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## Promoting Birth Parents' Relationships with their Toddlers upon Reunification: Results from Promoting First Relationships® Home Visiting Program

**Monica L. Oxford,**

Family & Child Nursing, University of Washington

**Maureen Marcenko,**

School of Social Work, University of Washington

**Charles B. Fleming,**

School of Social Work, University of Washington

**Mary Jane Lohr, and**

Family & Child Nursing, University of Washington

**Susan J. Spieker**

Family & Child Nursing, University of Washington

### Abstract

Birth parents, once reunified with their child after a foster care placement, are in need of in-home support services to prevent reoccurrence of maltreatment and reentry into foster care, establish a strong relationship with their child, and enhance child well-being. Few studies have addressed the efficacy of home visiting services for reunified birth parents of toddlers. This study reports on the findings from a randomized control trial of a 10-week home visiting program, *Promoting First Relationships*® (Kelly, Sandoval, Zuckerman, & Buehlman, 2008), for a subsample of 43 reunified birth parents that were part of the larger trial. We describe how the elements of the intervention align with the needs of parents and children in child welfare. Although the sample size was small and most of the estimates of intervention effects were not statistically significant, the effect sizes and the pattern of results suggest that the intervention may have improved both observed parenting sensitivity and observed child behaviors as well as decreased parent report of child behavior problems. Implications are that providing in-home services soon after a reunification may be efficacious in strengthening birth parents' capacity to respond sensitively to their children as well as improving child social and emotional outcomes and well-being.

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Corresponding author at: Monica L. Oxford, University of Washington, Department of Family and Child Nursing, Box 357920, CHDD 110 South Building, Seattle, WA 98195-7920. mloxford@uw.edu.

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## Keywords

Reunified Birth Parents; Home Visiting Intervention; Promoting First Relationships; Child Welfare; Foster Care; Parental Sensitivity

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## 1. Introduction

Young children are especially vulnerable to child maltreatment and subsequent child welfare removal, both as an entry cohort and post-reunification. Children birth to three years constitute one-third of first entries into out-of-home placement in child welfare, a rate higher than any other age group (Administration on Children, Youth and Families, 2013). Among those reunified, young children are at greatest risk of recurring maltreatment resulting in reentry to care, exposing them to further trauma and disruptions in primary nurturing relationships. It is estimated that 40% (Jonson-Reid, 2003) to 50% (Fuller, 2005) of young children will be maltreated post-reunification and 20% to 30% will again experience removal from their parents' care (Shaw, 2006; Wulczyn, 2004).

The three aims of child welfare in the U.S. are safety, permanency, and well-being. Although historically U.S. policy has focused on the first two, recent priorities have integrated well-being. In an April 2012 information memorandum, the Administration for Children and Families (Administration on Children and Families, 2012) explained the enhanced priority of promoting social and emotional well-being for children and youth receiving child welfare services. The memo acknowledged that "while ensuring safety and achieving permanency are necessary to well-being, they are not sufficient" (p. 2). That same year, Title IV-E demonstration programs and discretionary grants were designed in part to develop capacity to provide evidence-based parenting support to caregivers so they could provide their children with the secure relationships required for social and emotional well-being.

Stability and continuity of attachment relationships are critical to the well-being of children. In child welfare, all reunified toddlers, by definition, have experienced a disruption in their primary attachment relationship. Attachment disruptions further exacerbate social and emotional development that has already been adversely affected by maltreatment, and can result in toddler behavior that is challenging for the reunified caregiver (Newton, Litrownik, & Landsverk, 2000; Rubin, O'Reilly, Luan, & Localio, 2007). If the relationship further deteriorates as a result, well-being, safety and permanency can be jeopardized again.

Many of the risk factors associated with recurrence and re-entry are not modifiable (age, race, maltreatment type) or are difficult to address in the near term (parent mental health, education, income) and are therefore outside the control of the child welfare system (Hindley, Ramchandani, & Jones, 2006; Kimberlin, Anthony, & Austin, 2009). However, parenting and relationship quality constitute modifiable factors well within child welfare's purview and purpose. Unfortunately, most parenting programs provided to families in child welfare do not focus on relationship quality and do not use strategies with empirical support (Horwitz, Chamberlain, Landsverk, & Mullican, 2010).

On behalf of this argument for relationship-based parenting support for reunified parents, we describe a 10-week home visiting program, *Promoting First Relationships*<sup>®</sup>, (PFR; Kelly, Sandoval, Zuckerman, & Buehlman, 2008), that is strengths-based and grounded in attachment theory. We present results of a study that is part of a larger community-based randomized control trial in which PFR was assessed for its effectiveness (Spieker, Oxford, Kelly, Nelson, & Fleming, 2012a). The original aims of the parent study, called the *Fostering Families Project*, were to assess if PFR improved parenting and child outcomes for foster parents of toddlers recently placed in their care. However, because the program was designed as a community based participatory research project, engagement of the community led to alterations in the original design. The regional child welfare department stressed the importance of including reunified birth parents in the study. This change was accepted as feasible and implemented. Ultimately, 27% of the 210 caregivers in the *Fostering Families Project* were birth parents who were reunited with their children after a foster care separation.

### 1.1 Families Experiencing Removals: A Vulnerable Population

Young children who are removed from their parent's care due to maltreatment typically face risks that began in the prenatal period and potentially extend through early childhood, including low birth weight, birth abnormalities, lack of prenatal care, and exposure to drugs, alcohol, and other teratogens (Needell & Barth, 1998; Rosenfeld, Wasserman, & Pilowsky, 1998; Wulczyn, 1994). The resulting complex interaction between genetic and environmental factors (Tomalski & Johnson, 2010) compromises the infants' regulatory capacities, which can lead to problems in mood regulation, sensory integration, motor control, sleep, and behavioral control (Degangi, Breinbauer, Doussard, Porges, & Greenspan, 2000), and to adverse health and mental health outcomes through the life course (McEwen & Gianaros, 2010; Shonkoff et al., 2012). The key formative experience for children in foster care is the experience of significant risk in their birth family without adult protection, which resulted in placement into the foster care system. Maltreating parents can create an irresolvable paradox for their children; they can be simultaneously frightening and the only source of caregiving (van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). This paradox alters the behavioral and stress reactive systems of infants, becoming one of the mechanisms that lead to impaired behavioral, emotional, and health outcomes (Cicchetti & Rogosch, 2001; De Bellis, 2005; Twardosz & Lutzker, 2010).

While child removal from the family provides protection from maltreatment, it also exposes children to placement instability and relationship disruptions. Despite the risks associated with multiple relationship disruptions (multiple changes in primary caregivers) in the first years of life (Goldsmith, Oppenheim, & Wanlass, 2004), placement changes are the norm and may put the child on a trajectory of increasing placement instability (Webster, Barth, & Needell, 2000). Toddler participants in the *Fostering Families Project* experienced an average of 2.7 caregiver changes from birth to 18 months (Spieker et al., 2012a). Multiple placements and episodic foster care are linked to increased probability of mental health problems (James, Landsverk, Slymen, & Leslie, 2004; Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007; Rubin et al., 2004), as well as a diminished ability to develop secure attachments (Penzerro & Lein, 1995).

Following serious maltreatment, children who have been placed in out-of-home care can continue to experience relationship disruptions and insecure attachments to subsequent caregivers. Foster children often adapt to relationship disruptions by turning away from new caregivers when they are feeling distressed (Dozier, Zeanah, & Bernard, 2013). This behavior may fail to elicit responsiveness from caregivers (Stovall-McClough & Dozier, 2004), which in turn may increase their risk for a new insecure attachment and even further maltreatment. Although infants placed at younger ages and those fortunate enough to have parents who are themselves secure can subsequently develop more secure, coherent behavior and less avoidant behavior (Stovall-McClough & Dozier, 2004), most reunified toddlers are returning to parents who very likely have insecure attachment representations themselves (Marcenko, Newby, Mienko, & Courtney, 2011).

Child welfare involved parents are, like their children, a vulnerable population. Their histories contain reports of childhood trauma and abuse, with resulting consequences associated with exposure to maltreatment. In a study of 408 reunified birth parents in Washington, it was documented that 55% had mental health diagnoses, 38% were experiencing domestic violence, 36% had substance abuse problems, 55% had annual incomes of less than \$10,000, and 60% had less than a high school education (Marcenko et al., 2011). In this context of multiple vulnerabilities, parenting is scrutinized and judged. Not surprisingly, parents express a range of emotions including guilt, fear, anger and outrage, along with profound stigma (Scholte et al., 1999). Even when parents successfully navigate the child welfare system and are reunified with their children, they often feel fragile and uncertain in their parenting role (Carlson, Matto, Smith, & Eversman, 2006). Interventions that attend to the unique needs of the child/parent dyad in ways that are empathic and supportive are essential to creating a relationship that overcomes the negative experience of maltreatment and separation.

## 1.2 Reunified Dyads' Need for Services

Family reunification is a time of intense emotions, both positive and negative. Joy at being together as a family can be tinged by parental shame and guilt related to prior maltreatment and difficulties re-establishing a relationship with children who may exhibit distress and challenging behaviors (Carlson et al., 2006). Unfortunately for children in foster care, reunification does not automatically create a safe, secure, and emotionally supportive parent-child relationship. Birth parents face many challenges in re-reestablishing their relationship with their child after reunification. Very young children who have experienced the loss of one or more primary attachment figures through multiple placements may be emotionally dysregulated and show levels of distress that are overwhelming to a caregiver (Dozier, Higley, Albus, & Nutter, 2002).

Birth parents are typically only required to take parenting classes *prior to being reunified* with their child. These classes are "...generally delivered in an ad hoc way and often characterized by uninformed practices with very little, if any attention to whether actual parenting practices change...with one-size-fits-all curriculum" (p. 4) (Beckmann, Knitzer, Cooper, & Dicker, 2010). The classes are generally psychoeducational, and not individualized to the parent-child relationship. However, both members of the reunified

dyad may have needs for services (Heller, Smyke, & Boris, 2002). Intervention services aimed at birth parent-child relationships are critical to increase the likelihood of a healthy reunion and diminish the reoccurrence of maltreatment. In dyads that have had a history of maladaptation, the “real patient” is the parent-child relationship (Sameroff, 2004), which is why it is ineffective to only provide parenting classes *prior* to reunification. If the relationship is the *real patient*, then the parent and child must have an opportunity to interact in “real life” before parenting improvements begin (Beckmann et al., 2010).

Despite the need for evidence-based interventions for reunified families, in a recent survey of 46 states, “...most states reported a greater availability of post-permanency supports for adoptive parents compared to birth parents upon reunification...” (Child Trends and Zero to Three, 2013, p. 24). As noted by Barth (2012), there was only one program, *Child Parent Psychotherapy* (CPP; Lieberman, Van Horn, & Ghosh Ippen, 2005) identified by the California Evidence-Based Clearinghouse for Child Welfare (CEBC) for children birth-to-three that has the second highest endorsement, “well-supported by research.” CPP takes 52-weeks of service and is “hardly a good fit with the much shorter period of services typical for child welfare-involved families” (Barth, 2012, p. 28). Since Barth’s commentary in 2012, only one additional program has been added in this category, *Attachment & Biobehavioral Catch-up* (ABC; Dozier et al., 2009). Other relationship-focused programs that are shorter in duration have not been evaluated on samples of child welfare dyads and thus little is known about the generalizability to this population (Barth, 2012).

Services to support birth-to-three children who have been reunified with their birth parent must work in the “real world,” which means they should be short-term, efficient, and feasible. The results of a comprehensive meta-analysis (Bakermans-Kranenburg, van Ijzendoorn, & Juffer, 2003) indicated that home visiting services, which are the most feasible for reunified birth families given the demands of full-time parenting, the need to participate in mandated services and transportation barriers, are most efficient when there are fewer than 16 sessions, and when the service uses video feedback.

### 1.3 PFR Community Based Home Visiting Program

PFR, a home visiting program designed to support families, was adapted to address the social and emotional needs of families with toddlers for the *Fostering Families Project*. PFR is a brief 10-session intervention program that uses a manualized but flexible curriculum combined with video feedback, worksheets and handouts, and a strengths-based orientation to promote more sensitive parenting. Reflective consultation for PFR providers is also an essential element of the program. We believe that the use of video feedback is particularly helpful for parents because they are able to step outside of the interaction and observe the child’s cues and communications. Research indicates that video feedback is more effective than psychoeducational approaches in altering parental sensitivity (Bakermans-Kranenburg et al., 2003), and it has the capacity to increase insight and reflective functioning, which in turn supports sensitive caregiving (Fukkink, 2008).

## 1.4 Conceptual Model

The four main aims of PFR are 1) to increase the parents' understanding of the needs and feelings of their toddler and understand how they as parents are important to their child; 2) to help parents recognize their child's communications and cues and respond to the emotional content of those communications and cues with sensitivity; 3) to increase the parents' own sense of confidence and competence that they are capable of responding to their child's needs and feelings; and 4) to increase parents' awareness of their own feelings and needs as parents and how their feelings and needs impact their relationship with their child. The PFR training program instructs providers to use a strengths-based approach in their interactions with caregivers. Table 1 identifies risks that reunified birth families may have and how elements of PFR specifically can meet the needs of birth families in very personal ways. Taken together these elements are woven in with the use of video feedback, handouts, and "thoughts for the week." The provider and parent enter into a partnership of inquiry that is based on positive respect for parents and their relationship with their child. These methods, grounded firmly in the strengths-based model, support parents' capacity to learn more about themselves as parents and their child's emotional needs that give rise to certain behaviors.

## 1.5 The Current Study

The rationale behind a focused examination of the subsample of reunified parent-child dyads became evident during service delivery in the *Fostering Families Project*. The needs and the context of parenting for reunified birth parents were different from that of kin and foster care providers. Birth parents had significantly lower incomes, were predominantly single parents with less than a high school education, and had poorer health. Consequently, we examined outcomes in the reunified subsample using the same approach as the main effects study (Spieker et al., 2012a). In our review of the literature, we were unable to find similar studies that evaluated relationship based, home-visiting programs specifically for birth parents of children birth-to-three during the post-reunification period. As states move toward provision of more post-reunification services, they will be searching for evidence-based services for this population (Sciamanna, 2013). Closer examination of this small but important subgroup yields a pilot study of the efficacy of PFR for child welfare involved parents and their young children.

We hypothesized that relative to the comparison condition, parents who received PFR would demonstrate improvements in their self-report of understanding toddler's behavior, reductions in perceiving the child as difficult and reporting a dysfunctional parent-child relationship; improvements in observed parental sensitivity and parental support; and a reduction of parental report of child behavior problems. We also hypothesized an increase in observed child self-regulation, exploration of novel stimuli, engagement with parent, and secure based behavior among the children in the families who received PFR, relative to the comparison group.

## 2. Method

### 2.1 Participants

Two hundred and ten toddlers and their caregivers were recruited into the *Fostering Families Project* (FFP) (Spieker et al., 2012a), between April of 2007 and March of 2010. The primary recruitment area was a single, metropolitan county in Washington State. All study procedures and participant consent forms were reviewed and approved by the state IRB. Using state Department of Social and Health Services (DSHS) records, a DSHS social worker identified all children in state dependency between the ages of 10 and 24 months who had experienced a court-ordered placement that resulted in a change in primary caregiver within the prior 7 weeks. Toddler-caregiver dyads who were eligible and agreed to participate were randomly assigned to receive either the *PFR* intervention or a psychoeducational program developed for this study called *Early Education Support* (EES). Eligible caregivers spoke English and could be foster parents, birth parents, or adult kin. The consenting caregiver and child were assessed at baseline, received intervention services, and then assessed immediately post-intervention and six months later if they were still in the same household.

At enrollment there were 56 biological parents and their recently reunified toddlers. Forty-three dyads (18 in PFR and 25 in the comparison condition) completed all three research visits. Demographic and background characteristics of these 43 families are shown in Table 2. There were no statistically significant ( $p < .05$ ) differences between experimental conditions in any demographic or background variables.

### 2.2 Intervention Exposure

The PFR intervention consisted of ten weekly 60- to 75-minute in-home visits by trained providers from community mental health agencies. Of the parents in the analysis sample of the current study, 12 (67%) in the PFR condition received all ten sessions. Details about the intervention are provided by Kelly and colleagues (Kelly et al., 2008) and (Spieker et al., 2012a, b).

Families in the EES condition received three monthly 90-minute, in-home sessions delivered by an early education specialist. The sessions consisted of instruction in early childhood developmental issues as well as referral to service programs such as child care, housing, and mental health. Of the parents in the analysis sample who were in the EES condition, 24 (96%) parents received all sessions.

### 2.3 Data Collection Procedure

Infants and their caregivers were assessed in two-hour, blinded research home visits at enrollment in the project (*baseline*), and two times following the intervention (*post-intervention* and *six-month follow-up*). Because the PFR intervention took longer to complete than the EES intervention, the post-intervention assessment was closer to baseline in the EES condition than in the PFR condition, EES:  $M$  ( $SD$ ) = 2.88 (0.93) months; PFR:  $M$  ( $SD$ ) = 4.12 (1.36);  $t$  (173) = 7.05,  $p < .001$ . Also, months between baseline and the six-

month follow-up differed by condition, EES:  $M (SD) = 8.85 (0.97)$ ; PFR:  $M (SD) = 10.05 (1.59)$ ;  $t (127) = 5.25, p < .001$ .

## 2.4 Measures

Measures used in the present study are the same as those examined in the prior report of the larger FFP sample. Information on internal consistency and inter-rater reliability of scales was derived from data on the original sample of 210 for all three research visits.

**2.4.1 Parent report of caregiver outcomes—***Understanding of toddlers* was measured by *Raising a Baby* (RAB; Kelly, Korfmacher, & Buehlman, 2008), assessing caregiver knowledge of infant and toddler social emotional needs and developmentally appropriate expectations. Items such as “The best way to help a toddler through his tantrum is to ignore him” and “A toddler’s misbehavior is a sign they need help from his/her parent” were rated on a 4-point scale (strongly agree to strongly disagree) (16 items; Alphas = .73 – .77).

Parenting stress associated with the perception of having a *difficult child* or a *dysfunctional parent-child relationship* was measured with the *Parenting Stress Index Short Form* (PSI-SF; Abidin, 1995). The Difficult Child (12 items) and Parent-Child Dysfunction (11 items) subscales had alphas ranging from .87 to .89. Sample items include: “My child smiles at me much less than I expected”; “Sometimes I feel my child doesn’t like me and doesn’t want to be close to me”, and were rated on 5-point scale (strongly agree to strongly disagree).

**2.4.2 Observed caregiver outcomes—***Parent sensitivity* was measured by a modified total score of the *Nursing Child Assessment Teaching Scale* (NCATS; Barnard, 1994), a videotaped interaction of the caregiver teaching the child to do an activity. Cronbach’s alpha for the 21 item sensitivity scale ranged from .71 to .79. A single coder was trained to reliability by a certified NCATS instructor and passed quarterly reliability checks. Sample items include: “Caregiver laughs or smiles at the child during the teaching interaction”; “Caregiver avoids making critical or negative comments about the child’s task performance”. Items were scored *yes* or *no*, and yes scores were summed.

An observational measure of *parent support* (15 items; alphas = .76 – .84) was the *Indicator of Parent-Child Interaction* (IPCI; Baggett, Carta, & Horn, 2009). Caregiver support was rated by two coders and averaged across three activities: free play, book reading, and a distraction task. Each activity was rated on five four-point scales (never, rarely, sometimes, or often): acceptance/warmth; descriptive language; follows child’s lead; extends/maintains child’s focus; and stress reducing strategies. Inter-rater reliability was assessed on 34% of coded episodes, and ranged from  $r = .80$  to  $r = .84$ .

**2.4.3 Parent report of child outcomes—***Competence* (11 items; Alphas = .69 – .70) and *problem behavior* (31 items; Alphas = .77 – .79) were based on the *Brief Infant Toddler Social and Emotional Assessment* (BITSEA; Briggs-Gowan & Carter, 2002). Behaviors in the last month were rated on a 3-point scale (not true/rarely; somewhat true/sometimes; very true/often). At the six-month follow-up only, caregivers completed the *Child Behavior Checklist for Ages 1½ – 5* (CBC; Achenbach & Rescorla, 2000) to rate child behavior. The children were too young for caregivers to complete the CBC at previous assessments.



Descriptions of behavior in the last two months were rated on a 3-point scale (not true; somewhat true/sometimes; very true/often). Raw scores on the *internalizing* (36 items; Alpha = .80) and *externalizing* (24 items; Alpha = .90) scales were used.

**2.4.4 Observed child outcomes**—Data collectors used the Bayley Behavior Rating Scale (BRS; Bayley, 1993) to rate the child’s behavior during administration of the *Bayley-III Screening Test* (Bayley, 2005) at baseline and the six-month follow-up. Seven items comprise the *emotional regulation* scale and capture how well the child adapts to challenging stimuli and frustration. Examples include: “degree of negative affect in response to test materials, tester, or parent”, “hypersensitivity to test materials” and “adaptation to test materials change or transitions”; alphas = .87 at both time points. *Exploration* consists of six items rated for exploratory behavior in the testing situation. Examples include “degree of positive affect” and “animation and energy level in exploration of objects or environment”; alphas = .74 and .76. Two research visitors were trained to rate the BRS scales; inter-rater reliability was assessed on 10% of visits and ranged from  $r = .67$  to  $r = .70$ .

*Secure base behavior* was measured with the *Toddler Attachment Sort-45* (TAS45; Kirkland, Bimler, Drawneek, McKim, & Schölmerich, 2004), which was scored immediately after each research home visit. The TAS45 is a 45-item modified version of the *Attachment Q-Sort* (AQS; Waters, 1987), a gold standard attachment measure which has been extensively validated (van IJzendoorn, Vereijken, Bakermans-Kranenburg, & Riksen-Walraven, 2004). We used a sorting technique that the developers of the TAS45 termed *trilemmas*, in which the 45 descriptive statements are presented in specific sets of three. The three items in a sample trilemma are: “Child wants to be at the center of mother’s attention”; “Child is very independent”; “Child will go towards mother to give her toys, but does not touch nor look at her”. The observer decides which one of the three statements in the set is most like and which one is least like the child’s behavior during the observation. Each of the 45 statements appears in two trilemmas; there are 30 trilemmas in all. The scoring results in an overall secure base behavior score. Two research visitors were trained to administer the TAS45 by the first author; in 16% of visits the TAS45 was coded by the two raters on-site. Inter-rater reliability was  $r = .92$ .

Two coders rated *child engagement with parent* from the three videotaped *IPCI* activities (9 items, alphas = .79 – .82) (Baggett et al., 2009). Three 4-point scales, positive feedback to parent, sustained engagement to parent and non-social stimuli, and follows parent’s lead, were rated for each activity. Ratings were combined to create a total score. Reliability was assessed with the *IPCI* trainer on 34% of coded episodes, and coder-trainer agreement ranged from  $r = .80$  to  $r = .84$ .

## 2.5 Analysis

ANCOVA models were estimated to assess differences by experimental condition in caregiver and child variables at baseline, the immediate post-test, and six-month follow-up time points. Covariates included age of child, whether a child had experienced multiple removals from the birth parent home prior to enrollment, and months between baseline and the given follow-up assessment. Baseline score on the given measure (when available) was

also included as a covariate. Estimates of effect size are based on differences in adjusted means divided by the square root of mean square errors of the ANCOVA models. Positive effect sizes indicate that the difference between PFR and EES favored the PFR condition. According to Cohen's conventions (1992),  $d = .20$  is considered small,  $d = .50$  medium, and  $d = .80$  large.

### 3. Results

We hypothesized that parents who received PFR would show improvements in self-report of understanding toddler's behavior, reductions in perceiving the child as difficult and reporting a dysfunctional parent-child relationship; improvements in observed parent sensitivity and parental support; and a reduction of parental report of child behavior problems. We also hypothesized an increase in observed child self-regulation, exploration of novel stimuli, engagement with parent, and secure base behavior among the children in the families who received PFR.

None of the group differences in scores on measures at baseline were statistically significant. Adjusted means (based on results from the ANCOVA models) and standard deviations at the immediate post-test and the six-month follow-up are shown by condition in Table 3. Table 3 also includes results of tests for differences at post-test and six-month follow-up by condition, and the effect size for these differences.

Of the nine immediate post-intervention outcomes examined, there were no significant differences between parents and children in the PFR condition and the EES condition. Four of the five parent outcomes were more problematic for the PFR group, with the largest differences being medium effect sizes (one favoring PFR and one favoring EES) for the PSI parent-child dysfunction scale ( $d = -.46$ ), and the BITSEA competency scale ( $d = .41$ ). The two parenting observations had positive effect sizes, with the NCATS parent sensitivity score having a small effect ( $d = .30$ ).

Of the 13 six-month follow-up outcomes examined, one showed a difference by condition that was statistically significant at the  $p < .05$  level. Parents in the PFR condition were observed to provide more *parent support* in their interactions with their child than were parents in the EES condition; the effect size was  $d = .87$ . The direction of all but one of the differences at six-month follow-up favored the PFR condition.

### 4. Discussion

The purpose of the study reported here was two-fold: to describe how the elements of PFR align with the identified needs of parents and children who have experienced a child welfare placement and subsequent reunification, and to test PFR compared to a three-session intervention consisting of psychoeducation and referral services. This study is part of a larger randomized trial that included foster parents and kin providers, in addition to birth parents. Strengths of the study include blinded outcome assessments, multiple observational measures coded by trained and reliable raters, and a strong comparison group which received in-home psychoeducation and referral services.

Results indicate that PFR produced positive results in this small sample of reunified birth families at the six-month follow-up, although not evident at the immediate post-test. These results, compared to results reported for the full sample including foster, kin, and birth parents (Spieker et al., 2012a), indicate that the effect sizes at the immediate post-test were more negative for the birth parent sample. In contrast, the positive effect sizes at the six-month follow-up reported here for birth parents are larger than they were for the full sample. These results hint at a longer time required for the intervention to effect change for the birth parent subsample.

PFR aims to help parents interpret their young child's cues and respond sensitively, particularly around times of child distress. That parents exposed to PFR reported a decrease in problematic behavior as well as an increase in child competence lends support to the ability of the PFR to achieve this central goal. These results may reflect a change in parent perception or actual improvements in child behavior, or both effects could be operating. Regardless, when parents grasp the concept that "behavior has meaning" they are better positioned to reframe challenging behavior as resulting from the child's unmet social or emotional needs. The response then becomes one of helping the child with difficult feelings rather than "punishing" as defiant behavior. Clearly, this would be a desired modification in parenting response for a child welfare population.

We want to underscore the importance of parental capacity to reframe behavior, or at the least to see the child in a more positive light. Once parent perceptions start to shift, the dyad will become more positively engaged, the relationship will be punctuated with more positive, mutually enjoyable interactions, and the parent will have greater empathy and understanding of the child's needs. These changes create an iterative shift in the relationship toward a more positive trajectory. We theorize that the skill of reframing the meaning of challenging behavior is not only relevant for parents of toddlers. The importance of parents' ability to understand and reflect on the underlying meaning of behavior applies across all stages of development.

#### 4.1 Implications

When the child welfare system removes a child from the family home due to abuse or neglect, the goal of child welfare policy is safety, permanency, and child well-being (ACF, 2012). While reunification is the desired goal when feasible, it can be accompanied by conflicting emotions and distinct challenges. Parents and their children typically transition from limited time together in the context of supervised visitation, to becoming a full-time family with greatly increased interaction around all of the nuances of daily life. Parents report this as a time of joy mixed with guilt, anxiety, fear of a failed reunification, and loss, and also anger at the perceived lack of support from the child welfare system (Malet, McSherry, Larkin, Kelly, & Robinson, 2010).

In addition to the emotional aspects of reunification, the reunified parents in our study had many other obligations and service requirements during the time they were participating in PFR. These numerous and rigid compliance tasks meant it often took 16 weeks to complete the 10-week PFR program. The fact that parents had to juggle multiple demands during the intervention phase may account in part for the "sleeper effect" of positive outcomes

emerging only six months post-intervention, after a period of practice and consolidation. Being flexible in scheduling and rescheduling home visits was important to support the families' successful program completions. Beginning PFR before reunification, during visitation times, and then continuing with PFR as a support post-reunification is a model that could be effective. Visitation visits are often a missed opportunity for a therapeutic focus on the parent-child relationship and to scaffold parenting confidence and competence (Haight, Sokolec, Budde, & Poertner, 2001).

Reunifications fail for complex reasons, not all of which are addressed by a parenting program like PFR. Miller, Fisher, Fetrow, and Fordan (2006), however, found that parenting skill was an important positive contributing factor for successful reunifications, along with case management directed toward parental needs. PFR would be a good addition to a menu of services that should be offered by state agencies to strengthen the parent-child relationship. While in this sub-sample we showed improvement in parenting and child outcomes six months post-intervention, our earlier work with the full sample showed that receiving PFR did not reduce the rate of reentry into foster care after two years of follow up data, although PFR did improve permanency outcomes for those in foster care and kin care (Spieker, Oxford, & Fleming, 2014). Future research should identify the modifiable factors that contribute to re-entry for reunified birth families.

#### 4.2 Limitations

There are important limitations to be noted for this study. The primary limitation is the small sample size. With groups of 18 and 25, power to detect statistically significant ( $p < .05$ ) differences between groups was very limited, with type II error rates under .20 only when effect sizes are large ( $d > .80$ ). The power to detect a medium effect ( $d = .5$ ) is only .35. We can only speculate why positive outcomes emerged only at the six-month follow-up. Many of the effects in this pilot study are medium in size; with such low power due to sample size we were unable to demonstrate statistical significance. However, with a larger sample such as that in the parent study, medium effect sizes were statistically significant because we had sufficient power (Spieker et al., 2012a). Finally, the participants in this study may differ from the general population of reunified birth families. Parents consenting to participate in this research might represent a particularly motivated subset of reunified parents.

#### 4.3 Conclusions

The results of this pilot study are promising and a first step in understanding the types of services that will alter the trajectory of children after foster care. Parents receiving the PFR intervention eventually perceived their child in a more positive light and demonstrated improved parenting behavior, as observed by blinded coders. These gains may contribute to longer term improvements in the parent-child relationship and enhanced overall child well-being.

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TABLE 1

## Parental Risk Factors Addressed by PFR

Risk Factor	PFR Element
Low parental self-efficacy	<ul style="list-style-type: none"> <li>Provider use of positive instructive feedback during video feedback identifies positive shared moments and what the parent is doing well to support the child.</li> <li>Provider engagement that is respectful, contingent, and positive supports the parent's sense of self as worthy.</li> </ul>
Misattribution of meaning of toddler challenging behavior	<ul style="list-style-type: none"> <li>Parent learns to observe child's behavior via video feedback.</li> <li>Parent learns to reflect on the underlying social emotional needs via video feedback, provider's use of reflective questions and comments, and handouts all focused on identifying and labeling underlying social and emotional needs of children.</li> <li>Baby Cue (NCAST.org) cards and videos help parent learn how children communicate nonverbally.</li> <li>Reflective questions help parent "enter the mind of the child" and discuss what the child might be needing or feeling.</li> </ul>
Difficulty regulating self while distressed; difficulty regulating child's distress	<ul style="list-style-type: none"> <li>Handouts and exercises that specifically address distress of parent and child and methods for calming.</li> <li>Video feedback during times of distress; reflective questions about internal states of parent and child and how needs can be met for both.</li> <li>"Intervention Worksheet" handout takes the parent through steps in the process of understanding challenging behavior: 1) defining the behavior, 2) identifying underlying feelings of parent and child, 3) identifying the underlying needs of parent and child, 4) thinking about ways to meet the needs of parent and child.</li> </ul>
Difficulty being present, calm, and appropriately responsive to child fear, anger, distress	<ul style="list-style-type: none"> <li>Handouts to demonstrate attachment-based concepts and help parent understand the child's need for a secure base from which to explore and a safe haven from which to receive comfort, protection, and support.</li> <li>Video reflection to help parent "see" attachment-based behavior and needs.</li> <li>Providing parent with a supportive presence to enable them to feel safe and secure enough to help the child.</li> </ul>
Difficulty following the Child's lead in play	<ul style="list-style-type: none"> <li>Positive instructive feedback during video feedback to identify times when the parent successfully follows the child's lead.</li> <li>Handouts on play and teaching which discuss the importance of following the child's lead.</li> </ul>
Underestimating how important the parent is to the child	<ul style="list-style-type: none"> <li>During video feedback, provider points out how child is watching and responding to the parent's words and behaviors.</li> <li>Celebrating moments of shared joy during video feedback and other times.</li> </ul>
Child's trauma history leading to behaviors that do not elicit nurturing care	<ul style="list-style-type: none"> <li>Video observation to help caregiver see the world from the child's experience.</li> <li>Reflective questions help the caregiver think about the child's underlying social and emotional needs.</li> </ul>

**TABLE 2**

## Baseline Characteristics by Intervention Condition

	<b>EES (n=25)</b> <i>n (%)</i>	<b>PFR (n=18)</b> <i>n (%)</i>
Child male	11 (44)	9 (50)
Child Hispanic	3 (12)	0 (0)
Child race		
Native American/Alaskan Native	1 (4)	0 (0)
Black	1 (4)	3 (17)
Mixed race	2 (8)	5 (28)
Unable to determine	2 (8)	0 (0)
White	19 (76)	10 (56)
Multiple removals	1 (4)	5 (28)
Household income <\$20,000 per year	14 (56)	12 (67)
Caregiver male	4 (16)	1 (6)
	<i>M (SD)</i>	<i>M (SD)</i>
Child age in months	18.15 (4.79)	18.29 (5.32)
Number of caregiver changes prior to enrollment	3.04 (1.14)	2.94 (1.16)
Child age in months at first removal	8.59 (6.78)	7.23 (6.86)

Note: *M* = mean, *SD* = standard deviation.

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**TABLE 3**

Means and Standard Deviations of Post-Intervention and Six-Month Outcomes by Experimental Condition; Test Statistic, Significance Level, and Effect Size for PFR

	Post-intervention				Six-month follow-up					
	EES ( <i>n</i> =25) <i>Adj M</i> ( <i>SD</i> )	PFR ( <i>n</i> =18) <i>Adj M</i> ( <i>SD</i> )	<i>F</i>	<i>p</i>	<i>d</i>	EES ( <i>n</i> =25) <i>Adj M</i> ( <i>SD</i> )	PFR ( <i>n</i> =18) <i>Adj M</i> ( <i>SD</i> )	<i>F</i>	<i>p</i>	<i>d</i>
Parent Report Outcomes										
RAB Understanding Toddlers	51.57 (3.58)	51.22 (4.84)	0.06	.814	-.10	51.18 (5.09)	52.02 (4.95)	0.29	.594	0.22
PSI Difficult child	8.67 (3.95)	9.36 (4.84)	0.16	.691	-.16	9.95 (4.16)	7.96 (5.79)	1.29	.263	0.44
PSI Parent-child dysfunction	3.96 (3.90)	5.70 (4.11)	1.28	.265	-.46	4.47 (4.51)	4.96 (5.32)	0.12	.731	-0.13
Observed Parent Outcomes										
NCATS Parent sensitivity	11.46 (4.52)	12.58 (4.88)	0.55	.464	.30	13.27 (3.92)	14.64 (2.99)	1.37	.249	0.45
IPCI Parent support	2.04 (0.36)	2.05 (0.34)	0.01	.934	.03	2.05 (0.40)	2.36 (0.40)	5.14	.029	0.87
Parent Report Child Outcomes										
BITSEA Competence	16.77 (2.87)	17.72 (2.74)	0.94	.339	.41	18.05 (2.24)	18.52 (2.82)	0.32	.573	0.22
BITSEA Problem behavior	9.23 (4.46)	10.29 (6.54)	0.37	.549	-.26	10.59 (5.89)	7.75 (5.21)	2.07	.159	0.57
CBCL Internalizing						6.92 (5.16)	6.50 (3.61)	0.05	.818	0.09
CBCL Externalizing						15.54 (7.53)	11.48 (7.65)	2.06	.159	0.55
Observed Child Outcomes										
BRS Emotional regulation						3.92 (0.65)	4.19 (0.75)	1.30	.261	0.44
BRS Exploration						4.39 (0.58)	4.42(0.47)	0.02	.884	0.06
TAS45 Secure base behavior	0.15 (0.06)	0.13 (0.06)	0.59	.446	-.31	0.12 (0.07)	0.14 (0.10)	0.39	.537	0.23
IPCI Engagement with parent	2.14 (0.52)	2.01 (0.49)	0.42	.52	-.26	2.32 (0.53)	2.45 (0.38)	1.50	.228	0.29

Notes: *Adj M* = mean adjusted for ANCOVA model covariates, *SD* = standard deviation, *d* = effect size (difference in adjusted mean/square root of mean square error) with a positive effect size indicating the difference favors the PFR condition. ANCOVA models adjust for baseline score, age of child, whether multiple removals, and time between baseline and the given follow-up assessment.