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# How the Foster Care System Impacts Cognitive Behavioral Therapy (CBT)

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# How the Foster Care System Impacts Cognitive Behavioral Therapy (CBT)

Anna Bratushevskaya

# HOW FOSTER CARE SYSTEM IMPACTS COGNITIVE BEHAVIORAL THERAPY

## ABSTRACT

The number of children in foster care is growing at an alarming rate, and finding families who are willing and able to care for these traumatized children is not an easy task. Children land in foster care due to extreme traumatizing circumstances in the homes of their biological parents. It is therefore not surprising that these children have a higher incidence of psychological problems than their peers living with their biological parents. Cognitive behavioral therapy (CBT) is an umbrella term under which trauma-based cognitive therapy (TF-CBT) falls. Both CBT and TF-CBT show excellent results in treating children with serious psychological trauma, such as post-traumatic stress disorder, sexual abuse, and the like. The CBT/TF-CBT approach does not involve a lengthy therapy period (6–12 sessions) and achieves results equal to or better than conventional psychotherapy. One drawback of this therapy in the foster care situation is that it necessitates parental support during the treatment of children. In fact, the sessions are equally divided between the parent and child. As foster parents usually have complicated situations of more than one foster child, visitations of biological families, dealing with their biological children, and their own work situation—they therefore seldom provide full cooperation in the therapy situation. This may lead to diminished results in CBT/TF-CBT with children in foster care. Specifically, I use two examples of children in foster care who received CBT at the agency where I work to illustrate the typical parental support and to explore the impact of the lack of parental support on the success rate of CBT in these children. It is essential to provide a highly successful psychotherapeutic approach to this vulnerable group of children, and CBT/TF-CBT should be adapted such that its high success rate can be duplicated in children in foster care.

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# HOW FOSTER CARE SYSTEM IMPACTS COGNITIVE BEHAVIORAL THERAPY

## INTRODUCTION

Foster care signifies any government system that acts as safe care for minority-age youngsters who have been abused, neglected, or abandoned (Foster, 2001). Recently, an increasing number of children have been placed in foster care that places the system in a difficult situation (Geiger, Hayes, & Lietz, 2013; Vanderfaeillie, Van Holen, Trogh, & Andries, 2012). Children are placed in foster care following unacceptable circumstances in their parental home; these children are often traumatized not only because they have to leave their parents, but more so due to the circumstances that led to their removal (Akin, 2015). Foster care parents often provide loving care to these children (Dubois-Comtois, 2015); although this is an invaluable service, it is not enough for traumatized children.

The question arises as to what treatment would benefit these traumatized children the best. I am a registered cognitive behavioral therapy (CBT) therapist and trauma-focused CBT (TF-CBT) therapist, and recently served as an intern at a mental health clinic where I treated children in foster care using CBT/TF-CBT techniques. The foster situation in which there are two sets of parents—biological and foster parents—results in less than 100% cooperation from the significant adult in the lives of foster children. The outcomes of this therapeutic intervention in my practice with foster children were found to be somewhat compromised, and the question arises whether this is due to the lack of adult cooperation as the children are in foster care. As the number of children in foster care grows and nearly half of these children present with emotional and behavioral problems due to the circumstances they were in prior to foster care, it is deemed essential to provide therapy that is effective to successfully treat these children. It is equally important to understand and appreciate the position of the foster parent—who often has biological children as well and

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possibly does profitable work—in supporting the foster child undergoing CBT/TF-CBT. The theoretical discussion will focus more on TF-CBT, as this is the specialization of the researcher and an approach that achieves excellent results in a relatively short period. I am of the opinion that equally good results could be achieved with TF-CBT in the foster care situation and therefore focus my attention on this area of specialization.

Given the success of TF-CBT with children who experienced trauma (Berliner, Jungbluth, Dorsey, Sedlar & Menchant, 2014; Webb, Hayes, Grasso, Laurenceau, & Deblinger, 2014), it is deemed a suitable technique to use with children in foster care. The purpose of this study is to explore the reason(s) CBT and TF-CBT with children in foster care do not seem to achieve the same success rate compared to those in private practice. Furthermore, this study may lead to suggesting solution(s) that would facilitate increased success rates of CBT/TF-CBT with foster children.

To achieve these objectives, I will first explore CBT and TF-CBT by discussing its origins and later developments, including its uses and therapeutic principles. Specifically, as mentioned earlier, I discussed TF-CBT and its appropriateness in therapy for traumatized children is highlighted. The use and success rate of TF-CBT in private practice is examined for comparison with the successes achieved in my TF-CBT practice with foster children. Thereafter, the need for therapeutic intervention in foster children is addressed. The foster parents' and family situation received specific attention since this is the environment in which foster children find themselves. Particular attention was given to the situation and ability of foster parents to provide support to foster children who receive therapy. Although there is ample research indicating that TF-CBT significantly improves the

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mental health of traumatized children in private therapy (Allen & Johnson, 2012; Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013), there is a gap in the research related to the degree of support in CBT/TF-CBT which foster children receive from foster parents and the impact thereof on the success rate of CBT/TF-CBT in foster children. Due to this gap in the research, I dedicated the observational section of this thesis to exploring the impact of foster parents' support on the success rate of CBT/TF-CBT with foster children—the child's presenting problem dictates the therapeutic approach; therefore, TF-CBT may not always be chosen in actual therapy situations. I will specifically explore if/how foster parents support the foster children related to (a) their TF-CBT homework and (b) what barriers or difficulties foster parents could experience that might prevent them from supporting the foster child. I furthermore analyzed the changes that I implemented in the therapeutic intervention to determine which could facilitate better results in the relative absence of parental support.

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## LITERATURE REVIEW

### **Defining Cognitive Behavioral Therapy**

The Beck Institute for Cognitive Behavioral Therapy provides the following definition of CBT on their website: “Cognitive Behavior Therapy (CBT) is a time-sensitive, structured, present-oriented psychotherapy directed toward solving current problems and teaching clients skills to modify dysfunctional thinking and behavior” (Beck Institute Homepage).

The instructor’s manual on Meichenbaum’s approach to CBT (Wyatt & Seid, 2009), outlines CBT as sensitive to the intricate network of links between feelings, actions, and their results or consequences. The CBT therapist uses developing self-awareness, performing experiments, and self-monitoring to facilitate changes in the beliefs clients hold about themselves and the world (Wyatt & Seid, 2009). CBT is an umbrella for several cognitive therapies, including cognitive therapy, TF-CBT, rational-emotive behavior therapy (REBT), and others (Vernon, 2016).

### **History of CBT and Significance**

CBT is a combination of cognitive therapy and behavioral therapy. The psychologists Beck and Ellis developed cognitive therapy in the 1960s. Cognitive therapy is grounded in the assumption that poorly adapted behavior and troubled mood or emotions result from irrational thinking patterns or automatic thoughts. People displaying poorly adapted behaviors do not react to the real situation, but rather to their representation of the situation. For example, a child may think he is worthless because he lost a tennis match. In cognitive therapy, the therapist endeavors to let the client become aware of the distorted thinking patterns and then change them by means of cognitive restructuring. In contrast to other psychotherapies, behavioral therapy focuses on training the client to substitute



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undesirable behavior with healthier behavioral patterns (Beck Institute, n.d.).

Behavioral therapists do not spend time analyzing what could be the origin of the behavior; they instead focus on modifying the behavior (Beck Institute, n. d.).

According to the Beck Institute (n. d.), CBT was developed by Beck in 1976 as a therapeutic method dealing with clients with depression. Beck postulated that depressive patients have distorted cognition and negative self-talk and a negative view of the future. CBT aims to teach the client to identify, analyze, and change the relationship between negative thoughts and their self- and world views. By learning to identify the negative thoughts and responses that helped establish this mood, the person is able to address this destructive thought pattern by means of evaluating and challenging destructive thoughts and adopting behavior that lifts the mood. This therapy has been proven very useful and transferable to a variety of clinical cases. For example, research with Romanian foster parents (Gavița, David, Bujoreanu, Tiba, & Ionuțiu 2012) and sexually abused children (Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012).

A basic assumption of CBT is that maladaptive behavior—counterproductive to daily living—is caused by flawed thinking patterns and negative feelings. This pragmatic approach to therapy centers on changing the client’s thought patterns so that the behavior and emotional status could change as well (Beck Institute for CBT, n. d.). In theory, this therapeutic method can be used in any case where a pattern of undesirable behavior linked to stress and impairment occurs, such as mood disorders, phobia and obsessive-compulsive disorders, posttraumatic stress disorder (PTSD), chronic pain, and even insomnia. As CBT does not focus on understanding situations in the past that could cause the client’s current behavior patterns, it may not be suitable for patients who would like to delve into the past to understand the

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psychodynamics of their behavior (Beck Institute, n. d.). Clients must be ready to take an active role in the therapy by doing explorations or experiments at home and participating in role-plays and the like during therapy sessions (Beck Institute, n. d.; Wyatt & Seid, 2009).

Therapists use different techniques or procedures during CBT to facilitate self-awareness of thinking patterns and behavior in clients. These CBT techniques are:

- **Homework or experiments.** CBT therapists regularly ask clients to complete homework tasks between therapy sessions where clients have to experiment with new reactions to situations explored during therapy sessions.
- **Cognitive rehearsal.** During therapy sessions, a client will imagine a problematic situation while the therapist guides him/her through steps to manage the situation successfully. At home, the client has to practice these steps and hopefully will be able to use the new behavior should such a situation arise.
- **Modeling.** Role-plays during therapy sessions allow the therapist to model desired behaviors in specific situations.
- **Conditioning** refers to the reinforcement therapists provide to strengthen desired behaviors or eliminate unwanted behaviors.
- **Desensitization.** When clients fear situations (e.g., open spaces), the therapist will use relaxation techniques in combination with visualizing the situation to systematically overcome the fear.
- **Journaling.** Clients are requested to keep a journal of their emotions, thoughts, and actions in the face of certain situations. Journaling

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facilitates insight and awareness of the repetitive thoughts and their consequences.

- **Validity testing.** The therapist may ask or challenge the client to prove, provide evidence, or defend that a specific automatic thought is true. In this way, the faulty nature of the thoughts are explored.

**Rational-emotive behavior therapy.** Ellis developed the REBT approach as a variation of CBT in 1955 (Ellis, & MacLaren, 2002). REBT is based on the belief that people's past experiences influence their thoughts and behaviors. In some cases, people form illogical or irrational thoughts. REBT therapy employs steps to systematically identify and eliminate these thoughts and replace them with rational and healthier thoughts. According to Ellis, there are 10 basic hypotheses that trigger flawed emotions and behavior patterns:

- Nearly everybody and everything must love and approve adults.
- A person should be completely perfect in all respects.
- There are people who are inherently wicked and bad; they must be punished for their sins.
- When things do not go the way one likes them to, it is disastrous.
- A person has little or no influence on the external things that control his/her happiness and cannot rid him/herself of them
- It is correct to be extremely engrossed in something that could be dangerous or scary.
- It is better to avoid facing responsibilities and problems than to apply self-discipline.
- One cannot get away from one's past, as it determines your present and future.

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- One must immediately find solutions to the realities of life to make things different from what they are.
- People who do not take action and live with apathy are maximally happy.

After studying rational philosophy, Ellis embraced the notion of human choice and began teaching his clients that they could choose to be happy and fulfilled or fearful and anxious. REBT has as a basic premise that people must realize what their unhealthy thought patterns are and decide to participate in changing and replacing them with healthy thought patterns (Ellis & MacLaren, 2002).

**Trauma-Focused CBT (TF-CBT).** TF-CBT forms part of the interventions under the umbrella term CBT; other CBT-based interventions include CBT for depression and parent management training (PMT). These interventions are grouped as CBT+, which is a training model for providers of public mental health in evidence-based practices (EBPs) (Berliner et al., 2014; Greer, Grasso, Cohen, & Webb, 2014; Leffler, Jackson, West, McCarty, & Atkins, 2013). EBP aims at finding and using the best therapeutic approach for the specific client. This approach also considers the needs and circumstances of the client and allows the client to participate in the choice of a therapeutic approach. (Leffer et al., 2013).

TF-CBT is a structured approach that comprises eight steps represented by the acronym PRACTICE. (See Table 1 for a more detailed discussion of this acronym.) Therapy sessions are usually weekly sessions of 90 minutes that are split between the child-client and parents. As therapy progresses the two groups work increasingly together (Webb et al., 2014). The number of TF-CBT sessions is 12–16 and is provided in an outpatient setting. TF-CBT was initially developed to address posttraumatic stress disorder (PTSD) and associated emotional and/or behavioral problems of children who were sexually abused. As a more recent development, the

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intervention has been used in treating children who experienced traumatic loss (e.g., war situations or natural disasters) (Cohen, Deblinger, Mannarino, & Steer, 2004; Jensen et al., 2014).

Table 1  
*TF-CBT Techniques: PRACTICE*

Acronym letter	Child-client	Parent / Caregiver
<b>Phase 1</b>		
(P)sychoeducation	Education and awareness training about trauma and stress	In tandem with the child's sessions— Teach the parent or caregiver to practice the new knowledge and skills at home and how to use parenting techniques to minimize PTSD-related behavioral problems.
(R)elaxation	Training and practicing relaxation techniques	
(A)ffective	Verbalization and control of feelings	
(C)ognitive	Management or coping	
<b>Phase 2</b>		
(T)rauma	Narrate the trauma in detail	Therapist shares with the parents, processing their stress reactions and increasing their understanding of their child's emotions and perceptions
(I)n-vivo	Exposures to decrease stressful reactions when encountering reminders of the trauma	
(C)onjoint	Child and parents share the session giving the child the opportunity to share the trauma narratives with parents. Parents are urged to exhibit understanding, encourage the child to be open about feelings, praise the child's courage, and nurture the child	
<b>Phase 3</b>		
(E)nhance	Joint session—strengthen wellbeing and practice skills to safeguard the child in preventing or managing future trauma; mutual support and working together. Focus on the caregiver's support to the child.	

*Source:* Webb et al., 2014

**Parental / caregiver support.** As shown in the above table, the support of parents or caregivers is an integral element in TF-CBT, as the total therapy time is equally divided between the child and parents. Parents are expected to support the child at home by assisting in practicing the techniques and providing support by applying the techniques learned during the therapy sessions (Webb et al., 2014). TF-CBT capitalizes on parent involvement to be effective (Dorsey, 2014). Whereas TF-CBT instruction improved PTSD even without parent involvement, the other

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conditions, such as anxiety, did not improve without parental support. For instance, Scheeringa et al. (2007) used CBT techniques—relaxation and exposure techniques—on two children between 3.5–4.5 years and found that preschoolers benefit from this approach provided that they receive the assistance of their parents. Dorsey acknowledged that enlisting parental support, more specifically foster parent support in TF-CBT, is rather challenging. It is, however, worthwhile as the therapy sessions are duplicated and the child’s reactions are strengthened during the parent’s interaction at home (Dorsey, 2014). The author reported a higher incidence of therapy programs being completed when parents are involved in the therapy sessions. Paris, DeVoe, Ross, and Acker (2010) suggested using the Cohen and Mannarino (1993) adaptation of TF-CBT as it can be used for very young children who faced trauma. This variation of the TF-CBT is called the CBT-SAP (Cohen & Mannarino, 1993, cited in Paris et al. 2010), and is used to treat children of the military who were traumatized by the parent’s absence.

### **Efficacy of TF-CBT in the General Population**

In the aftermath of traumatic experiences, such as violence, war, sexual abuse, and natural disasters, children could develop PTSD or posttraumatic stress symptoms (PTSS). These conditions are debilitating, and effective treatment is needed to enable these traumatized children to live fruitful lives free of anxiety and stress (Jensen et al., 2014). TF-CBT has been tested in different controlled trials, and its effectiveness in treating children with PTSS was established (Jensen et al., 2014). The authors researched the effectiveness of 12–15 TF-CBT sessions compared to therapy as usual (TAU) in community clinics in Norway. The participants were children between the ages of 10 and 18, including 79.5% females who randomly received TF-CBT or TAU. The results of the data collected indicated that children who received TF-CBT

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reported significantly reduced levels of PTSS compared to the TAU group. The results on anxiety reduction did not yield any significant differences. Significantly fewer children in the TF-CBT group were diagnosed with PTSD compared to the TAU group. Jensen et al. (2014) found that TF-CBT also successfully reduced other co-occurring symptoms, which confirm previous researchers' findings—this is an important finding, as traumatized children often experience other symptoms apart from PTSS. The authors concluded that implementing TF-CBT was effective in the treatment of traumatized youth in and outside the U.S. where the TF-CBT program was developed. The Jensen et al. (2014) research design included a control group, which is considered the gold standard in quantitative research. A limitation was that more of the TF-CBT therapists held a post-graduate qualification in psychology and received more supervision (due to the TF-CBT training situation) compared to the TAU group. Jensen et al. (2014) concluded that TF-CBT was more effective in treating traumatized children at a community clinic outside the U.S.

James, Solder, & Weatherall (2007) examined 13 studies involving 498 participants with mild-to-moderate anxiety and 311 controls treated with CBT individual, group, and family (or parent) setups. The results showed that 56% of the CBT group were in remission compared to the 28.2% of the controls and that there was no difference in the outcomes of the various therapy setups. The authors concluded that CBT seems like a successful approach in dealing with anxiety disorders and that its effectiveness with children has not been sufficiently researched (James et al., 2007).

Webb et al. (2014) conducted a study regarding the success of TF-CBT in community health clinics. The findings suggested that therapists could maintain treatment fidelity and that the TF-CBT intervention was effective in those settings. In

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contrast with some studies on the efficacy of TF-CBT in school children, the externalization of problems seemed to rebound to some extent over the follow-up of six months. Although the results were not statistically significant, it indicated a relatively poor impact of TF-CBT on externalizing symptoms which could be due to differences in sampling. The authors did not exclude the teenagers' parents from the study, which is in contrast with the study of Cohen, Berliner, and Mannarino (2010) and may therefore be responsible for some of the differences in the therapy outcomes (Webb et al., 2014). Deblinger, Mannarino, Cohen, Runyon, and Steer (2011) suggested that the effect of TF-CBT on behavioral outcomes could be increased by increased focus on parenting skills, longer treatment duration, and follow-up sessions providing more parent support. For the purposes of this study, it is important to note the emphasis placed on parenting and parent support.

Webb et al. (2014) did not use a control group setting, and this limits the study design. The authors justified this as they were comparing TF-CBT results to treatment as usual as well as statewide comparison of TF-CBT. Due to the lack of a control group, the researchers could not make any causal inferences from the collected data. Furthermore, parents could enlist additional therapy concurrent with the TF-CBT. Despite the limitations of the study, the authors concluded that TF-CBT was worthy of its position on the National Registry of Evidence-Based Practices and Programs and the National Child Traumatic Stress Network.

In another follow-up study, six and 12 months post-treatment, Mannarino, Cohen, Deblinger, Runyon, and Steer (2012) found that a number of 4–11-year-old children who participated in the study continued improving after the six-month follow-up on two of the outcome measures. The 158 sexually traumatized children received eight or 16 therapy sessions that either included or excluded trauma narrative



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(TN) treatment. Significant gains were made across all 14 outcomes that were assessed. The authors (Mannarino et al., 2012) provided three therapy components to the children-participants and their parents:

(1) skills-building components to enhance children's affective, behavioral, biological, and cognitive self-regulation and parenting interventions to enhance caregiver coping, behavior management skills, and support of the child; gradual exposure to the child's trauma reminders is included throughout these components; (2) trauma narrative (TN) during which children describe and cognitively process their personal trauma experiences; and (3) treatment closure including conjoint caregiver-child sessions and safety planning. (p. 231)

Unfortunately, some of the participants dropped out of the study, which limited the ability to fully assess the therapy gains at the follow-up measurements. Significant results were achieved in 14 outcome measures and were retained six and twelve months after therapy. Continuing improvement on two aspects was reported by both the children and their parents during the follow-up measurements. In spite of the excellent results achieved through TF-CBT and regardless of whether TN was included in therapy, 11% of children continued to meet all the criteria for PTSD at the final follow-up after 12 months. These children's PTSD status at the 12-month follow-up was predicted based on their self-reported symptoms of depression and their internalizing of behavior problems. A small minority of the children whose pre-treatment results indicated above average internalizing behavior difficulties and above average scores of self-reported depressive symptoms were more likely to meet all the PTSD criteria at the 12-month follow-up.

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Two components continued improving after the therapy was concluded: (a) parental emotional distress and (b) children's self-report of anxiety. The authors argued that parents could experience less stress due to the improvement in their children's mental health. It is possible that the children consolidated the therapy techniques learned in TF-CBT over the 12-month period before the second follow-up, which resulted in increased self-confidence and less anxiety.

As indicated by the studies discussed, TF-CBT is effective in the treatment of traumatized children in a variety of settings and cultures. Webb et al. (2014) asserted that there were more than 22 studies confirming the effectiveness of TF-CBT with traumatized children and teenagers. The therapy outcomes compared to TAU indicate that TF-CBT is significantly more effective in the treatment of traumatized youth. Furthermore, follow-up assessments showed promising results, as the clients not only retained the positive outcomes but also showed gains in specific areas, such as anxiety reduction.

### **CBT in Foster Care**

There are many obstacles in providing therapy to children from foster care that affect outcomes of the therapy (Dorsey et al., 2014). Dorsey et al. (2014) conducted one of the few studies on the inclusion of foster parents in TF-CBT service delivery. The authors supplemented TF-CBT with EBP-strategies (e.g. parent training, problem solving strategies, culturally sensitive engagement) in the foster care situation and studied the impact thereof. The authors studied attendance, engagement as well as TF-CBT therapy outcomes in 47 children and teenagers in foster care. Follow-up assessments were made one and three months post-treatment. Dorsey et al. (2014) found that the combination of TF-CBT and EBP strategies were more beneficial, as the children and their foster parents were more likely to continue attending therapy

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and not drop out prematurely. The EBP-strategies focusing on engagement seem to be promising in retaining the children and foster parents in therapy until the completion of the program.

Dorsey et al. (2014) concluded that short-term evidence-based treatments (EBTs) showed the best potential for success with foster children. Treatment regimens involving the foster parents were found to be particularly successful when treating foster children. The authors found that therapy was often long-term with vague therapy goals and not involving the foster parents; this kind of intervention did not yield good results. Planned foster parent engagement in therapy that aims to provide coping mechanisms to the foster parents of children with mental health needs, and disruptive children, provided good results and substantially less dropouts (Dorsey et al., 2014).

### **Foster Parent Situation**

More children have entered the foster care system over the past few years, leading to concerns that the foster system may be in crisis (Chipungu & Bent-Goodley, 2004; Denby, Rindfleisch, & Bean, 1999; Geiger, Hayes, & Lietz, 2013; Vanderfaeillie, Van Holen, Trogh, & Andries, 2012). Foster parents have faced many challenges over the years. More recently, foster parents face more complex challenges (Ainsworth & Hansen, 2005). Due to the often violent environment foster children have been exposed to, some foster children are presenting with aggression and sexualized behaviors at young ages, while others are delinquent and struggle with emotional disturbance. Many foster children have special learning needs, developmental delays, and disabilities. Finally, more and more foster children are presenting with substance use and addiction as early as in-utero. Another challenge presented to foster parents is the increased demand to interact with the foster child's

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family of origin. Many foster parents feel insecure meeting the families of origin due to fear. Foster children are removed from their home for a number of reasons, such as domestic violence, breaking the law, and others. This potentially explosive situation causes discomfort to foster parents who need to provide a safe and stable home to the children. Brown and Bednar (2006) noted that foster parents were more likely to discontinue fostering when they felt that their own family is in danger.

**Financial and household situation of foster parents.** Historically women have been the main providers for foster children. A challenge the foster system is facing is the increased demand of having two-income households and women entering the workforce (Barber, 2001). With women becoming unavailable, fewer families are able to foster. Financing children's needs is expensive and further complicated by budgetary cuts to the foster care system due to the recent economic downfall (Daly & Perry, 2011). Although the state provides some monetary compensation, it is not sufficient to cover all child support expenses. Should the foster parents be employed outside the home, they are held responsible for the cost of childcare. Taking all these factors into consideration, fostering can easily become a financial burden to foster parents. On average, foster children stay between one to five years with their new families. The highest duration of stay in foster care is between two and three years when more permanent living arrangements are made (Administration for Children and Families, 2015).

**Kinship and non-relative foster care.** Approximately 50% of the more than 400,450 foster children live with nonrelative foster parents (U.S. Department of Health and Human Services, 2013; Geiger, Hayes & Lietz, 2013). On average, there remain around 415,000 children in the foster care system on a daily basis; this number rose sharply in 2014 when 650,000 children had to be accommodated in foster homes

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(Administration for Children and Families 2015; AFCARS Report, 2015). Not all children are placed with nonrelative foster parents. In 2014 29,000 children found accommodation with relatives, 46,000 were placed in nonrelative foster care, 6,000 children went to group homes, and 8,000 were housed in institutions (Child Trends Data Bank, 2015).

**Reasons for foster care and demands on the foster family.** People become foster parents for different intrinsic as well as extrinsic reasons. Burke and Dawson (1987) found that foster parents were commonly motivated by a need to “give back” to the community. Childless couples may become motivated to foster as a means to extend their family. Foster parenting is often complicated due to the interconnection between work and family. However, many foster parents remain motivated for reasons such as wanting to share and use their expertise, skills, and knowledge in caring and parenting, and wanting to become parents and build a family (Schofield et al., 2013). Older foster parents are motivated by the desire to help make a difference in other people’s lives, to accommodate their spouses, aspiring to participate in the development and achievement of younger generations, and the desire to contribute to society and its protection (Metcalf & Sanders, 2012). Individual persons and parents involved in kinship foster care do it because they are concerned for their own flesh and blood, and keeping commitments or promises they made to their relatives about caring for the latter’s children (Hong, Algood, Chiu, & Lee, 2011).

Caring for extra children places a burden on the foster family. Added to that, caring for traumatized children is extremely demanding due to the behavioral and emotional problems associated with PTSD. Although foster parents receive some training in parenting foster children, nobody can truly prepare a family for the real impact that a traumatized foster child will have on the family (Dorsey et al., 2016).

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This includes the parents' concern for their own children since the foster child may need considerable extra care and emotional energy from the parents.

### **Incidence of Maltreatment in Foster Children**

Fraser et al. (2013) noted that Child Protection Services reported 6.2 million cases in 2011 that resulted in 3.4 million referrals. According to Fraser et al. (2013), 48% of the referred children showed signs of emotional or behavioral difficulties and over 30% of the age group birth to three years displayed developmental delays. Yet, only 25% received some sort of intervention. Financially, the foster care situation places a tremendous burden on the public, as it costs the country \$124 billion per annum. The picture painted by Chamberlain in 2014 is even more alarming, as they stated that 15.5 million children in the U.S. were exposed to domestic violence. Even babies under a year old have witnessed domestic violence that consisted of physical or sexual assault (Chamberlain, 2014). The figures for domestic violence exclude emotional or psychological maltreatment and sexual intimidation; there is therefore reason to believe that the reported figures are actually higher.

Dorsey et al. (2014) asserted that more than half of children in foster care experienced some form of trauma and exhibit problems with mental health. This includes neglect and abuse to more than 50% of the children and 85% were reported witnessing violence. More than half of the foster children demonstrated a need for treatment (Dorsey et al., 2014) which is 2–3 times more than the mental health treatment needs of the general population. When left unattended, mental health and behavioral problems may lead to increased rates of disrupted placements and reduced possibilities of being reunited with the biological family (Dorsey et al., 2014; Fraser et al., 2013; Hurlburt, Chamberlain, DeGarmo, Zhang, & Price, 2010). The results of follow-up studies on former foster children who are adults indicated that problems

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with mental health can persist into adulthood (Kolko et al., 2010). Kolko et al. (2010) reported that 24.9% of foster children aged 8–10 suffered from PTSD compared to the 15.7% with PTSD in the 11–15 year group. The authors warned that these rates are much higher than the 4.7% of the general population.

**Maltreatment of children is not limited to the U.S.** The statistics for maltreatment and resultant mental health problems in Europe and Brittan are also high. Leenarts, Diehle, Doreleijers, Jansma, and Lindauer (2013) reported that in a representative sample of the British youth between 18–24 years, 16% indicated that they were exposed to severe maltreatment. Child protection services in the Netherlands reported that 3.4% of their child population was maltreated. The results from studies over the last two decades indicated that maltreatment of children gives rise to a higher prevalence of mental health problems, such as anxiety, PTSD, depression, substance abuse, and suicidal tendencies.

These shocking numbers indicate the dire need of foster children for access to suitable psychological treatment services. As discussed earlier, the failure to attend to the mental health needs of maltreated children most often leads to PTSD, depression, and other related mental health disorders that extend into adulthood. Timely treatment using proven successful treatment protocols is essential to assist this vulnerable group of children.

### **Significance of the Study in the Fields of Psychology and Social Work**

The fact that nearly 50% of children in foster care present with problems diagnosable in the DSM-IV (Lehmann et al., 2013) signifies the extent of the mental health needs of children in foster care. TF-CBT has been found to be very successful in children who experienced trauma (de Arellano et al., 2014; Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012). Few studies focused exclusively on foster

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children and the usefulness of CBT/TF-CBT as intervention strategy. For example, in the Mannarino et al. (2012) study only 12% of the children studied were in foster care and only two of those lived with foster parents. The current research is proposed to focus exclusively on foster children living with foster parents, and it is anticipated that this focus will contribute to the body of knowledge regarding CBT in the foster care population.

Moreover, there is a dearth of literature focusing on the perspectives of foster parents supporting foster children who receive CBT. Gavița, David, Bujoreanu, Tiba, and Ionuțiu, (2012) addressed the needs of foster parents by providing a parent training CBT program to better assist the child in therapy. To my knowledge, there is very limited research available that addressed the perspectives of foster parents supporting foster children during CBT intervention. Exploring the lived experience of foster parents could give psychologists and social workers a deeper understanding of the unique challenges these parents face when supporting foster children undergoing CBT intervention. The outcomes of this research would significantly benefit both psychologists in providing insights regarding the difficulties foster parents face when supporting foster children who receive CBT intervention as well as social workers who assist the foster families to overcome problems while fostering children.

In the following part of the thesis, I discuss the training in which I have participated to provide services to children. I also explore the observations I made during the intervention of two clinical cases to illuminate the central problem of this study, namely the relative lack of foster parent support in the TF-CBT intervention of foster children and how it impacts the success of the therapy.



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## REFLECTIONS ON CLINICAL WORK

Although there is a lot of research indicating that CBT significantly improves the mental health of traumatized children, the foster child subgroup did not receive much exclusive attention. Moreover, given the need for extensive parental or caregiver support in TF-CBT, and the participation of foster parents in TF-CBT have not been researched. Researchers have indicated that TF-CBT shows major promise in treating children who had to cope with ongoing trauma of which foster children form a significant part. The purpose of this section is to observe the impact of CBT/TF-CBT in managing traumatized foster children's mental health problems and assisting them to become less vulnerable—specifically, to observe how the participation (or the lack thereof) of foster parents impacts the outcomes of CBT/TF-CBT and what barriers to participation the parents might experience. More broadly, the observational section of my thesis explores the impact of (foster) parent support and cooperation in the outcomes of CBT/TF-CBT in traumatized children. I use the remainder of my paper to document my own reflections and impressions of these phenomena in my field placement.

I worked as a second-year intern at a mental health clinic where I provided CBT to children in foster care. Since many of the children came from traumatizing backgrounds, I made use of my specialized training in trauma-focused CBT during therapy. I found that the outcomes of CBT+ therapeutic interventions that I provided to the children in my care were somewhat compromised due to the lack of adult cooperation as the children were in foster care.

This may be due to the fact that CBT represents a model that necessitates 100% involvement from parents, which is very difficult to achieve when there are two sets of parents—biological and foster parents—and children live in foster group

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homes. Moreover, children in foster care live under continuous life stress, besides any trauma that they have experienced, which deserves special attention. Foster mothers are often employed or caring for other children, which means that available time to accompany foster children to therapy is limited.

In the reflection on actual clinical work with two children in foster care, it is important to note that the needs of the child dictate the therapeutic approach and in both samples the children needed regular CBT and not TF-CBT. To protect the privacy of the foster children and foster parents, pseudonyms were used.

### **Clinical Example 1: Eve**

The first example I present is that of a foster parent who did not participate in therapy and did not attend therapy regularly. This situation is often experienced at the clinic.

Eve is a five-year-old African American child who lives with an African American foster mother. She seemed shy as the foster mother (FM) had to prompt Eve to respond to questions. Eve has been in her FM's care for all her life—five years—and the FM would like to adopt Eve. Being in foster care for five or more years is not a unique situation in the foster care system. The biological parents have only about 15 months to get their children back, otherwise the child will be adopted either by the foster parents or other adoptive parents and biological parents' rights will be terminated. Even though Eve has been successfully fostered for five years, she can be taken away one day from the foster parents, whom she has grown to love and has strong attachment to, and given to people she does not know, albeit her biological parents.

Eve is the youngest of four foster children and has a healthy relationship with the foster parents; they plan to adopt Eve as soon as the parental rights are terminated.

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Eve shares a bedroom with one older foster child and often goes to the foster parents' bedroom at night because she is scared of the monsters and zombies that the older children talk about before bedtime.

**Biological parents.** Eve has had mandatory supervised visits with her biological parents twice a week since birth. Eve was removed from the biological home soon after her birth due to physical abuse and neglect from the biological parents. The FM described Eve's relationship with the biological parents as strained, and I witnessed some communication between Eve, her FM, and biological mother in the hallway. During the encounter, Eve found comfort by hiding behind the FM when asked to give her biological mother a goodbye hug and said "never," thus refusing to go to the biological mother. The FM stated that Eve appears anxious during visitations and always asks her to never give her up. According to the FM, the biological parents threatened Eve with the police by stating that they will put her in jail if Eve does not behave. These threats resulted in Eve being scared of police presence and she tends to freeze when she sees a police car.

The case manager who supervised the visitations confirmed that the relationship between Eve and her biological parents is not ideal. She described the biological father as aggressively emotional, who focuses his aggression on the FM to whom he curses and screams in front of Eve. The biological father is often not present at the visitations and reportedly has alcohol and drug abuse problems. The fact that Eve's biological parents' rights were not terminated is problematic, as it continues a situation in which Eve is emotionally traumatized by the visits and constant threats that she might have to leave the stable foster care situation to live with emotionally unstable strangers. (Although she has met the biological parents and has had visitations—strained contact—it does not constitute building a true loving

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family relationship to which she could look forward.) Normally, the biological parents have 15 months to regain supervision of their own child. In Eve's case, she has been in foster care for five years without the parental rights being terminated. There could be several reasons why this has happened, such as the biological parents' compliance with the mandatory two-hourly visits twice a week. In such cases, the court grants additional time to the biological parents to turn their situation around. This ruling can have a devastating impact on the child who lives in limbo and fears that she has to leave the foster home to live with relative strangers. In the case of Eve, it has had significant impact on her emotional development.

**Development, school, and social and religious relationships.** Eve seems tall for her age and all her physical and emotional milestones appear to be within normal limits. The FM stated that she goes to a Pre-K class where she has friends and does not display any difficulty to socialize with peers. The FM did not mention any difficulties with learning or school progress. According to the FM, they do attend church, although they are not religious and do not integrate religion in the parenting of the foster children.

**Initial intake.** Eve was referred to the clinic by her case manager six months earlier, and although the FM brought Eve for the initial intake, she did not attend follow-up meetings to complete the intake and commence with therapy, and the case was consequently closed. After six months, the referral was repeated—the FM was late for the appointment and the therapist contacted the FM. The FM explained that she had difficulty attending the scheduled appointment and undertook to bring Eve the following week at the same time. Eve attended the clinic for the intake assessment that was to be completed over a two-week period; a follow-up appointment was therefore made for the following week. The FM missed three consecutive follow-up

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visits, and on the fourth appointment the intake was completed. Two of the scheduled meetings were missed due to the cancellation of a visitation by the biological parents, which takes place in the foster care office building adjacent to the clinic. The biological mother was admitted to a rehabilitation facility due to drug abuse. Upon completing the intake assessment, there were not enough symptoms to give a real diagnosis as both *separation anxiety disorder* and *unspecified anxiety disorder* were ruled out. As the clinician felt that the FM needed support in parenting Eve, Eve was referred for CBT for anxiety.

**Therapy plan.** Below follows the therapy plan for Eve.

*Discharge criteria.* Eve will only be discharged after a self-reported reduction of her nightmares and anxiety. Eve needs to be able to identify and name different feelings—happy, sad, scared, anxious, and silly. Eve needs to be able to control her emotions around police cars using relaxation techniques.

*Therapy modality and rationale.* Eve will receive CBT for anxiety. This will mainly consist of psychoeducation regarding anxiety (a) how to deal with it; (b) FM will receive documentation on how to monitor anxiety levels; (c) FM will learn relaxation techniques and when to use them; (d) clinician will monitor progress and check in with the parent, ensuring that the parent implements the knowledge correctly.

*Therapy goals.*

1. Decrease number of nightmares from 3–4 per week to 1–2.
2. Decreased level of anxiety when around police cars on a scale from 8 to 5.
3. Increase FP's ability to successfully use relaxation techniques during Eve's anxiety episodes.

*Therapy objectives.* Therapy objectives involve close participation with the FP and include the following

1. Foster Parent will learn how to perform relaxation techniques.

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2. Foster Parent will learn how to help Eve to calm down by implementing relaxation techniques before bed time.
3. Foster Parent will learn how to help Eve to talk about her feelings and express them freely.
4. Foster Parent will learn how to validate and normalize Eve's experiences and feelings, so the child does not feel judged or scared to share.
5. Foster Parent will learn how to use the anxiety scale to monitor the progress.

*On the day of the first meeting.* Although appearing shy and a little clingy to the FM, Eve made normal eye contact, was cooperative and displayed a positive attitude toward the guardian. Eve separated from the FM and calmly played with toys showing full affect and using soft but distinct speech. The level of play throughout the session was concrete. After completing the psychosocial assessment, an appointment was made for the first therapy session.

*Problem description.* The FM stated that she needed assistance to lower Eve's anxiety and nightmares that occurred every two / three nights. The FM stated that the fighting with the biological parents made the child nervous, and when Eve sees a police car she panics and freezes up, as biological parents threatened to call the police to take Eve to jail if she does not behave.

**Therapeutic intervention.** Seeing that Eve's diagnosis did not warrant TF-CBT, the regular CBT approach was chosen instead. When asked why she attended the clinic, Eve did not know what the reason for the visit was. The clinician explained what the clinic did and gave information about future sessions with the assigned clinician. The only expression of her feelings that Eve offered was to say: "I get upset when people fight; it makes me feel scared."

Eve was 15 minutes late for her first therapy appointment, and another appointment had to be scheduled as the clinician and another scheduled appointment right after Eve, so it was very brief meeting with the FM and Eve. During the meeting the clinician explained why it was important to have consistency and the

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participation of the FM. The clinician attempted to engage the FM by exploring her feelings and thoughts about the situation—that Eve has to attend therapy regularly, and how the FM deals with the biological parents and her feelings about it.

Eve was almost on time for the next two sessions. The clinician took different measures assessing her depression, anxiety, and trauma levels, but everything came back within the normal range. Eve did not show any symptoms of anxiety and showed healthy attachment to her foster parents, created friendships at school, and has no academic difficulties. At this stage, the clinician could not find any aspect of her life that could be impacted by nightmares.

Seeing that the clinician did not find enough symptoms of anxiety, Eve will not continue to receive CBT, but supportive therapy will be provided instead. The clinician provided supportive therapy, which included empathic listening and normalizing Eve's experiences as a foster child. Eve has not brought up the foster care situation except by stating that she feels scared when she sees the biological mother of another foster child who lives at home with her. She sees her when her foster mother brings all the foster children to the agency for visitations with their biological parents.

**Summary and interpretation.** Eve is a five-year-old, African American female. She appears to be calm and obedient to her FM and shows healthy attachment to her. Eve had some separation anxiety on the first meeting, the FM had to leave the room, but Eve acted within the norm. It is appropriate to be anxious when left alone with the stranger. Eve was removed from her biological home soon after birth due to physical abuse. She has since been placed with one foster family who wants to adopt her. The FM is concerned with the child's nightmares (every two / three nights). The FM stated that fighting with Eve's biological parents makes the child nervous. She

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furthermore panics and freezes up when she sees police cars, as the biological mother threatened to take the child to the police if she does not behave. Eve presented with some separation anxiety—having hard time to separate before bedtime, finding her way back to FM’s bed at night. She would benefit from having supportive therapy instead of CBT to process the feelings she has regarding the situation she is in, a safe space to talk about the current family situation. Eve needs to learn how to identify and express her feelings appropriately. There is also an identified need for the foster parents and biological parents to learn how to appropriately interact and discipline Eve.

*Additional intervention.* The clinician attempted to provide psychotherapy on the telephone by (a) conducting monitoring of Eve’s progress; (b) providing more information to the FM; (c) discussing any questions or concerns of the FM. At this stage, the clinician decided to provide some CBT techniques in addition to supportive therapy. The FM was not very cooperative and forthcoming, leaving the clinician to do all the talking. It is not clear how much these telesessions achieved, as the FM did not apply the monitoring scale and produced vague replies about helping Eve with the relaxation techniques, applying them, and progress in terms of reduction in anxiety and nightmares.

**Conclusion.** In my opinion, Eve does not need CBT for anxiety (as stated in the referral) at this point in her life. She can benefit from supportive therapy and the support from her foster parents, who need to continue providing a safe environment at home and learn how to provide stable daily routines. This was aimed at by the information given to the FM during the therapy sessions; however, it is not clear how much of this information was taken to heart and implemented at home. Moreover,



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Eve needs consistency with her visitations and some sort of conclusion about her future (so does the FM).

The FM wants to adopt Eve and as the termination of parenting rights drag on seemingly indefinitely, she gets despondent and frustrated. Furthermore, she is hesitant to make any decisions about Eve, as she does not know when and if Eve's stay at her house will be terminated. The FM needs some sort of surety and closure about this situation that has been dragging on for years now. Therapeutic intervention for the FM is indicated to facilitate managing and processing her feelings and experiences as Eve's FM.

A concerning thought about financial compensation to the clinic and foster parents when a foster child attends therapy has crossed my mind more than once, as it did in this case. The FM receives financial compensation for attending therapy with a foster child who has psychological problems. This financial compensation may be the main reason in many cases for foster parents bringing children to the clinic with vague complaints. The other concern is that the clinic also receives financial compensation when treating foster children. A more tolerant wait-and-see approach may be followed in cases where there is no definite diagnosis, as the clinic keeps receiving compensation while the child is being seen. It is not my intention to cast suspicion on either foster parents or the clinic; I do, however, feel that the situation should be monitored very closely so that the decision to treat children is based purely on the needs of the child.

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### **Clinical Example 2: Mikki**

The second example I present is that of a foster parent who participates in therapy and attends therapy regularly.

Mikki is a three-year-old African American male who has lived with an African American foster mother since he was four months old. Mikki is the eldest of three biological siblings in the care of the same FM; besides them there is another foster child of two years and two older biological children of the FM. Mikki has a healthy, strong relationship with the FM and the other siblings, especially the eldest daughter, who is 21 years old. Mikki shares a bedroom with his biological brother who is 18 months old, but Mikki often goes to the FM's or the eldest daughter's bedroom at night.

The children enjoy books and spend time reading, and the eldest daughter often takes the younger children to the park to play.

**Milestone development.** Mikki achieved all developmental milestones at the expected age. He is not yet fully toilet trained.

**Family constellation.** The FM, the FM's biological daughters aged 21 years and 12 years; Mikki (three years), Mikki's biological siblings aged 18 months and six months, and another foster child aged two years. There are thus two adults (the FM and the eldest daughter), one teenager, and four foster children under the age of four in the house.

**Daily routines.** The FM runs a daycare facility that Mikki also attends, which results in his always being in close proximity of the FM. At the daycare, Mikki mostly plays with a tablet or phone and displays aggressive behavior when these items are taken away from him. He has a lot of energy and does not sleep while the other daycare children nap; this leaves him tired at 6 pm when he then takes a nap for about

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an hour, whereafter he stays up until around 12 midnight. *Behavior management*—the FM stated that she normally gives in to Mikki's demands to stop the temper tantrums, which in turn may upset the other children in the daycare or at home.

**Biological parents.** Mikki has had mandatory supervised visits with his biological mother twice a week since birth. Mikki was removed from the biological home soon after his birth (four months) due to domestic violence. The FM described Mikki's relationship with the biological mother as fair, as Mikki spends the prescribed weekly four hours' contact with her. There are, however, certain negative aspects regarding the biological mother and the visitations—(a) the biological mother is a drug addict and homeless or attends a shelter; (b) she is often in rehabilitation; (c) visitations are irregular due to the biological mother's life situation; (d) Mikki gets upset when the sessions are cancelled or the biological mother does not show up; (e) the biological mother does not seem to relate well to Mikki by playing with the toys provided by the FM or giving him the prepacked snacks; (f) although some bonding with the biological mother has taken place this does not seem adequate; (g) Mikki displays separation problems when the FM has to leave during the visitations. The biological mother's parenting rights are not terminated.

**Development, school, and social and religious relationships.** Mikki goes to a Pre-K class where he has friends and does not display any difficulty socializing with peers. The FM did not mention any difficulties with learning or school progress. Mikki knows his ABCs, can count beyond 30, can spell his name, and can play on his own or with peers. He likes coloring and gets upset when his crayons are taken away. He displays normal friendly relationships with his siblings and acts in a caring manner towards the younger siblings. According to the FM they used to attend a Baptist

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church, but with the current foster situation it is too difficult to attend church. The FM does not integrate religion in the parenting of the foster children.

**Initial intake.** Mikki seemed to be normally developed for his age and displayed sociable behavior by smiling and playing quietly.

*On the day of the first meeting.* Mikki calmly played with a toy phone that the FM gave him and appeared friendly and relaxed. He smiled when spoken to.

*Problem description.* The FM mother stated that she needed assistance to manage Mikki's temper tantrums and ritualistic behavior. The FM stated that Mikki tends to scream and bang his head when upset. Mikki displays certain ritualistic behaviors; for example, he has to have his shoes and socks ready at his bed and screams when this is not the case. Currently, the FM manages the unwanted behavior by prearranging the desired items (e.g., shoes and socks) so that Mikki would not awake and upset the other children with his screaming.

Upon completing the background information and problem description, the following observations were made:

- *Routine*—no healthy routine was established, as Mikki is allowed to do as he pleases. He goes to bed when he likes, plays with the tablet or phone when he wants to, and gets his way by throwing a temper tantrum.
- *Discipline*—the FM gives in to Mikki's demands and reinforces the temper tantrums by doing so. The FM displays this behavior both at home and during daycare that she runs, as she only desires Mikki to be quiet and not disturb the other children.
- *Family support*—the FM is a single mother and does not have the support of another adult in the home. She takes care of four foster children under the age of four, which places a lot of strain on her. The FM runs a daycare facility, which

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Mikki attends, and this leaves him experiencing the same discipline during daycare and at home. Furthermore, he does not have to separate from the FM to attend school—he does not learn the independence that he would have should he go to an outside daycare facility.

- *Visitations*—the FM has four foster children who have visitations with their biological parents. Although Mikki and his biological siblings represent one visitation, the other foster child has visitations with her biological mother. These visitations are normally taxing, and it can be assumed that the FM experiences pressure due to this. According to the FM, Mikki is usually upset during the visitations and the visitations are often cancelled or not attended by the biological mother. The biological mother is a drug addict and has been in and out of rehabilitation. When not in rehabilitation, she lives in a shelter or experiences homelessness. Non-attendance of the visitations often occur when the biological mother is homeless and cancellations when she is in rehabilitation. Although the FM usually packs toys, coloring books, and snacks for Mikki during the visits they are never get taken out of the bag, which leaves Mikki bored and hungry after the visits. Mikki is very attached to the FM and gets upset when she has to leave during these visits. The clinician has witnessed a temper tantrum by Mikki when he had to attend a visit after a therapy session, as he did not wish to go to the foster care agency in the same building.

Upon completing the intake assessment, Mikki was diagnosed with adjustment difficulties with disturbance of conduct (Axis 1, F 43.24).

**Recommendations for intervention.** The CBT model for behavioral problems or parenting management is indicated for Mikki's situation. This intervention will include (a) clarifying the confusion about the two mothers whom he

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both calls “Mommy”; (b) managing his attachment and separation issues; (c) dealing with the disciplinary issues at home and daycare—the FM tends to rely on “quick-fix” solutions, which mainly consist of giving in to Mikki’s temper tantrums and thus reinforcing the behavior; (d) the issues surrounding non-termination of the biological mother’s parenting rights, which influences the FM’s decisions about extramural activities, such as swimming lessons, as she realizes Mikki might go back to the biological mother where he will be unable to continue with these activities. On a deeper level, this may be influencing her parenting behavior, as she realizes the situation is temporary. The clinician will teach the FM relaxation techniques to help managing temper tantrums.

The psychosocial assessment was completed and the clinician explored the FM’s expectations from therapy. The FM showed interest in participating in therapy. The first therapy session with Mikki was scheduled for the following week.

**Therapy plan.** Below follows the therapy plan for Mikki.

*Discharge criteria.* Mikki needs to express his feelings and emotions in a healthy way—without throwing tantrums, follow the rules, and needs to control his aggression toward his siblings.

*Therapy modality and rationale.* CBT for behavioral problems. The clinician will provide psychoeducation on positive parenting and will support the FM in developing effective strategies and a concrete parenting plan. The clinician will monitor progress and check in with the FP weekly to ensure that the FM is implementing the plan consistently.

*Therapy goals.*

1. The FM will develop and implement effective parenting styles and strategies that will promote improved behavior in the child as rated at least 6 out of 10, where 10 is excellent.

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2. Mikki will decrease his number of temper tantrums during the day from 10 to 5 and increase his ability to follow the rules from never or rarely to most of the time.

*Therapy objectives include the following:*

1. FM will learn about positive parenting by (a) spending special time together, (b) specific praise and rewards, and (c) clear directions.
2. FM will learn how to establish rules and routines, and use effective discipline strategies.
3. FM will enforce rewards and consequences consistently and will monitor the progress in and out of session.
4. Mikki will learn how to recognize different feelings and emotions and how to express them in a healthier way by naming each feeling and verbalizing how he feels during conflict situations.

**Therapeutic intervention.** A short description of the therapeutic interventions will be provided per session attended:

*Therapy session 1.* The clinician provided psychoeducation regarding behavioral problems, normalized, and instilled hope for change. The FM and clinician identified one behavior to concentrate on: outbursts and screaming after not getting his way. The clinician and the FM discussed situations that trigger this behavior and identified which ones could be predicted and those that must be dealt with by reinforcing rules. The clinician provided information about positive parenting and active ignoring as parenting skills: for the following week, the FM will spend an additional 10 minutes with Mikki one-on-one to provide special attention and will not react on undesired behaviors, such as screaming (as long as it is safe for Mikki and other children around him). The clinician asked the FM to think about establishing a stable routine about watching the TV and playing on a tablet. The FM agreed to perform the suggested activities at home.

*Observations.* The FM's expectations regarding therapy were unrealistic, as she believed one session would be sufficient to handle the behavioral problems without her being involved. This was discussed, and the clinician reiterated that a lot

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of work needed to be done at home to manage the behavioral problem. The role of the SWI as guiding and facilitating change but not inducing it was emphasized, and some resistance from the FM could be sensed. The basic CBT model for behavioral problems was followed by providing a parenting management model. The clinician realized that the FM was not ready for this kind of intervention even though she acknowledged that her management of Mikki's behavior was not resolving the issue. This kind of behavior from parents is rather common, as they believe the problem rests with the child and that the therapist will provide a fix to the situation. This behavior is even more prevalent with foster parents who believe that the child's experiences prior to being admitted to foster care are to blame for the behavioral problems. Although previous experiences do play a significant role in the child's behavior, the current home environment, discipline, and routine also influence the child. Specific situations or occurrences at the foster home may also trigger the unwanted behavior. In the case of Mikki's FM, she was led to realize that the unwanted aggressive behavior could be triggered five minutes, 30 minutes or even an hour prior to and after the outburst. This facilitated the understanding that the FM's behavior actually serves to reinforce Mikki's undesired behavior.

*Therapy session 2.* An important aspect of CBT is the homework that must be performed regularly with the support of the parents or foster parents. For this reason, the clinician discussed the homework situation at every session to determine the progress made, if there were any challenges performing it, and how the parent coped. The clinician and parent will subsequently determine a way to manage the homework better to ensure effective implementation thereof.

When discussing the homework situation, the FM stated that she tried to implement everything she had agreed to do during the previous session, but that she



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found it challenging. She explained that her eldest daughter was not ready to deal with Mikki's difficult behavior and did not follow the new rules—not giving into tantrums and acting more firmly. This sabotaged progress. This information led to time being spent discussing everyone at home who has a stake in enforcing the homework and new routines and why this was important. Another avenue that was explored with the FM was what she did to cope when she felt stressed. Since she does not have anyone to rely on, the FM felt that she simply had to “deal with it”; she stated that she was “fine.” Although the clinician attempted to facilitate insight that being stressed is normal and that the FM could find ways to make her feel better, the FM refused to participate.

As part of the session, the FM was asked to play with Mikki to afford the clinician the opportunity to observe the interpersonal dynamic and how the play was happening. Although the clinician went to sit on the floor with Mikki, the FM remained in the chair. The FM told Mikki to bring her the red car and so on, discussed the color and other attributes of the car. Mikki participated by reacting appropriately to the FM's clear instructions and questions. The clinician gently suggested that Mikki should be allowed to choose toys and be in control of the play situation during the quality time with her. The FM was asked to practice this kind of play during her one-on-one time with Mikki.

*Observation.* Although the FM expressed her willingness to participate in therapy, she did not seem to be ready and convinced of the changed routine at home and daycare. Therefore, the eldest daughter's refusal to participate was used as a legitimate excuse, which may also be an indication of the FM's disciplinary behavior with any of the other children—she simply follows the way of least resistance and gives in. During the play situation, it was clear that the FM assumed the role of a

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“teacher” in her interaction with Mikki and did not interact with him at his level by really engaging in the play activity with him. Asking her to let go of her control of the situation may cause an internal reaction, as she may not be used to this, and it may catch her off-guard. It is important that she plays with Mikki on his terms and lets go of controlling every situation so that Mikki starts behaving more emotionally mature.

*Therapy session 3.* Mikki and the FM did not show up for the session. Upon calling the FM, the clinician was told that one of the children was very ill and that the FM had to care for the child and therefore not come for therapy. Although the eldest daughter normally looks after the children when the FM has to leave the home, she did not want to let the eldest daughter take responsibility for the very sick young child and therefore did not keep the appointment. Another session was scheduled for the following week.

*Observation.* It seems that the FM needed more social support so that she can relax and share her concerns with an understanding and supporting peer. This suggestion would be discussed with the FM during the next session. A concern is that the illness of the other child may have been used to avoid another session during which it might come to light that not much happened in terms of homework with Mikki. The clinician will have to approach this situation with tact, as the FM has a lot to deal with and changing behavioral problems is truly taxing. It might be a good idea to visit the foster home, although it should be discussed with the FM first so that she experiences the visit as a true attempt to assist and not checking up on her.

*Additional intervention.* After the FM aborted therapy sessions, the clinician attempted to continue therapy by means of calling the FM when she did not turn up for therapy; although she at first participated in telephone psychotherapy, she stopped taking the clinician’s calls. It seems that the FM has a pattern of giving in when

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standing firmly brings tension—she gave in to her eldest daughter although she knew her parenting style toward Mikki had to change. Her parenting style toward Mikki is also one of giving in to his wishes, although it meant eliciting unwanted behavior. It is my suspicion that she could not deal with having to handle the eldest daughter's negativity about changing the parenting style at home that caused her to stop coming for therapy or trying to change at home. Although the FM was warned that Mikki's behavior would get worse before it gets better, the clinician suspected that dealing with the escalated temper tantrums, the eldest daughter's contempt about the situation, and the fact that the therapy did not clear up all problems after the first couple sessions led to the FM's decision to abort therapy. By continuing the therapy telephonically, the clinician was hoping to provide more information and facilitate more insight into the need of changed parenting. It is sincerely hoped that the FM would decide to attend therapy again so that she and Mikki could be assisted to make the necessary changes.

**Summary and interpretation.** Mikki is a three-year-old African American male who entered foster care at four months of age. He appeared comfortable in the session with his FM, who gave him his phone to play with to occupy his time. Mikki smiled when spoken to and quietly played with the phone. The FM is experiencing difficulty with the Mikki, as she reported that he has anger issues—he throws things when he becomes upset, screams and bangs his head. The FM reported him as meeting the developmental milestones and the only problem is his unsociable behavior when upset. She would like him to be more sociable and able to be involved in social activities with other children without her being present. She believes that he would be able to engage in the therapy session; however, she stated that it might take some time due to his attachment to her. Mikki sees his birth mother for three hours

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once weekly and appears comfortable during their sessions. The FM is concerned about his aggression and anger, his ritualistic behaviors when it comes to his socks and shoes and to having them always by his bed, and his inability to control his temper if his shoes and socks are not readily available when he wakes up in the morning. The FM stated that although she has been able to work around his behavior in terms of ensuring that these items are available to prevent him from waking up the other children with his screams and tantrums, this behavior is unacceptable and she needs assistance in managing it.

**Conclusion.** In my opinion, the FM reinforces Mikki's undesirable behavior by giving in to his tantrums. This way of dealing with challenging situations could be the only way the FM deals with it—she exhibited the same kind of behavior when the eldest daughter did not want to participate in Mikki's homework. Giving in to others can be seen as avoiding the situation or avoiding confrontation, which may be the way the FM “deals with” situations. Given this assumption, it is concerning that the third therapy session was missed and not cancelled (a child fell ill) and that the FM did not attempt to make any alternative arrangements, as it leaves the question of whether not attending the session was truly unavoidable or whether it was part of the FM's tendency to avoid confrontation or challenging situations.

Since the clinician (1) was transferred to another agency, Mikki was transferred to another therapist. It was my opinion as clinician (1) that family therapy was indicated rather than CBT. The reason for this is that the CBT model is demanding and it seems that the FM cannot commit to this amount of time and work with Mikki. Family therapy will address separation issues, but not the behavioral problem, but due to the level of involvement of the FM, the outcomes of family therapy would be more satisfactory to her. When the FM has a better support system

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and emotionally and mentally ready to follow the guidelines of CBT, it is suggested that this route be followed to address Mikki's behavior problems

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## DISCUSSION

CBT has been adapted for the treatment of anxiety disorders in adolescents and children over the age of six years. This psychological treatment can be delivered in various formats: individual, group, and family /parent. Overall I agree with researchers I cited earlier (James, et. Al 2007) that CBT is worthwhile using with this population. Although the outcomes are just a little more than chance, compared to therapy as usual (TAU) CBT delivers positive results after only half the number of sessions needed in TAU.

As explained previously, CBT aims at helping children to identify possible deviations in their thinking patterns, teaching them new skills to manage these deficits, and to replace the old patterns with new more rational ways of thinking (James et al., 2007). In particular, the child learns to identify feelings of anxiousness, thoughts in situations that elicit anxiety, develop ways to handle these situations and associated thoughts, and assess the outcomes. Clearly this technique is not appropriate for children of all ages, as it needs a certain degree of cognitive development—it works best for older children and adolescents. According to James et al. (2007), children under six years are still in the preoperational stage, as described by Piaget. They are egocentric and may not be able to apply decentering methods (stories or descriptions).

In a discussion of CBT in children under 6 years, Paris, DeVoe, Ross, and Acker (2010) suggested using an adaptation of TF-CBT that can be used for very young children who faced trauma, the CBT-SAP (Cohen & Mannarino, 1993, cited in Paris et al. 2010), to treat children of the military who were traumatized by the parent's absence. Although this technique was initially developed to assist young children who were sexually abused and their nonoffending parent, this approach could

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be successfully used in other kinds of trauma with young children and was found to be superior to other therapeutic approaches (Paris et al., 2010). Using CBT techniques—relaxation and exposure techniques—on two children between 3.5–4.5 years, Scheeringa et al. (2007) found that preschoolers benefit from this approach provided that they receive the assistance of their parents. The authors pointed out that the cooperation of the parent is essential to the success of this therapy with young children.

Research studies that compare the outcomes of CBT/TF-CBT in very young children are limited; however, the indications are that this approach delivers excellent results in this age group, provided that there is cooperation and support from the parents. In the case of children in foster care, parental support and cooperation is often the one crucial factor that is missing, leading to failure to help the traumatized young child. It is also the experience of this researcher, as illustrated by the two examples discussed in the previous section.

Of particular interest for the current study is the research of Gavița, et al. (2012), who conducted a study on the “efficacy of a short cognitive–behavioral parent program in the treatment of externalizing behavior disorders in Romanian foster care children” (p. 1290). The researchers found that there was 18% attrition of foster parents of teenagers participating in the study, leaving the number of participants to 79. The CBT parent program aimed at reducing behavior problems of teenager foster children, managing the parent stress levels and dysfunctional parenting. The results indicated that the teenagers’ behaviors were normalized, the foster parents regulated their emotions better, and that the CBT approach was successful with children of this age group. In terms of the current study the children in foster care were very young

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and therefore need close supervision from the foster parents to practice and use the techniques. Unfortunately, the two children discussed in this study did not enjoy such close cooperation from the foster parents, therefore the gains from therapy were minimal.

In a more recent study, de Arellano et al. (2014) explored the successfulness of TF-CBT in children and adolescents by reviewing studies published across 1995–2013. The studies revealed that TF-CBT was successful in reducing the children's behavioral issues and depression symptoms. The authors concluded that TF-CBT was a feasible therapy option in reducing symptoms due to trauma experienced by youths and their nonoffending caregivers. The authors recommended that TF-CBT be covered by health plans and that more research in various settings is needed. Covering TF-CBT in health plans would be an excellent solution for those children and parents in need of this intervention but who cannot afford it.

In the same year, Jensen et al. (2014) performed a study on the effectiveness of TF-CBT compared with conventional therapy in Norway. What makes this study relevant to the present study is the comparison of TF-CBT with therapy as usual. The 156 participants were children and teenagers with an age range of 10–18 years. The results indicated that TF-CBT was successful in dealing with traumatized youth in mental health clinics, but unfortunately due to the differences in the diagnosis of the children assigned to the two groups, there were no significant differences found between the two modes of therapy. It is my experience that TF-CBT is very successful in traumatized children. Given the short duration of therapy needed to achieve the set outcomes it increases the possibility of the program being completed.

Fraser et al. (2013) focused their research of TF-CBT on children aged 0–14 years in a range of parental care including foster care, making this study of particular



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interest to the current research. The authors conducted a review of research studies to compare the results of different treatment protocols—medication, parent mediated intervention, and TF-CBT. Seventeen studies were eligible for inclusion, and unfortunately no conclusive findings were made, prompting the researchers to call for more rigorous studies to determine the effectiveness of the different therapeutic approaches. The review of the studies on TF-CBT indicated that this approach was more successful in the reduction of the child's symptoms than conventional psychotherapy. Moreover TF-CBT was also superior in addressing child and parent depression and positively impacting the parent-child relationship. I agree that this approach seems promising in dealing with this population.

The study findings of the discussed research indicate that CBT/TF-CBT provides excellent results in a variety of settings with traumatized children and adolescents. Studies that report on very young children under the age of five are still lacking; however, the indications are that with stable parental support, these young children can learn to apply the techniques. Adaptations of CBT to include storytelling and narrative also rendered good results in reducing anxiety. Further research is needed to explore alternative versions of this therapeutic approach to provide much needed help to vulnerable young children in foster care. The next section provides a conclusion and some suggestions for further research.

## CONCLUSION

In reviewing the literature for this study, the researcher could not find many references to the foster care situation in relation to CBT/CBT+. Of concern here is the unique situation that the foster child has to deal with—having two sets of parents, each with its own demands on the child. This gap in literature needs to be addressed by further research, of which this study could be one of the first.

Foster children go through a double trauma—first, the traumatizing situation and experiences that cause their removal from their biological home and second, the trauma of being removed and placed with strangers. This traumatic experience greatly impacts their ability to form attachments, their future attachment styles, and relationships. Foster children exhibit a fear for the future due to the experiences they had to go through, which include the foster situation as well. To be able to manage the foster situation, foster parents are trained not to get attached to the foster children in their care, as they could be removed at some stage. However, foster children do not have the same training or expectation and get attached to their foster parents. When they are consequently bounced from one home to the other, or reunited with their parents and taken away again, their trust in adults and ability to form relationships is seriously impacted. In such cases, the child has suffered multiple traumas and needs special care. Such children may then have more than one diagnosis—which is often the case—and the CBT clinician has to diagnostically determine which of the issues should be addressed first in therapy. This may also necessitate the inclusion of other professionals to address the needs of these children in a more holistic manner.

Foster parents require significant support emotionally and in terms of managing the children in their care as traumatized children; those who have been

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traumatizer over a prolonged period and more than once demand a lot of skill and support from the foster parent. Caring for traumatized children is not an easy task, and foster parents usually do not have only one foster child in their care. As in the two examples discussed in this research, the foster parents may have their own children as well as more than one foster child, each with their own needs and demands. By fostering children, these parents serve society in a unique manner—one that cannot be translated into monetary terms. The funding that foster parents receive for this selfless service is truly far too little and may lead to the foster parent needing money for daily sustenance of the children. One way that the foster parent could receive more financial support is to take the child to a mental health clinic as the additional burden gets recognized and the foster parent becomes eligible for more financial support. This unfortunate situation puts the foster child in a worse situation, and he/she now has to deal with the stigma of a mental health diagnosis on top of the previous and ongoing trauma.

The severity of the foster child's attachment issues necessitates additional training for the CBT clinician to manage this need of foster children. Furthermore, clinicians need a different set of skills to deal with the impact of having two sets of parents and how to incorporate both sets of parents in therapy provided to the children. Lastly, I identified the need to provide therapy in different environments, for example telephonically. Clinicians should receive additional training in providing therapy in alternative settings, for example at home, as this would enable the therapist to continue with therapy when the foster parents are unable or unwilling to bring the child to the agency for therapy. Unfortunately in the clinical situation where I worked, therapists were not allowed to make home visits. It is also the case that the foster parents could easily feel as if the therapist is checking up on them and this

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would break the trust relationship between the therapist and foster parent. Should home visits be possible and become necessary the therapist will have to work with the foster parent to ensure that these visits are welcomed and fruitful.

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