The Development and Implementation of a Mentalizing Intervention for Foster Parents

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Thesis Declaration Form

I, Tina Elizabeth Adkins, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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“If a community values its children it must cherish their parents.”

(Bowlby, 1951, p. 84)

Abstract

Mentalization-based interventions show promise in improving mental health outcomes for children and parents through increasing a family's ability to mentalize. Mentalization typically develops within the context of a secure, attached relationship and involves the ability to understand behavior in relation to mental states such as thoughts and feelings. In fact, mentalization might be a key factor responsible for the intergenerational transmission of attachment. (Allen, Fonagy, & Bateman, 2008). One area not given much consideration when recruiting or training foster parents is their attachment state of mind or their capacity to mentalize.

This project involved the development and implementation of a psychoeducational intervention for foster parents, designed to increase their knowledge and ability to mentalize and be reflective with their foster children. Fifty-two foster parents in Austin, Texas, received the intervention. Pre and post data were collected measuring reflective functioning, parenting stress and child adjustment. The same measures were collected with a comparison group of 48 foster parents who received a typical training. Results indicate there were significant differences between the groups post training, with the intervention parents' significantly increasing their reflective capacities and while somewhat lowering their parenting stress, while the comparison group did not show any such improvements.

These findings support the hypothesis that a short-term psychoeducational intervention can increase a foster parents' ability to mentalize themselves and their children. These skills are very beneficial for foster parents, as they frequently deal with children who come into their home with challenging behaviors, attachment issues and negative internal working models of relationships. They might be less likely to jump to

conclusions about their foster children's negative behaviors, and will be more likely to interact with them in a therapeutic manner. This type of intervention has the potential to lower placement breakdowns and improve the mental health of foster children.

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Section I

Theoretical Review

Introduction

"Ghosts in the Nursery", the seminal paper by Selma Fraiberg and her colleagues (1975), not only holds a creative title, but it aptly describes how some parents are essentially haunted by the "ghosts" of abusive or neglectful caretakers in their own childhood. These unfriendly specters sneak up on parents, overtaking them and influencing how they are now parenting their own children. The abuse or neglect they experienced as a child is repeated with their own children via this haunting (Fraiberg, Adelson, & Shapiro, 1975). The idea of using "ghosts" to describe this process is quite clever as it not only calls to mind fear of the unknown and frightening myths and legends, but it hints at the unconscious nature of such interactions with the self.

Fraiberg and her colleagues wanted to discover why some parents were haunted, while others who went through childhood abuse, did not fall prey to repeating this pattern with their own children. Researchers have been exploring these ideas ever since, and much has been discovered regarding what is often termed as "protective factors" that enable adults to rise above the trauma they experienced in childhood. Many individual factors have been found to serve such a protective function such as having a calm and easy temperament or high intelligence (Rutter, 1985; 1987; J. Smith & Prior, 1995). However, a child's social environment and caregiving experiencing have also proved important. More specifically, parental warmth, emotional response and competence can be a protective factor, as well as social support and a positive educational experience (Rutter & Quinton, 1984; J. Smith & Prior, 1995; Wyman et al., 1999). However, more recently, an exciting area of research is evolving and showing to be an important player in area of protective factors. This area examines the interactions between child and caregiver, particularly as it relates to attachment and

parental mentalization, and how these serve to not only protect the child but encourage healthy psychological development throughout their lifetime (Elicker, Engelund, & Sroufe, 1992; Fonagy & Target, 1997).

This project and thesis seeks to understand and enhance the complex and intimate relationship between a maltreated child and their foster parents. To this end, a mentalization-based psychoeducational intervention for foster parents was created, tested and implemented in hopes of increasing foster parent capacities and by extension, positively impacting foster children. The first section of this paper will start with a full exploration of the underlying psychoanalytic concepts, particularly within attachment theory, that influence and explain the parent-child relationship within the context of mentalization. Next, will come a discussion on the impact of maltreatment and foster care on a child the nature of foster parents who care for them. Following this, a discussion will ensue regarding attachment and mentalization-based interventions for both parents and families. Then comes Section II of this thesis. This section will contain information on the main study: the development of a new intervention, the pilot study of implementation, the major trial of the intervention and finally, a thorough description of the results of this study and a discussion of these results. All of this will lead to the third and final section, a summary of the entire thesis as a whole.

Chapter 1. Attachment Theory and Mentalization

Although it is quite common for parents to parent how they themselves, have been parented, it is more complicated than this simple prescription. Many things can affect a person's ability to have a healthy intimate relationship with their child: mental health, stress, poverty, substance use etc. In addition, there are certain traits that can increase the odds that a parent who was abused or neglected, will in fact, not parent as they have been parented. The most important of these traits has been found to be the ability to be reflective or to mentalize. Mentalizing, a term put into use by Fonagy and his team (Fonagy, Target, & Steele, 1998), is essentially being aware of mental states, such as thoughts, beliefs feelings etc., in both yourself and others. However, the simplicity of this definition belies the complexity of the theory to which it is rooted. Mentalizing is thought to develop within a "good enough" parent/child relationship, through a securely attached relationship with a caregiver. To understand the true meaning and impact of this skill, we first must understand its origins, which began within Attachment Theory.

Attachment Theory

Attachment theory began with the work of the famous British psychoanalyst John Bowlby. Most significantly, Bowlby began to formulate his ideas while conducting clinical work at a home for maladjusted boys when he was just 21 years old. He began to see a pattern with these boys, many of whom had a disruption in caregiving, most significantly, disrupted relationships with their mothers.

When he began his research with this population a decade later, he came to the conclusion that an early disruption in the mother-child relationship can be seen as a

precursor for a mental health disorder in the child (Bowlby, 1944). With his study of 44 juvenile thieves, he found that the children who were more disturbed and escalated into delinquency had something in common: they all had an extended separation from their caregivers. Furthermore, he termed the more severely impacted children as "affectionless." He went on to study these dynamics by concentrating on mothers and infants who have been separated via institutionalization. He found that children, who did not receive maternal care after such a separation, often developed the same symptoms as the "affectionless" juveniles (Bowlby, 1951). At his point in his career, he still had not outlined the process of how early separation and maternal deprivation might lead to mental health issues in children.

The prevailing psychoanalytic theories of the time viewed the origins of parental bonding and affection quite differently than Bowlby's developing theory of attachment. In fact, Bowlby and his theory went far in turning the field upside down in many ways. Most significantly, his ideas went against the prevailing psychoanalytic ideas of the time, namely the Freudian notion that an infant loves her mother primarily because of the oral gratification she provides. The bond a child feels for the caregiver was seen as a side effect, if you will. This bond is seen as a secondary to the libidinal oral drive.

Bowlby spent his early career working at the British Psychoanalytic Institute and was heavily influenced by Melanie Klein and the object-relations approach to working with children and families. Although he was attracted to its emphasis on early relationships and the ill effects of early loss, he eventually had serious doubts about the Kleinian approach to psychoanalysis (Bretherton, 1992). Most importantly, he disagreed with the Kleinian notion that children's emotional problems are due solely to

fantasies derived from the internal conflict between drives, rather than as a response to external events in the child's life.

Bowlby did not feel the primary reason for children's emotional disturbances was a result of drive conflicts or internal fantasies. Through his direct experiences working with such children, he felt the children's family experiences held a much larger place in causing their mental health issues. This broke significantly from the psychoanalytic theories of the time and it was such a divergence, that for some, Bowlby's theories were not even seen as "psychoanalytic".

Through his work, Bowlby eventually concluded that for a child to grow up healthy, he must have "a warm, intimate and continuous relation with his mother in which both find satisfaction and enjoyment" (Bowlby, 1951, p. 13). He did not see the child as developing independently from his mother. Instead, he saw the mother as an essential external organizer for the child (Bretherton, 1992). Bowlby developed his attachment theory based on these conclusions. Attachment theory rejects the notion that attachment is mainly libidinal in nature and that the emotional bond formed between parent and child is secondary. Bowlby did not feel that the traditional drive theory explains the intense attachment that infants have with their caregiver nor children's extremely negative reactions to being separated from them (Bowlby, 1959).

Bowlby theorized that infants have a biological urge to form attachments, so as to increase the odds of having interactions with the caregiver. These interactions and the resultant bonding create an environment of safety for the infant. Bowlby considered the behaviors associated with attachment to be part of a behavioral system (Bowlby, 1969). Since motivation is necessary in a behavioral system, this explains some of the opposition to his theory from the psychoanalytic camp. In other words, if

the behaviors are based on motivation (say for safety), then they cannot be reduced to that of a biological drive. This may have been quite controversial, but this distinction becomes quite important in the child welfare arena. It is this motivation that explains why attachment can occur with abusive parents (Bowlby, 1956).

Central to Bowlby's theory was the idea that an unbroken early attachment to a caregiver is absolutely essential to an infant. He felt that if a child does not receive this, then they are more likely to show symptoms of deprivation. On the mild end, this can result in an undue need for love or revenge, guilt and depression. More extreme reactions are that of listlessness or unresponsiveness, and inadequate development that can lead to being more superficial, and being prone to deception and delinquency (Bowlby, 1951). Through his research, Bowlby was eventually able to observe this same progression of behaviors within an infant's reaction to separation from it's primary caregiver (Bowlby, 1969; 1973). Infants will first protest the separation, or the threat of separation, by crying or displaying anger and will even try to escape to search for the caregiver. Next, the infant reaches a place of despair. His movements and crying lessen and he appears sad and in mourning. Finally, the infant enters detachment, where he appears to return to a type of social normalcy but does not appear to care about his relationship with his primary caregiver.

In Bowlby's later work, he elaborated on the goal of attachment being more about caregiver availability. This availability is two pronged, requiring both caregiver accessibility as well as responsiveness. What does this mean for the infant or child? How do they determine this? According to Bowlby, a child perceives their caregiver to be available when they have an assured expectation of availability built up over a long

period of time, via reasonably accurate representational (internal) experiences (Bowlby, 1973). These eventually became termed "internal working models".

Mary Ainsworth, a student and then colleague of Bowlby, also significantly influenced attachment theory. Using his early theories, Ainsworth undertook the first empirical study of attachment in 1953, while living in Uganda with her husband (Bretherton, 1992). This project included detailed mother-infant observations and data collection. Ainsworth was able to examine the individual differences in the quality of the mother-infant interactions. It was during this work that she first observed the connection between maternal sensitivity and attachment security. Based on her data, she developed three different attachment patterns (Bretherton, 1992). She noted that "secure" babies cried little and easily explored when their mother was present. "Insecure" infants cried frequently, were not easily soothed and explored less. Finally, there were infants that did not appear attached to their mother at all. Ainsworth also found that within this population, infants of the sensitively responsive mothers tended to be the ones who were securely attached. The opposite was true for the insecure babies. This early work of Ainsworth, combined with Bowlby's pioneering theories, formed the basics of attachment theory (Bretherton, 1992).

Ainsworth went on to develop a more extensive and rigorous study of infant attachment and separation that resulted in a now famous laboratory experiment that became known as "Strange Situation" attachment assessment procedure (Ainsworth, 1985; Ainsworth & Wittig, 1969). This procedure enabled one to observe infants' attachment behaviors and internal working models. From this study, it was determined that when infants are briefly separated from their primary caregiver in a mildly stressful situation, they will display several distinct sets of attachment behaviors. The

procedure itself involved placing a baby, usually around 12 months old, in a room with her mother and some toys. After a time, a stranger would come in and sit nearby but not engage the mother or baby. This stranger was designed to "activate" the attachment system of the infant. The mother would then leave the room, with no communications to their baby. Using ideas in her previous research, she classified some babies as "secure" if they could explore easily with their caregiver in the room, showed signs of anxiety when a stranger was in the room, was upset when their caregiver left the room and sought them out upon their return, being easily soothed by their caregiver and able to return to exploration shortly thereafter. The infants who reacted in other ways, were placed in the "insecure" category. Those who appeared less stressed by the separation and less likely to seek out their caregiver upon their return, were labeled "anxious/avoidant". Infants who were less exploratory in the presence of their caregiver, were highly upset at the separation and had a very difficult time being calmed and settling down, were termed "anxious/resistant".

It is thought that the behavior of a secure infant is due to a caregiver's sensitive and attuned interactions. This type of caregiver is able to resettle the infant's emotional responses when they become disorganized. The caregiver themselves must remain emotionally regulated to be able to help their infant in this way. When their infant experiences negative emotions, the caregiver is not threatened by this and can see these behaviors as communications and as having meaning (Grossmann, Grossmann, & Spangler, 1985; Sroufe, 1979). Infants who are anxious/avoidant are thought to over-regulate their affect or avoid upsetting experiences due to having a caregiver who was not able to stabilize their emotional arousal and perhaps contributed to their heightened arousal through intrusive parenting. In contrast, an anxious/resistant

attached child is thought to under-regulate, and as a result, increases their display of distress to perhaps improve the odds of a caregiver response. In later work by attachment researchers, a fourth group of babies were categorized as "Disorganized/Disoriented" based on their display of disorienting and disjointed behaviors such as head-banging, freezing, walking in circles and trying to escape the caregiver (Lyons-Ruth & Jacobvitz, 1999; Main, Solomon, & Cummings, 1990). It is thought that the caregivers of these infants were both a source of fear and comfort and as a result, triggered contradictory attachment motivations.

Bowlby and Ainsworth's work stimulated many others to expand upon their ideas and work in the area of attachment. For example, the work of Alan Sroufe and Everet Waters reformulated the goal of attachment to be that of "felt security" (Sroufe & Waters, 1977). This directed motivation inward as well, indicating that internal cues such as mood, physical ailments and even fantasy, can be just as important as the physical environment and social cues as to how a child responds to separation from their primary caregiver. This idea of felt security enabled attachment to be applicable to older children and even adults (Cicchetti, Cummings, Greenberg, & Marvin, 1990). In later work, Sroufe (1996) started thinking about attachment theory as it relates to affect regulation. He reconceived a secure individual as someone who has the ability to self-regulate, as opposed to the insecure/avoidant person who down-regulates their affect and the insecure/resistant individual who up-regulates (Sroufe, 1996). This extends the idea of attachment into adulthood, where one continues to be aware of the availability and responsiveness of the attachment figure.

Later work in attachment research tackled the area of child maltreatment. Maltreatment of a child was shown to be linked to both the disorganized classification

of attachment and parents with a history of unresolved trauma (Cicchetti & Barnett, 1991; Main & Hesse, 1990). It is thought that a parent's frightened or frightening behavior interferes with the child's attachment organization, being that this type of attachment figure is both a source of safety and behaving in a way that indicates danger to the child (Main & Hesse, 1992).

Psychoanalytic Roots of Attachment Theory

Most psychoanalysts would agree that the psychoanalytic clinician and researcher, John Bowlby, founded the field of attachment. Nevertheless, many within the field debate whether his ideas are psychoanalytic at all. If one examines the ideas of the father of psychoanalysis, Sigmund Freud, one will find many commonalities as well as differences between the two (Fonagy, 2001). Like Bowlby, Freud developed his theories over time and had many significant shifts. His first theories were not psychoanalytic in nature at all, but neurobiological. His second phase of theories concerned the affect-trauma model where he claimed that neurosis is the result of childhood events (Breuer & Freud, 1895). Eventually, this gave way to his third major shift in theory, toward the topographical model, which emphasized psychological fantasy that was driven by biological drives (S. Freud, 1900; 1905). Finally, his theories evolved into the structural model of the mind and the dual instinct theory (S. Freud, 1920; 1923).

Interestingly, both Bowlby and Freud began their careers by examining the consequences of childhood deprivation and maltreatment (Bowlby, 1944; A. Freud, 1954). Initially, both attributed these real life events to the later development of neuroses and psychopathology. However, only Bowlby explored this association as rooted in these external events. Freud eventually discarded his "seduction hypothesis"

(that emphasized the cause of neurosis being due to child seduction by an adult) for one that emphasized his psychosexual theory of development, one that focused more on internal psychic events and less on external reality. Interestingly, although some critics felt Freud did a disservice to childhood maltreatment by developing a theory that appeared to suppress the truth (Masson, 1984), Freud never claimed that these abuses or seductions did not happen. In fact, shortly after publishing "The Three Essays", he confirmed that all of his hysteria patients had told him true accounts of their abuse (Fonagy, 2001; S. Freud, 1906). Several of his later works also emphasized the ill effects of "real-life" seduction in childhood (S. Freud, 1917; 1931; 1939). For Bowlby, however, the real divergence for him began with Freud's movement towards a model where behavior and physic experiences are mainly seen as creations of the mind, with no connection to external reality (Bowlby, 1981).

With Freud's development of his dual-instinct theory, he once again produced ideas not unlike those of Bowlby. Most prominently, Freud described anxiety as a biologically determined event that was connected to both dangers in the real world and perceptions of internal threats (S. Freud, 1926). Similar to Bowlby, Freud considered the loss of the mother as a danger that was as fearful and threatening as the loss of a limb. The external world again became an important component in psychoanalytic thought (Fonagy, 2001). Meanwhile, another prominent psychoanalyst, Sándor Ferenczi, was focusing on interpersonal factors of parenting by examining the traumatic effects of parental miscommunications (Ferenczi, 1933). Although Freud is thought to be the beginning of psychoanalytic thought, there were other key figures and psychoanalytic ideas that Bowlby drew from and that paralleled some of his ideas and theories.

Attachment theory also draws on some important aspects of Freud's structural model of the mind. Freud theorized the mind contained three significant psychic areas: the id, ego, and superego (S. Freud, 1923). The mechanisms for how these psychic agencies dealt with conflict were a significant foundation for Bowlby in the development of his theory. Specifically, Bowlby was interested in the conflict between internal and external reality and wish versus reality. Of particular interest and impact to his theory, was the ego's ability to develop defenses that contribute to character construction and the development of symptoms as part of human development (Bowlby, 1980; Fonagy, 2001). These ideas helped inform his theory of how distortions develop to create internal working models.

There are additional ways in which Bowlby's theory aligns with Freud's ideas. Even his psychosexual theory of development considered all behaviors as originating from earlier infantile experiences. As Fonagy so aptly argues in his 2001 book on Attachment and Psychoanalysis:

> Freud (1917) could be said to have to anticipated Main and Hesse's (1990) notion of disorganized attachment in relation to the dependence on an abusive caretaker ("fear without solution") in his notion of the adhesiveness of the libido, which he describes as the "tenacity with which the libido adheres to particular trends and objects" (p. 348) - p. 50

In 1958, Bowlby himself reviewed the ways in which his theory was similar to Freud's thinking and ideas. He points out in his review that in Freud's later work, he did indeed emphasize the importance of the child's attachment to his mother (S. Freud, 1931). In addition, Freud did describe how the anxiety of 18 month olds to their isolation and abandonment was due to the fear of the loss of the mother (S. Freud, 1920). Finally, Bowbly describes how Freud eventually recognizes how a child's

relationship to their mother is utterly unique and that this is formed very early on and sets the stage for and creates the basis for all other relationships later in life (S. Freud, 1938).

Over time, it's easy to forget all the commonalities between Freud and Bowlby. However, by examining all of Freud's work and theories, one has to concede that the differences between his ideas and that of Bowlby and attachment theory are far greater than the similarities (Fonagy, 2001). However, to be fair to Bowlby, "Freud does not define psychoanalytic theory" (Fonagy, 2001, p. 52).

In recent years, it is thought that within the field of psychoanalysis there has been a healing of sorts with attachment theory. The controversy between the two has been lessening, perhaps in part, due to the increasing diversity within psychoanalysis. Fonagy and colleagues (2001) argue that the most controversial change in recent psychoanalytic thought has been rising of "relational psychoanalytic theories" (Mitchell, 1988). Attachment theory fits right into this matrix. Despite this healing, there are criticisms of modern attachment theory especially within the psychoanalytic community. One such critique is that attachment theory should pay more attention to the distortions children create in their perceptions of the external world (Fonagy, 1999). This relationship between the experience itself, and the representation of the experience becomes very confounded given that caregiver behavior may be experienced and translated in different ways by different infants (Eagle, 1997). When looking at the differences between the caregiver's behaviors towards two siblings for example, context of the interaction may account for these differences, but it also quite likely that alterations in the child's perception due to internal fantasies, affects, and conflicts contribute to these differences (Fonagy, 1999). Another issue seen with

attachment theory has to do with internal working models. More specifically, it has been criticized for not taking into account that internal working models are most likely often in conflict with each other and probably exist in a hierarchy, with some having better access to consciousness than others.

Another concern regarding attachment theory is that the developmental aspect is limited (Fonagy, 1999). Fonagy uses the example of how adult avoidance is clearly different than what manifests during adolescence, but that current work in the attachment field has only thus far "focused on the identification of continuities between these manifestations rather than expectable developmental changes, which are likely to accompany the maturational differentiation of the child's representational system" (p. 468). Another developmental issue arises when examining the gaps in the attachment classification system that theorists explain as due to environmental changes (Fonagy, 1999). However, it has been pointed out that they do not seem to ask the question as to why those changes then do not influence the attachment system. Attachment researchers have also been criticized for placing too much emphasis on attachment categories, considering them more as theories rather than collections of observed behavior. This runs the risk of researchers not seeing the psychic processes that might underpin such behaviors (Fonagy, 1999).

One last concern centers on Bowlby's hypothesis that attachment behavior is advantageous biologically because it promotes the survival of the species. Critics refute this assertion by suggesting that it is not the survival of the species that drives evolution but instead the survival of the genetic code of an individual (Fonagy, 1999). This then raises the question of what is the advantage of an infant showing distress, given this could be a high-risk behavior for an infant. This is supported by research that

has shown that when an infant's brain in distress for too long it can have a deleterious impact on cognitive development (Perry, 1997). Therefore, this flight or flight reaction is a high-risk strategy evolutionarily speaking and its purpose is unexplained and unclear from the attachment theory perspective.

Despite these criticisms, it is also true that many psychoanalytic ideas seldom take into account observations from the field of attachment, and therefore attachment theorists have felt they have little to gain from the clinical findings of psychoanalysis. However, both fields appear to have the same eventual goal, which is to understand developmentally psychological and personality disorders (Fonagy, 1999). Bringing both theories and approaches into closer collaboration could only enhance both traditions in significantly meaningful ways.

Attachment and Development

Psychopathology. Bowlby's work pioneered research in examining the links between a child's primary relationships and the development of behavioral and emotional disorders. However, it is only recently that researchers have truly used attachment theory to understand these disorders in the framework of having relational causes (Cicchetti & Toth, 1995). Research into the development of psychopathology had already been examining factors such as emotional and behavioral regulation and coping skills (DeKlyen & Greenberg, 2008). Attachment theory conveniently provides a structure for understanding how significant primary relationships influence these same processes. Most of the research that connects attachment and psychopathology examines the links between specific measures of attachment and behavior problems or disorders, resulting in attachment being seen as both a risk and a protective factor in the development of psychopathology. The more research that is conducted, the clearer

it becomes that it is most likely the case that attachment effects the development of psychopathology within the framework of other risk factors related to the child and family (Cicchetti & Rogosch, 1997; Greenberg, Speltz, DeKlyen, & Jones, 2001)9.

DeKlyen and Greenberg (2008) propose that the research on risk factors leads to several overall conclusions. First, most pathology will not be caused by a single factor (Greenberg & Speltz, 1993). Therefore, attachment insecurity is unlikely to by itself, cause a behavioral or emotional disorder (Sroufe, 1983; 1990). This leads to another important tenet that it is most likely that very few childhood disorders will be eradicated by treating only the child (Rutter, 1982). Secondly, it is most likely that there are multiple pathways that lead to psychopathology (Cicchetti & Rogosch, 1997). In addition, one risk factor can moderate the influence of another risk factor. A third conclusion from the research indicates that risk factors exist on many levels, such as with the individual, parent, family and environment (Kobak, Cassidy, Lyons-Ruth, & Zir, 2006; Weissberg & Greenberg, 2006). In contrast to risk factors, protective factors reduce the chance of poor outcomes in the face of such risk. The most studied protective factors include individual characteristics, the quality of a child's relationships and environmental factors (DeKlyen & Greenberg, 2008). Protective factors have been conceptualized to work by either directly lessening the dysfunction, or by interacting with risk factors to mitigate its effect, or even by preventing the first appearance of the risk factor (Coie et al., 1993). Greenberg and colleagues (1993, 2001) have used the basic tenets of developmental psychopathology to develop a model that incorporates attachment as a significant factor in understanding the development of disruptive behavior problems in children.

DeKlyen and Greenberg's model (2008) consists of four intersecting circles, with each representing four general risk areas. The first risk domain is that of child characteristics, such as neurocognitive factors and temperament. The second domain concerns the quality of early attachment relationships. The third risk domain focuses on a parent's strategies for managing behavior and relationships and the fourth domain concerns the family environment such as stress, trauma and social support. All of these risk areas have been shown in the research to contribute either individually or in part to a number of childhood psychopathologies. For example, all of these risk areas have been shown to contribute to the development of childhood internalizing disorders such as anxiety and depression (DeKlyen & Greenberg, 2008). Punitive parenting and a lack of involvement have been shown to increase the risk for externalizing problems in children (Patterson, DeBaryshe, & Ramsey, 1990). Research also supports the notion that some risk domains are more significant for some disorders, such as childhood trauma being closely connected to dissociative disorders, through attachment processes (Liotti, 1995; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997). Again, the authors of this risk model emphasize that there are few data that support the notion that one risk area alone will cause psychopathology.

It is clear that there are a significant number of factor combinations that could result from using this model. The authors prefer the reader to look at a few of the major risk patterns (DeKlyen & Greenberg, 2008). In one risk pattern, all of the domain areas intersect to impact developmental psychopathology. This means that high family adversity combines with insecure attachment, ineffective parenting and child characteristics to significantly increase the risk of childhood psychopathology. This has been born out in the research. Greenberg and colleagues (2001) used this model when

looking at preschoolers who had a diagnosis of Oppositional Defiant Disorder. Compared to the control group of children with no behavioral issues, this group of children had a far greater risk of having this disorder if all risk domains were present. Overall, the more risk domains present, the greater the chance a child presented with this disorder. This model was also studied longitudinally with teenage mothers (Keller, Völker, & Yovsi, 2005). In this study, a single risk domain was not enough to predict disorder but as little as two risk domains did predict problems behaviors. Most significantly, when insecure attachment and high-risk parenting were joined with a high stress family environment or negative infant temperament, this predicted the highest level of problem behavior.

This model is important in that it posits attachment as a causal factor for behavioral disorders. This is significant in not only understanding the complex relationship between attachment, risk and the caregiving relationship, but it elucidates why there is so much risk to foster and adoptive children. As a result, this carves a path for intervention. The authors of the model outline four ways in which attachment links to later maladaptation (DeKlyen & Greenberg, 2008). First, emotional regulation (via attachment) that develops within the parent-child relationship is thought to have a significant impact on later psychopathology. Research has already highlighted the importance of emotional regulation in the cause of many disorders (Chaplin & Cole, 2005; Izard, Youngstrom, Fine, & Mostow, 2006). Because of this close connection, the attachment system has been called a "relational emotional regulation system" (Guttmann-Steinmetz & Crowell, 2006). To explain further, an infant who experiences a securely attached relationship with a caregiver is more likely to be able to tolerate intense affects. This is in contrast to an insecure infant who might minimize or avoid

their feelings, which interrupts healthy regulation of affect. A second way attachment is thought to influence later maladaptation is through child behavior. One theory proposes that behavior labeled "disruptive" might actually be part of an attachment strategy designed to regulate the behavior of the parent (Greenberg et. al, 1993). For example, behaviors such as non-compliance, tantrums and negative attention seeking strategies, might keep the parent close to the child when other more appropriate behaviors did not. A third way attachment could contribute to later child maladaptation is through the child's development of an internal representation of relationships or their "internal working model" of relationships. It is thought that a sensitive caregiver helps an infant develop an internal relationship model that includes a positive expectation of treatment and closeness by others. In addition, it is thought that this internal working model can individually impact affects, thoughts and motivation (Bretherton, 1985; Sroufe & Fleeson, 1986). Therefore, a child will have internal working models of specific relationships, which then determine their individual attachment behaviors. Additionally, there is a mutually interdependent relationship between internal working models of self and other. This means that the quality/nature of the attachment relationship with a caregiver also reflects a child's self-esteem and sense of competency.

Protective factors. So what are the overall protective factors of having a secure attachment? There are several key relational outcomes in the research that are linked to secure attachment. One of the strongest outcomes of having a secure attachment is a more positive and successful parent-child relationship. Many studies show that securely attached children display more pleasure/excitement with their parents, more overall behavioral compliance and share positive affects with their parents (Frankel &

Bates, 1990; Matas, Arend, & Sroufe, 1978; Slade, 1987) and conversely, secure children display less aggression and frustration. These studies also showed that this secure relationship goes both ways in that mothers of securely attached children support their children's positive behaviors by being helpful and sensitive. Thus a major benefit of security appears to be a relationship between parent and child that mutually expects positive interactions (Maccoby, 1984). It should not be surprising then that another significant benefit of having an early secure relationship is an increase in the quality of later peer relationships, particularly close friendships (Kerns, Klepac, & Cole, 1996; Schneider, Atkinson, & Tardif, 2001). Additionally, such children benefit from feeling less lonely and have a greater self-perception that they fit in with their peer group (Berlin, Cassidy, & Belsky, 1995). From these studies, it can be surmised that securely attached children appear to have an increased ability to form close and successful relationships with other adults and peers.

Another significant benefit for early secure attachment appears to be in the area of personality development. One of the most comprehensive studies examining this association was the Minnesota Study of Risk and Adaptation from Birth to Adulthood (Sroufe, 2005). This was study was both prospective and longitudinal, following children from infancy through adulthood (age 28). The results indicate significant associations between secure attachment and personality traits such as self-esteem, agency, confidence, positive affect, social confidence/competency and higher levels of emotional health.

Bowlby (1969,1973,1980) strongly believed that attachment security influenced children's self-concept, especially whether they thought of themselves as loveable. Research supports Bowlby's argument. Many studies using different measures and

ages of children, have found that securely attached children appear to have higher self-esteem, positive sense of self, see themselves as more agreeable and have less negative affect (Cassidy, 1988; Doyle, Markiewicz, Brendgen, Lieberman, & Voss, 2000; Goodvin, Meyer, & Thompson, 2008).

Given that a major purpose of the attachment relationship is to help children regulate their emotional arousal, it comes as no surprise that research supports the link between secure attachment and increased ability for emotional regulation (Contreras, Kerns, Weimer, Gentzler, & Tomich, 2000; Thompson & Meyer, 2007). Parents who are sensitive to their children throughout their childhood are thought to also accept their feelings and are especially willing to talk openly about their children's more disturbing or upsetting feelings. Such parents are helping children develop emotional awareness that builds over time and results in capable emotional self-regulation (Thompson, 2011).

Related to the concept of emotional regulation is that of emotional understanding. Several studies have linked secure attachment to children having a greater ability to comprehend their own emotions and those of others (Ontai & Thompson, 2002; Raikes & Thompson, 2006; H. Steele, Steele, Croft, & Fonagy, 1999). In particular, secure children appear much better than insecure children at understanding complex negative and mixed emotions. It is thought that the open and easy communication between parents of secure children help them to process and share more troubling emotions, helping to lessen their confusion and increasing their ability to regulate (Thompson, 2011). In addition, a child who has a greater understanding of emotions may also display more social competency. Research has supported this connection between secure attachment and enhanced social competency

and social cognition (Cassidy, Kirsh, & Scolton, 1996; Denham & Kochanoff, 2002; Raikes & Thompson, 2006).

Just as scholars have examined how problems in attachment have lead to maladaptation, they have also been just as curious about how a secure attachment leads to such benefits later in life. One of the more significant mechanisms is thought to be the development of "internal working models" or IWMs. These are mental representations an infant develops over time based on their expectations that their caregiver's accessibility and responsiveness to their needs. The theory is that these expectations eventually expand to apply to self and others. It is thought that children and adults use their IWMs to create their understanding and expectations of new relationships, which has been based on their caregiving experiences. Thus, it would make sense that IWMs are connected with a child's ability to form successful relationships and with the creation of a positive self-image (Thompson, 2011). It also appears that IWMs can change over time with a child's advancing conceptual skills (Bretherton & Munholland, 1999). Further implications of this theory is that they are also more likely to change as a reaction to new relational experiences and can be shaped by language, such as dialogue between parent and child (Thompson, 2000; 2006). It is no surprise then how influential the caregiver-child relationship is throughout childhood, even beyond infancy when attachment initially forms. There is much research that supports the notion that early attachment interacts with the quality of later caregiving experiences to predict developmental outcomes (Thompson, 2011). The significance of this idea points to the conclusion that the quality of later caregiving experiences appear just as important as early attachment experiences. This provides

much hope for parents who foster and adopt children who have had a variety of early attachment experiences.

Thus far, much of this paper has focused on how and why attachment can lead to either maladaptive behavior or successful development. What might be helpful is to examine the type of parenting behavior that leads to secure or insecure/disorganized attachment in a child.

Adult Attachment and Caregiving

This focus on maternal states of mind came about through the work of Mary Main (student of Mary Ainsworth) and her colleagues. With the publication of their study titled "Security in Infancy, Childhood, and Adulthood: A Move to the Level of Representations", these researchers connected childhood security to adult states of mind (Kaplan, Cassidy, Main, Kaplan, & Cassidy, 1985). Their work relied on the development of the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985). This interview involves asking parents to describe childhood experiences as related to the caregiving they received. The researchers were able to take the transcribed responses and place them in one of three adult attachment classifications that correlated to the different classifications of the Ainsworth Strange Situation attachment protocol. Their research showed a significant correspondence between a child's attachment classification and the parent's AAI status. Since then, these findings have been well replicated. This is true for both high-risk samples and low-risk samples (Bus & van IJzendoorn, 1992; M. J. Ward & Carlson, 1995)Bus:1992wp, Grossmann:1988ue, Ward:1995uv}. This research has been significant in helping to elucidate the intergenerational transmission of attachment patterns.

It is no surprise that researchers wanted to further understand how this connection is formed and by what means. Mary Ainsworth's seminal attachment research had already theorized that "maternal sensitivity" was significantly related to secure attachment, and much research since then had supported this notion (Ainsworth, Blehar, Waters, & Wall, 1978; Braungart-Rieker, Garwood, Powers, & Wang, 2001; Isabella, 1993; Kochanska, Coy, & Tjebkes, 1998; Pederson & Moran, 1996). Maternal sensitivity is broadly defined as a mother being sensitive and responsive to their child. This includes being attuned with and responsive to a child's signals, behaviors and emotional expressions. However, other parental behaviors have been linked to secure attachment as well, such as a parent who quickly responds to their child's distress (Crockenberg, 1981; Del Carmen, Pedersen, Huffman, & Bryan, 1993) and parents who show warmth and involvement with their child (Leyendecker, Lamb, Fracasso, Scholmerich, & Larson, 1997; O'Connor, Sigman, & Kasari, 1992). On the other hand, parental behaviors such as being intrusive, controlling, and unresponsive have been linked to different types of insecure attachment (Belsky, Rovine, & Taylor, 1984; Isabella, Belsky, & Eye, 1989; M. Lewis & Feiring, 1989; Vondra, Shaw, & Kevenides, 1995).

Given these links, it was natural for developmental researchers to wonder if this trait of "maternal sensitivity" was the main conduit that allows a mother who has a secure-autonomous status on the AAI to transmit this to her infant, resulting in a secure attachment classification for her child in the Strange Situation experiment. Although there is a clear and convincing correlation between maternal sensitivity and attachment security (Belsky, 1997), researchers have been questioning if this was the transmission factor of secure attachment. One such team in the Netherlands led by De

Wolff and van Ijzendoorn (1997) undertook a large meta-analysis that examined data from 66 different investigations involving over 4,000 child-parent dyads. They found effect sizes between 0.17 and 0.24 in their analysis for the connection between attachment security and various measures of mothering and interactions, with the strongest effect size (0.24) between secure attachment and maternal sensitivity. Researchers have pondered why the effect size isn't larger and this has been called the "transmission gap", referring to a lack of convincing evidence that maternal sensitivity is, by itself, how intergenerational transmission of secure attachment occurs. Much research has transpired since and there is a strong case for the idea that there is a trait even more influential for bridging this transmission gap: the concept of parental reflective functioning and mentalization (Fonagy & Target, 2005).

Reflective Functioning and Mentalization

The term "reflective functioning" (RF) was developed by a team of researchers involved in the London Parent-Child Study (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). This work was a collaboration between The Anna Freud Centre and University College London, and one goal was to find out whether parent's adult attachment classifications would be predictive of their child's attachment to them at one year and again at 18 months. Their research involved the collecting and analyzing of 200 parent prenatal Adult Attachment Interviews, which were compared with a number of outcome measures including child attachment. While going over the AAI data and considering the different ways in which attachment might be transmitted across generations, Fonagy and his team formed an idea about mentalization and how this is revealed in parent's reflective capacities, in their use of certain words and phrases

(Slade, 2005). All of this helped lead to a scale on the AAI that is meant to measure RF, an adult's ability to reflect upon the mental states and intentions of their own parents within an attachment context (Fonagy et al., 1998). RF became the operational definition of mentalization. The scale specifically measures a parent's awareness of their own and other's mental states, as well as their ability to understand the mental states that might be behind behaviors. Results from this study showed a clear connection between RF and attachment. For instance, parents who had high reflective functioning on their AAI also tended to be classified as secure and were highly likely to have children who were rated as having secure attachment at 12 months (Fonagy et al., 1995).

Fonagy and colleagues conceptualize mentalization as the way in which human beings make sense of their interpersonal world, by imagining the mental states that lie beneath the behavior of self and other (Fonagy et al., 2002). Specifically, it is the process by which a person both implicitly and explicitly understands and interprets the actions of self and others as meaningful based on mental states such as feelings, needs, beliefs and desires. This theory came about as an integration of complementary ideas within the fields of psychoanalysis, developmental psychology and cognitive neuroscience. It is a multidimensional construct that has gradually developed to include a number of different parts. It has both a meta-cognitive component because it involves the ability to interpret thoughts and behaviors, but it also has an affective element (Fonagy, 1991; Fonagy & Target, 1996). However, a key aspect to effective mentalizing necessitates the inclusion of affectivity (Bateman & Fonagy, 2012). Despite this, critics of this theory have pointed out that the role of affect in mentalization is poorly developed and not fully explained (Jurist, Slade & Bergner, 2008). In fact, it has

been criticized for emphasizing cognition over affect. Given the authors of the theory propose a biological basis for mentalization in that it has given us a competitive edge in social groups, some critics feel that all of the emphasis on brain activity and evolution overshadows the how a traumatized child processes their experiences and overwhelming feelings (Jurist et al., 2008). Elliot Jurist has been the most outspoken about the need for more clarity around affects in both the theory and clinical aspects of mentalizing (2008; 2010). He feels that the theory runs of the risk of "ignoring that minds have emotional styles" (Jurist, 2010, pg. 289). As a result, he contributed to the theory of mentalization by coining the term "mentalized affectively" to describe the ability to reflect on and regulate affects and argues that this is a vital component of all therapies that aim to influence affect regulation (Fonagy et al., 2002; Jurist, 2005). He emphasizes that mentalized affectivity is not as simple as applying cognitive control over affective states, but involves actively experiencing and reflecting on current affects through a lens of past experiences (Jurist, 2010).

Fonagy describes mentalization as developing in early childhood and that departures from this developmental trajectory can lead to severe psychopathology, in particular Borderline Personality Disorder (BPD; Bateman & Fonagy, 2004).
Based on the theory that BPD is a disorder of mentalizing, Peter Fonagy and Anthony Bateman (2004) developed a psychoanalytically informed manualized psychotherapy program for this disorder that they termed Mentalization-Based Treatment (MBT). Studies of MBT have shown it can improve interpersonal functioning while reducing suicide attempts, self- harm, depressive symptoms and inpatient hospital stays for patients with BPD. These results held true for patients at the conclusion of partial hospitalization as well as 18 months post treatment (Bateman & Fonagy, 1999; 2001).

Additionally, MBT became the second psychotherapeutic treatment for BPD (Transference-Focused Psychotherapy being the first) that has been empirically validated by randomized controlled trials (RCTs) as more effective than psychiatric treatment as usual (Bateman & Fonagy, 2008). In fact, the originators of Transference-Focused Psychotherapy decided to use the only mentalizing measure at the time, the Adult Attachment Interview coded for Reflective Functioning, as a key outcome measure in one of their RCTs (Levy et al., 2006). The usage of Mentalization-based Treatment has extended to a wide variety other clinical areas such as the treatment of families, high-risk mothers and infants and school-based interventions just to name a few (Fearon et al., 2006; Sadler et al., 2006; Twemlow & Fonagy, 2006).

Despite MBT being a promising intervention for BPD, there have been criticisms both of how BPD is conceptualized from a mentalizing perspective as well as the treatment itself (Jurist et al, 2008). Otto Kernberg and his colleagues who created Transference-Focused Psychotherapy (TFP) feel that MBT, and the theory its based on, does not accurately conceptualize BPD and directly contradicts their notion of effective treatment. One critique of MBT is that its focus is on the developmental deficit of mentalization, when a more effective focus would be on the defenses processes of BPD (Kernberg et al., 2008). More specifically, they feel treatment of BPD should include facing highly affective transferences head one with interpretations, because emotionally laden experiences cannot be changed without both being activated in the moment and then dealt with cognitively (Kernberg et al., 2008). This is in direct contradiction to MBT that assumes that accurate and helpful mentalizing can only be brought about when attachment is not activated and affects are calm (Allen et al., 2008). We see yet again, a criticism of the lack of focus on affects within mentalization treatment.

Kernberg (2008) feels that you need to focus directly on affect regulation, in particular negative emotions, when treating BPD. In fact, TFP assumes that heightened arousal of affects will created needed insights as contrasted with MBT assuming such arousal will prevent effective mentalization.

Another issue that has been leveled against mentalization is that it lacks clarity about the early precursors of mentalization, in particular the specific processes involved between infant and caregiver that contribute to the development of affect regulation and mentalization (Blatt et al.; Swain et al., 2008). Mentalization theory proposes that the capacity to think about the mental states of others and self is dependent on a caregiver nurturing early affect regulation in their infant. Although this occurs before that infant has language and thus self-reflective abilities, it assumes a more passive role of the infant in the development of mentalization. There is a question of how active the infant is in this process and mentalization has been criticized for not including more about the infants subjective awareness of their emotional states and how these states contribute to the infants' experience of self, as well as self-regulatory abilities (Jurist et al., 2008). It has been argued that the findings of neuroscience suggest that infants from day one are active and conscious participants in their exchanges with their caregivers and that their internal experiences and drives are not being carefully considered within the theory of mentalization (Demos, 2009).

Another key criticism of mentalization is that she fact that the concept is difficult to assess (Choi-Kane & Gunderson, 2008). Thus far, the main measure used to assess mentalization has been the RF scale on the AAI. Not only is this a measure that is difficult to use in studies or in clinical settings due to its length and expense, it has been pointed out that the validity of this measurement needs more development (Choi-Kane

& Gunderson, 2008; Katznelson, 2014). Additionally, although this measure has been used to demonstrate that the mentalizing ability of parents impacts infant attachment (Fonagy et al., 1991), the results of this study is thought to be limited by the use of the AAI because it assesses mentalizing that has been drawn from parents' narratives about their own childhood. This implies that their mentalizing abilities are actually inferred instead of observed through a direct measure of parents' representation of their children (Katznelson, 2014). Despite these concerns, mentalization has become a promising theory that has sparked the development of new and effective treatments and inspired hopeful lines of inquiry within such fields as adult psychopathology, developmental psychology and neuroscience research.

Parental Mentalizing

Given the aim of this thesis, it is important to consider mentalization is conceptualized in parents and how this connects to attachment. The RF on the AAI scale measures how an adult evaluates the mental states of their own parents. Some researchers wanted to take this a step further and see if this also correlates with a parent's ability to keep their own child in mind (Slade, 2005). This kind of connection goes further to explain the processes that lead to the intergenerational transmission of attachment. The idea is that a secure parent's ability to be reflective and mentalize their child helps their child regulate his own emotions and behaviors and teaches him to mentalize as well. Researchers such as Meins and her colleagues had already been thinking about this in terms of a mothers' "mindmindedness", which is similar to RF in terms of a parent's being aware of their own child's mental world (Meins & Fernyhough, 1999). Meins work in this area linked this concept of "mindmindedness" with developmental outcomes in children (Meins, Fernyhough, Russell, & Clark-Carter,

1998). RF goes a step further however, in that it is the ability to not only see mental states but also being able to connect these states to behavior in a significant way (Slade, 2005). To further understand and elucidate the reflective functioning of parents, Slade and her colleagues took the RF scale on the AAI and adapted it for the Parent Development Interview or PDI (Slade, Aber, Bresgi, Berger, & Kaplan, 2004). Slade's research has done much in helping to understand RF and how it impacts parents and their parenting. As a result, we have a much richer picture of how a parent might mentalize their child and their experience of parenting. For example, a parent who has low RF might not recognize their infant's internal world and may not think that their child has feelings or thoughts that are unique. This means this parent would be more likely to not parent sensitively and parent in ways that contributes to their child having an insecure or disorganized attachment. A high RF parent understands the complex association between her own mental states and that of child, as well as the connection between her child's internal world and behavior (Slade, 2002). Such a parent decides how to parent based on these understandings and thus is more likely to parent sensitively. Parents with high RF are connected to their own feelings and thoughts about parenting and are therefore, less likely to deny or defend against them (Slade, 2005).

Slade's (2005) work really supported the idea that a parent's ability to mentalize about their child directly relates to both their own attachment status and that of their child. The data suggest we can assume that parents who are reflective in a way that supports their child having their own intentions, are parents who are more likely secure themselves in their own attachment history and have high reflective functioning (Fonagy & Target, 2005). In her study, Slade used the Parent Development Interview

and adapted it to code for RF. In doing so, she created a tool that measures more than common experiences and the components of the parent-child relationship. Instead, it indicates something more complex and specific: parents who score high on this measure have a keen awareness of the mental functioning of their children and understand the complex interactions between their own mental states and their children's internal experiences. As a result of this robust measure of mentalization and the supporting data of the studies, Fonagy and Target (2005) have proposed that RF and Mentalization have taken a huge step in filling this transmission gap. Mentalization could very well be the major factor responsible for the intergenerational transmission of attachment. To explain how this might be, Fonagy and Target restate how these findings might fill the gap in their 2005 paper on the subject. Basically, the secure attachment history of a parent allows and improves their ability to explore their own mind. This, in turn, encourages a similar mindset in being open to understanding the mind of their child. Fonagy and Target go on to explain:

> The awareness of the infant in turn reduces the frequency of behaviours that would undermine the infant's natural progression towards evolving its own sense of mental self through the dialectic of her interactions with the mother. In this context, then, disorganization of attachment is implicitly seen by Arietta Slade and her group as the consequence of an undermining of a mental self, or the disorganization of the self (p. 337).

Another way to conceptualize the influence of RF on attachment is with the theory that mentalization serves as a buffer against affect dysregulation in stressful moments (Grienenberger, Kelly, & Slade, 2005). Parents with high RF are thought to have a better capacity to regulate their child's fear, relating to the child without frightening or disorganizing them. In this way, it is easy to see how mentalization is connected to Bion's (1962) ideas on containment as well as Winnicott's (1960) concept

of good enough mothering/parenting (Fonagy & Target, 2005). (Bion, 1962; Winnicott, 1960)

It should be clear now how the early attachment relationship impacts the child, and his or her ability to be a secure, nurturing and healthy future parent. Early relationships are not only important for determining childhood outcomes, but they are essential for predicting parental capacities in the future. Attachment theory and mentalization are key players in the intergenerational transmission of trauma and attachment. Given the point of this project was to develop a mentalization-based intervention for foster parents so as to impact the health and well-being of foster children, it seems prudent to next examine who these children and foster parents are and how foster care impacts this relationship.

Chapter 2: Introduction to Fostering

Foster care is one of those services we are grateful to have, but wish we did not need. In the U.S., almost 700,000 children were substantiated as having been abused and/or neglected in 2012 and over 62,000 of these children were in Texas ("Child maltreatment", 2012). Each year in the U.S., there are over 500,000 children removed from their home and placed in substitute care ("Child maltreatment", 2012). In Texas, this number reaches over 30,000 (“Annual report”, 2013) The youngest children appear to be the largest percentage of children both maltreated and removed from their homes, with over a third being 0-4 years old. Not only are these the most vulnerable children due to their age, but being maltreated during this critical development period can have negative, long lasting global developmental effects.

When a child is removed from their home of origin and placed in foster care or with alternative caregivers, it is only because that child experienced substantial abuse or neglect. These children have not only experienced trauma within their family, but entering foster care means they must leave their caregivers, which is another frightening and destabilizing event. The abuse and neglect these children experience is often the result of pathological and intergenerational parenting and mental health issues within the family. Some children are removed at birth because their mother tested positive for drugs or alcohol. Still others are removed for neglect: physical neglect, medical neglect or neglectful supervision. In all of these instances, the child was either physically or emotionally harmed or at great risk because of parental neglect. Other children suffer physical abuse such as excessive punishments that leave marks or injuries or even intentional cruelty involving burning or broken limbs. Also, there are children that suffer sexual abuse at the hands of a family member. Finally,

there is emotional abuse/neglect, which could be seen as a category by itself, or one that is often layered with other forms of abuse and neglect. It is hard to imagine any abuse or neglect that is not emotionally abusive as well. Egeland and colleagues have identified a specific type of emotional neglect, that is particularly destructive, that entails the parent being psychologically unavailable to the child (Egeland, 1997; Erickson & Egeland, 1996). Their research has shown that this type of emotional neglect has greater negative impact on children's development than other types of abuse and neglect. In addition to interpersonal trauma, maltreated children often come from families with higher rates of poverty, mental illness, substance abuse and domestic violence. All of these issues place these children at risk for developing mental health issues, behavior problems and poor academic performance (Rosenfeld et al., 1997).

Childhood Maltreatment Outcomes

A child who is abused or neglected is under tremendous physical and emotional stress. Maltreatment is deleterious to the mind and body and puts a child at a lifetime risk for both physical and mental health problems (Arnow, 2004). For very young children who are abused and neglected, the effect on physical health is of particular concern. Injuries from maltreatment itself, such as fractures, brain injury, burns etc. can have long lasting effects on the developing brain and body. Being sexually abused sets the stage for genital injuries, sexually transmitted diseases and even pregnancy. Neglect contributes to health risk in the form of conditions related to malnutrition, accidental injuries, accidental poisonings and neglect of medical conditions (Hobbs, 2009). There are numerous studies that demonstrate that anywhere from twenty-two to eighty percent of maltreated children have acute and chronic health problems

(Chernoff, Combs-Orme, & Risley-Curtiss, 1994; Frame, 2002; Leslie, Gordon, & Meneken, 2005; Silver et al., 1999; Sullivan & Knutson, 2000). It has been well documented in the research literature that childhood abuse and neglect is related to significant physical and mental health problems that can span a lifetime (Afifi, Brownridge, Cox, & Sareen, 2006; Arnow, 2004; Chen et al., 2010; Kessler, Davis, & Kendler, 1997; MacMillan et al., 2001). What will be presented next is a review of the most recent evidence supporting the relationship between child maltreatment and adult health outcomes, specifically the impact on physical and mental health.

There has been an abundance of research that has found associations between childhood maltreatment and a variety of physical health problems in adults, such as migraines, cancer, pain disorders and heart disease (Dong, Anda, Dube, Giles, & Felitti, 2003; George & Main, 1979; Irish, Kobayashi, & Delahanty, 2010). Research has particularly focused on the connection between chronic pain and gastrointestinal disorders (such as fibromyalgia and chronic fatigue syndrome) and their link to childhood maltreatment (Finestone et al., 2000; Ross, 2005; B. W. Smith et al., 2010; Van Houdenhove M D et al., 2011). In fact, several studies have found significant associations between having been sexually or physically abused as a child, and being diagnosed with irritable bowel syndrome and other functional gastrointestinal disorders (Dodge, Petit, & Bates, 1997; Drossman, 1994; Ross, 2005). These adults are also more likely to report having all types of physical health symptoms and have more surgeries over the course of their lives.

In addition to the biochemical changes that can damage the body as a result of early life stress, it has been suggested that the poor health outcomes of this population can at least in part, be explained by either mental health issues or risky behaviors.

These additional factors help explain the link between poor health and history of maltreatment (Kendall-Tackett, 2002). These risky behaviors cover lifestyle choices such as smoking, alcohol abuse, and behaviors that lead to obesity, all of which contribute to the heart, lung and liver problems seen in adult survivors of childhood maltreatment (Anne Lown, Nayak, Korcha, & Greenfield, 2010; Springer, 2009). Lastly, poor mental health has been clearly associated with health problems in this population (Springer, 2009). This leads us to the next section, where the full impact of childhood maltreatment on mental health will be explored.

A broad range of psychiatric conditions and symptoms have been linked with a childhood history of maltreatment. The literature paints a clear picture that such adults demonstrate a number of poor mental health outcomes that include, amongst other issues, a greater chance of being diagnosed with a personality and/or mood disorder (Arnow, 2004; Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; Kaplow & Widom, 2007). There are a number of studies from around the world that solidly link a history of maltreatment to an increased chance of having short or long-term depression (Spatz Widom, DuMont, & Czaja, 2007; Wright, Crawford, & Del Castillo, 2009). In fact, it is not just one type of maltreatment that is linked to depression. Many types of abuse and neglect, such as physical or emotional abuse, are all associated with depression. Being a witness to domestic violence will also increase one's odds of having depression later in life (Roustit et al., 2009; D. Russell, Springer, & Greenfield, 2010). As one might expect, research indicates that the more often a child is maltreated, the longer their depressive episodes will last during adolescence and adulthood (Hovens et al., 2009). One particular study of US adolescents indicated that depressive symptoms tend to increase when several types of maltreatment are indicated, compared with only one

type of abuse or neglect or none at all (Arata, Langhinrichsen-Rohling, Bowers, & O'Brien, 2007). Most profoundly, emotional neglect was discovered to have the most significant impact on adulthood, increasing the chance of having depression by almost five-fold and increasing the likelihood of having both depression and anxiety by nine times (Hovens et al., 2009). A U.S. study has supported this type of comorbidity, noting that having another mental health disorder on top of depression is much more likely in adults who have a history of childhood maltreatment (Spatz Widom et al., 2007).

One of the most damaging effects of maltreatment on mental health is seen in those adults who have suicidal ideations and attempt suicide. Unfortunately, there are a number of studies that have found a positive correlation between childhood maltreatment and suicide (Brezo et al., 2007; Calder, McVean, & Yang, 2009; Chavoshi et al., 2009; For the Cedar Project Partnership et al., 2008). In 2010, one of the most thorough studies on this link was conducted (Bruffaerts et al., 2010). It relied on data from World Mental Health surveys in 21 countries. They discovered that overall, sexual and physical abuse were the types of childhood maltreatment that had the most powerful influence on whether that adult attempted suicide. In general, it increases the odds across their lifetime, but it also increases the odds of an early suicide attempt.

The exploration of the literature leaves little doubt that children who have been abused and neglected have a greater chance of developing a host of mental health problems throughout their lifetime. Many different types of abuse and neglect seem to contribute significantly to a large variety of psychological and physical disorders, particularly later in life. However, it is not just the maltreatment that is deleterious. When a child is removed from their primary caregivers and placed with strangers, this can result in a host of negative developmental consequences.

Foster Care Outcomes

When a child is experiencing significant maltreatment, one of the interventions available is the removal of the child into foster care. Given all of the deleterious effects and outcomes of childhood maltreatment just discussed, one could see why this would be perceived as a positive and necessary option for the seriously abused or neglected child. The point of foster care is to provide a maltreated child with a temporary and safe home environment, in hopes that the child can return home after the biological family goes through some form of legally mandated intervention. Unfortunately, a well-known and long-term issue within the foster care system is that these stays are rarely temporary and children often stay in foster homes for quite long periods of time, sometimes until they reach 18 years old (M. Dozier et al., 2006). Additionally, children frequently experience changes in their placement. One national survey gives the statistic that about 30% of children experience moving multiple placements within an 18-month period (Rubin, O'Reilly, Luan, & Localio, 2007). Other studies report placement instability of foster care youth to range anywhere from 22% to 56% (Kufeldt, Armstrong, & Dorosh, n.d.; Pardeck, 1984).

The main reason for most placement changes is due to child behavior problems (Chamberlain, Price, Reid, & Landsverk, 2006; James, 2004; Leathers, 2006). Other reasons include foster parent issues such as the family moving out of the area, or quitting foster care or even allegations of maltreatment against the foster family (James, 2004). Unfortunately, research has established a clear connection between multiple disruptions in placement and negative outcomes for children (Fanshel, Finch, & Grundy, 1990; Newton, Litrownik, & Landsverk, 2000). These children suffer a host of internal and externalizing behavior problems as a result of such placement instability (Newton

et al., 2000; Rubin et al., 2007). Additionally, physical and mental health issues have been shown to be a consequence of placement breakdowns (Takayama, Wolfe, & Coulter, 1998). Research has also shown that foster children's behavior problems increase the risk that they will not reunify with their biological family and have a longer stay in foster care (Landsverk, Davis, Ganger, & Newton, 1996; Lawder, Poulin, & Andrews, 1986). Given these children are already at risk due their history of maltreatment, the "intervention" of foster care could have far reaching long-term negative additive outcomes for these vulnerable children. Foster children who stay in foster care much of their lives are at higher risk for mental health problems, homelessness and criminal behavior and incarceration (Berridge & Cleaver, 1987; Fanshel et al., 1990; Rosenfeld et al., 1997). Although it is difficult to tease out whether foster children's negative outcomes are from foster care itself, or from their history of maltreatment, it would seem that multiple placements and inadequately prepared foster homes can increase the risk of negative outcomes for these children (Rosenfeld et al., 1997).

As disheartening as all this information might be, an interesting and hopeful discovery about resilience is that it is most likely not something that appears by itself, but is born and supported through an interactive process that develops over time (Stein, Fonagy, Ferguson, & Wisman, 2000). This means that it is not as simple or defeatist as some children have resilience, and some do not. It is more likely the result of a combination of environment and biology that changes over time and can be influenced by new interactions with the environment. This is especially hopeful for children in foster care. Research supports the notion that it is not what happened to the child that is the most important factor determining resilience, but instead it is how they

evaluate and process these events (Elman et al., 1996). This is great news for foster and adoptive parents. This means their relationship with children who have been traumatized, can be a healing and determining factor in their resilience. So given that a caregiver's relationship to a child helps them heal from trauma and can impact their resilience, it seems important to describe and explore the nature of those parents who decide to take in maltreated children and raise them.

Foster and Adoptive Parents

Because it has been well researched that parents can significantly impact the mental health and overall functioning of children (Elicker et al., 1992; Fonagy & Target, 1997), it is important to explore who are these adults who decide to care for foster children. Who decides to foster a maltreated child? What kind of psychological health or attachment history might they have? There are many factors that influence how a parent cares for a child, especially one that is not of their own blood. First and most importantly, one should consider the psychological stability of a parent, as well as the parent's own trauma and attachment history. Next, it is prudent to consider the training and support they receive to parent an unrelated maltreated child. In this section, I will explore these issues as well as common problems and barriers for foster and adoptive parents.

Given the fact that much is now known about foster children, it is then quite surprising to discover that so little is known about the parents who care for them (Triseliotis, Hill, & Borland, 2000; Warren, 1997). This is an extraordinary gap in our research given how many millions of children have been placed with foster parents over the decades (Orme et al., 2006). Even though foster parents are caring for some of the most vulnerable children, there is a pointed lack of psychological information about

this population. In addition, very little is known about foster parent's attachment history, adult attachment status or how they interact behaviorally with their foster children (Ballen, Bernier, Moss, Tarabulsy, & St-Laurent, 2010). These are areas that are not assessed or evaluated very often for foster or adoptive parents in the US. Foster parents sometimes have had a bad reputation in popular culture, perhaps due to sensationalized stories of abuse or neglect events that occasionally do happen in these homes (Rosenfeld et al., 1997). It is quite difficult to understand how a foster parent could take into their home an already victimized and vulnerable child and then abuse or neglect them further. As unconscionable as it sounds, it can and will happen with those parents that have their own history of unresolved trauma. Perhaps this was what Theodora Alcock was alluding to when she said "There exists in adults an impulse of hostility, often deeply unconscious, to children who are not actually or emotionally their own." (Alcock, 1946). Unfortunately, since unconscious motivations and deeper issues are rarely assessed with foster parents, this risk might go on unaddressed within the foster care system.

Researchers John Orme and Cheryl Beuhler conducted a very thorough review of the research literature to summarize what is known about foster parents in the US. This review was published in 2001 and is well known, and frequently cited, especially given it is one of the only reviews of this population that has been done to date. In this review, a majority of the studies examined parenting characteristics in some form, mostly around discipline and control. Thirty-four studies were reviewed and of those, only three assessed the mental health of foster parents. The authors concluded that in the areas of mental health, marital conflict and temperament of foster parents, there was just not enough data or information to determine if foster parents have any

significant issues in this area. However, based on their analysis, they do conclude that about 15-20% of foster parents demonstrated problematic parenting or issues in family functioning (Orme & Buehler, 2001). These problems ranged from having negative attitudes and heightened parental stress to employing harsh physical discipline with traumatized children. Other studies have indicated that anywhere from 10-25% of foster parents provide less than ideal care for the children in their home (Barth et al., 2008; Berrick, 2008). Perhaps we should consider these results in conjunction with the motivation to foster adopt a child who has been abused and/or neglected.

There are a myriad of reasons a person decides to foster or adopt a child. In fact, a parent who decides to foster only, without the desire to adopt, might have a different motivation than those wishing for a "forever child." It is a difficult population to study because of the complexity of the child welfare systems in most states and the difficulty collecting accurate data. For instance, many parents who want to adopt in the state of Texas are advised be become a foster parent first as they are more likely to have a child placed with them. Thus, they become a category of foster parents called "fost/adopt" parents. However, they are counted statistically as foster parents. Some parents have tried to have biological children and have failed. Perhaps they have even tried costly fertility treatments. Maybe they would even prefer a private or international adoption but cannot afford this route. Therefore, they turn to the child welfare system. How do we begin to think about these parents? Well it is important to think about how much trauma they have suffered going through this process, the pain, the money and the possible shame. If such parents have not grieved and fully processed this new parenting route, this could impact the way these parents mentalize their foster child. Perhaps this new child would be expected to fill a hole in their hearts, to help them heal

from the disappointment and loss. Perhaps such parents would filter out all the negative information about possible placements because they are blinded by their hopes and wishes. It is also important to consider how such parents would mentalize their foster child, how they would deal with a child who has been traumatized, and has attachment difficulties and behavior problems. Have these parents been counseled, advised or guided on mentalizing themselves through this process? Most likely, they have not. Now consider the foster or adoptive parent who came from a home where they experienced abuse and/or neglect. Perhaps they have a fantasy of rescuing a child from such a home. Maybe they are still trying to unconsciously find others to love them unconditionally, to compensate for their own childhood. Some foster parents are religious and feel compelled to "save the children". In fact in Texas, foster and adoption agencies frequently recruit through churches. Other parents have children who are grown and want to have children around again. No matter what their motivation, fully assessing these parents' attachment history and mentalizing abilities could not only improve the quality of the parents chosen for such an important task, but could positively impact the placement stability of these homes by enhancing their relationship with their foster children.

Attachment and Mentalization. As previously mentioned, very little research has assessed or explored the attachment status or mentalization abilities of foster parents or adoptive parents. There are only a few studies that have looked at foster parents attachment status and collectively, these studies suggest that a large proportion of foster parents have insecure states of mind compared with the general population (Ballen et al., 2010). Mary Dozier and her team found that 46% of foster parents had insecure states of mind, with 24% being classified as unresolved (M. Dozier, Stovall,

Albus, & Bates, 2001). Ballen et al., found upwards of 64% of their foster parent sample rated insecure while Steele et al., reported 68% of adoptive parents rated this status (Ballen et al., 2010; M. Steele, Kaniuk, Hodges, Haworth, & Huss, 2006). This is in contrast to only about 40% of the general population having insecure states of mind (M. J. Bakermans-Kranenburg & van IJzendoorn, 2009). When examining how this impacts foster children, Dozier et al. (2001) found that foster infants were more likely to develop disorganized attachment when placed with foster parents who had insecure and unresolved states of mind. This is not surprising given that foster children's exposure to previous trauma and maltreatment places them at heightened risk for further relational disorganization. A similar impact was found in the Steele et al. (2006) study that compared the attachment status of adopted mothers and the internal working models of their older adopted children. The adopted children of mothers who had an unresolved attachment status, demonstrated more negative story stems (reflecting negative internal working models) that persisted throughout the study and of this group of children, one placement disrupted while the other children failed to develop more secure attachments (Kaniuk, Steele, & Hodges, 2004).

One very important finding in Ballen's (2010) study was that the presence of abuse in the foster parent's childhood was by itself, predictive of fearful parenting behaviors, regardless of the foster parent's attachment state of mind. Although in this study, having an unresolved state of mind was significantly correlated with fearful parenting behavior, these results challenge the prevailing theory that having an unresolved state of mind is necessary for atypical parenting (Ballen et al., 2010). This finding makes sense when you consider that most traumatic experiences of childhood are connected to attachment figures and the attachment related behaviors of foster

children could be perceived as threatening to a foster parent's defenses against re-experiencing their own traumatic childhood experiences (Lyons-Ruth & Block, 1996).

All of these results certainly suggest that foster parents with insecure (and unresolved) attachment states of mind, are at risk of interacting with their foster child in an atypical/disruptive and even frightening manner. This is understandable given that a parent's ability to mentalize their child and interact with them in a sensitive manner, directly relates to their own attachment status (Slade, 2005). This is further supported by another study by Dozier and colleagues that found that children placed with foster parents who had a secure state of mind, displayed both earlier and higher rates of secure attachment the first few months of placement compared with the children placed with insecure foster parents (Stovall-McClough & Dozier, 2004). Parents with insecure or unresolved states of mind have been shown to have poor mentalizing abilities, which impacts parents' relationship and behavior towards their children, which ultimately impacts their attachment security (Fonagy & Target, 2005).

Perhaps one of the reasons some parents cannot be reflective and hold their child in mind, resulting in relationship disruptions, is due to that parent's own projections and projective identifications (Slade, 2007). Melanie Klein first introduced the term projective identification, which is meant to describe a process where parts of the self, both good and bad, are unconsciously projected on to another person, who then often becomes this projection (Klein, 1946). In the case of a parent and child, the child is essentially used by the parent as a medium for the projection of the material of the parent's unconscious mind. Being a parent can bring up intolerable feelings related to childhood. These feelings can be associated with minor or major childhood traumas, abuse or neglect or simply intense vulnerable moments. Projection is one way a parent

can relieve these intolerable feelings. By placing these unconscious feelings onto their child, they can avoid the anxiety and fear of these unacceptable thoughts or emotions. Unlike the psychoanalytic therapeutic goal of bringing the unconscious to light, Slade sees the psychoanalytically driven work of helping parents become more reflective so as to bear and tolerate their own and their child's mental states as instead, "making the unknowable knowable" (Slade, 2007, pg. 648). When parents gradually develop this ability, this can help lessen powerful defenses and aids in the appearance of higher-level ego functions (Slade, 2007).

Unfortunately, there are no known studies that specifically examine or explore the mentalization skills of foster parents beyond those examining attachment states of mind. We could assume from the current research that if they have higher rates of insecure states of mind, then their reflection functioning would also be lower. Given that the research thus far shows a concerning level of insecure states of mind among foster parents, it would seem prudent to then discover how this might be directly impacting their mentalizing abilities. It would also seem to follow that by encouraging or enhancing the mentalizing skills of foster parents, one might be able to impact their parenting by helping increase their capacity to regulate themselves and their children during stressful moments, by being able to interact with their children without frightening or disorganizing them (Grienenberger et al., 2005). Overall, both the lack of research on foster parents and the concerning level of insecure states of mind among the foster parents that have been studied, highlights possible concerns regarding how foster parents are selected, approved and trained.

Selection and training. Even though a history of trauma or abuse increases the odds of having insecure and unresolved states of mind regarding attachment, and thus

poor mentalizing skills, having such a history does not, by itself, preclude a foster or adoptive parent from becoming a licensed foster home and having children placed in their care in the U.S. In Texas, workers are given quite a bit of leeway to determine if a family is appropriate to care for foster children. To apply to be a foster parent in Texas, a person must meet certain age requirements and meet certain standards for both education and criminal history. However, for other requirements, the wording is open to interpretation:

> Each applicant must be physically, mentally and emotionally capable of providing care for children and have the ability to provide nurturing care, appropriate supervision, reasonable discipline and a home-like atmosphere for children. (Department of Health and Human Services, Children's Bureau, 2011)

The approval process includes a series of home and background checks, but is mostly dominated by the home study interview (Texas Department of Family and Protective Services, Licensing Division, 2014). Since there is no psychological testing and no assessments given, their capacities are often determined subjectively by the caseworker and social worker conducting the home study. It is this interview that determines if the above standard is met. This interview makes a number of highly personal inquiries, such as questions regarding marriage stability, history of mental illness and counseling, and questions regarding how they were raised and disciplined as a child. What is less clear is how social workers interpret the answers to these questions. Each home study interviewer decides what is concerning and what is not. In Texas, master's level professionals who are trained in the area of child welfare conduct the interview. However, understanding adult attachment status, mentalization or the complex interplay of psychological defenses is usually not part of child welfare professionals' training or education.

Orme's (2006) study, which examined the foster parent selection process in the U.S., discovered that most parents are generally assessed for psychosocial functioning, but are not using any standardized measures. Instead, this process usually relies on the subjective judgment of caseworkers, which has many limitations to say the least (Dawes, Faust, & Meehl, 1989; Kadushin & Martin, 1988). Among the most prominent issues with this method is that it relies on caseworkers who are usually in short supply given to high turnover, which leaves most caseworkers having less experience and education, and dealing with high caseloads and possible burnout (Orme et al., 2006). Thus, these caseworkers may not assess foster parents "adequately, especially regarding dimensions that can be complex or subtle" (Orme et al., 2006, p. 399). Due to the overall shortage of foster parents and pressure to find homes, it is not inconceivable that this leads to pressure to select families who might not be ideal or to overlook their history and/or rush the interview process in general. Although selection of the appropriate foster parent is clearly quite important, so is the ongoing training and support of these caregivers.

Keeping these vulnerable children with a stable placement where they can attach to their caregivers seems to be a very important piece in reducing risk for these children. Unfortunately, the placement disruption rate for foster homes seems to be anywhere from 20-70% (Chamberlain et al., 2006; Leathers, 2006; Minty, 1999). There are a number of factors that have been shown to be predictors of foster placement breakdowns, including age of the foster children, behavior problems and quality of the caregiving (Oosterman, Schuengel, Wimslot, Bullens, & Doreleijers, 2007; Parker, 1966; N. M. Stone & Stone, 1983). There is evidence that attachment behavior predicts placement success, with foster children who are securely attached to their biological

parents staying in their foster placements longer and with regards to foster children who fail to attach to their foster parents having more placement breakdowns (N. M. Stone & Stone, 1983; J. A. Walsh & Walsh, 1990). Training of foster parents has also been linked to placement success (Kalland & Sinkkonen, 2001). In fact, foster parent training is now seen as an important part of preventing placement breakdowns (Blakey et al., 2012). There are number of research studies that have identified the need for more intensive training and support to foster parents as necessary for helping improve their ability to handle foster children's difficult behaviors and emotions (Chamberlain et al., 2006; James, 2004). In the U.S., rarely is evidenced-based training used to address these issues (Blakey et al., 2012). Additionally, the effectiveness of many foster parent training curriculums is presently unknown and current research does not provide any evidence that the most common foster parent training programs actually change parenting behavior or improve these parents' success at parenting (Puddy & Jackson, 2003). As Dorsey and her team conclude in their review of foster parent trainings, there is just not much empirical evidence for the type of training that most foster parents receive in the US, including the two most popular training curricula, MAPP and PRIDE (Dorsey et al., 2008). The PRIDE curriculum is presently used in Texas to train most foster parents ("Foster Parent Training," 2014).

Although foster children need to have stable and secure relationships with their caregivers, foster parents appear to not receive the training or support needed to deal with the psychological needs of foster children (Timmer, Urquiza, & Zebell, 2006). Most programs that support foster parents are more focused on responding to crises, and when services are offered, they mainly focus on mental health services for the children (Timmer et al., 2006). In other words, these services and programs are designed to

focus on the children's problems, not to help or support the foster parents in managing their own reactions or improve their ability to parent their foster children. This is quite unfortunate given that foster parent training and support has been shown to be an important part of improving children's outcomes (Leve, Harold, & Chamberlain, 2012). Additionally, foster parent's perception of satisfaction with fostering and their desire to continue fostering has been found to be connected to their view of how useful a training is in helping them feel both prepared and supported when dealing with children's emotional and behavioral difficulties (Rhodes, Orme, & Buehler, 2001). Rork and colleagues, in their critical review of foster parent training programs, conclude that "It is imperative to provide foster parents with specialized education and skills to help manage the unique needs of the children for whom they plan to provide care." (Rork & McNeil, 2011).

Given how much is not known about foster parents, as well as the potential issues with foster parents' attachment status, how they are selected and the lack of adequate training and support, it seems they could immensely benefit from a training intervention that focuses on improving their mentalization skills. Before creating this intervention, it was first important to review the attachment and mentalization-based interventions that already exist for parents, particularly foster and adoptive parents.

Chapter 3 - Attachment-Based Interventions

There has been an abundance of attachment based prevention and intervention programs that have emerged since the late 1980s (Berlin, Zeanah, & Lieberman, 2008). Most have been created for mothers of infants or young children. Supporting these early relationships has become a more prominent goal for not only the mental health field, but also for community providers and even policymakers in the US (Development, Education, Institute of Medicine, & Board on Children, 2000; Sameroff, McDonough, & Rosenblum, 2005; Zeanah, 2000). Despite the proliferation of these attachment-based programs, researchers have had a hard time agreeing on what types of programs actually work. In more modern attachment interventions, one of the main goals is to focus on "parental sensitivity", as research has supported this trait being heavily correlated to attachment security (Belsky, 1997). However, the impact of such interventions on attachment and parental sensitivity was not clear. Bakermans-Kranenburg and colleagues (2003) conducted a thorough meta-analytic review of 70 attachment studies and discovered only a medium effect size for improving parental sensitivity and a small effect size for attachment security. In addition, it was not even clear anymore that it was parental sensitivity that mediated attachment security. When this transmission gap appeared, researchers started delving deeper into this issue in hopes of discovering other potential mediators. As a result, researchers have mounted evidence that perhaps it is "reflective functioning" (RF), the operational definition of mentalization, that mediates attachment security (Fonagy & Target, 2005). Because mentalization is a relatively new field of investigation, there are a small number of interventions and evaluations based on these concepts that have been produced. What

will follow will be a description of the most popular and evaluated interventions for parents and children that focus on increasing either parental sensitivity or mentalization. Because there are very few interventions in this field that have been designed for or implemented with foster/adoptive parents, interventions focused on traditional parents will also be reviewed. In addition, since the field of mentalization is quite new, promising interventions in this arena will be covered.

First, attachment-based interventions for parents will be reviewed. These will be interventions where measures of attachment itself are the primary outcome. Included in this section will be traditionally associated correlated measures of attachment such as "parental sensitivity". Next, programs that focus on increasing parents' mentalizing skills will be examined. Finally, interventions designed to increase one's mentalization will be discussed. Although reflective functioning and mentalization can be thought of as being one and the same, there are a few differences, namely that mentalization can be thought of as a broader idea that has farther-reaching outcomes than the operational definition of reflective functioning. In addition, mentalization as an emerging field is beginning to create its own measures (Luyten, Mayes, Nijssens, & Fonagy, in press) separate than reflective functioning.

Attachment-Based Interventions

Circle of Security. Circle of Security (COS) is an attachment based group intervention designed for parents of high-risk infants, toddlers or preschoolers (Marvin, Cooper, Hoffman, & Powell, 2002). It provides both education and psychotherapeutic intervention to parents and their children. This intervention is specifically designed to closely mirror attachment theory and research (Marvin et al., 2002). It is a 20-week program using highly trained therapists. Each weekly class lasts 75 minutes and is

designed for small groups of 6-8 parents at a time. This intervention includes a baseline attachment assessment, the Strange Situation and the Circle of Security Interview (COSI), which aims to assess the parent's internal working models (Berlin et al., 2008). Both the attachment classification and COSI responses are meant to guide treatment. COS attempts to impact five relationship skills that include (1) understanding children's needs, (2) observational and inferential skills, (3) reflective capacities, (4) emotional regulation, and (5) empathy (Cooper, Hoffman, Powell, & Marvin, 2005). The intervention is individualized for parents in that child-parent interactions are videotaped and reviewed with the therapist extensively, taking that parent's particular needs and challenges into account. The goal is to help each parent be able to identify and correct their attachment "miscues." Part of the therapeutic dialogue includes encouraging parental reflection on their own developmental history and how it might be impacting their current reactions. The therapist and group support and celebrate increases in empathy and parental sensitivity. Although there is a group psychoeducational component to this intervention, the heart of it is an intense psychotherapeutic guidance of the parent.

Research being conducted is relatively new for COS. One of the first published studies evaluated pre-post results from 65 toddlers/preschoolers recruited from Head Start or Early Head Start programs (Hoffman, Marvin, & Cooper, 2006). Thus, all of the children were low-income and a majority of the parents reported their own history of trauma. Results revealed significant decreases in both insecure and disorganized attachment classifications post intervention. Whereas initially, 80% of the children were designated as having insecure attachment, this lowered to 46% at the end of the intervention with 54% being classified as secure. Because some portion of the children

were classified as secure at the beginning of the intervention, researchers were pleased to report a 92% rate of stability for secure attachment, which supports the "do no harm" intervention perspective. The greatest limitation in this study is that there was no control group or random assignment of participants. In addition, caregivers might have been particularly motivated as they were selected based on their high participation levels in their Head Start program. This limits the generalizability of the results.

Attachment and Biobehavioral Catch-up. Attachment and Biobehavioral Catch-up (ABC) is an intervention developed by Mary Dozier and colleagues (M. Dozier, Dozier, & Manni, 2002) and is the only attachment based intervention that directly targets foster children and their caregivers and is supported by several research studies. The main aim of the intervention is to target the dysregulation of infants and young foster children brought on by the trauma of their attachment disruption or other attachment issues they might have as the result of being exposed to a maltreating caregiver before being placed in foster care. Dysregulation is essentially a breakdown in normal functioning, whether that is in the emotional, behavioral or neuroendocrine system (M. Dozier et al., 2006). The attachment literature supports the notion that a "good enough" caregiver helps their child develop regulatory capabilities through a securely attached and attuned relationship with the child (Dozier et al., 2006). This intervention targets dysregulation by helping foster parents create a relationship environment that enriches and develops a child's capacities to regulate his/her self. Specifically, ABC is designed to enhance sensitive parenting and decrease frightening behavior, both of which are important in forming secure attachments.

ABC is a brief intervention, consisting of 10, 1-hour sessions in the caregiver's home with their infant/toddler. It is designed for children from 10-24 months, but can be adapted for use with young children. During the sessions, the caregiver learns how to interact with their foster children using a parent coach/trainer. The three main components of the training are to help the caregiver learn how to follow the child's lead, help them develop nurturing behaviors towards the child and to help them understand and work with their child on emotional expression and understanding (M. Dozier et al., 2002). During the training, there is much psychoeducational material regarding attachment, nurturing behaviors, recognizing caregiver issues/negative responses towards child, helping the child take charge and lead the playtime and attending to the child's signals. In addition, there are plenty of opportunities for demonstrations and games. All of the components are designed to mirror sensitive parenting, through both teaching and modeling. The trainer also videotapes an interaction between the caregiver and child and reviews this tape with the caregiver, pointing out their strengths and barriers (M. Dozier et al., 2002). ABC helps build foster parents' comfort with their foster child's negative emotions. In addition, it is meant to raise parents' awareness of their own defensive responses that might be related to their own caregiving histories. Social workers track foster parents' states of mind throughout this process and individualize their approach to each parent (M. Dozier & Sepulveda, 2004). So even though this is a relatively short intervention, it is quite intense and therapeutic in nature.

Dozier and her colleagues have conducted several studies on the effectiveness of ABC (Bernard et al., 2012; M. Dozier et al., 2006). One of the first studies in 2006 involved a random sample of 60 foster infants and toddlers who either received the

ABC intervention, or a control group intervention. Primary outcomes measured were cortisol levels of the infants, which can indicate internal stress and dysregulation, and parent reported behavior problems. Results showed a significant difference in post cortisol levels, with the intervention group displaying much less stress, dysregulation and behavior problems as compared with the control group. Although the children and parents were randomized, baseline measures were not taken so it is unclear how much impact the intervention directly had on cortisol levels or behavior. Other limitations of this study include the small sample size and the fact that children who have experienced early trauma or adversity tend to already have atypical cortisol patterns (M. Dozier et al., 2006; Pears & Fisher, 2005).

Another study was conducted with at-risk parents and maltreated children that resulted in positive outcomes for the ABC intervention (Bernard et al., 2012). In this study, 120 children from about 12 – 32 months were randomly assigned to the intervention or control group. The intervention had been manualized so was delivered as it was in the previous study. About one month after both groups completed their sessions, the children were given the Strange Situation to assess the quality of their attachments. The intervention group showed significantly lower rates of disorganized attachment and higher rates of secure attachment compared with the control group. Limitations include using the Strange Situation procedure for toddlers older than 24 months and not examining the possible effects of the control intervention (Bernard et al., 2012). The above studies support the notion that foster and at-risk parents can be taught and coached on how to be sensitive parents and that this can in turn affect their children's regulatory and attachment systems in a positive way.

Video-Feedback Intervention to Promote Positive Parenting. Video-Feedback Intervention to Promote Positive Parenting (VIPP) is an intervention developed by the well-known attachment researchers in the Netherlands (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2007). They have designed and evaluated a few different versions of this intervention. VIPP is meant to be a short intervention, delivered in four, 90-minute home visits with parents of infants who are less than a year old. The goal is to enhance and develop maternal sensitivity through the presentation of both educational material and a clinically oriented review of videotaped parent-child interactions. Each session starts with a videotaped interaction for use with the next session. Each session also has a different theme or focus with the first one centering on the infant's seeking and exploratory behaviors, the second one highlighting the more subtle expressions and signals by babies, the third emphasizing the need for the parent to have prompt and appropriate reactions to their infant and the final session focusing on the sharing of emotions and attuning to one another (M. Bakermans-Kranenburg, Juffer, & van IJzendoorn, 1998). Every session includes discussing the videotaped interaction with the instructor highlighting key behaviors and interactions and encouraging the mother to do the same. At the end of each session, the mother is left with a brochure that includes written information about the session theme. The intervention developers went on to create another version of this intervention, termed VIPP-R, which is an expanded version of VIPP. In VIPP-R, the home visit time is increased to three hours per session and the intervener adds a discussion component that focuses on the parent's own attachment experiences in hopes of impacting their internal working models (Berlin et al., 2008).

There have been several studies that overall support VIPP as an intervention that promotes maternal sensitivity, but results are a bit mixed. One of the studies compared VIPP, VIPP-R and a control group between 81 randomly assigned first time mothers and their infants (Klein Velderman, Bakermans-Kranenburg, Juffer, & van IJzendoorn, 2006). These mothers were all selected based on having insecure states of mind on pre-intervention Adult Attachment Interview tapes. The intervention occurred when infants were between the ages of 7 and 10 months. Maternal sensitivity was assessed three times based on a 10-minute free play episode between parent and infant. Each of these sessions were rated using the Ainsworth's rating scale for sensitivity (Ainsworth, Bell, & Stayton, 1974) that rated sensitivity on a scale from (1) highly insensitive to (9) highly sensitive. Independent coders were used and intercoder reliability was high. In addition, infant attachment was assessed post intervention using the Strange Situation Procedure (Ainsworth et al., 1978). Post intervention, mothers who participated in VIPP or VIPP-R were significantly more sensitive than the control group mothers (Klein Velderman et al., 2006) leading researchers to summarize that both interventions appeared equally effective in increasing maternal sensitivity. Unfortunately, they found no differences between the groups for infant attachment security. Interestingly, in a follow up study when these children were preschool aged, children who had received VIPP only, were less likely to be scored as having externalizing behavior problems in the clinical range (Klein Velderman et al., 2006). These results lend credence to these researchers' earlier conclusions following a meta-analysis of attachment-based interventions, that large effect sizes can be gained via a small to moderate number of sessions with a specific focus on parenting behavior (M. J. Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003). These results seem to conflict

somewhat with a previous study examining the effects of VIPP and VIPP-R on a randomized group of 130 adoptive parents and their children (Juffer, Hoksbergen, Riksen-Walraven, & Kohnstamm, 1997). In this case, it was those parents in the VIPP-R intervention that seemed to make the most gains in maternal sensitivity and had higher number of securely attached infants when compared with the control group.

Reflective Parenting Programs

Reflective parenting programs arose from the idea that a parent's ability to make sense of her own, as well as her child's, mental states is crucial in helping the child develop a flexible way to regulate his emotions and in helping that child create healthy and long-term relationships (Fonagy, Gergely, Jurist, & Target, 2004; Slade, 2006). These programs started with Arietta Slade and her colleagues and their desire to specifically emphasize the development of these reflective capacities. Slade (2006) felt that although programs such as parent-infant psychotherapy and other attachment interventions did not specifically focus on measuring reflective functioning, they were successful due to being able to change the parent's internal representations of their child, thus influencing their caregiving abilities. In other words, Slade hypothesized that these changes were due to changes in parental mentalizing. This led to the development of two programs by Slade and her colleagues at Yale that focused on increasing a parent's mentalizing capacities: Parent's First (Goyette–Ewing et al., 2003) and Minding the Baby (Slade et al., 2005).

Parent's First. Parent's First (Goyette-Ewing et al., 2003) was designed to be a preventative group intervention for parents of infants, toddlers and preschoolers. It was designed to be a psychoeducational type intervention for more normalized parents, delivered by trained leaders, that can be delivered in practical settings such as schools

and daycare settings. The premise behind the intervention was that children's cognitive and socio-emotional development flourishes inside a healthy parent-child relationship. Goyette-Ewing and colleagues felt the best way to support a child's development was to enhance the parent-child relationship specifically by helping to engage parental mentalization (Slade, 2006). Parent's First consists mainly of parent workshops delivered over a period of 12 weeks. These workshops deliver developmental information within the context of both modeling and practicing reflective capacities. They engage parents in progressively reflective experiences over the 12-week period. Parents are also asked to complete family activities and exercises at home with their children that encourage and enhance mentalization.

The workshops begin with teaching and demonstrating to parents a basic premise that forms the foundation for more complex mentalization. This premise is that all children, even babies, have a rich internal world such as thoughts, feelings and intentions. The next classes in the series take this idea further with helping the parent understand and experience that their children's thoughts and feelings are what actually lie beneath their behavior. This helps parents understand their child's behavior, which impacts their own mentalizing of their child. The classes eventually touch on the interconnectedness of the child and parents' mind and the complexities of experiencing and maintaining a relationship. Near the end of the workshop series, the leaders provide tools and support for the reflective process (Slade, 2006). Unfortunately, there are no published studies that examine the outcomes of this intervention. Personal email correspondence with the author resulted in no further information. It does appear that the author and her team instead put their energy into developing and studying their other intervention, which is described next.

Minding the Baby. Minding the Baby (Slade et al., 2005) is a preventative intervention created for pregnant young mothers and their families. It is designed more for a high risk women who have histories of trauma and most likely did not have secure and nurturing caregivers themselves, resulting in weak mentalizing skills (Slade, 2006). Using the model of Parent's First, Slade and colleagues built in more therapeutic encounters and tools so as to contain and mentalize the mother, leading to a more supportive and intensive intervention. Due to this, Master's level clinicians are used and the intervention is delivered in the parent's home on a weekly basis starting during the mother's pregnancy and lasting until their child turns 2 years old. In addition, the program is meant to be linked to other community services the mothers need so that there is a wraparound supportive community component. Slade also decided to use an integrated mental health/nursing model based on successful home visiting programs, such as Nurse-Family Partnership (Olds, Kitzman, Hanks, Cole, & Anson, 2007) and Infant-Parent Psychotherapy (A. F. Lieberman, Silverman, & Pawl, 1999). This approach also supports the multiple needs of high risk mothers such as needing both practical/development understanding of their babies as well as help developing their reflective capacities (Slade, 2006). This intervention is very individualized and paces the mothers' needs and development. It also depends on developing a therapeutic relationship, which is an intensive and challenging task.

The intervention has been manualized and is designed to address not only these mother's parenting behaviors, but also their internal working models by building their mentalizing skills (Slade et al., 2005). This intervention begins with building a therapeutic relationship and helping the mother find the words to identify their own feelings and begin to reflect and regulate her own experiences. It is this mentalizing of

the mother that serves as a model for the mother mentalizing her own baby (Allen et al., 2008). As with Parents First, this intervention is designed to build on and scaffold reflective experiences and capacities. However, Minding the Baby goes further with routine videotaping of the mother interacting with her infant/child (Slade et al., 2005). These tapes are reviewed with the mother and provide unique opportunities for the mother to reflection on her own thoughts and feelings and that of her baby as well. Additionally, home visitors help mothers learn how to play and interact with their baby in the moment, also speaking for the baby when needed, which models and supports the mothers' mentalizing abilities.

It is only very recently that complete research results were published evaluating the Minding the Baby (MTB) intervention. Sadler and colleagues (Sadler, Slade, Close, & Webb, 2013) evaluated a pilot study of the differences between MTB and a control group of parents that received "treatment as usual." Mothers were vetted, consented and were randomly assigned to each group with the intervention group ending up with 60 mothers and the control group 45. Baseline measures were taken and data collection included health record information, videotaped interactions, the Strange Situation Procedure (Ainsworth et al., 1978) and the Parental Development Interview coded for reflective functioning (PDI; Slade, Aber, Bresgi, Berger, & Kaplan, 2004). Post data demonstrated that at 4 months, parents in the intervention group had less disrupted communications with their infants than the control group. Also noteworthy was that the intervention children had higher rates of secure attachment at 12 months and lower rates of disorganized attachment. Additionally, reflective functioning (RF) increased significantly for both groups. Although the intervention group did not differ overall from the control group with regards to RF, when the data was teased apart and

analyzed differently, it was discovered that the subgroup of parents who displayed hardly any mentalizing before randomization, did increase their RF abilities significantly compared with the control group.

It is interesting that in this study, the researchers did not feel they could adequately assess RF using the PDI. They found that for both groups, the limited range of their responses (between 2.5 and 4.5 on a 9-point scale) had an impact on detecting differences between the groups. They conjecture that perhaps there is a significant limitation with using the PDI for assessing RF with this population of mothers who were young, less educated and bilingual. They also point out that the lower end of the RF scale may not adequately capture prementalizing modes, which might help to make distinctions about these mothers' abilities to make sense of mental states (Sadler et al., 2013). Prementalizing modes are developmental precursors to mentalizing, such as the "psychic equivalence mode", which is when someone equates reality with their mental states, with no space for feelings or thoughts just being representational (Allen et. al., 2008). They suggest that future research must address the complexities of measuring change in RF. Overall, results of this study indicate that MBT has a positive impact on health, parenting and attachment outcomes. More specifically, although the mothers are "high risk" and have many challenges, the results seem to suggest that they are parenting in a more sensitive manner and displaying less frightening behavior towards their children, which is increasing their ability to form secure attachments.

Slade and her colleagues at Yale went on to follow this same cohort of parents and designed a prospective longitudinal study to assess the data collected 1-3 years post-intervention (Ordway, Sadler, Dixon, & Close, 2014). At the time of the data collection, the children ranged in age from 3-5 years old. Demographic data was

collected and the PDI was given, as well as assessments of internalizing and externalizing behaviors in children. Results demonstrated that intervention mothers reported significantly less externalizing behaviors in their children compared with the control group, and the effect size was large. The authors hypothesize that the MTB intervention may be impacting improved behavioral outcomes from these children up to three years after the study. This supports the notion that MTB improves parent/child relationships and the parents' ability to mentalize their children (Ordway et al., 2014). Interesting results emerged regarding the RF of the intervention group. RF for this group increased over time, while RF decreased over time for the control group. Although this difference was not significant, results indicate promising connections that contribute to the RF literature and suggest future directions for research. Limitations of this study include the small sample size and that significant portions of the original study participants were not available, indicating a possible sample selection bias that threatens the study's internal validity.

Mentalization-Based Interventions

Mentalization-based treatment (MBT) is a relatively new field of therapies and has recently become an evidenced-based approach for clients diagnosed with borderline personality disorder, and is quickly becoming a therapeutic model for working with a variety of adults and children (Fonagy & Bateman, 2006; Midgley & Vrouva, 2012). MBT is based on the field of developmental research and it's origins hail from both attachment and psychoanalytic theory. The authors broadly outline the aims of treatment as to promote mentalization about oneself, others and relationships. This is accomplished via working with the patient's mentalizing abilities, focusing on

internal states, helping the patient see and understand these internal states and keeping this focus in the midst of emotional dysregulation (Allen et al., 2008).

It is hard to imagine a situation more likely to result in a loss of mentalizing more than family interactions. For it is these intimate relationships that are most likely to active our attachment systems, thus rendering these particular relationships the most threatening. When one is under great stress, one tends to lose the ability to think about the mental states of others.

Mentalization-Based Family Therapy. Mentalization-Based Family Therapy (MBT-F) is a promising emerging intervention developed by Peter Fonagy, Mary Target, Pasco Fearon and their colleagues, and was formerly called Short-Term Mentalization and Relational Therapy or SMART (Allen et al., 2008). It is meant to be a different approach to family therapy with children (7 years and older) and adolescents. MBT-F was designed to be a rather short intervention, at 6-12 sessions, that was not intended to be a "fix all" but as a way to promote resilience in family members by enhancing their mentalizing skills to promote relationship building and problem-solving. One of the major goals of to help the parents understand their children's behavior, as it is usually this behavior that prompts parents to seek treatment. MBT-F assumes that a family comes into therapy due to mentalizing failures and that these failures are tied to a particular relationship. Additionally, it is hypothesized by the authors that the intergenerational transmission of trauma is facilitated by these non-mentalizing interactions (Allen et al., 2008). The authors think that by emphasizing mentalizing, the therapist can overcome common blocks in therapy, which in turn allow family members to be more open to seeing and understanding each other's mental states (Midgley & Vrouva, 2012, p. 100). Although MBT-F is inherently a psychoanalytic treatment model,

there is a strong psychoeducational component as well. The intervention consists of the therapist both modeling and promoting mentalization and includes consistently engaging each family member's interest in each other's thoughts and feelings and correcting distortions that arise. Psychoeducation is done throughout and is augmented via games, exercises and homework that supports and enhances mentalization. The psychoeducation is also sprinkled throughout the treatment via the therapist imparting her/her knowledge of attachment, trauma and mentalization.

The core therapeutic intervention elements of MBT-F are outlined below (Allen et al., 2008, p. 257):

1. Identifying, highlighting, and praising examples of skillful mentalizing
2. Sharing and provoking curiosity
3. Pausing and searching (interrupting a non-mentalizing interaction)
4. Identifying preferred non-mentalizing narratives
5. Identifying and labeling hidden feeling states
6. Using hypotheticals and counterfactuals
7. Therapists' making use of self

The initial evaluation of MBT-F yielded promising results (Midgley & Vrouva, 2012). Thirty families were asked to complete pre-post measures such as the parent report Strengths and Difficulties Questionnaire (SDQ; (Goodman, 1999). Findings suggest that MBT-F led to a significant reduction in emotional and behavioral difficulties of the children in the study. These children showed significant improvement in their emotional well-being for up to one year post intervention. Additionally, the therapists were asked to complete both the Health of the Nation Outcomes Scales for Children and

Adolescents (HoNOSCA; Gowers, Harrington, Whitton, & Lelliott, 1999) and the Children's Global Assessment Scale (CGAS; Shaffer et al., 1983). Results indicate significant improvement of families from pre to post intervention. Thus, the therapists appear to have felt that MBT-F improved the children's social and emotional functioning as well.

Mentalization-based psychoeducation. MBTs are designed to have a strong psychoeducational component. Psychoeducation is usually a professionally delivered treatment that combines both educational and psychotherapeutic interventions (Lukens & McFarlane, 2004). MBT lends itself nicely to having separate psychoeducational material and groups to support the clinical intervention itself. This is exactly what was done at The Menninger Clinic, a psychiatric facility with a long history of professional, as well as, public education and training (Allen et al., 2008). They developed psychoeducational groups that focused on mentalizing, in hopes of enhancing patient participation and collaboration in treatment. These groups meet weekly for 50 minutes and include lectures, discussions and group exercises. The total session number varies from 6-9 depending on how long the curriculum takes with each group. The curriculum has three main components (Allen et al., 2008, p. 297):

1. Understanding mentalization and its development
2. Psychiatric disorders and impaired mentalizing
3. Promoting mentalizing in treatment

Although patients are in a psychiatric hospital and are clearly dealing with issues that can strain emotional regulation and mentalizing capabilities, psychoeducational groups generally promote mentalizing. Due to their nature and structure, they are

usually not too emotionally challenging (Allen et al., 2008). As a result, professionals and staff who support the MBT process also attend these groups. This psychoeducation has not been studied independently for outcomes, but is part of an entire mentalizing program that is beginning to report successful outcomes for patients (Bateman & Fonagy, 2013).

Conclusions and Implications

Although there has been an abundance of attachment-based intervention programs in the last few decades, there has not been much of a consensus on what types of interventions have the most impact or success overall (Berlin et al., 2008). In 2000, Egeland and his team began to earnestly tackle this issue by reviewing 15 well-known attachment-based intervention programs. They concluded that successful programs must target both internal working models and parenting behaviors through interventions that are both long and intense (Egeland, Weinfield, Bosquet, & Cheng, 2000).

In great contrast, Bakermans-Kranenburg and colleagues meta-analysis of 29 attachment-based interventions led the team to conclude that successful interventions tend to be less broad, shorter in duration and focus on sensitive parenting (M. J. Bakermans-Kranenburg et al., 2003). Berlin (2005) went further and decided to review a subset of programs from both the Egeland's and Bakermans-Kranenburg's research. Berlin concluded that programs that focus on a child's attachment security as the outcome have been moderately successful, but it was when an intervention focused on the quality of that attachment or on maternal sensitivity that it rose to the level of having high success (Berlin, 2005).

Using van IJzendoorn's (1995) "transmission model", which describe how parent's internal working models shape their parenting behaviors and impacts the quality of attachment to their own child, as well as Bowlby's (1988) advice to clinicians on treating children and families from an attachment theory perspective, Berlin and colleagues (2008) have several guidelines for attachment based intervention and prevention programs that they call their "three therapeutic tasks" (pg. 747). Essentially, they recommend a supportive relationship between intervener and parents and an intervention that targets both the parent's internal working models and parenting behaviors (Bowlby, 1988; van IJzendoorn, 1995). It is suggested that by focusing on the parent's internal working models, the intervention will also impact the child's internal working models. In effect, changes to a parent's behaviors and experience of their child, should then in turn change their child's experience and behaviors (Berlin et al., 2008). Additionally, Slade and colleagues think that helping a parent understand their child better requires them to have the ability to be reflective and that targeting the parent's mentalizing skills could be very beneficial in this regard (Slade et al., 2005). Overall, Berlin and colleagues (2008) propose that such interventions include supportive relationships that help parents look at their own internal working models and how it connects to their actual parenting behavior. They also point out that these two tasks could well interact in a way that makes it hard to know which one is the change agent. For instance, if a parent has success in altering a behavior and gleans the reward of seeing her own child's behavior change, this could very well lead to a reworking of her own internal working models (A. F. Lieberman, Ippen, & Van Horn, 2006).

Based on these reviewed interventions, and keeping in mind this recent research and resulting recommendations, it was clear that a new type of intervention was needed specifically for foster parents. This population can have a tremendous impact on high-risk maltreated children and yet there is little in the way of successful attachment or mentalization-based interventions specifically designed for these parents. Taking into account the current interventions, research and recommendations, this author designed a mentalization-based psychoeducational intervention for foster parents. This new intervention will fill both a need and a great gap in the intervention literature. Details of the process and content of this new intervention will be discussed in the next section.

Section II

Empirical Research

Chapter 4 - The Development of a New Intervention

Aims and Purpose

David Howe, a world-renowned researcher in attachment and foster children, has stated that the most effective and impactful way to help foster children is to "work with and through" the foster parents themselves (2006, p.129). One of the ways to significantly impact the mental health and development of foster children is to give them caregivers who have the traits that generate secure attachment in children. By supporting foster parents' ability for mentalization, they are gaining the ability to not only regulate themselves, but also regulate the arousal of their foster children. Foster children, in particular, can significantly benefit from learning to recognize and reflect on their feelings in a more conscious and regulated way (Howe, 2006). He goes on to explain that first and foremost, foster parents should be as stress free as possible and have open reflective capacities to be able to be both psychologically available and responsive to these high risk children. Additionally, he recommends foster parents have access to training about how maltreatment not only impacts basic development, but also how it impacts children's behavior, mental health and attachment strategies (Howe, 2006). Teaching foster parents about this helps them understand their foster children and their behaviors better, and helps them interact with them in a more sensitive and reflective manner (Golding, 2003; Marvin et al., 2002; Schofield & Beek, 2006). In addition, helping parents understand their child better requires them to have the ability to be reflective, thus inherently helping to enhance their mentalization skills (Slade, 2005).

One factor not given much consideration when recruiting or training foster

parents in the U.S., is their state of mind regarding attachment. Those parents with insecure or even unresolved states of mind are more likely to be triggered negatively by their foster children's attachment needs and behaviors (Howe, 2006). As a result, this will likely activate childhood anxieties, traumas and defenses of these foster parents. Unfortunately, this prevents them from being able to successfully attune to their foster child and challenges their sensitivity. Maltreated children who are placed with such foster parents have an increased risk of placement breakdown (M. Dozier et al., 2001; M. Steele, Hodges, Kaniuk, Hillman, & Henderson, 2003). Unfortunately, it was outside the abilities and scope of this project to be able to evaluate foster parent's adult attachment status. However, it seemed prudent to assume there will be some parents included in this intervention that have challenges in this area. One strategy that can help prevent the negative impact in these cases are interventions for foster parents that involve helping them change their own internal working models by having them reflect on their past attachment relationships, as well as how their attachment history impacts their present relationships, parenting and functioning (Howe, 2006). Several researchers have recommended and suggested that group work with parents could not only support, but also enhance and strengthen their mentalizing abilities with regards to their children (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2003; Marvin et al., 2002). Research suggests that after experiencing parents who are safe, reliable and exhibit secure parenting traits, foster children can let go of their old mental representations of parents as threatening or unreliable and replace (or add to) them with internal working models that reflect available, caring and sensitive caregiving (M. Steele, Hodges, Kaniuk, & Steele, 2010).

Most of the foster parents in Texas receive standard parenting classes that are more focused on information sharing or skills training. These parent skills trainings mostly focus on practical behavior management skills such as learning how to employ rewards, negative reinforcement and the like. The goal of this type of training is usually to use immediate conflict management type techniques to stop the behavior itself. These types of trainings do not normally include information that helps parents understand the emotional needs that form the basis for their children's behavior (Suchman, Mayes, Conti, & Slade, 2004). They do not typically address the issues behind their behavior, which includes children not feeling emotionally or physically safe, needing reassurance or acceptance with regards to their relationship with their parent (Speltz, Greenberg, & DeKlyen, 2008). Typical parenting programs also do not tend to focus on helping enhance parents' responsiveness, emotional availability or ability to respond to their child in a mentalizing manner (Suchman et al., 2004).

Given all of these points, the aim of this new psychoeducational group training for foster parents is to provide an intervention that not only educates parents, but also increases their own mentalizing abilities. More specifically, it will include attachment information designed to help parents see behind their foster children's behavior, to reflect and examine the impact of how their own childhood influences their relationship with their children, and material to enhance and strengthen their mentalization skills. The purpose of this intervention is to help foster parents understand themselves and their children better, which will help lower their stress and help them problem solve behavioral and emotional issues more effectively. In addition, this intervention should improve and develop parents' reflective capacities and mentalization abilities, which will hopefully positively impact the quality of the relationship with their foster children

by helping them develop a more secure attachment and increase their children's mentalization skills.

Development and Design

The development of this new intervention was based on modern attachment research and theory, as well as intervention suggestions garnered from this research. Since the main purpose of this intervention is to impact parents' mentalization skills, it seemed judicious to use principles and guidelines set out by the few such interventions that currently exist. Arrietta Slade (2007), who helped develop the successful "Minding the Baby" (Slade et al., 2005) reflective parenting intervention, wrote an article in which she helpfully outlined the general principles one should follow when creating a reflective parenting program. One of the points the author makes is that many parents in the beginning of an intervention need to first learn how to tolerate their child's most basic internal experiences. Additionally, most parents find it fairly easy to simply talk about their child's external experiences, but to actually mentalize and think about the mental states of self and other is a far more complex task (Slade, 2006). Furthermore, even healthy secure parents might find it difficult to think about and understand how their thoughts and feelings might be directly affecting their own child (Slade, 2006). Given these points, this author felt it would be important to build and design the material in such as way as to ease the parents into mentalization and their children's internal world of experiences. To ensure understanding and tolerance, the material is designed to be cumulative and progressive.

Additionally, Berlin and colleagues (2008) have provided several guidelines for attachment based intervention and prevention programs based on van IJzendoorn's (1995) "transmission model", and Bowlby's (1988) advice to clinicians on treating

children and families from an attachment theory perspective. Essentially, they recommend that a supportive relationship between intervener and parents and an intervention that targets both the parent's internal working models and parenting behaviors (Berlin et al., 2008). It is suggested that focusing on the parent's internal working models will impact the quality of attachment to their own child, which also shapes the child's internal working models. In effect, changes to a foster parent's behaviors and experience of their foster child, should then in turn change that child's internal experiences and external behaviors. Given this sage advice, this author chose to design the intervention in such a way as to focus on parenting behaviors in the context of influencing the parents' internal working models by increasing their ability to mentalize themselves and their children.

Since the main goal of this intervention is to both educate and influence parents' mentalizing, it was important to reflect on what aspects might be most helpful given the population and the time constraints of a short intervention. It is important to understand that effective mentalizing is not just being able to accurately glean one's own or another's mental states, but it is also a way of coming into a relationship with an attitude that one's own thinking and feeling can be enhanced and altered by learning about the thoughts and feelings of another (Fonagy & Target, 1997). It reflects an attitude of curiosity and respect of others mental states while understanding the limits of truly knowing the inner emotions and thoughts of another. Good mentalizers understand that the feeling states of others are important for having and keeping a successful and meaningful relationship. Mentalization-Based Therapy for Families (MBT-F) posits that improving a parent's understanding of their child will help that child not only understand his own psychological experiences, but will help him increase

his own ability to both express his feelings effectively and better control/regulate his emotions (Fonagy et. al., 2010). MBT-F has several objectives that are both therapeutic and educational in nature. This author felt the following were the most useful and relevant for a psychoeducational intervention for foster parents (Fonagy et al., 2010, p. 50-51):

1. Using mentalizing to strengthen self-control and the capacity to regulate one's own and other family members mental states;
2. Promote awareness of one's own and other's mental states;
3. Promote parent's sense of competence in helping their children develop the skill of mentalizing; and
4. Initiate activities within the family to reinforce mentalizing

It is also important to note that the ability to mentalize develops within the context of an attachment relationship. Disruptions in this attachment can lead to developmental vulnerabilities that inhibit complex cognitive abilities (Fonagy & Target, 1997). The relationship between attachment and mentalization is two-way in that mentalizing difficulties negatively impact attachment and poor attachment challenges the development of mentalization (Asen & Fonagy, 2011). So it can be quite beneficial for a caregiver to better understand their child, for this will also help a child better understand the caregiver as well. Foster parents who understand their interactions with their child will naturally enhance their child's mentalizing skills. Asen and Fonagy (2011) outline several mentalizing strengths that MBT-F aims to foster (p. 350). The following concepts were also thought by this author to be quite useful and can be

incorporated into the content and experiential exercises within this psychoeducational intervention:

"Openness to Discovery"

This concept implies curiosity and requires an attitude where one is really interested in another's thoughts and feelings, especially regarding relationships. It includes refraining from making assumptions as well.

"Opaqueness of Mental States"

This concept is similar to the idea of being comfortable with ambiguity. It refers to understanding that you can never really know the thoughts of someone else, all you can do is guess. This opens up many possibilities when one is mentalizing and counteracts the rigidity and inaccuracy of non-mentalizing.

"Reflective Contemplation"

This strength refers to an open attitude that is both flexible and relaxed. This is in contrast to feeling the need to control and obsess over how another is feeling or thinking.

"Perspective-taking"

This stance reflects the ability to see a situation from many different angles; being able to mentalize all the different minds involved. It also involves a belief that every situation can look very different from different perspectives.

"Impact Awareness"

This is a key feature of successful mentalizing. It entails the importance of understanding how one's own mental states and actions affect others.

"Playfulness"

Being playful and being able to poke fun at oneself is an important aspect of helping family members see alternative perspectives. It can lead to more generous give and take interactions with loved ones.

"Belief in Changeability"

This refers to a general sense of optimism and hope that both mental states and situations can change. Nurturing this strength can help families who feel stuck.

The design of this intervention incorporated an educational primer on mentalization. Additionally, and of even more import, these above mentioned mentalizing objectives and strengths were incorporated into not only the educational material, but also into the experiential exercises and overall structure of the training.

Structure and Content

Most foster parents in central Texas prefer to attend training classes that are either held on weekday evenings or Saturday mornings, and the typical class they are used to attending is three hours long. Workers and staff state that parents prefer this length even if it is after work because it gives them the most "bang for their buck" in that if they are going to spend their weekday evening at a training, they would like the most hours they can obtain within reason. This has created a pattern where foster care agencies, as well as Child Protective Services, tend to provide 3-4 hour trainings either on weekend evenings or Saturday mornings. These trainings usually occur from 6-9 pm on weekdays or 9 am – Noon on Saturdays. Due to this preference and current routine, this intervention was designed to be delivered in three-hour classes.

Although foster parents in Texas have a minimum number of training hours they need to complete each year (20-30 hours depending on number of foster parents and type of home), it is up to them to decide when and how they complete these trainings. This means that foster care agencies do to make any training "mandatory" for their parents, unless it is the initial set of classes required to become a foster parent. Most agencies have a very flexible policy on foster parent trainings they deliver themselves. Most hold several monthly trainings on different weeknights and although they ask for parents to RSVP, often parents do not and they will either show up without an RSVP or no show although they did provide an RSVP. This makes holding trainings quite unpredictable as to how many parents, if any, will show up. Most agencies do not enforce an RSVP policy nor do they provide consequences for "no-shows". As a result, often these trainings are poorly attended. In addition, it is not uncommon to have no parents show to these trainings, yet they are held anyway.

Another issue for this population is that outside of their initial required foster parent training, they never again need or are made to attend a series of trainings that are multiple in number and build on each other. Given this and the fact that after their initial training they only attend one off, three hour classes, it was unclear whether foster parents would commit to lengthy, multiple classes. Because this intervention is designed to build on their skills, it is by necessity cumulative, meaning foster parents cannot just show up to classes without having started at the beginning of the series. Both the structure and commitment of this intervention would be different than foster parents in this area are used to attending. Given these limitations and the fact that research supports that attachment-based interventions can be successful if brief in nature (M. J. Bakermans-Kranenburg et al., 2003), this intervention is designed to be a

shorter length with three, 3-hour classes spread over 5-6 weeks. This timeframe would also allow for maximum flexibility in that foster parents would not need to commit to a class for weeks in a row and it would allow ample time to practice their new skills at home. It was hoped that this intervention schedule would be seen as less of an imposition or commitment on foster parent's busy schedules and would minimize missed classes.

The training itself is divided into three, three-hour classes. This intervention is described as a workshop, with three separate trainings. The workshop title is "Reflective Parenting: How to strengthen your relationship while helping your child cope." This title was chosen based on the desire to make it very clear what the intervention was and the potential benefits. Content was created to be progressive and each section would end according to a rough 2-3 hour estimate. Because the timeframe had to include data collection, total instruction time is approximately 7.5 hours. Curriculum is divided into three parts as outlined in Table 1 below. A detailed outline of the content follows.

Table 1

Intervention Parts and Timing

Part	Presentation Slides	Classroom Activities	Homework Activities	Data Collection Time	Training Time	Total Time
I	44	5	3	:45	2:15	3:00
II	37	5	2	n/a	3:00	3:00
III	25	3	n/a	:45	2:15	3:00
Totals:	106	13	5	1:30	7:30	9:00

Content outline.

Reflective Parenting Part I:

1. Thoughts on Relationships
    a. How and why relationships are important
    b. Our first relationships and their importance
2. Introduction to Reflective Parenting and Mentalization
    a. Mentalizing in action: "Restaurant Scenario" (group activity)
    b. Mentalizing in action: "Picture Exercise" (group activity)
    c. More on mentalizing
    d. Why learn about mentalizing
    e. Mentalizing and parenting
    f. Development of mentalization
    g. Let's practice mentalizing: "What's inside my mind?" (group activity)
3. Attachment
    a. Function of attachment
    b. Attachment and the brain
    c. Still face experiment video (group discussion)
    d. Basic attachment research
    e. Strange situation video (group discussion)
    f. Attachment and trauma
    g. Attachment and mentalizing
4. At-home Exercises
    a. Goals
    b. Descriptions and handout

Reflective Parenting Part II:

1. Discussion of at-home activities
2. Recap of session I

3. Benefits of being reflective/mentalizing
4. Let's practice mentalizing: "Family Scenario Video Vignette #1" (group activity)
5. Trauma
    a. Trauma and children
    b. Trauma and the brain
    c. Relational trauma
    d. Trauma and behavior
        i. Understanding behavior
        ii. Mentalizing behavior: "Understanding Buttons" (group activity)
        iii. Trauma and resilience video (group discussion)
6. Attachment Trauma
    a. Understanding insecure attachment
    b. Understanding disorganized attachment
    c. Understanding secure attachment
    d. Relationships and trauma video (group discussion)
    e. Mentalizing vignette: "Zoe" (group activity)
7. At-home Exercises

<u>Reflective Parenting Part III:</u>

1. Discussion of at-home exercises
2. Recap of session II
3. Let's practice mentalizing: "Family Scenario Video Vignette #2" (group activity)
4. Internal working models
    a. Overview
    b. Birth of the psychological self
5. Parental sensitivity and mentalizing
    a. Components of mentalizing
    b. How to know if you're mentalizing
6. Emotional regulation
7. Angry and controlling child behaviors
    a. Overview of insecure attachment behaviors
    b. Child histories and behavior reactions

c. Hidden emotional needs
d. Ways to help
e. Mentalizing vignette "Marcus" (group activity)
f. Class Examples (group activity)

8. Accurate mentalizing
9. Mentalizing difficulties
10. Final thoughts & questions

Curriculum. The curriculum in this intervention is tailored for foster and adoptive parents in Texas. Given the author's experience with training and creating curriculum for foster parents in Texas, she had knowledge of what they had previously been exposed to and their capacities. Foster parents in the central Texas area are not routinely exposed to information or trainings on attachment, reflective parenting or mentalization. The state of Texas, during their 82nd legislative session in 2011, changed the child welfare bylaws to mandate that all child welfare employees and adult professionals, such as foster and adoptive parents, must have ongoing trauma-informed training ("Texas Family Code, Chapter 264", 2014). Given this initiative began at the same time as the start of this intervention, the author included trauma knowledge and information in this intervention as it is not only very relevant for understanding the behaviors of these children, but provides a platform for introducing the concept of attachment trauma and helps local child welfare agencies meet this requirement. Additionally, the author wanted to model some of this intervention from MBT-F. One of the goals when working with adoptive families using this intervention is to help the parents understand their child's behavior by sharing knowledge about trauma, attachment and mentalization (Muller, Gerits, Sieker, 2012). Therefore, this curriculum includes information on trauma, attachment, foster children's behavior,

sensitive/reflective parenting and mentalization. All of these topics provide a wealth of information that easily relate to one another and that can be tailored for foster parents to help them understand their children's emotions and behaviors, as well as their own.

The content described in the preceding outline comes from several sources. In general, several main texts and papers guided the development of this material. These include the unpublished guides to Mentalization-Based Therapy for Families from the Anna Freud Centre in London (Fonagy et. al., 2010) and the "Mentalizing Treatment Workbook" from the Menninger Clinic in Houston (Williams et al., 2010). In addition, other content came from the books *Affect Regulation, Mentalization and the Development of the Self* (Fonagy et al., 2004), *Attachment Theory and Psychoanalysis* (Fonagy, 2001), *Mentalizing in Clinical Practice* (Allen et al., 2008) and *Nurturing Attachments: Supporting Children Who are Fostered and Adopted* (Golding, 2007). Finally, material also came from the National Center for Child Traumatic Stress, specifically course material from the "Child Welfare Trauma Toolkit" (2008). There were some videos included in the curriculum that came from either the Anna Freud Centre of London (Hillman, 2011) or open access video clips via www.youtube.com. Sample slides of the actual curriculum can be viewed in Appendix A. Below is a more detailed explanation of key concepts and activities that are contained in this curriculum that are most relevant to the goals of this intervention and that have not yet been described in this thesis.

<u>Explicit vs. Implicit Mentalizing:</u>

When describing mentalizing as focusing on mental states, this includes an incredibly large area that includes everything from basic feelings, needs, and desires, to more disturbing psychological processes such as dissociative states or hallucinations

(Allen et al., 2008). Fonagy and his colleagues have made understanding the facets of mentalizing a bit easier by breaking some of this into explicit and implicit mentalizing. Explicit mentalizing is an act of creation, of making sense of a feeling state by putting it into words or some other form. This is often what is encouraged in psychotherapy (Allen et al., 2008). Explicit mentalizing is quite purposeful and conscious and is often typified by accurate and rich narratives. Implicit mentalizing is something that is more unconscious and reflexive. It mainly occurs within interpersonal interactions and automatic, and out of our immediate control. This intervention is designed to educate the participants on these concepts, as well as give them exercises and activities to enhance their explicit mentalizing skills.

Mentalizing Emotion:

Mentalizing is a word that easily implies focusing on the world of cognition, however, it is more critical to think about mentalizing as intimately linked and dependent upon emotion. It is no coincidence that it is most difficult to accurately mentalize while experiencing intense emotions. It is "not just thinking clearly, but feeling clearly" (Allen et al., 2008, p. 59). Fonagy and his colleagues outline three main elements of mentalizing emotion: identifying, modulating and expressing emotions. Identifying emotions can be as simple as labeling basic emotions but it also includes understanding the layers of emotions including ambivalent emotions and elaborating on the meaning of emotions in regards to relationships. Modulating emotions is about regulating the intensity of emotions as well as sustaining a certain level of emotional arousal. It also includes being able to continually check-in regarding ones emotional state. Expressing emotions depends on both being able to identify and modulate emotions. Expressing emotions does not only mean outward communication but it also

includes being able to inwardly express emotions to oneself (Allen et al., 2008). All of these elements are part and parcel of successful mentalizing and being able to create, sustain and repair relationships. This is especially relevant to foster and adoptive parents as powerful emotions within intimate relationships make mentalizing extremely difficult. Therefore, understanding these concepts and practicing mentalizing emotion is part of this intervention.

Mentalizing Failures and Difficulties:

Children that have been abused or neglected, most assuredly had caregivers who were not aware of, or were blind to, their child's emotional needs or mental states. These are significant mentalizing failures on the part of the parents. Understanding the kinds of minds that care for foster children is an important piece for understanding the impact to these children, as well as relevant when creating a new secure relationship with them. Parents who abuse and neglect their children create a "psychological unavailability" (Allen et al., 2008, p.216) that is profoundly traumatizing to children, as it leaves them alone with intolerable emotions that they do not know how to process or manage. Parents who remain unavailable in such a way, are quite unresponsive to their children's requests and need for comfort and emotional nurturance. This type of neglect has been shown to have a more significant negative impact on development than other types of abuse or neglect (Egeland, 1997; Erickson & Egeland, 1996). Thus, foster children in particular, need new caregivers that understand how to attune to and sensitively respond to their children's needs. Keeping this in mind, having foster parents understand when and how their mentalizing abilities become disrupted can be key in helping them become aware of how this impacts their children and how to come back to a mentalizing stance.

90-10 Trauma Reaction:

One of the goals of mentalizing-based treatments is to move from a mode of psychic equivalence, which can be intensely painful, to the more tolerable state of just remembering, which can be thought of as simply mentalizing (Allen et al., 2008). Jon Allen outlined a particular psychoeducational group technique that helps with this goal (Allen, 2005; Allen et al., 2008). He named this the "90-10 trauma reaction" (p. 218). It describes the idea that due to having been sensitized to this trauma, it is likely that 10% of their current emotional reaction is due to what is actually happening in the moment and 90% of the reaction is based on the past trauma itself (L. Lewis, Kelly, & Allen, 2004). It is thought that when a person can bring this to mind during a powerful emotional response, they can more easily mentalize the emotion and regulate themselves. This is another concept quite useful for foster and adoptive parents to understand.

Classroom activities. These activities are presented below in the order they are delivered in the intervention. They are meant to progress from more general and safe mentalizing activities, such as mentalizing strangers, to the more personal such as mentalizing one other and mentalizing parent and child scenarios, and finally to the potentially more challenging task of mentalizing their own child. The order is designed to build skill, as well as to ensure the mentalizing activity is familiar and comfortable before potentially moving into mentalizing activities that could be more challenging or activate a participant's attachment system.

Restaurant Scenario:

This is a group activity created by this author to help participants see how one mentalizes implicitly and how everyone uses mentalization in relationships. It involves describing to participants the following scenario:

> You are newly dating and you have only been out with your partner a few times, but you already like them. One night, you go out to dinner with friends and you notice him/her having a quiet intimate dinner with someone else and it looks like date.

The group is then asked questions such as "How would you feel?", "What would you be thinking?" and "How would you react?" At the end of the scenario, the group is challenged further when the instructor offers an unexpected twist to elicit even more mentalizing experiences and discussion, such as "What if you discovered it was their sibling?"

Projective Picture Exercise:

This group activity is based on an exercise used at the Menninger Clinic (Allen et al., 2008) that was found to be an extremely fruitful exercise for mentalizing. The exercise uses projective stimuli that are ambiguous in nature and indicative of an interpersonal scene. The Menninger Clinic uses cards from the projective Object Relations Test (Phillipson, 1955; M. A. Shaw & Phillipson, 2002). For this intervention, this author drew a version of one of the scenes, using the same basic format and simulating an ambiguous interpersonal situation (See Appendix B). The intervention involves showing the drawing to the group, and asking them to write down a story of what is happening in the scene and what the characters might be feeling or thinking. The idea is that this scene will produce a wide variety of responses from participants, paralleling their own mentalizing of relationships and relational interactions. The goal

of the activity is to not only have participants practice explicit mentalizing, but by hearing the variety of responses, participants experience the sheer variety of mental perspectives one scene can elicit (Allen et al., 2008). Additionally, participants are asked to ponder where their own stories come from. This stimulates a new understanding of projection and of the role of their own unconscious in relation to their assumptions and perspectives. It can be quite powerful and insightful for participants (Allen et al., 2008).

What's Inside My Mind?:

This group activity was created based on a similar activity practiced at the Menninger Clinic (Allen et al., 2008) that involves asking a participant to describe a recent interpersonal interaction that was full of emotion, in an entirely objective way without any information about the feelings or thoughts of the parties involved. Then the group is asked to share their thoughts about what each person in the interaction might have been thinking or feeling. After the group discussion, the participant who described the interaction shares their own impressions of what they were actually thinking and feeling in the moment. Participants usually develop a deeper understanding of mental states through this discussion. For this intervention, the author would ask for a volunteer to come to the front of the class and present his/her scenario in a very factual manner, with no emotions or opinions about what had happened. The class would then try to guess what the presenter might be thinking and feeling, which would eventually be revealed and discussed.

Family Scenario Video Vignette #1:

This video vignette was produced by Saul Hillman, PhD of the Anna Freud Centre in London, as part of a project to create an online Adolescent Story Stems Assessment (Hillman, 2011). This author used this video with permission from Dr. Hillman. This video clip is titled "Story 1: Going to my Bedroom", is very short (38 seconds) and like the projective picture exercise, is meant to represent a somewhat ambiguous interpersonal scene (See Appendix C for screen shots). In this case, the scene appears to be of an adolescent and her parents. This video is not as ambiguous as the projective exercise, as it offers potential leading inferences that might imply conflict or negative feelings. This type of scene is more representative of a family interaction that might not be ideal. The ambiguity is still present, as there is no dialogue or story other than a few initial prompts. This video begins with the prompt "In this video, the teenager is at home watching TV with their parents. Watch what happens next." The video then shows a teenager sitting on a couch between her parents. No one talks and eventually, the girl goes to her bedroom and slams the door. There is much that is unclear about this video and leaves ample room for viewers to mentalize. For this intervention, this video is played for the group and then they are asked questions such as "What do you think is going on here?" and "What do you think this girl is thinking and feeling?" Several questions that probe the thoughts and feelings of the characters are asked. Similar to the projective exercise, this activity is meant to be both a means for practicing mentalizing and an opportunity to experience the variety of responses from others in the group. Additionally, it deepens the discussion on personal experiences of relationships that influence perception and gets the parents thinking about their own foster child's mind and history of relationship experiences.

Understanding Buttons:

This group activity is meant to expand on the information around how trauma impacts behavior, like the "90-10 Trauma Reaction" (Allen et al., 2008, p. 218). This author created this exercise, which involves helping parents think about their own, as well as their children's, "hot buttons" or knee jerk reactions to the behavior of others. Participants are invited to think about behaviors of their children (or others) that make them quite angry, irritated or simply hit their buttons. As a class, one or two of these behaviors are chosen to investigate further. A simple chart is drawn and a discussion begins about what the adult participant is feeling and thinking when they encounter such behavior. Then, they are encouraged to mentalize the child who displayed the behavior. These are compared and discussed. Additionally, the group is challenged to think about what is behind their hot buttons, to explore how their present feelings are often experienced through a lens of their past experiences. This helps parents understand how powerful emotions are often strongly determined by our internalized past (Allen et al., 2008).

"Zoe" Vignette:

By the time this activity comes up in the training, the participants have been introduced to basic attachment theory and how attachment impacts children's behavior. This vignette is taken from Kim Golding's 2007 book *Nurturing Attachments: Supporting Children Who are Fostered and Adopted* (p. 77) and provides an excellent real world example for foster parents to draw upon. The child in the story is a foster child who displays common difficult behaviors that most foster parents should be very familiar with. In this instance, "Zoe" is a child with an ambivalent-resistant version of insecure attachment. She is a demanding child who always wants attention and

sometimes has long temper-tantrums when she doesn't get her way. The vignette tells the story of an interaction between parent and child that starts out well, and then the child has behavior issues. For this intervention, the presenter begins by reading the first part of the vignette, and then having the group mentalize the child and the mother. Then the discussion moves into what class participants might do next with this child. Eventually, the rest of the vignette is read and the group learns how to deal with this child in a reflective and sensitive manner based on her needs and attachment history.

Family Scenario Video Vignette #2:

This vignette was also part of the video produced by Saul Hillman of the Anna Freud Centre in London, as part of a project to create an online Adolescent Story Stems Assessment (Hillman, 2011). This author used this video with permission from Dr. Hillman. This video clip is titled "Story 2: Mum's Headache", is very short (46 seconds) and like the projective picture exercise, is meant to represent a somewhat ambiguous interpersonal scene (See Appendix C). As with "Story 1", this video is not as ambiguous as the projective exercise, as it offers potential leading inferences that might imply conflict or negative feelings. This type of scene is more representative of a family interaction that might not be ideal. This video begins with the prompt "In this story a teenager's mum is not feeling very well. What happens next?" The video then shows a mother sitting on the couch looking a bit under the weather, when a teenager enters the room. The mother tells her she is not feeling well and to please make her some tea. The scene switches to the girl working on homework, when the doorbell rings. The mother answers and there are several teenage girls that are asking to come in to play video games with the daughter. Again, there is much that is unclear about this video and leaves ample room for viewers to mentalize. For this intervention, this video is played

for the group and then they are asked questions such as "What do you think is going on here?" and "What do you think this mother is thinking and feeling?" Several questions that probe the thoughts and feelings of the characters are asked. Similar to the projective exercise, this activity is meant to be both a means for practicing mentalizing and an opportunity to experience the variety of responses from others in the group. Additionally, it deepens the discussion on personal experiences of relationships that influence perception and gets the parents thinking about their own foster child's mind and history of relationship experiences.

"Marcus" Vignette:

This vignette is also taken from Kim Golding's 2007 book (p. 75) and provides another excellent real world example of foster parents dealing with a difficult foster child. The child in the story is a foster child that displays common difficult behaviors that most foster parents should be very familiar with. In this vignette, "Marcus" is a child with disorganized/controlling style of attachment. He is often angry and controlling, as well as oppositional and defiant. He can also be verbally and physically aggressive. The vignette tells the story of an interaction between parent and child that has the potential to escalate in a negative direction. For this intervention, the presenter begins by reading the first part of the vignette, and then having the group mentalize the child and the parent. Then the discussion moves into what class participants might do next with this child. Eventually, the rest of the vignette is read and the group learns how to deal with this child in a reflective and sensitive manner based on his needs and attachment history.

Class Examples:

This final group exercise was created by this author and involves having parents think about a child in their home and his/her difficult behaviors. By this time in the intervention, participants have had many opportunities to mentalize and understand their child's behavior from an attachment trauma perspective. For this activity, parents are asked to think about their child and answer several questions on a piece of paper. These questions are mentalizing promoting questions to help parents see behind the behavior and have a more flexible view of this child as well as their behavior. The exercise also involves asking for volunteers to share their answers and experiences, thus promoting a rich group discussion and mentalizing experience.

At-home activities. These activities are designed to be something a parent can do with their child at home. They are meant to be playful yet skill building for both parent and child. Some of these are based on family activities assigned or encouraged in Mentalization-Based Family Therapy and are designed to both enhance understanding emotions and increasing productive mentalization skills. All of these activities are meant for children 4 years or older so they can actively (and with language) participate in the mentalization process with their parents. For those few parents that might only have infants at home, they were given instructions on how to be verbally reflective and were encouraged to interpret their infant's behavior in terms of their desires, emotions or thoughts.

Fishing for Feelings:

This activity was designed by this author to promote understanding emotions in self and others. It involves using a feelings chart or feeling cards (See Appendix D for

samples) and is meant to be a playful, relaxed game between parent and child. The activity requires the parent and child to think about what feelings the other might have had that day. The parent chooses 1-2 emotions they think the child had that day and asks the child what they think about those choices. The parent reveals why he/she chose those emotions and the child is prompted to agree or disagree and reveal feelings they had that day. The process is repeated with the child choosing 1-2 emotions they though their parent might have experienced that day. This activity helps the child become familiar with both their own emotions, and those of others. It can enhance both the parent and child's mentalizing abilities and promotes sensitive parenting in the process.

Mindreading:

Since children regulate and practice emotions through story and metaphor, this author felt that having children practicing mentalizing through such formats could be quite beneficial. This activity involves a parent either reading a story or watching a movie with their child. It is tailored according to the age and interests of the child and is meant to be a fun and playful activity. If using a book, the parent is to stop every other page or so and wonder aloud what certain characters might be thinking or feeling. The parent asks the child and waits for the child to respond. If using a movie, the parent can pause the movie at certain places and ask the same questions. Parents are prompted to explain to the child what is going to happen ahead of time so it is no surprise. This type of activity enables the child to think about the mental states of others and encourages them to think about the thoughts or feelings that might lie behind the character's behavior.

Freaky Friday:

This is an activity that is offered to families in MBT-F that they refer to as "Inverted Role" (Fonagy et. al., 2010, p. 60). It is designed to help family members get inside the mind of another and to appreciate that other family members also have difficulties and might need help. It involves a role-play where the child identifies a scenario that he might be struggling with, for instance going to bed, waking up or completing chores. The child and parent then play out the situation but with switched roles. The child helps the parent out in the scene by telling him what to think, feel and say. Both parties then reflect on their experiences and how it was both similar and different from one another. For this intervention, the author renamed this activity to reflect a popular American movie "Freaky Friday" in which a child and parent switch bodies. It is presented as a play activity that involves the switching of places/roles between parent and child. It is also suggested they watch the movie if they think this would be helpful and fun.

What's Inside My Mind?:

This activity is very similar to the group activity of the same name. It was altered to make it a more age appropriate and playful activity for parent and child to complete together. For this activity, the parent and child would discuss a recent interaction they had that brought up strong feelings for either party. The parents are instructed to choose an interaction that brought up mild to moderate negative emotions, nothing that is too upsetting or anxiety provoking for parent or child. Then, they would each use arts and crafts to draw a head or brain and place words or images on this image that reflect feelings and thoughts they each had during this interaction. When done, they ask each other to guess what the other was feeling or thinking. They

each reveal their actual feelings and thoughts and discuss. This activity uses play and art to encourage and enhance mentalization in both parent and child.

Implementation Plan

The initial plan for this intervention was to pilot both the content and process at one foster care agency in central Texas in September of 2011. After the pilot, changes to the content and process will be considered and implemented. Starting in October of 2011 the intervention was offered to foster parents at several foster care agencies as well as via Child Protective Services, the state child welfare authority in Austin, Texas. The goal was to have at least 50 foster and adoptive parents receive this intervention starting in the fall of 2011.

Now that we have thoroughly explained how this intervention came to be, the next chapter will describe the pilot of the intervention. Details on the process, procedures and materials will be outlined, as well as outcomes, including preliminary data and subsequent changes made to the intervention.

Chapter 5 - Pilot Study of Implementation

Introduction and Aims

Given this is a new intervention with many moving parts, it seemed practical to pilot it to assess the process, procedures, and material. There were several areas of focus for this pilot evaluation. First, it was important to evaluate the quality and structure of the training itself, as well as the accompanying materials. Although the content was deemed appropriate and useful for this audience, it was unclear both how foster parents would respond to such new and unfamiliar material and whether it would be understandable and approachable by this population. Additionally, it was uncertain how foster parents would respond to the timing and length of this intervention, as this population is not used to having to commit to multiple classes that are cumulative in nature. Next, the pace and delivery of the training material needed to be tested with this particular audience. Finally, given the amount and variety of data collected, it was very important to evaluate the data collection procedure as well as the measures themselves. The aim of the pilot was to discover what specific aspects of these processes and materials worked and what did not, so adjustments to the intervention could be made.

The intervention consisted of three separate, three-hour classes delivered on weekday evenings from 6:00 pm to 9:00 pm on September 13th, 20th and 27th of 2011. A non-profit foster child placing agency (CPA) in Round Rock, Texas (Arrow Child and Family Ministries of Texas) hosted the intervention and assisted in inviting foster parents from their agency, as well as, other neighboring agencies. The host CPA agreed to help recruit parents for this pilot training and provided the facilities, equipment and snacks for the participants. This was a mutually beneficial arrangement as the

researcher was providing this training for their foster/adoptive parents for free (and giving the parents necessary annual training hours) and in exchange, they agreed to let this researcher gather data on the parents who agreed to participate in the data collection portion of the intervention. After collaborating with agency staff, it was decided that each class would be offered on a weeknight that no other classes were being held. The time chosen was the standard time most of their evening trainings are held: 6:00 pm to 9:00 pm.

Methods and Procedure

Recruitment and sample. For this project, a flyer and a short email (see Appendix E) were created, which described the intervention, which was titled "Reflective Parenting: How to strengthen your relationship while helping your child cope." These documents described the workshop details, as well as the potential benefits of attendance, which included learning opportunities and the earning of official training hours. In addition, these documents mentioned this workshop as being part of a research study and that data would be collected only from those foster parents who wished to participate in this process. They also stated that those who did choose to participate would be entered into a drawing for a $25 gift card. The host CPA sent several emails with this information out to their foster/adoptive parents, as well as to other CPAs with whom they frequently collaborate: Angel Heart and STARRY, both located in Round Rock, Texas. Using email and agency newsletters (in both electronic and paper formats), area foster parents were invited to attend the intervention workshop. In addition, the workshop was listed on the agency's training calendar that is placed online and mailed out in paper format. In total, participants were recruited via

email, printed materials, the agency website and in person when CPA staff interacted with foster parents directly.

The main requirement for participation in this intervention was that the parent was a foster parent in Texas. However, it was also deemed important to have foster parents who actually had a foster or adopted child placed in their home, so they could both practice their mentalizing skills with their children and so that they could complete the pre/post measures which consisted of parenting questions that necessitated having a child in their home. The agency contact person, with whom the researcher was working, agreed to screen the participants to only allow those who have foster or adopted children placed with them to attend. This person also requested that each parent who signed up for the training give their "RSVP" and commit to all three trainings in the workshop series.

The immediate agency feedback was that many parents who had signed up for the workshop were excited and were looking forward to a training that was different than their usual monthly classes, which consisted of repeated topics (such as "ADHD" or "Behavior Management") given by the same instructors. The day before the workshop was to commence, it was confirmed that 18 parents had committed to coming to the entire workshop. In collaboration with the host agency, it had been decided to limit the class size to 15 participants, given the physical size of the room and a desire to keep the class within a comfortable number to be able to share personal stories, and encourage active participation in discussions and activities. It was decided 18 participants could RSVP because usually a few parents do not show up to trainings even though they give their RSVP.

Attendance. On the evening of September 13, 2011, the first class in the workshop, 22 parents arrived. This was a surprise, as these four extra parents did not RSVP although this was a requirement for attendance. However, it is not that unusual within child placing agencies in Texas to have very relaxed requirements for RSVPs and it can be quite common for foster parents to show up unannounced to agency trainings. We had to ask two of the parents to volunteer to leave because there was not enough physical space for more than 20 participants. Two of the parents volunteered readily and stated they would come to the next workshop offering. Of the final 20 parents, only 16 had children placed in their homes. They were allowed to stay but data was not collected from these parents. The return rate for the second class was high with 90% (18) of the 20 parents returning. For the third and final class in the workshop, the return rate was again high with 18 parents attending (90%).

Some issues with who attended were noted. Almost 25% (4) of the parents who attended did not have a foster or adopted child placed in their home. Although it thought this intervention could benefit these parents, this material and the data collection instruments were carefully designed for those parents presently working with foster or adopted children. In addition, of these 16 parents who had a foster or adopted child in their home, almost 25% (4) of them had only children under the age of 4 years in their home, mostly infants. Most of the data collection instruments required the parent to refer to a child 4 years or older. Finally as previously noted, four parents attended without giving an RSVP. Although being able to reach and collect data on more parents is usually quite a boon, it was not practical given the limits of the training environment. In the end, only 16 parents were eligible for pre-test data collection and only 14 for post. Additionally, of these 14, only 11 parents had children over the age of

4 years. This means that only these 11 parents were able to complete all of the post assessments.

Delivering the Intervention

Preparation. Before the first class, there were several steps in preparing for the workshop. First, it was necessary to have an estimate of how many participants had signed up for the workshop. Based on that number, I would make all the necessary copies of the assessments and forms needed for data collection as well as handouts of the presentation itself. Because there were three assessments, an informed consent and a demographics form given to each participant, I needed a way to organize everything so that it would be easier to hand out and pick up during class. I decided to place the documents in a folder for each participant. This served two purposes. First, it allowed ease of distribution and a convenient way for the participants to hand in all their forms. Second, if the participant forgot to put their initials or nickname on one of the forms, I would most likely be able to identify it based on its placement in "their" folder. This proved to be a prudent decision, as it was often the case that a participant forgot to write their identification on at least one of the forms in their folder. In addition to these documents, copies of emotion face cards (see Appendix D) were added to the folder for some of the at-home activities participants would be asked to complete. Because part of the data collection involved obtaining a Five-Minute Speech Sample (FMSS), it was necessary to test each recorder to ensure functionality. Other materials I needed to make sure I had on hand were a sign-in sheet and certificates of completion. In addition, I needed to make sure I had a $25 gift card as for the drawing, which was compensation for participation in the research study.

Data collection. I arrived at the venue 30 minutes ahead of time so as to set up the computer and projector and sort all the training and data collection materials. As participants arrived, I greeted them and had them list all their contact information on the sign-in sheet. It was discovered during this pilot that it was common for a number of participants to be late. Several reasons for this include that it is a free class, so there is no investment, and because these are foster or adoptive parents who are often juggling work and caring for their children. Although the intervention was held on the days and times preferred by this population, they still often showed late for class. Because of this, I had to make sure to allow at least 15 minutes past the start time for participants to arrive. These classes are designed to be small (15 or less) so as to maximize interaction and to make data collection more feasible. Because every participant was a vital part of this study, it was necessary to wait for each to arrive before beginning the intervention. However, this "waiting" allowed for casual conversations that helped facilitate class cohesion.

Once all of the participants had arrived, I introduced myself and the study. As a secondary vetting process, it was necessary to ask the parents if they had any foster or adopted children presently in their home. If so, then they were invited to participate in the data collection process. They were informed this was completely voluntary and that they would get credit for the class regardless of their participation in the study. They were also told that if they chose to participate, their name would be entered into a drawing for a $25 gift card, to be chosen right after the data collection process. Every parent who had a foster or adoptive child in his or her home chose to participate.

Once it was decided who would participate, data collection folders were handed out to those parents. Inside each folder was a blank sticky note. They were instructed

to put their name on this sticky note and when they turned the folder in, these would be collected and placed in a box for the drawing. I verbally explained each form, including the informed consent. They were ensured confidentiality asked to choose a nickname or use initials on each form so their pre-tests could be associated with their post-tests. They were instructed to think of one foster or adopted child in their home and answer all of the questions with that particular child in mind. Finally, they were instructed to turn in their folder once the assessments were complete. In addition, participants were told there was one more bit of data collection that was needed, a Five-Minute Speech Sample (FMSS). Once all the parents had turned in their folders and completed the FMSS, I drew for the gift card. The parents really seemed to enjoy this process and the presentation of the gift card. They clapped and congratulated the winner. This entire process took an hour and fifteen minutes, when only 30-45 minutes was originally allotted. More details and outcomes of the data collection procedure are discussed below in the 'Results' section of this chapter.

Presentation and participation. The intervention mainly consisted of a presentation using a PowerPoint. Within this format, there were discussions, activities and videos. My presentation style is very interactive and open, often following the lead of the participants while keeping the overall intervention outline in mind. The material starts from a "safer" broad discussion of mentalization, using examples and activities that are relatively emotionally neutral. Throughout the workshop, the information and activities become more specific in discussing mentalization through the lens of parenting or how one was parented. The intervention was designed this way to allow the participants to warm up to the presenter and the material, without challenging them or activating their attachment system too soon. The idea was to keep the parents

within a window of tolerance so they can fully engage in the workshop without inadvertently shutting down (Allen et al., 2005). Now in truth, this dynamic was not formally assessed in any way. However, my clinical experience allowed me to subjectively determine that the progression of material worked as intended, with no signs of parents getting upset, agitated, resistant or shutting down early in the workshop. In fact, with each class, parents appeared more engaged and interested.

The first class began by trying to get to know the parents a bit by asking questions such as where they live and how long they have been a foster or adoptive parent. Then, I segued into discussing mentalization in general. The first class material consists mostly of discussions and activities about mentalization and reflective parenting. The idea is to introduce what this process entails and its' importance in mental health and creating successful relationships. One of the first and well-received activities involved having the participants look at a picture that is shadowy but clearly shows figures engaged in some sort of interaction. They were instructed to look at the picture and write a short paragraph about what is happening in this scene, describing what the characters might be thinking and feeling. The parents seemed to be very intrigued by this activity. They all participated and readily discussed their different stories about what is happening in this scene. Some parents developed elaborate stories about the scene, while some told of simple scenarios. Some parents saw sinister actions and negative emotions between the characters, while other saw loving scenes that involved positive emotions. While discussing the opaqueness of mentalization, I challenged participants to think about where their ideas came from. A lively discussion resulted with parents talking about their own personal experiences both from

childhood and adulthood. The group started developing a deeper understanding of both mentalization and of how previous relationships influence present interactions.

This idea is reinforced with another well-received activity in which a specific scenario is presented to the parents for contemplation. The scenario was "Imagine you have been dating a person for a few weeks and you really like them. Now imagine that one night you are out with your friends at a restaurant and you see this person having dinner with another man/woman and they appear happy and close." The parents are then asked what they might be thinking or feeling in this scenario, and what, if anything, might they do. They are also asked what the other person might be thinking or feeling. This activity was quite lively, brought out much laughter, and increased the energy of the class. Most parents participated and had amusing things to say. There were parents who described negative reactions from simply walking out, to confronting their date via text or by walking up to the table. Other parents had very positive, open and flexible reactions to the same scenario. The parents were amazed at all the different thoughts and feelings each other had about what might be happening. They also all wondered and discussed where these different viewpoints and reactions came from, as well as what each other's follow up behavior might be. In this scenario, I challenged the class further by revealing the following option: What if this person is actually the man/woman's sibling who has unexpectedly come to town? This is something most participants had not considered and led to more discussions about mentalization and relationships.

The second class began with a discussion of the "At-Home Activities" (See Appendix F). When asked for a show of hands of those who were able to complete at least one of the exercises (taking into account that only 14 of those 18 had children in

their home and could complete these exercises), eight of them raised their hands. When asked for volunteers to share their experiences, only three volunteered. Below is a summary of their experiences:

Parent #1:

This parent used the emotion cards, but not as the exercise dictated. She instead went through the emotion cards with her children one by one, and they were asked to guess what the person on the card was feeling. She discovered her foster children were usually wrong and were not very good at reading emotions in the faces. This provided a nice discussion for the class on why this might be so and how these exercises can be useful. This parent did complete the exercise involving reading a story with their child and stopping and asking what the characters were thinking or feeling. She said this provided rich discussion and was a fun exercise the children loved.

Parent #2:

This parent showed a movie to a group of foster teenagers in her home and used the activity where you stop the movie and talk about what the character might be thinking or feeling. She said it ended up being like a "group therapy" session that was very fruitful. The teenagers loved this activity, shared lots of insight about the characters and themselves. She said it was very bonding and they all seemed to feel a lot closer afterwards. She was very moved by the exercise.

Parent #3:

This parent said she did not use the cards so much as asked her kids what feelings they had that day. She said they reported only positive feelings and that they were happy and reported no issues. This generated a discussion on the usefulness of

play and activities for helping children access emotions. I brainstormed with the class about barriers to completing the at-home activities. Few parents responded with "I forgot" or "We had no time". I discussed with the participants the benefits of these at-home exercises and tried to secure their partnership in helping with this research (i.e. trying these out to see if they work, what doesn't work).

The third and final class also began with discussion of another set of "At-Home Activities" (See Appendix F). Only three people tried the exercises at home and the others admitted to not trying them at all. I asked for feedback about the process and activities. Participants suggested that perhaps having a separate handout of the instructions would help them remember to do the activities. Several of the parents with infants felt most of the activities did not apply to them. Of the three people that said they completed at-home activities, only one person actually tried the "Freaky Friday" exercise. The others just had examples of how they are incorporating mentalizing into their parenting. These parent's experiences are summarized below:

<u>Parent #1:</u>

She stated how her four-year-old foster daughter loved the "Freaky Friday" activity. But mainly she just wanted to tell her foster mom what to do, order her around etc. She did not have any interest in reversing the game. The class discussed possible reasons for this and attempted to mentalize mother and child. This foster parent admitted she did not complete the activity as directed, as she did not direct the child to tell her what to feel and think etc. I discussed why this was an important part of the game, and the class discussed how this game might be too advanced for a four-year-old and the parents offered ways to simplify it.

Parent #2:

This parent offered a mentalizing example with her foster child. She was very moved by her own story and it moved the class as well. She told the class how she has difficult teenagers and that she had been struggling in particular with her 17-year-old foster daughter. This child had been getting into trouble at school and issues were building so much so that this parent was considering asking for this child to leave the home. She said that one day that previous week the child had behavior problems at school and was on the verge of suspension. She was angry and fully prepared to yell at her foster child and give her a consequence when she got home. However, when the child got home, she thought about what she learned in this class about what could be behind the child's anger and behaviors and how mentalizing can help both herself and the child. She thought and wondered about what could be going on for this child. Instead of getting upset and confronting her child in an aggressive and angry manner, she instead expressed concern for her child, asking her how she felt and wondering what was going on inside of her, what thoughts she had been thinking etc. As a result, the child told her she had been very sad lately and had a plan to kill herself. She was very surprised by this response as she had no idea her foster child was experiencing such pain and sadness. As a result, she was able to get her foster child the help she needed and feels this class might have saved this child's life because she would have never really thought to do this before taking this course.

Parent #3:

This parent gave an example of using mentalization with his four-year-old foster child. The child was beginning to tantrum, which was making him angry and frustrated. Instead of reacting right away, he paused and got down on the child's level and started

asking, guessing as to what his child might be feeling, and thinking. As a result, the child quickly calmed down and did not escalate into a full-blown tantrum as usual. This parent was shocked by this result and was impressed that mentalizing can directly impact his child's behavior.

After the third and final class, many of the parents came up to me to ask questions, shake my hand and thank me for the workshop. Most participants appeared genuinely grateful and enthusiastic about what they had learned. Every class was a very positive experience for me, and the parents' verbal and written responses and feedback implied that this intervention had truly made a difference in these parents' lives.

Challenges. One of challenges with these classes was covering all of the material. Part of the intervention includes encouraging discussion, questions and participation, as this is an important part of learning and an essential to mentalizing. As a result, the timing (and amount) of what is presented is not always predictable. I found that sometimes the pacing and presentation of the material needed to be adapted in the moment to accommodate the longer fruitful discussions or moments of mentalizing. There are times when certain parts of the training needed to be cut due to time issues. It seemed prudent to ensure the bits cut would be ancillary pieces (like the didactic videos) and not the core activities or material on mentalization or reflective parenting.

Another challenge that was even more significant arose regarding the "At-Home Activities". One reason the classes are spread out is to allow time for the parents to have experiences practicing mentalizing at home, with their children. These activities were designed to reinforce these concepts and give the parents an experience of using these techniques and ideas with "real-world" interactions with their foster or adoptive

child. The challenge was getting the parents to actually try these activities at home. Most of the parents did not do the activities at all. When questioned, they gave reasons such as "we didn't have time" and they "forgot." It seems that these activities are thought of as "extra work" that they do not have time to attempt. Most of these parents work full-time and have limited time with the children in the evenings. The children usually have either extra-curricular activities or appointments such as biological parent visitations or counseling, so these activities involve a change to their routine that might have been perceived as stressful or too time consuming.

Results

Participant response. Parents were excited about participating in this workshop and as a result, the maximum amount of parents signed up for this class. In fact, too many parents showed to the first class. These extra parents had not signed up for the class and had to be moved to the next workshop, as there was no more physical space to accommodate them in the training room. During the first class, participants handled the data collection process quite well. They did not seem overwhelmed or frustrated by the amount of data collected and said as much verbally. They provided verbal feedback that they enjoyed the chance to win the gift card and earn training hours. Throughout the class, many of the parents participated enthusiastically in the discussions and activities. Their responses, stories and feedback indicate they not only found the information in the workshop useful, but they often saw the benefits with their children. After each class, many participants expressed how much they enjoyed the class and that they were looking forward to the next class. This appeared to be genuine as the return rate for both the second and third classes was 90%.

Although the parents participated in class activities and discussions proactively and with enthusiasm, this was not entirely the case regarding the at-home activities assigned to them after the first and second classes. At the beginning of the second class, when asked who completed at least one of the exercises (taking into account that only 14 of the 18 parents had children in their home and could complete these exercises) only five (35%) indicated they attempted the activities. When asked for volunteers to share their experiences, only three parents offered to share with the class. All three of these parents had very positive experiences with the exercises and shared their stories of what activities they used and how both the child and parent responded. This provided rich material for discussion. When the parents were asked the same question at the beginning of the third class, only three (21%) parents reported that they attempted any of the activities. These three parents shared their experiences, but it turned out only one of them actually completed the at-home activities as described in the intervention. The other two parents reported that based on what they learned from the first two classes, they found themselves trying "mentalization" in their homes and being reflective with their children. Their stories were quite moving and powerful, providing excellent examples of reflective parenting. Given the lack of participation in the at-home activities throughout the workshop, during the last class I questioned the parents about the issues or barriers to attempting these activities. Most parents reported they lacked the time to complete these exercises at home, or they simply forgot. They offered suggestions for increasing participation, which are included in the upcoming section on changes to the intervention.

At the end of the third class, the participants were asked to complete an overall evaluation of the entire workshop that was developed by me (see Appendix L).

Respondents were asked to rate a series of questions on 5-point Likert scale, with 1= "Strongly Agree", 2 ="Agree", 3 ="Neutral", 4 ="Disagree" and 5 ="Strongly Disagree." Data regarding the quality of material and training is outlined in Table 2.

Table 1

Pilot Evaluation

Question	*Mean*	***SD***
The training met my expectations.	1.69	.72
I will be able to apply the knowledge I learned.	1.69	1.07
The content was organized and easy to follow.	1.62	.62
The content was understandable.	1.62	.49
The trainer was knowledgeable.	1.31	.46
The quality of instruction was good.	1.46	.50
Class participation and interaction were encouraged.	1.38	.62
Adequate time was provided for questions and discussion.	1.38	.49
I found the at-home exercises interesting and useful.	2.45	1.16

Note: Items range from 1 to 5, with 1 representing highest/greatest level. N=13

Mean scores as well as standard deviation were calculated for each question. Out of the 14 parents who attended the third class, 13 (93%) completed this evaluation. Overall, results indicate participants felt highly about all aspects of the training. Most of the questions had mean ratings between "Strongly Agree" and "Agree." The only question that had a lower score was unsurprisingly about the at-home activities. The mean score

for this question (*M*=2.45) trended towards the positive side of neutral. Clearly these parents were not quite sure they found these activities were interesting and useful. Parents were also asked if they attempted any of the at-home exercises. Four of the thirteen (31%) reported they had not. When asked to list out reasons for non-participation, most of the responses revolved around not having kids placed in their homes yet or that the exercises did not apply to the age of their children because they were infants.

An additional question was included that used a different Likert scale, which is why this data is not included within Table 2. The question was "How would you rate the training overall?" and the respondents were asked to answer using a 5-point Likert scale with 1 representing "Excellent" to 5 indicating "Very Poor". Mean scoring for this question resulted in *M*=1.23, *SD*=.42. This indicates parents thought very highly of the intervention overall.

Participants were also invited to provide comments on how the intervention could be improved, or to provide overall feedback. A selection of these comments are provided below:

"No improvement needed; course should go deeper in behavior."

"Outstanding session!"

"This training has opened my eyes to fear/the faces behind fear. I realize that anger is not all that there is - it's fear. Learning and understanding my children's thoughts, feelings and desires and needs/ I have learned so much from this class."

"The training was very informative. It caused me to think about various behaviors and how to handle them. The training also explained the progression of age point, which was very interesting."

"More activities and videos."

"Role playing exercises to understand the 'at home' exercises."

"I enjoyed the class and was very surprised by how informative it was. I learned so much and would recommend to others to take."

"More emphasis on 0-4 kids; more time to talk through specific issues families are having."

"Since I have an infant the material did not apply easily. I wish the class would have been promoted for older kids. I was needing help with a baby so the class was a little frustrating. Training was excellent & can be used if I ever have older kids. I love your relaxed teaching style & would love to take any future training that applied to babies. Maybe more games for 0-4 w/ the homework. Third session was very helpful & tied everything together!"

Data collection procedure. In preparation for the collection of data on multiple measures with up to 20 participants, I decided to place all assessments and forms inside individual folders for each participant. Each initial data collection folder would contain an Informed Consent form (see Appendix G), a pre Demographics form (see Appendix H), a Strengths and Difficulties Questionnaire (SDQ; see Appendix I), a Parenting Stress Index – Short Form (PSI-SF; see Appendix J), and a Parental Reflective Functioning Questionnaire (PRFQ; see Appendix K). When the participants were finished filling out the documents, they would return the entire folder to the researcher so it would be easier to collect and track the data. Also, for this study 15 inexpensive voice recorders were purchased for the Five-Minute Speech Sample (FMSS). These voice recorders are small "thumb drives", also known as USB sticks, that could record up to 1 hour of voice data and are operated via a small on/off switch. They were chosen for being inexpensive, simple to use and because the recordings could be easily downloaded to a computer. The recorders were charged by plugging them into a USB port. All of the recorders were tested prior to data collection and were verified as properly working.

The process of data collection began with an explanation of the study and assurances of confidentiality. It was explained to the participants that the process was

voluntary and that if they completed the data collection, their name would be placed in a drawing for the chance to win a $25 gift card. Within their data collection folder was a blank Post-It note and participants were instructed to write their initials so they could be added to the drawing for the gift card once they turned in their folder. Participants were also given instructions for each of the forms in their folders were told to list either their initials or a nickname on the top of each form so the researcher could track their pre and post assessments. The process of the FMSS was also explained to the participants. This process entailed talking about their child into a recorder while they were alone and had privacy. The researcher decided that due to the large number of participants and small number of private areas, only five participants at a time could complete the FMSS.

Folders were handed out and then the researcher asked for five volunteers to complete the FMSS first. Only a few people volunteered. These first three volunteers were pulled out the class and instructed in the hallway. The verbal instructions included how to use the recorder and what to talk about in the recording. The prompt was "tell me about your child; talk about your child for five minutes." It took several minutes to train everyone on how to use the recorders and a few of the recorders did not appear to be working and needed to be switched out for other recorders. The participants were directed to different rooms within the building or outside for privacy while recording the FMSS. When they were finished, they handed the recorder to the researcher and went back into the main classroom to complete their paper assessments. After the first few participants had completed the FMSS process, the researcher asked for more volunteers; only 2-3 parents at a time would volunteer. As a result, this part of the data collection took longer than expected. In addition, two people

who had children did not want to participate in the FMSS. Once everyone else completed the FMSS and turned in their folders, the raffle was held for the $25 gift card. The gift card was given to the winner and then the intervention began.

At the end of the third and final class, participants were asked to complete "post" assessments. As in the initial data collection procedure, individual folders were created for the participants prior to this final class. These "post" folders contained a Workshop Evaluation form, as well as copies of the SDQ, PSI-SF and the PRFQ. As with the initial data collection, when each participant who wished to complete the forms turned their folder in to the researcher, their name was entered into the drawing for another $25 gift card. Due to the chaotic nature of the initial data collection process surrounding the FMSS, for this second data collection this researcher decided to simply ask just five people to follow her out into the lobby to begin the FMSS process. This worked well as no one objected and agreed to participate in the FMSS using this method. Due to the failure of some of the USB recorders during the initial data collection procedure, a variety of other types of voice recorders (that could be gathered on short notice) were used for this post data collection process. These recorders included some digital voice recorders as well as some cellular phones that included a voice recorder feature (i.e. IPhones). The same instructions about the FMSS were given to the participants, however each participant had to be shown how to work their individual recorders. After these initial five participants completed their FMSS, the researcher asked five more participants to complete the FMSS. This was repeated until all of the participants completed the FMSS. Once all the folders were turned in, the researcher held the drawing and the winner was given a $25 gift card.

There were a variety of issues that arose during the data collection procedure that will be described in detail. Most of these concerned the FMSS process. First, because each FMSS participant needed a private area or space for their recording, these recordings could not all be completed at the same time due to the limits of physical space. This provided both a logistical and time issue during the data collection process. It also took much longer than necessary to complete this portion of the data collection due to the process of asking for volunteers during the initial data collection procedure. Participants seemed hesitant and only a few at a time would volunteer. Also, the researcher continually interrupted the others who were filling out the paper assessments to ask for more volunteers. Thus, the process for the FMSS appeared confusing and chaotic and was overall inefficient. For the post FMSS procedure, the researcher decided to simply choose and ask five participants at a time to leave the room and participate in the FMSS. This method worked very well as no one objected and the FMSS was completed in less time the second time around.

The second significant data collection issue revolved around the voice recorders themselves. The first set of voice recorders, the USB sticks, seemed to work inconsistently or not at all. The researcher discovered after the first data collection process that some of the recorders did not record anything at all. In addition, they all had small lights that would go out after a few minutes of being "on", which confused participants who thought maybe the recorder was off. Some participants either switched the recorder to the off position by mistake or frequently came back to ask questions about the recorder. For the second post data collection procedure, the researcher had to gather a variety of voice recorders on short notice due to the malfunctioning USB recorders. As a result, the participants were not able to use the

same type of recorder for the post FMSS data collection. Some of these recorders were not easy to use for the participants. Some participants complained that they could not tell if the recorder was on, or that the recorders had readouts that were too small and thus they could not read the time display. Some participants did not have a watch or became confused about the time and only gave a speech sample that was 2-3 minutes long instead of the five minutes that was needed and required. Participants frequently came back to ask technical questions about these different recorders because of these issues.

A third issue arose regarding the verbal prompt for the FMSS. It seemed too vague for the participants as they had a difficult time understanding what the researcher wanted them to speak about. Participants had to ask the researcher several times, what she meant by the prompt and for more details about what to say in the FMSS. They often forgot the verbal prompt, which was evidenced by the content the recordings themselves (statements in the recordings such as "what was I supposed to talk about?") and the fact that most of them only managed to speak for 2-3 minutes, instead of the required five minutes. In addition, it was quite common for participants to stop somewhere in the middle of their FMSS and return to ask the researcher to repeat the prompt and instructions.

The folder procedure for the distribution and collection of paper assessments appeared to work very well. These individual folders kept all the forms and data organized and the procedure seemed simple and efficient for the participants, as evidenced by the ease and accuracy of survey completion as well as the lack of questions. It was proved convenient, as it was common for participants to forget to place their nickname or initials on all the forms on their folder and thus it was easy for

the researcher to identify these forms since the same participant's forms were in one folder. Regarding the individual paper assessments, most were filled out correctly but an issue arose for the SDQ. Those parents who had children younger than 4 years old had to skip the SDQ, as it is not designed to assess babies and toddlers. Unfortunately, there were a high number (25%) of parents who only had children under the age of four, thus they could not complete this assessment at all. In addition, to save paper, all of the forms and assessments were double-sided. However as a result, some of the participants did not turn various assessments over to complete the other side. One final issue regarding the data collection procedure was the amount of time the process entailed. Due to the amount of forms and the unwieldy FMSS procedure, the initial data collection took an hour and fifteen minutes of the first training class. It was estimated to only take 30-45 minutes and thus some of the first class material was not covered (but was moved to the second class instead).

Discussion

Overall, the pilot was a success with a large number of participants who agreed to have their data collected and positive responses from the participants regarding the intervention itself. The intervention material appeared to contain clear and useful information, and was presented at a pace appropriate for the audience. Changes to the intervention material did not seem necessary based on feedback from this pilot. However, during the pilot, technical problems and issues with processes arose. These findings, as well as changes made as a result are summarized below.

Starting with recruitment, a number of parents attended who either did not have any child in their home, or only had infants. Additionally, some parents showed up to the intervention without indicating they were attending. This intervention requires

parents who have children in their home, preferably older than 4 years, and that the researcher knows exactly how many will attend. These issues are mainly due to inaccurate screening and recruitment.

During the intervention, a significant number of parents did not participate in the at-home activities, which are an important part of the intervention as they are designed to increase participants' mentalization skills. When parents were debriefed about the reasons for their lack of participation, some of the reasons included lack of clarity and time. Adding clarification tools and incentives should help remedy some of these issues.

Finally, the most significant issues arose around data collection during the FMSS. Multiple technical issues ensued, including participants not understanding the equipment or not being able to track their time. In addition, the process was too time consuming and confusing, and the participants often forgot what they were supposed to discuss during their FMSS. The process would still need to include having a small number (3-5) of parents completing the FMSS at the same time, in batches as it were, due to space issues. However, the equipment, process and instructions needed to be streamlined and improved. The only other data collection issue arose when some of the participants did not turn over some of the assessments to complete the backside. This resulted in some missing data. After analyzing these findings as well as feedback from participants, the following changes were made to the pilot.

Intervention changes.

Screening

1. Participants will be screened more rigorously, and only those who have at least one child placed in their home, with one that is at least 4 years of age will be permitted to attend.
2. A strict "cap" on class size will be implemented based on the location and only those who provide an RSVP will be allowed to attend.

At-Home Activities

1. An incentive will be offered for completing the at-home mentalizing activities: Extra training credit can be earned and a certificate received for each activity completed.
2. New and separate "At-Home Activities" handouts with clear and easy to read instructions were created and will be distributed to each participant at each class (see Appendix M).
3. A new activity will be created that can be applied to infants and toddlers (see Appendix M).
4. During the intervention, the at-home activities will be described more thoroughly and demonstrated for participants.

Data Collection

1. The process for the FMSS was changed to be more efficient and organized. Initially, 3-5 participants will be chosen at random and asked to leave the room to complete the FMSS. The rest of the class will be instructed up front than when they complete and turn in their data collection folder, they will be asked to leave the room to provide a FMSS. Since everyone completes the forms at a different pace, the researcher will most likely only need to deal with one participant at a time after the initial group.
2. The FMSS prompt was changed to give the participant plenty of guidance and topics to speak about. Based on similar questions contained in the PDI, the prompt was changed to:

   "What is your child like? How do you feel about your child? Tell me about a problem you had recently with your child and how you dealt with it."
3. In addition, a simple FMSS written instruction sheet with color texts and graphics was created to assist the participant in remembering the prompts (see Appendix N). When the equipment is handed out, each participant will receive this instruction sheet to take with them.
4. Due to the technical issues with voice recorders, four of the same high quality digital voice recorders were newly purchased. These recorders are reliable, have large buttons and are very easy to operate.
5. Due to participants not being able to time themselves properly during the FMSS, digital kitchen timers that had very large numbers and buttons were purchased to participants in speaking for the full five-minutes. The new plan will be to

hand each participant a new voice recorder, timer and instruction sheet during the FMSS procedure.

6. For all of the double-sided assessments, the word “OVER” was added to the bottom to remind participants there are additional questions on the back of the form.

Chapter 6 - The Feasibility Study for a Phase III Trial

The results of the pilot were sufficiently encouraging to suggest undertaking a larger investigation to evaluate the mentalization focused supportive program for foster parents. The aim of this larger trial was primarily one of feasibility. Before undertaking more systematic randomized controlled trial, it is necessary to establish if the program is suitable for evaluation. Prior to full-scale phase III trials, two other types of investigations are required (see Craig, Dieppe, Macintyre, Michie, & Nazareth, 2008). Phase I trials are always non-randomized studies to ensure that the intervention can be delivered safely without causing harm or being rejected by participants. The Pilot study reported in Chapter 5 can be considered an adequate Phase I trial for this intervention. Craig and team (2008) suggest that Phase II trials are required to provide preliminary evidence on the clinical value of an intervention. Phase II trials may or may not be randomized. They prepare the ground (the platform) for Phase III trials, which are invariably based on substantial random assignment of participants to treatment arms, allow the comparison of two intervention strategies, and provide definitive information on efficacy and safety. Phase IV trials, are non-randomized surveillance studies to document experiences of how well an intervention is working in the field.

The reasons for undertaking a Phase II study in relation to this intervention can be considered under several headings of process, resources, management and scientific. The process reasons for undertaking this feasibility study were to ensure that steps that needed to be taken as part of a Phase III study in terms of achieving a certain rate of recruitment of foster parents and their retention in the evaluation and intervention protocol were sufficient to encourage the implementation of a large scale study (Van

Teijlingen & Rennie, 2001). A Phase II investigation was also needed to anticipate time and budget problems that could be encountered by a Phase III study. The Phase III trial would require information on such things as the length of time it might take to fill out all the survey forms or if postal or in-person completion if required. A Phase II study of this intervention will also yield important information on the management of the trial in terms of personnel and data handling optimization. Finally, and most centrally to this study, there is considerable scientific yield from feasibility studies including an evaluation of the length of the intervention, an estimation of treatment effect and its variance.

The scientific purpose of this study was then to establish if the specially designed mentalizing parental intervention (the experimental arm of a trial) is superior to the control arm, on the primary outcome and to examine if delivering this psychoeducational mentalization-based intervention to foster parents will increase their mentalization capacities and through this, lower their perceived stress around parenting and positively impact their children's behavior. As we know that an intervention is likely to have positive effects just because participants feel attended to (also known as the much researched Hawthorne effect; (S. Jones, 1992; McCarney, Warner, & Iliffe, 2007), in this study we adopted a comparison group approach. We matched two types of interventions for length and intensity. We wanted to establish if the mentalizing-based psychoeducation program had a greater impact on foster parenting than a psychoeducation intervention which included information concerning child behavior and appropriate parent training based on attachment and social learning theory, but had little information about social cognition and none about mentalizing (see Appendix N for content outline; Adkins, 2010).

This trial implemented the findings from the pilot study. The intervention program was modified in the following ways in the light of the pilot investigation. The screening process, at-home activities and data collection procedure were areas changed in response to the pilot. For the screening process, we added that not only did participants have to have at least one foster or adoptive child in their home, but they needed at least one child to be at least 4 years or older. This was to ensure the parents could not only complete the appropriate surveys, but also so they could make use of the at-home activities. Due to the under responsiveness of the parents to the at-home activities, several adjustments to this procedure were made. An incentive was added as well as detailed instructions in the form of a handout. Finally, the activities were to be described more in the class with demonstrations or examples. With regards to the data collection process, the changes made centered on the FMSS and the accompanying procedure. Because parents had a difficult time with the original open-ended prompt, a more detailed prompt was created that was more directive. Additionally, detailed instructions were provided in the form of an easy to read handout. Due to technical issues, higher quality and easier to use voice recorders were obtained as well as large digital timers for self-timing of the procedure. Details of all these changes are explained in detail at the end of Chapter 5.

We had the following hypotheses for the study. We expected that if the mentalization focused parenting training was effective, then parental reflective function would improve more in the experimental than the comparison group. We further predicted that parenting stress would decrease more for foster parents in the experimental than comparison group. Furthermore, we expected that parents'

perception of mental health problems in the child would decrease more in the mentalization focused foster parent education than the comparison condition.

Methods and Procedure

Design. The overall design of this study is an experimental comparison group design where participants were recruited to one of two treatment conditions. The first treatment condition involved the participants receiving the intervention designed for this study. The second treatment condition can best be described as "treatment as usual" and is referred to as the comparison group. This comparison group received a standard psychoeducational class that any foster parent in the same area might receive. In this case, the comparison group received psychoeducational material that consisted of information on attachment, trauma and behavior of foster children but did not include any information or experiential exercises related to mentalization (see Appendix O for content outline; Adkins, 2010).

Both groups were assessed in a pre-posttest design, once at the beginning and again at completion. As the groups would be drawn from parents who were due to receive foster parent training, it was anticipated that there could be differences between the groups in terms of average values of demographic parameters that may well require statistical control. It was predicted that the intervention group would change more between the two time periods than the comparison group. Specifically, it was hypothesized that the intervention group would increase their mentalization skills and lower their parenting stress more so than the comparison group. Additionally, it was hypothesized that if the intensity or amount of behavior issues of participants'

children in the intervention group would show more of a reduction than the comparison group.

Recruitment and sample. Participants for the intervention and comparison group were recruited from the Central Texas area using CPAs as well as the Child Protective Services (CPS), the state authority for foster care children. Staff at the various agencies were contacted via email and phone and were asked for their participation and cooperation in helping with this study. For the intervention, a flyer and email were created to help recruit foster parents (see Appendix E), each of which described the intervention, which was titled "Reflective Parenting: How to strengthen your relationship while helping your child cope." These documents described the workshop details, as well as the potential benefits of attendance, which included learning opportunities and the earning of official training hours. In addition, these documents mentioned this workshop as being part of a research study and that data would be collected only from those foster parents who wished to participate in this process. They also stated that those who did choose to participate would be entered into a drawing for a $25 gift card and receive training hours that counted towards their yearly requirement. Participants were recruited via email, printed materials, agency websites and in person when staff interacted with foster parents directly. For convenience and consistency, classes for both the intervention and comparison groups were held at CPS offices. Requirements for participation in the intervention group were that the parent was licensed as a foster parent for the state of Texas and have at least one foster or adopted child placed in their home that was at least four years of age.

The comparison group also consisted of licensed foster parents. However, because this group was designed to reflect "treatment as usual", that is, a typical foster

parent class, we could not mandate whether the foster parents who attended had children presently placed in their home. To recruit for this group, a class was offered that would count towards the required yearly training hours in behavior management. This class was also advertised as containing information on trauma and attachment and was given the title "Parenting the Traumatized Child: Understanding and Navigating Behaviors" (Adkins, 2010). This class (as well as the intervention workshop) was advertised as being given by this author, who is a popular and well-liked foster parent trainer. When foster parents attended this comparison group class, they were then recruited to participate in the data collection if they had at least one foster or adopted child placed in their home that was four years or older. They were offered the same incentives as the intervention group.

Power calculations were not performed prior to recruitment. Thabane et al. (2010) team recommend that sample size calculations may not be required for all Phase II studies as one of the aims of undertaking such studies is commonly to establish the sample size necessary for a Phase III trial. It is important that the sample for a Phase II study be representative of the target study population for the Phase III investigations and that the same inclusion/exclusion criteria be applied to both. In this investigation we followed the recommendation by Thabane et al. and ensured that the sample was large enough to provide useful information about the aspects that are being assessed for feasibility (Thabane et al., 2010).

Participants totaled 102 foster parents (64 mothers and 48 fathers) and were split almost evenly between groups with 54 completing the intervention and 48 participating in the comparison group class. Basic sociodemographic variables of these foster parents are displayed in Table 3. Parents ranged in age from 24 to 71 years (*M* =

44.27, *SD* = 10.60) and had been a foster parent anywhere from 1 month to 24 years with an average of just over 3 years (*M* = 37.70, *SD* = 48.29). This was a fairly well educated group of parents with the majority (84%) having at least some college education. Most parents reported their ethnicity as Caucasian (61%), with another 18% declaring Black and 15% Hispanic. The *t* test and chi-square analysis did not reveal any significant differences between the intervention and comparison group on any of the variables. Further analysis was completed comparing those parents who dropped out of the intervention group with those who did not. This analysis could not include comparison group parents, as there was only one class held for this group and thus no opportunity for them to not return. On most of the variables, there were no significant differences between completers and non-completers. The only significant difference arose when analyzing ethnicity ($X^2(4, N = 54) = 12.43$, $p < .02$) due to Hispanic parents dropping out of the intervention. This is most likely a chance observation (given the number of comparisons made) and the sample is too small to permit further exploration of this idiosyncratic observation.

Foster children of all the foster parents totaled 164 and again were split evenly between the intervention and comparison group (83 and 81 respectively). Basic sociodemographic variables of these children can be seen in Table 4. Children (57% female and 43% male) ranged in age from 2 months to 18 years with a mean age of about 6.5 years (*M* = 78.79 months, *SD* = 54.54 months). They have spent anywhere from 1 month to 17 years in foster care with an average of 19 months (*SD* = 26.8). CPS service level indicates the amount of emotional or behavioral problems a child might exhibit. Texas Department of Protective and Regulatory Services (Child Protective Services) has set service levels that determine foster home compensation and level of

services each child receives. When a child enters care, they are given a service level designation and these are reviewed every 90 days while in care. These levels are called "Basic", "Moderate" and "Specialized" ("Service Levels," n.d.). A child with a basic designation is one who displays typical and developmentally appropriate behaviors, emotions and difficulties. A moderate level child is one who needs more guidance and supervision than usual due to having increased problems in one or more areas of functioning. Moderate level children might be physically aggressive, self-injurious or have substance abuse issues. When a child is given a specialized designation, this implies they have severe problems in one or more areas of functioning and need a heightened level of supervision and services. These children might be violent or unusually withdrawn. They might display suicidal behaviors and have severe emotional issues. The majority (84%) of these children were designated at the basic service level, meaning they had fairly developmentally appropriate behaviors and issues. Only 3% were at the specialized level and there were no differences between the intervention and comparison groups in relation to this variable.

The *t* test and chi-square analysis did not reveal any significant differences between the intervention and comparison group on most of the child variables. The only difference to emerge was time in foster care, with the children in the intervention group spending significantly less time in care than the comparison group ($t(135) = 3.06$, $p < .01$). Further analysis was completed comparing the children of parents who dropped out of the intervention group with those children of parents who completed the intervention. Again, on most child variables there was no difference between groups. However, there was a significant difference between the groups in regards to

Table 2

Comparison of Groups on Parent Sociodemographic Variables at Baseline

	Total Parents (*N* = 102)		Intervention Group (*n* = 54)		Comparison Group (*n* = 48)		Dropped Out Parents† (*n* = 11)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Parent age (years)	44.37	10.60	44.69	10.62	44.00	10.69	46.26	11.30
Time as FP (months)	37.70	48.29	34.91	49.86	40.98	46.72	32.36	44.06
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Gender								
Male	38	37.3	21	38.9	17	35.4	5	45.5
Female	64	62.7	33	61.1	31	64.6	6	54.5
Education								
Some HS	2	2.0	1	1.9	1	2.2	0	0.0
HS degree	14	14.2	6	11.3	8	17.8	1	9.1
Some college	37	37.8	21	39.6	16	35.6	6	54.5
College grad	37	37.8	21	39.6	16	35.6	4	36.4
Grad degree	8	8.2	4	7.5	4	8.8	0	0.0
Ethnicity								
Caucasian	62	60.8	33	61.1	29	60.4	5	45.5
Black	18	17.7	10	18.5	8	16.6	5	45.5
Hispanic	15	14.7	8	14.8	7	14.6	0*	0.0
Asian	3	2.9	1	1.9	2	4.2	1	9.0
Native Am.	1	1.0	0	0.0	1	2.1	0	0.0
Multi-ethnic	3	2.9	2	3.7	1	2.1	0	0.0

Note: FP, Foster Parent; HS, High School.
† Dropped out families only came from the Intervention group
*$p < .05$

Table 3

Comparison of Groups on Child Sociodemographic Variables at Baseline

	Total Children (*N* = 164)		Intervention Group (*n* = 83)		Comparison Group (*n* = 81)		Children of Dropped Out Parents† (*n* = 23)	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Child age (months)	78.79	54.54	84.29	57.33	73.06	51.24	111.26*	59.79
Time in FC (months)	18.85	26.80	12.84*	16.56	26.57	34.57	7.64	6.46
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Gender								
Male	71	43.3	38	45.8	33	40.7	10	43.5
Female	93	56.7	45	54.2	48	59.3	13	56.5
CPS Level	130		75		56		22	
Basic	109	83.8	63	85.1	46	82.1	20	91.0
Moderate	17	13.1	9	12.2	8	14.3	1	4.5
Specialized	4	3.1	2	2.7	2	3.6	1	4.5

Note: FC, Foster Care; CPS, Child Protective Services.
† Dropped out families only came from the Intervention group
*$p < .05$

age of the children, with children of parents who dropped out of the intervention being significantly older than the children of parents who did not drop out ($t(81) = -2.75$, $p < .01$). It could be that these parents failed to complete the intervention due to the fact that older children tend to participate in more extracurricular activities in the evenings and on the weekends, when the intervention classes were held. Similarly, it is possible that the intervention felt more relevant to foster parents of younger children. This issue will be picked up again in the discussion of findings from this study.

Delivery and Data Collection Procedure

Preparation. Before the first class, folders for each participant were prepared that contained a hard copy of the presentation materials, as well as copies of the informed consent and data collection instruments. The pilot study revealed these folders to be an invaluable part of the data collection process as it provided an efficient and organized way to keep track of the multiple documents and assessments needed for this study. Because part of the data collection involved obtaining a speech sample, it was necessary to test each recorder to ensure functionality. This became an important task due to the technical difficulties of the equipment during the pilot. Other materials needed were sign-in sheets, certificates of completion, and $25 gift cards for the drawing, which was compensation for participation in the research study. Before each class began, I would arrive at the venue 30 minutes ahead of time so as to set up the computer and projector and prepare the materials for distribution. As participants arrived, I greeted them and asked them to list all their contact information on the sign-in sheet.

Data collection. It was discovered during this pilot that it was common for a number of participants to be late. Several reasons for this include that it is a free class, so there is no investment, and because these are foster or adoptive parents who are often juggling work and caring for their children. Although the intervention was held on the days and times preferred by this population, they still often showed late for class. Because of this, the author had to make sure to allow at least 15 minutes past the start time for participants to arrive. These classes are designed to be small (15 or less) so as to maximize interaction and to make data collection more feasible. Because every participant was a vital part of this study, it was necessary to wait for each to arrive

before beginning the intervention. However, this "waiting" allowed for casual conversations that helped facilitate class cohesion.

Once all of the participants had arrived, the author introduced herself and the study. As a secondary vetting process, it was necessary to ask the parents if they had any foster or adopted children presently in their home. If so, then they were invited to participate in the data collection process. They were informed this was completely voluntary and that they would get credit for the class regardless of their participation in the study. They were also told that if they chose to participate, their name would be entered into a drawing for a $25 gift card, to be chosen right after the data collection process. Every parent who had a foster or adoptive child in his or her home chose to participate.

Once it was decided who would participate, data collection folders were handed out to those parents. Inside each folder was a blank sticky note. They were instructed to put their name on this sticky note and when they turned the folder in to the author, these would be collected and placed in a box for the drawing. The author verbally explained each form, including the informed consent. They were ensured confidentiality and asked to choose a nickname or use initials on each form so their pre-tests could be associated with their post-tests. They were instructed to think of one foster or adopted child in their home and answer all of the questions with that particular child in mind. Finally, they were instructed to turn in their folder to the author once they were complete. In addition, participants were told there was one more bit of data collection that was needed, a Five-Minute Speech Sample (FMSS). Once all the parents had turned in their folders and completed the FMSS, the author drew for the gift card. The parents really seemed to enjoy this process and the presentation of

the gift card. They clapped and congratulated the winner. This entire process took an hour and fifteen minutes, when only 30-45 minutes was originally allotted. More details and outcomes of the data collection procedure is discussed below in the 'Results' section of this chapter.

Measures and Measurement Procedure

Main measures. Three different quantitative assessments and one qualitative evaluation were used at both time periods, for both the intervention and comparison group. Given that the main purpose of the intervention is to increase the mentalizing abilities of parents, two ways to measure mentalization were chosen: The Parental Reflective Functioning Questionnaire (PRFQ) and the Five-Minute Speech Sample (FMSS) coded for Reflective Functioning (RF). Presently, the only well-established measures of (parental) reflective functioning, such as the Reflective Functioning Scale (Fonagy et al., 1998), are scored on the AAI (George et al., 1985) or the PDI (Slade et al., 2004). Likewise, the Maternal Mind-Mindedness (MMM) interview is scored based on real-time commentaries of mothers when interacting with their children (Meins & Fernyhough, 2012). These measures have many advantages, such as they can provide clinically rich and detailed data that allow a thorough exploration of parental reflective functioning that is simply not achievable with questionnaires. Despite these benefits, their use in large-scale studies are hindered by the fact that they can be cost prohibitive and time intensive (Luyten, Fonagy, Lowyck, et al., 2012). The PRFQ (Luyten, Mayes, Nijssens, & Fonagy, in press) was chosen for this study because it was designed to overcome some of these barriers and provide a brief, multidimensional assessment of parental reflective functioning that is easy to

administer. However, given that interview assessments can yield rich data, it was decided to use an interview type assessment, the FMSS, and code it for RF in the style of the AAI or PDI.

Given that a significant negative outcome for foster children involves placement breakdowns due to foster parents having a difficult time managing the emotions and behaviors of children who have been traumatized, as well has handling the stress of fostering, we wanted to measure change in parenting stress and child behavior issues both prior to and following the intervention (Chamberlain, Price, Reid, & Landsverk, 2006; James, 2004; Leathers, 2006). It has also been theorized that parental reflective functioning can have a mitigating effect on parenting stress, which was demonstrated in Fonagy et al.'s 1994 study involving 200 first time mothers. The authors of this study found that high levels of RF buffered them against the effects of traumatic stress. Therefore, two more measures were chosen due to their well-established construct validity, clinical applicability and ease of use: The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) and the Parenting Stress Index – Short Form (PSI-SF; Abidin, 1995).

When the participants were finished filling out the documents, they would return the entire folder to the researcher so it would be easier to collect and track the data. Also, for this study 15 inexpensive voice recorders were purchased for the Five-Minute Speech Sample (FMSS). For both groups at time period one, all of the quantitative instruments were handed out in paper form to participants at the beginning of the class and were collected before either class began. This is also true for the qualitative measure (the FMSS). The FMSS procedure for both groups involved handing the participants a digital voice recorder, a digital timer and an instruction sheet

and were shown to a private area where they could give their speech sample before their respective classes began. Additionally, at time period one, both groups were given a demographics form to complete.

For the intervention group, the second time they were given these assessments would have been at the end of the final class, which was approximately 4-6 weeks later. The quantitative instruments were again distributed in paper form and collected in person before participants left. The procedure for collecting the speech sample at time period two was the same as time period one for the intervention group.

Because the comparison group class was structured to be given in one class session only, the second time period for their data collection would have been after their only class, but also approximately 4-6 weeks later. For the comparison group, all participants were handed a packet at the end of their class that contained an instruction sheet (see Appendix P), paper assessments and a self-addressed stamped envelope for returning the forms. This instruction sheet also included a phone number where they could leave their five-minute speech sample. They were also given verbal instructions to return these assessments (and make their speech sample call) 4-6 weeks from that point and were informed they would receive a small incentive for doing so in the form of a $10 gift card. Dates and details were also given, as well as an option to submit these assessments online. Additionally, this author used email and phone contact to remind comparison group participants and encourage the collection of this post data.

There was other data collected for the intervention group only, for the purposes of understanding and evaluating the impact of this new intervention. A standard training evaluation was given to the intervention group at time period two which included questions that elicited written feedback. Additionally, intervention

participants were given at-home exercises and activities and asked to write about their experiences and submit this material. Each of the assessments and measures used in the data collection are described in detail below.

SDQ. The Strengths and Difficulties Questionnaire (SDQ) was created in 1997 by Robert Goodman as a brief instrument for assessing the psychological adjustment of children and adolescents (Goodman, 1997). It has become a widely used and very popular instrument as evidenced by the fact that it has been translated into 40 languages, includes normative data from many countries, and can be accessed for free on the internet (Palmieri & Smith, 2007). It can be administered to parents and teachers of children aged 4-16, or taken by the children themselves if they are 11-16 years old. The SDQ contains 25 items that are split equally between five scales: Emotional Symptoms, Conduct Problems, Hyperactivity-Inattention, Peer Problems and Prosocial Behavior (Goodman, 1999). Throughout the SDQ, 10 items use strengths wording and 14 are worded as difficulties or challenges. One is neutrally worded but scored as a difficulty. Goodman (1999) created the SDQ with positive items that emphasized strengths, rather than an assessment that only focused on deficits, so that it would be more acceptable to parents and other informants. Each of the 25 items are scored on a 3-point scale with 0 = 'not true,' 1 = 'somewhat true,' and 2 = 'certainly true.' Subscale scores are summed and range from 0-10. For four of the subscales, higher scores indicate difficulties but for Prosocial Behavior, higher scores reflect strengths. In addition, a Total Difficulties score that ranges from 0-40 can be computed by summing the scores on Emotional Symptoms, Conduct Problems, Hyperactivity-Inattention and Peer Problems.

There have been many studies from a variety of countries that support the SDQ's construct validity and clinical applicability (Marzocchi, Capron, & Di Pietro, 2004; Obel, Heiervang, Rodriguez, & Heyerdahl, 2004; Woerner, Fleitlich-Bilyk, & Martinussen, 2004). It has also been significantly correlated with other well-researched assessments of childhood functioning such as the Rutter questionnaire and the Achenbach questionnaire (Achenbach, 1991; Goodman, 1997; 1999; Rutter, 1967). Goodman also found it to be able to discriminate very well between children with and without psychopathology (Goodman, 1997; 2001; Goodman, Meltzer, & Bailey, 2003). In addition, the SDQ has demonstrated that it is a sensitive measure for clinical outcomes (Mathai, Anderson, & Bourne, 2003). This research demonstrates that the SDQ has good internal consistency as well as test-retest stability.

Although previous studies suggest that the SDQ has satisfactory psychometric properties, all of these studies had limitations such as unrepresentative or small samples (Goodman, 2001). In 2001, Goodman published a study that was designed to overcome these limitations by using a nationwide representative British sample of parents, teachers and children in which all children were assigned psychiatric diagnoses. In total, SDQs were completed by 9,998 parents, 7,313 teachers, and by 3,983 11–15-year-olds. The analyses included an examination of the five-factor structure, cross-scale correlations, internal reliability and retest stability, and validity as judged against independent psychiatric diagnoses. Results confirmed and supplemented previous studies that reported satisfactory reliability and validity (Goodman, 2001). More specifically, factor analysis showed that nearly all items loaded on the predicted five factors (subscales). Additionally, results confirmed previous results that suggested the internalizing and externalizing scales of the SDQ are fairly

unspoiled by one another (Goodman & Scott, 1999). This is seen by the correlation between the internalizing and externalizing scales (.30) being about half that of the correlation between the externalizing scales by themselves. Results also indicated good reliability as judged by the internal consistency, interrater agreement and test-restest stability.

The internal consistencies were mostly satisfactory (mean 0.73), particularly for the total difficulties and total impact scores (all 0.80+). Additionally, interrater agreement was considerably better than the average agreement on other measures (Achenbach et al., 1987). Regarding test-retest reliability, usually this is measured by repeating the assessment after 1-4 weeks but for this study, it was not done until 4-6 months later. As a result, it can be assumed that changes in the scores over this long period will actually be due to changes in children's psychological adjustment as well as from measurement unreliability. Despite this, mean retest stability of 0.62 after 4 to 6 months does offer a lower bound for test-retest reliability and the genuine test-retest reliability is most likely to be substantially higher.

PRFQ. The Parental Reflective Functioning Questionnaire (PRFQ) is a brief self-report measure that is meant to assess the reflective capacities or mentalization abilities of parents (Luyten, Mayes, Nijssens, & Fonagy, in press). It is a recently developed measure designed to be an easier, less expensive and less time-consuming way to assess parental reflective functioning. It is presently the only brief self-report instrument that measures this capacity. The other way that reflective functioning (RF) is assessed is via the Reflective Functioning scale (RFS; Fonagy et al., 1998) on the Adult Attachment Interview (AAI; George et al., 1985). This same RFS has been used with the Parental Development Interview as well (PDI; Slade, Aber, Bresgi,

Berger, & Kaplan, 2004). Both the AAI and PDI necessitate time-consuming interviews that require costly and extensive training to be able to conduct. Neither are practical tools for field research. In addition, the RFS for both these measures produces a single overall score for reflective functioning. As RF is becoming more understood, it is thought to be more of a multidimensional construct (Choi-Kain & Gunderson, 2008; Fonagy & Luyten, 2009; Luyten, Fonagy, & Lowyck, 2012). The PRFQ was designed to assess RF in a number of ways and produces several sub-scores reflecting different aspects of reflective functioning. The items are scored into three subscales: Pre-Mentalizing (PM), Certainty about Mental States (CMS) and Interest and Curiosity in mental states (IC). PM describes a non-mentalizing stance or one in which the parent cannot put themselves in their child's "shoes." CMS scores reflect a parent's lack of ability to see the changing nature and flexibility of mental states, or their certainty that they know exactly what is inside their child's mind. Lastly, IC scores reveal a parent's curiosity about the inner mental world of their child.

The development and validation of the PRFQ (Luyten, et. al., in press) closely followed guidelines for the development of psychometric tests (Nunnally & Bernstein, 1994). First, items were created based on a thorough review of the relevant literature on mentalizing and social cognition (Allen et al., 2008; Bateman & Fonagy, 2004; Lieberman, 2007; Sharp & Fonagy, 2008; Sharp et al., 2008), with special attention paid to parental mentalizing. Also, items were designed according to the descriptions and examples in the reflective functioning manual for the AAI (Fonagy et al., 1998), the reflective functioning manual for the PDI (Slade et al., 2007), and the Reflective Function Rating Scale (Levy, Meehan, & Hill, 2005). This resulted in 57 items that were then rated by 20 experts, who were asked to rate each item in terms of

a "typical" high or low mentalizing mother. These experts were randomly divided into two groups of 10 and the first group rated the items while keeping a high mentalizing mother in mind and the second group with a low mentalizing mother in mind (Luyten, et. al., in press). Via the rating results and expert comments, the items appeared to successfully depict the capacity for maternal reflective functioning. After reviewing the results and taking into account additional suggestions from the experts concerning the clarity and comprehensibility of some items, the authors reduced the final set of items to 39 (Luyten, et. al., in press).

During the development of the PRFQ, the authors conducted three studies investigating its psychometric features (Luyten, et al., in press). Study 1 focused on the initial development of the PRFQ and its aims were to investigate the factor structure of the PRFQ in a sample of mothers with infants (N = 299) using exploratory principal components analysis (PCA) and confirmatory factor analysis (CFA). It also explored the relationship between the PRFQ, demographic characteristics, and distress, given that these elements may influence levels of parental reflective functioning features (Luyten, et al., in press). The last aim of study 1 was to explore the relationship between the PRFQ, adult attachment dimensions, and emotional availability of mothers, as these variables were theorized to be associated with parental reflective functioning dimensions. All mothers were given the PRFQ, the Brief Symptom Checklist (Lange & Appelo, 2007), the Experience of Close Relationships-Revised (ECR-R; Fraley et al., 2000) and the Emotional Availability –Self Report (EA-SR; Biringen et al., 2002; Vliegen et al., 2009)

Both exploratory factor analysis and CFA suggested that three theoretically meaningful factors underlie the PRFQ: pre-mentalizing modes (PM), certainty about

mental states (CMS), and interest and curiosity in mental states (IC). In this sample, CMS and IC were relatively independent of demographic features, symptoms, and attachment avoidance and anxiety. In contrast, PM was negatively correlated with level of education and working status, while positively correlated with distress, attachment anxiety and attachment avoidance. These findings correspond with what the authors describe as the "loose coupling" between parental RF and attachment, meaning that indicators of more adaptive parental reflective functioning seem to be fairly unrelated to attachment, which implies that they may be two independent factors (Allen et al., 2008). Parental RF and attachment also seem to be factors that are relatively independent of distress in this study. In contrast, maladaptive mentalizing (indicated by PM), was related to demographic features such as level of education, time spent working, distress, and insecure attachment.

This study also provided more information highlighting the relationship of emotional availability to the different PRFQ subscales. This is of particular interest because maternal sensitivity has been well researched, with many studies showing that infants of more sensitive mothers are likely to develop secure attachments, but this link has been shown to not be that strong and thus its role in attachment transmission has been questioned (DeWolff & van IJzendoorn, 1997). Likewise, findings of this study imply although they are clearly related, there is no direct corresponding relationship between emotional availability (key factor in parental sensitivity) and parental reflective functioning (Luyten, et al., in press). Specifically, the PM subscale was the most closely related to emotional availability in that it was negatively associated with all dimensions of emotional availability except for maternal intrusiveness. However, the authors of the study point out that other studies have shown that the intrusiveness

subscale of the EA-SR scale does not correlate with observer-rated intrusiveness (Vliegen et al., 2009).

Additionally, both the CMS and IC subscales were positively connected with features of emotional availability, but not as strongly as PM. Even more noteworthy, both of these subscales were also slightly positively correlated with intrusiveness. The authors conjecture that high levels of CMS and IC are maladaptive in that they may be related with intrusiveness (Luyten, et al., in press). This suggestion is in line with the postulation that being overly certain about mental states as well as being overly curious about mental states can be deleterious, as these inclinations are associated with distorted mentalizing or hypermentalizing (Allen et al., 2008; Sharp et al., 2011).

Study 2 used PCA and multi-group CFA with both mothers and fathers to research the factorial invariance of the PRFQ. The authors felt this was important because up to this point, the literature on parental reflective functioning has almost exclusively focused on mothers. Therefore they found it important to assess whether the factor structure and correlates of the PRFQ compare between mothers and fathers (Luyten, et al., in press). The sample consisted of 153 first-time parents with normally developing infants. This study also explored the relationship between the PRFQ and demographic characteristics, distress, adult attachment dimensions, and parenting stress using the same measures as Study 1.

The results of Study 2 both replicated the three-factor structure in Study 1 and provided preliminary evidence for the factorial invariance of this structure across both mothers and fathers (Luyten et al., in press). Also, given this was a high functioning and homogenous group of parents of normally developing children, relationships between the PRFQ, demographic characteristics, distress, and attachment were more

unexceptional than those in Study 1. Despite this, there were clear relationships between PRFQ variables and parenting stress. The authors felt this finding was congruent with studies of RFS that have found parental RF can serve as a protective factor against stress in mothers and fathers. For example, a research team at the Anna Freud Centre in London found that high levels of RF buffered against the effects of traumatic stress in a sample of 200 mothers and fathers (Fonagy et al., 1994). The authors of this study point out that further research is needed to replicate these findings with the PRFQ.

Study 3 investigated the relationship between the PRFQ and infant attachment as assessed by the Strange Situation Protocol (SSP; Ainsworth et al., 1978) in a sample of 136 community mothers and their infants (Luyten et al., in press). The authors expected the PRFQ scales to predict infant attachment security as assessed with the SSP. The other aim of this study was to explore the relationship between the PRFQ and three-way and four-way (adding the disorganized category) attachment classifications. Due to the small sample size, analyses were mainly exploratory. However, the authors did expect PM to be associated with all insecure attachment styles, including disorganized attachment. Additionally, they expected mothers of infants with anxious-avoidant attachment to be characterized by a combination of lower levels of IC and when compared with mothers of securely attached infants. In contrast, they expected both lower levels of IC and higher levels of CMS for mothers of infants with anxious-resistant attachment. Mothers of infants with disorganized attachment were hypothesized to have lower levels of IC and higher levels of PM.

Results were as expected with maternal PM and IC being highly significantly related to infant security of attachment (Luyten, et al., in press). The chances of having

an infant with an insecure classification were just over three times higher for mothers with high levels of PM. In contrast, the chances of having a child with a secure attachment classification were 2.64 times higher for mothers with high levels of IC. Unfortunately, CMS did not appear to predict attachment security for this sample. These results led the authors to conclude that the finding provide further support for the validity of the PRFQ. This is due to these findings validating one of the main predictions of parental reflective functioning: that the ability of parents to see inside the mind of their child is related to attachment security. The authors point out that given that attachment was assessed using the SSP in this study, and not simply based on self-report, provides even more credibility to their findings.

Overall, the results of the three preliminary studies appear to provide evidence for three subscales of mentalizing. They report that these subscales have good internal consistency (.70, .82, and .75 for PM, CMS, and IC, respectively) and were either unrelated or only minimally so, to demographic variables and parental distress. They also report findings suggest that the subscales were related (as was theoretically expected) to adult attachment dimensions, emotionally availability, infant attachment and parenting stress. Despite several limitations such as the use of self-report instruments and low risk samples, the authors feel that findings thus far provide preliminary evidence for the reliability and validity of the PRFQ as a brief multidimensional measure of parental reflective functioning (Luyten, et al., in press).

PSI-SF. The Parenting Stress Index – Short Form (PSI-SF; Abidin, 1995) is a 36-item shortened version of the 120-item PSI full version. The longer PSI was created to test a wide range of potential influences on parenting. It contains an almost equal number of parent and child focused items that cover 13 different subscales. Initial

reliability and validity of the PSI-SF supports that parenting stress is a measure that is useful across diverse populations, including inner-city, poor rural and Hispanic parents (Albdin, 1995). Overall reliability on the Child subscale was .78-.88 and .75-.87 on the Parent subscale. Reliability coefficients for these two domains and the Total Stress scale were .96 or greater, indicating a high degree of internal consistency. Test-retest reliability after one year was .70 on the Parent subscale and .55 on the Child subscale. Although a thorough model, the full PSI was thought of as too time consuming for both researchers and clinicians (Abidin, 1995). The PSI-SF was created to meet the need for a reliable yet brief screening measure for parenting stress. This shorter version was a consequence of exploratory factor analysis of the longer PSI (Castaldi, 1990; Saft, 1990). Albidin (1995) compared the PSI-SF to the full PSI and found the Total Stress scores between the two resulted in a correlation of .94 and that the PSI overall Parent Domain correlated at .92 with the PSI-SF Parental Distress. Additionally, the PSI Child Domain section correlated .87 with the PSI-SF Difficult Child subscale. He also used items pulled from both the Child and Parent domains of the PSI to create a new scale for the PSI-SF, which he called Parent-Child Dysfunctional Interaction. He was able to find a correlation of this new scale to the Child Domain of the PSI of .73 and a correlation of .50 with the Parent Domain (Abidin, 1995). Further exploratory research found that the internal consistency of the PSI-SF was comparable to the full PSI (Roggman, Moe, & Hart, 1994). Additional research has demonstrated that the PSI-SF performs very similarly to the full version of the PSI (Hutcheson & Black, 1996; Innocenti, Huh, & Boyce, 1992; Solis & Abidin, 1991).

More recent research (Reitman, Currier, & Stickle, 2002) investigated the psychometric properties of the PSI-SF using a sample of 196 mothers of young children.

Construct validity was supported through factor analysis and the researchers found internal reliability among the three scales high, with a Cronbach's alpha reaching .88 for Parental Distress, .89 for Difficult Child, .88 for Parent-Child Interaction and Total Stress yielding .95. Using a sample of 185 parents of young children, researchers (Haskett, Ahern, & Ward, 2006) found that scores on the Parental Distress subscale of the PSI-SF related significantly to the Global Severity Index scale (r=.54, p=<.001) and that scores on the Difficult Child subscale were significantly related to the Eyberg Child Behavior Inventory (r=.61, p=.001). Additionally, a portion of these parents were re-tested a year later and results indicated both predictive validity and test-retest reliability for both the Parent Distress scale (r=.61, p<.005) and the Total Stress scale (r=.61, p<.005).

The PSI-SF measures stress on a five-point Likert scale from (1) strongly agree to (5) strongly disagree. It results in a Total Stress score, as well as scores on three subscales, which are Parental Distress, Difficult Child, and Parent-Child Dysfunction Interaction. Raw scores are then converted into percentile scores with high stress scores being those that are at or above the 85th percentile (Abidin, 1995).

FMSS. The Five-Minute Speech Sample (FMSS) (Gottschalk & Gleser, 1969) was developed as a way to measure psychological states using content analysis of verbal behavior. It is a 5-minute recorded monologue in which the respondent is asked to speak about a topic for the entire five minutes, without verbal prompts from the interviewer. The most common way it has been used has been as an alternative method of measuring expressed emotion (EE), a term used to describe attitudes and feelings that a relative expressed about a patient (Magaña, Goldstein, Karno, & Miklowitz, 1986). Originally, EE was measured within the standardized interview procedure, the Camberwell Family Interview (CFI; G. W. Brown & Rutter, 1966). However, Magaña and

her team (1986) wanted to find a less cumbersome and more practical method for assessing EE than the CFI, so they created a way to code EE from a five-minute speech sample. This proved quite practical and successful and spurred other researchers and practitioners to use the FMSS in a similar way. The FMSS and the EE coding system has been used successfully with a variety of clinical populations that include schizophrenic patients (Hahlweg, Goldstein, & Nuechterlein, 1989; Magaña et al., 1986), patients with bipolar illnesses (Goldstein, Nuechterlein, & Snyder, 1988), children with attention deficit hyperactivity disorder (Marshall, Longwell, & Goldstein, 1990) and children with depressive disorder (Asarnow, Goldstein, & Tompson, 1993). It has also been a successful technique with families of clinical populations such as spouses of patients with Alzheimer's disease (Vitaliano, Russo, Young, & Teri, 1991), and families of Japanese patients with mood disorders (Shimodera, Mino, Fujita, & Izumoto, 2002). Additionally, the FMSS has been used with other coding scales to measure a variety of interpersonal traits such as "parental warmth" (Pasalich, Dadds, Hawes, & Brennan, 2011) and "parental criticism" (F. S. Wamboldt, Wamboldt, & Gavin, 1995).

For this project, the FMSS was collected from foster parents who were asked to either speak into a recorder for five minutes about their foster or adoptive child, or to call a phone number and leave a 5-minute voicemail with the same information. They were asked to speak about whatever comes to mind in response to three open-ended prompts: "What is your child like?," "How do you feel about your child?" and "Tell me about a problem you had with your child recently and how you dealt with it."

Developing of a coding system for FMSS. Given the flexibility of the FMSS and that others have successfully applied a variety of coding systems, it seemed quite likely that we could use this procedure to effectively assess mentalization of foster and adoptive

parents. An extensive review of published research appears to indicate that an RF coding scheme has not yet been applied to the FMSS. Due to this being new territory, it was thought best to use an RF coding manual (Fonagy et al., 1998) that was developed to be used with adult attachment measures, and that has already been applied successfully to both the AAI and the PDI. This coding system has been used in research studies evaluating the parent/child relationship and has been found to be reliable (Fonagy & Target, 2005; Meins & Fernyhough, 2012). This coding method assesses a parent's ability to both recognize and describe mental states as well as their ability to relate these mental states both to the behavior of themselves and their child. It employs an 11-point scale that ranges from -1 (Negative RF; the inability to understand the mental states of other) all the way to +9 (Full or Exceptional RF; the ability to converse in a dynamic and interpretive manner about their own and the other's subjective experience; Slade, 2007). A complete description of this scoring system can be found in Appendix Q. Speech samples were coded for three scales: Global RF, Parent RF and parent RF of the child (Child RF). The first significant turning point in the scoring is when a score of 4 moves to a 5, indicating the respondent has progressed from simply being able to verbalize mental states to being able to form more complex reflective statements. Having a score of less than 5 could be interpreted has having potential clinical repercussions for the parent and child. The next significant turning point is score 7, when a parent demonstrates sophisticated RF consistently throughout the speech sample. A high RF ability implies that a parent able to understand that emotions vary in intensity both within the self and during relational interactions, and that such affects are not always obvious and may trigger other emotions (Fonagy et al., 1998). An

individual who has high or exceptional RF abilities will have a well-developed internal working model of both intentions and affects (Slade, 2005).

Reliability of coding. Two MSc students at The Anna Freud Centre in London received training in order to learn RF coding and receive accreditation for being able to code RF on the PDI. In order to receive such accreditation, a student must complete a reliability test, which includes coding of 10 Parent Development Interviews. In order to pass the reliability test, one must become reliable at a level of at least 0.80 (results matching Arietta Slade's scoring at least 80% of the time). These student coders passed the reliability test and both became reliable above 0.80. Coders were blind to which time or group each speech sample belonged.

To assess Inter-Rater Reliability (IRR), 12 speech sample transcripts were randomly selected from both the intervention and comparison groups and the coding for Reflective Functioning (RF) was compared across two independent coders (see Table 5). IRR was assessed using a two-way mixed Intra-class Correlation Coefficient (ICC; McGraw & Wong, 1996) to assess the degree that the two coders provided consistency in their ratings of RF. The resulting ICC was in the excellent range, ICC = 0.85 (Cicchetti, 1994), indicating that coders had a high degree of agreement and suggesting that RF was rated similarly across the two coders. The high ICC suggests that a minimal amount of measurement error was introduced by the independent coders, and therefore statistical power for subsequent analyses is not substantially reduced.

Table 5

Inter-Rater Reliability Raw Scores

Speech Sample	*Coder 1 Global RF*	*Coder 2 Global RF*
SS 1	3	3
SS 2	6	5
SS 3	3	3
SS 4	3	3
SS 5	4	4
SS 6	3	3
SS 7	3	3
SS 8	3	4
SS 9	3	3
SS 10	5	5
SS 11	4	5
SS 12	4	4

N=12

Other measures.

Workshop evaluation. This is a post evaluation of the intervention created by myself (the researcher/instructor) and is typical of post-training type evaluations. It contains 13 questions and includes questions regarding the quality of the training, instructor and material. Additionally, questions were included for respondents to subjectively assess the impact of the intervention on their own parenting as well as their perception of their children's behavior. This evaluation has not been used before and is not standardized. On this evaluation, respondents were asked to rate the questions on 4-point Likert scale: (1) Very much, (2) Somewhat, (3) A little and (4) Not

at all. One question (to assess to the overall rating of the workshop) uses a 5-point Likert scale: (1) Excellent, (2) Good, (3) Average, (4) Poor and (5) Very Poor. Additionally, there are two statements/questions where respondents can write in their own response. These are "What aspects of the training could be improved?" and "Final Comments."

Qualitative material. There are several ways in which qualitative material was collected during this intervention. The plan is to examine this material for themes and related these to the other outcome measures provided.

Workshop evaluation comments. As mentioned above, a basic training evaluation of the intervention was distributed to foster parents at the end of the intervention. There are two questions that ask respondents to write in their answers. It is thought these comments might provide rich material for both improving the intervention and examining the impact.

At-home activities. After class one and two of the intervention, foster parents were given "At-Home Activities" to complete with their children at home, between classes. These are exercises and activities designed to help increase the parent and children's ability to mentalize, as well as help children recognize feeling states and increase the bond and connection between parent and child. Parents were asked to write up their experiences with these exercises and as an incentive, they would receive additional training hours, which count towards the annual training hours required for their foster parent licensure. These written experiences provide qualitative material that can be examined for themes and intervention impact.

Fidelity coding. To compare content and assess how the quality of the intervention compared with the comparison classes, a fidelity coding form was created

(see Appendix U). This fidelity form was based on the implementation fidelity literature (Dane & Schneider, 1998; Dusenbury, Brannigan, Falco, & Hansen, 2003; Mihalic, 2004). Based on this research and the scope of the current project, fidelity to intended content was measured in three areas: adherence, program differentiation and quality of delivery. The form contains 13 statements that are rated using a 7-point Likert scale that ranges from (1) Not at all, to (4) Somewhat, and all the way to (7) Very much. The first five statements describe the quality of the delivery, such as "The content was clearly explained." and "The presenter was engaging." The second part of the form includes statements that describe a variety of content that is included in both the intervention and the comparison class material. It is these statements that will measure both intervention adherence and program differentiation. These statements include descriptions that are more general such as "Presenter discusses attachment" to more specific statements like "Presenter focuses on the importance of parents' understanding of their own reactions/emotions." There were three specific items related to the mentalization-based program. These concerned: mentalization material, mentalizing exercises and content directed towards helping parents' understand their own emotions. Two independent raters coded 20 audio samples of 15 minutes each, taken at random from both the intervention (10) and comparison classes (10). Raters were blind to which audio samples belonged to which series of classes. Each 15-minute audio sample was chosen at random from a variety of intervention and comparison classes, after taking into account breaks in the audio where silence was recorded. The correlation between the raters was high; median r across the 13 items between the raters was 0.89 (range: 0.53 – 1.00).

Plan of Report

The main measures will be statistically analyzed and the data described in text and tables in the next chapter. This results chapter will begin with a reporting on the main measures of the study. It begins with reporting the results of analysis on the parental mentalizing measures, namely the PRFQ and the FMSS. Next, the results from the analysis of the PSI and SDQ will be discussed. The next major section of this chapter will include an analysis of the additional measures in the study, such as the training evaluation and the qualitative pieces, which will include a theme analysis on the comments from the training evaluations as well as the written experiences regarding the at-home activities. That last section of this chapter will include results from the fidelity coding of the intervention. The final chapter of this thesis will include a discussion of the meaning and impact of these results, as well as limitations of the study and next steps regarding the research.

Chapter 7 - Results

Analysis began with examining the correlations between all of the standardized measures and the demographic data. We computed change scores for all outcome variables and examined associations between these and the demographic information collected at baseline. The correlation matrix can be seen in Appendix R. There was only one demographic variable that significantly correlated with the outcome measures. Age of foster parent correlated significantly with Change in Dysfunctional Interaction on the PSI, $r = .25$, $p = \leq .05$, $n = 66$ and the Prementalizing scale on the PRFQ, $r = .21$, $p = \leq .04$, $n = 97$. Therefore, we used this variable as a covariate in further analysis. The correlation matrix also reveals some limited associations between the outcome variables. Nevertheless, in the light of the distinct domains covered by the measures, it was decided to analyze data yielded by the three instruments independently in the first instance.

Parental Mentalizing Measures

PRFQ. To test the hypothesis that parent reported reflective functioning (RF) increased more following the experimental condition than the comparison condition, we performed a 2 x 2 repeated measures one-way univariate analysis of variance (ANCOVA) on the total PRFQ scores and a two-way multivariate analysis of variance (MANCOVA) with the PRFQ sub-scales. In both these analyses, group (Comparison vs. Intervention) was an independent fixed effect and time (Baseline vs. Follow-up) was a repeated measures fixed effects factor. As there were only two time-points, Greenhouse-Geiser adjustments were not needed. As a follow up to the

MANCOVA, ANCOVAs were conducted on the same data. In all cases, we predicted a significant interaction between group and time, with greater change expected in the Intervention group. Accordingly, we further explored baseline to follow-up differences (test of simple effects) using separate paired t-tests for the comparison and intervention groups independently. PRFQ scores were centered and normalized to facilitate the interpretation of the findings. The analysis was performed on the z-scores obtained. The means of the PRFQ scores for both groups at baseline and follow-up are shown in Table 6. Raw mean scores are listed in Appendix S.

Table 6

Means and Standard Deviations of PRFQ Outcome Variables by Time and Group

	Intervention Group (n = 41)				Comparison Group (n = 27)			
Outcome	Baseline		Follow-up		Baseline		Follow-up	
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Total RF	.20	1.45	.89*	1.75	.58	1.62	.25	1.70
Prementalizing	-.16	.77	-.35*	.75	-.20	.91	-.28	.94
Certainty	.02	.99	-.37*	1.08	-.07	.96	.04	.91
Curiosity	.06	.89	.17	.92	.30	.76	.01*	.93

Note: Means are adjusted for covariate: foster parent age. PRFQ, Parent Reflective Functioning Questionnaire.
*$p < .05$

Total PRFQ analysis. Table 5 shows a slight increase in PRFQ scores in the Intervention group and a surprising slight decline in the Comparison group. The 2x2 ANCOVA showed no significant overall Group or Time effect (F (1, 65) = 0.19, *ns* and F (1, 65) = 0.06, *ns*, respectively). There was, however, a substantial Group x Time interaction (F (1, 65) = 8.86, $p < 0.004$, partial $\eta^2 = 0.12$). Figure 1 displays this interaction. While overall RF slightly decreased in the comparison group between baseline and follow-up, there was an increase in RF for the intervention group. The effect was moderate; although the increase in RF from baseline to follow-up was significant for the intervention group (t(42) = 2.98, $p = .005$) the decrease in the comparison group was not significantly different from chance (t(27) = 1.40, $p = .17$).

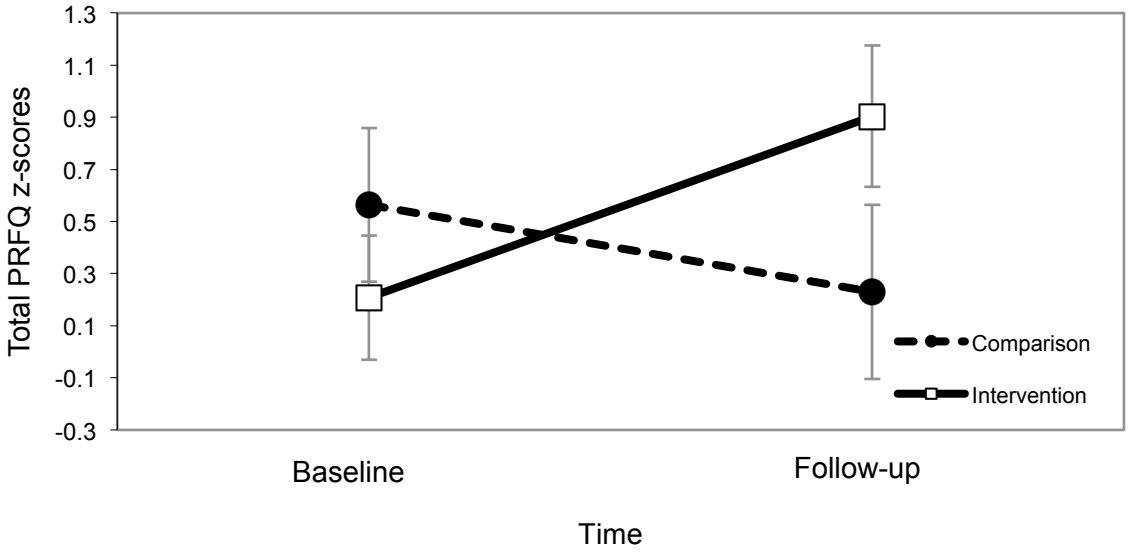


Figure 1. Interaction between Group and Time on Total RF on the PRFQ

Multivariate analysis. To explore which of the sub-scales contributed most to this interaction effect on PRFQ scores, a 2x2 MANCOVA was performed on the three sub-scales of the PRFQ (Prementalizing, unwarranted Certainty and Curiosity about mental states). In line with the univariate analysis reported above, the omnibus MANCOVA results yielded no significant Group effect, Wilks' Lambda = .993, F (3, 63) = .145, *ns*. There was also no significant effect of Time, Wilks' Lambda = .996, F (3, 63) = .088, *ns*. However, the interaction between Time and Group yielded a significant effect, Wilks' Lambda = 0.854, F (3, 63) = 3.60, $p < .02$. These results confirm that there were no differences between the group scores in general, aggregated across time points. However, those who participated in the intervention group recorded increased follow-up scores when compared with the comparison group, whose follow-up scores suggested either an unchanged or decreased RF. The effect size was a little more than moderate, $\eta_p^2 = .15$, which implies that 15.0% of the variance in PRFQ scores from baseline to follow-up was accounted for by group designation.

Univariate sub-scale score results. ANCOVA analysis on the same data performed separately on each scale revealed that the pattern of increased RF was clearest in in two of the three scales on the PRFQ, namely Certainty and Curiosity. On the Prementalizing scale, the Group and Time main effects were not significant, F (1, 65) < 1, *ns*, nor was the interaction between Group and Time, F (1, 65) <1, *ns*. Although there was no significant interaction, the decrease in Prementalizing in the comparison group was negligible (t(27) = 0.58, *ns*), yet the decrease of Prementalizing in the intervention group was significant on a paired t-test (t(42) = 1.70, p = .05 (one-tailed)) suggesting that this scale may also have been somewhat sensitive to the intervention.

On the Certainty scale, there was also no Group or Time main effect, F (1, 65) < 1, *ns,* but the interaction between Group and Time was significant F (1, 65) = 5.1, p < .03. This interaction is shown in Figure 2. As the figure illustrates, Certainty increased slightly in the comparison group between baseline and follow-up whilst it significantly decreased in the intervention group. The effect size was small but bordered on moderate, $\eta_p^2 = .07$. The baseline to follow-up increase in Certainty in the comparison group was not statistically significant (t(27) = 1.10, p = .28) but the decrease in the intervention group was above chance level (t(42) = 2.32, p = .026).

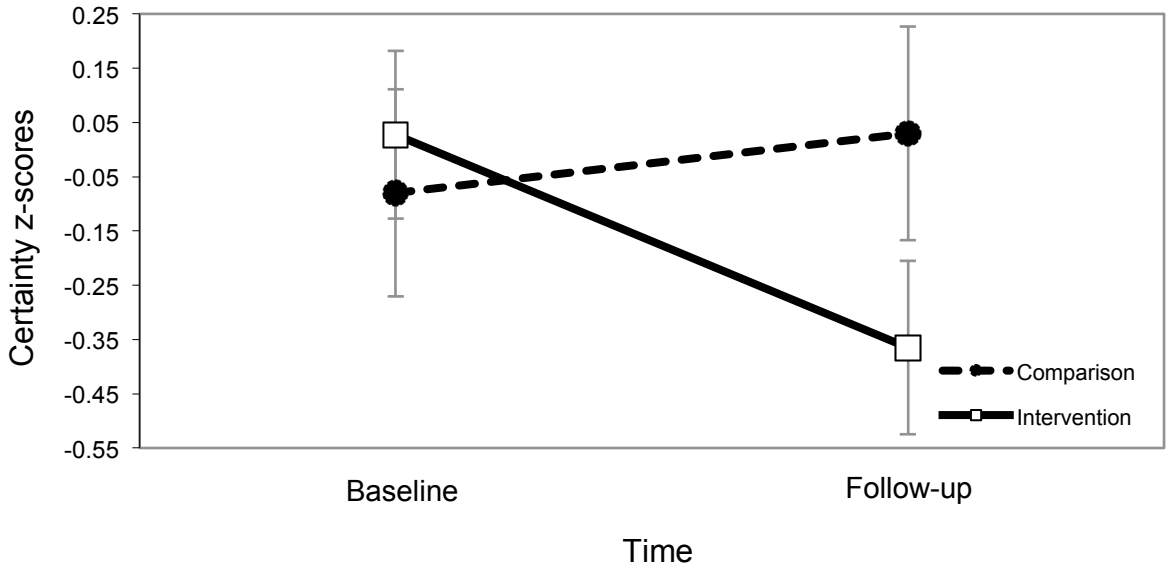


Figure 2. Interaction between Group and Time on the Certainty Scale of the PRFQ

As for the Curiosity scale, there was again no Group or Time main effect, F (1, 65) < 1, *ns,* but the interaction between Group and Time was again significant, F (1, 65) = 4.3, $p < .05$. This interaction is shown in Figure 3. This figure illustrates Curiosity somewhat increasing in the intervention group between baseline and follow-up although this increase is not statistically significant ($t(42) = 0.15$, *ns*), while at the same time decreasing significantly in the comparison group ($t(27) = 2.65$, $p = .013$). The effect size for the interaction was on the border between small and moderate, $\eta_p^2 = .06$.

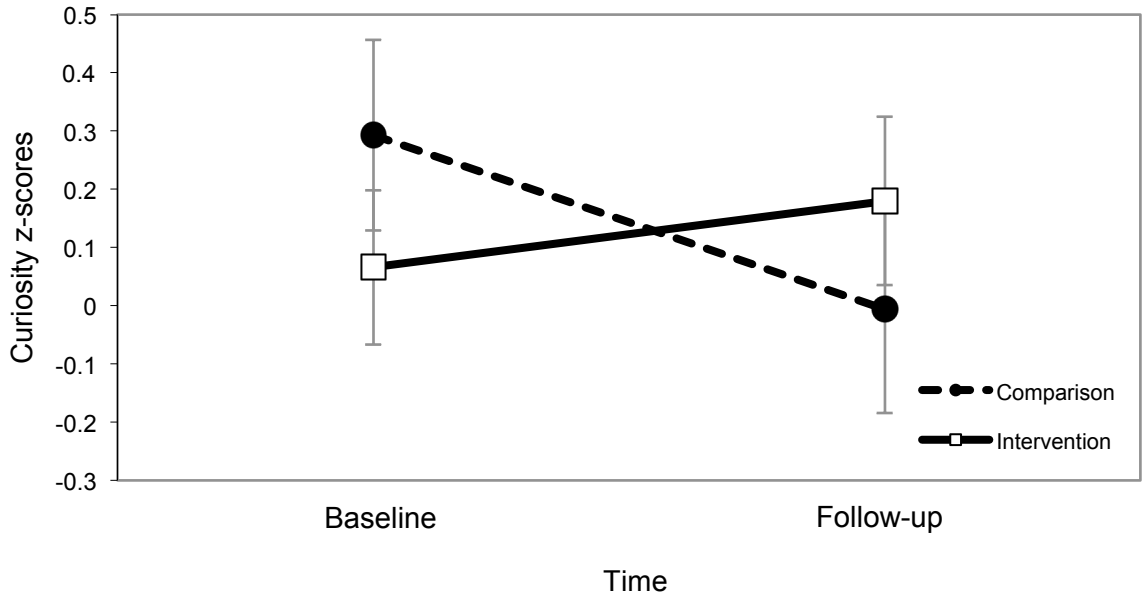


Figure 3. Interaction between Group and Time on the Curiosity Scale of the PRFQ

FMSS.

Descriptive analysis. RF coding was also applied to speech samples collected for descriptions of self (as foster parent), the indicated child and globally across the sample. All speech samples were assessed and coded on three scales (see Method section): Global RF, Parent RF and parent RF of the child (Child RF). This was done using the reflective functioning coding system based on the coding system used by the Parent Development Interview. This RF coding scale ranges from -1 (Negative RF) all the way to 9 (Full or Exceptional RF). A complete description of this scoring system can be found in Appendix Q. Coders were blind to the group from which parents were drawn. Means and standard deviations of scores on all three RF dimensions for both the comparison and intervention groups at baseline and follow-

up can be seen in Table 8. The scores ranged from 2 to 7, with no one indicating they had negative RF or that they were completely lacking in RF.

Table 7

Percentage of RF Level Change from Baseline to Follow-up by Group

Group	Baseline to Follow-up			
	Decreased RF Level	Remained at RF Level	Increased RF Level	Increased two RF Levels
Intervention (*n*=18)	6% (1)	38% (7)	50% (9)	6% (1)
Comparison (*n*=15)	27% (4)	66% (10)	7% (1)	0% (0)

Note: RF, Reflective Functioning; Percentages rounded up or down.

The first category shift in the scoring is when a rating moves from a lower score of 3-4 to 5-6, which indicates moving from simply verbalizing mental states to being able to form genuine reflective statements. The next significant shift is when a respondent moves to a score of 7, which demonstrates steady and sophisticated RF throughout the speech sample. Using frequency counts, movement up or down in RF levels from baseline to follow-up was evaluated and can be seen in Table 7. As this table illustrates, over half of the intervention group increased at least one RF level compared with only 7% of the comparison group. Additionally, although a third of the intervention group remained at the same RF level, this was true of two-

thirds of the comparison group. Finally, almost a third of comparison group participants lowered a level while this occurred with only 6% of the intervention group. It is of note that in only the intervention group did any participants raise as much as two RF levels. These descriptive statistics add to the evidence that this intervention did indeed increase parent's ability to be reflective or mentalize.

Table 8

Means and Standard Deviations of FMSS Outcome Variables by Time and Group

	Intervention Group (n = 18)				Comparison Group (n = 15)			
Outcome	Baseline		Follow-up		Baseline		Follow-up	
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Global RF	4.11	.90	5.00*	1.28	4.07	.80	3.53	.99
Parent RF	3.72	.58	4.50*	1.38	4.07	1.22	3.60	1.06
Child RF	4.11	1.18	5.00*	1.46	3.73	.96	3.60	1.18

Note: FMSS, Five-Minute Speech Sample; RF, Reflective Functioning.
*$p < .02$

Statistical analysis. To test the hypothesis that coded RF from speech samples would increase more following the experimental condition than the comparison condition, we performed a 2 x 2 repeated measures ANOVA on all three sub-scales of the FMSS (Global RF, Parent RF and Child RF). In this analysis, group (Comparison vs. Intervention) was an independent fixed effect and time (Baseline

vs. Follow-up) was a repeated measures fixed effects factor. As there were only two time-points, Greenhouse-Geiser adjustments were not needed. We predicted a significant interaction between group and time, with greater change expected in the Intervention group. Furthermore, we explored baseline to follow-up differences using separate paired t-tests for the comparison and intervention groups independently. The means of the FMSS scores for both groups at baseline and follow-up are shown in Table 8.

Multivariate analysis. Table 8 shows a significant increase in all FMSS scores in the Intervention group and a slight decline in the Comparison. The 2x2 ANOVA showed no significant overall Group or Time effect (F (3, 29) = .78, *ns* and F (3, 29) = .89, *ns,* respectively). There was, however, a significant Group x Time interaction (F (3, 29) = .70, p = 0.015, partial η^2= 0.30). While overall RF slightly decreased in the comparison group between baseline and follow-up, there was a significant increase in RF for the intervention group and the effect size was large.

Univariate sub-scale score results. ANOVA analysis on the same data performed separately on each scale revealed that RF increased significantly for all three sub-scales of the FMSS. On the Global RF scale, the Time main effect was not significant, F (1, 31) < 1, *ns*. However, the Group main effect was significant, F (1, 31) = 6.78, p = .014, $\eta_p^2 = .18$ and there was a significant Group and Time interaction, F (1, 31) = 11.79, p = .002, $\eta_p^2 = .28$. Both the Group main effect and the interaction between Group and Time can be seen in Figure 4. This figure illustrates that the groups were not different at baseline (F (1, 31) = .022, *ns*), but were clearly separate at follow-up (F (1, 31) = 13.07, p = .001) and the effect size was moderate

to large. Furthermore, the interaction is illustrated by the intervention group's baseline to follow-up significant increase in Global RF ($t(17) = -3.33$, $p = .004$) while the decrease in the comparison group was not above chance level ($t(14) = 1.66$, $p = .12$). The effect size of the interaction was large.

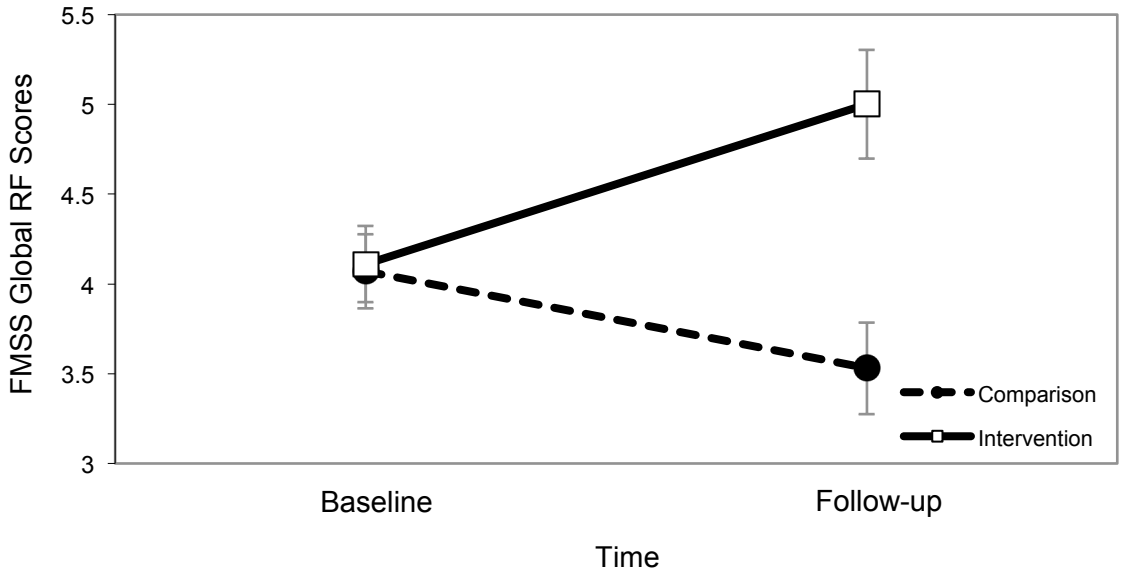


Figure 4. Interaction between Group and Time on the Global RF Scale of the FMSS

On the Parent RF scale, there was no Group or Time main effect, $F(1, 31) < 1$, *ns,* but the interaction between Group and Time was significant, $F(1, 31) = 6.68$, $p = .015$. This interaction is shown in Figure 5. As the figure demonstrates, Parent RF in the intervention group was actually lower initially than in the comparison group. However by follow-up, Parent RF had increased significantly in the intervention group while simultaneously decreasing in the comparison group. The effect size fell between moderate and large, $\eta_p^2 = .18$. The baseline to follow-up decrease in Parent

RF in the comparison group was not statistically significant ($t(14) = 1.13$, *ns*) but the increase in the intervention group was above chance level ($t(17) = -2.83$, $p = .01$).

When we examined the Child RF scale, we found similar results to the Global RF scale. Once again, the main effect for Time was not significant, $F(1, 31) = 2.61$, *ns*. However, the Group main effect was significant ($F(1, 31) = 6.21$, $p = .018$, $\eta_p^2 = .17$) and there was a significant Group and Time interaction ($F(1, 31) = 4.77$, $p = .037$, $\eta_p^2 = .13$). Both the Group main effect and the interaction between Group and Time can be seen in Figure 6. While the groups were not very different at baseline ($F(1, 31) = .986$, *ns*), by follow-up the groups were significantly different ($F(1, 31) = 8.94$, $p = .005$). This figure also illustrates the interaction showing a significant increase in Child RF from baseline to follow-up in the intervention group ($t(17) = -2.85$, $p = .011$) while the comparison group's slight decrease was at chance level ($t(14) = .381$, $p = .71$). The effect size for both significant results were moderate.

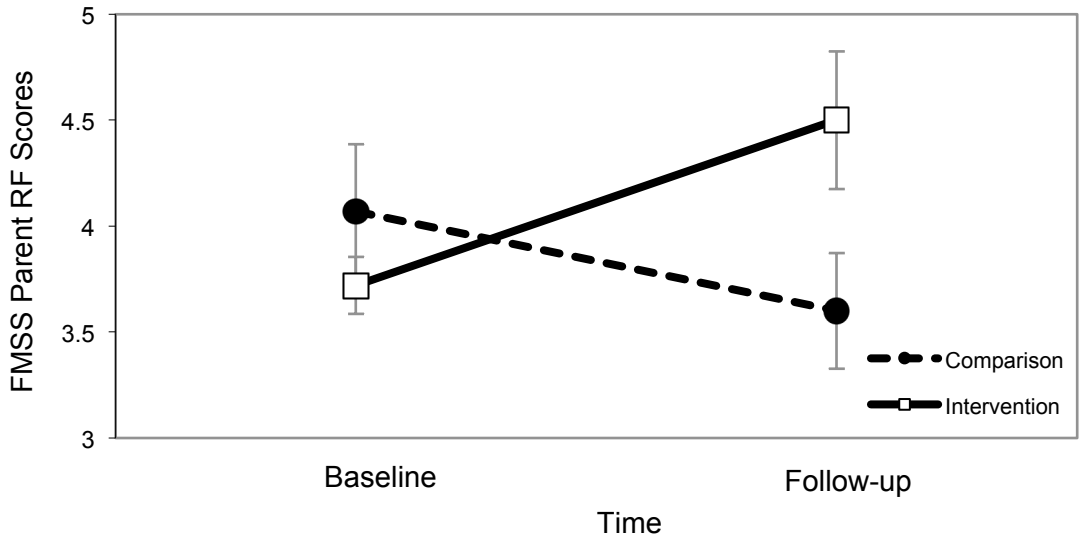


Figure 5. Interaction between Group and Time on the Parent RF Scale of the FMSS

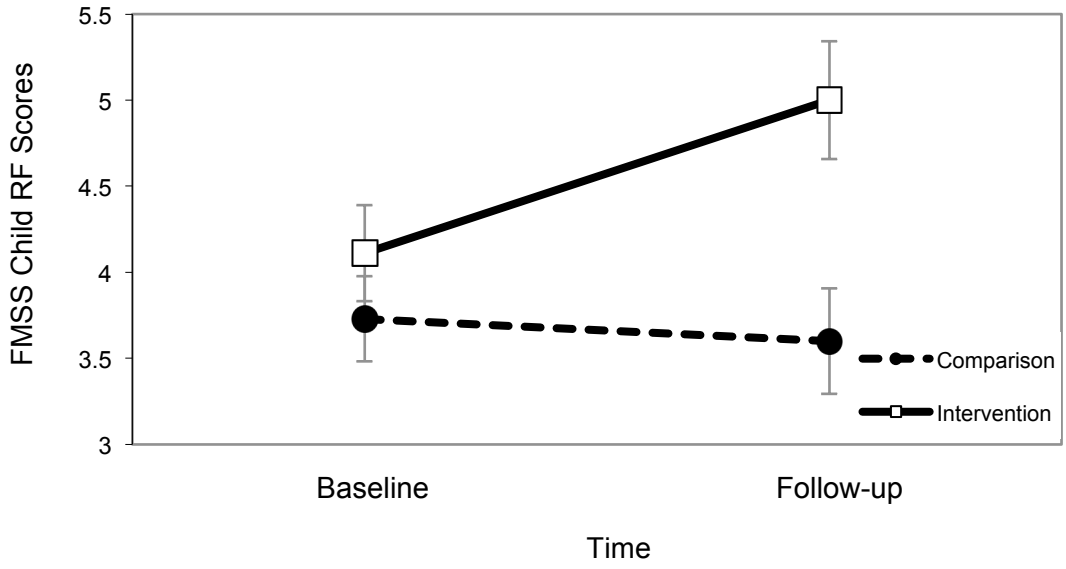


Figure 6. Interaction between Group and Time on the Child RF Scale of the FMSS

Other Measures

PSI. To test the hypothesis that parent reported stress decreased more following the experimental condition than the comparison condition, we performed a 2 x 2 repeated measures ANCOVA on the total PSI scores and a two-way MANCOVA with the PSI sub-scales. In both these analyses, group (Comparison vs. Intervention) was again an independent fixed effect and time (Baseline vs. Follow-up) was the repeated measures fixed effects factor. As a follow up to the MANCOVA, ANCOVAs were conducted on the same data. In all cases, we predicted a significant interaction between group and time. We further explored baseline to follow-up differences using separate paired t-tests for the comparison and intervention

groups independently. PSI scores were also centered and standardized to facilitate the interpretation of findings. The analysis was performed on the z-scores obtained. The means of the PSI scores for both groups at baseline and follow-up are shown in Table 9. Raw mean scores are listed in Appendix T. It is important to note that all of the mean scores for either group at both time periods fell well within the "Normal" range, with no mean scores approaching clinical significance.

Table 9

Means and Standard Deviations of PSI Outcome Variables by Time and Group

	Intervention Group (n = 41)				Comparison Group (n = 25)			
Outcome Variables	Baseline		Follow-up		Baseline		Follow-up	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Total PSI	-.03	1.00	-.19†	.90	-.05	1.05	.14	1.13
Defensive Responding	-.06	.93	-.17*	.83	-.08	1.04	.30	1.27
Parental Distress	-.05	.92	-.18*	.88	-.12	1.00	.28	1.21
Dysfunctional Interaction	-.01	1.02	-.14†	.89	-.01	1.01	.18	1.04
Difficult Child	.00	1.02	-.18	.92	-.01	1.02	.03	.87

Note: Means are adjusted for covariate: foster parent age. PSI, Parenting Stress Index.
† Approaches significance
*$p < .05$

Total PSI analysis. The 2x2 ANCOVA showed no significant overall Group or Time effect (F (1, 65) = 0.30, *ns* and F (1, 63) = 3.80, *ns*, respectively). Additionally, although the overall Group x Time interaction narrowly missed statistical significance (F (4, 63) = 3.74, p = 0.054) the linear component of this interaction was significant indicating that greater decline in stress of the Intervention compared to the Comparison group was not chance variation (F (4, 63) = 4.35, p = 0.043). This interaction is shown in Figure 7. As the figure illustrates, Total Stress increased in the comparison group between baseline and follow-up whilst it decreased in the intervention group. The effect size was between small and moderate, $\eta_p^2 = .06$. The pre-post contrast based on separate matched-paired t-tests show that neither the change in the comparison group (t(26) = 1.10, *ns*), nor the change in the intervention group (t(42) = 1.35, *ns*) was significant although they were clearly in opposing directions.

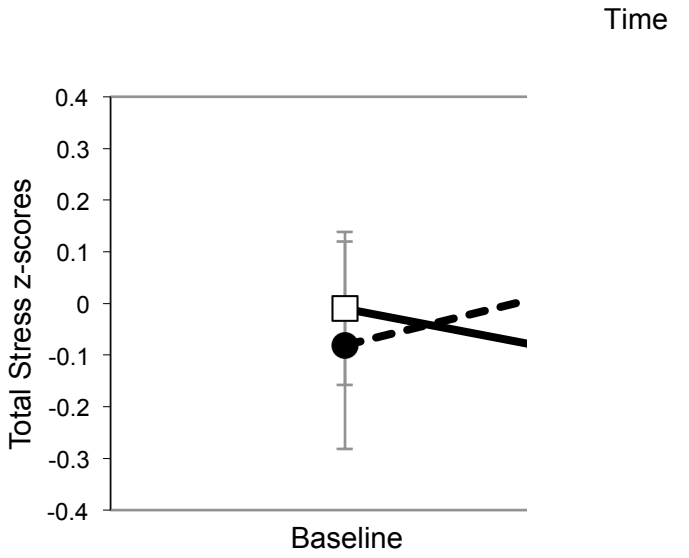


Figure 7. Interaction between Group and Time on the Total Stress Scale of the PSI

Multivariate analysis. In line with the univariate analysis reported above, the omnibus MANCOVA of the PSI subscales yielded no significant Group effect, Wilks' Lambda = .982, F (4, 60) = .273, *ns*. There was also no significant effect of Time, Wilks' Lambda = .934, F (4, 60) = 1.07, *ns*. The interaction between Time and Group also did not yield a significant effect, Wilks' Lambda = .892, F (4, 60) = 1.82, *ns*. These results suggest that overall there were no differences between the group scores in parenting stress aggregated across time points. Additionally, those who participated in the intervention group did not show a significant decrease in overall follow-up PSI scores when compared with the comparison group.

Univariate sub-scale score results. Although there was an overall interaction effect on total scores even though the MANCOVA interaction was insignificant, ANCOVA analyses were performed to determine which PSI sub-scales might account for the interaction of total scores (Defensive Responding, Parental Distress, Dysfunctional Interaction and Difficult Child). This analysis revealed significant interaction effects on two of the five scales on the PSI, with two more scales approaching significance.

On the Defensive Responding (DR) scale, there was also no Group or Time main effect, F (4, 60) < 2, *ns,* but the interaction between Group and Time was significant F (4, 60) = 6.5, p < .02. This interaction is shown in Figure 8. As the figure illustrates, DR increased in the comparison group between baseline and follow-up whilst it decreased in the intervention group. The effect size was moderate, $\eta_p^2 = .09$. The baseline to follow-up increase in DR in the comparison

group was statistically significant ($t(26) = -1.71$, $p = .05$ (one-tailed)) but the decrease in the intervention group was not significant ($t(42) = 1.21$, $p = .12$ (one-tailed)). This implies that the intervention mitigated a natural process of cumulative increase in defensiveness on the part of the foster parents as the course progressed.

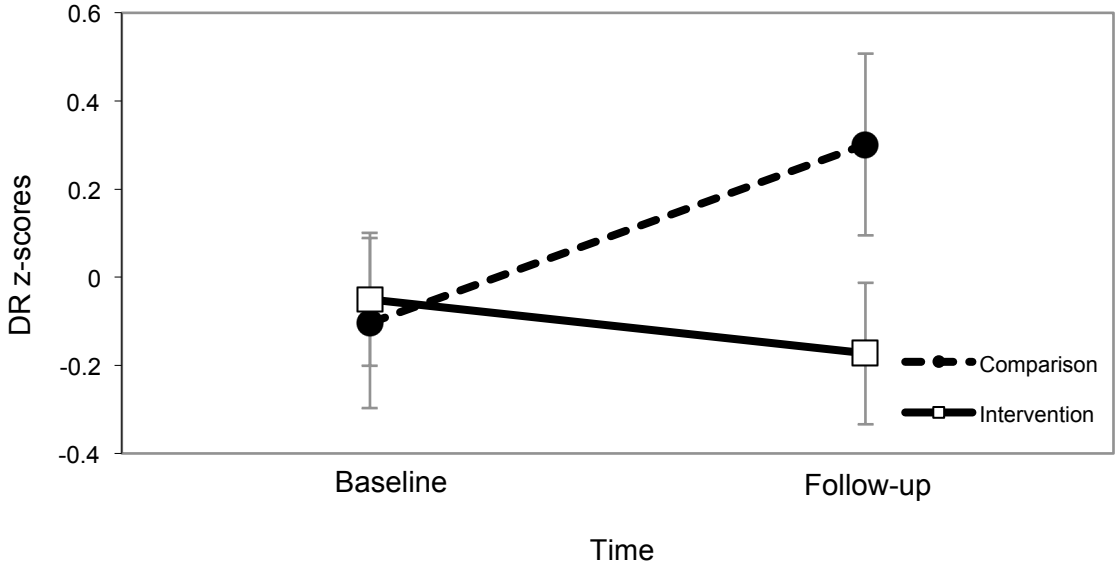


Figure 8. Interaction between Group and Time on the DR Scale of the PSI

As for the Parental Distress (PD) scale, there was again no Group or Time main effect, $F(4, 60) < 2$, *ns,* but the interaction between Group and Time was again highly significant, $F(4, 60) = 7.6$, $p = .008$. This interaction is shown in Figure 9. As the figure illustrates, between baseline and follow-up PD decreased in the intervention group, while at the same time significantly increased in the comparison group. The effect size was moderate, $\eta_p^2 = .11$. The baseline to follow-up increase in PD in the comparison group was again statistically significant ($t(26) = -1.97$, $p = .03$ (one-tailed)) whilst the decrease in the intervention group was not significant ($t(42)$

= 1.28, p = .10 (one-tailed)). The intervention can thus be suggested to provide mitigation against a tendency for un-addressed distress to increase with time.

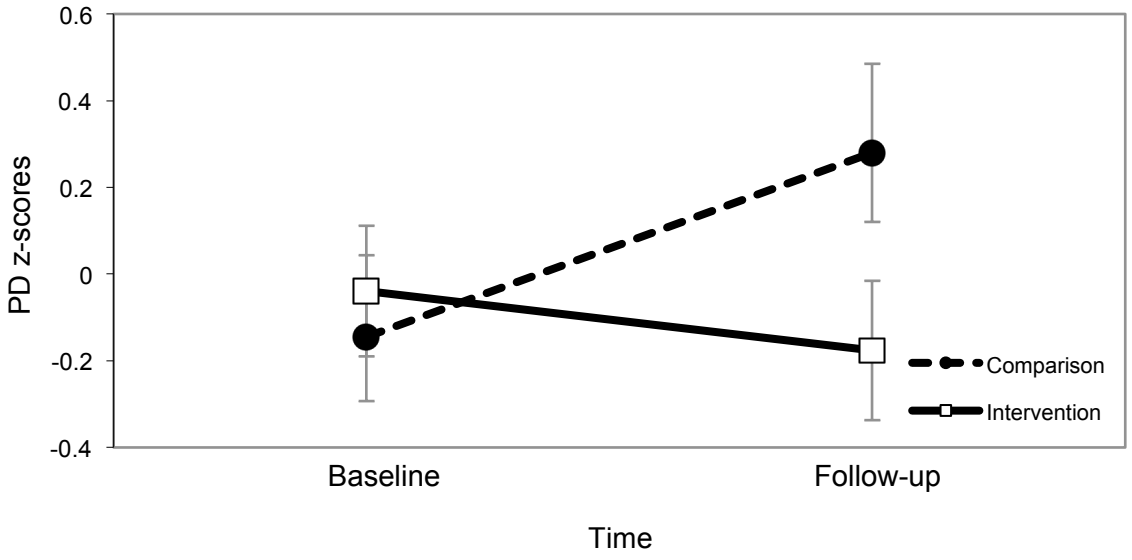


Figure 9. Interaction between Group and Time on the PD Scale of the PSI

On the Child Dysfunctional Interaction (CDI) Scale, the Group and Time main effects were not significant, F (1, 63) < 5, *ns*, however interaction between Group and Time approached significance, F (1, 63) = 3.1, p = .08. This interaction is shown in Figure 10. As the figure illustrates, CDI increased in the comparison group between baseline and follow-up while simultaneously decreasing in the intervention group. The effect size was small, $\eta_p^2 = .05$. Although the interaction was marginally significant, the baseline to follow-up increase in CDI in the comparison group was not statistically significant (t(26) = -1.24, p = .23, nor was the decrease in CDI in the intervention group (t(42) = 1.24, p = .22). As none of the interaction terms reached significance we should perhaps forego speculation about what this pattern of results

might indicate. Suffice it to say, the pattern was consistent with the assumption that the intervention brings about improved interaction with the child.

For the final scale, Child Difficulty (CD), the group and time main effects were again not significant, F (1, 63) < 2, *ns*, nor was the interaction between group and time, F (1, 63) = 1.28, p = .28. Although this interaction was not significant, the baseline to follow-up decrease in CD in the intervention group was marginally significant (t(42) = -1.60, p = .055 (one-tailed)) while CD for the comparison group from baseline to follow-up was unchanged (t(26) = -.256, p = .80). This implies that with a larger sample we might observe a statistically significant reduction of child perceived difficulty.

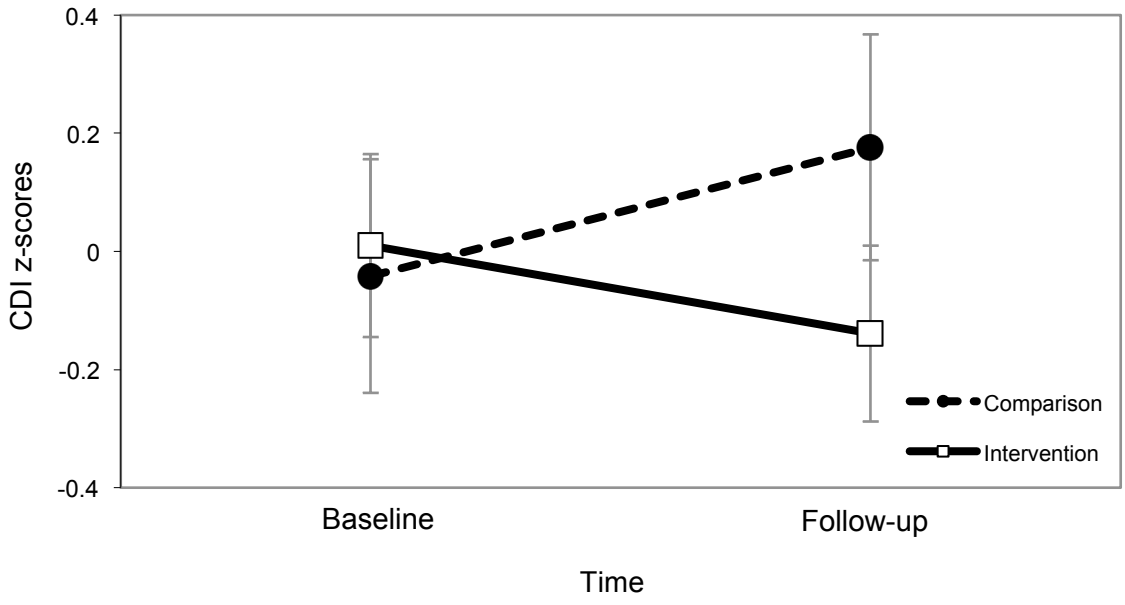


Figure 10. Interaction between Group and Time on the CDI Scale of the PSI

SDQ. To test the hypothesis that reports of child behavioral problems would decrease more following the experimental intervention than the comparison condition, we performed a 2 x 2 repeated measures ANCOVA on the total SDQ scores and a two-way MANCOVA with the SDQ sub-scales. In both these analyses, group (Comparison vs. Intervention) was again an independent fixed effect and time (Baseline vs. Follow-up) was the repeated measures fixed effects factor. As a follow up to the MANCOVA, ANCOVAs were conducted on the same data. In all cases, we predicted a significant interaction between group and time. The means and standard deviations of the SDQ scores for both groups at baseline and follow-up are shown in Table 10. It should be noted that the sample who filled in the SDQ was only a subsample of the total sample, although those who did not complete the measure were not significantly different from those who did on the demographic measures obtained.

Total Difficulties score SDQ analysis. On the Total Difficulties scale, Time as a main effect was not significant, F (1, 58) < 1, *ns.* There was no indication of change in the ratings across the two time-points., nor was the interaction between Group and Time, F (1, 58) < 1, *ns*. However, there was a Group main effect, F (1, 58) = 4.11, p < .05, confirming that the foster parents' rating of the children's difficulties was greater in the intervention than the comparison group. This reflects that the means for Total Difficulties (see Table 9) at both baseline and follow-up for the intervention group were slightly higher than 15, falling into a "Borderline" range in the SDQ classification (14-16), while the means for the comparison group pre and post test were within the "Normal" range (<14). Furthermore, the proportion of

clinical and borderline cases were similar as shown by a chi-squared test, which revealed no difference in the proportion of probable clinical cases either at baseline (26% vs. 38%) or follow-up (29% vs. 34%) (χ^2 (2, N=64) = 4.76, *ns* and χ^2 (2, N=64) = 1.3, *ns* respectively). The small sample size of the study and the attrition from the experimental group means that we cannot be certain if the selective loss of participants on this measure contributed to the significant group mean differences.

Table 10

Means and Standard Deviations of SDQ Outcome Variables by Time and Group

	Intervention Group (n = 35)				Comparison Group (n = 26)			
Outcome Variables	Baseline		Follow-up		Baseline		Follow-up	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Total Difficulties	15.34†	8.10	15.51†	7.69	11.31	5.95	12.19	6.33
Emotional Symptoms	2.89	2.61	3.14	2.59	2.00	1.81	2.31	1.96
Conduct Problems	3.77†	2.82	3.43†	2.51	2.15	2.01	2.58	2.10
Hyperactivity	6.20†	3.08	6.26†	2.77	4.96	2.60	4.88	2.39
Peer Problems	2.49	1.84	2.69	2.01	2.19	2.06	2.42	1.42
Prosocial Behavior	6.71	2.12	6.69	2.04	6.56	2.38	6.52	2.40

Note: Means are adjusted for covariate: foster parent age. SDQ, Strengths and Difficulties Questionnaire.
† Borderline scores as classified on SDQ

Multivariate analysis. In line with the univariate analysis reported above, the omnibus MANCOVA of the SDQ subscales yielded no significant Group effect, Wilks' Lambda = .890, F (4, 55) = .1.71, *ns*. There was also no significant effect of Time, Wilks' Lambda = .974, F (4, 55) = .364, *ns*. The interaction between Time and Group also did not yield a significant effect, Wilks' Lambda = .954, F (4, 55) = .67, *ns*. These results suggest that overall there were no differences between the group scores in children's behavioral problems aggregated across time points. Additionally, those who participated in the intervention group did not show a significant decrease in overall follow-up SDQ scores when compared with the comparison group.

Univariate sub-scale score results. Although the MANCOVA interaction was insignificant, ANCOVA analyses were performed to determine if there were differences on any one of the SDQ sub-scales (Total Difficulties, Emotional Symptoms, Conduct Problems, Hyperactivity, Peer Problems and Prosocial Behavior). Results revealed that although there were no significant interaction effects on any of the sub-scales, there was a difference between groups on three of the sub-scales.

We then looked at the sub-scales of the SDQ, it appears that the raised scores applied to two of the sub-scales: Conduct Problems and Hyperactivity. For both, neither Time (F (1, 58) < 1, and F (1, 58) < 1, *ns*, respectively) nor Group X Time was significant (F (1, 58) < 0.3, *ns* and F (1, 58) < 1, *ns*, respectively). However for both of these scales there was a significant group effect (F (1, 58) = 4.34, p < .05 and F (1, 58) = 4.16, p < .05, respectively). Again, means for both these sub-scales for the

intervention group indicate "Borderline" scores (Conduct = 3; Hyperactivity = 6), while the comparison group mean was in the "Normal" range (Conduct < 3; Hyperactivity < 6). There were no differences between the two groups in terms of the proportion of probable clinical cases across the groups.

In summary, although there are no pre-post differences between groups on any of the sub-scales, it appears that for the intervention group who completed the measure, their Total Difficulties scores were higher, and their Conduct Problems and Hyperactivity scores were somewhat higher and all these sub-scores fell into the "Borderline Clinical" range. Neither groups' scores changed significantly from baseline to follow-up. It is important to note that neither group had mean scores that fell into the "Abnormal Clinical" range (complete SDQ scoring interpretation can be found in Appendix U), although about 30% of the sample had scores in "Borderline Clinical" range. This is understandable given that 84% of these children (see Table 4 in Ch. 6) were given a "Basic" level of care designation by TDFPS, meaning that the last time these children were reviewed, they did not display a concerning level of behavioral or emotional problems. Given that most of these children had no significant problems, it was not likely that the benefit from the intervention would go beyond the foster parents increasing their own attentiveness to mental health problems in the child. It was most unlikely that a brief intervention could have brought about genuine changes in the children and any change was most likely to be attributable to changes of parents' sensitivity to their difficulties.

Qualitative Findings of Intervention

Workshop evaluation. It seemed helpful to include an evaluation of the intervention workshop itself, including questions regarding the quality of the training, instructor and the material. Included were subjective questions assessing the impact of the workshop on parenting and perception of their child's behavior. This was an evaluation the researcher created, the questions were not gleaned from other assessments, and this evaluation was not standardized. Respondents were asked to rate a series of questions on 4-point Likert scale, with 1 = "Very much", 2 = "Somewhat", 3 = "A little" and 4 = "Not at all".

Data regarding the quality of material and training is outlined in Table 11. Mean scores were calculated for each question.

Table 11

Means and Standard Deviations of the Training Quality of the Intervention

Question	*M*	*SD*
The trainer was knowledgeable.	1.00	.00
The quality of instruction was good.	1.12	.32
The content was understandable.	1.18	.57
Adequate time was provided for questions and discussion.	1.26	.50
I found the at-home exercises interesting and useful.	1.40	.66

Note: Items range from 1 to 4, with 1 representing highest/greatest level.
N=34

All of the questions on training quality resulted in mean scores that were very high. The data indicate participants "very much" thought the quality, content and structure of the training was good and that the trainer was knowledgeable. This speaks to the high quality of the intervention.

Data regarding how the workshop impacted respondents parenting is described in Table 12. Mean scores were calculated for each question. Again, all of the questions regarding parenting impact resulted in fairly high mean scores, indicating that the participants strongly felt the intervention helped improve their parenting skills and that the skills they learned were useful. Parents were less sure the intervention positively impacted their child's behavior, with the mean score leaning towards the answer "somewhat" more than "very much." However, this still implies that most parents saw a positive impact on their child's behavior after this intervention. Parents were also asked if other family noticed a positive change in their child's behavior. The scores indicate they felt that their family did notice, but perhaps only "a little". It is not sure if this question was useful however, due to the short timespan of the intervention. Perhaps these parents did not see other family members over the course of the workshop.

One last question about the training was asked to the respondents, with a different Likert scale, which is why this data is not included within Table 10 or 11. The question was "How would you rate the training overall?" and the respondents were asked to answer using a 5-point Likert scale with 1 representing "Excellent" to 5 meaning "Very Poor". Mean scoring for this question resulted in M=1.23, SD=.42

with n=46. This indicates parents' thought very highly of the intervention, as a perfect score would be 1.00.

Table 12

Means and Standard Deviations of the Parenting Impact of the Intervention

Question	*M*	*SD*
The workshop helped improve my parenting skills or taught me new ones.	1.18	.38
The skills were practical and easy to employ.	1.29	.52
The workshop positively impacted my child's behavior.	1.83	.73
Other family members noticed a positive change in my child's behavior.	2.44	.79

Note: Items range from 1 to 4, with 1 representing highest/greatest level.
N=34

Participant comments. At the end of the evaluation, foster parents were prompted to supply comments in their own words to two opened prompts. The first prompt was "What aspects of the training could be improved?" All of the comments to this question centered on requesting longer trainings, or more of them spread out so we could go more in depth. Foster parents also asked for more time to practice and even more discussions and interactions. The second prompt was simply "Final Comments." Of the 34 evaluations, 24 provided final comments. These comments can be divided in to three themes as outlined below. Sample comments follow:

Theme 1: This intervention helped foster parents understand themselves and their child better.

"It has helped me to understand the problems we were having in our household. I will continue to think about what I have learned and apply it to the core of our children."

"I feel the class has opened my eyes on how to handle stuff when it comes up."

"Very good class! Helpful and informative in understanding children."

"This training and concept is huge. Understanding why makes all the difference. You can't fix anything until you understand the problem!"

"The training has opened my eyes. I realize that anger is not all that there is – it's fear. Learning and understanding my children's thoughts, feelings, desires and needs/I have learned so much from this class."

Theme 2: This intervention provided useful information that could be applied at home.

"I am amazed at what I learned in this class. Also how when put to practice, how it really works! Tina is a very good, involved instructor. I would take it again. Practical stuff for us who are foster and adoptive parents and grandparents. You don't have to be a genius to understand Tina. She talks to the real issues."

"Well done, very very helpful in our day to day experiences. Makes us better parents which is what we aspire to be."

"Helped me understand new techniques to use to diffuse situations."

" I very much enjoyed the class and I do feel that I will be able to use a bunch of the stuff that was talked about."

"Will share it with extended family so that they can better understand what we and the girls are dealing with at home."

Theme 3: General praise for this intervention.

"Excellent information! Excellent presentation! By far the best foster parent training I have ever received."

"Love the material. It was very helpful and should be mandatory for foster/adoptive parents."

"I enjoyed the class and was very surprised by how informative it was. I learned so much and would recommend it to others to take."

"Great class and subject that needs to be utilized in every aspect of parenting, not just foster/adoptive. I hope our teacher can make great headway into the system to elicit some change for the better. Hopefully, there will be protégés in the future to further the study and practice of mentalizing."

"Information was practical and relatable. Explained in an easy to understand manner."

At-home activities. Foster parents were asked at the end of 2 of the 3 intervention classes to go home and try a number of games and activities with their children. These are activities designed to increase the parent's mentalizing of their children and encourage mentalization skills in the children themselves. The at-home activities can be seen in Appendix M. They were then asked to write their experiences down and submit them to the instructor for extra training credit. During the intervention, under half of all the foster parents admitted (by show of hands) to trying these activities at home with their children. This information is in line with the evaluations, in which 25 (46%) of the foster parents reported to have tried at-home activities with their children. A smaller number of parents (12) volunteered their experiences with these activities by submitting their written experiences for extra credit. After reviewing these written experiences, three

themes emerged from this material. In addition, all of these experiences depict instances of being reflective, of mentalizing themselves and their children. These themes are listed below, with a selection of quotes from the foster parents.

Theme 1: Deepening of the relationship and connection to their child.

"It was a very moving moment to see such deep understanding between us."

"I think you felt proud today because when mommy picked you up today at school, you show[ed] me your Pilgrim outfit you made and told me how awesome it was. Then I asked 'Am I right?' He acted shy and smiled real big. I then pointed out the Shy photo and said 'Is this how you feel now?' He looked shocked and smiled again nodding his head yes. RC wanted to guess my feelings so he picked up the Proud [card]. I asked him why he picked up proud and he just smiled. I then asked 'do you think mommy was proud of you?' He smiled again and said 'yes.' I said 'You are right little man!' He laughed and we had a tickle party as we call it."

"She is awake and I am going in to get her out of the crib and ready for the day. She hears/sees me and gets a big smile on her face. She is cooing and waving arms, bouncing legs/feet. I tell her 'You look happy (laughing) are you ready to get up?' D. smiles & rolls over towards me."

Theme 2: Seeing their child from a different and more complex perspective.

"She says Opal is scared she will lose her dog like she did her mom. I sat there listening and not believing that a 6 y.o. child could make such a connection. She also told me how important our dogs were to her as they listen to her when she talks to them."

"It was very clear to me that my child relates to the main character in many ways. There just seems to be an understanding of Opal's situation by my child. Like they were both part of a secret club no one talked about where their mama's left. I believe it was very healthy to label some of the feelings with her… it also made me realize no matter what I do for my child she will forever miss her biological mom on a very deep level. And my job is to not resolve that for her but make her feel safe and loved so she can grown into a strong woman and know I am there for her no matter what happens."

"My child chose the Happy and the Angry card [as feelings I was having today]. I was a little surprised that she chose the Angry card. I asked her to explain her choices. She said the Happy card because I was smiling when I picked her up from school and she makes me happy. Then the Angry card because after I drop her off I

drive to work through town and other people get in my way and I will be angry with them. And she was right and I was very aware at that moment that my child sees everything I do and remembers every reaction I have, even when she is not with me all day."

"Then for her I chose the Eager and the Worried card. I told her I chose the Eager because she was very excited about going to school that morning. Then I chose Worried because I know at school she worries about her work getting done. Then she told me I was right about her being excited about going to school because she had new boots and wanted to show her friends and teacher. But when she looked at the Worried card, she seemed a little confused by my choice. She said she does try hard to get her work done at school, but really she worried that I won't come get her after school. I was shocked my precious girl would think I wouldn't come get her after school. She is still very afraid that she will get left behind, even after being with me for 3 years. I didn't realize this was a concern for her anymore."

Theme 3: Child is able to safely express their emotions to foster parent

"My son always delayed bedtime. He would keep asking for water, nightlight, restroom. We traded places [as instructed in the exercise]. He told me [who was pretending to be him, the child] at bedtime to feel thirsty, and that I should need to use the restroom. Then he said [you] are scared and lonely. I told him [who was pretending to be me, the parent] to feel tired and frustrated as the adult because he kept making me come back into his room. We discussed our feelings and decided he gets a 30 minute bedtime warning to take care of restroom etc., then he gets to [have] mom and me time until bedtime. We put a night light in the hall since his older brother didn't want one in the room. He was okay with everything and there were no more problems."

"My foster daughter burst into tears and she cried extremely hard holding me. This is what she needed, to be in the arms of someone who could show her love. She was so shocked to know that someone could love her and all her badness."

"I was surprised at how in tune our kids were with being able to know what the characters were feeling and having interesting insights into the characters"

These themes and parent experiences indicate that the intervention did make an impact on their ability to understand their children on a different level, as well as deepen their connection to their child and allow them safe opportunities to express and share their emotions. All of these experiences contribute to increasing

mentalizing of self and other. There was only one parent who shared an experience of an interaction at home in which the child was clearly expressing a need/concern and the parent did not appear to be able to see past the behavior of the child. This experience reflects a parent who is not mentalizing the child very well:

"Our adopted 6 year old granddaughter comes into room and starts complaining that baby is too close to the furniture and says to get her away [from the furniture]. I say, all is fine. She says no grampa. I say look she's alright and I'm watching her [the baby]. I let her win the argument and move the baby. Now how do I feel. Not too happy about the outcome. But just blow it off. I feel the 6 y.o. does a lot of demanding and I do probably too much giving in. There are many instances like this. Many times I just walk away for a few minutes thinking Ok you win, I lose."

Fidelity of Intervention

Both treatment fidelity and adherence was measured for both groups, using a 13-question form that included five questions that evaluated the quality of training delivery, and eight questions that assessed type of content. A total of 20 random audio samples were coded by two independent raters using this form (see Appendix U). All questions were rated using a 7-point Likert scale that ranged from (1) Not at all, to (4) Somewhat, and all the way to (7) Very much.

Given that the variables used in this fidelity assessment were ratings independent samples *t*-test could be used, but as on many of the distributions were highly skewed, the non-parametric Mann-Whitney *U* test was used to determine if the means on each variable were significantly different between groups. The expectation was that the groups would not be different on any of the quality of training variables and that the only difference between the groups on the content would be on three variables: mentalization material, mentalizing exercises and

content directed towards helping parents' understand their own emotions. These three variables represent content that was only included in the Intervention. The rest of the variables refer to content that was included in both groups.

Means and standard deviations for the quality of training fidelity variables are displayed in Table 13. It is clear from the minor (to no) variation of these means that quality of training was very similar between groups. The statistical-tests revealed no statistical differences between the means of the quality of training variables. The ratings were at ceiling levels and there was no value on exploring the ratings further. The lack of difference between the two arms is in line with our hypothesis and lends credence that both trainings were delivered with the same quality by the instructor.

Table 13

Means and Standard Deviations of Quality of Delivery Fidelity Variables by Group

	Intervention Group (n=10)		Comparison Group (n=10)	
Quality of Delivery	*M*	*SD*	*M*	*SD*
Language was understandable	7.00	.00	7.00	.00
Content clearly explained	7.00	.00	6.95	.16
Presenter knowledgeable	6.95	.16	6.90	.21
Presenter engaging	6.95	.16	7.00	.00
Presenter enthusiastic	7.00	.00	7.00	.00

Note: Items range from 1 to 7, with 7 representing highest/greatest level.

The second part of assessing fidelity involved contrasting the content between the Intervention and Comparison groups. Means and standard deviations for these content variables are described in Table 14. Mann-Whitney *U* tests confirmed that there were statistical significant differences between the groups regarding content on mentalization ($U = 100.00$, $p < .000$), RF exercises ($U = 85.00$, $p < .01$), and helping parents' understand their own emotions ($U = 88.50$, $p < .01$). This supports our hypothesis that unique priority was given to mentalization-based content in the experimental intervention arm of the study. All of these results provide strong evidence of both treatment fidelity and adherence to high quality communication standards.

FMSS material. Although quantitative results of the FMSS have been analyzed in the first section of this chapter, there is much qualitative material as well. All speech samples were transcribed, providing a wealth of written descriptions of how these foster parents conceptualized their children and their relationship to their children. Although a thorough qualitative analysis of these transcriptions was not possible given the time constraints of this project, it would be quite interesting and useful to analyze this data at a future point. There are several ways this material could be analyzed. First, it might be interesting to have the speech samples coded for Expressed Emotion (as this was the original and a well validated coding scheme designed for the FMSS) and then comparing these results with the RF data. Another way to analyze this data would be using content analysis. More specifically, a conceptual analysis that examines the existence and frequency of concepts represented by specific words or phrase could be conducted on these speech

samples. For example, it might be interesting to analyze how often parents used negative or positive words to describe their children's behavior. Another avenue to explore would be searching for words or phrases that convey parental warmth. Comparing these analyses along side the current results could provide a rich variety of qualitative outcomes.

Table 14

Means and Standard Deviations of Content Fidelity Variables by Group

	Intervention Group (n=10)		Comparison Group (n=10)	
Content of Training	*M*	*SD*	*M*	*SD*
Attachment	3.80	2.73	4.60	2.90
Trauma	5.00	2.46	5.65	2.46
Child development	5.45	.99	5.85	1.80
Child behavior	6.15	.34	6.50	.47
Meaning of children's emotions	6.10	.39	6.30	.42
Mentalization†	6.80*	.26	1.00	.00
Mentalizing exercises/activities†	5.00*	2.77	1.00	.00
Helping parents' understand their own emotions†	6.45*	.44	5.45	.76

Note: Items range from 1 to 7, with 7 representing highest/greatest level.
† Only presented in the Intervention
*$p < .01$

Although a thorough qualitative analysis was outside the scope of this thesis, the transcript material can provide powerful examples of how these foster parents mentalized themselves and their children before and after the intervention. The following is a sampling of speech samples per group.

Intervention FMSS Speech Samples

The following snippets are from speech samples before and after the intervention. They provide examples of how these parents changed in regards to their mentalization of themselves or their children. These parents often moved from simply verbalizing mental states to being able to form genuine reflective statements.

Speech Sample 1 PRE

> Um she is four years old and she's very girlie. Um loves frills and sparkles and glitter and everything princess. She's um very loving and very helpful. Loves to help in the kitchen, wants to kind of learn, she found an etiquette book on our bookshelf and wants to learn how to do everything in it from how to plan a wedding, how to set a table properly. She's just very kind of old school traditional, very girlie.

Speech Sample 1 POST

> Before the class it just thought ok she's very sweet. After the class it's very apparent that she's doing that because its very important that she pleases us and that she feels that acceptance and that love. It's important to her to have those feelings which I wasn't aware of prior to this. She needs to hear myself or my husband say: your beautiful or yes I would love your help or thank you for helping us or you are such a big help or um yes I would love to sit next to you and yes you know of course I want to give you a hug and a kiss. And she needs that reassurance that she is wanted and desired in the family, in our household.

Speech Sample 2 PRE

She's very warm, she makes me feel when she kisses me and hugs me and loves on me, just makes me feel good all over. We've had some problems as far as her listening and some of the behavior that she has that are not appropriate are because she learned um through her sister who has some behavioral issues, she has had a hard time with that.

Speech Sample 2 POST

Um she needs a lot of attention, she needs attention all the time. After this class I have realized what is driving her to be so insecure, so this class has helped me a lot to understand what she has been through um why her behaviors are the way she is. Recently she is now starting to hit people, other children and not wanting to behave, and this has made us realize that she just needs more affection and needs more of our time.

Speech Sample 3 PRE

The child in my home is incredibly sweet. She is very caring and aims to please. My overall opinion is that she extremely positive and wants to do the best that she can. Um I love her very much and hope that she gets to be with me forever. The only real problem I have seen with her is her lack of wanting to listen to what needs to be done. She can be very stubborn. Um she definitely is very sweet and loving, she has no problem wanting to get to know new people um she very much enjoys playtime and being happy. Negativity she definitely breaks down and will throw not necessarily a fit but she will cry and she gets very emotional. Um she definitely feels a lot of remorse when she sees or understands that she has done something that she shouldn't have done, and the reasons behind why she shouldn't have done it. Once she understands she definitely feels bad and will continuous, like continuously apologize and try to fix the situation.

Speech Sample 3 POST

The child in my home is very sweet and kind. She cares a lot about others. People generally like her and think she's very sweet, I love her very much, I feel like she could be an extremely intelligent and fun, loving child if she can get past certain bumps in her overall aspect of

life I guess. She has a lot of fear about people leaving her. Or that you won't come back for her. Being that, she has been in a lot of homes and came from a very difficult place. I can understand that being very hard, the only real problems we have recently had are wetting in the bed, and acting out in not necessarily mean or disruptive but she wont listen or she decides that she doesn't need to listen to what you have to say or what needs to be done, recently she got in trouble and did not know how to express what it was she was feeling or why she did what she did. I figured out very quickly that she was overwhelmed by the situation, there were too many people in the room, there was too much going on. So I moved her and put her in another room just me and her and just talked and discussed her feelings and what happened and how she felt and why she felt like it happened the way it did.

Speech Sample 4 PRE

My child is warm and affectionate. He um tries to be a good kid. I like him a lot. He's seems to work pretty hard. As far as a problem goes, the only problem that I've had with him really is uh there seems to be a lot of anxiety, and a lot of learning issues. We've actually had him tested, uh he um he has trouble with his memory and we go over the same thing over and over and over again. And a lot of it seems to be when you ask him questions, he panics and so some of the stuff we've been doing with him is making the work a little easier and trying to celebrate his successes and trying to tell him he is smart because I don't feel like he thinks he's smart. It's hard for him like spelling because he doesn't pronounce the words correctly and so if he doesn't pronounce it correctly, it is difficult for him to spell it correctly. So we work a lot on that kind of stuff. As far as his anxiety, whenever we start to study, he will often burst into tears and start to cry even though he is not doing poorly. But once he starts to cry, his ability to think goes down substantially so we have him get up and get… give him a glass of water or something else. But I don't let him up right away, I try to pressure on him to make him respond under pressure. And I tell him its okay that its hard and um I continuously try to reinforce it, life is hard for most people. And the difference between people who do well and people that don't is the ability to continue to work and to continue to try cause most people have failure.

Speech Sample 4 POST

He is a good kid. I like him a lot. He seems to have a really good personality, he seems to make friends easily. He is way behind in school, it's a little problem we have had with him and school has been a regular struggle with him. He did not speak English well. He was a year behind when he started and he started in first grade where he had to learn English. So it was very difficult, he did not feel good

about himself, he felt he was unintelligent, he felt like he was dumb. When he was in a learning environment, his anxiety level goes up especially if he's doing it with the MELs. MELs apparently cause him anxiety. I have a feeling this is because of his background. Probably because this class and probably because what I was doing was not working um looking for ways to assist him with that. One of the ways, its funny a lot of the stuff that went on in this class is kind of helping and reinforces some of the changes I've made which is um when he becomes frustrated or angry we take breaks. We do breathing exercises or we take deep breaths. I gave him a lot of positive feedback and then I talk to him in non-stressful situations where we're not [unintelligible] and I stress how far he has come and how much he has improved. And I make sure he knows that he's improved because of his work and that he is getting better and thing and getting easier. And I talk to him about you know you have to control your own emotions and how you feel and when you get overwhelmed you have to learn how to reset. That is what I call it actually, reset. The class helped some with understanding what is going on in his mind and why some of his behaviors end up being the way they are and we will continue to try to get him to want to deal with the negative emotions rather than just kind of spinning out of control.

The following are more snippets from other speech samples post intervention. They provide specific phrases or examples of deeper understanding and mentalization, particularly how the parents mentalize themselves.

Speech Sample 5

I try to talk to her about her feelings and you know why she doesn't do something or you know just I try to take the time to know what she is thinking. I had an older daughter that was killed in a car crash and um I feel like I didn't ask enough and that I didn't truly know her as well as I did. I didn't see her through the eyes of her friends. With [child's name] I watch and try to listen because I want to be a better mother. And um I don't want to miss anything.

Speech Sample 6

I need to extend myself more to her and to reassure her, because what I see is [that she is] clingy is [this is] her showing me that she needs

more love from me, so I plan to work on that a little bit more. I just need to make myself slow down more, that I think that's one of the biggest issues that I have, is that my triggers are, or my tolerance for, for behavior issues is a lot smaller than somebody else's, so I need to slow down and be mindful that these kids are not doing stuff to make me crazy on purpose, it's just that that's all that they've ever learnt. And my husband's very good about helping me see all of that, but unfortunately he helps me see it after (laughs) I've had a big blow up. But it's up to me to avoid that, um and just be more of course, you know, reflective, and thinking ahead of how I'm making things worse or think ahead of how I can um make things better just by my own reaction.

Speech Sample 7

Me being calm helps them be calm. After the tantrum is over, the crying and the screaming, we can talk about what happened and why is happened and that [has changed] leaps and bounds in all three of the kids, doing the time in. and that is something that I learned here, and how to mentalize and talk about what they are feeling about, what they're thinking and what they are going through. And that has been one of the biggest helps that we have learned from the class.

Speech Sample 8

Honestly, when he first came in, I was a So those are some of the tools that I have learned from this class, is to be able to be a little more tender, a little bit more um patient, but I do like the word tender because I did find myself being a little harsh with him when he first came in because I didn't really understand where he was coming from and again I was very afraid to let my guard down because of my fear of being hurt because I still believe that CPS is going to take him away from us, snatch him away.

Speech Sample 9

We take it personally, or my husband especially takes it personally the fact that he feels like he is tuning him out when in fact that is his way of coping with things, of not seeing the things he shouldn't have been seeing at his age or any age. You know it's been good for us to talk, amongst my spouse and myself, about you know where our kid is coming from and why he might be exhibiting some of those behaviors that he has. So I feel its really important that he be heard because I'm actually seeing some emotion out of him during those times that I won't regularly see. I think the class has really helped us to talk about some ways that we can support his emotions and feelings without

allowing him to see it as a humongous deal but at the same time allowing him to feel heard which is something that has always been something that's been very important to me.

Speech Sample 10

It is easier to put myself in his place and to remember he is a child with lots of issues and he does have trauma and he does have memories. So I can think about it easier and put myself in his place and remember and he's not doing this out of meanness or he's not angry because he is angry but he's angry because he doesn't understand. So that's when I talk with him. I'm just amazed how just in a month's time our relationship has changed, he has changed and we are working through things. I hope that I help him and you know these classes are great for helping us understand ourselves, how to be in a relationship with a child who has been, who has had a trauma experience or who has not felt loved or felt like they were worth something. To learn about ourselves helps us with our children and it has helped me tremendously. I'm amazed at the things that I know now and the things I feel now and the things that I can work through and control myself. You know the things that would help regulate me, so that I can help him regulate himself.

Speech Sample 11

But I think as time goes on, this class is going to help me be able to deal with maybe some of his thoughts, his feelings, other children that come into the home. I think it'll enable me to be able to understand where they are coming from and be able to think about my actions in order to be able to figure out what's going on with them. I think the class has been great and I think it opened your eyes for a lot of things that you're really not thinking about for what can possibly be going on in the child's head and also opened my eyes for other people besides my own and you see how they're acting and the things that they're doing and um maybe other advice that you can give to the other parents because they're having issues.

Post Comparison Group FMSS Speech Samples

In contrast to the intervention group, after the comparison group class, foster parents talked about their parenting and their children in less reflective ways. This can be seen in the following snippets, which provide examples of simple descriptions of their child or superficial mental state language that lacks true or complex reflections of self or other.

Speech Sample 12

I love him very much. He's adopted; we adopted him at about 8 months old. We knew that it was going to be a challenge. We also prepared for his adoption by checking with our jobs, to see if they would be willing to work with us, in regards to being able to go to daycare and his school to be able to help him be able to be functional in society. We recently had to change his medications because he was starting to show more signs of anxiety, um, anger. Also with that, he started to have encopresis in his underwear or simply not going to the bathroom. So we changed his medicines. We are starting to have to retrain his bowel habits for him to be able to go at home and on his lunch break and also, when he gets home from school.

Speech Sample 13

My child is almost three, and he is like no other little boy. He runs, he plays, he's active, wild imagination. He's full of life, he's just curious about anything and everything. Loves to be very adventurous, likes to be a little bit dangerous as opposed to, nothing really scares him at all. He does not like to sit still, he does not like to be inside, he likes to be outside playing, jumping, running, climbing, he loves motorcycles. He knows when I'm upset. He'll come and ask me if I'm Okay. I just love that.

Speech Sample 14

What is your child like? She is a four year old who is very smart. She likes to play with Legos and other kids and wants to be a helper. Loves to be the center of attention. She likes to learn and do new

things um but overall she's just a sweet little girl who has had to overcome some issues regarding behavior. Um mostly because of a loss, seems like she had a lot of loss in her early life. That's about all I can really say about how she is. How do you feel about your child? Um I love her. I think she's a very sweet child.

Speech Sample 15

Hi. What is your child like? He is two and a half and very strong willed and kind of knows what he wants. I think a lots of typically two and half year behavior. He loves, his song right now is itsy bitsy spider and he uh likes riding his bike and he loves playing outside and going on hikes. How do you feel about your child? Um well I um love spending time with him and I work outside of house all day and so I always get really excited when I get to come home and spend time with him and my husband. I love him a lot and um he sometimes has a hard time where I guess he doesn't see my very often cause I'm at work all day and so he really likes to spend time with my husband and its always…sometimes its like I'm competition for something. I don't know. So that kind of hurts a little that he wants to spend more time with my husband than me.

Speech Sample 16

Um the response to the first question, what is your child like? He's 22 months old and he was removed from his biological parents when he was 4 weeks old so fortunately he didn't really stay with her a long time and he's so young that he really doesn't remember a lot of what went on and um he seems to be a really normal, typical toddler. Hard-headed [laughs]. Learning a lot of stuff right now and um just a very active and um testing limits so it's interesting every day. And as far as how I feel about my child, um I mean I loved him from the minute I met him and I love him even more today.

Speech Sample 17

He's real picky about foods and we have issues with that but he's healthy so I guess that's the main thing, its not like he's malnourished or anything like that [laughs]. Foods are a real problem but like I said, I couldn't be happier with him. I mean I'm sure that down the road there may be some issues if he inherits any of the mental issues from his mother you know that's just something we'll have to deal with once we reach that you know and there may never be a problem.

Speech Sample 18

But he does tend to just ignore you sometimes and that kind of gets on my nerves sometimes but we've been working on that. A lot of times what I'll end up doing is kind of getting his attention and have him actually look at me when I'm talking to him. That way I'll actually know he's hearing what I'm saying. 'Cause a lot of times he will just tune you out. But as far as a major problem, like I said, he's only 22 months so there's nothing really major in his behavior that's really a problem; sometimes it seems he is just flat out ignoring me when I am trying to tell him to do something or asking him something or you know, he just wont respond, just stand there and just keep doing what he's doing until I actually walk over and touch him.

Chapter 8 – Discussion

This is the first known study to demonstrate that a short-term intervention designed to increase mentalization can be effective with foster parents. This intervention was designed to increase foster parents' ability to mentalize. By increasing a parent's ability to understand the mental states of themselves and their children, you can positively impact their relationship with their children, which can increase positive outcomes for the entire family (Allen et al., 2008). Results indicate the intervention was effective in enhancing parental mentalization. Specifically, it was hypothesized that parents in the intervention group would increase their mentalizing abilities more so than the parents in the comparison group. Results from both mentalization measures (The Parental Reflective Functioning Questionnaire and the Five Minute Speech Sample coded for Reflective Functioning) support this hypothesis and clearly demonstrate that parents in the intervention group improved their mentalizing abilities significantly more than the comparison group parents. It was also predicted that the parents in the intervention group would report less parental stress after the intervention than the comparison group parents. Although there were significant differences between groups on this measure, results demonstrate that these differences were due to an increase in reported parental stress of the comparison group rather than a significant decrease of stress in the intervention group. Finally, it was hypothesized that parents in the intervention group would report their children to have less significant behavioral and emotional issues post intervention than the parents in the comparison group. The findings did not support this last hypothesis, as there were no significant differences in child behavior or emotional issues between the groups. This chapter is meant to

discuss the results of this study and examine in more detail the implications of this intervention on parents mentalizing, parenting stress and child behavior.

Mentalizing Capacity

These findings support the notion that a short-term psychoeducational intervention can indeed increase a foster parent's ability to mentalize themselves as well as their children. According to the Five-Minute Speech Sample results, foster parents in both the intervention and comparison groups began the study with the same relatively low level of reflective abilities, which indicates they frequently used mental state language but were not especially reflective and did not appear to have a complex view of the interactional nature of mental states in relationships. Having low reflective functioning (RF) could also indicate that a parent is not very aware that their child has individual thoughts and feelings that motivate their intentions and behaviors (Slade et al., 2004). By the end of the mentalizing intervention, it was only the parents who went through the intervention who significantly increased their overall ability to be reflective and mentalize themselves as well as their children. The intervention foster parents significantly increased their reflective abilities to a level that indicated definite reflective capacities, their ability to understand experiences in terms of feelings and thoughts. Some had even developed their RF abilities to a more sophisticated and complex level, such as being able to figure out the mental states that lie behind behavior. It is this more developed parental mentalizing that is thought to be key for helping children develop their own mentalizing skills as well as a sense of agency and self-regulation (Fonagy et al., 2002).

There are three key features of parental mentalizing that were also examined:

(a) curiosity in mental states, (b) the ability to recognize the opacity of mental states (certainty subscale of PRFQ), and (c) non-mentalizing (prementalizing subscale of PRFQ) modes characteristic of parents with impairments in parental reflective functioning. Results indicate that overall mentalizing increased significantly for the intervention group, and this was mostly accounted for by the increase in foster parents' abilities to recognize the opacity of mental states. This means parents in the intervention group became more flexible in their mentalizing, which counteracts the rigidity and inaccuracy of non-mentalizing states (Asen & Fonagy, 2011). This skill also implies these foster parents have a better understanding of the transient nature of feelings states, which is an important trait to have when working with children who have been traumatized and carry into their new relationship with their foster parents, old dysfunctional patterns of relating to parental figures. The difference between groups in overall mentalizing was also somewhat impacted via a reduction in the non-mentalizing modes for the intervention group, however it was not impacted by an increase in their curiosity about mental states but rather by the significant lowering of curiosity in the comparison group.

The mentalizing skills gained by the foster parents in the intervention group are, hypothetically, quite beneficial for foster parents to improve upon, as they frequently deal with children who come into their home with challenging behaviors, attachment issues and negative internal working models of relationships. A foster parent with such skills will be less likely to jump to conclusions about their foster children's negative behaviors, less likely to assume negative intentions to those behaviors and as a result will be more likely to interact with them in a therapeutic manner or in way that prevents triggering reactions related to previous traumas. These specific mentalizing

skills help parents emotionally and behaviorally regulate themselves during difficult interactions with children, and by extension, this helps to regulate the children themselves (Asen and Fonagy, 2011). These skills help parents experience their own, as well as their children's, emotions in a non-defensive manner without becoming overwrought or closing themselves off from their children (Slade, 2005). These skills support a relationship between foster parent and child that promotes trust, security and attachment.

An important and intriguing finding also concerns the comparison group parents and their mentalizing abilities. By the end of the study, their mentalizing capabilities appeared to have lowered. Although they did not lower their overall mentalizing abilities significantly as rated on the PRFQ, they did significantly lower their curiosity about mental states. These are opposite results from the intervention group and were surprising. The material presented to the comparison group was similar to that of the intervention group, minus the mentalizing pieces and interactive exercises/homework. The material and class the comparison group parents received was considered "treatment as usual" or a typical class given to foster parents in this area. This makes one wonder if short educational classes primarily meant to impart knowledge can have a negative impact on parent's reflective capacities. Perhaps a typical class might decrease foster parents' curiosity because they are learning specific facts about foster children, which gives them a feeling of "mastery", an overconfidence in "knowing" these children. This in turn, might either decrease a further curiosity about their children and/or support a non-mentalizing state. It could be that because the comparison class was shorter than the intervention and given in only one class, these parents did not have a chance to develop additional skills over time. However, given there was no

specific mentalizing information or exercises given to the comparison group this explanation seems unlikely. Overall, this finding might raise questions about the possible negative impact on mentalization for foster parents who receive traditional educational trainings in this manner and further exploration could be useful.

Given that both the intervention and comparison group contained similar material on some of the same topics, such as attachment and trauma, it is thought that the mentalizing information and exercises that exist solely in the intervention contributed to these differences between the groups. This is supported by the fidelity study results that indicated minor (to no) variation in the quality of training between groups with no statistically significant differences. The intervention material explicitly describes the importance and impact of mentalization and gave the parents opportunities to practice these skills both in the workshop and at home with their children. Almost all foster parents who volunteered information about these at-home activities gave detailed narrative accounts of experiences that indicate in increase in understanding either their own mental states or that of their children. More specifically, they appear to have deepened their connection to their children and saw them from a different and more complex perspective. Additionally, the foster parents felt the exercises helped their children more safely express and share their emotions. This qualitative data provides independent evidence of an increase in parental mentalizing as a result of this intervention. Other information gleaned from a general evaluation indicated the foster parents thought very highly of the intervention, thought it was taught well, was easy to understand, helped them improve their parenting skills or taught them new ones, and helped them understand themselves better as well as their children.

Parenting Stress

Parenting stress is generally defined as the stress and accompanying difficulties that result from the burden of parenting. It is well known that fostering children who have a history of trauma is quite stressful for foster parents. Parenting stress has been found to have a deleterious impact on the quality of attachment between an infant and caregiver (Belsky, 1999) and has consistently been linked with children's insecure attachment (Teti, Nakagawa, Das, & Wirth, 1991). Research has also shown that parents who see their children as demanding or moody, or that their relationship with their child is difficult, report higher levels of stress (Jackson & Huang, 1998; Ostberg & Hagekull, 2000). There is also a large body of research that implies parenting stress specifically impacts parenting behaviors in a negative way (Abidin, 1995; Deater-Deckard & Scarr, 1996). There have been a number of studies that reveal that when parents see their children as difficult, they also tend to lack sensitivity and warmth in their interactions with their children and display inconsistent or harsh discipline and inappropriate developmental expectations (Crawford a& Manassis, 2001; Creasy & Reese, 1996; Karrass et al., 2004; Pinderhughes et al., 2000; Rodriguez and Green, 1996). It is also hypothesized that parenting stress is linked to poor emotional and behavioral adjustment in children (Deater-Deckard, 1998). More specifically, it is assumed that parenting stress interferes with the parenting skills that help children regulate their emotions and behavior (Masten & Coatsworth, 1998). Such self-regulation is important for children's social and relational development and is a key factor in the development of mentalizing skills (Allen et al., 2008).

Our findings also partially support the hypothesis that a mentalization-based psychoeducational intervention could lower the parenting stress of foster parents. It is

important to note that for both the intervention and comparison groups, mean scores on the PSI fell into the "Normal" range, meaning that on average, these parents were not dealing with a clinically significant level of stress. This means their parenting stress is in line with the general population and is not apparently excessive although they are foster parents. Despite this, there was still an overall difference between the groups on Total Stress that approached significance. When looking at the different dimensions of parenting stress as defined on the PSI (Defensive Responding, Child Difficulty, Parental Distress and Child Dysfunctional Interaction), it seems the intervention most impacted a foster parents' perception of the difficulty of parenting their foster children. There was a marginally significant decrease in this perception after the intervention while the comparison group parents' perceptions of child difficulty remained unchanged. It is thought that with a larger sample we might observe a more obvious and significant reduction of child perceived difficulty. Despite this finding, the differences between the groups appears to have been mostly due to the significant increase in the defensive responding and parental distress of the comparison group parents. Again, the comparison group class seems to have ended up with scores that could indicate a trend towards negative outcomes for those parents who attended. One way of interpreting these results is to say that the intervention mitigated a natural process of cumulative increase in defensiveness on the part of the foster parents as the course progressed. The course inevitably confronts foster parents with emotionally evocative material that is both pertinent to them because of the direct relevance to the child they are looking after and because it may also resonate with aspects of their own personal histories. Under these circumstances it might be expected that if such material is distressing, than it may be treated dismissively, denying its personal relevance, and emotional

significance. We know that such a defensive attitude is common in the face of emotional trauma (Bond, 2004; Northoff, et al., 2007). By contrast, we might expect that a training primarily concerned with the mentalization of emotional experiences would disrupt this natural process of self-protection. Remaining reflective about emotional experience is a key feature of mentalization. We may imagine that two processes are at work: Firstly, reflecting on one's own emotional reactions helps to limit its impact and reduces the need for self-protection. Secondly, focusing on the potential impact of traumatic experience on the child in a thoughtful manageable manner, will serve to limit avoidance, and to openly contemplate distressing scenarios that a child in care is likely to have experienced prior to being taken into care. Both processes are likely to work in the direction of reducing cognitive distortion as a way of managing negative emotions.

In summary, both groups of parents appeared to have had a typical amount of parenting stress before they started their respective classes. As both groups completed their classes, the foster parents in the intervention appeared to have somewhat decreased their stress level in one specific area (child difficulty) whilst the comparison group foster parents significantly increased their perception of stress in two of parenting (defensive responding and parental distress). These results beg the question, was it the increase in mentalizing skills that helped the intervention parents feel a bit less stressed unlike the comparison group parents? When parents fail to mentalize their children accurately, this has an impact on their own emotions (Sharp & Fonagy, 2008). For when a child misbehaves, it is a parent's interpretation of the child's intentions that determines how upset the parent becomes (Dix & Crusec, 1985). Foster parents' written feedback indicate that they did feel they understood their children and

their behaviors better, which could indeed lower their perception of parenting stress. These foster parents also felt more competent after the intervention, reporting to have increased both their parenting skills and their understanding of their own reactions. This can be seen in statements such as "I feel the class has opened my eyes of how to handle stuff when it comes up" and "This training and concept is huge. Understanding why makes all the difference. You can't fix anything until you understand the problem!"

Child Adjustment

Given that foster children have more emotional and behavioral issues than typical children, they are at a higher risk for placement breakdown, which leads to a myriad of negative outcomes for this population (Bohman & Sigvardson, 1990; Claussen et al., 1998, Oosterman et al., 2007). Additionally, research has shown that an increased level of behavior problems in foster children can elevate the stress levels of foster parents (Chamberlain et al., 2006). Accurate and robust parental mentalizing affects children's emotions and behaviors by directly impacting the relationship between caregiver and child in positive way (Allen et al., 2008). One of our hypotheses was that the intervention would positively impact children's emotional and behavioral difficulties. Unfortunately, our results did not support this particular hypothesis. There were no significant changes in emotional or behavioral issues in either group. However, the intervention group did appear to report more total difficulties with their children at the start of the intervention, in particular more conduct and hyperactivity issues. Their children's behaviors were borderline clinical in these areas. It is unknown why this group reported more issues with their children than the comparison group, but given this was not a randomized controlled trial, it could be these parents self-selected themselves for the intervention due to having more issues with their children.

Interestingly, there were no abnormal clinical scores in either group, meaning these children did not have a significant level of emotional or behavioral issues that would require clinical intervention. This makes sense given these children are considered to only require a basic level of care in the state child protection system, meaning they have not yet displayed a concerning level of emotional or behavioral issues. Given this, there may only be a small window then for changes to show themselves on this measure.

Perhaps given most of these children had no significant adjustment issues, it was unlikely that they would benefit from the intervention in this manner. In addition, given the brief nature of the intervention, it is possible it was too short of a timeframe to bring about real changes in the children's emotional and behavioral states. Perhaps a more longitudinal following of the intervention group would reveal positive changes in emotions and behaviors over time. Even though there was no significant change in child adjustment within the intervention group, the fact that the intervention group began with more difficulties could be said to strengthen some of the findings of this study. In other words, it is intriguing that the intervention group improved their mentalizing skills despite having more children with adjustment problems. It is also likely that regression to the mean could be at play or they could simply be chance findings. Despite this, these results merit exploring the impact of increasing mentalizing skills with parents of children with clinically significant behavior problems and it would be exciting to see how this intervention could impact the behavior of such children in future studies.

Limitations and Strengths

It is important to note that here were several limitations to this study. First, participants were not randomly selected or assigned to the treatment conditions.

Foster parents chose which group to participate in, so they self-selected and assigned themselves to the conditions. This limits both the generalizability of the results, as well introduces the possibility of selection bias. Despite the lack of random assignment, both groups of foster parents proved extremely similar to one another with no significant differences between groups. Second, given the study's short timeframe and the challenges of conducting research with a foster parent population in which instability and attrition is common, the sample size was small and this reduced the power of some of the analyses as well as generalizability of the results. There were some results that approached significance and a larger sample size most likely would have pushed these scores into statistical significance.

Another limitation was that the intervention and comparison groups were not the same length of class time, with the comparison group being shorter in length and conducted in about half the time it took to conduct the intervention. Although the comparison group class was designed to be used as "treatment as usual", this limits the true comparability of the group, as it did not perfectly mirror the intervention group in this regard. The different timeframes could affect the results in a number of ways. Perhaps the fact that more time was spent with the intervention group influenced the positive results, given this group simply received more time and attention to their needs by the instructor than the comparison group. In addition, the intervention group was designed so that the parents would leave and return at a later time, giving them extra time to practice these new skills at home. This process allows extra time to digest the material and process their reactions and experiences. Even without having the mentalizing homework, this extra time might have benefited the comparison group in similar ways if it was designed in such a manner.

Another possible limitation concerns the trainer. The same trainer was used for both the intervention and comparison group, and this trainer was the author. It is possible that given the personal investment and belief in this intervention by the trainer, this could have influenced the outcome of the intervention group. Having both groups taught by the same instructor does improve the study in some ways (such as providing consistency and similar quality across groups), yet there is still a chance that because the trainer was not blind to the groups, that bias was introduced. This limitation is mitigated by the fidelity work done at the end of the study, which provides some evidence that both groups were conducted equally with regards to engagement and teaching skills (see Table 13).

Finally, although some standardized measures were used, there were two key measures of mentalization that are essentially new and not firmly established. The Parent Reflective Functioning Questionnaire (PRFQ; Luyten, Mayes, Nijssens, & Fonagy, in press) for instance, is a new measure that has established initial validity, but it has not yet been published and thus there are not many studies to support this measure. Additionally, the Five-Minute Speech Sample (FMSS; Gottschalk, 1969) was coded in a way that is not typical for this instrument. Although Reflective Functioning (RF) coding for the Parent Development Interview (PDI; Slade, Aber, Bresgi, Berger, & Kaplan, 2004) and Adult Attachment Interview (AAI; George et al., 1985) has been well studied, the coding of the FMSS for RF has not been established as a valid and reliable measure of mentalization. These are significant issues, however it must be stated that it the intention in using these measures in this study was so that this data contributes to the developing literature on ways to accurately and reliably measure mentalization. Another point regarding all these measures is that they were mostly via parent report

with no child or observational assessments of the key variables of interest. This would be fine for understanding parent report of stress and mentalization, but the research results might have been stronger with independent observations of parent stress and child emotional and behavior problems.

There were also a number of issues with the study in general. Although the total N was ample for a small study (N=102), the number of parents who completed the post assessments varied by instrument and group, and these numbers sometimes ended up significantly smaller than was expected, which limited matched comparisons. This was partially due to attrition in the intervention group (11/54=20%), but was more related to the measurement collection procedure used with the comparison group. Because the comparison group was only one class, we needed to match the timeframe more exactly for the post data collection. This meant that the participants in the comparison group needed to wait 4-5 weeks after their class to return their post measurements. Although incentives were offered, as well as frequent reminders to complete the measures, this significantly lowered the number of post assessments that were received from this group. This was in contrast to the intervention group, who were able to complete their post assessments at the end of the last class and under supervision. This was particularly true of the interview procedure, the Five-Minute Speech Sample (FMSS; Gottschalk, 1969). Even though the intervention group was left alone to speak into a recorder for this interview, they were more influenced to do this by the class structure and request of the instructor. For the comparison group, they were asked to complete the speech sample via a phone call where they left a voice recording. This method made it difficult to compel and supervise the post responses.

Despite these limitations, there are several strengths to this study as well. The main strength of this study was that it used a comparison group and pre-post test design, which increases the causal inference that can be made regarding the efficacy of the intervention. A promising intervention was delivered and data was collected from two similar groups at two different time points, in an under-researched population, i.e. foster parents. Great care was taken to make sure all the classes, as well as the data collection procedure, was done in a similar manner and similar timeframe. Also, many of the results had medium effect sizes, which supports foster parent improvement in key variables following the intervention. It is also important to note that the groups were conducted in the same area, with the same population of foster parents and using the same instructor. Additionally, the intervention was independently assessed for treatment adherence and fidelity. Results provide strong evidence that both the intervention and comparison class were conducted at a similarly high level of quality. Components of the intervention designed to impact mentalization were adhered to faithfully and consistently, and were different than the components of the comparison group. All of this provides ample support that it was indeed the intervention itself that was responsible for the positive outcomes in the intervention group. Another strength of this study concerns the Five-Minute Speech Sample. This measure was one of the only non self-report assessments used in this study. These speech samples were transcribed and coded by trained independent raters and provided a more objective measure of parent reflective functioning. They also provided rich qualitative material of the foster parents' experiences.

Future Directions

This study provided both a pilot study and feasibility trial for this intervention. Given the promising results of this study, this provides solid preliminary evidence that this intervention has clinical value. It is important to replicate these findings, as this is the first known study implementing a mentalizing intervention with foster parents. Thus, the next phase would be to undertake a systematic randomized controlled trial to provide further evidence of intervention efficacy. Further studies should provide both larger samples of foster parents, and include a more evenly matched comparison group as well as non-treatment group. Larger samples of randomized foster parents would go far in supporting the conclusions drawn from the results of this study. Additionally, it would be useful to follow foster parents longitudinally, to see if these mentalizing gains are stable over time. Longitudinal studies would also be more useful in assessing whether an increase in mentalizing skills has an affect on their children's emotional and behavioral difficulties over time, especially given this study was too short in duration to see an impact on these variables. It would also be prudent to add additional measures of RF such as the PDI (Slade, Aber, Bresgi, Berger, & Kaplan, 2004) or AAI (George et al., 1985), to demonstrate support of the results obtained on the relatively new self-report measure of RF, the PRFQ (Luyten, Mayes, Nijssens, & Fonagy, in press) and the FMSS coded for RF. Finally, the intervention needs to be tested with other populations and cultures so as to generalize beyond foster parents in Texas.

Additionally, one of the goals of this intervention was to improve and develop parents' reflective capacities and mentalization abilities so as to positively impact the quality of the relationship with their foster children, by helping them develop a more secure attachment and increase their children's mentalization skills. Further research

could extend the results of this study by examining both the attachment status of the foster children in the care of the foster parents, as well as these children's mentalizing skills. Furthermore, it might be very interesting to assess foster children's internal working models throughout a longitudinal intervention study, given that research suggests that after experiencing parents who reflect secure parenting traits, foster children can let go of their old mental representations of and replace them with internal working models that reflect available, caring and sensitive caregiving (M. Steele et al., 2010).

In the future, it is hoped that an RCT of this intervention will be conducted. If this were to happen, there are several recommended changes to the intervention based on the results and process information gleaned during this study. First, it is recommended that some of the didactic material be reduced so that less is said about topics and more is experienced. There is a lot of instructional material, and it is thought that it was the exercises and homework activities that provided the most powerful impact on the mentalizing abilities of the parents. This could reduce the overall length of the training as well, which might add to its' attractiveness as a short-term and practical intervention. It is also recommended that the instructor more thoroughly demonstrate the homework activities with the parents in the class before they leave. The homework activities were typically just described, but not demonstrated, which might provide more opportunities to mentalize within the class and increase the chances of the parents using the activities at home with their children. If possible, it would be good to provide actual resources to these parents related to the at-home activities as well, such as emotion charts, books, videos etc. In this study, parents were mostly responsible for finding those materials on their own, which could have reduced

participation. Another possible would be the addition of a co-trainer. This would have several benefits including logistical support as well as increasing engagement and participation, particularly by allowing mentalizing demonstrations and modeling by the instructors.

Conclusion

The goal of this study was to create a psychoeducational intervention for foster parents that would not only educate parents, but also increase their mentalizing abilities. Given the results, it is likely that this intervention achieved this goal. This intervention also appeared to have somewhat lowered foster parents' perceived stress, perhaps as a result of the increase in their mentalizing capacities. This study shows that a short-term psychoeducational intervention can make a positive impact on foster and adoptive parents' mentalizing skills. To this date, no known mentalization-based intervention has been tested with foster parents. Thus far, most attachment-based interventions have been clinical in nature and focused on impacting the parent/infant relationship (M. Dozier et al., 2002; Juffer et al., 2007; Marvin et al., 2002). This study was designed to be more practical and educational manner, administered in a group structure over a short timeframe (4-6 weeks), and designed to impact foster children of all ages. This study provides ample evidence and supports attachment researchers suggestions that group work with parents could enhance and support their mentalizing abilities (Juffer et al., 2003; Marvin et al., 2002).

Section III

Summary

Chapter 9 – Thesis Summary

The goal of this project was to develop and then implement, a mentalizing intervention for foster parents. This summary is meant to take the reader through the journey of this thesis, how this intervention came to be and the implications of the successful implementation of this intervention. In developing this intervention and in writing this thesis, it was necessary to begin with an examination of attachment theory and the development of mentalization to set the stage for the need and importance of such an intervention. When one thinks about the impact of fostering a maltreated child, it is hard to deny the importance of attachment theory in this endeavor. Attachment theory can be thought of as a relational psychoanalytic theory, and although it has at times been viewed controversially within the field of psychoanalysis, there are far more similarities between attachment theory and traditional psychoanalytic ideas than differences (Fonagy, 2001; Mitchell, 1988). After all, Freud also recognized that a child's relationship to their mother is entirely unique, formed early on and creates the basis for all other relationships in life (Freud, 1938). Bowlby noticed quite early on that it is essential for infants to have an unbroken attachment to their caregivers if they are to develop in appropriate and healthy ways. He discovered through his work that if a child's early attachment is disrupted, it could result in a number of ill effects as that child grows older (Bowlby, 1951). He theorized that the primary reason for children's emotional disturbances did not lie in their internal fantasies or drive conflicts, but as the direct result of their experiences with their caregivers (Bretherton, 1992). He eventually expanded his theory to include the idea that the caregiver needs to be emotionally, as well as physically, available to their children to create a secure

attachment, which serves as a protective factor in the development. Mary Ainsworth (1969;1985) expanded on Bowlby's work, helping create categories of attachment and caregiver behavior that corresponded to these categories. As attachment theory progressed, it was hypothesized that secure infants have caregivers that create sensitive and attuned interactions with their child, which helps their child emotionally regulate themselves as well as self-organize (Sroufe, 1979; 1996). Disorganized infants do not usually experience such interactions with their caregivers. Maltreatment has been linked to both disorganized attachment as well as with parents who have a history of unresolved trauma (Cicchetti, 1991; Main, 1990).

Eventually, when exploring attachment in adults, Mary Main was able to link the way adults talk about (organize their own thoughts and speech) about their own childhood experiences of attachment, to the attachment status of their own children (Main et al., 1985). Her team discovered a significant correlation between adult attachment state of mind on the Adult Attachment Interview (AAI) and children's attachment status and these results have been well replicated, and have been critical for clarifying the intergenerational transmission of attachment patterns (Bus & van Ijzendoorn, 1992; Grossman et al.,1988; Ward & Carson, 1995). It did not take long for researchers to want to understand more deeply, the factors that contribute to how this attachment is transmitted from caregiver to child. One theory that has been well researched, is that "maternal sensitivity" was the trait that most contributed to infant attachment security (Ainsworth, 1978). Although there is a fair amount of convincing evidence that there is a robust correlation between maternal sensitivity and attachment security, many have questioned whether this is the factor responsible for the transmission of attachment security (Beslky, 1997). One team of researchers in the

Netherlands undertook a large meta-analysis to determine just how robust this connection really is (DeWolff & van Ijzendoorn, 1997). They discovered that overall, maternal sensitivity has a small effect size on its contribution to attachment security and questioned why this effect size is not larger, labeling this the "transmission gap" of attachment. Since this, researchers in London have created a strong case that perhaps it is the trait of parental mentalization that is responsible for this transmission gap (Fonagy & Target, 2005).

The term "reflective functioning" (RF) was developed by a team of researchers involved in the London Parent-Child Study who wanted to find out whether parents' AAI classifications would be predictive of their childrens' attachment at one year and again at 18 months (Fonagy et al., 1991). When going over this data and considering the different ways attachment might be transmitted, Fonagy and his team formed the idea attachment might be transmitted via a parent's reflective capacities and their ability to mentalize, revealed in their use of certain words and phrases, which led to a new "RF" scale on the AAI (Fonagy et al., 1998; Slade, 2005). This team defines RF generally as the ability to reflect upon the mental states and intentions of both self and of others. Results confirmed this connection, with those parents scoring high in reflective functioning also tending to be classified as secure on the AAI and were highly likely to have children who were rated as having secure attachment at one year (Fonagy et al., 1995). Additional research since then has supported this data, as well as linked limitations in RF as contributing to the development of psychopathology in adults (Fonagy, 2000). Arietta Slade has taken much of this work and expanded it to include how RF impacts parents and their parenting (Slade, 2005). This work supports the theory that a parent's ability to mentalize about their child, to be reflective in a way that

supports their child having their own intentions, are parents who are more likely to have a secure attachment state of mind and have high RF (Fonagy & Target, 2005). It is thought that secure attachment state of mind allows parents to explore their own mind and encourages being open to understanding the mind of their child as well. Mentalization is also thought to serve as a buffer against affect dysregulation during stressful moments, so parents who have high RF are thought to have a better capacity to regulate their child's fear and other upsetting emotions without frightening or disorganizing them (Grienenberger, 2005). Fonagy and Target (2005) have proposed that the theory of mentalization has gone far in filling this transmission gap and that it could very well be a major factor responsible for the intergenerational transmission of attachment.

The next step in this thesis was to explain why attachment and mentalization is particularly important for the population of this study. As such, we continue with a summary of the impact of childhood maltreatment, the outcomes of foster care and a closer look at the caregivers of these children. It has been well researched and documented that child maltreatment has a significant negative impact on children's emotional and physical development and puts them at risk for a lifetime of mental and physical health issues (Arnow, 2004). There has been an abundance of research that has found associations between childhood maltreatment and a variety of physical health problems in adults, such as migraines, cancer, pain disorders and heart disease (Dong et al., 2003; George & Main, 1979; Irish et al., 2010). Additionally, a broad range of psychiatric conditions and symptoms have been linked with a childhood history of maltreatment. The literature paints a clear picture that being maltreated as child sets one up for a number of poor mental health outcomes that include, amongst other issues,

a greater chance of being diagnosed with a personality and/or mood disorder (Arnow, 2004; Johnson et al., 1999; Kaplow & Widom, 2007). There are also a number of studies from around the world that solidly link a history of maltreatment to an increased chance of having short or long-term depression (Spatz et al., 2007; Wright et al., 2009).

However, it is not just the maltreatment that is deleterious. When a child is removed from their primary caregivers, this can result in a myriad of negative developmental consequences. The main goal of foster care is to provide a child with a temporary and safe home environment. However, a well-known and long-term issue within the foster care system is that these stays are rarely temporary and children often stay in foster homes for quite long periods of time (Dozier et al., 2006). Also, foster children quite often experience changes in their placement, with a variety of studies reporting placement instability of foster care youth to ranging anywhere from 22% to 56% (Pardeck, 1984; Kufeldt et al., 1989). Unfortunately, there is a clear connection between multiple disruptions in placement and negative outcomes for children (Fanshel et al., 1990; Newton et al., 2000). These children suffer from a number of emotional and behavioral problems as a result of such placement instability (Newton et al., 2000; Rubin et al., 2007). It is even more important for such children to have a stable home, with foster parents they can form attachments to and that allow them to stay for as long as necessary. Unfortunately, the placement disruption rate for foster homes seems to be anywhere from 20-70% (Chamberlain, 2006; Leathers, 2006; Minty, 1999).

Given it has been well researched that parents can significantly impact the mental health and overall functioning of children, it becomes even more important to explore what is known about the parents who care for foster children (Elicker et al.,

1992; Fonagy & Target, 1997). Unfortunately, there is surprisingly little known about these parents (Trisellotis et. al. 2000; Warren, 1997). This is an extraordinary gap in our research given how many millions of children have been placed with foster parents over the decades (Orme, 2006). Even though foster parents care for some of the most vulnerable children, there is a clear lack of psychological information about this population. In addition, very little is known about foster parent's attachment history, adult attachment status or how they interact behaviorally with their foster children (Ballen et. al., 2010). After looking at the research that does exist on foster parents, it appears that about 15-20% of foster parents demonstrate problematic parenting or issues in family functioning (Orme & Beuhler, 2001). There are only a few studies that have looked at foster parents attachment status and collectively, these studies suggest that a large proportion of foster parents have insecure states of mind compared with the general population (Ballen et al., 2010). When examining how this impacts foster children, Dozier et al. (2001) found that foster infants were more likely to develop disorganized attachment when placed with foster parents who had insecure and unresolved states of mind. All of these results certainly suggest that foster parents with insecure attachment states of mind are at risk of interacting with their foster child in a disruptive and even frightening manner. This is understandable given that a parent's ability to mentalize their child and interact with them in a sensitive manner, directly relates to their own attachment status (Slade, 2005). Both the lack of research on foster parents and the concerning level of insecure states of mind among foster parents points to possible concerns regarding how foster parents are selected and trained. A prominent study that examined the foster parent selection process in the U.S., discovered that most parents are generally assessed for psychosocial functioning, but

not using any standardized measures (Orme et al., 2006). Instead, this process usually relies on the subjective judgment of caseworkers, which has many limitations (Kadushin & Martin, 1998; Dawes et al., 1989). In Texas, the foster home approval process includes a series of home and background checks, but is mostly dominated by the home study interview ("Minimum standards", 2014). Since there is no psychological testing and no assessments given, their capacities are often determined subjectively by the caseworker and social worker conducting the home study. Unfortunately, understanding adult attachment status, mentalization or the complex interplay of psychological defenses are usually not part of child welfare professionals' training or education.

Regardless of how these foster parents are selected, they must receive a basic level of training to become licensed. Given that foster parent training has been linked to placement success (Kalland & Sinkkonen, 2001) and is seen as an important part of preventing placement breakdowns (Blakey et al., 2012), it would seem that it is as important as ever to ensure that foster parent training be rigorously tested for positive outcomes and be standardized. Unfortunately, the effectiveness of many foster parent training curriculums in the U.S. is presently unknown and current research does not provide any evidence that the most common foster parent training programs actually change parenting behavior or improve these parents' success at parenting (Puddy & Jackson, 2003). Given how much is not known about foster parents, as well as the potential issues with foster parents' attachment status, how they are selected and the lack of adequate training and support, it seems they could immensely benefit from a training intervention that focuses on improving their mentalization skills. Before creating this intervention, it was first important to review the attachment and

mentalization-based interventions that already exist for parents, particularly foster and adoptive parents.

Although there has been an abundance of attachment based prevention and intervention programs that have emerged since the late 1980s (Berlin, 2008), more modern attachment-based interventions include outcome goals that center on "parental sensitivity", as research has supported this trait being heavily correlated to attachment security (Belsky, 1997). Also, since reflective functioning and mentalization are relatively new concepts, there are only a small number of interventions and evaluations that have been produced in this arena. This summary focused mainly on the most popular and evaluated interventions for parents and children that focus on increasing either parental sensitivity or mentalization. Because there are very few interventions in this field that have been designed for or implemented with foster/adoptive parents, interventions focused on traditional parents were mainly reviewed. Of the attachment-based interventions, three interventions for parents were reviewed. First was Circle of Security (COS), a group intervention designed for parents of high-risk infants, toddlers or preschoolers (Marvin et al., 2002). It provides both education and psychotherapeutic intervention to parents and their children. It is a 20-week program using highly trained therapists. The intervention is individualized for parents in that child-parent interactions are videotaped and reviewed with the therapist extensively, taking that parent's particular needs and challenges into account. Results have been positive, with significant decreases in both insecure and disorganized attachment classifications post intervention (Hoffman et al., 2006).

Next we looked at Attachment and Biobehavioral Catch-up (ABC), an intervention developed by Mary Dozier and colleagues (M. Dozier et al., 2002) and the

only attachment based intervention that directly targets foster children and their caregivers. ABC is a brief intervention, consisting of 10, 1-hour sessions in the caregiver's home with their infant/toddler. It is designed for children from 10-24 months, but can be adapted for use with young children. During the sessions, the caregiver learns how to interact with their foster children using a parent coach/trainer. These sessions are also videotaped and are highly individualized. Dozier and her colleagues have conducted several studies on the effectiveness of ABC (Bernard et al., 2012; M. Dozier et al., 2006). Results showed a significant difference in post cortisol levels, with the intervention group displaying much less stress, dysregulation and behavior problems as compared with the control group. Another study mirrored these positive results with the intervention group resulting in significantly lower rates of disorganized attachment and higher rates of secure attachment compared with the control group (Bernard et al., 2012). The final attachment-based intervention reviewed was Video-Feedback Intervention to Promote Positive Parenting (VIPP). This was developed to be a short intervention, delivered in four, 90-minute home visits with parents of infants who are less than a year old (Juffer et al., 2007). The goal is to enhance and develop maternal sensitivity through the presentation of both educational material and a clinically oriented review of videotaped parent-child interactions. There have been several studies that overall support VIPP as an intervention that promotes maternal sensitivity, but results are a bit mixed. Post intervention, mothers who participated in VIPP or VIPP-R were significantly more sensitive than the control group mothers (Klein Velderman et al., 2006) leading researchers to summarize that both interventions appeared equally effective in increasing maternal sensitivity. Unfortunately, they found no differences between the groups for infant attachment

security. All of these attachment-based interventions for parents clearly have value, but they are intensive, individualized and appear to require clinicians deliver.

Since this intervention is meant to focus on the mentalizing skills of foster parents, we reviewed the major mentalizing interventions for parents that exist in the literature. Two of the first and most prominent of these were developed by Slade and her colleagues at Yale: Parents First (Goyette–Ewing et al., 2003) and Minding the Baby (Slade et al., 2005). Parents First was designed to be a preventative group intervention for parents of infants, toddlers and preschoolers. It was designed to be a psychoeducational type intervention for more normalized parents, delivered by trained leaders, that can be delivered in practical settings such as schools and daycare settings (Goyette-Ewing et al., 2003). Parents First consists mainly of parent workshops delivered over a period of 12 weeks. These workshops deliver developmental information within the context of both modeling and practicing reflective capacities. They engage parents in progressively reflective experiences over the 12-week period. Parents are also asked to complete family activities and exercises at home with their children that encourage and enhance mentalization. Unfortunately, there do not appear to be any published studies examining the outcomes of this intervention. Email correspondence with the author did not result in a reply or additional information. The other intervention by this team has been studied and described in the literature. Minding the Baby (MTB; Slade et al., 2005) is a preventative intervention created for pregnant young mothers and their families. It is designed more for a high risk women who have histories of trauma and most likely did not have secure and nurturing caregivers themselves, resulting in weak mentalizing skills (Slade, 2006). Using the model of Parent's First, Slade and colleagues built in more therapeutic encounters and

tools so as to contain and mentalize the mother, leading to a more supportive and intensive intervention. Due to this, Master's level clinicians are used and the intervention is delivered in the parent's home on a weekly basis starting during the mother's pregnancy and lasting until their child turns 2 years old. It is only very recently that complete research results were published evaluating the MTB intervention. Sadler and colleagues (2013) evaluated a pilot study of the differences between MTB and a control group of parents that received "treatment as usual." Post data demonstrated that at 4 months, parents in the intervention group had less disrupted communications with their infants than the control group. Additionally, intervention children had higher rates of secure attachment at 12 months and lower rates of disorganized attachment. Unfortunately, there was no difference between the groups on reflective functioning (RF). The authors of the study conjecture that perhaps there is a significant limitation with using the PDI for assessing RF with this population of mothers who were young, less educated and bilingual (Sadler et al., 2013).

Although reflective functioning and mentalization can be thought of as being one and the same, there are a few differences, namely that mentalization can be thought of as a broader idea that has farther-reaching outcomes than the research based concept of reflective functioning. In addition, mentalization as an emerging field is beginning to create its' own measures separate from reflective functioning (Luyten et al., in press). However, because this is an emerging field there are only a few interventions that focus on mentalization. Mentalization-based treatment (MBT) is a relatively new field of therapies and has recently become an evidenced-based approach for clients diagnosed with borderline personality disorder, and is quickly becoming a therapeutic model for working with a variety of adults and children (Fonagy & Bateman, 2006; Midgley &

Vrouva, 2012). MBT is based on the field of developmental research and its' origins hail from both attachment and psychoanalytic theory. The authors broadly outline the aims of treatment as to promote mentalization about oneself, others and relationships. Mentalization-Based Family Therapy (MBT-F) is a promising emerging intervention developed by Peter Fonagy, Mary Target, Pasco Fearon and their colleagues, and was formerly called Short-Term Mentalization and Relational Therapy or SMART (Allen et al., 2008). It is meant to be a different approach to family therapy with children (seven years and older) and adolescents. MBT-F was designed to be a rather short intervention, at 6-12 sessions, to promote resilience in family members by enhancing their mentalizing skills to promote relationship building and problem solving. One of the major goals is to help the parents understand their childrens' behavior, as it is usually this behavior that prompts parents to seek treatment. The initial evaluation of MBT-F yielded promising results (Midgley & Vrouva, 2012). Thirty families were asked to complete pre-post measures such as the parent report Strengths and Difficulties Questionnaire (SDQ; (Goodman, 1999). Findings suggest that MBT-F led to a significant reduction in emotional and behavioral difficulties of the children in the study. These children showed significant improvement in their emotional well-being for up to one year post intervention (Midgley & Vrouva, 2012).

Finally, although this particular intervention has not been studied for outcomes, it is part of an overall mentalizing intervention that has resulted in successful outcomes for parents (Bateman & Fonagy, 2013). The Menninger Clinic, a psychiatric facility in Texas, has implemented MBTs and developed psychoeducational groups that focus on mentalizing in hopes of enhancing patient participation and collaboration in treatment (Allen et al., 2008). These groups meet weekly for 50 minutes and include lectures,

discussions and group exercises. The total session number varies from 6-9 depending on how long the curriculum takes with each group, and includes information on understanding the development, impairment and promotion of mentalizing in self and others (Allen et al., 2008).

Based on these reviewed interventions and keeping in mind the recent research, it was clear that a new type of intervention was needed specifically for foster parents. This population can have a tremendous impact on high-risk maltreated children and yet there is little in the way of successful attachment or mentalization-based interventions specifically designed for these parents. There is just not much in the literature about attachment-based/RF interventions for foster parents that are short, practical, less intense/clinical and more psychoeducational in nature. These are factors that could be very useful for this population. This new intervention would fill both a need and a great gap in the intervention literature.

Although there is a dearth of research regarding foster parents' mentalizing abilities, we can assume that if they have higher rates of insecure states of mind, then their mentalizing abilities would also be lower. It would also seem to follow that by encouraging or enhancing mentalization of foster parents, one might be able to impact their parenting by helping increase their capacity to regulate themselves and their children during stressful moments, by being able to interact with their children without frightening or disorganizing them (Grienenberger, 2005). This in turn, would enhance the relationship and attachment security between parent and child, and could have a positive impact both on placement stability and the mental/behavioral health the foster child. One factor not given much consideration when recruiting or training foster parents in the U.S., is their state of mind regarding attachment. Those parents with

insecure or even unresolved states of mind are more likely to be triggered negatively by their foster children's attachment needs and behaviors (Howe, 2006). Maltreated children who are placed with such foster parents have an increased risk of placement breakdown (Dozier et al., 2001; Steele et al., 2003). Unfortunately, it was outside the abilities and scope of this project to be able to evaluate foster parents' adult attachment status. However, several researchers have recommended and suggested that group work with parents could not only support, but also enhance and strengthen their mentalization with regards to their children (Juffer et al., 2003; Marvin et al., 2002). Research suggests that after experiencing parents who are safe, reliable and reflect secure parenting traits, foster children can let go of their old mental representations of parents as threatening or unreliable and replace (or add to) them with internal working models that reflect available, caring and sensitive caregiving (Steele et al., 2010). The literature also recommends that foster parents have access to training about how maltreatment not only impacts basic development, but also how it impacts children's behavior, mental health and attachment strategies (Howe, 2006). Teaching foster parents about this helps them understand their foster children and their behaviors better, and helps them interact with them in a more sensitive and reflective manner (Golding, 2003; Marvin et al., 2002; Schofield & Beek, 2006). In addition, helping parents understand their child better requires them to have the ability to be reflective, thus inherently helping to enhance their mentalization skills (Slade, 2005).

Given all of these points, the aim of this new group training for foster parents is to provide an intervention that not only educates parents, but also increases their own mentalizing abilities. The development of this new intervention was based on modern attachment research, mainly the theory of mentalization, as well as intervention

suggestions based on this research. Since the main purpose of this intervention is to impact parents' mentalization skills, it seemed prudent to use principles and guidelines set out by the few such interventions that currently exist, such as Arrietta Slade's successful "Minding the Baby" reflective parenting intervention program, as well as MBT-F and the mentalizing psychoeducation being conducted at the Menninger Clinic (Slade, 2005; Williams et al., 2010). Ms. Slade also wrote an article in which she helpfully outlined the general principles one should follow when creating a reflective parenting program (Slade, 2006). Since the main goal of this intervention was to both educate and influence parents' mentalizing, it was also important to be efficient in selecting what aspects to focus on, given the population and the time constraints of a short intervention.

The curriculum in this intervention is tailored for foster and adoptive parents in Texas. Given the author's experience with training and creating curriculum for foster parents in Texas, she had knowledge of what they had already been exposed to and their capacities. Foster parents in the central Texas area are not routinely exposed to information or trainings on attachment, reflective parenting or mentalization. Additionally, this author wanted to model some of this intervention from MBT-F, and one of the goals when working with adoptive families using this model is to help the parents understand their child's behavior by sharing knowledge about trauma, attachment and mentalization (Muller et al., 2012). Therefore, this curriculum includes information on trauma, attachment, foster children's behavior, sensitive/reflective parenting and mentalization. All of these topics provide a wealth of information that easily relate to one another and that can be tailored for foster parents to help them understand their children's emotions and behaviors, as well as their own. The

intervention also includes interactive classroom activities, as well as at-home activities for the foster parents to complete with their children. These activities are meant to be playful yet skill building for both parent and child. They are also meant to enhance the relationship between parent and child. Some of them are based on family activities encouraged in MBT-F and are designed to both enhance understanding emotions and increasing productive mentalization skills. For a full description of content of this intervention, including a curriculum outline, refer to Chapter 4 of this thesis. The training itself was divided into three, three-hour classes. It was designed this way to accommodate the schedule of most foster parents in this area, who prefer at a maximum, a three-hour class in the evenings or on the weekends. This intervention was described as a workshop, with three separate trainings. The workshop title is "Reflective Parenting: How to strengthen your relationship while helping your child cope." This title was chosen based on the desire to make it very clear what the intervention was and the potential benefits. Content was created to be cumulative and each section broke according to a rough 2-3 hour estimate. Because the timeframe had to include data collection, total instruction time is approximately 7.5 hours.

Given this was a new intervention, it seemed prudent to pilot it to assess the process, procedures, and material. There were several areas of focus for this pilot evaluation. First, it was important to evaluate the quality and structure of the training itself, as well as the accompanying materials. The aim of the pilot was to discover what specific aspects of these processes and materials worked and what did not, so adjustments to the intervention could be made. The pilot was conducted over three weeks in the fall of 2011 in Austin, Texas. The pilot began with 20 foster parents and concluded with 18, a pleasantly high return rate. Overall, the pilot was a success with a

large number of foster parents who agreed to have their data collected and positive responses from the participants regarding the intervention itself. The intervention material appeared to contain clear and useful information, and was presented at a pace appropriate for the audience. Changes to the intervention content did not seem necessary based on feedback from this pilot. However, during the pilot, technical problems and issues with processes arose. There were issues with recruitment, with a number of parents attending who either did not have any child in their home, or only had infants. Some parents even showed up to the intervention without indicating they were attending. Also, during the intervention, a significant number of parents did not participate in the at-home activities, which are an important part of the intervention as they are designed to increase participants' mentalization skills. When parents were debriefed about the reasons for their lack of participation, some of the reasons included lack of clarity and time. Finally, the most significant issues arose around data collection during the Five-Minute Speech Sample. Multiple technical issues ensued, including participants not understanding the equipment or not being able to track their time. In addition, the process was too time consuming and confusing, with the participants often forgetting what they were supposed to discuss during their speech sample. After analyzing these findings, as well as feedback from participants, changes were made to the intervention and data collection process that included altering the screening/recruitment procedure, as well as the at-home activities and FMSS process. A full list of these changes can be found at the end of Chapter 5.

The results of the pilot were sufficiently encouraging to suggest undertaking a larger investigation to evaluate the mentalization intervention for foster parents. The aim of this larger trial was primarily one of feasibility. Before undertaking more

systematic randomized controlled trial, it was necessary to establish if the program is suitable for evaluation. The scientific purpose of this study was then to establish if the specially designed mentalizing parental intervention (the experimental arm of a trial) is superior to the control arm, on the primary outcome and to examine if delivering this psychoeducational mentalization-based intervention to foster parents will increase their mentalization capacities and through this, lower their perceived stress around parenting and positively impact on their children's behavior. As we know that an intervention is likely to have positive effects just because participants feel attended to (also known as the much researched Hawthorne effect; Jones, 1992; McCarney et. al., 2007), in this study we adopted a comparison group approach. We wanted to establish if the mentalizing-based psychoeducation program had a greater impact on foster parenting than a psychoeducation intervention which included information concerning trauma, child behavior and appropriate parent training based on attachment and social learning theory, but had little information about social cognition and none about mentalizing (see Appendix N for content outline of comparison group; Adkins, 2010). We had the following hypotheses for the study. We expected that if the mentalization focused parenting training was effective, then parental reflective function would improve more in the experimental than the comparison group. We further predicted that parenting stress would decrease more for foster parents in the experimental than comparison group. Furthermore, we expected that parents' perception of mental health problems in the child would decrease more in the mentalization focused foster parent education than the comparison condition. The overall design of this study is an experimental comparison group design where participants were recruited to one of two treatment conditions. The first treatment condition involved the participants receiving

the intervention designed for this study. The second treatment condition can best be described as "treatment as usual" and is referred to as the comparison group.

Participants for the intervention and comparison group were recruited from the Central Texas area using child placing agencies as well as the Child Protective Services (CPS), the state authority for foster care children. Participants totaled 102 foster parents (64 mothers and 48 fathers) and were split almost evenly between groups with 54 completing the intervention and 48 participating in the comparison group class. Parents ranged in age from 24 to 71 years (M = 44.27, SD = 10.60) and had been a foster parent anywhere from 1 month to 24 years with an average of just over 3 years (M = 37.70, SD = 48.29). This was a fairly well educated group of parents with the majority (84%) having at least some college education. Most parents reported their ethnicity as Caucasian (61%), with another 18% declaring Black and 15% Hispanic. The t test and chi-square analysis did not reveal any significant differences between the intervention and comparison group on any of the variables. Both groups were assessed in a pre-posttest design, once at the beginning and again at completion. Three different quantitative assessments and one qualitative evaluation were used at both time periods, for both the intervention and comparison group. The main measures included two assessments of mentalization. The first such measure was the Parental Reflective Functioning Questionnaire (PRFQ), a brief self-report measure that is meant to assess the reflective capacities or mentalization abilities of parents (Luyten et al., in press). The second measure was the Five-Minute Speech Sample (FMSS) (Gottschalk & Gleser, 1969), a qualitative assessment in which foster parents were asked to speak into a recorder for five minutes about their foster or adoptive child. Typically, this has been a common way to measure expressed emotion (EE), a term used to describe attitudes and

feelings that a relative expressed about a patient (Magaña et. al., 1986). Given the flexibility of the FMSS and that others have successfully applied a variety of coding systems, it seemed quite likely that we could use this procedure to effectively assess reflective functioning of foster and adoptive parents. An extensive review of published research appears to indicate that an RF coding scheme has not yet been applied to the FMSS. Due to this being new territory, it was thought best to use an RF coding manual (Fonagy et al., 1998) that was developed to be used with adult attachment measures. This coding system has been used in research studies evaluating the parent/child relationship and has been found to reliable (Fonagy & Target, 2005; Meins & Fernyhough, 2012). The other measures used include the Parenting Stress Index – Short Form (PSI-SF; Abidin, 1995), which is a reliable yet brief screening measure for parenting stress and the Strengths and Difficulties Questionnaire (SDQ), a brief instrument for assessing the psychological adjustment of children and adolescents (Goodman, 1997).

Results indicate the intervention was effective in enhancing the mentalizing capacities and somewhat reducing parental stress. Full results can be seen in Chapter 7. Specifically, it was hypothesized that parents in the intervention group would increase their mentalizing abilities more so than the parents in the comparison group. Results from both reflective functioning measures support this hypothesis and clearly demonstrate that parents in the intervention group improved their mentalizing abilities significantly more than the comparison group parents. Results indicate that overall mentalizing increased significantly for the intervention group, and this was mostly accounted for by the increase in foster parents' abilities to recognize the opacity of mental states. This means parents in the intervention group became more flexible in

their mentalizing, which implies these foster parents may now have a better understanding of the transient nature of feelings states, which is an important trait to have when working with children who have been traumatized and carry into their new relationship with their foster parents, old dysfunctional patterns of relating to parental figures (Asen & Fonagy, 2011).

When examining the Five-Minute Speech Samples, one of the main mentalizing outcome measures, it seems foster parents in both the intervention and comparison groups began the study with the same level of reflective abilities, low RF, which indicates they frequently used mental state language but were not especially reflective and they did not appear to have a complex view of the interactional nature of mental states in relationships. Although no known studies to date have measured foster parents' reflective functioning in this way and given low RF has been connected with attachment insecurity in adults (Allen et al., 2008), these results are in line with Ballen's 2010 article which suggest that a large proportion of foster parents have insecure states of mind compared with the general population (Ballen et al., 2010). These results then become even more significant when by the end of the study, it was only the parents who went through the intervention who significantly increased their overall ability to be reflective and mentalize themselves as well as their children. The intervention foster parents increased their mentalizing abilities to a level that indicated definite reflective capacities and an ability to understand experiences in terms of feelings and thoughts. Some had even developed their RF abilities to a more sophisticated and complex level, such as being able to figure out the mental states that lie behind behavior. It is this more developed parental mentalizing that is thought to be key for helping children

develop their own mentalizing skills as well as a sense of agency and self-regulation (Fonagy et al., 2002).

It was also predicted that the parents in the intervention group would report less parental stress after the intervention than the comparison group parents. Results only partially support this outcome as the differences between groups are mainly due to an increase in parenting stress of the comparison group parents. Specifically, intervention parents reported less post parental stress on only one subscale of stress (child difficulty) while the comparison group parents significantly increased their stress level in two parenting areas. Finally, it was hypothesized that parents in the intervention group would report their children to have less significant behavioral and emotional issues post intervention than the parents in the comparison group. The findings did not support this last hypothesis, as there were no significant differences on the clinical level of child behavior or emotional issues

Despite some limitations, there are several strengths to this study. The main strength of this study was that it used a comparison group and pre-post test design, which increases the causal inference that can be made regarding the efficacy of the intervention. A promising intervention was delivered and data was collected from two similar groups at two different time points, in an under-researched population, i.e. foster parents. Additionally, the intervention was independently assessed for treatment adherence and fidelity. Results provide strong evidence that both the intervention and comparison class were conducted at a similarly high level of quality. Components of the intervention designed to impact mentalization were adhered to faithfully and consistently, and were different than the components of the comparison

group. All of this provides ample support that it was indeed the intervention itself that was responsible for the positive outcomes in the intervention group.

Discussion and Implications

The goal of this study was to create a psychoeducational intervention for foster parents that would not only educate parents, but also increase their mentalizing abilities. The results appear to indicate that this goal was most likely achieved. This study shows that a short-term psychoeducational intervention can make a positive impact on foster and adoptive parents mentalizing skills. To this date, no known RF or mentalization-based intervention has been tested with foster parents. Thus far, most attachment-based interventions have been clinical in nature and focused on impacting the parent/infant relationship ((M. Dozier et al., 2002; Juffer et al., 2007; Marvin et al., 2002). This study was designed to be more practical and educational manner, administered in a group structure over a short timeframe (4-6 weeks), and designed to impact foster children of all ages. This study supports attachment researchers suggestions that group work with parents could enhance and support their reflective abilities (Juffer et al., 2003; Marvin et al., 2002).

Most promising mentalizing or RF interventions are more clinical and intensive in nature, but interestingly, they all usually include a psychoeducational component (Allen et al., 2008; Goyette–Ewing et al., 2003; Slade et al., 2005; Williams et al., 2010). One of the goals of this project was to see if this type of psychoeducation alone could produce similar changes for these parents and their children. Creating such interventions are very important for the foster parent community as most agencies and systems in the U.S. that support foster parents and their children have limited funds and access to clinical services, especially evidenced-based clinical services. However, foster

parents are usually required to acquire a number of training hours each year to maintain their license (Dorsey et al., 2008). This condition provides an opportunity for affordable and easy-to-implement educational interventions for this population. Unfortunately, it does not appear that such interventions exist in ways that are evidenced based or supported by the research (Blakey et al., 2013; Dorsey et al., 2008). Additionally, the ones that are used most often focus more on practical, surface level parenting behaviors and do not go deeper in trying to impact the way parents think, feel and regulate themselves or their children (Timmer et al., 2006). Given the amount of mental and behavioral issues of foster children, and the potential issues with the quality of foster parents themselves, this is a huge gap in the intervention literature and an even larger opportunity to help impact real change in the child welfare community.

This study provides an original and significant contribution to two different intervention and scholarly fields: the attachment-based field of mentalization and the field of child welfare/social work. The results are promising in a variety of ways. They both support the emerging research on the benefits of mentalization and add to the literature about foster parents. Given there is a dearth of research about this population, this new information and data is especially valuable. Additionally, this study resulted in a new type of intervention that has not yet been explored in the research literature, particularly in this cross-disciplinary way. The results of the pilot, as well as the feasibility study, were sufficiently encouraging to suggest undertaking a larger more systematic randomized controlled trial investigation to evaluate this new intervention. This study can be considered to include both a Phase I and Phase II clinical trial of this intervention, and the results provide solid preliminary evidence and prepare the groundwork for a full Phase III trial of this intervention (Craig et al., 2008).

Appendix A

Sample Slides of Intervention

Reflective Parenting

How to Strengthen your Relationship
while Helping your Child Cope

Tina Adkins

University of London
Research Department of Clinical. Health and Educational Psychology
Psychoanalysis Unit

Caring for young minds
Anna Freud Centre

SESSION 1

- **Importance of Relationships**
- **Reflective Parenting and Mentalization**
- **Attachment and Trauma**

Thoughts on Relationships

Our first relationships are SO important, they determine:

- How our bodies and brain develop
- How well we make friends or have problems with peers
- Our sense of self; of who we are inside
- Our self-esteem; self-efficacy
- Our psychological and physical health

Mentalizing in Action

Thinking about another person's behavior in terms of their feelings and intentions, can make a big difference in how we respond to them!

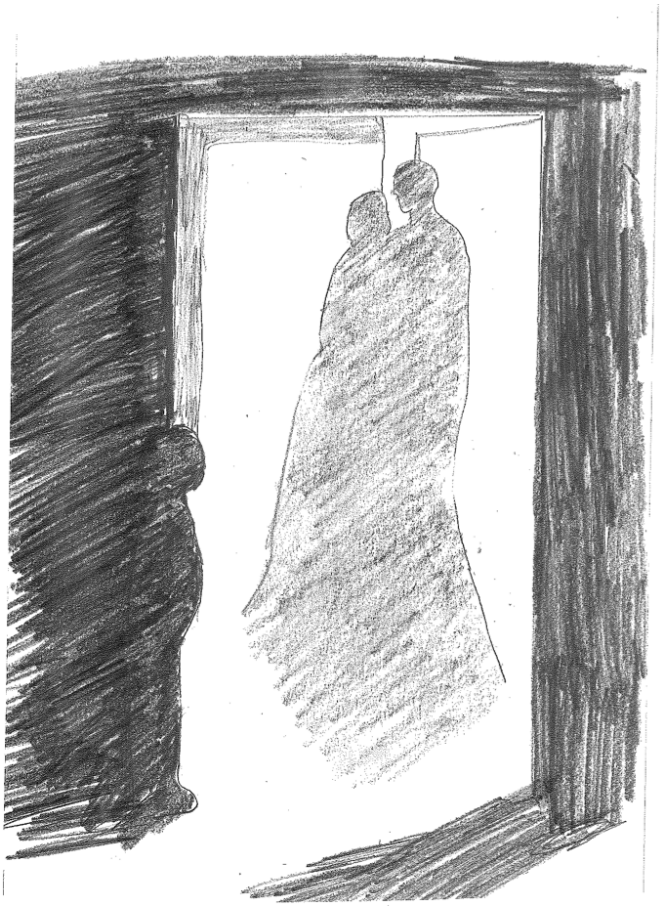
And our response can sometimes make the situation better, or make it worse.

Example: You are newly dating and you have only been out with your partner only a few times, but you really like them! One night, you go out to dinner with friends and you notice him/her having a quiet dinner with someone else and it looks like a date.

How would you feel?
How would you react?
Would you do or say anything impulsively?
What if you discovered that other person was their _____?

Appendix B

Projective Picture Exercise



Write a brief story about this picture, about what is happening.
Include the thoughts, feelings and beliefs of the characters involved.

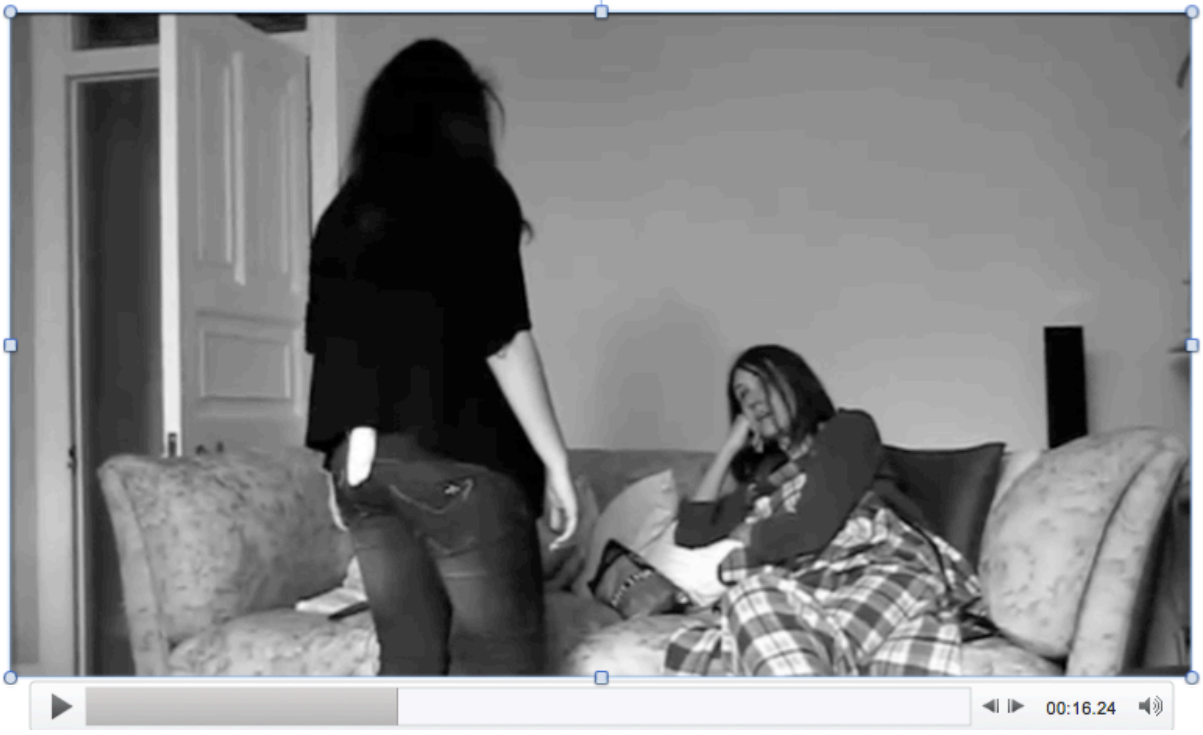
Appendix C

Screen Shots of Family Scenario Videos 1 and 2


In this video, the teenager is sitting at home watching TV with their parents. Watch carefully what happens next.
00:07.80


00:13.47


In this story teenager's mum is not feeling very well. What happens next?
00:05.45


00:16.24

Appendix D

Sample Feeling Cards

Surprised

Sad

Proud

Surprised

Appendix E

Intervention Flyer

Reflective Parenting

How to Strengthen your Relationship while Helping your Child Cope

A three-part workshop by
Tina Adkins, MA, MS

Benefits of being a Reflective Parent:

- ♥ Can help your relationships become more fulfilling and rewarding
- ♥ Can increase intimacy and attachment
- ♥ Helps you positively influence your child's thoughts, feelings and behaviors (as well as your own!)
- ♥ Helps reduce behavior problems, fighting, conflict and resentments

Content:

Come learn about attachment, trauma and therapeutic techniques involved in reflective parenting! This workshop introduces both the theory and practice of a parenting technique that is rooted in attachment theory, as well as evidence-based psychodynamic clinical interventions such as Mentalization-Based Family Therapy. You will also learn about the behavior of traumatized children and how this trauma has impacted their attachment and brain development. All of this is presented in a relaxed, conversational way with plenty of things to keep it interesting such as videos, games, exercises and discussions.

Details:

This training involves a total of **three, 3 hour classes spread over several weeks**. It is essential that you attend **ALL three classes** as they cannot be taken individually.

You will be participating in a PhD research project and as a result, should be open to filling out questionnaires (all who do will be entered in raffle to win a $25 gift card both at the beginning of the workshop and at the end!)

To participate - **you MUST RSVP and should have at least one foster or adopted child in your home that is 4 y.o. or older**. **FREE CHILDCARE** is provided!! Please list how many children you will be bringing when you RSVP.

Dates: Tuesdays, Sept. 11th, 25th and Oct. 16th from 6-9pm
RSVP: monica.horn@dfps.state.tx.us or call 512-834-4792

See You There!

Appendix F

Pilot At-Home Activities Slides

At-Home Exercises

1. Fishing for Feelings (ages 4+)

This game involves using a feelings chart or feelings cards. Choose a time in the evening where you and your child can interact in a relaxed manner: after school, before dinner etc.

- ✧ Introduce game by saying we are going to guess at least 2 different feelings (younger children might start with 1) each other might have had today, and then explain how you came up with the emotion.
- ✧ Use feelings charts or cards to pick the emotion
- ✧ The other person will either confirm or deny and explain if needed.

At-Home Exercises

2. Mind Reading

Using characters in a story or movie, we want to help children think about the emotions and behaviors of others in a non-threatening way. We want to encourage them to wonder what thoughts or feelings might be behind behavior.

For ages 4-10ish:
Read with (or to) them their favorite book (or any book!)– at different points, stop and wonder aloud what might certain characters be thinking or feeling; ask the child.

Book suggestions: Where the Wild Things Are; Frog and Toad are Friends; older kids (9-12) Holes or Everything on a Waffle

Appendix G

Informed Consent Form

INFORMED CONSENT

You have agreed to participate in a training program titled "Family Minds: Keeping families resilient with mentalization" delivered by Tina Adkins who is a PhD student in the Research Department of Clinical, Educational and Health Psychology at the University College London (UCL).

PURPOSE OF THE STUDY
The aim of this study is to evaluate a training program designed by Tina Adkins and delivered via your foster care agency as part of your required annual training hours. The goal for the training is to provide parenting support to foster/adoptive families by introducing the principles of social development.

PROCEDURES
Participants are asked to attend three (3), three-hour (3 hr) trainings over the course of several weeks (for a total of 9 training hours). These trainings consist of psycho-educational information and a presentation using PowerPoint, discussions, videos, role-plays, activities, games and at-home activities for you and your children.

In order to help us evaluate this program, this research project involves you completing several brief questionaires both before and after the training: SDQ (Strengths and Difficulties Questionaire), PSI (Parenting Stress Index), and the RFQ-P (Reflective Functioning Questionaire for Parents). In addition, participants will be asked to talk for 5 minutes about a child they are currently fostering.

The evaluations are designed to assess if the training has an effect on your perception of your foster child and perhaps on the well-being of the foster child.

POTENTIAL BENEFITS
The training you will undertake will help you to learn more about children including the children you care for and may improve your relationship with your foster child. Participants will also earn at least 9 training hours that count towards their annual agency requirement. By attending the training and completing the evaluations, participants will be making a significant and rich contribution to an important area of research; one that centers around improving the mental health of foster and adopted children and their families.

CONFIDENTIALITY
Strict confidentiality will be maintained throughout this research study. All information will be obtained anonymously and is kept private, accessible only to the researcher and her supervisors. All information collected is used for research purposes only. Anonymity will be maintained by having all participants identify themselves on all documents and evaluations by using a nickname or word that only they would be able to identify and would not identify them even to the researcher.

PARTICIPATION AND WITHDRAWAL
Your participation is voluntary. This means that you can choose to leave the training at any time or not complete the evaluations.

QUESTIONS AND CONCERNS
If you have any questions or concerns about the research, please feel free to contact Tina Adkins at teaUK9@gmail.com or 512-366-2301. You are also free to contact this researcher's supervisor: Peter Fonagy at p.fonagy@ucl.ac.uk or 832-671-0181.

SIGNATURE

I _____ (Name of Participant)

understand the procedures described above and agree to participate in this study.

_____
Signature of Participant

_____
Date

Appendix H

Demographics Form

Participant Information & Demographics

1. How long have you been a foster/adoptive parent?

2. What is your age?

3. What is your gender? ☐ Male ☐ Female

4. What is your primary ethnicity?

☐ White/Caucasian
☐ African American
☐ Latino
☐ Asian/Pacific Islander
☐ Native American
☐ Multi-Ethnic

5. Level of education?

☐ Some High School
☐ High School Graduate/GED
☐ Some College
☐ College Graduate
☐ Master's or Doctorate

6. Please list the children in your home by their initials in this chart:

Initials of Child	Gender	Age	Level (B,M,S,I) or put K=Kin or A= Adopted	Time in Home

Appendix I

Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire

P or T [4-10]

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior over the last six months or this school year.

Child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

Appendix J

Parenting Stress Index -Short Form

	1 Strongly Disagree	2 Disagree	3 NOT SURE	4 Agree	5 Strongly Agree
For the next statement, choose your response from the choices '1' to '5' below.					
22. I feel that I am: 1. a very good parent 2. a better than average parent 3. an average parent 4. a person who has some trouble being a parent 5. not very good at being a parent	1	2	3	4	5
23. I expected to have closer and warmer feelings for my child than I do and this bothers me.	1	2	3	4	5
24. Sometimes my child does things that bother me just to be mean.	1	2	3	4	5
			P-CDI		
25. My child seems to cry or fuss more often than most children.	1	2	3	4	5
26. My child generally wakes up in a bad mood.	1	2	3	4	5
27. I feel that my child is very moody and easily upset.	1	2	3	4	5
28. My child does a few things which bother me a great a deal.	1	2	3	4	5
29. My child reacts very strongly when something happens that my child doesn't like.	1	2	3	4	5
30. My child gets upset easily over the smallest thing.	1	2	3	4	5
31. My child's sleeping or eating schedule was much harder to establish than I expected.	1	2	3	4	5
For the next statement, choose your response from the choices '1' to '5' below.					
32. I have found that getting my child to do something or stop doing something is: 1. much easier than I expected 2. somewhat easier than I expected 3. about as hard as I expected 4. somewhat harder than I expected 5. much harder than I expected	1	2	3	4	5
For the next statement, choose your response from the choices '10+' to '1-3'.					
33. Think carefully and count the number of things which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc.	1-3	4-5	6-7	8-9	10+
34. There are some things my child does that really bother me a lot.	1	2	3	4	5
35. My child turned out to be more of a problem than I expected.	1	2	3	4	5
36. My child makes more demands on me that most children.	1	2	3 DC	4	5

Appendix K

Parental Reflective Functioning Questionnaire

Parenting Reflective Functioning Questionnaire

Listed below are a number of statements concerning you and your child. Read each item and decide whether you agree or disagree and to what extent.

Use the following rating scale, with 7 if you strongly agree; and 1 if you strongly disagree; The midpoint, if you are neutral or undecided, is 4.

Strongly **Disagree**	1	2	3	4	5	6	7	Strongly **Agree**

(1) ___ My child and I can feel differently about the same thing. (HL)
(2) ___ When I get angry with my child, I always know the reason why. (M)
(3) ___ I am often curious to find out how my child feels. (HL)
(4) ___ How I am feeling can affect how I understand my child's behavior. (HL)
(5) ___ My child knows when I am having a bad day and does things to make it worse. (LH)
(6) ___ I like to think about the reasons behind the way my child behaves and feels. (HL)
(7) ___ I try to see situations through the eyes of my child. (HL)
(8) ___ I always know why my child acts the way he or she does. (M)
(9) ___ My child sometimes gets sick to keep me from doing what I want to do. (LH)
(10) ___ I believe that how I think about my child will change over time. (HL)
(11) ___ My child can react to a situation very differently than I think he or she will.(HL)
(12) ___ I find it hard to actively participate in make believe play with my child. (LH)
(13) ___ At times, it takes several tries before I understand what my child needs or wants. (HL)
(14) ___ When my child is fussy he or she does that just to annoy me. (LH)
(15) ___ Now that I am a parent, I realize how my parents could have misunderstood my reactions when I was a child. (HL)
(16) ___ No matter how sick my child is, I can always tolerate him or her. (M)
(17) ___ How I see my child changes as I change. (HL)
(18) ___ My behavior towards my child cannot be explained by how I was raised. (LH)
(19) ___ I can always predict what my child will do. (M)
(20) ___ I wonder a lot about what my child is thinking and feeling. (HL)
(21) ___ Often, my child's behavior is too confusing to bother figuring out. (LH)
(22) ___ I can sometimes misunderstand the reactions of my child. (HL)
(23) ___ When my child is misbehaving it's a sign that he or she does not love me. (LH)
(24) ___ I believe that how my parents raised me affects how I raise my child. (HL)
(25) ___ My child cries around strangers to embarrass me. (LH)
(26) ___ I pay attention to what my child is feeling. (HL)
(27) ___ I can completely read my child's mind. (LH)
(28) ___ Understanding why my child behaves in a certain way helps me not to be upset with him or her. (HL)
(29) ___ I believe there is no point in trying to guess what my child feels. (LH)

(30) ____ I often think about how I felt when I was a child. (HL)
(31) ____ I try to understand the reasons why my child misbehaves. (HL)
(32) ____ I always know what my child wants. (M)
(33) ____ I hate it when my child cries and/or talks to me when I am on the phone with someone. (LH)
(34) ____ The only time I'm certain my child loves me is when he or she is smiling at me. (LH)
(35) ____ I'm certain that my child knows that I love him or her. (M)
(36) ____ The best way to know your child loves you is when he or she is well-behaved. (LH)
(37) ____ My child's temperament is what it is, and there is little that I can do about that. (LH)
(38) ____ I always know why I do what I do to my child. (M)
(39) ____ At times I get confused about what my child is feeling. (M)

Appendix L

Workshop Evaluation Form

Workshop Evaluation

	Very Much	Somewhat	A little	Not at all
1. The workshop helped improve my parenting skills or taught me new ones.	❍	❍	❍	❍
2. The skills were practical and easy to employ.	❍	❍	❍	❍
3. The workshop positively impacted my child's behaviour.	❍	❍	❍	❍
4. Other family members noticed a positive change in my child's behaviour.	❍	❍	❍	❍
5. The content was understandable.	❍	❍	❍	❍
6. The trainer was knowledgeable.	❍	❍	❍	❍
7. The quality of instruction was good.	❍	❍	❍	❍
8. Adequate time was provided for questions and discussion.	❍	❍	❍	❍
9. I found the at-home exercises interesting and useful	❍	❍	❍	❍

10. Did you do any of the At-Home Exercises?
(please circle one)

Yes No

If you answered "No" – please explain what prevented you or what issues you might have had:

11. How do you rate the training overall?

Excellent	Good	Average	Poor	Very poor
❍	❍	❍	❍	❍

12. What aspects of the training could be improved?

13. Final Comments:

Appendix M

At-Home Activities Handouts

Reflective Parenting
At-Home Exercises
Part 1

Babies/Toddlers (ages 0-3ish):

- Start out by simply observing your child while spending time them; you can observe and comment on positive behaviors/emotions as well as negative ones.

- Talk to the child about what you see:
  "Oh my! You are so excited about that toy!" or
  "Oh my goodness, so much crying!"

- NEXT - express curiosity and concern about what might be going on inside of them:
  "You really want me to see this exciting to you have discovered!" or
  "I wonder if you crying because you are tired? Or hungry?"

  ** Interpret your child's behavior in terms of their desires, emotions or thoughts **

- Try to do this in relatively neutral or mildly stressful moments. If you can do this during a difficult moment, that is even better – but it may be harder for YOU to do. Try it in different situations and see how both the child and you react.

TO GET CREDIT: Write up a one page summary of at least one time you interacted with your child in this manner. List 1) what were you and child doing at the time 2) what behavior or emotions you commented on and what you actually said to the child, 3) your interpretation of your child's behavior in terms of their desires, emotions or thoughts.

For each write-up/different interaction – you get 1 hour credit!

Fishing for Feelings (ages 4+)

This game involves using a feelings chart or feelings cards. Choose a time in the evening where you and your child can interact in a relaxed manner: after school, before dinner etc.

- ✧ Introduce game by saying we are going to guess at least 2 different feelings (younger children might start with 1) each other might have had today, and then explain how you came up with the emotion.

- ✧ Use feelings charts or cards to pick the emotion.

- ✧ The other person will either confirm or deny and explain if needed.

Examples:

Parent: "Ok my turn! Hmmm – I think you felt frustrated today because you seem to have an irritated look on your face. I am wondering what happened at school today and what thoughts you might be having? I am also thinking you might have felt happy today at some point because I made your favorite lunch!"

Let the child talk and just reinforce your concern and curiosity about their emotions and mind. If child doesn't respond – say something like "well, I can only really wonder and guess then as I don't really know what you are thinking or feeling unless you tell or show me. But I am SO curious and interested!"
Next, ask the child to guess what feelings you might have had today (point to feeling on chart or choose a card) and if they have a "reason" for why they think this. Make sure to tell them what emotions you did have today and why "well, I was frustrated today because my boss gave me some work that I don't really like."

** This game works well with teenagers too, just make it more mature; perhaps not use chart or cards unless they want too

TO GET CREDIT: Write up a one page summary. Include: 1) what tools you used – chart or cards 2) how you started the game and what you said 3) what emotions your child chose and how you responded and 4) what emotions you chose and how your child responded.

For each write-up/different interaction – you get 1 hour credit!

<u>Mind Reading Game</u>

Using characters in a story or movie, we want to help children think about the emotions and behaviors of others in a non-threatening way. We want to encourage them to wonder what thoughts or feelings might be behind behavior.

For ages 4-10ish:
Read with (or to) them either their favorite book or a new one (see below) – at different points, stop and wonder allowed what might certain characters be thinking or feeling; ask the child.

Book suggestions: Where the Wild Things Are; Frog and Toad are Friends; older kids (9-12) Holes or Everything on a Waffle

TO GET CREDIT: Write up a one page summary of at least one time you interacted with your child in this manner. List 1) what book was read 2) what things you reflected on the book, 3) your child's responses and reactions.

For each write-up/different interaction – you get 1 hour credit!

Older kids or Adolescents:

- Watch a movie with them, telling them ahead of time that we are going to play the "Mind Reading Game".
- Stop the movie at places of tension, arguments, or when someone is having an obvious emotion (warn them ahead of time that you will stop the movie at various points – might help to use a movie everyone has already seen.)
- Wonder aloud what different feelings the characters might be having, what thoughts might have made them act a certain way, etc.
- Express your thoughts and feelings too!

Questions/Comments to Encourage Exploration

- What do you make of what just happened?
- What do you think _____ was feeling just then?
- Why do you suppose he did that?
- I wonder what _____ was thinking during all that…..
- I wonder if he was feeling scared….. And maybe that's why he did that….. WHAT DO YOU THINK??

(If they don't know or don't answer – then YOU just keep wondering these things aloud – promoting an atmosphere of curiosity about mental states and behavior)

*Just have a light-hearted discussion; playfully wondering – with no answer that is right or wrong!

TO GET CREDIT: Write up a 2 page summary of at least one time you interacted with your child in this manner. List 1) what movie you used 2) examples of scenes (several different ones) where you paused and reflected aloud about the characters, 3) how your child responded and your reply.

For each write-up/different movie – you get 3 hours credit!

Reflective Parenting
At-Home Exercises
Part 2

"Freaky Friday"

This game involves trading places with your child! Both of you come up with a situation that sometimes involves difficulties for you or the child: waking up in the morning, getting ready for school, doing chores, taking a bath etc. ** Try to do this activity during a calm, playful time when the frustrating activity has not just happened or is coming up very soon **

- ★ Parent should switch places with the child, and "act out" the scenario. Feel free to make it fun by dressing up or wearing something of each other's!
- ★ Child tells the parent exactly what to THINK, what to SAY and how to FEEL.
- ★ Parent prompts the child through all of these continually throughout the play – child has tendency to just want to make the parent DO things – but encourage them to tell you what to FEEL and THINK.

TO GET CREDIT: Write up a one page summary of at least one time you interacted with your child in this manner. List 1) what were you and child doing at the time 2) what different things your child told you to feel and think as the

child 3) what different things you told the child to feel and think as the parent 4) your child's and your reactions afterwards.

For each write-up/different interaction – you get 1 hour credit!

What's Inside My Mind?

Think of a recent interaction or discussion you had with your child (that is already over), that brought up strong feelings for both of you in some way.

- For all ages (but for teenagers, use a more mature version of the exercise like we did in class last time).
- Use large art paper or poster board, markers or crayons or paint etc.
- For younger children, have copies of the feelings faces available so they can use pictures instead of words.
- Help kids (if needed) draw the image of the head/brain.

1. Ask them to paste a picture of or write the main emotions or thoughts they had at that time. You do the same! (turn projects away from each other if possible and if you have to help the child, pretend you didn't see their project!)

2. When done, cover each brain with a smaller piece of white paper, with tape at the top (so you can flip it up and see what's underneath!)

3. When everyone is done, it's show and tell time! One person starts by guess what feelings the other person had at the time. Then that person flips up their paper to reveal what they drew/pasted/wrote.

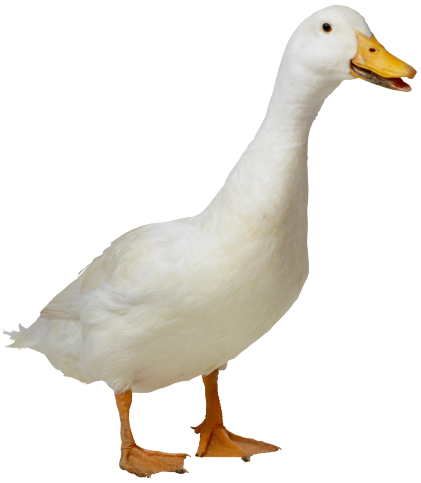
Appendix N

Five-Minute Speech Sample Instruction Form

Speech Sample Instruction Form

Switch to “On” and wait a few seconds before speaking. When you are finished speaking, wait a few seconds before sliding switch to “Off.”

Please speak for 5 full minutes about all 3 of the following topics:



What is your child like?

How do you feel about your child?

Tell me about a problem you had with your child recently and how you dealt with it.

Thank You!!

Appendix O

Comparison Group Content Outline

Parenting the Traumatized Child: Understanding and Navigating Behaviors

1. Trauma
    a. Trauma and children
    b. Trauma and the brain
    c. Relational trauma
2. Attachment
    a. Function of attachment
    b. Attachment and the brain
    c. Basic attachment research
    d. Trauma and attachment
    e. Insecure vs. secure attachment
    f. Helping children heal (video)
3. Impact of trauma on behavior and relationships
    a. Traumatic stress reactions
    b. Understanding children's behavior
        i. Trauma and resilience video (group discussion)
        ii. Case study example (group discussion)
        iii. The Invisible Suitcase
    c. Emotional regulation
        i. Be an emotional container
        ii. Tuning in
        iii. Correct and build
    d. Ways to help
    e. Class Examples (group activity)
    f. Final thoughts & questions

Appendix P

Comparison Group Post Data Collection Instruction Sheet

Instruction Sheet

* Please wait at least **3 weeks** before you fill out the forms and mail them back. This means wait until at least _____! You can take longer, however, please send the packet back by _____ at the latest.

* Remember to put your **INITIALS** or **NICKNAME** on each form!

* In addition, I need you to call this number and leave me a voicemail just like you did in class on the recorder:

Please call **760-661-7030** and leave a **5 minute voicemail** answering he same 3 questions about your child:

1. What is your child like?
2. How do you feel about your child?
3. Tell me about a problem you had with your child recently and how you dealt with it.

* Don't worry if you are answering the same as before – that is OK! ☺

* When I receive your packet and voicemail, I will mail you back a **GIFT CARD** as a Thank You gift!!! So BE SURE to put your **RETURN ADDRESS** on the envelope!

Thank you SO MUCH and if you have questions:
tina.adkins@gmail.com
512-366-2301

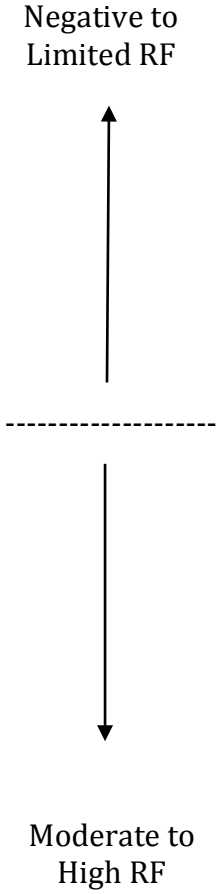
Appendix Q

Reflective Functioning Scoring used with FMSS

The Reflective Function Scale

(Fonagy, Target, Steele and Steele, 1998)

RF level	
-1 *Negative RF*	*Anti-reflective; bizarre; hostile; inappropriate* *"Why are you asking if I get angry? You're just trying to find bad things against me"*
0	
1 *Absent RF*	*Passively evasive; little or no hostility; disavowal explanations* *"I don't know. I really couldn't say"*
2	
3 *Questionable or low RF*	*Uses mental state language but not reflectively; superficial; clichéd* *"She just wants this and wants that"*
4	
5 *Definite or ordinary RF*	*Uses non-clichéd mental state language reflectively* *"I think he felt sad and that's why he started clinging to me"*
6	
7 *Marked RF*	*Sophisticated RF on mental states more than once but not continually; complex; an interactive perspective* *"She was so happy and kept cuddling up and kissing me, and that made me happy"*
8	
9 *Full or exceptional RF*	*Full awareness of reflecting on mental states; sophisticated*



Appendix R

Correlational Matrix of Standardized Measures with Demographic Variables

Correlational Matrix of Standardized Measures with Demographic Variables

		Time as Foster Parent in months	FP Age in Years	FP Gender	FP Ethnicity	FP Education	Child Gender	Child Age in months
Pre PRFQ Prementalizing	Pearson Correlation	.017	.213*	-.108	.033	-.072	.004	.207
	Sig. (2-tailed)	.863	.036	.281	.744	.484	.972	.080
	N	100	97	102	102	98	72	72
Pre PRFQ Certainty	Pearson Correlation	-.001	-.041	-.016	.083	-.112	-.061	-.031
	Sig. (2-tailed)	.991	.691	.869	.406	.271	.611	.796
	N	100	97	102	102	98	72	72
Pre PRFQ Curiosity	Pearson Correlation	-.045	-.177	.127	.073	.022	-.060	-.117
	Sig. (2-tailed)	.654	.082	.204	.465	.829	.616	.326
	N	100	97	102	102	98	72	72
Post PRFQ Prementalizing	Pearson Correlation	-.111	.095	-.039	-.003	.111	.005	.157
	Sig. (2-tailed)	.356	.440	.747	.977	.365	.969	.260
	N	71	68	71	71	69	53	53
Post PRFQ Certainty	Pearson Correlation	.052	-.104	-.123	.100	-.176	.164	-.125
	Sig. (2-tailed)	.666	.399	.306	.404	.148	.240	.371
	N	71	68	71	71	69	53	53
Post PRFQ Curiosity	Pearson Correlation	.030	-.123	.072	.098	-.011	.057	.023
	Sig. (2-tailed)	.804	.318	.552	.414	.929	.686	.869
	N	71	68	71	71	69	53	53
Prementalizing Change	Pearson Correlation	-.148	-.064	.061	.029	.145	-.032	-.101
	Sig. (2-tailed)	.218	.602	.616	.809	.234	.819	.473
	N	71	68	71	71	69	53	53

		Time as Foster Parent in months	FP Age in Years	FP Gender	FP Ethnicity	FP Education	Child Gender	Child Age in months
Certainty Change	Pearson Correlation	.064	-.069	-.132	.109	-.016	.155	-.017
	Sig. (2-tailed)	.595	.577	.273	.364	.894	.267	.904
	N	71	68	71	71	69	53	53
Curiosity Change	Pearson Correlation	.063	-.069	-.071	.035	.136	.252	-.043
	Sig. (2-tailed)	.603	.574	.554	.771	.265	.068	.762
	N	71	68	71	71	69	53	53
Pre PSI Defensive Responding	Pearson Correlation	.165	-.054	.094	.017	-.064	-.011	.030
	Sig. (2-tailed)	.101	.598	.352	.870	.534	.926	.807
	N	100	96	101	101	97	71	71
Post PSI Defensive Responding	Pearson Correlation	-.142	-.017	.032	.147	.028	-.078	-.199
	Sig. (2-tailed)	.240	.893	.792	.224	.822	.598	.174
	N	70	66	70	70	67	48	48
Pre PSI Parental Distress	Pearson Correlation	.095	-.092	.040	.053	-.060	.002	-.016
	Sig. (2-tailed)	.347	.374	.693	.596	.561	.985	.893
	N	100	96	101	101	97	71	71
Post PSI Parental Distress	Pearson Correlation	-.192	-.048	.009	.105	.037	-.048	-.244
	Sig. (2-tailed)	.111	.704	.941	.385	.767	.744	.095
	N	70	66	70	70	67	48	48
Pre PSI Child Dysfunctional Interaction	Pearson Correlation	.033	-.131	.016	.073	.064	-.173	-.164
	Sig. (2-tailed)	.742	.202	.872	.470	.532	.149	.173
	N	100	96	101	101	97	71	71
Post PSI Child Dysfunctional Interaction	Pearson Correlation	-.220	-.066	.044	.141	.232	-.119	-.161
	Sig. (2-tailed)	.067	.601	.715	.243	.059	.420	.275
	N	70	66	70	70	67	48	48

		Time as Foster Parent in months	FP Age in Years	FP Gender	FP Ethnicity	FP Education	Child Gender	Child Age in months
Pre PSI Child Difficulty	Pearson Correlation	.157	-.039	-.040	-.077	-.058	.028	-.070
	Sig. (2-tailed)	.120	.706	.694	.442	.574	.816	.561
	N	100	96	101	101	97	71	71
Post PSI Child Difficulty	Pearson Correlation	-.088	.017	.032	-.006	.108	.008	-.137
	Sig. (2-tailed)	.469	.890	.790	.961	.385	.959	.353
	N	70	66	70	70	67	48	48
Pre PSI Total	Pearson Correlation	.099	-.125	.047	.017	-.007	-.026	-.083
	Sig. (2-tailed)	.326	.225	.644	.868	.942	.829	.490
	N	100	96	101	101	97	71	71
PSI Defensive Responding Change	Pearson Correlation	-.193		.179	.011	.131	.084	.046
	Sig. (2-tailed)	.109		.151	.927	.279	.497	.755
	N	70		66	70	70	67	48
PSI Parental Distress Change	Pearson Correlation	-.203		.158	.066	.048	.060	.099
	Sig. (2-tailed)	.091		.206	.587	.691	.630	.505
	N	70		66	70	70	67	48
PSI Child Dysfunctional Interaction Change	Pearson Correlation	-.161		.250*	.036	.140	-.026	.166
	Sig. (2-tailed)	.183		.043	.770	.247	.837	.258
	N	70		66	70	70	67	48
PSI Difficult Child Change	Pearson Correlation	-.202		.112	.232	.124	.013	.148
	Sig. (2-tailed)	.093		.371	.053	.308	.918	.315
	N	70		66	70	70	67	48
PSI Total Change	Pearson Correlation	-.186		.240	.099	.144	-.046	.147
	Sig. (2-tailed)	.123		.053	.414	.236	.713	.319
	N	70		66	70	70	67	48

*Correlation is significant at the 0.05 level (2-tailed).

Appendix S

PRFQ Raw Mean Scores

PRFQ Raw Mean Scores

ID	Group†	Pre Prementalizing	Pre Certainty	Pre Curious	Post Prementalizing	Post Certainty	Post Curious
1.00	1.00	5.20	4.00	7.20	2.00	5.00	6.50
2.00	1.00	3.33	2.50	5.83	3.00	3.33	5.67
4.00	1.00	2.00	4.17	5.67	2.17	3.33	5.83
5.00	1.00	2.17	3.67	6.50	1.50	3.33	5.00
7.00	1.00	1.50	3.50	6.50	1.33	2.83	5.67
8.00	1.00	1.33	2.33	5.50	2.33	1.67	5.33
9.00	1.00	3.33	3.00	4.00	3.00	3.17	4.00
10.00	1.00	1.00	3.67	5.83	1.00	4.17	5.17
14.00	1.00	2.67	3.00	6.00	1.67	2.67	6.67
16.00	1.00	1.50	4.17	6.00	2.83	4.50	6.67
18.00	1.00	1.67	4.17	5.67	2.83	4.00	4.50
19.00	1.00	1.17	4.33	6.33	1.00	3.33	6.00
20.00	1.00	2.00	3.00	5.67	2.20	3.50	6.40
23.00	1.00	2.83	3.33	5.83	1.20	4.75	5.80
24.00	1.00	1.00	3.33	6.00	1.00	2.33	5.67
25.00	1.00	3.50	5.50	6.67	4.83	4.50	5.50
26.00	1.00	2.00	2.33	5.83	1.50	2.83	6.00
27.00	1.00	1.67	3.00	5.50	1.83	1.83	4.83
28.00	1.00	1.83	3.50	4.33	1.50	2.17	5.67
29.00	1.00	2.17	1.83	5.00	2.67	1.83	4.33
30.00	1.00	3.50	3.50	5.33	1.33	3.33	5.67
32.00	1.00	1.67	3.33	6.83	1.80	2.75	5.80
33.00	1.00	2.67	3.50	6.67	2.33	3.83	5.83
34.00	1.00	1.00	4.67	6.83	1.00	1.33	6.67
35.00	1.00	3.00	4.17	6.00	1.33	4.33	6.17
36.00	1.00	2.00	3.67	6.50	1.67	2.50	6.33
37.00	1.00	1.50	3.00	6.17	1.33	2.50	6.17
38.00	1.00	1.50	4.00	6.00	2.00	4.00	5.83
39.00	1.00	2.17	4.33	4.83	1.83	2.67	5.00
40.00	1.00	1.83	3.33	5.50	1.67	4.00	6.00
41.00	1.00	2.17	1.50	6.33	1.67	1.67	7.00
42.00	1.00	3.83	4.00	6.67	2.00	4.67	7.00
43.00	1.00	1.33	4.83	6.50	2.17	4.00	6.00
44.00	1.00	1.17	3.50	6.50	1.00	3.33	7.00
45.00	1.00	4.17	3.17	6.00	1.00	3.67	7.00
46.00	1.00	1.17	5.00	4.67	1.00	4.67	6.00
47.00	1.00	1.50	3.83	6.50	1.17	3.83	7.00
48.00	1.00	1.50	4.83	5.83	1.33	3.33	6.00
50.00	1.00	3.33	4.33	6.67	4.33	2.67	5.67
51.00	1.00	1.17	2.50	5.17	1.17	2.67	5.83
52.00	1.00	1.33	3.33	4.67	2.00	3.17	4.17

ID	Group†	Pre Prementalizing	Pre Certainty	Pre Curious	Post Prementalizing	Post Certainty	Post Curious
53.00	1.00	3.00	3.00	5.67	2.67	3.33	5.33
54.00	1.00	1.00	2.17	7.00	1.00	1.17	6.00
56.00	0.00	1.00	2.67	6.67	1.00	2.83	6.83
57.00	0.00	2.50	2.50	6.50	1.50	1.67	6.67
58.00	0.00	1.83	3.33	6.67	3.00	3.67	5.67
59.00	0.00	2.17	4.00	7.00	2.50	3.83	6.67
61.00	0.00	1.83	2.83	5.33	1.25	4.50	5.33
62.00	0.00	1.83	1.67	5.83	3.67	2.67	5.17
63.00	0.00	1.00	1.67	7.00	1.00	2.00	7.00
64.00	0.00	1.50	4.33	6.00	1.67	2.83	6.33
68.00	0.00	2.67	4.33	7.00	1.33	4.83	6.67
69.00	0.00	1.50	3.33	5.83	1.50	3.67	6.17
71.00	0.00	1.17	1.83	6.00	1.00	2.50	6.67
73.00	0.00	2.83	2.50	6.33	2.83	2.83	5.17
75.00	0.00	1.50	4.17	6.17	1.00	4.33	6.67
76.00	0.00	2.00	4.33	5.67	1.67	5.17	5.00
77.00	0.00	1.00	1.33	7.00	1.00	2.00	7.00
78.00	0.00	1.00	2.50	6.17	1.00	3.17	5.83
80.00	0.00	1.33	4.17	6.50	1.17	3.33	6.50
81.00	0.00	1.00	4.17	7.00	1.00	4.67	7.00
83.00	0.00	4.00	3.33	5.33	3.50	2.83	5.50
84.00	0.00	2.50	4.67	5.50	1.83	3.33	5.33
85.00	0.00	1.00	4.17	7.00	1.67	4.17	7.00
86.00	0.00	3.33	2.50	6.83	3.50	2.17	6.33
89.00	0.00	2.83	3.83	6.83	1.17	4.50	6.00
90.00	0.00	1.17	4.33	6.33	1.17	4.50	6.17
91.00	0.00	1.00	4.17	7.00	1.50	3.67	4.67
94.00	0.00	1.40	3.00	4.80	1.20	3.75	4.40
96.00	0.00	1.17	4.83	6.20	1.33	5.17	5.67
97.00	0.00	1.00	2.83	7.00	1.00	2.83	7.00

† Group designation: 1=Intervention, 0=Comparison

Appendix T

PSI Raw Mean Scores

PSI Raw Mean Scores

ID	Group†	Pre Defensive Responding	Pre Parental Distress	Pre Child Dysfunctional Interaction	Pre Difficult Child	Pre Total	Post Defensive Responding	Post Parental Distress	Post Child Dysfunctional Interaction	Pre Difficult Child	Post Total
1.00	1.00	18.00	25.00	20.00	30.00	75.00	14.00	24.00	21.00	28.00	87.00
2.00	1.00	18.00	27.00	30.00	41.00	98.00	17.00	27.00	25.00	40.00	92.00
4.00	1.00	21.00	38.00	25.00	34.00	97.00	20.00	36.00	24.00	31.00	91.00
5.00	1.00	15.00	23.00	28.00	35.00	86.00	14.00	23.00	20.00	34.00	77.00
7.00	1.00	20.00	34.00	24.00	37.00	95.00	17.00	30.00	20.00	30.00	80.00
8.00	1.00	13.00	23.00	21.00	25.00	69.00	20.00	30.00	29.00	30.00	89.00
9.00	1.00	25.00	41.00	26.00	22.00	89.00	24.00	42.00	23.00	36.00	101.00
10.00	1.00	12.00	26.00	9.00	16.00	60.00	16.00	29.00	13.00	34.00	76.00
12.00	1.00	17.00	26.00	12.00	37.00	48.00	16.00	21.00	17.00	19.00	57.00
14.00	1.00	16.00	29.00	21.00	30.00	80.00	26.00	41.00	26.00	36.00	103.00
16.00	1.00	25.00	42.00	15.00	12.00	69.00	22.00	36.00	22.00	28.00	86.00
18.00	1.00	13.00	23.00	30.00	25.00	78.00	13.00	21.00	24.00	23.00	68.00
19.00	1.00	15.00	20.00	12.00	14.00	46.00	15.00	27.00	18.00	21.00	66.00
20.00	1.00	17.00	31.00	26.00	30.00	87.00	16.00	26.00	25.00	22.00	73.00
23.00	1.00	16.00	32.00	17.00	26.00	75.00	10.00	19.00	15.00	23.00	67.00
24.00	1.00	20.00	31.00	27.00	38.00	96.00	18.00	29.00	29.00	36.00	94.00
25.00	1.00	20.00	29.00	27.00	37.00	93.00	17.00	32.00	21.00	26.00	79.00
26.00	1.00	20.00	38.00	24.00	31.00	93.00	18.00	30.00	25.00	24.00	79.00
27.00	1.00	12.00	19.00	20.00	20.00	59.00	13.00	22.00	13.00	23.00	58.00
28.00	1.00	28.00	46.00	24.00	41.00	111.00	25.00	43.00	29.00	31.00	103.00
29.00	1.00	15.00	27.00	29.00	46.00	102.00	14.00	27.00	25.00	47.00	99.00

ID	Group†	Pre Defensive Responding	Pre Parental Distress	Pre Child Dysfunctional Interaction	Pre Difficult Child	Pre Total	Post Defensive Responding	Post Parental Distress	Post Child Dysfunctional Interaction	Pre Difficult Child	Post Total
34.00	1.00	12.00	22.00	20.00	40.00	82.00	14.00	24.00	19.00	36.00	79.00
35.00	1.00	13.00	21.00	30.00	46.00	97.00	13.00	25.00	27.00	49.00	101.00
36.00	1.00	19.00	31.00	30.00	28.00	89.00	17.00	28.00	21.00	21.00	70.00
37.00	1.00	15.00	27.00	31.00	27.00	85.00	15.00	26.00	28.00	26.00	80.00
38.00	1.00	9.00	16.00	19.00	33.00	68.00	15.00	26.00	29.00	44.00	99.00
39.00	1.00	16.00	27.00	26.00	24.00	77.00	16.00	29.00	32.00	23.00	84.00
40.00	1.00	10.00	21.00	41.00	45.00	107.00	10.00	17.00	37.00	42.00	96.00
41.00	1.00	10.00	15.00	12.00	20.00	47.00	11.00	16.00	15.00	20.00	51.00
42.00	1.00	9.00	15.00	19.00	24.00	58.00	13.00	23.00	24.00	23.00	70.00
43.00	1.00	14.00	24.00	16.00	23.00	63.00	9.00	16.00	15.00	19.00	50.00
44.00	1.00	14.00	24.00	23.00	22.00	69.00	8.00	13.00	15.00	14.00	42.00
45.00	1.00	11.00	17.00	15.00	35.00	67.00	11.00	16.00	13.00	28.00	57.00
46.00	1.00	12.00	24.00	27.00	46.00	97.00	9.00	17.00	16.00	28.00	61.00
47.00	1.00	20.00	35.00	29.00	46.00	110.00	15.00	25.00	23.00	45.00	93.00
49.00	1.00	11.00	16.00	22.00	34.00	72.00	12.00	19.00	20.00	34.00	73.00
50.00	1.00	12.00	21.00	21.00	27.00	69.00	16.00	26.00	18.00	29.00	73.00
51.00	1.00	10.00	23.00	24.00	32.00	79.00	14.00	27.00	26.00	30.00	83.00
52.00	1.00	25.00	35.00	40.00	55.00	130.00	18.00	27.00	27.00	49.00	103.00
53.00	1.00	14.00	21.00	18.00	30.00	69.00	11.00	16.00	14.00	23.00	53.00
55.00	0.00	18.00	32.00	13.00	14.00	59.00	16.00	29.00	12.00	14.00	55.00
56.00	0.00	10.00	16.00	19.00	38.00	73.00	12.00	17.00	13.00	27.00	57.00
57.00	0.00	7.00	12.00	12.00	13.00	37.00	16.00	25.00	22.00	32.00	79.00
58.00	0.00	9.00	14.00	23.00	24.00	61.00	16.00	26.00	29.00	22.00	77.00
60.00	0.00	17.00	28.00	16.00	15.00	59.00	17.00	27.00	19.00	18.00	64.00
61.00	0.00	13.00	20.00	20.00	35.00	75.00	25.00	39.00	33.00	31.00	103.00
62.00	0.00	11.00	16.00	15.00	16.00	47.00	11.00	16.00	12.00	12.00	40.00
63.00	0.00	16.00	25.00	15.00	18.00	58.00	19.00	29.00	20.00	22.00	71.00
67.00	0.00	17.00	23.00	12.00	15.00	50.00	16.00	25.00	15.00	18.00	58.00

ID	Group†	Pre Defensive Responding	Pre Parental Distress	Pre Child Dysfunctional Interaction	Pre Difficult Child	Pre Total	Post Defensive Responding	Post Parental Distress	Post Child Dysfunctional Interaction	Pre Difficult Child	Post Total
68.00	0.00	14.00	24.00	23.00	28.00	75.00	11.00	17.00	15.00	25.00	57.00
70.00	0.00	15.00	26.00	12.00	21.00	59.00	15.00	25.00	13.00	15.00	53.00
72.00	0.00	18.00	28.00	30.00	41.00	99.00	20.00	30.00	30.00	34.00	94.00
74.00	0.00	7.00	13.00	12.00	14.00	39.00	7.00	15.00	14.00	15.00	44.00
75.00	0.00	10.00	19.00	22.00	28.00	69.00	8.00	14.00	18.00	24.00	56.00
76.00	0.00	10.00	17.00	14.00	19.00	50.00	9.00	18.00	22.00	21.00	61.00
77.00	0.00	7.00	12.00	15.00	20.00	47.00	7.00	12.00	13.00	17.00	42.00
79.00	0.00	14.00	24.00	14.00	24.00	62.00	25.00	36.00	19.00	24.00	79.00
80.00	0.00	11.00	16.00	15.00	20.00	51.00	9.00	14.00	12.00	13.00	39.00
82.00	0.00	18.00	30.00	27.00	30.00	87.00	17.00	29.00	21.00	26.00	76.00
83.00	0.00	13.00	23.00	27.00	38.00	88.00	14.00	26.00	26.00	38.00	90.00
84.00	0.00	21.00	31.00	21.00	34.00	86.00	20.00	33.00	21.00	33.00	87.00
85.00	0.00	18.00	30.00	35.00	29.00	94.00	19.00	32.00	33.00	27.00	92.00
88.00	0.00	7.00	12.00	13.00	14.00	39.00	14.00	26.00	25.00	31.00	82.00
89.00	0.00	7.00	12.00	16.00	21.00	49.00	7.00	12.00	12.00	13.00	37.00
90.00	0.00	17.00	26.00	20.00	26.00	72.00	15.00	26.00	23.00	28.00	77.00
93.00	0.00	8.00	14.00	11.00	14.00	60.00	8.00	13.00	21.00	32.00	66.00
95.00	0.00	14.00	23.00	22.00	15.00	60.00	11.00	19.00	18.00	22.00	59.00

† Group designation: 1=Intervention, 0=Comparison

Appendix U

SDQ Scoring

SDQ Scoring

Interpreting Symptom Scores and Defining "Caseness" from Symptom Scores

Although SDQ scores can often be used as continuous variables, it is sometimes convenient to classify scores as normal, borderline and abnormal. Using the bandings shown below, an abnormal score on one or both of the total difficulties scores can be used to identify likely "cases" with mental health disorders. This is clearly only a rough-and ready method for detecting disorders – combining information from SDQ symptom and impact scores from multiple informants is better, but still far from perfect. Approximately 10% of a community sample scores in the abnormal band on any given score, with a further 10% scoring in the borderline band. The exact proportions vary according to country, age and gender – normative SDQ data are available from the web site. You may want to adjust banding and caseness criteria for these characteristics, setting the threshold higher when avoiding false positives is of paramount importance, and setting the threshold lower when avoiding false negatives is more important.

Parent Completed	**Normal**	**Borderline**	**Abnormal**
Total Difficulties Score	0 - 13	14 - 16	17 - 40
Emotional Symptoms Score	0 - 3	4	5 - 10
Conduct Problems Score	0 - 2	3	4 - 10
Hyperactivity Score	0 - 5	6	7 - 10
Peer Problems Score	0 - 2	3	4 - 10
Prosocial Behaviour Score	6 - 10	5	0 - 4

Appendix V

Audio Fidelity Coding Form

Audio Fidelity Coding Form

Audio Sample: _____ Rater: _____

	Not at All			Somewhat			Very Much
Quality of Training	1	2	3	4	5	6	7
1. Language used was understandable.	❍	❍	❍	❍	❍	❍	❍
2. The content was clearly explained.	❍	❍	❍	❍	❍	❍	❍
3. Presenter sounded knowledgeable.	❍	❍	❍	❍	❍	❍	❍
4. Presenter was engaging.	❍	❍	❍	❍	❍	❍	❍
5. Presenter was enthusiastic.	❍	❍	❍	❍	❍	❍	❍
Content in Training	1	2	3	4	5	6	7
6. Presenter discusses attachment.	☐	☐	☐	☐	☐	☐	☐
7. Presenter discusses trauma.	☐	☐	☐	☐	☐	☐	☐
8. Presenter discusses child development.	☐	☐	☐	☐	☐	☐	☐
9. Presenter focuses on understanding children's behaviour.	☐	☐	☐	☐	☐	☐	☐
10. Presenter discusses reflective functioning or mentalization.	☐	☐	☐	☐	☐	☐	☐
11. Presenter discusses what lies behind children's emotions.	☐	☐	☐	☐	☐	☐	☐
12. Presenter leads class through an exercise designed to help them understand what another person might be thinking or feeling.	☐	☐	☐	☐	☐	☐	☐
13. Presenter focuses on the importance of parents' understanding their own reactions/emotions.	☐	☐	☐	☐	☐	☐	☐

References

Abidin, R. R. (1995). *The Parenting Stress Index professional manual*. Odessa, FL: Psychological Assessment Resources.

Achenbach, T. M. (1991). *Integrative guide for the 1991 CBCL/4-18, YSR, and TRF profiles*. Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T., McConaughy, S., & Howill, C. (1987). Child and adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychopharmacology Bulletin, 101*, 213–232.

Adkins, T. (2010). *Parenting the traumatized child: Understanding and navigating behaviors.* Unpublished manuscript.

Afifi, T. O., Brownridge, D. A., Cox, B. J., & Sareen, J. (2006). Physical punishment, childhood abuse and psychiatric disorders. *Child Abuse & Neglect*, *30*(10), 1093–1103.

Ainsworth, M. D. (1985). Patterns of attachment. *Clinical Psychologist*, *38*, 27–29.

Ainsworth, M., & Wittig, B. (1969). Attachment and exploratory behavior of one-year-olds in a strange situation. In B. M. Foss, *Determinants of Infant Behavior, Vol. 4* (pp. 111–136). London: Methuen.

Ainsworth, M., Bell, S., & Stayton, D. J. (1974). Infant-mother attachment and social development: Socialisation as a product of reciprocal responsiveness to signals. In M. Richards, *The integration of a child into a social world* (pp. 99–135). Cambridge, U.K.: Cambridge University Press.

Ainsworth, M., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, N.J.: Lawrence Erlbaum

Associates.

Alcock, T. (1946). Conclusions from psychiatric work with evacuated children. *British Journal of Medical Psychology*, *21*(3), 181–184.

Allen, J. G. (2005). *Coping With Trauma*. Washington, D.C.: American Psychiatric Publishing.

Allen, J. G., Fonagy, P., & Bateman, A. (2008). *Mentalizing in clinical practice*. Washington, D.C.: American Psychiatric Publishing.

Anne Lown, E., Nayak, M. B., Korcha, R. A., & Greenfield, T. K. (2010). Child physical and sexual abuse: A comprehensive look at alcohol consumption patterns, consequences, and dependence from the National Alcohol Survey. *Alcoholism: Clinical and Experimental Research*, *35*(2), 317–325.

Arata, C. M., Langhinrichsen-Rohling, J., Bowers, D., & O'Brien, N. (2007). Differential correlates of multi-type maltreatment among urban youth. *Child Abuse & Neglect*, *31*(4), 393–415.

Arnow, B. (2004). Relationships between childhood maltreatment, adult health and psychiatric outcomes, and medical utilization. *The Journal of Clinical Psychiatry*.

Asarnow, J. R., Goldstein, M. J., & Tompson, M. (1993). One-year outcomes of depressive disorders in child psychiatric in-patients: Evaluation of the prognostic power of a brief measure of expressed emotion. *Journal of Child Psychology and Psychiatry*, *34*(2), 129–137.

Asen, E., & Fonagy, P. (2011). Mentalization-based therapeutic interventions for families. *Journal of Family Therapy*, *34*(4), 347–370.

Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H. (2009). The first 10,000 Adult Attachment Interviews: Distributions of adult attachment representations in clinical and non-clinical groups. *Attachment & Human Development*, *11*(3), 223–263.

Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., & Juffer, F. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, *129*(2), 195–215.

Bakermans-Kranenburg, M., Juffer, F., & van IJzendoorn, M. H. (1998). Interventions with video feedback and attachment discussions: Does type of maternal insecurity make a difference? *Infant Mental Health Journal*, *19*(2), 202–219.

Ballen, N., Bernier, A., Moss, E., Tarabulsy, G. M., & St-Laurent, D. (2010). Insecure attachment states of mind and atypical caregiving behavior among foster mothers. *Journal of Applied Developmental Psychology*, *31*(2), 118–125.

Barth, R. P., Green, R., Webb, M. B., Wall, A., Gibbons, C., & Craig, C. (2008). Characteristics of out-of-home caregiving environments provided under child welfare services. *Child Welfare: Journal of Policy, Practice, and Program*, *87*(3), 5–39.

Bateman, A. & Fonagy, P. (2013). Impact of clinical severity on outcomes of mentalisation-based treatment for borderline personality disorder. *British Journal of Psychiatry, 203*, 221-227.

Belsky, J. (1997). Attachment, mating, and parenting. *Human Nature*, *8*(4), 361–381.

Belsky, J., Rovine, M., & Taylor, D. G. (1984). The Pennsylvania infant and family development project, III: The origins of individual differences in infant-mother attachment: Maternal and infant contributions. *Child Development*, *55*, 718–728.

Berlin, L. J. (2005). Interventions to enhance early attachments: The state of the field today. In L. J. Berlin, Y. Ziv, L. M. Amaya-Jackson, & M. T. Greenberg, *Enhancing early attachments: Theory, research, intervention, and policy* (pp. 3–33). New York: Guilford Press.

Berlin, L. J., Cassidy, J., & Belsky, J. (1995). Loneliness in young children and infant-mother

attachment: A longitudinal study. *Merrill-Palmer Quarterly*, *41*, 91–103.

Berlin, L. J., Zeanah, C. H., & Lieberman, A. F. (2008). Prevention and intervention programs for supporting early attachment security. In J. Cassidy & P. Shaver, *Handbook of Attachment* (2nd ed., pp. 745–761). New York: Guilford Press.

Bernard, K., Dozier, M., Bick, J., Lewis-Morrarty, E., Lindhiem, O., & Carleson, E. (2012). Enhancing attachment organization among maltreated children: Results of a randomized clinical trial. *Child Development*, *8*(3), 623–636.

Berrick, J. D. (2008). *Take me home : Protecting America's vulnerable children and families*. New York: Oxford University Press.

Berridge, D., & Cleaver, H. (1987). *Foster home breakdown*. Oxford: Wiley-Blackwell.

Bion, W. R. (1962). *Learning from experience*. London: Heinemann.

Biringen, Z., Vliegen, N., Bijttebier, P., & Cluckers, G. (2002). The Emotional Availability—Dutch Self-Report.

Blakey, J. M., Leathers, S. J., Lawler, M., Washington, T., Natschke, C., Strand, T., & Walton, Q. (2012). A review of how states are addressing placement stability. *Children and Youth Services Review*, 369–378.

Blatt, S., Auerbach, J., and Behrends, R. (2008). Changes in representation of self and significant others in the treatment process. In E.L. Jurist, A. Slade, Bergner, S., *In Mind to Mind: Infant research, neuroscience, and psychoanalysis.* New York: Other Press. In E.L. Jurist, A. Slade, Bergner, S., *In Mind to Mind: Infant research, neuroscience, and psychoanalysis.* New York: Other Press.

Bond, M. (2004). Empirical studies of defense style: Relationships with psychopathology and change. *Harvard Review Psychiatry, 12*(5), 263-278.

Bowlby, J. (1944). Forty-four juvenile thieves: Their characters and home life. *International*

Journal of Psychoanalysis, *XXV*, 19–52.

Bowlby, J. (1951). Maternal care and mental health. *World Health Organization Monograph*.

Bowlby, J. (1956). Mother-child separation. *Mental Health and Infant Development*, *I*, 117–122.

Bowlby, J. (1959). Separation anxiety. *The International Journal of Psychoanalysis*, *XLI*, 1–25.

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

Bowlby, J. (1973). *Attachment and loss, vol. 2: Separation*. New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss, vol. 3: Loss, sadness and depression*. New York: Basic Books.

Bowlby, J. (1981). Psychoanalysis as a natural science. *International Review of Psycho-Analysis*, *8*, 243–255.

Bowlby, J. (1988). *A secure base*. New York: Brunner-Routledge.

Braungart-Rieker, J. M., Garwood, M. M., Powers, B. P., & Wang, X. (2001). Parental sensitivity, infant affect, and affect regulation: Predictors of later attachment. *Child Development*, *72*, 252–270.

Bretherton, I. (1985). Attachment theory: Retrospect and prospect. *Monographs of the Society for Research in Child Development*, *209*(1-2), 3–35.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, *28*, 759–775.

Bretherton, I., & Munholland, K. A. (1999). Internal working models revisited. In J. Cassidy & P. Shaver, *Handbook of attachment: Theory, research and clinical applications* (pp. 89–111). New York: Guilford Press.

Breuer, J., & Freud, S. (1895). *Studies on hysteria*. New York: Basic Books.

Brezo, J., Paris, J., Barker, E. D., Tremblay, R. E., Vitaro, F., Zoccolillo, M., . . . Turecki, G. (2007). Natural history of suicidal behaviors in a population-based sample of young adults. *Psychological Medicine*, *37*(11).

Brown, G. W., & Rutter, M. (1966). The measurement of family activities and relationships: a methodological study. *Human Relations*, *19*, 241–263.

Bruffaerts, R., Demyttenaere, K., Borges, G., Haro, J. M., Chiu, W. T., Hwang, I., . . . Nock, M.K. (2010). Childhood adversities as risk factors for onset and persistence of suicidal behaviour. *The British Journal of Psychiatry*, *197*(1), 20–27.

Bus, A. G., & van IJzendoorn, M. H. (1992). Patterns of attachment in frequently and infrequently reading mother-child dyads. *The Journal of Genetic Psychology*, *153*, 195–203.

Calder, J., McVean, A., & Yang, W. (2009). History of abuse and current suicidal ideation: Results from a population based survey. *Journal of Family Violence*, *25*(2), 205–214.

Cassidy, J. (1988). Child-mother attachment and the self in six-year-olds. *Child Development*, *59*, 121–134.

Cassidy, J., Kirsh, S. J., & Scolton, K. L. (1996). Attachment and representations of peer relationships. *Developmental Psychology*, *32*, 892–904.

Castaldi, J. (1990). *Affective and cognitive patterns in the mother-child relationship during the second year of life*. Charlottesville: University of Virginia.

Chamberlain, P., Price, J. M., Reid, J. B., & Landsverk, J. (2006). Who disrupts from placement in foster and kinship care? *Child Abuse & Neglect*, *30*(4), 409–424.

Chaplin, T. M., & Cole, P. M. (2005). The role of emotion regulation in the development of psychopathology. In *Development of psychopathology: A vulnerability-stress perspective* (pp. 49–74). Thousand Oaks, CA: Sage.

Chavoshi, N., Teegee, M., Adam, W., Christian, W. M., Henderson, E., Craib, K. J. P., . . . Spittal, P.M. (2009). The Cedar Project: Correlates of attempted suicide among young Aboriginal people who use injection and non-injection drugs in two Canadian cities. *International Journal of Circumpolar Health*, *68*(3), 261–273.

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., . . . Zirakzadeh, A. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. *Mayo Clinic Proceedings*, *85*(7), 618–629.

Chernoff, R., Combs-Orme, T., & Risley-Curtiss, C. (1994). Assessing the health status of children entering foster care. *Pediatrics*, *93*(4), 594-601.

Choi-Kain, L., & Gunderson, J. (2008). Mentalization: Ontogeny, assessment, and application in the treatment of borderline personality disorder. *American Journal of Psychiatry*, *165*(9), 1127–1135.

Cicchetti, D., & Barnett, D. (1991). Attachment organization in maltreated preschoolers. *Development and Psychopathology*, *3*, 397–411.

Cicchetti, D. (Ed.) (1994). Advances and challenges in the study of the sequelae of child maltreatment [Special Issue]. *Development and Psychopathology, 6*(1), 1-247.

Cicchetti, D., & Rogosch, F. A. (1997). The role of self-organization in the promotion of resilience in maltreated children. *Developmental Psychopathology*, *9*(4), 797–815.

Cicchetti, D., & Toth, S. L. (1995). A developmental psychopathology perspective on child abuse and neglect. *Journal of the American Academy of Child & Adolescent Psychiatry*, *34*(5), 541–565.

Cicchetti, D., Cummings, E. M., Greenberg, M. T., & Marvin, R. (1990). An organizational perspective on attachment beyond infancy: Implications for theory, measurement, and research. In M. T. Greenberg, D. Cicchetti, & E. M. Cummings, *Attachment in the*

preschool years: Theory, research, and intervention (pp. 3–49). Chicago: University of Chicago Press.

Coie, J. D., Watt, N. F., West, S. G., Hawkins, J. D., Asmow, J. R., Markman, H. J., . . . Long, B. (1993). The science of prevention: a conceptual framework and some directions for a national research program. *American Psychologist*, *48*, 1013–1022.

Contreras, J. M., Kerns, K. A., Weimer, B. L., Gentzler, A. L., & Tomich, P. L. (2000). Emotion regulation as a mediator of associations between mother–child attachment and peer relationships in middle childhood. *Journal of Family Psychology*, *14*, 111–124.

Cooper, G., Hoffman, K., Powell, B., & Marvin, R. (2005). The Circle of Security intervention. In L. J. Berlin, Y. Ziv, L. M. Amaya-Jackson, & M. T. Greenberg, *Enhancing early attachments: Theory, research, intervention and policy* (pp. 127–151). Guilford Press.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., & Nazareth, I. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ*, *337*, a1655.

Crockenberg, S. B. (1981). Infant irritability, mother responsiveness, and social support influences on the security of infant-mother attachment. *Child Development*, *52*(3), 857–865.

Dane, A. V., & Schneider, B. H. (1998). Program integrity in primary and early secondary prevention: are implementation effects out of control? *Clinical Psychology Review*, *18*, 23–24.

Dawes, R. M., Faust, D., & Meehl, P. E. (1989). Clinical versus actuarial judgment. *Science*, *243*, 1668–1674.

De Wolff, M. S., & van Ijzendoorn, M. H (1997). Sensitivity and attachment: A meta-analysis on parental antecedents of infant attachment. *Child Development, 68*(4), 571-591.

DeKlyen, M., & Greenberg, M. (2008). Attachment and psychopathology in childhood. In J. Cassidy & P. Shaver, *Handbook of attachment: Theory, research, and clinical applications* (pp. 637–665). New York: Guilford Press.

Del Carmen, R., Pedersen, F. A., Huffman, L. C., & Bryan, Y. (1993). Dyadic distress management predicts subsequent security of attachment. *Infant Behavior and Development*, *16*, 131–147.

Denham, S., & Kochanoff, A. T. (2002). Parental contributions to preschoolers' understanding of emotion. *Marriage & Family Review*, *34*, 311–343.

Department of Health and Human Services, Children's Bureau (2011). *Home study requirements for prospective foster parents.* Washington, D.C.: Child Welfare Information Gateway.

Dodge, K., Petit, G., & Bates, J. (1997). How the experiences of early physical abuse leads children to become chronically aggressive. In D. Cicchetti & S. L. Toth, *Trauma: Theory, research, and intervention.* (pp. 263–288). Rochester, NY: Boydell and Brewer.

Dong, M., Anda, R. F., Dube, S. R., Giles, W. H., & Felitti, V. J. (2003). The relationship of exposure to childhood sexual abuse to other forms of abuse, neglect, and household dysfunction during childhood. *Child Abuse & Neglect*, *27*(6), 625–639.

Dorsey, S., Farmer, E. M. Z., Barth, R. P., Greene, K. M., Reid, J., & Landsverk, J. (2008). Current status and evidence base of training for foster and treatment foster parents. *Children and Youth Services Review*, *30*(12), 1403–1416.

Doyle, A. B., Markiewicz, D., Brendgen, M., Lieberman, M., & Voss, K. (2000). Child attachment security and self-concept: Associations with mother and father attachment style and marital quality. *Merrill-Palmer Quarterly*, *46*(3), 514–540.

Dozier, M., & Sepulveda, S. (2004). Foster mother state of mind and treatment use: Different challenges for different people. *Infant Mental Health Journal*, *25*(4), 368–378.

Dozier, M., Dozier, D., & Manni, M. (2002). Attachment and Biobehavioral Catch-Up: The ABC's of helping foster infants cope with early adversity. *Zero to Three*, *22*(5), 7–13.

Dozier, M., Peloso, E., Lindhiem, O., Gordon, M. K., Manni, M., Sepulveda, S., . . . Levine, S. (2006). Developing evidence-based interventions for foster children: An example of a randomized clinical trial with infants and toddlers. *Journal of Social Issues*, *62*(4), 767–785.

Dozier, M., Stovall, K., Albus, K. E., & Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development*, *72*(5), 1467–1477.

Drossman, D. A. (1994). Physical and sexual abuse and gastrointestinal illness: What is the link? *The American Journal of Medicine*, *97*(2), 105.

Dusenbury, L., Brannigan, R., Falco, M., & Hansen, W. B. (2003). A review of research on fidelity of implementation: implications for drug abuse prevention in school settings. *Health Education Resource*, *18*(2), 237–256.

Egeland, B. (1997). Mediators of the effects of child maltreatment on developmental adaptation in adolescence. In D. Cicchetti, S. Toth, & Sheree, *Developmental perspectives on trauma: Theory, research, and intervention. Rochester symposium on developmental psychology* (Vol. 8, pp. 403–434). Rochester: University of Rochester Press.

Egeland, B., Weinfield, N., Bosquet, M., & Cheng, V. (2000). Remembering, repeating and working through: Lessons from attachment-based interventions. In J. D. Osofsky & H. E. Fitzgerald, *WAIMH handbook of infant mental health: Infant mental health in*

groups at high risk (Vol. 4, pp. 35–89). New York: John Wiley & Sons, Inc.

Elicker, J., Engelund, M., & Sroufe, L. A. (1992). Predicting peer competence and peer relationships in childhood from early parent–child relationships. In R. D. Parke & G. W. Ladd, *Family-peer relationships: Modes of linkage* (pp. 77–106). Hillsdale, NJ: Erlbaum.

Elman, J. L., Bates, E. A., Johnson, M., Karmiloff-Smith, A., Parisi, D., & Plunkett, K. (1996). *Rethinking innateness*. Cambridge, MA: MIT Press.

Erickson, M. F., & Egeland, B. (1996). Child neglect. *The APSAC Handbook on Child Maltreatment*, *2*, 3–20.

Fanshel, D., Finch, S. J., & Grundy, J. F. (1990). *Foster children in a life course perspective*. New York: Columbia University Press.

Ferenczi, S. (1933). A confusion of tongues between adults and the child. In *Final contributions to the problems and methods of psycho-analysis* (pp. 156–167). London: Hogarth Press.

Finestone, H. M., Stenn, P., Davies, F., Stalker, C., Fry, R., & Koumanis, J. (2000). Chronic pain and health care utilization in women with a history of childhood sexual abuse. *Child Abuse & Neglect*, *24*(4), 547–556.

Fonagy, P. (1999). Points of contact and divergence between psychoanalytic and attachment theories: Is psychoanalytic theory truly different? *Psychoanalytic Inquiry, 19*, 448-480.

Fonagy, P. (2000). Attachment and borderline personality disorder. *Journal of the American Psychoanalytic Association*, *48*(4), 1129–1146.

Fonagy, P. (2001). *Attachment theory and psychoanalysis*. London: Karnac Books Ltd.

Fonagy, P., & Bateman, A. W. (2006). Mechanisms of change in mentalization-based

treatment of BPD. *Journal of Clinical Psychology*, *62*(4), 411–430.

Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology*, *21*(4), 1355–1381.

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, *9*(4), 679–700.

Fonagy, P., & Target, M. (2005). Bridging the transmission gap: An end to an important mystery of attachment research? *Attachment & Human Development*, *7*(3), 333–343.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2004). *Affect Regulation, mentalization and the development of the self*. London: Karnac Books Ltd.

Fonagy, P., Steele, M., Steele, H., Leigh, T., Kennedy, R., Mattoon, G., & Target, M. (1995). Attachment, the reflective self, and borderline states: The predictive specificity of the Adult Attachment Interview and pathological emotional development. In S. Goldberg, R. Muir, & J. Kerr, *Attachment theory: Social, developmental, and clinical perspectives* (pp. 233–278). Hillsdale, NJ: Analytic Press.

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, *12*(3).

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective-functioning manual, version 5.0, for application to adult attachment interviews*. London: University College London.

Fonagy, G., Williams, L., Fearon, P., Asen, E., Bleiberg, E., Target, M., . . . Bevington, D. (2010). *Mentalization-Based Treatment for Families*. Unpublished manual, The Anna Freud Centre, London.

For the Cedar Project Partnership, Moniruzzaman, A., Pearce, M. E., Patel, S. H., Chavoshi, N., Teegee, M., . . . Spittal, P. (2008). The Cedar Project: Historical trauma, sexual abuse and HIV risk among young Aboriginal people who use injection and non-injection drugs in two Canadian cities. *Social Science & Medicine*, *66*(11), 2185–2194.

Foster parent training (2014). Retrieved September 10, 2014, from http://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/Care_Training.asp

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, *14*(3), 387–421.

Frame, L. (2002). Maltreatment reports and placement outcomes for infants and toddlers in out-of-home care. *Infant Mental Health Journal*, *23*(5), 517–540.

Frankel, K. A., & Bates, J. E. (1990). Mother-toddler problem solving: Antecedents in attachment, home behavior, and temperament. *Child Development*, *61*(3), 810–819.

Fraley, R. C., Waller, N. G., & Brennan, K. A. (2000). An item response theory analysis of self-report measures of adult attachment. *Journal of Personality and Social Psychology*, *78*(2), 350.

Freud, A. (1954). The widening scope of indications for psychoanalysis: Discussion. *Journal of the American Psychoanalytic Association*, *2*, 607–620.

Freud, S. (1900). The Interpretation of Dreams. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 4). London: Hogarth Press.

Freud, S. (1905). Three essays on the theory of sexuality. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 125). London: Hogarth Press.

Freud, S. (1906). My views on the part played by sexuality in the aetiology of the neuroses. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 269–280). London: Hogarth Press.

Freud, S. (1917). Introductory lectures on psychoanalysis: Part III, general theory of the neuroses. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 16, pp. 243–463). London: Hogarth Press.

Freud, S. (1920). Beyond the pleasure principle. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp. 7–64). London: Hogarth Press.

Freud, S. (1923). The ego and the id. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 3–66). London: Hogarth Press.

Freud, S. (1926). Inhibitions, symptoms and anxieties. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 77–172). London: Hogarth Press.

Freud, S. (1931). Female sexuality. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21, pp. 221–246). London: Hogarth Press.

Freud, S. (1938). An outline of psychoanalysis. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 139–208). London: Hogarth Press.

Freud, S. (1939). Moses and monotheism. In *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 3–137). London: Hogarth Press.

George, C., & Main, M. (1979). Social interactions of young abused children: Approach, avoidance, and aggression. *Child Development*, 306–318.

George, C., Kaplan, N., & Main, M. (1985). *Adult Attachment Interview (AAI)*. Unpublished manuscript, University of California, Berkeley.

Golding, K. (2003). Helping foster carers, helping children: Using attachment theory to guide practice. *Adoption & Fostering*, *27*(2), 64–73.

Golding, K. (2007). *Nurturing attachments: Supporting children who are fostered or adopted*. London: Jessica Kingsley Publishers.

Goldstein, M. J., Nuechterlein, K. H., & Snyder, K. S. (1988). Family factors and the course of bipolar affective disorder. *Archives of General Psychiatry*, *45*(3), 225.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: a research note. *Journal of Child Psychology and Psychiatry*, *38*, 581–586.

Goodman, R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry*, *40*(5), 791–799.

Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child & Adolescent Psychiatry*, *40*, 1337–1345.

Goodman, R., Meltzer, H., & Bailey, V. (2003). The Strengths and Difficulties Questionnaire: a pilot study on the validity of the self-report version. *International Review of Psychiatry*, (15), 173–177.

Goodman, R., & Scott, S. (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: is small beautiful? *Journal of Abnormal Child Psychology*, *27*(1), 17-24.

Goodvin, R., Meyer, S., & Thompson, R. A. (2008). Self-understanding in early childhood: Associations with child attachment security and maternal negative affect. *Attachment & Human Development*, *10*(4), 433–450.

Gottschalk, L. A., & Gleser, G. C. (1969). *The measurement of psychological states through the*

content analysis of verbal behavior. Berkeley: University of California Press.

Gowers, S. G., Harrington, R. C., Whitton, A., & Lelliott, P. (1999). Brief scale for measuring the outcomes of emotional and behavioural disorders in children. Health of the Nation Outcome Scales for children and Adolescents (HoNOSCA). *The British Journal of Psychiatry*, *174*, 413–416.

Goyette-Ewing, M., Slade, A., Knoebber, K., Gilliam, W., Truman, S., & Mayes, L. (2003). *Parents First: A developmental parenting program*. Unpublished manuscript, Yale Child Study Center, Yale University, New Haven.

Greenberg, M. T., & Speltz, M. L. (1993). The role of attachment in the early development of disruptive behavior problems. *Development and Psychopathology*, *5*, 191–213.

Greenberg, M., Speltz, M. L., DeKlyen, M., & Jones, K. (2001). Correlates of clinic referral for early conduct problems: Variable and person-oriented approaches. *Development and Psychopathology*, *13*(2), 255–276.

Grienenberger, J. F., Kelly, K., & Slade, A. (2005). Maternal reflective functioning, mother–infant affective communication, and infant attachment: Exploring the link between mental states and observed caregiving behavior in the intergenerational transmission of attachment. *Attachment & Human Development*, *7*, 299–311.

Grossmann, K., Grossmann, K. E., & Spangler, G. (1985). Maternal sensitivity and newborns' orientation responses as related to quality of attachment in northern Germany. *Monographs of the Society for Research in Child Development*, *50*, 233–256.

Guttmann-Steinmetz, S., & Crowell, J. A. (2006). Attachment and externalizing disorders: A developmental psychopathology perspective. *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*(4), 440–451.

Hahlweg, K., Goldstein, M. J., & Nuechterlein, K. H. (1989). Expressed emotion and patient-

relative interaction in families of recent onset schizophrenics. *Journal of Consulting and Clinical Psychology*, *57*(1), 11.

Haskett, M. E., Ahern, L. S., & Ward, C. S. (2006). Factor structure and validity of the Parenting Stress Index-Short Form. *Journal of Clinical Child & Adolescent Psychology*, *35*(2), 302–312.

Hillman, S. (Producer & Director). (2011). *Adolescent Story Stem Vignettes* [Motion picture]. (Available from the Anna Freud Centre, 12 Maresfield Gardens, London NW3 5SU)

Hobbs, C. (2009). Nonaccidental trauma: clinical aspects and epidemiology of child abuse. *Pediatric Radiology*, *39*, 457-460.

Hoffman, K. T., Marvin, R. S., & Cooper, G. (2006). Changing toddlers' and preschoolers' attachment classifications: the Circle of Security intervention. *Journal of Consulting and Clinical Psychology*, *74*, 1017–1026.

Hovens, J. G. F. M., Wiersma, J. E., Giltay, E. J., Van Oppen, P., Spinhoven, P., Penninx, B. W. J. H., & Zitman, F. G. (2009). Childhood life events and childhood trauma in adult patients with depressive, anxiety and comorbid disorders vs. controls. *Acta Psychiatrica Scandinavica*, *122*(1), 66–74.

Howe, D. (2006). Developmental attachment psychotherapy with fostered and adopted children. *Child and Adolescent Mental Health*, *11*(3), 128–134.

Hutcheson, J. J., & Black, M. M. (1996). Psychometric properties of the Parenting Stress Index in a sample of low-income African-American mothers of infants and toddlers. *Early Education and Development*, *7*(4), 381–400.

Innocenti, M. S., Huh, K., & Boyce, G. C. (1992). Families of children with disabilities: Normative data and other considerations on parenting stress. *Topics in Early Childhood Special Education*, *12*(3), 403–427.

Irish, L., Kobayashi, I., & Delahanty, D. L. (2010). Long-term physical health consequences of childhood sexual abuse: A meta-analytic review. *Journal of Pediatric Psychology*, *35*(5), 450–461.

Isabella, R. A. (1993). Origins of attachment: Maternal interactive behavior across the first year. *Child Development*, *64*(2), 605–621.

Isabella, R. A., Belsky, J., & Eye, von, A. (1989). Origins of infant-mother attachment: An examination of interactional synchrony during the infant's first year. *Developmental Psychology*, *25*, 12–21.

Izard, C. E., Youngstrom, E. A., Fine, S. E., & Mostow, A. J. (2006). Emotions and developmental psychopathology. In D. Cicchetti & D. J. Cohen, *Developmental psychopathology: Vol. 1. Theory and method* (2nd ed., pp. 244–292). Hoboken, NJ: Wiley.

James, S. (2004). Why do foster care placements disrupt? An investigation of reasons for placement change in foster care. *The Social Service Review*, *78*(4), 601–627.

Johnson, J. G., Cohen, P., Brown, J., Smailes, E. M., & Bernstein, D. P. (1999). Childhood maltreatment increases risk for personality disorders during early adulthood. *Archives of General Psychiatry*, *56*(7), 600.

Jones, S. (1992). Was there a Hawthorne effect? *The American Journal of Sociology, November, 98*(3), 451-468.

Juffer, F., Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H. (2003). Enhancing children's socioemotional development: A review of intervention studies. In D. M. Teti, *Handbook of research methods in developmental science* (pp. 213–230). Oxford: Blackwell Publishers Ltd.

Juffer, F., Bakermans-Kranenburg, M. J., & van IJzendoorn, M. H. (2007). Introduction and

outline of the VIPP and VIPP-R program. In F. Juffer, M. J. Bakermans-Kranenburg, & M. van IJzendoorn, *Promoting Positive Parenting: An attachment-based intervention* (pp. 1-10). New York: Routledge.

Juffer, F., Hoksbergen, R., Riksen-Walraven, J. M., & Kohnstamm, G. A. (1997). Early intervention in adoptive families: Supporting maternal sensitive responsiveness, infant–mother attachment, and infant competence. *Journal of Child Psychology and Psychiatry*, *38*(8), 1039–5100.

Jurist. E. (2010). Mentalizing minds. *Psychoanalytic Inquiry, 20*, 289-300.

Kadushin, A., & Martin, J. A. (1988). *Child welfare services* (4 ed.). Upper Saddle River, NJ: Prentice-Hall.

Kalland, M., & Sinkkonen, J. (2001). Finnish children in foster care: evaluating the breakdown of long-term placements. *Child Welfare*, *80*, 513–527.

Kaniuk, J., Steele, M., & Hodges, J. (2004). Report on a longitudinal research project, exploring the development of attachments between older, hard-to-place children and their adopters over the first two years of placement. *Adoption & Fostering*, *28*(2), 61–67.

Kaplan, N., Cassidy, J., Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development*, *50*(1), 66–104.

Kaplow, J. B., & Widom, C. S. (2007). Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of Abnormal Psychology*, *116*(1), 176–187.

Katnzelson, H. (2014). Reflective functioning: A review. *Clinical Psychology Review, 34*, 107-117.

Keller, H., Völker, S., & Yovsi, R. D. (2005). Conceptions of parenting in different cultural communities: The case of West African Nso and Northern German women. *Social Development*, *14*(1), 158–180.

Kendall-Tackett, K. (2002). The health effects of childhood abuse: four pathways by which abuse can influence health. *Child Abuse & Neglect*, *26*(6-7), 715–729.

Kernberg, O., Diamond, D., Yeomans, F., Clarkin, J. and Levy, K. (2008). Mentalization and attachment in borderline patients in Transference Focused Psychotherapy. In E.L. Jurist, A. Slade, Bergner, S., *In Mind to Mind: Infant research, neuroscience, and psychoanalysis.* New York: Other Press.

Kerns, K. A., Klepac, L., & Cole, A. K. (1996). Peer relationships and preadolescents' perceptions of security in the child-mother relationship. *Developmental Psychology*, *32*(3), 457–466.

Kessler, R. C., Davis, C. G., & Kendler, K. S. (1997). Childhood adversity and adult psychiatric disorder in the US National Comorbidity Survey. *Psychological Medicine*, *27*(05), 1101–1119.

Klein Velderman, M., Bakermans-Kranenburg, M. J., Juffer, F., & van IJzendoorn, M. H. (2006). Effects of attachment-based interventions on maternal sensitivity and infant attachment: Differential susceptibility of highly reactive infants. *Journal of Family Psychology*, *20*(2), 266–274.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis*, *27*, 99–110.

Kobak, R., Cassidy, J., Lyons-Ruth, K., & Zir, Y. (2006). Attachment, stress and psychopathology: A developmental pathways model. In D. Cicchetti & P. Cohen, *Handbook of Developmental Psychopathology, Vol. 1* (pp. 333–369). Cambridge

University Press.

Kochanska, G., Coy, K. C., & Tjebkes, T. L. (1998). Individual differences in emotionality in infancy. *Child Development, 69*(2), 375-390.

Kufeldt, K., Armstrong, J., & Dorosh, M. (n.d.). In care, in contact? In J. Hudson & B. Galaway, *The state as parent* (pp. 355–368). Dordecht, Netherlands: Kluwer Academic.

Landsverk, J., Davis, I., Ganger, W., & Newton, R. (1996). Impact of child psychosocial functioning on reunification from out-of-home placement. *Children and Youth Services Review*, *18*(45), 447–462.

Lange, A., & Appelo, M. (2007). De Korte Klachten Lijst, KKL: Handleiding.

Lawder, E. A., Poulin, J. E., & Andrews, R. G. (1986). A study of 185 foster children 5 years after placement. *Child Welfare*, *65*(3), 241–251.

Leathers, S. J. (2006). Placement disruption and negative placement outcomes among adolescents in long-term foster care: The role of behavior problems. *Child Abuse & Neglect*, *30*(3), 307–324.

Leslie, L., Gordon, J., & Meneken, L. (2005). The physical, developmental, and mental health needs of young children in child welfare by initial placement type. *Journal of Developmental and Behavioral Pediatrics, 26*(3), 177-185.

Leve, L. D., Harold, G. T., & Chamberlain, P. (2012). Practitioner Review: Children in foster care–vulnerabilities and evidence-based interventions that promote resilience processes. *Journal of Child Psychology and Psychiatry*, *53*(12), 1197–1211.

Lewis, L., Kelly, K., & Allen, J. G. (2004). *Restoring hope and trust*. Baltimore, MD: Sidran Institute Press.

Lewis, M., & Feiring, C. (1989). Infant, mother, and mother-infant interaction behavior and subsequent attachment. *Child Development*, *60*, 831–837.

Leyendecker, B., Lamb, M. E., Fracasso, M. P., Scholmerich, A., & Larson, C. (1997). Playful interaction and the antecedents of attachment: A longitudinal study of Central American and Euro-American mothers and infants. *Merrill-Palmer Quarterly*, *43*, 24–47.

Lieberman, A. F., Ippen, C. G., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, *45*(8), 913–918.

Lieberman, A. F., Silverman, R., & Pawl, J. H. (1999). Infant-parent psychotherapy: Core concepts and current approaches. In C. H. Zeanah (Ed.), *Handbook of infant mental health*. New York: Guilford Publications.

Liotti, G. (1995). Disorganized/disoriented attachment in the psychotherapy of the dissociative disorders. In S. Goldberg, R. Muir, & J. Kerr, *Attachment theory: Social, developmental and clinical perspectives*. Hillsdale, NJ: Analytic Press.

Lukens, E. P., & McFarlane, W. R. (2004). Psychoeducation as evidence-based practice: Considerations for practice, research, and policy. *Brief Treatment and Crisis Intervention*, *4*(3).

Luyten, P., Fonagy, P., & Lowyck, B. (2012). Assessment of mentalization. In P. Fonagy & A. Bateman, *Handbook of mentalizing in mental health practice* (pp. 43–65). Washington D.C.: American Psychiatric Publishing.

Luyten, P., Mayes, L., Nijssens, L. & Fonagy, P. (2014). *The Parental Reflective Functioning Questionnaire: Development and preliminary validation.* Manuscript submitted for publication.

Lyons-Ruth, K., & Block, D. (1996). The disturbed caregiving system: Relations among childhood trauma, maternal caregiving, and infant affect and attachment. *Infant*

Mental Health Journal, *17*, 257–275.

Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. Shaver, *Handbook of attachment: Theory, research, and clinical applications* (pp. 520–554). Guilford Press.

Maccoby, E. E. (1984). Socialization and developmental change. *Child Development*, *55*(2).

MacMillan, H. L., Fleming, J. E., Streiner, D. L., Lin, E., Boyle, M. H., Jamieson, E., . . . Beardslee, W.R. (2001). Childhood abuse and lifetime psychopathology in a community sample. *American Journal of Psychiatry*, *158*(11), 1878–1883.

Magaña, A. B., Goldstein, M. J., Karno, M., & Miklowitz, D. J. (1986). A brief method for assessing expressed emotion in relatives of psychiatric patients. *Psychiatry Research, 17,* 203-212.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. Greenberg, D. Cicchetti, & E. M. Cummings, *Attachment in the preschool years: Theory, research and intervention*. Chicago: University of Chicago Press.

Main, M., & Hesse, E. (1992). Disorganized/disoriented infant behavior in the Strange Situation, lapses in the monitoring of reasoning and discourse during the parent's Adult Attachment Interview, and dissociative states. In M. Ammaniti & D. Stern, *Attachment and Psychoanalysis* (pp. 86–140). Rome: Guis.

Main, M., Solomon, J., & Cummings, E. M. (1990). Procedures for identifying disorganized/disoriented infants during the Ainsworth strange situation. In M. T. Greenberg & D. Cicchetti, *Attachment in the preschool years: Theory, research, and*

intervention (pp. 121–160). Chicago: University of Chicago Press.

Marshall, V. G., Longwell, L., & Goldstein, M. J. (1990). Family factors associated with aggressive symptomatology in boys with Attention Deficit Hyperactivity Disorder: A research note. *Journal of Child Psychology and Psychiatry*, *31*(4), 629–636.

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The Circle of Security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development*, *4*(1), 107–124.

Marzocchi, G. M., Capron, C., & Di Pietro, M. (2004). The use of the Strengths and Difficulties Questionnaire (SDQ) in Southern European countries. *European Child & Adolescent Psychiatry*, *13*(2), ii40–ii46.

Masson, J. (1984). *The assault on truth: Freud's suppression of the seduction theory*. New York: Farrar, Straus and Giroux.

Matas, L., Arend, R. A., & Sroufe, L. A. (1978). Continuity of adaptation in the second year: The relationship between quality of attachment and later competence. *Child Development*, *49*, 547–556.

Mathai, J., Anderson, P., & Bourne, A. (2003). Use of the Strengths and Difficulties Questionnaire as an outcome measure in a child and adolescent mental health service. *Australasian Psychiatry*, *11*(3), 334–337.

McCarney, R., Warner, J., & Iliffe, S. (2007). The Hawthorne Effect: A randomised, controlled trial. *BMC Medical Research Methodology*, *7*(1), 30.

McGraw, K.O. & Wong, S.P. (1996). Forming inferences about some intraclass correlation coefficients. *Psychol Methods, 1*, 30-46.

Meins, E., & Fernyhough, C. (1999). Linguistic acquisitional style and mentalising development: The role of maternal mind-mindedness. *Cognitive Development*, *14*(3),

363–380.

Meins, E., & Fernyhough, C. (2012). *Mind-mindedness coding manual, version 2.1* (Unpublished.). Durham: Durham University.

Meins, E., Fernyhough, C., Russell, J., & Clark-Carter, D. (1998). Security of attachment as a predictor of symbolic and mentalising abilities: A longitudinal study. *Social Development*, *7*(1), 1–24.

Midgley, N., & Vrouva, I. (2012). *Minding the child: Mentalization-based interventions with children, young people and families*. London: Routledge.

Mihalic, S. (2004). The importance of implementation fidelity. *Emotional & Behavioral Disorders in Youth*, *4*, 83–105.

Minty, B. (1999). Annotation: Outcomes in long-term foster family care. *Journal of Child Psychology and Psychiatry*, *40*(7), 991–999.

Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.

Muller, N., Gerits, L., & Sieker, I. (2012). Mentalization-based therapies with adopted children and their families. In N. Midgley & I. Vrouva, *Minding the child: Mentalization-based interventions with children, young people and their families* (p. 113-130). London: Routledge.

National Research Council and Institute of Medicine (2000). *From neurons to neighborhoods: The science of early childhood development.* Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, eds. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press.

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: Disentangling the relationship between problem behaviors and number of placements. *Child Abuse & Neglect*, *24*(10), 1363–1374.

Northoff, G., Bermpohl, F., Schoeneich, F., & Boeker, H. (2007). How does our brain constitute defense mechanisms? First-person neuroscience and psychoanalysis. *Psychotherapy and Psychosomatics, 76*(3), 141-153.)

O'Connor, M. J., Sigman, M., & Kasari, C. (1992). Attachment behavior of infants exposed prenatally to alcohol: Mediating effects of infant affect and mother-infant interaction. *Development and Psychopathology*, *4*, 243–256.

Obel, C., Heiervang, E., Rodriguez, A., & Heyerdahl, S. (2004). The Strengths and Difficulties Questionnaire in the Nordic countries. *European Child & Adolescent Psychiatry*, *13*(2), ii32–ii39.

Ogawa, J. R., Sroufe, L., Weinfield, N. S., Carlson, A. E., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology*, *9*(4), 855–879.

Olds, D. L., Kitzman, H., Hanks, C., Cole, R., & Anson, E. (2007). Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial. *Pediatrics*, *120*, e832–e845.

Ontai, L. L., & Thompson, R. A. (2002). Patterns of attachment and maternal discourse effects on children's emotion understanding from 3 to 5 years of age. *Social Development*, *11*, 433–450.

Oosterman, M., Schuengel, C., Wimslot, N., Bullens, R., & Doreleijers, T. (2007). Disruptions in foster care: A review and meta-analysis. *Children and Youth Services Review*, *29*(1), 53–76.

Ordway, M. R., Sadler, L. S., Dixon, J., & Close, N. (2014). Lasting effects of an interdisciplinary home visiting program on child behavior: Preliminary follow-up results of a randomized trial. *Journal of Pediatric Nursing, 29*(1), 3-13.

Orme, J. G., & Buehler, C. (2001). Foster family characteristics and behavioral and emotional problems of foster children: A narrative review. *Family Relations*, *50*(1), 3–15.

Orme, J. G., Buehler, C., Rhodes, K. W., Cox, M. E., McSurdy, M., & Cuddeback, G. (2006). Parental and familial characteristics used in the selection of foster families. *Children and Youth Services Review*, *28*(4), 396–421.

Palmieri, P. A., & Smith, G. C. (2007). Examining the structural validity of the Strengths and Difficulties Questionnaire (SDQ) in a US sample of custodial grandmothers. *Psychological Assessment*, *19*(2), 189.

Pardeck, J. T. (1984). Multiple placement of children in foster family care: An empirical analysis. *Social Work*, *29*, 506–509.

Parker, R. A. (1966). *Decision in Child Care*. London: George Allen & Unwin LTD.

Pasalich, D. S., Dadds, M. R., Hawes, D. J., & Brennan, J. (2011). Assessing relational schemas in parents of children with externalizing behavior disorders: Reliability and validity of the Family Affective Attitude Rating Scale. *Psychiatry Research*, *185*(3), 438–443.

Patterson, G. R., DeBaryshe, B. D., & Ramsey, E. (1990). A developmental perspective on antisocial behavior. *American Psychologist*, *44*, 329–335.

Pears, K., & Fisher, P. A. (2005). Developmental, cognitive, and neuropsychological functioning in preschool-aged foster children: Associations with prior maltreatment and placement history. *Journal of Developmental and Behavioral Pediatrics*, *26*, 112–121.

Pederson, D. R., & Moran, G. (1996). Expressions of the attachment relationship outside of the Strange Situation. *Child Development*, *67*(3), 915–927.

Perry, B. D. (1997). Incubated in terror: Neurodevelopmental factors in the 'cycle of violence.'. *Children in a violent society*, 124-149.

Phillipson, H. (1955). *The Object Relations Technique (ORT)*. London: Tavistock Press.

Puddy, R. W., & Jackson, Y. (2003). The development of parenting skills in foster parent training. *Child and Youth Care Forum*, *25*, 987–1013.

Raikes, H. A., & Thompson, R. A. (2006). Family emotional climate, attachment security and young children's emotion knowledge in a high risk sample. *British Journal of Developmental Psychology*, *24*, 89–104.

Reitman, D., Currier, R. O., & Stickle, T. R. (2002). A critical evaluation of the Parenting Stress Index-Short Form (PSI-SF) in a head start population. *Journal of Clinical Child & Adolescent Psychology*, *31*(3), 384–392.

Rhodes, K. W., Orme, J. G., & Buehler, C. (2001). A comparison of family foster parents who quit, consider quitting, and plan to continue fostering. *Social Science Review*, *75*(1), 85–114.

Roggman L.A., Moe, S.T., Hart, A.D., & Forthun, L.F. (1994). Family leisure and social support: Relations with parenting stress and psychological well-being in Head Start parents. *Early Childhood Research Quarterly*, *9*, 463–480.

Rork, K. E., & McNeil, C. B. (2011). Evaluation of foster parent training programs: A critical review. *Child & Family Behavior Therapy*, *33*(2), 139–170.

Rosenfeld, A., Pilowsky, D., Fine, P., Thorpe, M., Fein, E., Simms, M., et al. (1997). Foster care: An update. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(4), 448–457.

Ross, C. A. (2005). Childhood sexual abuse and psychosomatic symptoms in irritable bowel syndrome. *Journal of Child Sexual Abuse*, *14*(1), 27–38.

Roustit, C., Renahy, E., Guernec, G., Lesieur, S., Parizot, I., & Chauvin, P. (2009). Exposure to interparental violence and psychosocial maladjustment in the adult life course: advocacy for early prevention. *Journal of Epidemiology & Community Health*, *63*(7), 563–568.

Rubin, D. M., O'Reilly, A. L., Luan, X., & Localio, A. R. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics*, *119*(2), 336–344.

Russell, D., Springer, K. W., & Greenfield, E. A. (2010). Witnessing domestic abuse in childhood as an independent risk factor for depressive symptoms in young adulthood. *Child Abuse & Neglect*, *34*(6), 448–453.

Rutter, M. (1967). A children's behaviour questionnaire for completion by teachers: preliminary findings. *Journal of Child Psychology and Psychiatry*, *8*, 1–11.

Rutter, M. (1982). Psychological therapies in child psychiatry: Issues and prospects. *Psychological Medicine*, *12*(4), 723–740.

Rutter, M. (1985). Resilience in the face of adversity. *British Journal of Psychiatry*, *147*, 598–611.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, *57*(3), 316–331.

Rutter, M., & Quinton, D. (1984). Parental psychiatric disorder: Effects on children. *Psychological Medicine*, *14*(4), 853–880.

Sadler, L. S., Slade, A., Close, N., & Webb, D. L. (2013). Minding the Baby: Enhancing Reflectiveness to Improve Early Health and Relationship Outcomes in an

Interdisciplinary Home-Visiting Program. *Infant Mental Health Journal, 34*(5), 391-405.

Sameroff, A. J., McDonough, S. C., & Rosenblum, K. (Eds.). (2005). *Treating parent-infant relationship problems: Strategies for intervention*. New York, NY: The Guilford Press.

Saft, E. W. (1990). *A factor analytic study of the Portuguese translation of the Parenting Stress Index.* Unpublished master's thesis, University of Virginia, Charlottesville.

Schneider, B. H., Atkinson, L., & Tardif, C. (2001). Child–parent attachment and children's peer relations: A quantitative review. *Developmental Psychology*, *37*(1), 86–100.

Schofield, G., & Beek, M. (2006). *Attachment handbook for foster care and adoption*. British Association for Adoption and Fostering (BAAF).

Service levels for foster care. (n.d.). Retrieved May 14, 2014, from http://www.dfps.state.tx.us/Adoption_and_Foster_Care/About_Foster_Care/Care_Levels.asp

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). *Archives of General Psychiatry*, *40*(11), 1228–1231.

Shaw, M. A., & Phillipson, H. (2002). *The object relations technique*. ORT Institute, Incorporated.

Shimodera, S., Mino, Y., Fujita, H., & Izumoto, Y. (2002). Validity of a five-minute speech sample for the measurement of expressed emotion in the families of Japanese patients with mood disorders. *Psychiatry*, *112*(3), 231–237.

Silver, J., DiLorenzo, P., Zukoski, M., Ross, P. E., Amster, B. J., & Schlegel, D. (1999). Starting young: Improving the health and developmental outcomes of infants and toddlers in the child welfare system. *Child Welfare*, *78*(1), 148-165.

Slade, A. (1987). The quality of attachment and early symbolic play. *Developmental Psychology*, *23*, 78–85.

Slade, A. (2002). Moments of regulation and the development of self-narratives. *Journal of Infant, Child and Adult Psychotherapy*, *2*, 1–10.

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment & Human Development*, *7*(3), 269–281.

Slade, A. (2006). Reflective parenting programs: Theory and development. *Psychoanalytic Inquiry*, *26*(4), 640–657.

Slade, A. (2007). Disorganized mother, disorganized child: The mentalization of affective dysregulation and therapeutic change. In D. Oppenheim & D. Goldsmith, *Attachment theory in clinical work with children: Bridging the gap between research and practice* (pp. 226–250). New York: Guilford Publications.

Slade, A., Aber, L., Bresgi, I., Berger, B., & Kaplan, N. (2004). *The Parent Development Interview, revised*. Unpublished manuscript, The City University of New York, New York City.

Slade, A., Sadler, L., De Dios-Kenn, C., Webb, D., Currier-Ezepchick, J., & Mayes, L. (2005). Minding the baby: A reflective parenting program. *The Psychoanalytic Study of the Child*, *60*, 74–100.

Smith, B. W., Papp, Z. Z., Tooley, E. M., Montague, E. Q., Robinson, A. E., & Cosper, C. J. (2010). Traumatic events, perceived stress and health in women with fibromyalgia and healthy controls. *Stress and Health*, *26*(1), 83–93.

Smith, J., & Prior, M. (1995). Temperament and stress resilience in school-age children: A within-families study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *34*(2), 168–179.

Solis, M. L., & Abidin, R. R. (1991). The Spanish version parenting stress index: A psychometric study. *Journal of Clinical Child & Adolescent Psychology*, *20*(4), 372–378.

Spatz Widom, C., DuMont, K., & Czaja, S. J. (2007). A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up. *Archives of General Psychiatry*, *64*(1), 49.

Speltz, M. L., Greenberg, M. T., & DeKlyen, M. (2008). Attachment in preschoolers with disruptive behavior: A comparison of clinic-referred and nonproblem children. *Development and Psychopathology*, *2*(1), 31–46.

Springer, K. W. (2009). Childhood physical abuse and midlife physical health: Testing a multi-pathway life course model. *Social Science & Medicine*, *69*(1), 138–146.

Sroufe, L. A. (1979). The coherence of individual development: Early care, attachment, and subsequent developmental issues. *American Psychologist*, *34*(10), 834-341.

Sroufe, L. A. (1983). Infant caregiver attachment and patterns of adaptation in preschool: The roots of maladaptation and competence. In M. Perlmutter, *Minnesota Symposium on Child Psychology: Vol. 16. Development and policy concerning children with special needs* (pp. 41–81). Hillsdale, NJ: Erlbaum.

Sroufe, L. A. (1990). Pathways to adaptation and maladaptation: Psychopathology as developmental deviation. In D. Cicchetti, *Rochester Symposium on Developmental Psychopathology: Vol 1. The emergence of a discipline* (pp. 13–40). Hillsdale, NJ: Erlbaum.

Sroufe, L. A. (1996). *Emotional Development*. New York: Cambridge University Press.

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & Human Development*, *7*, 349–367.

Sroufe, L. A., & Fleeson, J. (1986). Attachment and the construction of relationships. In W. W. Hartup & Z. Rubin, *Relationships and development* (pp. 51–71). Hillsdale, NJ: Lawrence Erlbaum Associates.

Sroufe, L. A., & Waters, E. (1977). Heart rate as a convergent measure in clinical and developmental research. *Merrill-Palmer Quarterly of Behavior and Development*, *23*, 3–27.

Steele, H., Steele, M., Croft, C., & Fonagy, P. (1999). Infant-mother attachment at one year predicts children's understanding of mixed emotions at six years. *Social Development*, *8*(2), 161–178.

Steele, M., Hodges, J., Kaniuk, J., & Steele, H. (2010). Mental representation and change: Developing attachment relationships in an adoption context. *Psychoanalytic Inquiry*, *30*(1), 25–40.

Steele, M., Hodges, J., Kaniuk, J., Hillman, S., & Henderson, K. (2003). Attachment representations and adoption: associations between maternal states of mind and emotion narratives in previously maltreated children. *Journal of Child Psychotherapy*, *29*(2), 187–205.

Steele, M., Kaniuk, J., Hodges, J., Haworth, C., & Huss, S. (2006). *The use of the Adult Attachment Interview: Implications for assessment in adoption and foster care.* London: British Agencies for Adoption and Fostering.

Stein, H., Fonagy, P., Ferguson, K. S., & Wisman, M. (2000). Lives through time: An ideographic approach to the study of resilience. *Bulletin of the Menninger Clinic*, *64*(2), 281–305.

Stone, N. M., & Stone, S. F. (1983). The prediction of successful foster placement. *Social Casework*, *64*, 11–17.

Stovall-McClough, C., & Dozier, M. (2004). Forming attachments in foster care: Infant attachment behaviors during the first 2 months of placement. *Development and Psychopathology*, *16*, 253–271.

Suchman, N., Mayes, L., Conti, J., & Slade, A. (2004). Rethinking parenting interventions for drug-dependent mothers: from behavior management to fostering emotional bonds. *Journal of Substance Abuse Treatment*, *23*(7), 179–185.

Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and Disabilities: A Population-based Epidemiological Study. *Child Abuse & Neglect, 24*(10), 1257–1273.

Swain, J., Thomas, P., Leckman, J., & Mayes, L. (2008). Parent-infant attachment systems. In E.L. Jurist, A. Slade, Bergner, S., *In Mind to Mind: Infant research, neuroscience, and psychoanalysis.* New York: Other Press. In E.L. Jurist, A. Slade, Bergner, S., *In Mind to Mind: Infant research, neuroscience, and psychoanalysis.* New York: Other Press.

Takayama, J. I., Wolfe, E., & Coulter, K. P. (1998). Relationship between reason for placement and medical findings among children in foster care. *Pediatrics*, *101*, 201–207.

Texas Department of Family and Protective Services (2013). *Annual report and data book: Child Protecitve Services.* Available from https://www.dfps.state.tx.us/About_DFPS/Data_Books_and_Annual_Reports/2013/default.asp.

Texas Department of Family and Protective Services, Licensing Division (2014). *Minimum standards for child placing agencies.* Austin, Texas.

Texas Family Code, Chapter 264 (2014). Retrieved September 10, 2014, from http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.264.htm

Thabane, L., Ma, J., Chu, R., Cheng, J., Ismaila, A., Rios, L. P., . . . Goldsmith, C.H. (2010). A

tutorial on pilot studies: the what, why and how. *BMC Medical Research Methodology*, *10*, 1.

Thompson, R. A. (2000). The legacy of early attachments. *Child Development*, *71*(1), 145–152.

Thompson, R. A. (2006). Conversation and developing understanding: Introduction to the special issue. *Merrill-Palmer Quarterly*, *52*, 1–16.

Thompson, R. A. (2011). Emotion and emotion regulation: Two sides of the developing coin. *Emotion Review*, *3*, 53–61.

Thompson, R. A., & Meyer, S. (2007). The socialization of emotion regulation in the family. In J. Gross, *Handbook of emotion regulation* (pp. 249–268). New York: Guilford.

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

Triseliotis, J., Hill, M., & Borland, M. (2000). *Delivering Foster Care*. London: BAAF.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2013). *Child maltreatment 2012.* Available from http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf.

Van Houdenhove, B., Neerinckx E., Lysens R., Vertommen H., Van Houdenhove, L., Onghena, P., . . . D'Hooghe, M-B. (2011). Victimization in Chronic Fatigue Syndrome and Fibromyalgia in Tertiary Care: A Controlled Study on Prevalence and Characteristics. *Psychosomatics*, *42*(1), 21-28.

van IJzendoorn, M. H. (1995). Adult attachment representations, parental responsiveness, and infant attachment: A meta-analysis on the predictive validity of the Adult

Attachment Interview. *Psychological Bulletin*, *117*(3), 387–403.

Van Teijlingen, E. R., & Rennie, A. M. (2001). The importance of conducting and reporting pilot studies: the example of the Scottish Births Survey. *Journal of Advanced Nursing*, *34*, 289–295.

Vitaliano, P. P., Russo, J., Young, H. M., & Teri, L. (1991). Predictors of burden in spouse caregivers of individuals with Alzheimer's disease. *Psychology and Aging*, *6*, 392–401.

Vliegen, N., Luyten, P., & Biringen, Z. (2009). A multimethod perspective on emotional availability in the postpartum period. *Parenting: Science and Practice, 9*, 228-243.

Vondra, J. I., Shaw, D. S., & Kevenides, M. C. (1995). Predicting infant attachment classification from multiple, contemporaneous measures of maternal care. *Infant Behavior and Development*, *18*, 415–425.

Walsh, J. A., & Walsh, R. A. (1990). Studies of the maintenance of subsidized foster placements in the Casey Family Program. *Child Welfare*, *69*, 99–114.

Wamboldt, F. S., Wamboldt, M. Z., & Gavin, L. A. (1995). Parental criticism and treatment outcome in adolescents hospitalized for severe, chronic asthma. *Journal of Psychosomatic Research*, *39*(8), 995–1005.

Ward, M. J., & Carlson, E. A. (1995). Associations among Adult Attachment Representations, Maternal Sensitivity, and Infant-Mother Attachment in a Sample of Adolescent Mothers. *Child Development*, *66*, 69–79.

Warren, D. (1997). Foster Care in Crisis: A call to professionalise the forgotten service. *National Foster Care Association*.

Weissberg, R. P., & Greenberg, M. T. (2006). School and community competence-enhancement and prevention programs. In W. Damon, I. E. Sigel, & K. A. Renninger,

Handbook of Child Psychology: Vol 4. Child Psychology in Practice (pp. 877–954). New York: John Wiley & Sons.

Williams, L. L., Bleiberg, E., Green, L., Meyer, H., Grimes, C., Baumgardner, J., . . . Fisher, F. (2010). *Mentalizing treatment workbook*. Unpublished manual, The Menninger Clinic, Houston.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *International Journal of Psychoanalysis*, *41*, 585–595.

Woerner, W., Fleitlich-Bilyk, B., & Martinussen, R. (2004). The Strengths and Difficulties Questionnaire overseas: evaluations and applications of the SDQ beyond Europe. *European Child & Adolescent Psychiatry*, *13*(2), ii47–ii54.

Wright, M. O., Crawford, E., & Del Castillo, D. (2009). Childhood emotional maltreatment and later psychological distress among college students: The mediating role of maladaptive schemas. *Child Abuse & Neglect*, *33*(1), 59–68.

Wyman, P. A., Cowen, E. L., Work, W. C., Hoyt-Meyers, L., Magnus, K. B., & Fagen, D. B. (1999). Caregiving and developmental factors differentiating young at-risk urban children showing resilient versus stress-affected outcomes: A replication and extension. *Child Development*, *70*, 645–659.

Zeanah, C. H. (2000). Disturbances of attachment in young children adopted from institutions. *Journal of Developmental and Behavioral Pediatrics*, *21*, 230–236.