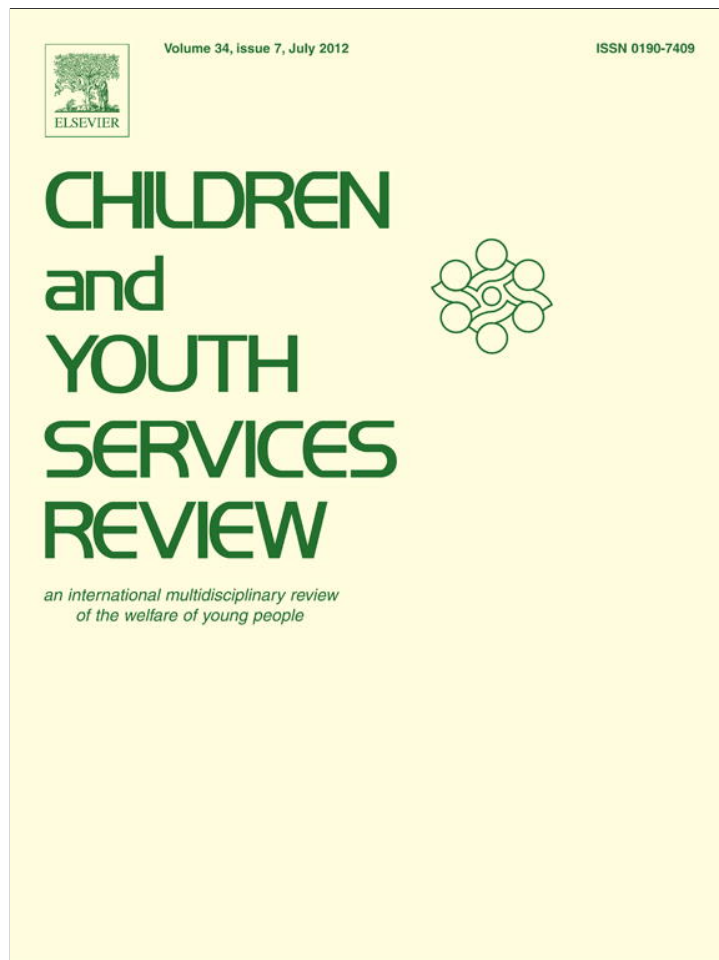


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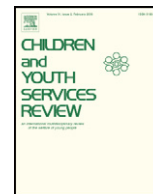
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The efficacy of a short cognitive–behavioral parent program in the treatment of externalizing behavior disorders in Romanian foster care children: Building parental emotion-regulation through unconditional self- and child-acceptance strategies

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ABSTRACT

Foster children manifest a high incidence of externalizing behavior disorders compared with children from the general population and these problems are associated with unplanned disruptions in foster care placement. This study is a randomized trial (Treatment vs. Waiting list) for investigating the efficacy of a short enhanced cognitive–behavioral group parenting program delivered to Romanian foster parents (N=97) for reducing externalizing behavior disorders in foster children, increasing placement stability, and reducing foster parents' emotional distress. Results supported the efficacy of the program, as compared to the waiting list, in treating child behavior problems and reducing parental emotional distress, but no differences were found regarding placement stability between the two groups. Implications of the findings are discussed in terms of designing and delivering viable parent interventions aimed at reducing externalizing disorders in foster children and unplanned placement disruptions.

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1. Introduction

Foster children manifest a high incidence of behavioral problems compared with children from the general population (McCann, James, Wilson, & Dunn, 1996; Smyke et al., 2007) and these problems are associated with unplanned disruptions in the foster care placement (Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007).

Many foster children were previously institutionalized. Research shows that children growing up in institutions are at great risk for health and developmental difficulties (Groza, 1999; Nelson et al., 2007). In addition to the potential severe behavior and emotional problems, such as aggressive or antisocial behavior, institutionalized children show difficulties with critical thinking, cause-and-effect thinking, and impulsivity, and display an array of learning problems, placing them at risk for psychiatric impairments into adulthood (Nelson et al., 2007; Smyke et al., 2007). School professionals working with these children report even more problems than do foster parents, particularly highlighting attention-seeking behaviors, restlessness, poor peer relations, and disobedience (see Wilson, 2003 for a review). Moreover, a substantial number of the children in foster care also come from

previous abusive and neglectful home environments and also show significant behavioral and emotional difficulties (Parker, Greer, & Zuckerman, 1988). These children are likely to have histories of parent–child conflict, aggressive behavior, self-destructive tendencies, disruptive behavior in the community, school difficulties, and emotional disturbance (Berridge, 1997). Therefore, it is not surprising that reports show foster children “to have three to seven times more chronic medical conditions, birth defects, emotional disorders, and academic failure than children from similar socio-economic backgrounds” (Blatt & Simms, 1997, p. 113).

Difficulties associated with working with children displaying challenging behaviors have turned the task of fostering into an extremely demanding job. Utting (1997) has suggested that many foster parents are unprepared to meet the demands of behaviorally and emotionally disordered children. Foster parents look to child welfare agencies for guidance, support, and reassurance, but the latter are generally short staffed and often crisis driven, which hinders their ability to respond to the on-going, every day needs of foster parents and children. This situation can result in placement breakdowns, which further strain the foster care resources.

Perhaps because parents do not typically receive training to parent their own children, the need to train foster parents on a large scale was not recognized until '90s (Pasztor & Wynne, 1995). It is now accepted that the provision of training for foster parents is an important factor contributing to the successful outcome of foster care placements. Foster

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parent training has been associated with enhanced caring attitudes and skills, reducing behavior problems in foster children, improving relationships between foster parents and child welfare agencies, and decreasing foster parent attrition (Hampson, Schulte, & Ricks, 1983; Runyan, Gould, Trost, & Loda, 1981). In contrast, lack of foster parent training was associated with failed placements (The Audit Commission, 1994; Runyan et al., 1981). Let us briefly examine the efficacy of parent training program in improving various health outcomes in foster care children.

2. Parent training programs in foster care children

There is extensive research showing that parent training is effective for child externalizing symptoms (see Bradley & Mandell, 2005; Kaminski, Valle, Filene, & Boyle, 2008; Lundahl, Risser, & Lovejoy, 2006; Scott et al., 2001). Indeed, UK National Institute for Health and Clinical Excellence (NICE, 2006) suggested that the group-based parent-training/education programs are recommended as the treatment of choice for conduct disorders in children aged up to 12 years. However, only a few published randomized clinical trials have investigated the potential value of parent training (most of them cognitive-behavioral) as a tool for helping foster parents and reducing externalizing behavior disorders in foster children (Dorsey et al., 2008; Kakavelakis & Macdonald, 2004; Letarte, Normandeau, & Allard, 2010; Petra & Kohl, 2010). A systematic review of them (see Turner, Macdonald, & Dennis, 2005), six trials involving 463 foster parents, showed little evidence to support the efficacy of behavioral or cognitive-behavioral foster parent programs in child psychological functioning, extent of behavior problems, and interpersonal functioning: however, flaws in the intervention designs could be

invoked as potential contributors to the final results (see Turner et al., 2005).

Recently, parent training programs have proliferated and numerous unpublished curricula have been developed by both state and private child welfare agencies using various formats and training methods (Barth, 2008; Zukoski, 1999). For example, one of the most well researched curricula is the Multidimensional Treatment Foster Care (MTFC) program which includes a multi-component broad-based approach to training (e.g., foster parent training and intensive ongoing support/consultation to the family, children receive individual skills training), with positive effects on parenting, child behavioral adjustment, and placement success, compared to the regular foster care (Chamberlain, 2003). Although there are multi-component (i.e., MFTC) programs for child welfare system that have been seriously documented to date, they usually involve training investments for all the professionals involved in the components delivery (e.g., MFTC sites in Norway, Denmark, the UK, Ireland, The Netherlands; Westermarck, Hansson, & Olsson, 2010) and system reforms, which in underdeveloped countries, like Romania, are only in their beginnings.

3. The overview and contribution of the present study

Parents' high level of distress (e.g., maternal psychopathology) has been shown to interfere with the establishment of change following trainings targeting child behavior problems (see Bugental, 2000; Reyno & McGrath, 2006 for a comprehensive review). Indeed, Scott and Dadds (2009) proposed that a common problem in current parent programs is that parents have difficulties in changing because although they know how they should behave, "they have strong beliefs

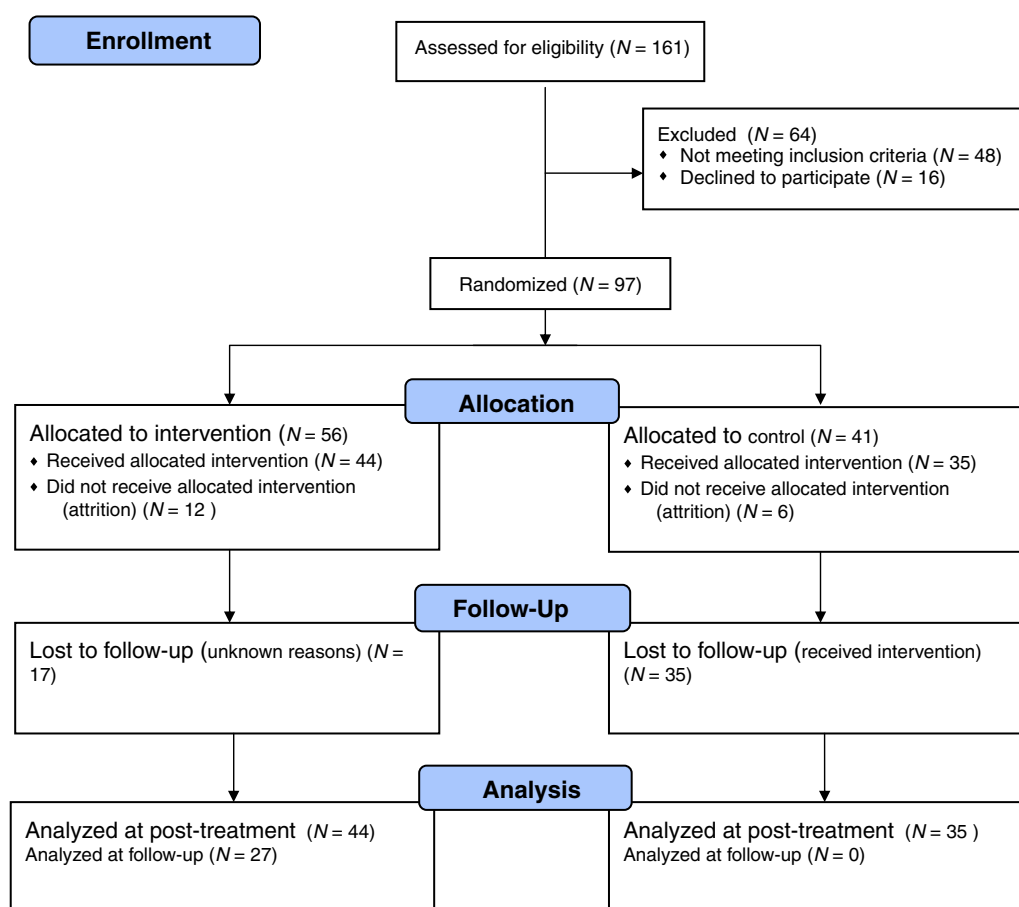


Fig. 1. Consort diagram flow with the progress through the phases of the trial.

that prevent them doing so" (pp. 1442). Consequently, it is thought that parental stress reduction by using emotion self-regulation strategies could augment the effects of classical parental interventions (Dix & Meunier, 2009; Gavița, 2011a, 2011b) and, therefore, recent calls have been made for developing cognitively enhanced versions of well researched parenting programs in the training provided for foster parents (Sanders, Markie-Dadds, Tully, & Bor, 2000; Webster-Stratton, 1994). The enhancement is "cognitive", because the parental distress is typically approach from a cognitive-behavioral theory paradigm (i.e., emotional-regulation paradigm; Beck, 1976; Ellis, 1994; Gross & John, 2003; Lazarus, 1991).

There are encouraging study results suggesting that the use of parent training enhanced with a cognitive module designed to teach parents effective emotion-regulation strategies may improve outcomes of traditional behavioral or cognitive-behavioral parenting programs (Azar, Nix, & Makin-Byrd, 2005; Ben-Porath, 2010; Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004; Dumas, 2005; Poitier & Day, 2007; White, McNally, & Cartwright-Hatton, 2003). To date, these new approaches in parent programs, targeting parent emotion-regulation strategies, have shown improved outcomes when compared to the un-enhanced behavioral parent programs (see Gavița & Joyce, 2008 for a review).

However, two main limitations of the new enhanced parenting programs. First, parental distress is not targeted following an evidence-based theoretical framework. Thus, sometimes it is targeted at the beginning of the program, at middle or at the end of the program. On the other side, the main cognitive-behavioral theories (Beck, 1976; Ellis, 1994; Lazarus, 1991) suggest that the "emotional problems" should be approached first, and then, after they are reduced and/or solved, we can focus on the "practical problems" (e.g., parenting skills deficit). Second, although there are increasing pieces of evidence for the importance of focusing on parent affect in parent programs little research has been done yet on the effectiveness of cognitively enhanced parent trainings in reducing externalizing behavior disorders in foster children (Dozier et al., 2009) and no integrated framework exists in helping foster parents manage the stress associated with child externalizing behavior disorders (Gavița, 2011a, 2011b).

We think that Romanian condition prove to be an excellent research setting to approach these two limitations of the previous studies. Indeed, starting in the 1960s, child abandonment became a national problem in Romania after the communist regime instituted policies affecting reproductive rights (lack of contraceptive options and banning abortions), in an effort to increase national population (Groza, 1999). Families that were unable to afford caring for their children were encouraged to place them in government-run institutions/orphanages. Decades later, after the fall of the communist regime in 1989, it was revealed that children raised in these institutions had experienced significant neglect and abuse with significant impact on their cognitive, emotional, and physical development. Recent changes in the Romanian child protection policies have targeted attempts to improve the situation of institutionalized children by placing them in foster families. Although there is evidence to support that such environmental changes lead to much improvement, the effects of institutionalization do not disappear completely over time and negative effects persist, particularly in school (Wolkind & Rutter, 1973).

3.1. Objectives of the study and hypotheses

The study aimed to determine the efficacy of a short enhanced cognitive-behavioral group parent program, enhanced with a module focused on teaching foster parents emotion-regulation strategies, in the first phase of the intervention, with the final goal of reducing externalizing behavior in foster children and in increasing the stability of the placement. In this study we compare a Short Enhanced Cognitive-Behavioral Parent Training (CEBPT) with a waitlisted control group (WL). The main difference compared to the standard parent management training approaches in the literature is that the short

cognitive-behavioral parent program was thought to reduce child externalizing behavior disorders by focusing first on teaching foster parents functional emotion-regulation strategies (the emotional problem or C in the ABC framework), through increasing their self and child unconditional acceptance, and in the second phase approaching their practical problem (the A in the ABC framework), by supporting better implementation of parenting skills.

For this study, it was predicted that significant reductions in externalizing behavior disorders would be seen in children from the intervention group when compared with waiting list. Furthermore, we anticipated that parent reports on parenting practices would improve, while the reports of distress related to parenting would decrease. Finally, we predicted that unplanned placement disruption will differ between the two study groups.

4. Method

4.1. Participants

The initial sample included 97 foster children from Bihor County Romania, aged 5 through 18 years who had externalizing behavior disorders as indicated by their score on the Child Behavior Checklist (93 percentile of the CBCL; Achenbach, 1991). The mean age of the children was 9.51 years ($SD = 3.47$). Recruitment of participants for the intervention occurred through the referral from the Child Welfare Directory and each parent signed an informed consent form, based on the ethical guidelines of Institutional Review Board at the BBU. For each child, only one of the foster parents participated to the study, since 86% of the parents had multiple children in care at the time. In the sample included, foster parents referred to one of the children in foster care presenting externalizing behavior disorders. The only exclusion criterion was that foster families not be biological relatives of the child (up to third grade relatives). Eligible subjects were randomly allocated in the two groups, CBPT or WL groups. For the intervention group, an intervention manual was developed based on components of already existing programs: stress reduction and rational thinking techniques (Joyce, 1995), monitoring procedures, and disciplining techniques and effective instructions (Froelich, Doepfner, & Lehmkühl, 2002; Kazdin, 2000; Sanders et al., 2000; Webster-Stratton, 1994). The therapists who co-led the parent program were trained in CBT according to the standards of the European Association of Behavioral and Cognitive Therapies and had extensive experience in providing therapeutic interventions in group settings (Fig. 1).

4.2. Design of the study

Foster parents were allocated in the intervention and WL conditions based on a block procedure. For the allocation of participants we used block sizes of four parents with series of six in order to cover all possible balanced combinations of assignment within the block. Foster parents and children in both conditions were assessed at pre-treatment (Pre), at post-treatment (Post), and at three month follow-up (FF) using a series of measurements.

4.3. Measures

4.3.1. Child outcomes

4.3.1.1. Placement disruption. The foster placement unplanned termination rate was obtained from the files of the Directorate of Social Assistance and Child Protection (the institution that monitors foster families). Foster parents provided basic demographic information and completed the following scales independently.

4.3.1.2. Child behavior checklist (CBCL; Achenbach, 1991). The CBCL is a commonly used scale of child psychopathology which includes behavioral

items rated by caregivers on the on a scale of 0 (not true about my child) to 2 (very true or often true about my child) over the past 2 months. The items are clustered into subscales, internalizing syndromes and externalizing syndromes, which to assess a range of behavioral difficulties. The externalizing syndrome subscale was utilized in this research, which includes Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problems. The validity of the CBCL is well supported in prior research including for Romanian samples, with the internal consistency of the measure ranging from 0.78 to 0.97 across subscales and test–retest reliability ranging from 0.95 to 1.00 across subscales (alpha Cronbach 0.95 for Romanian population; Rescorla et al., 2007).

4.3.2. Parent outcomes

4.3.2.1. The parenting scale (PS; Arnold, O'Leary, Wolff, & Acker, 1993). The PS is a 30-item self-report scale of parental discipline, where parents indicate their tendencies to use specific discipline strategies using 7-point Likert scales, where 7 indicates a high probability of using dysfunctional discipline and 1 indicates a high probability of using an effective, alternative discipline strategy. Factor analyses showed three parenting styles: overreactivity, laxness, and verbosity. The scale has good internal consistency (0.84) and is associated with behavioral observations of parenting children (Arnold, O'Leary, Wolff, & Acker, 1993; Irvine, Biglan, Smolkowski, & Ary, 1999).

4.3.2.2. Profile of emotional distress (PED; Opris & Macavei, 2007). The PED is a measure of psychological distress for adults and consists of 39 items. The subject is asked to rate each item (adjectives describing emotions) in assessing how he/she has felt during the last 2 weeks, on a 5 point Likert scale, ranging from *not at all* to *very much*. The scores can be summarized in functional negative emotions (e.g., concern, sadness) and dysfunctional negative emotions (e.g., anxiety, depressed mood), this subscale being used in this study. The PED was validated on the Romanian population (Opris & Macavei, 2007) with good internal consistency for the instrument (alpha Cronbach = 0.94) and its subscales (alpha Cronbach between 0.80 and 0.94).

4.4. Treatment

The program consisted of four weekly sessions plus a three-month follow-up session, each of four hours. These sessions were organized so that parents had multiple chances to continue in the study if they missed one or more sessions. This format was chosen not only to line up with research concerns on cost-effectiveness, but also to respond to families' limited resources of time and access to transportation. The program was co-led by two therapists certified in cognitive-behavioral therapy according to the standards of the European Association for Behavioral and Cognitive Therapies; www.eabct.com).

For the intervention group, an intervention manual was developed in line with cognitive-behavioral theory and practice and based on the main components of researched parenting programs (Beck, 1970; David & Szentagotai, 2006; Kaminski, Valle, Fillene, & Boyle, 2008; Levac, McKay, Merka, & Reddon-D'Arcy, 2008; Reyno & McGrath, 2006). The content of the emotion-regulation module of the program addressed types of cognitions that have been shown to mediate between adverse experiences and dysfunctional emotional/behavioral reactions commonly found in parents with children with behavioral problems (Deković et al., 2010; Hoza et al., 2000; Jacobson et al., 1996; Szentagotai, David, Lupu, & Cosman, 2008). Specifically, the program focused on: (1) psychoeducation about child development; (2) learning about the role of cognitions in parental distress (e.g., rational thinking life self and children acceptance), particularly in reaction to the children's behaviors (Joyce, 1995); (3) identifying strategies for emotion regulation and stress reduction, and (4) exploring disciplining/problem-solving and monitoring techniques, as well as

effective communication skills (Froelich et al., 2002; Kazdin, 2000; Sanders et al., 2000; Webster-Stratton, 1994). A manual was elaborated for this study, focusing on providing foster parents with child development information/psychoeducation, parenting skills, parental emotion-regulation and stress reduction strategies, problem solving skills and efficient communication skills (Froelich et al., 2002; Joyce, 1995; Kazdin, 2000; Sanders et al., 2000; Webster-Stratton, 1994).

The program consisted of a first module centered on reducing foster parents' stress and building emotion-regulation skills, by teaching them skills to identify and dispute their general and child-related irrational cognitions (e.g., unconditional self and child acceptance, low frustration tolerance, or demanding attitudes) and dysfunctional attitudes (e.g., child related attributions). After helping foster parents control their emotional reactions related to children's problematic behaviors (e.g., anger, anxiety), the program aimed at teaching the participants skills to effectively manage children's defiant behavior, skills for better communication, and problem solving skills through the use of educational materials, role-playing, and weekly homework tasks.

The sessions were structured as follows: *Session 1:* Child development stages; Emotional-regulation strategies – antecedent and consequence focused strategies; distress and functional reappraisal strategies (according to the ABC model, which postulates that perceptions and appraisals (B) of the situation (A) cause reactions (C); Ellis, 1962); Parental distress, including anger and underlying parental distorted cognitions; and self and child unconditional acceptance. *Session 2:* Positive discipline methods; Strategies for decreasing unwanted behavior in children; Designing family rules. *Session 3:* Positive discipline methods and strategies for increasing wanted behavior in children; Steps in discipline; Efficient communication with the child. *Session 4:* Discipline in the case of specific behavior problems for different ages; Problem solving strategies and coping plans with potential risk situations. *Session 5:* Follow-up: Progress monitoring; Past sessions review; Problems encountered and solutions.

4.5. Data analysis and statistics

Analyses concerning the child outcome were conducted using the intent-to-treat principle: the analysis included all parents' reports independent of the group assignment and regardless of their protocol adherence, subsequent withdrawal from study or deviation from the intervention protocol. The last available score on each outcome measure served as the termination score for dropouts. Treatment response at posttest and follow-up was also analyzed categorically. Children were considered improved if they had a post-test and follow-up externalizing subscale score on CBCL of less than the 93 percentile.

An alpha level of .05 was used for all statistical tests. Univariate analyses showed that the data were suitable for further analyses. Pre-treatment group differences were assessed by one-way analyses of variance (ANOVAs) and no significant group differences were found between the two conditions (all $ps > .05$).

5. Results

5.1. Attrition

The attrition rate was 18% overall, as 79 foster parents of the initial sample completed the study. Out of these, 44 foster parents completed the treatment arm (defined as having participated in all four sessions) and 35 for the control group at the post-treatment time. No differences were found in terms of demographic and initial study variables between the foster parents lost in attrition and the study completers, independent of the group assignment. For the follow-up measurements, data was obtained from 61.36% of the foster parents who received the whole intervention. Follow-up data from the foster parents on the waiting list was not collected at the three month period because parents had

been assigned for the intervention. In response to the overall positive response of the program, the Directorate of Child Protection and Social Assistance decided that all foster parents with behaviorally challenged children in the County, including the study controls, should be provided with support and our intervention.

5.2. Adherence to treatment protocol

The measure of treatment integrity and fidelity (treatment adherence) used in the present study was based on a checklist derived from the manual for the intervention group. Items reflected techniques that were unique to this program and general techniques used in other cognitive-behavioral parent group programs (Webster-Stratton & Herbert, 1994). The checklist contained items measuring parent home activities, focus on practice and role plays activities, group leader relationship building and group leadership skills, focus on knowledge, parents' responses and focus on review and home activities in the end of the session. Raters listened to audiotaped therapy sessions and rated each item on a scale ranging from 0 (not at all) to 6 (extensively). Two sessions were randomly selected for adherence ratings. The overall means of all the ratings for treatment fidelity were above the mean for each section of the measure.

5.3. Missing data

We minimized the chance of missing data by avoiding unobserved measurements as much as possible, and by encouraging the retrieval of data after the patient's dropout. Missing or incomplete data were imputed with the average score of the completed items when no more than four items were missing. No differences were registered between results obtain with or without the missing items replacement.

5.4. Descriptive analyses

Data obtained are presented in Table 1.

5.5. Inferential analyses

5.5.1. Pre-treatment analyses

No significant pre-treatment differences among treatment conditions were found (all $ps < .05$).

5.5.2. Treatment outcomes

5.5.2.1. Children externalizing syndromes. Repeated measures ANOVA analyses on child externalizing syndromes (CBCL) showed significant differences by main effect for groups $F(1,93) = 4.99, p = .05$, time (pre-/post-treatment) $F(1,93) = 52.00, p = .001$, and their interaction $F(1,93) = 11.86, p = .01$, with a medium magnitude of change (Cohen $d = .67$) between the two groups at post-test. No significant differences were found at three month follow-up for the treatment group ($p > .05$) when compared to post-treatment ratings of child disruptive behavior. In terms of response rates for the intervention group, categorical analyses show that 41.4% of the children no longer were rated

by parents in clinical range levels for externalizing behaviors at post-test and 48.14% at the 3-month follow-up time.

5.5.2.2. Parental distress. The results of repeated measures ANOVA comparisons for parental distress (PED) at post-treatment showed significant change for group condition $F(1,93) = 3.93, p = .04$, time (pre-/post-treatment) $F(1,93) = 13.87, p = .001$, and group by time interaction $F(1,93) = 9.32, p = .01$. The magnitude of change for parental distress levels at post-treatment between the two groups was medium ($d = .69$). No significant differences were found in terms of foster parents' stress levels at three month follow-up in the treatment group, when compared to post-treatment levels ($p > .05$).

5.5.2.3. Parenting. ANOVA comparisons in terms of dysfunctional parenting style (PS) revealed a main effect for group inclusion $F(1,93) = 7.78, p = .02$, time (pre-/post-treatment) $F(1,93) = 31.71, p < .01$, and group by time interaction $F(1,93) = 36.70, p = .001$. The effect size in terms of the magnitude of improvements in parenting practices at post-treatment was high ($d = .97$), when compared to the control group. No differences in terms of parenting style were registered at three month follow-up for the foster parents in the treatment group, when compared to their post-treatment ratings ($p > .05$).

5.5.2.4. Placement disruption. The Placement Disruption Rates for the Intervention were 4.5% of the total sample in the intervention group and 5.7% for the control group, with a total rate of disruption in the two groups of 5.1%. Similarly, there were no significant differences in placement disruption rates between the groups at the 3-month follow-up ($\chi^2 = .05, p > .05$).

5.6. Post-hoc analyses

Given the poor outcomes for interventions targeting adolescent externalizing behavior disorders in the literature (Kazdin, 2000), we pursued the hypothesis that having a teenager with these behavioral problems could affect the outcome of the intervention. For this purpose, we created two age subgroups: foster child under the age of 12 years [$N = 16$, mean age = 8.25, $SD = 1.84$], and adolescent group [$N = 11$, mean age = 13.72, $SD = 1.48$]. Twenty-seven subjects in the intervention group whose foster parents participated in all phases of the program were included in the analysis.

Results showed (see Table 2) that parents with children in foster care reported a significant improvement in terms of externalizing behavior disorders after the intervention, in contrast with the foster parents of adolescents $t(27) = -3.14, p < .05$. No differences were noted between in the report of externalizing behavior disorders for parents with either children or adolescents post intervention when compared to the control group $t(35) = -.68, p > .05$. For the treatment group, differences in terms of behavior problems between children and adolescents were no longer significant at the three month follow-up $t(27) = -1.07, p > .05$. For further characterization of the differences in child and adolescent behavior as impacted by the CBPT program, we used an estimated marginal means plot (Fig. 2).

Table 1
Descriptive statistics for the outcomes at pre-, post-treatment, follow-up for the experimental and waiting list groups.

Group	Outcomes	Pre-treatment			Post-treatment			Follow-up		
		M	SD	N	M	SD	N	M	SD	N
Intervention	Child behavior Problems (CBCL)	76.62	14.97	56	58.75	17.64	44	60.04	16.83	27
	Parental stress (PED)	13.39	6.61	56	8.90	7.09	44	11.77	5.33	27
	Parenting (PS)	99.07	32.21	56	74.06	29.73	44	96.81	20.14	27
Control	Child behavior Problems (CBCL)	81.87	20.36	41	70.88	18.08	35			
	Parental stress (PED)	14.29	6.57	41	13.68	7.09	35			
	Parenting (PS)	101.02	25.61	41	101.34	26.15	35			

Notes. M – mean; SD – standard deviation; N – number of participants.

Table 2
Descriptive statistics of behavior problems for children group and adolescent group.

Group	Subjects	Child behavior problems (CBCL) Pre-treatment			Child behavior problems (CBCL) Post-treatment			Child behavior problems (CBCL) Follow-up		
		M	SD	N	M	SD	N	M	SD	N
Intervention	Children	68	18.61	16	52.81	18.86	16	57.37	18.35	16
	Adolescents	70	22.18	11	69	19.64	11	64.72	16.73	11
Control	Children	67.3	18.11	26	67.81	18.60	26			
	Adolescents	71.21	22.86	9	70.45	21.40	9			

Notes. M – mean; SD – standard deviation; N – number of participants.

The plot shows that the group of younger children had greater improvements in externalizing behavior post-treatment, but this difference was not evident at follow-up time. For the adolescents group, there was less improvement of behavior right after the intervention (Post-treatment) but the improvement was maintained at the three month follow-up.

6. Conclusion and discussions

In this study, a short enhanced cognitive–behavioral parent program enhanced with a parental emotion–regulation component proved to be efficacious (medium effect size) immediately post intervention in reducing externalizing behavior disorders in foster children, levels of parental distress, and reports of dysfunctional parenting. Although most of the targeted outcomes improved as expected, no differences were found between the two groups in unplanned placement disruptions. While behavior problems have been proven to be a robust predictive factor for unplanned placement disruptions, they do so mostly in interaction with other factors (e.g., number of previous foster care interruptions; Oosterman et al., 2007). It is possible that our study did not find differences in unplanned disruptions between the two groups or within the treatment group due to the short time frame in which this aspect was assessed. Given that this study came as a response to the need to prevent/reduce foster placement disruption by addressing home behavior problems, it is clear that more research is needed in order to investigate the processes that contribute to this reality (i.e. time frame from placement to disruption, time frame from reports of child behavior problems to placement disruption, etc.) in order to formulate concrete recommendations to reduce the risk for unplanned placement disruptions.

The existing concern in the literature that having a teenager with externalizing behavior disorders would negatively affect the outcome of treatment was disconfirmed in our study. Although at post-intervention, children in foster care showed significantly greater improvements in their behavior, at three month follow-up both children

and adolescents were reportedly in better behavioral control. It might be that adolescents need a longer time to adapt to new parenting strategies in order for change to occur, while in the case of children, more monitoring might be needed in order to maintain the changes. These hypotheses need further investigation in future studies.

6.1. Implications for clinical practice, theory and policies

To our knowledge, no other clinical trial on the efficacy of a parental program has been conducted yet on Romanian populations of foster parents with the goal of reducing children's externalizing behavior disorders. The clinical findings of this study are furthermore relevant because the Romanian foster care system is quite new and has been portrayed as flawed. The innovative nature of this study is reflected by the specific cognitive module aimed at reducing foster parents' distress and increasing child acceptance, following cognitive–behavior theory. Overall, our results showed that the integration of parental emotion–regulation strategies into a theoretically coherent cognitive–behavioral parent program has the potential to impact favorably problematic child behavior, especially in the most vulnerable children. This finding is particularly important since classic parent group intervention strategies aiming to reduce child externalizing behavior disorders might not place enough focus on reducing parental distress and, therefore, not address a mechanism by which to obtain significant change.

However, future work needs to explore the theory/mechanisms of change related to such outcomes. Indeed, now that we know that an enhanced program is better than a waiting list condition, in the next step a componential analysis (e.g., cognitive–behavioral program versus enhanced cognitive–behavioral) should be considered in future studies. We did not do this in the first step because, before running a componential analysis, we had to prove that the whole package is working. This is important in a practical setting when ethics and clients care is prioritized over theoretical; this step by step approach is accepted in clinical research (Montgomery et al., 2009).

The study is not without several limitations. First, given socioeconomic and cultural coordinates of Romania, the study sample was formed mostly on the basis of access to the foster families. In the same realm, this study was conducted at the level of only one county within Romania, therefore further limiting the generalizability of these findings. Secondly, for the three month follow-up analysis, the study lost the control group due to policy decisions of the Directorate of Child Protection and Social Assistance that were out of the control of the researchers (parents on the waiting list were included in the intervention program before the 3-month follow-up time point). Another important limitation is that the results obtained rely heavily on self-report measures and the study did not include any observation-based outcomes. This aspect opens additional explanations for the results obtained, as mentioned in the literature (Choi & Pak, 2005). Also, the validity of the study findings could potentially be increased if, in addition to parent self-report instruments, future studies will introduce adjunctive objective measures (i.e. clinician observations of parent–child interactions).

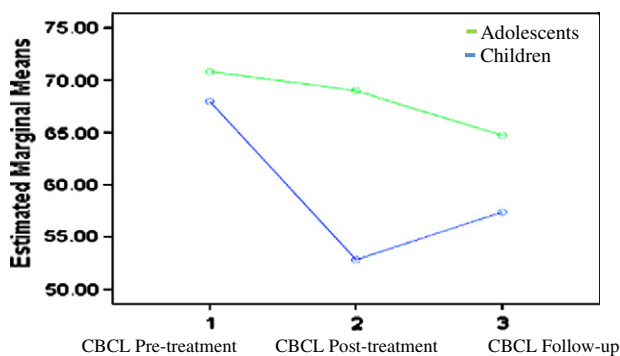


Fig. 2. Behavior problems at pre-, post-, and follow-up for the child group and the adolescent group within the treatment condition.

In conclusion, an important finding of the study is that a short program like the current one, enhanced with an emotion-regulation focused module for foster care parents, can lead to significant behavioral changes in foster care children. Future studies could explore comparative effects of this short (enhanced) cognitive-behavioral foster parent program to the full-length (enhanced) cognitive-behavioral parent program (e.g., 8–12 sessions), similar to the length of the well-researched parenting programs in the treatment of externalizing disorders in foster children.

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