Action Research reflecting the process of a collaborative, multi-theoretical group intervention with foster parents of children affected by childhood trauma

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Abstract

Children are received into the Care of the State in the Republic of Ireland due to chronic or acute maltreatment in their families of origin. Maltreatment may include neglect; physical, sexual, or emotional abuse; exposure to domestic violence; or a combination of these. Resulting emotional and behavioural consequences may be challenging to foster parents who might experience stress, secondary trauma, compassion fatigue or burnout, which along with the child's emotional and behavioural difficulties can result in placement breakdown.

After reviewing the literature on fostering internationally and in Ireland, this study sought to determine the types and level of stress in a sample of foster parents and the types of challenging emotional and behavioural difficulties of their fostered children. Results revealed that foster parents found fostering stressful; factors included biological parents; organisational issues; and the child's behaviour. According to the foster parents, nearly 60% of the foster children in this sample were showing high levels of emotional and behavioural distress. These difficulties differed according to age and gender. Adolescent Girls and Young Boys (5 – 11 years) were reported as having the most difficulties, including symptoms of behavioural and Conduct Disorder (CD). Symptoms associated with CD were reported in at least 40% of every age and gender category of children over five years.

Further, this study outlines the development, facilitation and outcomes of a small group psychoeducational-reflective foster parenting Course, involving six separate groups of parents (n=38) each meeting for eight sessions. In this Course, foster children were conceptualised from a bio-psycho-social-ecological viewpoint, utilising theoretical concepts from Prenatal Development, Attachment and Trauma, pertaining to vulnerable children to illustrate the cumulative effects of adversities. Time for discussion and reflection on the material was structured into the Course. This combination of knowledge, practical skills, reflection and support for parents aimed to promote healing relationship-based practices for the child within their foster home.

This multi-faceted study was grounded in Community Psychology, using mixed methods to gather data during action research processes, to reflect the different components of an action cycle. Ideas and modifications to the Course based on feedback from the foster parent participants' experiences have been included. It is recommended that the Course be provided to other foster parents and audiences such as social workers, teachers and solicitors. Furthermore, suggestions are made regarding assessment, diagnosis and interventions for foster children and parents, based on a multidisciplinary consultancy model.

Keywords: foster parents, fostering in Ireland, attachment theory, trauma in children, parenting groups

Declaration

I, Susan M. Cahill declare that this research is as result of my own work, except where otherwise stated. I have given the full acknowledgement of the sources referred to in the text. This study has not been submitted before for any degree or examination at any university.

This thesis has been formatted according to the APA 7th Edition referencing technique.

13th February2023

Acknowledgements

Camino de Santiago – the way of St James, is a network of pilgrim paths from different parts of Europe converging on the cathedral town of Santiago in Galicia, Spain. A PhD analogy and an actual personal journey, gruelling paths completed alone and others in the supportive company of Jacqui and John. The challenges are physical and mental, and although markers direct the journey, detours provide new vistas and self-discovery.

Actual and virtual persons accompany and encourage, lighten the weight of the load. These included epigenetically my grandmother who served on the eastern front in the First World War, and her daughter, my Aunt Audrey an academic role model. Family members especially my parents (RIP), sisters Margaret and Wendy, brothers in law, nieces and nephew(s), and now my grandniece Caitlyn.

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To Ireland, home and origin of a forefather, thank you for fostering me.

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Terms and abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
CBCL	Child Behaviour Checklist
CD	Conduct Disorder
FASD	Foetal Alcohol Spectrum disorder
HSE	Health Service Executive
ODD	Oppositional Defiant Disorder
PSI	Parent Stress Index
PTSD	Post-Traumatic Stress Disorder
SIPA	Stress Index for Parents of Adolescents
SoaP	Summary on a Page
TUSLA	Child and Family Agency

1. INTRODUCTION

1.1 Background to the study

This study proposes to explore the development and implementation of a small-group psychoeducational and reflective foster-parenting Course for foster parents in a district of the Mid-West region of Ireland, and to ascertain whether this was effective in providing information and support to these foster parents.

Children are usually received into the Care of the State in the Republic of Ireland as a result of chronic or acute maltreatment in their families of origin (Gilligan, 2019). Maltreatment may include neglect; physical, sexual, or emotional abuse; or a combination of these factors, which may have occurred over protracted periods of time, and would often have been perpetrated by individuals who should nurture and protect the child. International research indicates that children in Care are vulnerable and tend to be disadvantaged with regard to their mental and physical health as well as educationally (Hill & Thompson, 2003; Overstreet & Mathews, 2011; Richardson & Lelliott, 2003). Long-term implications include vulnerability to chronic mental ill health (Keyes, et al., 2012; Power, et al., 2011), as well as other lifelong physiological and psychosocial effects.

As a Clinical Psychologist who has worked in both the public and private sectors in Ireland, my experiences have been that fostered and adopted children provide challenges to carers, parents, professionals and to the Health and Educational systems, often requiring high levels of resources including ongoing intervention from psychology departments. These children's behaviour is difficult to manage and can leave parents feeling frustrated and exhausted, and in some cases, placements break down. Throughout this study, the term 'parent' will be used to describe foster carers. I believe that these individuals take on the roles and responsibilities of parents, in *loco parentis*, and the term carer devalues their contributions to these children's lives. In my clinical practice, those parents to whom I have provided theoretical, neurological and physiological explanations, as well as possible practical parenting ideas in the form of psychoeducation, appear to have gained more understanding, energy and hope, as well as reporting effective outcomes with their children.

Providing information in a small group context has been found to be an effective psychoeducational and support mechanism (Golding & Picken, 2004; Gurney-Smith, et al., 2010; Rushton & Monck, 2010). Small groups can be a more economical form of intervention, reducing the amount of time spent individually with separate parents, additionally providing group participants with a supportive environment of other parents who are experiencing similar difficulties.

1.2 Location of this research

The research was conducted within a county district of the Mid-West Region of the Republic of Ireland. The Mid-West region of Tusla comprises the counties of Clare, Limerick and North Tipperary - an area encompassing 8252 km^2 and an approximate population of just under 400,000. At the end of the second quarter of 2020, there were a total of 580 children in Care and a total of 413 foster parents in the entire Mid-West region. There were approximately 64 foster parents and 80 foster children registered in the specific geographic district of the Mid-West region between 2015 – 2016, at the time the foster parenting groups were convened and research data collected.

1.3 Background to the problems

Parenting a child with complex emotional and behavioural difficulties that are as a result of early and often chronic trauma (attachment, emotional, physical, verbal and sexual abuse, or neglect) is extremely challenging. In my experience, these children do not usually respond well to "normal" behavioural parenting strategies. However, their behaviour becomes more understandable when taking the emotional, neurological and physiological impacts of their negative early life experiences into account. Parenting styles therefore need to be adapted to allow for these differences, to enable the child to learn new appropriate methods of interrelating and getting their needs met. These new skills are more likely to be learned by children within the context of relationship and are best learned within the relationships they have with their foster parents.

Foster children have been referred to me as a Clinical Psychologist in both the public sector and my private practice with complex and often challenging emotional and behavioural difficulties. Parents looking for assistance are often confused, disheartened, frustrated and exhausted, and placements are at risk of breaking down. Research internationally indicates that placement stability is associated with best outcomes for Children in Care (Crum, 2010; Jones et al., 2011; Scott, 2011; Winters et al., 2020). In Ireland, training of foster parents generally happens prior to them taking on the responsibility of parenting these children. Issues covered during this induction training may not seem pertinent at the time of training as parents do not have a foster child in their home. In addition, useful information may have been forgotten due to the length of time that may have elapsed between the training and their taking a child into their homes.

As my knowledge and professional work with foster children and their foster parents evolved, from 2001 when I started working in Ireland, my insights and the consequent focus of my activities changed, as represented in the action process stages below.

1st stage of action prior to research

- Working with individual children / Providing fostering support to foster parents
- Professional ongoing training in Trauma and Attachment Theory and Practice, parenting theories and strategies

2nd stage

- Working with individual children / Providing fostering support to individual foster parents
- Group work with foster parents / Group work with adoptive parents / Group work with professionals
- Professional ongoing training in Interpersonal Neurobiology, Trauma and Attachment based Clinical interventions

3rd Stage

- Working with foster parents rather than the children directly
- Informing foster parents what certain behaviours might mean, based on the history of the child
- Providing suggestions on how the foster parent might adapt their behaviour, to provide a different response to the behaviour might elicit a different more positive behaviour from the child.

Providing both theoretical and practical knowledge to parents in general has the potential to be beneficial (Birmingham et al., 2017). Furthermore, in my experience, foster parents are often strongly motivated to learn, to understand why their children might be behaving in a particular way and to try to adapt their behaviour for benefit of the children. Small-group interventions have been shown to be beneficial to foster and adoptive parents (Golding, 2019; Gurney-Smith et al., 2010). Information can be shared with a number of parents at the same time, thus being a good utilisation of limited resources. Parents realise they are not the only ones experiencing a combination of the child's behavioural difficulties along with their own varying levels of confusion and feelings of ineffectiveness in parenting these children. The group format provides both implicit and explicit support from the facilitator and other group members.

The study to be described in what follows will therefore seek to determine the levels of stress that a sample of foster parents were experiencing and will explore the types of challenging emotional and behavioural difficulties of their fostered children. It will also outline the development and facilitation of a small group foster-parenting Course provided to the foster parents. The input to the group and its facilitation will attempt to provide specific relevant theoretical knowledge,

practical skills and support for these parents, to promote placement stability; hoping to kindle some healing of the child within the context of the foster parent-child relationship.

1.4 Research Questions

All data was to be obtained from the foster parents who attend the foster parenting Course; through quantitative and qualitative questionnaires (see Methodology chapter). The research procedures therefore involved no direct contact with or observation of any foster children. The following research questions guided the study and the associated collection and analysis of data:

1. What are the levels and nature of stress experienced by foster parents in parenting their children?
2. According to their parents, what emotional and behavioural patterns are foster children displaying?
3. What were the elements used to develop a Developmental, Trauma and Attachment based intervention for foster parents, and how did it unfold?
4. What were the foster parents' responses to, and experiences of, a small group psycho-education and reflective intervention?

1.5 Research Approach

The study was designed using mixed methods (Creswell, 2007) to collect both quantitative and qualitative data in response to the questions posed above. There were six small groups of participants who were either foster parents or foster parents who had adopted their foster children, all of whom from here on after will be referred to as foster parents. In circumstances where there were two parents in the home, both parents were encouraged to attend, but where this was not possible one parent was accepted into a group. It was stipulated that attendance at every session was a pre-requisite of participants' voluntary participation.

1.6 Significance of the research

This research hoped to provide a better understanding of a sample of Irish foster parents' experiences of fostering and the types of stress that fostering produces in their lives. Foster parents provide a home, care for, and parent a child, who is often a stranger prior to coming to live with them; and who has gone through many difficulties prior to being placed with foster parents. Child-related factors such as mood changes or problematic, sometimes aggressive behaviour at various times, can lead to stressors in the home (Harkin & Houston, 2016). Furthermore, in a social welfare system that is under resourced, with constant staff turnover, foster parents may feel neglected and placements can be undermined by worry and discontent, which can result in placement breakdown and termination.

The study also aimed to add to the body of knowledge pertaining to childhood trauma, especially in relation to emotional and behavioural symptomatology of fostered children. Research has clearly established that fostered children are likely to have more difficulties than the general population in areas related to mental health (Engler et al., 2022).

Furthermore, the study would like to contribute to the debate regarding the difficulties in diagnosing children who have experienced chronic or complex trauma, since symptoms can differ even when children have been exposed to similar adverse experiences. The diagnosis of post-traumatic stress disorder (PTSD) has been adapted from the adult diagnosis and many foster children do meet the criteria for PTSD. However, the more broadly encompassing Developmental Trauma Disorder (DTD) (van der Kolk et al., 2019), appears to describe the wide variety and subtleties of the symptoms of children who have experienced chronic neglect or maltreatment or both, from their primary caregivers from an early age.

The central objective of the study was to develop, deliver and research an intervention based on theory and practice, to address knowledge-based deficits and to increase the understanding of foster parents, to enable them to become sources of positive input and potentially healing in their child's life. Developing and evaluating a small-group foster parenting Course as a psychological intervention for foster parents could have a number of benefits. The small group component could provide mutual support and understanding for a group of people not known to each other, but with fostering in common, who can feel quite isolated due to the confidential nature of fostering. Participants could learn from each other and share concerns and experiences, both alleviating certain stress and building their knowledge both theoretically in the psycho-educational component and practically, by hearing how others may have coped with similar situations.

Finally, it was hoped that this study could provide a "voice" for the participant foster parents, in representing where possible the outcomes of the research to management and to policy makers. Carrying out research focused upon a specific local population provides insights into issues that might be arising for those parents and their children that could be better addressed when presented as a problem associated with a group rather than separate individuals.

1.7 Definitions of terms

ACEs	Adverse childhood experiences	Emotional, physical, or sexual abuse; emotional or physical neglect; domestic violence; parental substance use; parental mental illness; parental separation or divorce; or incarceration of a household member

CBCL	Child Behaviour Checklist	(Achenbach & Ruffle, 2000)
HSE	Health Service Executive	Irish Health Department
PSI	Parenting Stress Index	(Abidin, 2012)
PTSD	Post-Traumatic Stress disorder	Set of psychiatric symptoms meeting DSM-5 (APA, 2013) criteria for PTSD after a person has experienced or witnessed Trauma - a perceived or actual life-threatening event
SDQ	Strengths and Difficulties Questionnaire	(Goodman R. , 1997)
SIPA	Stress Index for Parents of Adolescents	(Sheras et al., 1998)
Trauma		The experience of a perceived or actual life-threatening event that threatens or causes harm to an individual's emotional and physical wellbeing
Tusla	Name of the Child and Family Agency in the Republic of Ireland	

In addition, throughout this thesis, certain terms will be formatted consistently with a capital letter:

Attachment and Trauma: when used in the context of the theories with which they are associated;

Care: when it is used in the context of the legal term of placing a child in a foster placement;

Course: when used to reference the small-group psychoeducational-reflective foster parenting intervention.

The term parent refers to the foster parent unless otherwise stipulated such as biological parent. Similarly, child refers to the foster child unless otherwise stipulated.

1.8 Personal motivations for developing the intervention and undertaking this study

At the time of submitting this research, I will have worked with foster children and foster parents for nearly 22 years. For over 17 of those years, I worked in the HSE in the Child and Family Psychology Service as a Clinical Psychologist and during that time, prior to it becoming a Primary Care Psychology Service, a large proportion of my work was with these populations. In the years since leaving the employment of the HSE, I have been contracted by Tusla to continue working with a small number of foster children and their foster families.

My work in this area has comprised emotional, cognitive and behavioural assessment and long-term psychological interventions with individual children; fostering support and training of

foster parents; access visit reviews, biological and foster parent evaluations. As a result, this has been the focus of the majority of my post-graduating training and continuing professional development, including conferences and workshops on upskilling in the areas of Attachment, Trauma and Dissociation.

In addition to reading Bowlby's three seminal *Attachment and Loss* publications, *Attachment* (Bowlby, 1969), *Separation* (Bowlby, 1973), *Loss* (Bowlby, 1980); and *A Secure Base: Clinical applications of Attachment Theory* (Bowlby, 1988), I was inspired by current specialists in their respective fields with whom I have had the privilege to train or attend workshops. These include amongst others: Hughes, Dyadic Developmental Psychotherapy (DDP) (Hughes et al., 2015), who has published many books including, *Building the bonds of attachment: Awakening love in deeply troubled children* (Hughes, 2006). Maté addresses issues such as ADHD, in *Scattered Minds* (1999), and Addiction, *In the realm of hungry ghosts* (2018) from a bio-psycho-social perspective. Perry who developed the Neurosequential Model of Therapeutics (Perry, 2006), and co-authored *The boy who was raised as a dog* (Perry & Szalavitz, 2006). Porges, who developed the Polyvagal Theory and authored *The Polyvagal Theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation* (Porges, 2011). Siegel, a psychiatrist who developed the field of Interpersonal Neurobiology, has written on Attachment Parenting (Siegel & Hartzell, 2003; Siegel & Payne Bryson, 2020), and the interactions of the mind and mental health including, *The Developing* Mind (Siegel, 2020). van der Kolk, a psychiatrist based at Harvard and a well-known specialist and researcher in Trauma and Dissociation, who wrote *The body keeps the score* (van der Kolk, 2014).

However, it has been the foster children and the foster parents who have provided me with the most insight into their situations. Their stories and struggles were also the main motivation to try to find a way to provide some input to those foster children and parents who were on lengthy waiting lists, unlikely to be seen for months, if not years. I wanted to develop an effective intervention drawing from all the clinical and theoretical knowledge to which I had been exposed over the years and to gift it to the foster parents. I also hoped to illustrate how combining elements of a number of theories makes sense of the difficulties and sometimes unexplainable behaviour of their children, in order for the foster parents to respond to them in a way that might help the child adjust their generally negative self-concept and world-view.

1.9 Summary of content

This chapter has outlined the development of action cycles that evolved out of many years of clinical practice, specialist training, continuing education and staying up to date in a field that draws from multiple theories and psychological concepts. It has required that this write up provides

some level of comprehensive coverage of the vast amount of literature surrounding these theories but to still remain pertinent to the primary topics of this research.

I begin with the subject of fostering in Chapter 2, considering the international context and features relevant to fostering in general such as foster parent training, support and factors that promote stability in foster placements or lead to their eventual breakdown, in a meta-synthetic way. I then look more specifically at the Irish perspective, providing some elements of the contextual ecology, embedded in the country's culture and legal system, which are relevant to my study.

Chapter 3 outlines the conceptual framework of the research using a number of interrelated theories to explain and explore the two subject groups (foster parents and foster children) and to try to make sense of the multiple, dynamic and mutually influencing, interactive elements that constitute these groups' experiences. The entire project was framed within a Community Psychology paradigm, representing the appropriate value system of knowledge creation and sharing of psychology for the benefit of communities of individuals. An Action research framework was used to portray that although this was only one phase of action cycles, it was still a constantly evolving process within which questions, in this case about clinical practice and the appropriateness and effectiveness of the intervention, were being asked and reflected upon. I then highlight the key features that contributed to developing the content of the intervention, with elements of Developmental, Attachment and Trauma theories, illustrating the foster child from a bio-psycho-social model (Engel, 1977), placed within the framework of Bronfenbrenner's (Bronfenbrenner & Morris, 2006) bioecological model, to illustrate the complexities of cumulative negative experiences.

Chapter 4 broadly reviews the literature associated with the three main foundational theories used to develop the intervention, a foster-parenting Course constituted using aspects of Prenatal Development, Attachment and Trauma. It identifies some of the relevant bio-psycho-social elements pertaining to vulnerable children, especially those removed from their biological parents and fostered. It should be noted that since this research was conceptualised, evolved and was conducted from the period 2009 to 2017, the design was influenced by the literature current at that time. However, in this write-up, where possible, more current literature has been included to supplement and reinforce the original literature. As far as possible it includes a spread of international research from Europe, the United Kingdom (UK), Australasia, the United States of America (USA) and Canada.

Chapter 5 describes the Methodology using a mixed methods approach whereby quantitative measures would be used to capture data measuring stress in foster parents and the emotional and behavioural symptoms of foster children. Qualitative data then further illustrates

fostering stress is then used to evaluate the development and impact of the small-group parenting Course on a particular sample of foster parents.

Chapters 6 to 8 present the findings from the accumulated quantitative and qualitative data and an analysis thereof. These chapters illustrate the data collected in relation to the research questions, associated with the levels of stress in foster parents and the foster children's emotional and behavioural symptoms. The small-group foster parenting sessions are all summarised using Summaries on a Page (SoaPs) to capture the essence of and synthesise a large amount of data about group construction, facilitation and processes. Although only minor changes were made in order to evaluate the Course over the Action Research iterations, the findings can be used to develop and improve prospective Courses with foster parents. The qualitative data captured in the post-session and post-Course questionnaires has been presented according to the themes evoked in the foster parents, through their experience of the parenting Course.

Finally, Chapter 9 discusses the outcomes of the data and the study, in relation to the chosen theoretical frameworks. It presents some ideas about assessment, diagnosis, and treatment of foster children, based upon the evidence generated in this study; and also raises the issue of secondary traumatic stress that may be experienced by parents. Suggestions are provided for ongoing work with both foster parents and foster children.

REVIEW OF LITERATURE
2. FOSTERING INTERNATIONALLY AND IN IRELAND

2.1 Introduction

Children are placed in Care as a last resort when their safety and care cannot be provided for by their biological parents. In many cases the biological parents are implicitly or explicitly the source of the harm encountered by these children. Countries have laws that protect children, and when parents are unable to provide a safe and nurturing environment, especially when a child is at risk of harm, that child is placed into the care of the State and found a more suitable place to live. Individuals and couples volunteer to take on the task of minding and parenting these children, providing them with an opportunity to grow up in a family home and receive the care they require. These individuals undergo induction training and they are assessed to establish whether they are able to provide a home to a foster child.

Offering a home to a child who is often a stranger, and who often arrives with many emotional and behavioural difficulties can be challenging and stressful. I have therefore reviewed the literature associated with the different elements that might contribute toward placement disruption and breakdown. I believe that maintaining trained foster parents is more effective than recruiting and training new and inexperienced foster parents. Placement breakdown also has adverse effects on the foster child, the foster parents and the family in general, and is only likely to reinforce many of the negative preconceptions the child has of themselves and of adults.

The Irish context deals with those elements relevant to the process through which the participants would have been trained, assessed and approved prior to them fostering a child. All the participants who attended the small-group foster parenting Course were supported from the public sector and were in the majority of cases providing long-term placements for the child(ren) they were fostering.

According to an international literature review (Sebba, 2012), that included studies from Canada, Southern Australia, the United States (USA), Sweden and the United Kingdom (UK), the motivation to become a foster parent was mainly found to be altruistic. Altruistic incentives included wanting to help a child, to give love to a child, to use parenting ability, and to give something back to the community. Religious motivation was also expressed in Canada and the USA, where the known scarcity of foster placements and the increase in children requiring a home were reported as the most persuasive reasons for fostering. Increasing the size of their family, providing a sibling for their own biological child, as well as fostering providing the means to remain at home and parent their own biological child(ren) were some of the additional practical reasons provided for fostering (Sebba, 2012).

2.2 The international context

Internationally the number of children requiring foster placements is increasing, whereas the number of foster parents is not keeping pace with the demand (Sebba, 2012). Randle et al., (2017) reported that this increase included both in-home foster placements and residential placements. They outlined that the increase in children requiring fostering in Australia was 20% between 2010 – 2014; in the UK it was 9% between 2010 – 2014; in North America it was 5% between 2010 – 2014; and in Ireland there was an increase of 15% between 2010 – 2013.

Petrowski et al., (2017) attempted to establish the number of children in residential and in-home foster placements world-wide. They outlined the difficulties trying to obtain these data, where 142 out of 197 UNICEF (United Nations Children's Fund) countries provided information. Of these, 86 countries had information on both residential and in-home foster placements, and the other 56 had information on either residential or in-home placements. In general, information on the numbers of children placed in-home was the most difficult to ascertain. However, based on data from higher income countries (of which Ireland is a small part), the authors estimated that 799,000 children are in home-based foster care.

2.3 Foster parenting and evaluating capacity

Parenting in general is a process whereby parents support the physiological and psychosocial development of children (Birmingham et al., 2017). Parenting fostered or adopted children requires a skill-set adapted to the needs of children who have experienced maltreatment and trauma. These experiences can include alcohol, drug and nicotine exposure during the prenatal period; neglect, abuse (including witnessing verbal and physical domestic violence), in their early development, childhood or adolescence, or a combination of any of these (Hawke et al., 2020). The impact would be unique to each child, dependent on a multitude of child-related factors including age, gender, temperament, chronicity, type and severity of the maltreatment. Other factors might include capacity of biological parents, the age at which a child was removed from the environment that did not meet their needs or where they were being harmed. Protective factors that neutralise the impact of harm could include the presence of encouraging or supportive extended family members (older siblings, aunts, uncles, grandparents, teachers), enrolment in an age appropriate crèche or school and social activities (Afifi & MacMillan, 2011)

The aim of evaluating the capacities and skills of potential foster parents is to establish motivation competence and safety (Buehler et al., 2006). These are not easy to evaluate prior to foster parents fostering a child, since much of the information provided cannot be verified until the foster parents are actually fostering. Consolidating information from Child Welfare League of America's standards criteria for successful foster applicants, elements of training programs in the

USA and research about foster parents, Buehler et al., (2006) identified 12 areas of competency for successful foster parenting. These include:

- Providing a safe and secure environment
- Providing a nurturing environment
- Promoting educational attainment and success
- Meeting physical and mental health needs
- Promoting social and emotional development
- Valuing diversity and supporting children's cultural needs
- Growing as a foster parent – skill development and role clarification
- Managing the demands of fostering on personal and familial well-being
- Supporting relationships between children and their families
- Working as a team member

Establishing that foster parents have these competencies is likely to provide an effective placement that is less likely to breakdown.

2.4 Placement stability and foster parent retention

Harden et al., (2008), whilst examining attitudes of a small sample of foster parents from a support group in the USA, discovered that the most important factor that influences placement stability and a positive outcome for the child, was what the authors describe as "attachment and commitment" to the foster child in their care. Other features included: having age-appropriate expectations of the children, as well as an appreciation that the child's behaviour is most likely as a result of their early life experiences. Furthermore, a foster parent's reasons for fostering related to their capacity to provide a stable placement, especially in those individuals who are motivated toward the child rather than themselves (for example, fostering to supplement their income). More flexible parenting styles were positively correlated with better outcomes; as were empathy and the ability of the foster parent to appreciate what their child might be experiencing. Good parenting skills and the presence of strong social supports were identified as key features contributing toward positive attitudes of foster parents and therefore positive outcomes for children.

A foster parent's motivation is evaluated when being assessed. Rock et al., (2015) found that foster parents in the UK whose motivation included factors relating to the child, and those parents who expressed more altruistic reasons for fostering, had more positive outcomes. However, they also found that when foster parents fostered for self-motivated, rather than child-motivated reasons, such as for their own gratification, that parents were disappointed when children did not demonstrate the hoped-for behaviour.

Van Santen (2015) who carried out research in Germany regarding reasons foster parents terminated foster placements, found that two-thirds of children aged between 6 years and 15 years in in-home foster placements were most often moved into residential placements after a placement breakdown. Identifying the actual cause of a breakdown was not always possible, as it can be a combination of effects. These most often included the child's behaviour, but can also include meddling by the biological parents, or insufficient support from the child welfare system to maintain a difficult placement. In some cases, foster parents were not sufficiently trained to understand, manage or neutralise problem behaviour. In van Santen's (2015) study, placements of children in statutory Care where biological parents had relinquished their rights, were ended more often than for children in voluntary Care. This may reflect the severity of the reasons behind the child needing to be placed into Care. Placements where a child was placed before the age of 3 were less likely to break down and the risk of placement breakdown increased as the age at which the child was placed increased, so that those who were placed between 6 years and 15 years were most at risk of the placement being ended by the foster parents. Adolescents older than this were more likely to request an end to the placement themselves or just leave, since they have more autonomy.

Harkin and Houston (2016), in their review of international literature regarding foster placement disruptions, identified a number of protective factors in retaining foster placements. These included: the quality of the relationship between the child and their foster parents; feeling a part of the foster family; a constructive relationship with their biological family; and capacity for resilience. According to Rock et al's. (2015) meta-analysis, foster children reported that foster parents who showed them kindness and affection had a positive effect on placement stability. They found however that foster parents on the other hand felt that, "…discipline and routine, being persistent, flexible and organised…" (p. 195) were factors that maintained placement stability.

McKeough et al., (2017) investigated the levels of stress in a sample of Australian foster parents in the role of parenting foster children. They reported that foster parents do not feel adequately prepared for the foster parenting task after their official training. Their levels of stress, anxiety and depression were not elevated, even in the context of parenting high needs children. However, they expressed high levels of stress within the parent-child dyad when caring for children with behavioural difficulties. These included, "challenging behaviour, lack of control, lack of organisational support and time management" (pp.16-17). Parents with what they perceived as challenging children, especially children with sexualised behaviour and behavioural difficulties, expressed a need for further training. The three most popular formats for foster parents with and without challenging behaviour to receive ongoing training included: online, group and face-to-face modalities.

Retaining foster parents reduces the costs of recruiting new foster parents and provides a resource of skilled parents (Randle et al., 2017). Experienced foster parents are more likely to maintain foster placements longer and are therefore their placements are more secure than parents who have recently trained, with reduced understanding about foster children's complex behaviours (Rock et al., 2015).

2.5 Interventions that promote Placement Stability

Reasons for placement disruptions, as discussed above, fall into two general categories: that the child's behaviour is too difficult to manage, or that the foster parent feels they do not have the ability to provide the support required by the foster child. Crum (2010) investigated private and public foster parents who had fostered for at least 2 years in a number of USA states wanting to establish what parenting characteristics led to fewer placement disruptions. According to that study, parenting support and the ability to set limits proved to be the most noteworthy independent variables facilitating placement stabillity.

Parenting support refers to the support a parent was receiving from the fostering organisation, a process the author suggested should be individualised to meet the needs of the foster parent. Crum (2010) also found a positive correlation between limit setting and placement breakdown. Comfort with setting limits, where foster parents feel in control of parenting and have firm boundaries promoted stability in placements. Parents who had an authoritarian parenting style, being too strict, feeling that they needed to be in charge, lacking flexibility and the ability to negotiate in their parenting, had more placement breakdowns. Two concerning outcomes of the study revealed that 40% of this sample of foster parents were dissatisfied with the parenting role and 40% also expressed difficulities communicating with their foster child.

Matching

Matching entails choosing foster parents with the appropriate training and experience to meet the child's psychological, behavioural, cultural, educational and any other needs (Haysom et al., 2020). According to an international literature review carried out by Zeijlmans et al., (2017) matching requires detailed historic and current information about the child, including the reasons for coming into Care, educational ability and needs, emotional and behavioural difficulties, and the family of origin's cultural beliefs and geographic location.

However, in most child protection systems the number of foster parents available has not been sufficient for the number of children requiring fostering. Further research carried out the following year by Zeijlmans et al. (2018) found three themes expressed by matching-practitioners in the Netherlands, "matching as planned", "matching being tailored" and "matching being

compromised". The first category refers to a match that took into consideration the child's needs (cultural, educational, emotional and behavioural); where the biological parents and foster parents were consulted and the placement was found to suit all requirements. Matching as tailored required matchers to establish the most important requirements for the child, since all features were not available in the match. Thirdly, matching being compromised occurred when for example, there was insufficient information about the child, or there were skills lacking in the foster parents to make an accurate match. However, the study found that the main difficulties were most often associated with organisational factors, such as not having sufficient time to consider all the information as the child needed a placement immediately, or having insufficient numbers of foster parents from which to choose, resulting in the child being placed with whatever family was available.

Haysom et al. (2020) carried out a scoping review of research regarding matching published over the past 81 years. Their findings conclude that the topic is under-researched and that there is inconsistency due to theoretical framework multiplicity. They illustrate the shift in focus in the 1930's from definable factors such as "race" and "IQ" to ''goodness-of-fit'' in the 1980's, toward more individualised issues such as foster parent expectations and the child's welfare in the 2000's. They expressed surprise however at the minimal use of Attachment and Trauma theories in the research, and the concept of risk not being more evident, in even the more recent studies.

> Trauma theories, frequently paired with Attachment theory, are significant from an attachment and bonding perspective and contribute to mental and emotional health issues…Traumatic events disrupt emotional and neurological development and bonding with caregivers. The impacts on bonding and attachment are compounded when caregivers are also the causes of trauma and danger. (Haysom et al., 2020, p. 17)

Ideally children should be matched with families, that is, their needs and behavioural difficulties should be balanced with the foster parents' skills and capacity. Unfortunately, as there are insufficient foster placements available in Ireland, and the urgency with which children often require placements, they are generally placed where there is a placement available (O'Brien & Cregan, 2015).

Training, Support and Mentoring

Training

According to Cooley et al., (2019) little research has been carried out internationally on preparatory or pre-service foster training. They found that in the USA there was no standard format of pre-service training, although in the 11 studies they reviewed, 4 programs were mainly used. However, in one State alone, 5 different programs had been used. The 4 main programs in these

studies generally provided prospective foster parents with 12 face-to-face modules lasting 2.5-3 hours; in some programs a few modules were provided online.

Research articles including studies from Australia, Canada, New Zealand, UK, and the many from the USA (Denlinger & Corius, 2018; Everson-Hock, et al., 2011; Kaasboll et al., 2019; Randle et al., 2017), whilst evaluating different aspects of fostering and foster parent needs, recommended increased amounts of fostering-related training to improve the likelihood of placement stability. Training that focused on self-efficacy or fostering competence was more likely to lead to foster placement stability and these would require providing foster parents with both knowledge and realistic expectations about what fostering entailed (Whenan, et al., 2009).

Kaasboll et al., (2019) in a multinational systematic review of literature regarding foster parents' opinions regarding training also found that foster parents expressed a need for training, especially in parenting children with special needs; and to be provided with real-life examples of what might be expected of them as foster parents, within that training. Golding (2019) also found in providing groups to foster parents in the UK, based on Dyadic Developmental Psychotherapy (DDP) to encourage relational healing, that foster parents reported feeling supported and better equipped to parent children with emotional and behavioural difficulties. Newquist et al., (2020) who carried out a small qualitative study on the impact of foster placement endings on foster parents, recommended that pre-service and periodic ongoing training should place more emphasis on placement endings, whether for reasons of placement breakdown or because the child is returned to their biological family.

Support

Across the literature, there was a positive correlation between the amount of support foster parents received and their level of satisfaction with being a foster parent (e.g., Leathers et al., 2019). Suggestions for increased support include regular training sessions and home visits that are supportive in nature and open communication between the foster parent and the agency (Mihalo et al., 2016).

Mentoring

Pope et al., (2020) carried out research in Kentucky, USA, in which more experienced foster parents provided mentoring to newly qualified foster parents. Experienced foster parents provided learning and support to new foster parents. These included mentors providing ideas about boundary setting with foster children; and suggestions about managing interactions with the agency staff and other professionals working with the foster child. In their discussion, they described how

mentoring provided new foster parents with reflective skills, which enabled participants to consider the effect of fostering on themselves and their families and promoted stability in foster placements.

Treatment foster care

Australia and the US both have a specific placement called "treatment foster care" where foster parents are professionally trained, receive regular supervision, and are paid a salary. These placements have been found to be more stable and the child's emotional and behavioural difficulties improve (McKeough et al., 2017).

Agency factors

Cooley et al., (2017) found that foster parents expressed an interest to be included in decision making processes along with all the professionals involved in their child's life. Denlinger and Corius (2018) carried out research in the USA with a sample of foster mothers, to establish what factors were important in developing and maintaining a positive relationship between foster parents and their child's case worker. A number of themes were identified from this study. These included the social worker assisting the parent to access resources required by the child. An imbalance was often created by having to be available to the social worker and system, whereas the social worker was often not available to the foster parent when they needed them. Receiving communication regularly from the social worker, in the form of a quick phone call or email were identified by foster mothers as important to them. However, they expressed frustration with social workers who did not respond to communications or return calls within a reasonable period of time, many foster mothers going so far as to say that a lack of communication severely negatively impacted the placement and how they experienced fostering; and would most likely result in placement breakdown.

2.6 Foster placement disruptions

Whenan et al., (2009) carried out a mail survey in Australia in which foster parents reported that their well-being and satisfaction with fostering was associated with their sense of parenting effectively; a positive relationship with their child; and that these were most often correlated with the training they had received. Placements have to sometimes be discontinued. The reasons for placement disruptions can be as a result of issues pertaining to the child, the foster parents or agency concerns. Disrupted foster placements in Ireland are terminated by the foster parents or by the Child and Family Agency (Moran et al., 2017). International research (e.g., Montserrat et al., 2020; Vinnerljung et al. 2017) suggests that between 20-50% of placements break down as a result of combinations of reasons. Harkin and Houston (2016), describe how it is seldom one factor that leads to a placement breakdown, but a combination of interrelated factors, and that each child's

individual circumstances and histories need to be considered when evaluating the potential for placement breakdown.

Konijn et al., (2019) found 6 major factors from a meta-analysis examining the most common factors leading to foster placement disruption. In rank order, the studies they analysed showed that placement disruption was most often associated with unmanageable externalising behaviours from the foster child. Secondly, placements of children in non-kinship Care, those who have not been placed in the home of someone related to them, were more likely to break down. Foster parenting of inadequate quality was the third factor with modest significant effects. The next three factors that had lower significant effects and included the age at which a child is placed into foster-care, with children of older age when initially placed into Care being more disruptive than children initially placed at a younger age. The fifth factor was being separated from siblings and being placed into a foster placement without siblings; and the sixth factor was a history of childhood abuse and or neglect.

Griffiths et al., (2021) also found that the strongest predictive factor of foster parents' satisfaction was related to them feeling they had achieved something positive with their foster child. A placement was therefore less likely to break down when a foster parent believed they were doing an effective job in meeting their child's needs.

The effects of placement breakdown

The effects of foster placement breakdown are systemic. The child, their biological family, the foster parents, the biological children of the foster parents, the social workers and their organisations are all impacted to differing degrees.

Small qualitative studies in Australia (Riggs & Willsmore, 2012), the UK (Lynes & Sitoe, 2019) and the United States (Newquist, et al., 2020) analysed themes surrounding the endings of foster placements. Both Lynes and Sitoe (2019) and Riggs and Willsmore (2012) refer to the foster parents experiencing disenfranchised grief when placements end; that their feelings of grief and loss were not sufficiently acknowledged or supported. In most cases participants loved the child as if they were one of their children, and felt that their loss was discounted by family and friends as well as the professionals involved in the case. Newquist et al., (2020) refer to the foster parents experiencing "ambiguous grief", where they miss the physical presence of the child, wonder how they are getting on, and whether they might someday meet again. Participants themselves were surprised at the level and strength of their grief and felt that they were not sufficiently supported at the end of placements, describing professionals as indifferent to the loss they were experiencing.

Factors associated with the child

Research indicates that disruptive behaviour associated with emotional difficulties were the most often cited cause for placement breakdown (Randle et al., 2017; Whenan et al., 2009). Vreeland et al. (2020) found in a large sample of children and adolescents (n=8853) in State Care in Tennessee in the USA, that the emotional and behavioural presentations that were most disruptive to placements included both internalising and externalising behaviours and affect dysregulation. Externalising behaviour was found to be the strongest predictor of placement disruption and breakdown. Internalising and Externalising were terms devised in the 1960's by Achenbach, who developed the Child Behaviour Checklist (CBCL), to describe behaviours that were displayed inwardly or outwardly respectively. Therefore, Internalising was quiet, shy, often compliant behaviour associated with conditions such as Anxiety, Depression and Psycho-somatic illnesses. Externalising, on the other hand is seen as aggressive, loud, often violent behaviour associated with individuals who lie, steal and fight (Achenbach & Rescorla, 2007).

Hannah and Woolgar (2018) carried out an online survey in the UK and reported that nearly half of their sample (48%) of foster parents surveyed regarding secondary trauma, had experienced primary trauma in the form of being physically assaulted by their foster child. This disturbing statistic reveals the real-life threats to which foster parents are exposed in their own homes, which makes fostering difficult.

The age at which a child is placed into fostercare can also impact on placement stability, with studies (Rock et al., 2015; Rostill-Brookes et al., 2011; Vreeland et al., 2020) indicating that the older the child when they are placed into fostercare, the more likely the placement could break down.

Moran et al., (2017) interviewed Irish children who were in Care or in After-Care to try to understand placement stability and breakdown. The young people identified age at coming into Care as a factor that was likely to impact on placement, saying that the older they came into Care the more difficult it was to settle foster placement and the more they felt connected to their biological family, which impacted their relationships with their new family. Other issues reported by young people in the Moran et al. (2017) study included: not knowing the family's rules and routines, which made them feel insecure; not feeling a sense of belonging in their new family and finding it difficult to negotiate ongoing relationships with their biological family; feeling different and being treated differently because they were in fostercare.

Factors associated with the child's family of origin

As noted above, the young people interviewed in Moran et al., (2017) reported varying degrees of relationship with their family of origin. The most emotionally damaging relationships were reported to be sporadic meetings, especially when children perceived their families were

rejecting of them. Biological parents and other relatives can try and disrupt placements. This is more likely to occur when a child is placed into Care under an order from the Courts, rather than voluntarily by the child's parents (Gilligan, 2019).

Contact with the biological family was often reported as a source of discontent by both the biological family and foster parents. All the biological parents in the Moran et al., (2017) report expressed wanting more contact with their children, and believed it was their right to be informed about their child's school progress, activities they enjoyed and services they were attending. Foster parents in the same study expressed discontent regarding access meetings being facilitated when the child was emotionally disturbed by such meetings, especially the impact on a child when biological parents cancelled meetings at the last minute or did not attend. Some foster parent participants also expressed concerns for the child returning to their biological family when they left Care, that they would be exposed to the same neglect or abuse that had originally brought them into Care.

To quote a recent scoping review (Ruiz-Romero et al., 2022, p.1) that was questioning whether contact with biological parents is beneficial to foster children,

> …the findings to date are neither conclusive nor generalizable, although they are not generally encouraging; c) under the right circumstances (e.g., adequate supervision, conducted in a context of emotional security for the child), contact can contribute to the child's well-being and increase the likelihood of family reunification; and d) more robust research is needed to guide the development of interventions that can improve parent–child relationships and the quality of contact visits.

Factors associated with foster parents' biological children

Höjer et al., (2013) carried out a literature review of international research to find out the impact of a foster child on the biological children of foster parents. Results indicated that when biological children are part of the decision of their parents to foster; providing them with an age-appropriate amount of information about the child being fostered; and keeping this information updated, made biological children feel more included and they were also better able to cope when the foster child displayed problematic behaviour. The biological child also needs to be prepared for the ending of placements especially recognising the biological child's sadness and loss. Another useful finding from the literature reviewed included suggestions from the biological children that their parents allocate specific time for them, since many reported feeling that their parents became consumed by fostering and that they felt left out or forgotten. An important recommendation from the literature review was that the biological children of foster parents need ongoing consultation and support.

Barter and Lutman (2016) found in a small exploratory study in the UK that foster parents were most worried about how the foster child's difficulties would affect their own biological children or grandchildren. These included especially violent and abusive behaviour toward any member of the family, but most especially their own children.

Gypen et al., (2020) surveyed a sample of foster mothers and their biological children in Belgium to identify the characteristics of foster children, as perceived by the mother and child. Both the foster mothers and their biological child identified that 20-21% of the foster children had emotional difficulties; 14.5-20.5% had behavioural difficulties and 25.2-33.1% showed symptoms associated with hyperactivity. Foster mothers reported higher levels of acceptance of the foster child by their biological child and higher levels of family cohesion (29%) than reported by the biological child (15%). Behavioural difficulties were reported as the main reason for reduced acceptance of the foster child by the biological child, especially when the family had to make major adaptations to accommodate to the foster child's needs. Acceptance was more likely when the biological child was young at the time a foster child was placed. The authors suggested that younger children are more adaptive and might develop empathy and understanding during the experience of fostering. The recommendations included a more family systems approach, valuing the opinions of all family members, providing them with relevant information and including them, by listening to their concerns and difficulties and including them in decision-making processes.

Factors associated with foster parents

> The personal impact of fostering also had a substantial impact upon the overall satisfaction of the respondents in the study. Those who felt that foster parenting was harder than they originally anticipated, was difficult, who experienced adverse health effects, and/or who felt burned out were understandably less satisfied. (Griffiths et al., 2021, p. 8)

The Whenan et al., (2009) study in Australia looked at foster parent factors that resulted in either placement success or failure. They assessed 58 foster parents and identified that a parent's ability for cognitive empathy or the ability to understand the nature and origin of the child's behaviour as being associated with placement stability. They found the relationship between the foster parent and the child and the foster parent's sense of competence regarding fostering were related to increased satisfaction with fostering.

Stressful life events, stress associated with parenting a child with emotional and behavioural difficulties and not being able to contact the child's social worker as and when required were identified in the Randle et al. (2017) study as issues that were most likely to impact on placement stability and lead to placement breakdown. Miller et al. (2019) on the other hand who was assessing foster parent factors associated with placement stability and disruption in Australia, found that

factors such as finding fostering satisfying, having a supportive social and family network, and a good relationship with their spouse or partner led to more positive outcomes in foster placements.

Compassion fatigue

Fostering a child can represent a context of chronic stress as well as family members experiencing the trauma of the child vicariously, when the child's behaviour represents the trauma they have endured prior to coming into Care. Hannah and Woolgar (2018, p. 630) define the terms as:

> **Compassion Fatigue:** the emotional impact of working with traumatised individuals including secondary trauma and burnout.
>
> **Secondary Trauma**: the tension and preoccupation with the suffering of others as a result of working in trauma-related contexts. Secondary trauma symptoms are similar to symptoms of post-traumatic stress disorder (PTSD) and include heightened states of arousal, intrusive thoughts or images, and avoidance of thoughts or reminders of the person's traumatic experiences.
>
> **Burnout:** occurs as a result of prolonged exposure to demanding interpersonal situations and is characterised by emotional and physical exhaustion, depersonalisation and reduced personal accomplishment. The symptoms of burnout tend to develop gradually over time but if ignored can progressively worsen.

Hannah and Woolgar (2018), in an online study in the UK found high levels of Secondary Traumatic Stress (STS) with levels of the more severe symptoms associated with Burnout. Their findings illustrate that low job satisfaction was positively correlated with high levels of secondary trauma and burnout, leading to psychological inflexibility, which impacted their parenting capacity and these individuals were more likely to terminate a placement. In a large study in the USA, that sought to establish whether foster parents were exposed to their foster child's trauma and whether that had a negative outcome such as STS, Whit-Woosley et al., (2020) found that nearly 80% of foster parents were exposed to their child's trauma, which was in most cases were numerous forms, thus placing foster parents at risk of developing secondary traumatic stress (STS), which was related to dealing with the foster child or to the case workers. Approximately 25% of their sample reported symptoms associated with STS that were causing difficulties in day-to-day tasks, with 15% of the sample at levels so high that they indicated PTSD.

Whit-Woosley et al., (2020) further suggest agency protocols of supervision and support for foster parents who have children that show symptoms associated with high levels of trauma, inclusion in decision making processes about the child, and matching. Group programs need to be

provided for foster parents, to increase compassion satisfaction and feelings of competence. In addition, interventions with the child should include the foster parent(s).

Factors associated with the system

Khoo and Skoog (2014) carried out a qualitative study in Sweden, in which they interviewed foster parents who had experienced a placement breakdown. They found that foster parents felt they were not provided with sufficient information about the child prior to the placement starting; that social workers were not available when they looked for assistance; and that they were not provided with adequate support during the placement, which they felt might have prevented the placement breaking down.

In their review of literature in relation to placement breakdown, Harkin and Houston (2016) found that placements where foster parents felt supported by their social worker were less likely to break down, especially where they were assisted to meet the needs of the children for whom they cared. Pertinent to the lack of resources related to hiring and retaining of social workers (e.g., ("Shortages of Social Workers…", 2021), is that placement breakdown has been found to be associated with changes of social workers.

In the USA, Cooley et al., (2017) found that foster parents reported that the child welfare system was complicated, leading to discontent. They discovered that this was often associated with foster parents and social workers having differing ideas on the foster parents' roles in the foster child's life; as well as lack of availability or failure to allocate supportive interventions for foster parents experiencing difficulties with their foster child.

According to a study in the USA, Denlinger and Corius (2018) found that the relationship between foster-parents and their social worker was a key factor in placement success. A weak relationship, insufficient information sharing and poor communication were likely to result in the foster parent becoming disheartened and more likely to give up fostering, resulting in placement breakdown, which was detrimental to the child they have fostered. Their research discovered a number of themes associated with foster mothers' satisfaction in fostering. These included that the foster mothers felt that they could not have been prepared for what fostering entailed, but felt supported when case managers helped them find informal supports that helped the children. Foster mothers were frustrated that they had to be at the disposal of the system, but often case managers were not available when a foster mother required support for the child. They appreciated that case managers were busy and formal communication was not always possible, however foster mothers felt valued when case managers made informal visits and communications. Foster mothers and case managers do not always agree on what is best for the child: disagreements can result in a decrease in trust and this combined with an imbalanced power-dynamic where case managers have the

ultimate say, can lead to frustration and demotivation in the foster mothers and ultimately placement breakdown, which impacts negatively on the child.

2.7 The Irish context

According to Gilligan (2019), Ireland has the highest number of family home-based placements of foster children in Europe. The formal Irish foster Care system originated in the 1980s as a result of a specific policy change based on the problematic history associated with institutional Care in Ireland, after it emerged that large numbers of children were abused and had been exploited in the care of mainly religious order institutions. Child Welfare Social Work services had started developing a decade before in the 1970s, with the function of finding placements for children who were no longer being placed in institutions and who could no longer live with their birth parents, relatives or non-relatives.

The Child and Family Agency (CFA) in Ireland, renamed Tusla, was created in 2014 as a result of the 2013 Child and Family Act. This government agency was tasked with child protection and welfare and has responsibility for all children placed in Care. Tusla is therefore responsible for decision-making regarding all children in Care, via an allocated social worker in regional and district departments who assumes case management, from the time a child is taken into Care under a Care Order (Coulter, 2015).

According to Coulter (2015), director of the Child Care Law Reporting Project, the Child Care Act 1991 and amendments is the main legislation pertaining to Child Protection in the Republic of Ireland. This act is embedded in the Constitution under the rights of the family, and since the Children's Amendment in 2001, outlines the rights of children. According to Section 3 (2) (c), the act states that it is in the best interests for children to grow up in their families. However Tusla, the CFA, is required to identify children at risk and when the option of maintaining a child in their family is not possible, it is required to seek an order from the courts to place that child in alternative living arrangements. There are three categories of foster placements in Ireland. The child may be placed with relatives, known as relative or kinship Care; they may be placed with non-relatives in general or in-home fostercare; or the child might be placed in residential Care (Gilligan, 2019).

A child is received into Care via a Court Order, known as a Care Order that is obtained through an application to the District Family Court, where these cases are heard by a non-specialist judge (Gilligan, 2019). A child being placed into Care with the permission of their parents, is known to be in Voluntary Care. Care Orders imposed by the Courts can be granted for any time period, with set review periods and these are mainly dependent on the likelihood of reunification with the biological parent(s). Long-term Care Orders can be put in place until the child is 18 years old, and

the Court has the right to influence decision-making in relation to the child under these orders. However, the child's parents can legally challenge a Care Order at any point (Coulter, 2015).

According to O'Mahony et al., (2016) in Europe, England, Wales, India, Australia, New Zealand, and the USA these child Care Order cases are heard within a specialist family court. Switzerland and the Nordic countries of Norway, Sweden and Finland have a system whereby the application is heard in one sitting and a team of three to five individuals, including judges, professionals and lay persons, decide whether a child should be taken into Care.

Gilligan (2019) outlines the organisations and departments involved in the fostering system in Ireland, which include: the Office of the Ombudsman of Children; and the Department of Children and Youth Affairs (DCYA), the government department responsible for all children and young people in the State. The Health Information and Quality Authority (HIQA), is responsible amongst other quality controls within the health services, for inspecting the services provided to children in the Care of the State, including audits of Social Work departments and inspections of residential facilities. The Irish Foster Carers Association (IFCA), an independent organisation run by foster parents, was started in 1981 for the purpose of information sharing, education and support of foster parents and the promotion of fostering countrywide. EPIC (*Empowering People In Care*), a name developed by young persons in the Care system, was founded in 2000 to support and promote the needs of children and young people in Care. It is partially funded by Tusla and the board is made up of individuals who have been in, or are currently in the Care system, as well as professionals with knowledge of the Care system.

Services that may be required to meet the child's psychological and disability needs are outsourced from Primary Care, Disability Services and CAMHS (Child and Adolescent Mental Health Services). Primary Care services include separate Speech and Language, Occupational Therapy, Physiotherapy and Psychology Departments. Disability Services are regional services that are made up of multidisciplinary teams that include Speech and Language Therapists, Occupational Therapists, Physiotherapists and Psychologists, specialising in working with children with disabilities. CAMHS are a psychiatrist-led service providing assessment and treatment of children and adolescents with diagnosable acute mental health difficulties, including suicidality and Attention Deficit Disorder with or without Hyperactivity (ADH[D]).

The population of the Republic of Ireland in 2020 was 4.985 million with 1,199,349 children under 18 years old (Minister for Children, 2022), and approximately 0.5% of children under 18 were in Care. Table 1 that follows illustrates the number of children that were fostered in the second quarter of 2020. This includes a majority of children who are fostered within in-home settings including with relatives. Those in residential and special residential care settings are also illustrated.

Table 1

Number of foster parents and foster children in the Second quarter of 2020 in Ireland (Tusla, 2020)

Foster Parents TOTAL	Registered Foster Parents	Private Foster Parents	Relative Foster Parents	Unregistered Relative Foster Parents		
4381	2527	490	1107	257		
4124*	3017		1364			
Foster Children TOTAL	General Foster Care		Relative Foster Care	Residential Care	Special Residential Care	"Other" Care
5957	3885		1565	390	16	101
5450**	3885		1565			

Note. * Total Excluding Unregistered Relative Foster Parents

** Total Excluding Children in Residential facilities

Organisational structure

The Social Work system for Children in Care in the county region of the Mid-West of Ireland (where the study took place), is structured in such a way that the foster child is allocated their own social worker from the Child in Care team and the foster parents have a Fostering social worker from the fostering team. The child's social worker supports the needs of the child and has responsibility for the child's biological parents and family, whereas the Fostering social worker provides support and guidance to the foster parents and their family. Statutory Child in Care reviews take place on an annual basis where all professionals involved with the foster child are invited. These reviews are chaired by a senior designated social worker from the region, in the role of independent chair.

Foster parent recruitment

Tusla is the statutory organisation responsible for recruiting, training and overseeing foster parenting in Ireland. Individuals or couples who have space in their homes and believe they have the time and skills to provide care to a child, are invited via Tusla's website to contact them and register as prospective foster parents. According to the website, "diversity is welcomed" and the following quoted list of criteria are provided (Tusla, 2022).

Foster carers can be:

Couples – married, co-habiting, same gender

Single people – widowed, separated, divorced

People with disabilities – provided your disability or medical condition does not prevent you from caring for a child

People with or without children

People who own their own homes, are in private rented accommodation or local authority housing

Employed / Unemployed people

Those over 40 years of age

Those who smoke

People from different cultures, ethnic or religious backgrounds – having carers from different cultures allows us to match children and young people with suitable families.

The website (Tusla, 2022), also expresses the importance of the following features of prospective foster parents:

Can provide a stable, nurturing and loving environment for children

Relate well to and have respect for children

Do not have a Garda record for violence, offences against children or other serious offences

Can demonstrate flexibility, openness and patience

Are willing to attend training courses to support ongoing learning and skills base.

Individuals and couples who contact Tusla are interviewed telephonically by the fostering social work department regarding suitability and are then offered positions on the induction training.

Foster parent induction training

The "Induction to Foster Care" training takes places over a three-day period. The majority of the material is taught to prospective foster parents by fostering social workers from the regional district fostering department. Local teams also try to get a speaker to share their experience of fostering (e.g., a foster parent, birth child of foster parents, an adult who was previously fostered, or a parent of child who was in fostered). Some teams try to get a psychologist to discuss the sections on Attachment and Common Behaviours of children in care. The topics covered in the training include:

1. What is Fostering?
2. Working with Tusla
3. Children's First Guidance
4. Child Development and Attachment
5. Common Behaviours of children in Care and how to respond to them

6. Consultation with children in Care and children's rights
7. Safe Care and your family
8. Taking care of children who foster (birth children of foster carers)
9. Birth Families, access, and contact
10. Moving children (reunification home, transitioning to a new placement, placement disruptions or moving into independent living).

Foster Parent Assessment

In Ireland, once training has been completed and individuals still wish to pursue fostering, foster parent applicants are accepted for a full fostering assessment. It is not uncommon for departments to lose applicants after completing the training, as some of the realities of fostering are quite clearly presented to prospective foster parents during the training and some may find the prospect of fostering daunting, or may not be in a position to provide the level of care required.

The assessment of foster parents is competence and safety-based and includes personal background information, financial, medical and security checks. These are important factors, however, psychological assessment is absent.

Once the assessment is completed, it is presented to a multidisciplinary foster care committee (FCC) who make a determination on whether or not to approve the applicants, based on the report generated by the fostering social workers' assessment. The applicants are invited to attend the FCC meeting the day their assessment is being considered, however it is not mandatory for them to attend. If approved, the applicants' approval stipulates the type of foster placements they can be offered. These include, emergency, respite, short-term, day, mother and baby, and long-term placements. Long-term placements can, although they are seldom approved at this stage (because departments do not know the foster parents' competencies and weaknesses until they start fostering).

A newly qualified foster parent is initially usually only considered for short-term placements. However, depending on the case, these short-term placements often become long-term, especially when it is in the best interest of the child, and suits both the child and the foster parent, since then the child does not have to endure an unnecessary move. In the Republic of Ireland both non-relative and relative foster parents are provided with a financial allowance to cover the needs of the child (Coulter, 2015).

Foster parent ongoing training

The Tusla website (2022) goes on to say:

"Throughout your time as a foster carer various training courses will be offered to you and we hope you will find these courses both interesting and enjoyable".

Ongoing training is recommended, but not mandatory. Foster parents are encouraged to attend a minimum of two training modules per year. The only mandatory training that they have to do is Children's First Guidance training every three years, which outlines the policies and protocols regarding child protection and welfare policies and reporting protocols. Social workers from the fostering department carry out a training needs analysis with each of their allocated foster families and make recommendations to them in terms of what training modules would be most beneficial for them to attend but again these are not a compulsory requirement to continue fostering.

To summarise, this meta-synthetic review of the fostering literature illustrated that many of the issues experienced by foster parents are fairly universal within the European, UK, Scandinavian, Australasian, American and Canadian contexts. Parenting foster children can be challenging because of many factors, these include factors associated with the foster child such as disability or behaviours related to the circumstances leading to them requiring a foster placement. However, the entire ecological system needs to be considered, as there is an overlap of the child and foster parent(s)' individual factors, family factors (biological and foster family), organisational factors including different social work departments and individual social workers, the legal system and judiciary, which all need to be contextualised within the country's particular history and culture.

This chapter has focused on the foster parent, especially those factors leading to foster placement stability and those that contribute toward foster placement disruption. Maintaining children in their foster family appears to be economically, practically and emotionally the best option. Training has been identified as a supportive and protective factor to effective fostering. The Irish fostering system was outlined, illustrating some of the processes that the research participants would have completed in order to become approved foster parents. The following chapter will outline the theoretical elements used to construct the conceptual framework for this research; and these were also the basis of the foster parenting Course, in order to amalgamate the complex multifactorial interactive nature of the foster child's and foster parent(s)' experiences.

3. CONCEPTUAL FRAMEWORK

3.1 Introduction

Psychology by its very definition is individualistic. The British Psychological Society (BPS) on their website defines Psychology as "… the scientific study of the mind and how it dictates and influences our behaviour, from communication and memory to thought and emotion" (BPS, 2021). However, humans do not exist in isolation and evolutionary blueprints show how humans have developed large brain size, social cooperation, and the capacity for reflection and adaptation, enabling the human species to survive and thrive (Sherwood et al., 2017).

This chapter discusses the multidimensional and therefore multi-theoretical conceptual framework of this research. Two demographic groups were being researched, foster children and foster parents. To explore and explain the predominant features of foster children emotionally and behaviourally and the aetiology thereof, a bio-psycho-social framework (Engel, 1977) was used to depict the cumulative impact of a child's unique biological, psychological and social circumstances on their Development. Bronfenbrenner's (1994) Bioecological model of Development was incorporated to expand the Social element of the bio-psycho-social framework and structurally depict the Social element as a larger ecological context. These are represented in some of the complex ecological network of systems, including the reciprocal interrelationships between foster children, foster parents, and the numerous organisations with whom they interrelate. The research methodology for the study to be described was developed from a Community Psychology perspective, emphasising the interactions between and influences of the two subject-groups' interpersonal, psycho-social and systemic aspects. Community-based Collaborative Action Research will then be discussed in chapter 5 to describe the methodological framework within which both mixed methods were used in order to try to understand the emotional and behavioural features shared by foster children, the stresses experienced by foster parents, and to explore the design and efficacy of a small group parenting intervention with foster parents.

As a trained and practising Clinical Psychologist, the nature of my work is individualistic. I consult mainly with individuals or sometimes in groups; and even in a group context, the focus is often on individual treatment or learning. However, understanding the influence of an individual's systemic context is vital to both assessment and treatment, including the influences of societal power structures at relevant points in time, as these constitute the larger cultural and societal contexts within which an individual exists. The research involved assessing individual symptoms of foster children as recognised by their foster parents, who both exist within a certain organisational structure that has developed over time, all of which is influenced the broader cultural values and legal structures. The work is therefore embedded in the tenets of Community Psychology, as

summarised below from Orford (2008), from which I found meaning in relation to the research I was conducting. I therefore link my practice and research values, objectives and methodology where I am able, to the draft of 17 points prepared by the UK Community Psychology Network (J. Akhurst, personal communication, 28 September, 2010) as a proposal for the BPS, for the development of Community Psychology as a separate section in 2009. Please note that since this research was conceptualised, evolved and was conducted over the period 2009 to 2014, the design was influenced by the literature current at that time.

3.2 Bio-Psycho-Social Model

I would have been introduced to the bio-psycho-social model (BPSM), based on Engel's writings in the 1970s (Engel, 1977), as part of my training as a psychologist in the 1990s. He developed the model as an attempt to move away from the predominantly bio-medical model and introduce psychological, social and behavioural phenomena into the conceptualisation of disease in medicine in general (Smith et al., 2013).

The BPSM proposed by Engel (1977) was an attempt to humanise medical practice, where the emphasis was on pure science and biochemical processes in relation to human disease. The suggested model (based on General Systems Theory) introduced biological, psychological and social elements of psychological make-up, such as temperament and personality; as well as social conditions for example poverty, to better understand lifestyle choices and conditions under which disease develops, presents and progresses. The BPSM has not however been able to establish itself strongly in medicine, but has become a holistic way of identifying disparate elements that may impact on a person, in psychology and social work, the model lending itself to multidisciplinary teams (Benning, 2015).

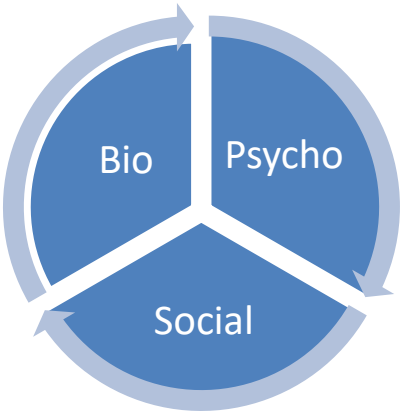
The main argument against the BPSM has been that it was not scientific enough for medicine. Smith et al., (2013), provide the example that information obtained by two interviewers would differ and therefore as a method would not be replicable. The critique by Ghaemi (2011) in relation to BPSM and psychiatry suggested that the biggest weakness was BPSM's eclecticism, which he defined as "an unprincipled mixing of many different approaches—and thus is both unscientific and not useful for the progress of psychiatry" (p. 1). Other weaknesses he suggested was Engel's (1977) inclusion of psychology, initially narrowly defined as psychoanalysis; and the social component of the original model only referring to the relationship between the doctor and patient, rather than in broader terms, which would include the person's context and social environment. Ghaemi (2011) stated that the main strength of the BPSM was its flexibility regarding theory, in that it valued no particular method over another. He went on to argue that this becomes its greatest weakness as these unclear boundaries create an unclear model of the body-mind relationship.

Despite his criticisms, which were specifically in relation to BPSM's use in psychiatry, the model has found popularity in psychology and social work.

Using the BPSM to conceptualise the foster child, I define "Bio" as the biological, biochemical, physiological, epigenetic and genetic nature of a person. The "Psycho" relates to the psychological nature of a person, including temperament, impact of previous life experiences, resilience, personality and capacity for relationship. The "Social" refers the social inter-relatedness with others from primary through tertiary relationships, which includes family (biological and foster), and friends.

Figure 1

The interactive nature of the bio-psycho-social elements of the foster child



The BPS individual (foster child) in the context of the research, is then placed within the broader Ecological component of Bronfenbrenner's (Bronfenbrenner & Morris, 2006) Bioecological model (see Figure 2.). These are similarly represented as described in Bronfenbrenner's model below, where the different levels are represented in the concentric circles diagram (of nested systems); from close relationships with family and peers extending outward to the impact of a person's country's social, economic, political and legal structures; all taking place within a particular era in time and impacted by historicity.

3.3 Bronfenbrenner's bioecological model

In 1979 Bronfenbrenner described his theory entitled, "The Ecology of Human Development", which incorporated those elements he believed impact on a child's development and socialisation, which later went on to evolve into the Bioecological model (Bronfenbrenner & Morris, 2006).

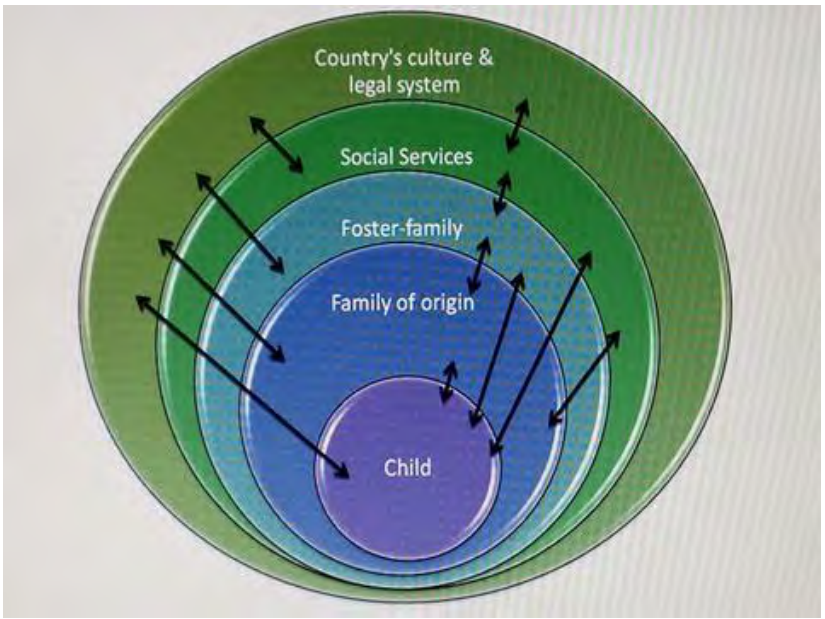
> Human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate environment…The form, power, content, and

direction of the proximal processes effecting development vary systematically as a joint function of the biopsychological characteristics of the developing person; of the environment, both immediate and more remote, in which the processes are taking place, and the developmental outcomes under consideration. (Bronfenbrenner, 1995, pp. 620-621)

In the model, there were initially four environmental systems nested one within the other, with the Chronosystem added later to acknowledge that development is influenced by the particular period within which it takes place. The model is visually depicted as interrelated and interactive concentric circles placed within one another, each representing those elements of the environment that impact on the development of the child. The central circle, the **Microsystem**, contained those environments that directly impact on the child such as family; school and neighbourhood containing friends and peers, illustrating reciprocal relationships between the child and their immediate network. The **Mesosystem** represents the connections and inter-relationships between the child's microsystems, for example the connections between the child's family and school experiences. The **Exosystem** illustrates links between the child's microsystems and social systems in which that child does not have an active role (for example parents' workplaces). The **Macrosystem** represents the overall societal culture such as belief systems, socioeconomic structures and laws enclosed within societal or regional boundaries. The **Chronosystem** is the time period within which development takes place, where the different systems impact on a child's development based on the influences, beliefs, policies and laws of that particular period of time (Härkönen, 2007).

Figure 2

The context of the foster child in the centre of multiple interactive relational and social systems



The above diagram (Figure 2.) illustrates the bio-psycho-social elements of the child (in blue), placed within the original Bronfenbrenner (1979) concentric circle model, illustrating simplistically some of the systems that impact on the foster child, and on which the child impacts. Other relevant Microsystems such as school, neighbourhood and religious community are acknowledged but not included in the above diagram. The foster child has two significant family microcosms: their birth family and the foster family. These are both influenced by the Social Services system, which in Bronfenbrenner's model (1994) would represent as an Exosystem, functioning within the country's Macrosystem. The arrows between the different systems illustrate different interactions to and from the child's Microsystems and their broader systems.

Placing the BPS subject (foster child) within the Bronfenbrenner (1994) model illustrates the child's complex context of existence, simultaneously illustrating the complexities of the foster parents' situation. The foster parent-child relationship takes place in the context of many other direct and indirect relationships, within the broader context of socio-cultural and legal influences, taking place during a certain time in history.

The progression of Bronfenbrenner's theory from Ecological (1994) to Bioecological (Bronfenbrenner & Morris, 2006) involved the inclusion of the developmental "processes" of the individual and outlined "proximal processes" which occur within a specific "context", and during a certain "time" or epoch (Rosa & Tudge, 2013). Another important feature is that rather than representing the model in the familiar nested concentric systems, it was reconceptualised by Neal and Neal (2013) using Social Network Theory, as a network of dynamic and mutually interacting network systems.

A more recent revision (Vélez-Agosto et al., 2017), acknowledges the original broader cultural context of the model, and included equally important micro-cultural constructs, within the macro-culture, of the child's lived and interactive experiences. This feature is particularly relevant to the foster child, who is born into one micro-culture and brought up in another potentially disparate micro-culture of the foster family.

3.4 Community Psychology

Bronfenbrenner's (Bronfenbrenner & Morris, 2006) bioecological model visually represents the crux of Community Psychology, which seeks to understand people within their particular social groups. This extends from immediate family and friends, through networks within and between work / school / community environments, to the macro-levels of society that exist within a national and global context, at a specific point in time. Foster parents constitute a community (in relation to each other), in that they have in common that they have made a commitment to providing a home

environment to children who have been removed from their birth families, due to issues relating to parental incompetence, abuse or neglect.

Orford (2008) outlined 17 key elements of the field, which were developed by a working group of the Community Psychology Network in the United Kingdom. I have customised the following summary and application of these as a framework for my research.

1. Context – foster children and parents exist within their own personal settings, which are to be found within a larger social context of the broader community.
2. Causality – comes about through multiple connections between the individual and the different elements of their social context, and extends from family and peers to cultural values, to global issues; and hence is well illustrated by Bronfenbrenner's (Bronfenbrenner & Morris, 2006) Bioecological model.
3. Community Psychology strives to be critical about individualism in psychology, therefore finding relevance in external causative factors rather than focussing on an individual or their family. Hence groups of foster parents were recruited for this research, to understand their lived experience of parenting foster children.
4. Individuals are perceived as active participants in their own lives who are making choices within their particular constraints, to make the most of the circumstances.
5. The unequal distribution of power and resources is seen as a source of difficulty for communities and therefore individuals. Psychological or difficulties in coping with certain circumstances may emanate from the disparities in society. Community Psychology proposes that increasing power for individuals and groups has positive outcomes. Using Sir Francis Bacon's maxim, "Knowledge is power" (Bacon, 1597) providing a psychoeducational / reflective group for foster parents was intended to increase their knowledge regarding parenting foster children, as well as their knowledge of the experiences of other parents in relation to parenting, but also in relation to the power structures relevant to fostering.
6. A goal of Community Psychology is consciousness-raising within communities, where it seeks to reveal the damaging effects of power that are not noticed due to being a way of life. Foster parents may be aware of and have experienced the effects of unequal power distribution, but have been unable to address the imbalance of power as one individual against a larger statutory organisation. Being part of a group who experience similar power imbalances could result in parents no longer accepting these and being more proactive in balancing the power differences.
7. An aim of Community Psychology is therefore to promote equality and work toward a redistribution of power between and within groups in the community. Identifying as a group

with common difficulties, strengths and experiences, it was hoped foster parents might be empowered.

8. Difference is identified and encouraged as a way of empowering minority groups. One of the precepts of the Course (to be described) was that parenting foster children is not the same as parenting biological children. This applies to both the format of parenting and the involvement of other professionals in the lives of the parents and children. Identifying as foster parents was an important feature of the Course.
9. In Community Psychology groups of people, rather than individuals, where social, economic and legal policies or environmental issues may be the cause of existing difficulties, are identified for intervention. A group intervention was developed for foster parents because it was hypothesised that foster parents would find strength in identifying with others experiencing similar parenting but also policy difficulties, and possibly be empowered to express their discontent and therefore effect change.
10. A strong theme in Community Psychology is sharing psychology with the affected people, which is a strong personal professional value of mine (as in the idea of "giving psychology away" suggested by Miller, 1969). The basis of the content of the psychoeducational element of the Course was to share psychological material, both theoretical and practical, with the group in order to increase their knowledge and understanding and thus empower them as parents. Ideally, participatory research is used, where the group decide to research themselves and design the research process themselves. However, it also includes research that is practitioner or researcher led in agreement with the group, such as in Collaborative Action Research (Akhurst, 2022), which was used in this study.
11. Attempts are made to equalise the relationship between practitioner and group by developing collaborative investigations and interventions, thus distributing the power more evenly and avoiding the dichotomy of power in the expert–client model. Historically I have always framed my work with foster parents as perceiving them as co-professionals in the treatment of their children. I made explicit in the research model that, with the exception of the psychoeducational input (which was developed based on information foster parents had found useful in practice), the reflective or discussion element of the Course was knowledge-sharing and that we were learning together. Participants were also encouraged to request any input that would suit their particular circumstances and it would be added to the Course as a form of co-construction.

12. The expertise is located within the group, where participants know more about their situation than any outsider. This lived-experience knowledge and expertise is encouraged and using this knowledge, investigations and interventions that benefit the group can be co-created.
13. Openness between practitioner or researcher and group is vital, sharing each other's knowledge and expertise, and avoiding professional jargon. Participants were contacted telephonically before the Course to explain my motivation and intent in running the Course. They were also provided with an information sheet, which outlined the nature of the groups, risks and benefits and expectations. They also had the freedom to remove themselves from the research process at any point, even after the Course was completed.
14. Research in Community Psychology entails using multiple types of methods, where supplementing quantitative methods with qualitative methods can potentially capture the voice of the group being researched. Mixed methods were used in the design of the current study, to on one hand quantitatively measure symptomatology in both foster children and foster parents; and on the other using qualitative questionnaires, to capture the experiences of members of the group individually and collectively.
15. The location of a group is normally within their environment and is specific to the group being researched. It provides an opportunity to learn more about the particular group and focusses on empowering that group within that setting. Placing members of the same group together, even within the artificial setting of a meeting room, would enable information sharing and more importantly group identification. It had the potential to reduce foster parents' sense of isolation, providing an opportunity to find solutions for their difficulties from within the group.
16. Community Psychology is reflective. This involves self-evaluation of and by the group for the purpose of improving the group's circumstances. The second part of each session was a discussion/reflective process whereby members could share and evaluate their experiences. Evaluation questionnaires after each session also allowed participants to evaluate their own process during each session. These were used by me as practitioner and researcher to monitor learnings, tensions and growth within each group as a measure of how to present material going forward.
17. Action research is a popular method of research in Community Psychology as it connects the building of theory to an action process that involves the participation of the group or community that is being researched. This was central to this study.

Community-engaged research moves away from the academic subject(s)-dominated form of research, instead developing meaningful co-operation with social groups or communities, where no member of the group is more important than another (Luger et al., 2020). However, when a group

does not possess the opportunity, research knowledge or understand the value of their information, a clinician or academic may enable the research to progress. As stated by Corrigan (2020, p. 123), an advantage of collaborative research with communities is that "professional researchers have the expertise to promote rigorous and valid science within the constraints of the real world. Community stakeholders have the expertise to make sure the science is relevant to their community".

3.5 Summary

The conceptual framework suggested for this research, which involved obtaining data on two interrelated subject groups, foster parents and foster children, utilises two systems theory models. Firstly, Engel's (1977) BPSM is used to illustrate the complex biological, psychological and social features, to provide some level of understanding about a foster child's emotional and behavioural difficulties. Secondly, placing the BPS foster child within Bronfenbrenner's (Bronfenbrenner & Morris, 2006) Bioecological model enables the illustration of the multiple environmental factors that impact on the child; and also illustrates the complexities of interrelationships within the child's microsystems, including those with and between their biological and foster parents. The Bioecological model also allows for the inclusion of the organisational structures such as social services, which in turn develop policies and procedures based on the Macrosystem, comprising the country's political, social, economic and legal systems.

Using this combined model illustrates the complexity of a foster child's development from conception, including their genetic inheritance and prenatal environment, which influence the child's biological expression (physiological and neurological). The child's relational experiences after birth, including any difficulties they may have encountered through abuse or neglect and other factors such as temperament, epigenetic inheritance, and resilience all contribute toward the psychological functioning of the child. The social element of the child develops within the context of relationships, initially primary caregiver relationship and family, which extend outward to more interactions with unrelated individuals including friends, peers and teachers. However, this becomes more complicated for a foster child as they are removed from the context of their birth family and placed into the context of another family. Then, each of these BPS elements are linked with each other in complex ways (for example the social will influence the psychological thinking processes). Taking the BPS development of an "at risk" child and placing them within these interrelated and interacting substructures in society are all relevant to the challenging emotional and behavioural difficulties of foster children and the complex nature of the context and inter-relationships of foster children and foster parents.

The theories contributing to this conceptual framework also highlight various implications for assessment, diagnosis and treatment of foster children. These processes emphasise that each

child needs to be considered individually within their own unique set of bio-psycho-social-ecological circumstances. Foster children may display similarities in their emotional and behavioural presentations, based on having experienced similar forms of maltreatment for example, however they cannot be perceived as an homogenous group. Elucidating all the features that affect the child biologically, psychologically and socially and placing them within a larger contextual ecological model allows for a child- or client-centred approach.

Community Psychology developed out of dominant models of mainstream Psychology (Lorion, 2021), valuing the information of the group over the individual, focussing on empowerment and the redistribution of power through knowledge acquisition. Defining foster parents as a community provided the opportunity to evaluate some of their needs, leading to the decision to provide a foster-parenting group intervention; simultaneously providing an opportunity for group membership and to gain support from each other, amongst a group of people often isolated by the nature of their commitments. Community Psychology also provided encouragement to develop the methodological means to investigate different aspects of foster children and foster parents. These include developing, delivering and evaluating a small group foster-parenting intervention for foster parents using an Action Research (McNiff , 2013) methodology. The mixed (or blended) method methodology underpinned by the Action Research will be further discussed in Chapter 5.

Conceptualising the multifaceted elements and interactions of the two groups being researched required combining the BPSM (Engel, 1977) with the revised versions of Bronfenbrenner's (Bronfenbrenner & Morris, 2006) Bioecological model of Development. This amalgamation of theories allows for the inclusion of pertinent factors relevant to a foster child's development that may have a lasting effect on their sense of themselves and how they might perceive and respond to others under different circumstances. Some of the relevant ecological factors were previously discussed in Chapter 2 in relation to how the Irish CFA, Tusla, oversee both foster parents and foster children, and the laws, policies and protocols that govern how these are implemented. The following chapter will outline some of the biological (e.g., prenatal conditions), psychological (e.g., a sense of self, based on how a child is nurtured), and social factors (inter-relationships with those in their lives). Explicating the three main areas outlined in the next chapter, prenatal development, Attachment and Trauma illustrates how the child's bio-psycho-social experiences and outcomes interact and overlap. An oversimplified example would be how exposure to trauma leads to chemical and neurological adaptation in the body and brain (biological) may affect the way the child perceives the self (psychological) and interacts with their peers (social).

4. FOUNDATIONAL CONCEPTS FOR THE COURSE

4.1 Introduction

The literature reviewed in this chapter explores the foundational theoretical concepts that were the basis for the creation of the psychoeducational element of the foster parenting Course. Since the Course contained information about child development, Attachment theory and Trauma, which are all extensive topic areas, the reviewed literature to follow pertains specifically to those topics, selected from these three large subject areas, focused upon what was to be covered in the Course, as applicable to children at risk and those who ultimately require a foster placement. The reviewed literature is therefore selective and is evidence from research carried out in the "western world", from countries whose systems and ways of working with foster children and parents is similar to that of Ireland. To access as much peer-reviewed and evidence-based literature as possible, systematic reviews are included.

In order to describe the profile of a child who has been placed into fostercare and many children who are at risk but are not removed from their biological parents, requires an understanding of that child's journey from the time they were conceived. Each individual child's profile is different because so many factors (both positive and negative) can influence their developmental trajectories and survival, by way of adaptations to difficult circumstances. Providing a comprehensive description of every element that might affect these children, would be too complex and potentially overwhelming, and risks losing perspective of the child in the process.

The topics to be covered in this chapter will broadly follow the content explored in an intake interview developmentally, where the practitioner is simultaneously trying to uncover as much relevant information about a child's parents, family history, socioeconomic context, relationships, life events and experiences, as possible. Obtaining details about a foster child requires information from numerous sources, often important information from biological parents may not have been revealed prior to the child being fostered, some may be tucked away in different professionals' files, and some details may not be known at all.

The first area of literature investigates aspects of prenatal development that may influence the development of a fostered child. Emphasis was placed on unwanted pregnancy, the mother's mental health and the influences of toxic substances in the womb environment, including alcohol, nicotine and illegal drugs.

The second area covers the period of birth, through to childhood and adolescence from the perspective of Attachment theory. Attachment in adulthood is also included: to explain the types of Attachment-style parenting that a child may have received from their primary caregiver; and

because participants were asked to examine their own Attachment styles and the relational messages they received from their own parents, and how these might affect their foster-parenting.

The third area examines some of the large body of literature in the field of Trauma identifying the short and long-term bio-psycho-social effects of maltreatment on the child. Framing the outcomes as adaptive strategies. PTSD and DTD are both outlined to illustrate their similarities and differences, and their value to the constantly evolving field of Trauma especially in relation to children.

Throughout, the review the literature reveals the value of identifying those factors that may have an effect on the foster child through the lens of the BPS model. The effects of a suboptimal or toxic womb environment, insufficient nurturing, connection and reflection during childhood and the effects of Trauma cumulatively affect the child's sense of themselves and illustrates how they emotionally and behaviourally learned to survive in the world. Exploring some of these direct and indirect biological, psychological and social factors that have the potential to severely impact a child's normal development, therefore provides a better understanding, from a cumulative risk perspective, but also illustrates that each child will be affected and present similarly, but differently.

It is important to acknowledge however, that the focus in what follows is on elements that negatively impact the child and no emphasis was placed on positive or protective factors such as resilience (Woodier, 2011), which is a vital element of foster children's capacities to survive numerous chronic psychically or physically life-threatening incidents. By framing the child's emotional and behavioural presentation as adaptive, what follows does indirectly acknowledge foster children's resilience.

4.2 Prenatal Development

The psychological (emotional and behavioural) life of a child starts before they are born. Physiologically two gametes create a zygote at conception, the combination of a father and mother's genetic material. Parents also share epigenetic material with their child, which may include intergenerational unresolved trauma (Narayan et al., 2021). Useful information can be obtained during an intake interview, from understanding the circumstances of the parents at the time a child was conceived, including stressors such as finances, grief and loss, health, social supports, relational stress, and importantly whether the pregnancy was planned or the child wanted. Creating a genogram (Sandu, 2022) outlining the family structure and possible transfer of intergenerational issues, enables the mapping of any known significant historic events in both families' and prenatal environments that could potentially influence the psychological well-being of the client.

Pregnancy is a time during which the mother's body and mind are readied for the process of bringing a baby into the world. During pregnancy physiological and psychological changes occur through adaptations of certain brain structures as a result of chemical changes in the brain of an expectant mother (Tal & Taylor, 2021). Ideally, these changes prepare the mother-to-be to support the infant's emotional and physical development. However, the mother's own upbringing or adverse childhood experiences have the potential to disrupt foetal development as well as impact negatively on the mother-child relationship even before the child is born (Rusanen et al., 2018). Prenatal stress can be caused by socio-economic issues such as poverty; relational issues such as domestic violence (whether physical or verbal); mental health issues in the mother such as depression and anxiety, to name a few. These issues individually or in combination can impact the foetus's neurological and physical growth, leading to long-term consequences related to the child's cognitive and physical development, and increases the likelihood of difficulties in soothing them when they are distressed (Slade & Sadler, 2019).

Wanted or unwanted pregnancy

According to Bearak et al., (2020) there were 121 million unwanted pregnancies per annum between 2015-2019. According to their calculations, this translates into 48% of all pregnancies being unwanted and 61% of these unwanted pregnancies ended in abortion. According to the authors, the rates of unintended pregnancies worldwide have decreased and the number of abortions increased. Their data also revealed that even in countries where abortion was limited or illegal, women sought out terminations of pregnancies.

Bourke et al., (2015) investigated data regarding crisis pregnancies in Ireland. In their sample there was an increase in crisis pregnancies in women aged 18-45 from 4.9% in 2003 to 5.7% in 2010. During this time period, Ireland changed economically from being relatively prosperous into a recession; larger numbers of people were receiving higher levels of education; the strong influence of the Catholic church was waning; women were falling pregnant slightly later in their lives; and women reported wanting smaller families. The authors suggest that these changes affected the demographics and meaning of what constituted a crisis pregnancy, as more women had access to contraceptives, which had historically been prohibited on religious grounds. They found in their 2010 survey that women who were young; and those who had less education, were more likely to report crisis pregnancies, with nearly two-thirds of their sample having not used contraception.

Ireland has had an historical legal and religious standpoint on unwanted pregnancies. It was as recently as May 2018 that the 8th Amendment of the Constitution was repealed in Ireland allowing unwanted or crisis pregnancies to be aborted up to 12 weeks. Prior to May 2018, abortion was illegal (Nolan, 2018). In an Irish survey in 2010, 1 in every 7 pregnancies was reported as a crisis

pregnancy, crisis pregnancy being defined as unplanned. The outcome of these pregnancies was reported as: parenthood (74%), miscarriage (18%), abortion (4%), adoption (1%). 15% of participants reported not using contraception as sex had not been planned, and 16% reported that alcohol and drugs had been consumed (McBride, et al., 2012).

Foster, et al., (2019) examined the impact of a mother carrying an unwanted pregnancy to term on other children in the household. Their research was part of a telephonic study carried out in California, USA, whereby women who had undergone an abortion and those that had continued their pregnancies to term were interviewed in order to compare their physical and mental health, and socioeconomic status, including that of their existing children. There were two major effects on the children of women who continued their pregnancies. The mothers' existing children had lower child development scores; and they lived in poorer conditions than the other group, whose mothers had terminated through abortion. Both of these effects related to having to share resources between more children, whether these were the mother's time and attention or money.

A study in Oklahoma, USA (Lindberg et al., 2015) compared health behaviours in mothers carrying intended and unintended pregnancies. Data collected prenatally, postpartum and during early childhood found that mothers with unintended pregnancies, both mistimed and unwanted, were unlikely to engage in health-promoting behaviours such as attending antenatal classes or stopping smoking in the prenatal period. These finding support findings of a meta-analysis previously carried out by Gipson, et al., (2008).

The above meta-analysis also identified higher levels of neonatal death and that mothers were less likely to breastfeed when pregnancy was unwanted (Gipson, et al., 2008). The children had higher rates of illness, especially upper respiratory problems and diarrhoea. Furthermore, being unwanted had a negative impact on the child's development and unwanted children attained less schooling. Mothers were less likely to be involved in their children's leisure activities and were more likely to use authoritarian parenting and physical punishment. The mothers themselves had high levels of anxiety and depression as well as general unhappiness. In addition, children who are born as a result of an unwanted pregnancy were more likely to suffer abuse or neglect (Rodriguez, 2009).

Hayatbakhsh et al., (2011) carried out a longitudinal study to examine the emotional and behavioural outcomes of a large sample of children born as a result of an unplanned pregnancy in Australia. Findings at a 14-year-old follow up found that children had more symptoms associated with mood disorders, delinquency, internalising behaviours and cigarette smoking at age 14. When data were adjusted for mother-related factors such as age, marital status, mental health and smoking during pregnancy, unplanned pregnancy was still associated with aggression, externalising behaviour and using alcohol at 14 years.

Sharp (2021) recently completed a thesis at Regent University, Virginia, USA, entitled *Giving voice: An interpretive phenomenological analysis of those born from unwanted pregnancies,* examining the experiences and feelings of individuals who were born as a result of unwanted pregnancies. The findings illustrate an important but less understood area of prenatal psychological development. The participants reported mental health difficulties associated with distorted self-belief; diagnoses included anxiety and depression; including self-harm and suicidal behaviours. All had a sense of not being wanted or worthy. However, it is important to note that the participants were adults reporting retrospectively and many of their life experiences had reinforced their sense of not feeling wanted.

The mother's mental health

A mother's mental health during pregnancy affects the foetus, which has implications for the later emotional and behavioural features of the child and resultant adolescent and adult mental health.

Vismara (2017) explored qualitative and quantitative studies internationally and outlined the individual experience of each expectant mother from a cumulative risk model perspective, whereby difficulties develop as a response to an accumulation of that individual's specific experiences, within a certain context. These may include mental health difficulties prior to pregnancy, age, relational circumstances, or a combination of these and other issues. He described for example how each individual may express depression, PTSD, or attachment behaviour differently (physiologically, emotionally and behaviourally), and goes on to discuss how elevated levels of stress, trauma and PTSD affect the mother's biochemical processes. Stress hormones can be transmitted to the foetus, which can only to some extent be mediated by the placental hormones. The secretion of adrenaline for example causes a reduction in blood flow to the placenta. When these stress hormones are secreted regularly or chronically, they can impact the normal development of the foetus, have long term developmental consequences for the child and later result in psychopathology or major health difficulties for these individuals as adults.

The result of high pregnancy anxiety, especially in the middle of pregnancy was, according to Buss, et al., (2010) associated with reduced brain volume in the prefrontal cortex, premotor cortex, medial temporal lobe, lateral temporal cortex, postcentral gyrus, cerebellum and fusiform gyrus. These reductions in volume did not occur in the offspring of mothers who experienced high pregnancy anxiety later in pregnancy (measured at 25 and 31 weeks). These changes in the structure of the brain were still evident in 6 - 9-year-old children and were found to result in cognitive and motor development delays, as well as emotional dysregulation. Pregnancy anxiety, rather than general anxiety, is according to Field (2017) often the result of an unplanned or

unwanted pregnancy, socio economic difficulties or relationship problems; and can result in inflammatory chemical reactions and increased levels of cortisol in the mother's body. This may result in changes in chemical reactions in the foetus that may result in premature birth, or emotional dysregulation and difficulties breastfeeding postpartum. Field (2017), who reviewed international studies on prenatal anxiety effects between 2007 and 2017, also found evidence of low grey matter volume in the brain, reduced immunity and lower levels of vagal activity in the first two years of life, resulting in cognitive difficulties, increased negative emotion expression, and internalising behaviour through childhood into adolescence, especially anxiety disorders.

Spry et al., (2020) carried out an investigation of one-year olds born to mothers with mental health difficulties as part of a large longitudinal, prospective study in Victoria, Australia. They found that challenges to mothers' mental health prior to conception resulted in elevated levels of emotional reactivity in children at age 1, after adjusting for perinatal conditions.

Neurological development

Development of the brain is a highly complex, intricate, dynamic process. The organisation of the brain's circuitry occurs prenatally (Thomason, 2018). Specialised development begins a few weeks after conception and the process of specialisation ends somewhere around the age of 25. The main prenatal processes include neurogenesis, which starts around the fifth week; and during maximum production in the third and fourth months, several hundred thousand neurons are produced per minute. Synaptogenesis, the creation of contact points between neurons and myelination, the insulation and protection of neuronal axons allowing for the conduction of electrical impulses, occur at different phases during brain region specialisation. Sensory and motor regions of the brain start to myelinate before birth and frontal lobe myelination only ends toward the end of adolescence. Different regions of the brain create synapses at different times and all overproduce synapses requiring pruning, whereby obsolete synapses are pared back during certain specific developmental time periods (Berens & Nelson, 2019).

The size and function of the human brain is relatively similar for individuals who experience normal developmental conditions. If sub-optimal conditions are experienced in utero, the development and specialisation of specific areas of the brain can be disrupted, leading to structural and functional deficits that have lifelong consequences. These include physiological, cognitive, behavioural or psychological, or combinations of all four (Berens & Nelson, 2019).

Neuro plasticity refers to the ability of brain tissue to change in structure and function depending on the environment to which it is exposed (Sherwood & Gómez-Robles, 2017). This can be a double-edged sword as changes can take place positively and be adaptive if conditions are ideal or remediative; or negatively should conditions be sub-optimal.

It is also important here to differentiate between sensitive and critical periods of brain development. Critical periods require a specific environmental input for an area of the brain to develop or else permanent structural or functional damage occurs. Sensitive periods refer to developmental time periods when the brain requires certain environmental input, however if this does not occur although there may be deficits, these may be rectified to some degree should the correct environmental stimuli eventually be provided. Sensory and perceptual processes have specific critical periods of development in humans, whereas most other developmental processes of the brain are defined as sensitive and are therefore to some extent remediable. However, toxic chemical substances such as drugs and alcohol, may cause the death of neuronal cells or they may not differentiate appropriately, leading to structural and functional abnormalities (Berens & Nelson, 2019).

Foetal Alcohol Spectrum Disorder

The umbrella term Foetal Alcohol Spectrum Disorder (FASD) is hereby used to describe Prenatal Alcohol Exposure (PAE), previously called Foetal Alcohol Syndrome (FAS) where physiological dysmorphia is present and Alcohol-related Neurodevelopmental Disorder (ARND). FASD was never intended to be diagnostic, but there is no consensus on diagnostic categories for prenatal alcohol or drug-related conditions, since over time different terminology as well as diagnostic criteria have been used for assessment and diagnosis (Popova, et al., 2016). Miller (2013) describes the terminology as ambiguous and flawed, as it gives rise to debates surrounding diagnosis and the problematic implications of linking a child's difficulties to maternal behaviour.

Popova et al., (2016) note that Foetal Alcohol Syndrome (FAS), the previous term used to describe FASD, was first described in a paper in the *Lancet* in 1973. They report that FASDs are underdiagnosed internationally and that it is the most preventable cause of developmental disabilities: prevention requires mothers not consume any alcohol during pregnancy. Research in both animal and human modalities illustrates the harmful effects of alcohol on most organs of the developing foetus, especially the Central Nervous System, which causes neurological damage and physical disabilities (Popova et al., 2016). The difficulties experienced by the child when they are born, and throughout life may be cognitive, physical, behavioural or emotional, or a combination of all these areas of functioning. FASD has a high likelihood of resulting in long-term disabilities, hence early identification, diagnosis if possible and intervention are necessary to improve the influences of long-term effects (Fleisher, 2014; Lange et al., 2017; Mukherjee, 2014).

Lange et al., (2017), estimated the global prevalence of children with FASD as 7.7:1000 population, with Europe as the region with the highest incidence at 19.8:1000 population. South Africa was the country with the highest rates, at 111.1:1000 population; the second highest was

Croatia at 53.3:1000 population; and Ireland was reported as having the third highest rate at 43.5:1000 population.

In a study that examined alcohol consumption in the UK, Australia, New Zealand and Ireland, O'Keeffe et al., (2015) found that alcohol use during pregnancy in Ireland ranged from 20% to 80%. Of concern was that there were high levels of binge drinking during pregnancy recorded in Ireland, at a rate in excess of 45%. The findings suggest that up to 75% of pregnant women may consume alcohol in the UK and Ireland. The main predictor of drinking during pregnancy in all the countries investigated was smoking (O'Keeffe et al., 2015).

Another study of eleven European countries including the UK, but not Ireland (Mardby et al., 2017) found that 16% of pregnant women, who knew they were pregnant, consumed alcohol during their pregnancy and that 39% of those drank at least one unit of alcohol per month. There was however a large variation between the European countries.

Impact of alcohol on the foetus

Alcohol is a teratogen, meaning a substance that affects normal foetal development and causes irreversible damage to the foetus. Lipinski, et al., (2011) examined the changes in the physiology of the face of mice foetuses exposed to alcohol and conclude that these effects are based on the timing of alcohol consumption during the pregnancy, and are also correlated with specific neurological anomalies.

The impact of prenatal exposure to alcohol depends on the amount of alcohol consumed, how often it was consumed, and the stage of development of the foetus when the alcohol was consumed. The use of alcohol during pregnancy affects neurological and physiological development leading to cognitive impairment, physiological deformities and social and behavioural difficulties that impact the individual throughout their lives, and this is all preventable (Dörrie et al., 2014; Mukherjee, 2014; Petrenko, et al., 2014).

Some research (e.g., Popova, et al., 2016) suggests that there are 428 neurological and physiological comorbidities with FASD. It is important to note that this does not necessarily mean that alcohol was the cause of all the comorbid conditions, since research subjects may have had pre-existing vulnerabilities. However, it may also suggest that FASD may be under-diagnosed as many of the comorbidities may be interpreted as independent conditions without taking alcohol use during pregnancy into consideration. Summarising some of these comorbidities reported from the Popova et al., (2016) meta-analysis include:

- Premature birth
- Developmental delays, cognitive disorders

- Behavioural issues: Conduct disorder, behavioural problems, disruptive behaviour, impulsivity / attention deficit hyperactivity disorder (ADHD)
- Speech & Language: Receptive Language deficits / Expressive & Receptive Language deficit / Speech, language delay, disorder, retarded speech development speech defects, or acquisition
- Problem with ears: Chronic or recurrent otitis media / Central hearing loss / Conductive hearing loss / Acute otitis media
- Problems with eyes: Refractive errors / Subnormal, decreased visual acuity, problems or visual impairment / Hypotelorism (eyes situated close to one another) / malformation of the retina
- Abnormalities in peripheral nerves
- Malformations of the spine: fusion of cervical vertebrae / Coccygeal fovea
- Alcohol dependence or drug dependence.

Carpenter (2014) who has carried out extensive work in the educational sector in the UK and written or edited a number of books on children with special needs (including FASD) lists further difficulties:

- General intelligence: Maths performance / Language comprehension
- Executive functioning: Manage time / Pay attention / Switch focus / Plan and organize / Remember details /
- Learning & Memory: Verbal & Non-verbal memory and understanding / Visual Spatial ability
- Motor Function: Gross & Fine Motor
- Sensory Processing difficulties
- Emotional immaturity
- Social difficulties
- Difficulties understanding consequences of behaviour.

Diagnosis of FASD

Astley (2010) evaluated a multidisciplinary diagnostic program in Washington, USA, examining the data of 1400 individuals ranging from birth through adolescence with confirmed prenatal exposure to alcohol. An important statistic often quoted from this study is that a little over 10% of the sample presented with the facial features associated with FAS. Another diagnostic criterion is growth deficiencies, and only 42% of Astley's (2010) sample presented with significantly below average height and weight. Data from the CBCL revealed elevations in Social Problems, Thought Problems and Attention Problems on the Syndrome Scales. However, it should also be noted that 70% of Astley's (2010) sample were not residing with either their biological mother or father, having experienced multiple (3-4) placement changes.

The diagnostic profile of an individual with FASD is idiosyncratic to each individual as the neurological and physiological effects depend on the quantity and timing of alcohol consumption and what might have been impacted by its toxic effects, mediated by certain protective factors. Secondary issues that increase with age include mental health difficulties, school related problems, inappropriate sexual behaviour, alcohol and drug misuse (Petrenko, et al., 2014).

Fleisher (2014) outlines the overlapping symptoms of mental health diagnoses, socio-economic and environmental factors that may result in the similarities of symptoms as children with FASD that could lead to misdiagnosis. These include symptoms associated with: Sensory integration disorder, Autism and ADD/ADHD; Bipolar Disorder, Reactive Attachment Disorder, Depression, and Oppositional Defiant disorder; trauma and poverty.

Diagnosing FASD is complex and requires specialist resources, ideally a multidisciplinary approach. Mukherjee (2014) outlines the four areas that require assessment to obtain a FASD diagnosis, which include facial features, pre-and post-natal growth, neurological anomalies, and confirmed alcohol consumption during pregnancy. Other physical differences listed by Mukherjee (2014) include differences in the structure and reduced functioning of the eyes and ears; maxillofacial and teeth problems including defective enamel; Musculo-skeletal problems associated with arms, hands, fingers, toes, foot position, joints, cervical spine and thorax irregularities. Other organs adversely affected include the heart, kidneys, and genitals.

McLachlan et al., (2015) described the challenges assessing children between the ages of one and five years old. They retrospectively reviewed the files of children exposed to alcohol during pregnancy referred to a FASD clinic in Alberta, Canada. Fifteen percent of their sample had been exposed to high levels of alcohol in utero, yet did not meet the established criteria for diagnosis as they did not have sufficient growth deficits, noticeable facial features or neurological abnormalities. Notably, very few of their sample exhibited the physical anomalies required for diagnosing FASD.

Other drugs, including nicotine

Smoking

Smoking during pregnancy has been found to have numerous adverse effects on the foetus that persist through childhood development into adulthood. Lange et al., (2018) carried out the first global frequency and quantity prevalence study and discovered that despite women being discouraged to smoke during pregnancy, of the 174 countries included in their meta-analysis, more than 10% of pregnant women smoked in 29 countries, and more than 20% smoked in 12 of these countries. 70% of those who smoked, smoked daily rather than occasionally and were less likely to give up smoking, with over half continuing to smoke after they discovered they were pregnant.

Globally, Lange et al., (2018) report the prevalence of smoking during pregnancy at as 1.7%; however, Ireland had the highest estimated prevalence at 38.4%, followed by Uruguay (29.7%) and Bulgaria (29.4%).

Smoking during pregnancy was found by Ekblad et al., (2015) to cause reduced head growth. In their review of international literature, they found the head circumference was on average approximately half a centimetre smaller and that the brain weighed 48 grams less at birth than in children whose mothers did not smoke. Infants whose mothers stopped smoking early in their pregnancies had normal head circumference at birth, illustrating that smoking throughout pregnancy has more significant negative outcomes for the infant. The smoke from cigarettes contains thousands of chemicals, many toxic to the developing foetus, with both nicotine and carbon monoxide affecting brain development. Nicotine passes through the placenta and stays in the body of the foetus longer and at higher levels than those of the smoking mother. These toxic effects are noticed when the child is born and experiences symptoms of withdrawal (Kayemba-Kay's et al., 2021).

Smoking cigarettes during pregnancy reduces the amount of oxygen reaching the tissues of the foetus due to constriction of blood vessels and inadequate blood supply to the foetal heart. Nicotine affects specific receptors in the brain, which may be the cause of limiting growth, problems breathing and abnormal arousal patterns. These result in symptoms associated with withdrawal, altered blood pressure, reduced brain growth and changes in brain functions, which may affect neuroplasticity and cause neurodevelopmental delays, and can potentially be transmitted intergenerationally. Smoking has also been found to restrict general body growth possibly for the same reasons as above. Ekblad et al., (2015) report studies that showed the brains of adolescents exposed to smoking prenatally had, "thinner frontal, temporal and parietal lobes and smaller cerebral cortex grey matter and corpus callosum volumes, smaller amygdala and pallidum volumes" (p.15). They also report on a study of 6 - 8-year-olds replicated many of the volumetric deficiencies and structural differences illustrating that the effects were long lasting. Emotional and behavioural outcomes included mood problems and ADHD as measured by the CBCL.

Women who smoke during pregnancy are at risk of miscarriage, ectopic pregnancy, placental abruption, placenta praevia and stillbirth (Grangé et al., 2020). Recent meta-analyses (e.g., Grangé et al., 2020; Torchin et al., 2020) describe the risks to the infant and child associated with smoking during pregnancy. These include, sudden death syndrome, impaired lung function, respiratory infections and asthma, obesity, cancers, high likelihood of tobacco use, nicotine dependence and starting smoking young, cognitive difficulties including academic difficulties at school, and behavioural disorders (which may be partially explained by environmental factors).

Grangé et al., (2020) in their systematic review also examined stopping smoking during pregnancy. Their study described some of the physiological and hormonal changes during pregnancy that might make it more difficult to give up smoking, as nicotine is metabolised slightly differently during pregnancy and could result in increased cravings. They found the risk factors associated with smoking during pregnancy included younger age, lower education, first pregnancy, unemployment, being single, and having a partner that smokes. Giving up smoking was also less likely to happen if the woman already had other children.

Illicit drugs

Tavella et al., (2020) reported the statistics from the 2019 World Drug Report, that between 2010 and 2017 illegal drug users rose in number around the world from 5% to 5.5% of the global population, which in numerical terms equated to 271 million people. Reviewing the published databases, they estimated that studies using toxicology results showed that 12.28% of pregnant women use illicit drugs during pregnancy and that nearly half of these (5.16%) are adolescent women.

Cannabis is known as the most widely used recreational drug in the world and the use of cannabis during pregnancy has increased, most likely as a result of changes in legislation that have decriminalised the recreational use of cannabis in different parts of the world (Bahji & Sephenson, 2019). A meta-analysis identifying negative outcomes of using cannabis whilst pregnant found that mothers were more likely to be anaemic during pregnancy, and new-born babies had lower birth weight and needed to be placed in neonatal care units more often than babies of mothers who did not use cannabis (Gunn, et al., 2016). A Canadian retrospective study correlating both registry data on cannabis use and health administration data bases found an association between cannabis use during pregnancy and cognitive disabilities or learning disorders. An increase in Autistic Spectrum Disorder (ASD) diagnosis was also noted with the rates being reported as 4:1000 in children exposed in utero, in comparison with 2.42:1000 in unexposed children (Corsi, et al., 2020).

According to Carlier et al, (2020) the main three groups of illicit drugs besides cannabis that have been studied and are most often tested for at birth to ascertain prenatal use, include opiates, cocaine and amphetamines. Less is known about the effects on the foetus of some of the more recent drugs including synthetic cannabinoids, cathinone and opioids. Heroin, a semisynthetic opiate works on the central nervous system. It is usually either smoked or injected causing a numbing, painkilling, tranquilising euphoric effect. Cocaine is a natural “tropane alkaloid” stimulant obtained from coca leaves that creates energised senses of euphoria and confidence (Gullapalli et al., 2019). It can be smoked, or inhaled into the nasal cavities in powder form, or injected into the muscle or vein.

Amphetamines belong to a group of synthetic psychostimulants, the effects of which cause elation, increased cognitive ability and sexual desire. Amphetamines have similar effects as cocaine.

According to Conradt et al., (2019), the neonatal withdrawal rate from opiates increased from 1.2:1000 births in 2000 to 5.8:1000 births in 2012 in the USA. These infants have tremors when they are born, are hypervigilant, lack concentration, have an unusual high-pitched cry, have difficulties feeding, but are able to self-soothe. The meta-analysis carried out by Conradt et al., (2019) illustrated how early studies showed little to no effect of opioid use and short-term outcomes, however findings were mixed for longer-term outcomes. They concluded that there appeared to be a higher risk of cognitive difficulties at school age, if a child had been exposed to opiates and experienced withdrawal symptoms at birth, compared to children who had not experienced withdrawal symptoms. Furthermore, children prenatally exposed to heroin and methadone are more likely to be raised in poverty, which is likely to affect the neurological functioning of the child.

Cestonaro et al., (2022) reviewed the international literature to ascertain the current understanding of the effects of cocaine use during pregnancy on the child, once they are born. Evidence suggested that the babies have reduced size measurements in weight, length and head circumference. However, it was not possible in reviewing previous studies to ascertain whether there were any initial or long-term neurological consequences. Most studies reporting concerns in neonates exposed to cocaine also reported that these concerns tended to improve to within normal limits fairly quickly. However, a longitudinal study carried out by Richardson et al., (2019) regarding prenatal cocaine exposure (PCE) found associations between PCE and emotional problems, including conduct disorder. A link was also found between PCE and internalising behaviours, impulsivity and emotional dysregulation recorded at age 21, as well as early onset use of cannabis.

Parenting children with FASD

A study carried out in the UK with foster parents who had foster children diagnosed with FASD (Mukherjee et al., 2013) found that foster parents reported numerous difficulties caring for such children, but what made it worse, was that they felt they were not sufficiently supported and felt isolated. Parents did not believe that they had been given sufficient information by the social workers about the child for them to make appropriate decisions. They also perceived that professionals believed that they (the parents) were responsible for the difficult behaviours their children were exhibiting. Those families who experienced difficulties with their children reported becoming isolated, as they could not go out with the child. As stated by Mukherjee, et al., 2013, p. 52), “Helping these parents adapt their child-rearing skills to the needs of children with FASD, and encouraging parents not to blame themselves, may be key to longer-term reduction of stress in the

family". Their recommendations include that professionals working with children with FASD have better training and that parents who foster children with FASD are also provided training to help them understand the needs, behaviours and possible disabilities related to the diagnosis.

Kapasi and Brown (2017) examined those factors that foster parents raising children with FASD found most useful. They reported that parents felt they needed to change their parenting techniques for children with FASD, depending on the child's strengths and difficulties. It was important to keep the home environment calm and routine and repetition was imperative. It was also very important for parents to adapt their expectations of the child according to the level of the child's difficulties. As cognition, speech and language are often delayed in children with FASD, communication styles needed to be adapted according to the child, using non-verbal cues and shorter clearer sentences when speaking. Patience, adaptability, understanding and commitment were parenting factors that resulted in better outcomes for children with FASD. Social and family supports as well as professional supports and good respite care were identified as important.

According to Petrenko et al., (2019), who studied a group sample of foster and adoptive parents' stress and their impressions of what contributed toward their stress, one major difficulty experienced by these parents was professionals' lack of knowledge and the negative attitudes toward FASD. Parents tended to believe that in relation to the children, their stress was related to the primary disabilities of social, cognitive and behavioural difficulties of the child, and trying to obtain the services and support needed to prevent secondary deficits in social skills and social integration with peers, school failure or suspension, mental health difficulties and trouble with the law. One of their unique findings was the sadness that foster and adoptive parents experienced as they observed the difference between their child's abilities and their peers becoming more apparent over time. Parenting a child with FASD required increased levels of structure and routine, including constant supervision and more time with the child individually to support their social, emotional and academic needs. These required more time and patience resources that can then affect the rest of the family negatively. Parents expressed needing a different type of parenting from the type of parenting required for biological children. Their findings illustrate how individuals with FASD require more services than the general population, including disability services, healthcare, education and emotional and behavioural support services.

Kautz et al., (2020) examined self-care in caregivers of children with FASD who attended a family resource centre in New York, USA. They found that caregivers of children with FASD had elevated levels of parenting stress. These were associated with "time constraints, lack of resources, family needs and challenges, exhaustion, health issues, mood, logistics and pride" (pp. 7-8). Being

able to connect and communicate with others who were experiencing similar difficulties was reported as an important need in order to reduce stress, as they felt understood.

4.3 Attachment Theory / Theory of Mind

A short history

Bowlby's initial interest was the way in which difficulties in a child can be traced back to the way the child's mother experienced her own childhood. After World War II he became the head of the Department for Children and Parents. Ainsworth, from Canada came from the perspective of Security Theory, one of its tenets being that infants and children need to be securely dependent on their parents before being able to deal with novel situations.

In the 1950s, Bowlby proposed ethology as a way of studying the relationship between mothers and their children. Ainsworth joined Bowlby's research team in 1950 (Bretherton, 1992). Ainsworth analysed observations of children who had been institutionalised or hospitalised and thus separated from their parents. Bowlby wrote a report on homeless children in Europe after the war, resulting in the publication *Maternal Care and Mental Health* (Bowlby, 1951).

Ainsworth left the Tavistock in 1953 and went to Uganda. There she observed and studied Ugandan infant-mother proximity-seeking behaviours, later publishing *The development of infant-mother interaction among the Ganda* in 1963 and *Infancy in Uganda: Infant care and the growth of love* in 1967, by which time she and Bowlby had started working collaboratively again.

Ainsworth's data from Uganda, including mother-infant relational connection, illustrated mothers' responses to their infants that ranged from naturally responsive to hardly noticing their infant's needs. She noted that babies of mothers who were sensitive and responded to their needs appeared more regulated and referred to them as "securely attached". She observed behaviour that was meaningful in the mother-child relationship. She noted especially that some mothers responded appropriately, whereas others appeared mismatched or were unable to meet their child's needs for much of the time.

Later Ainsworth went on to develop *The Strange Situation* laboratory playroom-based observation method that measures whether a child is securely or insecurely attached. This was measured according to the way the child responded to the mother briefly leaving the room and being replaced by a stranger who plays with the child until the mother returns. Ainsworth became more interested in some of the unusual responses from the infants when their mothers returned, which resembled those of hospitalised children separated from their mothers for extended periods, that had previously been written about by Bowlby (Bretherton, 1992).

In 1969 Bowlby published the first volume of his trilogy, entitled *Attachment*. Around the same time Ainsworth published data regarding her Baltimore, USA study. The second volume of Bowlby's trilogy, *Separation* (1973), outlines the origins of fear in children as the perceived danger of something frightening; and the absence of the child's attachment person. He explores the importance of the development of Internal Working Models (IWM) whereby the child experiences themselves as valued and competent; or conversely unvalued and incompetent. Based on their IWM, which developed as a result of their secure or insecure parenting, they respond to their attachment person accordingly, thus contributing to the cyclical and possible intergenerational transmission of attachment patterns. *Loss* (Bowlby, 1980), is the third volume of the trilogy wherein Bowlby explores how patterns of interacting become habit, through repetition and reporting that dyadic change becomes more difficult as both parties have preconceived expectations about each other. He also describes some of the defense strategies that deactivate the attachment system and result in emotional shutting down, or projection of emotional pain onto the self or a third party.

Bowlby's interest in the last ten years of his life was the use of attachment theory in therapy (Bowlby, 1988). The therapist provides the "secure base" which comprises safety, consistency and appropriate responding to allow the client to uncover the source of unhealthy working models and develop new ways of functioning in relationship (earned security).

Recent areas of development in Attachment theory from the 80's and 90's include: attachment relationships in adulthood; attachment and its role in the development of psychopathology; attachment in family systems; attachment relationships with fathers or extended family members. A development in the 1980s incorporates Bronfenbrenner's Ecological model to understand how the family and other wider socio-cultural factors influence attachment relationships and behaviours (Bretherton, 1992).

Attachment from an evolutionary perspective

Evolutionary theory as described by Darwin in the 1800s posited that the continuation of a species is based on natural selection, or the development and entrenchment of characteristics that will allow a species to procreate, thrive and survive into the future. The theory has obviously developed in complexity since the 1800s as more is now known for example, about the impact of genetics, however Attachment theory can still as Simpson and Belsky (2016) state, be described as "one of a handful of major middle-level evolutionary theories" (p. 91).

All human infants are said to be born "premature" (Bluestone, 2005); or in anthropological terms, humans are "secondarily altricial", meaning they are underdeveloped at birth and would require a gestation period of 18-21 months to reach the same level of neurological development as a chimpanzee at birth (Martin, 2007). Being born in an immature form is an evolutionary adaptation

that occurred when hominids became bipedal, which resulted in the narrowing of the birth canal and a simultaneous increase in brain size. The brain size of a human new-born is 25% of the adult, whereas in other primates it is between 33%-50% of the adult size, illustrating that much of brain development takes place after birth in all primates, but more so in humans (Sherwood & Gómez-Robles, 2017).

Other mammals at birth are able to get to their feet and access sustenance from their mothers within minutes. They are soon able to walk and therefore get away from danger almost immediately post-partum. Human gestation is 9 months or about 270 days, and infants begin to walk between ages 9 - 12 months, which together equates with the 18 - 21-month gestation period suggested by Martin (2007).

According to Sherwood and Gómez-Robles (2017), the combination of a large volume increase in cerebral white matter in the neocortex, excessive neuronal proliferation, and vast dendrite and synaptic connection in human infant brain development, along with exposure to social and environmental stimuli, results in neuroplasticity (adaptability) and the ability to experience joint attention (connection). However, the energy cost to maintain this neural development requires not only mother-infant dependence through feeding, but cooperation from the extended family and the resultant characteristic of social cooperation within communities of humans. Neuroplasticity, the ability throughout the lifespan for humans to adapt to changes in environment or through experience, enables flexibility in adapting to culturally specific environments including language, belief systems and skills, increasing cooperation in groups and therefore survival (Sherwood & Gómez-Robles, 2017). The value of understanding attachment from an evolutionary perspective is that it provides an explanation into the requirement for the infant to develop and maintain connection with a protective adult for safety.

Attachment across the lifespan

Prenatal Attachment

Bowlby (1988) originally outlined attachment as a mother-child bonding process that took place once a child is born for the function of protection. There is now evidence to suggest that chemical changes occur in mothers during pregnancy, the purpose of which is to promote attachment behaviours in expectant mothers (Markova & Siposova, 2019). According to Slade and Sadler (2019), the pregnant mother's attachment style influences her experience of pregnancy, which later affects the relationship with her child, and results in their child's own attachment style. They discuss how pregnancy is likely to remind the mother of their own relational experiences as an infant and child with their parents or caregivers, and consequent positive or negative emotions growing up. The secure mother who has healthy reflective functioning is able to understand and

reconcile the positive and negative memories and feelings evoked through pregnancy. Avoidant mothers try to evade any feelings of emotional discomfort by pretending negative feelings are not happening; and mothers who are ambivalent in attachment style are likely to be overwhelmed by the fluctuations of their emotional states. Women with disorganised attachment tend to be re-traumatised by the memories of the adverse experiences they had during childhood especially those of frightened or frightening caregivers (Slade & Sadler, 2019).

Bonding with the foetus whilst pregnant impacts a mother's parenting and care-giving ability once her child is born (Slade & Sadler, 2019). Røhder et al., (2020) investigated the associations between prenatal bonding, mother's adult attachment style, prenatal reflective functioning and depressive symptoms in a group of socially vulnerable pregnant women in their second trimester at risk of mental health difficulties. Results of their Danish study illustrated that half of the sample had less than ideal Maternal Antenatal Attachment Scale (MAAS) scores, which measured prenatal bonding. Positive MAAS scores were found to be associated with better caregiving capacity when the child was born. Røhder et al., (2020) found that a pregnant woman's reflective functioning or ability to keep their child in mind was positively correlated with higher MAAS scores and Avoidant attachment was most highly correlated with low MAAS scores. The benefit of this type of research when women are pregnant, is that assessment can result in preventative interventions being implemented that facilitate post-natal bonding.

Infancy & childhood

Rosenblum, et al., (2019) outline the three phases of social and emotional development in infancy. When a child is born, they are able to indicate through vocal noises such as crying and facial movements that they require contact, warmth or nutrition. If the primary caregiver, usually and ideally, the biological mother anticipates and satisfies these needs in a timely manner, the infant only seeks proximity as needed as they know their physiological needs will be met. As their sight and hearing start to develop, infants visually seek out faces and are auditorily tuned in to the human voice, especially their mother's. This first phase normally lasts until the child is 2 - 3 months old.

The second phase is a progression of phase one, however the direction of behavioural control changes and although still reciprocal in nature is directed more by the child, who is now able to reach and grasp for what they can see. They are also able to recognise and direct their behaviour toward familiar individuals and actively seek out, rather than passively respond, to their primary caregiver from approximately 3 months. It has been proposed that the way in which the parent-child dynamic plays out in meeting the child's needs at this early stage results in the secure or insecure attachment style that develops in the child, based on how appropriately the parent responds to the child's needs.

Phase three occurs between 7 - 9 months, during which time the infant's capacity through their expression of distress, physical movement and vocalisations (all care-seeking attachment behaviours), aids proximity to the primary caregiver. The infant uses their established attachment style, either secure or insecure, to elicit (care-giving) attachment behaviour from the primary caregiver (Rosenblum, et al., 2019).

The type of maternal care an infant receives results in different attachment styles (Levy, 2013). Insecure styles can be seen as adaptive malfunctioning of the normative secure style developed by the child, in an attempt to have their needs met from a parent whose care-giving ability may have been compromised by their own attachment style, or for other reasons such as mental health or substance use. Fearon and Belsky (2016) state that Ainsworth's main theoretical concept of maternal sensitivity has been linked to attachment security. They also describe research that supports that a child's sense of fear in the attachment relationship results in disorganised attachment. Originally frightening and frightened messages from the primary caregiver were said to produce a disorganised style of attachment (Main & Solomon, 1990). Contributory factors to disorganised attachment have been extended to include a primary caregiver's unpredictable and confusing behaviour or communication, sexualised behaviour, role reversal, or unwarranted physical and verbal distancing.

Bowlby (1969) framed attachment behaviour as protection from danger or a survival mechanism, which can be linked back to the evolutionary theory of humans being born prematurely and therefore having to establish a reliable connection with their caregiver. Marvin et al., (2016) describes how the toddler becomes more mobile and is able to move away from their caregiver to explore their environment, potentially increasing their vulnerability to danger. They describe how attachment behaviour or showing distress in order to connect with their caregiver is as easily evoked and at the same level in two to three-year-olds as one-year olds, illustrating that it remains important as a connection strategy as the child develops and does not just disappear as the child develops. Toddlers are also extremely vigilant regarding their mother's emotional and physical presence and if the child senses absence, they will use vocalisations and other attachment behaviours to elicit a response from the mother. This behaviour occurs especially when the mother moves away as the toddler is still mastering walking, so maintaining physical proximity is not yet within their control.

Marvin et al., (2016) describe that by the child's third birthday, being left alone provokes strong attachment behaviour. Between 3 - 4 years the child's tolerance of short separations from their caregiver improves and they are able to tolerate spending more time with familiar but not necessarily familial peers and adults. Bowlby (1980) proposed that attachment as a "goal directed"

behaviour system is developed and has served its original function, the protection of the infant and child from danger, by the age of four. However, this system and way of interacting with primary caregivers leads to a particular pattern of relating to others that extends through childhood, adolescence and into adulthood. As stated by Lahousen et al., (2019), "…the attachment pattern established forms an enduring relational context for later affective, cognitive, and social development of the child" (p.1), which extends into adulthood.

Adulthood

Secure or "autonomous" adult attachment is described by Siegel and Hartzel (2003), as seen in adults who exhibit flexibility when describing their attachment relationships; and are able to coherently combine past, present and future parts of their lives when talking about themselves. As previously discussed, secure attachment develops from securely attached experiences, similarly with insecure attachment. "Avoidant" children are likely to become "dismissive" adults and "ambivalent" children are likely to become "preoccupied" adults, with "disorganised" children being likely to become "unresolved-disorganised adults" (Howe, 2011). This cyclical nature is said to perpetuate secure or insecure attachment intergenerationally (Verhage, et al., 2016).

Attachment is not static, and although early patterns developed as a child can remain unchanged throughout the lifespan, often evident in an individual's closest relationships and ways of interrelating to others, improvements can occur (Zeegers et al., 2020). These changes generally occur either in "good-enough" close relationship contexts or through therapy, whereby insecure styles can develop into what is termed, "earned security" (Lawson-McConnell, 2018). As part of a longitudinal study in Texas, USA, Saunders, et al., (2011) assessed a group of women pregnant with their first child retrospectively, to ascertain what had contributed toward their earned security style of attachment (having previously been classified as insecure attachment style). These women reported having more emotional support from significant people in their lives and had spent more time in therapy, than women who remained insecure. The findings also revealed that they were able to form secure attachments with their infants when they were born, in comparison to the insecurely attached women in the sample.

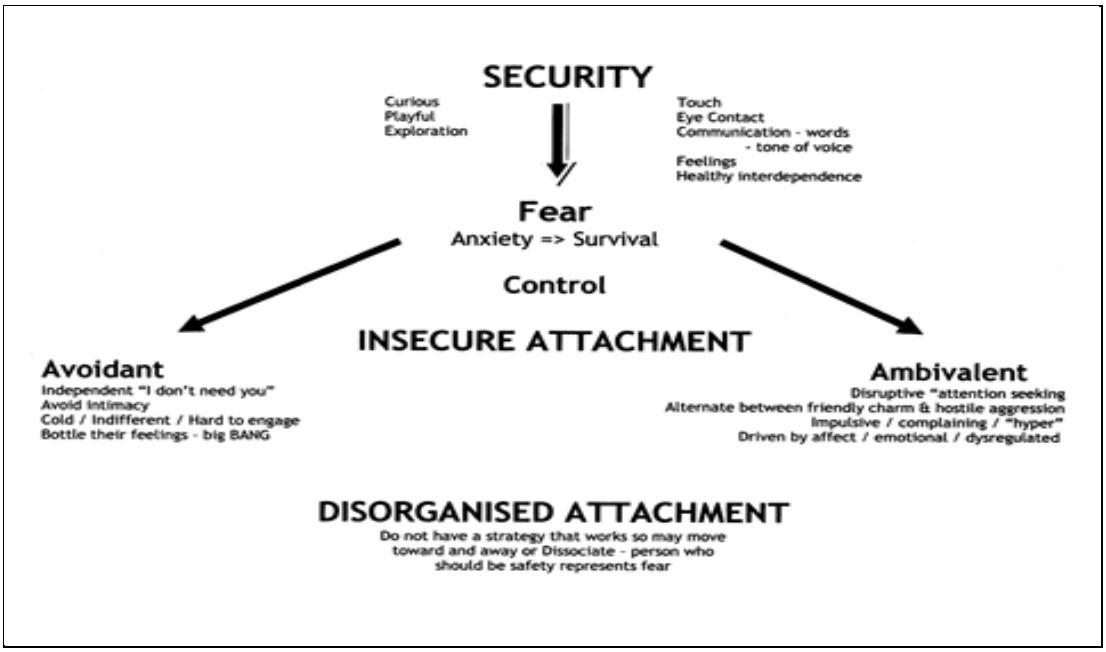
Psychological healing requires insight into how experiences have impacted people's lives. In advice to parents, Siegel & Hartzell, (2003) explain, "making sense of our lives can help us to provide our children with relationships that promote their sense of wellbeing, give them tools for building an internal sense of security and resilience, and offer them interpersonal skills…" (pp. 122-123). Such understanding allows for developing different ways of responding to people and situations that occur, as well as parenting differently.

A consolidated teaching model of Attachment Theory

The model of Attachment shown in the figure below was developed to visually represent a simple explanation of Attachment described in the Course, using material from Siegel and Hartzell's (2003), *Parenting from the Inside Out*.

Figure 3

Diagram created to illustrate secure and insecure attachment



The diagram (Figure 3.) illustrates "Security" as the Attachment behaviour that results from a healthy caregiving relationship between the infant and their primary caregiver. Infants who have a primary carer who consistently meets their physical and emotional needs develop in the knowledge that they will be appropriately pacified in a timely manner develop secure attachment (Dozier, et al., 2001). Siegel and Hartzell (2003) outline the "ABC" of Attachment that is required by a child from the parent to create security. "Attunement" is the ability of a parent to tune in to their child's emotional state and adjust their own emotional state in order to support their child, often non-verbally. "Balance" is acquired when children gain their emotional and physical competence through their caregiving adult's attunement with them. "Coherence" occurs when children come to feel physiologically and emotionally safe and whole in relationship, with predictable and consistent caregivers, which in-turn allows them to become interpersonally connected with others. This is conveyed to the child by the parent's appropriate touch, eye-contact and the tone of voice used in their communication. In this position of felt security, the child is able to be curious, playful and is more likely to explore their environment.

The introduction of "Fear" illustrated in the diagram (see Figure 3.), through danger, stress, illness, fatigue or perceived loss, evokes care-seeking behaviour from the child, which in the securely attached child is usually received from their "attuned" caregiver, which reduces their anxiety and they return to a neutral form of affective and physiological homeostasis (Boldt et al., 2020). Children who received caregiving that was not adjusted to their needs, whether dismissive, inconsistent, or unpredictable; and caregivers who were unable to provide the child with a sense of safety; lead to the child's behaviour becoming dysregulated, as an attempt to try to receive the care they need from the adult, or they shutdown to survive without it.

Children who are insecurely attached are unlikely to be able to be easily pacified, and go into survival mode or try to control the situation by eliciting reactions in the caregiver that they unconsciously feel will resolve their fear. Avoidant children who were reared by a caregiver whom they perceived as rejecting or not available to them when they needed them, grow up seeming to be independent and self-reliant, which hides the loneliness and isolation with which they learned to cope. The child becomes avoidant of physical and emotional interaction with their parent and this is likely to continue through into their adult relational style (Howe, 2011). A parent whose connection with the child is unpredictable or who tends to over-connect with the child when the child is not seeking connection, which leads to the child becoming anxious about the unpredictability of the parent. The child's resultant dependent behaviour illustrates their lack of confidence about whether or not the parent is going to meet their needs, and their attachment is described as ambivalent (Siegel & Hartzell, 2003).

A third insecure category of attachment was later added by Main and Solomon (1990) called disorganised attachment (see Figure 3.). Disorganised attachment occurs in children where the caregiver is perceived by the child as frightening or frightened. This usually occurs when parents have unresolved trauma and loss, and have disorganised attachment themselves, which either frightens the child or leads to the parent themselves being frightened by the child's needs, emotions or demands. Disorganised attachment is associated with numerous emotional and behavioural difficulties. Forslund et al., (2020), investigated associations between disorganised attachment and symptoms of Oppositional Defiant Disorder (ODD) or ADHD and found that children with disorganised attachment were more at risk of ODD than ADHD.

In the material presented to foster parents in the Course, avoidant attachment was simplified to "Withdrawn" and ambivalent attachment to "Clingy" (see Appendix D, Session 2 Slides), based on the common behavioural presentation of children with these styles. Disorganised was described as a combination of the two, with the child "pushing and pulling", desperate to connect in relationship, using either rejecting or appeasing behaviours, sometimes simultaneously, with both

the parent and child becoming frustrated, confused or feeling rejected (see Appendix D, Session 2 Slides). Using these same slides, participants were encouraged to identify their own attachment style based on the parenting they had received, and asked to identify how that might influence their parenting, and invited to think about what they might need to heal.

Internal working models, mentalising, Theory of Mind

The way in which the original primary caregiver responds to, and interacts with their infant, especially when the infant is uncomfortable or upset, influences the way in which the infant, and later as child, adolescent and adult, learns to perceive themselves and others through these repeated experiences. This early interaction results in attachment templates, termed Internal Working Models (IWM) that influence the child's sense of safety in relationship, and can influence how they respond relationally throughout their lives (Rosenblum, et al., 2019).

The process is cyclical and therefore potentially intergenerational, since IWMs are a result of the infant's experience of the way in which their caregiver initially received care from their own parent(s), which in-turn influences their capacity to care for their child (Kim et al., 2014). Thus, the parent's attachment style in adulthood, based on their own internal working models, influence their ability to deal with their infant's array of negative and positive emotions. The primary caregiver's representations of their child both before and after pregnancy (based on their IWMs), therefore has a direct impact on the security of the infant and child, influencing their perception and interaction with them from the time they are born. "Parent sensitivity", which could also be described as Siegel and Hartzel's (2003) "ABC of Attachment" (Attunement, Balance and Coherence) as outlined previously, has been found to be a critical factor in children's attachment security (Rosenblum et al., 2019).

As a dyadic relationship, issues relating to the child have also been found to influence the development of the child's IWMs and attachment security. These include the child's temperament and early or chronic medical conditions or medical situations. The father's role has also been found to influence the child's developing attachment pattern and although fathers tend to be less attuned and less verbally responsive to their infants, their levels of mind-mindedness according to Planalp et al., (2019) remain fairly constant.

Mind-mindedness refers to the parent's reflective capacity; their own sense of self, and their ability to perceive and treat the child as a separate individual with their own thoughts, feelings and wishes (Schultheis et al., 2019). The mind-minded mother who is able to communicate with the child in a perceptive way has been shown to influence the child's security more so than behavioural sensitivity alone. Mind-mindedness is also said to develop the child's ability to realise that others

have their own thoughts and feelings that differ from their own, and is termed Theory of Mind (TOM) (Gallant et al., 2020), which forms the basis of empathy.

Baron-Cohen (1995) argues that the capacity to "mind read", that is, to perceive what another might be thinking, feeling, or how they might act or react in certain circumstances is biological, instinctual and developed as a result of natural selection or for the continuation of the species. In contrast, according to Siegel (2020), TOM, mentalisation or mind-mindedness comes about through the process of attunement within attachment. Mentalisation is defined by him as "the ability to understand one's own and other people's minds" (Siegel, 2020, p. 507).

Siegel (2020) describes TOM as developing through reflective communication with a sensitive primary caregiver who provides words associated with thoughts, feelings and memories that develop metalizing networks in the child's brain. During the first three years of a child's life, the majority of development is taking place in the right hemisphere of the brain. Children who experience sub-optimal nutrition, stimulation and emotional development at this time are at risk of reduced brain differentiation in areas of the brain, such as the corpus callosum that provides a bridge between the right and left hemispheres of the brain (Johnson et al., 2016). The outcomes of reduced development of the right hemisphere and the corpus callosum at this particular developmental stage can include difficulties understanding non-verbal communication, facial expressions and tone of voice. It may also result in a reduced ability to participate reciprocally in interpersonal relationships (Siegel, 2020).

Attachment of fostered children

As the evidence suggests, attachment relationships are extremely important during the first few years of life and these affect the social and psychological development of individuals and result in emotional and behavioural expressions in the context of relationships. Therefore, disruptions in attachment to primary caregivers and placing children into foster placements is likely to affect the child and their ongoing relational capacity, mental health and resultant behavioural difficulties. Briggs-Gowan et al., (2019) investigated the impact of separation on a sample of young children from the general population who had experienced separation from their primary caregivers due to hospitalisation, and were referred to community mental health and paediatric services in the north-east and mid-west regions of the USA. Having excluded other potentially traumatic experiences such as maltreatment and harsh parenting; and socioeconomic status, findings revealed the serious impact of primary caregiver separation and its link to subsequent difficulties and diagnoses such as PTSD, attachment difficulties and other emotional difficulties.

According to Cole (2005), 67% of the fostered infants in their sample in mid-west USA were securely attached, and of those with an insecure attachment, 87% displayed a disorganised

attachment style. Protective factors included the foster parents' own secure attachment style and an organised home environment, with age-appropriate learning resources and developmentally sufficient stimulation according to the needs of the child. The strongest negative factor was the foster parent's own negative childhood experiences of trauma, which adversely influenced the foster child's development and resulted in insecure attachment. Cole's (2005) recommendations included special training about setting up the home environment to best support the needs of infants in fostercare, focussing on child development. Furthermore, it was suggested that foster parents could be trained to look at their own childhood experiences and how these might affect the infant.

McLaughlin, et al., (2012) examined a sample of children who had been in orphanages in Romania then placed in fostercare in Bucharest, Romania, to assess whether there was an improvement in mental health outcomes for these children. Girls placed in fostercare who had symptoms associated with internalising (i.e., anxiety and depression) improved compared to those who remained in the orphanage. They suggest that developing an attachment relationship with a consistent adult improved the mental health outcomes for girls in childhood. Boys were less able to develop secure attachments in fostercare, which the authors suggest may be because boys might find it more difficult to activate nurturing attachment from foster parents, since their behaviour might be more difficult than girls. They recommended teaching foster parents to respond sensitively to attachment behaviours in order to promote secure attachment in general, but especially in children who demonstrate difficult behaviours, to which parents might find it difficult to respond.

Gabler et al., (2014) studied the development of attachment relationships in the first six months of children being placed in fostercare in Germany. They discovered, as might be predicted, that attachment levels were lower at the beginning of the placement and that these increased over the 6-month time period of their study; although levels were measured as still low at 6 months. However, whether the children were able to develop attachment behaviours in this time-period was dependent on the capacity and presence of the foster parent. In this particular study younger foster parents had higher levels of attachment security, illustrating that parents who had fostered longer might have had more experience of loss and therefore perhaps did not engage at the same level as newer foster parents, at the risk of being hurt by the potential loss should children move on or return home. Foster parent sensitivity and support were positively correlated with the child's attachment security, as were lower stress levels in parents. Behaviourally, half of their sample of foster children scored within the clinically significant and borderline range on the CBCL, illustrating behaviour problems, and these did not improve or diminish over the 6-month time period. They conclude that attachment security might be more changeable than behaviour difficulties, as a result of appropriate caregiving.

As stated by Gribble (2016), whose article compared issues pertaining to having a premature baby and children being received into fostercare, "it is advantageous for children in fostercare to have caregivers who are strongly attached to them" (p. 113). She believes that foster parents face a similar dilemma to biological parents whose children are born prematurely, which is the fear to attach due to the fear of loss. Other factors that might be similar included the circumstances surrounding the arrival of the child being a stressful experience and the child tending to give mixed messages regarding care or proximity seeking. Furthermore, the child might be unable to trust adults and may appear self-sufficient rather than seeking help when stressed, tending to want to control the relationship with the parent or being extremely rejecting. Foster parents need to be made aware that this behaviour is a reaction to the child's earlier experiences and not personal to the foster parent. According to Gribble (2016), healing both premature babies' and foster children's early experiences may require similar interventions. They require experiences that promote safety and soothing within proximity to others, which may involve touch and other verbal and non-verbal reassurances repeated over time.

Groh et al., (2017) carried out a meta-analysis to identify whether there was a link between attachment style of children under 5 years and their temperament and to verify whether there was a link between early attachment and social skills, externalizing and internalizing behaviours. Behaviourally, studies revealed that the child with secure attachment had better social capacity and less externalising behaviour. Avoidant attachment was associated with both externalising and internalising behaviours, whereas ambivalent attachment was not significantly associated with either. Disorganised attachment was associated with externalising behaviour but not with internalising behaviour. Male children were more prone to externalising behaviours, as were children of both genders whose parents had psychiatric illness.

Fishburn et al., (2017) conducted three research studies in the UK to investigate the concept of mind-mindedness being a relational concept. Their findings from samples of foster, adoptive and biological parents supported Mein et al.'s (2014) results, which suggested that mind-mindedness is an element of personal relationships, rather than a trait. Fishburn et al., (2017) found that foster and adoptive parents had lower levels of mind-mindedness than biological parents, illustrating that mind-mindedness is most likely based on the quality of the relationship. Furthermore, the more difficult a child's behaviour, the less likely the parent was able to be mind-minded; and the more likely they were to focus on the behaviours of the child thus resulting in a more negative interpersonal relationship.

Re-parenting these children from an Attachment perspective is often required whatever the age of the child, at their emotional age rather than chronological age, to allow the child to feel safety

in the presence of their caregiver (Gordon & Grant, 2015). It is clear from the above section that foster parents require special training to understand the source of much of the behaviour, to be able to respond appropriately. It is important that social workers and foster parents are made aware that if early bonds are not healed within the context of a loving attachment-attuned relationship, then the child will have lifelong difficulties (Gribble, 2016).

Other interventions that attempt to rectify children's early experiences of attachment insecurity include, *Dyadic Developmental Psychotherapy* (Hughes, 2006; Hughes et al., 2015), a relationship-based therapy that is carried out with the current primary parent (biological, foster or adoptive) and their child, to create better understanding between them and promote more stable functioning and interaction in the home. *Theraplay*® (Booth & Jernberg, 2010), is aimed at, *Helping parents and children build better relationships through attachment-based play,* as the by-line of the book's title describes. *Circle of Security Parenting* (Hoffman et al., 2017) is a group-based parenting intervention that teaches parents the basic Attachment language of children. This Course reinforces the message that the parent provides the secure base from which the child goes out to explore and comes back to be reassured and have their needs met.

4.4 Trauma and Dissociation

The topic of Trauma is complex and well researched from many different theoretical and disciplinary perspectives and therefore far too extensive to cover either in the foster parent Course or the literature reviewed. Developing the Course, I focussed on elements of adverse life events, including the different types of maltreatment and trauma that could result in a child being taken into fostercare. The literature explored below includes some of the emotional, behavioural, physical, cognitive and neurological consequences of childhood adversity. The intention of concentrating on these areas was to provide foster parents with an introduction to, and broad understanding of, the topic of Trauma and the resultant implications for their child(ren).

All forms of maltreatment (abuse, neglect and domestic violence) have the potential to be damaging to varying extents (Vachon et al., 2015), dependent on the combination of negative and protective factors associated with the individual child and their particular circumstances. There is more lay knowledge and even publicity regarding physical and sexual abuse, so slightly more emphasis was placed on the three less well known, and by their nature less explicit, but at the same time very damaging forms of maltreatment: neglect, emotional abuse and domestic violence or intimate partner violence. Emphasising these subtler, but pervasive forms of maltreatment was also intended to highlight the damaging impacts of the more explicit and better-known types of abuse.

Toward the end of the section to follow, PTSD is summarised, including ideas about dissociation as an adaptive protective strategy often used by traumatised children. The section concludes with an outline of the potentially more appropriate diagnostic features of DTD, that takes into consideration development and the interpersonal nature of the complex trauma foster children experience, and which encompasses more of the diverse emotional and behavioural manifestations seen by clinicians working with these children. Although DTD was not included in the most recent Diagnostic and Statistical Manual, DSM-5 (APA, 2013), many clinicians are already using the clusters of symptoms to describe children who have experienced complex trauma from an early age.

Trauma Theory

In the past, adult theories associated with Trauma have been adapted to child trauma (Alisic, et al., 2011). They suggest that between 14%-65% of children are exposed to at least one trauma-inducing incident and that excluded war-torn populations. The current DSM-5 diagnostic criteria includes adults, adolescents and children over 6 years old, with slightly adjusted criteria for children under 6 years of age (Sadock et al., 2015).

Children exposed to trauma respond differently to adults, it is therefore not recommended to use an adult Trauma model to explain the short or long-term consequences of trauma on children. Alisic et al. (2011) carried out a meta-analysis of longitudinal studies that identified children who were reported to heal after trauma, in order to distinguish positive and negative factors associated with whether a child exposed to trauma might heal or not. Although the focus of the review was mainly medical trauma, findings revealed that symptoms of acute and short-term post-traumatic stress in children were associated with the presence of depression and anxiety, being female and having a parent who had post-traumatic stress symptoms. They also noted that the majority of articles focussed on risk factors rather than protective factors and suggested that more focus on protective factors might enhance prevention and treatment strategies. Further, they remarked that much of the research focusses on the individual, and although this may be relevant in adult Trauma theory, there are other elements including the family and the child's developmental phase that need to be considered in developing a child-centred Trauma theory (Alisic et al., 2011).

Adverse Childhood Experiences (ACE)

Adverse Childhood Experiences (ACE) research was first published in 1998. This research is described here due to the sample sizes of two of the studies. According to Felitti et al. (2019), the research developed out of insights gained whilst running an obesity clinic in a department of Preventive Medicine in California, USA in the 1980s, during which it was discovered that over 56% of participants acknowledged having been sexually abused during childhood. The original study comprised a large sample of 9508 adults who filled out an ACE questionnaire that originally included

seven areas of adverse childhood experiences, prior to a health evaluation. These they compared to adult risk behaviour, health status and physical disease that could result in death during adulthood. One-half of the sample had experienced at least one ACE and a quarter of the sample, two or more. A major finding was that there was a dose effect, that is the more ACEs an individual had experienced, the increase in adult health risk behaviours such as smoking, substance (alcohol and drug) misuse and suicidal behaviour. The diseases included, heart disease, cancer, lung disease, bone fractures and liver disease.

The Felitti, et al. (1998; 2019) ACE categories included:

- Emotional Abuse
- Physical Abuse
- Sexual Assault
- Emotional Neglect
- Physical Neglect
- Mother treated violently
- Household Substance Abuse
- Household Mental Illness
- Parental Separation or Divorce
- Incarcerated Household Member

Anda et al., (2006) sought to correlate the epidemiological information from an ongoing ACE study in USA with the different structural and functional brain changes that occur in individuals who experienced adverse stress through different forms of maltreatment during childhood. Their study included 9367 women and 7970 men who attended a Health Appraisal Centre in California. The study revealed that as an individual's ACE score increased, so did the frequency and risk of affective disturbances (depressed mood, anxiety, panic and hallucinations); somatic health disturbances (sleep disturbance and obesity); substance abuse (smoking, alcohol, and drugs); issues regarding sexuality (early age intercourse, promiscuity and sexual dissatisfaction); impaired memory of eras of childhood; and higher levels of stress, anger and perpetration of intimate partner violence.

Anda et al., (2006) then took data from MRI brain scan research that correlated with the epidemiological findings of their ACE study, to identify whether the mental health outcomes were linked to neuroendocrine and brain structure changes. The main neuroendocrine systems impacted were those responsible for emotional and physiological regulation (norepinephrine, dopamine and serotonin), known as the monoamine neurotransmitters systems. Brain structural changes included a decrease in size of the hippocampus and amygdala, as well as changes in the function of the hippocampus and prefrontal cortex. They concluded that these changes most likely contribute toward the emotional and behavioural difficulties of individuals who have experienced adverse experiences, including affecting their cognitive ability, especially in relation to memory.

According to Finkelhor et al. (2015), the original ACE scales were not devised to any systematic method. As a valuable and predictive scale, they sought to develop these further, suggesting adversities identified in their research in 2014 on childhood, from their data obtained from The National Survey of Children's Exposure to Violence. From these findings they suggested including the following adversities in the original scales above, to create revised ACE Scales:

- Low Socioeconomic status
- Peer victimisation
- Peer isolation/rejection
- Exposure to community violence

Acknowledging the value of the ACE scales from a preventative health strategy intervention perspective, Finkelhor et al., (2015), also suggested that the scales could be used as a predictor for mental and physical health in children and young people. In their survey, they measured the impact of socioeconomic status, which was found to be the most significant indicator of physical health, with young people of low socioeconomic status having almost double the number of negative health conditions compared to youth with higher socioeconomic status. However, socioeconomic status did not predict poor mental health. Having included 28 items from Briere's (1996) Trauma Symptoms Checklist for Children (TSCC) in order to measure participants' depression, anxiety, dissociation, anger/aggression, and post-traumatic stress, their study found that five of the original child maltreatment items (physical abuse, neglect, emotional and sexual abuse, and household mental illness) were significant contributors toward emotional distress. So too were three of their adversity items, including peer victimisation, peer isolation and community violence, with peer isolation being the greatest predictor of all ACE items (Finkelhor et al., 2015).

Development and trauma

The age at which a child is exposed to traumatic experiences is likely to affect them differently, based on the requirements and vulnerabilities of their particular stage of development. Depending on their physical, neurological, and psychological development (including their dependence on their caregivers) at the time of the negative experience, results in different outcomes (Perry, 2006). Hawes et al., (2021) sampled a nationally representative sample of the general population in Australia alongside a clinic referred population, to validate their Adverse Life Experiences Scale (ALES). They had developed the ALES to measure a child's adverse experiences in the context of their caregiving environment, simultaneously measuring their symptomatology and found that the number of experiences, and length of time a child was exposed to adverse experiences, resulted in adult psychopathology. The following two studies also produced evidence supporting the development of such a measure.

Dunn et al., (2017; 2018) used data obtained from a large socio-disadvantaged adult population of an ongoing National Institute of Mental Health (NIMH)-funded study in Georgia, USA to examine biological, environmental and resilience factors associated with the development of PTSD and other psychiatric disorders. Adults exposed to trauma as children had higher levels of depression, PTSD and emotional dysregulation, than those who had not been exposed to trauma. They discovered two developmental stages where higher outcomes of psychological difficulties appeared to occur. Children who were exposed under 5 years old had levels of depression and PTSD double those exposed during later developmental stages; and children between ages 6 and 10, who witnessed violence in their homes or community settings were twice as likely to develop depressive symptoms than individuals who witnessed the same violent events as an adult (Dunn et al., 2017).

Hambrick et al. (2019) collected descriptive data from 190 clinical sites internationally (in USA, Canada, Europe, and Australia), from clinicians working with children aged 6 - 13 years who had been referred, having lived through harmful experiences during childhood. Clinicians were all trained in and submitted their data according to Perry's (2006) Neurosequential Model of Therapeutics (NMT). NMT is an assessment and intervention model that assesses the timing and outcomes of negative experiences, in order to supplement the deficits or trauma-related difficulties with corrective interventions.

Their study (Hambrick et al., 2019) examined whether there was a link between the age at which a child encounters potentially harmful experiences including poor attachment, and different outcomes for that child. They discovered, having divided up the developmental time periods into four subdivisions: Perinatal (0 – 2 months), Infancy (2 – 12 months), Early Childhood (13 months to 4 years), and Childhood (4 to 11 years), that the most sensitive period was the Perinatal. Therefore, an infant experiencing adversity in the first two months was likely to have poorer outcomes than a child experiencing the same adversity later on. They also found that the damage appeared to be worse when the infant came from a poorly nurtured relational environment. A weak caregiving relationship was a stronger predictor of poorer outcomes than the adversity itself, although this effect reduced as the child got older. Thus, the impact of early adverse life experiences was reduced when the child came from an environment where they were appropriately cared for and nurtured.

Intergenerational transmission of the effects of trauma

Biomedical research (e.g., Lerner & Yehuda, 2018; Yehuda et al., 2016) has discovered some innovative findings that provide evidence that the effects of trauma could be transmitted intergenerationally. Yehuda et al. (1998) sought to investigate the levels of PTSD and other psychiatric disorders associated with trauma in children of Holocaust survivors, who had not been exposed to the trauma of the Holocaust. They found that the adult children of Holocaust survivors

had higher incidences of PTSD and other psychiatric diagnoses than a similar control group. She and her colleagues went on to identify further effects of both the mother's and father's PTSD on their children, and discovered alterations in the sensitivity of the glucocorticoid receptor and increased susceptibility to psychiatric illness. Their findings also suggested different inheritability pathways based on the gender of the parent, also acknowledging the further association of being raised by parents who remain traumatised by their past (Yehuda et al., 2014).

Wolynn (2016) in his book, *It didn't start with you*, uses this previous research (Yehuda et al., 2016) and suggests that clinicians should look back into the experiences and suffering of three generations of a client, to identify any historic unresolved adverse experiences that may be currently impacting their client. He describes an individual's history as starting before conception, because of the shared cellular connectivity with mothers and grandmothers: the person's egg is already present in the mother's reproductive system when the grandmother was pregnant with the mother, and similarly with the father's sperm cells. The difference between the sexes is that once eggs are formed they stop dividing, whereas sperm continue to multiply from adolescence through adulthood, and may therefore be more vulnerable to the impact of more recent traumatic events, up until conception.

Grasso et al. (2020) assessed the ACE scores, adult adversity, PTSD and other psychological difficulties of pregnant women in their third trimester from an urban prenatal clinic in Connecticut, USA. They then measured these outcomes against the mother's saliva samples and those of their infants just after birth. They were hoping to establish whether there was transmissibility between a mother who had ACEs and their new-born child. They distinguished between "deprivation-based" ACEs, which encompassed emotional and physical neglect and threat-based ACEs, which involved physical or sexual abuse. Their findings suggest that a mother who had experienced "threat-based" rather than "deprivation-based" ACEs and had PTSD symptoms during pregnancy, impacted the epigenetic makeup of the mother and the infant.

Maltreatment

The impact of maltreatment depends on the type of maltreatment, the child's age or developmental phase, who perpetrated the harm and how severe it was, how often it occurred, and the mental state and resilience of the child's primary caregiver (Adams et al., 2018). Keyes et al. (2012) carried out a large retrospective study in the USA to establish whether there was a link between different forms of maltreatment and psychiatric illness in adulthood. They also sought to uncover whether certain types of maltreatment were linked to either internalising or externalising symptoms. Their findings illustrated that neglect did not predict mental illness whereas all types of abuse did. Differences in responses to maltreatment varied according to gender, for example

physical abuse led to externalising behaviour in males and internalising in women. However, importantly their research confirmed previous findings that experiencing maltreatment in childhood leads to different types of mental health difficulties later in life.

In a health-information review article for paediatricians, Sege et al. (2017) outline the broad range of impacts of maltreatment on children. They discuss how maltreatment affects a child's normal development and results in cognitive and behavioural difficulties and that the most common diagnosis for these children is PTSD. These authors describe how during adolescence maltreated individuals are more likely to have higher rates of sexualised behaviour, self-harm including suicide attempts, alcohol and drug use and that emotional, behavioural, cognitive and physiological difficulties persist into adulthood.

Savage et al's (2019) meta-analysis consisted of 32 international studies prior to 2018, involving research into the impact of a mother's maltreatment during childhood and its effects on their parenting. They found a weak but significant connection in these studies that maltreatment in childhood led to difficulties in parenting and as such, they highlighted childhood maltreatment as a potential risk factor.

Childhood maltreatment encompasses the different forms of abuse, neglect and exposure to interpersonal violence, which a child may experience during their development. Continuing the theme of intergenerational transmission, St-Laurent et al., (2019) sought to distinguish between mother-child relationships where maltreatment was perpetuated across generations from those where it was not. The sample, which included both maltreated and non-maltreated children living with their biological mothers, came from both urban and rural areas of Quebec, Canada. The mothers of these children completed questionnaires regarding their own childhood experiences and trauma, current psychological status, parenting stress and socio-economic status. The authors found that those mothers most likely to continue maltreatment had experienced neglect during childhood and more than one form of maltreatment. During adulthood they were also found to be in, or at risk of poverty, were experiencing domestic violence and reported little family support. These findings illustrated that it was more likely to be social and relational factors rather than psychological ones that resulted in intergenerational maltreatment.

Emotional abuse

Emotional abuse is defined in the Irish Department of Children and Youth Affairs (DCYA), (2017) *Children First Guidance* as,

> …the systematic emotional or psychological ill-treatment of a child as part of the overall relationship between a caregiver and a child. Once-off and occasional difficulties between a parent/carer and child are not considered emotional abuse. Abuse occurs when a child's

> basic need for attention, affection, approval, consistency and security are not met, due to incapacity or indifference from their parent or caregiver. Emotional abuse can also occur when adults responsible for taking care of children are unaware of and unable (for a range of reasons) to meet their children's emotional and developmental needs. Emotional abuse is not easy to recognise because the effects are not easily seen (DCYA, 2017, p. 8).

Emotional abuse, also referred to as emotional maltreatment or psychological abuse has not been investigated to the same extent as physical and sexual abuse, or witnessing domestic violence (English et al., 2015; Lavi et al., 2019; Teicher et al., 2006). One of the difficulties is that the impact cannot been seen, and children who experience it may not consider it abuse as they may have been desensitised, and consider it their norm. Lavi et al., (2019) in a meta-analysis of nine studies obtained by searching terms related to child maltreatment and parental emotional reactivity or regulation, in order to examine emotional reactivity or regulation in parents who emotionally abuse their children, describe emotional abuse as, "the most pervasive but least studied form of abuse" (p. 376). They found that emotionally abusive parents have higher levels of negative emotions, depression, verbal hostility and anger; they also have less ability to control or cope with negative emotions and express these aggressively.

Sexual abuse

> The Irish *Children First Guidance* (DCYA, 2017) defines Sexual abuse as follows:
> Sexual abuse occurs when a child is used by another person for his or her gratification or arousal, or for that of others. It includes the child being involved in sexual acts (masturbation, fondling, oral or penetrative sex) or exposing the child to sexual activity directly or through pornography... Child sexual abuse may cover a wide spectrum of abusive activities. It rarely involves just a single incident and in some instances occurs over a number of years. Child sexual abuse most commonly happens within the family, including older siblings and extended family members (DCYA, 2017, p 10).

Sexual abuse during childhood or adolescence has varying degrees of short-term and long-term physiological, psychological and psycho-sexual consequences for each individual child (da Cruz et al., 2021). Da Cruz et al., (2021) reviewed 16 articles researching adults who had been sexually abused as children or adolescents, to establish the impact of sexual abuse during childhood. They found the symptoms resulting from Childhood Sexual Abuse (CSA) included poor self-esteem, difficulties sleeping, PTSD, substance misuse (drugs and alcohol), mood disorders often associated with depression, personality disorders from adolescence into adulthood such as Borderline Personality Disorder. Self-injurious behaviours, suicidal ideation or intent as well as parasuicide and

completed suicide were also associated with individuals who have experienced CSA (da Cruz et al., 2021).

Nearly half of all victims of CSA are at risk of re-victimization across the lifespan (Papalia et al., 2021). Scoglio, et al. (2021), carried out a meta-analysis of peer-reviewed articles before 2017 related to CSA and risk factors associated with re-victimization. They found risk factors included concurrent adverse treatment in the home environment; unsafe sexualised behaviour, such as unprotected sex or multiple partners, especially during adolescence; PTSD, including, but not necessarily resulting from the original CSA; and an inability to regulate emotions or behaviour. A protective factor identified by the authors was the child's perception that their parent(s) cared about them.

Re-victimization needs to be considered when placing children who have experienced CSA. For example, Euser et al. (2013) found that the prevalence of sexual abuse in out-of-home placements was higher than in the general population in the Netherlands; more so in residential placements than in foster families, although fostercare prevalence was the same as at-home prevalence in the general population. Their research did not identify whether these children had been previously abused before coming into Care, bearing in mind that in relation to re-victimization such children would be at higher risk.

Van der Kolk (1989) wrote an article on the way in which individuals who have been traumatised by others by others might then proceed to hurt themselves or others in the same way that they were hurt. Penning and Collings (2014) researching a secondary school population in South Africa, found that sexual abuse during childhood was the most likely form of abuse to result in re-enactments. Their data revealed that re-enactments occurred in approximately 50% of cases, which could be further categorised into perpetration, victimisation and self-harm.

Purcell et al. (2021) investigated 300 young people from Alabama, USA to find out whether physical or sexual abuse created an altered response to stress. They examined whether there were any changes to the stress centres of the brain, including the prefrontal cortex, hippocampus and amygdala, using MRI scans. They concluded that there was a connection between childhood sexual abuse and changes in the activity of the prefrontal cortex and hippocampus that were not evident in children who had been physically abused.

Physical abuse

> The Irish *Children First Guidance* (DCYA, 2017) defines physical abuse as follows,
>
> Physical abuse is when someone deliberately hurts a child physically or puts them at risk of being physically hurt. It may occur as a single incident or as a pattern of incidents. A reasonable concern exists where the child's health and/or development is, may be, or has

been damaged as a result of suspected physical abuse. Physical abuse can include the following: physical punishment, beating, slapping, hitting or kicking, pushing, shaking or throwing, pinching, biting, choking or hair-pulling, use of excessive force in handling, deliberate poisoning, suffocation, fabricated/induced illness, and female genital mutilation. (DCYA, 2017, p. 9)

Research over the past 25 years into physical punishment such as slapping, which was previously considered benign, has revealed the detrimental effects to child development. Durrant and Ensom (2017), in their review of literature highlight that it was in the 1990s that a correlation between physical punishment and aggression in children was discovered.

Adams et al., (2018) examined a number of characteristics of physical and sexual abuse experienced in childhood that might result in psychopathology in young adults of both genders. Participants came from three different US states (Alabama, Texas and California), with just over 50% being female. Participants completed questionnaires regarding physical and sexual abuse, including age at which it started and severity. They also completed questionnaires relating to symptoms of depression, anxiety and PTSD. The outcomes revealed that for children who had experienced physical abuse, the age of onset of the abuse, rather than chronicity or level of cruelty was more likely to lead to more severe symptomatology associated with psychopathology. Early onset (under 6 years) and onset in adolescence (over 13 years) predicted symptoms of PTSD, whereas experiences of physical abuse when children were between 6 - 12 years old were linked to symptoms associated with anxiety, depression and PTSD.

Neglect

The Irish *Children First Guidance* (DCYA, 2017) defines neglect as follows,

Neglect occurs when a child does not receive adequate care or supervision to the extent that the child is harmed physically or developmentally. It is generally defined in terms of an omission of care, where a child's health, development or welfare is impaired by being deprived of food, clothing, warmth, hygiene, medical care, intellectual stimulation or supervision and safety. Emotional neglect may also lead to the child having attachment difficulties. The extent of the damage to the child's health, development or welfare is influenced by a range of factors. These factors include the extent, if any, of positive influence in the child's life as well as the age of the child and the frequency and consistency of neglect (DCYA, 2017, p. 7).

Neglect in children has been associated with poverty; a mother's own history of physical and sexual abuse; lack of a supportive social structure; and maternal substance abuse including drugs and alcohol. However, it is complex and often a number of these factors are interrelated (Cash &

Wilke, 2003). According to the DCYA (2017) neglect is the most commonly reported form of maltreatment in Ireland and internationally.

Neglect during childhood occurs more frequently in families with socioeconomic difficulties and its effects impact the psychological wellbeing of children (Mawson & Gaysina, 2021). Poverty itself has been shown to be associated with mental health difficulties. Using data from a representative population sample from a large longitudinal study in England, Scotland and Wales, these authors sought to separate the effects of socioeconomic poverty and neglect on mental health difficulties. They did find that neglect had independent effects on poor mental health outcomes and recommended that neglect is given the same amount of importance as other forms of abuse, when investigating the source of mental health difficulites.

The role of the primary caregiver, most often the biological mother, is to nurture, comfort and protect the child, as human babies are completely dependent on their caregivers for their survival. Nurturing not only includes feeding, but also involves the way in which the infant experiences their world; and includes cognitive and physical stimulation, and especially emotional connection and safety (Humphreys, et al., 2019). When these needs are met in sufficient amounts during infancy, the appropriate conditions occur in which neural connections are made that support normal development throughout an individual's lifetime. Insufficient stimulation through neglect leads to reduced capacity for learning and the likelihood of behavioural problems.

Strathearn (2011) in a review comparing animal studies with human endocrine and brain scanning studies describes how child neglect has the most profound negative effects on child development. Outcomes of the review illustrated that neglect impacts the child's cognitive capacity, and results in speech and language delays, difficulties in the child's social and academic ability, and behaviourally they are more likely to develop aggression. The biological mother is most often the perpetrator of neglect, even though their bodies have been chemically adjusted through evolutionary neuroendocrine processes to provide maternal caregiving. There are two forms of neglect: physical neglect whereby the child is not provided with food, clothing, hygiene, medical care or age-appropriate education; and emotional neglect is when a child is not provided with sensitive nurturing physical touch, soothing when upset, or appropriate amounts of time and attention. Strathearn (2011) concludes in his review of international studies that the majority of children who are neglected experience a combination of both physical and emotional neglect.

Research into children brought up in institutional Care in Eastern European orphanages (Miller et al., 2009) illustrates the extreme impact of severe neglect on the child's physical growth, cognitive functioning, social skills, speech and language development, and motor coordination. Furthermore, the longer a child was in an institution, the worse the outcome. Rutter et al. (2007)

investigated the levels of quasi-autism in adoptees from Romania and found that 10% of their sample of adopted children showed symptoms associated with quasi-autism. The term "quasi" was used, since when children were placed in an appropriate caregiving environment post-institutionalisation, the symptoms associated with autism reduced, which does not happen in children diagnosed with autism in the general population. The difficulty however with institutional research is that it is not representative of the large population of children neglected in their own families by primary biological caregivers (Humphreys et al., 2019).

Intimate partner violence

Intimate partner violence (IPV), also termed domestic violence, can be defined as one or both partners using physical, sexual or psychological violence within the context of a relationship, be it partnership or marriage. The child is often a witness to IPV, meaning they may be present when it occurs; might hear it, or perceive the varying strong emotions in the adults, including extremes of rage or helplessness.

Rode et al. (2015) carried out research on a prison population in Poland of men and women convicted according to Polish law of "cruelty towards family members" (p. 56), to try to identify some of the psychosocial commonalities in a sample of male and female IPV perpetrators. Their research confirmed that IPV was more often reported by women. A common feature of both male and female perpetrators in their sample was that they had a lower capacity for measures of emotional intelligence. Male offenders were more likely to be anxious-ambivalent in attachment style and reported feeling high levels of anxiety and anger as well as fear of abandonment. Women were more likely to report being dependent in their relationships and became angered when they perceived their partner to be unavailable to respond to their needs. Their findings revealed that the majority of both male and female IPV perpetrators came from homes that were not financially or socially disadvantaged, nor were they divorced or single parent households. However, over 30% reported fathers with drinking problems; many reported previous emotional abuse and some sexual abuse; and more than 20% had experienced physical violence against them in their homes (Rode et al., (2015).

According to Schechter et al.'s, (2019) chapter in the *Handbook of Infant Mental Health* where they examine the effects on infants and young children of being exposed to violent events, there is a dosing effect associated with children witnessing violence in their home environments. There is a positive correlation between the number, frequency and length of each episode of violence and the number and extent of behavioural and developmental problems in the child. In examining many studies published internationally they report that these include, sleep, eating and toileting problems; affective disorders such as depression and anxiety; delayed language

development; ADD(H); self-harm; and health problems including autoimmune disorders; behavioural difficulties including aggressive behaviour and conduct disorder; difficulties with social interactions; and cognitive delays leading to academic difficulties.

The importance in understanding the effects of witnessing interpersonal violence from the child's perspective is related to the concept of safety. Parents or caregivers are the main source of the child's safety and the younger the child, the more reliant they are on the calm presence of a caring adult. Violence that involves the child's caregiver evokes an escalated sense of anxiety, especially when the adult cannot calm the child due to them being victimised and therefore distressed themselves. The child therefore develops protective strategies in order to protect themselves from unmanageable anxiety when they were not soothed by a regulated adult. These protective strategies become the basis of the child's difficulties and additionally a possible source of insecure attachment style, as their experience impacts their sense of themselves and others in the world potentially affecting the child's TOM (Schechter et al., 2019). The resultant neurobiological outcomes include the engagement of the survival system associated with high levels of repeated fear. When the fear response is engaged repeatedly, it can result in a hypersensitive fight-flight-freeze response that can be difficult to de-escalate (Schechter et al., (2019).

Trauma

To provide a definition of trauma, the diagnostic criteria from the previous Diagnostic and Statistical Manual, DSM-IV-TR (APA, 2000), were used in the Course to illustrate the requirements for a diagnosis of PTSD, as the DSM-5 was only being published around the time the first Courses for this research were being presented.

> Criterion A1
>
> Direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.
>
> Criterion A2
>
> The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behaviour). DSM-IV-TR (APA, 2000)

Three forms of trauma

Van der Kolk (2005), a leading clinician and academic at the forefront of Trauma research, outlines three forms of trauma. Acute trauma is identified when an individual experiences a once-off traumatic event that is overwhelmingly shocking or life threatening. The situation might involve an extreme nature-based event such as a tornado or volcano; other events may include a serious car accident; hijacking; or a once-off sexual assault. The defining features of acute trauma are that it occurs once and happens without warning and can result in PTSD (Visser et al., 2017). Chronic trauma as the name suggests is a series of traumatic experiences that are repeated over time. Such trauma may include ongoing medical procedures such as corrective surgery or repeated sexual or physical abuse. The difference between chronic trauma and complex trauma is the interpersonal nature of the ongoing trauma. Complex trauma is chronic ongoing trauma that started at a young age when the infant or child was dependent on caregivers who should have been caring for, rather than harming them. Van der Kolk (2005) defines complex trauma as, "the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature…and early life onset" (p.2).

Trauma and the body and brain

Neuropsychological and brain imaging research has shown evidence that trauma experienced by children especially at certain developmentally sensitive periods has the capacity to change the brain chemically and structurally (McClean, 2016). These changes can result in emotional, behavioural or physiological difficulties, or a combination of all three (Hambrick, et al., 2019). Children exposed to trauma who develop pathology were more likely to have been affected during a critical time of development or may have a predisposing genetic vulnerability (Neigh et al., 2009).

In a practice resource, published by Child Family Community Australia for Australian clinicians working with children who have experienced trauma, McClean (2016) described the difficulties of correlating subtypes of trauma and specific impacts on the brain, as many children in vulnerable populations have experienced more than one form of maltreatment. The author noted, having explored the current international literature at the time that in relation to specifically foster children, that there broadly appears to be a correlation between the type of trauma experienced and the outcome. For example, children who mainly experienced neglect present with cognitive delays, whereas for children who principally experienced threat and fear, their cognitive ability fragments. Therefore, as a summary, exposure to trauma according to McClean, (2016) can result in:

- Cognitive and Language Delay
- Memory difficulties

- Problems processing social/emotional information
- Executive Functioning difficulties
- Metacognitive skills – auditory processing, concentration, problem solving
- Impulsivity and behavioural regulation

The body's response to threat, commonly known as the fight or flight response, requires the engagement of the Hypothalamic Pituitary Adrenal (HPA) axis, whereby the central nervous and endocrine systems work in collaboration to divert energy resources in order to confront or get away from the source of threat (Bevans et al.2005; Neigh et al., 2009; Zeanah, 2019). Norepinephrine and epinephrine are released into the bloodstream from the sympathetic nervous system and adrenal medulla respectively. Corticotrophin releasing factor is released in the brain that stimulates Adrenocorticotropic hormone from the pituitary gland, which in turn is the catalyst for the secretion of cortisol from the adrenal cortex into the bloodstream. The second phase of the HPA axis response involves the Glucocorticoid receptors in the brain and pituitary being stimulated which allows for a reduction or end to the stress response. A child who is exposed to multiple stressful encounters or where stress is chronic in nature is likely to acquire damage to the system described here, which is supposed to be an emergency survival system (van der Kolk, 2014). There are also consequences for the body when this system is activated, as the chemicals in circulation affect heart rate, blood pressure, gastric process and the immune system, resulting in physiological dysregulation.

According to Neigh, et al., (2009), the long-term effects of chronic stress on children include:

- Neurodevelopmental Delays
- HPA Axis Dysfunction
- Metabolic Syndrome
- Cardiovascular Disease
- Immune System Dysfunction
- Major Depressive Disorder
- Post-Traumatic Stress Disorder
- Compromised Reproductive Health
- Transgenerational Effects

These effects illustrate the broad variety of physiological, neurological, psychological consequences of chronic stress and trauma on the body and brain. One of the results of trauma is post-traumatic stress that can ultimately result in a mental health disorder.

Post-traumatic stress and the related disorder

Duke and Vasterling (2005) define PTSD as an anxiety disorder that develops as a result of individuals being exposed to life-threatening and overwhelming conditions. It first appeared (somewhat late compared to other diagnoses) as a diagnostic category in the DSM-III in the 1980s despite the psychosocial and emotional sequelae of traumatic events having been noted since the

1800s (van der Kolk, 2014). Interestingly, they describe PTSD as the only diagnosis that is directly linked to the event or stressor that caused the condition (Duke & Vasterling, 2005).

According to van der Kolk (2014), the inclusion of PTSD in the DSM-III came about because a group of Vietnam veterans lobbied the APA to create a new diagnostic category. He describes how a PTSD diagnosis needed to include the symptoms associated with what many of the veterans who had returned from the war experienced. These included debilitating symptoms of helplessness, flashbacks to the terrifying and horrifying events they had endured, which seemed to be linked to mood and other psychiatric disorders, violent outbursts, substance abuse, relationship difficulties, and unemployment amongst other outcomes (van der Kolk, 2014).

Because of the timing of the research that forms the basis of this thesis, the DSM-IV-TR (APA, 2000) PTSD diagnostic criteria were outlined to participants in the Psychoeducational Course to illustrate the impact of trauma on individuals. PTSD is the diagnosis that may apply to many children who have experienced trauma and have developed PTSD symptoms and the resultant behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
- Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience; illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted range of affect (e.g., unable to have loving feelings)
- Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal lifespan)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response
- Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor. DSM-IV-TR (APA, 2000)

In addition to listing the relevant elements of the criteria, a slide (Appendix D, Session 3 slides; slide 30) was developed from van der Kolk's (2014) book, *The body keeps the score,* to illustrate the impact of trauma on the body, brain and mind.

Dissociation

As discussed in Loewenstein's (2018) commentary, dissociation has been written about since Charcot wrote about his work with "hysterical" patients in Paris in the 1860's. Loewenstein describes dissociation as a spectrum ranging from normal to pathological. For example, it is within the human brain's normal capacity to be mentally in two places at the same time, such as when driving, a person might not remember passing a familiar landmark due to daydreaming or thinking about what needed to be done at the destination. In the context of trauma however, this normal ability for humans to adjust their minds or personality can become an effective defense mechanism when an individual is confronted with extreme, overwhelming and perceived life-threatening circumstances (van der Kolk, 2014). Dissociation is defined in by Sadock et al., (2015) as, "a disruption in one or more mental functions, such as memory, identity, perception, consciousness, or motor behaviour." (p. 451); for the purposes of reducing …the impact of trauma by psychobiologically sequestering information about trauma through protective activation of altered states of consciousness". Subsequently, "…dissociation segregates from ordinary awareness the full meaning and impact of traumatic events for the person" (Loewenstein, 2018, p.230).

Research carried out by Hulette et al., (2011) in Oregan, USA, to assess whether foster children who had experienced maltreatement had higher levels of dissociation than a matched sample not fostered. They found that foster children who had experienced multiple types of maltreatment or had been physically abused seemed to evidence much higher levels of dissociation than children who had not experienced maltreatment. Children who had experienced abuse and

neglect prior to 3 - 5 years old were more likely to have higher levels of dissociation in middle childhood; and their research also highlighted a gender bias, where girls appeared more likely to develop dissociative symptomatology than boys. There was also a positive correlation between the number of foster placements experienced by a foster child and the likelihood of dissociation, illustrating the negative and cumulative effects of placement change.

Dissociation may therefore be interpreted as an adaptive survival strategy that often comes into force, when "fight" or "flight" become ineffective in keeping the child safe. Dissociation becomes an effective means for an infant or child, and later adult, to psychologically distance themselves from danger and reduce intolerable feelings of distress, especially when physical distancing is not possible (Wieland, 2011). Unfortunately, when dissociation has had to be used repeatedly as a protective strategy, it may become entrenched as a way of coping with stress. This may be evident in losing all sense of reality, and creating their own reality (derealisation); or depersonalisation, which entails losing a sense of self, or taking on a different form of themselves (sometimes described by parents or teachers as "Jekyll and Hyde"). When a child has had to use dissociation as protection, and they are faced with a stressful situation that reminds them unconsciously of previously overwhelming situations, they are likely to dissociate and shut down physically or emotionally, or even enact another form of themselves.

Behaviours associated with dissociation vary from minor adjustments of consciousness and behaviour to more explicit absences or unprovoked rages and changes in personality, and are, as in the outcomes of trauma, primarily dependent on the chronicity, type(s) and extremes of trauma a child has endured (Luoni et al., 2018). As described by Silberg (2022), "Dissociation presents in traumatized children as states, confusion in identity, voices, or apparent 'imaginary friends' that influence behaviour, along with a variety of dysregulations in behavior (sic), mood, cognitions, somatic experiences, and relationships" (p. xiii). It can result in the complete separating out of uncomfortable emotions and sensation into different "self-states", diagnostically known as Dissociative Identity Disorder (DID), if as a moderate or severe presentation it is left untreated and becomes entrenched as a coping strategy that progresses through adolescence and into adulthood (Wieland, 2011).

Developmental Trauma Disorder (DTD)

In a study in the USA that examined the cumulative effect of multiple events of trauma, Cloitre et al., (2009) found that the more traumatic events a child is exposed to, the more severe their symptomatology, and this will be further compounded should they experience further trauma during adulthood. Although many of the symptoms were related to PTSD, there were additional emotional, physiological and behavioural dysregulation symptoms that could not be accounted for

within a PTSD model. Van der Kolk, (2005) therefore proposed Developmental Trauma Disorder (DTD) to the APA as a diagnostic category that took into account these additional dysregulatory symptoms in children, to be included in the DSM-5 for children who had experienced complex trauma. Other differences to especially the aetiology of PTSD noted by van der Kolk (2005) were that complex trauma refers to traumas that begin early in childhood when the brain is still developing, are repeated and chronic; and occur within the context of relationship, 80% of the mistreatment being most often carried out by the infant or child's primary carers.

In addition to the different aetiology and additional symptoms that are specific to DTD, professionals' seeking a separate child-focussed trauma diagnosis was also to avoid the risk that children might be misdiagnosed or not diagnosed at all if they do not fulfil all the diagnostic criteria required for PTSD. Misdiagnoses of children with complex trauma presentations include conditions ranging from Separation Anxiety to Bipolar disorder (van der Kolk, 2005).

According to van der Kolk et al., (2019) comorbidities with DTD but not PTSD include Separation Anxiety Disorder, ODD, conduct disorder and Panic Disorder, which are more externalising types of conditions. Disorders that present alongside PTSD tend to be more internalising conditions including Generalised Anxiety Disorder and Major Depressive Disorder. However, the authors caution that children who do not meet all the diagnostic criteria for DTD should still be assessed for trauma, since children with symptoms associated with DTD were likely exposed to insufficient caregiving parents and other family related maltreatment or community violence (van der Kolk et al., 2019).

The proposed criteria for DTD are as follows (van der Kolk et al., 2019, p. 5):

A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:

A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and

A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse

B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:

B. 1. Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization

B. 2. Disturbances in regulation in bodily functions (e.g. persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions)

B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states

B. 4. Impaired capacity to describe emotions or bodily states

C. Attentional and Behavioral (sic) Dysregulation: The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:

C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues

C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking

C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)

C. 4. Habitual (intentional or automatic) or reactive self-harm

C. 5. Inability to initiate or sustain goal-directed behaviour

D. Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following:

D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation

D. 2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness

D. 3. Extreme and persistent distrust, defiance or lack of reciprocal behaviour (sic) in close relationships with adults or peers

D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults

D. 5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance

D. 6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others

E. Posttraumatic Spectrum Symptoms. The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, & D.

F. Duration of disturbance (symptoms in DTD Criteria B, C, D, and E) at least 6 months

G. Functional Impairment. The disturbance causes clinically significant distress or impairment in at two of the following areas of functioning: (van der Kolk et al., 2019)

- Scholastic: under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credential(s), conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors.
- Familial: conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfilment of responsibilities within the family.
- Peer Group: isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age-inappropriate affiliations or style of interaction.

- Legal: arrests/recidivism, detention, convictions, incarceration, violation of probation or other court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards.
- Health: physical illness or problems that cannot be fully accounted for physical injury or degeneration, involving the digestive, neurological (including conversion symptoms and analgesia), sexual, immune, cardiopulmonary, proprioceptive, or sensory systems, or severe headaches (including migraine) or chronic pain or fatigue.
- Vocational (for youth involved in, seeking or referred for employment, volunteer work or job training): disinterest in work/vocation, inability to get or keep jobs, persistent conflict with co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

DTD may therefore provide a more comprehensive categorisation system of the effects of trauma on children, including the PTSD, developmental and relational aspects. It also provides a more inclusive description of the numerous categories of outcomes that define "polytraumatised" children (van der Kolk et al., 2019).

4.5 Conclusion

The three areas of knowledge and theory examined in this chapter appear to combine well. They describe many of the factors that affect a foster child, which might assist parents in gaining understanding about how their foster child(ren), and to some extent how they themselves, respond and react in different circumstances that evoke conscious or unconscious reminders of difficulties they have endured. Foster children are not an homogenous group and the three areas explored illustrate how each child is likely to have a unique combination of bio-psycho-social influences, that need to be contextualised from an ecological, for example, socioeconomic perspective, to try to understand the resultant multifaceted cumulative effect. The more difficulties they have been exposed to, and foster children have more likely been affected by multiple difficulties (bio-psycho-social-ecologically), the more likely they are to experience physiological, psychological and social problems.

An important outcome of exploring this range of literature was how the complexity and difficulty of diagnosing foster children was highlighted. Many of the outcomes of the prenatal conditions, attachment relationships and possible trauma result in similar cognitive, emotional, and behavioural responses; many also overlap, and are therefore described as comorbid. The literature therefore suggests that there is no linear relationship between the aetiology and expression of the difficulties foster children may have endured. The literature infers that fostered children have most likely experienced numerous undesirable life circumstances, over protracted time periods, some of which may have occurred before they were born.

Many children who have experienced maltreatment or trauma may show symptoms associated with PTSD. However, a larger majority of these children have additional emotional and behavioural symptoms that cannot be accounted for within the PTSD diagnostic criteria. The proposed DTD diagnosis outlined and proposed by van der Kolk and his colleagues (2019) seems a better match diagnostically, especially for foster children, who in most cases fulfil the aetiological conditions of experiencing or perceiving repeated life-threatening events that have taken place during stages of childhood development in the presence of, or carried out by their primary caregivers. DTD also includes the multitude of effects on the body, brain and mind of a child with which foster parents and clinicians working with foster children are familiar. Unfortunately, this diagnosis is not yet available to use clinically, having not been included in the DSM-5 (APA, 2013).

The following chapter will describe the methodology of developing and evaluating a small-group parenting intervention for foster parents that included an outline of the relevant information contained in the literature review, whilst simultaneously eliciting some aspects of the lived experiences of foster parents through mutual discussion. Furthermore, it was also hoped that emotional and behavioural information regarding a sample of foster children could be obtained (from the parents) and evaluated, in order to contribute toward the debate around the possible future inclusion of DTD as a diagnosis. Having such a diagnosis with which to work might not only provide a better understanding of vulnerable and foster children, but also assist with their assessment, diagnosis and intervention.

5. METHODOLOGY

5.1 Introduction

The following chapter is divided into six sections. Starting with the aims and objectives of the research, I then outline the research questions. The philosophy, practice and purpose of Action Research as an expression of the pragmatic research paradigm (Morgan, 2007) is presented. Thereafter, the research design section describes the benefits of using a mixed methods design, blending data forms (Creswell, 2014) in this study, based on the different types of data collected, in order to answer the research questions. This section also includes the ethical considerations required in psychological research in general according to the Psychological Society of Ireland, additionally outlining international guidelines specific to children.

The research process is then described, illustrating the evolution of the small group foster-parenting intervention as an outcome of many years of clinical practice working with foster children and their foster parents. This includes the design, participant selection, obtaining informed consent, and format of delivering a small-group foster-parenting Course to foster parents. The data collection section provides an outline of the measures of both quantitative and qualitative nature, used to measure stress levels in parents and evaluate emotional and behavioural difficulties in children, as well as for evaluating the small group intervention. The chapter ends with a description of the types of data analysis utilised, followed by an outline of research integrity to provide a framework of what is required to provide credibility to qualitative research.

5.2 Research aims and objectives

The research study evolved out of my practice as a Clinical Psychologist in a Child and Family Community Psychology Service in the Mid-West of Ireland where much of my work for many years involved working with foster children and their foster parents. The motivation behind the project was multifaceted and included a special interest in, and gaining more understanding about, the unique nature of these two populations and their impact on one another. Trying to provide a psychological service in a climate of resource limitations, an option was group interventions whereby clinical time can be distributed more fairly and potentially more effectively, especially if the group identify with one another and are able to gain support from one another. A third incentive for the research related to the non-inclusion of the diagnostic category, Developmental Trauma Disorder (DTD) in the DSM-5. Having spent many years attending conferences and workshops learning about Trauma, especially chronic and relational trauma, I hoped to provide further evidence, even if only in a small sample, of the emotional and behavioural difficulties of foster children that mirror the multi-

symptomatic diagnostic criteria for DTD, to support the proposals of Cloitre et al., (2009) and van der Kolk et al., (2009).

Some of my initial reflections on my work led to the questions that were expressed broadly in my ethical approval application and included:

- Are foster/adoptive parents showing high levels of stress in parenting? The likelihood is yes, but could I measure this stress and find out more about whether the foster child or other factors associated with the foster parents contributed?
- What emotional and behavioural presentations are foster/adoptive children displaying? Having worked with this population for approximately 14 years at the time, there appeared to be some similarities in their presentation and I wondered whether these symptoms could be attributed to foster children in general and whether they might be in keeping with those symptoms put forward for DTD.
- Does the presentation of these children influence the foster parents' feelings of stress or competence regarding parenting? If there were to be a positive correlation between the children's level of difficulties and the foster parent's stress, then this would identify an area of intervention.
- Is small group psycho-education a useful intervention for this population? Identifying whether this format was beneficial to foster parents would allow a more resource-effective way of working with foster parents.
- In what ways might foster parents feel that a small-group foster-parenting Course benefits them and their capacity to parent their child(ren); and would there be any drawbacks? Evaluating the outcome of a clinician/researcher-developed intervention program would provide evidence regarding its efficacy and substantiate its possible use as an intervention for this population and perhaps other groups of foster parents in the future.

These reflections were reworked and refined in order to develop a research strategy, identify and create tools to gather pertinent data from the participants, and led to the Research Questions that evolved through these deliberations, which are listed in the next section.

5.3 Research Questions

The following research questions were thus formulated to guide this study:

1. What are the levels and nature of stress experienced by foster parents in parenting their children?

2. According to their parents, what emotional and behavioural patterns are foster children displaying and is there any relationship between the children's presentation and the parents' level of stress?
3. What were the elements of the psychoeducational program and how did it unfold?
4. What were the foster parents' responses to, and experiences of, a Developmental, Trauma and Attachment based small group psycho-educational and reflective intervention?

5.4 Action Research

Action Research (AR) is a way of developing knowledge through action, and action evolves though knowledge and reflection; and is a favoured research methodology of Community Psychology (Orford, 2008). Clinical Psychology has been firmly embedded in a medical model of practice, a positivist model (Creswell, 2014) that values science, diagnosis and quantifiable evidence-based interventions. In contrast, the model that evolved from both Community Psychology and AR perspectives is one of collaboration between practitioner "expert" and participant client(s) as "experts" through their lived experiences.

The practitioner's knowledge consists of theoretical learning, professional experience, continuing professional learning and self-development, located within the context of daily personal life, historic experience, culture and world-view of that clinician. The person or group (participants) with whom we work represent the source of the most relevant knowledge about their situations as they live their experiences. An objective of AR is therefore to shift the unequal power dynamic (van der Riet & Boettiger, 2009) that has developed from the medical model, where the clinician is deemed the expert; and for both clinician/researcher and client to jointly identify difficulties and possible solutions for that client or client-group. Power-shared learning and knowledge, which is more person and group-centred, thus combines science-based theoretical knowledge and the reality of lived experience.

All features involved in AR are dynamic in that they are constantly changing. Academic theories change and adapt, and diagnostic criteria and interventions are also modified according to developing knowledge (Clark, et al., 2017). The clinician's knowledge and practice needs to adjust to the changing theoretical bases and their increasing practical knowledge. This knowledge base importantly includes the clinician's exposure to multiple clients' narratives about their lived experiences regarding their difficulties, symptoms and circumstances. The more balanced democratic nature of this clinician - client relationship can result in the co-development of mutually beneficial knowledge (van Veen et al., 2013). Evidence acquired through the evolving AR provided

subjective evaluations of the benefits or limitations of an intervention rather than statistically significant quantitative measurements.

AR's popularity as a research model is that theory is developed as a by-product of research, and is co-created with the research participants (Tossavainen, 2016). The reflexive nature of the model requires constantly evaluating and restructuring theory and practice according to the outcomes of ongoing reflection. AR therefore provides the opportunity to constantly reflect on, and evaluate one's practice in order to meet one's own professional standards (Leitch & Day, 2000), simultaneously establishing whether one's practice meets the needs of one's client group. Reflexivity allows for changes in practices to be made, in a way that both practitioners, but more importantly, the client group think is best (McNiff, 2010).

AR's main difference to more formal scientific research (that often has one specific question to which the outcomes provide answers), is that in AR the question under consideration continually reinvents itself through enquiry and ongoing curiosity. McNiff (2013) states, "…the 'end' of the enquiry turns into the beginning of a new one; the process is ongoing, a continual process of asking questions and seeing possibilities in everything, which is the very nature of a life of enquiry" (p.2). Therefore, it may not be possible to determine the definitive beginning or end of AR, as it is an ongoing process that may elicit more questions than answers.

Action Research in the context of this study

AR corresponds with two of my own personal professional principles: to improve my clinical practice and to improve the quality of life for my clients. Improving clinical practice in order to improve the quality of life of clients requires knowledge and experience, but more importantly reflection on that experience, an ability to self-evaluate and incorporate information from the clients themselves, supervisors and collegial peers, and adjust one's practice accordingly (McNiff, 2010).

The research was an attempt to simultaneously improve both the quality of life of two of my clinical populations (foster parents and foster children); and develop and improve my clinical practice through mutual sharing and co-creating knowledge, in the process of doing research to inform the way I might work with these populations in the future. The purposes of AR therefore lent themselves to a clinician-led research study comprising a participatory small-group foster-parenting Course for foster parents.

Principles of PAR and CAR

According to Akhurst (2022), the fundamental difference between Participatory Action Research (PAR) and Collaborative Action Research (CAR) is that in PAR everything about the research is designed and carried out by the group themselves, whereas CAR is clinician/researcher led. This research study, although based on action reflections of work carried out with foster parents over a

number of years, was designed and carried out by me as a clinician/researcher. Ideally, and if time had allowed, the foster parents would have carried out their own research, however, based on personal and professional time constraints, CAR was the most efficient format methodologically. As many of the principles of PAR also underpin CAR, I have used Kemmis and McTaggart's (2005) seven principles of PAR to outline some of this study's principles. These are briefly described by those authors as follows: "Participatory action research is a social process; is participatory; is practical and collaborative; is emancipatory; is critical; reflexive (e.g., recursive, dialectical); and aims to transform both theory and practice" (pp. 280-282).

The research involved groups of foster parents meeting in predetermined small groups, receiving psychoeducational input and then reflecting on the material and sharing their own information and experiences. Foster parents make up a social group of individuals and couples who provide a family home-based placement for children who have been removed from their own biological families. Individually, foster parents possess their own knowledge based on their lived experiences and as a group there would be an opportunity to share and combine knowledge and provide support to one another. Forming groups of individuals involved in fostering had the potential to provide opportunities to develop their knowledge about themselves, each other and the roles they play in the organisational structures of which they are part.

Participation in the research process was voluntary and by informed consent; and participants were asked to request any input they felt would benefit them personally and as a group. The reflective section of sessions was not predetermined by me as the researcher and was an interactional discussion between participants, including my involvement as part of the group.

Identifying individuals and placing them together in a group because they share a common activity and intention provided an opportunity for participants to share their own experiences, thus contributing toward collective information regarding the group and their common activity of parenting foster children. An anticipated outcome would be that by sharing information and experiences during group meetings, would provide new knowledge and empower the group in their common purpose of parenting. It also provided participants the opportunity to identify as part of a group that shared a common purpose.

Foster parents are relatively isolated from one another. They are grouped together during their initial induction training and again in larger groups when additional trainings are intermittently facilitated. Confidentiality policies further isolate them, since foster parents may not discuss their foster children with other parents in an informal way, in contrast to the ways that parents might discuss difficulties and achievements of their biological children with other parents. Grouping individuals together and confining the confidentiality to within the group, parents could discuss

positive and negative experiences openly. Individuals thereby become part of a collective experience, learning and being reassured by one another that their experiences were not unique, which had the potential to be liberating.

An underlying motivation in creating groups was for participants to re-evaluate their positions within the organisational structure, to question the status quo, and with increased knowledge to empower foster parents to appreciate their value. In my work with foster parents, I have considered them as co-professionals, part of the multidisciplinary team working with a child. In my position as researcher and co-participant in the groups, I tried to role-model this philosophy.

In day-to-day living, we seldom question our realities. Foster parents might only question their reality as foster parents when in crisis; when the child they are parenting creates risk or an intolerable level of discomfort in their home. This is not a strength-based process and has the potential to lead them to identifying weaknesses in themselves, the organisation and the child. Reflection and reflexivity can occur in groups; where listening to others and sharing similar experiences, may lead to thinking and re-evaluating and potentially changing ways of parenting proactively through increased knowledge and understanding. Identifying their personal strengths as foster parents, their roles as foster parents, the impact of the organisation on their identities and capacities to carry out these roles, and how these elements fit into the historic and cultural landscape all become potential areas to explore.

Theory exclusively in the hands of clinicians creates a power dynamic between the professional and the individual or group they are treating or researching. The psychoeducational section of each group meeting was constructed in a way that I could share my own clinical experience and relevant psychological theoretical information that I had found useful in understanding foster children. The reflective discussion section that followed then provided the opportunity to learn more about and appreciate the lived experiences of foster parents, and for foster parents to identify with each other and realise that other parents were dealing with similar difficulties. The intention of this combination was to develop mutual knowledge and understanding to refine and modify relevant treatment strategies, potentially contributing to both theory and practice.

5.5 Research Design

Mixed methods research within an Action Research paradigm

The research required a relatively complex multilevel investigation of a number of interrelated questions that meant using mixed method research methodology (Creswell, 2014) to obtain and analyse both quantitative and qualitative data. Fetters et al., (2013) describe how health

research uses a mixed method research format, including both quantitative methods to measure factors numerically, statistically using these data to generalise findings to larger populations; as well as qualitative methods to establish how participants may have experienced something.

Formal clinically appropriate measures were used in this study to measure symptoms such as stress in parents using the Parenting Stress Index, (Abidin, 2012), and Stress in Parenting Adolescents (Sheras et al., 1998); the emotional and behavioural presentations of children through the Strengths & Difficulties Questionnaire, (Goodman, 1997) and Child Behaviour Checklist, (Achenbach & Ruffle, 2000). These quantitative measures were used to identify different clusters of symptoms, the severity and possible patterns of symptomatology. Qualitative measures comprised post-session and post-Course structured questionnaires that were developed to investigate the learning and knowledge development of individual participants in relation to parenting foster children and self-knowledge; as well as their experience of participating in the small-group foster-parenting Course.

Ethics

Obtaining ethical approval

Research in the Republic of Ireland in the field of psychology and other medically related areas requires vetting and approval by the HSE Ethics Committee. The 5.5 version of the Standard Application Form for the Ethical Review of Health-Related Research Studies, which are not Clinical Trials of Medicinal Products for Human Use as defined in S.I. 190/2004, was completed, submitted and approved (see Appendix A). Allan's (2011) text on the law and ethics as applied internationally to psychology was referred to when completing the requisite ethics application for the Irish Health Service Executive (HSE).

The ethics application form required that I outline the following elements of the study:

- General Information
- Study Descriptors
- Study Participants
- Research Procedures
- Data Protection
- Indemnity
- Cost and Resource implication and funding

Foster parents are a semi-professional group of individuals who have been trained and assessed in order to be able to provide a home for foster children. They therefore do not constitute a vulnerable population and were able to provide informed consent. Groups were designed according to participant's availability in their particular geographic area. It was not possible to know

whether participants might know one another outside of the group context, but groups were designed in a way that no related foster parents were assigned to the same group.

As a practicing Clinical Psychologist, I am required to follow the ethical practice principles of my profession. I practice professionally in the Republic of Ireland, which is regulated by the Psychological Society of Ireland (PSI). Below I describe the four main summarised principles of the relevant code of practice (PSI, 2019) and explain how these were adhered to.

Principle 1: Respect for the rights and dignity of the person

This Principle requires that psychologists value and protect their clients, that they treat their information confidentially and that they ensure that their clients understand and give their permission for any psychological intervention undertaken.

Participants were provided with an Information document (see Appendix B), which informed them about the research, how it would be conducted and by whom. Confidentiality was outlined in the document and anonymity through data coding was assured. The benefits and risks were explained and participants were informed that they could leave the research at any time, although they were encouraged to continue attending the groups even if they chose to discontinue their participation in the research. The information document was discussed during the Introduction session and confidentiality within groups was covered at the beginning of the Course sessions under the title “Reminders”. Foster parents, as part of their training and contract are aware and have committed to the principle of confidentiality especially regarding information pertaining to the children they foster.

Principle 2: Competence

Psychologists are required to develop and keep their professional knowledge up to date and practice within their established and developing skills base, with the understanding that there are limitations to all knowledge.

As the primary researcher, I carried out all elements of the research. These included designing and delivering the small-group foster-parenting Course, data collection and analysis. My qualifications at the time of carrying out the research included a Masters of Social Science - Research (Psychology) as well as a Masters in Clinical Psychology. The quantitative instruments used to collect data were all instruments I was qualified to use, and were familiar to me from regular use in my clinical practice. During my professional career, I have specialised in Attachment, Trauma and Development and in addition to clinical and educational assessment, individual therapy sessional work and supervision, have provided many hours of psychoeducational group work, group supervision and lectured at post-graduate level.

Principle 3: Responsibility

Psychologists do not formally take an Hippocratic oath but are still bound by the ethical principle of non-maleficence (not harming), and are expected to work in a responsible and accountable ways. Treatment and research protocols have to be constantly evaluated to ensure that clients and participants are kept safe during psychological interventions or research protocols.

The information document (Appendix B) outlined the potential risk that participants could become upset by the disturbing nature of some elements of the topics being discussed, especially abuse and neglect in relation to children. Participants were assured that stress levels would be monitored throughout and that warnings would be provided before any difficult topics were discussed. In the group context, it was not possible to know what difficult life events individuals might have experienced themselves and whether these experiences might cause individual participants distress. It was therefore incumbent on me as group facilitator to monitor the wellbeing of individual participants and the group as a whole, to ensure that individuals were emotionally comfortable as well as monitor the group dynamic to moderate any potential harmful effects.

Principle 4. Integrity

Integrity in the context of research can be defined as honesty and openness about one's intentions as a psychologist/researcher. Important features of integrity include avoiding any forms of deception or coercion and dealing with ethical dilemmas timeously.

The information sheet introduced me as the researcher and set out my intentions in carrying out the research. Many of the participants had either met me or had knowledge of me in the context of my work in the field of children in Care, so were familiar with my work. The information sheet also set out what was expected of participants, the benefits and risks, time commitment and their rights, including that they had the right to discontinue their involvement in the research project at any point during the Course.

Researching children

ERIC (*Ethical Research Involving Children*), an international organisation in partnership with Unicef's office of research, *Inocenti* and *Childwatch International Research Network*, elaborates in their Guidance the main ethical considerations when researching children. They outline 4 main areas: Harm and Benefits, Informed Consent, Privacy and Confidentiality and Payment and Compensation (ERIC, 2019).

Children would seldom be able to provide informed consent under a certain age. Foster children are a difficult population to research because of their legal status and the complexities of obtaining permission from state bodies. In order to stay within the ethical boundaries of

researching foster children, the methodology was designed so that there was no direct contact with any child. Quantitative questionnaires filled out by parents were used to provide the information about the children, thus avoiding any direct contact.

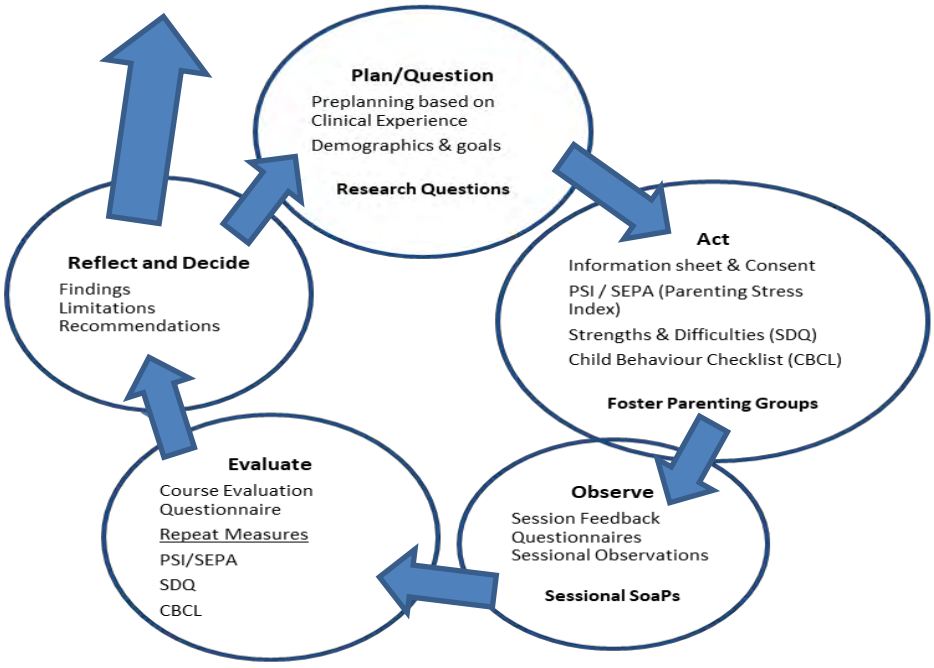
The purpose of researching this population was to provide additional information to add to the field of children in the Care of the State, illustrating trends in their emotional and behavioural presentations. Furthermore, it was to provide their parents with the knowledge as to potential contributors to their behaviour, thereby to promote better adaptations in these children, through informed and enriched parenting. The small group intervention delivered to foster parents was based on current theory and relevant practice in the fields of Infant mental health, Attachment and Trauma and was developed in order to strive to improve the quality of parenting of foster children. No payments were made or received during the research, since it was complimentary to my role as psychologist in the Child and Family Psychology Service. There were no identified conflicts of interest. All data were anonymised, so that no child or parent could be identified.

The Research Process

The following diagram (Figure 4) provides a summarised overview of some of the steps taken in the formulation and development of the research within an Action Research model. These elements of an action cycle will be discussed in further detail thereafter.

Figure 4

Illustration of the overall action cycle from preplanning to evaluation



Preplanning based on clinical experience and theoretical knowledge

The research was designed based upon a clinical intervention that appeared to be assisting individual foster parents to reduce their stress and parent more effectively, which I had been developing over a number of years in my clinical practice. Almost all foster child referrals to Child and Family Psychology Service were labelled as urgent. In general, referrals occurred when a foster child's behaviour had become so difficult for the foster parent that the child's home or school placement was at risk of breaking down and possibly being terminated by the foster parents.

Individual psychological intervention with any child in distress has the potential to increase the stress of the child. In my experience, focussing on the child, whether biological or fostered, when they are distressed can result in them becoming more defensive, most likely because many children can feel responsible for what is going on around them, and foster children appear to be more sensitive to this egocentric feature of childhood. Foster children may therefore be more likely to believe that there is something wrong with them due to their traumatic experiences and may correctly or incorrectly assume that the difficulties being experienced by those around them are due to them. Children are often not in a position to understand or find solutions to their own behaviour and they are seldom likely to understand why they are behaving in a particular way. I have therefore found it more effective to address issues and concerns through the foster parents. However, an important consideration is that the parents are also likely to be in a state of emotional distress; and often need reassurance and to de-escalate their emotions and reactions before they can engage in finding ways to soothe the child. It is also an extremely vulnerable time for an individual parental intervention as they may be guarded, hyperaware of criticism, and often tend to blame the child or lack of services for the difficulties they are experiencing. Therefore, by the time a foster child is referred for a psychological intervention, the tipping point may often already have been reached and crisis intervention in order to save the child's placement would be required.

Clinically, I have found it helpful to engage foster parents in a psychoeducational information sharing process, using their knowledge of their foster child's history and life experiences as a starting point, to determine why the child might seem emotionally or behaviourally out of control. This approach identifies that in many cases the child may be experiencing fear associated with feelings of loss or abandonment, often related to their early life experiences (rather than their current circumstances), potentially leading to oppositional, violent or emotionally or behaviourally provocative behaviour. Reframing for parents in this manner and illustrating that behaviour is communicating something important and often very difficult for the child, generally elicits compassion and greater understanding, thus reducing the parents' frustration and defensiveness, and can often be an effective means to find more effective ways to assist the child.

Barriers to this type of parental engagement are often associated with timing. The relationship between the foster parent and their child, or the social work system, may have already broken down. The distressed child may at the time of referral be so out of control that they become a risk to themselves, somebody in the family or a valued pet. Another main barrier encountered in my practice has been the parent(s)' own personality difficulties, unresolved trauma or attachment issues, or a combination of these that the child may have unwittingly activated. These then render the parent unable to disentangle themselves from their own sense of fear and danger. Lastly, at the time of referral, the parent(s) would often have persevered for some time trying to maintain the placement; and may as a result be in a state of exhaustion or burnout, thus feeling hopeless.

Designing the small group psychoeducational model

Participants

After ethical approval had been gained, the fostering social work department was informed of the study and were asked to identify potential foster parent participants. Inclusion criteria comprised parents who had children who were presenting with moderate to severe emotional and behavioural difficulties. This criterion was included because these children and parents were likely to be referred to the Child and Family Psychology Service in the future and their inclusion justified the Course being held during working hours. As the researcher, I then screened these parents telephonically, assessing suitability, availability and willingness to participate.

Four groups (each to meet for a number of sessions) were originally planned; however, two more were added, following a request from the fostering department, because more foster parents who had heard about the Course were interested in attending. Including foster parents who were interested meant that the sample of foster children included children who were not necessarily presenting with moderate to severe emotional and behavioural difficulties. Furthermore, parents often had more than one foster child, with one perhaps presenting with difficulties and the other(s) not. Both of these factors meant the sample was potentially more representative of the population of foster children in the geographic locality, as it included foster children with a range of difficulties that could be categorised from minor to severe.

The research therefore comprised six small groups of between six and eight foster parent participants (n=38), representing 69 foster children. In circumstances where foster parents were a couple, both parents were encouraged to attend, although in most cases this was not possible and attendance of one parent was accepted. An important criterion for all participants was that once they had volunteered, attendance at every session was a pre-requisite.

Content

The Course was designed using current theoretical information of child development pertinent to foster children. Information included the prenatal environment from conception, Attachment theory in relation to early childhood experiences; and the impact of repeated or chronic trauma on the brain; and the impacts of these on the child's resultant behaviour. Attachment theory was then discussed in relation to the foster parent(s)' own styles of attachment and how these might impact on their relationships, including those with their foster child(ren). Participants were also invited to consider their own upbringing and childhood experiences and how these might influence their style of relating and parenting. Vicarious trauma, burnout and self-care elements were introduced toward the end of the Course to illustrate the impact of the child's experiences and behaviour on the foster parent(s) and their family. Ideas on how these negative consequences could potentially be prevented or the effects moderated, were discussed.

Each session focussed on a specific area of the topic being covered; a parenting message; and often there would be a theme running through the material covered during that session (see SoaPs in chapter 7). Teaching methods used in the design of the content of the Course included shocking visuals or novel information that had the potential to bring participants' attention to the subject matter. Humour and using cartoon figure drawings were included to relax participants, so that they could stay "present" to hear some difficult material about childhood abuse and neglect, thereby encouraging the learning process. A furry "laughing monkey" toy was introduced during the introductory session and was visible on the desk for all meetings. The monkey represented a symbol that some of the material was difficult to listen to, and participants could request the monkey be "switched on" to make people laugh as another way to lighten the mood. Case studies and information from my own clinical experience, without revealing identifying information, were shared with the groups to provide supporting evidence of foster children's behaviour, difficulties and possible interventions. Relevant self-disclosure was also used on occasion to provide a sense of safety and collegiality; and to encourage information sharing.

Introductory Session

The research groups began with a pre-Course introductory meeting whereby participants were provided with a verbal overview of the program, pre-test measures, and the Information Document and consent forms. I introduced myself and provided a background to my interest in the research topic; I also explained that although I was facilitating some of the learning in the psychoeducational section, I was also a co-learner in the process, especially during the discussion section of each session. I explained that my role was to participate in discussions rather than provide

solutions for individual behavioural problems. Introductions between members were facilitated and group rules were discussed and decided upon.

Groups were provided with a brief demonstration on how to fill in the pre-test questionnaires and were asked to complete them, after having consented to participate in the study by signing the consent form. They were asked to bring the completed consent form and questionnaires to the first group session, scheduled for the following week. Participants were informed verbally and in writing that they could withdraw from the study at any point, including after the program was completed and that withdrawal from the study would not exclude them from continued participation in the psychoeducational/reflective Course.

Group format

After the Introductory session, group sessions were held weekly for 2.5 hours over 5 consecutive weeks. A three-month break coinciding with school holidays was structured into the time-frame, after which two further sessions of 2.5 hours were scheduled. Thereafter, participants were provided with a post-Course evaluation questionnaire, as well as post-measures of the original pre-test questionnaires during the last session of the Course, and they were asked to complete them and return them by post.

The psychoeducational component of the group consisted of an hour-long talk on a specific topic. The Course followed a developmental model and included prenatal development, Attachment Theory and Trauma, and resultant emotional and behavioural effects on the body, brain and mind. The design of the content was to initially focus the information content on the child and then after three sessions to turn the focus of the information toward the foster parents allowing them to reflect on their early relational experiences of being parented and how these might impact their own parenting style. The material was summarised in the 5th session prior to the scheduled long holiday break and repeated again in the 6th session when participants returned. The seventh and last session addressed the topic of stress, vicarious trauma and burnout, where participants were encouraged to seek out ways of reducing their stress in the context of parenting foster children. At the start, and throughout the Course, participants of all groups were encouraged to request additional topics that they felt would benefit their capacity to parent their children, a way of co-developing the program according to their needs.

The group discussion/reflection section of the session followed a brief comfort break. This part of the session followed a different format and although facilitated by me, the researcher, I was also part of the group discussing the material that had been covered in the psychoeducational section in the previous hour. My dual role as participant and facilitator was to encourage discussion, provide examples, validate participants experiences, time-keeping and to maintain the agreement

about not being critical about the organisational issues or social workers. This role also required that I role-model group behaviour by sharing information, being empathetic and reacting appropriately to the material being shared by participants. The motivation behind including the discussion-reflection section of the session was to provide the opportunity for peer-learning and support. It would also allow participants to engage with the theoretical material that had been presented, relate it to their own situations and find possible understanding or solutions for themselves. A challenge as facilitator was therefore not to lapse into the professional to client problem solving format, thereby reducing participants' experiential learning.

5.6 Data Collection

A standard clinical assessment of a foster child would include an emotional and behavioural screening tool. Measures used in this study included the Strengths and Difficulties Questionnaire (Goodman, 1997), a measure used to evaluate foster children in the UK (Goodman et al., 2004). The Child Behaviour Checklist (Achenbach & Ruffle, 2000) was used as it reveals additional specific information and is more sensitive to the emotional and behavioural symptoms of children, including possible diagnoses. These questionnaires were both designed to be completed by parents or guardians and therefore did not require any involvement from children. The Parenting Stress Index (Abidin, 2012) and Stress Index for Parenting Adolescents (Sheras et al., 1998) were used to try to establish whether foster parents were experiencing stress in parenting their fostered children and adolescents. Custom-designed post-session and post-Course questionnaires were used to collect qualitative data on foster parents' experiences of the sessions, their learning and opinions on what further information was required from the Course. The post-Course questionnaire sought feedback on both the small-group foster-parenting sections of the group; information regarding the stress associated with being a foster parent and possible solutions; and whether or not they would recommend the Course to other foster parents.

- The Parenting Stress Index (PSI/SIPA) was used to evaluate current levels and nature of parenting stress in foster parents [Research question 1.]
- Strengths and Difficulties Questionnaire (SDQ) and Child Behaviour Checklist (CBCL) were used to identify the emotional and behavioural presentation of the participant's children [Research question 2.]
- Feedback forms were provided after each session to obtain information on key learning points, relevance and understanding of the material, and overall satisfaction with the group. [Research question 3.]
- Evaluation forms were completed by participants at the end of the small group psychoeducational /reflective Course [Research question 4.]

5.6.1 Quantitative measures

5.6.1. i The Parenting Stress Index (PSI)

The Parenting Stress Index (PSI), Fourth Edition, developed and updated by Abidin (2012) in the USA, was the measure used to evaluate the level and sources of stress in parents of foster children aged 1-12 years. When developing the measure, he noted that there was no specific formula to parenting and that a combination of many skills and abilities contribute toward children's development. He was therefore curious to understand why, since most parents care about the wellbeing of their children, dysfunctional parenting develops. Abidin (2012) was aware that all parents experience stress of different kinds and intensity, and that the more intense the stress and the less their coping skills, the more likely they were to develop dysfunctional parenting skills, which in turn resulted in emotional and behavioural problems in their children.

The PSI is a paper and pencil format with a separate question booklet and answer sheet comprising 120 questions designed to assess stress in parents from multiple sources of children between the ages of 1 month and 12 years old. Question responses are divided into those associated with elements of stress associated with the child (Child Domain) and stress associated with the parents themselves (Parent Domain). The responses for these first 101 questions follow a Likert scale format and consist of 5 options, Strongly Agree, Agree, Not Sure, Disagree and Strongly Disagree. A third category, Life Stress comprises nineteen Yes or No questions about life stressors outside the relationship between parent and child that might place stress on the parent and potentially contribute toward difficulties between the parent and child. The parent answers these questions in relation to one particular child, thus foster parents with multiple foster children were required to fill out separate questionnaires for each of their children.

5.6.1. ii Stress Index for Parents of Adolescents (SIPA)

The SIPA (Sheras, et al., 1998) is an extension upwards age-wise of the PSI, and is a similar format and questionnaire to the PSI, but relevant to adolescents from age 11yrs to 19yrs. It consists of 112 questions. Similar to the PSI, the first 90 questions consist of a 5-point Likert scale from Strongly Agree to Strongly Disagree. The Adolescent and Parent domains comprise 4 subdomains each listed below, and the Life Stress scale consists of 22 items at the end of the questionnaire and require a yes or no answer. Normative data were derived from 778 parents of adolescents from the general population and a clinical sample of 159 parents of adolescents who had received a *DSM-IV*™ diagnosis. Internal consistency coefficients range from .80 to .90. Test-retest reliability coefficients for the subscales range from .74 to .91. (Sheras et al., 1998)

5.6.1. iii The Strengths and Difficulties Questionnaire (SDQ)

Goodman's (1997) Strengths and Difficulties Questionnaire (SDQ) is a brief screening questionnaire used to evaluate the behavioural difficulties of 2 - 4-year-olds and 4 - 17-year-olds. There are different versions of the questionnaire depending on the respondent (parent/carer, teacher and self-report). These are only slightly different depending on the respondent and are available for a small fee online. Only the parent report version was used in this research, having been evaluated and found to effectively identify emotional and behavioural difficulties in foster children in the UK (Goodman et al, 2004; Goodman & Goodman, 2012). The SDQ consists of 25 questions. These questions evaluate overall stress, emotional symptoms, behavioural difficulties, hyperactivity and inattention symptoms, conduct problems, peer relational difficulties and prosocial behaviour. The age appropriate versions used in the research also included the impact supplement, which asks the respondent whether they feel the child/adolescent has difficulties, how long they feel these have been in existence, and the impact of their difficulties on the child themselves and/or others. (Goodman, 1999).

5.6.1. iv Achenbach Child Behaviour Checklist (CBCL)

The Child Behaviour Checklist (CBCL) is a standardized questionnaire filled out by parents/guardians to describe their child's emotional and behavioural difficulties (Achenbach & Ruffle, 2000). Two versions (1.5-5yrs and 6-18yrs) of the CBCL were used in the research depending on the age of the child. The CBCL is a self-explanatory pen and paper questionnaire allowing parents to fill it in without supervision from a clinician. The initial section of the questionnaire requires demographic as well as adaptive behaviour information including their child's participation in sports, hobbies, clubs, teams or groups and their jobs and chores. The second page requires information on relationships with friends, siblings, peers and parents. The questions on the second half of page two relate to the child's academic needs and performance in school. It also asks parents to describe their main concerns regarding their child as well as the best things about their child. Thereafter the main body of the questionnaire consists of 120 items regarding emotional status or behaviour over the past 6 months in Likert scale format; 0 = Not True (as far as you know), 1 = Somewhat True or Sometimes True, 3 = Very True or Often True (Achenbach & Rescorla, 2007).

The CBCL 1.5-5yrs version was used for children under 5 years old or non-school going age and the 6-18 version was used for children of school going age. The 1.5-5yr old version is slightly shorter with 100 questions, and does not have questions about the child's adaptive functioning, social relationships or academic ability. It includes a Language Development section that participants were not required to complete, since that was not being measured.

5.6.2 Qualitative Measures

5.6.2. i Post-session Questionnaire

A post-session questionnaire was designed for participants to fill out after each session (see copy of questionnaire in Appendix E). These were designed to provide feedback on what information participants were learning; to what extent they felt they were learning in each session; how they might use the learning in their everyday lives; who might benefit from the information they had been exposed to during the session; and what they might add to each session. The structure of the questionnaire was designed to encourage individuals to think about, and write down elements of the day's session that stood out for them including what information they could use in their own home contexts, as a means of reinforcing their learning process.

The first question was designed to encourage participants to think about the material presented in each psychoeducational session; to identify something novel or something that had evoked a response in them. The purpose of this question was to encourage a mental review of the material and to write down what they remembered, reinforcing that memory through writing it down. It also provided me with an insight into what participants had learned, and provided an opportunity to reflect on whether these learnings included the important messages of the sessions.

The second question required a mark on a 10-point Likert scale visual graph to indicate how much participants' felt they had learned during that session. It provided me with feedback about how relevant the material was to participants and whether the teaching style and methods were effective.

The third question was similar to question one, but in this instance required the participant to reflect on the material and think about how they might implement their new-found knowledge. This re-examination of the material was to encourage reinforcement of learning. It also reflected the areas in which a participant had potentially moved from Knowledge to Insight, thus increasing the potential for Behaviour Change.

Question 4 requested feedback on what other people or professions participants felt might benefit from hearing the information provided to them during that session. The data obtained from these responses would indicate where participants felt the information would be useful and could be used in the design of further programs targeting relevant persons or professional groups.

Question 5 provided participants with the opportunity to express what else they might like to hear about in the session. Responses would illustrate any information or topics that they felt had not been covered sufficiently and could potentially be included or reemphasised before the end of the Course. The purpose of requesting this information was to adapt the Course to the needs of the participants and improve the Course for future presentations.

All questionnaire responses were read after each session, which provided the opportunity for self-debriefing and risk-evaluation, to ascertain if any major difficulties had been expressed about the material presented or the session as a whole. This reflective practice was part of the AR format and allowed for adjustments in the length or content to be made to upcoming sessions.

5.6.2.ii Post-Course Evaluation Questionnaire

The Post-Course evaluation questionnaire was divided into a number of areas (see copy of post-Course questionnaire in Appendix F). The first was to determine which sessions participants had found most beneficial. Secondly, to find out the advantages and disadvantages of participants being part of, and learning information in a small group setting. Thirdly, how the Course may have impacted on how participants parent their children, and whether there were any disadvantages experienced. Fourthly, to find out whether there were benefits or drawbacks to the reflective parts of the sessions. The next part of the questionnaire asked participants directly whether or not they found fostering stressful; what makes it stressful; and what is required to make it less stressful. The reason for including this line of questioning was to supplement the prospective quantitative data and try to establish the reality of foster parents lived experience fostering children with emotional and behavioural difficulties. Lastly, participants were asked whether or not they would recommend the Course to other foster parents, and why.

5.7 Data Analysis

Quantitative Data

Participants completed pre and post questionnaires of 3 measures depending on the age(s) of their child(ren). These included a parenting stress measure and two child emotional and behavioural measures. The only measure standardised for the entire foster child population was the Strengths and Difficulties questionnaire, which covered the ages 2 - 18 years.

Parenting Stress Measures

The parenting stress measures and CBCLs were age specific. The PSI included children from 1 - 12 years old and the SIPA adolescents from 12/13 upward, depending on whether the child was attending secondary school. The CBCL had 2 versions, one for children 1.5 years to 5, for children under five, not yet attending school and the 6 - 18 year was allocated to children 5 years and above who were attending school. The different age categories meant that measures had to be analysed separately.

The PSI and SIPA raw scores were manually calculated and converted into percentiles on the associated profile sheets according to the respective manual's instructions. Some parents with more

than one child, had to fill in multiple forms of varying age groups. These were recorded on an Excel data sheet as Significant, High or Elevated, alongside each foster parent, in relation to the child for whom they were filling in the form.

PSI: 90-100 Clinically Significant / 85-89 High / (75-84 Elevated)

SIPA: 95-100 Clinically Severe / 90-94 Clinically Significant / 85-89 Borderline / (75-84 Elevated)

The last category labelled "Elevated" in both the PSI and SIPA was included to assess scores that were elevated but did not reach the Clinically Significant or Borderline ranges. "Elevated" was calculated as 10 percentile points below the Borderline range. Taking "Elevated" scores into consideration would be usual clinical practice when assessing parents and children, to consider scores that do not quite reach statistical relevance, but may reach significant in the near future. It also safeguards against symptoms being overlooked when underreporting is possible in self-report questionnaires.

The Strengths and Difficulties Questionnaire

The SDQ is a computer-generated printable questionnaire. The pen and paper forms filled out by foster parents were used to complete the online data analysis. A printout was generated for each foster child measuring difficulties in broad categories of Very High / High / Slightly Raised / Normal. These data were transferred onto an Excel spreadsheet in order to generate the proportion of children in the sample with difficulties associated with Overall Stress / Emotional Distress / Behavioural Difficulties. The fourth category measured a child's Kind & Helpful behaviour. This category was reversed for the purposes of measurement so that the generated graph illustrated the category in the same direction as the other categories and was renamed (Not) Kind & Helpful. The fifth category reflects the extent to which the foster parent believes the child's difficulties impact on the child's life. The second part of the SDQ analysis measures the child's risk of developing a disorder and is divided into; Any Disorder / Emotional Disorder / Behavioural Disorder / Hyperactivity.

The Child Behaviour Checklists

The CBCL was used in two age-based formats depending on the age of the foster child. One for children and adolescents aged 6 – 18 years, and the other for children 1.5 – 5 years. A slight adjustment was made because children start school at 5 years old in Ireland, therefore the 6 - 18-year-old questionnaire was administered to children 5 years and older and the 1.5 - 5-year-old questionnaire to children 4 years and younger.

The 6-18yr questionnaire is divided into 5 sections.

The 1.5 - 5-year questionnaire results are divided into 3 areas.

The two age specific questionnaires overlap in the Total Problem scales, which is made up of Internalising and Externalising problems. These headings were used to generate graphs illustrating the proportion of the entire sample of foster children reported by their foster parents to display these symptoms.

Qualitative Data

Post Session Questionnaire

The weekly post-session questionnaires were broadly analysed using concepts (of one response) or themes (more than one response). It was important to include both concepts and themes because of the small sample size and in an attempt to portray an impression of all the respondents' experiences and ideas. Participants' responses were broadly categorised into what they had learned about the Child; elements that would contribute toward the child's healing into Intervention; what participants learned about themselves and might do differently were grouped under Parent/Self. Experiences during the session, especially those during the discussion were listed under Group; and overall concepts regarding the Course as a whole were grouped under Course. None of these categories is mutually exclusive, for example, concepts relating to different styles of attachment listed under Child could also have been listed under Course when the main theme of the session was Attachment. One response may contain a number of concepts that belong in different categories. A respondent may refer to something they learned about the child, themselves and something they experienced in the group that day. Their number would then appear in all three categories in relation to the concept.

Post-Course Questionnaire

The first question of the questionnaire was displayed in a graph to provide a visual representation of which sessions of the Course parents found most useful. Thereafter data was broadly analysed using concepts (of one response) or themes (more than one response) as per the post-session questionnaire, without any specific categorisations. The section of the questionnaire pertaining to Fostering in General, where parents were asked about the causes and possible solutions to the stress experienced in parenting foster children, was subdivided into 4 categories, Child, TUSLA/HSE, Biological parents/family and Foster Parents. Examples of participants responses are provided to substantiate the analysis.

Data analysis

Paired Samples T-Tests

Paired sample T-Tests were carried out on the data from the Pre and Post Questionnaires to ascertain whether there were any changes in the parents of foster children and adolescents stress levels after attending the Course. While the sample size is small, repeated-measures tests have substantially more power than between-samples comparisons. T-test comparisons are intended to help ascertain whether observed changes are greater than we would expect by sampling error alone, rather than as generalizable estimates of effects, therefore no corrections for familywise error are applied.

5.8 Research Integrity

An important feature of research is building in the concepts of trustworthiness and credibility. These according to Yin (2011) are based on “Transparency”, “Methodic-ness” and “Adherence to evidence”. Transparency refers to the openness with which research is documented in an open and honest way that allows reviewers to follow the researcher’s process. It includes the self-reflection and acknowledgement of the biases, for whatever reasons, of the researcher. Methodic-ness refers to the researcher being able to evidence how the research was carried out in a logical format and document it in a systematic way, allowing for possible replication of qualitative studies. The SoaPs (Akhurst & Lawson, 2013) in chapter 7, outline each session of the foster parenting group that was carried out six times and summarises these, illustrating the research process. Evidence in qualitative studies refers to the input provided by each research participant and values the humanness and uniqueness of the data. In the qualitative component of this study, a large amount of qualitative data will be thematically presented in extensive detail, as per the information provided by the participants, and then summarised in order to relay the experiences and messages of the participants. Finally, the generalisability or transferability (Stahl & King, 2020) of findings need to be considered. In this study, possible generalisability to other similar contexts is evident in that the Course was replicated over a period of time in six different groups, with extensive participant evaluations to support its potential utility.

6. FINDINGS FROM THE QUANTITATIVE DATA

6.1 Introduction

This chapter contains the quantitative data pertaining to the first two of the four research questions.

1. What are the levels and nature of stress experienced by foster parents in parenting their children?
2. According to their parents, what emotional and behavioural patterns are foster children displaying?

The foster parents who attended the small-group foster-parenting Course were requested to complete pre- and post- measures before and after the Course. These included a questionnaire that measured foster parents' stress, as well as two questionnaires to measure the emotional and behavioural presentations of their foster children, according to their parents. The only measure that encompassed the entire age range of the sample of foster children was the SDQ.

To measure the foster parents stress, the PSI for children under 13 years and the SIPA for adolescents 13 years and older, were used. Despite the measures having been developed by the same author, the sub-scales are different and therefore both versions have to be reported separately. The same applies to the CBCL: there is one for children aged 1.5-5 years and another for children/adolescents from 6-18 years. As discussed in Methodology, the CBCL 1.5-5 was used to assess children under 5 years who had not yet attended school, and will be referred to as CBCL-PS (Pre-school), and the CBCL 6-18 was used to assess children from 5 upwards who were attending school and will be referred to as CBCL-SA (School Age).

Paired sample T-Tests were carried out on the data from the Pre and Post Questionnaires (PSI, SIPA, SDQ, CBCL-SA and CBCL-PS). These results would establish whether any changes occurred in the stress levels of the parents, or in the emotional or behavioural presentations of the children after the parents had completed the Psychoeducational-Reflective parenting Course. Although differences were observed from time 1 to time 2, paired sample *t*-Tests show no statistically significant changes on any of the subscales measured, except one, which could have been due to chance based on the small sample size especially at time 2. These findings replicate previous research (for e.g., Gabler et al., 2018), who suggested that behavioural changes in foster children might take time. The results have not therefore been included in this chapter, but can be found in Appendix G.

The chapter begins with the PSI and SIPA results, illustrating the data regarding foster parent stress. Thereafter the results of the SDQ (the only measure that incorporates the entire age-range of

the cohort of foster children) follows, illustrating in broad categories the difficulties reported by foster parents to be evident in the sample of foster children.

The CBCL distributes data into more defining categories regarding the children's behavioural and emotional features. The first section of the CBCL in this chapter illustrates the results of the CBCL-SA, as it represented the largest sample of the children in the research. This is followed by the results from the CBCL-PS. The chapter ends with a graph combining both CBCL age categories results, to illustrate the Total Problems, including Externalising and Internalising behaviours for the whole sample of foster children, in order to provide a sense of the number of children in this sample presenting with emotional and behavioural difficulties.

6.2 Demographics

Thirty-eight foster parents attended the small-group foster-parenting Course, 31 foster mothers and seven foster fathers. Six of the foster fathers attended with their spouses, one attended without his spouse. The 38 foster parents represented 63 children (There were approximately 64 foster parents and 80 foster children registered in district between 2015 – 2016); and three of these children had been formally adopted by their foster parents. The total sample of foster children's gender distribution was 36 boys and 27 girls. Foster parents had between one and three foster children in their homes, and completed a set of questionnaires per child.

The results from all fully completed questionnaires were used where possible. This means that a foster parent may have answered three out of four questionnaires as required, those three were used for data collection whereas the fourth could not be used. This resulted in subtle changes in the sample size between questionnaires including even between the two sections of the SDQ, where numbers ranged from N=59 to N=63. Numbers of completed Pre- and Post-test questionnaires are listed in Table 2.

Table 2

Number of valid responses for each questionnaire

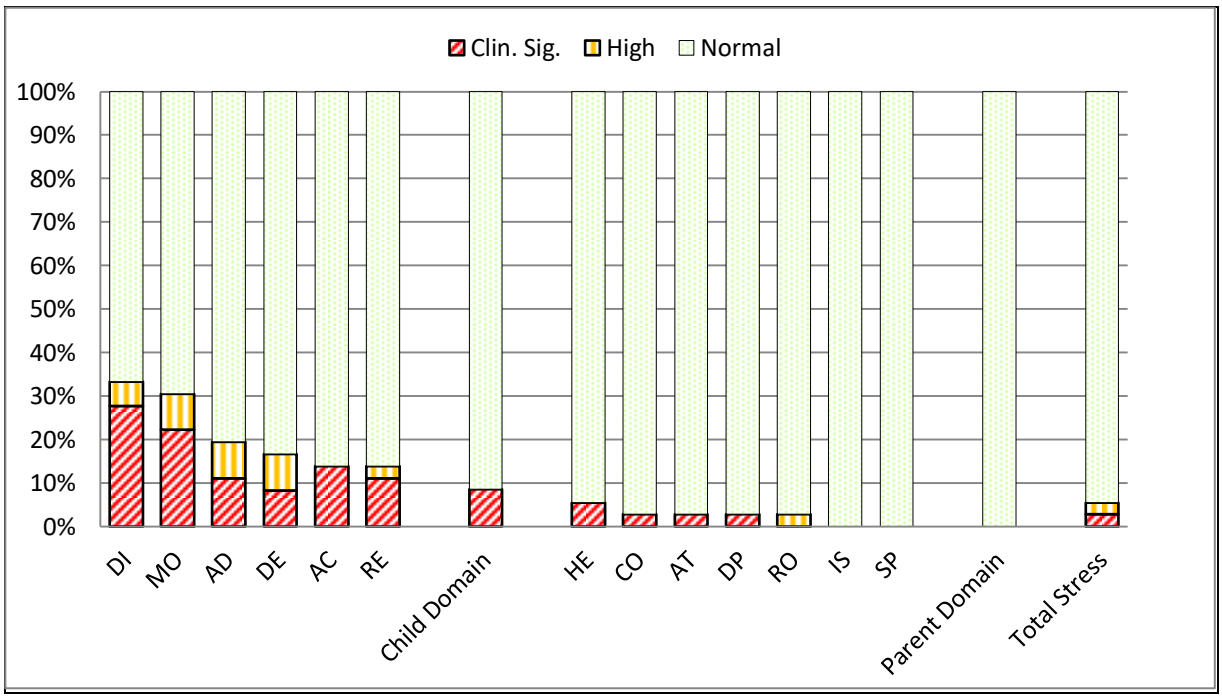
Questionnaire	**Pre-test**	**Post-test**
Parenting Stress Index (PSI)	n36	n=22
Stress Index for Parents of Adolescents (SIPA)	n=23	n=14
Strengths & Difficulties Questionnaire (SDQ) SDQ Disorders	n=62 n=59	n=37 n=37
Child Behaviour Checklist School Age (5-18 years) (CBCL-SA)	n=51 5-11 Young Boys n=13 5-11 Young Girls n =10 12-18 Adolescent Boys n=17 12-18 Adolescent Girls n=11	n=29
Child Behaviour Checklist Pre-School (under 5) (CBCL-PS)	n=12 (boys 6 / girls 6)	n=6

6.3 Parenting Stress Index

The PSI was completed by foster parents of 36 foster children aged between 1.5 and 12 years and measured areas of stress that might be experienced by the parent, either associated with the child or the parent themselves. Clinically Significant and High responses were calculated as per the PSI manual percentile rankings (Abidin, 2012). A graphical representation (Figure 5.) follows with a legend outlining the different categories measured by the questionnaire. The Child Domain has 6 subscales that assess the child characteristics that may contribute to the foster parent's overall stress. The Parent Domain has 7 subscales that are designed to assess the parent's own characteristics that may contribute to their overall stress.

Figure 5

Participant Response frequency on the Parenting Stress Index (1-12 years old) n=36



Child Domain	Parent Domain
(DI) Distractibility/Hyperactivity Behavioural characteristics associated with (ADHD) symptoms	**(HE) Health** Level to which the parent's health contributes to their overall parenting stress
(MO) Mood Assesses the child's affective status	**(CO) Competence** Extent to which the parent feels comfortable and capable in the parenting role
(AD) Adaptability Child's ability to adjust to change in their social or physical environment	**(AT) Attachment** Parent's sense of their relationship with the child and his/her ability to notice and respond appropriately to the child's needs
(DE) Demandingness Extent to which the parent feels the child places demands on them	**(DP) Depression** Assesses the parent's affective status
(AC) Acceptability Extent to which the child's characteristics	**(RO) Role Restriction** Degree to which the parent feels their freedom is limited and

meet the expectations of the parent	identity is constrained because of the parenting role
(RE) Reinforces Parent Exchanges with the child are experienced as positively reinforcing	**(IS) Isolation** Assesses the extent of the parent's social support
	(SP) Spouse/Parenting Partner Relationship Parent's perception of the emotional and physical support from their parenting partner

Note. The key above is adapted from the *Parenting Stress Index Manual* (Abidin, 2012) and describes the Child and Parent Domain labels on Figure 5. The Child Domain subtests are located on the left and the Parent Domain subtests on the right of the Figure and Key. Subscale results are ranked from left (highest) to right (lowest), in both the Child and Parent domains and are listed in the same order in the Key.

The calculation of the PSI revealed that 20% of the sample had responded with a substantial defensive response style that indicated they were likely to be underreporting their responses, seeming to be less stressed. These results are however still included in the overall data, and the graph needs to be interpreted keeping this in mind. Furthermore, evidence of underreporting was only calculated according to the protocol of one of the assessments, there is a possibility that all the other assessments were also underreported, impacting all findings.

The graph (Figure 5) illustrates that the majority of foster parents' overall stress comes from the Child Domain (8%) rather than the Parent Domain (0%). The results indicate that foster parents of children under 12 years old find their Distractibility/Hyperactivity (34%), Mood (30%) and Adaptability (20%) the top three most stressful characteristics. Results were minimal in the Parent Domain and indicated that Health (6%) was the most reported characteristic, followed equally by Competence, Attachment, Depression and Role restriction at 3%.

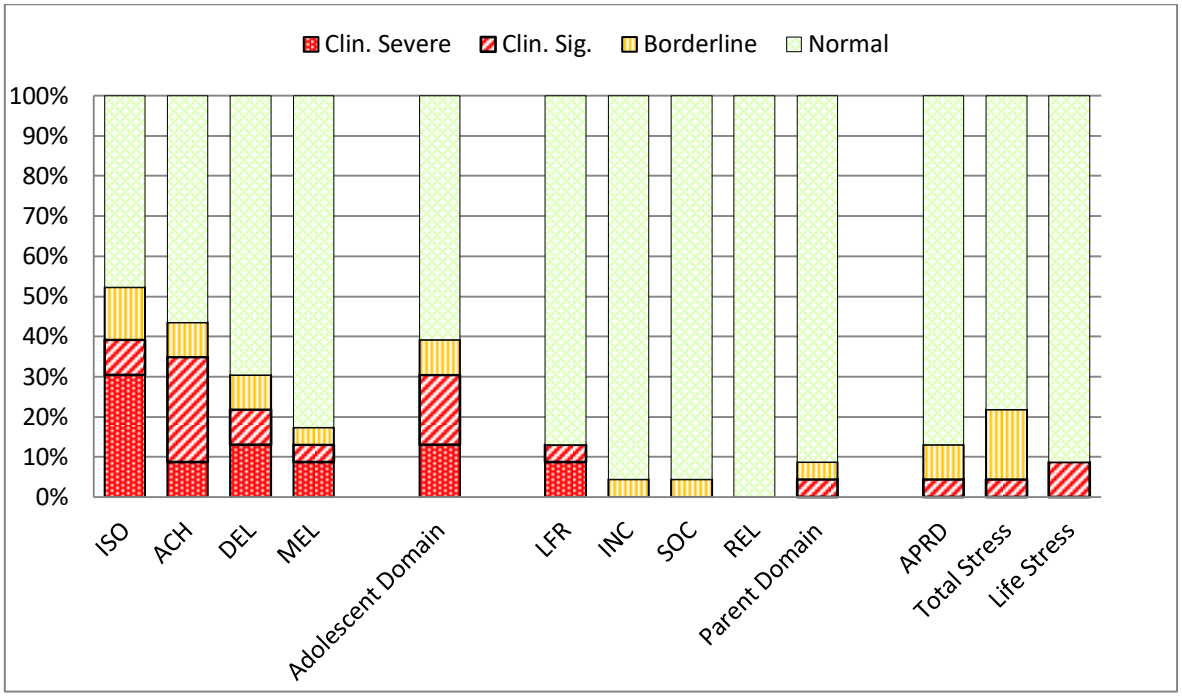
The Total Stress score, a combination of both Child and Parent Domains revealed that only 6% of parents in this sample reported having high levels of stress. That equated to 1 parent at Significant level and 1 parent at High level.

6.4 Stress Index for Parents of Adolescents (SIPA)

The SIPA was completed by foster parents for 23 foster children aged between 12 and 18 years and measured areas of stress that might be experienced by the parent, either associated with the adolescent or the parent themselves. The Adolescent and Parent Domains each have 4 subscales that assess the adolescent or parent characteristics that may contribute to the foster parent's overall stress. A graphical representation follows, with a key outlining the different categories measured.

Figure 6

Participant Response frequency on the Stress Index for Parents of Adolescents (SIPA) (13-18 years old) n=23



Adolescent Domain Level of stress experienced by a parent as a function of the characteristics of the adolescent	**Parent Domain** Level of stress experienced by a parent as a function of the impact of parenting on their other life roles
(ISO) Social Isolation Withdrawal Parent's perception of the adolescent's social isolation and passivity	**(LFR) Life Restrictions** Parent's perception of how parenting restricts their other life roles and activities
(ACH) Failure to achieve or persevere Parents perception of adolescent's lack of persistence in achieving goals, including motivation, task completion including school	**(INC) Incompetence/Guilt** Parents lack of confidence in their ability to cope with the adolescent, and feelings of guilt
(DEL) Delinquency Antisocial Stress parent experiences as a result of the adolescent's violation of social norms and delinquency	**(SOC) Social Alienation** Parent's perception of being alienated from friends and family, including a lack of social support and assistance in parenting
(MEL) Moodiness Emotionally Labile Parent's perception of the adolescent's affective presentation such as mood change irritability and temper	**(REL) Relationship Partner/ Spouse** Parents perception of the quality of the relationship with the person with whom they share parenting

Note. The key above is adapted from the *Stress Index for Parents of Adolescents Manual* (Sheras, et al., 1998) and describes the Child and Parent Domain labels on Figure 6. The Adolescent Domain subtests are located on the left and the Parent Domain subtests on the right of the Figure and Key. Clinically Severe result frequencies are charted from the horizontal axis, followed by Clinically Significant (red stripe), moving upward to the Borderline category results (orange stripe). Subscale results are ranked from left (highest) to right (lowest), in both the Adolescent and Parent domains and are listed in the same order in the Key.

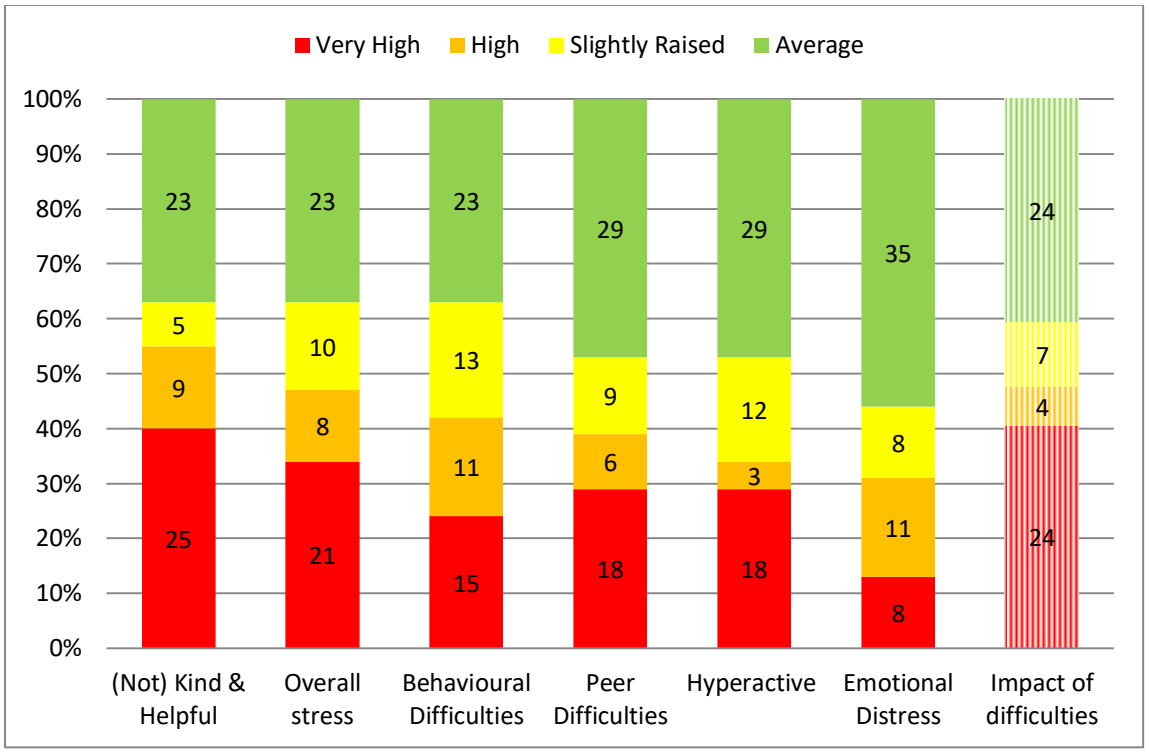
The results in Figure 6. show Clinically Severe, Clinically Significant and High responses calculated as per the SIPA manual's (Sheras, et al., 1998) percentile rankings. The graph illustrates that the majority of foster parents' overall stress comes from the Adolescent Domain (39%), rather than the Parent Domain (8%). Results indicate that foster parents of adolescents find their Social Isolation/Withdrawal (52%), Failure to achieve (44%), Delinquency/Antisocial (31%) and Moodiness / Emotionally Labile (17%) characteristics the most difficult, in ranked order. The Parent Domain sub-scales regarding their own stress characteristics rank Role Restriction (13%), Social Alienation (4%), Incompetence/Guilt (4%) as features, and there were no significant results for Partner Relationship.

The Total Stress score, a combination of both Adolescent and Parent Domains revealed that 22% of parents reported experiencing high levels of Stress. That equated to 1 parent at Clinically Significant level and 4 parents at Borderline level.

6.5 Strengths & Difficulties Questionnaire (SDQ)

Figure 7

Participant Response frequency on the Strengths and Difficulties Questionnaire (SDQ) for the total sample of Foster children (1.5-18 years old) n=62

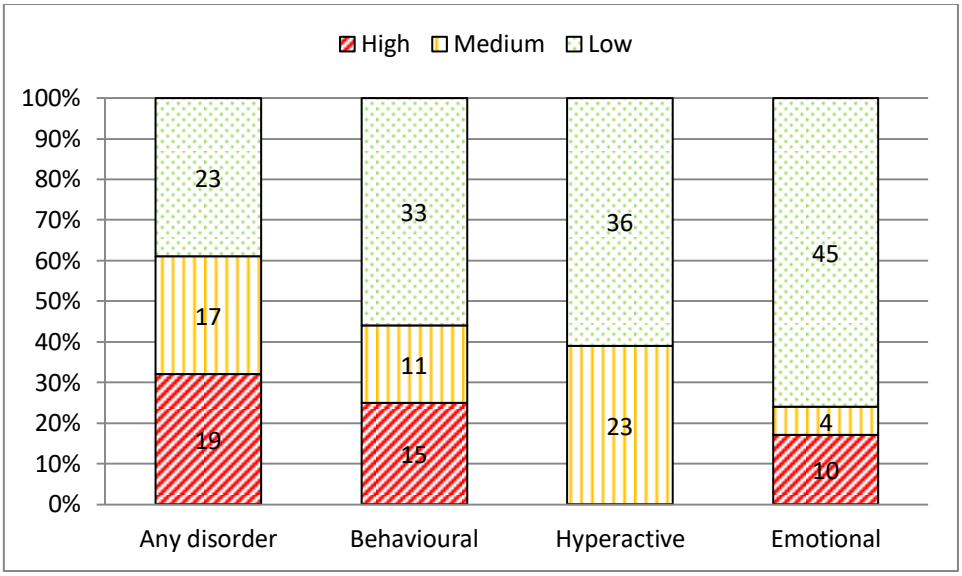


Note. Results are ranked from left/highest to right/lowest responses in each category. The chart represents the percentage of children with difficulties and the numbers represent the numbers of foster children in each category with difficulties. Impact of difficulties is a separate category that represents the level of impact of a child's difficulties on their lives and contains only 59 children as 4 results were not recorded.

The Pre-Test SDQ was filled out by 38 foster parent participants representing 62 foster children of ages ranging from 1.5-18 years old. The results indicated that according to their foster parents, 63% of children/adolescents in the study are presenting with Overall Stress. The highest score was for Behavioural Difficulties (63% raised, high or very high); Hyperactivity and Peer Difficulties were both 53% raised, high or very high; and Emotional Distress was lower at 39% raised, high or very high. The category of Kind and Helpful, which would be considered a strength, has been reversed for the purposes of the graph and results indicated 63% of the sample were rated as above average on the not kind and helpful dimension. The Impact of Difficulties scale represents whether a parent believes that the difficulties their child is experiencing impacts on their lives. The results indicated that foster parents believe that 60% of the children's lives are impacted by their emotional and behavioural difficulties and 41% of these were scored at a Very High level.

Figure 8

Participant Response frequency on the Strengths and Difficulties Questionnaire (SDQ) regarding risk for emotional and behaviour difficulties for the total sample of Foster children (1.5-18 years old) n=59



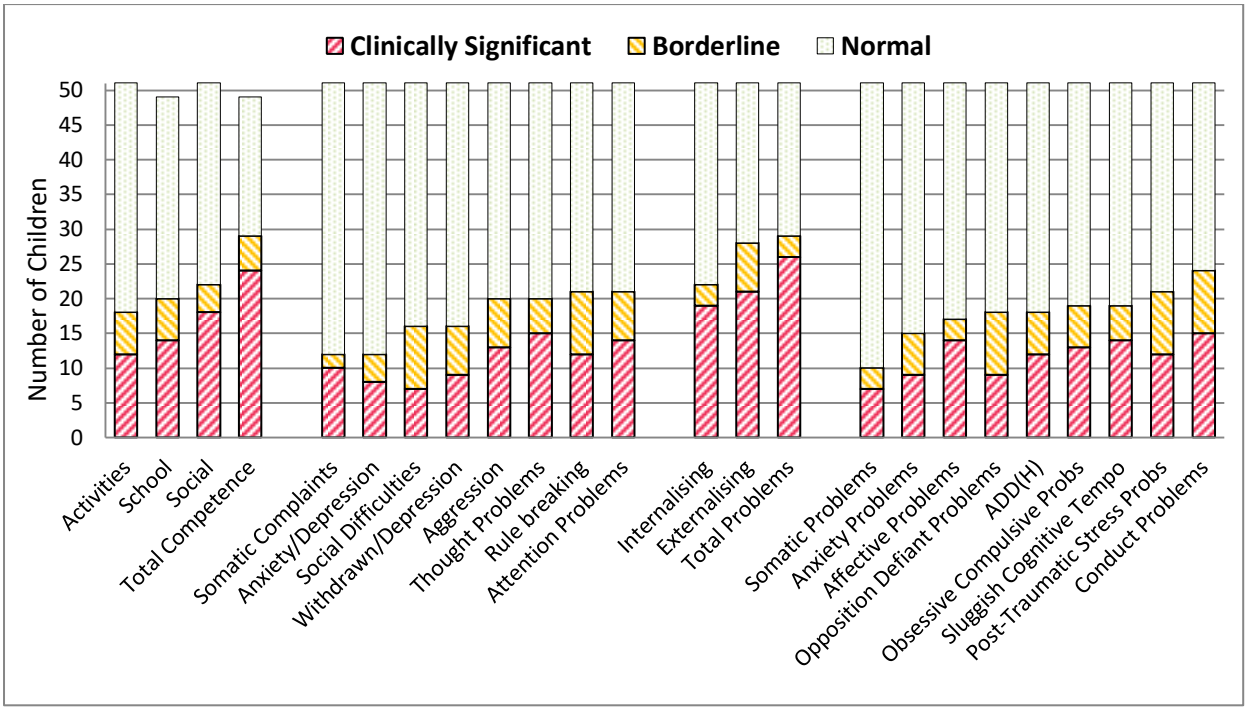
Note. Results are ranked from left/highest to right/lowest and from bottom/high to top/low levels of symptoms associated with the different disorders. Hyperactivity was only reported at Medium and Low levels as per the manual's scoring criteria. The numbers in each bar represent the actual number of foster children in each category (n=59).

The second part of the SDQ calculates the risk of Disorder based on the information provided by the respondent. Figure 8. above illustrates that according to their foster parent, 61% of the foster children are at risk of developing Any Disorder, 44% a Behavioural Disorder, 39% are at risk of developing a disorder associated with Hyperactivity, and 24% an Emotional Disorder.

6.6 Child Behaviour Checklist School Age (CBCL-SA)

Figure 9

Participant Response frequency for the total sample of Foster children (5-18 years old) for all scales on the CBCL-SA (Pre-Test Data) n=51



Note. Scales in all categories are ranked from lowest to highest from left to right and outcomes from highest (Clinically Significant - red stripe) at the bottom to lowest (Normal - light green dot) at the top. Categories are separated by a space. 'Totals' represent a combination of the scores to their left, e.g. Total Problems is a cumulative score of Internalising and Externalising categories; Total Competence is a cumulative score of the Activities, School and Social categories.

Figure 9 illustrates the outcome of the entire CBCL-SA, which includes the results of an adaptive category, the emotional/behavioural difficulties; and diagnostic categories of children and adolescents between 5-18 years old. 59% of children scored within the Clinically Significant and Borderline Range for Total Competence, which identified a large number of the children in the sample who had difficulties with Daily Activities, School and Social Relationships. The pattern illustrated by the categories representing emotional and behavioural difficulties shows this sample of foster children present with more externalising types of behaviours such as Aggression, Rule Breaking Behaviour and Attention Problems. This was confirmed in the Internalising / Externalising / Total Problems category where Externalising was reported to be more prevalent than Internalising. The Total problems score shows that nearly 60% of these children have high levels of emotional and

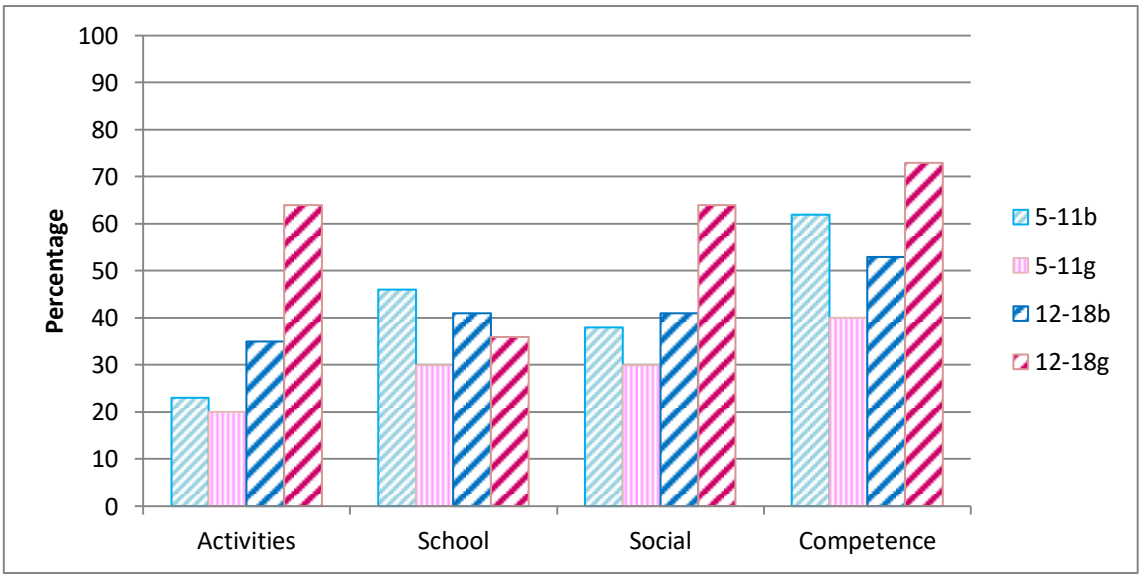
behaviour difficulties. The fourth category entitled DSM Diagnostic category showed that the most predominant diagnostic categories for this sample of foster children were Post Traumatic Stress (41%) and CD (47%).

The graphs that follow look more closely at some of the patterns reflected in Figure 9 illustrating the different age and gender categories and are divided into 5 - 11 year old girls (Young Girls) and boys (Young Boys), and 12 - 18 year old boys (Adolescent Boys) and girls (Adolescent Girls). The scores represent the number of children who scored within the Clinically Significant and Borderline ranges, which due to the different numbers in each group, are represented as percentages to provide a comparison.

6.6.1 CBCL-SA (5-18 years) Adaptive functioning/Competence

Figure 10

Participant Response frequency according to age and gender on the CBCL-SA (5-18 years) Adaptive functioning (Pre-Test Data) n=51



Note. Scales are illustrated in the same direction as per the overall CBCL-SA graph Fig. 9. and represent the number of children/adolescents presenting with Borderline Significant and Clinically Significant scores in the different competence scales. Numbers of children/adolescents differ in each age and gender category, therefore percentages were used to illustrate the groups comparatively. They are grouped according to age and gender; Young Boys 5-11 years (light blue) and Adolescent Boys 12-18 years (darker blue); Young Girls 5-11 years (pink) and Adolescent Girls 12-18 years (red).

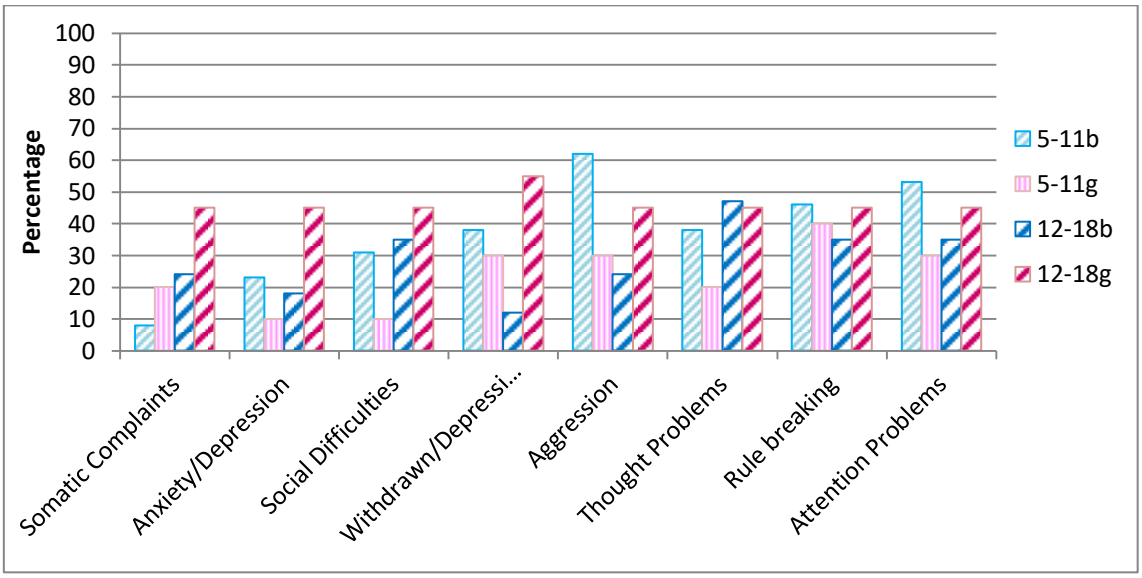
Adolescent Girls scored the highest in difficulties associated with Competence or Adaptive functioning, especially regarding Activities and Social or peer relationships. Younger and older boys

in this sample have the most difficulties associated with School, however 30-45% of the entire sample have difficulties associated with School. Competence is a cumulative score of daily Activities, Social (peer relationships) and School and reveals that the sample are ranked, Adolescent Girls were reported as having most difficulties, followed by Young Boys, then Adolescent Boys and lastly Young Girls, with 40% of Young Girls scoring within the Clinically Significant and Borderline ranges.

6.6.2 CBCL-SA (5-18 years) Syndrome Scales

Figure 11

Participant Response frequency on the CBCL-SA (5-18 years) Syndrome Scales (Pre-Test Data) n=51



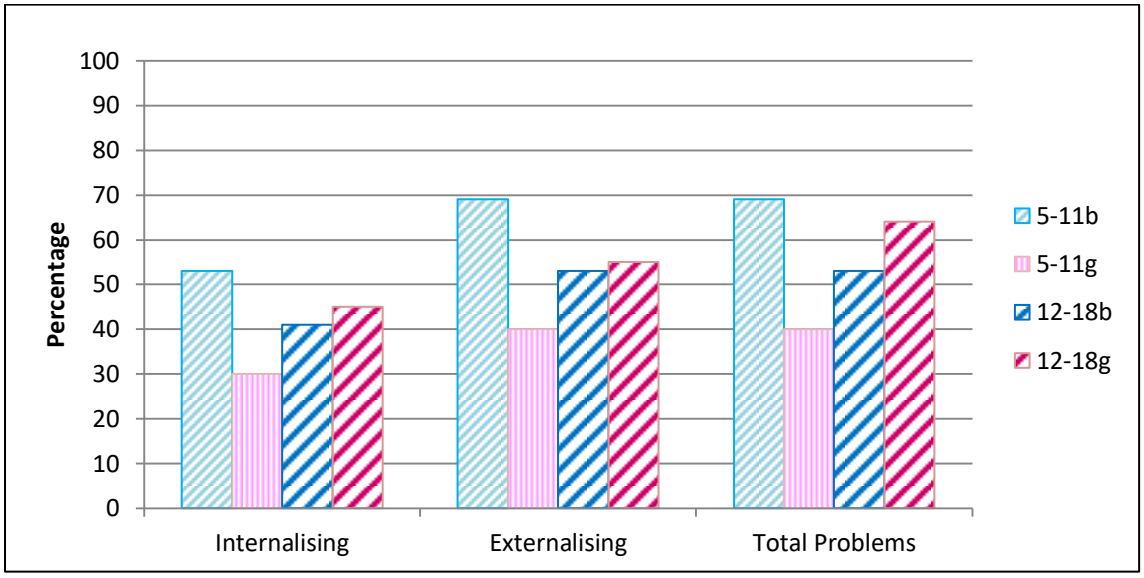
Note. Scales are illustrated in the same direction as per the overall CBCL-SA graph Fig. 9 and represent the number of children/adolescents presenting with Borderline Significant and Clinically Significant scores in the different syndrome scales. Numbers of children/adolescents differ in each age and gender category; therefore, percentages were used to illustrate the groups comparatively. They are grouped according to age and gender; Young Boys 5-11 years (light blue) and Adolescent Boys 12-18 years (darker blue); and Young Girls 5-11 years (pink) and Adolescent Girls 12-18 years (red).

Adolescent Girls (45% and over) have elevated scores on all of the Syndrome Scales, Young Boys exceeded Adolescent Girls in scores for rule-breaking behaviour (46%), attention problems (53%) and especially aggression (62%). Young Boys have the least amount of difficulty with somatic complaints (8%), and Young Girls have the least amount of difficulty with social difficulties (10%). Adolescent Boys' lowest score was for withdrawn/depression (12%) and their highest score was for thought problems (47%) which was similar to those of Adolescent Girls (45%).

6.6.3 CBCL-SA (5-18 years) Internalising, Externalising and Total Problems

Figure 12

Participant Response frequency on the CBCL-SA (5-18 years) Internalising, Externalising and Total Problem Scales (Pre-Test Data) n=51



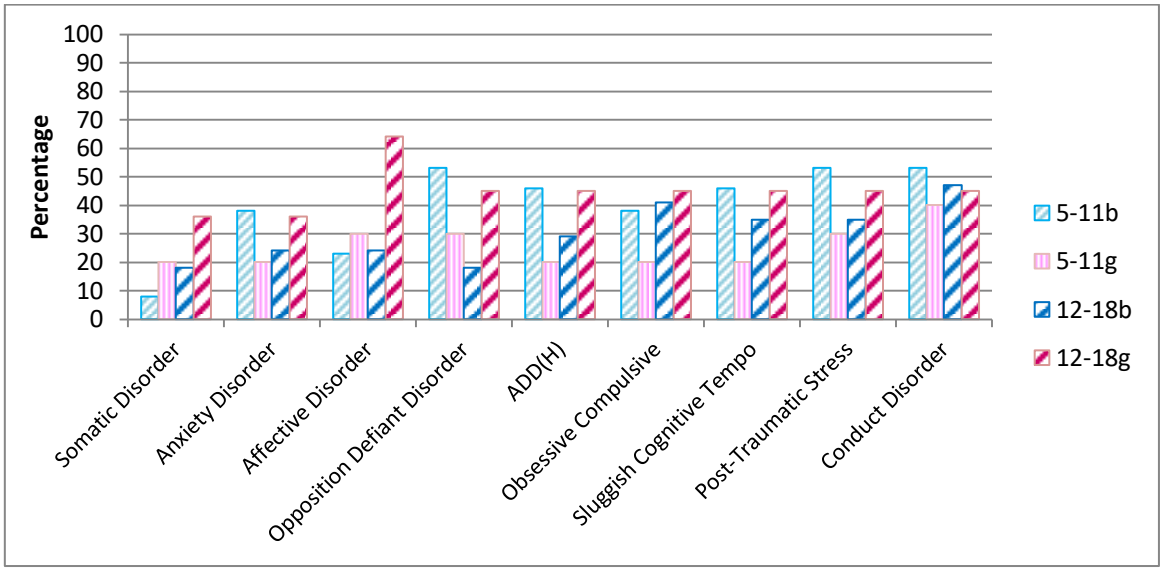
Note. Scales are illustrated in the same direction as per the overall CBCL-SA graph Fig. 9 and represent the number of children/adolescents presenting with Borderline Significant and Clinically Significant scores in the different problem scales. Numbers of children/adolescents differ in each age and gender category; therefore, percentages were used to illustrate the groups comparatively. They are grouped according to age and gender; Young Boys 5-11 years (light blue) and Adolescent Boys 12-18 years (darker blue); Young Girls 5-11 years (pink) and Adolescent Girls 12-18 years (red).

Figure 12 illustrates the way in which this group of the sample of foster children are reported by their foster parents as expressing their difficulties. Total Problems is the cumulative score of Internalising and Externalising, and ranges from 40% in Young Girls to 70% in Young Boys. Externalising behaviours are more evident in this group of foster children than Internalising behaviours. Young Boys have the highest score regarding Externalising behaviours, 70% having a Clinically Significant or Borderline Range scores, followed by Adolescent Girls (55%), Adolescent Boys (53%) and Young Girls (40%). Internalising behaviour, by its nature, is less explicit or evident, but has been reported in all age and gender categories in this sample (Young Boys 53%; Adolescent Girls 45%; Adolescent Boys 41%; and Young Girls 30%). There is a pattern in all categories that more Young Boys have difficulties, followed by Teenage Girls, Teenage Boys and Young Girls.

6.6.4 CBCL-SA (5-18 years) Diagnostic Scales

Figure 13

Participant Response frequency on the CBCL-SA (5-18 years) DSM Diagnostic Scales (Pre-Test Data) n=51



Note. DSM Diagnostic Scales are illustrated in the same direction as the overall CBCL-SA graph Fig. 9 and represent the number of children/adolescents presenting with Borderline Significant and Clinically Significant scores in the different diagnostic scales. Numbers of children/adolescents differ in each age and gender category, therefore percentages were used to illustrate the groups comparatively. They are grouped according to age and gender; Young Boys 5-11 years (light blue) and Adolescent Boys 12-18 years (darker blue); and Young Girls 5-11 years (pink) and Adolescent Girls 12-18 years (red).

DSM Diagnostic Scales, represent the diagnostic categories that when Clinically Significant or Borderline scores are obtained, need to be further investigated in order to diagnose a child. Rather than providing an actual diagnosis, the categories can be interpreted as a symptom cluster of a diagnostic category that requires further exploration in order to form a diagnosis.

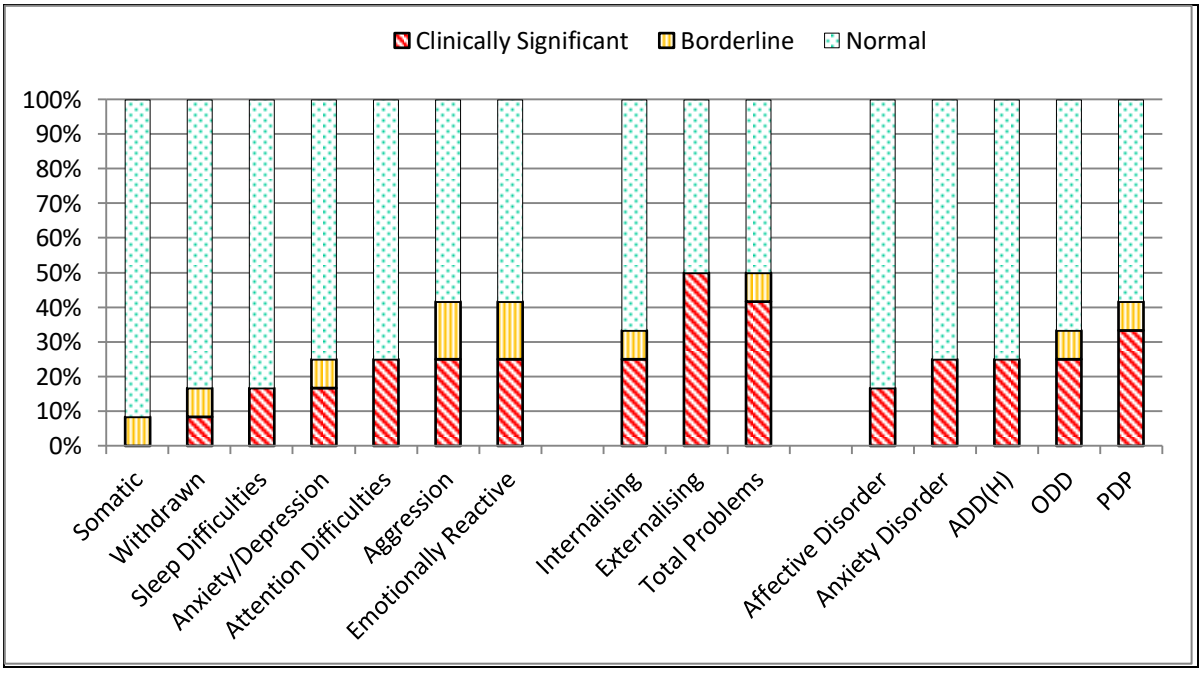
Adolescent Girls in this sample are most at risk of developing affective or mood disorders (64%), and also obtained elevated scores in all other diagnostic categories. Young Boys are most at risk for oppositional defiant disorder (53%), PTSD (53%), conduct disorder (53%), ADD-Sluggish Cognitive Tempo (46%), and ADHD (46%), as well as other diagnostic categories, but least likely to present with Somatic Disorder (8%). Adolescent Boys show elevated symptoms associated with conduct disorder (47%), obsessive compulsive disorder (41%), as well as ADD (35%) and PTSD (35%). Young Girls show the least elevated symptomatology of all four age/gender categories, their most

elevated category being conduct disorder (40%), followed equally by affective disorder, oppositional defiant disorder and PTSD at 30%.

6.7 Child Behaviour Checklist Pre-School (Under 5 years)

Figure 14

Participant Response frequency for the total sample of Foster children (Under 5 years) for all scales on the CBCL-PS (Pre-Test Data) n=12

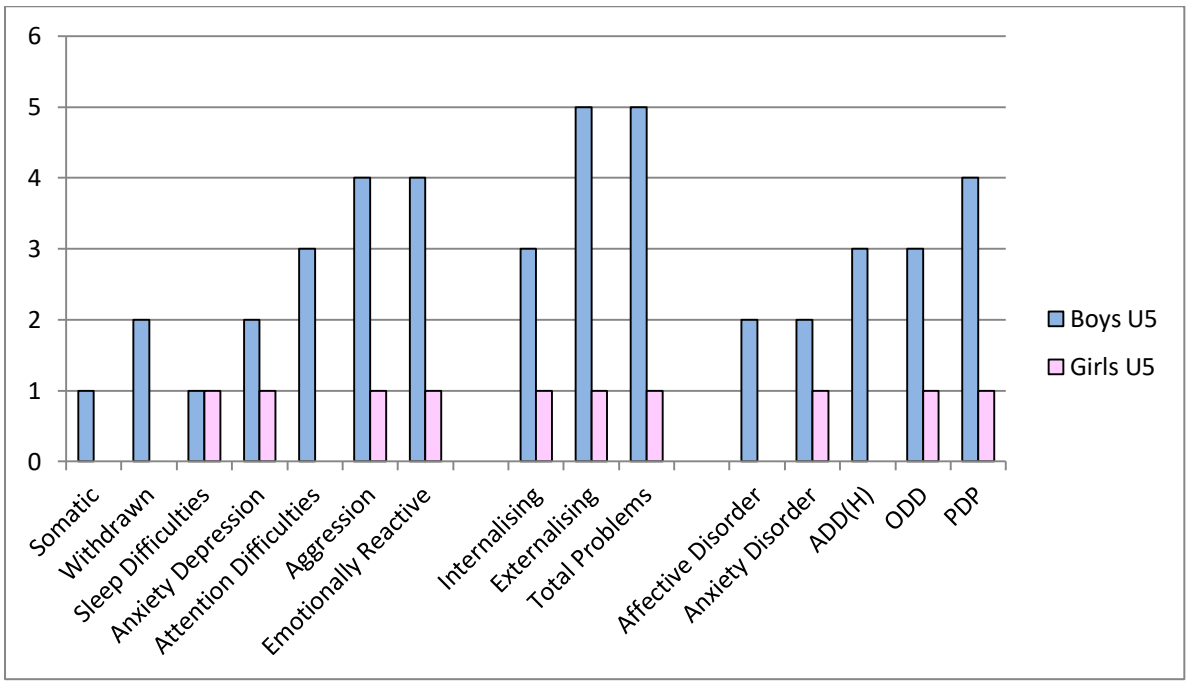


Note. Scales in all categories are ranked from lowest to highest from left to right and outcomes from highest (Clinically Significant/red stripe) at the bottom, Borderline (orange stripe), to lowest (Normal/light green stripe) at the top. The 3 categories are separated by a space. Total Problems = a combined calculation of Internalising and Externalising. Clinically Significant or Borderline scores represent children who had statistically significant difficulties in these areas.

Figure 14 shows that half of the foster children under 5 years old in this sample present with Externalising problems (50%). Within the Syndrome Scales, these include Aggression (40%) and Emotionally Reactive Behaviour (40%), and within the Diagnostic Categories, the highest results were for Oppositional Defiant Disorder (33%) and Pervasive Developmental Disorder (42%).

Figure 15

Participant Response frequency according to gender for the total sample of foster children (Under 5 years) for all scales on the CBCL-PS (Pre-Test Data) N=12



Note. Scales are illustrated in the same direction as Figure 14 from lowest on the right to highest on the left in the 3 categories. n=12 divided into 6 Boys and 6 Girls under 5 years old

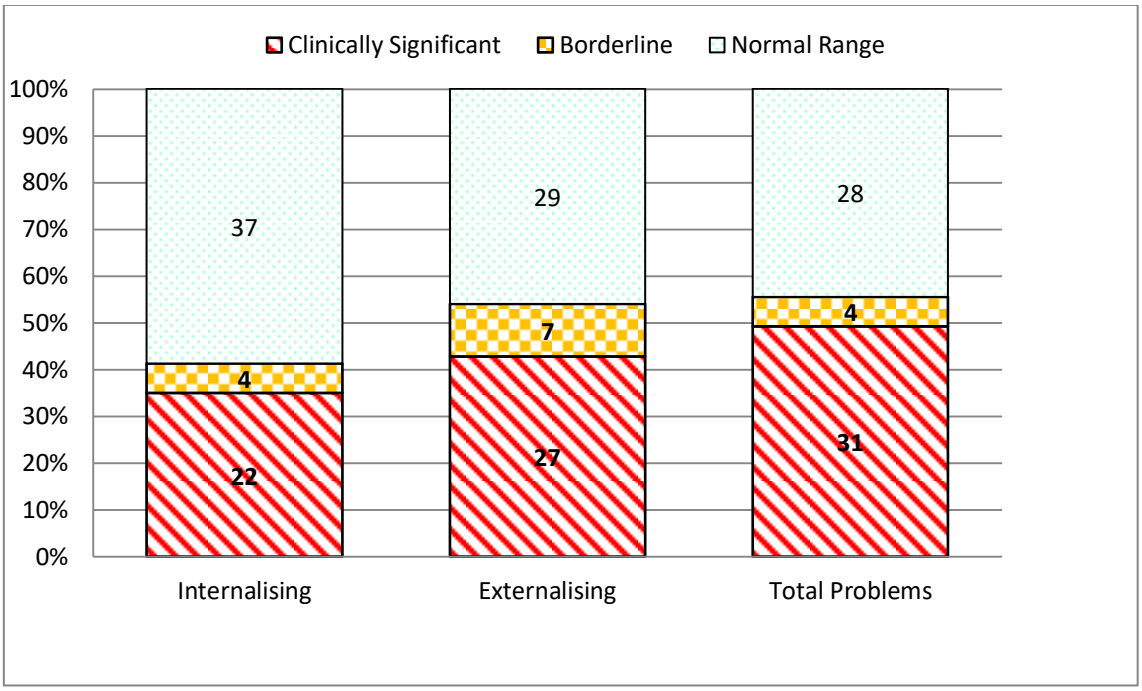
Dividing the sample according to gender illustrates (Figure 15) the prevalence of these difficulties according to gender. Five out of six boys present with Externalising behaviours, four out of six with Aggression and Emotionally Reactive Behaviour. Three out of the six boys have symptoms associated with ADHD and ODD, and four out of six boys have the symptoms associated with PDP. In comparison, the categories where girls are reported to have symptoms (Sleep Difficulties/Anxiety-Depression/Aggression/Emotionally Reactive/Anxiety Disorder/ODD/PDP), it is only one out of six girls.

6.8 Combined CBCL-SA and CBCL-PS (1.5 – 18 years) Data

The one category that is measured in both the CBCL-SA and CBCL-PS questionnaires is the Total Problem category. Data have been combined from both sets of results from the CBCL-SA and CBCL-PS to obtain outcomes for the total child and adolescent sample.

Figure 16

Participant Response frequency on the CBCL-SA and CBCL-PS (Total Foster Child sample 1.5-18 years) Internalising, Externalising and Total Problem Scales (Pre-Test Data) n=63



Note. The graph represents the total number of foster children evaluated. The figure within each bar represents the total number of foster children with Clinically Significant, Borderline and Normal levels of Internalising and Externalising Behaviour and Total Problems scales.

Figure 16 shows that some children in this sample may exhibit predominantly Externalising behaviours, whereas others internalise their worries and distress. However, these are not discreet categories and some of the children in this sample present with Internalising and Externalising behaviours simultaneously. The Total Problems result revealed that 35 children (56%) presented with Clinically Significant or Borderline Significant scores; 54% of the sample presented with symptoms associated with Externalising behaviour and 41% with Internalising symptoms.

6.9 Summary

1. What are the levels and nature of stress experienced by foster parents in parenting their children?

The levels of stress reported by this sample of foster parents was similarly lower than predicted, as was found in previous studies (e.g., Gablera et al., 2018). The PSI and the SIPA both show a similar pattern in the source of parenting stress, both reveal that foster parents find certain

characteristics of the foster children/adolescents stressful, rather than characteristics of their own lives.

In children under 12 years old the highest-ranking characteristics relating to the children that caused stress were Distractibility/Hyperactivity, Mood and Adaptability. In relation to adolescents, their impact on parents' stress was higher than children under 12 and related to the characteristics of Social Isolation/Withdrawal, Failure to Achieve, Delinquency/Antisocial and Moodiness/Emotionally Labile.

In the Parent Domain for children under 12, Health was the most reported personal characteristic, followed equally by Competence, Attachment, Depression and Role Restriction, the results for which were all the same. In parents of adolescents the personal characteristics most reported were Role Restriction, Social Alienation, and Incompetence/Guilt. In neither the PSI or the SIPA, was the spousal relationship reported as a source of stress.

2. According to their parents, what emotional and behavioural patterns are foster children displaying?

The SDQ results showed that 63% of children/adolescents in the study were rated by their foster parents as presenting with Overall Stress. The highest score was for Behavioural Difficulties; followed by Hyperactivity and Peer Difficulties; with Emotional Distress the least severe. Kind and Helpful, the strength-based category was reversed for the purposes of the graph, which illustrated that 63% of the sample were not considered Kind and Helpful. Incidentally, this is the same percentage of children in the sample presenting with Overall Stress.

The Impact of Difficulties scale showed that foster parents believe that the lives of two-thirds of the children and adolescents in this sample are negatively impacted by their emotional and behavioural difficulties, 41% of these at a Very High level. The results of the SDQ also revealed parents reported that over two-thirds of the foster children are at risk of developing Any Disorder, most likely a Behavioural Disorder or a disorder associated with Hyperactivity and less likely an Emotional Disorder.

Child Behaviour Checklist School Age (CBCL-SA)

The CBCL-SA showed that two-thirds of the children and adolescents in this sample between 5-18 years old scored within the Clinically Significant and Borderline Range for Total Competence, illustrating that they have difficulties with Daily Activities, School and Social Relationships. Results illustrated that they present with more externalising types of behaviours such as Aggression, Rule

Breaking Behaviour and Attention Problems. Diagnostically their symptoms clusters were most often indicative of Post-Traumatic Stress and conduct disorder.

According to these data, Adolescent Girls have the highest levels of difficulties associated with Competence or Adaptive Functioning, especially Daily Activities and Peer Relationships. Younger Boys and Adolescent Boys have the most difficulties associated with School, although 30-45% of the entire sample has difficulties with School. Young Girls have the lowest level of Competence difficulties and yet two-fifths scored within the Clinically Significant and Borderline ranges.

Adolescent Girls were scored with elevated scores (45% and over) on all of the Syndrome Scales, the Young Boys scores exceeded Adolescent Girls in Rule Breaking behaviour, Attention problems and especially Aggression. For Adolescent Boys the highest score was for Thought Problems, which was similar to the scores of Adolescent Girls. Young Girls have the lowest number of Syndrome Scale difficulties but still reportedly have problems associated with especially Rule breaking behaviour, and Withdrawn/Depression, Aggression, and Attention.

The Total Problems Category revealed that Externalising behaviours, which include aggressive, rule-breaking types of behaviours, are more evident in this sample of foster children than Internalising behaviours. A pattern to Externalising, Internalising and Total Problems emerged, with Young Boys reported with the highest scores, followed by Adolescent Girls, Adolescent Boys and Young Girls. Total Problems, which is the cumulative score of Internalising and Externalising, ranged from 70% in Young Boys to 40% in Young Girls.

Adolescent Girls in this sample were most at risk of developing Affective or Mood Disorders and were also reported as having elevated scores in all other diagnostic categories. Young Boys were reportedly most at risk for oppositional defiant disorder, PTSD, conduct disorder, ADD-Sluggish Cognitive Tempo, and ADHD, as well as other diagnostic categories. Adolescent Boys were categorised with elevated symptoms associated with conduct disorder, obsessive compulsive disorder, as well as ADD and PTSD. Young Girls were reported to have the least elevated symptomatology: their most elevated category was conduct disorder, followed by affective disorder, oppositional defiant disorder and PTSD.

Child Behaviour Checklist Pre-School (Under 5 years)

Half of the foster children under 5 years in this sample, according to their foster parents, presented with Externalising problems, including Aggression and Emotionally Reactive Behaviour. Within the Diagnostic Categories, these children were most likely to present with symptomatology associated with Oppositional Defiant Disorder and Pervasive Developmental Disorder (PDD).

When the data were divided according to gender, it illustrated that boys under five presented with the majority of difficulties in this group. Five out of six boys presented with Externalising behaviours; including Aggression and Emotionally Reactive Behaviour (4/6); symptoms associated with ADHD and ODD (3/6); and PDD (4/6). In comparison, in the categories where girls under 5 years were reported to have symptoms (Sleep Difficulties / Anxiety-Depression / Aggression / Emotionally-Reactive / Anxiety Disorder / ODD/PDP), it was only one out of six girls.

Combined Data CBCL-SA and CBCL-PS (1.5 – 18 years)

In order to see the extent of the emotional and behavioural difficulties experienced across this whole sample of foster children, the one category that is measured in both CBCL questionnaires was the Total Problem category. When the scores were combined for all 62 foster children, results revealed 35 children (56%) presented with Clinically Significant or Borderline Significant scores for Total Problems, very similar to the findings of the SDQ where nearly 60% of these children reportedly had significantly high levels of emotional and behaviour difficulties.

These data include 34 children with symptoms associated with Externalising behaviour and 26 with Internalising symptoms, some of these children expressing both Externalising and Internalising symptomatology simultaneously. Interpreting the data positively also suggests that 28 children in this sample were not presenting with noticeable difficulties.

7. THE DEVELOPMENT AND EVOLUTION OF GROUP SESSIONS

7.1 Introduction

The purpose of this chapter is to summarize, describe and explore the evolution of the content and activities of the small-group foster-parenting Course over the seven small-group sessions. This chapter responds to research questions 3 and 4:

3. What were the elements used to develop a Developmental, Trauma and Attachment based intervention for foster parents, and how did it unfold?
4. What were the foster parents' responses to, and experiences of, a small group psycho-education and reflective intervention?

This chapter explains the rationales for decisions taken, what unfolded session by session (illustrating the AR steps and cycles), including observations, feedback from participants and reflections that influenced changes to the next session(s).

Because there were six different groups that completed the seven-week Course, the Summaries on a Page (SoaPs, Akhurst & Lawson, 2013) that follow present an account of the process of each session from one week to the next, however these are somewhat generalised because the specific minor differences between groups cannot be described in detail. Participant comments obtained from post-session feedback questionnaires have been thematically grouped, with relevant examples of participant responses inserted after each session. Post session feedback questionnaires were read after each session to assess the learning that was taking place, as well as to see how to adapt to their needs and requests in future sessions.

7.2 Overview of Course Design

The Course was designed using the four Attachment principles outlined in Siegel & Payne Bryson (2020), focussing on the participants being "safe", "seen", "soothed" and "secure". It was important for me as the facilitator to role model these principles both explicitly and implicitly. The content of the sessions was designed to follow the potential developmental trajectory of an at-risk child, who may become a child who is fostered. This involved describing some of the many risk factors most associated with foster children from conception to their teenage years. The three main areas of information were Development, Attachment and Trauma (with background as described in the literature review).

The motivation for providing both theoretical and practical information in a combined small-group foster-parenting Course for foster parents was threefold. Firstly, for participants to learn about the difficulties their child(ren) might have experienced and the resultant emotional and behavioural features that might be evident. Secondly, for participants to learn about themselves, how their own histories or experiences may be impacting upon their reactions and parenting. Thirdly, combining the knowledge about how children are affected by their early experiences, that

their behaviour is adaptive; and communicating their current stress based on past experience, for parents to be able to respond to their child(ren) in a more insightful and measured way. The hypothesised outcome was that responding in this way increases the potential to reduce the child's stress and therefore behavioural dysregulation; to increase the child's potential for healing within relationship; to provide a more stable and satisfying experience for foster parents; and ultimately to result in fewer placement difficulties and hence placement breakdowns.

7.3 Course structure, teaching materials and strategies

The following outlines the structure of Course, highlighting the topics covered:

Introductory session

1 Role of parenting and prenatal development

2 From Birth through Childhood: Birth / Attachment (Infancy and Childhood) / Theory of Mind

3 Trauma and Dissociation

4 Adult Attachment and Healing Attachment

5 Recap and Healing strategies

Break

6 Attachment and Trauma / How they make us feel what they are feeling / Re-enactment

7 Self-care: Stress / Compassion Fatigue / Vicarious trauma / Burnout

The most challenging part of designing and presenting the psychoeducational material was timing. Presenting information that was potentially emotionally disturbing and required participants to focus on the child or themselves, or simultaneously on the impact of each on the other, had to be timed to reduce it being overwhelming or leading to defensiveness, negativity or disengagement. It was important for participants to be able to identify their children's difficulties and at the same time feel sufficiently safe to explore their own personal issues that potentially impact on their parenting and their children's responses, in a way and at a time that would maximise learning.

Having previously provided training to professionals based upon *Parenting from the Inside Out* (Siegel & Hartzell, 2003), an Attachment-based parenting program within which parents need to look at their own attachment styles, I decided to follow a similar format. The Course was therefore designed in a way that the focus was initially on material associated with the child, that is prenatal development, Attachment, and Trauma. It was only during the fourth session that the types of adult attachment that impact upon child attachment difficulties were more closely explored. At this point participants were required to consider how their own life experiences might have influenced their attachment and parenting styles, or created certain insecurities that might be triggered by their foster child(ren). The fourth session was chosen as it was hoped that the level of rapport and support had been sufficiently developed to allow this type of discussion and learning to take place;

and there was still the fifth session before the long break, to assess how participants had coped with the material. Another element of the fourth session was to provide reassurance that everyone at any age has the potential to heal (mal)adaptive coping mechanisms that might have developed earlier in life to cope with certain life circumstances), which are no longer effective or beneficial. This element was used to provide hope about the children's capacity to improve, and for the parents to realise their need to be aware of their own issues and that they have the ability to change.

The fifth session was designed to bring the material together and to consider how healing might be facilitated by parents, especially if they understand the possible causes of a child's behaviour. Healing in this context does not mean a fix or cure, but rather the facilitation of a relational environment in which improvements in the child's sense of themselves might lead to a reduction of emotional and behavioural symptoms, and an improved quality of life. A strong emphasis to promote healing in the children was that a parent's self-awareness, understanding the origins of the child's behaviour, not taking behaviour personally; and responding only when they, as parents are in an emotionally strong position, rather than reacting, were suggested as important requirements for a parent to assist a child's healing. It was also designed to promote learning by recapping and summarising the four previous sessions before the planned Summer or Christmas break. In order to promote connection over the break and to represent each of us keeping the participants in mind (as an attachment-based strategy), each person was given a small vanilla scented candle. I had a large version of the same candle, which I said I would light at times during the break and think about how they were all getting on; and encouraged them to do the same. Sweets and chocolates were handed out during the session to promote a more relaxed atmosphere. However, the main purpose of the sweets was also to talk about the impact of sugar on the brain and body, and to think about what treats might be better than others.

After a substantial break, which was timed for the Summer or Christmas holiday, session six was designed to revise the two main theoretical sections of Attachment and Trauma, elements that affect both the child and the parent. I placed a strong emphasis on the theme that adversity affects the body, brain and mind (in that order). The reason for highlighting these body, brain mind influences was to encourage parents to see how the emotional and behavioural presentations of their children may be expressed as Externalising or Internalising behaviour. Secondly, and more importantly, that it was also the direction in which we should consider assisting the child (body, brain, mind). This would increase the possibilities of the types of strategies parents themselves could use with their children and allow them to move away from the preconceived idea that psychological therapies were the best option, which in my experience was not necessarily true. Two other concepts were introduced: one that I called "Projective Transference", where the child makes the

parent feel the way they are feeling; and "Re-enactments", that children go on to do to others that which was done to them. Identifying Projective Transference can be a useful way of knowing how a child is feeling, and requires the parent to remain in adult mode and provide support when they possibly feel least able. The concept of Re-enactments was included to provide parents with current research at the time (Penning & Collings, 2014), which illustrated potential behavioural re-enactments that may become evident in regard to childhood sexual abuse according to gender. Simultaneously I was trying to moderate participants' potential anxiety, in that not all children who are victims become perpetrators, which might be a preconceived belief.

Session seven used information about the impact of stress on the body and especially the brain, previously covered in Session three, to illustrate that people working closely with foster children are at risk of developing stress-related issues such as Compassion Fatigue, Vicarious trauma and Burnout. The majority of this final session time was spent looking at ways in which foster parents might reduce their stress and find valuable sources of self-care, which would preferably include time away from the children, developing hobbies and social connections. The session was designed as an interactive discussion, rather than dividing it into an input and discussion session (as in previous sessions), since I wanted to end on the positive theme of looking after themselves.

The psychoeducation section of each session utilised a semi-didactic teaching style, with PowerPoint slides as stimuli, where participants were encouraged to ask questions and add to the material throughout, creating an understanding that we all had knowledge to share. Methods included repetition of material; the use of simple cartoon visuals to explain complex issues; humour (where appropriate) to try and lighten the mood; some shock tactics including facts, diagrams and visuals; all of which were hoped to enhance remembering.

Small group format

Group parenting interventions for parents in the general population (e.g., Högström et al., 2016; Barlow & Coren, 2017), have been found to be effective in improving parenting skills and reducing difficult behaviours associated with conditions such as ADHD and conduct disorder. They have also been found to be a more cost-effective way of providing an intervention to a larger number of parents. Programs for parents who foster (e.g., Golding, 2016; Van Holen et al.,2017) have also been evaluated and found to have positive outcomes including an increase in confidence; participants reported better understanding their children and their children's behaviour; feeling that their relationship with their child had improved; and reducing foster parent stress. Adkins et al., (2022) have developed and evaluated a foster parent group program called *Family Minds* intended to increase reflective functioning and mentalisation in parents. Results show an increase in reflective functioning, a decrease in parenting stress, and an improved capacity to co-regulate their

foster children. Based on findings like these, I decided to develop a small-group foster-parenting Course as a way of increasing the understanding and reflective capacity of foster parents, as an intervention for foster parents and their foster children.

The psychoeducational section of each session was designed using the structure of a PowerPoint presentation. Slides included text, pictures, diagrams, photos and cartoon illustrations. A DVD of the *Still Face Experiment* was used in session 2 to illustrate the impact on an infant, when a mother disconnects from them emotionally, supplementing Attachment information as well as showing foster parents what it might be like for the infant of a parent who is emotionally absent due to mental health, or drug and alcohol difficulties. The material being presented throughout the Course was also potentially traumatising: what foster children have experienced is unpleasant to talk about, listen to, and explore. There was also a risk that some participants might have experienced the types of neglect and trauma being discussed, and could therefore be re-traumatised.

Safety features, including the ground-rules about minding themselves and minding each other; and reassurance that they would be pre-warned before being presented potentially disturbing material. Participants were introduced to a small furry monkey toy that rolls around and laughs when switched on. It was suggested that if the atmosphere was getting too heavy that someone suggest activating the monkey. The monkey was placed on the desk, along with a plastic model of the brain (used to identify the areas of the brain most impacted by the material being discussed).

Other ground-rules were provided to create a sense of safety and boundaries. These included confidentiality and an important request that there was to be no HSE, Tusla or social worker-"bashing", meaning that I wanted participants to avoid discussing their individual difficulties with the organisation(s), especially with individual social workers who were not there to defend themselves, and might be known to other participants. I had previously attended meetings of foster parents where these very real difficulties became a distraction in the meeting and nothing else was discussed. Participants were asked to "speak to the group". As much as I was presenting the material, I wanted people to discuss matters and find out information amongst themselves. I wanted them to consider me part of their group, but that the expertise of fostering children lay with each one of them, not with me. To build on this concept and in order to reduce the likelihood of someone else in the group taking over a dominant role, I included the following two comments, "Nobody's opinion is more important than anyone else's" and "Listen – you never know what you might hear". These ground rules were presented as reminders before each session.

The reflection section of each session occurred after a short comfort break. The point of this part of the session was to discuss the material heard in the psychoeducational section, as it pertained to their children or themselves. In the first few sessions, I provided participants with some

possible questions relating to the material, but thereafter it was no longer necessary as the groups found their voices and discussed matters quite freely with each other. I hoped that discussing the material would deepen their understanding and make it possible to use the information practically in their parenting. Furthermore, I hoped that participants would recognise that others shared similar difficulties, that is that they were not alone; and that they would feel supported by others in the group as they jointly tackled the challenges, recognised and enjoyed minor successes in fostering.

7.4 Session by session explanation

The selected participants were invited to an introductory meeting a week before the actual group sessions commenced; on the day and at the time that they would be required to attend going forward. The purpose of this meeting was to explain the purpose and content of the sessions. It included providing sufficient information for informed consent, which along with a verbal explanation, comprised a Participant Information sheet and Consent form (see Appendix C) distributed to participants at this meeting. The pre-Course questionnaires were given to participants at this meeting and a brief explanation regarding the questionnaires' purposes, and how to complete these. Participants were asked to complete one set of questionnaires for each of their foster children and to return them at their first session the following week. Signed consent forms were collected at the end of the introductory session.

The introductory meeting provided the opportunity for participants to meet each other; describe and hear each other's current fostering situation; and to explore what they hoped to accomplish by attending the Course. It was also an opportunity for me to introduce myself and give the group some insight into my professional journey, which had resulted in a special interest in fostered and adopted children. Using self-disclosure, and identifying myself as a co-professional working and learning together with them, I hoped to set them at ease. An important element of this disclosure included declaring my independence from Tusla and the Social Work Department. To reassure participants that although my current employment was within a related sector of the HSE, I was carrying out this research independently and that what emerged from the questionnaires or was discussed during sessions was confidential. Relevant research information would only be shared with my supervisor in South Africa (not Ireland) and when the information was ready to be published, in the form of articles or policy documents, that the identifying information would have been anonymised and no individual adult or child would be recognisable.

An overview of the Course was provided session by session, giving participants a flavour of the material to be covered. Participants were given notebooks and encouraged to keep a journal of issues that arose at home with their child(ren) that could be discussed during the discussion part of the session. It was suggested that they bring the notebooks to sessions in order to make notes,

since handouts would not be provided until the end of the Course, when they would be provided with a selection of relevant slides to prompt memories of what they had learned during the Course. Before they left the introductory session, I expressed my enthusiasm and gratitude for their participation and looked forward to the Course starting the next week.

The data to follow include each of the seven SoaPs to orientate the reader to the planned and actual content and structure of the repeated group sessions. Below each is a summary of the responses provided by participants in the post session questionnaires about the information learned by them and ways in which they might implement it practically in their homes. This is divided thematically and mostly presented in their own words, in partial or full responses. They were also requested to suggest what might be added to each session, and again their comments have been included. The following describes the numbering system used and the formatting of quotations.

Numbering:

- (2,7,22) in round brackets and reduced font denote the respondent number. Questionnaires were completed confidentially after each session (no names or identifiers were used), and responses do not appear to follow any pattern. Furthermore, a respondent may not have completed all questions on the form, so the number used to illustrate feedback of the participant in question one, that number does not necessarily represent the same participant in question four. These numbers are used to illustrate the number of participants who identified different themes and provides a link back to the response in the original anonymous data.
- When a number within brackets is in bold, that particular respondent's quotation has been used in another part of that question's analysis.
- Square brackets [3/27] denote the number of respondents who referred to a concept or theme and may or may not include a percentage (when substantial numbers had similar responses).

Quotations:

After the SoaPs, both full and partial responses are quoted to illustrate the participants' actual responses in relation to concepts. Quotation marks and italics have been used for verbatim individual responses. Because I value the words of each participant and the efforts made by them to complete evaluations each session, my role as the researcher has been to order and group these thematically; wishing to present their authentic responses. Responses are used to provide an example of a theme, or to represent a theme itself. A bullet point demarcates each theme. There were many spelling, grammar and punctuation mistakes or omissions in participants' responses and many responses were difficult to read due to differences in hand writing: they are quoted as they were recorded and (sic) has not been used in any of the quotations.

SoaP 1: Role of Parenting & Prenatal Development

Planning

- Parenting message: Foster parents' roles in the process of foster-parenting; to illustrate that parenting a child in Care is different from parenting a biological child; and for participants to make links between material presented and their child/ren
- Main focus of material to be presented was prenatal development with an emphasis on FASD and the possible physiological, emotional and behavioural implications of a sub-optimal womb environment, including whether the pregnancy/child was wanted or not
- Theme: emotional and behavioural symptoms of children in Care are communications of their stress/distress and adaptive NOT bad behaviour, pathology or necessarily diagnostic
- Prepare slides for hour long presentation, including Parenting, Prenatal development with focus on FASD – including shocking visual of Normal brain vs FASD brain
- Provide reminders for safety: Confidentiality / No HSE, Tusla or SW Bashing / Mind yourselves and each other / Speak to the group, rather than the facilitator / Nobody's opinion is more important than anyone else's / Listen – you never know what you might hear [Slide:2]
- Summarise overall lessons that I wanted them to learn throughout the Course in the form of precepts I'd developed to assist parenting fostered children [Slides:4-5]
- Encourage participation, both questioning during slides and discussion section in second half
- Consider participants comfort, seating with sight-lines to screen, water, mid-way toilet break
- Admin - collect questionnaires from intro session
  - provide and collect feedback questionnaires at end of session

Acting

- Welcomed and thanked participants for attendance, reiterated "safety" reminders
- Use of humour and some "shock tactics" (so participants respond / react / remember)
- Questions; a poem re FASD; Myths about alcohol; Case examples used to supplement content
- Contextualised emotional status of mother to reduce criticism / blame and increase empathy
- During break left room to provide participants with space to chat informally with each other
- 2nd half discussion prompted by sample questions on slides when discussion did not develop
- During discussion I sat "at the same level", to not dominate space, content or conversation

Observations

- Course and book title evolved: "Creative parenting for complex problems"
- People who hadn't heard me before appeared slightly shocked by some of my comments
- Participants were attentive whilst I presented, mostly kept comments and questions for later; interruptions were helpful to clarify and develop areas of relevance to individuals and group
- Participants encouraged to talk to each other and not to me during discussion session; some tried to get direct input from me; when discussions flowed, participants seemed to really enjoy hearing experiences and ideas from other participants

Reflections

- Length of session – optimal for facilitator managing dual roles (facilitator and co-learner)
- Difficult but possible to mix roles of facilitator and participant – valuable learning for participants to be treated as experts and co-learners
- Participants appeared enthusiastic about the learning and left the session chatting amongst themselves
- Thoughts for next session – reduce number of slides

Comments from participants on Session 1, n=36
Name the things about today's session that stand out for you

The majority of participants (69%) referred to FASD, with 50% [18/36] of these responses naming FASD directly. The most prevalent theme (30%), described the negative impact of alcohol on the brain or on Development, including the possible long-term consequences.

"Learning all about the brain and what alcohol can do to an unborn baby and how it can affect a child in later life" (31)

Other aspects of FASD referenced were:

- FASD is not always visible (14,35)
- Myths associated with drinking alcohol during pregnancy (15)
- Behavioural issues associated with FASD (2,22,33)
- Similarities between FASD and other diagnoses and the difficulties diagnosing FASD (7,24)

  "…And how alike ADHD, ASD FASD are ..." (7)

Other themes regarding the child included:

- The uniqueness of each child / complexity (1,5,17,21)

  "Each child is different and we need to remember that at all times…" (1)
- Impact of Trauma or separation can cause damage to brain structures (4,19)

  "…That the brain can be so damaged through the trauma or separation…" (19)
- Impacts on the child from conception (11,25,30,36)

  "Mothers pregnancy and the environment, effects on child during pregnancy" (11)
- Behaviour as communication / child's reactions to situations (7,16,17,22,33)
- Wantedness (15)

Themes associated with intervention or helping the child heal included:

- Work on what is currently presenting *"…How you work with each as it arises"* (7)
- *"…Also it was very good to hear that we have to treat our children as normally as possible for future life"* (27)
- Being aware of different triggers for the child (17)
- Simplify things for the children (17)
- Repetition can bring healing (20)
- Dealing with behaviours (22,33)

  "The way children act out for no reason…and how to calm them down at their own level" (22)

Themes associated with parents themselves included:

- The need to recognise their style or needs and adjust accordingly (5)
- *"A lot of things stood out. But the biggest for me is the triggers in myself…"* (7)
- Recognise my child probably has FASD (25)

Themes associated with the group discussion:

- Similarity of experiences with difficulties (**3**,25,36)
- Openness to other opinions (**3**)
- Other laypeople's opinions about foster children's behaviour (22)
- Discussion with "*people talking*" / sharing (8,26,34,36)

"Everybody has difficulty with their children and are really open to taking on board other peoples opinions, even if they differ from their own. A lot of similar problems with children" (3)

Themes associated with the Course in general:

- Two of the Course Precepts were mentioned,
  - Foster children need to be parented 4 years younger than their chronological age (15,32)
  - Foster children have to be parented differently (19)
- Teaching Materials
  - PowerPoint: *"Slide show was very interesting and informative"* (23)
  - Photos of the two brains (20,27) *"The difference between the photos of the two brains…"* (27)
- Learning from the facilitator (26,34)
- Information relevant to participant's context (28,34)

  "Great information which relates to our home situation" (28)
- Information was helpful (29,34) / Interesting (32)

"How the brain development before the child is born, size of the damaged brain. It can be helpful" (29)

"The information at the start led to very good discussion at the end, everyone's input to Susan's insight, explanations has really helped me understand specific behaviours that are recurring in our home" (34)

How do you think today's session might benefit you?

Themes regarding the child included:

- Behaviour is communication (3,4,6,9,33)

  "…Explanations as to why a child behaves a certain way and what they are trying to tell us" (3)

  "Greater understanding of behaviours and at least what causes them" (6)

- *"Might benefit me when dealing with behaviours and outbursts, remind me things can happen for no reason at all"* (15)
- Need to check for FASD (2)

Themes associated with intervention or helping the child included:

- Ways of dealing with behaviours (**3**,4,7,9,**15**)

  "How to deal with behaviour – about being firm; knowing boundaries. Listening and hearing what they are actually saying to you" (4)
- *"To help our children in care with any problems that arise"* (10)
- *"…Remind me to keep instructions short and sweet for this child"* (12)
- Child's behaviour and mood not within their control but rather a bodily response to stress (19, 20)

  "…That I now know that the child can't help having his mood swings or tantrums that it's the body way of coping with their stress" (19)
- Never ask the question, "*why?*" (32)

Themes associated with parents themselves included:

- More patience and understanding / empathy / insight (12,16,18,20,21,26,27,28,31.32)

  "*Allow for more patience and understanding of the difficulties that one of my children has*" (12)

  "I think it gives me more understanding and insight" (27)

  "Great insight into problems which affect our children and ways to cope" (28)
- Parents' reactions impact on the child (1,22,29)
- Stop and think, slow down and see the problem from the child's perspective (5,8,11,17)

  "How to look at things through a child's eyes and mind…" (17)
- Confidence to deal with situations differently (13,28)

  "It will give me the confidence to deal with [my child's] behaviour in a different way…" (13)
- *"Understanding it is ok that the child is upset, it's all a learning process"* (18)
- *"It will help me to change how I plan activities with the child"* (19)
- Be more aware of behaviours daily (5,23)

Themes associated with the group discussion:

- *"Group discussion was great finding out about the different types of behaviour"* (23)
- Learning different techniques other people use (24,36)

  "Sharing some of our issues and getting feedback from other foster parents and child psychologist about different techniques and approaches we might use at home" (36)

Themes associated with the Course in general:

- Behaviour is communication (**3**,4,**6**,9,33)
- Seeing the situation from the child's perspective (**11**,**17**)
- Answers some of my questions regarding behaviour (25)
- Practical information to use at home (34,**36**)

  "Getting advice and information to implement with children/at home" (34)
- *"The [children] are so young now that I cannot see any of the symptoms in them (may not be there at all). Things to watch out for, as they get older"* (14)

What would you add to today's session?

- **Nothing** [20/36]

  "Nothing – great mornings work" (5) / *"I really enjoyed it."* (23) / *"I learn every time"* (18)
- **Specific requests**
  - *"…how to encourage child to do something when [they] totally ignore you"* (6)
  - "*Explain how to explain FASD to teachers or tell them what's expected"* (12)
  - *"Learning coping mechanisms for both child & parent"* (17)
  - Handouts [4/36]

    "Could we have copies of class, as I feel I need to go over and process it more, and have the time and space to do so" (7)

    "A printout of all today's information would be a huge help in dealing with and understanding the problems we all deal with" (20)
- **More time** [2/36]

  "Longer time!! Its great to learn and listen to other people with the same concerns and how they are addressing them and the correct way to address them" (22)
- **Positive comments** [7/28]

  "Today's session went very well" (21)

  "Found class extremely interesting and looking forward to more" (24)

SoaP 2: From Birth through Childhood

Planning

- Main focus: Theory of Attachment in evolutionary survival and practical terms as it presents itself in day-to-day experience; summarising the impact of child's initial experiences on their perceptions of self and others in an oversimplified visual representation of the Theory of Mind
- Themes: Experiences that impact a child from birth and during infancy (e.g., prematurity, birth-parent's feelings of (in)competence)
- Parenting message: Start developing the theme of mutual intersubjectivity – children impact on the foster parents' state of mind, a foster parent's internal state impacts on their child's presentation and behaviour; hence try not take the children's negative responses 'personally'
- Challenge the myth that a child does not remember negative experiences in infancy; and promote the concept that children are connection-seeking, rather than attention-seeking
- Use fewer slides (13 content slides included)
- Admin: provide feedback questionnaires at end of session

Acting

- Reminder of safety ground rules verbally
- Started with overview of content of session
- Presented ideas from Attachment theory (using Siegel's ABC and own summary diagram) and Theory of Mind (as a visual concept to supplement complex verbal explanation)
- Used different ways to present complex ideas; cartoon pictures to aid understanding of attachment styles; described the survival / instinctual nature of attachment behaviour as a consequence of a fear response; included Still face Experiment video clip to emphasise the impact of attachment failure; and illustrated Attachment as a relational dance
- During discussion we started to consider ideas of "healing" attachment difficulties and improving the attachment dance

Observations

- A long, intense session - the breadth of what was covered could have been a full three sessions!
- Participants seemed to want to understand Attachment, as they were familiar with the term
- Need to emphasise that Attachment is part of human development, from birth to death, influencing our reactions and relationships (positively and negatively) throughout the lifespan
- Challenging to simplify ideas of a complex theory and clarify some terms especially when labelled slightly differently by different theorists
- Diagrammatic summaries of attachment styles including disorganised attachment [slides: 8-9]; and Theory of Mind [slides: 12-13], seemed a very useful teaching tool, all of which seemed to resonate with foster parents.

Reflections

- Number of slides seemed better this session
- Session seemed to flow; and the emphasis on Attachment theory seemed well-received
- Helpful to start with child attachment; in order to link to their own attachment in Session 4 when they might be more trusting as well as familiar with the topic
- This topic needs to be presented by a facilitator with a sound knowledge and understanding about Attachment concepts.

Comments from participants on Session 2, n=33

Name the things about today's session that stand out for you

Just under 60% of respondents mentioned the main topic Attachment, including the different types, Secure/Avoidant/'Clingy'/Disorganised, and just under 20% of respondents mentioned Theory of mind, referencing the visual of the broken mirror image.

"Very informative about attachment and how our children behave and the reasons behind it also how we can improve how we parent knowing this…" (25)

Other aspects of Attachment referenced were

- ABC of Attachment *"…attachment/balance/coherence…"* (4)
- The idea of humans born prematurely / kangaroo pouch (10,14)
- Brain is social (14)
- Relevance of Attachment to adult relationships (9,26)
- *"…the different methods kids might use to connect"* (24)

Themes associated with intervention or helping the child included:

- *"…Calm down with your child it's the parents job to bring them down…"* (3)
- Being consistent and having boundaries (5,6)
- Be cautious with praise (6,10)

  "…child not being able to deal with being praised, needs to be gradually done…" (10)
- Establish trust (10)
- *"…Sensitive care in childhood is a great foundation for a child mentally"* (16)
- Seeing things from the child's perspective, can help them (20)
- The Attachment Dance (1,4,16)
- Repair (1,6,10)
- Acceptance *"…of where [the child] is at"* (30)
- Healing takes patience (27,28,32)

Themes associated with parents themselves included:

- Seeing yourself as the child might see you (21,22,23)

  "Dealing with different types of situations, seeing yourself as they see you" (21)
- *"[Attachment] Area I need help with…"* (2)
- *"The importance of managing one's own behaviour and reactions"* (8)
- More understanding regarding attachment issues (13)

- *"How we trigger reactions [in the children]…"* (19)
- How we can improve our parenting by knowing about Attachment (**25**)
- Positive impact on relationship through understanding (26)

Themes associated with the group discussion:

- Learn from others as we talk (18,25) *"…I learn from others when we talk…"* (18)
- *"…The discussion afterwards was good…"* (33)

Themes associated with the Course in general:

- Teaching materials
  - *"The visual slide showing the different types of attachment, it is only when you see the description of the types, that you understand what you are dealing with"* (29)
  - Still Face Experiment video clip with baby /relate to my child (4,18,28)
  - Theory of Mind - Broken Mirror visual (8,14,15,18,19,22)
    "I find the broken mirror very good to show how the children feel…" (18)
  - Clingy monkey visuals (10)
- *"Never quite understand attachment, but today cleared it up for me. Plus the effects that it can have on these kids for the rest of their lives"* (12)
- Healing the child (27,29,33)

  "HEALING, deliberately put in block letter will take patience, and there is a healing process and not a cure…" (27)
- Precept: Parent your child as if they were emotionally 4 years younger (3,8,13,28)

How do you think today's session might benefit you?

Themes regarding the child included:

- Behaviour associated with attachment difficulties and what it means /control / rejection / reaction to praise (**12**,**15**,16,20,24,**25**,26,27)

  "Gives me a better understanding of why the foster kids in our care do the things they do, acting out and distancing themselves" (12)
- Recognition of child's diagnosis or difficulties (1,10)
- Understanding the child's attachment style (21)
- *"It will benefit me in the way I now know how the child is feeling and how he sees himself"* (22)
- What they have been through before they came into care (**17**)
- *"Much better understanding of child's perception of reality"* (18)

- *"…how the children actually react to how you react to them both verbally and through your face features"* (19)

Themes associated with intervention or helping the child included:

- *"Learning about the attachment behaviour will give me a better understanding of my child's needs and how to nurture or fill the holes in the bucket"* (11)
- *"I hope to see more of what the children are really trying to say with their actions and react in a more positive way for them"* (15)
- *"Be in the moment with the child…"* (21)
- Limit the number of options: *"…give only two options not three or four"* (28)
- Try and avoid saying "don't" and "no" (28)
- *"Need to keep putting the love out, need to show them more and more that no matter what they throw at us we are there for them always"* (30)

Themes associated with parents themselves included:

- *"Hope to take into consideration the calmness aspect"* (3)
- Connect with my children (4)
- *"Feel better equipped with how to deal with problems – to recognise the symptoms"* (5)
- *"Methods of dealing with issues I didn't fully understand beforehand"* (7)
- Put information into practice (6)
- To be aware of what the children have been through (8,**17**)

  "Allow me to be more aware of our children's needs. Be more patient / be mindful of what our children have been through (their insecurity / fears / needs)" (8)
- Learning how to nurture attachment (**11**)
- Re-evaluate how I do things at home (**14**,**15**)

  "Everything benefits, I take it home and relook how I do things at home, they help in my family" (14)
- *"…Sensitive care giving as the formation of psychological attachment"* (21)
- Learning how to cope (**31**)
- *"We can identify with some of the context – so we can use this information for the benefit of our children"* (33)

Themes associated with the group discussion:

- Knowing that others have been through similar situations (23,31)

"Learned how to cope with these and what to do and to know that others have similar situations and you are not alone" (31)

- *"The discussions after the presentation are very helpful and gave a very wide range of children and their very specific needs, you pick up a lot e.g. small points when put together are very relevant to everyday problems we encounter"* (29)

Themes associated with the Course in general:

- Understanding (**7**,**11**,**12**,18,21,22,**25**,32)

  "Very valuable as gained greater understanding of how and why our children behave with regards to attachment. We can hopefully put some of knowledge, techniques used to good effect at home" (25)

- Awareness (8,13,17)

  "Talking about these issues gives you more awareness of what they have gone through..." (17)

- *"It's knowing I'm going the right way about things regarding emotions and the best thing to put into practice"* (26)
- *I'm really enjoying it as my 5-year-old is suffering attachment disorder"* (1)
- *"It will help me on a daily basis"* (2)

What would you add to today's session?

- **Nothing** [21/33] *"I though today's session was a treat. I wouldn't change it"* (9)
- **Specific requests**
  - *"…maybe another video or two but don't know either as video was hard to watch"* (10)
  - *"Maybe a bit more on what we can do to help the healing process as much as possible*" (11)
  - *"Just wondering – the more placements = the more issues / or does the quality and quantity of FC effect attachment disorders"* (13)
  - More discussion time (specifically)
  - Tea/Coffee
  - Handouts: *"Printouts would be very helpful to go back over the session"* (7)
- **More time** [3/34]

  "A lot more time, every session is so fulfilling and no one eager to rush out the door, as busy as our lives are" (12)

- **Positive Comments**

  "Today's session was very good, learnt how to try and understand how the child is feeling" (4)

  "I thought today's session was a treat. I wouldn't change it" (9)

SoaP 3: Trauma and Dissociation

Planning

- Main focus: Trauma, Dissociation and post-traumatic stress and how the child's presentation is a result of reactions in the body and brain
- The material needed to be linked to child's age and developmental level and associated impacts in terms of timing and chronicity
- Parenting message: Child's current emotional / behavioural responses are most often triggered by something in the present that reminds them / their body about the past. Situations / sensations (e.g. smell, hunger) are reminders, not the source of the problem
- Slides prepared (28), some contained merely a sentence, few words or a diagram
- Metaphors (e.g. "cook", "smoke detector", "watch tower") to describe the fight-flight response; photo of cat's eyes with dilated pupils to illustrate the neuroendocrine process; and colour coded 3-part brain visual to simplify descriptions of complex neurological processes

Acting

- From title slide it was very important I remind them that Trauma is an upsetting topic, potentially "triggering" for themselves; the needed to "mind themselves" / tune out if needed
- Asked participants to consider the impact of material presented at different ages and stages
- Began with DSM IV(TR) criteria for Trauma – emphasising perceived threats to life-threatening danger through neglect; witnessing includes hearing or sensing, not only direct experience; outline cute, chronic and complex trauma terminology; children experience trauma within an interpersonal / relational context; child's helplessness is contextually an important factor
- Used nested systems diagram [slide:10] as framework to visually represent all the things that could and do interact and impact on the child (starting centrally from the child and moving outward to more systemic and organisational issues)
- Brought material back to ideas about impact of being fostered; the need to provide a secure environment; but also difficulties associated with legal system's bias toward biological parents
- Diagrammatically introduced three-part brain: fight, flight, freeze responses; dissociation
- Impacts of PTSD on body; how the senses and certain perceptions induce flashbacks
- Used questions to personalise the discussion, to make links to their children; and to consider "healing" as a more positive ending to session

Observations

- Realised Trauma material is complicated technically and emotionally difficult; although I simplified wherever possible, this mainly new material for them increased stress levels
- Content could have been 2-3 sessions, given the volume and potential impact of material
- Used opportunity to explain elements of Social Work and legal system to defuse unspoken angers, but held the boundary on not "knocking" the social work and larger system
- Slide 25, need to emphasise order: trauma affects 1st body, then brain, then mind

Reflections

- Parents slightly subdued but seemed grateful for the information, reflected on deepened understandings and their comments seemed more empathetic and aware why merely talking to, or explaining things to their children, might not be helpful
- Was concerned I might have overly emphasised dissociation, because of my own interest and wanting to normalise the associated behaviour, however feedback indicated that it was a topic of interest

Comments from participants on Session 3, n=35

Name the things about today's session that stand out for you

Trauma and Dissociation were each mentioned by participants: 25% and 22% respectively. The brain was mentioned in 34% of responses and PTSD, including flashbacks, triggers, stress and fear associated with the past was mentioned in 31% of responses.

"Trauma, dissociation, parts of brain affected, greater understanding of it and how much it all has affected children" (1)

"How the brain of a child in care functions compared to average and different quirks that our kids have make more sense to me now" (34)

"How recall of trauma, can be triggered by numerous sensory inputs. How the "logical" brain is not connected" (7)

Other aspects of Trauma and Dissociation referenced were:

- Behaviours and symptoms (24,29), associated with what happened to the children in the past (33)
- Understanding how much trauma affects children (1,2,16)
- Impact on development (3)
- Impact on memory (13)
- Disconnection of the logical part of the brain (5,**7**,8,15,18)
- Seeing the chemical response in the eyes (2,32)
- Trauma can be caused by coming into care (8)
- Verbal abuse can be worse than sexual abuse (20,21,26)
- Need for sugar (23,24)
- However bad it was in their homes of origin, the draw is to go back (33)

Themes associated with intervention or helping the child included:

- *"Understanding trauma and what can trigger memories"* (17)
- "*Understanding how the child thinks so differently"* (19)

Themes associated with parents themselves included:

- Can see it in my children (6,27,31) "*Identify both children in what you were saying*" (27)
- Not to blame yourself for child's fear, try to help (14)
- Not to take things personally (33)
- Quirks make more sense to me now (**34**)

And the group discussion: *"The discussion at the end really jog your mind and relate the courses to your own situation with the foster kids in your care"* (35)

Themes associated with the Course in general:

- Trauma / Dissociation / PTSD, triggers and flashbacks / The brain (as above)
- Teaching Materials
  - *"The changing of the eyes (cat) fight or flight dissociation. I can relate to these*" (32)
- Really enjoyed today (12)
- Understanding (1,3,16,17,19)
- So much to take on (25,28) *"So much to take in, very interesting and intense"* (28)
  "There was so much to take on that I really need to process it all when I go home" (25)

How do you think today's session might benefit you?

Themes regarding the child included:

- Better understanding of trauma, triggers and flashbacks (7,8,18,29) *"Better understanding of triggers that may appear completely innocuous yet have a significant response"* (7)
- Understanding behaviour and foster children's responses [8/35] (2,13,19,20,21,23,24,34)
  "Understanding my children's responses and behaviours much better..." (19)
- How the brain works (11,12.19)
  "Gave a good insight on how the brain works…" (11) *"…frontal lobe not online"* (19)
- Knowing about dissociation – *"need to research more"* (10)
- Understanding from the child's perspective (14,28)
  "Greater insight from your child's point of view" (14)
- Understanding the child's needs (15); especially in relation to change (9); feelings (16); presentation based on their experience (2,17,34); trauma and ongoing stress (25)
- *"…that their whole body is affected from the trauma that occurred to them"* (18)

Themes associated with intervention or helping the child included:

- *"Methods to deal with trauma and dissociation. Recognising symptoms of same"* (3)
- How to respond to the child (16,17,29)
  "…It helps to understand how a child is feeling and when it might help us figure out how to react more accordingly" (16)
- *"…Make me pause and think before I react to a problem"* (11)
- *"It helps us understand our child needs and to be more patient*" (15)
- Cut out sugar (28)

Themes associated with parents themselves included:

- Explains what I deal with daily (1,12,27) *"It has put words on things that I dealt with daily with [my children], and help understand much more" (1)*
- Recognising symptoms of trauma and dissociation (**3**)
- Be more patient / more relaxed (15,32)

  "My reaction again towards [my child] will be a more relaxed view on what's going on" (32)
- *"…How [the children] can press my buttons…"* (19)
- *"It will benefit me and our family in a way in … understanding of PTSD for the child in care"* (22)
- See things differently: *"In a lot of ways make you look at things a lot better"* (31)
- Understand negative reactions toward me (33,34) *"That negative reactions the foster child might show towards you the foster parent is not because you are doing something wrong but more to do with what the child perceived as being normal as that is what they are used to"* (33)

Themes associated with the Course in general:

- Word, "Understand(ing)" used in [17/35] (49%) responses (1,7,8,9,12,15,16,17,18,19,20,21,22,23,29,30,34)
- More awareness of reasons for behaviour (2,6,33,34)

  "Really opens your eyes to what lies beneath" (6)
- Not to take things personally (**33**)
- Precept: Parent foster children differently to biological kids (4)

  "How to cope with situations in a different way to how I deal with my biological kids" (4)
- A lot of information, hope I will remember (26)

What would you add to today's session?

- **Nothing** [29/35] (83%) *"A lot of talking on this one, nothing needed to add to it"* (6)

  "It was very serious and in-depth, so I feel you couldn't include much more in this session" (9)
- **Specific Requests**
  - *"More on dissociation"* (1)
  - *"A little bit more about the child in the womb after traumatic birth and concealed pregnancy, just to touch on these things for foster parents that have babies that … issues apply to"* (15)
  - *"Maybe have a social worker sit in"* (12)
  - Handouts
- **More time** [2/35] *"More time for discussion/problem solving"* (7)
- **Positive comments**
  - *"Today's session was excellent"* (10) / *"Very full session, thank you"* (11)

SoaP 4: Adult Attachment and Healing Attachment

Planning

- Main focus: Return to Attachment material, but now carefully reinforce parent's understanding through making links to their own attachment experiences and style, by illustrating the types of parenting processes that lead to attachment strengths and difficulties.
- Parenting message: to become aware of how their own attachment style could impact on their relationships especially with their foster child(ren) and result in some of the child's and their own emotional and behavioural reactivity at times
- Themes: Attachment is a life-long relational presentation that can be improved; 'healing' takes place in meaningful relationships
- Number of slides needed to be reduced; 20 slides prepared. Some slides repeated to revise and reinforce messages; and hopefully deepen understandings
- No discussion questions prepared, since group interactions had provided ample material in previous sessions and was developing from the content more naturally

Acting

- Began with the importance of self-knowledge. Needed participants to realise why it is helpful for them to be linking and identifying with the material experientially
- Provide reassurances about difficult pasts in their own lives; that we're all on a journey of discovery; and understanding our attachment styles improves our reactions and relationships
- Presented participants with a hard copy of a set of questions for parental self-reflection (sourced from Siegel & Hartzell, 2003), discussed them broadly and asked them to take them home for reflection, but not to complete if feeling unsure / fragile
- Using familiar slides showed how child's attachment styles become adult styles; going through each of four patterns and an adults' potential "adaptive" insecure pattern
- Explored ideas about "healing" through relationships, for themselves and their child(ren)
- Reiterated three-part brain diagram: how they as parents can stay on the "high road" (and discussed their "triggers" to reflect upon at home); considered "rupture and repair" as important role modelling and attachment healing (illustrated with personal disclosure)

Observations

- Need to be careful to try to promote understanding rather than to locate blame
- Re-wording parents use of negative terms like "manipulative"'/lying toward survival and adaptation; and assist foster parents understanding of where the children are "coming from"
- Useful to use some personal disclosure; seemed to relax participants and encouraged them to tell their own stories (they also seemed to be feeling safer by this stage in the Course)

Reflections

- This seemed an important session to start working toward the concept of "healing" within relationships
- It was a relatively "quiet" more reflective session from participants' perspectives; perhaps internalising material. I didn't want them to feel vulnerable and this was not a therapy session, so I needed to proceed very carefully
- Again, this material seemed to be comprehensive and could have been split over two sessions and the following session to be a more in-depth discussion / reflection on this material, however the number and timing of the planned groups precluded this

Comments from participants on Session 4, n=30
Name the things about today's session that stand out for you

Themes regarding the child:

- Triggers (child) (12,19,22)
- How the brain works (10,29,30) *"Learning about how the brain works, different parts etc and how it affects both us and the children"* (10)
- Realising the reasons behind behaviours (2)

Themes associated with intervention or helping the child included:

- Rupture and repair [5/30] (11,14,18,19,28)

  "That when an incident triggers a reaction, that we as adults need to keep calm and we need to know what our triggers are. That these ruptures need to be repaired" (18)
- *"The shaming to be so careful not to shame them…"* (3)
- "*…ask kids when everything is over to tell us what might help"* (13)
- *"…talk about what has happened and try to understand their feelings"* (17)
- *"…not to answer or react straight away"* (25)

Themes associated with parents themselves included:

- Know your triggers [21/30] (70) (1,3,4,5,6,7,8,9,11,12,13,14,15,18,21,22,26,**27**,28,29,30)

  "Wow really amazed at the list of things that could be my own triggers and what I could do to handle situation differently" (15)
- High Road - Low Road [6/30] (1,8,11,12,17,19)
- Different areas of the brain - related to self (1,10) [2/30]

  "…red, orange and green part of brain and how they function, and relate to myself" (1)
- Foster parents' attachment style (7)
- What I can do to handle situation differently (15)
- How the way we were parented impacts on the way we parent (16)
- Calmness and repetitive behaviour (17)
- *"Starting with me, recognising past issues and how I am feeling today and how to react with the children, especially paying attention to my humour [mood] on the day and my triggers"* (27)

Themes associated with the group discussion:

- *"The discussion during and after the session…"* (23)

Themes associated with the Course in general:

- *"Learning, going back to our childhood memories. How our different upbringings bring up different ways of dealing with our children's behaviour"* (17)
- *Triggers: "Our triggers and how they affect everyday situations, everybody has a trigger"* (5)
  "My triggers and coping abilities, how well or not that I deal with situations, very intense and thought-provoking session" (26)
- High Road / Low Road: "*…concept high road/low road, where you are on the road*" (8)
- Rupture and repair: "*… the importance of mending situations even if you are in the right" (*28)

How do you think today's session might benefit you?

Themes regarding the child included:

- *"…Aware how child feels when he is fearful and cannot cope with situations"* (4)
- What triggers a child's reactions (7,19)
- When a child is in turmoil / fear their brain is not working properly (10,15)
  "Realising that when a child is in turmoil, part of the brain is not functioning properly" (10)

Themes associated with intervention or helping the child included:

- How to cope with triggered behaviours (2,9)
- Don't shame the child (5,6)
- *"Identify where I am emotion wise and knowing that this will have an effect"* (14)
- *"…make a statement, don't ask a question..."* (5)
- *"…and how timing of interpersonal interactions can compound problems"* (20)
- Talk to children after they calm down (7,25)
- Rupture and Repair: *"…If you recognise a rupture, you need to be the bigger person and try to repair it, even if you think you are right"* (18)
- *"Learnt to stand back and not answer questions straight away but give an answer to help situation…"* (25)
- After consequence and repair – don't revisit [the incident/behaviour] (6)

Themes associated with parents themselves included:

- Recognise my own triggers so as not to transfer them to the child (13,14,18,19,20,21,23,26,28) [9/30]
- *"It made me realise how much I was functioning in red and orange part of the brain…"* (1)
- *"Dealing with what I might have considered previously unreasonable behaviour"* (2)
- Be more aware how I am feeling / speak when correcting (3,4)

- Awareness and understanding of how child feels when he cannot cope/every day (4,5)
- Insight into my own attachment style, my spouses and my children (11,19)
- Remember to calm down (16)
- *"Be able to cope better with situations that arise"* (17)
- *"To look at my own attachment and my life growing up…"* (19)
- Keep in mind the high road and low road (20)
- Pause before reacting (22,25)
- How the adult and child's attachment styles work together (24)

Themes associated with the Course in general:

- Benefitting my understanding of children in care [7/30] (2,4,5,6,8,15,29)

  "All the sessions are benefiting my understanding of children in care…" (6)
- Self-awareness [10/30] (33%) (3,4,5,8,14,15,17,23,19,30)

  "Made me aware and be in touch with my feelings…" (4)

  "This topic was really good as you can help identify your triggers which in turn helps you" (23)
- Parents' impact on their children [5/30] (3,8,13,14,24,)

  "I have to recognise my triggers and step back not to transfer on to the children" (13)
- Don't ask questions (**5**)
- *"React differently to things that trigger me and to either ignore the trigger or react to it in a different manner"* (25)

What would you add to today's session?

- **Nothing** [23/30] (77%) *"Nothing its very intense*" (14)

  "Nothing it was great I learned a lot thanks a mill Susan" (19)
- **Specific requests** *"Chocolate!!"* (2)

  "I would have social workers and foster parents meet with mediations!! Or someone who will help both sides relay/discuss problems / issues" (11)
- **More time** *"Time flies, longer sessions"* (5)
- **Positive comments** *"Nice to be able to discuss situations with other "parents"* (1)

  "I thought that today's session was just right" (3)

  "Learning something new all the time" (4)

  "Nothing, it was very clear and thought provoking" (7)

  "Very informative – don't know what to add. Thank you" (10)

SoaP 5: Recap and Healing strategies

Planning

- Main focus: Repeat material already covered (coming from slightly different angles) to remind participants of the main ideas; provide opportunities to expand on anything needing clarification. (This was the last session before a 2-3 month break for groups, the purpose of recapping material was to consolidate learning for possible implementation of relevant concepts during the break)
- Parenting message: Foster parents' role in 'Healing'
- This session was still to be split into two sections, 1st half a complete overview of all 4 sessions and the 2nd half a led discussion covering the material again but sharing ideas about Healing
- Large number of slides consolidated from the 4 previous sessions and some repeated again in the Healing discussion section
- Active engagement through discussion was to be encouraged throughout
- To establish which of the sessions to date they valued most

Acting

- Began as per Session 1 with thinking about requirements for effective parenting; and went through precepts ideas one slide at a time, prompting discussions on each
- Recapped sessions 1-4 – often with one concept summarised per slide; and used now familiar pictures / images and metaphors as reminders, as well as some new photos as stimuli
- Re-emphasised how being taken into Care was an additional trauma for the foster child(ren)
- Deepened all the material, especially session 4, regarding how the parents' parenting strategies, presentation and insecure attachment styles (when tired, stressed or ill) might impact on their child(ren); and also reminding them of their own triggers
- After Break (after 39 slides); changed discussion to thinking about the same material but now in relation to possible strategies – opening floor to their suggestions (what does it look like in your child, what can you do to assist the child?); using single familiar images as reminders
- Addressed the lengthy holiday break and possible self-care strategies; presented participants with a candle to take home, to light and think of process and connections to group; that I would do the same with a larger candle, that when I lit it I would be keeping them in mind

Observations

- Had to keep momentum going and not get delayed on particular slides or in a specific area; a challenge to time presentation; keeping them engaged through appropriate use of humour
- Parents made comments showing deeper understanding
- It did feel a bit rushed to go over all the material of sessions 1-4 in an hour, but I was also aware of not dwelling too long or over-emphasising any particular aspect; and providing examples
- They seemed to like the idea of us all lighting our candles to think about the group / learning and they left the session expressing enthusiastic motivation

Reflections

- This session seemed well-timed, prior to the pre-planned break. I felt that they needed a longer period to take responsibility and try things with the material they had learned and thereafter return to the group, so that it wasn't merely a course attended, and forgotten
- Hoped that after the discussion there might be suggestions of needs for other material to cover in Session 6 & 7, however no strong themes emerged.

Comments from participants on Session 5, n=25
Name the things about today's session that stand out for you

Themes regarding the child included:

- Healing (1,13,17) *"…healing being key word…"* (17)
- Foster children respond differently to biological children (2)
- *"Dissociation - I have an understanding of it now"* (3)
- Attachment (18) / The attachment dance (4)
- Brain (20) / offline (**14**)
- Theory of mind / Broken mirror (**14**)
- *"…importance of where they came from and what went on in their lives before they came"* (18)
- *"…Reminder of all [the child] has to deal with"* (19)
- *"Understanding trauma and how the brain is at what stage"* (20)
- Psychological effects on baby before they are born (23)

Themes associated with intervention or helping the child included:

- Healing *"The whole matter of healing, practical steps to deal with behaviours eg, time in – breathing"* (**1**)
- Time in, (**1,2**) *"…Time out doesn't work…"* (2)
- Rupture and repair (2,25)
- Attachment (4, 8)

  "…Move gradually towards the child…make a child feel wanted…" (4)

  "…making a child feel safe and secure." (8)
- Foods – avoid sugar (4)
- *"…Firm consistent Clear boundaries all the time"* (25)

Themes associated with parents themselves included:

- More understanding of behaviours (5)
- Self-awareness: *"Make sure my green light is on before dealing with issues"* (6)
- Bringing everything into context **(7)**
- Knowing my triggers (**7**,12)
- Insight (9)
- Getting in tune with my child (12)
- Being aware of the highs and lows in our own lives (17)
- *"…how far myself and [my child] have come…"* (19)

- *"…learn to pause"* (22)

Themes associated with the group discussion:

- *"…realising I was not on my own"* **(7)**
- *"…Other people's views – always an insight and interesting"* (9)
- *"Learning from each other…"* (21)

Themes associated with the Course in general:

- Recap of all sessions [12/25] (8,9,10,13,14,15,16,17,19,22,24,25)

  "It was good to go back over everything again and recap" (10)

  "Connecting previous sessions together" (11)
- Healing (**1**,13) *"…we can help the healing"* (13)
- Insight into possible mistakes: *"…I can see today what I am doing wrong this week"* (21)
- Understanding: *"How we all have a little more understanding of children's behaviour"* (5)
- Getting goodies (9)
- *"Just a recap on how much behaviour is associated with the brains activity and that I need to remember that my [child] is working off line most times and its working with that and understanding him more, recognising that they have a broken image of themselves and the world around them"* (14)

How do you think today's session might benefit you?

Themes regarding the child included:

- Not to forget their trauma (7,19)

  "Use it to deal with situations better and not to forget what he has been through" (19)
- More understanding of our children (8,25) *"To understand our children in care more"* (8)
- *"Trying to read between the lines more and understand the meaning behind certain behaviours and dealing with them"* (14)
- Their triggers (7,**18**) *"Bringing everything into context, realising what were triggers, realising I was not on my own*" (7)

Themes associated with intervention or helping the child heal included:

- Different methods of dealing with different issues better [6/25] (5,6.10,11,15.19) *"Helped me see how to deal with the kids in a way that will help them without making them feel bad about themselves"* (10)

- Time in versus Time out (3,4,**6**)

  "Time in instead of time out, breathing exercise – to calm one or both of us down, repair when [the child] is calm and able to listen, acknowledge what happened and repair" (6)
- Understand and deal with attachment difficulties (13,15) *"It helped me understand a lot about attachment and how to help the kids and also what I need to do to help us as a family"* (15)
- "*Help to listen to the children and not ask too many questions and learn what triggers them and me"* (18)
- *"Not to go into it but how to stay out of the problem…"* (**21**)

Themes associated with parents themselves included:

- Better understanding of behaviours and how to cope with them (1,11,14)
- My triggers (2,7,13,**18**,25)
- High Road / Low Road (2)
- Be calmer toward the child (4,**6**)
- Repair and acknowledge what happened (**6**)
- *"…realising I'm not doing everything wrong!!"* (9)
- *"It will help me to give myself some time and not feel guilty about it"* (12)
- Knowing my own attachment (13,25)
- What I need to help us as a family (15,24)
- *"The most important thing I think is pause"* (20)
- *"Learned what I did wrong this week. Not to go into it but how to stay out of the problem, Now I have to practice"* (21)
- *"Benefit me greatly every day"* (23)

Themes associated with the group discussion:

Sharing views and ideas (9,22) "*It was great to recap on everything and to hear other people experiences"* (22)

Themes associated with the Course in general:

- Handouts (9,17)

  "The fact Susan has leaflets we bring home with us will help in different situations" (17)
- *"With the long summer ahead of us, we have help – to hopefully avoid confrontation keep safe and help the children in our care"* (16)

What would you add to today's session?

- **Nothing** [20/25]
- **Specific requests**
  - *"Maybe more ideas how to deal with certain behaviours"* (1)
  - *"More about dissociation and trauma"* (3)
  - *"More about dissociation"* (4)
- **More time**

  "More time to chat and learn from other carers and how to handle different situations" (5)
- **Positive comments**

  "Very informative" (7)

  "Nothing, everything dealt with in clear way" (8)

SoaP 6: Revision of Trauma and Attachment after the holiday break

Planning

- Main focus: Bring Course together by explaining motivation for covering the information included, from conception: Humans are resilient and behaviour is adaptive to each individual's experiences; symptoms and can be useful in identifying what might have occurred to a child, and where they might require assistance, but are not necessarily diagnostic
- Revise Attachment, Trauma and Dissociation, PTSD and flashbacks we had learned together in previous sessions before the holiday break
- Parenting message: How might you contribute toward the child's presentation and how might you assist in the healing process; focussing on an intersubjective relational, interactive view rather than "locating" the problem or solution "in" the child
- Theme: Attachment and trauma affect the Body, Brain and Mind
- At the end of the feedback form of session 6, add question about how the previous 5 sessions may have helped them

Acting

- Reminders about group agreements around confidentiality and not "bashing" the system / social work
- Used some earlier slides, esp. with images – on purpose to reiterate ideas
- Use of some slides with questions, to encourage self-reflection regarding how parents might contribute toward their children's presentations, illustrating the two way interactive processes in relationships – quite direct and somewhat provocative
- Emphasising simultaneously the importance to not take words or behaviours directed toward them 'personally' – introducing the idea of Projection/Transference where children make parents feel their (the children's) feelings or provoke responses they received from their birth-parents; as well as discussing latest research on re-enactments as perpetrators / victims to allay concerns that children automatically do to others what was done to them

Observations

- I felt the need to be very cautious not to provoke defensiveness because of the time gap from the previous session as well as the subjective nature of the content
- The positive energy of the participants who seemed to be pleased to be back re-engaging with each other and the material, the timing felt appropriate to address the parents' impact on their child(ren) in that they appeared enthusiastic to get to work and there was still another session to repair or settle them, if it was necessary, before the Course ended
- Participants seemed to relate to the ideas of Projection/Transference, and gain some relief from this new understanding

Reflections

- The ideas around projection / transference possibly need to come earlier in the Course, and for me to reiterate and deepen their understanding as the Course progresses
- A reminder that the slide about trauma effects must emphasise the order: body – brain – mind
- The broken mirror slide representing 'mind-mindedness' as a major theme could be expanded on over a number of sessions
- This session was potentially more personally challenging and provocative; so, the final session would need to be one where they feel supported and emotionally "held"

Comments from participants on Session 6, n=26
Name the things about today's session that stand out for you

Themes regarding the child included:

- Attachment (4,11,20)
- Self-image (4)
- How the brain works (12), including impact of Trauma on the brain (18)
- Triggers associated with facial expression, smell (8,9,12,13)

  "… information on how our reactions and expressions can trigger reactions" (13)

Themes associated with intervention or helping the child heal included:

- How to deal with situations (7,8)
- Provide a narrative vs asking questions (7)
- Healing requires sensitive care giving (15)
- Remember the child's needs (18)
- Ideas regarding soothing (23)

Themes associated with parents themselves included:

- Projection/transference how I end up feeling what the child is feeling [5/26] (5,14,15,16,17)
- We also impact on the children (9,10,18) *"Recapped on everything , our stuff and their stuff"* (9)
- *"Reinforcing and reminding me of all the issues these children deal with*" (10)
- *"…How our reactions and expressions can trigger their reactions"* (13)
- *"…Take myself out of situation if feeling stressed/upset with child..."* (14)
- *"…Knowing what can tick you off as a parent"* (17)
- Understanding is energising (2)

Themes associated with the group discussion:

- "*It was good to go back over that we done before Christmas and to ask about situations that have arisen since the last session"* (3)
- *"…and the fact that people are more comfortable and interact better*" (21)

Themes associated with the Course in general:

- Recap (1,3,4,9,10,11,15,17,19,20,21,22,25,26) [14/26]; FASD (15); Attachment (11,20,22); Broken Mirror (1,4); Trauma and anxiety (1,15); Fight / Flight / Freeze and Flashbacks (15)

  "…The fact we went over everything from last sessions brought back things like – soothing and comfort things…" (22)

- Projection / Transference (5,14,15,16,17)
- *"Therapy is not always good there are other ways to help child to self soothe"* (24)

"Brilliant, I feel things but sometimes can't put a finger on it. Its great today with all your insight. They are so broken the children so much pain. To hear you talk about how the children feel and how they read it. It gives me such a boost when I go home all the time" (2)

How do you think today's session might benefit you?

Themes regarding the child included:

- Understand behaviour, child's reaction (3,19)

  "I have a better understanding of why my child acts the way he does when he is angry, frustrated or destructive" (3)
- Brain development and emotional development (4)
- Observe your child (8)
- Seeing things from the child's perspective (17)
- Trauma (21)
- Child emotionally 4yrs behind chronologically (21)
- Dissociation (22)
- Bowel issues: *"…the bowel overload"* (22)

Themes associated with intervention or helping the child heal included:

- *"I really find these sessions informative, for dealing with everyday issues…"* (4)
- Ideas on how to deal with my child wetting by day (14)
- *"…To be able to bring them* [the dissociative child] *back to the 'now'…"* (22)
- *"It certainly will be very helpful to try the suggestions for [my child] with regards to sleeping"* (23)

Themes associated with parents themselves included:

- Understanding (3,16,18)

  "A better understanding of self and the trauma both child and I experienced…" (16)
- *"I think today session is to remember not to take it personal, try to stay calm"* (1)
- *"Loved it, I go home and see things so bright I get more insight"* (2)
- *"Would be relevant every day"* **(7)**
- "…identifying your own "fears" needs etc." (8)
- *"Learning more patience in dealing with everything"* (10)
- Insight into my reactions (13,19)

- Remind myself who owns what I'm feeling (20)
- *"Just to think before reacting…"* (21)

Themes associated with the group discussion: *"The great discussion between the group and the different challenges that each person faces gives us a great insight into how we are all coping and adapting to out roles as foster parents"* (26)

Themes associated with the Course in general:

- *"Revision necessary…"* (19)
- Projective Transference (5,18) *"…they are projecting/transferring their feeling onto me/us"* (18)
- Precept: Child as emotionally 4 years behind chronological age (21)
- "Great to be back learning about our kids the way they look at stuff" (9)
- Empowerment: *"I will most likely take more of a role in what's best for the kids when it comes to outside help"* (24)
- *"Huge – so beneficial – the advice is so helpful going forward, I as a foster parent feel I needed the advice today, thank you"* (15)
- *"Would be relevant every day"* (7)

What would you add to today's session?

- **Nothing** [21/26]

  "Nothing I was very happy with the way the meeting went and I felt it was very helpful to me with regards [my child]" (5)

- **Specific requests**
  - *"I would like to know how to deal with behaviour when he hits me*" (1)
  - *"Could we have more, transference / projection"* (3)
- **More time** [2/26]

  "More time as it is so beneficial to the way we think about the kids feelings" (4)

- **Positive comments**

  "I would like to thank you Susan for all your help" (7)

  "Can't think of anything – well done Susan" (10)

SoaP 7: Stress / Compassion Fatigue / Vicarious Trauma / Burnout / Self-Care

Planning

- Main focus: Parenting foster children is stressful and requires time out and self-care
- Theme: Keeping Siegel's Attachment philosophy in mind (individuals need to be "safe, seen, soothed and secure"), parents need to recognise that they can be stressed (not necessarily caused by their own material), however by strengthening themselves they will cope better
- Parenting message: You can only parent these children if you mind yourself. Aeroplane metaphor: put your own oxygen mask on first before trying to assist anyone else
- Reduced the number of slides because of focus and time for closure needed
- No reflective half of the session planned, since final session of Course – need time for ending
- Prepare final handout of 12 selected slides on two-page format that could be placed on fridge
- Produce final session evaluation form to accompany the post-group measures for participants to complete and return in envelope provided prior to an individual meeting at a later date

Acting

- Reminders
- Used previous slides of the brain (green/orange/red) and bodily stress response to remind about the way that stress involving fight, flight, freeze responses and how these can be experienced by the participants themselves; sometimes mirroring the child's state
- Introduced ideas of compassion fatigue and vicarious trauma, which may lead to burnout
- Symptoms of burnout described – to enable participants to recognise it in themselves
- Discussion regarding self-care as caring people – different ways to look after themselves; emphasising practical, psychological, social and spiritual/philosophical considerations

Observations

- The Siegel idea referred to in planning (above) recurred in the sessions, but needs to be reiterated and perhaps used on earlier slides in sessions
- The framing of the final four slides was about giving themselves permission to care for themselves
- I felt surprised at their energy, the topic seemed to catch their attention; they clearly needed this material and it seems that they seldom, if ever, receive this sort of input
- Wanted to provide handout that would not just be filed away, but could be referred to often, but feel unsure of its usefulness now
- Sense of sadness and disappointment that the Course was complete from both participants and myself, although I also felt relief to have provided what I had in such a short time frame

Reflections

- There were requests for continued support, and I wonder what that might look like as I was unable facilitate this in my work role
- The system does not promote peer support of foster parents due to confidentiality concerns, but it seemed that connections between people had been made and there were possibilities of such groups being promoted, but this would need to be done in benign environments
- Alternately perhaps using existing opportunities for mindfulness / yoga / ways of caring for themselves for foster carers, rather than predominantly child-focussed trainings
- It is important to plan for participants to complete all post group questionnaires after last session, rather than these being taken away, due to reduced response rate when asked to return at later date

Comments from participants on Session 7, n=27
Name the things about today's session that stand out for you

Themes regarding the child included:

- Impact of stress on children (14,15) *"Stress – the impact it has on our life and on the children"* (14)
- Impact of decisions on children (16)
- *"Going back over the brain and how it functions, in "normal" and "foster" children and our own…"* (25)

Themes associated with intervention or helping the child included:

- How to deal with the stress of our child (19)
- Saying no sensitively and appropriately helps the child in later life (23)

Themes associated with parents themselves included:

- Self-care [15/27] (1,**2**,5,6,7,9,10,11,18,19,20,21,23,25,26)
  "Looking after yourself, time out to exercise and rest, connect with others" (10)
- For example, taking time for myself / time out [11/27] (3,4,5.9,**10**,14,16,19,20,25,27) *"Hearing about burnout and that we need to stand back and take some time out for ourselves"* (27)
- *"Look after myself better, go and do things as a couple and not feel guilty"* (2)
- The effect of stress physically and psychologically (4,21)
- Knowledge: *"…Loving all the knowledge the group brings every week"* (7)
- *"…I have a better understanding of the damaged mind of any fostered child past & present"* (8)
- Recap (3,9) *"…A recap of "issues" that we face every day"* (9)
- Try not get stressed, to avoid burnout (11,18,22) *"…stay calm - keep on the high road…"* (22)
- Be aware of our triggers (11,21)
- Recognise impact of stress (in self and for families) [5/27] (14,15,16,17,26)
  "Stress- how to recognise the symptoms – on ourselves and our family" (17)
- Children respond to how we are feeling (16)
- Self-awareness (22) *"…and be able to ask for help"* (21)

Themes associated with the group discussion:

- Discussion with facilitator and other foster-parents (3,24)
  "The information from Susan and the attending foster parents were very beneficial" (24)
- Difficulties associated with self-care e.g., who looks after the children (5)

Themes associated with the Course in general:

- Looking after myself benefits the child [6/27] (1,6,9,11,**22**,23,)

  "Looking after ourselves, we can't help to heal if we are not well ourselves …" (23)

  "Just to be more aware of taking care and making time for ourselves as parents, and how this will benefit the children in the long term" (1)

- Stress, Compassion, fatigue, vicarious trauma, burn out, (13,**18**,26)
- Work/Play/Pause (**18**)
- Cyclical/mutual impact of stress (ours and theirs) (14,15,22)
- Self-awareness: *"Study form – yours and theirs, try to keep on the high road – stay calm, the body is a great indicator of the goings on in our lives"* (22)
- Insight: (12,18) *"Everybody experiences difficulties when working with and rearing children"* (12)

  "Stress – how it impacts on our bodies – v similar to children in care, self-care. Know triggers and limitations. Work play pause. Prevent burn out - awareness of signs" (18)

How do you think today's session might benefit you?

Themes regarding the child included:

- *"We're very similar to our children i.e. stress…"* (15)
- Knowing that children struggle to control their reactions (21,23)

  "…knowing that children can't control their reactions as they are usually in red zone" (21)

Themes associated with intervention or helping the child included:

- How to deal with different situations (**14**,**23**)
- Take time, think and respond with knowledge (6,13,20)

  "Stand back and review situation before acting or replying" (6)

Themes associated with parents themselves included:

- Self-care [7/27] (1,5,9,10,13,15,20) *"Learning to look after myself and signs of stress"* (9)
- Take time out [6/27] (3,7,8,17,18,20) *"Help me to recognise if I need time out or a break or help…"* (18)
- Be aware of my stress levels (9,5) *"I need to look at my stress levels and do something on a daily basis but mostly when I hit a bump on the road"* (5)

  "*Be more conscious of my own triggers…*" (8)

- Doing something for myself feels good (4)
- Not selfish taking time for myself (3,10)

  "I feel positive about taking time out and not to feel torn or guilty." (10)

- Acknowledgement of burnout *"In every way, I have been burned out…"* (4)
- Meet others not involved in fostering (10)
- Awareness, including complexity of what we are dealing with (12)

  "…today brings awareness of effects of stress" (15)
- Mindfulness (16)
- Get help when needed (17,18)

Themes associated with the group discussion:

"…listening to each other's stories and how to deal with different situations" (23)

Themes associated with the Course in general:

- Difficulty not having family to fall back on like one would have in a biological situation (4)
- Need to mind myself in order to be able to mind them (13,16,17)

  "It has reminded me that I have to look after myself as well as the children in our care…" (16)
- *"…Work, Play, Pause"* (15)
- *"Learning something new every day on how to cope and deal with different situations that may arise"* (14)
- Confidence (22,23)

  "As a foster parent it gave me confidence and tools to deal with situations and going forward what to do" (22)

What would you add to today's session?

- **Nothing** [19/27] *"Nothing at the moment"* (1)
- **Specific requests**
  - *"I think you should consider having sessions with children*" (5)
  - *"Stress levels on other kids in household"* (8)
  - *"More discussion…"* (7)
- **More time**

  More sessions. [2/13] *"Another session and another and another, more!"* (11)
- **Positive comments**

  "Thank you, Susan – well done, and we are all brilliant now take care" (10)

  "A great big thank you" (12)

  "It was great to be able to talk to the group because they understand you. Thank you so much Susan" (13)

Is there any other group of people/professionals that you think would benefit from today's information?

Responses below have been classified according to 3 broad categories and the responses have been ordered broadly within those. The most numerous responses were then ranked 1-10 based on the number of responses (these are noted in square brackets); followed by number of sessions in which they were recorded.

Table 3

Summary of Participant's Responses to Question 4, across the sessions

HSE/TUSLA	EDUCATION	MISCELLANEOUS
Social Workers [72] 7/7	Teachers [71] 7/7	Anybody who works with children in care [15] 5/7
All foster parents [33] 7/7	SNA's [5] 5/7	Anyone involved with children [11] 5/7
Families of foster parents incl. Husbands and children [10] 4/7	Schools [12] 6/7	Sports coaches [3] 2/7
People thinking of fostering or adopting	Trainee Teachers	G.P.s [3] 2/7
Training for foster carers [2] 1/7	Principals (especially)	Occupational Therapist
Adopters	Crèche owners/ workers [6] 3/7 sessions	Therapists
Child Care Workers [3] 3/7		Play therapists
HSE Early Intervention teams [4] 4/7		Judges [8] 5/7
Biological Parents / Family of children in care [8] 4/7		*Guardian ad litem* [4] 4/7
Family Support Workers		Students at school [3] 3/7
Health Care Workers		Teenagers 14-18
Anyone involved in fostering or adoption		Girls aged 16-18
Everyone in the Care system [2] 1/7		All pre marriage couples
The children themselves		Young people before they start a family
		Politicians
		Everyone[3] 3/7

Comments associated with question about professionals who should attend the sessions

Session 1. *The role of parenting, prenatal development, especially FASD* (n=33)

- **Teachers** [15/33] *The teacher would benefit greatly with this information to be able to deal with the children and learn to understand their behaviour"* (20)

  "…to understand the child – to understand he's not the same he's very different." (18)

- **Social Workers** [10/33] *"I believe that SW could benefit from the day it would definitely give them a greater understanding of my [children] and others like them"* (7)
  "Social workers they don't fully understand what's going on in our home, don't comprehend behaviours" (30)
- **Girls aged 16-18** *"…girls 16-18yrs about harm with drink and drugs even prescribed drugs do to unborn babies"* (30)

Session 2. ***From Birth through Childhood: Birth / Attachment / Theory of Mind*** (n=27)

- **Foster parents** [10/27] *"Foster parents could do with a top up of this info every so often*" (1)
  "All carers should be advised strongly to attend these meetings (22)
- **Schools** [3/27] *"…the schools should have more information on attachment issues"* (15)
- **Everybody** *"…everybody would benefit knowing this information"* (12)

Session 3. ***Trauma and Dissociation including Post-Traumatic Stress*** (n=27)

- *"Legal professionals – Judges, also teachers/ foster parents also, Politicians"* (24)
- *"All parents, school and teachers should definitely have this information to help assist these children"* (27)

Session 4. ***Adult Attachment and Healing Attachment. Respondents*** (n=23)

- **Social workers** [7/23] *"Social workers so they can maybe learn and read different triggers in children*" (14)
- **Biological parents of children in care** [4/23] *"Would love natural parents to do some training and see the effects the children get from life"* (15)
- **Training for foster carers** [2/23]
  "…a slight bit of information would be good during the [foster parent training] course" (11)

Session 5. ***Recap and Healing strategies*** (n=20)

- **Teachers** [13/20] *"Teachers need to know more about attachment issues and they can affect the child's behaviours greatly"* (12)
- *"As before young people before they start family be aware of drink, drugs including prescribed drugs can do to unborn baby"* (15)

Session 6. Recap after break - *Attachment and Trauma / Projection-Transference* (n=21)

- **Teachers and Crèches** *"Teachers and crèches working with children on a daily basis should definitely attend this course*" (19)
- **Foster /adopted parents** [3/21] *"All foster carers"* (12)

  "foster parents recap as a group once or twice a year – optimistic but it would be so helpful if this could happen" (16)

  "I would love a group like this once a month with a professional" (2)
- **Children of foster parents** [2/21] – *"…a child friendly version of this"* (13)
- *"All students before leaving school, should have knowledge of unborn baby – with substances, medication – food"* (18)

Session 7. *Stress / Compassion Fatigue / Vicarious Trauma / Burnout / Self-Care* (n=21)

- **Social Workers** [12/21] *"Social workers need this probably once a week so as they don't become desensitised*" (18)
- **All groups and people who work with fostered children** [5/21]

  "Anyone and everyone who deals in fostering children, from doctors to social workers and parents" (20)
- **Parents of children in Care** [2/21] *"…To see the impact a bad visit or access can have on kids"* (14)

7.5 Summary

The purpose of Chapter 7 was to present the data related to Research Question 3 (summarised first below) and then the themes provided by the participants relating to Research Question 4.

> Q.3. What were the elements used to develop a Developmental, Trauma and Attachment based intervention for foster parents, and how did it unfold?

The chapter therefore provided sessional summaries in the form of SoaPs of the creation of the content and implementation process of the seven group sessions, consolidating the collective themes over the 6 groups of participants. Important elements that were achieved included following a developmental trajectory in order for participants to gain an understanding of the difficulties foster children may experience at different times in their development, including from before they are born, up until and including coming into a foster placement.

Structural and functional elements that allowed the participation and interaction of group members included, that groups were closed, so participants got to know fellow foster parents and a level of comfort and safety developed as groups were confidential and people were encouraged to

share their experiences of fostering. Sessions were held at the same time each week, in the same place and for the same time-period, which provided predictability. The groups were strongly discouraged and were reminded regularly to avoid the topic of Tusla and social services. It was explained that it could be both potentially distracting and was unfair to discuss individual professionals who were not present to defend themselves.

Timing of material presented the biggest challenge. Presenting information that followed a developmental trajectory from prenatal development, through childhood and adolescence, enabled the portrayal of the cumulative effects and diagnostic difficulties associated with the child's experience of multiple types of adversity. However, the reason for originally choosing the format was to initially focus on the child and their difficulties and then when participants were more familiar with each other and the format, and were hopefully more trusting of the facilitator, turned the focus toward the foster parents. This timing was to allow them to assess the impact of their own attachment and life experiences from where their own relational and parenting style might have evolved; and to see how that might impact their foster child. The dual effect of understanding the child and themselves better would thereby potentially provide an environment in which the parents through their self-awareness could become more effective in adjusting their responses to the children's mostly maladaptive coping strategies seen in their behaviour.

Q.4: What were the foster parents' responses to, and experiences of, a small group psycho-education and reflective intervention?

The participants' responses illustrate a number of themes of both their learning and implementing of the information learned, discussed and reflected upon during each session. These included the "Precepts of parenting foster children" (see Appendix D, Session 1 Slides), the pertinent themes of each session and how these affected their child(ren) or themselves, their learning from each other in the discussion section. There was also a sense of increasing knowledge, understanding and hope expressed along with empowerment and some feeling more energised. These responses have been further summarised along with participants' suggestions for other groups of people who would benefit from sessions or the Course as a whole, in the following chapter.

8. SUMMARY OF OUTCOMES OF THE INTERVENTION AND POST-COURSE EVALUATION

Chapter 7 integrated the data by providing the SoaPs and the comments of participants after each session. This chapter is more summative and illustrates overall evaluative comment themes, by session (blank version of questionnaire may be found in Appendix E). It includes a graph illustrating the participants' top ranked session preferences mid-Course, which they were asked to complete at the end of session 5, before the break. These are followed by a graphically represented summary of the question they were asked after each session, about how much they felt they had learned in the session. The next subsections contain a table ranking and summarising the data from Chapter 7 regarding which professionals participants believe would benefit from each session; as well as a summary of the data regarding what they felt could be added to each session.

The tables that follow summarises all participants responses from each session in two columns representing the questions, Name the things about today's session that stand out for you? (left) and How do you think today's session might benefit you? (right). Although these questions sound very similar, the intention behind them was to firstly find out what had made an impact from the material; and secondly, establish what participants felt they could utilise from the sessions in their everyday lives. Another objective was to reinforce the information that each individual had learned during the session, by having to think about what they had learned and write it down. The summarised responses were thematically grouped according to: information related to the child; the intervention (how the parent might understand or respond differently that could lead to healing in the child); the parent (what they learned about themselves); group (what they learned from each other) and the Course (the main themes associated with the session). After the summary for session 5, a graph has been inserted, illustrating the findings of an extra question, before the holiday break, about which sessions participants had preferred. This would provide information on which sessions were more useful or had made more of an impression.

The second half of the chapter contains the data obtained from a final Course evaluation questionnaire (blank version of questionnaire may be found in Appendix F), which respondents were asked to complete at the end of the Course, when they submitted their other post-Course quantitative questionnaires. These questionnaires sought to gather participants' opinions about the structure and content of the small group format. There were also questions regarding fostering in general, especially related to the stress of fostering and participants were asked what might be helpful to alleviate that stress. The final question asked whether participants would recommend the Course to others. As with the data in Chapter 7, many of the responses have been included in order for the voices of the participants to be represented here.

8.1 Summary of post-session questionnaires

Session 1 **Child:** FASD in children; not always visible; associated behavioural issues; consequences of a poor womb environment; impact on the brain	**Session 1** ***Child:*** *Behaviour is communication; what might be behind the child's behaviour; some behaviours occur for no reason at all; need to check for symptoms of FASD*
Intervention: Work on what is currently arising behaviourally; treat the child as normally as possible; simplify instructions; use repetition	***Intervention:*** *Childs behaviour and mood not within their control but rather a bodily response to stress; ways of dealing with behaviours e.g. being firm / boundaries; listening to what they are actually saying; deal with difficulties as they arise; keep instructions short; never ask the question, "why?"*
Parent: We need to recognise their style/needs and adjust accordingly; identify and acknowledge my triggers	***Parent:*** *More patience / understanding / empathy / insight regarding our children; parents reaction impacts the child; stop and think; see the problem from the child's perspective; think more about what is happening and why; slow down and remember where behaviour originates; confidence to deal with situations differently; it is ok when the child is upset; change how I plan activities; be more aware of behaviours daily*
Group Similarity of experiences with difficulties; hearing other opinions; people sharing	***Group:*** *Sharing our issues and getting feedback from other foster parents and facilitator; group discussion provided examples of different behaviours; learning different techniques that other people use*
Course: Behaviour as communication/ similarity between FASD and other possible diagnoses eg ADHD and ASD; Precepts: parent younger and parent differently; PowerPoint, visuals, video clip and other teaching strategies made an impact, Psychoeducational section led to interesting discussion; Information relevant to participants' situation	***Course:*** *Seeing the situation from the child's perspective; answers some of my questions regarding behaviour; practical information to use at home; information/knowledge that might be useful in the future*

Session 2 **Child:** Attachment; styles and presentation; evolutionary basis of survival and nurture; Theory of Mind/self and other perception	**Session 2** ***Child:*** *Behaviour associated with attachment difficulties and what behaviours represent, control / rejection; recognise child's diagnosis / difficulties; understand child's attachment style; and how child is feeling, how they perceive themselves, us and reality; what child went through before they came into Care; child reacts to parent based on how parent communicates with them, tone of voice / facial features*
Intervention: Parents responsibility to calm the child; being consistent and having boundaries; establish trust; repair; acceptance; healing a child takes patience; be cautious with praise	***Intervention:*** *Learning about attachment behaviour gives me a better understanding of my child's needs and how to nurture them; hope to see more of what the child is really trying to say with their actions and react in a more positive way; be in the moment with the child; limit the number of options you give; avoid saying don't and no; show them no matter what they throw at us we are always there for them always.*
Parent: Seeing yourself as the child might see you; importance of managing our behaviour and reactions; how we trigger reactions [in the children]; we can improve our parenting by knowing about Attachment; understanding Attachment can have a positive impact on relationship	***Parent:*** *Be calm; connect with my child; better able to recognise symptoms and how to deal with problems/issues I didn't understand previously; more aware of my child's needs, insecurities and fears; aware of what child has been through; learning how to cope. re-evaluate and change how I do things at home; learning how to nurture attachment; sensitive caregiving is the formation of attachment.*
Group: Learn from others as we talk; all dealing with different issues; discussion good	***Group:*** *Knowing others have been through similar situations; you're not alone; discussions after presentation very helpful providing a wide range of examples; pick up lots of small points relevant to everyday problems we encounter*
Course: Understanding of Attachment; Theory of Mind broken mirror visual, Still Face Experiment clip, Clingy monkey visuals made an impact; PowerPoint explanation made sense; parents' role in healing the child; behaviour as connection rather than attention seeking; Precept: Parent your child 4 years younger	***Course:*** *Understanding Attachment; especially with regard to child's presentation and behaviour; techniques and ideas regarding attachment behaviours that can be used at home. Greater awareness of the experiences a child has been through; adapt our responses to the child.*

Session 3 **Child:** Trauma, Dissociation, PTSD and flashbacks; Understanding how much it affects children, including the impact on memory; the 3 areas of the brain and the disconnection of the logical part of the brain when stressed and/or dysregulated; can see the chemical response in the eyes; leads to sugar cravings; trauma can be caused by coming into Care; however bad it was in their homes of origin, there is always a draw to go back	**Session 3** ***Child:*** *Better understanding of trauma / triggers / flashbacks; especially foster child's responses/behaviour associated with these; how the brain works especially after experiencing traumatic events; may result in dissociation as an adaptive response; how the frontal lobe is not online when these children experience stress; impact of trauma ongoing; greater understanding of child's perspective; need to prepare these children for transitions / change; the body is affected by trauma*
Intervention: Increased understanding – of trauma and what can trigger memories; and how the child thinks so differently	***Intervention:*** *Recognise symptoms of trauma and dissociation and use methods learned to deal with same; try to understand how child is feeling and how to respond more appropriately; pause and think before reacting to the child; be more patient; cut down on sugar*
Parent: Can see the result of trauma in my children; not to take things personally; not to blame yourself for child's fear, try to help	***Parent:*** *The session explained what I deal with daily; being able to recognise the symptoms of trauma and dissociation; need to be patient / calm / more relaxed when dealing with my child; see their behaviours differently, therefore perceive the child more positively; understand how they manage to push my buttons especially their negative reactions toward me, which is associated with what they experienced prior to coming into Care; helps to have an explanation to explain to my family why a child with PTSD reacts in certain ways.*
Group: Discussion at the end jogs your mind and relates the Course to your own situation with the foster children in your care	***Group:*** *(no comments regarding discussion) may be because the material was very heavy and lots stood out*
Course: Don't take things personally Participants reported having enjoyed the session, developing increased understanding, finding it interesting and very good. A few responses indicated that there was "a lot to take on" and that it was "very intense", which considering the topic and the content were not surprising responses.	***Course:*** *Word 'Understand(ing)' used in nearly 50% of responses; increased awareness of origins and reasons for behaviour; how to deal with behaviours in a different way than with biological children who haven't experienced trauma; message: not to take things personally* *Precept: Parent foster children differently to biological kids*

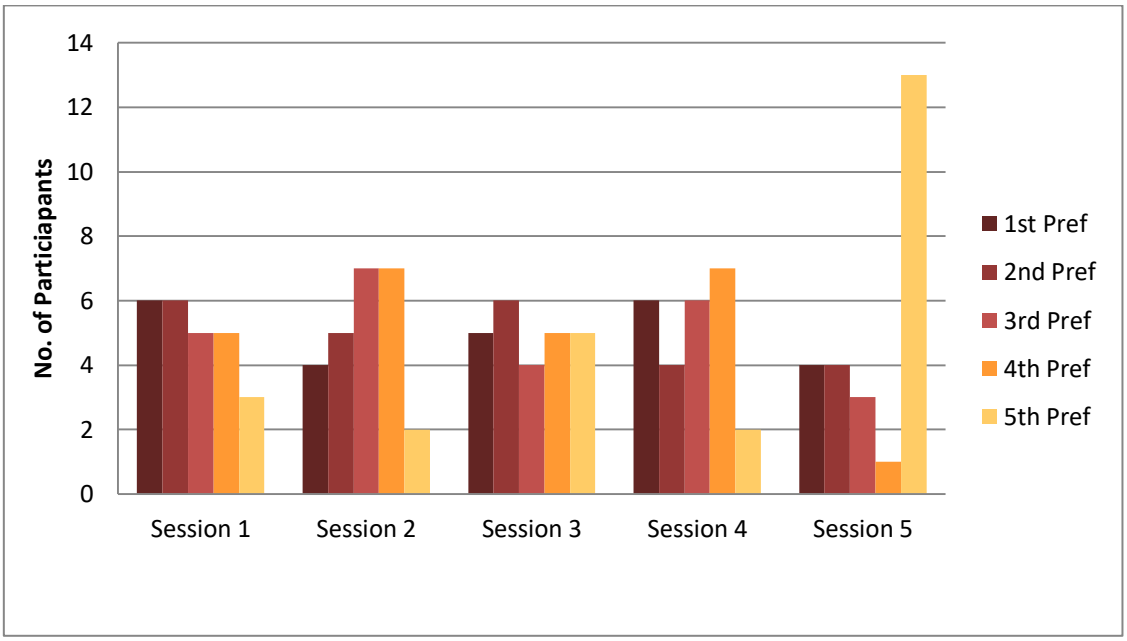
Session 4 **Child:** Their triggers; how the brain works; realising the reasons behind their behaviours	**Session 4** ***Child:*** *Awareness of how a child feels when they are fearful and cannot cope with a situation; ideas about what triggers a child's reactions; when a child is stressed and / or fearful their brain is not working properly*
Intervention: Rupture and repair, we need to recognise what went wrong in the situation and repair ruptures; address issue only when it is over and everyone is calm; when talking with children try and understand their feelings; not necessary or advisable to answer or to react immediately; be careful not to shame the children	***Intervention:*** *Ideas on how to cope with triggered behaviours; remember not to shame the child; Identify where I am at emotionally when child is dysregulated (my emotional status / presentation affects the child); do not ask questions; Timing - intervening whilst child in fight / flight /dissociate more likely to escalate situation; reflect briefly on what happened/ consequences after child's calmed down; Rupture & Repair: it's the adult's responsibility to repair ruptures, not the child's; No need to answer questions immediately, provide response that allows time to think*
Parent: Know your triggers; the High Road - Low Road regarding emotions and conflict; Different areas of the brain – relate the different areas (previously learned) to ourselves; Our own attachment style; How the way we were parented impacts on the way we parent; What I can do to handle situations differently; Communicate calmly and use repetition; Start with myself, recognise past issues and how I am feeling today and how to react to the children, keeping in mind my mood and my triggers	***Parent:*** *Recognise my own triggers so as not to escalate and increase the children's stress; be aware how I am feeling (tone of voice) when correcting the child; realisation that I also function in red and orange part of the brain; need to look at my own attachment style and my life growing up; the parent and child's attachment styles work together; awareness of how child feels when he cannot cope; remember to calm down; keep High and Low road in mind; pause before reacting; now able to deal with what I might have previously considered unreasonable behaviour.*
Course: Adult attachment and how we were parented Findings in how we parent. Participants commented on the topic of Adult attachment and the brain, that they found it interesting and were learning a lot and that they found it intense and thought provoking. Acknowledged that they contribute toward healing the child	***Course:*** *Benefits my understanding of children in Care; Session continued to provide insight into the children's presentations; but moved toward the participants' gaining more self-awareness; including how they themselves affect their children; 2 important messages: identify your own triggers to be able to respond in a more enlightened way; and, "Don't ask the child questions!"*

Session 5 (Review) **Child:** Psychological effects on baby before they are born; foster children respond differently in comparison to biological children; Attachment; The Attachment Dance; Theory of mind (Broken mirror); Understanding Trauma and Dissociation; how the brain is functioning at what stage; when the brain is on and offline; Child's past affects their current presentation; keep in mind all the child has had to deal with.	**Session 5** ***Child:*** *Have more understanding of our children in Care; must not forget what they have been through in their lives including their trauma; use that information to understanding the meaning behind their behaviour, their triggers, and to assist me in how I respond to them*
Intervention: Healing the child; practical steps to deal with behaviours e.g., Time In vs Time Out, breathing together; food, avoid sugar; Attachment, move gradually towards the child; make a child feel wanted; make a child feel safe and secure; repair after rupture; Precept: Have firm consistent, clear boundaries all the time	***Intervention:*** *Different methods of dealing better with different issues; try not to shame child; try to not go into the problem and remain adult; use Time-in versus Time-out, breathing exercises (to calm both of us down); repair when child's calm and able to hear; acknowledge what happened and repair; Understanding, and how to deal with attachment difficulties; listen rather than ask questions; learn what triggers them and me*
Parent: More understanding of children's behaviours; insight; self-awareness; knowing my triggers, learn to pause; being aware of the highs and lows in our own lives; getting in tune with my child; information brings everything into context; realising how far myself and [my child] have come	***Parent:*** *Better understanding of child's behaviours and how to cope with them; The information benefits me greatly every day / provides what I need to help us as a family; identify my triggers; understand my own attachment style; know when I'm on the High or Low Road; repair ruptures, explain/ acknowledge what happened; be calmer toward the child; pause before responding / reacting; able to identify what I might be doing wrong and try something else*
Course: Recap 4 previous sessions; connecting previous sessions together; bringing everything into context; behaviour result of the brain's activity; foster children often off-line; more understanding of our children and their behaviours; recognising their broken image of themselves and the world around them; foster parents can help child's healing; practical steps to deal with behaviours; Insight into my triggers; realising I am not on my own	***Course:*** *Recap of all 4 previous sessions for learning purposes; handouts to provide reminders over the summer break* *Confidence: "…realising I'm not doing everything wrong!!"*

The graph that follows illustrates the participants expressed preferences for the sessions that they had attended up until that time, which was just before the holiday break. The key that follows are the percentage amount of top three preferences participants allocated to each session.

Figure 17

Participant's session preference recorded after session 5 (n=25)



Session	Session Theme	Top 3 preferences
Session 1	Conception to birth including FASD	17/25 (68%)
Session 2	Birth through Childhood including Attachment	16/25 (64%)
Session 3	Trauma and Dissociation including PTSD	14/25 (56%)
Session 4	Adult Attachment including Triggers/Rupture & Repair	16/25 (64%)
Session 5	Recap of sessions and Healing	11/25 (44%)

Note. Data are recorded from left (1st preference – darkest colour) to right (5th Preference – lightest colour)

Findings

Findings illustrated in Figure 17 show that preferences were fairly evenly clustered into Sessions 1 – 4, with session 5 receiving the most 5th preferences. Analysing participants' top 3 preferences, illustrates that Session 1 was the most popular and that Sessions 2 and 4 were ranked second, with sessions 1 and 4 receiving the highest number of 1st preferences. The session that gained the least number of top 3 preferences, as well as the highest number of 5th preference votes, was Session 5, which provided participants with a recap of all the information that had previously been covered in sessions 1 – 4, as well as covering possible healing strategies.

Session 6 **Child:** Attachment including the child's self-image; how the brain works, including impact of trauma on the brain, and what might be a trigger for a child such as our reactions, facial expression and different smells	**Session 6** ***Child:*** *Understand behaviour; child's reaction, especially angry / frustrated / destructive; brain development and emotional development; Trauma and Dissociation; bowel issues associated with PTSD; observe your child; see things from the child's perspective; Precept: Child emotionally 4yrs behind chronologically*
Intervention: Provide child with an explanation rather than asking questions; remember the child's needs; healing requires sensitive caregiving; ideas regarding soothing	***Intervention:*** *Find these sessions informative for dealing with everyday issues; practical ideas to deal with issues such as wetting by day, sleeping; being able to bring a dissociative child back to the here and now.*
Parent: Projection/transference how I end up feeling what the child is feeling; how we also impact on them ("*our reactions and expressions can trigger their reactions");* How to deal with situations; knowing what can irritate me as a parent; take myself out of the situation if feeling stressed/upset with child; reinforcing/ reminding me of all the issues these children have to deal with; Understanding is energising	***Parent:*** *A better understanding of myself and the trauma both my foster child and I have experienced; need to identify your own "fears" needs etc.; remember not to take the child's reaction personally; to think before reacting; and try to stay calm; have more insight into my reactions; and learning more patience in dealing with everything; need to remind myself who owns what I am feeling; information relevant every day and see things more positively when I go home due to gaining more insight*
Group: Discussion about issues that had arisen over the break; people appear more comfortable and interact better	***Group:*** *The discussion illustrates the different challenges that each person faces and gives us great insight into how we are all coping and adapting to our roles as foster parents.*
Course: Recap of FASD, Attachment (Broken Mirror, Projection/Transference) and trauma (Fight/Flight/Freeze, Flashbacks, Anxiety) The idea that individual Therapy not necessarily the best option for foster children was introduced	***Course:*** *Responses indicated participants were glad to be back learning about their children; revision necessary; advice helpful to foster parents; relevant every day. Projective Transference: projecting / transferring their feeling onto me / us. Empowerment: A participant indicated that they would take more of a role in relation to what was best for their children regarding outside services.*

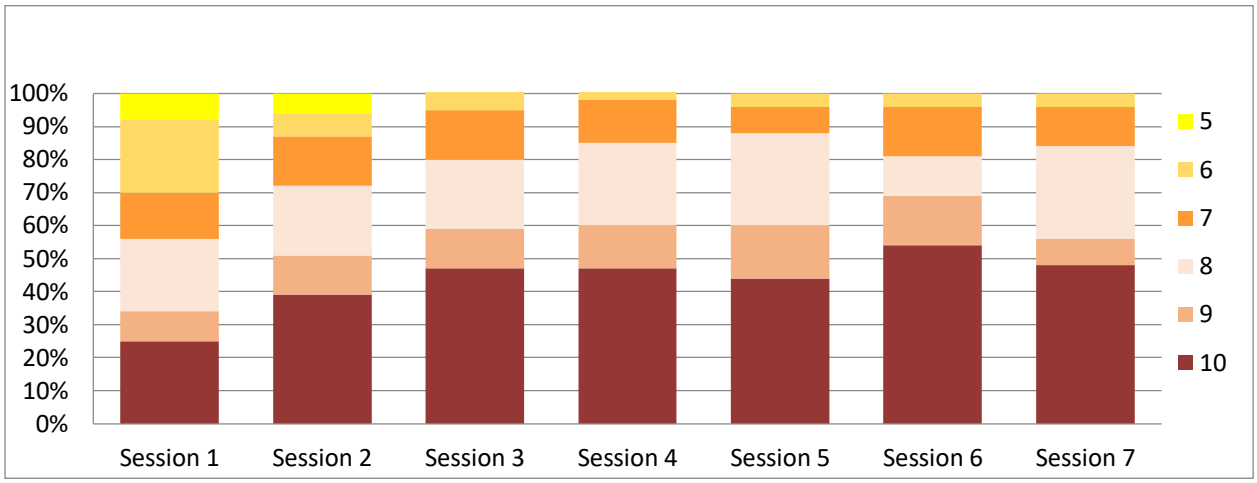
Session 7 **Child:** Impact of stress on our life and on the children; how the brain functions: biological children vs foster children; impact of decisions that are made on the children **Intervention:** Saying no sensitively and appropriately helps the child in later life; how to deal with the stress of our child **Parent:** Recap of issues that parents' face every day; the effect of stress psychologically and physically; try not to get stressed as a way of avoiding burnout; be aware of our triggers; recognise stress (in ourselves and our families) and don't let it increase; self-awareness; learn how to ask for help; self-care; taking time for myself/timeout; Look after myself better, go and do things as a couple and not feel guilty; Impact of stress on your family, your children and yourself **Group:** Discussion with facilitator and other foster parents was beneficial; discussion included difficulties associated with self-care e.g. who looks after the children; Insight that everybody experiences difficulties when working with and rearing foster children **Course:** Stress, Compassion, fatigue, vicarious trauma, burn out; How stress impacts our bodies; Cyclical/mutual impact of stress (our and theirs); Work/Play/Pause Looking after myself benefits the child; children respond to how we are feeling (16) Growth: Now I see how much my child and I have both come on; Self-awareness: being aware of how I feel, and how they are feeing – the body indicates what is going on in our lives; Knowledge: Love all the knowledge the group brings every week; Understanding: I feel I have a better understanding of the damaged mind of any of the children I have fostered.	**Session 7** ***Child:*** *We are similar to our children with regard to stress; Knowing that children who have experienced trauma cannot control their reactions* ***Intervention:*** *Take time, review the situation, think, and then respond with knowledge.* ***Parent:*** *Main theme: Self-care; be aware of my triggers and stress levels; the effects of stress on mind and body; take time out; not selfish taking time for myself; doing something for myself feels good; meet others not involved in fostering; mindfulness; get help when needed* *Awareness of the complexity of the children and what we are dealing with on a daily basis; acknowledgement of burnout* ***Group:*** *listening to each other's stories and how to deal with different situations* ***Course:*** *Need to mind myself in order to be able to mind my children in care;* *Mantra: Work, Play, Pause.* *Learning something new every session on how to cope and deal with different situations that may arise.* *Confidence and tools to deal with situations; going forward into the future* *Difficulty not having family to fall back on like one would have in a biological situation*

How much did you learn today?

This Question was included in all the post-Session questionnaire as an evaluation to establish how much participants felt they had learned during each particular session. A Likert scale was used so that respondents just had to mark on the scale between 1-10 (see Appendix E). Figure 18 below summarises the responses from each of the 7 sessions.

Figure 18

Participant responses regarding amount learned during each session



Note. Data were converted to percentages as the number of feedback questionnaires differed between sessions. Most learned (10/10) is represented from the horizontal axis in the dark red colour upwards to the least amount learned (5/10) in yellow. No participants indicated that they had learned less than 5/10 in any of the sessions, Findings were therefore only illustrated from 5/10 to 10/10.

Classifying 8 to 10 as Large [amount learned], Findings over the 7 sessions illustrated the following pattern in Figure 18., Session 1: 56%, Session 2: 72%, Session 3: 80%, Session 4: 85%, Session 5: 88%, Session 6: 81%, Session 7: 84%. This pattern shows an increase in the amount participants reported they learned from the first two sessions with a levelling off in the 80% range. The broader spread of responses indicating the least amount learned in Sessions 1 and 2, might also illustrate that despite being prepared by means of the introduction, that participants' expectations to be provided with solutions to behavioural problems and the format of the Course were at odds. Alternatively, they may have settled into the format as time went on and became more comfortable with the different style of learning, as it became more familiar.

Is there any other group of people/professionals that you think would benefit from today's information?

Table 4

Groups of professionals that participants felt would benefit from different sessions

Rank	Professional Group	Total Responses	No. of sessions mentioned	Sessions not mentioned
1.	Social Workers	72	7/7	
2.	Teachers	71	7/7	
3.	All foster parents	33	7/7	
4.	Anybody who works with children in Care	15	5/7	1 & 4
5.	Schools	12	6/7	5
6.	Anyone involved with children	11	5/7	2 & 7
7.	Judges	8	5/7	1 & 2
8.	SNA's	5	5/7	4 & 5
9.	Biological Parents / Family of children in Care	8	4/7	1,6 & 7
10.	GALs	4	4/7	1,2 & 6
10.	HSE Early Intervention teams	4	4/7	4,5 & 7

Note: Data are ranked from highest to lowest according to the people or groups of people foster parents reported would benefit from the different sessions of the Course. Total Responses represents the number of times participants stated the individual or group would benefit, No. of sessions mentioned is how many sessions this individual/group were mentioned and the last category illustrates the sessions that individual/group were not mentioned.

Findings

These data in Table 4 represent the groups of people that the sample of foster parents would appreciate knowing more about the topics covered in the Course that represented information about their children. This information is a useful guide to explore regarding providing this Course to other groups of people and professionals in the future. The first three highest ranked categories include social worker, teachers and foster parents and includes all seven sessions illustrating that many participants felt that these three groups would benefit from attending the whole Course.

What would you add to today's session?

Responses were divided into 4 broad categories: Nothing, Specific comments, More time, and Positive Comments.

Table 5

Percentage participants who responded "Nothing" to Question 5

Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7
56%	64%	83%	83%	80%	81%	71%

Table 5 illustrates that the first and second session had the lowest percentage of "Nothing" responses to Question 5, illustrating that perhaps respondents felt the sessions needed more input. This response increased and remained with the 80% range from Session 3 until it decreased to 71% in Session 7. The requests and comments to question 5 of those participants who did not answer "Nothing" are outlined below.

Specific Requests

Specific requests included requests for handouts in the first 3 sessions. Participants had been informed during the Introduction session that they would only be receiving a printout of an amalgamation of specific slides at the end of the Course. This request stopped after Session 3. Other specific requests included more information on specific areas that had been discussed during that day's session, or how to deal with specific behaviours

Examples included a request for a social worker to sit in on sessions, as well as for someone to be made available to provide a form of mediatory role between foster parents and social workers in general (Session 4). One individual requested tea and coffee in Session 2, as this had been brought up during the discussion that day. The reasons for tea and coffee breaks not being included due to time constraints was discussed with that group. However, from Session 3 onwards, participants from that group were offered tea or coffee, invited to join me to make it, and asked to bring it back into the venue to continue with the second half of the session. The same individual jokingly requested "Chocolate!!" in session 4. And coincidentally part of the content of Session 5 included providing participants with sweets and chocolates in order to discuss sugar, treats, their impact and a comparison thereof. Specific requests decreased as the Course progressed. This decrease may be because participants were getting the information they required as the Course progressed.

More time

The requests for "more time" were extracted from Specific Requests as at least one person made this request after each session. The dilemma of time-length was an important consideration during the development of the Course especially as foster parents are busy doing school runs,

appointments and managing their homes; and some participants were taking time off work to attend the Course.

Sessions were 2.5hrs to allow for two discreet learning/interaction phases with a short comfort break in-between. It was hoped that by keeping to a shorter time-period that less participants would drop out. Sessions could potentially be increased by half an hour, but no more, as discussions can become more nebulous if there is too much time.

Furthermore, presenting and facilitating sessions was very energy consuming due to multi-tasking and the multiple roles it required. Presenting the content requires accurate theoretical knowledge. Additionally, much of the material was serious and emotive, which required looking after participants emotionally whilst they learn simultaneously keeping them focussed on relevant topics throughout the time period allocated. An alternative solution would be to reduce the content of each session and extend the time period of seven sessions to ten or more.

Positive comments

Positive comments were also extracted from responses to Question 5. These included that a participant found it *"extremely interesting",* that it was *"very good"* or *"excellent"*. One participant reported that they were *"Learning something new all the time."*, and another, *"Nice to be able to discuss situations with other parents",* illustrated that for some participants, their needs and the goals of the Course were being met.

Participants were aware that responses were confidential as no names were required on the questionnaire; however, they still chose to make positive comments even though this was not what had been requested, as the question was looking for suggestions about what might be added to a session. It therefore made these comments very meaningful and provided the motivation required to run such a large number of groups.

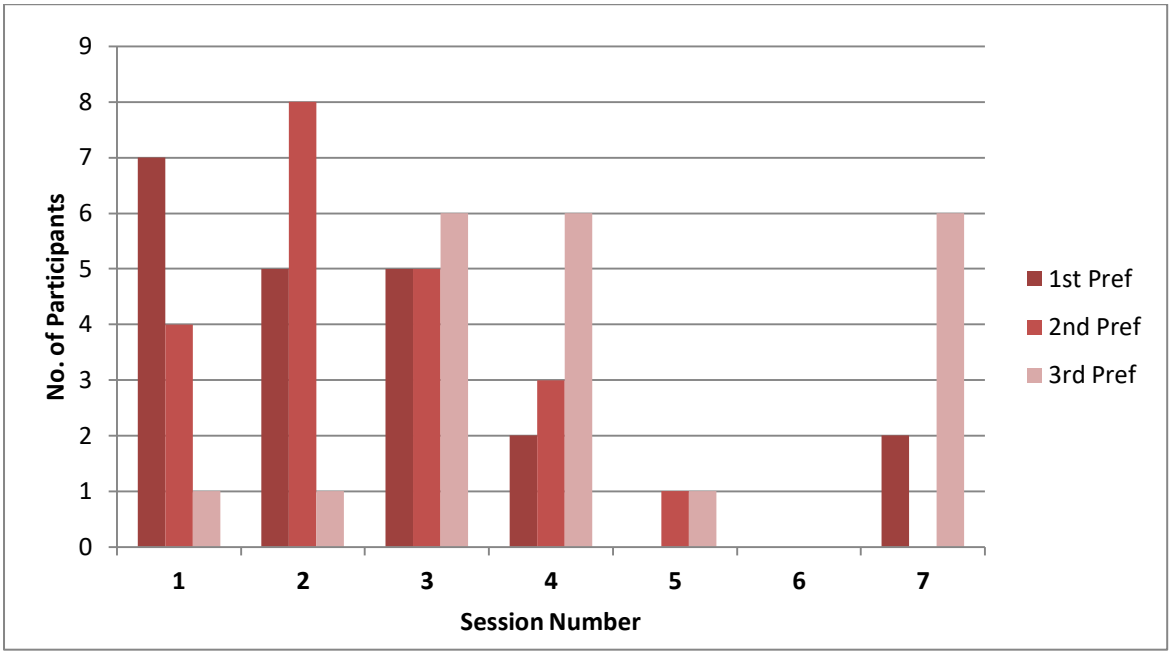
8.2 Summary of post-Course questionnaire n=22

Please list the top 3 sessions you found most beneficial to you and / or your child(ren).

This was a similar request to the one made after session 5 (see Figure 17. above) except that this time the entire Course was complete and participants were only asked to give their top 3 preferences.

Figure 19

Participant's session preference recorded after session 7



Note: Data are recorded from left (1st preference – darkest colour) to right (3rd Preference – lightest colour)

Findings

The responses in Figure 19 illustrate the three preferences are clustered mainly in the first 4 sessions. These are the four main sessions that cover the fundamental information of the Course including Prenatal Development including Foetal Alcohol Spectrum Disorder, Attachment Theory and the impact of insufficient parenting, trauma and its impact on the developing child, and Adult attachment and parents' own triggers in fourth session.

Sessions 5 and 6 were both types of revision of the main information contained in the initial sessions. The first occurred before a few months break in order to consolidate the learning and the second after the lengthy break in order to remind participants about what they had previously learned. The recaps were also included as a way of reinforcing learning through repetition.

However, the low response to 5 and no responses to 6 will need to be considered when reviewing the structure of the Course for future participants.

Were there advantages to being part of a group, rather than learning the information individually?

- Hearing others experiences / opinions/ ways of dealing with similar issues [18/22] (82%) (2,3,4,6,9,10,17,18,20,22,25,28,29,31,32,34,36,38)
  "Being part of a group was good as we shared experiences and tips and also knowing that other parents are going through (and even worse) situations" (10)
  "Well for me it was good to hear what others were going through and be able get a bit of knowledge of how everyone else handles things" (25)
- *"Yes, Less Intense, Enjoyable, Easier to absorb info"* (1)
- *"Yes. Our particular group worked well together, I thought. Everyone was open and everyone seemed at ease to get their points across or ask questions and often other questions were relevant in your case too"* (5)
- *"Definitely – People stories enhance the information being passed on and also despatches the loneliness one can feel with trying to live a normal life with abnormal situations"* (30)

What were some of the disadvantages to being part of a group?

- None [13/22] (59%) (1,2,3,4,19,20,25,28,29,32,34,36,38)
- Confidentiality [4/22] (6,10,18,30)
  "Small group great but small town I haven't shared children's situation with people so concern if others would" (18)
  "Confidentially huge in the mist of strangers wanting to protect the child yet seeking help and advice" (30)
- Dominance of certain group members [3/22] (5,17,31)
  "Dominate personalities with poor insight" (17)
- Withholding information for concern of seeming incapable [1/22]
- Nervousness of meeting unknown people [1/22]

In what practical way(s) do you think the foster parenting program benefitted you in parenting your children?

- Understanding and insight into the reasons for child's behaviour [16/22] (73%) (1,2,3,4,6,9,10,18,19,22,29,30,31,34,36,38)
  "It definitely gave me a clearer insight into a lot of the "whys" of the children's behaviour and ways of resolving issues" (2)

"It gave me a better insight into why the child is behaving in the way he is and that he has little or no control of the way he behaves" (9)

"Helped me understand the different aspects to raising and looking after a foster child" (29)

- Resolve behaviour issues / parent in a different way [10/22] (45%) (**2**,4,10,19,20,25,28,**29**,31,36)
  "Re thinking how to parent and different ways of dealing with issues that arise, learning triggers and how to cope or dilute them" (28)
- *"A greater understanding of behaviours due to start in life and past traumas, feel better equipped to deal with such behaviours in a calm manner"* (5)
- *"Give me great insight to my own attachment and highlighted areas to work on"* (17)
- *"This course was hugely beneficial I think every foster parent should part take pre placement"* (32)

What were the disadvantages?

- None [18/22] (82%)
- Too much information [2/22] (31,34)
  "A lot of information to take in and hope I retained some of it" (34)
- *"Knowing its going to be a long road ahead of us, very emotional reflecting on your own life and your child find it very difficult to bond"* (10)

The participants were then asked specific questions about how they found the second half of each session, which was dedicated to talking about the material they had just been taught and how it might relate to their situation with their child. The question read,

The time in the second half of the group was made up of small group discussion where group members reflected on their own children.

Did you find this helpful? 20/22 participants answered yes, and 2 left the question unanswered.

If yes, in what way(s)

- Hearing other people's experiences, how they dealt with difficulties, and the similarity of our own experience [14/20] (70%) (2,**3**,**5**,6,9,10,18,19,20,22,28,29,32,38)
  "Everyone seemed to have similar experiences with their childrens behaviour" (19)
  "Hearing from others about how they have overcome some of the challenging behaviour and their strategies" (20)
  "Lots of people had gone through similar things. Good to hear different points of views" (22)
- Reduced feelings of isolation [3/20] (3,5,10)
  "How others dealt with difficulties and that I wasn't alone in my problems" (3)

"…It was helpful to hear others opinions and suggestions. One felt one was not alone with a problem" (5)

- *"In fostering its always a stress buster to talk to fellow foster parents*" (1)
- *"Helped me realise how far I had come regarding self-awareness and knowledge, increased knowledge"* (17)
- *"Discovering all homes are not normal helps us to understand we are not doing things wrongly good enough is good enough"* (30)
- *"The way we could discuss what why our children were affected by the topics and how to help them"* (36)

If no, in what way(s)

There were 2/22 responses to this question and the one was a positive comment, *"So grateful to experience course"* (17), and the negative comment pertained to individuals dominating the time, *"If someone takes over the limited time"* (30).

Fostering in General

Would you say that being a foster parent is stressful?

21/22 **(95%)** foster parents responded that being a foster parent is stressful.

- **Dealing with birth parents** [9/20] **45%** (2,3,5,9,19,22,28,**34**,36)
  "You are trying to do best for child, can be made difficult by family members…" (22)
- **Access visits** [7/20] **35%** (3,9,10,20,23,34,36)
  "Access and all the impact this and the birth families have on the children" (34)
- **Social Work-related issues** [7/20] **35%** (2,3,4,10,22,30,36) *"…working with Tusla can be stressful at times as shortage of social workers…"* (22)
  "A carer takes a strangers child / children into their home to care for them 24/7 sometimes with very little support and a lot of interference – a carers has no voice but will scream for services" (30)
- **Behavioural issues** [7/20] **35%** (1,5,9,10,17,31,32)
  "Children through no fault of their own carry so many difficulties and behaviours v challenging" (17)
  "Managing our own family as well as our foster children. Sometimes challenging behaviours at the most stressful of times, it can be constant no let up" (31)
  "Inexperience, not knowing how to deal with certain behaviours" (32)

- **Uncertainty of fostering** [2/20] (9,18)

  "The uncertainly of fostering knowing that the children can be removed at any point" (9)

  "Court Orders for children is always looming" (18)

- Impact on our own family (25,**31**)
- Lack of information about the child
- Not enough good respite
- High expectations from the system
- Lack of professional help / waiting lists for services
- *"On a daily basis you are dealing with a little broken person"* (1)

If yes, what do you think is required to reduce the stress?

- **Support** [6/20] (2,4,9,18,30,36)

  "Someone to talk to who understands…" (9)

  "Stability, Assurance, people being contactable" (18)

- **To be listened to, and believed** [4/20] (5,6,10,20)

  "To be listened to and your point of view taken into account" (5)

  "Being believed and acted on when reporting problems…" (10)

- **More information about the child** [2/20] (2,38)

  "All foster parents should have more knowledge of child's history including mothers life – abuse of drugs, drink, extra stress etc" (38)

- Respite [3/20] (2,4,31)
- Self-care [2/20] (1,9)
- **Access issues:** [2/20]

  "Less access/contact in certain situations" (19)

  "Put the children's needs for access before the parents needs" (34)

- **Training and courses** [3/20] (10,25,32)

  "Lots of courses like these so you can gain a better understanding of how to cope, and maybe get-together with other families in fostering in courses where our own children can hear about other families and what they go through" (25)

  "This training on a long term or once a year over a couple of weeks" (32)

- *"…I strongly believe that children in long term foster care should be allowed to be adopted by their foster parents i.e. open adoption as it would give the children more security in life"* (6)
- *"Place only 1 child per family"* (17)

- *"More TUSLA involvement in working together for the child…joint parenting between TUSLA and carer and bio parents if possible"* (30)
- *"Early assessment when you get child…"* (36)

Would you recommend this group to other foster parents?

100%

Why *would you* (or) *would you not* recommend this group to other foster parents?

- Informative / Learning / understanding of why a foster child behaves in certain ways [15/22] (**1**,**2**,3,**5**,**9**,10,**18**,19,**20**,22,25,29,31,36,**38**)
- How to deal with situations that arise and help the child (19,20,36,**38**)
- Small groups provided safe environment (**5**)
- Parent in a different way
- Take time for yourself
- Insight into our own attachment
- *"It was a great course, informative and enjoyable"* (1)
- *"Definitely recommended. It gives great insight into the "world of fostering"* (2)
- *"In fostering you are always learning. This group was small, it was a "safe" environment where anything discussed stayed within the group. Confidentially was very important. The information given was easy to understand and helpful day to day"* (5)
- *"It gave me a better understanding of the children in our care"* (9)
- *"Helpful for different situations that may arise in your home"* (18)
- *"It was brilliant to know that the behaviours are for reasons and helps you to understand what is happening for the child and how you can help"* (20)
- *"To be honest there is so much to gain from these courses, knowledge, understanding, coping and listening to others that are going through the same thing and been able to give your best to the child in your care"* (25)
- *"There is a lot to be learned here to benefit both child and foster carer"* (30)
- *"As foster parents we need all the help and support we can get"* (34)
- *"It is a great learning and understanding of foster children an eye opener of what they may be going through and how foster parents may help"* (38)

8.3 Summary

The SoaPs in chapter 7 illustrated the information that foster parents had heard during each session, as well as information that they had personalised and indicated they were going to try and implement in their own lives, regarding how they interacted with their foster child(ren). These data obtained through their comments closely resemble the psychoeducational information presented in each session. The tables at the beginning of the chapter illustrate and summarise all participants who completed the post-session questionnaires, responses from each session in two columns about the information that stood out for them, and the information that might benefit them. These data provided a good ongoing evaluation regarding whether or not the participants were understanding the information and finding it useful, or not.

Group preferences illustrated that participants preferred the sessions where novel information was provided, rather than recaps or reviews of material. This is useful information when considering the design of future versions of the course. Interestingly, Session 4 would have also provided a recap of some of the Attachment material, but participants may not have noticed as the material had been adjusted to an adult context for participants to consider their own personal attachment experiences. However, the qualitative data in the participants' responses do not reflect any negativity regarding the recap sessions, so they appear to have been valued, but possibly less so according to participants reported quantitative preferences, than sessions where new information was provided.

Participants revealed that the amount they learned in each session ranged from a minimum of 5/10 to 10/10. Collating the data to include the top scores of 8-10 illustrated that these ranged from 56% (Session 1) to 88% (Session 5), with one other in the 70's and the others in the 80's. When considered in the light of participants' session preferences, Session 5 and Session 6 were scored the lowest, especially in the post-Course questionnaire. However, cross-referencing this with the amount that participants said they had learned revealed scores of 88% and 81% in these sessions respectively.

Participants proposed that the main groups of individuals/professionals that would benefit from the information contained in the entire Course were social workers, teachers and foster parents. Other groups that would benefit from elements of the information provided included people who work with children in Care, schools, anyone involved with children, Judges, SNA's, foster children's biological parents, the child's *guardian ad litem* and HSE Early intervention (Disability) teams amongst others.

As part of utilising the participants' opinions on the Course, to find out what else each session required, many answered "nothing", ranging from 56% in Session 1, increasing to the 80's for sessions 3,4,5 and 6, and dropping to the 71% for session 7. The main addition suggested in the first

three sessions was for handouts, despite participants having been told that a summary handout encompassing all of the sessions would be provided at the end of the Course. Some of the other requests included information on dealing with specific behaviours or more information on the day's Session. Requests for anything additional decreased as the Course continued. A request that remained stable throughout the Course however, was for more time. This request can be interpreted as a positive reflection on the Course. It was not possible to change the length of the sessions or duration of the Course, but these both need to be considered in future manifestations of the Course.

The majority of participants (82%) found that being part of a small group, rather than learning the information individually was beneficial, as they were able to hear others' experiences and ways of dealing with different foster parenting issues. One person mentioned that this format was less intense and made it easier to absorb information; and someone else mentioned that it reduces the loneliness of a difficult situation. Nearly 60% of participants felt there were no disadvantages to being part of a group. However, confidentiality was the largest concern noted by 4 participants and dominance of certain group members by 3 participants.

The most dominant theme expressed by 73% of participants regarding the way in which the Course benefited parenting their foster child(ren) was that they felt they now had more understanding, and more insight into why the child might be behaving in certain ways. The Course provided 45% of the respondents with ways to resolve behavioural issues and ideas to parent in a different way. A disadvantage specified by two participants was that there was too much information. Another noted that the information provided them with the knowledge about how difficult the process of fostering was going to be especially if it was difficult to bond with the child, and that it was emotionally difficult to reflect on their own life.

Asked about the second half of each session, which involved reflecting and discussing the material covered in the first half, in relation to their own child or any other experiences that were relevant, 20 out of 22 answered they found it helpful and 2 respondents left the answer blank. The majority (70%) found hearing other people's difficulties, how they dealt with those difficulties and how their experiences were similar to their own, the most helpful. Some respondents felt the discussion reduced their sense of isolation, one felt it reduced their stress to talk to other foster parents, another said it helped increase their self-awareness and knowledge, and another that they were not doing anything wrong and that what they were doing was good enough.

The second half of the summative questionnaire started with questions regarding Fostering in general. Asked whether they felt being a foster parent was stressful, 21 out of 22 responded affirmatively. The most reported reasons included: dealing with the child's birth parents (45%);

access or contact visits and the consequences thereof (35%); Tusla and social worker-related issues (35%); and behavioural issues in the children (35%). Other issues included, the uncertainly of fostering; the impact on foster parents own families; not having enough respite Care; high expectations from the system; the lack of professional help and long waiting lists for services for children.

Suggestions provided by foster parents to reduce their stress included: being provided with more support (30%); being listened to, and believed (20%); and a comment about joint parenting between Tusla and the foster parents. Respite Care was mentioned, illustrating that parents require time out from fostering occasionally. Training and courses were suggested to enable parents to understand their children better, including being provided with this Course on a longer-term basis. A reduction in access or contact with parents and biological family was mentioned, as well as a suggestion that access should be provided according to the child's needs rather than the biological parents' needs. Some parents felt they needed to be given more information about the child that they were fostering, especially a better history about parents' substance abuse and what had happened before the child was fostered. Other specific suggestions included self-care, early assessment of the child when they are initially placed; placing only one child in a family; and allowing children in long-term fostercare to be adopted by their foster parents, to provide them with more security.

All the respondents (100%) said they would recommend this Course to other foster parents. Some reasons given included: that it was enjoyable, confidential and informative; and provided parents with understanding of why a foster child might behave in certain ways; including practical ways to help the child by dealing with situations in a certain way that is different from parenting biological children. They appreciated that groups were small and offered a safe, confidential environment to learn information that was easy to understand; giving a great insight into the "world of fostering". They valued the insights gained into their own attachment, simultaneously with information about the child(ren), including what they have been through, and might be going through now; and that behaviours happen for reasons; and how to deal with them on a daily basis in their own homes.

9. DISCUSSION AND CONCLUSIONS

This research project was conceptualised to elucidate an action cycle within an Action Research model. As a clinician, I sought to bring together theory and practice, to find out whether a small group parenting intervention for foster parents might provide insight into two major issues in two of my clinical populations: *viz*., Foster parents' stress and foster children's emotional and behavioural symptoms. Providing psychoeducational information within a supportive, reflective environment, I wanted to illustrate that foster children's responses to others and the world are similar, and as a result of what they have endured in their families of origin. The overlap of symptomatology, whether as a result of suboptimal prenatal conditions; insecure attachment styles due to inadequate relational connection during infancy and early childhood; or as a result of trauma following experiencing maltreatment, makes diagnosis difficult. Providing foster parents with more understanding about the origins of behaviours and illustrating how these are adaptive for the child, and not personal to the foster parent-child relationship, I hoped to reduce some of the day-to-day stress of parenting foster children and stabilise placements, potentially leading to less placement breakdowns. My main objective was to try to create a relational context within which the child would be responded to with understanding, rather than reactively as a result of their behaviour, and as such heal some of the maladaptive strategies they had developed in order to survive their earlier adverse conditions.

The idea came about as a result of the individual work I had done over a number of years with both foster parents and foster children. Having attended many courses and conferences specialising in the area of especially trauma, and providing attachment parenting groups from *Parenting from the Inside out* (Siegel & Hartzell, 2003) and *Circle of Security* (Hoffman et al., 2017) to both professionals, biological parents and foster parents decided to design a group program. Using an action research format, I wanted to track the development and efficacy of providing psychoeducational input about prenatal Development, Attachment and Truama to small groups of foster parents. Prior to leaving the public service, I therefore devised and conducted six small groups, each meeting for eight weeks (including the introductory week), collecting pre- and post-Course quantitative data in relation to both the participant foster parents and their foster children, as well as qualitatively evaluating the Course after each session and then implementing a post-Course questionnaire at the end.

Statistical effects were not evident on the quantitative pre- and post-data comparison, perhaps as a result of the measures not being sufficiently sensitive to the possible subtleties of changes in behaviour or stress, if there were any. Furthermore, the measures used for evaluating parenting stress did not appear to effectively measure the types of stressors foster parents

experience. The quantitative data were however useful descriptively, illustrating especially from pre-test data the levels of emotional and behavioural difficulties experienced by foster children in this sample.

Fortunately, having used mixed methods, the qualitative data complimented and supplemented the quantitative data. The feedback from the confidential post-session questionnaires provided a barometer regarding participants' experiences and impressions of the sessions; and whether or not they were coping with the material during each session. The confidential post-Course questionnaire provided participants the opportunity to not only evaluate the whole Course, but also to express some of their personal impressions about their experiences of fostering and some of the difficulties they encounter.

The content of this next chapter explores the outcomes of the research in relation to each question. Further questions are posed in an action research-type reflection with the discussion also containing some of the research limitations, areas for development and recommendations. A postscript has also been included to demonstrate that action is ongoing and using some of the participants' suggestions and my own personal reflections through this research process, the content of the Course itself continues to provide foster parents with knowledge and understanding. I thereafter include the unedited comments of the participants about the Course at the end, to reinforce its efficacy and to conclude the research by hearing their opinions.

What are the levels and nature of stress experienced by foster parents in parenting their children?

Quantitative data from the PSI and SIPA revealed that the foster parents in this sample indicated that the stress they were experiencing was associated with the foster children and adolescents, rather than aspects of their own lives. These data revealed relatively low levels of stress, however the qualitative data from the post-Course questionnaire showed that 21 of the 22 foster parents who completed the post-Course questionnaire responded that being a foster parent was stressful.

Ranking their responses, the most reported stressor theme was, "dealing with the biological parents" (9/20). The next three factors ranked equally in terms of the number of participants reporting (7/20) and included, "access visits" (contact with biological parents); "issues related to social workers", including unavailability and frequent changes; and "difficult behaviour in the children".

This illustrates that nearly half of the foster parents who answered this question find dealing with the child's biological parents the most stressful aspect of fostering. Furthermore, access visits

were also mentioned and related to having to deal with the consequences of how visits with biological parents are managed. Foster parents have to live with the child's demeanour and behaviour before or after the visit and some participants expressed their powerlessness in trying to protect the foster child from the difficulties that they may have to endure during a visit, which the child might express in angry, confused, ambivalent, or sad feelings before, during or after a visit.

Professionally, I believe that contact with biological parents, siblings or extended family members requires specialist assessment, decision making, and constant review, taking all the bio-psycho-social-ecological issues relating to the foster child into consideration. Starting from the position of whether there is any likelihood the child will be reunited with their biological parents. Evaluating what the child has endured in terms of neglect, abuse or both whilst with their parents also needs to be carefully considered, since contact or visits could repeatedly re-traumatise the child. Thirdly, the purpose of the contact needs to be clarified in order to evaluate and review, whether, and in what ways the child's needs are being met.

Foster parents should be part of the multidisciplinary team planning and evaluating family contact. Foster parents who are aware of why decisions are being made, or are involved in the decision-making process, are more likely to understand and be more patient as contact options are being trialled. They are also strategically placed to observe the child's reactions to family contacts and monitor changes in behaviour before and after visits.

International research into the value and implications of the relationship and support provided by social workers to foster parents is quite extensive (Cooley et al., 2017; Khoo & Skoog, 2014). I cannot comment about whether or not recommendations are being implemented, however, providing the recommended ongoing communication and support foster parents require is unlikely based on the high turn-over and shortage of social workers (RTE, 2021). As a result, foster parents reported feeling abandoned when they were unable to contact their allocated social worker with questions or concerns, especially as they felt that they have to constantly be on call for the child; and be available to the social worker at short notice (Denlinger & Corius, 2018).

Repeated changes in the fostered child's social worker is also likely to be disturbing to the child as it represents recurrent loss. In my experience, foster children have difficulty trusting, generally as a result of the belief that the most important persons in their lives, their biological parents, have let them down, and these children appear to suffer this loss and the aftershocks thereof, throughout their lives. In my work with foster children, I have noticed that in most cases when the social worker works with that child for longer periods, the better the relationship and the more effective it can be. Perhaps staff changes could be better managed by including the foster parents in the transition process.

The child's behaviour was also reported by this sample of foster parents as one of the factors causing them stress, which is in keeping with previous research (for e.g, Hiller & St. Clair, 2018). The types of behaviours that the foster parents in this sample are reportedly living with in their homes are discussed further in the next question.

According to their parents, what emotional and behavioural patterns are foster children displaying?

The results of the SDQ revealed that approximately 60% of foster children in this sample were showing high levels of emotional and behavioural distress according to their foster parents, which is within the upper limits range previously reported of 30-65% for a sample of foster children in the UK (Hiller & St. Clair, 2018). Participants also indicated that these were most frequently behavioural difficulties, followed by peer difficulties (social skills), then hyperactivity (physical dysregulation) and lastly emotional difficulties. As these reflect the opinions of the foster parents, there may be an element of them reporting behaviours that are more noticeable, or those that most affect the parents and their households. As a clinician, I would prefer to recognise both behavioural and emotional expressions as equally important, since certain behaviours are often an expression of emotional distress. However, what the results do reveal is that two-thirds of the sample of foster children are showing above average levels of distress that require some sort of intervention.

Further exploration of the data pertaining to the foster children, especially that from the CBCL illustrated that adaptive functioning (daily living skills), and emotional and behavioural difficulties differ according to age and gender. This important finding might be helpful in guiding assessment, intervention and even prevention in relation to foster children.

Adolescent Girls and Young Boys between the ages of 5 - 11 years in this sample were reported by their foster parents as having the most difficulties according to the data from the CBCL-SA. Below I have colour-coded the results from the data in Chapter 6 according to the percentage of children in a particular age and gender category who were reported to have scored within the borderline and clinically significant ranges, in order to portray some of the trends in the data. By colour tabulating these data it was possible to identify concerns from the different age and gender categories and to illustrate the differences between childhood and adolescence, as was evident in this cohort.

Table 6

CBCL-SA measure of Competence: Colour tabulated prevalence for children and adolescents

	Activities	School	Social	Competence
Adolescent Girls				
Young Girls				
Adolescent Boys				
Young Boys				

Note. Percentages represent the number of children or adolescents presenting with borderline or clinically significant scores in each category. Colours illustrate 20% bands, 0-19%- no colour / 20-39% yellow / 40-59% dark pink / 60%+ dark red. The darker the colour, the more children or adolescents in that category with those symptoms or difficulties.

Adaptive behaviour difficulties, as measured by Competence was reported to range from 40% of Young Girls to 73% of Adolescent Girls. There does not seem to be a pattern, however focussing intervention as early as possible in all 3 areas by encouraging hobbies, supporting school placements and actively encouraging socialisation, prior to and including adolescence, might reduce the likelihood of the severity of difficulties being experienced especially by teenage girls and boys between the ages of 5 and 12.

School appears to be more of a difficulty for boys, therefore working with the school or acquiring extra supports from the outset of a child's schooling, rather than waiting for the difficulties to emerge, might promote school attendance, participation and achievement (Lynch,et al., 2017; Pears et al., 2013). Individual maths and reading tutoring have been found to benefit foster children's progress in these subjects (Hickey & Flynn, 2020).

Table 7

Colour tabulated prevalence of children and adolescents presenting with symptoms on the CBCL-SA

	Internalising				Externalising			
	Somatic	Anxiety Depression	Social	Withdrawn Depression	Aggression	Thought	Rule breaking	Attention Problems
Adoles. girls								
Young girls								
Adoles. boys								
Young boys								

Note. Percentages represent the number of children or adolescents presenting with borderline or clinically significant scores in each category. Colours illustrate 20% bands, 0-19% - no colour / 20-39% yellow / 40-59% dark pink / 60%+ dark red. The darker the colour, the more children or adolescents in that category with those symptoms or difficulties.

The colour-tabulated Symptom scales data illustrated additional patterns. Larger numbers of Adolescent Girls in this sample were presenting with difficulties across all of the categories. Even if this represents the same girls in every category, this means that there were at least 5 teenage girls in difficulty, which is 10% of this entire sample of foster children. Adolescent girls who have endured emotional and physical abuse have previously been found to have higher levels of aggression, depressive symptoms, and PTSD symptoms (Auslander et al., 2016).

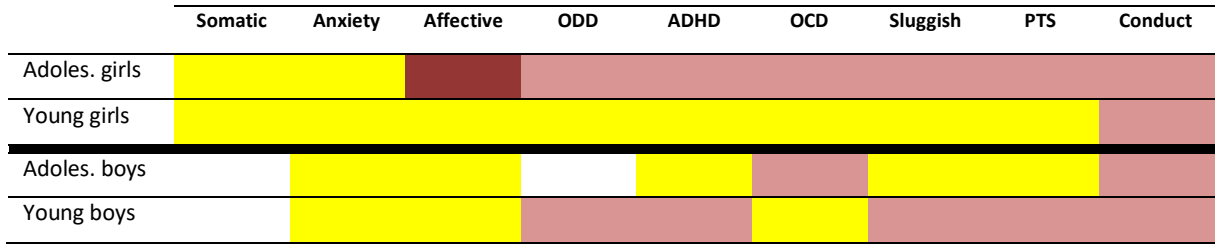
Externalising behaviours or symptoms, which have been found to be the highest predictor of placement disruption and breakdown (Konijn et al., 2019; Vreeland et al.,2020), were more common in this sample of children and adolescents, rather than internalising behaviours. These results should be cautiously interpreted, since by their very nature, Internalising behaviours are subtler and therefore can be more difficult to identify and some internalising behaviours might be imperceptible in the presence of externalising behaviour. Externalising behaviour in children has been associated with the child having been the result of an unwanted pregnancy (Hayatbakhsh et al., 2011); exposed to prenatal nicotine (Ekblad et al., 2015), cocaine (Cestonaro et al., 2022) and alcohol (Petrenko, et al., 2014); insecure attachment (Groh et al., 2017); and different forms of maltreatment. Aggression as an externalising behaviour is notable in a larger proportion of both Young Boys and Adolescent Girls, as were Rule Breaking Behaviour and Attention Problems.

Thought problems, which would indicate faulty thought patterns and therefore mental distress, were reported in larger numbers of adolescents and lower numbers of young children. This is in keeping with previous research especially with regard to teenage girls (Farley et al.,2022) and is more appropriate developmentally, since thought problems are associated with developing personality (Farley et al., 2022). However, this finding is concerning as it shows that nearly half of

the adolescent girls and boys in this sample were showing symptoms that are likely to result in problematic mental health and possible psychiatric distress in adulthood.

Table 8

Colour tabulated prevalence of children and adolescents presenting with sufficient symptoms to meet criteria for diagnosis on the CBCL-SA



Note. Percentages represent the number of children or adolescents presenting with borderline or clinically significant scores in each category. Colours illustrate 20% bands, 0-19%- no colour / 20-39% yellow / 40-59% dark pink / 60%+ dark red. The darker the colour, the more children or adolescents in that category with those symptoms or difficulties.

A borderline significant or clinically significant score obtained on the CBCL Diagnostic scales requires that an individual be further investigated to establish whether they meet the diagnostic criteria for such a diagnosis (Achenbach & Ruffle, 2000). Hence, the outcomes shown above should be interpreted as screening for possible diagnoses, rather than actual diagnoses (Achenbach & Rescorla, 2007). As an extension of the Symptom scales, the pattern in the Diagnostic scales table (Table 8) illustrates that more Adolescent Girls and Young Boys are presenting with a level of symptoms that might lead to a diagnosis of ODD, ADHD, Sluggish Cognitive Tempo (ADD), PTSD and CD. In excess of 40% of both Adolescent Girls and Adolescent Boys in this sample are presenting with symptoms associated with OCD. In children and adolescents in the general population, obsessive-compulsive behaviours are most associated with anxiety or depression (Krebs & Heyman, 2015).

Two further concerning findings include firstly that over 60% of this sample of Adolescent Girls had symptoms associated with Affective or Mood Disorder. Although this is similar to the figures for fostered teenage girls in previous research (Farley et al.,2022), it still represents a group of girls in significant emotional distress, with few, if any of whom in this sample receiving psychological support. Secondly, 40% and more, of every age and gender category were presenting with the symptoms associated with a diagnosis of Conduct Disorder. Numerically this equals 24 children and adolescents aged between 5 years and 18 years, nearly half of this age category sample (n=51). CD at a severe level during adolescence, often when associated with aggressive or cruel

behaviour may be the precursor to antisocial personality or psychopathy (Speranza, 2017). Questions include whether this sample of foster children and adolescents illustrate some level of genetic vulnerability (Neigh et al., 2009), or could having been exposed to levels of maltreatment predispose foster children to problematic psychiatric conditions? Or, are quantitative emotional and behavioural measures, normed on the general population, too sensitive to the patterns of problematic behaviour commonly expressed by foster children, and therefore this measure may be over-diagnosing the probability of CD?

The literature reviewed revealed that CD could be associated with FASD (Popova et al., 2016); prenatal cocaine exposure (Richardson et al., 2019); and infants and young children being exposed to violent events in their home environments (Schechter et al., 2019). Van der Kolk et al., (2019) also list CD as one of the comorbidities with DTD. Further investigation of and research into CD in foster children and adolescents is required as they represent a vulnerable population; risk factors for CD listed by Sadock et al., (2015) include physical and sexual abuse, neglect, cognitive difficulties and poor academic achievement, negligent or extremely punitive parenting. The difference between ODD and CD is that although there is strong oppositional predisposition and disregulated emotions and behaviours, children and adolescents with CD lack prosocial behaviours and empathic understanding (Speranza, 2017). Both the lack of prosocial behaviours and empathic understanding may be related to the adaptive coping strategies that result from their primary adverse experiences and maltreatment, having become maladaptive as form of self-protection. Another hypothesis worth investigating further would be the effect of adverse experiences and maltreatment on mindmindedness and Theory of Mind (TOM) in foster children, including the potentially damaging effects of the original separation of child and biological mother on TOM.

Results from the preschool CBCL indicated that preschool boys, those under 5 years old in this sample of foster children, showed a lot more difficulties than girls of similar ages. Their main difficulties were those associated with externalising behaviours, such as being emotionally reactive and aggressive, although some boys exhibited both coexisting Internalising and Externalising behaviours. Half of the preschool boys had symptoms associated with ADHD and ODD and four of the six boys, and one of the 6 girls had symptoms associated with PDP.

There is therefore a trend in this sample of foster children and adolescents, for boys under the age of 12 years to present with high levels of behavioural difficulties. Early intervention is more likely to be effective, but is not the only time period sensitive to interventions (Wachs, 2014). However, the sooner a child is provided with opportunities to adjust to their difficulities, the fewer the difficulites they might have at a later age. (See also my comment later regarding assessment as a form of early intervention).

At the time of this research, there were major difficulties regarding foster children accessing appropriate services. CAMHS for example only accepted children with symptoms associated with an "acute mental health" diagnosis and had waiting lists for ADHD assessments. This meant that children have to be displaying severe emotional or behavioural symptoms to be accepted into a service and by the time they reach that level of difficulty, their placements both in school and foster home were likely to be in jeopardy. Ideally, these children require a specialist service. Their difficulties are multifaceted and therefore they would benefit from the involvement of a multi-disciplinary team, which I discuss further under the heading Assessment, Diagnosis and Intervention.

What were the elements used to develop a Developmental, Trauma and Attachment-based intervention for foster parents, and how did it unfold?

"Trauma informed" is currently a very popular catch-phrase for promoting trainings and interventions within Child Healthcare (e.g., Duffee, 2021), and Education (e.g., Thomas et al., 2019), and treating foster children (e.g., McPherson et al., 2018). However, it only represents one element in respect of foster children. Hence, I chose to include two further elements in my Course, Child Development, and Attachment Theory, to create a more comprehensive lens through which to view the foster child, but also for foster parents to view themselves. This was not an arbitrary choice, but a decision made, based on my clinical experience, ongoing training and the literature. There is an Indian parable about 6 blind men and an elephant, the moral of which Siegel (2007) often quotes when describing the multidisciplinary conceptualisation and development of Interpersonal Neurobiology. Paraphrased, each of the 6 blind men touch a different part of the elephant and have a different concept of what they are touching (for e.g. trunk, tusk, toe), however were all 6 of the blind men's impressions to be amalgamated, there would be a better understanding of the whole elephant. The analogy demonstrates that by conceptualising the foster child within a bio-psycho-social-ecological framework, so many more elements can be taken into consideration, from genetics through to politics.

An Action Research format means there is ongoing evaluation and reflection. Adaptations and changes, including other questions arise from the primary action process. The following summaries were devised from reflecting on the participants' feedback and my own experience devising and facilitating the Course.

What could stay the same?

- Closed small groups
- Professional facilitation (knowledgeable in Development, Attachment and Trauma, specifically in relation to foster children)

- Same time period per session (2.5 hours)
- Introduce the fostering parenting precepts (see Appendix D, Session 1 Slides) in the introductory session. However, possibly reintroduce a single precept per session to make them easier to remember as they are quick reminders that could be utilised by foster parents when they are finding parenting difficult.
- In general (and in the same way) restrict the topic of the organisation and social workers. However, set aside time during a prearranged session, where the topic is introduced and carefully managed, sensitive to individual professionals and with a potentially proactive outcome. For example, perhaps an open document could be co-constructed to provide feedback to the agency regarding foster parent's concerns and difficulties that they encounter.
- Follow the same developmental and psychoeducational material timing from prenatal, through childhood and adolescence to adulthood. It was important for participants to be able to identify their children's difficulties and later on feel sufficiently safe to explore their own personal issues that potentially influence their parenting and their children's responses. Focussing initially on material associated with the child and later turning specifically the Attachment material to focus on the participants own experiences.
- From that point onwards stressing the premises that to promote healing in the children requires the parent's self-awareness; understanding the origins of the child's behaviour; not taking behaviour personally; the ability to repair after rupture; and only responding to provocative issues when the parent is in an emotionally strong position.
- Use the same, or similar appropriate pictures, brain model, video clips etc. as teaching materials, to vary the presentation and maximise learning, and
- Include light relief such as the "laughing monkey" or similar props to acknowledge that the material is emotionally difficult and time-out during sessions might be necessary (emotional safety).
- Both parents should be encouraged to attend where possible, as it is very difficult for one parent to change parenting processes, with their new knowledge, within a dual parenting context when the other partner does not have the same information.

What could be improved upon or developed further?

Course

- Extend the time-frame of the Course (from 7 to a minimum of 10 - 12 sessions / perhaps bi-weekly or monthly rather than weekly, over six months or a year).

- Spend time during the introduction at the beginning of the Course co-creating and designing the content of Course with participants (see Research, below).
- Reduce the amount of formal psychoeducational content and time per session, and
- Increase discussion time per session to get to know participants and their children more personally and for participants to get to know each other and each other's children.
- Create opportunities within discussions and reflection to recap on previous material, rather than using full sessions to recap.
- Emphasise the Developmental component of the Course more and relate it to the age of the participant's foster children (both the time period(s) they experienced adverse events and their current age).
- Increase time and emphasis on Theory of Mind, and developing the reflective capacity of foster parents, as according to literature this is an important area of intervention to reduce parenting stress in relation to difficult behaviour in foster children (Adkins et al., 2022).
- Provide an opportunity to discuss the impact of biological parents and access visits, perhaps including information about the legal system and protective strategies for the foster children.
- Time needs to be taken at the end of each session establishing what material would be helpful and relevant to the participants' needs in relation to the next session's topic (see Research, below).
- There were numerous requests for handouts. Provide brief handouts at the end of each session, or 1-2 page outlines that participants could write on during sessions and then use for reflection and discussion in the second half of the session.
- The self-care session was positively received; consider introducing the topic of self-care at times throughout the Course. Additionally, a short breathing or mindfulness exercise could be used to start and end sessions.

Research

- Place more emphasis on the Community Psychology Action Research process by getting participants to design the Course themselves and identify the questions they need answering and the information they would like to know more about in relation to their child. This could be part of the introductory session where it would assist participants getting to know each other and working together.

- Increase the level of post-test compliance by requesting post-test data be completed on-site at the end of the last session.
- Use mixed methods, since although the data from the pre- and post T-test comparison provided little useful information, the pre-test quantitative data regarding the foster children's emotional and behavioural difficulties can inform both the co-creation of future input, and
- Evaluate these data longitudinally, perhaps six or even twelve months later, might reveal different results.
- Use the outcome of this research and the Course material to develop an intervention with individual foster parents, and other professional groups as recommended by participants (see Postscript below).
- Although the results from these data based on a small sample size were not generalizable, there were certainly themes that compare with the international literature. By utilising PAR methodology this Course could be adapted to other foster parent groups both within Ireland and possibly internationally (taking into account different countries and regions ecological factors, such as culture, social-welfare structures and legislation).
- Further research would be valuable on the outcome of certain emotional and behavioural features found in foster children in this research and in the literature. Specifically, the following should be considered: affective disorders in adolescent girls, thought disorders in adolescent girls and boys, and most importantly the aetiology and symptomatology associated with Conduct Disorder, found to be high in this entire sample.

What were the foster parents' responses to and experiences of a Developmental, Trauma and Attachment based small group psycho-education and reflective intervention?

As a clinician, I was trained to not have preconceived goals or intentions for clients, as psychotherapy needs to proceed at the client's pace, in their direction, toward their goals (Geurtzen et al., 2020). Judging by the volume of material and some of the participant's comments, perhaps I needed a less goal-oriented process in this research. I recognise my wanting to share as much of the information I possessed with the participants in the short eight sessions we had together. As such, I may have at times overwhelmed the learning process for some participants with too much information. This was probably also as a result of having motivated receptive groups of participants, who appeared to share my interests, wanting to know as much as they could about foster children.

The ongoing evaluation after each session and the post-session questionnaire responses provide a wealth of information about what was learned, how information was received and whether or not the process was beneficial or not. The nature of Action Research or reflective practice is to reflect, evaluate, adjust, change and improve (McNiff, 2010). Hence, the participants' responses and my reflections provide important insights into the Course, including that:

- ✓ Participants gained an understanding of the effects of prenatal development, Attachment and Trauma on their child's life;
- ✓ Participants implemented some of the learning in their relationships with their children;
- ✓ I managed to avoid a cause-effect behavioural type expert-client process. Many of the participants learned to think about how their children were presenting and link it to what the child might have previously experienced; including how they the foster parents might contribute toward some of the foster children's presentations; and how foster parents have the capacity to assist their child by changing their responses to the behaviour, or the child.
- ✓ The Course valued and reflected important elements of Community Psychology (information sharing/empowerment/identification as a group);
- ✓ Participants learned about themselves during the process of the Course;
- ✓ Participants learned more about, and identified with other group members and articulated gaining strength, support, encouragement and hope from being part of a group and hearing other participants' stories;
- ✓ Some foster children of participants reportedly benefited from the Course;
- ✓ The material emphasised that a child's behaviour was adaptive and as a result of what they had experienced before being fostered;
- ✓ Self-care was an important topic to introduce to this group of foster parents;
- ✓ I learned more about foster children and foster parents from the participants;
- ✓ I learned more about myself as a clinician and as a researcher;
- ✓ I learned information that would improve my clinical practice.

What was learned or reinforced through this research?

Foster Parent Stress

The task of parenting a non-biological child who has experienced adversity prior to that child being fostered should be assumed to be stressful. Methods that are used to measure stress in parents in the general population, such as the PSI and SIPA, may not measure the types of stress with which foster parents are dealing. Furthermore, there was a sense from some responses, as well

as the 20% underreporting measured on the PSI, that foster parents may feel that they are constantly being evaluated, therefore there is the possibility that foster parents might under-report being stressed, for fear of being perceived as not coping.

The literature suggested that the child welfare system is a source of stress (Harkin & Houston, 2016), which was also evident in this research. Although I deliberately excluded the topic of Tusla and other organisational issues except in Session 3, this was mainly because my Course was time limited. I have previously experienced group meetings of foster parents who spent entire meetings that were scheduled for learning, criticising the system and speaking negatively about individual social workers, which did not seem a constructive way to spend time, as nothing except frustration including the contagion of powerlessness and discontent, emerged from those meetings.

The more difficult a foster child's behaviour, the higher the likelihood parenting that child will be more stressful (Randle et al., 2017; Whenan et al., 2009). However, it should not be assumed that only externalising behaviour, because it is more obvious, is more difficult to parent, or that the child has fewer difficulties because they internalise their behaviour. Both externalising and internalising behaviour require skill to parent (Vreeland et al., 2020), and both take commitment and energy. As a clinician I often worry more about internalised behaviour as there may be a lot more within the child's psyche that is not being expressed, and could be overlooked.

I would therefore suggest that every child, as they enter the foster system needs to be comprehensively assessed from a psychological perspective, rather than waiting until the child or parent experiences difficulties. Assessment then becomes a form of "early intervention" (Holmes, et al., 2018), providing the foster parents with an increased understanding of the child's needs and actual abilities. In my experience, foster parents are often shocked after an assessment as there is usually a fairly substantial discrepancy between the child's chronological age versus their emotional and developmental age, which is often much lower. Foster children, probably as an adaptive strategy, appear to have learned to mimic age-appropriate behaviour and therefore mask their difficulties. Hence my precept: "Foster children should be parented 4 years below their chronological age".

The assessments used in this research, for example the SDQ and CBCL can be administered without the child being put through a formal assessment process. In addition, I would strongly suggest including a validated adaptive behaviour and functioning assessment such as the Vineland-3 (Sparrowet al., 2016). The Vineland-3 assesses the communication, daily living skills, socialisation, fine and gross motor functioning and maladaptive behaviour (internalising, externalising and critical behaviours) of an individual (from 0 to 90 years). This measure also only requires completion by foster parents, rather than interviewing the child, and results provide a summary of a child's capacity

with day-to-day living skills as listed above, providing an age-equivalent score of the child's current functioning. This information enables parents to understand their child's difficulties and adapt their parenting style to the child's measured ability and age. If the child is of school age or attending a preschool facility, teachers or preschool teachers can also complete these questionnaires, thus providing more information about the child in a different context. Foster children tend to present differently in different environments, sometime even presenting differently to each parent.

Foster parents and their families are being exposed to secondary trauma on a daily basis. Professionals working with foster children are familiar with, and are trained to prevent the negative outcomes of working constantly with traumatised clients. However, it is not a strong consideration regarding foster parents, who might be exposed to higher levels of secondary trauma in numerous formats, whether PTSD or Attachment, in an ongoing, daily relational context in the foster parents own home. Whit-Woosley et al., (2020) found that nearly 80% of foster parents in their sample were exposed to their foster child's trauma, in numerous forms, thus placing them at risk of developing secondary traumatic stress (STS). If we assume that foster parents are experiencing stress, then we need to envisage that they require skills and support in relation to the impact of long-term stress, which are similar to and can mirror some of the symptoms of their foster children and might ultimately result in burnout and placement breakdown.

Mismatched placements are likely to break down, and research has indicated that foster parents are more likely to retire permanently from fostering after a difficult placement breakdown (Haysom et al., 2020). Unfortunately, there are insufficient individuals coming forward internationally and in Ireland to foster in relation to the number of children requiring a foster placement. Matching a parent's ability, style and experience with the child's needs (emotional, physical and cognitive), leads to better outcomes and reduces the likelihood of placement breakdown (Haysom et al., 2020).

Improving a foster parent's knowledge and skills in relation to fostering has been recommended as a way in which to improve the quality of placements, which are then less likely to breakdown, which reduces the number of foster parents the fostering system is likely to lose (Golding, 2019). An important aim of this research project was to develop foster parents' knowledge and skills base through the parenting Course that was developed. Their participation and feedback reflect the need for more Courses like this one to be made available to foster parents, to improve the quality of foster parenting and provide parents with the skills to maintain difficult placements.

The fostering social work team comprehensively assess prospective foster parents and a multidisciplinary fostering committee ratifies this assessment. However, this assessment does not include what I would consider valuable psychological information, such as the prospective foster

parent's own experience of being parented and their resultant attachment style(s). Establishing this information is likely to lead to less placement breakdowns, as possible conflict or rejection situations might be avoided when both the foster parent and foster child's vulnerabilities are combined or mutual sensitivities provoked. Hence, my inclusion in the Course of a tentative process of self-discovery for the participants (see Appendix D, Session 4 Slides).

Evaluating adult attachment and the resultant parenting and personality styles requires an in-depth, lengthy psychological assessment, which is not the remit of the fostering social work team. A previously trialled consultancy model for foster children that included psychology showed positive results in the UK (Hibbert & Frankl, 2011), might benefit all services and individuals involved in the foster child's life. In my private practice, I use a consultation model with the Tusla cases with which I am currently involved. This involves some degree of intervention with the child on an individual basis, which mostly occurs within the assessment phase; and then possibly within a play therapy or equine assisted psychotherapy model; but mostly dyadically (with the foster parent or social worker) as per DTD. The main emphasis of using a consultation model would be working with the foster parent(s), which includes a mainly psychoeducation focus; consultation with social workers involved with the child including fostering and children in care, and the *Guardian ad litem* where applicable; and consultation with teachers and principals, consultant psychiatrists, GPs and any other professionals involved with the child.

A team-based psychology consultation model provides psychological insights to the different professionals and incorporates information from their perspectives, increasing the overall understanding about the child, therefore improving information-based decision-making. It assists when interventions need to be timely and can potentially be encouraged through suggestions about how a parent or teacher might adjust their response to the child, which can often be achieved via a telephone call. A team-based approach also provides mutual support to all professionals and individuals involved. Below, I continue to explore the multi-disciplinary format further, but before doing this, would like to emphasise the importance of the inclusion of the foster parent(s) in this model.

Assessment, diagnosis and intervention for foster children

Assessment

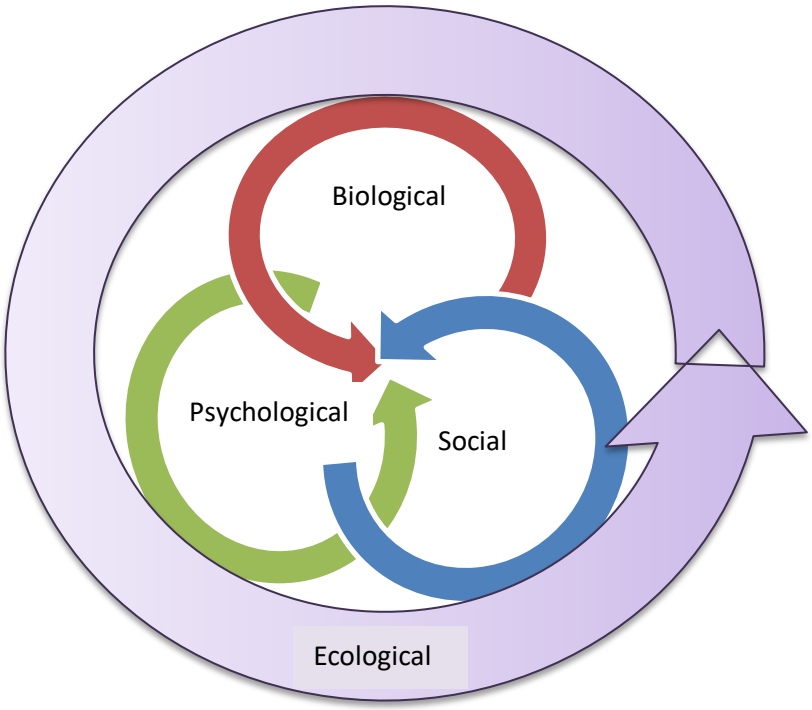
As a psychologist, when I am trying to find out more about someone with whom I am working, I tend to focus on their psychological presentation from an historic perspective; social elements especially relationships; and systemic issues that might be affecting that person. However, using a bio-psycho-social-ecological model we need to know more about the biological, keeping in

mind inheritability. This includes inheritability of genetics, the transmission of epigenetics, and also possible intergenerational transmission of attachment, parenting styles, mental health and substance use to name a few, going back as far as grandparents and further if possible. Furthermore, using a combined Developmental-Attachment-Trauma model to understand the particular nature of a foster child provides insights into that child's issues, sensitivities that could elicit flashbacks, distressing them and resulting in dysregulation. These sensitivities based on the child's early experiences could inform possible ways of adjusting foster parents' responses in order to allow the children to function better in the world.

Ecologically, perhaps a "chrono-gram" could run alongside the genogram. The relevance of the larger, cultural, regional and country's laws, policies and constructs impact the personal lives of all citizens. Examples in Ireland that might need to be considered in a "chrono-gram" include historic abortion laws and the resultant psychological effects of a mother carrying an unwanted pregnancy to term (Bourke et al., 2015); or the long-term residual effects of historic institutional child abuse and subsequent de-institutionalisation (Gilligan, 2019), when trying to place a child in a residential placement that is in their best interests to prepare them for living in a family.

Figure 20

Biological-Psychological-Social-Ecological information representation of the foster child



Assessing the needs and behaviours of foster children requires a comprehensive model preferably from a multidisciplinary perspective. In the diagram above (Figure 20), I have included the bio-psycho-social model (Engel, 1977) within Bronfenbrenner's Bioecological framework (Bronfenbrenner & Morris, 2006) considering all the elements pertinent to a foster child and illustrating the uniqueness of each individual child from the perspective of their own particular context. Observing the child from this viewpoint, rather than categorising them diagnostically, facilitates the identification of their difficulties and interprets emotional and behavioural difficulties as ways they have previously coped with suboptimal or traumatic conditions. This shifts the paradigm from pathologising the behaviour and the child to interpreting them as adaptive, additionally potentially providing a starting point for intervention. This neither focusses on, nor excludes relevant individualist elements, but also considers the broader factors within their bio-psycho-social-ecological context that may affect a child and their capacity or style of behaving and interacting relationally.

Based on the behavioural and mental health complexities of foster children, and all the interactive relational intricacies of the child's ecological circumstances, a multidisciplinary team who specialise in working with these children is required. As suggested by Zilberstein and Popper (2016, p.1), "Treatment of foster children should be seen as a subspecialty within the field of child mental health, and trainings that help clinicians gain more knowledge of foster children's unique needs should be more available". Suggestions of professionals and individuals who would make a valuable contribution to a specialist multidisciplinary team and where their knowledge would be valuable in the assessment, diagnosis and treatment of foster children is outlined in Figure 21 below. An important inclusion in this model is the foster parent(s). How this team is constituted and run requires further investigation and co-creation as there are numerous professional and ecological factors that require consideration in order that its focus is child-centred.

Figure 21

Biological-Psychological-Social-Ecological information representation required for Assessment and Diagnosis and multidisciplinary team members responsibilities within these areas

Biological Genetic inheritability / Intergenerational transmissibility	**Psychological** Mental Health / Emotional and behavioural presentation	**Social** Interpersonal factors / Social and community interrelationships	**Ecological** Child & Family Agency / Legal * Educational * Religious systems / Culture / Time frame
Social Worker	Social Worker	Social Worker	Social Worker
Biological parent (s) and family members	Biological parent (s) and family members	Biological parent (s) and family members	Biological parent (s) and family members
Foster parent	Foster parent	Foster parent	Foster parent
Psychologist Clinical Educational Neuropsychologist	Psychologist Clinical Educational Neuropsychologist	Psychologist Clinical Educational	Psychologist Clinical Educational
School	School	School	School
Speech & Language / OT / Physiotherapist / GP	Speech & Language / OT / Physiotherapist / GP	Speech & Language / OT / Physiotherapist / GP	Speech & Language / OT / Physiotherapist / GP
Psychiatrist	Psychiatrist	Psychiatrist	Psychiatrist
Paediatrician			Guardian ad litem
PHN			Solicitor / Barrister
			Judge

Diagnosis

Emotional and behavioural symptoms in children who are born with the toxic and teratogenic effects of their mother's alcohol use during pregnancy; who have learned to survive in the world without the safety of a nurturing consistent relationship; or have suffered different forms of maltreatment, all share similarities. The literature outlined the neurological, physiological, cognitive, and psychological outcomes of these three areas, which a foster child will have experienced at least one of, if not elements of all three, negatively affecting normal development, with resultant long-term consequences. However, it also illustrates that this could potentially lead to misdiagnosis or at least complicate diagnosis, as the children and adolescents' symptoms from these three aetiological areas are so similar and often overlap.

Distress, anger, or any forms of difficult behaviour take up more energy and effort for the child than regulated behaviour. As stated in their book on the *Circle of Security* Parenting program, Hoffman et al., (2017, pg. 77) state, "Dysregulation of emotional (or behavior [sic]) is deviation from what's typical in how, when, and how much we experience emotion". Therefore, interpreting behaviour as an expression of distress, would infer that the more difficult the behaviour, the higher the level of stress or distress. Another important interpretation is that behaviour represents what

the child has previously endured and therefore provides clues as to how the child has learned to survive in the world (Silberg, 2022). Emotion and behaviour should therefore be our guide as professionals and foster parents to gain a better understanding of the child. Defining behaviour as adaptive rather than dysfunctional, de-pathologizes the child and provides clues about how and where adjustments need to be made by professionals and foster parents for the child to be better able to cope. As stated by Silberg, (2022),

> For many chronically traumatized children, the symptoms learned in a lifetime of thwarted goals remain their only comfort. These symptoms represent the tools they developed to navigate the unpredictable worlds of their childhood—tools that they do not want to give up despite our interventions. (p. xxii)

Then, Bremness and Polzin (2014, p.142) state that, "…there is need for a more flexible diagnostic system to consider emerging data from both genetic and environment interactional studies within the framework of attachment, developmental and systems theory". Assessing a foster child through combined bio-psycho-social-ecological lenses, identifying the elements of Development, Attachment and Trauma that may have affected that child, allows for a more comprehensive understanding of the child and their current difficulties. Assessment therefore requires identifying the circumstances of a child, from pre-conception, during pregnancy, relationally with those significant to them and currently, along with all the reported adverse life experiences of abuse and neglect. If this information cannot be obtained, it is often possible to hypothesise what the child might have endured based on how they currently function in different contexts, such as academically and with their peers at school, relationally and behaviourally with their foster family, or when they have contact with their biological parent(s) or siblings.

Post-traumatic stress explains some aspects of many foster children's reactions and behaviours. However, PTSD was originally developed as an adult diagnosis (van der Kolk, 2014), and has been adapted to provide diagnosis criteria for children. Developmental Trauma Disorder (DTD) was devised for, and takes account of the elements of trauma unique to a diagnosis for children (Bremness & Polzin, 2014; Cloitre et al., 2009). These include that when a child experiences adverse experiences, they are at some point on the complex trajectory of (physiological, neurological and psychological) development. Furthermore, they are in relationship and reliant to a greater or lesser extent for survival on the adults that are causing them harm.

The diagnosis debate remains controversial. Labelling children before they are fully developed may categorise and stigmatise them with something out of which they may grow. This may be particularly true of foster children who due to the adverse circumstances prior to being fostered might only start to thrive and develop once they are in a safe and nurturing environment.

Furthermore, comorbidities need to be considered as well as the sources and reliability of all diagnostic information (Kendall & Drabick, 2010). Regarding foster children, information may be missing or inaccurate as biological parents may not be available to provide a genetic and historic background, and the child may not have been in a foster home long enough for emotional and behavioural difficulties to be identifiable. However, children without a diagnosis within the systems in Ireland are unlikely to be able to access services. Worse still, children with a diagnosis, such as FASD did not fulfil the criteria for any service at the time the research was carried out as their numerous difficulties often overlapped or were excluded by the remit for CAMHS, Disability Service and Primary Care Psychology Service, meaning none of the services would provide a full assessment or an intervention. Many children were often then excluded from all three services as for example their difficulties might be too severe for Primary Care, but not severe enough for CAMHS!

Intervention

Having examined the literature in relation to complex trauma in foster children and established that abuse and neglect usually occur in the context of early dependent relationships with biological parents, so too does the formation of their psychological-self through "mind-mindedness" and the way they perceive themselves and others based on their original attachment relationship. Relationship and the capacity for relationship or social interaction, would therefore seem like a logical place to assist the child to heal (Pearlman & Courtois, 2005). Foster children are placed into foster families to normalise their upbringing within a family environment. However, much harm has already potentially been done prior to their being placed in a foster family. It is therefore difficult for the child, the foster parents and their families, to adjust to a child who is living in their new environment, but behaving and responding to their new family relationships as if they were still in the place, or with the people, who caused them harm.

Many years ago, whilst working dyadically with a foster child and his foster mother, he came into my consulting room and angrily shouted, "I'm not a psycho!". When he had calmed down, I was curious to know what made him think he was a psycho, and he went up to some shelves at the side of the consulting room and reached up to a box containing envelopes that were addressed to the Psychology Department and covered the end of the word Psycho ~~logy~~. In discussions with him when he was older and with other foster children who attended individual or dyadic sessions, the theme was broadly the same, "we felt there was something wrong with us, that was why we were in care. Attending therapy reinforced this and made us think we were mad". I value and respect the individual therapy process and have worked in methods that have had some small effects on individual foster children, including play therapy, dyadic developmental psychotherapy and equine assisted psychotherapy. However, I have mixed feelings about consulting with anyone who does not

have the choice, or feels implicit or explicit pressure to attend therapy, as would most foster children, especially if it reinforces their self-concept that there is something wrong with them!

This foster-parenting Course was not originally designed as a way of reducing waiting lists, as the majority of this sample of foster children were not on a waiting list. Some foster children were on the list; however, due to the ongoing nature of their difficulties, few were able to be discharged, initiating the idea of providing a fostering parenting Course. In hindsight it is a concern that not more foster children had been referred, considering that 60% of this sample were reported by their foster parents to have above average levels of overall stress, including emotional, behavioural, social and attention problems. The Course was designed with the intention of sharing psychological knowledge with foster parents, whilst simultaneously providing them with support and acknowledging the difficult work that they do. The small group format was employed to allow foster parents to meet others and possibly identify with one another, including gaining support and information from each other. Peer support has been found to provide some relief as foster parents are able to share their day-to-day experiences, knowledge of and strategies for dealing with their children and elements of the system with other foster parents (Golding & Picken, 2004; Lotty et al., 2020). An important aim included developing an intervention that might keep foster children out of the therapy room in order not to increase their sense that they are the source of the problem. Gabler et al., (2014) concluded that attachment security, within the context of appropriate caregiving, might be more changeable than behaviour difficulties. Therefore, the main aim was empowering foster parents with increased knowledge and understanding about themselves and their children, so that they might provide a source of healing to their children, within the context of their relationship - a loving, attachment-attuned relationship that might reduce the foster child's prospective trajectory toward lifelong adversity.

Postscript

The responses of the participants about attending the Course were mostly positive and any negative comments were useful in identifying weaknesses that could be adjusted to improve the overall experience for future participants. All of the foster parents who completed the post-Course questionnaire said they would recommend the Course to other foster parents. There were also many suggestions from the post-session questionnaire of professionals who would benefit from attending either specific sessions or the entire Course. A group of social workers who worked with many of the participants and their children, requested in-service training on the Course and the content. When I left my position in the public sector, I held a seminar based on the Course entitled "Some of what I learned" to which foster and adoptive parents, social workers, speech and language

professionals, occupational therapists were invited. The education sector was also well represented by local teachers, principals and the regional special needs co-ordinators. Notably, very few psychology colleagues, CAMHS or Disability Services staff attended. More recently, I have been contracted by local Tusla fostering and children-in-care services to provide the now entitled "Creative Parenting for Complex Problems" Course to some foster parents individually.

The last word…from the participants

Were there any ways in which this Course helped you?

- *Yes, this course was very helpful to me in 1. Understanding that a child in womb develops attachment issues, trauma, wanted or unwanted 2. Behaviour issues and why it caused 3. A better understanding of the way children think and for me to be on the same page 4. What side of the brain which the child uses and to help them using both.*

- *Made me more aware of a couple items I didn't know about. Used your chart about 18 FAS child /adult in my case re aftercare and new payment. Also used it to get 3 ½ hours more resource time in school re emotional and disorganised / disruptive child. Reminding me it's not their fault ie this a.m. I am a fucking bitch, a whore and that was only at 730 am!!*

- *The way the brain works very interesting. To learn the difference between a teenager and FAS there is the line. Talking and sharing with each other a great help I found this. Susan your explanation is a great help.*

- *Understanding attachment difficulties more also understanding more about the brain, reminding ourselves that children in care often act 4 years younger than their age and keep reminding ourselves about this. The most important thing Ive learnt is that every child is different.*

- *Yes this course has given me a better understanding of the reason why our children act the way they do, and the fact that they have little or no control of their actions. Also, it gave me a better understanding of the damage that can be done to the children while still in the womb, also how the children perceive themselves as being inferior, bold or worthless. Attachment was a bit of a mystery to me before I started these sessions, I have a better understanding now.*

- *OMG yes really made us aware of behaviour issues and causes. Also, even though you think everything is ok deep down there might be underlying problems and after the course we really watched for different triggers and what anxiety might stem from them. We found that home visits really caused problems and we were very aware of this and after the course we found a different way to handle these issues, really understanding.*

- *Yes, in understanding the kids behaviours and why they are behaving in that way and also how to react to these situations. It also helped to explain to other adults more i.e. Teachers and coaches. Understanding how hard the kids are working to function normally in different*

settings, when it is not coming naturally to them. Overall a new understanding of challenges facing the kids now and in the future.

- *It helped with the bonding with the 8-year-old and have a better knowledge of what going on with him, to have more patience with him.*

- *In general, all of them, helped me. They reminded me of things had forgotten and taken for granted, or not realised, like the impact of my own experiences but what helped the most was high road and low road. Very much the high & low sides are working very well in our family. It has helped me to be more relaxed and calm when talking to the children. I have learnt a lot listening to other stories.*

- *Yes, very much, gave a very good insight into the problems children in care have. The affect their background has. Attachment, foetal alcohol, how the brain works, how to be in Tune with them. Be more aware of our own triggers and have a better understanding of the problems they experience.*

- *Be aware of my child's needs, stay cool, repair a rupture once my child has calmed down, work things out together. Prepare him for situations in advance. Have time to yourself, nurture relationships.*

- *Logical Brain – very helpful, rupture and repair, to be treated different than biological (pull them back to you when the run) Dissociation, broken mirror, time out doesn't work.*

- *Gave me a greater understanding of mentality of these children in care especially the 18 yr old. Methods of dealing with the children. Understanding the effects of trauma and separation. Made me more aware of signs of behavioural difficulties and dealing with them.*

- *I found it was useful in allowing a more objective perspective on what was happening within the placement and why. Some aspects seemed counter-intuitive and it was reassuring to have a practitioner's input about the more abnormal behaviours.*

- *More aware of different behaviours. Different way to dealing with situations made me question how to deal with matters. Learnt more about the brain and how from birth and even before the impact of drink, drugs intake by mam has such an effect. The cracked mirror image stood out. The sessions answered a lot of questions on difficulties with learning and behaviour the kids suffer from and their image of themselves*

- *Discussing children's issues with other foster carers gaining advice and understanding that other children do have / did have same /similar issues. Hearing about different problems/issues children in care have. Understanding how to deal with them and how to get help.*

- *Self Awareness – the biggy for me pressure points. Memories, Rupture & Repair. Repair necessary for good relationships. Right and Left brain. Constant conversations necessary to get in shoes of children. Understanding attachment and trauma understanding structure of their brains vital to working with them. Listening! Children comprehension of times and events totally*

different than ours. High Road and Low Road, so helps my insight to self and the children. Our past i.e. attachment etc memories impacts on us all our lives.

- *Yes, to realise and understand the children in care. Try to work with them with the understanding that they are mixed up with so many emotions. See the positive side of behaviour rather than the negative.*

- *Yes, there are ways the session helped with my family in understanding or trying to understand tantrums or meltdowns and try to see things the way the children might be seeing them and understand their coping mechanisms. The sessions made me realise even more how different each child is and how they react completely different to each other, you're always dancing with one of them.*

- *Yes, learning all about the brain and the difference a child is born with the effect of drink and alcohol. Attachment was very informative, to wrap the child in a blanket, just to be able to understand the child. I find the information so informative, would love to have training on a more continued basis. To learn all about the broken mirror image. Shows you how the child is feeling.*

- *It helped me a lot about the ways the brain works about attachment, bonding, the troubles in a child's life what can happen when you are pregnant if you don't do the right things, drink is a no no when I had him in my house with a lot of his problems every time you think about things before you do it now and you know you are doing the right thing. Trauma is a big thing for everyone.*

- *I found the training informative, the cause and effect of different situations, why certain behaviours occur. It also got me as foster parent thinking, taking time to think why behaviour is occurring.*

- *Yes, I learned to be more patient and listen, I give her choice but at same time push a little towards what I'd like her to do. My nephew's girlfriend is trying to be pregnant, I've told her to make sure she doesn't take anything to hurt unborn, just made her more aware of everything including stress affects unborn, she listened will.*

- *Yes absolutely, I learned how to respond in a better way, not panicking anyone when he throws a tantrum out of fear that he will get hurt, so by just distracting him quite quickly and it has worked really well and there is a lot more calmness now, My child has had a really good summer and we found that by putting strategies from this course into play that it has helped him in numerous ways. He looks at us straight in the eye now and answers up perfectly when we are speaking to him…he still has outburst but we can overcome them now without spoiling him. We had a few issues around mam coming and him lashing out but that has improved a lot as well.*

- *Yes, I looked at parenting the kids with new perspective, took into consideration levels of attachment and keeping a diary helped with identifying patterns of behaviour, to seek out play therapy and more specific to their needs. I used some of the suggestions made in groups to help*

children to adapt to a new way of life. I found the training session very good for development of my techniques and developing the children's skills.

- *Ive got more of an understanding so I can get (my adolescent son) better but it's harder and harder to keep peace when he is in a disruptive mood. The course helped me to realise I am not alone many carers have the crazy life that exists in our house.*

- *The group together brought a lot of different queries and questions in relation to all the topics covered while led to very interesting discussions. It is great to be able to access such information which gives us a lot better understanding of the different situations which we find ourselves in. These courses and workshops expose foster parents to a lot more experiences of foster parents and social workers which can only help to improve the skills required to act as a foster parent.*

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Appendix A
ETHICAL APPROVAL LETTER

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE West,
University Hospital,
Dooradoyle,
Limerick, Ireland.

Tel: 00353 (0) 61 301111
Fax: 00353 (0) 61 301165
Website: www.hse.ie

25th March, 2014

Ms. Susan Cahill,
Child & Family Psychology, Service,
HSE,
Tyone Health Centre,
Nenagh Hospital,
Nenagh,
Co. Tipperary.

Re/ Protocol Title
Development, exploration and evaluation of a small group psycho-educational training program for foster parents and adoptive parents whose children present with moderate to severe emotional difficulties.

Dear Ms. Cahill,

The Research Ethics Committee at the University Hospital Limerick has received a submission for ethical approval for the above study.

The following documents were reviewed and approved by the Research Ethics Committee:

Application to the Research Ethics Committee	*Approved*
PSI-4 Item Booklet	*Approved*
Strengths & Difficulties Questionnaire	*Approved*
Child Behaviour Checklist for Ages 6-18	*Approved*
Child Dissociative Checklist (CDC) Version 3	*Approved*

From an insurance perspective, please note that cover does not extend to those parties not employed by the Health Service Executive (HSE), or non-HSE Institutions.

Yours sincerely,

Fionnuala O'Brien,
Clinical Programmes Co-Ordinator,
(For and on behalf of the Research Ethics Committee & the Risk Management Department).

Appendix B
PARTICIPANT INFORMATION SHEET

PROJECT TITLE

Development, exploration and evaluation of a small group psycho-educational training program for foster parents and adoptive parents whose children present with moderate to severe emotional and behavioural difficulties

INVITATION

You are being asked to take part in a research study about children in care and adoptive children who often present with varying degrees of emotional and behavioural symptoms, as well as academic difficulties. These complex behavioural presentations are often confusing to parents and may result in difficult interpersonal relationships and sometimes even placement breakdown. Based on 14 years of my own clinical practice as a Clinical Psychologist and the most recent research, I hope to present a psycho-educational teaching program using relevant aspects of Prenatal and Infant/Child Development, Attachment theory, Interpersonal Neurobiology, and Trauma informed practice to provide a better practical understanding of the roots of emotional and behavioural presentations. In addition it hopes to explore how this along with small-group support from other parents experiencing similar difficulties impacts on a parent's wellbeing and increases their ability to be creative in their parenting strategies.

Please note that this research project has been approved by the HSE (Mid West Region) Research Ethics Committee.

WHAT WILL HAPPEN

In this study, you will be asked to:

- Participate in a psycho-educational group (all sessions will be audio recorded)
- Complete a number of questionnaires in relation to your children
- Complete a questionnaire relating to the impact of your child's behaviour
- Make entries in a journal regarding significant behaviours/interventions/learnings
- Provide feedback on the content of the group and suggestions for later groups

Please be aware that participation in this study involves completion of some standardised tests [SDQ, CBCL, CDC, PSI], which are routinely used as preliminary screens for possible emotional and behavioural difficulties in children and information regarding their relationships with their parents. These assessments in the absence of a clinical interview are not sufficient for diagnostic purposes, nor will they be used in this manner in this study. I do not intend to inform participants of individual test scores, however in the event that scores are of potential clinical concern, you will be informed and relevant referrals made with your permission. No individual reports will be generated from this research.

TIME COMMITMENT

- The study starts with one 2 hour session of explanation to provide the background information in order for participants to give informed consent. During this session, questionnaires will be provided to participants to complete. An outline of the group sessions will be provided.
- Five 2 hours sessions of group will be provided once a week. Much of this time will be spent exploring specific issues pertaining to foster and adoptive children.
- A three month break will be provided over Christmas.

- Another two 2 hour sessions will be provided, taking into consideration content suggestions of participants
- Follow up and questionnaires will be provided six months thereafter to end the project

PARTICIPANTS' RIGHTS

- You may decide to stop being a part of the research study at any time
- You have the right to omit or refuse to answer or respond to any question that is asked of you
- You have the right to have your questions about the project answered. If you have any questions as a result of reading this information sheet, please ask the researcher before the study begins.

BENEFITS AND RISKS

Benefits

That the content of the psycho-educational groups will be of benefit in assisting parents deal with complex emotional and behavioural issues their children may present.

That the group context will provide both implicit and explicit support to participants

That the participant's data will provide data that can inform professionals working in this area

Risks

Discussing issues pertaining to children's trauma and attachment can be upsetting and this will be discussed before the information sessions and monitored throughout. Participants will be given suggestions on how to manage this information and encouraged to seek support if necessary.

CONFIDENTIALITY/ANONYMITY

The data will be used to write and publish journal articles and give presentations at conferences – no individual participants will be identifiable. The data I collect will contain some personal information about you, however all information will be coded to provide anonymity and no one will be able to link the data you provide to the identifying information you supplied (e.g. name / years fostering etc.).

Feedback may be provided to the relevant Tusla/HSE departments or policy makers. Prior to any submission, you will be provided with a copy of this paper to demonstrate that no confidentiality/anonymity issues have been breached.

FOR FURTHER INFORMATION

As the lead researcher, I can be contacted at any time to answer your questions about this study. I may be contactable via phone (087 90 60 216) or email (cahillsm@eircom.net).

If you want to find out about the final results of this study, you will need to provide me with your email address and I will inform you as soon as it is completed.

Appendix C
INFORMED CONSENT FORM

PROJECT TITLE

Development, exploration and evaluation of a small group psycho-educational training program for foster parents and adoptive parents whose children present with moderate to severe emotional and behavioural difficulties

By signing below, you are agreeing that:

(1) you have read and understood the Participant Information Sheet,

(2) questions about your participation in this study have been answered satisfactorily,

(3) you are aware of the potential risks (if any), and

(4) you are taking part in this research study voluntarily (without coercion).

_____

Participant's Name (Printed)

_____ _____

Participant's signature Date

_____ _____

Name of person obtaining consent (Printed) Signature of person obtaining consent

Appendix D

Session 1 Slides

Session 1

Reminders

What is Parenting?

From Conception to Birth

1.

Reminders

- Confidentiality
- No HSE, TUSLA or SW Bashing
- Mind yourselves
- Mind each other
- Speak to the group
- Nobody's opinion is more important than anyone else's
- Listen – you never know what you might hear

2.

Parenting

*The role of parenting is to provide a **safe environment** in which a child can **feel secure** enough to **interrelate** with others and **learn** from the environment around them. To **play creatively**, and have the capacity to **face challenges** resourcefully, having the ability to **self-soothe** and bounce back (resilience) when things do not go their way.*

3.

Parenting Children in Care / Adopted children

- Cannot be parented in the same way as biological children (Behaviour modification - cause and effect does not work)
- Should never be pitied - they only learn how to become victims
- Have damaged brains (through trauma, separation unresolved loss and grief as well as genetic / organic issues) that can be improved over time through ongoing repetition and developmental maturation

4.

- Need firm, consistent, clear boundaries ALL THE TIME!!
- Require patience, understanding, forethought and foresight, and an immeasurable amount of energy (generally when you don't have any of the above)
- Should be parented approximately 4 years below their chronological age

Require creative flexible parenting for often chronic complex problems

5.

The psychological life of a child starts long before they are born...

6.

WANTEDNESS

7.

&
Wellbeing

8.

UNWANTEDNESS

9.

- Age
- Socio-economic (poverty)
- Culture (Race / Religion)
- Unplanned
- Marital status
- Non-consensual / violent sex

10.

The Womb Environment

- **Foetal Alcohol Spectrum Disorder**
- **Mother's Mental Health** (neuro-chemical impact on the foetus)
- **Domestic Violence** (physical violence and stress)

11.

Foetal Alcohol Spectrum Disorders

My son will forever travel through a moonless night with only the roar of the wind for company. Don't talk to him of mountains, of tropical beaches. Don't ask him to swoon at sunrises or marvel at the filter of light through leaves. He's never had time for such things and he does not believe them… a drowning man is not separated from the lust for air by a bridge of thought – he is one with it – and my son, conceived and grown in an ethanol bath, lives each day in the act of drowning. For him there is no shore. (Dorris, 1989)

12.

Myths

13.

MYTH 1

X Guinness is good for pregnant mothers because of the iron content'. During the 1935 'Guinness is good for you' campaign, pregnant women were advised to drink Guinness.

✓ Today, Diageo, the distributors of Guinness, back the campaign for 'zero alcohol in pregnancy'. The potential damage that alcohol can do to the brain and other organs of the foetus outweigh any benefits from the iron content of Guinness, which can be found in other healthy sources. The damage caused by alcohol to the unborn child is irreversible and permanent.

14.

MYTH 2

X 'Moderate drinking after the first trimester of pregnancy is risk-free.' In 2007, the National Institute for Health and Clinical Excellence (NICE) advised pregnant women that the main risk of damage was only during the first trimester. They suggested that women could drink moderately in the second and third trimesters.

✓ In fact the foetus is vulnerable throughout the entire pregnancy. In the first trimester, in addition to the risk of miscarriage, the organs are forming. Towards the end of pregnancy, during the third trimester, the disruption to the final development of the brain and nervous system can affect learning, memory and nervous disorders.

15.

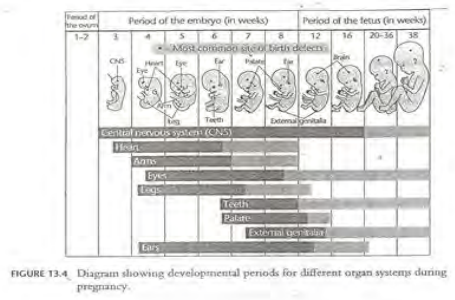


FIGURE 13.4 Diagram showing developmental periods for different organ systems during pregnancy.

16.

MYTH 3

X 'FASDs are genetic – they can be inherited'

✓ FASDs are not genetic and cannot be inherited.

17.

MYTH 4

X 'Heroin, cocaine, cannabis and hard drugs are more damaging to the foetus than alcohol'

✓ Alcohol is more damaging than any of these drugs.

18.

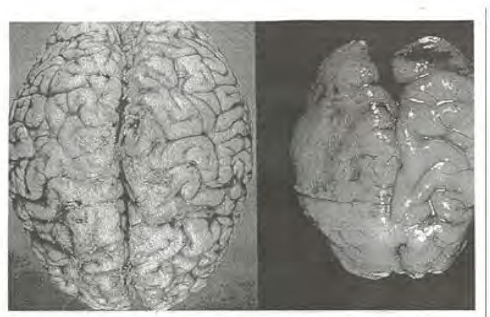


FIGURE 11.1 Comparison between the brain of a typically developing baby and that of a baby with FAS (courtesy of Dr Sterling Clarren).

19.

Impact on Brain

- General Intelligence
- Executive Functioning
  - Manage time
  - Pay attention
  - Switch focus
  - Plan and organize
  - Remember details
  - Avoid saying or doing the wrong thing
  - Do things based on experience

20.

Impact on the brain cont...

- Learning & Memory
  - Verbal & Non-verbal
- Visual Spatial ability
- Language
- Motor Function
  - Gross & Fine Motor

21.

Diagnosing FASD's

22.

The emotional status of the mother impacts on the developing foetus

- Mother's Mental Health
- Domestic Violence
- Financial, Family, and other stressors...

23

BREAK

24.

Impact on:

body ?

brain ?

behaviour?

25.

Brainstorming...

- Interventions
  - What type of environment would suit a child with FASD?
  - How would you speak to the child keeping in mind language difficulties (receptive and expressive), memory difficulties, impulsivity etc.?
  - What types of hobbies or interests would you promote?

26.

Session 2 Slides

Session 2

From Birth through Childhood

1.

Topics

- Birth
- Attachment infancy and childhood
- Theory of Mind
- Discussion

2.

Birth

Disruptions

Pain of labour and giving birth
- can trigger flashbacks to CSA
- can evoke rejection

Fear / lack of preparedness/ feelings of incompetence / hormonal imbalance
- can trigger post-natal depression

3.

Attachment

- Prematurity
- Protection from predation
- Sensitive care-giving as the foundation of psychological health
- Importance of Attachment throughout the lifecycle (birth to death)

4.

The brain is social

Our brains are structured to be in relationship with other people....

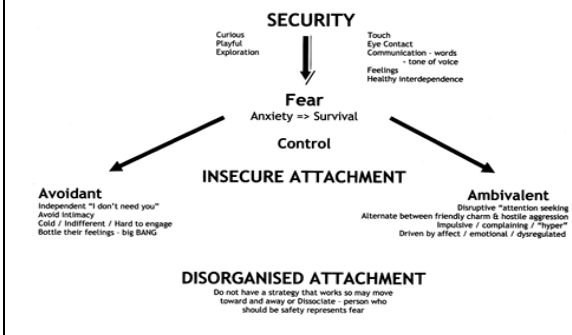
5.

The ABC of Attachment

- **Attunement:** aligning your own internal state with the child's /mostly non-verbal
- **Balance:** your children attain balance of their body, emotions & states of mind through attunement with you
- **Coherence:** the sense of your child's integration through your relationship with them – both internally integrated and interpersonally connected to others

(Siegel, D. 2003)

6.



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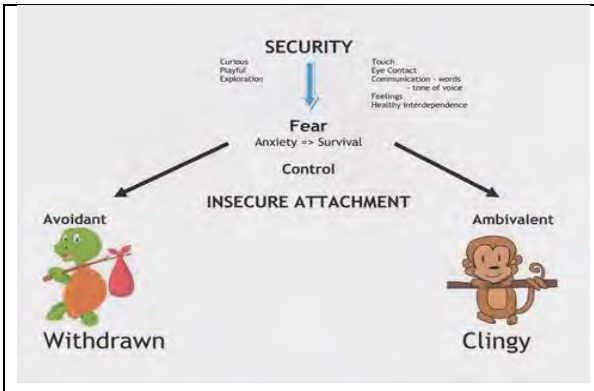

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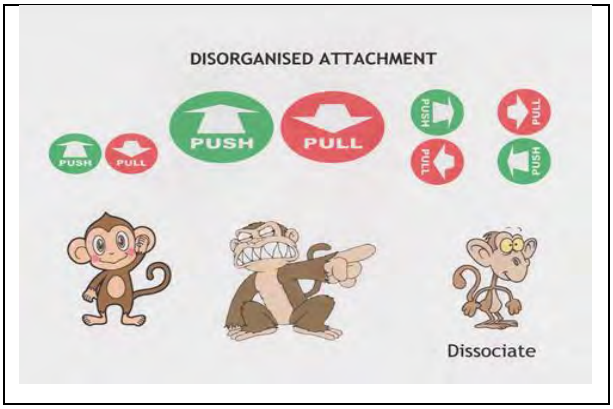

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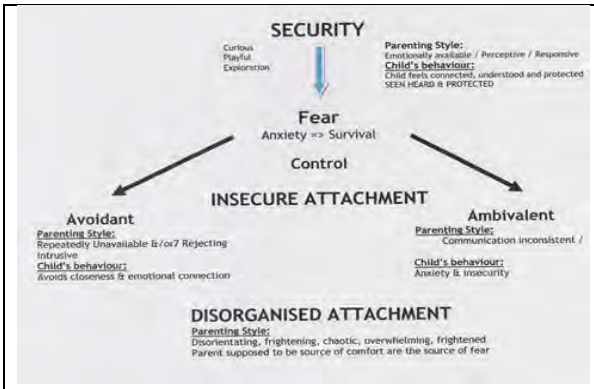

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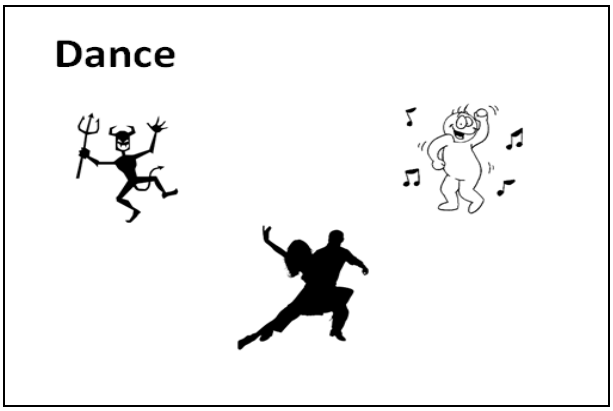

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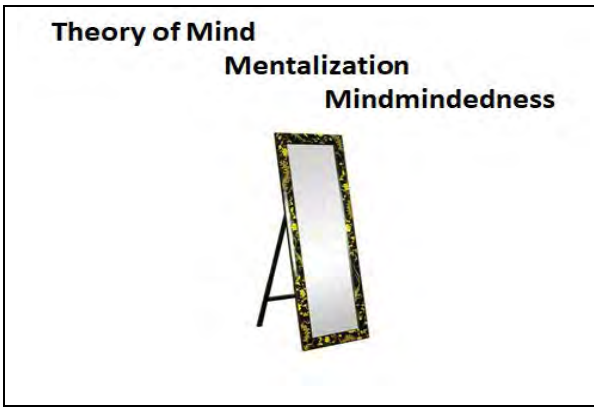
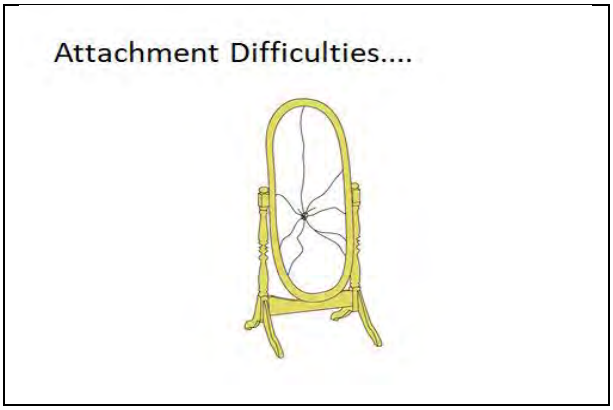


12.



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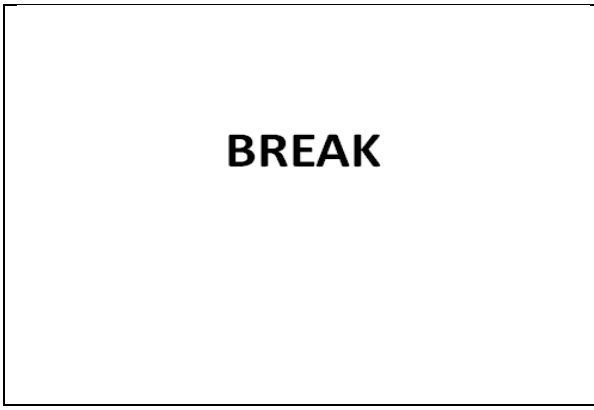

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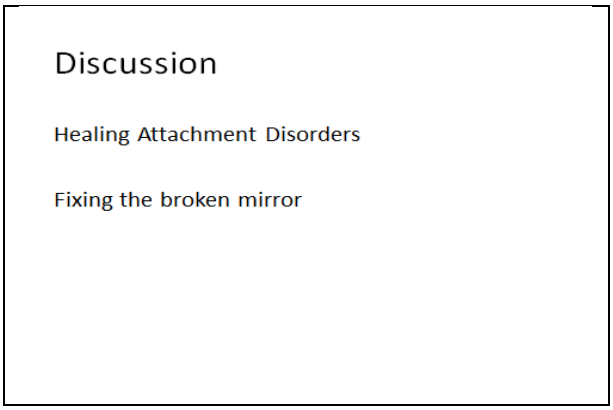

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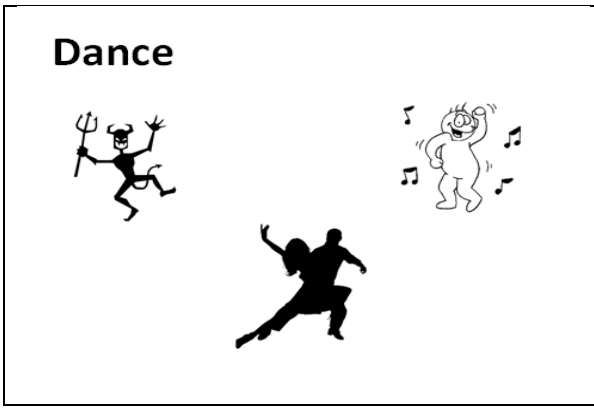

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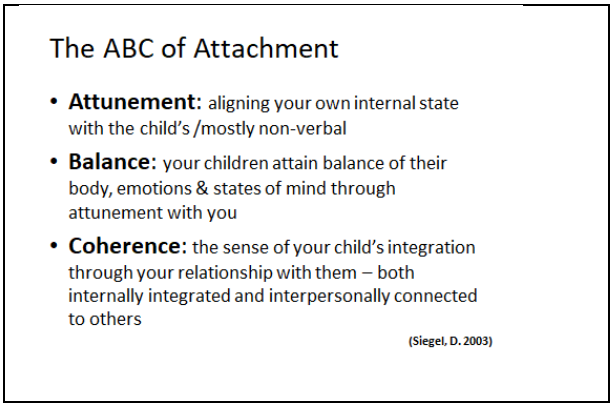
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• Balance: your children attain balance of their body, emotions & states of mind through attunement with you
• Coherence: the sense of your child's integration through your relationship with them – both internally integrated and interpersonally connected to others
(Siegel, D. 2003)

17.

Session 3 Slides

Session 3

Trauma
&
Dissociation

1.

Topics

Development
Trauma & Dissociation
PTSD

Discussion

2.

DEVELOPMENT

Ages & Stages

Adolescents
Children
Toddlers
Babies

3.

TRAUMA

Criterion A

Direct personal experience of an event that involves actual or threatened death or Serious injury, or other threat to one's physical integrity;

4.

or witnessing an event that involves death, injury, or a threat to the physical integrity of another person;

5.

or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.

6.

Criterion A2

The person's response to the event must Involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behaviour).

(DSM-IV-TR, p. 424)

7.

Acute: Single incident (mugging, car accident, natural disaster)

Chronic: Repeated, prolonged trauma (domestic violence, abuse, war)

Complex: chronic, interpersonal trauma; varied and multiple traumas; early onset; often by trusted caregivers

8.

What types of Trauma have Children in Care or Adopted Children experienced?

9.

TRAUMA

- **ABUSE**
  - Verbal
  - Physical
  - Sexual

Prenatal (FASD / Smoking / Domestic Violence / Mental Health....)

- **NEGLECT** — **Attachment Trauma**
- **BEING TAKEN INTO CARE**

10.

Children and Trauma

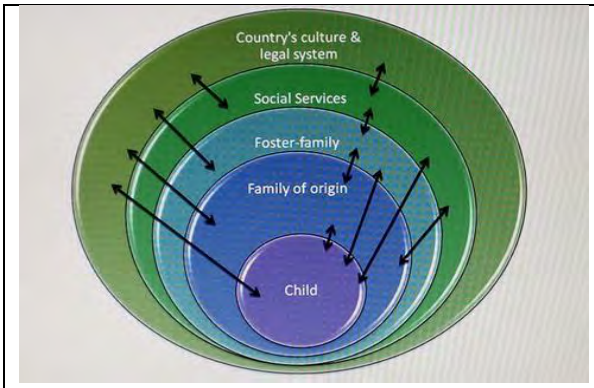
11.

Children in Care

Chronic (ongoing)
and
Complex (interpersonal)
Trauma

Developmental Trauma Disorder

12.



13.

Child

Being taken into Care

Despite how terrible the child's experience might have been, that was the child's reality in which they existed and survived.

14.

Family of Origin

Primary Carer:
- Mental Health
- Drug or Alcohol addiction
- Capacity to parent
- Physical incapacity through illness or disability

Family Environment:
- Social Deprivation/Poverty
- Domestic violence
- Drug & Alcohol use

15.

Foster Family

- How well child able to relate to them
  (personality / class / gender / race etc.)
- How many other children in placement
  (biological / foster – ages gender etc)
- Carer's ability to interpret and relate at level (more or less) required by child (attunement)
- Foster-carers
  - reason for fostering
  - temperament
  - ability to parent safely and appropriately
  - own experience of parenting from their parents
  - own life story might reflect child's own difficulties and trigger each other

16.

The Social Service system

- **Relationship of Carers with Social Services**
- **Multiple Teams responsible for 1 Child**
- **Changes in Child's Social Worker**
- **Multiple Professionals**
- **Placements**
  - Geographic in relation to environment of origin
  - Breakdown => Change in schools / living situation / rules

17.

The country's culture and legal system

At present

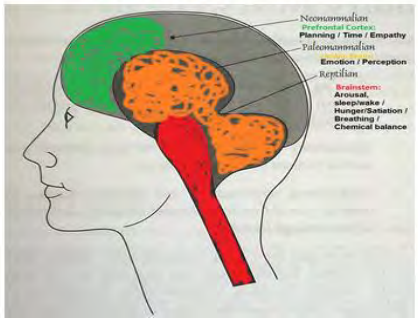
Appears to favour the Biological Parents rights over the child's rights

Care Orders – Time Limited

Access – a statutory right of the parent

18.

The 3 Part Brain



19.

The Cook and The Smoke Detector

The Cook (area inside the Limbic system) mixes all the ingredients and creates an integrated coherent picture from the signals it is receiving

= "this is what is happening to me"

The Smoke Detector (Amygdala) if it senses threat it sends a message down the brainstem recruiting the stress hormone system and the Autonomic Nervous System to bring about a whole-body response

Adrenaline & Cortisol released / Increased heart rate, blood pressure & breathing in preparation for:

FIGHT OR FLIGHT

20.

21.

The Watch Tower

Frontal Lobes keeping an eye out from above

Smoke: house on fire or BBQ

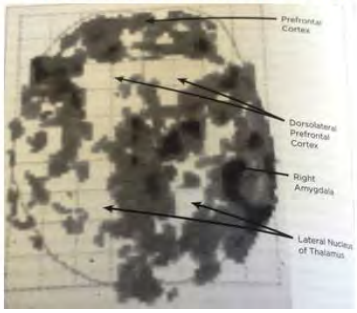
Function: To control the stress response

In PTSD this area is shut down making it harder to control emotions and impulses

The smoke detector is stuck on all the time signalling DANGER!!!!!

22.

Reliving the Trauma
Smoke Detector is on overdrive



23.

When Fight & Flight don't work...

FREEZE

Evidence from the animal world

24.

What is Dissociation?

A mental process that causes a lack of connection in a person's

- thoughts,
- memory &
- sense of identity.

DEFENSE AGAINST CHRONIC TRAUMA

25.

Dissociation falls on a continuum of severity.

Mild dissociation would be like daydreaming, getting "lost" in a book, or when you are driving down a familiar stretch of road and realize that you do not remember the last several miles.

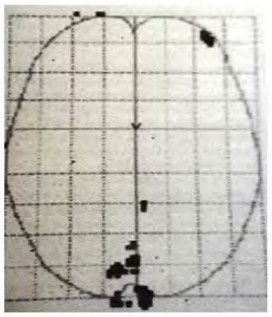
A severe and more chronic form of dissociation is seen in the disorder where there is a lack of remembering especially of traumatic events and there can be changes in mood and sometimes personality.

Symptoms include, loss of time and hearing voices, being accused of things they don't remember doing etc.

26.

27.

Dissociation



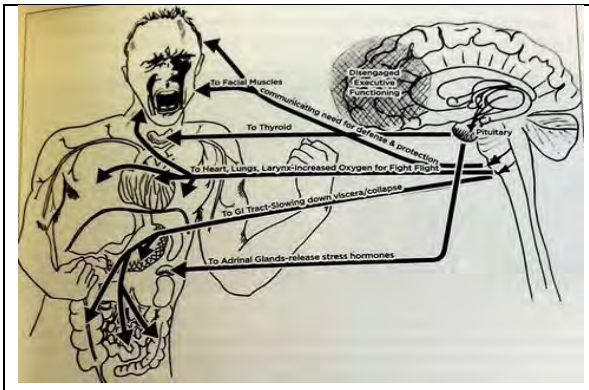
28.

PTSD

Trauma affects the BODY / MIND / BRAIN

The body continues to defend against a threat / multiple threats from the past

29.



30.

Flashbacks

Senses

- Sight
- Hearing
- Taste
- Touch
- Smell **

=> Plus

31.

Hunger

Rejection / Perceived rejection

Emotions

32.

BREAK

33.

Discussion

Impact of bringing your child into Care at the age they were and the circumstances from which they came...

Have you noticed times when your child goes into flashback mode – what could have the trigger been?

Ideas regarding healing trauma

34.

Session 4 Slides

Session 4

Adult Attachment

&

Healing Attachment

1.

Self Knowledge

Why is a deeper understanding of yourself helpful?

to you...

and

to the children you parent...

2.

The past CANNOT be altered ☹

However a deeper understanding of yourself changes who you are...

HOW?

3.

Being able to make sense of your past, present and possible future, and integrate this knowledge allows for more coherence (calmness / balance / logic / patience), which allows for a movement toward

Adult Secure Attachment

☺

(Siegel, D. & Hartzell, M. 2003)

4.

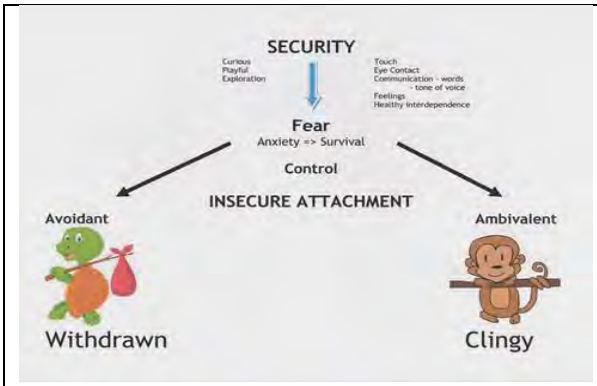
Questions for Parental Self-Reflection

5.

Attachment patterns from child to Adult

Child	becomes	Adult
Securely Attached	=>	Secure
Avoidantly Attached	=>	Dismissing
Ambivalently Attached	=>	Clingy / Entangled
Disorganizedly Attached	=>	Unresolved & Disorganised

6.



7.

Avoidance / Dismissing Parent

Adaptation: (for survival)

- Minimise the importance of interpersonal relationship and the communication of emotion
- More left brain than right brain to reduce emotional vulnerability
- Independence and emotional distance – can leave partners feeling lonely
- Self-reflection limited

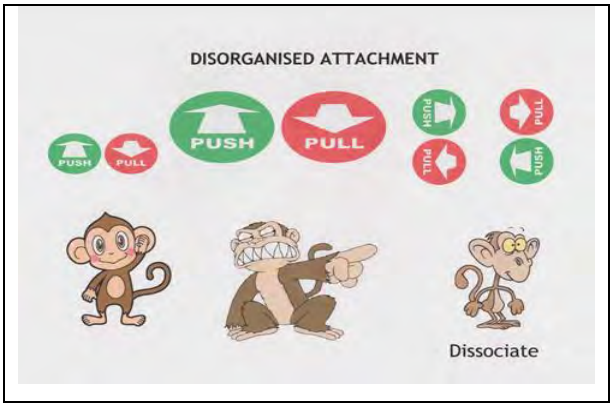
8.

Entangled / Inconsistent / Intrusive Parent

Adaptation: (for survival)

- Anxiety about whether or not others are dependable
- Desperate need for others knowing that they will never meet their needs
- Self-doubt and underlying sense that something is defective

9.



10.

Disorganisation / Fear / Trauma / Loss

Adaptation: (to survive)

- Internal Disorganisation
- Disconnection from others and sometimes the Self => Dissociation => Fragmented and unreal
- Become frozen under stress
- States of rigidity and/or chaos – lack flexibility
- Overwhelming emotion

11.

Healing Insecure Attachment Styles

Understanding through knowledge & reflection
Acknowledgment to self
Integration of information

Recognising where it impacts on interpersonal relationships and trying to do things differently realising where the feelings and reactions are coming from...

Growth requires connecting the right and left hemispheres of the brain (bilateral integration)

12.

Avoidance (left brain dominated)
Use left hand logic to explain the pattern of relationships
Guided imagery to increase sensations in the body

Clingy Ambivalent (right brain dominated)
Combination of self-soothing techniques such as self-talk and relaxation exercises and open communication within intimate relationships

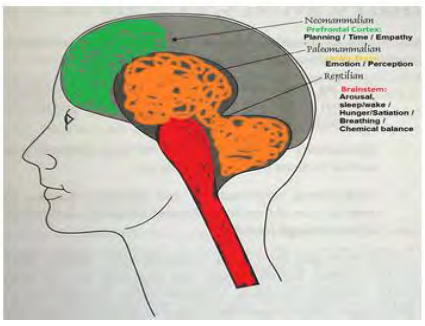
13.

Disorganised (fragmented)

- Trying to make sense of childhood and how it influenced us
- Bringing back elements of the past with reflections on the present
- Facing unbearable feelings (preferably with support)

14.

The 3 Part Brain



15.

High Road vs Low Road

High Road
Higher / Rational / Reflective Thought Processes
=>
Presence / Flexibility in Responses / Self-Awareness

Low Road
Intense Emotions / Impulsive Reactions / Rigid Repetitive Responses / Lacking self-reflection or consideration of another's point of view

16.

The low road

Triggers: Internal or external events that initiate the beginning of the low road process

Transition: The movement from the integrated higher mode of processing toward the depth of the low road

Immersion: On the low road. High road processes of self-reflection, attunement and mindsight become suspended

Recovery: Reactivating the high road processes. High risk of re-entering the low road during this phase

17.

Triggers

18.

Rupture & Repair

Ruptures without repair lead to greater disconnection

Prolonged disconnection can create shame and humiliation that is toxic

19.

Parents need to take responsibility to make a timely reconnection with their children after a rupture

Rule of thumb: In relationships in general, it is up to the person who recognises the rupture to make the attempt to repair it even when they feel they are in the right...

20.

BREAK

Session 5 Slides

Session 5

Recap
&
Healing Strategies

1.

Parenting

*The role of parenting is to provide a **safe environment** in which a child can feel secure enough to **interrelate** with others and **learn** from the environment around them. To play **creatively**, and have the capacity to face challenges resourcefully, having the ability to **self-soothe** and bounce back (resilience) when things do not go their way.*

2.

Parenting
Children in Care/Adopted children

Requires
creative flexible parenting
for often
chronic complex
problems

3.

- Cannot be parented in the same way as biological children (Behaviour modification - cause and effect does not work)

4.

- Should never be pitied - they only learn how to become victims

5.

- Have damaged brains (through trauma, separation unresolved loss and grief as well as genetic / organic issues) that can be improved over time through ongoing repetition and developmental maturation

6.

- Need firm, consistent, clear boundaries ALL THE TIME!!

7.

- Require patience, understanding, forethought and foresight, and an immeasurable amount of energy (generally when you don't have any of the above)

8.

- Need to be parented approximately 4 years younger then their actual age

9.

Session 1

From conception to birth

The psychological life of a child starts long before birth

10.

The womb environment

11.

FASD Impact on Brain

- General Intelligence
- Executive Functioning — **Unable to:** Manage time; Pay attention; Switch focus; Plan and organize; Remember details; Avoid saying /doing the wrong thing; To do things based on experience
- Learning & Memory — ➢ Verbal & Non-verbal
- Visual Spatial ability
- Language
- Motor Function — ➢ Gross & Fine Motor

12.

Session 2

From Birth through Childhood

13.

Our brains are structured to be in relationship with other people....

Attachment

- Sensitive care-giving is the foundation of psychological health
- Importance of Attachment throughout the lifecycle (birth to death)

14.

The ABC of Attachment

- **Attunement**: aligning your own internal state with the child's /mostly non-verbal
- **Balance**: your children attain balance of their body, emotions & states of mind through attunement with you
- **Coherence**: the sense of your child's integration through your relationship with them – both internally integrated and interpersonally connected to others

(Siegel, D. 2003)

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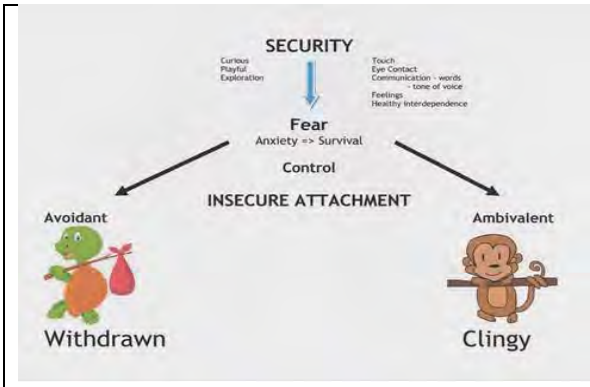

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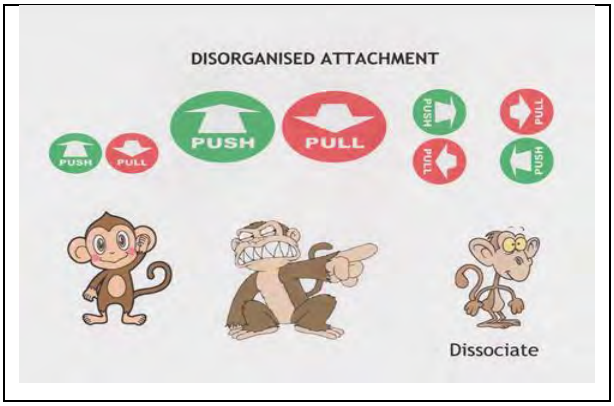

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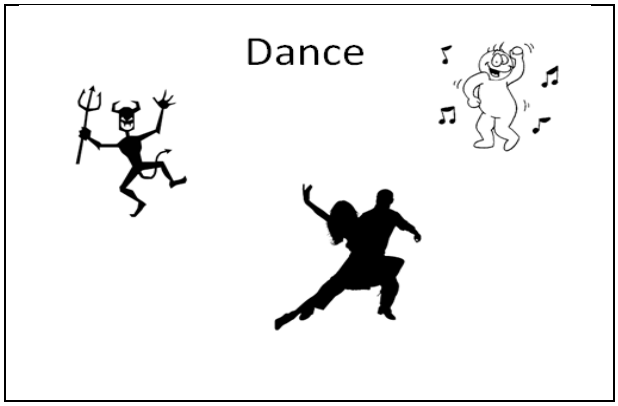

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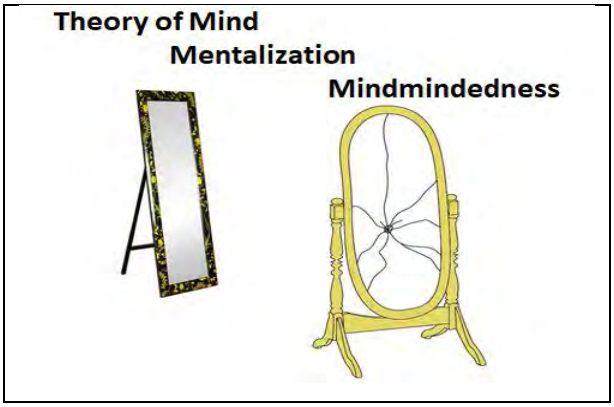

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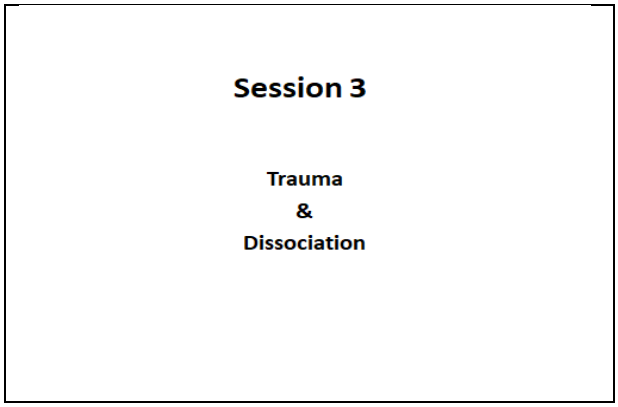

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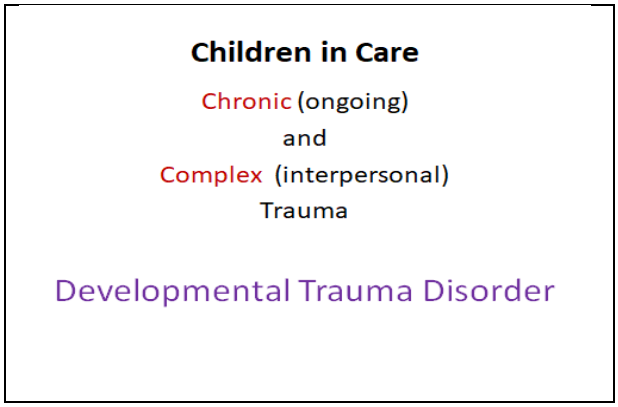

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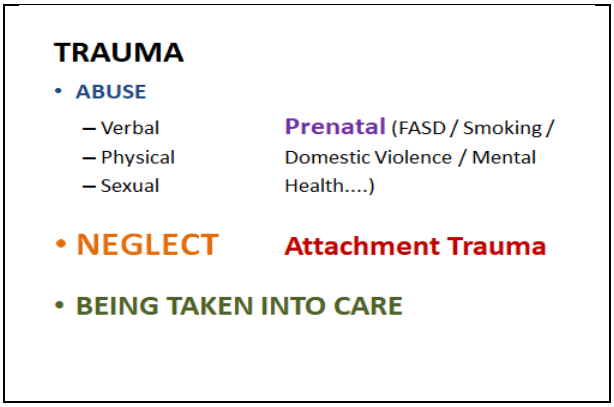

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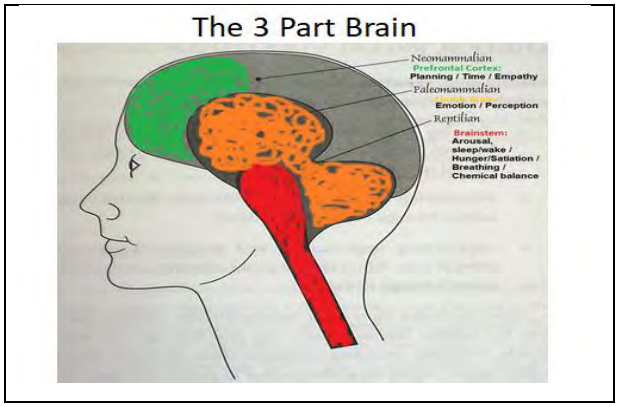

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The Cook and The Smoke Detector

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= "this is what is happening to me"

The Smoke Detector (Amygdala) if it senses threat it sends a message down the brainstem recruiting the stress hormone system and the Autonomic Nervous System to bring about a whole-body response

Adrenaline & Cortisol released / Increased heart rate, blood pressure & breathing in preparation for:

FIGHT OR FLIGHT

25.

The Watch Tower

Frontal Lobes keep an eye out from above

Smoke: house on fire or BBQ

Function: To control the stress response

In PTSD this area is shut down making it harder to control emotions and impulses...The smoke detector is stuck on all the time signalling DANGER!!!!!

If FIGHT OR FLIGHT don't work then FREEZE

26.

Dissociation

A mental process that causes a lack of connection in a person's thoughts, memory and sense of identity.

DEFENSE AGAINST CHRONIC TRAUMA

Continuum of severity...

Daydreaming, getting "lost" in a book, or not remembering part of the journey when you are driving...

=>

Lack of remembering especially traumatic events and there can be changes in mood and sometimes personality.

Symptoms include, loss of time and hearing voices, being accused of things they don't remember doing etc.

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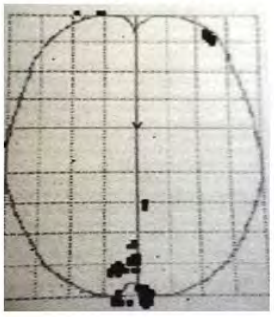
Dissociation



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PTSD

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The body continues to defend against a threat / multiple threats from the past

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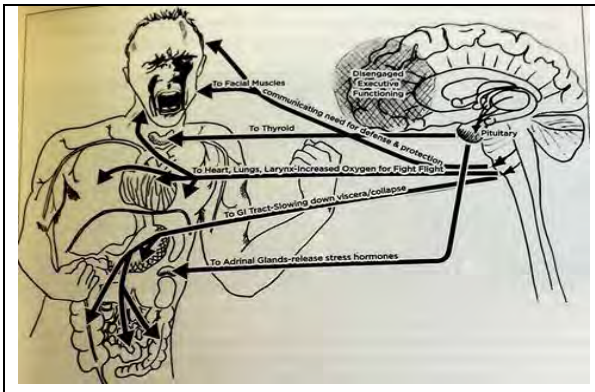


30.

Flashbacks

Senses

Sight

Hearing

Taste

Touch

Smell **

⇒**Plus**

Hunger

Rejection / Perceived rejection

Emotions

31.

Session 4

Adult Attachment

&

Healing Attachment

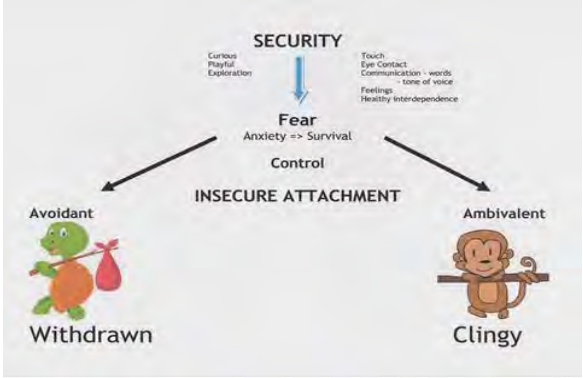
32.

What is your insecure attachment style?

When you suffer loss, are in a fearful state, sick, or very angry...
What do your behaviours or connections with important others tell you about your attachment style?

Do you become avoidant, angry or dismissing, avoiding contact and not speaking...
Or do you become ambivalent and entangled, looking for connection even though you believe your needs will not be met...
Or does your behaviour or communication become disorganised and chaotic...

33.



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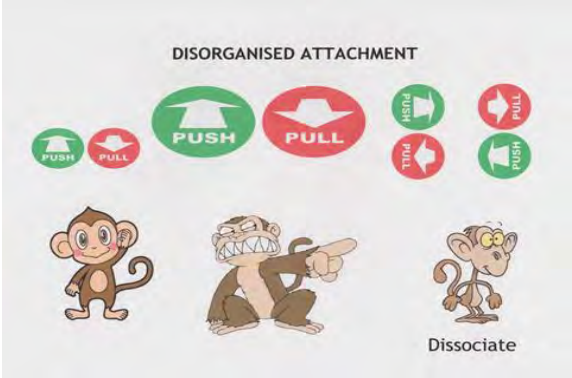

35.

High Road vs Low Road

High Road

Higher / Rational / Reflective Thought Processes
=>
Presence / Flexibility in Responses / Self-Awareness

Low Road

Intense Emotions / Impulsive Reactions / Rigid Repetitive Responses / Lacking self-reflection or consideration of another's point of view

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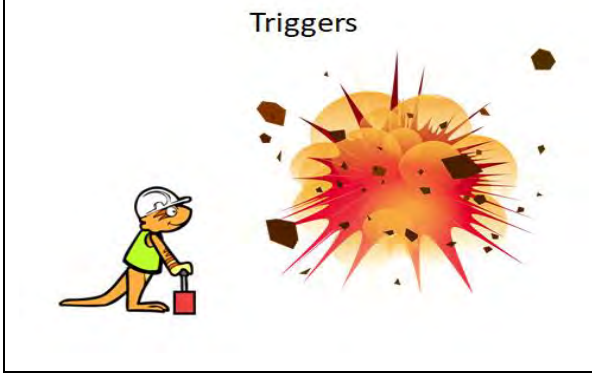

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Rupture & Repair

Ruptures without repair lead to greater disconnection

Prolonged disconnection can create shame and humiliation that is toxic

Parents need to take responsibility to make a timely reconnection with their children after a rupture

Rule of thumb: In relationships in general, it is up to the person who recognises the rupture should make the attempt to repair it even when they feel they are in the right...

38.

BREAK

39.

HEALING STRATEGIES

40.

Conception to Birth

Wantedness vs Unwantedness

Suggestions…

41.

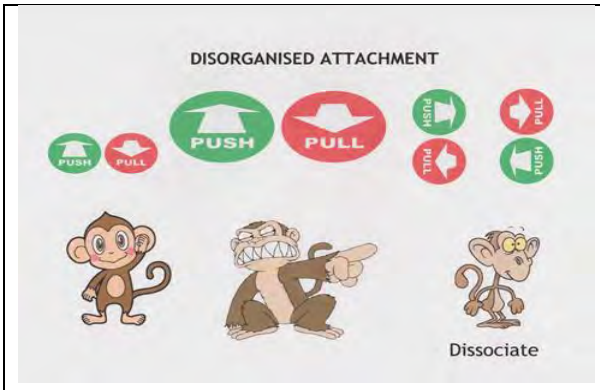
Foetal Alcohol Spectrum Disorders

- General Intelligence
- Executive Functioning — **Unable to:** Manage time; Pay attention; Switch focus; Plan and organize; Remember details; Avoid saying /doing the wrong thing; To do things based on experience
- Learning & Memory ➢ Verbal & Non-verbal
- Visual Spatial ability
- Language
- Motor Function ➢ Gross & Fine Motor

42.

The Attachment Dance

43.

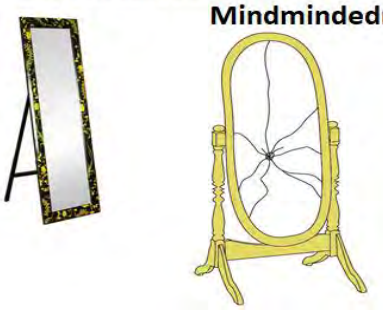


44.

Theory of Mind

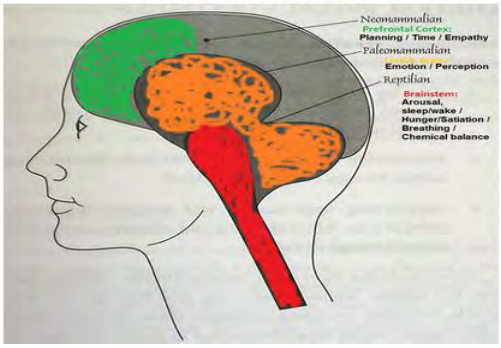
Mentalization

Mindmindedness



45.

The 3 Part Brain



46.

Soothing the Brain

The Cook, The Smoke Detector and The Watch Towers

FIGHT OR FLIGHT

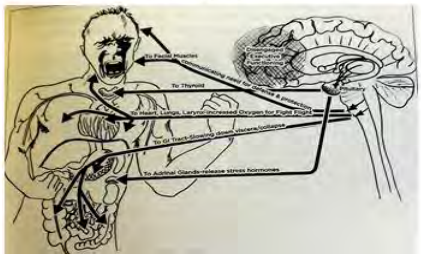
FREEZE

47.

PTSD & DISSOCIATION

Trauma affects the BODY / MIND / BRAIN

The body continues to defend against a threat or multiple threats from the past



48.

Think about how your Attachment Style might trigger your child's Attachment Style.

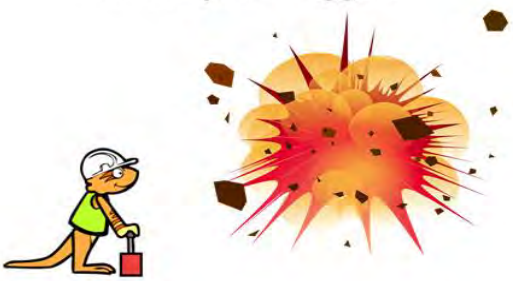
Eg. If your child is clingy and you are avoidant...

or

You need to get a response from the child and they ignore you...

49.

Know your Triggers



50.

Take time out when you can and spend that time in a way that will recharge your batteries....

Rest
Socialise
Talk
Develop a hobby
Walk
Get away for a few hours
Nurture valuable relationships

51.

No animals were harmed in the process of making these slides...

52.

Session 6 Slides

Session 6

Reminders

Attachment / Trauma

How they make us feel what they are feeling

Re-enactment

1.

Group Agreement

- Confidentiality – what is said in the group stays in the group.
- No Tusla or SW bashing

2.

Why did I choose to teach information regarding...

- Foetal Alcohol Spectrum Disorder
- Attachment
- Trauma

Parenting and Adult Attachment

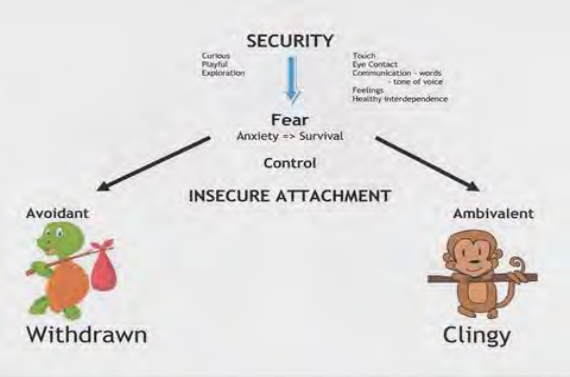
3.

Our brains are structured to be in relationship with other people....

Attachment

- Sensitive care-giving is the foundation of psychological health
- Importance of Attachment throughout the lifecycle (birth to death)

4.



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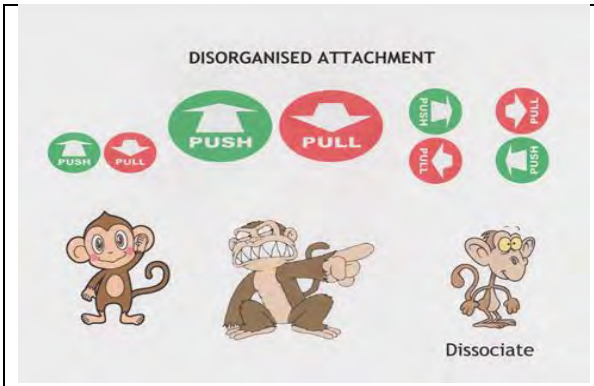


6.

What is your child's attachment style?

Secure
Withdrawn
Clingy
Disorganised

What is your attachment style?

Secure
Withdrawn
Clingy
Disorganised

7.

TRAUMA

- **ABUSE**
  - Verbal
  - Physical
  - Sexual

Prenatal (FASD / Smoking / Domestic Violence / Mental Health....)

- **NEGLECT**

Attachment Trauma

- **BEING TAKEN INTO CARE**

8.

Trauma

Trauma effects the

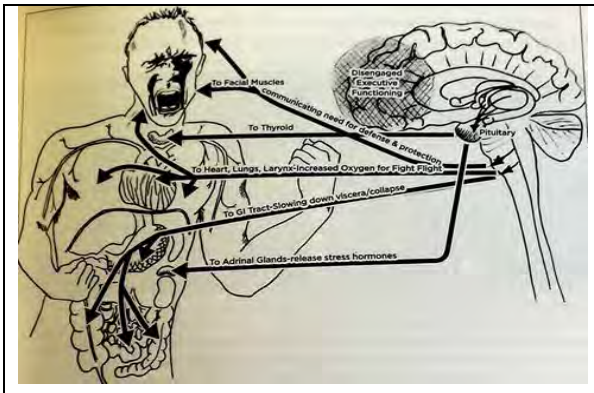
Brain

Mind

&

Body

9.



10.

Flashbacks

Senses

Sight

Hearing

Taste

Touch

Smell **

⇒**Plus**

Hunger

Rejection / Perceived rejection

Emotions

11.

How do you contribute to flashbacks?

12.

- Facial expression
- Body posture
- Availability / Non-availability
- Smell
- Tone of voice
- What you say

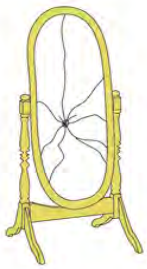
13.

Mind

- INTERPERSONAL TRAUMA

TRUST (You)

SELF-CONCEPT (Me)



14.

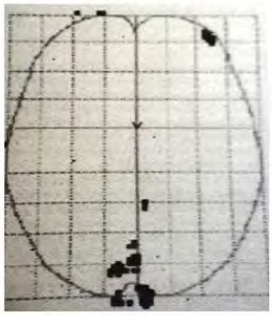
Dissociation

Symptoms

- Jeckel & Hyde
- Daydreaming
- Blanking
- Changes in ability
- Memory loss

15.

Dissociation



16.

SYMPTOMS

Have developed as a way of COPING with how they feel as a result of what they have been through...

Unless the child is relaxed and "on line", they are most likely responding to what happened to them in the past, not the present...

17.

Your fear or anxiety...

Is likely to provoke a response whereby the child will feel fearful and need to take control...

FEAR looks like...

Cheekiness / Anger / Oppositional behaviour / Avoidance / Giddiness /

18.

DO NOT TAKE THINGS PERSONALLY

This is NOT about you...

19.

That is why you need to at least identify

your stuff

WHY

Because you are the adult and we don't need *your stuff* contaminating the situation

20.

PLUS

PROJECTION / TRANSFERENCE

In their interactions with us, these children Project their feelings onto us and they are transferred so that we end up feeling their feelings or being tempted to respond to them in a way they were responded to in the past...

21.

Re-enactments

Risk of:

- Perpetration
- Re-victimization
- Self-Injury

(Research related to CSA)

22.

Session 7 Slides

Session 7

Stress

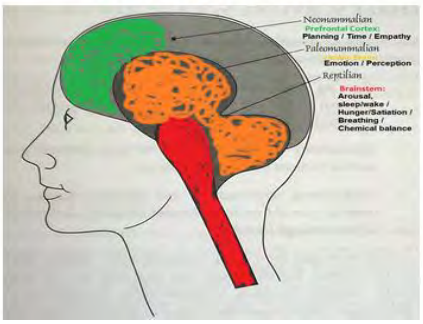
Compassion Fatigue / Vicarious Trauma

Burnout

Self Care

1.

The 3 Part Brain



2.

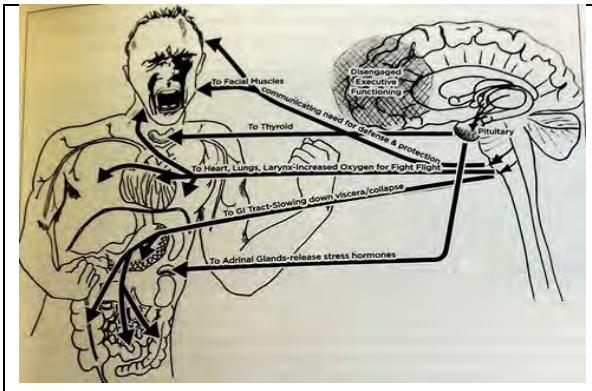
Stress

- Fostering can represent a context of chronic stress
- Placing the carer in a similar situation to the child for whom they are caring as stress leads to a fight flight response which can mirror and increase levels of fight / flight in both child and adult

3.

- Fight
- Flight
- Freeze

4.



5.

Compassion Fatigue & Vicarious Trauma

Compassion Fatigue

- observable symptoms (sleep disturbance & hyper-vigilance)
- Acute

Vicarious Trauma

- internal symptoms (shift in belief about trustworthiness of people)
- Pervasive and permanent effect on the person
- Maladaptive coping mechanism to cope with the pain that their work brings into their life

6.

Compassion fatigue

Vicarious Trauma

BURNOUT

7.

Burnout

- Emotional Exhaustion
  Psychological Depletion – lack of energy to engage in the basics of life/work
- Depersonalisation
  Involuntary acquisition of a jaded and distrustful outlook (generally directed toward the organisation or clients)
- Reduced feelings of professional efficacy
  Sense of inadequacy => powerlessness & futility

8.

Symptoms of Burnout

- Psychosomatic

Meaning: physical maladies that have a psychological origin

Headaches / Backaches / Nausea / Impaired vision / Compromised immune system

9.

Self-Care

People in the caring professions are often better at minding others rather than minding themselves…

Put your own oxygen mask on before you put on the child's oxygen mask

10.

Looking after yourself…

Physical

Rest

Exercise

Balanced eating

11.

Looking after yourself…

Psychological

- Know your triggers
- Know your limitations
- Create balance – work / play / pause
- Engage in activities that don't involve the children
- Develop your own sense of identity though your interests

12.

Looking after yourself…

Social

- Connect with others
- Ask for and accept emotional support
- Create and develop friendships and activities that are not foster-care or work related

13.

Looking after yourself

Philosophical / Spiritual

Nurture your spiritual growth

Understand your own moral, value and belief system

14.

Appendix E

POST-SESSION QUESTIONNAIRE

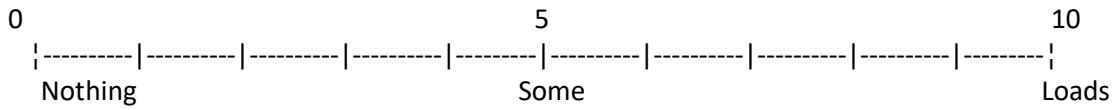
Name the things about today's session that stand out for you.

_____

_____

_____

How much did you learn today?



How do you think today's session might benefit you?

_____

_____

_____

Is there any other group of people/professionals that you think would benefit from today's information?

_____

_____

_____

What would you add to today's session?

_____

_____

_____

Thank you and look forward to seeing you next time...

Appendix F

POST-COURSE QUESTIONNAIRE

Thank you for participating in the research group. Please could you fill out the following questionnaire? The questions may seem a little repetitive, but they are relevant to different aspects of the group process. I hope that you gained something out of participating and please provide feedback so that I can improve the program.

Name:_____

Creative Parenting for Complex Problems

I attended the following sessions of Creative Parenting for Complex Problems: *(please sign the box below each session you attended and leave blank those you did not attend – the dates are provided if you need to check your diary)* If you are not sure, put a question mark in the box and I can check back on the tapes.

Date	Topic	Signature
Introduction	**Introduction & filling in Questionnaires**	
Session 1	**Parenting from conception to birth including Foetal Alcohol Spectrum Disorders**	
Session 2	**From Birth Through Childhood including Attachment & Theory of Mind**	
Session 3	**Trauma & Dissociation including the impact of Care on the child & PTSD**	
Session 4	**Adult Attachment & Healing Attachment including Triggers & Rupture and Repair**	
Session 5	**Recap & Healing Strategies**	
BREAK	**BREAK**	**BREAK**
Session 6	**Recap of all the themes plus Projection Transference and Re-enactment**	
Session 7	**Stress /Compassion Fatigue / Vicarious Trauma / Burnout / Self-Care**	

Please list the top 3 sessions you found most beneficial to you and/or your child (ren).

	(Session 1 – 7)
1st preference	Session:
2nd preference	Session:
3rd preference	Session:

Were there advantages to being part of a group, rather than learning the information individually?

_____

_____

What were some of the disadvantages to being part of a group?

_____

_____

In what practical way(s) do you think the program Creative Parenting for Complex problems benefitted you in parenting your children?

_____

_____

What were the disadvantages?

_____

_____

The time in the second half of the group was made up of small group discussion where group members reflected on their own children.

Did you find this helpful? | Yes | No |

If yes, in what way(s)

_____

_____

If no, in what way(s)

_____

_____

<u>Fostering in General</u>

Would you say that being a foster parent is stressful? | Yes | No |

If yes, what do you think are some of things about fostering that makes it stressful?

_____

_____

_____

If yes, what do you think is required to reduce the stress?

_____

_____

Would you recommend this group to other foster parents? | Yes | No |

Why *<u>would you</u>* (or) *<u>would you not</u>* recommend this group to other foster parents?

_____

_____

Thank you and all the very best with your children and the good work that you do.

Susan

Appendix G

QUANTITATIVE DATA

These results illustrate whether any changes occurred in stress levels of the parents, or in the emotional and/or behavioural presentations of the children after the parents had completed the Psychoeducational/Reflective Course.

Demographics

Thirty eight foster parents attended the Psychoeducation/Reflective group, 31 females and 7 males The 38 foster parents represented 63 children whose gender distribution was 36 males and 27 females. Pre- and Post-test sample numbers are listed below

Table G1

Number of respondents for each questionnaire

Questionnaire	Pre-test	Post-test
Parenting Stress Index (PSI)	n=36	n=22
Stress Index for Parents of Adolescents (SIPA)	n=23	n=14
Strengths & Difficulties Questionnaire (SDQ) Disorders	n=62 n=59	n=37 n=37
Child Behaviour Checklist School Age (5-18yrs) (CBCL-SA)	n=51 (5-11 boys n=13 / 5-11 girls n =10 12-18 boys n=17 / 12-18 girls n=11)	n=29
Child Behaviour Checklist Pre-School (under 5) (CBCL-PS)	n=12 (boys 6 /girls 6)	n=6

Parenting Stress Index

The Parenting Stress Index (PSI) was originally completed by foster parents of 36 foster children aged between 1.5 and 12 years and then completed by 22 foster parents at post-test stage. It measured areas of stress that might be experienced by the parent, either associated with the child or the parent themselves. The Child Domain has 6 subscales that assess the child characteristics that may contribute to the foster parent's overall stress. The Parent Domain has 7 subscales that are designed to assess the parent's own characteristics that may contribute to their overall stress. The key below is included for definitions of the subdomains.

Child Domain	Parent Domain
(DI) Distractibility/Hyperactivity Behavioural characteristics associated with (ADHD) symptoms	**(HE) Health** Level to which the parent's health contributes to their overall parenting stress
(MO) Mood Assesses the child's affective status	**(CO) Competence** Extent to which the parent feels comfortable and capable in the parenting role

(AD) Adaptability Child's ability to adjust to change in their social or physical environment	**(AT) Attachment** Parent's sense of their relationship with the child and his/her ability to notice and respond appropriately to the child's needs
(DE) Demandingness Extent to which the parent feels the child places demands on them	**(DP) Depression** Assesses the parent's affective status
(AC) Acceptability Extent to which the child's characteristics meet the expectations of the parent	**(RO) Role Restriction** Degree to which the parent feels their freedom is limited and identity is constrained because of the parenting role
(RE) Reinforces Parent Exchanges with the child are experienced as positively reinforcing	**(IS) Isolation** Assesses the extent of the parent's social support
	(SP) Spouse/Parenting Partner Relationship Parent's perception of the emotional and physical support from their parenting partner

Paired Samples T-Tests

Paired sample T-Tests were carried out on the data from the Pre and Post PSI Questionnaires (n=21/22) to ascertain whether there were any changes in the parents of foster children under 12 years old Stress levels after attending the Course (Table G2). While the sample size is small, repeated-measures tests have substantially more power than between-samples comparisons. These comparisons are intended to help judge whether observed changes are greater than we would expect by sampling error alone, rather than as generalizable estimates of effects, therefore no corrections for familywise error are applied.

Table G2

Paired Samples T-Tests of Pre and Post Test Results Parenting Stress index (PSI) Child Domain

Child Domain	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 to t2 (DI) Distractibility/Hyperactivity	-0.289	21	0.776	1.27(2)	1.36(2.26)	-0.0909	0.315	-0.0615
t1 to t2 (MO) Mood	1.784	20	0.090	1.86(1.8)	1.19(1.99)	0.6667	0.374	0.3892
t1 to t2 (AD) Adaptability	0.460	21	0.650	1.05(1.76)	0.91(1.66)	0.1364	0.296	0.0981
t1 to t2 (DE) Demandingness	0.000	21	1.000	0.59(1.82)	0.59(1.65)	0.0000	0.287	0.0000
t1 to t2 (AC) Acceptability	0.149	20	0.883	0.91(1.70)	0.86(1.28)	0.0476	0.320	0.0325
t1 to t2 (RE) Reinforces Parent	1.571	21	0.131	0.59(1.62)	0.18(1.40)	0.4091	0.260	0.3350
t1 to t2 TOTAL Stress (Child Domain)	0.370	21	0.715	0.82(1.47)	0.73(1.55)	0.0909	0.245	0.0790

Although differences were observed from time 1 to time 2, paired sample *t*-Tests show no statistically significant changes on any of the subscales. Distractibility/Hyperactivity increased, whereas Mood, Adaptability, Acceptability and Reinforces Parent all decreased. There was no

change in Demandingness. Overall, there was a small decrease in the Total Stress of the Child Domain. However, since the t-tests were not significant, there is no statistical evidence that these changes were unlikely to be due to chance.

Table G3

Paired Samples T-Tests of Pre- and Post-Test Results Parenting Stress index (PSI) Parent Domain

Parent Domain	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 to t2 (HE) Health	0.843	21	0.409	-0.05(1.53)	-0.32(0.95)	0.2727	0.324	0.1797
t1 to t2 (CO) Competence	-4.000	21	0.693	-0.14(0.89)	-0.05(1.09)	-0.0909	0.227	-0.0854
t1 to t2 (AT) Attachment	0.237	20	0.815	0.10(0.77)	0.03(0.92)	0.0276	0.201	0.0517
t1 to t2 (DP) Depression	-1.000	21	0.329	-0.18(0.73)	0.05(1.13)	-0.2273	0.227	-0.2132
t1 to t2 (RO) Role Restriction	-1.402	21	0.175	-0.23(1.11)	0.18(1.50)	-0.4091	0.292	-0.2990
t1 to t2 (IS) Isolation	0.175	19	0.863	-0.35(1.14)	-0.40(0.88)	0.0500	0.285	0.0392
t1 to t2 (SP) Spouse Relationship	-1.240	21	0.229	-0.68(1.09)	-0.41(1.44)	-0.2727	0.220	-0.2643
t1 to t2 TOTAL Stress (Parent Domain)	-0.900	20	0.379	-0.43(0.75)	-0.29(0.72)	-01429	0.159	-01965
t1 to t2 TOTAL Overall Stress	0.00	21	0.500	0.14(1.21)	0.14(1.17)	0.000	0.174	0.000

As above, both upward and downward trends in the different subscales were evident. Results for the categories, Health, Attachment and Isolation decreased, whereas the results for categories Competence, Depression, Role Restriction and Spouse Relationship increased, leading to an increase in the category Total stress (Parent Domain). However, paired sample t-Tests show no statistically significant changes, and there is no statistical evidence to argue that these changes are larger than might be expected by chance. There was no change in the Total Overall Stress of parents of children under 12 years.

Stress Index for Parents of Adolescents (SIPA)

The Stress Index for Parents of Adolescents (SIPA) was completed by foster parents for 23 foster children aged between 12 and 18 years and measured areas of stress that might be experienced by the parent, either associated with the adolescent or the parent themselves. The Adolescent and Parent Domains each have 4 subscales that assess the adolescent or parent characteristics that may contribute to the foster parent's overall stress. A graphical representation follows with a key outlining the different categories measured

SIPA Paired Samples T-Tests

Paired sample T-Tests were carried out on the data from the Pre and Post SIPA Questionnaires (n=14) to ascertain whether there were any changes in the parents of foster children under 12 years old Stress levels after attending the Course (Table G4).

Adolescent Domain Level of stress experienced by a parent as a function of the characteristics of the adolescent	**Parent Domain** Level of stress experienced by a parent as a function of the impact of parenting on their other life roles
(ISO) Social Isolation Withdrawal Parent's perception of the adolescents social isolation and passivity	**(LFR) Life Restrictions** Parent's perception of how parenting restricts their other life roles and activities
(ACH) Failure to achieve or persevere Parents perception of adolescents lack of persistence in achieving goals, including motivation, task completion including school	**(INC) Incompetence/Guilt** Parents lack of confidence in their ability to cope with the adolescent, and feelings of guilt
(DEL) Delinquency Antisocial Stress parent experiences as a result of the adolescent's violation of social norms and delinquency	**(SOC) Social Alienation** Parent's perception of being alienated from friends and family, including a lack of social support and assistance in parenting
(MEL) Moodiness Emotionally Labile Parent's perception of the adolescents affective presentation such as mood change irritability and temper	**(REL) Relationship Partner/ Spouse** Parents perception of the quality of the relationship with the person with whom they share parenting

Table G4

Paired Samples T-Tests of Pre and Post Test Results Stress index Parenting Adolescents (SIPA)

Adolescent Domain

Adolescent Domain	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 – t2 (ISO) Social Isolation Withdrawal	-1.325	13	0.208	1.50(2.53)	1.86(2.11)	-0.3571	0.269	-0.3542
t1 – t2 (ACH) Failure to achieve/persevere	-1.351	13	0.200	1.64(2.34)	2.29(1.90)	-0.6429	0.476	-0.3610
t1 – t2 (DEL) Delinquency/Antisocial	-1.336	13	0.205	1.79(1.89)	2.29(1.73)	-0.5000	0.374	-0.3570
t1 – t2 (MEL) Moodiness /Emotionally Labile	-0.168	13	0.869	0.43(2.03)	0.50(1.95)	-0.0714	0.425	-0.0449
t1 – t2 TOTAL (Adolescent Domain)	-0.186	13	0.856	1.57(2.14)	1.64(1.55)	-0.0714	0.385	-0.0496

Descriptively, there was an increase in mean scores from time 1 to time 2 in all subscales (Social Isolation/Withdrawal, Failure to achieve/Persevere, Delinquency/Antisocial, Moodiness/ Emotionally Labile). There was therefore an increase in the Total Stress (Adolescent) Domain. However, paired sample T-Tests were carried out on the data from the Pre and Post SIPA Tests in the Adolescent Domain show no statistically significant changes on any of the subscales.

Table G5

Paired Samples T-Tests of Pre and Post Test Results Stress index Parenting Adolescents (SIPA) Parent Domain and Totals (n=14)

Parent Domain	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 to t2 (LFR) Life Restrictions	-1.64	13	0.125	-1.00(1.11)	0.14(2.38)	-0.857	0.523	-0.438
t1 to t2 (INC) Incompetence Guilt	0.00	13	1.000	-1.36(0.93)	1.36(1.01)	0.000	0.148	0.000
t1 to t2 (SOC) Social Alienation	-1.23	13	0.239	-1.29(1.44)	0.36(2.21)	-0.929	0.752	-0.330
t1 to t2 (REL) Relationship Partner	-1.46	13	0.168	-1.50(0.94)	0.86(1.29)	-0.643	0.440	-0.391
t1 to t2 Parent Domain	-2.37	13	0.034	-1.86(0.36)	1.00(1.47)	-0.857	0.361	-0.635
t1 to t2 TOTAL Parenting Stress	-1.42	13	0.179	0.29(1.86)	0.86(2.03)	-0.571	0.402	-0.380

Descriptively, although results for the subscales, Health, Attachment and Isolation decreased, most mean scores trended upward, including Competence, Depression, Role Restriction and Spouse Relationship, leading to an increase in the category Total stress (Parent Domain). Paired sample t-Tests on t1 to t2 differences were not significant for subscales, but showed a significant difference in the Parent Domain overall (t = -2.37, df = 13, p = 0.034). While there was a fairly large increase the Total Overall Stress of parents of adolescents, this was not consistent enough to be statistically significant.

Strengths & Difficulties Questionnaire (SDQ)

SDQ Paired Samples T-Tests

Table

Paired Samples T-Tests of Pre and Post Test Results Strengths and Difficulties Questionnaire (SDQ) Stress n=37

	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 to t2 Kind & Helpful	-0.380	36	0.706	-1.49(1.45)	-1.41(1.36)	-0.0811	0.214	-0.0624
t1 to t2 Overall Stress	1.260	36	0.216	1.54(1.32)	1.27(1.28)	0.2703	0.215	0.2071
t1 to t2 Behavioural Difficulties	1.091	36	0.282	1.41(1.21)	1.19(1.29)	0.2162	0.198	0.1794
t1 to t2 Peer Difficulties	-0.784	36	0.438	1.16(1.34)	1.32(1.29)	-0.1622	0.207	-0.1288
t1 to t2 Hyperactivity	1.888	36	0.067	1.43(1.34)	1.16(1.14)	0.2703	0.143	0.3104
t1 to t2 Emotional Distress	0.167	36	0.868	0.84(1.09)	0.81(1.13)	0.0270	0.162	0.0274
t1 to t2 Impact	-0.984	36	0.332	1.35(1.38)	1.57(1.34)	-0.2162	0.220	-0.1618

The results of the Paired Sample t-Tests comparing the results of the pre and post SDQ were not statistically significant (P>0.05). However, there were subtle observed changes noted between T1 and T2, both increases and decreases as illustrated by changes in the mean. There was a small increase in (not) Kind & Helpful, a moderate increase in Peer Difficulties and a large increase in Impact. There was a small decrease in Emotional Distress; and fairly large decreases for Overall Stress, Behavioural Difficulties and Hyperactivity. However, since these changes were not significant, there is no clear evidence that these changes are larger than expected by chance.

Table G6

Paired Samples T-Tests of Pre and Post Test Results SDQ Emotional and Behavioural Disorders N=37

	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 – t2 Any Disorder	0.215	36	0.831	1.86(0.82)	1.84(0.87)	0.0270	0.1255	0.0354
t1 – t2 Behavioural Disorder	0.206	35	0.838	1.67(0.83)	1.64(0.83)	0.0278	0.1350	0.0343
t1 – t2 Hyperactivity	0.000	36	1.000	1.41(0.5)	1.41(0.5)	0.0000	0.0775	0.0000
t1 – t2 Emotional Disorder	-1.160	36	0.254	1.22(0.42)	1.32(0.58)	-0.1081	0.0932	-0.1907

Paired sample T-Tests were carried out on the data from the Pre and Post SDQ Disorders show no statistically significant changes (P>0.05). However, using the mean scores, both upward and downward trends in different categories were observed. There were small decreases noted in the categories Any Disorder and Behavioural Disorder. There was an increase in the category Emotional Disorder. It was not possible to calculate the difference in the category Hyperactivity due to limited category coding options.

Child Behaviour Checklist School Age (CBCL-SA)

CBCL-SA (5-18 years) Adaptive functioning/Competence

Table G7

Paired Samples T-Tests of Pre and Post Test Results CBCL-SA (5-18 years) Adaptive Functioning n=29

	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 to t2 Activities	0.000	28	1.000	0.45(0.87)	0.45(0.91)	0.0000	0.172	0.0000
t1 to t2 Social	0.757	28	0.455	0.69(1.00)	0.52(0.91)	0.1724	0.228	0.1405
t1 to t2 School	-0.273	28	0.787	0.69(0.97)	0.72(0.96)	-0.0345	0.126	-0.0507
t1 to t2 Total Competence	-1.361	28	0.184	0.93(0.96)	1.14(0.92)	-0.2069	0.152	-0.2528

Paired sample T-Tests carried out on the data from the Pre and Post Tests in the Adaptive Functioning category of the CBCL-SA show no statistically significant changes (P>0.05). However, using the Mean scores, some upward and downward trends were observed in different categories. Activities stayed the same, Social decreased, School increased, and there was an increase in the cumulative Total Competence category.

CBCL-SA (5-18 years) Syndrome Scales

Table G7

Paired Samples T-Tests of Pre and Post Test Results CBCL-SA (5-18 years) Syndrome Scales n=29

	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 to t2 Somatic.	-0.626	28	0.732	0.38(0.78)	0.45(0.91)	-0.0690	0.110	-0.1162
t1 to t2 Anxiety / Depression	-0.722	28	0.762	0.31(0.76)	0.41(0.95)	-0.1034	0.143	-0.1340
t1 to t2 Social Difficulties	-1.271	27	0.893	0.54(0.96)	0.79(0.92)	-0.2500	0.197	-0.2402
t1 to t2 Withdrawn / Depression	0.254	26	0.401	0.44(0.80)	0.41(0.80)	0.0370	0.146	0.0488
t1 to t2 Aggression	-0.493	28	0.687	0.59(0.98)	0.66(1.26)	-0.0690	0.140	-0.0916
t1 to t2 Thought Problems	-0.769	28	0.776	0.59(0.91)	0.69(1.00)	-0.1034	0.135	-0.1428
t1 to t2 Attention Difficulties	-0.183	28	0.572	0.93(1.31)	0.97(1.30)	-0.0345	0.189	-0.0339
t1 to t2 Rule Breaking Behaviour	0.465	28	0.323	0.59(0.78)	0.52(1.00)	0.0690	0.148	0.0863

Paired sample t-Tests were carried out on the data from the Pre and Post PSI Tests in the Syndrome Scales of the CBCL-SA show no statistically significant changes (p>0.05). However, using the Mean scores, both upward and downward trends in the different syndrome categories were observed. Small increases at the Post-test were noted in Somatic Difficulties, Aggression, and Attention Difficulties; larger increases were noted in Anxiety/Depression and Thought Problems, with the largest increase in Social Difficulties. The only small decreases were in Withdrawn/Depression and Rule Breaking Behaviour.

CBCL-SA (5-18 years) Internalising, Externalising and Total Problems

Table G8

Paired Samples T-Tests of Pre and Post Test Results CBCL-SA (5-18 years) Internalising, Externalising and Total Problem Scales n=29

	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 to t2 Internalising	-0.441	28	0.669	0.79(1.01)	0.86(1.06)	-0.0690	0.156	-0.0819
t1 to t2 Externalising	-0.372	28	0.644	0.90(0.98)	0.97(1.27)	-0.0690	0.185	-0.0691
t1 to t2 Total Problems	-0.619	28	0.729	1.03(1.09)	1.14(1.13)	-0.1034	0.167	-0.1149

Paired sample T-Tests were carried out on the data from the Pre and Post Problem scales of the CBCL-SA. Tests in the Problem Scales show no statistically significant changes (P>0.05). However, observed differences show increases in Internalising, Externalising and Total Problems.

CBCL-SA (5-18 years) Diagnostic Scales

DSM Diagnostic Scales, represent the diagnostic categories that when Clinically Significant or Borderline scores are obtained, need to be further investigated in order to diagnose a child. Rather than providing an actual diagnosis, the categories can be interpreted as a symptom cluster of a diagnostic category that requires further exploration in order to form a diagnosis.

Table G9

Paired Samples T-Tests of Pre and Post Test Results CBCL-SA (5-18 years) DSM Diagnostic Scales N=29

	statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 to t2 Somatic Problems	-1.684	28	0.948	0.24(0.64)	0.52(1.06)	-0.2759	0.164	-0.3127
t1 to t2 Anxiety Problems	-1.653	28	0.945	0.31(0.66)	0.55(0.87)	-0.2414	0.146	-0.3070
t1 to t2 Affective Problems	-1.864	28	0.964	0.38(0.73)	0.66(1.08)	-0.2759	0.148	-0.3461
t1 to t2 ODD	-0.254	28	0.599	0.48(0.83)	0.52(0.87	-0.0345	0.136	-0.0472
t1 to t2 ADD(H)	-0.941	28	0.823	0.52(0.79)	0.66(0.94)	-0.1379	0.147	-0.1747
t1 to t2 Obsessive Compulsive Problems	0.183	28	0.428	0.59(0.98)	0.55(0.99)	0.0345	0.189	0.0339
t1 to t2 Sluggish Cognitive Tempo	1.996	27	0.028	0.79(0.10)	0.57(0.92	0.2143	0.107	0.3772
t1 to t2 Conduct Disorder	1.072	28	0.146	0.66(0.81)	0.52(1.02)	0.1379	0.129	0.1990
t1 to t2 PTSD Problems	-0.961	28	0.828	0.52(0.83)	0.691.04)	-0.1724	0.179	-0.1784

Paired sample T-Tests were carried out on the data from the Pre and Post PSI Tests in the Diagnostic Scales of the CBCL-SA show no statistically significant changes (P>0.05) except for Sluggish

Cognitive Tempo. However, using the Mean scores, the data revealed both slight upward and downward trends in the different diagnostic categories. There were large increases in the symptom clusters of Somatic, Anxiety, Affective; a moderate increase in ADHD and PTSD; and a small increase in Oppositional Defiant Disorder. There was a small decrease in Obsessive Compulsive symptomatology and a moderate decrease in symptoms associated with Conduct Disorder.

Child Behaviour Checklist Pre-School (Under 5 years)

Table G10

Paired Samples T-Tests of Pre and Post Test Results CBCL-PS (Under 5 years) DSM Diagnostic Scales continued n=6

	t statistic	df	p	T1 M(SD)	T2 M(SD)	Mean difference	SE difference	Effect size
t1 to t2 Somatic	0.000	5	0.500	0.17(0.41)	0.17(0.41)	0.000	0.258	0.000
t1 to t2 Withdrawn	0.000	5	0.500	0.67(1.21)	0.67(1.03)	0.000	0.258	0.000
t1 to t2 Sleep Difficulties	1.581	5	0.087	0.67(1.03)	0.00(0.00)	0.667	0.422	0.645
t1 to t2 Anxiety / Depression	0.542	5	0.305	1.00(1.27)	0.67(1.21)	0.333	0.615	0.221
t1 to t2 Attention Difficulties	1.000	5	0.182	1.00(1.10)	0.67(1.03)	0.333	0.333	0.408
t1 to t2 Aggression	-1.633	4	0.911	1.00(1.41)	1.40(1.95)	-0.400	0.245	-0.730
t1 to t2 Emotional reactivity	1.581	5	0.087	1.67(1.63)	1.00(1.55)	0.667	0.422	0.645
t1 to t2 Internalising	0.791	5	0.233	1.33(1.51)	1.00(1.27)	0.333	0.422	0.323
t1 to t2 Externalising	0.791	5	0.233	1.67(1.37)	1.33(1.75)	0.333	0.422	0.323
t1 to t2 Total Problems	1.581	5	0.087	1.67(1.51)	1.00(1.67)	0.667	0.422	0.645
t1 to t2 Affective Disorder	0.415	5	0.348	0.67(1.03)	0.50(1.23)	0.167	0.401	0.170
t1 to t2 Anxiety Disorder	0.307	5	0.386	1.17(1.33)	1.00(1.10)	0.167	0.543	0.125
t1 to t2 ADD(H)	1.000	5	0.182	1.00(1.10)	0.67(1.03)	0.333	0.333	0.408
t1 to t2 ODD	-0.307	5	0.614	0.83(0.98)	1.00(1.55)	-0.167	0.543	-0.125
t1 to t2 PDP	1.000	5	0.182	1.33(1.03)	0.83(1.33)	0.500	0.500	0.408

Paired sample T-Tests were carried out on the data from the Pre and Post Tests of the CBCL-PS even though there were far too few in the sample to carry out such a test. There were no statistically significant changes (P>0.05). However, using the mean scores, both upward and downward trends were observed in the different categories. No change was recorded within the Syndrome Scales for Somatic Difficulties and Withdrawn behaviour and there was insufficient data to evaluate Sleep Difficulties. There was an increase for Aggression; decreases for Anxiety/Depression and Attention Difficulties, and a larger decrease for Emotionally Reactive Behaviour. Internalising, Externalising and Total Problems all decreased. Within the Diagnostic

scales, there was a small increase for ODD; and small decreases associated with Affective Disorder and Anxiety Disorder; with a larger decrease in ADHD and PDP.

Summary

PSI and SIPA paired samples T-Tests

Paired sample T-Tests were calculated on the data from the Pre- and Post- PSI and SIPA Questionnaires. There were no statistically significant changes on any of the subscales (P>0.05). However, using the mean scores, there were both upward and downward trends in most of the subscales.

In the PSI Child Domain, Distractibility/Hyperactivity increased, whereas Mood, Adaptability, Acceptability and Reinforces Parent all decreased; there was no change in Demandingness. There was therefore a decrease in the Total Stress score of the Child Domain. In the Parent Domain, Health, Attachment and Isolation decreased. Whereas, Competence, Depression, Role Restriction and Spouse Relationship increased leading to an increase in the category Total stress (Parent Domain). There was no change in the Total Overall Stress of parents of children under 12 years.

In the SIPA Adolescent Domain there was an upward trend of varying degrees in all the subscales (Social Isolation/Withdrawal. Failure to achieve/Persevere, Delinquency/ Antisocial, Moodiness/ Emotionally Labile) There was therefore an increase in the Total Stress (Adolescent Domain). In the Parent Domain, Health, Attachment and Isolation results decreased. Whereas, Competence, Depression, Role Restriction and Spouse Relationship increased leading to an increase in the category Total stress (Parent Domain). There was also a fairly large increase in the category measuring Total Overall Stress of parents of adolescents.

SDQ Paired Samples T-Tests

The results of the Paired Sample t-Tests comparing the results of the pre and post SDQ were not statistically significant (P>0.05). However, there were subtle changes noted between t1 and t2, both increases and decreases as illustrated by changes in the mean. A fairly large decrease was noted for Overall Stress, Behavioural Difficulties and Hyperactivity, and a small decrease in Emotional Distress. There was a small increase in (not) Kind & Helpful, a moderate increase in Peer Difficulties and a large increase in Impact (of difficulties on the children's lives).

Within the Disorders category, there were small decreases noted in the categories Any Disorder and Behavioural Disorder. There was an increase in the category Emotional Disorder and it was not possible to calculate the difference in the category Hyperactivity due to limited category coding options.

Child Behaviour Checklist School Age (CBCL-SA)

The Paired sample T-Tests that were carried out on the data from the Pre and Post CBCL-SA Questionnaires showed no statistically significant changes (P>0.05). However, using the Mean scores, some upward and downward trends were noted in the different subscales. Activities stayed the same, Social decreased, School increased, and there was an increase in the cumulative Total Competence category, illustrating a deterioration in ability.

Small increases were noted in Somatic Difficulties, Aggression, and Attention Difficulties; larger increases in Anxiety/Depression and Thought Problems; with the largest increase in Social Difficulties. The only decreases, which were small, were for Withdrawn/Depression and Rule Breaking Behaviour.

There were large increases in the diagnostic symptom clusters of Somatic, Anxiety, and Affective; a moderate increase in ADHD and PTSD; and a small increase in Oppositional Defiant Disorder. There was a small decrease in Obsessive Compulsive symptomatology and a moderate decrease in symptoms associated with Conduct Disorder.

Child Behaviour Checklist Pre-School (Under 5 years)

Paired sample T-Tests were carried out on the data from the Pre and Post PSI Tests of the CBCL-PS show no statistically significant changes (P>0.05). However, using the mean scores, they do reveal both upward and downward trends in the different categories. No change was recorded within the Syndrome Scales for Somatic Difficulties and Withdrawn behaviour and there was insufficient data to evaluate Sleep Difficulties. There was a moderate increase for Aggression; moderate decreases for Anxiety/Depression and Attention Difficulties, and a larger decrease for Emotionally Reactive Behaviour. Internalising, Externalising and Total Problems all decreased. The Diagnostic scales revealed a small increase for ODD; and small decreases associated with Affective Disorder and Anxiety Disorder; with a larger decrease in ADHD and PDP.