Placement breakdown in foster care: Reducing risks by a foster parent training program?
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Chapter 7

Summary and General Discussion
Chapter 7

Introduction

This thesis examined the possible mechanisms for and solutions to reduce the risk of placement breakdown for foster children in long-term foster care. The studies that were undertaken comprised three steps: 1) gaining insight into the well-being and mental health of Dutch foster children and related risk factors; 2) examining placement stability in Dutch foster care and related risk factors; and 3) investigating the effectiveness of Parent Management Training Oregon (PMTO) in long-term foster families with foster children with severe behavioral problems, by conducting a randomized controlled trial. This chapter first summarizes the main findings of this thesis, and then discusses the general conclusions, clinical implications, limitations and directions for further research.

Summary of main findings

The first step, gaining insight into the well-being and mental health of Dutch foster children and related risk factors, started with a survey study conducted among 59 foster children (aged 10-18) placed in long-term foster care (Chapter 2). These children completed standardized questionnaires on their well-being and their relationship with their biological parents and foster parents respectively. The results showed that the children’s well-being was good, on average, but slightly lower than that of the average Dutch child (Ter Bogt et al., 2003). Furthermore, foster children generally reported positive feelings of loyalty and attachment towards both their foster parents and their biological parents, but on the whole, their level of well-being appeared to be related to stronger attachment representations towards their foster parents. There were no indications of competing loyalties between the biological parents and the foster parents from the perspective of the child. Nevertheless, foster children felt worse if they perceived their foster parents and biological parents as vulnerable or authoritarian (i.e., setting strong rules and boundaries).

As part of the first step, we also conducted a cross-sectional study that investigated the behavioral and emotional problems, reported by the foster parents of 239 foster children (aged 4-12) living in long-term foster care in the Netherlands (Chapter 3¹). The results revealed a wide range of behavioral problems, ranging from no problems to very serious problem behavior, and showed that a third of the children had total difficulty scores (TDS) in the clinical range. More behavioral difficulties were related to the age of the foster child, age upon entering the current foster family, the number of prior foster placements, non-kinship placement, and the fostering experience of the foster parents ($M = 6.58$ years, $SD = 6.37$). Considering the child and placement risks together better explained the variance in TDS than considering them separately. Interestingly, we found a linear relationship between risk factor accumulation (i.e., the number of risks regardless of their content) and

¹ The data for this study were retrieved from the screening data that were used to screen eligible foster families for participation in the RCT, as described in chapters 5 and 6.
the foster child’s behavioral problems. These findings underline the importance of the early
detection of potential risk factors in foster children and their families, and the need to help
foster parents to handle their foster child’s behavioral problems effectively.

In the second step (Chapter 4), we examined placement stability (planned vs unplanned
terminations including reasons for termination) in Dutch foster families and the associated
risk factors. We conducted a retrospective study using the case files of 169 foster children
aged 0-20. The results showed that 35% of all foster placement terminations were
unplanned. Behavioral problems, the foster child having a non-Dutch ethnic background,
and parenting stress were factors that had a multivariate relationship with the likelihood
of a placement termination. Again: a higher number of risks was related to an increased
chance of unplanned breakdown. The results suggest that helping foster parents to manage
a foster child’s problematic behavior and reducing parenting stress may play key roles in
effective interventions to prevent disruption to foster care placements.

The aim of the third step of this thesis was to heighten our understanding of how
best to support Dutch foster parents, so as to reduce the risk of placement breakdowns
(Chapters 5 and 6). We conducted a Randomized Controlled Trial (RCT) to investigate the
effectiveness of the intensive and individualized Parent Management Training Oregon
(PMTO) intervention as a means of reducing parental stress, improving parenting behavior
and reducing child behavioral problems among long-term foster families in three different
regions in the Netherlands. PMTO is a fully manualized program (Forgatch, 1994) with 15
to 25 individual treatment sessions, typically once a week. The main role of the PMTO
therapist is to teach and coach parents, through role play and modeling exercises, to use
effective parenting strategies (e.g., setting limits and discipline, positive involvement;
Patterson, 2005). Although a number of previous studies had revealed the effectiveness
of PMTO in varying populations of families (e.g., traditional families, stepfamilies, single
parents and ethnic minorities; Bullard et al., 2010; DeGarmo & Forgatch, 2005; Forgatch
et al., 2005a; Martinez & Forgatch, 2001; Ogden & Hagen, 2008; Patterson et al., 1982), its
effectiveness had never been examined in a foster care sample. Using a two-step screening
procedure with the Strengths and Difficulties Questionnaire (SDQ, n = 606) and Parent Daily
Report (PDR, n = 225), we targeted a final sample of foster parents (n = 86) who were
daily experiencing severe behavioral problems in their foster child (aged 4-12) on a daily
basis, and were therefore considered at high risk of placement breakdown. Foster parents
were randomly allocated to either PMTO or Care as Usual (CAU). CAU typically included
an appointment with a foster care supervisor once every three to six weeks. If necessary,
foster parents from the CAU condition (as well as the PMTO condition) were free to ask
for more intensive or specialized support, including every available form of treatment or
intervention except PMTO.
Chapter 5 reported on pretest-posttest effects and moderating variables (i.e., child gender, age, initial levels of child behavioral problems and parenting stress). Multi-informant (foster mothers, foster fathers and teachers) data were used from 86 foster families. Multilevel analyses based on the intention to treat principle (retention rate 73%) showed that compared to CAU, PMTO reduced parenting stress (small to medium effect sizes on general stress as well as child and parent-related stress) in the short term. With regard to parenting behavior, compared to a decrease in parental warmth in the CAU group, PMTO helped foster mothers to maintain parental warmth. PMTO had no other effects on self-reported parenting behaviors. Child behavior problems were reduced in both conditions (small to medium effect sizes), indicating that PMTO had no additional effects on child functioning in comparison with CAU. Additional analyses showed that none of the moderator variables that were investigated moderate the effects of PMTO.

Chapter 6 built on the findings of Chapter 5, covering the four-month follow-up (fourteen months from baseline) outcomes and the role of non-specific treatment variables (i.e., prior motivation of foster parents to take part in the intervention, treatment fidelity of the therapist and the working relationship with the therapist as perceived by foster parents at PMTO termination). Multilevel analyses showed that PMTO, as compared to CAU, had no significant (sleeper) effects at follow-up on parenting stress, parenting behavior and child behavioral problems. The significant short-term effects of PMTO on reduced parenting stress (i.e., general stress, as well as parent and child-related stress) were not retained at follow-up. The reduced child behavioral problems at posttest, were retained at follow-up in both conditions. Reliable and clinical change analyses (Jacobson & Truax, 1991) were also performed, but revealed no differences between the PMTO and CAU groups. Additional predictor analyses on the role of non-specific intervention factors in PMTO effects showed that higher fidelity scores for the therapist predicted a stronger increase in parenting warmth, responsiveness, and parental explaining and autonomy-granting at follow-up. Unexpectedly, higher fidelity scores for the therapist also predicted a smaller drop in parenting stress levels. Finally, parental motivation to participate in PMTO and the working relationship between the parents and the therapist did not seem to contribute to any long-term PMTO effects.

General discussion

The functioning of Dutch foster children in long-term foster care

From a transactional perspective (Sameroff, 2009), the development of a child is the product of continuous dynamic interactions between the child and the experiences provided by the social systems surrounding the child. Child-rearing can be seen as a self-regulating process of mutual participation involving the child and their social systems (Hermanns, 1998). In
In other words, parenting and child development regulate one other within a system that tends towards self-adjustment and self-correction. Long-term foster care aims to provide foster children with a family life that is as stable and ‘as normal as possible’, in which child rearing processes are assumed to develop in a natural way as a self-regulating system. Our findings suggest that a considerable percentage of foster children fare well in foster families. In particular, there is a link between a foster child’s well-being and their relationship with their foster parents, which underlines the importance of establishing a good and secure relationship with the foster parents in long-term foster arrangements.

However, we also found that according to their foster parents, half of Dutch foster children experience emotional and behavioral problems in the borderline or clinical ranges and that these problems seriously encumber foster parents’ daily family life. Foster children’s problem behavior has been shown not to improve over time (Goemans et al., 2015), to have a negative impact on foster parenting and to result in more parenting stress (Vanderfaeillie et al., 2012). Our findings thus reaffirm the view that the behavioral problems of foster children must be seen as an important risk factor that tends to destabilize the child-rearing system and self-regulating processes in foster families.

Moreover, we specifically found that the accumulation of multiple risks, such as age upon entering the foster family, number of prior placements and foster parents’ experience, appeared to be related to behavioral and emotional problems in foster children. This is in line with the bio-ecological theory of Bronfenbrenner and Ceci (1994), which proposes that the critical factor in child development and family functioning is not the specific nature of risks, nor the social system (e.g., meso, exo, or macro system) from which these originate, but the accumulation of risks (Hermanns, 1998). If a child-rearing system is ‘overcharged’ with risk factors, of whatever origin, self-regulating processes become unsettled. One specific risk factor, or set of risk factors can have different outcomes, dependent on the other characteristics of the child, the parents or the context, and one specific outcome or set of outcomes can be caused by a number of different risk factors. In system-theoretical terminology, these phenomena are known as multifinality and equifinality, respectively.

Thus from a transactional perspective, we would expect deregulating processes to occur especially in those foster families that are experiencing severe behavioral difficulties in their foster children, mostly in the context of an accumulation of stressors. This leads to an increase in parental stress, resulting in increasingly ineffective parenting, which in turn has a negative effect on the behavior and development of the child. This ultimately threatens the participation of the child in the family and other social systems, and puts the child at serious risk of placement breakdown.
**Foster placement breakdown**

Our findings indeed suggest that when these deregulating processes occur in foster families, they can pose a serious threat to placement stability. We found that a third of foster placements ended unintentionally, and that the behavioral problems of the foster child and parenting stress (plus having a non-Dutch ethnical background) were related to unplanned placement breakdowns. Again, we found that the more risk factors that were presented, the higher the chance of placement breakdown, regardless of the specific characteristics of the risk factor. Although behavioral problems are a prominent cause of the unplanned termination of foster family placements (Chamberlain et al., 2006; Oosterman et al., 2007), aside from investigating the origins of these problems, it is thus of crucial importance to understand the circumstances in which these problems develop (or are sustained). For instance, whether behavioral problems result in placement breakdown or not, may depend upon the quality of care provision, in the sense that placements with warm, child-oriented and committed foster parents are more successful (Daniel, 2011; Sinclair & Wilson, 2003). The quality of care provision is related to the foster parents’ own attachment styles (Dozier & Sepulveda, 2004) and the stressful life events they experienced prior to the foster child’s arrival in the family (Farmer, Lipscombe, & Moyers, 2005), which in turn are both considered important determinants of placement success or failure (Dozier & Sepulveda, 2004; Farmer et al., 2005; Oosterman et al., 2007). Thus a linear (or univariate) approach to the risk factors predicting placement breakdown is unable to offer a sufficiently broad framework for understanding what causes placement breakdown. In order to enhance placement stability, it is crucial that we understand how the risks in each individual family system accumulate and destabilize proximal child-rearing processes and how they are influenced by distal processes (e.g., how foster parents and children are matched or how foster parents are supported by agencies). (see also Oosterman et al., 2007).

As a whole, the first part of this thesis (Chapters 2, 3 and 4) shows that, embedded in a cumulative interplay of proximal and distal risk factors, there is a strong link between the behavioral problems of foster children and placement breakdown, and this is thought to have a negative effect on the development of foster children. This suggests that: 1) routine screening in foster families across a wide range of potential risks, including the cumulative impact on the foster family, may help to provide foster families with the support they need in a timely manner; and 2) helping foster families so as to decrease the risk of placement breakdown, should not only focus on reducing child behavioral problems, but also on the related destabilizing factors in the child-rearing system, parental stress and the wider context and history of the child and the foster family.
Giving effective support to foster parents

Considering the need to focus on these destabilizing processes in foster families, the positive effect of PMTO on levels of parenting stress (i.e., perceived stress related to a child, as well as stress about their personal and marital functioning) immediately after treatment termination would seem to make it a promising intervention. The clinical relevance of the level of change was limited, however, and parenting stress levels tended to increase again at follow-up. The latter finding is in line with other reviews (Barlow & Coren, 2003; Barlow et al., 2012), which show that parenting interventions can indeed make a significant contribution to the short-term psychosocial well-being of parents, but that they tend not to contribute to long-term effects. Clearly, further research is needed on how foster parents can best be helped to strengthen and maintain the intervention’s benefits for their parental well-being. However, we also found that PMTO did not change parenting behavior (with the exception of the short-term effect on maintained parenting warmth), and had no additional effect on child behavior functioning as compared to CAU. Before we draw conclusions on the effectiveness of PMTO in long-term foster families with children with severe behavioral problems, we need to address several questions.

First, why did PMTO not improve the targeted parenting behaviors? The lack of a systematic main effect on parenting behavior was unexpected, for three reasons. First, earlier PMTO studies had shown main effects on parenting (e.g., Forgatch et al., 2005a; Ogden & Hagen, 2008). Second, according to the Social Interaction Learning theory underlying PMTO, parenting behaviors are the presumed and validated mechanism of change in child adjustment (Patterson, 2005a). We found that while parenting behaviors did not change, however, child behavioral problems lessened (in both conditions). Third, another body of research shows that positive parenting improves when feelings of parental competence and wellbeing increase (e.g., Jones & Prinz, 2005). Although we found that PMTO did reduce foster parents’ stress levels and improved their well-being in the short-term, we did not find that parenting behaviors improved. So the question is: what makes it so hard to change foster parenting behavior? It may be that foster parents differ from other parents in their general parenting behavior (see also Bywater et al., 2010; MacDonald & Turner, 2005). Indeed, foster parents are selected on the ground that they have sufficient parenting skills to manage the range of disruptive behaviors encountered in (or by) children with the troubled backgrounds typically seen in foster care (Lindsey, 2001). Furthermore, the process of coercive cycles in foster parent-child dyads may develop differently from biological parent-child dyads, because a child’s behavioral problems often originate from neglectful and/or abusive parenting from former caregivers, but not (or only secondarily) from the current foster parents (see also Leve et al., 2012; Timmer et al., 2006). One could speculate that if the foster parents’ difficulties with managing their foster child’s disruptive
behavior were not primarily caused by ineffective parenting practices, there would also be less scope for improving these parenting practices.

Second, what role does treatment fidelity play in the effect that PMTO has on foster-parental functioning? The fact that PMTO affects foster parents differently than other biological parents in general populations is also indicated by the predictor results of PMTO fidelity (i.e., the extent of competent therapist adherence to the PMTO manual). Although we found no systematic changes in self-reported parenting behavior, we did find that better adherence by PMTO therapists to PMTO principles was related to an increase in desired parenting behavior (responsiveness, autonomy-granting and explaining). Thus, as expected, more competent adherence to the original PMTO protocol seems to have a positive effect on parenting (Forgatch et al., 2005b). However, we also found that stronger adherence by the therapist to the PMTO manual predicted a smaller reduction in parental stress. This contradicts the results of the PMTO trial in general Dutch parents (Thijssen, 2016), which showed that higher treatment fidelity was related to greater improvements in parental functioning (i.e., less parenting stress). In our study, it may have been that stronger adherence to the PMTO protocol also meant that less attention was paid to additional stressors in the PMTO family. As such, focusing exclusively on improving parenting skills might unintentionally attenuate efforts to reduce parenting stress. Indeed, foster-parenting stress is probably caused by more factors than having difficulty managing disruptive child behaviors alone (e.g., complicated contact with biological parents, lack of say in foster child’s future; Farmer et al., 2005). As discussed above, it is the accumulation of different risks that seems to burden foster parents. This suggests that in order to improve levels of foster parenting stress, it may be critically important not only for the therapist to adhere strongly to the PMTO protocol, but also to target all relevant stressors with a degree of sensitivity and competence. In this way, giving effective support to foster parents to enhance their personal well-being seems to require having professionals who have the skills and knowledge to go beyond the focus on improving parenting practices, if needs be, and treat the wider array of stressors that foster parents encounter.

Third, how can we understand the effects of CAU in this study? In our study, the significant reduction in child behavioral problems in the CAU condition was unexpected, because behavioral and emotional problems in foster children generally tend to persist during foster care (Goemans et al., 2015), and there is little evidence that established interventions are effective in improving child and parent functioning in foster families (Turner et al., 2009). Since the results of an RCT depend as much on the selected control condition as on the experimental intervention, this raises the question (Mohr et al., 2009): what exactly was meant by CAU in this study? To answer this question, it is important to stress that we conducted an effectiveness trial. Unlike efficacy trials conducted in highly controlled research contexts with no-treatment control conditions, the importance...
of an effectiveness trial such as the one undertaken in this study is to test whether an intervention works in a real-life setting (Hoagwood et al., 1995; Weisz, 2014). In our study, all foster parents allocated to the control condition received regular support services from the foster care institution, typically including an appointment with a foster care supervisor once every three to six weeks. At least two thirds of the CAU group, but also almost half of the PMTO group, received some other, mostly less intensive form of parenting support or child treatment (or a combination of the two). Due to the high variability of the additional support (content, dosage and delivery institution), we were not able to analyze the specific effects of CAU. A recent Flemish foster care study (Van Holen et al., 2015) has demonstrated, however, that the parents in the control condition of their study tended to receive more frequent counseling from foster care services and showed more external help-seeking behavior (finding and using additional support). In our study, we did not inform foster care agencies and supervisors about the study participation of the control families, in an effort to prevent intensification of regular assistance services. Still, we cannot completely exclude the possibility that foster parents in our control condition took the initiative to seek more additional support than they would normally have done, which may have affected the results.

In addition, it is important to consider the potential impact of the screening procedure preceding the RCT allocation on the reduced child behavioral problems in both conditions. Screening followed by an intervention for those who are considered at risk is a long-standing strategy for intervention implementation in all care systems, because it uses objective, valid and reliable criteria for the eligibility of cases (Frankenburg & Camp, 1975). In this way, the applicability of an intervention for a specific group is optimized. However, considering the intensity of the procedure we employed (screening with the SDQ and PDR), a Hawthorne effect may have occurred (Franke & Kaul, 1978), such that child behavior (as reported by foster parents) improved due to parental awareness of being studied or due to a different understanding of the child’s behavior (as a result of explaining our research aims to foster parents). A study sample that included participants after clinical referral based on the personal needs of foster parents might have yielded different results.

To conclude, the intensive, individualized PMTO approach provided by qualified therapists might help foster parents to feel less stressed, which may in turn enhance the self-regulating functions of the child-rearing system. However, considering that the effect on reduced stress was not sustained over time, that no changes were observed in parenting behavior and that PMTO, as compared to CAU, had no effect on the child’s behavioral problems, the notion that PMTO brings added value as a means of substantially reducing the risk of placement breakdown is unconvincing. We can tentatively conclude that effectively improving foster parents’ well-being with a view to enhancing placement stability requires a broader form of support than one focused on parenting practices alone, and demands
that one takes an eclectic perspective on the risks and destabilizing processes in the family. Therapeutic competence may play a crucial role in ensuring that this support is provided in such an individualized and comprehensive way that foster parents feel understood and empowered in their challenging situation.

Clinical implications
The clinical implications of this thesis cover three important areas: 1) screening for potential risk of placement breakdown; 2) how PMTO can support foster parents with children with severe behavioral problems; and 3) optimizing regular support services for burdened foster families in general. Considering the first area, routine screening for risks is important to detect for what, or to whom, support can be offered to reduce the risk of placement breakdown. The child behavior problem screening tools in current use that have proven value for predicting placement breakdown are the Parent Daily Report (Chamberlain et al., 2006; Fisher, Stoolmiller, Mannering, Takahashi, & Chamberlain, 2011; Hurlburt et al., 2010) and the shortened version of the CBCL (Barber, & Delfabbro, 2002; Strijker et al. 2008). These tools only focus on child functioning, however, and our interpretation of the results of this thesis suggests that routine screening in foster families should focus on a variety of areas related to the child and the foster family, such as the number of prior placements of the foster child and the level of parenting stress in the current family. Very little is known about how the child’s behavioral problems are embedded or interact with other stressors in the family and the cumulative impact of all combined stressors on the foster parents.

A recent study on the use of the SDQ to predict placement breakdown (Folkering, 2015) indicates that the impact supplement of the SDQ (e.g., Do the difficulties put a burden on you or the family as a whole?) may be a better predictor of placement breakdown than the child’s problem behavior alone. Although more comprehensive research is needed, the present study also indicated that the predictive value of child behavioral problems on placement breakdown increases with the occurrence of other risk factors in a family (e.g., multiple prior placements; Folkering, 2015). Furthermore, in cooperation with various Dutch foster care institutions, the Dutch Youth Institute (In Dutch: Nederlands Jeugd Instituut) recently developed a screening tool aimed at systematically monitoring long-term foster placements (Monitor Foster Care, MFC; Lekkerkerker, de Baat, Verheijden, Holdorp, & Van Yperen, 2016). This tool is based on six indicators that represent the presumed aims and quality features of long-term foster care placements (e.g., realization of support aims, child development, contact with the biological family). The MFC, or the SDQ combined with the impact supplement, might offer useful tools to detect foster families at risk of placement breakdown, but further research is needed.

Second, the results of the RCT undertaken for this research do not suggest that there is a need for wide implementation of PMTO to improve child functioning for all foster
parents who are experiencing severe behavioral problems in their foster child. Overall, PMTO did improve levels of parenting stress immediately after treatment termination, but PMTO did not prove to be more effective than CAU in terms of parenting behavior and child functioning. At the same time, we also found no clear contra-indications (i.e., negative effects) for offering PMTO to the foster parents of a foster child with severe behavioral problems. It would be important to consider cost-effectiveness results, so as to assess the extent to which PMTO can be regarded as providing value for money, but these analyses were not conducted in this study. What the short-term effect of PMTO on reduced parenting stress does indicate is that it can be useful to provide foster parents who feel seriously burdened in their daily child-rearing practices with intensive and individualized support from qualified and sensitive counselors or therapists.

The third implication of this study is it may be advisable to optimize the regular support services provided by foster care organizations to all foster parents who perceive severe difficulties in their foster child’s behavior. A substantial number of foster parents feel burdened by the impact of their foster child’s behavioral problems and the high percentage of foster parents seeking additional support in our RCT sample, indicates that they are in need of help. The provision of external support seems to be highly fragmented (i.e., provided in a wide variety of youth and mental health care settings), however, which suggests that the integration of various forms of support can be improved. The supposed importance of the intensive and individualized nature of PMTO for reducing levels of parenting stress supports the notion that it might be beneficial to intensify and professionalize (i.e., improve therapeutic skills) the regular assisting services provided by foster care supervisors. Supervisors would then have the time and competence to support foster parents in all the difficulties they encounter in everyday child-rearing. Meanwhile, systematic screening for (an accumulation of) risk factors may facilitate referral to additional specialized services. If there is a strong need to reduce parenting stress, PMTO might be the preferred intervention; if the attachment relationship is of most concern, an attachment-based program would be designated; or if the child is traumatized, trauma-based treatment would be appropriate, and so forth. Intensifying regular assisting services would fit within the principle of treatment foster care or wraparound foster care (Macdonald & Turner, 2008). Wraparound-based services offer enhanced foster care assistance that aims to fulfill the individual needs of the foster family and can be integrated with interventions that target specific problems in different systems (e.g., disruptive behavior, traumas, parenting skills; Fisher et al., 2009). At all times, the supervisor retains their central role in the foster family system. This would prevent discontinuity in basic care, which in itself can be a trigger for stress. Implementation of these services in long-term foster care in the Netherlands should be further explored in future.
Limitations

This thesis is not without its limitations. First, the studies described in Chapters 2, 3 and 4 are predominantly based on cross-sectional study designs, meaning that data collection was carried out at one point in time. This means that it is neither possible to give an indication of the sequence of events nor possible to describe processes over time. We could therefore only test parts of the model and not the full transactional model underlying foster placement breakdown. Furthermore, examination of this theoretical model also requires a follow-up investigation of placement breakdown in the RCT sample. Next, all of the studies measured the concepts under investigation using self-reports only. The quality of attachment representations in the first chapter was measured using young people’s self-reporting alone, but it could have been enhanced with additional diagnostic interviews. Parenting and child behavior in the RCT were based exclusively on parents’ self-reporting and not on observational data which may have yielded more objective assessments. Objective evaluation of behavioral changes would prevent a biased perception of PMTO-participants from emerging.

An RCT study design is considered the gold standard for evaluating the efficacy and effectiveness of an intervention (Nezu & Nezu, 2008). Implementing an RCT study design in a ‘real world’ foster care setting is a rather challenging undertaking, however, and one that often fails. Despite the methodological rigor of the RCT design, various limitations can still hamper the external validity of the study results (Rutter & Pickles, 2016). This means that the results cannot be extended directly to all foster parents with foster children with severe behavioral problems. For example, the drop-out rate (27%) after treatment allocation is a cause for concern. On the one hand, for example, families dropped out because their foster child moved out of the family, which underlines the considerable risk of placement breakdown in this sample. On the other hand, some families rejected PMTO because they felt no need to receive help. This indicates that for at least a part of our sample, the presence of child behavior problems did not necessarily imply a need for this kind of support. Furthermore, we excluded families from randomization to the RCT if they were referred to PMTO by the foster care organization for emergency indications, or if they only wanted to participate in one of the two conditions. This may have led to bias the sample, meaning that it was not a true representation of the whole population of foster parents with a child with severe behavioral problems. One should also consider, however, that additional analyses showed that the PMTO participants in our study, based on CBCL scores measured at the start of PMTO, did not differ on average from other foster parents who received PMTO outside our study, something that strengthens the generalizability of our results. Finally, the sample size in the RCT was quite small which increases the likelihood of Type II errors. The statistical power was sufficient to detect small/moderate main effects, but the analyses of moderator effects were underpowered.
Future research

We can identify a number of important areas for further research on long-term foster care. First, in many foster care studies (see Oosterman, et al., 2007), risk and protective factors are divided across child, family and placement characteristics and often comprise static characteristics (e.g., gender, kinship vs. non-kinship placements). The results of this thesis demonstrate that placement breakdown for foster children in long-term foster care should be investigated more thoroughly in the form of longitudinal study designs to understand the influence of interplaying risk- and protective factors over time on the development of foster children. Extensive and longitudinal research is needed to investigate which combination of factors puts children at risk of, or protects them from, placement breakdown.

The next area of research should be a more detailed investigation of the effectiveness of PMTO in Dutch foster care. Although a reduction in parenting stress was only observed in the short-term, this may have been a trigger to elicit a cascade effect (Patterson et al., 2010). One could speculate that lower levels of parenting stress may have had an impact, directly or indirectly, on the self-regulating processes in the child-rearing system. For example, reduced levels of parenting stress may lead to an improvement in the parent’s confidence in their ability to handle their foster child’s behavioral problems effectively, which in turn may enhance parent-child interactions and positively affect child development. Follow-up studies on our cohort one and two years later, for example, may further our understanding of this important matter. Similarly, monitoring the case files of the participating families could also generate important insights into whether fewer placement breakdowns eventually occurred in the PMTO group as compared to the control group. Future studies should also focus on the question of for whom PMTO works particularly well. Our sample size was too small to allow for robust moderator analyses to disentangle for whom, or under which circumstances, PMTO was most effective. Next, although an interesting finding and a promising result, we lack a good understanding of how PMTO reduced parenting stress at posttest and why this effect was not maintained in the long run. Future studies could investigate the importance of therapeutic processes, as compared to specific program contents, in reducing foster-parenting stress. Furthermore, future studies could test whether and what kind of additional post-intervention support, such as follow-up booster sessions or group sessions with other foster parents, would best suit foster parents in order to maintain intervention effects.

The final area of further research concerns the potential effectiveness of optimizing regular assisting services to support foster parents in the long-term foster care system in the Netherlands. It would be extremely interesting, also from a cost-effectiveness perspective, to find out whether intensifying regular assisting services according to the wraparound principles (Bruns & Walker, 2008; Fisher et al., 2009) would match the needs of these parents. In the Netherlands, the use of wraparound-based services in foster
care is not new, and most agencies offer an adapted version of a treatment foster care program. However, the methodology has not been systematically described, implemented or investigated. Moreover, these programs (e.g., Therapeutic Family Care; Multi Treatment Foster Care; Jonkman, 2015) often have a maximum placement duration (6-12 months) and are therefore not immediately suited to foster parents providing long-term care. A foster care agency in the south-west of the Netherlands recently conducted a pilot study (Wiegeraad, 2015) to describe and implement wraparound care services in long-term foster care. Rigorous further research would be warranted to investigate the effects on placement stability. Clearly, the national elaboration, implementation and investigation of interventions to support Dutch foster parents in order to reduce the risk of placement breakdown in long-term foster care has only just begun.

**General conclusion**

This thesis started by focusing on Dutch foster children’s well-being, emotional and behavioral functioning and placement stability. Subsequently, we attempted to identify how foster families who are considered to be at a high risk of placement breakdown could be given effective support.

The findings from our studies demonstrate that a considerable proportion of foster children are functioning well, but that approximately half of the foster children suffer from problems at a clinical or borderline level, the level associated with placement breakdown. The transactiional or bio-ecological perspective on foster child adjustment and foster family functioning, which acknowledges the importance of foster families’ different ecologies, was presented as a useful approach for systematically screening for risks and protective factors and subsequently organizing evidence based interventions to support foster families. At the first sight, PMTO seems a promising direction for reducing foster care stress. However, the hypothesized added value of PMTO, above and beyond CAU, to improve parenting practices and child functioning could not be confirmed in this study. It is recognized that in these highly burdened foster families, many stressors have to be addressed effectively in order to reduce the risk of placement breakdown. This strategy is in need of thorough investigation, along with a number of related themes for future research outlined in this thesis.

Overall, we were truly impressed by the overwhelming number of foster parents who showed great willingness to cooperate and participate in the research, in order to give their foster child the best care possible. We hope that the results of this thesis will contribute to the further development of a comprehensive and effective foster-care support system.