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ADAPTATION AND EVALUATION OF A NONVIOLENT RESISTANCE INTERVENTION FOR FOSTER PARENTS: A PROGRESS REPORT

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Foster care faces serious challenges, such as behavioral problems in foster children and parental stress and ineffective parenting behavior in foster parents. The results of a pilot study that evaluated a training program for foster parents based on nonviolent resistance are described. In a pretest–posttest design, data were collected from 25 families. Significant reductions in externalizing, internalizing, and total problem behavior in the foster children and in parenting stress were found. Using a reliable change index, significant improvements in externalizing, internalizing, and total problem behavior were found in, respectively, 72, 44, and 80% of the cases. Most improvements proved to be clinically relevant. Effect sizes ranged from medium to large for problem behavior, and from small to medium for parenting stress.

In the United States (U.S. Department of Health & Human Services, 2009), as well as in several European countries (Hollin & Larkin, 2011), family foster care is preferred to placement in group homes or institutions. International studies suggest that an increasing number of children is placed in family foster care (Fernandez & Barth, 2011). Yet, the foster care system faces serious challenges, such as managing behavioral problems in foster children (Sawyer, Carbone, Searle, & Robinson, 2007). These problems are associated with parental stress (Carbone, 2009), ineffective parenting behavior (Vanderfaeillie, Van Holen, Trogh, & Andries, 2012), premature and unintended endings of foster care placements due to negative reasons, also called breakdowns (Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007), and frequent relocations into residential or foster care (James, Landsverk, & Slymen, 2004). Hence, interventions to support foster parents in dealing with behavioral problems in foster children are needed. In this article, we report on the development of such an intervention. First, we will briefly review the literature on behavioral problems in foster children and the associated effects. Next, the model of nonviolent resistance (NVR; Omer, 2004, 2011) and its adaptation into an intervention for foster parents (Van Holen, Vanderfaeillie, & Vanschoonlandt, 2013) are described. Subsequently, preliminary data on the effectiveness of the intervention are presented and discussed.

BEHAVIORAL PROBLEMS IN FOSTER CHILDREN

Foster children are at a high risk of manifesting emotional and behavioral problems (Sawyer et al., 2007). In Flanders (the Dutch speaking part of Belgium), a representative sample of 194

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newly started long-term foster care placements of children aged 3–18 years showed that 51.5% of these children had a clinical or borderline clinical score on the internalizing and/or externalizing problem scale of the Child Behavior Checklist (CBCL1.5–6/6–18; Achenbach & Rescorla, 2000, 2001): 16% had only internalizing behavioral problems, 13.9% only externalizing behavioral problems, and 21.6% both internalizing and externalizing behavioral problems (Vanschoonlandt, Vanderfaeillie, & Van Holen, 2012). Internationally, the proportion of foster children with clinical scores ranges between 33 and 85% (Holtan, Ronning, Handegard, & Sourander, 2005). Several authors have noted that the number of foster children with serious problems is increasing (Holland & Gorey, 2004).

Foster children's behavioral problems are often seen as the consequence of stressful experiences in the past, such as abuse, neglect, and inadequate parenting (Holland & Gorey, 2004). A recent analysis by Strijker and Knorth (2009) of the history of 419 Dutch foster children aged from 0 to 18 years showed that 24% had been physically, 31% emotionally, and 14% sexually abused. About 60% of these children had been neglected and 36% had witnessed severe domestic violence.

Although placing a child in a better child-rearing situation should result in the reduction of behavioral problems, this expectation is seldom met. In a few studies (Barber & Delfabbro, 2005; Wilson, 2006), foster parents did report a small decrease ($d < 0.30$) in problem behavior in foster children shortly after the start of the placement. However, this positive trend did not endure and stabilized after four months. Most researchers found that internalizing and externalizing behavioral problems in foster children reported by foster parents or foster care workers remained stable or even increased during foster care placements (Fernandez, 2009; Nilsen, 2007; Vanderfaeillie, Van Holen, & Trogh, 2008; Van Oijen, 2010).

Problem behavior in foster children, particularly externalizing problem behavior, is largely associated with parenting stress experienced by the foster parents (Carbone, 2009), and with a reduced sense of well-being (Whenan, Oxlad, & Lushington, 2009), which in turn influences the children's well-being and neurobiological stress (Fisher & Stoolmiller, 2008). Furthermore, several studies show that negative behaviors in foster children and foster parents are mutually reinforcing. In addition, Linares, Montalto, Rosbruch, and Li (2006) found that child characteristics, particularly behaviors related to conduct disorder, were associated with parental self-reports of less effective discipline (harsh discipline). Foster children's problem behavior was associated with less supervision, less positive reinforcement and more inconsequent punishment, which in turn increased the problem behavior (Fisher, Gunnar, Chamberlain, & Reid, 2000). In a Flemish study (Vanderfaeillie et al., 2012), both internalizing and externalizing problem behaviors in foster children were associated with less positive parenting strategies by the foster mother, and with more negative control (more punishment and inconsequent discipline). These findings are consistent with a systemic perspective, stressing the bidirectional relations between parental and child characteristics as well as reciprocal pathways among parents and their children over time (Claridge et al., 2014; Lengua & Kovacs, 2005). At the same time, these findings are not only consistent with the systemic perspective, they are also consistent with the reciprocal influence described in the social learning and transactional model of family interaction.

Behavioral problems in foster children are, together with age at placement, robust predictors of placement breakdown (Chamberlain et al., 2006; Oosterman et al., 2007; Vanderfaeillie, Van Holen, & Coussens, 2008). Internationally, the breakdown rate is estimated to be 25–50% (Vanderfaeillie, Van Holen, & Coussens, 2008). In Flanders, within a follow-up period of six years, an average breakdown rate of 44% was found (Vanderfaeillie & Van Holen, 2010). Breakdown can in turn lead to more emotional and behavioral problems (James et al., 2004), thus leading to a vicious cycle of repetitive placement breakdown and increasing behavioral problems (Oosterman et al., 2007).

In light of this research, interventions aiming at improving the well-being of foster children and their foster families are desperately needed (Leve et al., 2012). However, few evidence-based programs exist for foster families. In a recent review, Leve et al. (2012) only identified eight effective programs. Overall, these programs are attachment focused or based on social learning frameworks and usually focus on young children. Only two programs include children over the age of 12. Moreover, a recent meta-analysis shows that parent training programs based on the social

learning paradigm show the smallest effects in the age category 12–16 years (Maughan, Christiansen, Jenson, Olympia, & Clark, 2005).

This is one of the main reasons to choose a NVR approach, because it is shown to be effective regardless of the age of the child. Furthermore, NVR focuses on the foster parents; the cooperation of the foster child is not necessary. In addition, parenting stress, a central aspect of the NVR approach, is shown to be a critical target for interventions aiming at improving the well-being and the neurobiological stress of foster children (Fisher & Stoolmiller, 2008). Finally, the focus on creating a supportive network in NVR could be promising. Indeed, research shows that without additional support, the stress level of foster parents remains high and that they might lose their resilience in the face of behavioral problems (Fisher & Stoolmiller, 2008).

In the following sections, the model of NVR and its adaptation into an intervention for foster parents are described.

NONVIOLENT RESISTANCE (NVR)

Contents

NVR originated in the socio-political sphere where power-disadvantaged groups used protest, public opinion, and other tenacious but nonviolent means of resistance to achieve their goals (Sharp, 2005). Recently, the NVR approach has been adapted to help parents cope with violent and self-destructive behavior in children and adolescents (Omer, 2004, 2011). NVR focuses on four intervention areas:

1. Resistance by presence.

The parents aim at resisting rather than controlling the child's negative behaviors by manifestations of parental presence. According to the risks and the child's specific problems, Omer (2004, 2011) developed well-documented techniques to increase parental presence in a respectful and nonviolent way, such as:

- Giving the child a formal written announcement in which the parents declare their intention to resist specific unacceptable behaviors
- Performing parental "sit-ins" through which parents can express their commitment to change and their dissatisfaction with the current situation The parents enter the child's room, sit down, and announce that they will stay there and wait for the child's proposal to resolve the problem behavior that triggered the sit-in. The parents are asked to remain quiet and to strictly avoid arguments and provocations. They are prepared in advance to resist various possible reactions and instructed as to how to end the sit-in and resume normal daily life.
- Documenting violent and aggressive episodes and notifying their support network about these behaviors
- Telephoning around in reaction to the child's refusal to come home at a specified hour Parents are encouraged to call the child's friends and their parents, telling them that their child has not come home, asking for their help and asking the child's friends to tell their child that they have called to look for him/her. They are rigorously instructed as to how to prevent escalation once the child returns home.

2. Prevention of escalation.

Parents are helped to prevent and halt escalating cycles in a number of ways. They are trained in self-control and emotional regulation. They are helped to recognize escalatory patterns and identify their own and their child's typical reactions and their associated thoughts and feelings. They also learn alternative ways of responding in a nonescalating manner. The principle of delayed response (as illustrated by the statement: "Strike the iron when it's cold") and the development of a noncontrolling stance (as illustrated by the phrase "You don't have to win, only to persevere!") are central emphases of the treatment.

3. Creating a network of support.

Parents are helped to activate potential sources of support in their immediate and wider social network such as family, friends, acquaintances, and other persons who might be supportive (e.g., professionals, school staff). When possible, a supporters meeting is organized to explain the purpose and principles of the treatment and to discuss in concrete terms how and when they can be of help.

4. Reconciliation gestures.

Parents are encouraged to initiate positive interactions by systematically and cumulatively offering restorative gestures (e.g., signs of appreciation, suggestions for shared activities, symbolic gifts). These gestures are unilateral and unconditional initiatives by the parents. They are independent of the child's behavior and aim at promoting the positive aspects of the parent–child relationship.

NVR places escalation processes at the center of attention (Omer, Schorr-Sapir, & Weinblatt, 2008). The underlying assumption is that parental submission and power struggles are mutually enhancing and that they feed on and are fed by negative feelings. The parents take unilateral steps to bring about changes not only in the child's behavior but also in the whole interactive cycle (Omer, Steinmetz, Carthy, & von Schlippe, 2013). Parents are helped to resist without retaliation and, thereby, to systematically cultivate presence and self-control (Lavi-Levavi, Shachar, & Omer, 2013). Parental presence is an integrative concept linked to behavioral views on effective discipline, to the views of attachment theory on the need for a secure parental figure, and to systemic ideas on parental systemic support and weakening (Omer, 2014). For a detailed discussion on the similarities and differences between the NVR approach and the paradigms mentioned above, we refer to the relevant literature (Omer, 1999, 2014).

An increasing number of applications of the NVR approach are described in literature, and the target group is widening (Van Holen, Lampo, & Vanderfaeillie, 2011). Furthermore, the model has been successfully implemented with parents from various social, ethnic, and religious backgrounds, albeit with adaptations (Omer et al., 2013). The four intervention areas are always covered. However, the usability and acceptability of the specific techniques put into practice can differ across cultures. For example, in an Israeli study, parental sit-ins were used in 65% of the cases (Weinblatt & Omer, 2008), while only 2% of German families used this technique (Ollefs, 2008). Parents from different cultural backgrounds may also differ with regard to the kinds of support they are able to recruit: Orthodox Jews, for instance, will under no circumstances agree to convene a support group from outside the immediate family (Omer et al., 2013).

Empirical Evidence

Three studies to date provide evidence of the effectiveness of NVR. Weinblatt and Omer (2008) delivered a five-session individual NVR training (completed by 10 sessions of telephone support) to 21 families of children aged four to 17 years with acute behavioral problems and compared it with a waiting list control group of 20 families. Parents who received NVR training showed reductions in parental helplessness and escalatory behaviors and improvements in perceived social support. Furthermore, parents reported significantly less externalizing problem behavior in their children. The effectiveness of the treatment was independent of the age of the children: The authors found similar results in families with adolescents (12–17 years) and in families with children under 12 years of age. Moreover, attrition in this study was very low: Only one family ended the treatment prematurely. Ollefs, von Schlippe, Omer, and Kriz (2009) compared an NVR treatment of 6–10 individual sessions in 59 families with a Group Teen Triple P treatment in 21 families and a waiting list control group (nine families). NVR and Group Teen Triple P showed comparable improvements relative to the control group in terms of increased parental presence and decreased feelings of helplessness and depression in parents. A significant decrease in externalizing problem behavior was found only in the NVR group. Follow-up one month after treatment in both studies showed that the results remained stable. Levavi (2010) focused on escalation patterns. She compared 26 treatment families (NVR trained) with a waiting list group of 20 families. Fathers and mothers reported on their own and on their spouse's escalation patterns. Three components of escalation were measured: parental submissiveness, power struggles and negative emotions. There were improvements in all three, especially from the fathers' point of view. There was also a significant reduction in parental helplessness.

NVR INTERVENTION IN FOSTER CARE

The findings above suggest that NVR might be relevant for foster families. An adaptation of the original program developed by Omer (2004, 2011) was offered to foster parents. A training

manual for foster care describes the theoretical background of the intervention, provides guidelines for use, and outlines the sequence and contents of each session (Van Holen et al., 2013). Furthermore, it contains specially developed materials including handouts, worksheets, a workbook for foster parents, DVDs with role plays of less conventional techniques (e.g., parental sit-ins), and testimonies of foster parents who have completed the training. The main changes to the original program include the use of a home visit format, the addition of group sessions, the decision to introduce experienced foster care workers as therapists, and the manner in which the regular caseworker and the biological family are involved.

Program Format

The intervention was offered as a combination of 10 individual home visits, combined with three group sessions. The home visit model was chosen for the following reasons: (a) The support offered to Flemish foster parents is based on a home visit model. Moreover, foster parents do not usually attend group sessions organized by foster care agencies (Bronselaer, Vandezande, & Verreth, 2011); (b) Hampson, Schulte, and Ricks (1983) showed that home-trained foster parents reported greater improvement in foster children's behavior than foster parents receiving the same training in a group; (c) the home visit format lowers barriers to service access and enables the inclusion of difficult-to-reach families: Foster parents do not have to leave home, do not have to find a babysitter, etc. (Weiss, 1993), and (d) home sessions provide the opportunity to adapt the homework assignments to the actual problem setting.

Because foster parents can also be an important source of support for each other (Brown, 2008; Holmes & Silver, 2010; Laybourne, Andersen, & Sands, 2008; MacGregor, Rodger, Cummings, & Leschied, 2006), group sessions were added. These were held on a monthly basis. They entailed sharing experiences, discussing implementation problems, and finding solutions to new problems. Several steps were taken to facilitate attendance at the group sessions (e.g., refunding the costs of a babysitter and travel expenses).

Providers

Foster parents are considered to be capable and skilled parents (Nilsen, 2007). This makes it difficult for them to ask for help (van den Bergh & Weterings, 2010). The foster care agency offering the counseling seems to be the best option available (Maaskant, 2010). Furthermore, foster care is a complex form of care. By definition, there are several parties involved (the foster child, parents and members of the family of origin, foster parents, the referring agency, and the foster care worker). Within this tangle of relationships, there is a high level of tension (Bronselaer et al., 2011; van den Bergh & Weterings, 2007). For these reasons, the training was delivered by experienced foster care workers, hired by the foster care service, and referred to as therapists throughout the manuscript. They are caseworkers with a bachelor's degree in social work or a master's degree in psychology, and they have all followed additional therapeutic training. They thoroughly understand the specific position of foster parents and the nuances and sensitivities within the tangle of changing relationships and know how best to approach foster parents as "partners in care" (Choy & Schulze, 2010). They received a six-day NVR training. Furthermore, biweekly supervision sessions with an experienced NVR therapist were organized to assure treatment integrity. These sessions comprised a detailed case report combined with a fidelity measurement through comprehensive treatment checklists.

Assessment of the data showed high fidelity of the therapists to the treatment protocol. In each case, all intervention domains were covered. In addition, the extent to which the intended strategies were actualized by the foster parents was high: 100% of the foster parents reported in detail on their de-escalation and reconciliation steps, 88% of the foster parents decided to involve external support, and all foster parents made use of one or more of the documented techniques to increase their presence and resist problem behavior, in particular making an announcement (100% of foster parents), performing parental sit-ins (28%), documenting negative behavior and notifying supporters (28%), and increasing supervision by parental visits or telephone rounds (64%). Furthermore, in 40% of the cases, the biological family was involved in reconciliation and/or support.

Program Description

The intervention is offered to foster parents of foster children aged between 6 and 18 years with externalizing problem behavior, in addition to regular foster care support. On average, a foster care worker in Flanders monitors 25 foster care placements with a mean of 11.5 face-to-face contacts a year per foster care placement, divided between the foster parents, the foster child, and the biological family (Sprangers, 2009). Approximately 60% of the foster parents report meeting their foster care worker less than once a month (Bronselaer et al., 2011).

The intervention comprises 10, if possible weekly, home sessions of a maximum of 75 min and three group sessions of a maximum of 120 min. The total duration of the treatment is approximately four months.

During the intake session, besides the foster parents and the therapist, the foster care worker is present to provide the necessary background on the child and his or her problem behaviors and to clarify the role of the therapist (focusing on strengthening parenting skills in addressing problem behavior) and the foster care worker (other aspects of foster care guidance such as visiting rights, mediation between foster parents and the biological environment, etc.) during the intervention phase. During the final session, in the presence of the regular caseworker, the intervention and possible progress are evaluated and discussed. Furthermore, a plan for the future is developed.

What About the Biological Family?

On condition that it is perceived as supportive by the foster parents, members of the biological family of the foster child are involved in the intervention. Specific guidelines describe how to involve members of the biological family in the supportive network and how to engage them in reconciliation.

Case Example

The following case example briefly describes the course of the intervention. Mary is a 10-year-old foster child. She was placed in family foster care when she was five months old due to neglect by her biological parents. During the intake session, in the presence of the foster parents, the regular foster care worker, and the therapist, a detailed anamnesis and problem identification was made. In summary, the following problem behaviors were identified as being very annoying for the foster parents: almost limitless attention seeking, bossiness, domineering, controlling and manipulative behavior, lying, and a lack of empathy. Escalating conflicts between the foster mother and Mary were a regular occurrence. Feelings of powerlessness in the foster mother were leading to an accumulation of pent-up frustration and anger, which now and then resulted in shouting and screaming toward Mary. At the end of the intake session, the treatment goals were defined. The foster parents chose two problem behaviors for which a plan was developed. They received the homework assignment to write an announcement, in which they respectfully but vigorously expressed the problem behaviors they would no longer accept and announced that they were going to take action to counter these behaviors. They had to focus on their own behavior and not on the enforcement of obedience. During the second and third sessions, this announcement was discussed and adapted. Furthermore, its implementation was thoroughly prepared, including a role play.

The foster parents wrote:

Mary,

You are a nice, smart and helpful girl. We are very happy that you live in our family. Nevertheless, there are a few things we dislike.

— You often demand attention by endlessly talking, asking questions and making noises, even if we repeatedly ask you to be quiet.
— You often lie at us (for example when you said that you found the pencil you brought home from school).

We will do whatever we can to help you change these behaviors. We're going to frequently check and ask other people whether what you tell us is true. We will do that as long as we

cannot believe your words. We will also ask family members and our friends to support us. We ourselves are going to do our very best to be less angry. We love you and we want things to be pleasant when we are together.

A big hug,

Tom and June.

A week later, at a quiet moment, the foster parents entered Mary's room, sat down on the floor, read the announcement, handed it to Mary, and left the room. This event was deliberately ritualistic in nature, highlighting a shift in approach by the foster parents. The increase of targeted supervision was also concretized: When in doubt, the foster parents asked family, friends, and the school whether Mary's stories were truthful.

Sessions four and five handled emotional regulation. Increasing self-control to reduce escalations was a difficult task, especially for the foster mother. Utilizing the feeling thermometer (Spanjaard & Haspels, 2005), the foster mother was supported in identifying several stages in the development of frustration. Subsequently, alternative responses were sought and practiced, first in role play and then in real family situations. The most workable responses for the foster mother were calling in support from the foster father, evoking a rock image ("I'm strong as a rock, I stay calm") and the principle of delayed response: The foster mother learned to give short messages ("I don't accept this behavior, I'll think about it and come back to you later!") and leave the potentially escalatory situation.

During session six, a plan for reconciliation gestures was made. In the past, the foster parents did lots of fun activities with Mary and expressed their care and love in different ways. Reconciliation gestures were now more consciously made and deployed not only more frequently, but also more strategically. For example, after every negative interaction, when peace had returned, the foster parents planned a relationship gesture to make Mary understand that they were dealing with the problem behavior, but that they did not reject her as a person. Simple reconciliation gestures (small gifts, expressions of respect, etc.) that were frequently used by the foster parents, and relationship gestures that required more effort, were listed. The foster parents began doing pleasant activities with Mary again (crafts, swimming, skating, cooking) and also deliberately made more time for a bedtime ritual: They created a moment of quiet reading and cuddling. Particular attention was paid to an album of positive memories that documented positive behaviors, funny moments, and positive opinions about Mary, such as short stories, a map of a nice holiday, photos, a party, happy memories, and so on. The foster parents started working on the album, invited Mary to cooperate, and asked Mary's mother and other people in their environment to contribute.

The seventh session addressed the activation of the family and social network. Using a relationship diagram, 12 potential supporters from a wide circle of friends and acquaintances were identified. They were then invited to a supporters meeting in the eighth session. The situation was discussed, and specific support was elaborated (the foster mother could always telephone a friend whenever she needed to talk to someone, an aunt who had a good relationship with Mary started inviting her to go swimming on a regular basis, the neighbors were willing to provide practical assistance such as babysitting, etc.).

During sessions nine and 10, other methods of active resistance to Mary's problem behavior were explained and practiced, namely a sit-in and a campaign of concern. During the intervention, however, due to a decrease in problem behavior, it was no longer necessary to put them into practice.

The intervention ended in a ritualistic way with an evaluation in the presence of the foster care worker. The therapist wrote a personal, closing letter with an empathic and authentic message for the foster parents, read the letter, and handed it to the foster parents. This ritual marked the end of the intervention. In this letter, from the perspective of the therapist, some important elements of the intervention process were summarized, such as actions the foster parents had taken that had brought about change or movement, resistances that had been overcome, and the efforts made by the foster parents. The letter ended with a reminder that problem behavior would still occur in the future and that relapses could occur, plus a suggestion that they continue to use skills they had learned or competencies they had acquired.

METHODS

A pretest–posttest design was used to evaluate the usefulness of the training for the first 25 families enrolled between October 2010 and September 2011.

Participants

All new foster care placements with a long-term perspective (>1 year) of children aged between 6 and 18 years in three of five Flemish provinces were screened approximately four months after the start of the placement. Foster mothers completed a CBCL, and foster care workers completed a questionnaire about the characteristics of the foster care placement. Foster parents were eligible if their foster child had a borderline or clinical score on the externalizing broadband or on one of the externalizing small-band scales of the Child Behavior Checklist. Exclusion criteria were foster children with mental retardation, autism or unstable use of psychotropic medication, behavioral problems as a result of medical problems or medication, and foster parents with a mental/psychological disability, who were involved in divorce proceedings or already receiving counseling for the behavioral problems. Eligible foster parents were encouraged to participate by their foster care worker. In addition to newly started foster care placements, foster care workers could sign up eligible foster parents of ongoing foster care placements. The same inclusion and exclusion criteria were used for this group. This enrollment procedure led to a convenience sample of 25 participating foster families out of 36 eligible foster families. All the participants in this study took part on a voluntary basis and gave their informed consent prior to inclusion. The intervention was offered on top of regular foster care support. Refusal to participate did not influence the regular foster care support offered.

All the participants, both foster families and foster children, were Belgian from Caucasian ethnicity. Mean age of the foster children (15 girls and 10 boys) at start was 12.5 years (SD = 3.7, min = 6.3, max = 17.4), and the mean duration of the foster care placement was three years (SD = 3.7). Fourteen children (58%) had a placement history of one to five former out of home placements in residential or family foster care.

Of the 25 foster families, five were single parent (20%) and 20 two-parent families (80%) (17 nuclear and three reconstituted families). In 11 cases, caretakers were nonkinship foster carers (44%). The remaining 14 children (56%) were placed with their extended family (nine with grandparents, three with other relatives) or within their broader social network (n = 2). The mean age of the foster mothers was 49.3 years (SD = 13.2, min = 21, max = 71) and of the foster fathers, 51.2 years (SD = 12.9, min = 28, max = 71). Five foster mothers (20.8%) and six foster fathers (30%) had higher education.

Measures

Foster mothers filled out a questionnaire within a period of two weeks prior to the start of the intervention and immediately after the intervention. The questionnaires were handed over to the foster parents by the foster care worker in a sealed envelope and returned directly to the researchers by mail. All posttest measures were returned within a month of the intervention ending. There were no missing data. The questionnaire consisted of standardized measures for foster children's behavioral problems and foster parents' parenting stress. Foster fathers were exempted, not only to avoid creating a heavy burden of questionnaires, but also because strong agreement between foster fathers and foster mothers regarding behavioral problems (McAuley & Trew, 2000) and parenting stress (Bastiaensen, 2001) on the instruments we used has been reported earlier.

The behavioral problems of foster children were measured using the CBCL/6–18 (Achenbach & Rescorla, 2001). For 118 concrete behavioral, emotional, and social problems, foster mothers were asked to indicate how often they had occurred on a three-point scale (0 = "not at all," 1 = "somewhat or sometimes," 2 = "very true or often"). The results of the questionnaire form a total problem score and an internalizing and externalizing score, as well as eight problem scale scores. We used the total problem score and the internalizing and externalizing scores as (general) indices for internalizing, externalizing, and overall behavioral problems. To distinguish normal

from deviant scores, cut-off points were used. The authors of the CBCL scales marked *T*-scores ≥60 as deviant scores for the internalizing, externalizing, and total problem score. The CBCL is a reliable instrument with Cronbach's alpha ranging from .90 on the internalizing, .94 on the externalizing to .97 on the total problem scale, and test–retest reliability ranging from .91 on the internalizing, .92 on the externalizing to .94 on the total problem scale (Achenbach & Rescorla, 2001). Based on a review, Nassen (2008) concludes that the CBCL can be considered a sound, highly used, extremely validated instrument.

Parenting stress was measured using the Nijmeegse Vragenlijst voor de Opvoedingssituatie (NVOS—Nijmegen Questionnaire for the Parenting Situation—Wels & Robbroeckx, 1996). This self-report questionnaire consists of four parts. We only used four scales from the first part of the questionnaire, namely experienced coping ability (eight items—$\alpha_{T0} = .72$; $\alpha_{T1} = .79$), experience of problem severity (seven items—$\alpha_{T0} = .70$; $\alpha_{T1} = .77$), experiencing parenting as a burden (seven items—$\alpha_{T0} = .73$; $\alpha_{T1} = .83$), and desiring changes (eight items—$\alpha_{T0} = .73$; $\alpha_{T1} = .84$). Examples of listed items are the following: "Raising...is a burden to me" with the response options 1 = "absolutely incorrect" to 5 = "absolutely correct," or "I feel I am slowly loosing grip on..." with the response options 1 = "I certainly deny" to 5 = "I certainly admit." The four scales we used are viewed as the core components of parenting stress by the authors of the NVOS. The reliability and validity of the NVOS are rated as satisfactory (Evers, Vliet-Mulder, & Groot, 2000).

In families with more than one foster child, the foster child with the highest *T*-score on the externalizing scale of the CBCL was included.

Data Analysis

The effects of the training were examined at group level (for both problem behavior and parenting stress) and at case level (for problem behavior). As the pre- and posttreatment data had a normal distribution for each scale (verified with the Kolmogorov–Smirnov test), the dependent *t* tests were used to investigate the effect at group level. Furthermore, Cohen's *d* effect size was calculated with the most commonly used pooled standard deviation in the denumerator (Rosnow & Rosenthal, 1996): $d = M_1 - M_2/\sqrt{(n_1 - 1)SD_1^2 + (n_2 - 1)\ SD_2^2/2}$ $(n - 1)$. Cohen (1988) suggested that effect sizes should be interpreted as small when above 0.20, medium when above 0.50, and large when above 0.80. With a standard alpha level of .05 and a recommended power of .80, the desired sample size is 34 to detect a medium effect ($d = 0.50$ for *t* test on means). This study had a sample size of only 25 cases, which is fewer than desired. However, post hoc power analyses showed that the power (1 − beta) of the analyses regarding the evolution of behavioral problems ranged from .83 to .99, which is adequate and thus shows that the probability of rejecting the null hypothesis (no evolution) incorrectly is low. Power analyses of parenting stress ranged from .37 (parenting is a burden) to .96 (desire changes) with a mean of .65, showing that the risk of incorrectly rejecting the null hypothesis (no evolution) is 35%, which is considerable.

As development at group level does not provide insights into the effect on the individual participants, the evolution was also examined at case level. For this purpose, a Reliable Change Index (RCI) was used. This statistic is calculated by dividing the change in pretest and posttest scores by the standard error of the differences for the used measures (Jacobson & Truax, 1991). A RCI of at least |1.96| indicates that the change in pretest and posttest scores is statistically significant; that is, it is unlikely to be due to measurement error (Jacobson & Truax, 1991). Statistically significant changes are not necessarily clinically relevant. Clinical relevance refers to whether the individual has moved from being more like a clinical population to being more like a nonclinical comparison population (Zahra & Hedge, 2010). To determine whether significant changes were also clinically relevant, we used the standardized *T*-scores of the CBCL. A significant and clinically relevant change is defined as a RCI score >1.96 or <−1.96 in combination with a transition from a clinical score (*T*-score ≥ 64) to a borderline clinical score ($63 \leq T\text{-score} \geq 60$) or to a normal score (*T*-score < 60), from a borderline clinical score to a normal score, or vice versa.

Although the training mainly focuses on externalizing problem behaviors, we also report on the internalizing and total problem CBCL scales.

RESULTS

Preliminary Results at Group Level

As shown in Table 1, the decrease in behavioral problems was significant for externalizing problems ($t = 4.84$, $df = 24$, $p < .001$) and for internalizing problems ($t = 3.30$, $df = 24$, $p = .003$), as well as for total problems ($t = 6.18$, $df = 24$, $p < .001$). The effect sizes range from medium for the internalizing problem scale ($d = 0.61$) to large for both the externalizing problem scale ($d = 0.89$) and the total problem scale ($d = 1.09$).

After treatment, foster mothers felt significantly more able to cope with the child ($t = 2.73$, $df = 24$, $p = .012$), experienced parenting significantly less as a burden ($t = 2.16$, $df = 24$, $p = .041$), and desired significantly fewer changes ($t = 3.59$, $df = 24$, $p = .001$). The decrease in experiencing problems in the parenting situation was close to significant ($t = 1.97$, $df = 24$, $p = .060$). The effect sizes on the parenting stress scales range from small for "experiencing problems in the parenting situation" ($d = 0.44$) and "experiencing parenting as a burden" ($d = 0.34$) to medium for "feeling able to cope with the parenting situation" ($d = 0.51$) and "desiring changes in the parenting situation" ($d = 0.77$).

Preliminary Results at Individual Level

At the start of the treatment, 25 children scored on the clinical or borderline clinical range on the externalizing scale (20 clinical and five borderline clinical), 11 children on the internalizing scale (10 clinical and one borderline clinical), and 24 on the total problem behavior scale (20 clinical and four borderline clinical). In 18 children (72%), there was a significant decrease in externalizing problem behavior, and in six children (24%), there were no significant changes, while in one child (4%), there was an increase in externalizing problem behavior (Table 2). Also the internalizing problems (Table 2) decreased significantly in 11 cases (44%), remained unchanged in 12 cases (48%), and increased in two cases (8%). There were also significant changes in the total problem

Table 1
Evolution of Behavioral Problems and Parental Stress

Measure	Pre *M* (*SD*) *T* (SD)	Post *M* (*SD*) *T* (SD)	*t*	*df*	*p*	Effect size *d*
Behavior						
Externalizing	22.56 (6.83) 68.28 (4.98)	15.20 (9.52) 61.08 (9.88)	4.84	24	.000	0.89
Internalizing	12.40 (8.16) 60.08 (9.64)	8.20 (5.37) 54.80 (8.30)	3.30	24	.003	0.61
Total	61.32 (16.26) 67.24 (4.43)	41.60 (19.72) 59.88 (8.22)	6.18	24	.000	1.09
Parenting stress						
Feeling able to cope	19.00 (3.58) 55.66 (7.34)	16.94 (4.53) 51.43 (9.29)	2.73	24	.012	0.51
Experiencing problems	19.04 (4.09) 59.63 (8.23)	17.14 (4.61) 55.76 (9.28)	1.97	24	.060	0.44
Parenting is a burden	20.98 (3.98) 60.75 (7.49)	19.32 (5.72) 57.63 (10.75)	2.16	24	.041	0.34
Desire changes	15.74 (3.65) 60.83 (8.00)	12.92 (3.80) 54.84 (8.67)	3.59	24	.001	0.77

Note. $n = 25$; Pre = pretreatment; Post = posttreatment.

Table 2
Evolution at Individual Level in Externalizing, Internalizing, and Total Problem Behavior

Behavior	Decrease RCI > 1.96 (%)	No development 1.96 ≥ RCI ≥ −1.96 (%)	Increase RCI < −1.96 (%)
Externalizing behavior	18 (72)	6 (24)	1 (4)
Internalizing behavior	11 (44)	12 (48)	2 (8)
Total problem behavior	20 (80)	4 (16)	1 (4)

Note. $n = 25$; RCI = Reliable Change Index.

scores (Table 2): In 20 cases, total problem behavior decreased significantly (80%), in four they remained unchanged (16%), and in one case, the total problem score increased (4%).

Table 3 shows the evolution in clinical status between T1 and T2 of the children who made significant progress. In cases where the externalizing behavior decreased significantly ($n = 18$), this change was clinically relevant for 11 children (61.1%). In cases where the internalizing behavior decreased significantly ($n = 11$), this was clinically relevant for seven children (63.6%). When a decrease in the total problem score occurred ($n = 20$), this was clinically relevant for 14 children (70%).

In the case of an increase in externalizing ($n = 2$), internalizing ($n = 2$), or total problems ($n = 1$), these changes were clinically relevant in, respectively, one, one, and none of the cases.

DISCUSSION

Foster parents are often faced with serious problem behavior in their foster child. Research finds bidirectional and reciprocal associations between problem behavior, parenting stress, ineffective parenting, and placement breakdown. Foster children in foster care placements where foster

Table 3
Evolution in Clinical Status

	Scores post			
Behavior	Normal	Borderline	Clinical	Total
Externalizing Pre				
Normal				
Borderline	4			4
Clinical	6	1	7	14
Internalizing Pre				
Normal	2			2
Borderline	1			1
Clinical	5	1	2	8
Total problems Pre				
Normal	1			1
Borderline	3			3
Clinical	6	5	5	16

Note. Pre = pretreatment; Post = posttreatment.

parents receive only routine support seldom show a reduction in behavioral problems (Vanderfaeillie, Van Holen, & Trogh, 2008). This points to a central weakness in the support of foster parents and calls for remedial action.

In this article, we described a NVR intervention adapted to the foster care context. A manualized support program including 10 individual and three group sessions aimed to help foster parents prevent escalation, engage social support, make use of reconciliation gestures, and deploy active NVR to problem behaviors. The intervention was provided as an extra service by the foster care agency and was delivered by experienced and specially trained foster care workers. These therapists were familiar with all aspects of this complex form of care and knew how to best approach foster parents as "partners in care." A main home visit format not only placed fewer burdens on the participating foster parents, but also facilitated the inclusion of difficult-to-reach foster parents. The fact that no foster parents dropped out might indicate that the intervention was felt as supportive by the foster parents, although the fact that it concerned a convenience sample could have also influenced the high completion rate.

The intervention showed promising results, both at group and at case level. At group level, statistically significant reductions were found in externalizing, internalizing, and total problem behavior, and in three of four parenting stress scales. At case level, the reliable change analyses showed that, respectively, 72, 44, and 80% of the treated foster families demonstrated reliable improvements in externalizing, internalizing, and total problem behavior of their foster child. Although the intervention focused on externalizing problem behavior, a decrease in internalizing problem behavior was also found. Furthermore, in cases of improvement, these were mostly clinically relevant (ranging from 61 to 70% of the cases). The results of the effect size analyses support the clinical importance of the improvements. Effect sizes for behavioral problems range from medium for internalizing behavior ($d = 0.61$) to large for externalizing ($d = 0.89$) and total problem behavior ($d = 1.09$). The effect sizes for the parenting stress scales are smaller and range from small for "parenting is a burden" ($d = 0.34$) and "experiencing problems" ($d = 0.44$) to medium for "feeling able to cope" ($d = 0.51$) and "desire changes" ($d = 0.77$). Possibly the effects on parenting stress are less pronounced because bringing up of a foster child remains burdensome for foster parents and they are continuously confronted with problems they need to solve, despite improvements in the child's behavior. Furthermore, foster parents had just finished an intensive training course, which on itself could have been experienced as burdensome. Nevertheless, foster parents seem to feel more able to cope and to be more satisfied with their foster child, desiring fewer changes. Generally speaking, most effect sizes in this study are very promising as meta-analyses show that the effect sizes of psychological, educational, and behavioral treatments are situated between approximately 0.40 (Bartels, Schuursma, & Slot, 2001) and 0.50 (Lipsey & Wilson, 1993, 1998); the results from evidence-based programs for foster parents mostly have small to medium effect sizes that typically reduce over time (Leve et al., 2012).

These encouraging findings should, however, be interpreted with caution. Firstly, the group treated was small and concerned a convenience sample. Secondly, as we used a pretest/posttest research design without comparisons with a control group, no sound conclusions about the efficacy of the intervention can be made at this time. Therefore, it cannot be ruled out that evolutions were the result of maturity, organic progression, et cetera. The internal validity could be threatened, and allegiance effects cannot be ruled out. Thirdly, one-group pretest/posttest designs generally overestimate treatment effects (Lipsey & Wilson, 1993). Especially regarding the effect on the parenting stress, the risk of incorrectly rejecting the null hypothesis (no evolution) exists. Fourthly, outcomes were only assessed immediately posttreatment. We cannot be sure whether the changes will endure. Fifthly, all data were derived from the foster mothers only and were solely based on self-reporting.

An increasing number of applications of the NVR approach are described in literature (Van Holen et al., 2011), and it has been implemented successfully with parents from various social, ethnic, and religious backgrounds (Omer et al., 2013). Our results suggest that the approach also works with children and parents with no biological bond. Although promising, at this point, it is insufficiently clear as to what extent the intervention we have described is generalizable to foster care in other countries. Moreover, further research is desperately needed before sound conclusions about the efficacy or effectiveness of this intervention can be made. Future research should include

larger samples and use randomized controlled and multitrait-multimethod designs, comprising more sources and methods, and replications by independent research teams. Furthermore, examinations in the longer term are needed to evaluate which specific actions and ingredients of this intervention (e.g., involving biological parents, attending group sessions, performing parental sit-ins) make an essential contribution to its effectiveness (Van Holen et al., 2011), and further research on population characteristics (e.g., age range foster child, kinship vs. nonkinship foster parents) and placement characteristics (e.g., new vs. long-term placement) is needed to outline target groups.

As interventions aimed at improving the well-being of foster children and foster families are desperately needed, it is important to inform therapists about the development and implementation of new and promising approaches that focus on the problems foster families face. According to Leve et al. (2012), interventions for foster families are unique in several regards, predominantly because foster children have been exposed to neglectful and/or abusive parenting from a former caregiver, while it is the foster parent currently parenting the child who is involved in the intervention. In addition, foster children are more likely to exhibit vulnerabilities that expose unique challenges to caregivers. Thus, standard parenting intervention programs might not be sufficient or appropriate for foster families (Leve et al., 2012). The adaptation and implementation of a parenting program based on NVR to the specific needs of foster parents appeared to be feasible, seemed acceptable to foster parents, and might be a promising approach. The strategies outlined in NVR provide parents with ways to manifest their power as caregivers in a loving, respectful manner and enable them to increase their connection to the foster child despite problematic behavior (Omer et al., 2013). Parents are strengthened by involving external support, which is associated with positive parenting strategies (Coyl, Newland, & Freeman, 2010). Parents are helped to build a secure and stable relational framework (Lavi-Levavi et al., 2013). Although future work is needed, we hope this study conducted in a practice setting can inspire practitioners to help parents and children avoid being drawn into vicious cycles of interaction, and contribute to the adaptation and implementation of an effective and highly acceptable intervention for foster parents.

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