Relationally focused specialized foster care

-Relational experiences and changes in mental health and adaptive functioning

Anna-Karin E. Åkerman
Relationally focused specialized foster care
- Relational experiences and changes in mental health and adaptive functioning

Anna-Karin E. Åkerman
Det var nånting dom aldrig nämnde
Jag frågade aldrig var han var
Man bara hoppas man är älskad
Och att han inte hade vår adress idag

Du kanske ville komma över då och snacka
Du kanske borde sagt nåt, vad vet jag
Jag släppte ändå aldrig någonsin in nån
Du hade kanske ändå inte vår adress idag

Hurula, Min adress, 2022

NEBRASKA VÄLLINGBY
- alla törrs inte bli amerikanska massmördare

Inte rymde jag
Inte sa jag emot
Inte pratade jag för högt
Inte smällde jag i deras dörr
Inte stack jag kniven i hennes bröst
Inte sköt jag honom med hans gevär

Jag bara väntade väntade väntade
Inuti mig & här

Men jag undrade en del:

Varför är jag fel?
Blir aldrig hel

Bodil Malmsten, ur Padden och branden, 1987
Abstract

**Background:** Foster care is a relatively common arrangement when parents are unable to meet the needs of their children. Specialized foster care is sometimes applied in cases when problems are more serious and complex. More knowledge is needed about the effects of such specialized foster care.

**Aims:** To explore trajectories of change associated with specialized foster care in a treatment model with a relational and mentalization-based orientation, and to develop the understanding of foster children’s and their foster parents’ experiences of their relationship living in a treatment foster family.

**Methods:** Children and young people between the ages of 5 and 20 years who received treatment within a specialized foster care model, Treatment By Foster care (TBF), participated in this study. Longitudinal data collected in a naturalistic setting were analyzed quantitatively. In Studies 1 and 2, the number of participants at baseline varied for different instruments between 76 – 105. The Achenbach System of Empirically Based Assessment (ASEBA) was used to measure how psychiatric symptoms change from the perspectives of the foster children, the foster parents, and teachers. The Adaptive Behavior Assessment System – second edition (ABAS-II) was used to measure adaptive functioning from the foster parents’ perspective. Self-ratings by the children and young people of their emotional and social problems were measured with the Beck Youth Inventories of Emotional and Social Impairment (BYI). Data about experiences of the relationship between child and foster parent were collected through repeated individual short interviews/speeches with both children and their foster parents according to Five Minute Speech Sample (FMSS) (n = 14). Interviews/speeches were analyzed using Thematic Analysis (TA).

**Results:** The ratings of foster parents and foster children differed. The analyses showed a significant reduction in psychiatric symptoms, emotional and social problems according to the self-ratings by the children and young people. According to foster parents and teachers, psychiatric symptoms did not decrease. The baseline ratings of adaptive functioning by foster parents showed that adaptive functioning was considerably below peers from the Swedish non-clinical norm group. Adaptive functioning did improve but not enough to approach or catch up with peers.

Analysis of the interviews/speeches generated three main themes containing seven subthemes. Main themes were: No ‘real’ family, A co-created relationship, and Time. Participants related to a norm for what a ‘real’ family is and seemed to presuppose that the biological family is the ‘real’ family. A co-created relationship related to No ‘real’ family as an answer or a solution. The challenges in the foster family constellation could be overcome by a mutual ambition to build a relationship and by liking each other. Time appeared as a common theme and both as an opportunity and a threat to the rela-
tionship. Despite the fact that no interview question concerned the duration of the relationship, the participants described their relationship based on how long they had known each other.

**Conclusions:** According to the foster children’s and young people’s self-ratings, their mental health improved, and their social problems decreased. It is likely that the TBF-model contributed to this improved psychological well-being, although causal relationships could not be established without any comparison group. However, the model did not seem to contribute to the foster parents experiencing improvement in the foster children’s psychological well-being or adaptive functioning.

Based on the results of this thesis, it may be effective to place children and young people in specialized foster care with a relational and mentalization-oriented focus, but the results are not clear-cut. Practice and policies should take greater account of the time aspect in foster care, and work with the aim of increasing clarity and security, and thereby enabling a more stable upbringing for some of society’s most vulnerable children. Also, this may make foster parents want to continue their mission.

More studies are needed to gain knowledge about how specialized foster care should be applied. Future studies also need to focus on creating knowledge about which aspects of the treatment are decisive.

Keywords: foster care; specialized foster care; intervention; outcome; mentalizing; relational; mixed methods

---

**Svensk sammanfattning**

Familjehemsnödförhållanden är vanliga åtgärder när föräldrar inte kan tillgodose sina barns behov. Specialiserad, mycket förstärkt familjehemsvård används ibland i de fall då problemen är mer allvarliga och komplexa. Det behövs mer kunskap om effekterna av sådana insatser.

Syftet med denna avhandling har varit att utforska förändringsbanor förknippade med mycket förstärkt familjehemsvård in en relationsinriktad och mentalisering-baserad behandlingsmodell, och att utveckla förståelsen för familjehemspöklade barns och deras familjehemföräldrars upplevelser av sin relation i en behandlingsfamilj.


Utifrån resultaten av denna avhandling kan det vara verkningsfullt att placera barn och ungdomar i mycket förstärkt familjehems vård med en relations- och mentaliseringbaserad inriktning, men resultaten är inte entydiga. Praxis och poliser bör ta större hänsyn till tidsaspekten vid familjehemsplaceringar och arbeta för att öka tydlighet och trygghet, och därigenom möjliggöra en stabilare uppväxt för några av samhällets mest utsatta barn. Detta kan också få familjehemsföräldrar att vilja fortsätta sitt uppdrag.

Fler studier behövs för att få kunskap om hur insatser och behandling i familjehems vård bör tillämpas. Framtida studier behöver också fokusera på att skapa kunskap om vilka aspekter av behandlingen som är avgörande.
List of papers
This thesis is based on the following papers:


Abbreviations

ABC  The Attachment and Biobehavioral Catch-up
AMBIT  Adaptive Mentalization-Based Integrative Treatment
ABAS-II  The Adaptive Behavior Assessment System – second edition
ASEBA  The Achenbach System of Empirically Based Assessment
BUS  Becks Ungdomsskalor (Swedish version of BYI)
BYI  Becks’ Youth Inventories
CBCL  Child Behavior Check List
EAS  Emotional Availability Scales
EE  Expressed Emotions
FMSS  Five Minute Speech Sample
ICDP  International Child Developmental Program
KEEP  Keeping Foster Parents Trained and Supported
MTFC  Multidimensional Treatment Foster Care
PBE  Practice Based Evidence
PMT  Parent Management Training
PRF  Parental Reflective Functioning
PRO  Practice Oriented Research
RCT  Randomized Controlled Trial
RF  Reflective Functioning
RFP  the Reflective Fostering Programme
TA  Thematic Analysis
TBF  Treatment By Foster care
TFC  Treatment Foster Care
TFCO  Treatment Foster Care Oregon
TRF  Teachers Report Form
YSR  Youth Self Report
**Table of Contents**

**Foreword** ........................................................................................................... 1

**Introduction** ........................................................................................................ 3
  Foster care .............................................................................................................. 3
  Foster care research findings .................................................................................. 5
  Models of interventions in foster care .................................................................... 7
  The Treatment By Foster care-model ....................................................................... 9
    The International Child Development Program .................................................... 11
    Mentalizing .......................................................................................................... 12
  Differences and similarities .................................................................................... 14

**Methods** ............................................................................................................... 17
  Participants ............................................................................................................. 17
  Data collection ....................................................................................................... 18
  Instruments ............................................................................................................ 19
    The Achenbach System of Empirically Based Assessment .................................... 19
    The Adaptive Behavior Assessment System – second edition ............................ 20
    Beck Youth Inventories of Emotional and Social Impairment ............................. 21
    Five Minutes Speech Sample .............................................................................. 22
    Ethical considerations .......................................................................................... 23

**Aims of the thesis** .................................................................................................. 25

**Summary of the included studies** ......................................................................... 27

Paper I: Effects of mentalization-based interventions on mental health of youths in foster care ................................................................. 27
  Methods .................................................................................................................. 27
  Results ..................................................................................................................... 27
  Discussion ................................................................................................................ 27

Paper II: What changes during specialized foster care? A study on adaptive functioning and emotional and social problems ........ 28
  Methods .................................................................................................................. 28
  Results ..................................................................................................................... 29
  Discussion ................................................................................................................ 29

Paper III: Experiences in the relationship between foster children and foster parents in specialized foster care ...................... 30
  Methods .................................................................................................................. 30
  Results ..................................................................................................................... 31
  Discussion ................................................................................................................ 31

**General discussion** ................................................................................................ 33
  Discussion of findings ............................................................................................. 33
Discussion of methods ................................................................. 35
Strengths and limitations ............................................................. 37
Implications for practice and policy .......................................... 39
Implications for the Treatment By Foster care-model ............... 40
Future studies ............................................................................. 40
Conclusions .............................................................................. 41
Contributions ............................................................................ 43
Acknowledgements .................................................................... 45
References .................................................................................. 47
Foreword

In my work as a psychologist and psychotherapist, I have met many children, young people and parents who have had contact with the social services, many of them in foster care or in residential care. The context has been different depending on where I have been employed (at social authorities, at Statens institutionsstyrelse [The Swedish National Board of Institutional Care] or in child- and adolescent psychiatry). However, I often found the interventions to be insufficient and sometimes misguided, despite good intentions. My experiences raised many questions about how to help when the needs are greatest.

The work with this thesis began when I worked as a psychologist in the Treatment By Foster care-model (TBF), the model studied in this thesis. The experience of having worked in the model myself and being part of the treatment team has been significant. It also made it possible to gain access to existing data (Studies 1 and 2) and to carry out the data collection in Study 3. Having met many foster children, young people, foster families, biological parents, school staff as well as social workers has been very important in the work with this thesis.
Introduction

The focus of this thesis is to explore trajectories of change in specialized foster care in a treatment model with a relational and mentalization-based orientation, and to develop the understanding of foster children’s and their foster parents’ experiences of their relationship in this context. In this introduction, a background about foster care in Sweden is given. An overview of previous research in the field and some different models for interventions in foster care are presented. The model studied in the thesis is described and compared with other models. The purpose is to provide a background and context to the included studies.

Foster care

Moving children and young people from their parents to community care is a relatively common intervention within the social services and it has been so for a long time. Looked-after children and young people form a heterogeneous group, but common to the vast majority are experiences of neglect and/or abuse. In a formal sense, there are differences between children who are placed ‘voluntarily’ according to Socialtjänstlagen (SoL) [The Social Services Act] (SFS 2001:453, kap.6), and children who are forcibly taken into care according to Lagen med särskilda bestämmelser om Vård av Unga (LVU) [Swedish Care of Young Persons (Special Provision) Act] (SFS 1990:52), either because the young person her/himself behaves in a way that makes compulsory care necessary or because the parents are not able to take care of the child adequately.

According to the most recently published statistics, about 26 200 children were in foster care or in residential care in Sweden at some time point in 2021 (Socialstyrelsen, 2022a). The number of children and young people in foster care was 18 700, making it the most common form of placement. A majority of these placements were made on a voluntary basis (66%). In comparison to other countries in the Western world, Sweden has relatively few children and young people in foster care or residential care (Gilbert et al., 2011). The trend in recent years is that the number of children in care is decreasing in Sweden, but the open interventions within social services have not increased either (Socialstyrelsen, 2022a).

Foster care in foster families is usually preferred over residential care, in Sweden as in many other countries (Höjer, 2019; Socialstyrelsen, 2022a; Washington et al., 2018). Studies have shown that young people in foster care have a more positive development than young people in residential care (Gutterswijk et al., 2020; Li et al., 2019; Strijbosch et al., 2015). Children in long-term foster care develop more positively in terms of psychological well-being, but also describe the experience of foster care more positively than those placed in residential care (Li et al., 2019). Partly, this can be explained by the fact that the young people who are placed in residential care generally have more serious behavioral problems (antisocial and criminal life) than those who are placed in foster care. Therefore, the groups are not completely comparable. However,
residential care may even cause harm to young people when they are placed in a group with others who also have serious problems and thus risk being exposed to both negative peer influences and repression from staff (De Valk et al., 2016). Another motive for preferring foster care over residential care is that living in a family is considered normalizing and less stigmatizing. Arguably, especially regarding infants and children, living in a family better corresponds to what children need for their psychological development (Dozier et al., 2012).

Perceptions and ideas about the concept ‘family’ affect child welfare. A family service-oriented model has guided social childcare in Sweden and the Nordic countries for decades (Andersson & Sallnäs, 2019; Gilbert, 1997). This perspective implies that children’s upbringing is seen as a matter for both family and society. Non-compulsory interventions and cooperation between families in need of support and the social services is preferred over compulsory interventions. A family service-oriented perspective also implies the overall goal that children in foster care are supposed to return to their biological parents, if and whenever possible (Andersson & Sallnäs, 2019). Other countries, such as the UK and the USA, have historically had a child protective- oriented approach (Andersson & Sallnäs, 2019; Gilbert et al., 2011). A child protective-oriented model implies that society should only intervene when a child is in danger and needs to be protected from its parents. Support for vulnerable or dysfunctional families is not seen as a primary task for the social authorities. A child protective-oriented approach also implies that, in most cases, parents are seen as ‘good-enough’ and that the social authorities should not interfere with the family’s internal affairs.

In recent years, these contrasting orientations have approached each other and been mixed in various ways. A newer and alternative approach called a child-focused orientation has been developed (Gilbert et al., 2011). A child-focused orientation emphasizes the child as an individual. This becomes particularly important when the child’s interests differ from those of the parents. A child-focused orientation focuses on the child’s overall development and well-being, in addition to child protection. The child’s positive development can be seen as a social investment, where childhood is a preparation for adulthood that will pay off by producing productive adults later. It also means that the child’s right sometimes becomes stronger than parents’ rights. In Sweden, a child-focused orientation can be noticed, for example, in the fact that Sweden has made the UN Convention on the Rights of the Child (CRC) law since 2020 (SFS 2018:1197). Upsetting events when society has broken down in its care and protection of children, such as in the tragic case of Lilla Hjärtat (Little Heart), when a three-year old girl died after being moved from foster care to her biological family, have also sparked debate and led to amendment of the law; Lex little heart. In July 2022 Lex little heart led to new regulations in SoL (SFS 2001:453) and LVU (SFS 1990:52) concerning the best interests of the child when care according to LVU ends (Socialstyrelsen, 2022b). These regulations mean a stronger child-orientation, for example by making it mandatory to consider if it should be prohibited to move the child to its biological family when foster
care ends, and to follow up the child’s situation when foster care according to LVU ends and the child has moved back to its biological family.

Foster care research findings

Although society’s ambition with placing children and young people in foster families is to give them protection and good care so that they can develop like their peers, research shows that merely moving the child to a new family is insufficient. A large number of studies have shown that children who grow up in foster care have poorer psychological development and more behavioral and emotional problems than children living with their biological families (e. g. Burns et al., 2004; Egelund & Lausten, 2009; Engler et al., 2020; Heflinger et al., 2000; Lehmann et al., 2013; Leslie et al., 2004; Leslie et al., 2010; Pears & Fisher, 2005; Pecora et al., 2009). Goemans et al. (2015) found no change in psychiatric symptoms or in adaptive functioning in a meta-analysis of longitudinal studies of children in foster care. In a prospective observational study, Teyhan et al. (2018) found that adults who had experienced being in foster care had increased risk of adverse psychological and social outcomes in adulthood, such as weak support from social network, internalizing symptoms, addiction and criminality.

Swedish research in the foster care field has in registry- and cohort studies examined e.g. school performance, psychiatric health and drug use in young adults who have been placed in longtime foster care. These studies have shown a multifold increased risk of suicide attempts or serious psychiatric problems, serious criminality, not being able to support oneself and addiction (Berlin et al., 2011; von Borczyskowski et al., 2013; Vinnerljung et al., 2006). Poor school performance has been shown to be a major risk factor in this population (Berlin et al., 2011). Another registry study found that adults who had been in foster care had shorter education and weaker attachment to the labor market (Österberg et al., 2016).

Qualitative studies have, for example, focused on children’s and young people’s experiences of foster care, parents’ experiences of having their child in foster care or foster parents experiences of being foster parents (e. g. Andersson, 2016; Christiansen et al., 2013; Höjer, 2009; Ie, 2022; Join-Lambert & Reimer, 2022). Other qualitative studies aim to deepen the understanding of processes in foster families and in the context of foster care (e. g. Rostill-Brookes et al., 2011; Sprecher et al., 2022; Wissø et al., 2019). As the number of qualitative studies has become large, reviews and research overviews have also been made of qualitative studies in recent years. One meta-study showed how foster children emphasized relational aspects, both regarding contact with social workers and with foster parents (McTavish et al., 2022). To the children, relationships and connections to people, pets, places and personal belongings emerged as important and should be taken into account in assessments and care planning. Also, foster children reflected on power and how adults had used or not used their power to help them, or to be oppressive.
Experiences of the relationships in the foster family is another recurring theme in research (e.g. Ahmed et al., 2015; Andersson, 2009; Christiansen et al., 2013; Ellingsen et al., 2011; Nelson & Colaner, 2020; Storer et al., 2014). The relationship between the foster child and the foster parents seems to be a factor that most significantly affects the outcome of foster care (Cooley et al., 2015; Cooley et al., 2021; Rayburn et al., 2018). A positive relationship from the young person’s perspective has been related to better outcomes in terms of less symptoms (Cooley et al., 2015). Warmth, security and commitment in the relationship have been shown to lead to less internalizing and externalizing symptoms, but not to less trauma symptoms (Rayburn et al., 2018). However, research about experiences of the relationship between the child or young person and their foster parents in specialized foster care is scarce.

Foster parents’ perspectives and experiences of being foster parents have also been a recurring topic in research. One reason for this is that there is a shortage of foster families, both in Sweden and in other countries, and therefore the retention of foster families is considered important. Foster parents’ need for communication with social workers as well as for support and training has emerged in various studies (Leffler & Ahn, 2022). That foster parents feel listened to and that their needs are taken into account can reduce the risk of breakdowns. It is also important to understand various motives for becoming foster parent in order to understand processes in foster families and how to retain foster parents (Andersson, 2001). One can imagine several motives for becoming a foster parent. Some persons may have altruistic reasons, wanting to make a contribution to society or to help neglected children, perhaps based on the foster parents’ own difficult experiences growing up. For others, becoming a foster parent can be a way to earn a living instead of, or as a complement to, having a job outside the home. Or, it can be a way to have children if you cannot have biological children or if the biological children have grown up and moved away from home. It can be a way to work at home which can be combined with, for example, farming (Andersson, 2001). For most families, it is probably a combination of different motives that make them decide to become foster parents.

A problem in foster care is that a large number of placements end unplanned and prematurely, i.e., break down. This phenomenon has been noticed in both quantitative and qualitative research (Harkin & Houston, 2016; Rock et al., 2015; Rostill-Brookes et al., 2011; Vinnerljung et al., 2017). About 25 – 35% of placements end in breakdown both in Sweden and in other countries (Olsson et al., 2012; Sallnäs et al., 2004; van Rooij et al., 2015; Vinnerljung et al., 2017). Placement instability is a serious problem as it contributes to foster children’s suffering. Foster children and young people who have already experienced neglect and abuse and therefore are in great need of protection and security, are instead exposed to an even more insecure and unpredictable life. Several different factors can contribute to breakdown, such as poor planning and handling of the social services, foster families that do not have sufficient resources to
take care of children with problems, and behavior problems of the foster child or young person.

In summary, research shows that children and young people who are placed in foster care, usually due to neglect and/or trauma, are at risk of developing worse psychologically, socially, financially, and medically than their peers. It seems to be difficult to achieve sufficiently safe, stable living conditions that also compensate for the consequences of previous neglect and/or trauma. In addition, the situation can worsen for foster children and young people through repeated break-ups and relocations. The relationship between foster children and foster parents is important for the outcome of foster care.

Risholm Mothander and Broberg (2015) have specified the specific measures that must be taken in cases of serious neglect: it requires a particularly well-functioning foster family, long-term planning, a supportive organization for the foster family to lean on, specifically adapted training and supervision and that the foster family is allowed to focus on the child’s well-being and not be burdened with demands for extensive cooperation with biological parents. However, Risholm Mothanders and Brobergs conclusions specifically relate to young children in foster care and not older children and young people. Providing more training, support and guidance for the foster parents as well as treatment interventions aimed at foster children and young people can be a way to both achieve fewer breakdowns and more stable placements but also enable positive development and reduced suffering for a very vulnerable group of children and young people (Forslund et al., 2022).

Models of interventions in foster care

There are many different models of interventions in foster care (Bergström et al., 2018; Luke et al., 2014; Powell et al., 2013; Schoemaker et al., 2020; Webster-Stratton, 2001). These models vary in theoretical bases, in scope and in intensity. Some models are based on behavioral and social learning theories, while others are based on attachment theory or mentalization theory. Some models are also based on a combination of these theories. Scope in terms of intensity, content and duration also varies considerably between models. Few of these models or interventions have been systematically evaluated. Despite the fact that many children and young people in foster care are adolescents, relatively few models have been developed for them (Bishop-Fitzpatrick et al., 2015). Foster care models that are more extensive, containing both interventions directly aimed at the foster child or adolescent and continuous interventions for the foster parents such as training, support and supervision can be termed specialized foster care. Usually, the foster child is surrounded by a treatment team that includes the foster parents. Specialized foster care has a more clearly stated treatment goal in addition to care for the foster child. These models may also include interventions in school or directed to the biological network. The aims of the various models are similar, namely, to create safety and conditions for positive development for children or young people with
particularly severe problems and circumstances of life. In Sweden, various interventions are used but few of these have been evaluated (Swedish Agency for Health Technology Assessment and Assessment of Social Services, 2017).

Treatment Foster Care (TFC) is an umbrella term for several models of specialized or agency developed foster care. Theoretically, TFC is based on social learning theory and behaviorism. TFC is based on four basic principles: the foster parents are the primary change agents, the foster parents are the ones who implement interventions, advanced training and support is available for the foster parents, and the role of agency staff is as consultants (Bishop-Fitzpatrick et al., 2015). Treatment Foster Care Oregon (TFCO) is probably the most studied and most internationally established model of TFC, and in addition the most studied of all models of foster care (Bishop-Fitzpatrick et al., 2015; Åström et al., 2020). TFCO has been developed from Multidimensional Treatment Foster Care (MTFC) and is a manualized program intended for young people with antisocial and/or criminal behavior (Chamberlain & Mihalic, 1998; Buchanan et al., 2017). In Sweden and internationally, TFCO has been highlighted as a resource-saving and better alternative to residential care (Gutterswijk et al., 2020; Bergström et al., 2018). TFCO has shown some evidence in reducing risk of future criminal behavior but less evidence of reducing mental health problems like depression (Åström et al., 2020).

KEEP (Keeping Foster Parents Trained and Supported) is another model that has been developed from MTFC (Price et al., 2009). Originally, KEEP is a foster parent training program for foster parents of children aged 5–11 years. The program is based on the principles of Parent Management Training (PMT), e.g. to increase parental behaviors aimed at positive reinforcement and avoid inconsistent parenting (Mabe et al., 2001).

Specialized foster care models that focus on sensitive parenting and the interaction between foster parent and foster child, instead of directly focusing on behavioral change in the parents and foster child, can be described as relationally focused. Relationally is used here as an umbrella term to denote relationship-focused models. The theoretical bases for these models are usually attachment theory, mentalization theory and/or theories of interaction. Mentalizing is defined as both an implicit and explicit understanding of human behavior based on internal mental states, i.e. thoughts, feelings and intentions (Bateman & Fonagy, 2016). I will return to the concept of mentalizing later in this thesis. Mentalization theory is closely linked with and based on attachment theory (Allen, 2018). From an attachment perspective, Ainsworth et al. (1978) identified four factors as necessary for a child to experience its family as a secure base: sensitivity, availability, acceptance, and cooperation. These criteria have been developed further by Schofield and Beek (2006) who also added a fifth criterion for foster families: family membership. This criterion refers to the importance of the child both feeling included in the foster family and also being helped to feel belonging to two families.

The relational model that has the strongest support in research is the Attachment and Biobehavioral Catch-up (ABC) intervention, created by Mary Dozier (Dozier et al., 2006; Dozier et al., 2018). RCTs of the ABC intervention have shown that it
promotes more secure and organized attachment and better affect regulation than a non-attachment-based intervention (Dozier et al., 2018). The ABC focuses on promoting foster parents to provide nurturance to children when they are distressed, and to follow the child’s lead when not distressed. However, this intervention is created for infants and toddlers, ages 0 - 4 years. There are no adaptations for older children or young people. Attachment-based models that are aimed at supporting older children and young people are less common, at least models that have been evaluated in research (Kerr & Cossar, 2014). Connect is a parent training program based on attachment theory that focuses on foster parents who take care of children in the middle childhood or young people (Moretti & Obsuth, 2009). Originally, Connect was created for parents of acting-out adolescents with serious behavior problems. In Sweden, Connect has been adapted to and is used in foster care (Humana, 2023).

Two other models that are relationally focused are Family Minds and the Reflective Fostering Programme (RFP) (Adkins et al., 2018; Redfern et al., 2018). Both models are mentalization based foster parent training programs. Family Minds aims at promoting a positive relationship between foster parent and foster child by supporting and developing Parental Reflective Functioning (PRF). PRF refers both to the caregivers capacity to reflect on their own mental state (self-mentalizing) and their child’s mental state (mentalizing the child) (Redfern et al., 2018). Higher PRF is associated with both attachment security and better mentalizing ability in children (Camoriano, 2017). The training in Family Minds contains psychoeducation and training distributed on three occasions over 4 - 6 weeks. The RFP, like Family Minds, aims to improve foster parents’ PRF, in order to improve the relationship between foster parent and foster child to reduce the risk of placement breakdown and improve the child’s wellbeing (Redfern et al., 2018). The RFP is an adaption of the Reflective Parenting Model (Cooper & Redfern, 2015). The adaption is intended for foster parents of children between 4 - 11 years of age, who experience some difficulties in relation to their child. The RFP is more extensive than Family Minds and contains a total of 30 hours of training in small groups spread over 4 - 6 months. The content is similar to Family Minds and consists of both psychoeducation, exercises and homework (Redfern et al., 2018). Two pilot studies have shown that the RFP may reduce foster carer stress and child difficulties rated by foster parents (Midgley et al., 2019; Midgley et al., 2021). However, these programs do not include supervision or support over a longer period of time or direct interventions to treat or support the foster child or the child’s biological family.

The Treatment By Foster care-model

Based on existing models for interventions in foster care, there seem to be a lack of models that are aimed at helping children and young people with serious, complex problems, that also have a relational focus and includes support and treatment that lasts over a longer period of time. Treatment By Foster care (TBF) is a model for spe-
cialized foster care that incorporates this. Through increased support for the foster families (referred to as treatment families in the model), the aim is to create a secure and supportive environment that can contribute to the development of the children and young people in care.

Early emotional neglect such as strongly rejecting, intrusive or controlling, hostile, or frightening behavior by caregivers can produce insecure attachment (Riggs, 2010; Van IJzendoorn, 1995). Insecure attachment is associated with impaired affect regulation, may give rise to negative images of self and others, and lead to poorer coping strategies, disrupted social functioning and reduced capacity for close relationships, as well as contribute to poorer mental health (Riggs, 2010). Hence, a foster family must offer a secure base for the child or young person (Schofield & Beek, 2006). The TBF-model takes the above into account and aims to make the foster family a secure base to which the child feels a sense of belonging. The TBF-model has no specified target group but is often used to treat older children and young people and very rarely children under the age of five.

The TBF-model is relationship-oriented and mentalization-based. The treatment is organized with a treatment team around each child consisting of the foster parent (treatment parent), a treatment coordinator and a child psychologist. The foster parent is full-time employed in the model, as part of creating a secure and stable context for the foster child. This is to promote the opportunity to new experiences of being taken care of and, if possible, offer a new attachment relationship. The role of the treatment coordinator is to coordinate all interventions around the child, to support and guide the foster parent in everyday life and maintain contacts such as with the child’s biological network, social services, and school. The child’s contact with the biological network is planned individually, based on what the social authorities have decided. In the case of voluntary placements, this is planned in cooperation with the biological parents. However, the TBF-model does not generally include treatment interventions directly aimed at the biological family.

The psychologist in the team is directed towards the child or young person and is responsible for the psychotherapeutic work and psychological assessments, but also to contribute with in-depth psychological knowledge. As part of the treatment, all foster children and young people who are in need of psychotherapy must also be offered psychotherapy. The psychotherapies are individually adapted but psychodynamic oriented, mainly mentalization-based. Most common is individual psychotherapy, but in some cases psychotherapies are conducted in constellations with the foster parent/s, adapted to the child’s needs and what is feasible. Some of the young people in care attend mentalization-based group therapy.

An important feature of the TBF-model is that the model also contains several different routines and structures. This applies to routines for regular meetings with the social authorities and school staff, but also routines regarding internal and external su-
pervision and staff meetings. The guidance given to the foster parents takes place regularly and partly individually, partly in groups with other foster parents. Furthermore, there are also routines for the treatment, such as psychotherapeutic interventions and recurring assessments. The assumption is that the routines should have a stabilizing and containing function.

Theoretically, the treatment model is based on attachment theory, mentalization theory and a relational-oriented approach. This means focusing on sensitive parenting and parental reflection. The guidance and training given to the treatment parents is based on mentalizing and the International Child Development Program (ICDP) (Hundeide, 2001; Bergman & Edenhammar, 2008). A basic idea is that we are shaped largely by meetings with people in our environment and the possibility of change lies in new meetings and relationships. All treatment coordinators and psychologists get training in mentalization-based therapy (MBT) (Bateman & Fonagy, 2016). Through seminars about mentalization, the foster parents in turn get education about mentalization by the treatment coordinators and psychologists. In addition, foster parents and all professionals in the team are trained in ICDP. ICDP has similarities with mentalization-based practice since both approaches assume that the interaction and relationship between the caregiver and the child are of great importance to the child’s development. The objective of the ICDP training is to help participants to develop their capacity for self-observation and self-evaluation, promote empathy to become more sensitive to others and become more aware of their attitudes toward others. As a result of the training, the participants should be more confident in their role as foster parents and more aware of their own influence on the foster child’s development (Hundeide & Armstrong, 2011).

The International Child Development Program

The International Child Development Program (ICDP) has been developed by Karsten Hundeide and Henning Rye (Hundeide, 2001; Hundeide & Rye, 2010). ICDP is a community based program whose aim is to promote parent or adult sensitivity in people who are responsible for the care of children (Bergman & Edenhammar, 2008; Hundeide & Rye, 2010). It is a non-instructive and relationally oriented program, also described as an approach, not a method (Sherr et al., 2014).

ICDP can be applied in many different interpersonal contexts such as preschools, schools and child health care. The target group is parents, teachers or other caregivers. The program has a broad theoretical base in both an emotional and cognitive perspective but attachment theory and developmental psychology are fundamental. Another important principle and goal is to realize the humanistic ambitions expressed in the UN Convention on the Rights of the Child (Hundeide & Armstrong, 2011). ICDP has been implemented in different cultures and in at least 35 countries (Sherr et al., 2014). The program is summarized in three dialogues: the emotional dialogue, the comprehension dialogue and the regulative dialogue (Sherr et al., 2014). Within each dialogue there are guidelines that are practical operationalizations of the dialogue. The
emotional dialogue aims at promoting emotional sensitivity through encouraging the caregiver to 1) show loving feelings, 2) follow the child’s lead, 3) have a positive personal dialogue with the child and 4) praise and acknowledge the child. The comprehension dialogue aims at making meaning to the outside world by 5) helping the child to focus attention, 6) giving meaning and enthusiasm to the child’s experiences and 7) expanding and enriching the child’s experiences. The regulative dialogue focuses on helping the child to achieve self-regulating skills. This is operationalized through 8) planning step-by-step, providing customized support, the creating of routines and setting boundaries in a positive way by guiding the child.

There are a few studies of the effects of ICDP, most of them carried out in low-income countries in Africa or South America (Isaeva & Volkova, 2016; Sherr et al., 2014; Skar et al., 2019; Skar et al., 2021). In comparison with a non-attending comparison group, non-clinical care givers attending ICDP showed more positive development in child management and less impact of child difficulties (Sherr et al., 2014). Another study showed that ICDP reduced family violence more than a comparison group that received social activities (Skar et al., 2021).

ICDP has also been adapted and used in foster care but, to my knowledge, no outcome studies on this adaption have been published yet. However, it is a reasonable assumption that ICDP can support and develop caregiving for children who have experienced neglect or are traumatized (Hundeide & Armstrong, 2011). In the TBF-model, the ICDP training is arranged in groups with other foster parents but also other TBF professionals. The training lasts for two semesters and is both theoretical and practical, using active participating and empowering strategies. The exercises and homework that are used aim to help the participants to get in touch with the participants’ own feelings regarding their upbringing but also regarding parenting, and to share this with others in the group. Homework that is used is, for example, choosing a children’s book you like and presenting the book and why you chose it in the group. Another task is to film yourself together with a child when you do an activity together and then show this to the group, who then reflects on the interaction together.

Mentalizing

Inner states are opaque, and often complicated and multifaceted, which means that imagination is required to be able to understand oneself and others. To mentalize implies an ‘act of imagination’ because it implies trying to imagine how others, or the individual itself, experience and feel (Fonagy & Bateman, 2019, p.3). Thus, mentalizing can be seen as a central component underlying human interaction. Mentalizing is to be considered as a process that varies based on situation and relationship, but at the same time also as a trait-like capacity of the individual (Möller, 2018).

The development of the ability to mentalize occurs in the young child in interaction with its parents or other caregivers and is thus not an innate ability. However, mentalizing develops through interaction between genes and environment (Kovács et
Research on various aspects of mentalizing shows that the parent’s mentalizing capacity predicts attachment security in the child (Fonagy et al., 2018). In ordinary cases under common conditions, mentalization ability and secure attachment develop simultaneously, entwined (Fonagy & Bateman, 2019).

As previously mentioned, mentalizing can be a theoretical and practical base also in foster care. Research has been focused on foster parents’ attachment organization and mentalizing skills, as these factors are likely to be significant for the quality of the relationship between the foster child and the foster parent, which in turn can be decisive for the young person’s development (Allen, 2018; Jacobsen et al., 2015). There seem to be at least three reasons which motivates mentalizing focused work in foster care:

1. Children and young people who have experienced various forms and degrees of neglect and relational traumas are at great risk of not being able to develop a stable mentalizing capacity, which is why foster parents in particular need to have the capacity to help them develop their mentalizing capacity (Allen & Fonagy, 2006; Sharp & Rossouw, 2019).

2. To mentalize implies to be able to hold, regulate and experience one’s own and others’ emotions without shutting down or becoming overwhelmed (Slade, 2005). To parent a foster child or young person who has been traumatized may involve living in an emotional ‘force field’ that is exhausting even for people who usually have a stable capacity to mentalize. To support and develop the foster parents’ mentalizing capacity, their PRF, may help them to endure and manage the emotional strain that it can entail taking care of a neglected child (Cooper & Redfern, 2015; Midgley et al., 2021; Redfern et al., 2018).

3. The capacity to mentalize seems to be central when it comes to being able to process trauma, and among children and young people in foster care there are an overrepresentation of experiences of abuse and relational traumas (Allen, 2018). The relationship between trauma and maladaptive development should be understood as the absence of resilience instead of a vulnerability, i.e. as the consequence of a state of deficiency as in cases of neglect (Luyten & Fonagy, 2019).

A relevant and related concept to mentalizing is epistemic trust. Epistemic trust is defined as trust in the authenticity of interpersonally transmitted knowledge (Sperber et al., 2010). The human social environment, societies and cultures, have for a long time evolved towards becoming more and more complex. At the same time, information about culture cannot be inherited biologically. Learning about the culture, about customs
and social norms, must therefore take place in a developmental context in close relationships with caring people who can be trusted (Bo et al., 2017). From this perspective, attachment figures also become important for the child’s socialization and integration into society (Fonagy et al., 2015). Secure and trusting relationships open up an ‘epistemic super-highway’ of learning opportunities which reduces the natural epistemic vigilance, developed to deal with potential misinformation from others. The consequences of a ‘closed epistemic super-highway’ for social learning is that the child is prevented from learning about the culture and the interpersonal world as well as from making use of valuable feedback on its own actions and its own person. Social and relevant information may not be accepted, which in turn leads to difficulties in adapting to society.

It is not unusual for conflicts to arise around children or young people in foster care, and this is even more evident in specialized foster care. These conflicts can stem from the placement itself, which can take place under duress and thus against the will of the biological parents and/or the will of the young person. In addition, the effects of neglect and relational trauma may give rise to tension and epistemic mistrust which may result in conflicts among professionals and other involved actors, including social services, foster families, schools, and foster care agencies (Fonagy & Campbell, 2017; Redfern et al., 2018). A model for working to promote epistemic trust in such networks of involved professionals and clients has been developed: Adaptive Mentalization-Based Integrative Treatment (AMBIT) (Bevington & Fuggle, 2019). To address the often good but conflicting intentions of different professionals or clients is important. Mentalizing focused work can facilitate the understanding of these conflicts and strengthen the awareness and importance of different perspectives and intentions. This, in turn, can lead to more manageable conflicts and reduce the risk of destructive acting-out, even among professionals.

**Differences and similarities**

The TBF-model has both similarities and distinguishing features compared to other models or interventions in foster care. In similarity with Family Minds and the RFP, the TBF-model is mentalization-oriented but not as sharply focused on mentalizing. TBF has a broader theoretical and methodological base, which can be a strength in that it may provide more flexibility in interventions but a weakness in that it may lose focus. Also, the TBF-model has a more ambitious content both in terms of scope and intensity of interventions as well as in the routines of the model. The target group is also different; TBF focuses on children and young people who have particularly high needs for care and treatment when ordinary, community-based foster care is not assessed as sufficient by the social authorities.

In its structure, on the other hand, the TBF-model is more similar to TFCO. In both models, foster parents (treatment parents) are seen as professional members of the treatment team that exists around each foster child or young person. Interventions are aimed both at supporting foster parents but also in direct work with the foster child or
young person, as well as collaboration with school or other contexts around the young person. Furthermore, the extensive interventions are given over a longer period of time although TBF is not time limited. However, the content of the interventions and focus differs between TBF and TFCO. One important difference is that the goal of TFCO is for the young person to move back to its biological family, while in TBF it is not an obvious goal that the child should move back to its biological family. TFCO also includes treatment interventions directed to the biological family, which the TBF-model does not.

In summary, since many children in foster care also need psychological treatment, various interventions are needed to meet the needs of different children. To achieve this and to prevent placement breakdowns, support and training are also needed for the foster families. We need to know more about whether efforts in the form of interventions in foster care settings help foster children and young people to improve their wellbeing and to develop positively. In addition, the relationship between the foster child and the foster parent affects the outcome of foster care. Knowledge about the significance of the relationship between foster child and foster parent within specialized foster care is insufficient. We do not know how or if this relationship is affected by the fact that the family is a treatment family and thus also constitutes a professional context. The overall aim of this thesis is to explore trajectories of change associated with specialized foster care in a treatment model with a relational and mentalization-based orientation, and to develop understanding of foster children’s and their foster parents’ experiences of their relationship living in a treatment foster family.
Methods

Participants

Participants in this project were children and young people (5–20 years old) in foster care who received treatment within Treatment By Foster care (TBF). All live or have lived in TBF foster families in Sweden. The participants were children and young people with serious problems and complex life situations. The social service has, for various reasons, assessed that ordinary, community-based foster care is insufficient as it does not correspond to the young person’s needs. The participants form a heterogeneous group, but what they all have in common is that before foster care they have, with few exceptions, experienced serious neglect, some of them traumas, and separations and ruptures of important relationships. Many of the participants have difficulties and complicated life circumstances of a dignity that have led to breakdowns in previous placements. This has entailed a series of separations from parents and other caregivers, and also break-ups from peers, teachers and other important relationships. Unstable school circumstances have been the rule rather than the exception.

Common problems in participants’ biological families were severe psychiatric problems, dysfunctional family relationships, addiction, criminality, and poverty. Some had experienced physical and sexual abuse. Many of the participants themselves had symptoms of emotional problems, behavioral problems, and neuropsychiatric diagnoses. Common occurring psychiatric diagnoses were for example post-traumatic stress disorder, attachment disorders, conduct disorders, attention disorders, autism spectrum disorder, and intellectual disabilities.

The number of participating foster children and young people varies between different instruments and between different times (see Table 1). At baseline, the number of participants was 105 in Study 1, but at T2 the number had dropped to 60 for Child Behavior Check List (CBCL), 37 for Teacher Report Form (TRF) and 41 for Youth Self-Report (YSR) (Achenbach & Rescola, 2001). In Study 2, the number of participants at baseline was 89 regarding the Beck Youth Inventories (BYI) (Beck et al., 2001) and 76 regarding the Adaptive Behavior Assessment System (ABAS) (Harrison & Oakland, 2003). Also in Study 2, data attrition was large. As data were partly collected during the same time period, participants in Study 1 and Study 2 overlap to some extent (44 of 101 in Study 2, i.e. 44%). In Study 3, 7 foster children and young people and 7 foster parents participated.
Table 1.
Number of participants in Study 1 and Study 2. Instruments and measuring points.

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Baseline n</th>
<th>12 mth n</th>
<th>18 mth n</th>
<th>24 mth n</th>
<th>36 mth n</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASEBA:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBCL</td>
<td>105</td>
<td>60</td>
<td>44</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>TRF</td>
<td>85</td>
<td>37</td>
<td>32</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>YSR</td>
<td>79</td>
<td>41</td>
<td>27</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>BYI</td>
<td>89</td>
<td>61</td>
<td>35</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>ABAS</td>
<td>76</td>
<td>70</td>
<td>45</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

The foster parents were also participants in this project. All of them were employed full-time as foster parents within TBF. Their experiences as foster parents varied greatly, ranging from many years of experience in taking care of a large number of foster children and young people, to little experience as foster parent. In most cases, the foster parent had a partner who was also involved in the commitment, in some cases both were employed as foster parents, but in other cases the foster parent was a single foster parent. Beyond the training provided within the TBF-model, the level of education also varied, but was generally modest. Many of the families lived in the countryside, having farms with various animals, but some lived in an urban environment. Some families had biological children living at home, while others had grown up children living on their own.

All of the foster parents had been assessed as suitable for the task as foster parent before the assignment within TBF. These assessments may have been carried out in slightly different ways but were made according to practice within Swedish social services. In such an assessment, psychological suitability as well as social resources and financial stability is assessed.

Data collection
In the TBF-model, data is collected for each foster child as a quality assurance, both for the individual foster child and for the TBF organization. This is a way to follow the child’s development. Studies 1 and 2 were using longitudinal data collected in this routine. Every six months, data were collected using ASEBA (Achenbach & Rescosta, 2001), which was collected by the child’s treatment manager. Every twelve months, a follow-up assessment was done by psychologist. The instruments used in Study 1 were ASEBA and in Study 2 ABAS-II (Harrison & Oakland, 2003, Swedish version by Tideman, 2008) and BYI (Beck et al., 2001, Swedish version Becks Ungdomsskalor, BUS; Tideman, 2004). The ASEBA and ABAS-II rating instruments were filled out
either at the homes of the foster families or at the TBF offices. The teachers filled in their ratings individually, usually in the school. BYI ratings were filled out at the TBF offices, as part of the assessment done by the psychologist. Efforts were made to find missing data afterwards, and some data could then be added.

With the aim to capture central aspects of the treatment within TBF and measure important and effective mechanisms in a complex treatment process over time, another and more extensive data collection was carried out between 2018 and 2022. The main questions of this project is: how do qualities of the relationship between foster child and foster parent affect the foster children’s and young peoples’ development? How do emotional qualities of the relationship and the ability to reflect on one’s own and the other’s affective reactions as in Reflective Functioning (RF) relate to foster children’s and young peoples’ development? Data have been collected with the aim to study these competences both in the foster child and in the foster parent. In addition to the rating instruments, the foster children and foster parents were given playful tasks to solve by working together, and these interactions were videotaped. Also, short interviews/speech samples about their relationship were collected and recorded. Data were collected from both children and their foster parents. This study has a longitudinal within-group design, where each individual and each dyad are studied on three occasions, T1 – T3, with 6 months between data collections. Data collected in this larger project will, hopefully, be processed and analyzed in the future, but this lies outside the scope of this thesis. Study 3 used interview/speech sample data from this data collection.

**Instruments**

**The Achenbach System of Empirically Based Assessment**

The Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescola, 2001) was used as outcome measure in Study 1. ASEBA has been used in many countries and in various clinical settings for measuring child psychiatric symptoms. The instrument has been developed over several decades and has been translated into many languages, one of which is Swedish. The instrument consists of three separate instruments: Child Behavior Checklist (CBCL) for parents’ ratings (ages 6 - 18 years), Youth Self-Report (YSR) for adolescents’ self-ratings (ages 11 - 18 years) and Teacher Report Form (TRF) for teachers or school staff. ASEBA is a standardized instrument that consists of a problem scale and a less extensive competence scale. In Study 1, only the problem scale was used. The problem scale contains 112 or 113 questions for both the youth, parents, and teachers. For every question, the rater is asked to rate on a three-point scale: 0 = not true, 1 = somewhat true, and 2 = very true or often true. The questions are combined into eight subscales, which in turn are combined into the two broad-band dimensions Internalizing and Externalizing problems. The Internalizing dimension consists of the following sub-scales: Withdrawn, Somatic Complaints and Anxious/Depressed. The Externalizing dimension consists of the two sub-scales Delinquent Behavior and Aggressive Behavior. Total problems are constructed by the
dimensions Internalizing and Externalizing problems and adds the subscales Social Problems, Thought Problems and Attention Problems.

Studies have shown that ASEBA has good validity and reliability (Achenbach & Rescorla, 2001). Through research and feedback, a long series of studies have provided support for good content validity of ASEBA. The problem scales of ASEBA discriminate well between referred and non-referred children and the results have provided a basis for clinical cut-off points. Construct validity is supported by, for example, predictions of long-term outcome. Reliability has also been studied in many different ways, and among other things has shown very high test-retest reliability for most scales. Cross-cultural studies have shown that correlations between parents and teachers are modest and that parents rate more problems than teachers (Rescorla et al., 2014). Adolescents tend to rate more problems than parents. This applies to all types of problems in normal populations (Rescorla et al., 2013).

The Adaptive Behavior Assessment System – second edition

The Adaptive Behavior Assessment System – second edition (ABAS-II; Harrison & Oakland, 2003, Swedish version by Tideman, 2008) is a rating instrument available in two versions, a parent form and a teacher form. The versions are similar, but some subscales differ. In study 2, the ABAS parent form was used as one of two outcome measures. ABAS has been standardized and adapted to Swedish conditions by Tideman (2008), for ages 5 - 21.

According to ABAS, adaptive behavior is defined as the repertoire of competencies that every individual needs to possess to meet the demands and expectations of other people in their surrounding environment. Adaptive functioning refers to the individual’s independent display of behaviors associated with taking care of themselves and relating to others with social responsibility, that is, what the individual carries out by her/himself and initiates her/himself. The definition of adaptive functioning that is used and operationalized in ABAS has relevance in most cultures (Oakland et al., 2013). However, there is no universal definition (Price et al., 2018).

The instrument contains 185 items in nine subscales: communication, community use, functional academics, home living, health and security, leisure, self-care, self-direction and social skills. The subscales contribute to one of the three domains: Conceptual (subscales: communication, functional academics, self-direction), Social (subscales: leisure skills, social skills) and Practical (subscales: community use, home living, health and safety, self-care). The domain scores are used to obtain the summary value, the total score, called General Adaptive Composite (GAC). The frequency of an observed behavior is rated on a four-point Likert scale: not able = 0, never/almost never = 1, sometimes = 2, always/almost always = 3. Good adaptive functioning is indicated by high scores. Raw scores are transformed into a norm-referenced scaled score ranging between 1 and 19, with a mean of 10 (SD = 3) for each subscale. The domain scores and
total skills (GAC) can be transformed into an index score with a mean of 100 (SD = 15).

ABAS is one of the most widely used measures of adaptive functioning and has been considered useful in various clinical settings (Lindblad et al., 2013; Tideman, 2008; Price et al., 2018). The validity and reliability of ABAS have been shown to be good (Harrison & Oakland, 2003; Richardson & Burns, 2005; Tideman, 2008). ABAS correlates with other instruments intended to measure adaptive functioning and has also been shown to discriminate between children of different ages, meaning that each subscale score increases as age increases (Harrison & Oakland, 2003; McDonald et al., 2016). Sensitivity and specificity for clinical populations have been shown to be good (Community-University Partnership for the Study of Children, Youth, and Families, 2011). The internal consistency reliability is high for both composites and subscales (Community-University Partnership for the Study of Children, Youth, and Families, 2011; Harrison & Oakland, 2003; McDonald et al., 2016).

**Beck Youth Inventories of Emotional and Social Impairment**

The Beck Youth Inventories of Emotional and Social Impairment is a well-established self-rating instrument measuring emotional and social problems (BYI; Beck et al., 2001). BYI was constructed to be used in different clinical contexts and can be used to evaluate treatment interventions. BYI has been adjusted and standardized in Sweden and the Swedish version of BYI (Becks Ungdomsskalor; BUS) was used as outcome measure in study 2 (Tideman, 2004). In the Swedish version, norm data are available divided on gender for ages 9 - 18 years.

BYI consists of five subscales, i.e. inventories, that measure emotional and social problems: anxiety, depression, anger, disruptive behavior and self-concept. Each inventory contains 20 statements. The child or adolescent answers each statement by marking how well the individual thinks the statement is true for her/himself by choosing one of the following options: never = 0, sometimes = 1, often = 2 or always = 3. High scores indicate more severe problems (self-concept has a reversed scale).

In studies, both BYI and BUS have shown satisfactory reliability (Beck et al., 2001; Tideman, 2004). Conceptually, BYI is based on the cognitive theory of psychopathology (Beck et al., 2001). BYI has good convergent validity which has been shown in studies of how the BYI correlates with other established instruments (Steer et al., 2005). Satisfactory empirical validity provides support for using BYI in contexts where clinical assessments need to be carried out (Runyon et al., 2009).
Five Minutes Speech Sample

Study 3 is using data from short interviews/speeches according to Five Minute Speech Sample (FMSS) (Magaña et al., 1986; Midgley et al., 2017). The main purpose of collecting FMSS-data was to rate RF but in Study 3, a sample of FMSS-data were qualitatively analyzed with Thematic Analysis (TA) (Braun & Clarke, 2006).

FMSS has been developed and mostly used for assessing caregivers’ expressed emotion (EE) regarding a relative with mental illness in adult psychiatry. However, the method has been increasingly employed for studying parent and child relationships (Midgley et al., 2017; Sher-Censor, 2015). The FMSS procedure has mainly been used with adults, but there are some studies in which the method has been used with children in adapted versions (Marshall et al., 1990; Przeworski et al., 2012; Yelland & Daley, 2009). FMSS data is associated with and have usually been analyzed with the EE coding system, but other coding systems have been developed and used in research (Sher-Censor, 2015).

In this study, both parties of the dyad provided a short, maximum five-minutes, description of the relationship to the other based on four open questions (Magaña et al., 1986; Midgley et al., 2017). The questions are related to how the interviewee perceives her/his relationship to the other in the dyad. In order to surprise defense mechanisms and get in touch with emotions the questions are directly formulated. Both the foster child and the foster parent, each separately, answered the following questions:

1. How is your foster parent/child (name)?
2. How do you feel about your foster parent/child (name)?
   2b. How can it be that you feel that way?
3. How do you think your foster parent/child (name) feels about you?
   3b. How can it be that (name) feels that way?
4. Briefly describe a difficult situation that you and your foster parent/child (name) experienced recently. How did you feel, and how do you think (name) felt at that time?

The speeches by the foster parents followed the procedure of FMSS, which means that they recorded their answers to the questions as a speech sample on their own. This procedure was chosen to facilitate for the foster parents to speak as freely as possible. The children, no matter the age, were interviewed with the same questions by a TBF professional whom the child was familiar with as it was considered too difficult for the children to answer the questions without the support of an interviewer. Also, some of the children were not able to read good enough. With the ambition to create a situation in which the children could express themselves as freely as possible, the interviewer was not a part of the child’s treatment team. Sher-Censor (2015) has suggested that children need aiding probes when FMSS data is collected. As a rule, those who conducted the interviews adhered to the intended questions, however, they sometimes
chose to ask in-depth follow-up questions to the child if they considered it necessary. Thus, not every interview followed exactly the same framework. Some speeches were recorded on video while other speeches were recorded as an audio file. The same procedure with the same questions was repeated on three occasions, 6 months apart.

**Ethical considerations**

Ethical approval for Studies 1 and 2 was obtained from the Central Ethical Review Board in Sweden 2016-10-31 (application number 23-2016). This research project concerns a very vulnerable group in society, as it concerns children and young people who have experienced neglect, separations and trauma, and who are in society’s care. Some special ethical considerations have therefore been made:

Studies 1 and 2 used data that were collected as a routine practice of the TBF-model. Since the treatment was not presented to the clients as a research project but as a foster care placement and treatment intervention, consent to use data in research was not obtained from the outset. The research project was planned several years after the data was collected. Although this may be seen to be in conflict with research ethical practice, this exception can be justified by the significant improvements in society within, for example, social services and for vulnerable groups that can be envisioned. There are also societal risks with not doing this kind of research (Kalman & Lövgren, 2012).

The research subjects (children and young people placed in specialized foster care) belong to a group in society whose situation and needs are rarely made visible in research. This is (partly) due to their unstable living conditions and the fact that their biological network often has its own difficulties. This means that they do not take part in information about, for example, participating in research or do not respond to such requests. Many of them may have a distrust of society and thus also of research. Subsequently obtaining consent from the biological parents and the young people to participate in the study was judged to be very difficult because many of the participants were no longer in TBF treatment. The children and young people may be living under insecure conditions and therefore be extra difficult to get in touch with. Given these conditions, data loss would likely have been too extensive. Still, research is necessary to improve foster care treatment. The research value was judged to be sufficiently large and the risk to the individuals’ integrity as sufficiently small in this context, which motivated us to go ahead despite lack of informed consent. However, this entails an extra responsibility for the researcher and considerations when publishing results.

Ethical approval for Study 3 was obtained from the Regional Ethical Review Board in Linköping 2017-06-13 (application number 2017/115-31). Special ethical considerations were also made for this study: The foster children and young people needed protection by getting help to make decisions about participation in research so that they did not consent to something they could not assess the consequences of, or consent even though they did not really want to participate. The children and young people were given
both verbal and written information about the study and what participation would entail for them. The information was individually adapted based on age and maturity. The foster children and young persons were given the opportunity to ask questions and were given time to consider their decision. The information was given by TBF treatment coordinators together with the foster parent. Informed consent was also obtained from biological parents and the social authorities. However, informed but only passive consent was obtained from some of the biological parents. It applied to cases where the parent had only sporadic or no contact with their child or with the TBF staff; parents with very unstable lives, living in circumstances that would have made it difficult to obtain informed and active consent as in most cases. If we had not applied passive consent, there would have been a great risk that the foster children who had the most difficult life circumstances would have been excluded, which we wanted to avoid. In cases where TBF professionals judged that there was a risk that the request to participate in the study could actualize conflicts with biological parents of such a nature that it could harm the foster child’s treatment, the foster child was excluded from the study and was not asked about participation. However, this only came to pass in a few isolated cases. The treatment has not been affected in any way for those who refused to participate.

The foster parent received their own information sheet and gave consent separately, for their own participation. Since the foster parent has an employment relationship in relation to the company where the study was conducted, we have also considered it important that the foster parent’s participation was voluntary. No individual participant in the study is recognizable in the reports of results. Quantitative results have been reported statistically and at group level. Nor should it be possible to recognize any individual participant, child, young person or adult, in the qualitative study. Name, gender and other details have been changed or removed.
Aims of the thesis

The overall aim of this thesis is to explore trajectories of change associated with specialized foster care in a treatment model with a relational and mentalization-based orientation. The purpose was to study how psychiatric symptoms, adaptive skills, emotional and social problems, and self-image of foster children and young people changed during the foster care treatment. The hypothesis was that wellbeing would increase and that there would be a positive development in the sense of reduced symptoms, and emotional and social problems, improved self-image and improved adaptive functioning. Longitudinal data that was collected as a routine of the TBF-model were analyzed (Studies 1 and 2). In addition, new data was collected with the aim to provide increased knowledge of experiences of living in a foster family in such context, with focus on the relationship between the foster child and the foster parent from both perspectives (Study 3).
Summary of included studies

Paper I
Effects of mentalization-based interventions on mental health of youths in foster care

This exploratory study was conducted in a naturalistic setting consisting of a specialized foster care model with a relational and mentalization-based orientation; the TBF-model. The purpose was to conduct an outcome study regarding how psychiatric symptoms of foster children and young people changed during foster care treatment. Internalizing/emotional problems, externalizing/behavioral problems and total problems that also include social problems, thinking and attention problems were examined from the foster children’s, foster parents’ and teacher’s perspective. The hypothesis was that child psychiatric symptoms would decrease over time.

Methods

The study used data collected as a routine in the TBF-model. All children and young people in treatment between 2008 and 2016 were included, a total of 105 individuals (n = 105). At baseline, participants were between 5 and 18 years of age and the mean age was 13.27 years (median 14 years, SD = 3.08 years). Gender distribution was 49% girls (n = 51) and 51% boys (n = 54). The study used a longitudinal design, using data from assessments that were carried out every 6 months with ASEBA.

Results

The foster children’s and young people’s self-ratings confirmed the hypothesis about symptom reduction; foster parents’ and teachers’ ratings did not. Within-group analyses showed a significant reduction in psychiatric symptoms according to the young people themselves. The improvements in internalizing, externalizing and total problems were significant from 18 months in treatment. Total problems decreased, showing small to medium effect at 18 months (d = .45) and continued to decrease approaching large effect on total problems at 24 months (d = .72). The effect was largest on internalizing symptoms (d = .82 at 24 months). Self-ratings and ratings by foster parents correlated significantly and positively. Teachers’ ratings showed fewer significant correlations than foster parents’ ratings and self-ratings. However, symptoms rated by the foster parents or teachers did not show significant change. A tendency for girls to improve (but not boys) according to teachers and foster parents was found. No effects of age were found when comparing children in a younger and an older group.

Discussion

From the young people’s perspective, their mental health improved substantially but not from the foster parents’ or teacher’s perspective. Internalizing problems improved the most. The young person’s self-ratings of their own well-being should be given great importance, given that especially considering internalizing problems it is only the young person her/himself that could know how she/he is feeling.
Different informants have different perspectives and may have limited agreement in their ratings, as have been shown in other studies (Achenbach et al., 1987; Handwerk et al., 1999; Ladakos, 2000). From foster parents’ as well as teachers’ perspectives, symptoms did not decrease. This could be due to low power in the study, i.e. too few participants and data attrition. However, this result can also be explained in other ways. One explanation is that when the adults surrounding the foster child get to know the young person better, the problems and suffering also may become more visible. Foster parents may struggle to get to know and get in emotional contact with their foster child or young person, hoping that their care will be received and help the child. Their concerns may be rejected because of the young person’s earlier negative attachment experiences, which creates a complicated relational situation (Redfern et al., 2018). Even though the foster child or young person is rejecting the foster parent’s care or efforts to get emotional contact, the foster child may experience some relief in suffering and symptom reduction even though not communicating this. The foster child may feel more seen in this process.

This study had several limitations; most evident was the lack of a control group but also the high data attrition. Most of the attrition was caused by termination of the placement, but we lack exact data on the reasons for these terminations.

Paper II
What changes during specialized foster care? A study on adaptive functioning and emotional and social problems

This study was exploratory and conducted in specialized foster care using the TBF-model. The purpose of the study was to conduct an outcome study regarding how the foster children’s and young peoples’ self-rated emotional and social problems and self-image, and adaptive skills in everyday life develop over time according to foster parents. There are fewer studies of adaptive skills in children and young people in foster care than of psychiatric symptoms. The hypothesis was that the extensive interventions of the TBF-model would improve adaptive functioning, especially social functioning. We also hypothesized that emotional and social problems would be reduced and that the self-concept would become more positive.

Methods
This study used ratings of the foster child’s adaptive skills made by the foster parents and self-ratings of emotional and social problems, rated by the foster children. The ratings were made every 12 months after the baseline rating. Adaptive skills were measured with the ABAS-II parent form. The participants who were rated with ABAS-II were between 5 and 17 years of age at baseline (n = 76) and the mean age was 12.71 years (SD = 3.32 years). There were 55.3% boys (n = 42) and 44.7% girls (n = 34) at baseline. As a measure of emotional and social problems, the BYI was used. The participants who rated BYI were between 10 and 17 years of age. The mean age at baseline
was 12.83 years (SD = 3.33 years). Gender distribution was 47.2% boys (n = 42) and 52.8% girls (n = 47). Ratings were analyzed using a longitudinal multilevel model.

**Results**

The results of the foster parents’ ABAS ratings showed that adaptive functioning at baseline was significantly below the Swedish norm group, i.e. below average scores from peers from the population. Analyses made on the raw scores showed significant improvements in all domains of adaptive functioning during treatment. For General Adaptive Composite (GAC; i.e. sum of scores on all items), the estimated mean rate of change was 19.09 ([-11.98, 26.21], \( p < .001 \)) per year. However, when the data were analyzed using scaled scores, none of the domains showed significant improvement. For GAC scaled scores, the estimated mean rate of change was 1.19 ([-1.12, 3.50], \( p = .31 \)) per year. This means that the participants did not approach peers in the norm group regarding adaptive functioning.

In comparison with the Swedish norm group, i.e. non-clinical peers, self-rated emotional and social problems were higher for the study participants at baseline. During treatment, their symptoms of anxiety, depression, feelings of anger and disruptive behavior decreased. Anger and disruptive behavior improved the most. For anger, the estimated mean rate of change per year was -2.42 ([-3.54, -1.29], \( p < .001 \)) and for disruptive behavior -2.08 ([-2.94, -1.21], \( p < .001 \)). The estimated mean rate of change for anxiety was -1.43 ([-2.58, -0.29], \( p = .02 \)) and for depression -1.79 ([-3.12, -0.47], \( p < .001 \)). Self-concept showed close to, but not significant, change (reversed scale: 1.43 ([-1.19, 3.05], \( p = .08 \)).

The hypothesis that emotional and social problems would be reduced was confirmed, but self-concept did not improve. Our hypothesis that adaptive functioning, especially social functioning, would improve was only partially confirmed. The foster parents’ ratings and the young peoples’ ratings did not correlate.

**Discussion**

The results of Study 2 showed that the TBF-model is associated with improvements in emotional and social problems. The self-concept of the participants did not improve significantly during treatment. However, at baseline self-concept was rated at a level close to the Swedish norm group, i.e. negative self-concept did not seem to be a general problem for the participants in this study. Most notably feelings of anger and disruptive behavior decreased. It is possible that this could be an effect of the treatment’s focus on relationships, including collaboration between members of the team surrounding each young person as well as collaboration with the biological network, schools, and the social services. Perhaps specialized foster care that is focused on relations and mentalizing can improve mental health more than foster care in general, and also more than specialized foster care with another focus (Goemans et al., 2015; Åström et al., 2020).

Despite extensive support and treatment interventions, the children and young people in this study were not able to approach or reach the norm group’s level of adaptive skills. This finding may be interpreted in different ways:
1. The group of children and young people who are placed in TBF families have
during their early childhood experienced neglect, separations and some of them
abuse. Pechtel and Pizzagalli (2011) have shown that early life stress has long-
term consequences for psychological development, affect regulation and exec-
utive functions. In line with their findings, the results from this study also sug-
gest that the consequences of exposure to maltreatment and neglect may lead
to a relatively chronic impairment of adaptive skills.

2. This finding may be related to epistemic mistrust, if the learning of adaptive
skills by others is viewed as an expression of epistemic trust (Sprecher et al.,
2022). Foster care is an uncertain business and in many cases both the TBF
family and the foster child do not know how long the placement (and thus the
relationship) will last. This could make it difficult for foster parents to succeed
in building a sufficiently secure and trustworthy relation with the child in foster
care and affect how the foster child and the foster parent dare to invest in this
relationship. If this is the case, emotional and social problems as experienced
and rated by the individual, may be less dependent on epistemic trust than adap-
tive functioning is.

3. Another way of understanding this finding is as an effect of regression in the
psychodynamic sense, meaning that unfulfilled longings and needs to be cared
for like a small child could be activated in the safe context of the foster family
which means that they would not be motivated to show adaptive skills (that
would be associated with autonomous functioning rather than dependency).

The lack of control group in this study constitutes a limitation that makes it
difficult to draw causal conclusions. It is uncertain whether the intervention is the cause
of observed changes. Data attrition was another limitation of this study. However, data
attrition analysis showed no significant difference in baseline ratings of participants who
had data at later occasions in comparison with those who did not have any additional
data beyond baseline.

Paper III
Experiences in the relationship between foster children and foster parents in special-
ized foster care. – Thematic Analysis conducted on Five Minute Speech Sample-data

Given the research showing that one of the factors that most significantly af-
ffects foster care outcomes is the relationship between the foster child and the foster
parent (Cooley et al., 2015; Luke et al., 2014), the purpose of this study was to develop
and deepen the understanding of foster children’s and their foster parents’ experiences
of their relationship. Research about experiences of foster parent – foster child relation-
ship in specialized foster care is scarce. The main questions were how the participants
experience and describe their relationship, and what impedes and promotes the development of their constructed relationship, in the context of a relationally and mentalization-focused foster care model. This study was qualitative, using data from a larger and quantitatively oriented project with the main question how qualities in the relationship between foster child and foster parent is related to outcome of foster care treatment.

Methods

Seven foster children and young people and their seven foster parents (i.e. the foster parent who was employed and thus had the main responsibility for the foster child) answered four questions according to FMSS individually, about their relationship and how they could understand their own and the other person’s experience (Magaña et al., 1986; Midgley et al., 2017). This was repeated on three occasions, six months apart. The total number of interviews was 40 (data loss: 2 missing due to technical problems). Data were analyzed with TA. The participating children and young people were 8 – 17 years of age and the gender distribution was five boys and two girls. The seven participating foster parents in this study had various experiences as foster carers, but all were part of a treatment team according to the TBF-model. The gender distribution of the foster parents was four women and three men.

Results

The analysis generated three main themes, containing seven subthemes. Main themes were: No ‘real’ family, A co-created relationship, and Time. The first theme, No ‘real’ family, describes how the participants relate to a norm for what a ‘real’ family is. Both foster children and foster parents seem to presuppose that the biological family is the ‘real’ family and they need to relate their foster family to the concept of the ‘real’ family. The second theme, A co-created relationship, relates to the first theme as an answer or a solution to No ‘real’ family. A mutual ambition to build a relationship and liking each other can overcome challenges in the foster family constellation. The third and most common theme was Time, despite the fact that no interview question concerned the duration of the relationship. Time seems to be a foundational aspect of the whole relationship and appears as both an opportunity and a threat.

Discussion

Both foster children and foster parents described their relationship in predominantly positive terms, but the experience of living in a foster care relationship seemed to be multifaceted, and to some complicated. Even though the participants were part of a specialized foster care treatment model, the results from this study seem to be consistent with previous research on what is required to build the relationship between the foster child and the foster parent. To spend a lot of time together in everyday life, humor and having fun together (Hedin, 2014; Hedin et al., 2011) seem to be important factors that are necessary to build a sense of security in the relationship, and security becomes a prerequisite for liking each other (Biehal, 2014; Schofield & Beek, 2005). To be a foster parent in a specialized foster care context could be experienced as more compli-
cated since it can be perceived as a role conflict to be a parent on one hand, and a professional carer on the other. However, even if these families provided specialized foster care, it does not seem to have affected these aspects of the relationship in a different way. The TBF-model’s focus on reflection and sensitive parenting may support the emotional side of parenting and thus be helpful in bridging and finding a balance between these two roles. However, this was not explicitly stated in any speech sample.

Many of the participants, both foster children and foster parents, seem to value and understand their relationship based on how long they have known each other. It is the legislator’s intention that foster care in Sweden, including specialized foster care, in the vast majority of cases should lead to the child moving back to the biological family (Höjer, 2019). This shows a paradoxical situation between society’s ambition to place neglected children in specialized foster care to compensate for the consequences of this neglect, the efforts made by the TBF team to strengthen the relationship between the child and the foster parent and the goal of reuniting children with their biological parents.
General discussion
Discussion of findings

The aim of this thesis was to explore trajectories of change associated with effects of a relational and mentalization-based specialized foster care treatment model and to gain a deeper understanding of the experiences of the relationship between foster child and foster parent in this context. The results of Studies 1 and 2 showed that the children’s and young people’s self-ratings of internalizing and externalizing symptoms and social problems decreased, i.e. that their well-being improved, after 18 months. We did not have a comparison group, which made it difficult to draw causal conclusions about the effectiveness of the treatment model, but it is seems unlikely that children in specialized foster care, i.e. children with extensive needs due to early neglect and complicated life circumstances, would have experienced such positive development of their psychological well-being if they had not received treatment. It is likely that the treatment model contributed to improved psychological well-being of the young people in care. If the causal relationships could be confirmed, it could mean important effects on a population level, especially considering that this is a group of children with serious problems and lack of resilience. An important and interesting question is, of course, which interventions or elements of the treatment model contributed to this improvement. However, it is impossible to distinguish the effects of various components of the model. An alternative explanation would be spontaneous maturation, which in that case could have happened without the special interventions of the TBF-model, or without foster care. However, previous studies of the effects of foster care or of maltreated children who have not been placed in foster care do not show that such spontaneous maturation usually happens (Engler et al., 2020; Goemans et al., 2015; Goemans et al., 2016; Gypen et al., 2017; Nilsson & Tingberg, 2020; Pecora et al., 2009).

The foster children and young people improved according to their self-ratings but foster parents and teachers did not rate improvement to the same extent. Explaining and understanding this result is not straightforward, but it is a clear finding. One should not expect too high agreement between adults’ ratings and young people’s self-ratings, as they have different perspectives. Limited agreement between raters have also been found in previous studies (Achenbach et al., 1987; Handwerk et al., 1999). However, it is important to try to understand why the young people rated improved well-being but adults who know them did not, at least not to the same extent. Neither did the foster parents rate enough improved adaptive functioning for them to approach the level of adaptive skills of peers. Thus, the TBF-model does not seem to contribute to foster parents experiencing such an improvement. For foster parents who are committed and who have undertaken the task as foster parents, one can imagine that it could constitute parental stress not to experience that the wellbeing and adaptive skills of one’s foster child improve. One explanation of the results could be that the first rating reflects a kind of
‘honeymoon phase’ of the placement. The young person does not show the whole register of his mood or behavioral problems, but when they start to get to know each other better, more sides of the person emerge. It could also indicate that the foster child is starting to feel more secure and is therefore showing more of her or his problems. Such development can also explain why the young person feels better and has fewer symptoms, in particular internalizing symptoms.

However, foster parents’ and teachers’ ratings did not show that the TBF-model had the desired effect on the foster children’s and young people’s psychological well-being or on adaptive functioning. Study 2 confirms results from previous studies, which have shown that foster children have adaptive difficulties that seem to be difficult to remedy (Goemans et al., 2015; Viezel et al., 2014). A meta-analysis by Goemans et al. (2015) of longitudinal studies of the development of children in foster care found neither improvement, nor deterioration in adaptive functioning. In addition, the results indicated that longer-term studies with larger sample sizes revealed a trend towards negative development in adaptive functioning compared to those with shorter durations or smaller samples. It seems that almost chronic adaptive difficulties could be a consequence of neglect and maltreatment, or at least that it takes much longer to develop these than to improve psychological symptoms. The youngest children in TBF were 5 or 6 years old. This indicates that many of the children were placed late, both in terms of how long they probably experienced neglect and abuse, but also in terms of not having their developmental needs met. In other words, they have been placed and/or received treatment too late.

Both the foster children and the foster parents in Study 3 relate to what a ‘real’ family is assumed to be, and they often try to build something that is similar to a ‘real’ family, or different, but still valuable. This is consistent with previous foster care research that has shown the importance of inclusion in the family and how both parties work with these issues (Christiansen et al., 2013; Ie, 2022; Schofield & Beek, 2005; Storer et al., 2014). Most of the children and foster parents like each other but struggle with concepts such as ‘family’ and with defining their relationship. Time is a condition for building a trusting parent-child relationship. It is striking that the time aspect is a recurring theme in both children’s and foster parents’ statements. Considering the data attrition in Studies 1 and 2, one can also assume that a large number of placements have ended after 1-3 years. This also shows that time is a critical issue. We do not know the reasons why the placements ended, why the placements didn’t last longer, despite the extensive interventions and the ambitious treatment model. It could be due to flaws in the model or because of a lack of adherence to the model, or because of external factors.

It is common for foster children to have an indeterminate time frame for how long they will live in their foster family, whether it is a long-term placement for the rest of the child’s childhood, or not. Foster children can live for years in their foster family without knowing if or when they will move back to their biological parents. This is a consequence of the general goal of foster care, which is for the child to move back to its
biological parents when possible, in line with a family service-oriented perspective. Although a more child-focused perspective in recent years has influenced foster care in Sweden, this problem sometimes still remains as an issue of the social authorities. There are also risks with a child-focused perspective. It can, for example, mean that children are left on their own to make difficult decisions about whether they should move back to their biological parents or not. Foster children and young people are seldom free to express what they want, e.g., because of loyalties to their biological parents, even if they are asked what they want. Another reason could be that, as a result of neglect and abuse, they have no well-developed ability to recognize their own needs or in taking care of themselves. Among attachment researchers, there is a consensus that permanent placements are needed in cases where reunification is deemed unlikely, and that temporary foster care should only be applied in cases where the goal is for the child to be reunited with its biological family (Forslund et al., 2022). Continuity is of great importance. The results of this thesis also support this.

Foster parents’ task and situation is complicated. Living with and caring for children who have lived in neglect means being in an emotional force field. There is a risk of mentalizing breakdown (Redfern et al., 2018). If there is uncertainty about the duration of a foster child’s or young person’s placement, it can also influence the foster parent to be more cautious in getting involved emotionally in the relationship. This, in turn, can negatively affect the relationship. Another aspect that complicates the role of the foster parent is, on the one hand, to understand that the child is affected by its history of neglect and/or abuse, but on the other to reflect on what is going on here-and-now in the child’s life and within the child. In three studies, Fishburn et al. (2017) found that foster parents and adoptive parents who tended to explain and understand their child in terms of what the child had experienced before placement or adoption had a lower ability to tune into the child’s mental and emotional state. Placing too much importance on what the child experienced before the placement can reduce the foster parents’ ability to see the child here-and-now and thus their own influence on the relationship. This also underlines that foster parents may need support to be able to have a mentalizing stance in relationship to their foster child.

Discussion of methods

This thesis uses both quantitative and qualitative methods. A mixed methods approach that combines quantitative and qualitative methods may provide a comprehensive understanding of foster care interventions and social work practice. In addition to the quantitative data collected under naturalistic conditions, voices from within have been allowed to emerge from both foster children and young people and their foster parents.

Although it was possible to examine effects of specialized foster care quantitatively, to examine the effects of the TBF-model in an RCT was deemed impossible based on existing resources, practical circumstances, and ethical considerations. Doing
RCTs in foster care research is complicated for various reasons. In practice, it is difficult to standardize different treatment interventions (Sallnäs, 2019). Social work interventions take place in complex, dynamic, and multi-layered environments and it may be difficult to fully capture this complexity through RCT studies. It is difficult or impossible to control a number of influencing factors surrounding children in foster care, which in turn makes the results of RCTs less reliable (Mezey et al., 2015). Transferring results from RCTs to everyday social work practice could also be problematic. RCTs entail ethical problems considering randomization and control groups when it concerns children and families with severe difficulties and extensive needs who are also in problematic life situations. There is a lack of qualified foster families which means that there is a risk that interventions will not be of the same high quality for all participants in a study. In addition, there are other practical circumstances such as where geographically there is access to foster families. Mezey et al. (2015) have also pointed out the lack of research culture and infrastructure for research in social work as an obstacle. Overall, this means that RCTs are resource-intensive and difficult to implement. Despite this, some RCTs have been conducted, although there are relatively few such studies (e.g. Adkins et al., 2022; Dozier et al., 2006; Price et al., 2019). It is important to note that explorative naturalistic research also has limitations. Naturalistic research resembles natural conditions, which allows for generalization to broader contexts, but one significant limitation is that we cannot show or explain causality.

Another and complementary way to RCTs to develop knowledge through research is Practice Oriented Research (POR) (Castonguay et al., 2021). One aim of POR is to reduce the gap between research and practice. The model is based on research taking place bottom-up, starting in practice, instead of top-down, i.e. starting in interventions designed and questions formulated by the researchers. Castonguay et al. are psychotherapy researchers, but these arguments can also be transferred to research in social work. They have described different approaches within POR, one of which is Practice Based Evidence (PBE). Three defining features of PBE are: data are collected as a part of routine practice, what is assessed reflects everyday practice and what is studied does not involve constraints imposed by the researcher (Castonguay et al., 2021). Studies 1 and 2 of this thesis correspond to the defined features of PBE. The data collection and procedure in Study 3 aim at assessing everyday practice but involve constraints imposed by the researcher.

Another question is what to measure in order to best study the outcome in foster care and in particular specialized foster care. It is not a given to use ratings of symptoms or adaptive skills as outcome measures. Defining what constitutes good mental health and well-being for this heterogeneous group of young people is complex. Specialized adapted instruments or procedures need to be developed to measure quality of life, the experience of being able to influence one’s situation (experience of power/powerlessness) and of having access to information about, for example, one’s own life history. Method development is ongoing in this important field (e.g. Bromark et al., 2023).
Strengths and limitations

As previously discussed, the lack of a comparison group is a limitation. It is of course uncertain whether the effects (and the non-occurring effects) result from this specific treatment model or whether there are other factors that contribute to the outcome. Another significant limitation of Studies 1 and 2 is data attrition. One consequence is likely low statistical power, which constitutes a limitation. Data attrition is a problem in studies of children and young people in community care and can be seen as symptomatic of the participants’ unstable living conditions. In our studies, we do not know about the reasons behind this attrition in each individual case, but in general there are two reasons: that placements ended or that routines for follow-up assessments were not completed. In many cases, the placements ended as planned and the foster child or young person moved back to its biological family or to another form of settlement, e.g. supported settlement for young people. In other cases, placement ended in breakdown. We do not know how many ended up in breakdown, but this is an important question for future studies, especially as the TBF-model aims to achieve stable placements. That routines for follow-up assessments are not followed seem to be a relatively common problem in TBF and a significant amount of data is also missing because of this. If we had access to more detailed demographic data at the individual level, both about foster children and foster families, as well as data on how placements ended, additional important analyses could have been carried out. Another limitation is that we do not have any measures of mentalizing, RF, PRF or attachment organization, as these are central theoretical and methodological elements of the TBF-model. Having such measures could provide knowledge about moderating and mediating factors. Measuring mentalizing skills in foster children and young people as well as in all professionals, and PRF and sensitivity in foster parents could have contributed to the knowledge of whether these abilities are affected by training and by working in the context of a relational and mentalization-focused foster care model. It is also a limitation that we do not have any measures of adherence to the TBF-model.

A potential limitation is bias regarding participants. In Studies 1 and 2, all available data from the population of foster children and young people in TBF were included. Therefore, the participants should be representative of the population. In Study 3, on the other hand, there is likely a bias in terms of participants. Regarding foster parents, one can imagine that there was a skewed distribution with more foster parents who felt more satisfied with their task and perhaps had better self-confidence in their mission, than among those who did not consent to participate in the study. A similar bias among foster children and young people is likely; that those who had the most severe problems and had the most avoidant attachment did not consent to participate. Among the participants, however, some foster children and young people had severe problems. Interestingly, even several biological parents who were negative to the placement itself consented to their children participating in the study. This suggests that selection bias was present, but perhaps not a decisive problem.
To compensate to some extent for the various limitations, the three included studies are longitudinal. Data has been collected on repeated occasions, and over a relatively long period of time. This has given the opportunity to follow the development of the participants in different ways. It would have been interesting to do follow-ups after an even longer time and after the placements had ended.

In Study 3, efforts were made to meet quality criteria for TA (Braun & Clarke, 2006; Braun & Clarke, 2013). To ensure the quality of the transcriptions, these were checked against the recordings to avoid errors. The coding process was thorough including cross-coding of some of the interviews, which suggested that consensus was high. To strengthen the validity of the analysis, both codes and themes were checked against each other, and back and forth to the transcriptions several times. Furthermore, both codes and themes were triangulated between the researchers. Triangulation was not used with the purpose to arrive at an underlying truth in the data, but to reach a deeper analysis and rather capture multiple voices or ‘truths’ (Braun & Clarke, 2013). Through the different backgrounds of the researchers, different perspectives could be highlighted. The majority were psychologists, several with an interest in mentalizing, which may have influenced the conceptualization process. Co-researcher Münger has a different background, as a qualitatively oriented child researcher and ethnologist, which contributed to other perspectives in the analysis process. Through discussions consensus about themes was reached. I, researcher Åkerman, participated in the data collection and have worked as a psychologist in the TBF-model, which meant closeness to data and insider knowledge. The other researchers have not worked in TBF, which contributed to different perspectives through greater distance to data. Conceptualization and re-conceptualization were made with the aim of telling a convincing, yet multifaceted, story about the data and the topic. Enough interviews/speech samples were included to describe both recurring themes but also deviant voices. Various stories emerged. It was also a conscious choice to handle data from foster children and foster parents as one dataset. This as an attempt to make foster children’s and young people’s voices equal to those of adults. We were not interested in comparing them as two different groups but wanted to gain a deeper understanding of their relationships by considering them as one conjoint group.

The experience of having worked in the TBF-model myself has been significant to the work with this thesis. This has affected both the formulation of research questions, data collection, data processing and interpretation of data. It has mostly been an advantage for data collection, data analysis and interpretation of data. At the same time, it may have impeded my ability to think critically and ask critical questions. In order to add other perspectives and help to think critically, it has been important to have outside supervisors and co-writers, who have been able to contribute with other perspectives.
Implications for practice and policy

Generalizability is a problem when studying only one organization. However, some of the results of this thesis could be of relevance to other foster care settings, especially models or interventions with a relational and/or mentalizing focus. Other models for interventions in foster care, also behaviorally focused, could follow the TBF-model’s structures for meetings and routines. Structures may be an important and stabilizing part of a treatment model. The routines and structures are also easier to implement than the rather complex treatment content of the TBF-model.

The results from Studies 1 and 2 may be interpreted as showing that it makes sense to place children and young people with particularly vulnerable life circumstances in specialized foster care, and to work relationship- and mentalization-oriented in such a treatment setting. The results of Study 3 seem to be similar to the results from community-based foster care, i.e. regarding what is described as important for a relationship to be experienced positively in a foster family. This may suggest that these results are generalizable to foster care in general.

Based on the results of this thesis, practice and policies should take greater account of the time aspect in foster care. Both foster children and foster parents are in a relatively powerless position as many factors and external influences on the relationship can make time a very scarce resource. Transparency and participation in decisions is a way to create more security and reduce stress for the foster children, young people as well as their foster parents. Children need information too. Planning the duration of placements is important. The time aspect is also significant in another way; time is needed to build a relationship to be able to compensate for previous neglect and relational traumas. One reason for short duration of foster care may be economic; that specialized foster care costs significantly more than community-based foster care. Another problem is the lack of suitable foster families and the retention of foster families. Providing foster families with clearer time frames and also more long-term planning can create better conditions for building a trusting relationship with the foster child, which may make foster parents want to continue their mission.

The very lack of clarity regarding placements’ length and goals is a problem in itself. Floating between two models, one child-focused and one family-service oriented, makes it difficult to plan the content of treatment as well. If the goal is for the foster child or the young person to return to their biological family, then there is doubtful value in working attachment-focused with the relationship between foster child and foster parent if the time in TBF is short. From this perspective, the TBF-model is problematic. However, some foster children are unlikely to be able to move back to their biological family and at the same time be safe and have their needs met. The social authorities need to make such assessments more quickly and communicate decisions clearly.
Implications for the Treatment By Foster care-model

In the TBF-model, routine follow-up assessments are carried out, including how adaptive functioning develops in the foster child. Given that the routines do not seem to be followed very carefully, it is unclear how and to what extent these ratings are used, that is, if they are used to introduce more adapted and targeted interventions in everyday life to help the child or young person develop. An approach with more targeted interventions could involve more behavioral interventions. However, behavioral interventions may have difficulty being successful unless the relationship between foster child and foster parent is trusting.

The TBF-model is unclear regarding expectations on the other, non-employed, foster parent and also regarding other family members in the foster family. From a relational perspective, it is obvious that other relationships within the family and the relationship between the foster child and other family members, especially to the other foster parent, may play a major role in the child’s well-being and inclusion in the foster family. The foster child’s role in the foster family and the relationship with other foster family members probably have an impact on whether epistemic trust can develop or not. This can be seen as a critical point in the model where theory and practice differ. What is the role of that foster parent and what does the TBF-model expect of that parent? What demands are placed on that foster parent’s participation in the treatment, and on participation in training and supervision? What are the expectations of the foster family as a whole and of, for example, older siblings in the family?

Another question is whether the model should be modified for the younger children and/or for the young people. The model holds flexibility and adaptation, but differences in treatment between older and younger children have not been formalized to any great extent. This would be reasonable based on different needs from a developmental psychological perspective.

Future studies

A question that remains and is important for future studies is whether it is the placement itself in a treatment foster family that is significant or whether it is the treatment interventions. Is it the structures around the foster family and the fact that a parent is employed full-time for the task that is important, or is it the more specific treatment interventions carried out by other professionals in the team around the foster child but also by the foster parents?

Future studies of foster care and foster care interventions should use measures of mentalizing such as RF, PRF or of attachment organization or parental sensitivity. A relatively extensive data collection has been carried out in the TBF setting, i.e. the one from which Study 3 uses data. The main question of this project is how qualities in the relationship between foster child and foster parent affect the foster children’s and young peoples’ development. We refer both to 1) emotional qualities in the relationship such as availability, sensitivity, parents’ structuring ability and absence of intrusiveness and
hostility and reciprocity in the interaction as in the Emotional Availability Scales (EAS) (Biringen et al., 2014), and 2) the ability to mutually take each other’s perspective and to be able to reflect on one’s own and the other’s affective reactions as in RF. The overall hypothesis is that qualities in the relationship between the foster child and foster parent affect the outcome in the form of reported symptoms and problems. With a higher degree of emotional availability and a higher RF, the treatment outcome during the ongoing treatment process will be more positive according to our hypothesis.

Conclusions

The answers from both foster children, young people in TBF and their foster parents indicate that the trajectories of change do not seem to be experienced equally. Self-ratings show reduced symptoms over time, while their foster parents’ ratings do not show an equally positive development.

In the relationship between children, young people in care and their foster parents within specialized foster care, the same factors seem to be important as in community-based foster care. Warmth, humor and doing things together appear to be important elements in a positive relationship. That both parties mutually have the ambition to build a good relationship appears to be important. Both parties struggle with defining their relationship and relate to notions of what a ‘real’ family is.

There is a paradox in that society places children in foster care, invests in extensive interventions aimed at healing damage from neglect and abuse, but does so under unpredictable and unstable premises. It is not justifiable to allow already vulnerable children and young people to live in such insecure and unstable conditions. Continuity is a key issue. Of course, the child’s needs must also be met in its foster family. This also applies to the need for treatment interventions. It is probable that children and young people in TBF have been placed in foster care and/or received treatment too late.
Contributions

Åkerman is the first author of the three articles included in this thesis. All co-authors have been involved and contributed to discussions of results and in the writing of the articles. Åkerman has been involved in the data collection in all the studies. In Study 1, data processing and analysis was made by Åkerman. Frostell and Holmqvist were also involved in data analyses. In Study 2, data processing and analysis was made by Åkerman. Falkenström also contributed to the data analysis.

In Study 3, authors Mansfeldt and Östergren transcribed half of the recorded interviews each. The first coding and conceptualization into themes according to TA was made by authors Mansfeldt and Östergren. Themes were then confirmed by triangulation with authors Münger and Åkerman (Mansfeldt & Östergren, 2020). In a second step, a re-conceptualization of themes was carried out by author Åkerman.
Acknowledgements

This thesis was made possible by support from Tjust Behandlingsfamiljer. The thesis was partly financed by research grants from the Allmänna Barnhuset Foundation.

I feel gratitude towards all children, young people and their foster parents for their participation and contribution to this thesis. I would also like to thank all other TBF professionals who contributed in various ways to the collection of data. A special thanks to Pia Skillberg, Karin Brunbäck, Åsa Hörnell, Mattias Bradley, Anna Ege, Charlotte Lindwall and Gunilla Nyström who especially contributed to this project.

Warm thanks to my main supervisor during the second half of this project, Fredrik Falkenström. You have generously and patiently supported me with the statistical analyses, but also contributed with important thoughts and knowledge about what a family is and about psychoanalytic theory. Your article writing skills have also been an important contribution.

A heartfelt and warm thank you to my co-supervisor Rolf Holmqvist who was involved in this project from the very beginning to the very end. Without you no thesis. I have learned a lot thanks to your deep knowledge of relational processes in treatment, psychotherapy, research, and about many other things.

Anneli Frostell, my main supervisor during the first years. Thank you for your support and encouragement and for your important contributions regarding the planning of the studies.

The research group at IBL, Linköping University, has been a supportive resource as well as a context for interesting discussions and lots of laughs. Thank you Erika Viklund, Annika Ekeblad, Carl-Johan Uckelstam, Niclas Kullgard, Björn Philips, Clara Möller, Mattias Holmqvist Larsson and Börje Lech. Warm thanks to Malin Bäck and Liselott Lindegren for support in ups and downs, and to Malin also for the APA-check. Special thanks to Ylva Söderberg Gidhagen for valuable feedback, and to Paul Bergman for reviewing the section on ICDP.

All the colleagues at the department of psychology and the head of the department Örjan Dahlström. A special thanks to Maria Jannert and Mikael Sinclair, and also to Anna Malmquist for input on ‘family’ in the work on paper 3. Thank you Britt-Marie Alfredsson and Maria Hugo-Lindén for administrative support.

Thanks to Inga Tidefors and Doris Nilsson who commented on my work at the half-time seminar and contributed with important comments and points of view. Many thanks to Pehr Granqvist who was my reviewer at the final seminar. Your comments and encouragement helped me to improve this thesis.

Thanks to Ann-Charlotte Münnger, for your constant critical eye, and to Kajsa Mansfeldt and Olle Östergren for good cooperation in the work on paper 3, but also for our continued reading parties!
Warm thanks to my brother Kalle Blomberg who painted the picture on the cover, based on an anecdote from a social worker, and to my sister Marita Blomberg Tapper for English language review.

As you know, you are born, live and die alone, but it’s nice to have company on the road. With love, Johan, my best friend: thank you for your loving patience, support and for always believing in my ability to complete this work. Thank you to our wonderful children Aston and Ylva for being there. Loving thanks to the rest of my family, extended family and all wonderful friends who made me think about fun things other than research.
References


52


Papers

The papers associated with this thesis have been removed for copyright reasons. For more details about these see:

https://doi.org/10.3384/9789180752664
Relationally focused specialized foster care

-Relational experiences and changes in mental health and adaptive functioning

Anna-Karin E. Åkerman

At the Faculty of Arts and Sciences at Linköping University, research and doctoral studies are carried out within interdisciplinary research environments, often addressing broad problem areas. Linköping Studies in Arts and Sciences is the Faculty’s own series for publishing research. This thesis comes from the Division of Psychology at the Department of Behavioural Sciences and Learning.

www.liu.se