

“Fostering” Effective Foster Parent Training Programs: Adaptations of Parent-Child Interaction Therapy for the Child Welfare Setting

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Key Words: Parent-Child Interaction Therapy, PCIT adaptations, foster parent training

Abstract: Foster parents face considerable challenges in caring for children in the child welfare system, many of whom have significant behavioral difficulties (Stahmer et al., 2005). Foster parents often lack the training and support needed to manage these externalizing behaviors, which contribute to parenting stress and are highly predictive of placement breakdowns (Baum, Crase, & Crase, 2001; James, 2004). Although child welfare agencies provide foster parents with pre-service training experiences, they often lack the capacity and financial resources to implement gold standard, evidence-based interventions that address child behavior difficulties. Parent-Child Interaction Therapy (PCIT) has been well-established as an empirically supported treatment for disruptive behaviors, yet standard delivery of PCIT to children in the foster care system is often impractical due to time, financial, childcare, and personnel constraints. Adaptations of PCIT for the foster care setting may remove some of these barriers to treatment. These adaptations have typically retained the parent-coaching principles inherent to PCIT, but replaced the traditional 12- to 20-week format with a shorter, less intensive treatment regimen in order to maintain feasibility within the child welfare context. Preliminary findings from studies using a two- or three-day intensive parent workshop and follow-up phone consultations suggest effectiveness of PCIT adaptations in reducing externalizing behaviors in foster children and maintaining behavioral improvements several months after the end of treatment.

Background

The role of foster parents in the child welfare system is a multi-faceted one; foster parents are responsible for meeting the physical, social-emotional, educational, and medical needs of the children in their care. These children often have a history of maltreatment or neglect that put them at risk for developing externalizing symptoms and, in many cases, psychological disorders (Oswald, Heil, & Goldbeck, 2010). Data from a national survey of 2,813 foster children under the age of 6 indicated conduct problems to be the most common area of difficulty, more so than cognitive, communication, social, or adaptive difficulties (Stahmer et al., 2005).

Previous studies have shown that disruptive behaviors are associated with adverse outcomes for foster children, including greater placement instability (Baum, Crase, & Crase, 2001; James, 2004) and lower rates of reunification with biological parents (Landsverk, Davis, Ganger, Newton, & Johnson, 1996). Many foster parents feel ill-equipped to handle severe conduct problems, which ultimately contribute to parenting stress and caregiver burden (McCarthy, Janeway, & Geddes, 2003). In fact, foster parents have identified the management of challenging behavior as one of their greatest training needs (Hebert & Kulkin, 2017) and cited the inability to handle a foster child’s behavior as a major consideration for ending a placement (Brown & Bednar, 2006). Thus, foster parents require training in effective management of maladaptive child behavior. By providing parenting interventions that address child behavior difficulties, child welfare systems can set foster parents up for greater success, thereby increasing placement stability and foster parent retention (Rork & McNeil, 2011).

Problem Statement

Although foster parents receive mandatory pre-service training, the content of these programs vary widely by state and often do not provide training in parenting skills that specifically target

negative child behavior (Dorsey et al., 2008). Two of the most commonly used pre-service training curricula are Model Approach to Partnerships in Parenting Group Preparation and Selection of Foster and/or Adoptive Families (MAPP/GPS) and Foster Parent Resources for Information, Development, and Education (PRIDE). Despite their widespread adoption by numerous child welfare agencies across the country, the MAPP and PRIDE programs lack empirical study and support (Festinger & Baker, 2013). Several meta-analyses and literature reviews on parenting interventions in foster care have been conducted in recent years and have demonstrated positive parent and child outcomes (Hambrick, Oppenheimer-Weller, N'zi, & Taussig, 2016; Rork & McNeil, 2011; Schoemaker et al., 2019; Solomon, Niec, & Schoonover, 2016; Van Andel, Grietens, Strijker, Van der Gaag, & Knorth, 2014). Training programs used in the foster care setting are diverse in theoretical framework (e.g., behavioral, attachment-based, cognitive-behavioral, psychodynamic) and service delivery methods (e.g., group training, wraparound services, phone consultations, home/clinic-based; Hambrick et al., 2016). In a review of foster parent training programs, Rork and McNeil (2011) recommended the use of empirically supported treatments, especially those that are behaviorally based, to guide interventions for foster parents. Schoemaker et al. (2019) conducted a series of eight meta-analyses of parenting interventions for foster and adoptive parents that included such programs as PCIT, Incredible Years, Keeping Foster and Kin Parents Supported and Trained (KEEP), Multidimensional Treatment Foster Care for Preschoolers (MTFC-P), and Attachment and Biobehavioral Catch-Up. The results of the meta-analyses showed significant improvements in child behavior problems, as well as parental sensitivity, dysfunctional discipline, parenting knowledge, and parenting stress. However, no significant changes were observed in placement stability, children's cortisol levels, or attachment security following intervention (Schoemaker et al., 2019). Certain elements of foster parent training programs seem to be particularly important to improving outcomes for both child and caregiver. A meta-analysis of foster parent trainings by Van Andel et al. (2014) highlighted the importance of enhancing the foster child-foster parent relationship, improving attachment quality for young children, and targeting behavior problems and symptoms of stress in order to improve emotional and behavioral outcomes for foster youth. PCIT encompasses the key components outlined in these meta-analytic reviews (e.g., empirically supported, behaviorally based, targets externalizing behaviors, enhances the parent-child relationship) and is thus a strong contender among the myriad of foster parent training programs.

Several studies have examined the effectiveness of PCIT for foster child-foster parent dyads (Timmer et al., 2006; Timmer, Urquiza, & Zebell, 2006). A case study on a foster mother and her four-year-old foster son demonstrated significant reductions in parenting stress and child behavior problems that were no longer in the clinical range on the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) and Child Behavior Checklist (CBCL; Achenbach, 1991; Timmer et al., 2006). Observational data from the Dyadic Parent-Child Interaction Coding System (DPICS; Eyberg & Robinson, 1982) showed an increase in the foster mother's use of praise and behavioral descriptions and a decrease in questions and commands. Fricker-Elhai, Ruggiero, and Smith (2005) conducted a clinical case study of PCIT with two biological siblings with significant maltreatment histories and their foster parents. PCIT was effective in bringing the ECBI Problem and Intensity scores below clinical range for both children and to normal limits on the Teacher Rating Form (TRF; Achenbach, 1991) completed by the children's teachers, except for an elevated Aggressive Behavior score for one sibling. In a study comparing non-abusive biological parent-child dyads to foster parent-foster child dyads, Timmer et al. (2006) found that PCIT yielded strong treatment effects on child problem behavior and caregiver distress, but no major differences were found between the two parent groups.

Despite these preliminary findings in the child welfare context and the overwhelming evidence that PCIT is effective in improving behavioral outcomes for children with challenging behavior or histories of maltreatment, the reality is that PCIT may not be feasible in some child welfare contexts due to a number of logistical and financial restraints. PCIT may be cost-prohibitive for some child welfare agencies, with start-up costs estimated at \$14,000 and treatment costs estimated at \$1,000 per client (Goldfine, Wagner, Branstetter, & McNeil, 2008). PCIT also requires delivery by trained mental health providers with masters' degrees, which for many agencies may require training of staff and restructuring of personnel (Mersky, Topitzes, Grant-Savelle, Brondino, & McNeil, 2016). High attrition rates pose another problem for child welfare agencies looking to use PCIT as a model for pre-service training. Standard PCIT has an estimated 33% dropout rate (Werba, Eyberg, Boggs, & Algina, 2006), and non-kin foster parents have higher attrition rates than kinship foster parents (Timmer, Sedlar, & Urquiza, 2004). Mersky and colleagues (2015) cited the intensity and duration of treatment as a major barrier to the implementation of PCIT in the foster care setting. Foster parents typically have multiple children in their care and may be less inclined to participate in an intensive 12- to 20-week program focused on a single child. The recognition of these barriers to treatment has served as a catalyst for the development of PCIT adaptations for the child welfare system.

Solutions

Researchers have developed a number of creative PCIT adaptations in order to enhance the feasibility of implementation in the foster care system. (1) *PCIT with in-home coaching*. One such adaptation maintained all the components of standard PCIT but added one hour per week of in-home coaching (Timmer, Zebell, Culver, & Urquiza, 2010). The rationale for the additional in-home coaching practice was to promote generalizability of skills and allow the caregiver to practice skills with therapist support in a real-world setting, complete with siblings, other adults, and environmental distractions. Although the study did not focus on foster parents, non-kin foster parents were included in the sample, along with biological parents and kin caregivers. Both PCIT with and without in-home coaching yielded similar improvements in child and caregiver behavior, yet those who received in-home coaching used significantly more positive verbalizations, had lower parental stress, and experienced behavior as less problematic.

(2) *Two-day PCIT workshop*. McNeil, Herschell, Gurwitch, and Clemens-Mower (2005) conducted an exploratory single-group study on a condensed version of PCIT with 30 foster child-foster parent dyads. Instead of the individualized, multi-week format, foster parents in this study attended a two-day group training. On the first day of training, foster parents attended a didactic session without their foster children in order to learn CDI skills and engage in discussions and role-plays to enhance skill acquisition. On the second day of training, foster parents brought their foster child with them and were trained in PDI skills. They were then given an opportunity to practice discipline skills with their children while a therapist coached from behind a one-way mirror. Other foster parents watched these parent-child interactions from the observation room, and childcare was provided any time a parent-child dyad was not being coached. In this study, the key components of PCIT were maintained (e.g., CDI and PDI skills, live caregiver coaching). However, a number of elements from the standard format were excluded in order to adapt PCIT to the child welfare context: at-home practice, coding of CDI and PDI skills, progress based on mastery, and the use of a back-up room in the time-out procedure (i.e., foster parents had the option of using a back-up room or another consequence such as restriction of privilege). This modified format of PCIT presented a number of advantages for the foster parent population. The two-day workshop significantly reduced the time commitment for caregivers and the cost of training for child welfare agencies, thereby increasing the feasibility of implementation. The group-based format lent itself to discussion, observational learning, and social support among the foster parent participants. After the 2-day

workshop, 27 of the 30 participants completed a 1-month follow-up, and 8 participants completed a 5-month follow-up. Although the average pre-treatment ECBI Problem and Intensity scores were measured in the clinical range, these scores fell in the average range one month after treatment. Interview data collected at the 1-month follow-up indicated that 80% of foster parents were using skills acquired during the workshop and 68% were satisfied with the time-out procedure.

(3) *Project Connect*. Project Connect is a PCIT adaptation that was developed as an extension of the McNeil et al. (2005) study in collaboration with two community partner agencies (Topitzes, Mersky, & McNeil, 2015). The group format was retained, but biweekly phone consultations and homework were added to support the transfer of skills to the home environment. Observational data using the DPICS-III (Eyberg, Nelson, Duke, & Boggs, 2005) was also added to track changes in parenting behavior from baseline to eight weeks after baseline. The authors examined two variations of the model: (1) Brief PCIT, a two-day workshop followed by six phone consultations conducted over eight weeks and (2) Extended PCIT, a three-day workshop followed by four phone consultations conducted over six weeks (Mersky, Topitzes, Grant-Savelle, Brondino, & McNeil, 2016; Topitzes et al., 2015). Trainings were delivered by PCIT-trained therapists and took place on Saturdays for approximately eight hours with a group of six to eight families. Phone consultations were 15-20 minutes in length and typically occurred in the evenings. Additionally, childcare was provided for all Saturday sessions to remove barriers to participation, namely for foster parents with multiple children in their care. The schedule of the first Saturday workshop began with didactic instruction on CDI skills, followed by role-playing to practice these skills. The therapists then coached the foster parents as they practiced CDI skills on one another. The bulk of the training was dedicated to live coaching; there were 3, 45-minute live coaching sessions, and all parents received at least 2 coaching sessions. Foster parents not actively engaged in live coaching observed another parent's live coaching session from an observation room. The second workshop followed the same format as the first but with PDI skills instead of CDI skills. For the three-day workshop, foster parents received an additional Saturday session at the eight-week mark. Phone consultations allowed providers to follow up with families on homework, answer any questions, and ensure foster parents were implementing PCIT skills in the home.

Families were randomly assigned to the two-day workshop condition, three-day workshop condition, or a waitlist control group. Rates of attrition were similar across the 3 groups (i.e., approximately 25%), a relatively low rate of attrition compared to other PCIT studies (Lyon & Budd, 2010; Werba et al., 2006). The fact that the attrition rate did not differ between the brief and extended conditions indicated that the booster session did not negatively impact foster parent engagement (Topitzes et al., 2015). Mersky and colleagues (Mersky, Topitzes, Janczewski, & McNeil, 2015; Mersky et al., 2016) reported more detailed findings from this investigation. Foster parents in the two treatment conditions reported significant decreases in parenting stress on the Parenting Stress Index-Short Form (PSI-SF; Abidin, 1995) and improvements in parenting behavior (Mersky et al., 2015). Foster parents improved on measures of labeled praise, positive parenting behavior, and negative parenting behavior, but no differences between groups were found on the use of negative talk. There were no significant outcome differences between the brief PCIT and extended PCIT versions, which supports the use of the more time- and cost-effective two-day model over the three-day model (Mersky et al., 2015). Both interventions yielded significant changes in child behavioral outcomes (Mersky et al., 2016). Scores on the ECBI Intensity and Problem Scales decreased for all 3 groups, and all groups had ECBI Problem scores below the clinical cut-off at 14 weeks after the baseline assessment. However, only the two treatment groups saw scores drop below the clinical cut-off on the ECBI Intensity Scale. Similarly, scores on the CBCL Externalizing and

Internalizing Scales significantly decreased for all three groups, but only the two intervention groups had scores that fell below clinical threshold post-treatment. Upon further analysis, Mersky et al. (2016) found that those in the extended condition experienced further improvement in internalizing and externalizing behavior after the 8-week mark, but this was not the case for those in the brief condition.

A Brief PCIT Model. An exploratory study based on the abbreviated PCIT models for foster parents utilized a 5- to 7-session, clinic-based, individualized format (Blair, Bennett, Mersky, Topitzes, & McNeil, 2017). Sessions lasted 90-120 minutes as opposed to the typical 45-60 minutes in standard PCIT. This brief PCIT model maintained more of the standard format of PCIT than the group-based formats, and thus provided foster parents with more opportunities for individualized coaching. The first session was a typical intake/observation session, followed by 2-3 sessions dedicated to CDI teaching and coaching. Foster parents then received 2-3 sessions of PDI teaching and coaching. Preliminary findings from a sample of six participants demonstrated a decrease in scores on both ECBI Intensity and Problem Scales for all but one participant. Two of the participants had clinically significant pre-treatment scores on both ECBI scales that were no longer in the clinical range post-treatment. A qualitative study on Brief PCIT in the child welfare context identified additional barriers by asking foster parents and providers about their experiences with the intervention (Blair, Topitzes, Winkler, & McNeil, in press). In this particular study, PCIT providers added elements to this brief PCIT model in order to address child traumatic stress (e.g., psychoeducation for parents on traumatic stress and physiological and cognitive relaxation strategies). Overall, foster parents cited minimal challenges to participating in treatment, but stated that the time commitment was difficult to manage. Foster parents deemed the therapeutic alliance with their PCIT provider to be a tremendous source of support that promoted success and retention. They also found the integration of trauma-informed treatment to be helpful to understanding their foster children's behavior and emotions. The practitioners cited two main barriers to treatment: (1) foster parents' perceived stigma associated with participating in treatment and (2) foster parents' tendency to overreport child behavior difficulties. To problem-solve around these issues, practitioners formed small groups or "learning collaboratives" comprised of approximately seven therapists to discuss challenges, brainstorm possible solutions, and promote fidelity to the model. The work of Blair et al. (2017; 2019) introduced yet another abbreviated PCIT adaptation with its own modifications for both foster parents and their providers.

Conclusions and Recommendations

Preliminary research on PCIT adaptations for foster parents have demonstrated improvements in child behavior problems, parental stress, and positive parenting behavior. There is empirical support for an abbreviated version of PCIT for the child welfare context and the addition of in-home coaching or follow-up phone consultations. The abbreviated models of PCIT reduce many of the barriers to treatment and make this adaptation a more feasible option for both foster parents and child welfare agencies. However, further study is needed to disaggregate the effects of these adaptations and determine which elements are most effective in reducing problem behavior, parental stress, and negative parenting behavior. Although there is some evidence that a booster session may be helpful in solidifying parental knowledge and use of skills, more research needs to be conducted on dosage effects with more follow-up assessments to determine if effects wear off over time. There is also evidence that some behavior (e.g., negative talk; Mersky et al., 2015) may be harder to change with only a two- or three-day workshop and may require more intensive intervention to see significant improvement. Studying individual components of the adaptation (e.g., phone consultations, observational learning, group discussions, booster sessions) will be helpful in building a more robust parenting intervention that child welfare agencies can adopt more widely.

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