's behavioral problems. Secondly, behavioral problems are evident internationally (Oosterman et al. 2007) and in Flanders (Vanderfaeillie et al. 2008), an important reason for the breakdown of the foster care placement. Providing adequate and more intensive support to foster parents can reduce placement disruptions (Chamberlain et al. 1992). A third indication is the interest shown by foster parents in more intensive support. Several international studies showed that foster parents were seeking more support and training about the difficult behaviors they experienced on a day-to-day basis (Hudson and Levasseur 2002; Murray et al. 2011). A Flemish study on the support needs of foster parents (Van Holen 2005) found that 54 % of the foster mothers needed support concerning their foster child's behavior. Lastly, foster parents are currently looking for and receiving extra support in other sectors. Bronselaer et al. (2011) found that 25 % of the foster parents had at least one contact with a mental health service during the past year and 32 % had contacted a parenting support initiative (i.e., general parent education initiatives, not specifically targeting foster parents) during the past year. Referrals to external services are, however, difficult because these services often miss the specific expertise in foster care (Van Holen et al. 2006). Foster parents who attended parenting courses offered by community agencies indicated that the taught techniques were not effective for the behaviors they dealt with (Murray et al. 2011). We therefore decided to develop an intervention specifically for foster parents and which is offered as a foster care service.

Interventions for Foster Parents of Young Foster Children with Externalizing Behaviors

In developing intervention programs for foster parents of toddlers and school-age children, mainly two approaches exist (Oke 2010): adaptations of evidence-based parent training programs for non-foster parents and specifically designed curricula for foster parents.

The first approach relies on well-established treatments in the general population. Effective treatments for disruptive children mostly have a cognitive-behavioral theoretical foundation (Brestan and Eyberg 1998). Examples of evidence-based generic parenting programs are Incredible Years (Webster-Stratton and Reid 2003), Parent Child Interaction Therapy (PCIT; Brinkmeyer and Eyberg 2003), and Parent Management Training Oregon Model (PMTO; Patterson et al. 1975). Common to these interventions are (1) the assumption that children's behavior is a function of the reinforcement (e.g., social attention) and punishment that children receive in daily interactions, mainly from their parents and (2) the goal to establish a shift in these social contingencies such that prosocial behaviors are positively reinforced and aversive behaviors are punished or ignored (Serketich and Dumas 1996).

Some of these interventions have been (adapted and) implemented in foster care, but with only moderate success. McNeil et al. (2005) found that an adaptation of PCIT in a 2-day workshop for foster parents did not reduce the foster child's behavioral problems. Timmer et al. (2006) compared the traditional PCIT with regular parents and foster parents. They found that the training reduced the behavioral problems of the foster child and the parenting stress of the foster parents, but the effects were less than in non-foster children and non-foster parents. Concerning the Incredible Years program, two studies reported a decrease in the foster child's behavioral problems (Bywater et al. 2010; Nilsen 2007), while another other study (Linares et al. 2006) reported no decrease. An implementation of PMTO with foster parents (KEEP: *Keeping Foster and Kin Parents Supported and Trained*) consistently showed positive effects on the behavioral problems of the foster child (Chamberlain et al. 2008), also with urban African-American foster parents (Leathers et al. 2011). In Norwegian foster parents, however, PMTO did not result in a significant decrease in behavioral problems (Jakobsen and Solholm 2009). Reviewing the evidence of (cognitive) behavioral training interventions for foster parents, Turner et al. (2007) conclude that these programs have very little effect on the behavioral problems of the foster child.

Partly because of the shortcomings of generic parenting programs, interventions were especially developed for this target group taking into account the specific needs of the fostering context, mainly from an attachment theory viewpoint (Oke 2010). In these programs, the main focus is psycho-education for the foster parents about attachment in order to understand the foster child's behaviors and to apply the principles of attachment theory in their parenting practices (e.g., creating a positive atmosphere, providing a

secure base, being responsive) (Laybourne et al. 2008). The effectiveness of these programs has not yet been shown: either there was no pre- and post-treatment measurement (Allen and Vostanis 2005; Golding 2004), no decrease in behavioral problems was found (Laybourne et al. 2008), or there were doubts about the reliability of the obtained effects (Golding and Picken 2004). Barth et al. (2005) conclude that there is little empirical evidence for the effectiveness of attachment-based interventions. They are, however, attractive for foster parents because they explicitly refer to the specific vulnerabilities of their foster children and offer an explanation of their behaviors and specific needs (Herbert and Wookey 2007).

In short, several authors suggest that an adaptation of evidence-based interventions to the specific needs of foster parents and foster children may prove successful in this population (Barth et al. 2005; Golding 2007; Rork and McNeil 2011). In the following sections, we describe how such an adaptation was attempted.

Development of an Intervention for Foster Parents

In order to prevent an escalation of disruptive behaviors of foster children, an intervention was developed for foster parents of young children (age 3–12) with externalizing problems. The intervention was limited to this age since most behavioral parent trainings target this age-group (e.g., only 8 out of 69 (11 %) behavioral training programs reviewed by Lundahl et al. (2006) targeted children older than 12 years) and because a meta-analysis of behavioral parent training programs (Maughan et al. 2005) showed the smallest effect size in the age-group 12–16 years. Next, we describe how decisions were made about the content and form of this intervention.

Content of the Intervention

Three elements were decisive in the development of the content (i.e., included parenting skills): important parenting skills from a social-interaction perspective, characteristics of effective parent training programs, and specific characteristics concerning the parenting of foster children.

Coercive behavior (Patterson 2002), the escalation of coercive interactions between child and parent (Snyder and Stoolmiller 2002), and the principles of operant conditioning (positive and negative reinforcement and punishment) are important in the development of disruptive behavior (Forgatch et al. 2004). Since we also found evidence for such an escalation in foster child–foster parent interactions, the core of our program is the enhancement of parenting skills that are believed to alter this process. Patterson (2005) states that five parenting skills are important. *Positive involvement* refers to 'caring about the child'. An important aspect is the time spent with the child. It implies an investment in the relationship with the child (as opposed to withdrawing from interaction) (Peeters 2000). *Positive reinforcement* means that prosocial behavior is encouraged and reinforced. *Problem solving* refers to a constructive way of making decisions/finding solutions. While these first three skills concern stimulations of positive behavior, the fourth skill, *limit setting*, refers to calm and consistently reacting to misbehavior (Peeters 2000). *Monitoring* refers to keeping track of the child's whereabouts and arranging for appropriate supervision (Patterson and Forgatch 1987). It may also take the form of parent-initiated conversations about the child's activities and friends (Laird et al. 1994).

For a further elaboration of how these skills should be addressed, research about key ingredients of effective interventions was consulted. Kaminski et al. (2008) conducted a meta-analysis and identified several components that were associated with more effective programs. They found that interventions were more effective when attention was paid to: increasing positive parent–child interactions (e.g., teaching parents to be enthusiastic, to give positive attention to positive behavior), teaching emotional communication skills to parents (e.g., active listening, helping the child in recognizing and dealing with emotions, decreasing negative communication (such as criticism, sarcasm)), the importance of consistency (i.e., responding every time to a particular misbehavior with the same consequence), and the use of time-out. These components were integrated in the program. Increasing positive parent–child interactions (by introducing a daily playtime) and teaching communication skills (active listening, I-messages) were added as ways to increase positive involvement. Helping the child recognizing emotions was included as a step in the problem-solving skills. The importance of consistency and the use of time-out were already included as part of limit setting skills. Wells (1997) showed that parent training programs that combine a positive approach with effective limit setting are the most effective. Most program developers first focus on this positive approach and first teach parents to interact in a positive way with their child, because strict limit setting is only effective in an accepting and warm relationship (Pearl 2009). Moreover, it avoids the overuse of punishment instead of reinforcing positive behaviors (Bosch and Seys 1998). This order was maintained in our intervention.

A last input was the literature about the specific needs of foster children. Bowlby (1969) demonstrated the importance of a close relationship of a child with his/her caregiver(s) as a basis for developing a sense of confidence in themselves and others. Foster children's biological parents were often not sufficiently available. Moreover, a foster placement implies a breakup of the relationship with the parents. Based on these

negative experiences, children may develop behavioral strategies, such as aggression or withdrawal, to deal with the unavailability of the caregiver (Ainsworth et al. 1978). Furthermore, children may develop a persistent image of the world characterized by mistrust and insecurity (Bartholomew and Horowitz 1991). From this attachment perspective, foster children may be more likely to be suspicious when the foster parent attempts to provide a secure base (Schofield and Beek 2005). Foster children may act as if they do not want foster parent's care/involvement (Tyrrel and Dozier 1999). To meet the specific needs of foster children, Schofield and Beek (2005) developed a parenting model with five important parenting skills. *Promoting trust in availability* of the foster parent is the first skill. This can be done by giving the child small verbal and nonverbal signals that the foster parent is available and trustworthy. Also, a good structure and clear expectations of the foster parents can promote this (Dozier et al. 2002). *Promoting reflective function* is the second skill. Foster parents who are able to understand their foster child's problem behaviors from his/her history and specific needs can better cope with these behaviors (Schofield and Beek 2005). Concerning this issue, Wilson (2006) stresses the importance of not interpreting this behavior as a personal attack on the foster parents. The third skill, *promoting self-esteem* implies that foster parents show their foster child that he/she is accepted and appreciated for who he/she is (independent of his/her behavior), by praising him/her and giving affection. This may be difficult when foster children display provocative behavior or reject affection. *Promoting autonomy* is the fourth skill and is done by giving the child opportunities for exploration, offering choices, and supporting exploration (finding a good balance between the child's efforts and active encouragement by the foster parent). The last skill is *promoting family membership.* Foster parents can express in different ways that the child is a full family member (e.g., by family rituals, giving certain household duties). At the same time, they should acknowledge the child's belonging to their birth families (by giving the message that both sets of relationships are to be valued). In our opinion, these skills are not fundamentally different from the skills usually included in parent training programs. This overview, however, prompted us to put more emphasis on some specific aspects. Firstly, concerning positive involvement, psycho-education about the influence of a foster child's history on his/her behavior (from an attachment perspective) was added. We believed this would make it easier for foster parents to keep investing in the relationship with the foster child (even if the child rejects involvement). The ways of showing involvement (e.g., nonverbal praise, indirect praise) should be adjusted to a level that the foster child can accept. Secondly, being predictable was already included in the program by focusing on consistent limit setting. More emphasis was, however, given to this skill by teaching foster parents how they could provide more structure and how they could express clear expectations. Thirdly, concerning monitoring, we added the importance of finding a balance between autonomy and support. Lastly, the importance of expressing family belonging was stressed more by exploring ways of doing this throughout the whole intervention (e.g., introducing the same sleeping ritual for all (both biologic and foster) children, putting the foster child's drawings on the refrigerator together with drawings of the biological children).

Form of the Intervention

Decisions had to be made about format (group and/or individual), trainers, and conception of the intervention.

Most of the foster parent interventions reviewed above use a group training format. Leathers et al. (2011) provided a group training with the possibility of home visits when foster parents could not attend group sessions. Timmer et al. (2006) provided only individual sessions. We opted for a mainly individual home visiting format. Reasons for this choice were (1) Flemish foster parents are used to home visits by foster care workers. Moreover, they rarely attend group sessions, organized by foster care agencies (Bronselaer et al. 2011); (2) a home visiting format enables reaching difficult-to-reach families since it removes important barriers to service access (e.g., transportation, costs for child care) (Weiss 1993); (3) Hampson et al. (1983) showed that home trained foster parents reported more improvement in foster child's behavior than foster parents receiving the same training in group; (4) a home-based approach enables practicing of the new skills in real situations. Interventions that include more active practice of parenting skills are more effective (Kaminski et al. 2008). Dorsey et al. (2008) state that interventions that offer foster parents coaching and feedback on skill implementation are promising; and (5) foster parents' suggestions for improvements in group formats are providing them close at hand and at more convenient times and giving more specialist advice on individual problems (Herbert and Wookey 2007). These drawbacks of group sessions can be met by individual home visits. We decided to teach and practice skills for managing the foster child's problem behaviors during individual home visits. We were, however, also aware of the benefits that foster parent groups offer. Qualitative research about the support needs of foster parents shows that foster parents feel the need to share their experiences with other foster parents (Brown 2008; MacGregor et al. 2006). Participants of foster parent group training stress the benefit of realizing that they are not alone in experiencing difficulties (Holmes and Silver 2010) and feeling less guilty (Laybourne et al. 2008). We therefore decided to also organize monthly group sessions

where foster parents can share their experiences and support each other. Several measures were taken to lower the threshold for joining group sessions: costs for a babysitter are refunded, traveling expenses are paid, and the location of the group session is determined in consultation with the foster parents (e.g., it can be organized at a foster parent's home).

Decisions had to be made about the type of trainers and their position. Concerning the type of trainers available, we had the option of experienced therapists in parent management training. We, however, decided to select experienced foster care workers and provide them with a 3-day training in this intervention. We wanted the trainers to have expertise in foster care because they are aware of the specific needs of foster children and take these into account when delivering the program. Also, their familiarity with all the aspects of foster care (e.g., visits to birthparents, court appearances) would enable them to establish a good collaboration with foster parents, foster care workers, and other parties involved. Taking into account that foster care workers have a high caseload (Swann and Sylvester 2006) and multiple tasks (e.g., service planning, contacts with birthparents, collateral contacts, court hearings (Unrau and Wells 2005)), we found it not feasible to provide the program as part of the regular foster care work. We thus decided to train three foster care workers and exempt them from their regular foster care work. The position of the trainer is thus one of a provider of an extra service within the foster care system. The trainers support foster parents using our protocol, while the regular foster care worker stays responsible for the other aspects of the foster placement. This approach has a few advantages: (1) the trainer can solely focus on the behavioral problems of the child, giving the regular foster care worker more time to focus on other aspects of the foster placement (e.g., contacts with birthparents); (2) within the foster parents–foster care worker relationship problems may have occurred (e.g., disagreement on goals, misunderstanding the foster parents, inappropriate interventions) that caused a therapeutic impasse (Hill et al. 1996). This can lead to avoidance of direct confrontation or a failure to be open to the multiple realities in a given situation (Rober 2005) and thus to "stuck" therapeutic systems (Andolfi and Haber 1994). Introduction of new perspectives and reflecting on the situation with outsiders can be a way out of the impasse. The trainer, who is new to the foster care placement, can offer both foster parents and foster care workers a new perspective on their situation and can thus lead to a new dynamic; and (3) the trainer is not responsible for evaluating the foster placement. The monitoring of the placement and reporting to the Youth Court or the Committee for Special Youth Care stays the responsibility of the foster care worker. In working with their foster care worker, foster parents are often reluctant to reveal doubts and personal stress because they fear criticism or being perceived as incompetent (Morrissette 1994). Making it clear to the foster parents that the trainer is never involved in an evaluation of a foster placement may make it easier for them to openly discuss problems.

This position of the trainer, however, also involves some pitfalls: (1) the trainer visits the foster parents weekly while personal contacts with the foster care worker are generally less frequent. This entails the risk that foster parents also want to discuss other urgent issues with the trainer (e.g., a recent conflict with birthparents). It is therefore important to make concrete agreements about tasks and responsibilities of both parties (this is done during the joint intake with the foster care worker) and to act upon these agreements and (2) foster care workers received no training in this intervention and are not able to visit foster parents weekly. Foster parents might, thus, be disappointed in the amount/quality of support offered by the foster care worker after the intervention. Several measures were taken to prevent this: Firstly, during the last training session, foster parents are offered a plan for dealing with future problems. Secondly, the intervention ends with a joint session where the regular foster care worker gets information about the most helpful skills/techniques the foster parents learned. Thirdly, for every module foster parents receive a brochure summarizing the key points. Foster care workers can use this information to further support the foster parents. Lastly, foster parents can continue to participate in the group sessions (even after the intervention has ended) where they can discuss their problems with the trainer and other foster parents.

Given the fact that the trainers had no experience with the intervention program and given their sometimes difficult position, we thought it necessary to provide 2-weekly supervision sessions. Supervisions are important to assess, and if necessary, adjust treatment delivery (Moncher and Prinz 1991) to ensure treatment integrity. During these supervision sessions, all trainers, as well as the developers of the intervention, discuss issues such as how to create a reward program, how to motivate foster parents to implement certain techniques, how to deal with foster parents who want to discuss other issues, how to adjust the training to the level of the foster parents (e.g., low-educated foster parents), and how to deal with common problems (e.g., lying, eating problems).

A last aspect we had to decide upon was the conception of the training. In this regard, it is important to be aware of the special position of foster parents. Firstly, foster parents are screened (in the case of kinship placements) or selected (in the case of non-kinship placements) and therefore thought to be good caregivers (Nilsen 2007). Secondly, foster parents may have proven to be skilled parents in raising their own children (Nilsen 2007). Thirdly, foster parents are often

considered partners in a professional relationship (Fisher et al. 2000a). This position of foster parents makes it difficult for them to admit they experience problems (Van den Bergh and Weterings 2010) and to explicitly ask for support (Maaskant 2010). Nilsen (2007) states that a parenting intervention for foster parents "should be framed as a specialized training to develop expertise specific to foster care and not as a method of enhancing one's own caregiving skills". Maaskant (2010) suggests that offering the training as an extra service of the foster care agency is the best approach. Several measures were taken to meet this special position of foster parents. Firstly, the intervention is imbedded as an extra service in the foster care system. The program developers visited all foster care agencies to inform the foster care workers about the intervention. Sixteen out of the seventeen foster care agencies decided to participate by enrolling foster parents. Within these agencies, a screening procedure was set up for all new foster placements. At the start of a placement, the foster parents are informed that an extra service could be offered when their foster child demonstrates externalizing behaviors and they are told that they will be screened for enrollment during the fourth month after the start of the placement. By introducing the screening for enrollment as a routine foster care service, we aim to avoid a situation where foster parents of new placements feel they have failed when the intervention is offered to them. If the foster parents are eligible for enrollment (see further), the foster care worker motivates them to participate. For longer lasting placements, the foster care worker informs his/her foster parents about this extra service and motivates foster parents who experience problems in handling their foster child's behavior to participate. All information about this intervention thus runs through the regular foster care worker, who is also present at the intake (see further) and thus offers it as an extra service. Secondly, the intervention is conceptualized as a specialized training in adapting parenting skills to meet the specific needs of foster children. This is done by choosing experienced foster care workers as trainers and depicting them as experts in foster care. During the intervention, the trainers treat the foster parents as partners in the care of the child. Foster care workers are also asked to communicate about the intervention as a specialized training and to emphasize the professionalism of foster parents and the specific needs of foster children when informing foster parents about the intervention.

Program Description

The intervention is offered to foster parents of foster children aged between 3 and 12 years who have a borderline or clinical score on the externalizing small-band scales or the externalizing broad-band scale of the Child Behavior Checklist (CBCL). Exclusion criteria are foster child has a mental retardation or autism or uses psychotropic medication in an inconsistent way, behavioral problems are the result of medical problems or medication, foster parents have a mental/psychological disability, and foster parents are involved in a divorce.

The intervention *starts* with a joint intake with trainer, foster parents, and foster care worker. Objectives are gaining insight into the needs and strengths of the foster family (from both foster parents' and foster care worker's perspective), setting treatment goals, making agreements about cooperation between trainer and foster care worker and psycho-education about coercive interactions and principles of behavior modification. During the next eight (to maximum 13) individual sessions (*training phase)*, trainer and foster parents work on the treatment goals. During this phase, 2 monthly group sessions are also organized. When a group session takes place, no individual session is offered. The intervention *end*s with a joint session with the foster care worker. He/she gets an overview of the progress made by the foster parents (with special attention to what worked for them) and how the foster care worker can help foster parents maintain these changes. The intervention takes about 4 months. As a *follow-up,* one group session is organized 1 month after the intervention.

The individual training phase has a modular design that enables an individual tailoring of the intervention to address the foster child's and foster parents' needs. Some modules are mandatory; others are facultative and should only be used when indicated. Guidelines about the use of these modules (e.g., sequence, when to offer facultative modules) are included in the treatment protocol.

As displayed in Fig. 1, the intervention starts with a positive approach: enhancing the quality of the foster parent–foster child relationship and creating a positive atmosphere. The module *'positive involvement'* involves psycho-education about the need of foster children for warmth and acceptance from their foster parents. It is stressed that foster children may not always show this need. Possible aggressive or rejecting behavior is framed within the child's history. Emotional communication skills (e.g., active listening, using I-messages) are discussed and practiced. As a homework assignment, foster parents are asked to introduce a daily 10-min play activity. Having a fun and positive interaction is the main purpose. Because it is a time-limited and routine activity, it may be more feasible to do for both foster child and foster parent. The module *'praising'* deals with focusing on positive behavior of the foster child and encouraging him or her (e.g., by giving verbal praises). Because not all foster children may accept direct verbal praises, trainer and foster parents search for praises that are acceptable for this foster child (e.g., nonverbal praise, indirect praise). The next two

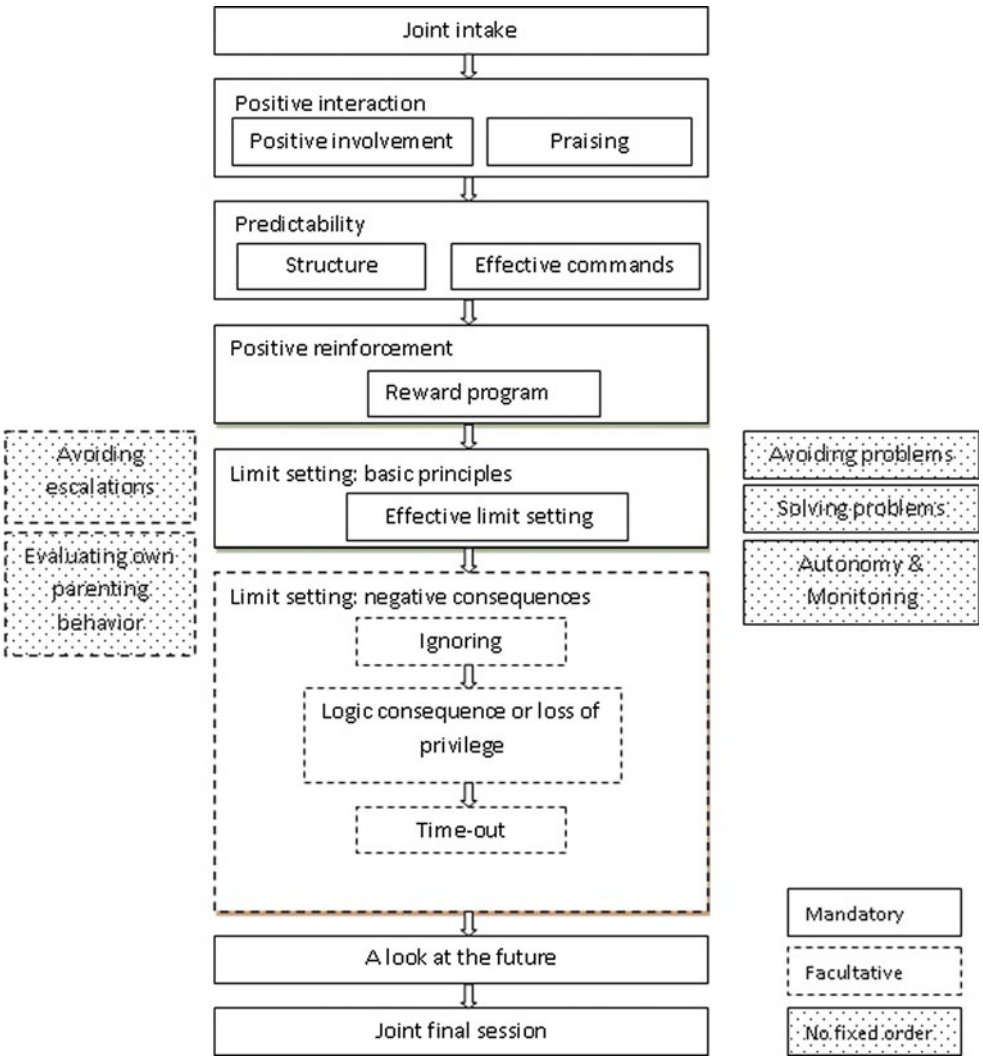

Fig. 1 Overview modular design individual sessions

modules deal with creating predictability and clear expectations. In the module *'structure'*, psycho-education is given about how a good structure and clear expectations give foster children a sense of safety. The trainer looks, with the foster parents, for ways to make their expectations clearer (e.g., formulating household rules) and for ways to increase the predictability (e.g., introducing family routines). The module *'effective commands'* deals with communicating expectations in an effective way (e.g., short, direct commands). By giving effective commands, the chance that the foster child obeys increases (which may also lead to more positive interactions). At this point in the program, we anticipate the child already shows more positive behavior and that negative foster child–foster parent interactions have decreased. For the realization of some specific treatment goal behaviors, more actions may be needed. In the module *'reward program'*, tangible rewards are given for behaviors that have increased insufficiently. The reward program ensures a consistent positive reinforcement and thus increases this behavior. It is only after this positive approach that we handle how to deal with misbehavior. The module *'effective limit setting'* provides psycho-education about the basic principles (being consistent and calm) and specific strategies for reacting to misbehaviors: ignoring, disapproving, logical consequence (e.g., turning off the TV when fighting over it), and loss of privilege (e.g., not allowing a computer game to be played). Depending on the specific problem behaviors of the foster child, a more elaborate discussion of effective limit setting can be done by offering one or more of the following facultative modules. Each of these modules focuses on one specific technique to decrease specific remaining problem behaviors. The module *'ignoring'* is discussed when foster parents often react (and thus give a lot of attention) to behaviors that could be ignored (i.e., frequently occurring mild misbehaviors such as whining). For misbehaviors that cannot be ignored (e.g., aggressive or destructive behavior), foster parents are instructed to react consistently with a specific negative consequence (module *'logical consequence/loss of privilege'*). Foster

parents also inform their foster child about this approach. The module *'time-out'* is used for preventing escalation by foster child and foster parents. Putting the child in time-out for specific aggressive or destructive behavior before the situation escalates offers foster parents an alternative to shouting or hitting, for example, as well as allowing the child the chance to calm down.

The sequence of the above mentioned modules is fixed (main focus on positive approach, selective use of negative consequences). The remaining modules have no fixed order and can be offered once the module 'reward program' has been offered. The module *'avoiding problems'* mainly deals with increasing the predictability of difficult situations (e.g., play dates, visits to the supermarket). Foster parents learn to plan these situations in advance and communicate clearly which behavior is expected and the consequences for positive behavior and misbehavior. They also help the foster child to think of fun things to do during these activities. The module *'problem solving'* provides psycho-education about a constructive, stepwise problem-solving process (defining the problem, brainstorming solutions, making a plan, executing the plan, and evaluation) and teaches the foster parents how they can help their foster child in solving problems. Since emotion regulation may be difficult for foster children, foster parents are offered tools to help their foster child in recognizing and expressing emotions. The module *'autonomy and monitoring'* provides psycho-education about the importance of this parenting skill and offers tools to monitor young children's behaviors (e.g., asking concrete questions, checking if the child does what he/she is expected to do). Since lack of autonomy may also occur, foster parents are assisted in finding a good balance in providing safety/control and stimulating autonomy (e.g., giving more responsibilities, asking the foster child's opinion).

Throughout the intervention, the trainer pays attention to the opinion of foster parents and possible resistance against certain skills/strategies (e.g., praising, reward program, time-out) or specific difficulties for foster parents. It may, however, be necessary to discuss foster parents' experiences more explicitly to bring about change or to enhance their reflective function. For this purpose, two modules can be used. The module *'avoiding escalations'* provides psycho-education about coercive processes. The trainer also explores what makes it difficult for foster parents to avoid escalations (e.g., specific emotions, expectations) and what can help them to prevent escalations (e.g., relaxation). In the module *'evaluating own parenting behavior'*, foster parents are encouraged to critically reflect on their own parenting values and behaviors (e.g., influence of own parenting history on their values) in order to decrease resistance or help them maintain a certain approach.

The module *'a look at the future'* is always treated in the session before the joint final session with the foster care worker. The trainer offers the foster parents a plan for dealing with future behavior problems and tips for maintaining changes. Trainer and foster parents also prepare the transfer to the foster care worker.

Preliminary Outcomes of the Intervention

The Flemish government subsidizes the implementation and evaluation of the intervention. For the evaluation, a randomized controlled trial (RCT) is used. By randomization, participating foster parents are assigned to an intervention or control group (i.e., care-as-usual). Control families also receive the intervention after the data collection for the RCT is finished (i.e., 7 months after enrollment). This RCT commenced in January 2011 and runs until January 2013. The first report on the results of this RCT is expected in the second half of 2013. In this paper, we report on the first 22 foster families who received the intervention as to determinate early findings associated with our approach.

Enrollment of Participants

New foster placements are compulsorily screened 4 months after the start of the placement (i.e., foster parents complete a Child Behavior Checklist (CBCL 1.5-6/6-18; Achenbach and Rescorla 2000, 2001), and foster care workers complete a questionnaire about the exclusion criteria). The results of this screening are consequently discussed with the foster care workers. The foster care workers inform the foster parents whether they are eligible and motivate them to participate. Since enrollment of participants is still ongoing, we have no final data about response rate. Until now, 78 % of the foster parents of new placements filled out the CBCL, of which 25 % fit the enrollment criteria. Sixty-four percentage of the eligible foster parents enrolled. Foster care workers can also fill out a screening questionnaire for foster parents of longer ongoing foster care placements. If foster parents fill out the questionnaire and foster parents are eligible for enrollment, they can also participate in the project.

Design and Instruments

Development of Foster Child's Externalizing Problems and Foster Parents' Parenting Stress

A pretest, posttest design was used to examine the development of foster child's externalizing behaviors and foster parents' parenting stress in the group of foster families who received the intervention. Foster mothers filled out a questionnaire before the intervention and immediately after

the intervention. We did not survey foster fathers in order to limit the burden of data collection for foster parents.

The foster child's behavioral problems were measured with the CBCL and the foster parents' parenting stress with the Nijmeegse Vragenlijst voor de Opvoedingssituatie (NVOS-Nijmegen Questionnaire regarding child-rearing circumstances; Robbroeckx and Wels 1996). The NVOS consists of 28 items concerning the burden parents experience in raising their child. Four subscale scores can be calculated for which norms are available: not feeling able to cope, experiencing problems in parenting the child, experiencing the child as a burden, and desiring changes. These four subscales load on one factor, defined as 'parenting stress'.

The effects of the intervention on case level were examined by the Reliable Change Index (RCI). This statistic is calculated by dividing the change in pretest and posttest scores by the standard error of the differences for the used measures (Jacobson and Truax 1991). An RCI of at least 1.64 demonstrates that the change in pretest and posttest scores is statistically significant (Veerman 2008). A significant decrease in externalizing problems is defined as a RCI $\geq$ 1.64 for the Externalizing scale of the CBCL. A decrease in parenting stress is defined as a RCI $\geq$ 1.64 for at least two (of the four) subscales of the NVOS.

Client Satisfaction

At the end of the intervention, both the foster mother and the regular foster care worker filled out a client satisfaction questionnaire (BEoordelingsSchaal Tevredenheid en Effect (BESTE; Rating Scale for Satisfaction and Effect); De Meyer et al. 2004). Foster mothers and foster care workers indicated whether the intervention led to improvements in the foster child's behavior, the functioning of the foster family, the foster parents' parenting behavior, and the foster parents' understanding of the child's behaviors. They also indicated their opinion on the duration of the intervention and whether they would recommend the intervention to other foster parents.

Treatment Fidelity

Trainers kept a log of recorded contacts/actions. They also registered the degree of implementation of new skills by the foster parents.

Results

Since the start of the project, 22 families have participated in the intervention. One foster family did not complete the intervention because of multiple deaths in the family and social network during the training. One foster family, who completed the intervention, did not fill out the post-treatment questionnaire. The results of the remaining 20 foster families are discussed below.

Treatment Fidelity

The mean duration of the intervention (without follow-up session) was 3.4 months (Min = 2, Max = 6, *SD* = 1.19). During this period, foster parents had on average 10.3 individual sessions with the trainer (including intake and joint final session with the foster care worker) (Min = 9, Max = 13, *SD* = 1.08). The group sessions occurred less often than planned. Only 35 % of the foster families joined at least one group session during the individual training phase. Only 20 % of the foster families joined the follow-up group session. Concerning the treatment fidelity during the individual sessions, we found that most of the mandatory modules were discussed by the trainer with the foster parents (see Table 1). Only the modules 'avoiding problems', 'solving problems', 'autonomy & monitoring', and 'a look at the future' were not discussed with all foster parents. None of the facultative modules seemed unnecessary; all of these were discussed with at least half of the foster parents.

Data on the implementation of techniques by the foster parents showed that all the foster parents combined a positive approach (with positive involvement and praising),

Table 1 Overview of treatment fidelity and implementation by foster parents

Module	Discussed with the foster parents (%)	Implemented by the foster parents (%)
Mandatory		
Positive involvement	100	100
Praising	100	100
Structure	100	90
Effective commands	100	100
Reward program	100	75
Effective limit setting	100	90
Avoiding problems	75	40
Solving problems	90	20
Autonomy and monitoring	85	60
A look at the future	85	n/a
Facultative		
Ignoring	90	75
Logic consequence/ loss of privilege	90	40
Time-out	70	45
Avoiding escalations	50	n/a
Evaluating own parenting behavior	70	n/a

with predictability (structure and effective commands) and effective limit setting. More systematic changes in positive (reward program) and negative consequences (ignoring, logic consequence/loss of privilege, or time-out) of desired and unwanted behaviors were not always implemented by foster parents. The techniques of avoiding problems, solving problems, and finding a balance between monitoring and stimulating autonomy were implemented by a limited number of foster parents.

Development of Foster Children's Externalizing Problems and Foster Parents' Parenting Stress

Table 2 displays the significant changes in both dependent variables.

We found a very positive outcome in four families (significant decrease in both behavioral problems and parenting stress) and a positive outcome in ten families (decrease in behavioral problems only in seven families and decrease in parenting stress only in three families). In five foster families, no effect was found (no significant change in behavioral problems or parenting stress), and in one case, a negative effect was found (a significant increase of behavioral problems and parenting stress).

Client Satisfaction

Table 3 displays foster parents' (FP) and foster care workers' (FCW) judgments about the improvement on the different domains. For all four domains, the majority of foster parents and foster care workers reported that it improved at least some.

Moreover, all of the foster parents indicated that they would probably (4) or definitely (16) recommend this intervention to other foster parents. Also, all the foster care workers who filled out the questionnaire indicated they would recommend this intervention (4 probably, 14 definitely). The foster parents' and foster care workers' opinion about the duration of the intervention is displayed in Table 4. A significant number of foster parents and foster care workers indicated the intervention was too short.

Discussion

Foster parents are often faced with externalizing behaviors in their foster child. Because foster parents are not always well-prepared to address these problem behaviors, they are a robust predictor for breakdown in the placement. Furthermore, coercive interactions between foster child and foster parents may lead to antisocial behavior of the foster child in adolescence. For an improvement in the effectiveness of foster care (with respect to continuity and short- and long-term outcomes for foster children), foster parents of foster children with externalizing behaviors should be supported in dealing with/decreasing these behaviors. Given the small effect of standard behavioral training interventions for foster parents (Turner et al. 2007) and the possible added value of an attachment perspective in working with foster parents (Oke 2010), we decided to develop a modified foster parent intervention. We only included those behavioral training components that proved to be important in meta-analyses, reviewed literature on the specific needs of foster children and adjusted the intervention to these needs and the specific foster care context of Flanders. Concerning the content, developing/maintaining a positive relationship with the foster child is an important focus of the intervention. Psycho-education about attachment enables the foster parents to understand behaviors of their foster child and to keep investing in the foster child (who may be rejecting them). Furthermore, foster parents create a more predictable environment for their foster child and apply behavior management skills to increase desired behavior and decrease misbehaviors. The analysis of the techniques used by foster parents indeed showed that they combine a positive approach with predictability and effective limit setting. As the program developers intended, there was limited use of negative consequences for unwanted behaviors. More general parenting skills were also included in the program because the developers thought they would be of value in working with foster parents and foster children. Increasing predictability in difficult situations could avoid problems. Helping children in recognizing their emotions and solving problems could increase

Table 2 Overview of significant changes in foster children's externalizing behavior and foster parents' parenting stress

	Parenting stress (at least two of four scales)		
	Decrease RCI > 1.64 (%)	No change $1.64 \geq$ RCI ≥ -1.64 (%)	Increase RCI < -1.64 (%)
Externalizing problems			
Decrease RCI > 1.64	4 (20)	7 (35)	
No change $1.64 \geq$ RCI ≥ -1.64	3 (15)	5 (25%)	
Increase RCI < -1.64			1 (5)

Table 3 Results of foster parents' and foster care workers' satisfaction questionnaire

Did this intervention have an effect on	Got worse	Didn't change	Improved some	Improved a lot	Missing
The foster child's behavior?					
FP	1	0	9	10	
FCW	0	1	9	6	4
Functioning of the foster family?					
FP	0	2	8	9	1
FCW	0	1	12	5	2
Foster parents' parenting behavior?					
FP	0	0	7	13	
FCW	0	0	10	7	3
Foster parents' understanding of the foster child's behaviors?					
FP	0	1	5	14	
FCW	0	2	5	10	3

Table 4 Foster parents' and foster care workers' opinion about the duration of the intervention

What do you think about the duration of this intervention?	Too short	Good duration	Too long	Missing
Foster parents	6	11	1	2
Foster care worker	7	7	0	6

foster children's emotion regulation and problem-solving skills. Finding a balance between stimulating autonomy and monitoring may be difficult in parenting foster children who had become too independent or whose parents had been over-involved. Only a limited number of foster parents, however, implemented these skills. Further exploration of the experiences of trainers and foster parents and further data analyses should give more insight into the importance of these modules.

Concerning the format of the intervention, the role of foster parents as paraprofessionals prompted us to provide the training as an extra service of the foster care agency, offered by an experienced and trained foster care worker. Informing foster parents about this extra service from the start of the placement and introducing a routine screening for enrollment proved to be an effective method. In our opinion, this approach induces less feelings of failure when foster parents are asked to participate in the training. In motivating foster parents of longer ongoing placements to participate, it was decided to conceptualize the intervention as a specialized training in adapting parenting skills to meet the specific needs of foster children and to approach the foster parents as partners (instead of clients). Moreover, our trainers were experienced foster care workers who were familiar with all the aspects of foster care and who knew the specific needs of foster children and foster parents. In our opinion, this foster care expertise made it easier to collaborate with the regular foster care worker (and other parties involved). Lastly, we chose a mainly home visiting format. This approach enabled us to also include difficult-to-reach foster parents, to take into account the home environment in implementing certain techniques (e.g., time-out) and to tailor our service to the busy schedules of foster parents. The fact that only one foster parent dropped out during the intervention suggests the intervention is feasible for foster parents.

The preliminary results of the intervention are promising. Teaching foster parents to be positively involved and to implement behavioral management skills led to a reduction in externalizing behaviors in several foster children and parenting stress in some foster parents. Even foster families where no statistically significant differences were found reported improvements in the satisfaction questionnaire and showed (although statistically not significant) improvements on the pre- and post-treatment measurements. However, since no comparisons were made with a control group, no conclusions about the efficacy of the intervention can be made at this time. Currently, an RCT is being conducted with the goal of including 60 foster families (30 interventions and 30 control groups). Foster mothers complete questionnaires at enrollment, when terminating the intervention (4 months later) and again 3 months later (7 months after enrollment). Breakdowns in placement during this period are also registered for both groups. Only when the RCT is finished, we will be able to make more sound conclusions about the short- and

longer-term effectiveness of the intervention. The results of the RCT will determine the further development and implementation of this intervention.

However, we have already learned much. For example, we found that an important group of foster parents and foster care workers indicated that the duration of the intervention was too short. In some cases, a longer intervention might be indicated (e.g., foster parents who find it difficult to implement the different skills may need more time to change their parenting approach). In addition, it might be necessary to offer individual follow-up sessions instead of follow-up group sessions since as few of our families participated in them. Furthermore, foster parents who can rely on their foster care worker after the intervention in accordance with the techniques and skills taught during the intervention might possibly be more satisfied with the duration of the intervention. However, this implies that all foster care workers are trained in the intervention. This was not yet possible during the RCT due to the risk of contamination in the control group. If the intervention proves to be effective, we, however, plan to train all foster care workers, so they could provide appropriate ongoing help and advice. Furthermore, this general training for foster care workers may contribute to the professionalism of the social workers since they can use parts of the training in other foster families.

Another element to consider during evaluation and further development of the intervention is the fact that the two paradigms (behavior management and attachment) may call for different reactions on certain behaviors of foster children. From a behavioral perspective, for example, children are best placed in time-out when having a tantrum; from an attachment perspective, however, closeness of the foster parent is advised (Oke 2010). Pithouse et al. (2002) also state that behavior management techniques may have a varied impact on foster children, depending upon their history (e.g., sexual abuse). Certain techniques may, thus, have unwanted effects for (some) foster children. Our trainers carefully monitor the effects of behavioral management techniques on the foster child during the intervention. Based on the experiences of our trainers and a study of moderating factors, we hope to gain more insight into this important matter.

In sum, an increased emphasis on evidence-based practice and an increase of foster care placements call for an effective intervention for foster parents of children with externalizing behaviors to make foster care (more) effective. Adapting evidence-based interventions to the specific needs of foster children and foster parents may be a successful approach for this population. Based on the results of our study, we hope to gain more insight into the development and implementation of an effective foster parent intervention.

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References

Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for Aseba preschool forms & profiles*. Burlington: ASEBA.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the Aseba school-age forms & profiles: child behavior checklist for ages 6–18*. Burlington: ASEBA.

Agentschap Jongerenwelzijn (2011). *Evolutie van het aantal begeleide jongeren naar begeleidingsjaar en soort voorziening*. Resource document. http://wvg.vlaanderen.be/jongerenwelzijn/PDF/OB_Cijfermateriaal/kerncijferrapporten2011/evolutie_7.pdf. Accessed 6 June 2012.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: Assessed in the strange situation and at home*. Hillsdale, NJ: Erlbaum.

Allen, J., & Vostanis, P. (2005). The impact of abuse and trauma on the developing child. An evaluation of a training programme for foster carers and supervising social workers. *Adoption and Fostering, 29*(3), 68–81.

Andolfi, M., & Haber, R. (1994). *Please help me with this family: Using consultants as resources in family therapy*. Philadelphia, PA: Brunner/Mazel.

Barth, R. P., Crea, T. M., John, K., Thoburn, J., & Quinton, D. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based intervention with foster and adoptive families in distress. *Child and Family Social Work, 10*, 257–268.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young-adults: A test of a 4-category model. *Journal of Personality and Social Psychology, 61*, 226–244.

Bastiaensen, P. (2001). *Belaste pleegouders en verscheurde pleegkinderen? Onderzoek naar de wijze waarop pleegouders de opvoedingssituatie beleven en pleegkinderen de relatie met het pleeggezin en het gezin van oorsprong beleven*. Zundert: Vorsselmans.

Bosch, J. D., & Seys, D. M. (1998). Mediatietherapie en operante technieken bij ouders, leerkrachten en in de residentiële setting. In P. J. M. Prins & J. D. Bosch (Eds.), *Methoden en technieken van gedragstherapie bij kinderen en jongeren* (pp. 51–88). Houten: Bohn Stafleu.

Bowlby, J. (1969). *Attachment and loss, Vol. 1: Attachment*. New York: Basic Books.

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5272 kids. *Journal of Clinical Child Psychology, 27*, 180–189.

Brinkmeyer, M. Y., & Eyberg, S. M. (2003). Parent-child interaction therapy for oppositional children. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidenced-based psychotherapies for children and adolescents* (pp. 204–223). New York: Guilford.

Bronselaer, J., Vandezande, V., & Verreth, K. (2011). *Vlaamse pleegzorgers in beeld*. Brussel: Koning Bouwdewijnstichting.

Brown, J. D. (2008). Foster parents' perceptions of factors needed for successful foster placements. *Journal of Child and Family Studies, 17*, 538–554.

Brown, J., & Calder, P. (1999). Concept-mapping the challenges faced by foster parents. *Children and Youth Services Review, 21*, 481–495.

Bywater, T., Hutchings, J., Linck, P., Whitaker, C., Daley, D., Yeo, S. T., et al. (2010). Incredible years parent training support for

foster carers in Wales: A multi-centre feasibility study. *Child: Care, Health and Development, 37*, 233–243.

Chamberlain, P., Moreland, S., & Reid, K. (1992). Enhanced services and stipends for foster parents: Effects on retention rates and outcomes for children. *Child Welfare, 71*(5), 387–401.

Chamberlain, P., Price, J., Leve, L. D., Laurent, H., Landsverk, J. A., & Reid, J. B. (2008). Prevention of behavior problems for children in foster care: Outcomes and mediation effects. *Prevention Science, 9*, 17–27.

De Maeyer, S., Klingels, M., Vanderfaeillie, J., & Van Holen, F. (2012). Selectie van bestandspleegouders in Vlaanderen: een kritische analyse. In J. Vanderfaeillie, F. Van Holen, & F. Vanschoonlandt (Eds.), *Op weg met pleegzorg: kansen en risico's*. Leuven: Acco.

De Meyer, R. E., Janssen, J., & Veerman, J. W. (2004). *Handleiding beoordelingsschaal tevredenheid en effect*. Nijmegen: Praktikon.

Dorsey, S., Farmer, E. M. Z., Barth, R. P., Greene, K. M., Reid, J., & Landsverk, J. (2008). Current status and evidence base of training for foster and treatment foster parents. *Children and Youth Services Review, 30*, 1403–1416.

Dozier, M., Albus, K., Fisher, P. A., & Sepulveda, S. (2002). Interventions for foster parents: Implications for the developmental theory. *Development and Psychopathology, 14*, 843–860.

Fisher, T., Gibbs, I., Sinclair, I., & Wilson, K. (2000a). Sharing the care: the qualities sought of social workers by foster carers. *Child and Family Social Work, 5*, 225–233.

Fisher, P. A., Gunnar, M. R., Chamberlain, P., & Reid, J. B. (2000b). Preventive intervention for maltreated preschool children: Impact on children's behavior, neuroendocrine activity, and foster parent functioning. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 1356–1364.

Forgatch, M. S., Bullock, B. M., & Patterson, G. R. (2004). From theory to practice: Increasing effective parenting through role-play. In H. Steiner (Ed.), *Handbook of mental health interventions in children and adolescents* (pp. 782–812). San Francisco: Jossey-Bass.

Golding, K. (2004). Providing specialist psychological support to foster carers: A consultation model. *Child and Adolescent Mental Health, 9*, 71–76.

Golding, K. (2007). Developing group-based parent training for foster and adoptive parents. *Adoption & Fostering, 31*(3), 38–48.

Golding, K., & Picken, J. (2004). Group work for foster carers caring for children with complex problems. *Adoption & Fostering, 28*(1), 25–37.

Hampson, R. B., Schulte, M. A., & Ricks, C. C. (1983). Individual vs. group training for foster parents: Efficiency/effectiveness evaluations. *Family Relations, 32*, 191–201.

Heflinger, C. A., Simpkins, C. G., & Combs-Orme, T. (2000). Using the CBCL to determine the clinical status of children in state custody. *Children and Youth Services Review, 21*, 55–73.

Herbert, M., & Wookey, J. (2007). The child wise programme: A course to enhance the self-confidence and behaviour management skills of foster carers with challenging children. *Adoption & Fostering, 31*(4), 27–37.

Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology, 43*, 207–217.

Holmes, B., & Silver, M. (2010). Managing behaviour with attachment in mind. *Adoption & Fostering, 34*(1), 65–76.

Hudson, P., & Levasseur, K. (2002). Supporting foster parents: Caring voices. *Child Welfare, 81*, 853–878.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12–19.

Jakobsen, R., & Solholm, R. (2009). *Evaluering av PMTO-kurs for fosterforeldre – en effektstudie*. Bergen: Ubifob Helse.

Kaminski, J. W., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology, 36*, 567–589.

Laird, R. D., Pettit, G. S., Mize, J., Brown, E. G., & Lindsey, E. (1994). Mother–child conversations about peers: Contributions to competence. *Family Relations, 43*, 425–432.

Laybourne, G., Andersen, J., & Sands, J. (2008). Fostering attachments in looked after children: Further insight into the group-based programme for foster carers. *Adoption & Fostering, 32*(4), 64–76.

Leathers, S. J., Spielfogel, J. E., McMeel, L. S., & Atkins, M. S. (2011). Use of a parent management training intervention with urban foster parents: A pilot study. *Children and Youth Services Review, 33*, 1270–1279.

Linares, L. O., Montalto, D., Li, M., & Oza, V. S. (2006). A promising parenting intervention in foster care. *Journal of Consulting and Clinical Psychology, 74*, 32–41.

Lundahl, B., Risser, H. J., & Lovejoy, M. C. (2006). A meta-analysis of parent training: Moderators and follow-up effects. *Clinical Psychology Review, 1*, 86–104.

Maaskant, A. (2010). Pleegkinderen in de CGGZ. In P. van den Bergh & T. Weterings (Eds.), *Pleegzorg in perspectief. Ontwikkelingen in theorie en praktijk* (pp. 271–284). Assen: Van Gorcum.

MacGregor, T. E., Rodger, S., Cummings, A. L., & Leschied, A. W. (2006). The Needs of foster parents: A qualitative study of motivation, support, and retention. *Qualitative Social Work, 5*, 351–368.

Maughan, D. R., Christiansen, E., Jenson, W. R., Olympia, D., & Clark, E. (2005). Behavioral parent training as a treatment for externalizing behaviors and disruptive behavior disorders: A meta-analysis. *School Psychology Review, 34*, 267–286.

Mayers-Pasztor, E. (1987). *Model approach to partnerships in parenting/group preparation and selection of foster and/or adoptive families*. Atlanta: Child Welfare Institute.

McCarthy, G., Janeway, J., & Geddes, A. (2003). The impact of emotional and behavioural problems on the lives of children growing up in the care system. *Adoption & Fostering, 27*(3), 14–19.

McNeil, C. B., Herschell, A. D., & Gurwitch, R. H. (2005). Training foster parents in parent-child interaction therapy. *Education and Treatment of Children, 28*, 182–196.

Moncher, F. J., & Prinz, R. J. (1991). Treatment fidelity in outcome studies. *Clinical Psychology Review, 11*, 247–266.

Morrissette, P. J. (1994). Foster parenting: A developmental model. *Child and Adolescent Social Work Journal, 11*(3), 235–246.

Murray, L., Tarren-Sweeney, M., & France, K. (2011). Foster carer perceptions of support and training in the context of high burden of care. *Child & Family Social Work, 16*, 149–158.

Nilsen, W. (2007). Fostering futures: A preventive intervention program for school-age children in foster care. *Clinical Child Psychology and Psychiatry, 12*, 45–63.

Oke, N. (2010). *Against the odds': Foster carers' perceptions of family, commitment and belonging in successful placements*. Unpublished doctoral dissertation, University of Birmingam.

Oosterman, M., Schuengel, C., Slot, N. W., Bullens, R. A. R., & Doreleijers, T. A. H. (2007). Disruptions in foster care: A review and meta-analysis. *Children and Youth Services Review, 29*, 53–76.

Patterson, G. R. (2002). The early development of coercive family process. In J. B. Reid, G. R. Patterson, & J. Snyder (Eds.), *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention* (pp. 203–218). Washington: American Psychological Association.

Patterson, G. R. (2005). The next generation of PMTO models. *The Behavior Therapist, 28*, 25–32.

Patterson, G. R., & Forgatch, M. S. (1987). *Parents and adolescents living together: The basics*. Eugene, OR: Castalia.

Patterson, G. R., Reid, J. B., Jones, R. R., & Conger, R. E. (1975). *A social learning approach to family intervention: Families with aggressive children*. Eugene, OR: Castalia.

Pearl, E. S. (2009). Parent management training for reducing oppositional and aggressive behavior. *Aggression and Violent Behavior, 14*, 295–305.

Peeters, J. (2000). *Antisociale jongeren*. Leuven: Garant.

Pithouse, A., Hill-Tout, J., & Lowe, K. (2002). Training foster carers in challenging behavior: A case study in disappointment? *Child and Family Social Work, 7*, 203–214.

Pleegzorg Vlaanderen (2011). *De pleegzorgregistratie 2010*. Resource document. Pleegzorg Vlaanderen. http://www.pleegzorgvlaanderen.be/files/pages/files/Registratierapport_2010.pdf. Accessed 6 June 2012.

Robbroeckx, L. M. H., & Wels, P. M. A. (1996). *Nijmeegse vragenlijst voor de opvoedingssituatie: Handleiding*. Lisse: Swets & Zeitlinger.

Rober, P. (2005). The therapist's self in dialogical family therapy: Some ideas about not-knowing and the therapist's inner conversation. *Family Process, 44*, 477–495.

Rork, K. E., & McNeil, C. B. (2011). Evaluation of foster parent training programs: A critical review. *Child & Family Behavior Therapy, 33*, 139–170.

Sawyer, M. G., Carbone, J. A., Searle, A. K., & Robinson, P. (2007). The mental health and wellbeing of children and adolescents in home-based foster care. *Medical Journal of Australia, 186*(4), 181–184.

Scaramella, L. V., & Leve, L. D. (2004). Clarifying parent-child reciprocities during early childhood: The early childhood coercion model. *Clinical Child and Family Psychology Review, 7*, 89–107.

Schofield, G., & Beek, M. (2005). Providing a secure base: Parenting children in long-term foster family care. *Attachment & Human Development, 7*, 3–25.

Serketich, W. J., & Dumas, J. E. (1996). The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. *Behavior Therapy, 27*, 171–186.

Smith, M. C. (1994). Child-rearing practices associated with better developmental outcomes in preschool-age foster children. *Child Study Journal, 24*, 299–326.

Snyder, J., & Stoolmiller, M. (2002). Reinforcement and coercion mechanisms in the development of antisocial behavior: The family. In J. B. Reid, G. R. Patterson, & J. Snyder (Eds.), *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention* (pp. 203–218). Washington: American Psychological Association.

Sprangers, A. (2009). *Eindrapport labofunctie "Project pleegzorgpalet": Een intersectoraal, gedifferentieerd en flexibel pleegzorgaanbod voor minderjarigen en hun gezin*. Resource document. http://www.pleegzorglimburg.be/cms/wp-content/uploads/file/EindrapportLabofunctieprojectpleegzorgPalet.pdf. Accessed 6 June 2012.

Strijker, J., & Zandberg, T. (2005). Breakdown in foster care. *International Journal of Child and Family Welfare, 2*, 76–87.

Swann, C. A., & Sylvester, M. S. (2006). The foster care crisis: What caused caseloads to grow? *Demography, 43*, 309–335.

Timmer, S. G., Urquiza, A. J., & Zebell, N. (2006). Challenging foster caregiver—maltreated child relationships: The effectiveness of parent-child interaction therapy. *Children and Youth Services Review, 28*, 1–19.

Turner, W., Macdonald, G., & Dennis, J. (2007). Cognitive behavioural training interventions for assisting foster carers in the management of difficult behaviour. *Cochrane Database of Systematic Reviews,*. doi:10.1002/14651858.CD003760.pub3.

Tyrrel, C., & Dozier, M. (1999). Foster parents' understanding of children's problematic attachment strategies: The need for therapeutic responsiveness. *Adoption Quarterly, 2*, 49–64.

Unrau, Y. A., & Wells, M. A. (2005). Patterns of foster care service delivery. *Children and Youth Services Review, 27*, 511–531.

Van den Bergh, P., & Weterings, T. (2010). Factoren die de pleeggezinsituatie kunnen beïnvloeden. In P. van den Bergh & T. Weterings (Eds.), *Pleegzorg in perspectief. Ontwikkelingen in theorie en praktijk* (pp. 211–220). Assen: Van Gorcum.

Van Holen, F. (2005). Ondersteuningsbehoeften van pleegouders in Vlaanderen. *Tijdschrift voor Orthopedagogiek, 44*, 472–483.

Van Holen, F., Haarsma, C., & Schittekatte, M. (2006). Het gebruik van psychodiagnostisch instrumentarium in de voorzieningen Bijzondere Jeugdbijstand. Bevindingen en bedenkingen bij een rondvraag. *Agora, 22*, 12–22.

Vanderfaeillie, J., Van Holen, F., & Coussens, S. (2008). Why do foster care placements break down? A study into the factors influencing foster care placement breakdown in Flanders. *International Journal of Child and Family Welfare, 11*, 77–87.

Vanderfaeillie, J., Van Holen, F., De Maeyer, S., Vanschoonlandt, F., & Andries, C. (2012a). De ontwikkeling van probleemgedrag bij pleegkinderen: een Vlaams longitudinaal onderzoek. *Pedagogiek, 32*, 13–31.

Vanderfaeillie, J., Van Holen, F., Trogh, L., & Andries, C. (2012b). The impact of foster children's behavioural problems on Flemish foster mothers' parenting behaviour. *Child and Family Social Work, 17*, 34–42.

Vanschoonlandt, F., Vanderfaeillie, J., & Van Holen, F. (2012). De instroom in Vlaamse pleegzorg nader bekeken. Welke kinderen worden om welke redenen geplaatst? In J. Vanderfaeillie, F. Van Holen, & F. Vanschoonlandt (Eds.), *Op weg met pleegzorg: kansen en risico's*. Leuven: Acco.

Veerman, J. W. (2008). Methoden voor het kwantificeren en toetsen van effecten. In T. van Yperen & J. W. Veerman (Eds.), *Zich op effectiviteit: Handboek voor praktijkgestuurd effectonderzoek in de jeugdzorg* (pp. 307–329). Delft: Eburon.

Verreth, K. (2009). *(Rechts)vergelijkend onderzoek naar beleid en wetgeving in Vlaanderen en enkele Europese landen*. Brussel: Kenniscentrum Welzijn, Volksgezondheid en Gezin.

Webster-Stratton, C., & Reid, M. (2003). The incredible years parents, teachers, and children training series: A multifaceted treatment approach for young children with conduct problems. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidenced-based psychotherapies for children and adolescents* (pp. 224–240). New York: Guilford.

Weiss, H. B. (1993). Home visits: Necessary but not sufficient. *The Future of Children, 3*(3), 113–128.

Wells, K. C. (1997). The death of discipline: Is the requiem premature? *Aggression and Violent Behavior, 2*, 337–341.

Whenan, R., Oxlad, M., & Lushington, K. (2009). Factors associated with foster carer well-being, satisfaction and intention to continue providing out-of-home care. *Children and Youth Services Review, 31*, 752–760.

Wilson, K. (2006). Can foster carers help children resolve their emotional and behavioural difficulties? *Clinical Child Psychology and Psychiatry, 11*, 495–511.