Carer-Child Relationships in Permanent Care Programs

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A thesis submitted in fulfilment of the requirements for the degree of

Master of Philosophy

School of Psychology

Australian Catholic University

St Patrick's

July, 2008

Statement of Authorship and Sources

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution. No other person's work has been used without due acknowledgement in the main text of the thesis. All research procedures reported in the thesis received the approval of the relevant Ethics/Safety Committees (where required).

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Abstract

Over the past 20 years, there has been a steady increase in permanent care placements in Australia, however, relatively little research has been conducted on how to best support this growing population. Little is known about what variables contribute to the development and preservation of positive carer-child relationships. The current study examined the relationship of carer and child variables in permanent care carer-child relationships. In particular, the role that carer empathy, carer parenting style, child emotional and behavioural problems, child temperament, and child resilience played in the prediction of carer-child relationships was investigated.

Using quantitative and qualitative approaches, the current study gathered data from a total of 46 permanent carers in Victoria. Participants were permanent carers who had at least one child aged between 3-12 years. Carers were recruited from metropolitan and rural permanent care agencies. Participants completed a questionnaire booklet on their empathy, parenting styles, their relationship with their child, and on child variables including emotional and behavioural difficulties, temperament, and resilience. Thirteen carers also participated in the qualitative part of the study, consisting of an interview that aimed to further target the study's key variables.

It was hypothesised that both carer and child variables would correlate with and predict carer-child relationships and that carer variables would emerge as the strongest predictors. The findings from the quantitative analyses indicated that carer variables were less important in predicting carer-child relationships and only authoritarian parenting was related to less positive carer-child relationships. Child variables, particularly the emotional and behavioural difficulties children manifested, had greater significance in the prediction of carer-child relationships. Qualitative data

were consistent with quantitative findings, showing that it was the child's troubling behaviours which were the most taxing on the development of positive carer-child relationships. Where carers perceived improvements in their children's behaviours or could recognise positive aspects in their children and their relationships with them, this seemed to support carer-child relationships. From a policy-driven perspective, it is in the best interests of permanent care agencies to connect children and their carers with services and strategies which help promote child adjustment and well-being, whilst simultaneously educating carers on how to most effectively manage the emotional and behavioural challenges evidenced by their children.

Acknowledgments

The success of the current thesis is, in part, attributable a number of persons, all of whom have in one way or another contributed assistance, supports, or guidance instrumental to the thesis' progression. Sincere gratitude is extended to Associate Professors Sabine Hammond and Michael McKay, whose ongoing feedback and insightful comments were truly invaluable. Undertaking this thesis under their supervision was nothing short of a pleasure. Many thanks also to the extended faculty for their valuable, thought-provoking criticisms. Thank you to the six collaborating agencies for their generous assistance in recruiting research participants. Heartfelt thanks are extended to the permanent carers who so eagerly contributed their time, insights, and parenting experiences. It is hoped that existing permanent care programs transpire the restructuring that you seek. All the best to you, and your endeavours, to support children in need.

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List of Symbols and Abbreviations

α	Alpha; Cronbach's index of internal consistency
β	Beta; standardised multiple regression coefficient
CSOs	Community Service Organisations (permanent care agencies)
DHS	Department of Human Services
F	Fisher's F ratio
M	Mean
N	Total number of participants in a sample
p	Test probability
r	Pearson's Product Moment Correlation
Δr^2	Adjusted coefficient of multiple determination
SD	Standard deviation
SE	Standard error of measurement

CHAPTER ONE: INTRODUCTION

It is each child's fundamental right to grow up in a safe, nurturing, and consistent caregiving environment, free from maltreatment, including physical, sexual, and emotional abuse, neglect, and inadequate physical care. This elemental right is upheld by the Australian constitution, and is enforced through federal and state laws (Department of Human Services, 2003; Geary, 2007). Notifications of significant family dysfunction resulting in maltreatment are systematically investigated by social service organisations and if substantiated, can initiate the implementation of child protection intervention strategies (Kufeldt, Simard, Thomas, & Vachon, 2005). In fact, in instances where compelling evidence exists that a child has encountered significant harm, each state retains the authority to apply to the applicable court to seek to remove the child from parental care (Department of Human Services, 2003; Smyth & Eardley, 2008; Turner, 1995; Victorian Auditor General, 2005). In these instances, it is the contention of the state that the child's best interests are best served by his or her placement into out of home care. Ideally, where the intra-familial dysfunction initially triggering the child's removal into out of home care can be reasonably addressed, common practice dictates that the child be returned to his or her original birth family (Geary, 2007). Where a return to the child's family is not possible due to persistent risk or multiple short-term placements are problematic, the child may be placed in permanent care (Humphrey, Turnbull & Turnbull, 2006; Kufeldt et al., 2005; Mulligan, 2003; Wise, 2003). Permanent carers are granted legal guardianship, and care for the child within their home until the child becomes legally independent (Department of Human Services, 2003; Smyth & Eardley, 2008; Victorian Auditor General, 2005).

Many children in permanent care have endured significant maltreatment, multiple carers, and placement instability (Dorsey, Mustillo, Farmer, & Elbogen, 2008; Humphrey

et al., 2006). Children in these circumstances may feel hurt, betrayed, lonely, and unloved (Hughes, 1999). Further, as a consequence of their unstable upbringings, children may exhibit a range of challenging behaviours (Barber & Delfabbro, 2005; Nilsen, 2007; Rubin, O'Reilly, Luan, & Localio, 2007). These include attachment related disturbances, impulsivity, poor regulatory function, and a range of emotional and behavioural difficulties. The instability roused by children's previous experiences may present carers with a range of challenges in parenting them (Gordon, 1999; Lipscombe, Farmer, & Moyers, 2003).

In spite of a child's previous negative experiences, permanent caregivers are required to take in the child and incorporate him or her into their homes and lifestyles, build a relationship, and provide stability, while supporting the multiple transitions and adjustments the child must make to changed living conditions. Often the child is placed in a different neighbourhood, away from friends and any known adults, including teachers and other familial relations (Herrenkohl, Herrenkohl, & Egolf, 2003). Further, at times, permanent carers lack the common grounding of a mutual, shared history with the child. In effect, the child may enter the caregiver's home as a virtual stranger. These elements may combine to hinder the caregiver's abilities to care adequately for the child. Perhaps unsurprisingly, where a caregiver is either too rigid or ignorant in how to best cope with their child's problem behaviours, inability to trust, or to form secure attachment relationships, placements may dissipate (Hughes, 1999; Tomlinson, 2008). Essentially, this may act to damage the child further, reassuring him or her of their unworthiness to be loved; and that the placement broke down because nobody cares for them. Therefore, one may assume that it is a combination of both carer and child variables that contribute to the success or failure of out of home care placements (Wilson, Petrie, & Sinclair, 2003).

The damaging effects of fragmented care, multiple placements, and welfare drift have been empirically documented. Studies have consistently demonstrated that children placed in care are considerably more prone to a range of poorer outcomes throughout the course of their lives. Children have an increased likelihood of developmental disability, chronic illness, and mental health problems (Leslie et al., 2003; Schneiderman, 2003). In adulthood, they achieve poorer educational, physical, and psychosocial outcomes (Payne, 2000). Examples include low rates of secondary school completion and tertiary study, developmental delay, depressive symptomology, psychosis, social aggression, violence, poor peer relationships, and a detached, disconnected association with the local community (Edwards, 1995).

It has been proposed that at the root of a child's developmental damage is a deficit in the continuity and availability of adequate caregiving (Eitzen & McIntosh, 2004). In this sense, the significance of a steady, secure environment cannot be underestimated (Edwards, 1995). Even children who have experienced much instability can be protected from the harms of maladjustment when placed within the parameters of a sustained, supportive, substitute caregiving relationship (Higgins, 2005). Furthermore, emotionally guarded children are able to surrender their psychological guardedness by formulating a close, enduring attachment relationship with an adult attachment figure (Hodges, Steele, Hillman, Henderson, & Kaniuk, 2003). It is thus possible to modify a maladaptive trajectory to comprise more positive perceptions of one's self and expectations of others (Payne, 2000). Hence, one would assume to find mutually rewarding carer-child relationships at the core of successful permanent care family units (Rushton, Mayes, Dance, & Quinton, 2003). Indeed, empirical investigations have demonstrated that in spite of a child's early unfavourable caregiving experiences, the majority of children are able to develop suitable attachments with substitute caregivers (Rushton et al.). It is

possible for children to adapt to their new family's lifestyles and social environments. Further, over time, children are able to learn to depend on their caregivers. Through developing confidence in their carers, children's social, psychological, and scholastic development progresses.

A number of carer attributes may influence the development of secure carer-child relationships. A deficiency in caregiver empathy for example, can have harmful consequences on the child's psychological wellbeing and development of self (Brems & Sohl, 1995). In fact, low empathy has been linked to child abuse potential, violent behaviour, neuroticism, and similar psychopathologies (Chlopan, McCain, Carbonell, & Hagen, 1985). Experiential research has highlighted the centrality of empathy in nurturing carer-child relationships (Brems & Sohl, 1995). The carer's style of parenting, too, determines the levels of responsiveness and control that carers exhibit towards their child. It has been asserted that caregiving typified by high levels of responsiveness and control alike, supports the positive development of the child (Baumrind, 1999). Still, little research has been undertaken both within Australia and internationally, which specifically examines the contributions of carer empathy and parenting style in the development and maintenance of positive carer-child relationships within permanent care populations.

Further, formulating new attachment relationships may be easier for some children than others (Rushton et al., 2003). Likewise, carers may experience greater difficulty in parenting some children more so than others. A number of factors have been studied relative to adjustment to and effects of care. There is ample research indicating that children in out of home care often have significant mental health and behavioural problems (Nilsen, 2007; Rutter, 1985; Sargent & O'Brien, 2004). In turn, these difficulties in emotion and behaviour have been shown to place strain on carer-child relationships (Sinclair & Wilson, 2003). A child's temperament may also present as an

enduring mediating factor contributing to a caretaker's ability to provide quality caregiving (Wahler, 2002). Essentially, a child's temperament can have a considerable impact on the overall demand of the caregiving task (Svanberg, 1998). Resilient children, too, may be easier to parent. In effect, resilient children are more likely to persevere through conditions which may amalgamate to challenge psychological development (Dent & Cameron, 2003). Therefore, resilient children may exhibit fewer problem behaviours.

Research into permanent care practice, especially variables affecting carer-child relationships, is needed to strengthen existing child protection standards and procedures. Much remains to be learnt on the subject matter of policy implementation and the mechanisms by which agencies and caregivers can bolster placement stability and ultimately improve children's life outcomes. Nonetheless, in an era where elevated rates of placement continue to challenge permanent care agencies (Winkworth, 2003), systematic research remains correspondingly dismal (Cashmore, Higgins, Bromfield, & Scott, 2006; London, Moslehuddin, Mendes, Cashmore, 2007).

The current thesis aimed to investigate how carer and child variables, namely, carer empathy and parenting style, and child problem behaviour, temperament, and resilience, are interrelated and influence and predict carer-child relationships. Whether carer or child variables are stronger predictors of positive carer-child relationships was also examined. Qualitative interviews examined these relationships in greater depth. The following section will provide the theoretical basis supporting the inclusion of these variables in greater depth. Similarly, there will be further discussion of the predicted associations and interactions between these variables.

CHAPTER TWO: LITERATURE REVIEW

Out of Home Care

Out of home care can be defined as an overnight care service providing accommodation for children aged 17 years and under, ordered or otherwise sanctioned by the court, in which the state makes statutory payment, and the child ceases to reside with biological parents (Johnstone, 2003). Throughout the literature, out of home care is also commonly referred to as *substitute* or *alternative care*. Out of home care aims to provide safe living conditions for children in need of care and protection in which positive child development and permanency are actively promoted (Smyth & Eardley, 2008; Victorian Auditor-General, 2005).

For family welfare reasons such as parental incapacity, extreme intra-family conflict, or serious mental or physical illness, out of home care may be provided on a voluntary basis (O'Neill, 1993). More frequently however, it is provided involuntarily, for protective reasons through the child protection system (Bath, 1994; Berger, 2005; Victorian Auditor-General, 2005). An array of housing arrangements comprise out of home care, each catering to the child's specific family situation, the duration and type of abuse endured, and the anticipated length of time that the child is to spend in care. Accordingly, the child may be placed in either one, or a combination of, temporary (or emergency) care, respite care, reception care, short-term (or transitional) placement, long-term placement, or permanent care. *Temporary care* describes a very short-term placement wherein a temporary disruption has disturbed the family's ability to provide adequate care. *Respite care* refers to a very short-term placement that is typically part of a planned intervention, perhaps of a recurrent nature. *Reception care* succeeds protective intervention, in which the child is separated from the birth home pending court ruling in relation to the implementation of a case-plan. *Short-term placements* provide housing

arrangements for children whose case-plan objectives are likely to be fulfilled with a 24-month period. *Long-term placements* offer shelter to children whose case-planning objectives will take longer than 24 months to achieve. In *permanent care,* children who are unlikely to return to their birth parents are placed with a permanent non-biological caregiver (Smyth & Eardley, 2008; Victorian Auditor-General, 1996).

Placement types generally fall under two categories: home-based care and residential (or facility-based) care. *Home-based care* is provided within the home of a volunteer carer who is financially reimbursed for the costs associated with rearing the child (Victoria Auditor-General, 1996). Forms of home-based care include foster care and kinship care. *Foster care* is the most common form of home-based care (Ainsworth, 1997; Bath, 1994; Farmer, Lipscombe, & Moyers, 2005; McAuley & Trew, 2000; Minty, 1999; Tilbury, 2007), and encompasses three distinct service types; *shared family care* focusing on the joint placement of siblings, *adolescent community placement* concentrating on the placement needs of adolescents, and *specialised home-based care* directed at placing adolescents with more challenging behaviours (Victoria Auditor-General, 1996). *Kinship care* refers to placing children with next of kin or other known adults. The latter generally the more preferred type of home-based care (Ainsworth, 1997; Simms, Dubowitz, & Szilagyi, 2000), primarily because children are placed with adults who are known to them, offering them the possibility of maintaining existing family, societal, and communal ties (Holtan, Ronning, Handegard, & Sourander, 2005; Rutter, 2000).

Residential care is provided within a group home or similar community-based facility, by paid, rostered staff who administer care on a 24 hour day-to-day basis (Victorian Auditor-General, 1996). Children in residential care typically present with

behaviours that are difficult to manage within the milieu of home-based care (Howe & Fearnley, 2003; Kelly, Allan, Roscoe, & Herrick, 2003; Marinkovic & Backovic, 2007).

Numbers of Children in Out of Home Care

Recent research has indicated that over 500,000 Australians experienced out of home care throughout the 20th century (Mendes, 2005). As at the 30th of June 2004, a total of 21,795 children were placed in out of home care within Australia (Victoria Auditor-General, 2005). Of the states and territories, New South Wales had the highest number of children in out of home care, specifically 9,145 children or 5.7 per 1,000 children aged 0-17 years, followed by Queensland with 4,413 children or 4.6 per 1,000, and Victoria with, 4,309 children or 3.7 per 1,000 (Victorian Auditor-General). The Australian national placement rate is 4.5 per 1,000 (Victorian Auditor-General). From the 30th of June 1995 to June 2004, the Victorian placement rate climbed a staggering 27%. In fact, it has been proposed that within Victoria approximately 4,000 children spend any given night in care (Forbes, Inder, & Raman, 2006).

Across all Australian states and territories, Aboriginal children are over-represented in out of home care (Barber, Delfabbro, & Cooper, 2000; Bath, 1994; Victorian Auditor-General, 2005). On the 30th of June 2004, 531 of the 4,309 children living in out of home care within Victoria were of Aboriginal decent (Victorian Auditor-General, 2005). This amounts to a placement rate of 41.4 per 1,000 Aboriginal children, in contrast to 3.3 per 1,000 for non-Aboriginal children (Victorian Auditor-General). Despite the fact that Aboriginal children are between six to seven times more likely to be in out of home care than non-Aboriginal children (Bath, 1994; Cashmore et al., 2006), Barber et al. (2000) found that the Aboriginal children in their sample, regardless of voluntary or involuntary placement, did not spend any additional time in care than non-Aboriginal children.

The majority of Australian children entering out of home care, (i.e., 94%) are in some type of home-based care (Sawyer, Carbone, Searle, & Robinson, 2007). Nation-wide, foster care placements have plummeted. For the period of June 1999 to June 2004, foster care placements reduced from 45% of all total placements to 33% (Victorian Auditor-General, 2005). Similarly, throughout the same period, Australia has undergone a drop in residential care placements from 13% to 9% (Victorian Auditor-General). On the other hand, during the same five-year period, the proportion of kinship care and permanent care placements rose from 25% to 31%, and 17% to 26% respectively (Victorian Auditor-General). It is clear from these figures that permanent care placements saw the greatest increase over this period.

Legislative Framework

The two Acts governing the welfare and protection of Victorian children are the Community Services Act 1970 and the Children, Youth, and Families Act 2005 (Victorian Auditor-General, 2005). The Community Services Act 1970 describes the standards to which the Department of Human Services (DHS) must adhere to when providing its community services. The code also applies to Community Service Organisations (CSOs), namely, non-government organisations subsidised to perform services on behalf of the DHS. On the other hand, the Children, Youth, and Families Act 2005 stipulates the manner in which the Children's Court and child protection services function (Victorian Auditor-General). In particular, the Act grants child protection workers the legislative authority to investigate accusations of child abuse and neglect, and essentially, gives them the power to apply to the Children's Court and remove children from maltreating parents (Brydon, 2004b, Smyth & Eardley, 2008; Victorian Auditor-General, 2005). In addition, the Children, Youth, and Families Act 2005 describes, and oversees, the roles and power of the child protection division of the Children's Court. The

Act denotes the statutory responsibilities of the DHS to safeguard children and young people from the damage and consequences of abuse and neglect. In partial response to its accountability, DHS administers out of home care services. Several principles underpin the ways in which the Children, Youth and Families Act functions. First, the overriding ideology is that in each case, the child's safety and wellbeing prevails. Second, when the DHS' involvement is required in order to maximise a child's safety, the least invasive form of intervention should be implemented (Victorian Auditor-General, 2005). Third, it is preferable that children are cared for by their biological parents, and ideally, family preservation policy should be put into practice where possible (Brydon, 2004a). Hence, the preferred option is to keep the child in his or her own home, and engage the services of a child protection worker. If this is inappropriate under current family circumstances, the child will be placed into out of home care as a last resort (Brydon). On occasion it may be crucial to provide a range of specialist family support services in order for birth parents to continue parenting their child (Victorian Auditor-General, 2005). Referral services are utilised with the intention of empowering birth parents to adequately care for their child (Brydon, 2004a). In line with the child's best interests, the child's reunification with his or her family or origin is always the primary objective (Smyth & Eardley, 2008; Victorian Auditor-General, 2005). Lastly, children and their parents should, whenever possible, actively involve themselves in the decisions which affect them (Victorian Auditor-General). Even so, some parents, regardless of the amount of support given, continue to provide inadequate or maltreating care (Brydon, 2004a, 2004b). These cases necessitate the child's placement into permanent care (Bath, 1994; Brydon, 2004a). For this, child protective services will apply to the Children's Court for a Permanent Care Order. Whilst it is never clear if permanent placement will result in a higher quality of care, or, in more favourable developmental outcomes (Brydon, 2004a), the damaging

effects of child maltreatment have been extensively documented, and is further explored in the following section.

Maltreatment

Research into child maltreatment has evolved noticeably over the last 40 to 50 years. Shifting from a strict focus on extreme physical child abuse, today, child maltreatment has broadened to embrace a more sophisticated understanding of child abuse and neglect (Higgins, 2005). In its simplest form, child maltreatment can be defined as an incident of omission or commission in which a child obtains injury, be it physical, sexual, developmental, or emotional. Child maltreatment typically occurs within a context of family or social dysfunction, and is categorised by a deficit of the environment to fulfil a child's developmental requirements (Edwards, 1995). The five most commonly cited forms of maltreatment are physical and sexual abuse, psychological maltreatment (i.e., emotional abuse and psychological neglect), physical neglect, and witnessing family violence (Higgins, 2005; Lee & Hoaken, 2007). Specifically, *physical abuse* denotes the physical assault of a child that results in the manifestation of bodily pain. Lacerations, fractures, bruises, and burns are products of physical abuse (Kinyard, 1998). *Sexual abuse* relates to the sexual exploitation of a child in which sexual advances, coercion, or manipulation is imposed upon the child, leading to the child's participation in acts such as sexual language, fondling, and intercourse (Patton & Mannison, 1996). *Psychological maltreatment* refers to the harm of a child's social, emotional, behavioural or cognitive functioning through the means of *emotional abuse*, namely, acts of rejection, corruption, isolation, terrorism, verbal assault, overpressure, or degradation (Glaser, 2002; MacMillan & Munn, 2001; Rosenberg, 1987) *and psychological (or emotional) neglect*, where the caregiver provides inadequate loving care, support, and affection (Brydon, 2004b; Glaser, 2002; Hildyard & Wolfe, 2002). *Physical neglect* results from a

caregiver's failure to provide one or more of; adequate housing, nutrition, sanitation, supervision or medical attention, thereupon endangering the child's welfare (Carter & Myers, 2007; Hildyard & Wolfe, 2002; Manly, 2005). *Witnessing family violence* refers, in most cases, to the occurrence of exaggerated inter-parental conflict, wherein repeated beatings, weaponry assaults, suicidal or homicidal attempts, and property damage are observed by a child (Rosenberg, 1987). On the whole, maltreatment research has attracted considerable criticism. Encapsulating these is an ambiguity in the construct's dimensions, inconsistency in the definitions adopted by researchers, and variation in utilised empirical methodologies (Manly, 2005). To a great extent, researchers continue to debate the characterisation of particular maltreatment subtypes (Higgins & McCabe, 2000; Rosenberg, 1987). Clearly, a concise, constant, operationalised definition of child maltreatment, and its subtypes, is essential for progress within the child maltreatment arena.

It is not uncommon for children living in out of home care to have experienced abuse or neglect at the hands of their original family (Dorsey et al., 2008; Herrenkohl et al., 2003; Holtan et al., 2005; McAuley & Trew, 2000; Minnis & Devine, 2001; Patton & Mannison, 1996; Payne, 2000; Vig, Chinitz, & Shulman, 2005; Zima et al., 2000). In fact, child abuse and neglect are the chief underlying causes as to why children are removed from their homes into out of home care (Pearce & Pezzot-Pearce, 2001; Schneiderman, 2003; Stovall & Dozier, 2000). For example, in an Australian study by Bromfield and Higgins (2005), sampling 100 families from a regional child protection jurisdiction, the most common incidences of child maltreatment were found to be neglect and physical abuse, affecting 38.5% and 26.3% of the sampled population respectively. According to other research, however, of the various forms of child maltreatment identified, psychological maltreatment appears to be the most prevalent (Khamis, 2000).

Psychological maltreatment has been assumed to be the central constituent of all other maltreatment types (Manly, 2005; Ney, Fung, & Wickett, 1994). Still, being the most recently recognised category of child maltreatment, the conceptual foundation upon which psychological maltreatment research is built is feeble (Brydon, 2004b; Khamis, 2000; Rosenberg, 1987; Schneider, Ross, Graham, & Zielinski, 2005).

In general, researchers have studied the various maltreatment subtypes in separation, with little effort undertaken to assess interrelations between maltreatment subtypes. However, there is mounting evidence to suggest that maltreatment subtypes do not occur in isolation (Higgins, 2005; Higgins & McCabe, 1998; MacMillan & Munn, 2001; Manly, 2005; Ney et al., 1994). In fact, it has been estimated that a large percentage of maltreated children are liable to experience a variety of maltreatment subtypes rather than the repetitive acts of a single form of maltreatment (Higgins, 2005; Higgins & McCabe, 1998; Richards, Wood, & Ruiz-Calzada, 2006; Vranceanu, Hobfoll, & Johnson, 2007). In contrast to children with no maltreatment history, or victims of a single form of maltreatment, children who have experienced multiple forms of maltreatment typically exhibit more excessive trauma symptomology, that may well consist of anxiety, depression, sleep disturbance, and so forth (Higgins, 2005; Higgins & McCabe, 2000). Poor family connectedness, inflexibility, and deprived interfamilial relationships have been identified among the best predictors of multi-type maltreatment (Higgins & McCabe, 2000).

The common characteristics connecting the various maltreatment types have been poorly investigated, leading to the potential over-approximation of some types of maltreatment, and under-approximation of others (Higgins, 2005; Manly, 2005). There is literature to suggest that each form of maltreatment – be it physical or sexual abuse, psychological maltreatment, physical neglect or the witnessing of family violence – bears

unfavourable immediate and long-term consequences on children (Brydon, 2004b; MacMillan & Munn, 2001; Mastern, Best, & Garmezy, 1990; Rosenberg, 1987). It is imperative to recognise that each form of maltreatment is harmful, and that every subtype is equally worthy of empirical investigation, clinical intervention, and identification of mechanisms of prevention (Higgins, 2005; MacMillan & Munn, 2001).

Throughout Australia, child protection notifications have been found to be on the steady increase (Cashmore et al., 2006; Clark, 1995; Edwards, 1995; Winkworth, 2003). In fact, national figures have more than doubled over the last five years, from 107,134 in 2000, to 252,831 in 2005, an increase of 42.4% (Cashmore et al., 2006). In the state of Victoria, 6,024 of 26,622 notifications made between the years of 1993-94 were substantiated (Clark, 1995). Specifically, of these 6,024 substantiations, 1,224 were deemed severe enough to involve the Children's Court (Clark). Approximately half of the cases warranting court action resulted in the removal of the child into out of home care, typically foster care, by way of court order (Clark). Each subsequent year post 1995, the number of Australian children in out of home care has risen. In particular, placement rates have increased by 69%, from 13,979 children in 1996 to 23,695 in 2005 (Cashmore et al., 2006). As child protection notifications and overall numbers of children entering out of home care systematically rise, it becomes progressively obvious that child welfare systems throughout Australia will be unable to manage all their service requirements (Cashmore et al.). The breakdown of out of home care placements and the subsequent replacement of children into other homes, places additional strain on Australian welfare systems. The literature and implications of multiple placements are discussed below.

Multiple Placements

It is not unusual for carers to find themselves at a loss when caring for a child in out of home care. The carer may be ill-equipped for the child's difficult behaviours, disturbed history, and seeming inability to form attachments (Holloway, 1997; Kalland & Sinkkonen, 2001). In addition, the carer may also lack the emotional tolerance, flexibility, or parenting experience necessary to establish a mutually harmonious relationship (Banyard, Englund, & Rozelle, 2001; Delfabbro, Osborn, & Barber, 2005; McDonald, Propp, & Murphy, 2001). Perhaps in a natural course of action, where these issues are irresolvable, placement breakdown, it may be argued, is inevitable.

Literature from a series of sources postulates that placement breakdown is not always disadvantageous for a child (Holloway, 1997; Minty, 1999). If a child was placed in an out of home care placement that was, by definition incongruous, its collapse could permit child protection services to evaluate its nature and the reasons behind its downfall, and ultimately arrange for a more fitting placement (Mitchell et al., 2003). Nevertheless, for a number of children, placement breakdown may further impair the child's emotional and behavioural development, and become an additional source of pain and suffering (Kenrick, 2000; Newton, Litrownik, & Landsverk, 2000; Pardeck, 1984; Strijker, Zandberg, & van der Meulen, 2005; Webster, Barth, & Needell, 2000; Taussig, 2002; Tomlinson, 2008). Multiple placements refer to recurring moves whilst in out of home care.

Research has consistently demonstrated the widespread use of multiple out of home care placements. In Australia, an investigation undertaken by Barber, Delfabbro, and Cooper (2001) established that of 235 South Australian children entering out of home care between May 1998 and April 1999, after four months 125 had experienced at least two changes in placement. It may be fair to argue therefore, that with every subsequent

placement, children experience a progressively greater impermanence, perception of rejection, and inability to form stable attachment relationships (Webster et al., 2000). Future placements are also likely to become unstable (Leathers, 2006; James, Landsverk, & Slymen, 2004; Webster et al., 2000). The number of placements a child experiences while in out of home care has been connected to the emotional and behavioural difficulties displayed by the child, along with the child's age, gender, and ethnicity (Webster et al., 2000). These authors have criticised prior research regarding multiple placement and placement instability because of different methodologies, fluctuating variables of significance, and enquires dated 10 to 20 years back. Nonetheless, Webster et al. have noted that a constant and reliable finding is that children who remain in out of home care for longer periods of time are prone to experiencing more multiple placement changes. Other empirical research examining emotional disturbances among out of home care populations concluded that multiple placements, as opposed to the overall period of time in care, had greater momentum in driving the development of emotional disturbances (Brydon, 2004a). Furthermore, these authors have argued that multiple placements, along with the delays associated with re-placement, may in fact further damage a child's health and sense of security, perhaps more so than their original family situation.

Outcomes of Children Exiting Out of Home Care

It is not unusual that parents of children in out of home care have histories of drug addiction, alcohol abuse, or emotional disturbance (Kupsinel & Dubsky, 1999; Schwartz, 1991). Exposure to an environment of adversity renders these children susceptible to an increased vulnerability to out of home care placement stressors, such as the potential loss of birth parents and adjusting to a new family (Kupsinel & Dubsky, 1999). The potential costs and benefits of keeping a child in the biological home must be thoroughly and

thoughtfully assessed before placing a child into out of home care (Colón, 1978). Stripping the child from his or her home, attachment relationships, and social surroundings is unfavourable (Bath, 1994; Brydon, 2004a; Colón, 1978). This avenue may also result in additional emotional damage upon the child (Kelly et al., 2003). Severing a child's ties to the biological family system can result in a shared familial sensation of profound personal loss (Colón, 1978; Singer, 2008). Still, without sufficient care and support, it is possible that these children will experience greater impairments in their physical, psychological, and social developments (Rutter, 2000; Victoria Auditor-General, 2005). The social and economic implications are enormous. A large proportion of these children will require ongoing supports for homelessness, substance abuse, and mental health issues (Bath, 1994; Kelly et al., 2003; Mendes & Moslehuddin, 2004; Morris, 2007; Schwartz, 1991; Victoria Auditor-General, 2005). In fact, at the time of exiting out of home care, children are developmentally behind their same-aged counterparts in the general population, and continue to realise poorer outcomes throughout their lives (Forbes et al., 2006; Howe & Fearnley, 2003; Lonne & Thomson, 2005; Roy & Rutter, 2006; Rutter, 2000; Taussig, 2002; Yeatman & Penglase, 2004). Frequently, children formally cared for by the state experience poor social connectedness, coupled with poor personal relationships (Schwartz, 1991). Many researchers assert that there is a profound lack in ongoing state-funded support for former out of home care populations. These researchers declare that young people exiting the out of home care system are forced to fend for themselves within the community (Forbes et al., 2006; McMillen & Tucker, 1999; Mendes & Moslehuddin, 2004). In their study, Forbes et al. (2006) reported that at the time of exiting care, approximately half of the children in their sample were unemployed, undertaking parenting responsibilities, or serving jail sentences. Of the limited number of young people holding full-time working positions,

standard incomes were exceptionally low. International studies have reported similar results (McMillen & Tucker, 1999). For example, Hill and Thompson (2003) stated that 75% of care leavers (children exiting the out of home care system) in the United Kingdom had no academic qualifications, 50% were out of work, and 17% of all females were either expecting, or already, mothers of children. Moreover, 20% of out of home care leavers become homeless within two years of leaving care in the United Kingdom (Hill & Thompson). A recent South Australian study investigating the mental health and wellbeing of children and young people aged between 6 to 17 years residing in home-based foster care in metropolitan Adelaide (Sawyer et al., 2007), identified a high prevalence of mental health issues across its sample. Specifically, 61% of all participants displayed problem behaviours, the most widespread being attention problems, social problems, and delinquent problems. Ratings provided by caretakers suggested that 53.4% of the sample required professional services for their mental health problems, of which only 26.9% sought help over the previous six-month period (Sawyer et al.). A Canadian study evaluating mental health issues among 115 out of home care children (Stein, Rae-Grant, Ackland, & Avison, 1994), found the prevalence of psychiatric disorders in the sample to be between 41% and 63%. It was further established that 25% of the children had two disorders, and 33% had at least three (Stein et al.). The most prevalent psychiatric disorder, affecting anywhere between 28% and 60% of out of home care children is conduct disorder (Kelly et al., 2003). Other common psychiatric disorders affecting these children include panic disorder, major depression, oppositional defiant behaviour, and generalised anxiety disorder (MacMillan & Munn, 2001). Further, elevated rates of co-morbidity are widespread amongst out of home care populations (Hill & Thompson, 2003). Children are reported as displaying increasingly more intricately severe difficulties than previously known to child protection and health care professionals

(Kelly et al., 2003; Sawyer et al., 2007). It is possible that less extreme problems may also lay undiscovered (Hill & Thompson, 2003).

A disproportionate number of children previously cared for in out of home care grow up to have children that too, become involved with Child Protection Unit (CPU). This is referred to as the Cycle of Care. Within the general population, 0.43% of children are on Care and Protection Orders. Whereas, Forbes et al. (2006) found that 54% of the children of previously cared for young people in their study had been placed on Care and Protection Orders. The children of former out of home care youth typically enter child protection services at a younger age, and remain in out of home care for greater periods of time (Forbes et al., 2006). The literature also addressed the cost of out of home care, especially when outcomes may be negative. The annual cost of keeping a single child in care in Victoria equates to $33,791. Throughout their lifetime, each individual that leaves the out of home system at age 18 costs the Victorian Government $738,741 (compared to -$78,879 for the general Victorian adult). This figure does not take account of Commonwealth Government outlays, the private costs connected with supporting young people, and the costs maintained by past carers and caseworkers who may, even after the cessation of their responsibilities, continue emotional and monetary supports. Further still, this figure does not account for the loss of opportunity and reduced quality of life these children experience as a result of their multiple disadvantages (Forbes et al.).

Process Towards Permanent Care

Family Preservation

Both nationally, and internationally, the escalating costs associated with the rising numbers of children entering out of home care have begun to put tremendous strain on the limited child welfare resources (Ainsworth, 1997; Lindsey, Martin, Doh, 2002; Hussey & Guo, 2005; Kelly & Blythe, 2000; Mattingly, 1998). In order to reduce government out of

home care service expenditure, a cost effective alternative to out of home placement is necessary (Kelly & Blythe, 2000; Lindsey et al., 2002). Pioneered as a possible solution, family preservation was conceptually introduced in 1974 through the *Homebuilders* program by two American psychologists who wanted to assist families in the fundamental skill acquisition requisite to care adequately for their children (Ainsworth, 1997; 2001; Bagdasaryan, 2005; Biehal, 2005; Campbell, 2004; Denby & Curtis, 2003; Gendell, 2001; Lindsey et al., 2002). The Homebuilders' model was first introduced to Australia in 1991 (Campbell, 2004), and has since resulted in a number of family preservation program initiatives (Ainsworth, 2001; Mattingly, 1998).

Theoretically, family preservation is grounded in a shared philosophy of child rescue and conventional child welfare practice (Ainsworth, 1997). Where investigations of alleged child maltreatment identify examples of severe abuse or neglect, and the child is perceived to be under threat, the child welfare worker examining the case has the authority to apply to the Children's Court to secure their right to continue to implement protective practices (Lindsey et al., 2002; Littell, 2001). Family preservation ideology rests on the premise that it is always in the child's best interests to preserve familial bonds and prevent his or her removal into out of home care (Ainsworth, 1997; 2001; Melton, 1996). In accordance with this stance, US out of home placements have been designed to be as short as possible with a presiding emphasis on family reunification at the soonest opportunity (Ainsworth, 1997). Increasingly, Australia is beginning to operate under a similar perspective (Ainsworth, 1997; 2001; Campbell, 2004; Scott, 1994). Intervention and treatment support facilities are now considered to be suitably equipped to guarantee the wellbeing of children, even within the context of the original maltreating environment (Lindsey et al., 2002). Intensive services performed by qualified child protection caseworkers may thwart many preventable placements (Ainsworth, 1997; Campbell,

2004; Lindsey et al., 2002) and result in a decrease in the number of children entering out of home care.

It is acknowledged that a number of families may well benefit from family preservation services; however, families with increasingly complex familial, social, and economic backgrounds may need intervention in excess of the 30 to 90 days provided by family preservation services (Denby & Curtis, 2003; Kelly & Blythe, 2000; Lindsey et al., 2002; Littell & Tajima, 2000). Seen this way, a much broader approach aimed at addressing a multitude of deep rooted structural problems may be more effective in producing the true long lasting effects desired for these families (Ainsworth, 1997; 2001; Lindsey et al., 2002).

Where attempts towards family preservation do not appear promising, and the child seems unlikely to reunify with his or her family or origin, it is common procedure to take steps towards placing the child permanently with alternative caregivers.

Permanency Planning

During the 1980s, permanency planning was introduced in America as a mechanism of attaining well-timed permanency for children and evading out of home care drift (otherwise referred to as placement instability or placement break-down) (Barber & Delfabbro, 2005; Barber et al., 2001; Berry, Propp, & Martens, 2007; Brydon, 2004a; Gendell, 2001; Kupsinel & Dubsky, 1999; O'Neill, 2000b; Scott-Heller, Smyke, & Boris, 2002). In 1997, with the establishment of the Adoption and Safe Families Act, permanency planning received further legislative support (Barber & Delfabbro, 2005; Berry et al., 2007; Budd, Felix, Poindexter, Naik-Polan, & Sloss, 2002; Humphrey et al., 2006; McWey & Mullis, 2004; Scott-Heller et al., 2002; Silverstein & Kaplan-Roszia, 1999). The Act stipulated provisions to ensure that children did not return to unsafe homes after experiencing stays in out of home care. Further, under the Act, alternative

permanent homes were sought for children who were not able to safely return to the care of their parents (Ansay & Perkins, 2001; Barber & Delfabbro, 2005; Budd et al., 2002; Humphrey et al., 2006; Webster et al., 2000). As a practice, permanency planning can be conceptualised as a sequence of acts centred towards the realisation of adoption (Brydon, 2004b).

According to American legislation, within 12 months of residing in out of home care, a child's case must be brought before the court for a permanency hearing (Barber & Delfabbro, 2005; O'Neill, 2000b). From then forward, permanency hearings must be conducted on a continual, once yearly basis (Barber & Delfabbro, 2005; Webster et al., 2000).Where a child has been under the care of the state for 15 of the previous 22 months, the state is required to commence an appeal for the termination of parental rights (Barber & Delfabbro, 2005; Berry et al., 2007; Gendell, 2001; Kemp & Bodonyi, 2000; O'Neill, 2000b). In Australia, the term *dispensation of consent* is used to refer to a corresponding process. Specifically, under the provision of the Victorian Adoption Act 1984, in instances where a parent has, devoid of reasonable grounds, failed to release the responsibilities of a child's parent/s for over a year, dispensation of consent is expected to take place (O'Neill, 2000b). Likewise, in accordance with the Victorian Children, Youth, and Families Act 2005, the court is able to grant a Permanent Care Order for children who have been in out of home care for at least two years, or alternatively, for two of the preceding three years (Brydon, 2004b). Moreover, the child's parent must be incapable or indisposed of recommencing care and guardianship of the child or conversely, continuing parental care and guardianship must be perceived to be detrimental to the child's safety and wellbeing (O'Neill). Victorian legislation provides no further reference to a permanency planning framework (Brydon, 2004a; 2004b). Hence, it is generally accepted that permanency planning cannot commence in Victoria until two years post child welfare

intervention (Brydon, 2004a). Clearly, this belief is not consistent with permanency planning philosophy. Be that as it may, dispensation of consent is comparatively uncommon in Australia (Barber & Delfabbro, 2005). It would be plausible to imply therefore, that many Australian children remain in out of home care for indefinite periods of time (Barber & Delfabbro). In the interim, efforts aimed at family reunification continue, and unless evidently hazardous or upsetting to the child, parent-child contact is preserved (Barber & Delfabbro).

Parental Visitation

Regular contact between children in out of home care and their birth parents is necessary in instances where family reunification is the objective (Ansay & Perkins, 2001; Leathers, 2002; 2003; McWey & Mullis, 2004; Maluccio, 1998; Masson, 1997; Sanchirico & Jablonka, 2000). The concept of contact is centred on parental visitation, however contact can also be made otherwise, via telephone, celebrative attendance, or written media (Masson, 1997; Sanchirico & Jablonka, 2000). Typically, the parental visitation system is initiated with closed, supervised meetings between parents and their children. With time, successful visitation may progress to unsupervised day visits, and subsequently, weekend visits (Sanchirico & Jablonka, 2000). Under this arrangement, as a child nears his or her homecoming, parental visits become longer, and occur on a more regular basis with fewer restrictions. Hence, when the time comes for the child to be reunited with his or her family of origin, the transition is likely be made as smoothly as possible (Sanchirico & Jablonka).

Parental visitation is an integral component of many case plans in which birth parents wish to resume care and guardianship of their children (Leathers, 2003; Masson, 1997; Sanchirico & Jablonka, 2000; Sykes, 2001). A parent's awareness of his or her child's safety, happiness, and comfort, can be attained through parent-child contact. This

knowledge could assist parents in managing any feelings of loss and anguish that may surface (O'Neill, 2000b). Continued parent-child contact may promote the caregiver's self-assurance in performing their out of home care parenting responsibilities (Sykes, 2001). Even though parental visitation can be harmful for some children, most cases, consistent contact from birth parents is considered favourable to a child's emotional and physical development, adjustment, and wellbeing (Colón, 1978; Leathers, 2003; McWey & Mullis, 2004; O'Neill, 2000b; Robinson, Kruzich, Friesen, Jivanjee, & Pullmann, 2005; Sykes, 2001).

Parental visitation has been found to predict children's overall lengths of stay in temporary out of home care (Kemp & Bodonyi, 2000; McWey & Mullis, 2004; Robinson et al., 2005). In addition, parental visitation may aid in maintaining parent-child attachments and strengthening children's perceived sense of security (McWey & Mullis, 2004; Masson, 1997; Robinson et al., 2005). This is particularly important in cases where family reunification is desired (D'Andrade & Duerr-Berrick, 2006; Leathers, 2003; McWey & Mullis, 2004; Masson, 1997; Sanchirico & Jablonka, 2000). In addition, it is possible that these actions will also reinforce the emotional connection between children and their out of home carers, reducing the likelihood of placement breakdown (McWey & Mullis, 2004; Masson, 1997). All the more, previous data confirms that deprived parent-child attachments may have disadvantageous effects on the wellbeing of children in out of home care (McWey & Mullis, 2004). In support of this view, there is research showing that children who receive frequent visits from their birth parents have less emotional and behavioural difficulties, when compared to children that receive no parental contact (Leathers, 2003; McWey & Mullis, 2004). In contrast, other empirical studies have found no connection between parental contact and child adjustment and wellbeing among out of home care populations (Leathers, 2003; McWey & Mullis, 2004). Elsewhere, the

perception that parental contact has the potential to hinder carer-child bonding processes has also been put forward (Sykes, 2001). Where a relationship between parental visitation and wellbeing has been found, it may be equally plausible perhaps that children scoring higher on measures of adjustment are more likely to maintain contact with their biological parents merely because they possess greater competence in social interaction. Thus, the relationship between parental visitation and child adjustment is likely to be bidirectional, and therefore cannot be attributed to the participation in visitation alone.

Family Reunification

Recent years have seen mounting interest in family reunification studies (Maluccio, 1998). Still, the overwhelming majority of these studies are American based, while Australian investigations of family reunification are minimal at best (Ainsworth, 2001). This is a potential cause for concern, as inevitably, most Australian children in out of home care are reunited with their biological families at some point (Ainsworth). Theoretically, family reunification is well aligned with family preservation and permanency planning philosophies, in that each weighs significance on family connectedness and champions a child's right to a safe, and preferably biological, familial environment (Ainsworth, 1997). Family reunification specifically relates to the process of providing support and services to children, families, and out of home carers, in an effort to move towards the reunification of children and their birth families. In particular, supports and services endeavour to facilitate the most favourable child-family relations feasible at any one time, ranging from parental visiting during the child's out of home stay, to the full re-integration of the child within the family of origin (Ainsworth). Recent work stipulates that through the continued maintenance of parent-child bonds, child wellbeing is augmented during out of home care (Ainsworth, 1997, 2001; Maluccio, 1998). It is for this reason that regular contact is scheduled between children and their

birth families. Children from minority backgrounds, so it has been proclaimed, may be in predominant need for continued parent-child contact (Ainsworth, 1997). Denying minority children the opportunity to interrelate with members of their own cultural group may negatively influence the development of their ethnic identity (Ainsworth). Further, it appears that the majority of children are reunified with their families, or alternatively, initiate contact with their family upon exiting the out of home care system (Ainsworth, 1997, 2001). Countless numbers of children have experienced unsuccessful placement prevention and reintegration efforts (Ainsworth, 1997, 2001; Maluccio, 1998). In these cases, deficits in parents' caregiving capacities continue to be visible (Ainsworth, 1997, 2001; Maluccio, 1998). Inadequate parenting proficiency, negligible awareness of child development, poor social support mechanisms, and an inability to moderate one's own behaviour have all been established to predict re-entry into out of home care (Ainsworth, 1997, 2001). Further still, children displaying emotional and behavioural difficulties are half as likely to be reconnected with their biological families (Maluccio, 1998). Where exceedingly inadequate parenting practices continue within an ailing and potentially dangerous family system, it may indeed be in the child's best interests to enter permanent out of home care, sparing the child from the joint damages of maltreatment, and the instabilities of systematic forced attempts at reunification (D'Andrade & Duerr-Berrick, 2006; Mulligan, 2003).

Dispensation of Consent

Dispensation of consent, or termination of parental rights, as the process is otherwise known in America and the United Kingdom, can be defined as the course of action in which parental contact is severed, including all modes of correspondence. Parents are no longer able to prepare for their children's future, and are not informed about their status and welfare (O'Neill, 2000b). Essentially, parents have no power or

authority in matters that relate to their children. Dispensation of consent may occur voluntarily, in cases where a parent willingly relinquishes his or her parenting rights, or involuntarily, in which a parent has presented with a pathological condition or has demonstrated criminal behaviour, and is unable to provide a safe home for their child, even after significant intervention (Barone, Weitz, & Witt, 2005; Dyer, 2004; Maynard, 2005; Walton, 2002). Dispensation of consent occurs in concert with the Victorian Adoption Act 1984. In congruence with similar state and international Acts, the Victorian Adoption Act stipulates that dispensation proceedings might be initiated if a child's case plan objectives have not been met by the birthparents within the time frame specified (Gendell, 2001; Humphrey et al., 2006; Kemp & Bodonyi, 2002). Once dispensation of consent has been ordered by the court, the child becomes legally free, and a permanent placement for the child is sought (Kemp & Bodonyi, 2002). However, there is no guarantee that permanency will be established, primarily because legal requirements denoting the security of a permanent care placement before the initiation of dispensation hearings do not exist (Kemp & Bodonyi). As a consequence, children can experience long waits, and numerous other short-term placements, before permanency is legally obtained (Kemp & Bodonyi). A report by The Victorian Auditor-General (1996) found that 331 of the 1,287 children in state care three years post their initial removal into out of home care, had not found permanency. In addition, isolated incidents have been reported to extend over periods of 10 years.

Permanent Care

Permanent care is an out of home care service providing legally free children with a permanent home-based living arrangement (O'Neill, 1999). Permanently placed children can be cared for by members of their existing, extended families, or otherwise, by alternative caregivers, whom receive accreditation from the permanent care agency

responsible for the child's placement (Kirby & Hardesty, 1998; Smyth & Eardley, 2008; Victorian Auditor-General, 1996). In congruence with children's rights provisions, permanent care aligns itself conceptually with the belief that safe, constant, and encouraging caregiving actively supports positive child development (Ajduković & Sladović-Franz, 2005; Victorian Auditor-General, 1996). Permanent carers assume all legal responsibilities over the child, including the child's guardianship or custody, by way of a Permanent Care Order, until the child is considered to be of age. Depending on the particular country and state, this age can range from 16 to 18 years. Victorian children are cared for permanently until the age of 18 years (O'Neill, 2000a). The terms *long-term foster care*, *permanent foster care* and *adoptive arrangement* can be used almost interchangeably to refer to the process of permanent care, depending upon which state or country one finds him or herself in. Trends in current research support the claim that permanent care placements are considerably less likely to result in breakdown when compared to other, short-term placements, such as foster care (Mulligan, 2003; Triseliotis, 2002).

For each child meeting the applicable legislative requirements, permanent care teams carefully consider the suitability of permanent care placement (Smyth & Eardley, 2008; Victorian Auditor-General, 1996). Permanent care teams must match children with available families in a manner that is favourable to both parties. In most cases, younger children under the age of eight, with no intellectual disabilities, and with limited facility-based care are easiest to place (Victorian Auditor-General, 1996). Within Victoria, many children currently reside in permanent out of home care. Figures from the Department of Human Services confirm a total of 994 special needs adoption and permanent care placements between the years of 1987 - 2000 in Victoria alone. Indeed, authors such as Winkworth (2003) propose a continuing upward trend in the issue of child protection

orders and numbers of children living in permanent out of home care. Within Victoria, roughly 6,000 children enter temporary out of home care arrangements, such as short-term foster care, on an annual basis (O'Neill & Absler, 1998). Of these children, a large proportion will, in time, be converted from short-term placement to permanent placement or removed and re-placed into permanent care (O'Neill & Absler). Similarly, available data from 1992 to 1995 show an increase in the number of Permanent Care Orders issued by the state of Victoria. Specifically, 1992 to 1993 saw 11 Permanent Care Orders, 1993 to 1994, 44, and 1994 to 1995, 135 (Victorian Auditor-General, 1996). While it is clear that Permanent Care Orders were issued progressively more in the later years, the number of Permanent Care Orders is still substantially below international, and indeed requisite, state figures. Several explanations can be employed to address these low statistics. They include an unwillingness by some caregivers to undertake permanent parenting responsibilities for the child currently under their care. This may be especially apparent where children are perceived as challenging or biological parents are obstinate or uncooperative (Victorian Auditor-General). Likewise, even if a Permanent Care Order is issued by the courts, biological parents have the right to appeal against the Order (Edelstein et al., 2002). Perhaps as a result, DHS has demonstrated a substantial disinclination in petitioning for Permanent Care Orders, with the exception of cases in which consent is willingly relinquished by parents. Furthermore, for the eligibility of a Permanent Care Order to take effect, it is necessary for children to have established permanency within the permanent care placement (Smyth & Eardley, 2008; Victorian Auditor-General). Generally, this means that the child must reside with the family for an extensive period of time before a Permanent Care Order can legally be granted. An audit conducted in 1996 found that permanent care placement teams had little funding, limited power to endorse their objectives, and restricted support from DHS (Victorian Auditor-

General). DHS was accused of placing preference on short-term out of home placements, and incessantly attempting family reunification. Little effort was made to find suitable permanent placements that could eventually evolve to Permanent Care Order (Victorian Auditor-General). In response to these criticisms, DHS has in more recent years endeavoured to reinforce the permanent care program's services and operations, and ultimately increase the accessibility of permanent placements state-wide.

Summary

Legislation exists to govern the procedure leading to placement into permanent care. With the child's best interests in mind, the primary objective is to have the child returned to the biological family. For children who are unable to return home safely, stability is often achieved through permanent care placement. Permanent care involves the placement of a child on a protection order with an approved permanent carer. Permanent carers become the legal parents of the child.

Children can adjust favourably to permanent care placements and develop stable relationships with new carers. The following section explores how relationships are formed between children and caregivers in biological and permanent care contexts.

Forming Relationships

Caregiving and Attachment

The connection between quality of care and subsequent attachment quality has been extensively acknowledged throughout the literature. Timely, consistent, effectual responsivity from caregivers has been empirically linked to secure attachment, and exploratory behaviour in children (Marty, Readdick, Walters, 2005). Conversely, care characterised by apparent lacks in sensitivity, such as when a caregiver is irresponsive, emotionally unavailable, or abusive, is an efficient predictor of insecure attachment (Carlson, Sampson, & Sroufe, 2003; Stovall & Dozier, 2000). More specifically, negative

responses, rejection, and emotional unavailability from caregivers have been associated with anxious-avoidant attachment, while unpredictable, intrusive, inattentive care has been linked to anxious-resistant attachment (Carlson et al., 2003). More current literature has established a link between frightening and confusing caregiving and disorganised attachment (Howe & Fearnley, 2003; Pearce & Pezzot-Pearce, 2001; Reder & Duncan, 2001). When compared to socioeconomically matched, non-abused children, previously maltreated children are considerably more prone to developing anxious-avoidant, anxious-resistant, or disorganised attachment relationships with their primary caretakers (Carlson et al., 2003). Parental depression, perceived loss, and prenatal substance abuse, have also been connected to disorganised attachment in infancy (Carlson et al.).

A child's repeated experiences lead to the development of generalisations about adult availability, the contingency of others' behaviours, self worth, and one's own ability to master the environment (Bowlby, 1969; Milan & Pinderhughes, 2000; Svanberg, 1998). These generalisations develop to form internal representations of self (or working models), specifically, underlying beliefs about the self, which guide future attachment behaviours (Bartholomew, 1990; Bowlby, 1969; Hodges, Steele, Hillman, Henderson, & Kaniuk, 2003; Moss, Cyr, & Dubois-Comtois, 2004). It has been extensively documented that erratic or insensitive parenting may impair a child's internal working models, contributing to significant problems in his or her interpersonal relationships (Milan & Pinderhughes, 2000). Children who have experienced insensitive parenting typically enter new situations with pessimistic beliefs and expectations, uncertainties, and low levels of perceived self-competence (Milan & Pinderhughes). In contrast, children whom are securely attached display increasingly more inquisitive, autonomous, ego-resilient behaviours (Marty et al., 2005). Further, securely attached children typically outperform

their insecure counterparts in tests of development and language acquisition (Marty et al.).

Disturbances in Attachment

The quality of attachment a child experiences with his or her adult caretaker has been associated with the specific style of interaction the child experiences early in life (Bartholomew, 1990; Smyke, Dumitrescu, & Zeanah, 2002). According to Bowlby (1969), disturbances in attachment begin to manifest between four to six months of age, and are triggered by the unavailability of the caregiver to share a physical or emotional bond with their child. Ample literature concurs that separations occurring while a child is between six months to four years of age regularly result in the experience of psychological disturbance (Smyke et al., 2002; Zeanah et al., 2004; Zilberstein, 2006).

Out of home care, where the loss of the child's primary attachment figure is frequently endured, may bare witness to an overwhelming experience of grief, anxiety and despair (Vig et al., 2005). On top of their loss of all that known to them, children removed from biological homes with maltreating adults may fear subsequent maltreatment from new caretakers and may be highly anxious (Vig et al.).

Children who are unable to develop secure attachment relationships often present with attachment disorder (Hughes, 1999; Zeanah et al., 2004; Zilberstein, 2006). Attachment disorders can result from a single traumatising event such as a sudden disruption of the family environment or parental abandonment, or through repeated traumatising events including abusive or neglectful parenting, hospitalisation or multiple placements (Hughes, 1999; Zeanah, 1996). On this basis, children entering out of home care may fit the criteria for a Reactive Attachment Disorder (RAD) diagnosis, distinguished as noticeably troubled and developmentally unsuitable social relatedness in the first five years of life (Vig et al., 2005; Zeanah et al., 2004).

Due to its relatively recent introduction, Reactive Attachment Disorder in children is not fully understood (Zeanah et al., 2004; Zilberstein, 2006). Criteria for RAD are indistinct and under researched (Zeanah et al., 2004; Zilberstein, 2006). Researchers disagree about the common symptoms RAD children display, and whether RAD is under-diagnosed or over-diagnosed (Zilberstein, 2006). As a consequence, the diagnostic utility of RAD is limited (Zilberstein). Further still, child psychopathology is often determined by a multitude of factors, and indeed, attachment may be but one constituent of many (Zilberstein). In effect, backgrounds that foster attachment difficulties typically consist of multiple risks and deficits separate from the respective attachment style displayed by the child (Hughes, 1999; Zilberstein, 2006). Similarly, many aspects of the carer-child relationship fall outside of the area of attachment. These include disciplining and playing with the child (Zilberstein, 2006), and may also influence the child's self-development and regulation (Smyke et al., 2002; Zilberstein, 2006). It may be fair to argue therefore, that RAD symptomologies emerge from a variety of etiologies encompassing both child qualities, and factors, so too, independent of the caretaking environment, namely temperament, poverty, Foetal Alcohol Syndrome, and premature birth (Zilberstein, 2006). This notion is supported by research from various populations (Hughes, 1999; Smyke et al., 2002; Vig et al., 2005). Particularly in the case of young children, whose internal working models may by no means at that stage be concrete, a dysfunctional relationship with a primary caretaker may in reality reflect the relational skills and abilities of the caregiver him or herself rather than the child's internalised schema of attachments (Zilberstein, 2006).

Attachment in Out of Home Care

When a child is placed into out of home care, the quality of attachment the child experiences is influenced by the timing of the placement, the child's case history, and by the quality of caregiving received by the child (Carlson et al., 2003; Cole, 2005; Dozier, 2005; Howe, 2001; Howe & Fearnley, 2003). Children who establish permanence early within their first 12 months of life are as likely to formulate healthy attachments with caregivers than children cared for by their biological parents (Carlson et al., 2003; Cole, 2005; Howe, 2001; Howe & Fearnley, 2003). This is particularly true when children are reared within safe, affectionate, and consistent environments (Carlson et al., 2003). Alternatively, children who are placed permanently later in life experience problems with their social, emotional, and behavioural adjustments (Carlson et al., 2003; Howe, 2001; Neil, Beek, & Schofield, 2003). Current trends corroborate previous fears that child maltreatment, separation, loss, and placement drift have potentially detrimental effects on child development (Carlson et al., 2003; Howe, 2001; Hughes, 1999; Robinson, 2002). Placement disruption has been associated with distorted attachment relationships, maladaptive behaviour, and interruptions in social cue perception and interpretation (Carlson et al., 2003). Indeed, older infants separated from their primary caregivers demonstrate behaviours which are exceedingly resistant, depressive, clingy or withdrawn (Dozier, 2005; Stovall & Dozier, 2000). Moreover, children with insecure attachments may have gaps in their development that ultimately hinder their willingness and capacity to develop attachment relationships with substitute carers. These attachment difficulties can challenge even amongst the most devoted and affectionate of families (Hughes, 1999).

Previous research has consistently highlighted the relevance of affective caregiver-infant relations on infant growth and development within institutionalised

settings. It is widely accepted that affective caregiver-child interactions nurture children's cognitive, perceptual, motoric, and emotional development (Carlson et al., 2003). It may be unsurprising therefore, that developmental disintegration may well result where a primary attachment relationship is for whatever reason unavailable (Carlson et al.). Similarly, emotional and behavioural problems are likely to manifest in children who have experienced privation before being placed into temporary out of home care (Howe, 2001). It is extensively recognised for example, that previously institutionalised children have a propensity to form disordered attachments when placed into out of home care. Further, these children have multiple problems that include aggression, tantrums, and attention-seeking (Carlson et al., 2003; Howe, 2001; Vorria et al., 2003). Short stays in institutional care, limited to the first few months of life are found to be less deleterious than when institutionalisation is prolonged. Still, there is research indicating that although harmful, consequences of maternal privation may be less than enduring (Rutter & Sroufe, 2000). However, further research is required to form any definite conclusions.

It has been suggested that children who have experienced significant trauma in their attachment relationships are largely unable to comprehend parent-child relational dynamics (Hughes, 1999; 2003). Having devised strategies to enable them to endure their maltreating environments, these children feel threatened to enter potentially rewarding, complementary, carer-child relationships (Howe & Fearnley, 2003; Hughes, 1999). By dropping their guard, they believe they risk losing their independence and self control, thereupon leaving themselves susceptible to vulnerability. For this reason, the child comes to accept that he or she must frighten or manipulate the caregiver (Hughes, 1999). By appearing happy, polite, fun-loving, and pleasant, the child takes command over the environment. This way, the child is able to influence the adult into providing what is desired. Then, upon having served his or her needs, the child loses interest in the adult

and emotionally withdraws him or herself from the relationship (Hughes). Subsequently, should the child require something from the adult once again, he or she displays superficial friendliness to manipulate the adult as before. Where the adult elects not to pursue the child's desires, the child will attempt to locate another adult capable of doing so (Hughes). If this is not possible, the child may once again return to the carer and in an explosion of anger, threaten or intimidate the carer into getting what he or she wants (Hughes). At this point, should the child not succeed in achieving his or her means, he or she will endeavour to hurt, upset or anger the carer. Most of the time, this is achieved by stealing or breaking the carer's belongings (Hughes).

In summary, it is clear that the child's previous attachment experiences may present challenges for permanent carers attempting to form new relationships with them. Still, the relationships achieved by permanent carers and their children may also be influenced by a range of carer and child variables; these will be discussed in the following section.

Carer Characteristics

Parenting

As a consequence of their traumatic pasts, maltreated children may come to believe that all parents are unreliable, rejecting, and hurtful (Gordon, 1999). They enter out of home care uncertain of how to instigate receptive care from their caregivers; and even when supportive, sensitive care is indeed elicited, children are hesitant and ill-equipped to respond (Howe, 2001; Howe & Fearnley, 2003). In consequence, the behaviours of their caregivers are often misconstrued. In line with pre-established internal working models, even the most affective of actions can be interpreted as masking insincere motives. Apprehensive children may refrain from placing uncontrolled confidence or trust on their out of home caregivers, choosing instead to remain aloof

(Gordon, 1999). Their independence is instrumental, and children are reluctant to release their reins of control. They may be angry and insecure, having considered themselves as undeserving of love (Gordon). They support poor perceptions of self, and are regularly overcome by bouts of sadness and anxiety (Kretchmar, Worsham, & Swenson, 2005). Their erratic histories have taught them that at times they are fed, whilst at others, inevitably abused or neglected. This imposes upon their capacities to infer rationally from, and predict adequately, their environments (Gordon, 1999). As these variables combine and interplay, caregivers might feel unneeded or inadequate and begin to engage in an increasingly disconnected way with the child (Dozier, 2005; Howe, 2001; Howe & Fearnley, 2003). Ultimately however, this reaction may act to re-traumatise the child (Gordon, 1999).

As a process, parenting is complex, stressful, and diverse (Daniel, Wassell, & Gilligan, 1999; Stams, Juffer, & vanIJzendoorn, 2002). According to Banham, Hanson, Higgins, and Jarett (2000), a parent's role consists of guiding and supporting the child under their care, while simultaneously facilitating his or her learning and development. Constituents universally common to parenting include the provisions of basic care such as feeding, clothing and housing; security and protection; consistency and stability of care; emotional and physical intimacy; encouragement and praise; supervision and control; delegation of age-appropriate tasks and responsibility; and the allowance of age-appropriate autonomy to facilitate independent decision making (Daniel et al., 1999). Non-biological parent figures can undertake parenting (Daniel et al., 1999; Hoghughi & Speight, 1998). However, parenting a child in the context of out of home care may be considerably more stressful (Banyard et al., 2001; Gordon, 1999; O'Neil, 2006), and can involve variables that differ from parenting a biological child (Lipscombe et al., 2003; Neil et al., 2003). Clear amongst these are recognising, accepting and understanding the

child's past, including preceding parenting practices and any unfavourable experiences associated with these, difficult or disturbed behaviours and their management, the child's defence mechanisms and any attachment difficulties, and the carers' attempts at forming secure emotional ties with the child while simultaneously maintaining contact with the child's family of origin (Lipscombe, et al., 2003).

Certainly, permanent placement and birth relate to two exceptionally dissimilar processes of joining families (Gordon, 1999). The permanently placed child arrives with pre-established attachment figures, a history of maltreatment or abandonment, issues of separation and loss, and has, in all probability, encountered at least one preceding short-term placement or welfare drift. For this reason, one could argue that the permanent carer-child relationship is by its very essence compensatory (Milan & Pinderhughes, 2000), meaning that the permanent carer essentially assumes the role of parent for the permanent care child. Consistent with this view, Eizen and McIntosh (2004) coined the term "psychological mother" to reflect the position adopted by primary out of home carers. In addition to their newfound parenting role, permanent care parents need to accommodate for their permanent care child's potential behavioural and emotional difficulties, mistrusts, and issues of separation and loss (Orme & Buehler, 2001; Stams et al., 2002). Even so, the emotional and behavioural problems displayed by children are not easily overcome, and close, intimate relationships are met with resistance, at any rate. Affection, compassion, and parenting strategies useful in parenting securely attached children appear unbefitting when parenting children with attachment difficulties (Gordon, 1999). Years of patience, love, and protection can go unanswered, seeing countless problem behaviours increase in severity sooner than decrease (Gordon).

It has been asserted however, that carers do possess the capacity to sufficiently manage the problematic behaviours displayed by their children (Gordon, 1999). Further,

existing data suggest that children with attachment disturbance are able to develop healthy attachment relationships when placed within a positive family environment (Gordon). According to Milan and Pinderhughes (2000), children with a dysfunctional primary caretaker may sustain or return to an adaptive trajectory by establishing a positive relationship with an alternative adult. It may be fair to suggest therefore, that the permanent care child's out of home care parents may aid in the child's adjustment and concept of self. Thoughtful, accessible, empathic care from caregivers may help to conquer damaged perceptions of self, and help children to restructure internal working models (Howe, 2001). In a longitudinal study conducted by Schofield and Beek (2005), children who had an increased capacity to use their primary out of home carers as a secure base were progressing better in their placement than those children who could not. In line with this assumption, studies have found that higher quality parent-child relations predict better cognitive and social development (Stams et al., 2002). Further, positive parenting behaviours displayed by the permanent carer may lower the incidence of problem behaviours, and defend against maladjustment, by developing a positive emotional bond between the carer and his or her permanently placed child (Cairns & Kalsbeek, 2006; Lipscombe, Moyers, & Farmer, 2004; Mastern et al., 1990; Orme & Buehler, 2001).

Empathy

Empathy: History, Definitions, and Conceptualisation

The construct of empathy is complex and has been defined in a variety of ways. There is considerable variability in construct composites; different theories proposing different operationalisations and phenomenological applications.

In a parallel notion of *Einfühlung*, that was expanded upon by Lipps (1903; 1905; cited in Davis, 1994), Titchener (1909; cited in Davis, 1994), introduced the word

empathy to the English speaking world. Over the years, the Lipps/Titchener conceptualisation of empathy, involving an active, intentional effort on part of the observer to place the self emotionally within the experience of another, continued to influence literary approaches to the empathy construct until 1929, and the work of Köhler. Köhler (1929; cited in Davis 1994), hypothesised that empathy reflected the observer's understanding of another's emotions. In this sense, empathy was underpinned by a cognitive capacity, enabling the observer to construe the emotional and physical cues of another. This perception held the sharing of emotions to be, at best, secondary to the fact (Davis, 1994). Following in this direction, two theorists, Mead (1934) and Piaget (1948), had momentous influence in identifying the cognitive element of empathy. Mead, in his work on role-taking, expressed the observer's ability to assume the role of the other in an attempt to comprehend his or her experience. Piaget, conversely, was progressing theoretically within the child development arena. According to his premise of decentering, children, initially born with an inability to draw distinctions between the occurrences encountered or observed by the self and the other, come to construct such an understanding later in their cognitive development (Piaget, 1948).

Similar to the views of Mead and Piaget, a succession of researchers came to expand the theoretical grounding of the cognitive concept of role-taking. In particular, a string of researchers contributed to the substantial growth in role-taking aptitude assessment measures (Davis, 1994). In a second wave of research, investigators inspected the function of empathy in boosting social acuity, namely the precision of one's perception of another. Still, in the 1950s, a series of methodological problems in key assessment systematology resulted in the withdrawal, and ultimate discarding of cognitive role taking inquiry (Davis). To some extent, for a period thereafter, subsequent investigations of the construct were focused on empathy's emotional component (Davis).

In recent times, authors have pushed for an inclusive, multifaceted approach to address the absolute dimensionality of the empathy construct. A series of theorists, including Hoffman (1987) and Davis (1983) have proposed comprehensive, multilayered theoretical models. Hoffman suggested six ways in which an observer comes to experience affect somewhat comparable to that of the target. The first, *motor mimicry*, and the second, *primary circular reactions*, relate to essentially biological, automatic, elementary cognitive functions. The third, *classical conditioning*, and the fourth, *direct association*, involve relatively superior processes, necessitating the presence of at least moderately complex cognitive capacities within the observer. Lastly, the fifth, *language-mediated association*, and the sixth, *role-taking*, comprise the two most highly developed modes. Language-mediated association concerns the activation of semantically stored emotions and occurrences within the observer, potentially analogous to those expressed by the target. Role-taking on the other hand, necessitates a conscious attempt by the observer to mentally envision him or herself within the incident experienced by the target, and react affectively. As such, Hoffman's conceptualisation clearly involves an interaction between the humanistic inbuilt capability for emotional response and a person's expanding cognitive capacity, ultimately enabling him or her to react empathically.

Davis (1983, 1994), arguably the most prominent figure in more recent empathy-related research, and developer of one of the most commonly accepted, and frequently utilised models of empathy, defines the construct as a personality trait or stable ability, ultimately comprised of a series of cognitive and emotional components. Included amongst these are the cognitive ability of perspective taking, the affective abilities of empathic concern and personal distress, and the shared cognitive/affective abilities of fantasy. *Perspective taking* refers to the cognitive ability of acquiring another person's

perception, and consequently, viewing things as they would. *Empathic concern* refers to the inclination to feel sympathy or apprehension for an individual other than the self. *Personal distress* refers to the propensity to become distressed by negative episodes or incidents experienced by others. *Fantasy* refers to the ability to become emotionally engaged in imaginary conditions. As fantasy necessitates the individual to change their perspective and respond emotionally, both cognitive and emotional elements comprise this component.

With an intention of examining the dimensionality of empathy, Brems (1989), surveyed 122 undergraduate psychology and sociology students at an American university. Using several measures of empathy, including the Interpersonal Reactivity Index (IRI; Davis, 1980), Brems identified two independently occurring facets of empathy, one being cognitive in nature, and the other, affective. Consistent with Hoffman (1987) and Davis (1983), Brems' suggested that the affective facet of empathy was, to a greater extent, a dimension of primitive sophistication, occupying constructs shown to surface early on in the humanoid developmental cycle. Conversely, high scores on the perspective taking component of the IRI, combined with low scores on the corresponding personal distress constituent, were interpreted to confirm the higher cognitive capacity and non-egocentric affect of the cognitive facet of empathy (Brems, 1989).

Empathy and the Caregiving Environment

A number of studies, across a variety of populations, have provided support for a relationship between empathic parent characteristics and child adjustment (Barber, Bolitho, & Bertrand, 2001; Bell & Richard, 2000; Kochanska, Friesenberg, Lange, & Martel, 2004; Labay & Walco, 2004; Solantaus-Simula, Punamaki, & Beardslee., 2002; Walker & Cheng, 2007). These empathic characteristics include parental warmth, affection and positive involvement. Further, evidence exists that low parental empathy

can be a cause of child maltreatment (Kilpatrick, 2005). In comparison with non abusing parents, abusive parents are predisposed to engaging in more negative, forceful, coercive interactions with their children, responding less suitably to their children's needs, expressing more negative affect, and utilising harsher disciplinary practices, and punitive rearing strategies (Miller & Eisenberg, 1988). In a study investigating the connection between empathy and the utilisation of various parenting practices, Brems and Sohl (1995) found that participants scoring lower on their measure of empathy more readily approved corporal punishment as a suitable mode of discipline. Empathic participants, on the other hand, more frequently utilised rewarding parenting strategies (Brems & Sohl). Taking this into consideration, parental empathy from permanent caregivers may be particularly important for permanent care children who may have experienced low parental empathy from their biological parents (Miller & Eisenberg, 1988). Oosterman, Schuengel, Slot, Bullens, and Doreleijers (2007) found a lower incidence of placement breakdown amongst children who were cared for by supportive, nurturing, motivated, and concerned out of home carers. Nevertheless, due to the adversities associated with separation and incidences of maltreatment, it may be difficult for permanent care parents to provide a constantly empathic environment for their permanently placed children.

The central role of empathy in the emotional bond between individuals has been noted in research literature (Barnett, King, Howard, & Dino, 1980; Brems & Soul., 1995; Crenshaw & Hardy, 2007; Eisenberg & McNally, 1993; Kiang, et al., 2004). Kiang et al. (2004) postulated that parental empathy was frequently experienced by children who assumed a secure relationship with their primary caretaker. In his own work, Bowlby (1969), provided support for a relationship between attachment and empathy. Similarly, contemporary investigations have also provided empirical support for this relationship (Britton & Fuendeling, 2005). Researchers have suggested that empathy from caregiving

figures is fundamental throughout infancy, contributing the survival and thriving of the young child (Kochanska et al., 2004; Zahn-Waxler, Robinson, & Emde, 1992). Yet, it would be erroneous to assume that an empathic carer-child dyad has benefits only in infancy. Evidence suggests that empathy from caregivers is critical across the entire carer-child relationship (Brems & Sohl., 1995).

In accordance with Davis (1994), Flory (2004) postulated that empathy is comprised of both cognitive and affective components, namely perspective taking and other-oriented emotions including empathic concern for another's distress. Essentially, however, Flory's theory of parental empathy extends on Davis' in that Flory stresses the influence of parental cognitions in the facilitation or hindrance of a parent's empathy towards their child. In particular, Flory proposes four cognitions fundamental in determining whether a parent will have empathy for their child. These are the beliefs that the child is a good person; is reasonable; genuine in the emotions that he or she is exhibiting; and emotionally dependant on the parent (Flory, 2004, 2005). Alternately, the cognitions that preclude parental empathy are that the child is antagonistic, difficult to deal with, dubious or disingenuous in the emotions he or she is displaying, and that the child is not emotionally dependant on the parent (Flory, 2004, 2005). Parents who regard their children as hostile attribute malice to their children's underlying motives (Flory, 2004). Similarly, in believing their children are unreasonable, parents distance themselves psychologically from their children, ultimately trusting that irrational or insincere thoughts and judgements underpin their children's actions. In much the same way, by believing their children conceal their true inner emotions, choosing instead to communicate insincerely, parents bar themselves from appreciating the true emotional conditions of their children. Lastly, by perceiving their children as emotionally independent, parents numb themselves to their children's actual state of dependency,

possibly leading to a loss in parenting drive. In this respect, parental cognitions may have an important influence on the interpretation of child behaviours and sense of parental competence.

Literature has examined the ways in which parents' interpretations of child behaviour and parent capabilities influence parental affective response and control strategies (Bugental, Blue & Cruzcosa, 1989). These authors have reported that cognitive inferences may contribute to long-range coercion in parents. Parents with more positive future expectations show more adaptive coping responses through an increased capacity to attribute negative life events to their own controllable behaviour, whereas abusive parents embrace beliefs reflective of low perceived control, and respond to difficult children with elevated physiological reactivity (Bugental et al.).

It would appear likely that parents can have different levels of empathy towards each of their children, with cognitions diverging between each specific child (Bugental et al., 1989; Flory, 2004). It is possible for a parent to have positive cognitions about one child, and negative cognitions about another. Moreover, a parent may have a different interpretation for the same behaviour depending on which child is exhibiting the particular action or reaction (Flory, 2004).

Numerous elements may be attributed to the development of negative cognitions. Clear amongst these are, beliefs about the child formulated before the child's delivery, stress and any unfavourable events, the resemblance of the child to a disliked relation, as well as the parent's own experience of deprived parental care (Flory, 2004). Similarly, a host of secondary situations, such as the unfavourable assessment of the child by members of extended or nuclear family, and the child's own conduct and behaviour may possibly act to initiate, or strengthen further, a parent's negative cognitions towards their child.

According to Flory (2004, 2005), the negative cognitions a parent has about his or her child disturb the parent's ability to interpret empathically the behaviours the child displays. Further, negative cognitions may result in negative parental affect and behaviours that do not meet the child's emotional needs, therefore increasing child distress. For example, maternal preconceptions about parenting can present lasting qualities in the child's care giving environment (Kiang et al., 2004). These attitudes are stable and considerably resistant to change, more so than the parenting behaviours themselves, and can even influence parent's accuracy in perceiving and responding to their children's cues (Kiang et al.).

In line with this proposition, researchers examining mothers' hostile attribution tendencies have asserted that mothers' negative attributions about their children may indeed serve as self-fulfilling prophecies. Nix et al. (1999) found that mothers' harsh discipline practices mediated mothers' hostile attribution tendencies and children's externalising behaviour problems exhibited at school. In the same way, other literature postulates that parents' negative child-centred emotions, such as hostility, dislike, anger, and rejection correlate with numerous unfavourable and damaging child outcomes. These outcomes include child social, motor, attachment, and cognitive development impairments (Kilpatrick, 2005).

Deficits in parental empathy may support the development and prolongation of childhood psychological disorders (Brems & Sohl, 1995; Flory, 2004; Kilpatrick, 2005). According to Flory (2004), through parental empathy, parents acquire the information about their children's needs necessary to parent their child. Parents who are empathic are able to distinguish the conditions which distress their children, and are capable of responding appropriately to their children's cues. Alternatively, parents who are not empathic are unable to provide supportive parenting. As a result, their children have

difficulty in regulating their emotions. Over time, dysregulation may lead to depression or anxiety.

Research by Mehrabian (1977) suggested a positive association between empathy and arousability. Overall, individuals scoring higher on ratings of empathy were found to be more arousable, screening stimuli less. As such, empathic persons were more sensitive to interpersonal cues. Of the genders, females were more arousable, and were shown to screen less than males. Mehrabian's results also established a higher rate of neuroticism, anxiousness, sensitivity to rejection, and affiliation among non-screeners. Similarly, non-screeners were driven less by achievement (Mehrabian).

Empathic parents are less likely to engage in parenting dictated by attributional biases and stereotypic formulations (Brems & Sohl, 1995; Dix, Ruble, & Zambarano, 1989). Conversely, parents who are unable to infer their children's emotions, or are uncertain of how to respond to the cues displayed by them, are more likely to base subsequent behaviours on stereotypic conventionality. When speaking, playing, or disciplining their children, parents act in response to the gender and temperamental characteristics of their child, rather than the child's state of emotions (Brems & Sohl, 1995). Preconceived notions may interfere with a parent's capacity to interpret the behavioural cues exhibited by their child (Brems & Sohl). All the more, a connection has been established between negative attributional tendencies, unsuitable emotional responsivity, excessively forceful, coercive, and punitive rearing strategies, and harmful or abusive parenting practices (Kilpatrick, 2005). Still, Brems and Sohl (1995) suggested that parental attributions and associated expectations are not always detrimental to the parent-child relationship. Arguing that certain child behaviours do remain constant across time, the authors maintained that assumptions do not necessarily become problematical unless they are strictly upheld, at which point they may potentially obstruct parental

objectivity and the appropriate evaluation of the emotion, thereupon resulting in a poor selection of parenting strategy (Brems & Sohl). A cause for concern, perhaps, was that empathic participants in the Brems and Sohl study chose also to approve punitive rearing strategies upon receiving previous information of a child's challenging behaviour. Empathic caregiving, therefore, may do little to deter negative parenting practices guided by negative preconceptions of child behaviour.

There is empirical evidence that children can influence parenting behaviour. Strayer and Roberts (2004) noted that a child's constant demonstration of anger may reduce parental warmth. However, the reverse is also acknowledged; wherein the parent's warmth may alleviate the child's anger. Still, in interpreting their results, Strayer and Roberts concluded that parental effects are more pronounced than child effects, at least, in the period of middle childhood. Thus, in accord with the literature, it would appear that permanent carers capable of sustaining a parenting strategy high in child focussed empathy would be more likely to support the development of positive carer-child interactions, child resilience, and child psychological adjustment.

Parenting Styles

Parents contribute substantially to their children's cognitive, emotional, physical and social development (Banham et al., 2000). The influence of different parenting styles has been noted in various child developmental literature (Baumrind, 1996; Banham et al., 2000; Hoeve, Blokland, Semon-Dubas, Loeber, Gerris, & van der Laan, 2008; Lengua, 2006; Russell, Hart, Robinson, & Olsen, 2003; Steinberg, Lamborn, Darling, Mounte, & Dornbusch, 1994; Werner, 1994; Winsler, Madigan, & Aquilino, 2005; Zhou, Deng, Eisenberg, Wolchik, & Tein, 2008). *Parenting styles* can be defined as the relatively stable overall emotional climate within which particular parent-child interactions occur (Baumrind, 1996; Coplan, Hastings, Lagace-Seguin, & Moulton, 2002; Darling &

Steinberg, 1993). Baumrind, a key figure in parenting experiential and observational research, identified three independently occurring styles of parenting, each based upon separate sets of expectations, behaviours, beliefs, and value systems, entitled authoritarian, authoritative, and permissive parenting. In particular, Baumrind established that interplay between two variables, responsiveness and demandingness, moulded the style of parenting exhibited by caregivers (Aunola, Nurmi, Onatsu-Arvilommi, & Pulkkinen, 1999; Baumrind, 1996; 2005; Berg-Nielsen & Holen, 2003; Lengua, 2006; Letcher et al., 2004). The former, *demandingness*, concerns the parent's engagement of the child in mature, accountable behaviours, in an attempt to achieve socialisation (Baumrind, 1996, 2005). The latter, *responsiveness*, refers to the parent's appointment of accommodative, helpful, and encouraging actions to fulfil the child's needs; thus, ultimately encouraging development of self-confidence and independence (Baumrind, 1996, 2005). Empirically, the constructs of demandingness and responsiveness are also recognised alternatively as parental control and warmth, respectively. *Authoritarian* parents employ harsh, boundary-stricken rearing strategies against a widespread lack of warmth (Kaufmann et al., 2000; Winsler et al., 2005). As such, authoritarian parents are high on demandingness, but low on responsiveness (Aunola & Nurmi, 2005; Baumrind, 1996; Coplan et al., 2002; Darling & Steinberg, 1993; Steinberg, Blatt-Eisengart, & Cauffman, 2006). They scrutinise the behaviours of their children ensuring they conform and comply with a pre-established set of standards (Carter & Welch, 1981; Coplan et al., 2002). Their disciplinary regulation is stern and unrelenting (Dix et al., 1989; Patock-Peckham, Cheong, Balhorn, & Nagoshi, 2001). By and large, children are considered subordinates and are allowed little autonomous activity. Parents demand respect and power of authority and household rules must be followed inevitably (Coplan et al., 2002; Patock-Peckham et al., 2001). In many cases children with authoritarian parents are given

developmentally inappropriate, adult-like responsibilities. Authoritarianism is liable to produce children whom are exceedingly reliant, inert, and insecure (Coplan et al., 2002).

Authoritative parenting is demanding, yet responsive (Aunola & Nurmi, 2005; Baumrind, 1996; Darling & Steinberg, 1993; Kaufmann et al., 2000; Steinberg et al., 2006). Parents are involved and affectionate. They exercise firm control, emphasising standards of behaviour consistent with the developmental capacities of the child, ensuring the child performs various age-appropriate tasks (Carter & Welsh, 1981; Coplan et al., 2002; Winsler et al., 2005). The child's independence and individualism is respected, however, the child is taught that he or she is accountable for one's own actions (Darling & Steinberg, 1993). Parents promote a free exchange of parent-child communication, and discipline is consistent, logical and implemented after due explanation and opportunity for objection (Baumrind, 1996; Coplan et al., 2002; Dent & Cameron, 2003). Parenting objectives are achieved through a delicate balance of authority, consistency, and democratic rationality (Kaufmann et al., 2000). The children of authoritative parents are cooperative, inquisitive, mature, affective, and confident (Coplan et al., 2002; Robinson, Mandleco, Frost-Olsen, & Hart, 1995; Steinberg et al., 2006). *Permissive* parenting is typified by low levels of demandingness and low to high levels of parental responsivity (Aunola et al., 1999; Baumrind, 1996; Winsler et al., 2005). Permissive parents are positive, tolerant, and accepting of their children's needs. They use little punishment, and have few demands and expectations of their children (Patock-Peckham et al., 2001). Compliance is achieved through a combination of child motivation and compromise. Literature has established that at the onset, children act in accordance with their parent's desires; however, sooner or later, children come to influence their parents in an attempt to achieve their own objectives. Permissive parents play little part in shaping their children's behaviours, believing their children are capable of making choices for themselves (Carter

& Welch, 1981; Patock-Peckham et al., 2001). Generally speaking, permissive parents fit one of two subtypes, indulgent or indifferent. *Indulgent* parents are affectionate and care deeply for their children. They are undemanding and highly responsive (Darling & Steinberg, 1993; Steinberg et al., 2006). On the other hand, *indifferent* parents can, through carelessness and inattention, project child-related negligence. Their self-involvement concentrates family life and disciplinary action in accord with adult needs. They proffer autonomy as a method of avoiding the responsibilities associated with parenting their child. The views and attitudes of their children are not prioritised. Habitually, indifferent parents do not supervise the play of their children (Daniel et al., 1999). For these reasons, the indifferent parenting style is low in both demandingness and responsiveness (Darling & Steinberg, 1993; Steinberg et al., 2006). Children of indulgent parents are increasingly reckless and immature, and are easily overcome by peer pressure. Children of indifferent parents are impetuous, delinquent, and narcissistic (Daniel et al., 1999).

It has been proposed that the authoritarian (highly demanding and directive) and permissive (tolerant, low limit setting) parenting styles constitute a negative emotional environment within which the child needs are rarely met (Banham et al., 2000). On the other hand, authoritative parenting, where the parent is demanding yet responsive, promotes psychological autonomy and behavioural compliance (Baumrind, 1996; Coplan et al., 2002). Empathy and affective warmth from parents, typical of the authoritative parenting style, provides children with an incentive to partake in collaborative or cooperative action with their parents (Baumrind, 1996). Further, it can be speculated that these patterns are likely to be reflected in the child's subsequent social interactions. Parents with this parenting style convey the message that their child is worthwhile (Hattie, 1992). This factor may therefore assist children in developing inner controls and

clearer definitions of self (Hattie). Furthermore, research suggests that children with authoritative parents have a higher self concept (Dent & Cameron, 2003; Hattie, 1992) and a greater internalised moral orientation (Baumrind, 1996). On the contrary, exaggerated use of unrelenting or abusive disciplinary practices, at times emblematic of the authoritarian parenting style, may have the unintentional effect of enduring child problem behaviours (Nix et al., 1999). Dent and Cameron (2003) postulate an indefinite link between parenting style and attachment constructs. Secure attachments have been proposed to flourish amidst environments of caregiver accessibility, reliability, and compassion (Dent & Cameron). It is for this reason, that the authoritative parenting style, encapsulating all of these aspects, presents children with the potential to achieve secure attachment relationships (Dent & Cameron). Still, despite consistent findings throughout the literature, a clear criticism of parenting style typologies is the categorisation of parents into a single style of parenting, authoritarian, authoritative, or permissive. Certainly, it is plausible to suggest that a single parent can diverge in his or her childrearing practices in concurrence with differing situations, conditions, and child characteristics. Indeed, there is data in support of this suggestion (Carter & Welch, 1981; Coplan et al., 2002).

The parenting styles of out of home carers have been found to be influential in the overall development of out of home care placements and children's relationships with their carers (Lipscombe, et al., 2004). It has been documented that the optimum approach for parenting children in out of home care involves sensitive and open interactions that encourage emotional security, attachment and exploration, and constant, firm, and reliable control that places boundaries whilst supporting mastery and sense of control (Lipscombe, et al., 2003). This form of parenting shares similarities with the authoritative parenting style (Baumrind, 1996). As out of home care parenting becomes more insensitive, conflicting, confrontational and aggressive, child behavioural, emotional, and

cognitive development becomes increasingly challenging (Lipscombe, et al., 2004). A study focusing on the essential skills required to parent older children in out of home care (Schofield, Beek, Sargent, & Thoburn, 2000, cited in Lipscombe et al., 2004) stated adequate sensitivity in considering the child's behaviours, the carer's reactions to the child's behaviours, the carer's ability to accept the child's emotional needs, positive and negative characteristics, the carer's capacity for promoting negotiation and co-operation, and the carer's emotional and physical openness and accessibility to the child. A further critical aspect of adaptive parenting is the carer's empathy towards their child (Davis, 1994; Flory, 2005; Kilpatrick, 2005). Parental sensitivity and appropriate response to child signals, distinctive of empathic care, have been previously linked to the authoritative parenting style (Baumrind, 1996; Hattie, 1992).

Summary

Existing research has found evidence to support the importance of parental empathy and parenting style in parent-child relationships. Parents who are high in empathy and who are more authoritative in their parenting style appear to have more positive relationships with their children. Limited research conducted with out of home care populations seems to suggest that carer empathy and parenting style may be at least as important in carer-child relationships. In mind of the child's previous experiences, there is the potential for these variables to support children in their abilities to develop secure relationships with their permanent carers, whilst actively supporting child development.

Child Characteristics

Problem Behaviours

Disruption, trauma, and disordered relationships are characteristics universally common to children cared for by local authorities (Cairns & Kalsbeek, 2006; Sargent & O'Brien, 2004). Multiple stressors, both pre and post placement, predispose children to vulnerabilities in mental health (Legault, Anawati, & Flynn, 2006; Rutter, 1985; Sargent & O'Brien, 2004). Many children entering out of home care arrive with chronic developmental, health, and psychiatric disorders (Leslie et al., 2003; Nilsen, 2007; Simms et al., 2000). By measuring the prevalence of internalising and externalising behaviours, researchers have been able to assess the psychological adjustment of children living in out of home care. Generally speaking, *internalising behaviours* relate to the inner, more inhibited, essentially problematical, emotions and experiences of an individual (Aunola & Nurmi, 2005). Anxiety, depression, phobias, and withdrawal are exemplars of internalising behaviours (Liu, 2004). *Externalising behaviours* on the other hand, comprise difficulties of a more overt, outwardly nature (Aunola & Nurmi, 2005; Miller & Eisenberg, 1988). Physical aggression, conflict, hyperactivity, and disobedience are case in point examples (Campbell, Shaw, & Gilliom, 2000; Liu, 2004; Miller & Eisenberg, 1988). When externalising behaviours are at their most extreme, children may meet classifications for certain externalising disorders. Depending on the particular pattern of behaviours exhibited, children may be diagnosed as displaying one or more of conduct disorder, oppositional defiant disorder, or attention-deficit/hyperactivity disorder. *Conduct disorder* describes markedly disturbed interpersonal communications and relations (Rutter & Sroufe, 2000). Children with conduct disorder are forceful, violent, and aggressive (Campbell et al., 2000). Alternatively, *oppositional defiant disorder* refers to overindulgence in unlawful, predatory behaviours (Rutter & Sroufe, 2000). Children

with oppositional defiant disorder present with antagonistic, cantankerous behaviours that are often directed at figures of authority (Campbell et al., 2000). It has become increasingly clear that oppositional defiant disorder is often a precursor of conduct disorder, which manifests later in life (Liu, 2004; Rutter & Sroufe, 2000). *Attention-deficit/hyperactivity disorder* is a term used to describe two diverging, yet potentially co-occurring sets of problems. Children may meet guidelines for diagnosis by displaying either an inability to adapt or maintain one's attention within the confines of a controlled environment or by exhibiting a surplus of impetuous, restless, or overactive behaviour (Liu, 2004). Children presenting with conduct disorder are significantly more prone to engaging in a diversity of antisocial acts as adolescents, and continue their violent, delinquent ways well into adulthood (Liu). Hyperactivity has also been empirically correlated to criminality later in life, although be it, to a lesser extent. Children whom display a combination of conduct related problems alongside those of hyperactivity, inattention, and impulsivity have a predisposition to developing psychopathology later in life (Liu). Indeed, quantities of children undergoing clinical assessment for attention-deficit/hyperactivity disorder are also found to exhibit symptoms of conduct disorder or oppositional defiant disorder (Campbell et al., 2000). Alternatively, internalising behaviours developed during childhood are likely to result in anxiety and depression at maturity. In all actuality, literature supports a sizable co-morbidity between internalising and externalising problem behaviours (Liu, 2004).

Anxiety, depression, and disorders of conduct and hyperactivity plague out of home care populations. Current approximations suggest that anywhere between 29 to 96% of children exhibit emotional and behavioural difficulties of some sort (Simms et al., 2000). In one study, problematic emotional and behavioural difficulties were identified amongst 60% of five to 16 year olds (Minnis & Devine, 2001). Indeed, in their study,

Sargent and O'Brien (2004) reported a 77 - 99% prevalence of emotional and behavioural problems among their sample of foster care children. Further, disturbances in attachment were similarly paramount. Violent, aggressive, and overly sexualised behaviours together with irresponsive, self-destructive activities such as self-harm, criminality, and drug abuse were identified as particularly threatening to placement stability (Sargent & O'Brien). Clearly, a child's emotional and behavioural difficulties can invade and challenge each facet of his or her life, from his or her academic performance, to his or her capacity to converse and interact with caregivers (Sargent & O'Brien). Providing efficient and supportive care to children with emotional and behavioural disturbance and a history of instability can be a very difficult task. Out of home carers must be competent in managing a diverse range of mental health problems, varying from the less severe to the intricate. In many cases caregivers are likely to face worrying, discerning, and highly troublesome behaviours which can further complicate their caregiving roles. In addition, caregivers must sustain a variety of extra-familial relationships including relations with welfare workers and biological parents. Older children are likely to have spent longer periods of time in care, and have experienced greater instability, and a longer line of previous carers. Their overriding emotional and behavioural difficulties may place enormous strains on their caretakers (Sinclair & Wilson, 2003). In these cases, without adequate support from external services, placement breakdown can be expected to result (Rubin et al., 2004; Sargent & O'Brien, 2004).

Temperament

Deemed central to the child developmental process, temperament has received substantial empirical validation as a key contributing factor in the formation and maturation of a child's emotionality, sociability, and personality (Izard, 2002; Lengua, 2006; Szewczyk-Sokolowski, Bost, & Wainwright, 2005; Russell et al., 2003). Theoretically, temperament accounts for the differences present in individual arousal, self-regulation, reactivity, control, and styles of action (Coplan, Bowker, & Cooper, 2003; Eisenberg et al., 2005; McBride, Schoppe, & Rane, 2002; Szewczyk-Sokolowski et al., 2005). The characteristics underlying temperament, are, for the most part, believed to be biologically based. Traits emerge early in the developmental cycle (Katainen, Räikkönen, & Keltikangas-Järvinen, 1997; Smart & Sanson, 2001), and persist largely throughout the individual's life span (Belsky & Rovine, 1987; Lengua, 2006; Masten et al., 2005; Szewczyk-Sokolowski et al., 2005). Although temperamental characteristics are essentially innate, they are receptive to influence from the external environment (Katainen et al., 1997; Lengua, 2006; Ormel et al., 2005; Rutter, 1985; Smart & Sanson, 2005). The bulk of literature appears to propose that approximately half of the variance present in scores of personality is influenced by the individual's biology, while the other half is influenced by the external environment (Oniszczenko et al., 2003). Still, it is rare that a child's style of temperament will be subject to dramatic alteration. Smart and Sanson (2005) state the improbability, for example, of a withdrawn child growing up to become overly extroverted in adolescence. Hence, it would be more plausible to expect changes of a more modest magnitude (Smart & Sanson). From a conceptual perspective, temperament is considered to account for a series of personality traits instrumental to both the quality of, and regularity, of interpersonal interactions (Szewczyk-Sokolowski et al., 2005). Accordingly, some children are regarded as temperamentally easy, whist others are

temperamentally difficult. This continuum of easy-to-difficult temperament resulted from the work of Thomas and Chess (1977) in the New York Longitudinal Study (Daniels, Plomin, & Greenhalgh, 1984). Temperamentally easy children are highly adaptable to eternal circumstances, are attentive and aware, persevere regardless of difficulty, and are enjoyable and easy-going (Porter et al., 2005; Scaramella & Leve, 2004). Temperamentally difficult children, in contrast, oppose control, lack determination and enthusiasm, are negative and irritable, are difficult to comfort, are demanding and impulsive, and have difficulty in maintaining their attention (Nelson, Stage, Duppong-Hurley, Synhorst, & Epstein, 2007; Scaramella & Leve, 2004). Consequently, children displaying more difficult temperaments are often described as being short-tempered, disobedient, and irritable (Nelson et al., 2007). Similarly, they have difficulties adapting their emotions to suit external conditions, and can be socially inept (Szewczyk-Sokolowski et al., 2005). As infants, they cry often, and become easily agitated (Caldera & Hart, 2004). Of the children sampled in the New York Longitudinal Study, roughly 10% were characterised as demonstrating difficult temperaments during infancy (Daniels et al., 1984).

Some literature supports a connection between temperament and attachment. Sampling a total of 111 mother-child dyads, Lee and Bates (1985) suggested that a child's early relationship with his or her mother may mediate the link between temperament and the child's future development of challenging behaviour problems. Also, there is evidence that an infant's temperament, for example, may elicit a range of caregiving responses that may, sequentially, contribute to the style of attachment the child experiences thereafter (Vorria et al., 2003). It is likely therefore, that the infant's temperament, along with the caretaker's behaviour with the infant, share a hand-in-hand association with the quality of attachment experienced by the dyad (Morrisin & Mishna, 2006). However, other

researchers propose that the constructs of temperament and attachment relate to different psychological domains (Pierrehumbert, Miljkovitch, Plancherel, Halfon, & Ansermet, 2000). In partial accord, Szewczyk-Sokolowski et al. (2005) found that the attachment and temperament constructs contributed separately to peer acceptance. Temperament, for instance, emerged as a stronger predictor of peer rejection (Szewczyk-Sokolowski et al.). Also, Belsky and Rovine (1987) in their research of temperament and attachment security concluded that infant temperament influences the conveyance of attachment security or insecurity more than the development of attachment per se. Even so, empirical data on the temperament-attachment connection is far from unambiguous, and much research is required before any conclusions can be substantiated. From the emerging literature, one could quite plausibly assert that the effects of child temperament and parenting are bidirectional, each variable functioning to produce variance in the other (Berg-Nielsen & Holen, 2003; Kochanska et al., 2004; Lengua, 2006). It seems however, that a child's temperament may contribute to difficulties in attachment (Barth, Crea, John, Thoburn, & Quinton, 2005; Vorria et al., 2003). In line with his or her temperament, a child may be more inclined to react in certain ways to events or situations which may influence the way a parent in turn interprets and responds to the needs of the child (Edwards, 2002; Smart & Sanson, 2005). Overall, Szewczyk-Sokolowski et al. (2005) found a relationship between temperament and attachment security. In another study, Kochanska et al. (2005) found that security moderated the link between children's difficult temperament and their future socialisation. Thus, a child's temperament can operate in an indirect manner on attachment security by ensuring a potentially disadvantageous caregiving relational environment (Finzi-Dottan, Manor, & Tyano, 2006). Hence, the outcomes of a child's temperament on development are twofold; for one, eliciting behaviours within the self, as well as reactive response from others (Belsky, Hsieh, & Crnic, 1998; Smart & Sanson,

2005; Werner, 1994). It appears that although a child's temperament may predispose him or her to developing certain emotional or behavioural difficulties (Karp, Serbin, Stack, & Schwartzman, 2004; Kochanska, Aksan, & Carlson, 2005; Lee & Bates, 1985; Manders, Scholte, Janssens, & De Bruyn, 2006; Pierrehumbert et al., 2000), environmental factors too, present significant influence (Ormel et al., 2005; Smart & Sanson, 2005). In fact, empirically, environmental factors have been attributed to the development of behavioural difficulties such as hyperactivity and aggression (Smart & Sanson). Nevertheless, theorists argue that a warm, receptive caretaker is capable of developing a secure attachment with his or her child, in spite of the child's temperamental predispositions (Cole, 2005; Donald & Jureidini, 2004; Szewczyk-Sokolowski et al., 2005). For instance, Nelson et al. (2007) advocate that even children with the most difficult of temperaments may not show signs of challenging behaviour if they are parented by a caregiver who displays exceptional expertise in the management of child and family related responsibilities, and is able to competently resist stress. In this way, positive parenting can buffer the development of childhood behaviour problems (Letcher et al., 2004).

Common elements comprise temperamental dimensions across cultures (Porter et al., 2005). According to Smart and Sanson (2005), Australian children have undergone little change in temperament over the last 20 years, highlighting the stability of styles of temperament. Yet, trends in Smart and Sanson's research suggest that today's children may be slightly easier in temperament. Children of the 2000's are more sociable and less irritable (Smart & Sanson). The researchers nominate two plausible grounds upon which these changes can be attributed. The first of these is that there has been a growth in parental education and the second, that there has been a growth in the country's economy. These aforementioned factors have been associated with more effective parenting,

including superior relational qualities and disciplinary practices. Effective parenting has been linked to a reduction in substance abuse, antisocial behaviour, and depression incidences (Letcher et al., 2004). Still, it may be considerably more complicated to parent a child who is temperamentally difficult (Belsky, 1984; Finzi-Dottan et al., 2006; McBride et al., 2002; Oyserman, Mowbray, Meares, & Firminger, 2000; Scaramella & Leve, 2004). Furthermore, different children are affected by parenting in different ways (Stright, Gallagher, & Kelley, 2008; Kochanska et al., 2005; Sheffield-Morris et al., 2002). Not only can two children experience the same care from a parent in different ways, it is more than probable, that one may elicit consistent, responsive, empathic care from the caregiver, while the other is less able to do so (Finzi-Dottan et al., 2006; Sheffield-Morris et al., 2002). Sheffield-Morris et al. argued that children who are temperamentally susceptible to vulnerability may be more greatly affected by unresponsive, negative parenting. Scaramella and Leve (2004) suggested that despite empirical documentation that temperamentally difficult children appear to obtain more response and evaluation from their parents during analytic-type tasks such as problem solving, feedback is typically comprised of condemnation, parental interference, physical redirection, and a smaller number of opportunities to independently perform the set task. This may further aggravate a child's emotional or behavioural problems. Fagot and Leve (1998; cited in Scaramella & Leve, 2004) stated that children, categorised as temperamentally difficult, receive higher ratings of externalising behaviours from both teachers and parents at age five. It is possible that it is the caregiver's perception of the child as temperamentally difficult, rather than the child's scaled score of temperament, which determines the caregiver's use of inappropriate parenting practices, which include low sensitivity and harsh discipline (Smart & Sanson, 2001).

Repeatedly, hostile and controlling parenting has been empirically related to the development of childhood internalising and externalising behaviours (Sheffield-Morris et al., 2002). Hostile parents subject their children to verbal and physical violence (Sheffield-Morris et al.). Controlling parents can be psychologically and/or intrusively controlling. Psychological control is comparable to concealed anger, whilst intrusive control involves a parent's endeavour to dictate their child's actions and self-concept through the employment of forceful, intimidating tactics including conditional love, shaming, and disapproval (Sheffield-Morris et al.). Two aspects of temperament commonly recognised as relating to child adjustment are effortful control and negative reactivity. *Effortful control* requires the child to refrain from engaging oneself as one typically would, so as to produce a secondary, controlled response (Lengua, 2006). Children with low effortful control are generally more aggressive, and exhibit more troublesome behaviours (Sheffield-Morris et al., 2002). *Reactivity* relates to the child's arousability to changing situations, and includes displays of negative emotionality to instances of stress and aggravation (Lengua, 2006). Both internalising and externalising behaviours have been associated with children who are high in negative reactivity (Sheffield-Morris et al., 2002). In a study examining negative infant emotionality amongst 125 first-born three year old boys, Belsky et al. (1998) established that a mothers' negativity interrelated with an infants' negative emotionality to produce externalising behaviours visible at the time of study.

According to Sheffield-Morris et al. (2002), children who demonstrate poor effortful control and/or negative reactivity have trouble in regulation of negative affect, are particularly inclined to experience damage associated with parental antagonism and psychological control. In possibly the first study evaluating the moderating affects of child temperament on parenting and child adjustment, Sheffield-Morris et al. emphasised

the role of child temperament as a chief mediator of parenting and child psychological wellbeing. It was found that children with elevated levels of negative reactivity were more susceptible to the effects of coercive parenting. This result lends support to the position that children who express greater negative emotional reactivity may be particularly more receptive to the adversities accompanying parental control (Sheffield-Morris et al.).

A study evaluating the temperament of children in biological and residential group care (Vorria et al., 2003), identified significantly greater rates of introversion, inactivity, unsociability, and negative affect amongst children residing in group care. Taking this into account, one could assume the possible moderating effects of temperament upon adversity. It has been postulated for instance, that temperamentally difficult children may become increasingly distressed by instances of maltreatment or environmental variance, such as out of home placement (Pearce & Pezzot-Pearce, 2001). Whereas a child's easy temperament can provide him or her with some emotional stability, and can guarantee some affirmative reaction from out of home carers, a temperamentally difficult child may be less proficient in adapting to any shifts in stability (Pearce & Pezzot-Pearce). In fact, upon entering a disordered family, temperamentally difficult children may further frustrate, and draw upon themselves, negative familial behaviours that manifest themselves in such a way as to punish or blame the child for any presenting domestic disorders (Pearce & Pezzot-Pearce; Rutter, 1987). On the other hand, research has found that children with an easy temperament seemingly boast higher aptitudes for problem-solving, social proficiency, and abilities to activate defensive mechanisms as required (Pearce & Pezzot-Pearce, 2001). These characteristics may serve as protective factors (Flynn, Ghazal, Legault, Vandermeulen, & Petrick, 2004; Luthar & Zigler, 1991; Mastern et al., 1990), promoting resilience in times of hardship (Iwaniec, Larkin, & Higgins,

2006), ultimately aiding children in developing secure relationships with their out of home carers.

Adversity and Resilience

Faced by the same level of risk, certain children develop a range of psychological disorders whilst others, seemingly immune; do not (Luthar & Zigler, 1991; Rutter & Sroufe, 2000). *Resilience* encompasses the phenomenon within which a person, hindered by considerable adversity or disturbance, is able to adapt positively to those circumstances (Cicchetti & Rogosch, 1997; Grados & Alvord, 2003; Lansford et al., 2006; Little, Axford, & Morpeth, 2004; Luthar & Cicchetti, 2000; Masten et al., 1990; Masten et al., 1999; Oosterman et al., 2007; Rutter, 1999; Schoon & Parsons, 2002). In this way, resilience represents a favourable mode of functioning within unfavourable conditions (Gilligan, 2008; 2000; Fonagy, Steele, Steele, Higgitt, & Target, 1994; Kenrick, 2000). Resilience does not embody any specific characteristic or trait of personality (Arrington & Wilson, 2000; Cicchetti & Garmezy, 1993; Luthar & Cicchetti, 2000; Rutter, 1999; Schoon & Parsons, 2002). There is extensive evidence supporting that people exhibiting successful adaptation at any given point may react differently to similar stressors afterwards, when their circumstances have changed (Rutter, 1987). Therefore, resilience refers to a construct that is comprised of two equal dimensions, an experience of adversity, and an end product indicative of positive adaptation (Luthar & Cicchetti, 2000). Each dimension has its own, separate operational definition (Luthar & Cicchetti). *Adversity*, for one, relates to those situations that ordinarily pose threat to an individual's psychological adjustment (Dent & Cameron, 2003). Adversity can refer to a single, critical incident, or a cluster of life events (Arrington & Wilson, 2000). Seen this way, a child's placement into out of home care may represent a high risk situation. Children who reside in out of home care consistently demonstrate poorer psychological

outcomes than their same aged counterparts in the general population. The literature distinguishes between the term *risk*, which is a statistical correlate of negative outcome at times used interchangeably or in connection with the term adversity within empirical literature. *Vulnerability,* another key term in resilience research, relates to one's propensity to be affected by adversity (Dent & Cameron, 2003; Werner, 1994). *Positive adaptation*, most typically describes an individual's achievement of developmentally appropriate milestones or his or her exhibition of social competence (Cicchetti, Rogosch, Lynch, & Holt, 1993; Legault et al., 2006; Luthar & Cicchetti, 2000; Masten et al., 1999). In early childhood, competence may be implied by way of secure attachment formation with a primary caretaker. Later, the child's scholastic performance, and his or her involvement in adequate peer relations are examples of social competence (Luthar & Cicchetti, 2000). Nevertheless, high social proficiency is not inevitably essential for the classification of successful adaptation within investigations of resilience (Rutter, 1999). Luthar and Cicchetti (2000) stressed, for example, that depending on the level of risk encountered, at times, the absence of psychological maladjustment is in itself, indicative of resilience.

Vulnerability, and one's resilience to it, emerges from a combination of interrelated sources (Basic Behavioural Science Task Force of the National Advisory Mental Health Council, 1996; Curtis & Cicchetti, 2003; Iwaniec et al., 2006; Rutter, 1985; 1999). Specifically, one's genetic predisposition, articulated through a person's intelligence, personality, and temperament, interacts with the individual's other qualities, including, their aptitude for social interaction and perceptions of self (BBSTFNAMHC, 1996; Iwaniec et al., 2006). Sequentially, these elements are further influenced by a diversity of environmental factors (Iwaniec et al.; Rutter, 1985; Schoon & Parsons, 2002). Early carer-child bonding, for one, affects the child's future expectations of his or her

environment, which in turn, indirectly affect his or her social experiences. Moreover, the child's developing preconceptions and expectations may also affect his or her self-esteem and the behaviour that the child exhibits (BBSTFNAMHC, 1996). This notion is in accord with the work of Benard (1995, cited in Arrington & Wilson, 2000), who proposes that resilience is not only promoted by a collection of individualistic, protective, and environmental processes, but also, that resilience produces within itself, positive qualities within the individual. In this way, resilience can facilitate one's analytic skills, social proficiency, independence, and self-worth (Benard, 1995, cited in Arrington & Wilson, 2000; Schneider et al., 2005). Resilience has also been linked to insightfulness, empathy, and achievement (Dent & Cameron, 2003).

The significance of specific vulnerability and protective factors in the promotion of resilience largely relates to the nature of the negative event the child is experiencing. For instance, Lansford et al. (2006) illustrate that the central developmental matters concerning children who have experienced maltreatment are likely to vary considerably from those of children who have faced some form of natural disaster. For that reason, one may be correct to expect that the vulnerability and protective factors operating to enhance each child's resilience are also different (Lansford et al.).

A child who is resilient will recover swiftly from his or her experience of adversity, and even amidst prolonged risk, will continue to function favourably (Gilligan, 2000; Mancini & Bonanno, 2006). In this sense, disruptions are fairly mild and transitory (Bonanno, 2005). Although a resilient child may encounter distress, changes in emotional disposition, insomnia, restlessness, or inattention, these challenges to the child's psychological equilibrium are offset relatively quickly, and the child maintains a level of function that is close, if not equivalent to, normal levels (Bonanno; Mancini & Bonanno, 2006). The resilience the child manifests is believed to be derived from a combination of

sources that may be constitutional or peripheral in nature (Gilligan, 2000). Hence, while the child's character, traits, and behaviours are central to the conceptualisation of resilience construct, so too, are the events experienced by the child and the ways in which the child processes them (Gilligan). On this basis, underlying protective mechanisms may ameliorate the child's response to stressful stimuli, increasing the possibility for successful adaptation (Masten et al., 1990; Rutter, 1985, 1993; Schoon & Parsons, 2002; Werner, 1995). Protective processes operate to reduce the probability of the individual experiencing unfavourable outcomes (Andersson, 2005; Arrington & Wilson, 2000; Dishion & Connell, 2006; Little et al., 2004; Ong, Bergeman, Bisconti, & Wallace, 2006). A supportive school environment, encouraging teachers, regular school attendance, engaging in extracurricular activities, community involvement, and ethnic identity are all examples of protective factors (Dent & Cameron, 2003; Dishion & Connell, 2006; Rishel, Sales, & Koeske, 2005; Schoon & Parsons, 2002; Shearer, 2002; Ungar, 2005). The stronger the presence of protective factors in the child's life, the more feasible it is to expect that the child will demonstrate resilience (Rishel et al., 2005). Similarly, when emotionally taxing personal circumstances overshadow pre-existing protective factors, problems may prevail amongst the most resilient of children (Werner, 1994). Fonagy et al. (1994) identified three separate factorial categories predictive of resilience. These were within-child factors such as temperament and social competence, within-home factors such as parenting, and outside-home factors such as school environments and peer relationships. These predictors do not operate in isolation. Instead, a complex interaction is present between variables (Dent & Cameron, 2003; Iwaniec et al., 2006; Mancini & Bonanno, 2006).

The protective barriers safeguarding the child's adjustment seemingly surpass social and cultural parameters (Werner, 1995). In the Kauai Longitudinal Study, Werner

found that of the children who had experienced four or more risk factors by their second year of life, approximately 75% were experiencing severe learning deficits or challenging behaviours by the age of 10. By 18, many had developed significant mental health issues, were involved in criminal activity, or experienced pregnancy (Werner, 1994). Still, roughly one third of the Kauai sample grew up to become confident, considerable, and proficient young adults. It appears that children displaying superior coping strategies in unfavourable circumstances have temperamental traits that elicit positive reactions from caretakers (Werner, 1994, 1995). Within the Kauai study, mothers of resilient infants constantly portrayed their sons and daughters as cuddly, pleasant, lively, and lovable (Werner, 1994). In preschool, children classified as resilient commonly exhibit a unified pattern of coping comprised of self-sufficiency and independence amidst a capacity to seek help when it is required (Werner, 1994, 1995). This mode of coping prevailed even throughout later years.

Academic proficiency and intelligence are two variables that have been consistently shown to influence children's abilities to prevail over challenges (Masten et al., 1999). Werner (1994) too, found, that resilient teenagers were self-confident in their own abilities. Even amongst the most extreme of conditions, resilient children appeared particularly skilled at formulating secure relationships with at least one capable and emotionally responsive adult. Similarly, Rishel et al. (2005) found that children who had good relationships with non-parental adults were better able to cope with daily stressors, and had fewer emotional and behavioural difficulties than children who did not have similar supportive relationships. In much the same way, resilient children appear to possess a superior ability to access and utilise social support systems (Taussig, 2002).

Resilience is in itself a dynamic process that is largely determined by an interplay between the growing person and his or her socio-historical context (Johnson-Garner &

Meyers, 2003; Schoon & Parsons, 2002). By espousing this perspective, Schoon and Parsons (2002) uncovered that age and period effects appeared to mediate children's experiences of vulnerability and protective processes. A major finding was that secure and supportive family units seemed to provide the ideal milieu for child development. Ultimately, however, even the most resilient of children were at least to some measure psychologically restricted by their earlier experiences of social disadvantage (Schoon & Parsons). According to Iwaniec et al. (2006), the loss of an attachment figure, or the emergence of abusive parenting within a previously supportive relationship can offset any previous advantages concerning the experience of positive early caregiving. In a study concerning the connection between self-organisation and resilience among 213 maltreated children, Cicchetti and Rogosch (1997) found a lower incidence of resilience amongst previously maltreated children than non-maltreated children.

Empirical data exist to support the notion that resilience can be encouraged and promoted (BBSTNAMHC, 1996; Gilligan, 2008; Rutter, 1993; Schofield & Beek, 2005). Factors such as self-esteem and self-efficacy can enhance resilience (Daniel, et al., 1999; Glaser, 2002; Legault et al., 2006; Masten et al., 1990). Further, the experience of secure attachment can increase an individual's resistance to stress and actively promote resilience (Carlson et al., 2003; Dent & Cameron, 2003; Gauthier, Fortin, & Jéliu, 2004; Iwaniec et al., 2006; Legault et al., 2006; Repetti, Taylor, & Seeman, 2002; Rutter, 1987). Supportive relationships offer a number of mechanisms to support the effective development of a protective function for children whom have experienced incidences of emotional maltreatment. Such mechanisms include assisting children to work through their troubling experiences, the modification of internal working models to comprise for positive definitions of self and others, and the subsequent development of positive relationships with others (Iwaniec et al., 2006). Moreover, the presence of a supportive

adult can also endorse the development of resilience and assist in diminishing the detrimental effects of maltreatment. Correspondingly, the child would be inclined to develop his or her morals, self-competence, social proficiency, appreciation of other relationships, decision making skills, and would consequently formulate some understanding of the maltreatment he or she had experienced (Iwaniec et al.). Significant adults in the child's care giving network, understood as permanent carers in the context of permanent out of home care, can act to assist in regulating or modifying a child's resilience (Daniel, et al., 1999; Flynn et al., 2004). By commending their children's good behaviours and accomplishments, out of home carers can foster positive perceptions in their children (Iwaniec et al., 2006).

Existing theoretical literature and empirical investigations have operationalised resilience in different ways. Laboratory studies have diverged in their descriptions of what constitutes a condition of adversity, with circumstances varying from single life stressors to manifolds of cumulative unfavourable situations (Luthar, Cicchetti, & Becker, 2000). The range of definitions used in resilience research can lead to discrepancies in the interpretation of the construct's dimensions, and may also wrongly approximate the true prevalence of resilience amid comparable risk groups (Cicchetti & Garmezy, 1993; Luthar et al., 2000). Further, there is only modest agreement on essential terminology across construct models. For example, the terms 'vulnerability' and 'protective' factors receive conflicting use (Luthar et al., 2000). In much the same way, reservations in the measurement of adversity complicate one's ability to verify if across-study participants labelled as resilient, were, in effect, exposed to analogous rates of risk (Kaufman, Cook, Army, Jones, & Pittinsky, 1994; Luthar et al., 2000; McGloin & Widom, 2001). The construct of resilience has also been criticised as children who have labelled resilient sometimes experience incompetence in changed conditions or periods of time. A single

child, for instance, may evidence competence in several domains, and challenges in others (Cicchetti & Garmezy, 1993; Dishion & Connell, 2006; Hines, Merdinger, & Wyatt, 2005; Luthar et al., 2000; McGloin & Widom, 2001; Rutter, 1999). To illustrate, a study by Kaufman et al. (1994), investigating resilience amongst maltreated children, classified approximately 66% of their sample as academically resilient, whereas only 21% were categorised as socially competent. Correspondingly, research examining resilience amongst out of home care populations is likewise, quite limited, with studies plagued by a host of methodological problems. These include extensive use of self-report measures, retrospective reporting, and definitional variability (Taussig, 2002). Ultimately, the shortage in empirical investigations limits the compelling application of causality between variables. Still, even though countless questions linger devoid of answers, significant progress has been advanced towards the understanding of resilience (Curtis & Cicchetti, 2003). Luthar et al. (2000) assert that in spite of the intricacy of the resilience construct, and the challenges that its study poses, systematic research concerning risk and resilience is both imperative and indispensable.

Summary

As a consequence of their previous caregiving experiences which may include maltreatment and multiple placements, and other adversities, children entering permanent care may bring with them a range of emotional and behavioural difficulties. Children entering out of home care may also exhibit difficult temperaments. Further, the temperament the child displays may make it easier or harder to establish new relationships, depending on whether the child has an easy or difficult temperament. Resilient children too, may settle into their placements more easily, and form stable relationships relatively readily. As such, developing new relationships with their carers may be easier for some children than others.

Rationale for the Current Study

In the face of ever-increasing numbers of children entering out of home care, and mounting reliance on allied home-based permanent care living arrangements (Winkworth, 2003), comparatively few studies have examined which variables are related to or predict a child's adjustment to permanent care and his or her relationship with the carer. Literature has consistently demonstrated the negative effects of maltreating conditions on the psychological functioning of children, linking child mistreatment and out of home care placement to a range of unfavourable life outcomes. Not only do these outcomes have major long-standing psychological consequences for the wellbeing of children in care, they too, encompass social and financial repercussions in both state-wide and national arenas. Nonetheless, currently implemented strategies do little in the way of supporting children and their substitute families. Hence, by gaining a better understanding of the needs of children in care, respective organisations could attend better to the progression of current care services. By allocating well thought-out and empirically backed economic resources, the out of home care system is likely, in its entirety, to move towards the eradication of some of the obstacles that currently plague its most effective operation. Thus far, little research has contributed towards meeting these requirements.

The current study attempts to explore a number of theoretically driven variables in the development and maintenance of secure, mutually beneficial, growth promoting permanent carer-child relationships. These variables include carer empathy, carer parenting style, child emotional and behavioural problems, child temperament, and resilience. From the review of the literature it has become apparent that permanent carers are instrumental in the lives of those in their care (Orme & Buehler, 2001). Empirical findings overwhelmingly support the influence of positive parenting behaviour on the promotion of nurturing caregiving and positive child outcomes (Liable et al., 2004;

Strayer & Roberts, 2004). It is unclear exactly which mechanisms underlie, or on the other hand undermine, the success of permanent care placements. Caregiver empathy and parenting style may have particular relevance in carer-child relationships. Accordingly, it is extremely important to examine these carer attributes, and the ways in which they might unfold and impact carer-child relational dynamics. Similarly, child variables may also contribute to carer-child relationships. The behavioural problems the child manifests, their temperament, and resilience may impact on their abilities to develop and sustain positive relationships with their carers. Further, both nationally, and internationally, there have been few systematic attempts to ascertain parenting data directly from caregivers themselves. Permanent carers require ongoing, practical supports from permanent care agencies that may aide in the psychological adjustment of the children under their care (McDonald et al., 2001). It is the objective of the current study to contribute to the pool of knowledge about permanent care programs by addressing some of the gaps in the empirical data. The current study may also provide information that could assist placement agencies to increase the overall success and effectiveness of their permanent care placements.

Study Aim and Hypotheses

It was the intention of the current thesis to examine the influence of carer empathy and carer parenting styles on carer-child relationships within permanent care arrangements in the state of Victoria. The contribution of several child variables, namely emotional and behavioural problems, temperament, and resilience was examined to paint a more comprehensive picture of permanent care carer-child dyads.

In accordance with the conceptual framework presented within this chapter, the focus of this thesis is on the relationship between the carer variables – carer empathy and carer parenting styles – and carer-child relationships. Some literature has found that

parental empathy and styles of parenting are moderating variables in parent-child relationships. Still, these studies do not typically examine the influence of both carer and child variables on carer-child relationships. Further, even fewer studies have examined these relationships in permanent care families. On these grounds, and in accord with the theoretical literature, it is expected that carer-child relationships will be predicted by carer empathy and carer parenting styles. Consistent with prior studies which have noted that parenting behaviour can be influenced by child attributes, it is expected that child emotional and behaviour problems, temperament, and resilience will also contribute variance to carer-child relationships. Ultimately however, it is expected that the influence of child variables will be secondary to the influence of the carer variables.

On the basis of these considerations, the following hypotheses have been proposed:

1. That a positive relationship will be present between carer empathy and carer-child relationships;
2. That there will be a positive relationship between carer authoritative parenting style and carer-child relationships and a negative relationship between the authoritarian and permissive parenting styles and carer-child relationships;
3. That the child variables – emotional and behavioural difficulties, difficult temperament, and low resilience – will be negatively related to carer-child relationships; and
4. That the carer variables – empathy and parenting style – will more strongly predict carer-child relationships than child variables.

Study Design

Data were collected using a mixed method approach comprised of quantitative and qualitative methodologies. This bidirectional approach amalgamates each method's unique contribution to the study of psychological phenomena, whereby each research technique essentially complements the other. Where one technique may overlook contributory phenomena, prospectively rendering certain effects invisible, the other may efficiently isolate and reveal these apparently salient phenomenal contributions (Griffin & Phoenix, 1994; Johnson, Onwuegbuzie, & Turner, 2007). As a result, a more comprehensive, multifaceted representation of existing phenomena is likely to emerge.

In the current thesis, quantitative and qualitative methods, their results, and discussions are outlined separately. The quantitative data is presented in the section titled *Quantitative Results*. In much the same way, the study's qualitative data is reported in the section entitled *Qualitative Results*. The findings of the two research techniques are brought together in the *Integrative Discussion.*

CHAPTER THREE: QUANTITATIVE METHOD, RESULTS, & DISCUSSION

Method

Participants

Forty-six permanent carers (5 males, 41 females) were recruited from six metropolitan and regional Victorian permanent care child placement agencies. Carers were aged between 34 to 66 years (M = 48.39, SD = 6.82), and were the legal caretakers of at least one permanent care child (25 males, 21 females) aged between 3.25 to 12.33 years (M = 8.10, SD = 2.67). The study yielded a 23% participation rate, with 46 of the 204 carers invited to participate agreeing to take part in the study. This rate of participation is consistent with other studies soliciting data from out of home carers (cf. Denuwelaere & Bracke, 2007; Holloway, 1997; Millward, Kennedy, Towlson, & Minnis,

2006; Minnis, Pelosi, Knapp, & Dunn, 2001; Rodger, Cummings, & Leschied, 2006; Sanchirico & Jablonka, 2000; Zima et al., 2000). Married couples accounted for 63% of permanent carers, de-facto couples for 10.9%, 4.3% of carers were separated, 8.7% were divorced, 4.3% were widowed, 4.3% were single and another 4.3% were unspecified. Most carers had completed secondary schooling (73.9%), with another 23.9% having completed Year 10 or its equivalent. 19.6% of carers had also completed a TAFE Certificate or Diploma, 26.1% had completed an Undergraduate University Degree, and 8.7% had completed a Postgraduate University Degree. Twenty-six percent of carers received a gross family income of $40,000 or under, 8.7% of carers received between $40,001 - $60,000, 15.2% received between $60,001 - $80,000, 15.2% received between $80,001 - $100,000, and 17.4% reported a gross income of $100,001 or greater.

To participate in the study children needed to be between the ages of 3 to 12 years and to have lived with the carer for at least 6 months. On average, children were aged between several days to 5 years on initial separation from their family of origin (*M*=.74 years, *SD*=1.18). At the time of survey children were aged between 3 to 12 years and had undergone between one to 39 placements before entering their current permanent care placement. Children had been in the care of their current carers for between .67 to 11.50 years.

Ethics approval was obtained from the Australian Catholic University Human Research Ethics Committee (Appendix A), the Department of Human Services, and participating placement agencies (Appendix B) prior to commencing data collection for the study.

Measures

Participants completed measures on empathy, parenting style, carer-child relationships, child behaviour, child temperament, and child resilience.

Interpersonal Reactivity Index (IRI; Davis, 1980, 1983)

The IRI is a 28-item multidimensional self-report measure of empathy. Amongst empathy assessment measures, the IRI is certainly the most widely used (Pulos, Elison, & Lennon, 2004). The instrument has four related, yet independent, 7-item subscales (r = .29 to .33; Britton & Fuendeling, 2005), derived from factor analysis (Johnson, Cheek, & Smither, 1983), and yielding scores for separate facets of empathy. Two of these subscales, *perspective taking* and *fantasy*, address cognitive empathic propensities, whilst the other two, *empathic concern* and *personal distress*, constitute affective empathic responsivity (Bernstein & Davis, 1982).

Items are rated in Likert-style format, from 0 = does not describe me well to 4 = describes me very well. Sample items from the inventory include "I try to look at everybody's side of a disagreement before I make a decision" and "I sometimes feel helpless when I am in the middle of a very emotional situation". The items comprising each subscale are independently summed to produce a score ranging from 0 to 28 per subscale.

All four subscales possess acceptable internal consistencies ranging from .71 to .77 (Davis, 1983). A number of studies have also indicated moderate to higher levels of internal consistency for the four IRI subscales (Britton & Fuendeling, 2005; Fabes, Eisenberg, & Miller, 1990; Loudin, Loukas, & Robinson, 2003; Parez-Albeniz & de Paul, 2004; 2003; Pulos et al., 2004). Reports of the IRI's test-retest reliability vary from .62 to .71 (Davis, 1983). In addition, across studies, the IRI subscales have been found to have

sound construct validity (Bernstein & Davis, 1982; Britton & Fuendeling, 2005; Davis, 1983; Davis, Luce, & Kraus, 1994; Parez-Albeniz & de Paul, 2004).

Researchers such as Coke, Batson, and McDavis (1978) have found empirical evidence to corroborate a two-stage process of empathy encompassing both perspective taking and varying emotional processes, a result consistent with the multidimensional conceptualisation of the IRI (Chlopan et al., 1985). Moreover, the individual subscales of the IRI correspond well with other inventories of empathy (Johnson et al., 1983), such as the Hogan Empathy Scale (HES; 1969) and the Questionnaire Measure of Emotional Empathy (QMEE; 1972), and also, to indictors of emotionality and interpersonal functioning (Davis, 1983; Henry, 2006).

Parenting Styles and Dimensions Questionnaire (PSDQ; Robinson, Mandleco, Olsen, & Hart, 1995)

The PSDQ, formally titled the Parenting Practices Questionnaire (PPQ), is a 62-item self-report measure of parents' parenting practices with preadolescent children. Based on the Baumrind typology of authoritarian, authoritative, and permissive parenting, the PSDQ was devised and substantiated through factor analysis to confer a single, continuous score for each category of parenting (Winsler et al., 2005). Higher scores reflect greater utilisation of parenting practices connected with the particular style of parenting. The authoritarian parenting subscale is comprised of 20 items, 4 pertaining to *verbal hostility*, 6 to *corporal punishment*, 6 to *non-reasoning/punitive strategies*, and 4 to *directiveness*. The authoritative parenting scale contains 27 items, 11 relating to *warmth and support*, 7 to *reasoning/induction*, 5 to *democratic participation*, and 4 to *responsiveness*. The permissive parenting scale has 15 items, 6 associated to *lack of follow through*, 4 to *ignoring misbehaviour*, and 5 to *lack of self-confidence.* Amongst a subsisting shortage of parenting assessment measures, the PSDQ recently emerged as one

of a small number of existing questionnaire inventories with sufficiently sound psychometric properties pertinent to measurements of control, nurturance, and discipline in parenting (Locke & Prinz, 2002). In fact, versions of the PSDQ are being used in a diversity of cultural settings, including China and Russia (Winsler et al., 2005).

Items are rated on a 5-point Likert scale ranging from 1 = never to 5 = always. Sample items include "I express affection by hugging, kissing, and holding our child" and "I allow our child to give input into family rules". By summing the respective subscale composites, three separate scale scores are derived, one for each dimension of parenting. In a sample of 1251 parents of school-aged children, Robinson et al. (1995) obtained very good internal consistencies across all three subscales, specifically, .86 for the authoritarian subscale, .91 for the authoritative subscale, and .75 for the permissive subscale. Winsler et al. (2005) similarly reported adequate Cronbach alphas for the PSDQ, with consistencies ranging from .73 to .89 across subscales.

Child-Parent Relationship Scale (CPRS; Pianta, 1992)

The CPRS is a 30-item self-report inventory that describes the caregiver-child dyad by providing global appraisal of the caregiver's perception of the quality of the adult-child dyadic relationship. The CPRS is comprised of three subscales, namely *conflicts*, *positive aspects*, and *dependence*. The conflicts subscale contains 14 items, the positive aspects subscale 12 items, and the dependence subscale 6 items. Respondents rate items on a 5-point Likert scale ranging from 1 = definitely does not apply, to 5 = definitely applies. Sample items from the inventory include, "my child spontaneously shares information about him/herself" and "if upset, my child will seek comfort from me". The items comprising the conflicts subscale are reverse scored. Three independent scores are calculated. Higher scores on the positive aspects and dependence subscales, alongside a lower score on the conflict subscale, mirror a closer, more affectionate adult-

child relationship. Normative data attained from a sample of 714 caregivers of primary school-aged children (Pianta, 1992) indicated adequate internal reliability for two of the three subscales. Cronbach alphas varied from .83 for the conflicts subscale, .72 for the positive aspects subscale, and .50 for the dependence subscale (Pianta). The CPRS has received little empirical application, but presents as a potentially valuable tool in the measurement of caregiver-child relational quality.

Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997)

The SDQ is a 25-item behavioural screening questionnaire that is employed to appraise emotional and behavioural difficulties amongst children aged between 3 to 16 years (Glazebrook, Hollis, Heussler, Goodman, & Coates, 2003; Goodman, 1999; Goodman, Meltzer, & Bailey, 1998; Goodman, Renfrew, & Mullick, 2000; Mathai, Anderson, & Bourne, 2004; Mellor, 2005; Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004). The SDQ includes a caregiver informant version, a teacher informant version, and a youth self-report version. The current study used the caregiver informant version. Of the 25 items comprising the SDQ, 10 are strengths, 14 are difficulties, and 1 is neutral (Smedje, Broman, Hetta, & von Knorring, 1999). Items are distributed evenly amongst five subscales; *emotional symptoms*, *conduct problems*, *inattention-hyperactivity*, *peer-problems*, and *prosocial behaviour*. Inventory items are rated on a 3-point Likert scale ranging from 1 = not true, to 3 = certainly true. Excluding prosocial behaviour, which is an indicator of child strengths, the four deficit-centred subscales are summed together after first reverse scoring negative items, to produce a *total difficulties* score. Generated scores range from 0 to 40. Sample items from the SDQ include, “thinks things out before acting” and “often complains of headaches, stomach-aches, or sickness”.

In concurrence with the SDQ's expanding empirical and clinical application (Becker, Woerner, Hasselhorn, Banaschewski, & Rothenberger, 2004; Goodman, 2001, 1999; Goodman et al., 2000; Goodman & Scott, 1999; Muris & Maas, 2004; Ronning et al., 2004; Smedje et al., 1999), two Australian studies (Hawes & Dadds, 2004; Mellor, 2005) have examined the psychometric properties of the SDQ. Using a community sample of 1, 359 primary school children, Hawes and Dadds (2004) found moderate to strong coefficient alphas across all subscales of the SDQ, ranging from .66 for emotional symptoms, .66 for conduct problems, .80 for inattention-hyperactivity, .59 for peer problems, .70 for prosocial behaviour, to .82 for total difficulties. In a random sample of 910 Victorian primary and secondary school students, Mellor (2005) found similar internal consistencies. According to the parent informant data, 12% of children were reported to be in the abnormal range, while 6% were in the borderline range (Mellor, 2005). Factor loadings supported the SDQ's five-factor structure (Hawes & Dadds, 2004). Subscales correlated significantly with one another ($p < .01$), ranging from -.14 to .52. Cross-informant conformity was substantiated between subscales, and test-retest reliability was stable over a period of 12 months. Likewise, a strong association was detected between SDQ scores and Axis 1 diagnoses.

Short Temperament Scale for Children (STSC; Sanson, Smart, Prior, Oberklaid, & Pedlow, 1994)

The STSC is a 30-item informant-report measure of temperament centred upon the period of childhood. Adapted from Thomas and Chess' (1977) Childhood Temperament Questionnaire, the STSC was derived following factor analysis within a large Australian-based study ($N = 2443$), the Australian Temperament Project (Shamir-Essakow, Ungerer, & Rapee, 2005). Scaled items target four dimensions of temperament, namely, *approach, inflexibility, persistence,* and *rhythmicity*. With the exception of

inflexibility, which is comprised of nine items, all three remaining subscales are respectively comprised of seven items. By averaging the approach, persistence, and inflexibility subscales, a mean score of temperament is derived. Respondents rate items on a 6-point Likert scale varying from 1 = almost never to 6 = almost always. Sample items from the inventory include, “my child is shy with strange adults” and “my child likes to complete one task or activity before going on to the next”. The child is rated as being temperamentally easy or difficult depending on whether he or she falls one standard deviation above or below the mean. Thus, high scores across subscales indicate high rates of inflexibility, non-persistence, withdrawal, and arrhythmicity. Low scores, in contrast, represent flexibility, persistence, approach, and rhythmicity.

The STSC demonstrates sufficient internal consistency across all four of its subscales, with alpha coefficients ranging from .70 to .84 (Shamir-Essakow et al., 2005). Alternatively, Paterson and Sanson (1999) reported uniformly higher alpha coefficients for the STSC that ranged from .82 for inflexibility to .85 for persistence amongst children within the 5 to 6 year bracket. In much the same way, the various subscales of the STSC have been found to display adequate predictive and concurrent validity (Paterson & Sanson). The factors of the STSC correspond well with factors established in other studies employing factor analysis methodologies (Paterson & Sanson). In fact, questionnaires based upon the original Thomas and Chess conceptualisation of temperament dominate temperamental applications of clinical assessment and research (Sanson et al., 1994).

Although specifically designed to assess the structure of temperament in 3 to 7 year olds, the quantitatively small difference in factor solutions identified by Sanson et al. (1994) at years 3 to 4, 5 to 6, and 7 to 8 of age, alongside pre-existing Australian

normative data, suggests that the STSC is also an appropriate research tool in the measurement of temperament in children up to the age of 12 years.

International Personality Item Pool NEO, Vulnerability Subscale (IPIP NEO; Goldberg, 1992)

The IPIP NEO is a 300-item self-report inventory of personality. A non-commercial alternative to the extensively utilised and sufficiently validated revised NEO Personality Inventory (NEO PI-R; Costa & McCrae, 1997), the 30 facet subscales comprising the IPIP NEO correlate well with parallel NEO PI-R subscales (Johnson, 2005). Specifically, the average correlation across IPIP NEO and NEO-PI-R subscales is .73 (Johnson, 2005) indicating sufficient concurrent validity. The two scales also share a similar system of forward and reverse scoring items. Further, the versatility of the IPIP NEO enables the inventory to be used in either self-report or informant-report format (Johnson, personal communication, 7 August, 2006). Of the 30 facet subscale composites encompassing the IPIP NEO, only *vulnerability* was used in the present study. Items are rated on a 5-point Likert scale ranging from 1 = very inaccurate to 5 = very accurate. Example vulnerability items include "my child panics easily" and "my child gets overwhelmed by emotions". To produce a score of vulnerability, negative items are first reverse scored, and each of the 10 items comprising the subscale summed together. As vulnerability reflects the low end of resilience, by reverse scoring the 10 items of the subscale yet again, a score indicative of one's resilience was constructed.

Items are based on the five-factor model employed by Costa and McCrae (1997), currently the most influential paradigm in personality research (Goldberg, 1992; Gow, Whiteman, Pattie, & Deary, 2005; Johnson, 2001, 2005). Reliability analysis on a large sample (N = 20, 993), yielded adequate internal reliabilities, with an alpha coefficient of .85 for the vulnerability subscale.

Procedure

Following ethics approval from Australian Catholic University's Human Research Ethics Committee, approval was obtained from the Department of Human Services, and a range of Community Service Organisations (CSOs). In accord with the age and duration of care inclusion criteria, CSO's identified a sample of potential participants to whom they distributed a questionnaire package by post. Contained within this questionnaire package was an introductory cover letter from the respective agency indicating the agency's endorsement of the study, an information letter to participants (Appendix C), a consent form and conjunctive duplicate for participant records (Appendix D), a questionnaire booklet for each permanent care child between 3 to 12 years (Appendix E), and return addressed pre-paid envelope.

In homes headed by two permanent carers, one carer elected to complete each questionnaire booklet. Approximately one hour was required to complete the questionnaire booklet. By filling in their contact details on the consent form, carers were able to register their interest in participating in the second phase of the research study. Completed questionnaire booklets and consent forms were mailed back directly to the researcher. Approximately two weeks after the initial mail-out, a reminder letter was sent out to potential participants. Upon receipt, questionnaire booklets were immediately coded and de-identified. Data collection was undertaken from May to December of 2007.

Data Analysis

Raw questionnaire data were coded and entered into a Statistical Package for Social Sciences (SPSS) for Windows Version 13 computer software data file for analysis. Prior to analysis, the dataset was inspected for errors in data entry. As per each inventory's scoring instructions, negative items were recoded and reverse scored to compute scaled scores for each of the IRI, PSDQ, CPRS, SDQ, STSC, and IPIP-NEO

vulnerability subscale. New variables were generated where multiple items were used to form instrument scales. Using Cronbach's alphas, estimates of reliability were calculated for each inventory. Pearson's Product Moment Correlations and Multiple Regression analyses were conducted to analyse relationships between variables. Inferential analyses were set at $\alpha = .05$.

Results

Preliminary Analyses

Data Screening

Missing values were assigned to responses that were either absent or ambiguous. Missing values were substituted with the mean score of the item in an attempt to reduce the overall number of missing values (Allison, 2002). Where mean substitutions did occur, they were few, and in no single instance did mean substitutions for any participant on any scale exceed 10%. On the whole, missing values were few, presenting minimal concerns for data analysis.

Assumption Testing

Through the use of scatter-plots, data were inspected for violations to linearity, equality of variance, and normality. No gross violations were detected.

Analysis of Reliability

Internal consistency estimates were obtained for each scale included in this study. Cronbach's alphas for all scales and respective subscales are presented in Table 1. A coefficient of .70 is commonly used as a reliability cut-off; however, for exploratory research an alpha coefficient of .60 can be considered acceptable (Streiner & Norman, 2003). Adequate internal consistency was demonstrated across the majority of subscales with alpha coefficients for total scores ranging from .62 to .89. Cronbach's alphas for subscales were less adequate, especially for PSDQ Permissive Parenting ($\alpha = .36$), and its

dimensions Lacks Follow Through (α = .28), Ignoring Misbehaviour (α = -.18), and Lacks Self Confidence (α = .55). Other low Cronbach's alphas included the IRI's Perspective Taking (.42), PSDQ's Verbal Hostility (a = .53), Non-Reasoning/Punitive Strategies (.56), and Democratic Participation (.44), and the CPRS' Dependence scales (.53). For this reason total scores were used for the main analyses. Further, in taking into account the very low alpha obtained for the permissive parenting subscale, the decision was made to omit the subscale from the current study.

Table 1

Cronbach's Alphas for Subscales

Subscale	Cronbach Alpha
Interpersonal Reactivity Index	
Total Score	.62
Perspective Taking	.42
Fantasy	.68
Empathic Concern	.63
Personal Distress	.68
Parenting Styles and Dimensions Questionnaire	
Authoritarian Parenting	.72
Verbal Hostility	.53
Corporal Punishment	.66
Non-Reasoning/Punitive Strategies	.56
Directiveness	.75
Authoritative Parenting	.73
Warmth and Support	.75
Reasoning/Induction	.78
Democratic Participation	.44
Responsiveness	.77
Permissive Parenting	.36
Lacks Follow Through	.28
Ignoring Misbehaviour	-.18
Lacks Self Confidence in Parenting	.55
Strengths and Difficulties Questionnaire	
Total Score	.77
Emotional Difficulties	.75
Conduct Difficulties	.70
Hyperactivity	.87
Peer Problems	.80
Pro-Social	.67
Child-Parent Relationship Scale	
Total Score	.66
Conflicts	.87
Positive Aspects	.69
Dependence	.53
Short Temperament Scale for Children	
Total Score (Difficult Temperament)	.76
Flexibility	.84
Persistence	.78
Approach	.73
Rhythmicity	.70
International personality Pool Item Pool NEO	
Resilience	.89

Sample Characteristics

In accordance with publicized norms, current sample mean score comparisons across measures revealed largely discrepant results. Please see Table 2 for a complete list of subscale means and standard deviations for the present study. Specifically, current sample means for the IRI were compared to normative data (Davis, 1980). There was some variation between current sample scores and the norms reported by Davis. Specifically, the carers in the current study scored comparatively higher on the perspective taking subscale (19.98; *SD* = 3.04) than did the participants from Davis' normative sample (*Males* 16.78, *SD* = 4.72; *Females* 17.96, *SD* = 4.85). However moderately lower scores were obtained by the current sample on the fantasy and personal distress subscales (12.33, *SD* = 5.06 and 9.04, *SD* = 3.95 respectively, compared with *Males* 15.73, *SD* = 5.60; *Females* 18.75, *SD* = 5.17 and *Males* 9.46; *SD* = 4.55; *Females* 12.28, *SD* = 5.01 for Davis' sample). Scores on the empathic concern subscale were comparable to those reported by Davis (21.53, *SD* = 4.10 vs *Males* 19.04, *SD* = 4.21; *Females* 21.67, *SD* = 3.83).

For the PSDQ, there was some divergence between means attained in the present study and those of Winsler et al. (2005). Means and standard deviations for each of the parenting styles in Winsler et al's study are as follows: Authoritarian parenting style (2.10, *SD* = .38 vs 7.65, *SD* = 1.99 for the current study), authoritative parenting style (4.05, *SD* = .32 vs 16.68, *SD* = 1.51), and permissive parenting style (2.08, *SD* = .45 vs 5.34, *SD* = .88). Permanent carers in the present sample scored higher on each parenting style than did the parents of pre-schoolers in Winsler et al's study. Means and standard deviations for the various dimensions comprising each parenting style were not reported in Winsler et al's study.

Comparisons with publicised norms for the SDQ (Goodman, 1999) and recent Australian normative data (Hawes & Dadds, 2004) showed some variation between scores. Children in this study received uniformly higher scores across all problem subscales, and lower scores on the pro-social behaviour subscale. Scores ranged from 15.57, *SD* = 13.08 for total difficulties (compared to 7.1, *SD* = 5.7), to 2.78, *SD* = 2.74 for emotional difficulties (compared to 1.6, *SD* = 1.8), to 2.93, *SD* = 2.19 for conduct difficulties (compared to 1.3, *SD* = 1.6), to 6.43, *SD* = 3.1 for hyperactivity (compared to 2.8, *SD* = 2.5), to 2.91, *SD* = 2.67 for peer problems (compared to 1.4, *SD* = 1.5), to 7.24, *SD* = 2.00 for pro-social (compared to 8.6, *SD* = 1.8; Goodman, 1999). The preceding figures indicate some clear disturbance in the emotional, behavioural, and social functioning of the children in the current sample.

Comparing means for the current study to normative data for the CPRS produced mixed results. Means and standard deviations for this sample compared to established norms as follows: Total Score (115.13, *SD* = 13.08 vs 106.85, *SD* = 10.27), Conflict (52.85, *SD* = 10.84 vs 26.33, *SD* = 6.87), Positive Aspects (47.61, *SD* = 4.74 vs 47.93, *SD* = 4.31), and Dependence (14.61, *SD* = 3.73 vs 10.75, *SD* = 2.62). This suggests that while carers reported higher levels of conflict in their carer-child relationships, carers also seemed to parent more dependent children, and ranked comparatively in the positive aspects they could identify in their carer-child dyads. In fact, overall, carers reported more positive carer-child relationships than did the parents on whom the normative CPRS data is based.

An investigation of normative factor scores for the STSC revealed some differences between current sample scores and normative data. Please note only means are available in this instance and that these vary depending on the age group targeted. Difficult temperaments are defined as being 1SD above the mean. Normative factor

scores are as follows: Flexibility 3.20 to 2.89 (compared to 3.35, *SD* = 1.33 for the present sample), persistence 3.23 to 2.81 (compared to 3.93, *SD* = .98), approach 3.03 to 2.75 (compared to 2.63, *SD* = .87), rhythmicity 2.63 to 2.38 (compared to 2.52, *SD* = .85), total score 3.15 to 2.82 (compared to 3.30, *SD* = .65). From this information it would seem that the children in this sample have more difficult temperaments. Although they rated comparatively in terms of rhythmicity, they were more inflexible, approachable, and less persistent than children in the general population.

As the resilience subscale was adapted for the current study, comparisons could not be made regarding the resilience of the children in the present sample.

Table 2

N, Means, Standard Deviations, Minimum, and Maximum for Subscales

Subscale		N	Mean	SD	Minimum	Maximum
IRI	Perspective Taking	45	19.98	3.04	12.00	25.00
	Fantasy	45	12.33	5.06	2.00	22.00
	Empathic Concern	45	21.53	4.10	12.00	28.00
	Personal Distress	45	9.04	3.95	1.00	19.00
PSDQ	Authoritarian Parenting	44	7.66	1.49	4.70	11.95
	Verbal Hostility	46	2.13	.411	1.25	3.00
	Corporal Punishment	46	1.54	.448	1.00	2.60
	Non-Reasoning	45	1.50	.385	1.00	2.60
	Directiveness	45	2.47	.708	1.25	4.50
	Authoritative Parenting	43	16.68	1.51	13.43	19.17
	Warmth	43	4.64	.368	3.63	5.00
	Reasoning	46	4.41	.448	3.33	5.00
	Democratic Participation	45	3.44	.724	1.67	4.67
	Responsiveness	46	4.16	.475	3.00	5.00
	Permissive Parenting	45	5.34	.884	3.33	7.77
	Lacks Follow Through	45	2.04	.400	1.33	3.17
	Ignores Misbehaviour	46	1.55	.550	1.00	3.00
	Confidence in Parenting	46	1.77	.413	1.00	2.60
SDQ	Total Score	46	15.07	8.22	4.00	36.00
	Emotional Difficulties	46	2.78	2.74	0.00	10.00
	Conduct Difficulties	46	2.93	2.63	0.00	9.00
	Hyperactivity	46	6.43	3.13	0.00	10.00
	Peer Problems	46	2.91	2.67	0.00	9.00
	Pro-Social	46	7.24	2.00	2.00	10.00
CPRS	Total Score	46	115.13	13.08	75.00	136.00
	Conflicts	46	52.85	10.84	28.00	69.00
	Positive Aspects	46	47.67	4.74	30.00	54.00
	Dependence	46	14.61	3.73	8.00	24.00
STSC	Total Score	45	3.30	.651	2.10	4.76
	Flexibility	45	3.35	1.33	1.29	6.57
	Persistence	45	3.93	.978	2.00	5.71
	Approach	45	2.63	.871	1.29	5.71
	Rhythmicity	45	2.52	.848	1.29	4.43
IPIP-NEO-PI	Resilience	45	31.33	9.08	12.00	45.00

Note. IRI=Interpersonal Reactivity Index, PSDQ=Parenting Styles and Dimensions Questionnaire, SDQ=Strengths and Difficulties Questionnaire, CPRS=Child-Parent Relationship Scale, STSC=Short Temperament Scale for Children, IPIP-NEO-PI= International Personality Item Pool NEO

Correlations between Variables

Relationship between Carer Empathy and Carer Parenting Styles

Table 3 shows a significant but low correlation between carer empathy and authoritarian parenting style. Approximately 10% of the variability in authoritarian parenting is attributable to differences in carer empathy. The correlation is negative, signifying that lower scores on carer empathy are associated with higher scores on authoritarian parenting. Carer empathy and authoritarian parenting style were not correlated.

In summary, of the two parenting styles tested here, carer empathy is correlated with the authoritarian parenting style only.

Table 3

Correlation between the Variables Carer Empathy, Authoritarian Parenting Style, and Authoritative Parenting Style

Subscale	1	2	3	Mean	SD	N
1. Empathy	-	-.32*	.17	62.89	9.13	45
2. Authoritarian	-.32*	-	-.36*	7.66	1.49	44
3. Authoritative	.17	-.36*	-	16.68	1.51	43

*$p < .05$.

Relationship between Child Temperament, Child Resilience, and Child Emotional and Behavioural Difficulties

Table 4 shows a negative correlation between carer ratings of difficult child temperament and carer ratings of child resilience. Child temperament amounts for 58% of the variability in child resilience. Higher ratings in difficult child temperament reflect lower ratings in child resilience. This signifies that resilient children are more likely to have less difficult temperaments.

A statistically significant relationship can also be seen between scores in difficult child temperament and scores in child emotional and behavioural difficulties. Approximately 39% of the variability in child emotional and behavioural difficulties can be accounted for by differences in child temperament. Higher scores in difficult child temperament are likely to be associated with higher scores in child emotional and behavioural difficulties. In other words, children with difficult temperaments also demonstrate more emotional and behavioural difficulties.

Table 4 also shows a strong negative correlation between child resilience and child emotional and behavioural difficulties. About 46% of the variability in child emotional and behavioural difficulties is accounted for by differences in child resilience. Higher scores in child resilience are generally associated with lower scores in child emotional and behavioural difficulties. Thus, resilient children seem to have fewer emotional and behavioural difficulties.

Table 4

Correlation between the Variables Difficult Child Temperament, Child Resilience, and Child Emotional and Behavioural Difficulties

Subscale	1	2	3	Mean	SD	N
1. Temperament	-	-.76**	.63**	3.30	.65	45
2. Resilience	-.76**	-	-.68**	31.33	9.08	45
3. Difficulties	.63**	-.68**	-	15.07	7.82	46

** $p < .01$.

Relationship between SDQ Subscale Scores

Table 5 shows a number of significant correlations across the five SDQ subscales. Emotional difficulties are correlated with conduct difficulties and peer problems. Emotional difficulties explain about 19% of the variability of conduct problems and about

26% of the variability in peer problems. It is likely therefore, that children displaying emotional difficulties are also likely to have difficulties in their conduct and peer relationships.

Statistically significant relationships are also seen between conduct difficulties and emotional difficulties, hyperactivity, peer problems, and pro-social. Conduct difficulties account for 19% of the variability in emotional difficulties, 29% of the variability in hyperactivity, 9% of the variability in peer problems, and 26% of the variability in pro-social. From this it would seem that children with conduct problems are likely to have difficulties across each of the five SDQ subscales.

Hyperactivity is correlated with conduct difficulties, peer problems, and pro-social. Hyperactivity explains about 29% of the variability in conduct difficulties, 9% of the variability in peer problems, and 24% of the variability in pro-social. High scores in hyperactivity are likely to accompany high scores in conduct difficulties, peer problems, and low scores in pro-social.

Peer problems correlate with emotional difficulties, conduct difficulties, hyperactivity, and pro-social. Peer problems account for approximately 17% of the variability in emotional difficulties, 9% of the variability in conduct difficulties, 9% of the variability in hyperactivity, and 11% of the variability in pro-social. This denotes that children with peer problems are likely to have emotional difficulties, and be more hyperactive and less pro-social.

Pro-social significantly relates to conduct difficulties, hyperactivity, and peer problems. Pro-social explains about 26% of the variability in conduct difficulties, 18% of the variability in hyperactivity, and 11% of the variability in peer problems. The directions of the relationships are negative, suggesting that low ratings on pro-social are likely to be coupled with high ratings on conduct difficulties, hyperactivity, and peer

problems.

In sum, within the current sample, clear inter-relationships are present between the five SDQ subscales.

Table 5

Correlation between the Variables Child Emotional Difficulties, Conduct Difficulties, Hyperactivity, Peer Problems, and Pro-Social Behaviour

Subscale	1	2	3	4	5	Mean	SD	N
1. Emotional	-	.43**	.27	.42**	- .20	2.78	2.74	46
2. Conduct	.43**	-	.58**	.31*	1.51**	2.93	2.19	46
3. Hyperactivity	.27	.54**	-	.31*	- .49**	6.43	3.13	46
4. Peer	.42**	.31*	.31*	-	- .33*	2.91	2.67	46
5. Pro-Social	- .20	-.51**	- .49**	- .33*	-	7.24	2.00	46

* $p < .05$. ** $p < .01$.

3.2.4 Testing of Hypotheses

Primary analyses consisted of Pearson Product Moment Correlations. In spite of the small sample size ($N = 46$), secondary, exploratory Multiple Regression analyses were also conducted between variables to examine whether any independent variable was a stronger predictor of the criterion variable, carer-child relationships. Multiple Regressions were conducted for exploratory purposes only and offer a direction for future empirical research.

Relationship between Carer Empathy and Carer-Child Relationships (Hypothesis One)

No significant relationship was found between carer empathy and carer-child relationships. Accordingly, hypothesis one is not supported.

Relationship between Carer Parenting Style and Carer-Child Relationships (Hypothesis Two)

Table 6 indicates a significant negative correlation between authoritarian parenting style and carer-child relationships. Authoritarian parenting accounts for 16% of the variability in carer-child relationships. The direction of the correlation suggests that more authoritarian parenting is associated with less positive carer-child relationships. No significant relationship is apparent between authoritative parenting style and carer-child relationships.

These results indicate that only the authoritarian parenting style is related to lower carer perceptions of the carer-child relationship. Thus, there is partial support for hypothesis two.

Table 6

Correlation between the Variables Authoritarian Parenting Style, Authoritative Parenting Style, and Carer-Child Relationships

Subscale	1	2	3	Mean	SD	N
1. Authoritarian	-	-.36*	-.40**	7.66	1.49	44
2. Authoritative	-.36*	-	.25	16.68	1.51	43
3. Relationships	-.40**	.25	-	115.13	13.08	46

* $p < .05$. ** $p < .01$.

Relationship between Child Emotional and Behavioural Difficulties, Child Temperament, Child Resilience, and Carer-Child Relationships (Hypothesis Three)

Table 7 demonstrates a significant relationship between child emotional and behavioural difficulties and carer-child relationships. Approximately 44% of the variability in carer-child relationships is accounted for by child emotional and behavioural difficulties. The direction of the correlation is negative suggesting that higher scores in child emotional and behavioural difficulties are associated with lower scores in carer-child relationships. This means that children displaying greater emotional and behavioural problems are more likely to have less positive relationships with their permanent carers.

A significant negative correlation between ratings on difficult child temperament and ratings in carer-child relationships is also present. Around 37% of the variability in carer-child relationships is attributable to differences in child temperament. Caregivers parenting children exhibiting more difficult temperaments are more likely to have less favourable carer-child relationships.

Table 7 further indicates a significant correlation between child resilience and carer-child relationships. Child resilience explains up to 28% of the variability in carer-child relationships. The direction of the relationship suggests that higher rankings in child resilience are likely to accompany higher rankings in carer-child relationships. Resilient children are more likely to have more positive carer-child relationships with their caregivers. Hypothesis three is therefore supported.

Table 7

Correlation between the Variables Child Emotional and Behavioural Difficulties, Difficult Child Temperament, Child Resilience, and Carer-Child Relationships

Subscale	1	2	3	4	Mean	SD	N
1. Difficulties	-	.63**	-.68**	-.66**	15.57	8.22	46
2. Temperament	.63**	-	-.76**	-.61**	3.30	.65	45
3. Resilience	-.68**	-.76**	-	.53**	31.33	9.08	45
4. Relationships	-.66**	-.61**	.53**	-	115.13	13.08	46

** $p < .01$.

Predictors of Carer-Child Relationships (Hypothesis Four)

Carer and child characteristics predicting carer-child relationships. Table 8 demonstrates that when all carer and child variables are entered into a single regression equation, child emotional and behavioural difficulties solely emerge as a most significant predictor of carer-child relationships $F(6,46) = 7.06$, $p < .01$. None of the other variables – carer empathy, authoritarian parenting style, authoritative parenting style, difficult child temperament, and child resilience, appear nearly as important in predicting carer-child relationships, and did not contribute significantly to the regression equation. Together, the variables explain about 47% of the variance in carer-child relationships. The linear relationship between emotional and behavioural difficulties and carer-child relationships

(*beta* = -.46), suggests that as perceived child emotional and behavioural difficulties increase, positive aspects of carer-child relationships decrease.

Table 8

Standard Multiple Regression of Carer and Child Characteristics Predicting Carer-Child Relationships (N = 46)

Variable	*B*	*SE B*	β	t-value	p-value
Empathy	- .08	.18	-.05	- .41	.69
Authoritarian	-1.19	1.25	-.13	- .95	.35
Authoritative	1.40	1.09	.16	1.28	.21
Difficulties	- .81	.29	-.46	-2.78	.01
Temperament	-6.32	3.70	-.31	-1.71	.10
Resilience	- .10	.28	-.07	- .35	.73

Note. $\Delta R^2 = .47$ ($p < .01$)

Carer characteristics predicting carer-child relationships. Table 9 shows a significant linear relationship between the predictor authoritarian parenting style and criterion carer-child relationships $F(3,46) = 2.73$, $p < .05$. The predictors empathy and authoritative parenting style did not contribute any unique variance to the regression model, making authoritarian parenting style the single predictor of carer-child relationships (*beta* = -.36). The regression equation accounts for 11% of the variation in carer-child relationships. Authoritarian parenting is associated with less positive carer-child relationships.

Table 9

Standard Multiple Regression of Carer Characteristics Predicting Carer-Child Relationships (N = 46)

Variable	B	SE B	β	t-value	p-value
Empathy	- .03	.23	-.02	- .14	.893
Authoritarian	-3.22	1.45	-.36	-2.23	.032
Authoritative	1.07	1.38	.12	.78	.441

Note. $\Delta R^2 = .11$ ($p < .05$)

Child characteristics predicting carer-child relationships. Table 10 suggests that of the predictors emotional and behavioural difficulties, difficult temperament, and resilience, emotional and behavioural difficulties is the only predictor that contributes significantly to the regression ($t = -.52$, $p < .01$). Jointly, the predictors accounted for 48% of the variability in carer-child relationships $F(3,46) = 14.12$, $p < .01$. The significant linear relationship between emotional and behavioural difficulties and carer-child relationships indicates that perceived problematic behaviour in children is associated with less positive carer-child relationships.

In sum, the regressions performed to test hypothesis four suggest that when examining carer variables in isolation authoritarian parenting is the most important predictor of carer-child relationships. Of the child variables alone, emotional and behavioural difficulties is the most important predictor of carer-child relationships. When both carer and child variables are entered into the equation, child emotional and behavioural difficulties remain the single most important predictor of carer-child relationships. Hypothesis four is not supported by these results.

Table 10

Standard Multiple Regression of Child Characteristics Predicting Carer-Child Relationships (N = 46)

Variable	*B*	*SE B*	β	t-value	p-value
Difficulties	- .90	.27	-.52	-3.36	.002
Temperament	-6.98	3.54	-.34	-1.97	.056
Resilience	- .13	.27	-.09	- .50	.623

Note. $\Delta R^2 = .48$ ($p < .01$)

Exploratory Regression Analyses

Individual Carer Characteristics Subscales Predicting Carer-Child Relationships

Table 11 demonstrates that none of the predictors – perspective taking, fantasy, empathic concern, or perspective taking contribute significantly to the regression model. As such, carer variables did not predict carer-child relationships.

Table 11

Standard Multiple Regression of IRI Subscales Predicting Carer-Child Relationships (N = 46)

Variable	*B*	*SE B*	β	t-value	p-value
Perspective Taking	.90	.79	.21	1.14	.262
Fantasy	.08	.43	.03	.18	.856
Empathic Concern	-.70	.58	-.22	-1.22	.231
Perspective Taking	.53	.56	.16	.94	.355

Note. $\Delta R^2 = .-.02$ ($p = > .05$)

Table 12 shows that of the parenting style dimensions, responsiveness emerged as the only predictor that offered any unique contribution to the regression equation (t = 2.32, $p < .05$). None of the other predictors appeared to contribute significantly to the regression $F(8,46) = 1.77$, $p < .05$. The predictors jointly accounted for 13% of the variance in carer-child relationships. From the observed linear relationship between responsiveness and carer-child relationships it would seem that responsiveness in parenting is linked with more positive carer-child relationships.

Table 12

Standard Multiple Regression of PSDQ Subscales Predicting Carer-Child Relationships (N = 46)

Variable	*B*	*SE B*	β	t-value	p-value
Verbal Hostility	3.66	6.34	.11	.58	.567
Corporal Punishment	- .10	5.06	-.00	- .02	.984
Non-reasoning	- 7.40	6.73	-.22	-1.10	.279
Directiveness	1.29	3.29	-.07	- .39	.698
Warmth	- 6.20	6.80	-.17	- .91	.368
Reasoning	- 2.61	6.36	-.09	- .41	.684
Democratic Participation	.92	3.03	.05	.30	.765
Responsiveness	13.19	5.70	.48	2.32	.027

Note. $\Delta R^2 = .128$ ($p < .05$)

Individual Child Characteristics Subscales Predicting Carer-Child Relationships

Table 13 indicates significant linear relationships between the criterion variable carer-child relationships, and two of the predictors entered into the regression equation $F(5, 46) = 14.92$, $p < .01$. Conduct difficulties are the most significant predictor (*beta* = -.45), followed by pro-social (*beta* = .32). Altogether, the predictors accounted for 61% of the variance in carer-child relationships. From the regression, it appears that fewer conduct difficulties and more pro-social behaviours are associated with positive carer-child relationships.

Table 13

Standard Multiple Regression of SDQ Subscales Predicting Carer-Child Relationships (N = 46)

Variable	*B*	*SE B*	β	t-value	p-value
Emotional Difficulties	- .49	.53	-.10	- .92	.363
Conduct Difficulties	-2.66	.75	-.45	-3.56	.001
Hyperactivity	- .73	.49	-.17	-1.49	.145
Peer Problems	.33	.53	.07	.62	.537
Pro-Social	2.11	.76	.32	2.79	.008

Note. ΔR^2 - .61 ($p < .01$)

Table 14 illustrates a significant linear relationship between inflexibility and carer-child relationships ($t = 5.31$, $p < 1$). None of the other predictors, approach, rhythmicity, and persistence contributed significantly to the regression, making inflexibility the only significant predictor of carer-child relationships ($F(4, 46) = 9.31$, $p < .001$). The predictors accounted for 43% of the variation in carer-child relationships. Accordingly, one can infer that inflexibility is associated with less positive carer-child relationships.

Table 14

Standard Multiple Regression of STSC Subscales Predicting Carer-Child Relationships (N = 46)

Variable	*B*	*SE B*	β	t-value	p-value
Approach	- .75	1.80	-.05	- .42	.679
Rhythmicity	-2.71	1.82	-.17	-1.49	.145
Inflexibility	-6.13	1.16	-.62	-5.31	.000
Persistence	-1.70	1.56	-.13	-1.09	.284

Note. $\Delta R^2 = .430$ ($p < .001$)

Summary of Quantitative Results

In reviewing the quantitative results presented in this section, several factors have emerged. Analyses suggest that carer empathy, as measured in this study, did not relate to carer-child relationships. On the other hand, carer parenting style served as a much more accurate predictor of carer-child relationships. In particular, it was the authoritarian parenting style that predicted carer-child relationships.

With respect to the relationship of child variables and carer-child relationships, all correlations were significant. In fact, when carer and child variables were examined within the same regression equation, child emotional and behavioural difficulties were the most important predictor of carer-child relationships.

Although not directly concerned with the hypotheses tested in this study, the subscales of each measure utilised were later inspected for their independent contributions to carer-child relationships. Again, none of the subscales comprising the IRI presented any unique variance on the criterion. Of the parenting style dimensions, responsiveness was the most important predictor. Examination of the SDQ showed that conduct problems and pro-social were most critical in predicting carer-child relationships.

Finally, inflexibility was the only subscale from the STSC to predict carer-child relationships.

In sum, within the current sample, quantitative results point towards the importance of child variables, rather than carer variables, in the effective prediction of carer-child relationships.

Discussion

The current study served to examine the relationship of several carer and child attributes in permanent care carer-child dyads using quantitative and qualitative measures. Carer variables were empathy and parenting style, while child variables included emotional and behavioural difficulties, temperament, and resilience. The remaining part of the chapter discusses the results of the quantitative aspect of the study.

Overview of Quantitative Findings

Specific hypotheses were, 1. That a positive relationship would be present between carer empathy and carer-child relationships; 2. That there would be a positive relationship between carer authoritative parenting style and carer-child relationships and a negative relationship between authoritarian and permissive parenting styles and carer-child relationships; 3. That the child variables – emotional and behavioural difficulties, difficult temperament, and low resilience – would be negatively related to carer-child relationships; and 4. That the carer variables would more strongly predict carer-child relationships than child variables.

No relationship was evident between carer empathy and carer-child relationships, and thus no support was found for Hypothesis One. In reference to the second hypothesis, only the authoritarian parenting style was correlated with carer-child relationships, indicating partial support for this hypothesis, suggesting that authoritarian carers experienced less positive relationships with their children. Results for the third hypothesis

indicated that all child variables – emotional and behavioural difficulties, temperament, and resilience – were correlated with carer-child relationships. Carers tended to have less positive relationships with children who were perceived as being difficult in their emotions, behaviours, and temperaments. Conversely, caregivers experienced more positive relationships with children who were seen as resilient. Full support was hence obtained for the third hypothesis.

In examining carer variables in isolation, only authoritarian parenting was a significant predictor of carer-child relationships. Of the child variables, only emotional and behavioural difficulties predicted carer-child relationships. Further, when examining both carer and child variables child emotional and behavioural difficulties was the single most important predictor of carer-child relationships. The fourth hypothesis was therefore not supported.

At least for the sample utilised in this study, the quantitative results suggest that carer variables may not be as fundamental to carer-child relationships as child variables. What follows is a more in depth discussion of these results.

Interpretation of Correlations among Carer and Child Variables

The moderate negative relationship between carer empathy and authoritarian parenting signifies that carers who were low in empathy were more authoritarian in their style of parenting. This is in line with existing literature (eg., Brems & Sohl, 1995; Kilpatrick, 2005; Strayer & Roberts, 2004), which has found that parents who are low in empathy are more likely to engage in negative parenting or punitive rearing practices. Results did not concur with current empirical research (Ang, 2006; Koestner et al., 1990) indicating that authoritative parents are better able to interpret and respond to their child's demands empathically.

It was found that children with difficult temperaments were more likely to display

challenging behaviours. This is consistent with current research (Goodnight, Bates, Staples, Pettit, & Dodge, 2007; Orme & Buehler, 2001; Lengua, 2006; Letcher et al., 2004; Roosa, 2000; Sheffield-Morris et al., 2002; Stams et al., 2002) which postulates that temperament contributes to the behaviour and development of individuals. Indeed, the bulk of research shows that difficulties in ones' emotional, behavioural, and social adjustments are often associated with particular temperament styles or temperamental characteristics (Bussing et al., 2003; Dixon, 2000; Kochanska et al., 2005; Manders et al., 2006; Paterson & Sanson, 1999; Sheeber & Johnson, 1992; Smart & Sanson, 2005). Temperament pre-disposes children to react to events and experiences in particular ways, and depending on the individual, these may be more positive or negative. A child's temperament can serve as a protective mechanism or as a source of vulnerability and can even influence caregiver response (Lengua, 2006; Luthar & Zigler, 1991). Thus, an easy temperament may enable children to evade negative developmental outcomes (Henry, 1999).

Consistent with current resilience research, the resilient children in this study displayed fewer emotional and behavioural problems (Curtis & Cicchetti, 2003; Hines et al., 2005; Perkins & Jones, 2004; Rishel et al., 2005), and had more easy-going, undemanding temperaments (Richardson, 2002; Rutter, 1985). Longitudinal research conducted by Werner (1994; 1995) found that resilient children had a range of temperamental characteristics that enabled them to educe positive reactions and responses from their caregivers.

Results directly replicate existing research with out of home care populations indicating that children who have been in the care system are likely to manifest greater challenges in their emotions, attention, regulation of affect, and sociability than their counterparts in the general population (Kelly et al., 2003; Leslie et al., 2003; Sargent &

O'Brien, 2004; Richards et al., 2006; Schofield & Beek, 2005).

Interpretation of Results on the Carer-Child Relationship

Empathy. Contradictory to expectations, no relationship was found between carer empathy and carer-child relationships. There is little literature on empathy and permanent care populations, and as such, it is difficult to determine whether this result was due to a true absence of a link between empathy and carer-child relationships, sampling, or methodology. Research from the general population seems to suggest that empathic parents are more likely to report positive relationships with their children (Barber et al., 2001; Donald & Jureidini, 2004; Fabes et al., 1990; Kiang et al., 2004; Koestner et al., 1990; Moor, 2006; Oppenheim, Koren-Karie, & Sagi, 2001; Walker & Cheng, 2007); while the potential for child abuse has been linked to deficits in caregiver empathy (Kilpatrick, 2005; Miller & Eisenberg, 1988; Moor, 2006, Perez-Albeniz & DePaul, 2003; 2004). The incongruence between existing research from the general population and results the current study suggest the need for further investigation of the role of empathy in permanent care relationships. It is possible that the instrument used to measure empathy in the current study, a general empathy questionnaire was not sensitive to empathy in carer-child dyads, as is the child-specific Parental Empathy Questionnaire (Flory, 2004).

Parenting style. Of the parenting styles, authoritarianism was the only significant predictor of carer-child relationships. Essentially, authoritarian carers experienced less positive relationships with their children. Some existing literature supports this finding (Aunola et al., 1999). Carer authoritarianism, it appears, is not the ideal style of parenting in permanent care.

Even though the carers in the current study were more authoritative than authoritarian in their parenting orientations, and more authoritative than participants in

Winsler et al.'s study (2005), authoritativeness was not related to carer-child relationships. Authoritative carers neither experienced more positive nor more negative relationships with their children. This is in contrast to literature from general (Ang, 2006; Aunola et al., 1999; Baumrind, 2005; Kaufmann et al., 2000; Lewis, 1981) and short-term care populations (Dent & Cameron, 2003; Lipscombe et al., 2003; 2004), showing the importance of authoritativeness in positive caregiver-child relationships. These results suggest that it is an absence of authoritarianism which is more important in positive carer-child relationships than the utilisation of an authoritative style of parenting.

Behaviour Problems. Carers of difficult children reported poorer carer-child relationships. In line with prior research conducted with general and out of home care populations (Fabes et al., 2001; Gilbertson & Barber, 2003), difficult behaviours seemed to contribute to more strained carer-child relationships. Children exhibiting difficult behaviours may also educe negative parenting responses from their caregivers (Fabes et al., 2001), that have in turn been connected to poor child adjustment (Fabes et al.; Mulvaney & Mebert, 2007; Sheffield-Morris et al., 2002). Further, where behavioural disturbance is marked and unrelenting, placement breakdown may result (Gilbertson & Barber, 2003; Triseliotis, 2002; Wilson, 2006).

Temperament. Difficult child temperament was related to less positive carer-child relationships. It is possible that carers had greater difficulty in connecting with and responding to children who displayed challenging temperaments (Mulvaney & Mebert, 2007; Sheeber & Johnson, 1992). Alternatively, it may have been a mismatch of carer and child temperaments that affected carer-child relationships. Research has found that where temperaments diverge greatly, this may result in a clash of temperaments (Dixon, 2000). Moreover, temperamentally difficult children may be more prone to eliciting negative parenting behaviours such as hostility, disapproval, criticism, and abuse from their

caregivers (Harrington, Black, Starr, & Dubowitz, 1998; Luthar & Zigler, 1991; Trentacosta & Shaw, 2008; Vig et al., 2005; Werner, 1994).

Resilience. It appeared that even after exposure to risk and the experience of adversity, resilient children were able to develop positive relationships with their carers. This finding adds further weight to a growing research base that shows that resilient children continue to function more positively after the experience of adversity (Gilligan, 2000; Mancini & Bonanno, 2006; Rutter, 1985). This ties in with results reported previously in this section showing that resilient children maintained relatively fewer emotional and behavioural difficulties and exhibited easier temperaments. Thus, data collected in this thesis suggests that resilient children possessed particular traits which enabled them to adapt to changed caregiving situations and rise above their previous negative experiences. Further, different children may experience the same form of parenting differently (Finzi-Dottan et al., 2006). Specifically, more resilient children, with easy temperamental dispositions may be influenced less by negative carer-child parenting interactions (Sheffield-Morris et al., 2002).

In summary, carer empathy was not related to carer-child relationships. Authoritarian carers experienced less positive relationships. Correlations between the child variables and carer-child relationships showed that carers who had children with emotional and behavioural problems, were temperamentally difficult, and less resilient, were more prone to experiencing less favourable carer-child relationships. On the other hand, children who were low in emotional and behavioural problems, temperamentally easy, and resilient were more likely to have positive relationships with their carers.

Predictors of the Carer-Child Relationship

Results from the multiple regression model incorporating both carer and child variables in the prediction of carer-child relationships failed to support the influence of any carer variables. Ultimately, it was child emotional and behavioural difficulties that best predicted carer-child relationships. It would seem that it is harder to have positive relationships with difficult children, but easier to have positive relationships with less difficult children. Prior research has also documented the significance of child behaviours in influencing relationships and parenting (Sargent & O'Brien, 2004).

Interpretation of Exploratory Regression Analyses

A series of multiple regressions were conducted in an exploratory manner to examine whether any specific carer or child variables predicted carer-child relationships. With respect to empathy, none of the four IRI subscales – perspective taking, fantasy, empathic concern, or perspective taking – predicted carer-child relationships. Indeed, empathy is a complex construct which is defined in many ways (Davis, 1994; Kilpatrick, 2005), and it is possible that the IRI, being a measure of general empathy, did not provide the conceptual and structural sensitivity to accurately measure child-directed empathy. Measuring empathy with an alternative measure may have produced an alternative result.

Of the dimensions underlying the authoritarian and authoritative parenting styles of the PSDQ, responsiveness best predicted carer-child relationships. Responsiveness refers to the caregiver's ability to utilise appropriate, encouraging, and supportive parenting techniques to meet the child's needs. The absence of responsiveness in parenting has been linked to child externalising behaviour problems (Baumrind, 1996). That a caregiver is able to decode their child's feelings and respond appropriately, may have particular significance in carer-child relationships (Aunola et al., 1999; Baumrind, 1996; Berg-Nielson & Holen, 2003; Lengua, 2006; Letcher et al., 2004). Children who

have come from troubled backgrounds and have entered the alternative care arena, often experience greater insecurity in their relationships and have an inability to accurately express feelings and needs (Banyard et al., 2001; Gordon, 1999; O'Neil, 2006). This creates a sizable discrepancy between hidden and expressed needs. Therefore, that a carer is able to respond in a sensitive and appropriate manner appears particularly important.

Of the emotional and behavioural difficulties measured by the SDQ, conduct difficulties and pro-social behaviour predicted carer-child relationships. Conduct difficulties and a lack of social skills presented substantial challenge to carer-child relationships. There is much literature to support the finding that externalising behaviours, such as problems with conduct, pose particular challenges to parenting and relationships (Orme & Buehler, 2001). Further, good relationships are also dependant on the child's ability to behave in a pro-social manner with their carer (Banham et al., 2000; Howe, 2001).

Of the four temperament dimensions comprising the STSC, inflexibility best predicted carer-child relationships. Inflexibility refers to trouble in coping with and regulating change, disappointment, and anger. Their intense resistance to change and inability to control their emotions appears to challenge and frustrate carers (Scaramella & Leve, 2004) compromising carer-child relationships.

The results discussed in this section are exploratory in nature, and as such, should be interpreted cautiously. It is possible that the limited number of cases assigned to the numerous variables unduly compromised the significance or direction of the exploratory regression analyses. A future replication of this study with a much larger sample would assist in clarifying the validity and reliability of emergent results.

CHAPTER FOUR: QUALITATIVE METHOD, RESULTS, & DISCUSSION

Method

Participants

Approximately half of the quantitative sample expressed interest in participating in an interview. From these self-selecting carers, 13 participants (1 Male, 12 Females), were selected randomly by the researcher to take part in the second phase of the research study, a semi-structured interview. Carers were aged between 40-66 years (M = 49.36, SD = 7.02). Year 10 was the highest level of secondary school completion for 50% of carers, while 28.6% of carers had completed at least an undergraduate university degree. Most carers were married (57.1%), 14.3% were divorced and 14.3% were living in defacto relationships. 7.1% were single. More males were represented in the interviews (71.4%) than females (28.6%). Children were aged between 3.75 to 12.08 years (M = 7.12, SD = 2.79), and had been living with their carers for 2 to 8.5 years (M = 4.54, SD = 1.83). Numbers of previous placements ranged 1 to 39, with 54.6% of children having had at least 2 placements. Mean comparison tests showed that qualitative and quantitative samples ranked comparatively across demographic variables.

Ethical approval was obtained from the Australia University Human Research Ethics Committee (Appendix A), the Department of Human Services, and participating placement agencies (Appendix B) prior to commencing data collection for the qualitative component of the study.

Measure

Semi-Structured Interview Schedule

For the purpose of guiding the direction of the discussions, a semi-structured interview schedule was devised (Attachment F). Target questions paralleled the key concepts addressed in the quantitative section, and aimed to obtain carers' accounts of

challenging and positive behaviours, carers' relationships with their children, early impressions and expectations of their children and the carer-child relationship, changes in the carer-child relationship across the placement, child history and development, carer disciplinary behaviour, and so forth. Where relevant, various interview techniques including reflection, clarification, probing, and narrative expansions were used to solicit further information from participants (Hesse-Biber, 2006; Huberman & Miles, 2002). Still, to ensure the natural flow of discussions certain flexibility in question sequencing was expressed throughout the interviews. As such, questions were pre-arranged but open to the flow of the interview. Preliminary information, including the time and date of the interview and the granting of informed consent were also documented. Interviews lasted for approximately one hour and were tape recorded and transcribed. The semi-structured interview schedule was trialled prior to the commencement of interview procedures.

Procedure

Carers demonstrating interest in participating in the second phase of the research were contacted by telephone to organise a suitable time and date to conduct the interview. Of the 15 carers contacted for an interview, 13 proceeded to schedule an interview. All interviews were conducted at Australian Catholic University, Fitzroy campus. Participants (N=6) living in rural locations were interviewed by telephone. Participants were given an information letter (Attachment G) and consent form (Attachment H) to complete. To contain for the effects of social desirability, carers were not directly informed that their levels of empathy and parenting behaviours formulated additional key focal points within the study. Instead, carers were advised that the study's focus lay on obtaining a better understanding of carer-child relationships, child behaviour, and carers' experiences of parenting their permanent care child. Permission to audiotape was

obtained, allowing the opportunity for brief, succinct note-taking to be undertaken throughout the interviews.

Data Analysis

Interviews were transcribed by the researcher and reviewed for accuracy, with initial thoughts and statements of significance recorded in transcript margins. Emerging preliminary data were then classified both thematically and categorically, ultimately condensing the total amount of data. In effect, statements pertaining to each target variable were grouped together where they were assigned preliminary codes. For this, a qualitative codebook, indicating the codes for the data was developed. Where descriptive accounts required inference, this was addressed through the utilisation of inferential coding (Hesse-Biber, 2006; Huberman & Miles, 2002). Broader thematic codes were devised by examining preliminary codes and determining associations amongst them. Coded evidence and ideas were entered into an analysis grid as a means of further condensing interview data and allowing examination of thematic consistency, clustering of predominate themes, and identification of analysis direction ultimately enabling the efficient drawing of conclusions.

Results

As stated in Chapter Three, qualitative interviews were conducted with the purpose of providing supplementary information on carer-child relationships. This section organises the interview data into a priori topics whilst subsequently discussing emergent themes.

Carer-Child Relationships

Relationship Characteristics

Consistent with the results presented in the previous section, interview data offered similar information on the carer-child dyads of this sample. Overall, most carers

described positive relationships with their children, and were able to speak freely about the positive aspects that comprised them. Carers often recalled the positive attributes of the child; as did Carer 1 for example, *"Oh I really like her as a person. She's really outgoing and she's got a really great sense of humour"*. Carers commonly used words like *love*, *bond*, and *attachment* when describing their relationships. Statements included: *"We love each other very much". (Carer 2); "I think we've strongly bonded". (Carer 3);* and *"He responded very positively to us from the beginning and showed signs of attaching, so we actually have a very strong bond". (Carer 4).*

The special connection carers had to their permanent care children was a theme consistent through the interviews. Comments such as the following were frequently made by carers: *"He's very much mine". (Carer 2); "We feel as if we're his parents and you know although not biologically, it's still a very strong sense of him being our child". (Carer 4)*; *"As far as I'm concerned, I see him as my son, and I regard myself as his mum". (Carer 5);"I feel incredibly close to our children. I don't feel any different to any other mother or father". (Carer 11).*

Indeed, this connection was often evident even in cases where permanent carers had biological children of their own: *"They're the same as my own birth children". (Carer 6); "He's our child. It feels like I've given birth basically like the other children that I have". (Carer 7); "He's just like my own son. We don't really see a difference. Apart from perhaps he doesn't look that much like me". (Carer 8); "The attachment with [permanent care child] in some levels is actually stronger than with my natural son...because I feel [permanent care child]'s had more challenges and obstacles to overcome so I'm more protective of him". (Carer 3).*

That carer-child relationships were permanent was a viewpoint shared by all carers. The following statements illustrate this: *"I see it as something permanent; until*

more or less, death do us part so to speak". (Carer 5); "He's ours. He's ours for life". (Carer 9).

Indeed, many carers were unable to envision their lives without their permanent care child. *"His presence is so felt that you miss him when he's not there". (Carer 3); "I can't imagine life without [him]". (Carer 5).*

Relationships with Other Family Members

All children had positive relationships with the other members of the immediate permanent care family. Children appeared to have been accepted within their family units and identified themselves as belonging to their families. The majority of children also seemed to have typical, positive relationships with extended permanent care families as well. The following quotes are reflective of the above: *"He gets on quite well with both sides of our family". (Carer 4)*; *"I think they treat them all as equal siblings". (Carer 6); "She accepts my family as her family and they her". (Carer 10); "He's the youngest in our extended family now and everyone really welcomed him with open arms and have really tried hard to make sure he's one of the family". (Carer 12); "They're all older and they treat him as something special because they're old enough to understand what he's been through". (Carer 13).*

Establishing relationships

First impressions. A variety of thoughts and feelings were reported by carers when asked to reflect upon their first meetings with their permanent care children. The majority of first impressions were positive (77%) with many carers making some reference to the child's physical appearance. Respective comments included: *"Very attractive; he had these lovely big brown eyes and lovely brown skin". (Carer 4); "Cute as a button". (Carer 7); "He was a very good looking little baby". (Carer 12).*

Four carers described feeling an instant connection to their permanent care child. For example, in her account, Carer 2 stated: *"He was just gorgeous. I fell in love with him minute one I suppose"*. Likewise, Carer 11 explained: *"I thought she was gorgeous. I would stare at her in the cot at night and couldn't believe we'd been given this gorgeous, gorgeous little girl and she was just a delight to be with"*.

Two carers portrayed less positive early impressions of their permanent care children. *"He was real skinny. He had bad eyesight but he was very skinny. Probably ugly would describe him as a baby. He had no hair and a funny shaped head". (Carer 6); "She just screamed all the time". (Carer 10).*

A number of carers (46%) recalled a sense of liveliness or over-activeness in their permanent care children. Their comments included: *"I thought she's the fastest crawler I've ever seen". (Carer 1); "He was crawling at the time but he was going at about a hundred miles an hour. He was just so busy. I thought to myself, "Am I going to have the stamina to keep up with this child?" (Carer 3)*; *"He was a whirlwind, a bundle of energy and couldn't sit still". (Carer 5).*

Anticipations. Upon commencing their permanent care placements, most carers (62%) acknowledged having at least some preconceptions about their children and the behaviours they would exhibit. Many carers anticipated the possibility that children could be resistant to their efforts to establish a bond with them. Carers were largely aware that children may have come from troubling backgrounds which may have impacted on them psychologically. The prospect that children may display emotional and behavioural difficulties was also known by carers. Two of these carers noted however: *"It was a much more difficult time than we ever anticipated, either of us, my husband or myself". (Carer 5); "I didn't recognise that it was going to be as difficult as it has turned out to be". (Carer 9).*

Clearly, in these two cases, carers were not completely prepared for the challenges that parenting their permanent care children would involve.

Summary

For the most part, carers noted positive relationships with their children. There did not appear to be any significant difference in the depth of carer-child relationships between carers who had parented biological children compared to those who had not. Carers all shared the common view that carer-child relationships were permanent.

Most carers reported positive first impressions of their children. At the commencement of the placement, carers had preconceptions of their children and how the placement would be. Carers had an understanding that children may present with a range of emotional and behavioural challenges. The majority of children displayed at least some difficult behaviour.

Carer Variables that Challenge and Support Carer-Child Relationships

Empathy

Even though quantitative results found no relationship between empathy and the carer-child relationship, general interview data found evidence to support all four constructs of empathy as identified by Davis (1994), and for an empathic understanding of the child.

Perspective taking. The subsequent statements show that carers were able to take on the psychological perspectives of their children. *"I expect him to be difficult, but I don't expect for example my other son to be difficult, so I'm less tolerant of him when he does something wrong". (Carer 3); "I think he was pretty freaked out from being with them basically from birth to suddenly being with another family". (Carer 8); "I try to put myself in her position". (Carer 11).*

Fantasy. There was some evidence that carers were capable of envisioning imaginary situations that may potentially cause distress to their children as the following statements demonstrate. *"I think at some point she will be angry with her birthmother for being a drug addict and for taking drugs while she was pregnant". (Carer 11); "I think the biggest thing for him will be to understand why his birth mother doesn't want to have contact with him and why we don't know where she is, and why she doesn't know where we live". (Carer 12).*

Empathic concern. Carers were empathically concerned for their children. They also showed a tendency to feel compassion for other children who had experienced adversity or were in out of home care. The following statements capture this tendency. *"It's devastating to see these kids drinking, on drugs, getting into trouble, and that's why I want it to stop". (Carer 6); "It would be devastatingly cruel to say "OK, here, you're too hard – see ya". So you couldn't do it". (Carer 7).*

Personal distress. In witnessing their children undergo great distress, carers also became quite upset or disturbed at times. For example, in speaking of a past event Carer 5 related: *"That's not why I'm crying. I'm crying because I can see the hurt [he's] going through and there's nothing I can do about it".*

In addition, two questions were constructed to indirectly assess carer empathy. The first of these, a dual themed question, pertained to carers' first impressions of their children. The second concerned how sensitive carers were to understanding their children's feelings.

First impressions. As described in an earlier section, carers were mostly positive in the early impressions they recalled of their children. Of relevance here, descriptions from Carer 3 and Carer 13 also depicted an underlying empathic inclination that seemed to at least partially explain these carers' care-giving motives. Their statements included:

"I felt overwhelmed with emotion. I felt really proud that I was going to be able to give this child an opportunity to have a better life". (Carer 3); and *"I just could not believe that this child could ever be like he was. I just couldn't believe that someone could neglect a child. That this child didn't know what love was". (Carer 13).*

Understanding their children's feelings. The majority of carers (77%) did not encounter any difficulties in the perception or interpretation of their child's feelings. Comments from carers included: *"He doesn't hide the way he's feeling". (Carer 4); "He's not really good at hiding his feelings". (Carer 8); "Knowing his history certainly helps to understand". (Carer 9); "I try to put myself in her position". (Carer 11); "I know when he's sad. I know when he's happy. I know when he's deep in thought". (Carer 13).*

Alternatively, 17% of carers described the task of understanding their child's feelings as challenging. To illustrate, Carer 5 said: *"I can get distracted by his emotions, by what he's displaying".*

The majority of carers (92%) found that over time they were better able to interpret their child's feelings. This increased capacity was assumed to have stemmed from a deeper understanding of the child and the child's personality, an improvement in child speech and expression, and decreasing behavioural problems.

On the whole, target questions generated responses from carers which seemed to parallel a sense of understanding; as well as a capability to relate to children on an emotional level. In conjunction with other emergent empathy-related data however, carers, it seemed, were not equal in the levels of empathy they portrayed towards their children. In other words, some carers appeared more empathic than others. This trend is consistent with quantitative data which found notable variability in empathy-related construct scores.

Perceived child talents. Ninety-two percent of carers believed their children displayed special talent in at least one area. Most talents concerned physical capabilities such as balance, hand-eye co-ordination, and sporting activities. Quotes from carers included:

"He's a fantastic athlete". (Carer 3); "The sooner he gets into some organised sport he'll be some sort of champion at something I wouldn't be surprised". (Carer 8); "She's incredibly acrobatic". (Carer 11).

This shows that carers were able to identify positive characteristics in their children, observing them as superior to their age peers in some regard. This was also seen to be reflective of an empathic tendency towards their child, with carers being able to make positive attributions of their children and their abilities.

Parenting and Parenting Styles

Spending time with the child. Typically, carers spent time with their children both before and after school. Pre-school aged children spent even more hours with their carers. Time spent together also peaked during school holiday periods. All carers reported that they enjoyed spending time with their children and participated in many activities with them. These included attending sporting activities, going for bike rides and walks, swimming, shopping, and attending family functions. Carers also spent time in activities with their children within the home. These activities included cooking, reading, and watching television. In addition, several carers stated that they also enjoyed spending time away from their children as did Carer 6: *"I spend special time without them as well as together".*

Supervision. All carers supervised the activities of their children. In most cases carers watched over their children's activities by either participating in them or by remaining in close proximity to their children. Where children were not in their carer's

presence, carers enforced timelines and set boundaries for their children to follow. Carers also determined what activities were suitable for their children to involve themselves in.

Discipline. All carers stated that they encountered at least a little difficulty in disciplining their child. Approximately half (54%) of carers spoke of their child's defiance or confrontational reactions to attempted discipline. For example, Carer 12 said: *"He gets more angry when he's being told off rather than upset";* while Carer 13 stated: *"He doesn't listen. I'm sure he hears but he'll ignore you".* Carer 4 further elaborated on the difficulty associated with disciplining her child in public*: "His reaction will sometimes be to turn around and yell at you quite loudly in terms of he's not happy about whatever you were disciplining him about".*

Carers often used reasoning to try to persuade their children to behave. One carer spoke of her need to use reward and positive reinforcement when disciplining her child: *"I find with him the carrot on the stick is often there" (Carer 9).* Another carer found it testing to remain calm when disciplining her child for the more challenging behaviours she exemplified. Fifteen percent of carers were mainly concerned with the possibility of upsetting their child during discipline. Carer 2 exemplified: *"I don't want to make him unhappy or upset him".* A further 15% of carers stated that although they did not find the task of disciplining their children difficult within itself, the continuous need for discipline caused it to become so. On this issue Carer 7 commented: *"It's just continuing and in that sense it's difficult".*

Parenting experiences. Although carers found parenting their children difficult at times, most seemed confident and largely satisfied with their role. *"I don't know what I'd do with myself without [him]. He's my whole world". (Carer 2); "We love being parents". (Carer 11).*

Carers were open to their children's opinions and feelings and tried to take their children into consideration when making decisions that involved them. Carers often responded to their children's distress with little delay and attempted to get to the cause of what was unsettling them. Even so, carers were able to set boundaries and discipline their children where it was seen necessary.

Carers had rather varied perceptions on the issue of whether parenting permanent care children differed significantly from parenting biological children, as reflected in the following comments: *"You're sort of having to parent a child that is just different from your own experiences and that may be good or it may be bad; and for me I guess most of the time it's quite good". (Carer 4); "Generally speaking I would say it's like parenting my own child most of the time – so that can be very difficult at times, much easier at others. Having done both I wouldn't say it's significantly different. He hasn't brought a whole history, a whole heap of issues from the past as he was placed so young". (Carer 8); "I wouldn't think it's all that different. The biggest issue I think with permanent care is managing access and how that affects children and how you tackle their background and how you keep that feeling of security and normality in family life". (Carer 11); "They're just totally different to other kids. I had three sons and a daughter and there's nothing remotely like his emotional needs from what they were". (Carer 13).*

Many carers found observing growth and development in their child rewarding. Carers felt a level of satisfaction in supporting the maturation and well-being of their children. *"There's something about the satisfaction of just watching somebody grow and develop and caring for them and making sure they're OK, they've been cleaned and fed and that sort of stuff". (Carer 8); "What I'm really proud of is people who knew him before we got him just cannot believe he's the same child. There's been a big turn-around". (Carer 13).*

Another issue was the desire of carers to be acknowledged as parents both legally and by others. This prospective acknowledgement was seen as beneficial for carers and their children alike. *"Also for us as parents it can be quite hurtful sometimes too because we're not always recognised as parents – we're recognised as just carers". (Carer 11).*

The concern was largely inter-connected with the inability of children to adopt their caregiver's surnames. *"The only thing I think I'd really like for him would be to have our name because he's living with us. We're his parents". (Carer 8).*

A number of carers remarked on the level of intrusiveness parenting a permanent care child elicited from others and about the difficulty in finding a balance between disclosing information about the child versus keeping it confidential. *"When they know the situation, people would ask sort of really personal stuff about his background and stuff which wasn't fair on him about the birthmother". (Carer 8).*

Carer support. All carers felt they had sufficient support mechanisms available to them should they be required. Systems of support for carers fell largely under three categories – emotional, professional, and respite.

In 62% of cases emotional support was elicited principally from the primary carer's spouse. Emotional support also came from other family members, friends, case workers, and support networks such as playgroups and permanent care groups. Two carers noted feeling unable to speak to family or friends about parenting their children. In these two cases, carers felt their family and friends were unable to relate to their unique parenting experiences. In both respects, these carers had other emotional support systems to which they could turn.

With respect to professional support, carers expressed comfort in contacting their placement agency or case worker to seek support with their child's permanent care placement. Carers stated that their children's placement agencies were capable of linking

them with specialist services where required. Carers also often received support from their children's schools or day care centres.

Several carers made reference to the need for an occasional brief break from their children. This short period of respite allowed carers the opportunity to unwind by momentarily separating them from their parenting duties. Respite was sometimes provided in a formal manner by placement agencies. In the majority of cases however, respite merely involved the arrangement of friends or family to look after the child for an afternoon or weekend.

Preparation and training to become permanent carers. All carers attended the mandatory permanent care training workshops conducted by their respective placement agencies. Carers found workshops relevant and informative. A highlight for a number of carers was listening to the stories of others who had already been though the permanent care system. In relation to his training, Carer 8 commented: *"It was useful, but it did sort of prepare us for the worst. They had a couple come in who had a pretty traumatic time. It was good in a sense because it sort of made you fully aware of what you might get yourself into. You weren't going in with your eyes closed or anything"*.

Most carers felt that they were equipped to handle their parenting role, and believed they did not need to undergo any further training. If additional training was required at a later date, carers generally felt capable of eliciting this help when it was needed.

Two carers noted however that information on how to parent and support children with attachment disorder was deficient. Carer 5 stated: *"There was no way I was prepared for how to deal with [attachment disorder]. We didn't understand what attachment disorder was"*. Carer 10 too commented: *"I think what needs to be addressed*

more is attachment disorder. I think people need to be more aware of how abuse and neglect can damage these kids beyond repair".

Information carers received. All carers received information on their children. Information was primarily in the form of brief reports that provided detail on the child, his or her family, and the reason for the child's placement. Approximately 62% of carers were happy with the information they received. Comments included: *"We certainly felt that they were very respectful of us in terms of giving us as much information as they could and answering questions as best as they could". (Carer 4); "I was very happy with all the information we had and thought we could ask questions and we would get information". (Carer 12).*

Where carers wanted more information this usually related to the child's medical history. Fifteen percent of carers wanted information on the biological father. Essentially in these cases the biological father's identity was unknown. A further 15% desired more detailed accounts of the child's history so that they could have a better understanding of their child's current behaviours and how to best support their child's development.

Summary. With respect to carer variables, many carer statements reflected an empathic understanding of their child. Statements reflected the four aspects of empathy identified by Davis (1994), although some carers appeared more empathic than others. Carers enjoyed spending time with their children and routinely supervised their activities. The majority of carers felt capable in decoding their children's feelings and were able to identify positive attributes including special talents in their children.

With respect to parenting, all carers felt challenged when disciplining their children. Although parenting their children was at times difficult, carers were largely happy and confident within their role. Perhaps this was partially reflective of authoritative approach to parenting. Authoritative caregivers regularly experience periods of warmth in

their relationships with their children (Kaufmann et al., 2000). In addition, authoritativeness has strong elements of caregiver-child communication and reasoning (Ang, 2006; Baumrind, 1999). It is possible thus, that an authoritative style of parenting is helpful in identifying positive elements within the child. All carers had support mechanisms available to them.

All carers received the minimal permanent care training and did not feel they required any more. Although the information carers received about their children from placement agencies was often limited, carers were mostly understanding and satisfied with the amount of information they received.

Child Variables that Support and Challenge Carer-Child Relationships

Problem Behaviour

Initial behaviours. The majority of carers (69%) encountered at least some child-related difficulties early in their child's placement. These challenges stemmed from a number of areas but fell mainly under three categories: emotional, behavioural, and social. Examples of challenges identified by carers included, but were not limited to, issues with trust and affection, hyperactivity, aggression, and social anxiety. In many cases these challenges served to delay the attachment process. Four children had notable attachment disturbances, one child severe enough to meet clinical diagnosis for Reactive Attachment Disorder. Several children reportedly did not pose any significant difficulty in settling into their new placements. In fact, the carers of these children affirmed happy, positive relationships from the onset of the permanent placement.

A smaller number of carers (38%) described their children as emotionally withdrawn and disobedient, capable of theft, violence, or aggression. The following extracts illustrate this: *"He wasn't an affectionate being when he came here". (Carer 3); "She wasn't overly affectionate to begin with". (Carer 11); "He wouldn't follow*

instruction, like any sort of instruction". (Carer 7); "He was a dreadful shoplifter when we first got him". (Carer 13); "He was very aggressive". (Carer 3); *"Oh I was scared – I don't mind admitting it. I was scared for my own safety and that increased as [he] got older". (Carer 5); "He used to be terribly aggressive...he liked to hurt things". (Carer 13).*

Moreover, across a few interviews some evidence of a "honeymoon period" emerged. This period appeared to take place very early in the relationship, when children were only beginning to settle into their placement. In effect, upon entering the caretaker's home some children were more compliant and controlled in the behaviours they exhibited. As they began to settle in however, troubling behaviours began to escalate, becoming increasingly problematic. Carer 5 explained: *"Once that honeymoon period stopped he started becoming violent and we couldn't convince people that he was coz it was funny he was very rarely violent or aggressive in front of others".*

A few children were described as experiencing phobias. Phobias included fears of men, women, and the toilet as the following statements demonstrate: *"She was absolutely terrified of strange men to the point where if someone strange sat beside her at the table she'd put up a hand to shield her face". (Carer 11)*; *"He had a real dislike for women";* and *"He was absolutely petrified of the toilet".* (Carer 13).

Carer 13 also spoke of her child's initial eating habits: *"He used to gorge"; "He used to pick things off the supermarket [shelves], take a quick bite out of them and put them back";* and *"We've got a lounge suit that's got loose cushions on it...I took them off and found all this food planted".* This child's actions seemed to stem from a need to ensure that he would not go without food. While one other carer voiced concerns about her child's eating habits, Carer 13's child displayed the most extreme of behaviours towards food.

Current behaviours. The majority of carers (69%) noted improvement in their children's behaviours over the course of their placements. Comments included: *"It's all been extraordinary; the way she's come along has been amazing really". (Carer 1); "There are longer periods of calm and peace". (Carer 5); "He's work. The work is getting easier though as he get's older". (Carer 7); "He's relating more to me". (Carer 9); "She's come a long way I think. She needed a lot of attention and a lot of reassuring and she still does sometimes too". (Carer 11); "I just cannot believe where we were to where we are now". (Carer 13).*

Thirty-one percent of carers stated that their children's behaviours remained consistent throughout the placement. All but one of these carers had children with apparently little, or no behavioural issues. Carer 12 proposed that her child had become slightly more difficult since the onset of the placement as the following extract from her interview highlights: *"He's going through a bit of a challenging stage where he's starting to challenge boundaries but I see that as really normal, age appropriate".*

Although most carers described improvements in their children's behaviours, 62% of carers still found their children's behaviours challenging. Below are some of their statements: *"He's challenging and he has to be disciplined". (Carer 3); "There is certainly behaviour that he presents that is quite challenging". (Carer 4); "He's extremely demanding". (Carer 7).*

Several carers remarked on how relatively minor incidents could trigger moments of rage in their children. Carer 3 stated for example, *"His reactions are so extreme to things"*. Likewise Carer 7 explained, *"He gets cranky very quickly over nothing sometimes"* and Carer 12 affirmed *"He will get into a rage about something that's quite small".*

Another consistent theme for children concerned the need for routines and the implementation of boundaries in daily life. At least 38% of carers made reference to the importance these factors played in their relationships. The following extracts are some of their statements: *"He's very happy and a lot more contented child when we're doing our normal routines". (Carer 3); "He needs a lot of routine. He certainly needs lots of firm, clear limits". (Carer 4); "[He] still very much wants parameters even though he'll fight them". (Carer 5); "As long as she's in a routine she's fine". (Carer 10).*

Temperament

Some carers attributed certain difficulties that their children exhibited to difficult temperament rather than to the experience of adversity. In these instances children were labelled as demanding, impulsive, inflexible, or easily distressed. Their temperamental characteristics were sometimes seen to contribute to the emotional and behavioural difficulties they exhibited. The following statements reflect this: *"He has little quirks in his personality that make me stop and look at times". (Carer 7);* and *"He's not a stop, slow down, think kind of person. That would be one of our main sources of frustration in the family". (Carer 8).*

Adversity and Resilience

Previous placements. All children entered their permanent care placements subsequent to experiencing a period in foster care. More than half (54%) had only one previous foster care placement; 23% of which were fostered by their current carer. In these cases carers applied to have their foster care placements converted into permanent care. Other children ranged from two to 39 foster care placements. Three carers were unaware of the total number of foster care placements their children had, but speculated that there had been numerous placements.

Prior to permanency, a minimum of 46% of children experienced a preceding foster care placement of 12 months or more. In the main, carers were satisfied with the level of care they witnessed in their child's most recent foster care placement:

"They looked after him. We had a four week hand-over period and we were going to their house so we could see what type of care he was getting. It was very good". (Carer 8); "She had a very experienced foster mum and I believe it was a good placement". (Carer 11); "I think he was really lucky with the placement that he had. They were obviously very loving foster parents to him". (Carer 12).

Four carers continued to maintain contact with their child's previous foster care parents. In referring to her child's previous foster carer, Carer 5 stated for example: *"She always remembers him at crucial times – birthdays and Christmas – and we might hear from her for a particular reason. He knows she's there".*

Previous vulnerabilities. Permanent cares identified a range of vulnerabilities that may have posed a threat to their children's development. These included maternal alcohol and drug use during pregnancy, poor neonatal care, parental mental illness, exposure to parental alcohol and drug use. *"She didn't look after herself health-wise";* and *"There was some substance abuse". (Carer 4).* Further statements illustrate physical abuse and neglect including domestic violence, lack of adequate physical, emotional, and health care, inappropriate housing and relocation, and abandonment.

"[He] has some serious memories of abuse or danger and violence". (Carer 5); "I know that he has seen mum being hurt, bashed. He can relate times of living in the bush in tents hiding from the police. Staying with other people he didn't know, leaving all his toys". (Carer 9); "I know for a fact that he must've been shut in his room because no way will he ever have that bedroom door closed, and we do not shut our bedroom door"; and *She*

put [him] and [his] younger sister in day care. Never came back and got them". (Carer 13).

Contact with birth family. Most carers (77%) reported that their permanent care children maintained contact with their biological families; however, 15% of carers elucidated that their children had not seen their biological families in over 12 months. Contact usually took place in the form of scheduled access visits, which typically involved either or both biological parents. The frequency and duration of visits differed between on a case by case basis. Carers also had mixed views on contact as the following statements demonstrate: *"In general it's very positive". (Carer 3); "We've had our ups and downs with it". (Carer 11); "We would love to have more contact so that we can keep in touch with what's been happening with the birth family". (Carer 12); "When we had access to his mother he'd regress something dreadful. He'd go back to wetting, smearing, became really, really angry again towards me". (Carer 13).*

From these statements it appears that contact with birth families can be both favourable and unfavourable for children and their permanent care families.

Seeking Help from Caregivers

Eighty-five percent of children sought their primary caregiver for help, with 77% also comfortable in seeking help from other family members. Carer 1 stated for example, *"She will come to me in preference to other people; but if there are other people around her that she knows quite well and I'm not there, she'd be quite happy to go to [them]".* Similarly Carer 2 also acknowledged that her permanent care child was *"Quite good at asking for help".*

Conversely 15% of children did not ask for help and another 15% had had issues with accepting help as the following quotes indicate: *"He doesn't particularly like asking for help";* and *"If you sort of say well "why don't you try this or try that?" he will*

become extremely frustrated with you and probably mess up the puzzle in spite of you trying to help him". (Carer 3); "One of his main problems is he can't accept help really". (Carer 5); "No he doesn't relate a problem. You have to be aware of it and you can tell if his behaviour becomes really, really difficult and uncooperative and obnoxious and that continues". (Carer 9); *"It's like guess-work. You've got to try and work it out...she just keeps it all bottled up". (Carer 10).*

Fifty-four percent of children were reportedly capable of seeking the help of a teacher within the school environment as Carer 12 described of her child: *"With other carers certainly if he's hurt himself or questions about other things he's confident in going and asking or seeking comfort from them".*

Problem Solving

Fifty-four percent of carers reported that their children were quite capable of working out their problems. Carer 1 said for instance: *"Generally she's a good problem solver which surprises me. I think in that way she's quite strong for her age – in problem solving".* Carer 2 contributed: *"He doesn't sort of give up on things; he keeps at it until he gets it".* Conversely, 46% of carers described their children as ineffective problem solvers. Some children did not recognise that they had a problem:

"Sometimes he doesn't realise he's got a problem". (Carer 5); "He doesn't probably even see that he has a problem. It just builds up until eventually he explodes". (Carer 9).

Other children became easily upset in light of a problem: *"He's not a problem solver he just goes in bull to gate". (Carer 7); "He will very quickly get frustrated and so he needs reminding to say "OK let's calm down. How can we sort this?" (Carer 12).*

Summary. All children came into permanent care following foster care. For the most part, carers reflected positive foster care placements for their children. Carers spoke of a wide variety of factors that may have impeded their child's development. With time

child behaviours had improved however children continued to present with at least some challenges. Behavioural difficulty appeared to be associated with temperament. Specifically, children with more difficult temperaments seemed to exhibit more challenging behaviours, while children with easier temperaments seemed less challenging behaviourally. Seemingly resilient children, who had experienced considerable adversity, showing less emotional and behavioural problems were also less difficult to parent.

The majority of children continued to maintain contact with their biological families. Contact was viewed differently by different permanent care families. Some saw contact as a very positive experience while others found contact to be difficult or unsettling for the child.

All children had good relationships with the immediate permanent care family and generally found no difficulty in eliciting the help of family members. Despite this, almost half of the children were described as ineffective problem solvers. Some children did not realise they had a problem while others did not know how to react suitably in light of a perceived problem.

Summary of Qualitative Results

The majority of carers described positive relationships with their permanent care children. Over time, relationships had flourished to the point where carers were essentially unable to envision their lives without their children. Most children had settled into their placements and enjoyed relatively good relationships with all members of the permanent care family unit. That their children exhibited a range of emotional and behavioural difficulties was an observation shared commonly by carers. In most cases children displayed at least some emotional or behavioural difficulty.

Even though most carers felt their children continued to present challenges that were often testing in multiple areas, they were able to focus on the positive behaviours

with their children and to maintain positive relationships. Many carers felt rewarded by the significant improvement they had witnessed in their children's emotional and behavioural difficulties across time.

For the most part, children continued to have contact with members of their biological family. Carers were divided on whether contact was beneficial for their child's development. While generally children in care were able to approach their caregivers for help, many were described as ineffective problem-solvers. Many children did not perceive that they had a problem, while others reacted inappropriately, usually with anger or violence.

Carers appeared to differ in their levels of empathy, even though most felt they possessed the ability to decode their children's feelings. At times carers still felt challenged by their children's behaviours. However, carers also had access to enjoyed multiple avenues of support that acted to sustain carer-child relationships at their most trying of times.

Discussion

Carer-Child Relationships

Qualitative data supported the notion that although carer-child relationships were mostly positive, there were multiple sources of carer-child conflict. Children were in need of continuous discipline, and often engaged in limit testing behaviours. Carers also spoke of the dependence their children had on them as caretakers. Factors such as troubles at school, a dislike of school, poor social skills, and health needs amplified the level of reliance children had on their carers. The amalgamation of these elements added to the strenuousness and overall demandingness of the parenting task.

That parenting out of home care populations is a complicated, trying role has been noted by other researchers. Beek (1999), for example, found that carers were often so

exhausted by their day to day parenting routines that they often became stressed, burdened, or even depressed as a result. Noticeable in the current sample however, was that carers were able to attribute positive aspects to both their children and their relationships with them. Seeing the good in their child appeared to offset the influence that conflict and demandingness placed on the relationships with their children.

Carers had strongly integrated their permanent care children into their pre-existing family units, so much so, that the presence of their child was seen as permanent by all carers. This concept was reinforced by the fact that children had formulated stable relationships with all members of the nuclear permanent care family. Predominately positive relationships were also reported with extended permanent care family members. This finding lends support to current research that children, even those who have been placed late or have experienced multiple placements, can form positive attachment relationships with alternative caregivers (Rushton et al., 2003).

The majority of the carers in the current study depicted marked affection for their children. More than this, carers took pleasure in spending time with their children. They participated in a range of activities with them – from doing family chores to bike riding. When not at school, children were constantly under the supervision of their carers. Also, in the interests of the child, boundaries were routinely enforced. The level of care carers conveyed, and the contentment they had in sharing time with their children may have contributed to the establishment of positive relationships (Lipscombe et al., 2004). Thus, consistent with Eitzen and McIntosh (2004), it appears that a natural fondness for the child does develop with time and that this is maintained through shared positive experience.

Carer Characteristics

Empathy. In terms of Davis' (1994) components of empathy, carer comment provided evidence that carers could take on the perspectives of their children. Carers could also envision imaginary future scenarios that may at some point confront their children. Carers were concerned for the welfare and psychological well-being of their children and other children in the out of home care system. There was evidence too, that carers would become upset or anxious in light of witnessing marked distress in their children.

Additional inferences made in the current study relative to carer empathy concerned carer cognitions, preconceptions, understanding, and relatedness. There is some literature tying these components of emotionality to empathy and healthy caregiver-child relationships (Bugental et al., 1989; Flory, 2004, 2005; Kiang et al., 2004; Kilpatrick, 2005). Moreover, qualitative results were consistent with Flory's notion of empathy, in that carer cognitions appeared critical in how carers perceived and interacted with their children, and in the relationships they developed with them.

Carers had predominately positive preconceptions of their children. Carers were aware that their children may have come from troubling backgrounds and that challenging behaviours could stem from their experiences. Despite this, carers felt capable of influencing the lives of their children for the better. The emotional and behavioural improvements carers observed in their children reaffirmed them of the positive contribution they were making in their children's' lives.

Positive first impressions of the child mirrored positive relationships at the point of study. Only one carer's negative attributions were sustained during the course of the placement. Whether preconceptions were recollected correctly, or whether they had changed through parenting experiences over time, is uncertain. However, preconceptions,

and the attributions carers make about their children, appear important in the relationships caregivers develop with their children. Prior research also corroborates this notion. Kiang et al. (2004), for example, found that the preconceptions mothers had about parenting remained relatively constant across time. Preconceptions were harder to change than the behaviours parents displayed, and could affect parents' abilities to perceive, and respond accurately to, their children's cues (Kiang et al., 2004). It seems possible therefore, that attributions, be they positive or negative, can serve as self-fulfilling prophesies (Nix et al., 1999).

The large majority of carers felt they were able to understand their children's feelings. Many carers believed they could correctly interpret the cues displayed by their children. Literature suggests that more empathic caregivers can more readily decode the emotional cues of their children (Strayer et al., 2004). Several carers, on the other hand, were regularly confronted by the child's behaviours, and encountered difficulty in separating the child's behaviour from the underlying need or emotion. In these instances, children would demonstrate behaviours that were exceptionally disturbing. On the whole, carers who were more able to read the emotional cues of their children generally also had more positive relationships with them. Thus, it may be plausible to assume that caregivers who are warm and responsive are also more empathic (Strayer et al., 2004). For the most part carers would become concerned when their children displayed distressed affect, showing at least, that carers were receptive to extreme anxiety in their children.

Over time, the majority of carers felt better able to understand their child's feelings. Carers identified several factors which they saw as instrumental to their increased capacity to interpret child cues. These were a better understanding of the child's personality, increased child verbalisation, and decreased behaviour problems. Clearly,

factors such as a difficult temperament and behaviour problems can interfere with caregiver's capacities to relate to their children (Brems & Sohl, 1995; Fabes et al., 2001).

Most carers were able to identify special talents in their children, highlighting once again that many carers could attribute positive characteristics to their children. Caregiver's hostile attributions can increase negative parenting (see Nix et al., 1999). So it appears likely therefore, that the reverse is also possible, positive attributions may be linked with more positive parenting practices and emotions, such as caregiver empathy.

Results suggest that empathy seemed to fluctuate between carers, circumstances, and children. This directly accords with the existing literature of researchers such as Flory (2004) who have postulated that one's empathy is time, situation, and child specific, supporting the importance of caregiver cognitions in carer-child relationships.

Parenting. Due to the ongoing challenges these children presented to carers, there was a constant need to engage in child discipline. Children often became defiant or confrontational in light of their carers' attempted discipline. All carers reported experiencing at least some difficulty disciplining their children. In many cases, it was the constant need for discipline, more than the discipline itself, which was the source of stress for carers. Past literature suggests that children in out of home care can be harder to parent (Rodger et al., 2006). Although most carers agreed that parenting their permanent care child was difficult, carers diverged on whether parenting their child was different from parenting a biological child. Carers who had children with fewer behaviour problems seemed to think that parenting children in permanent care was not all that different from parenting biological children. On the other hand, carers with exceptionally challenging children considered parenting in permanent care to be significantly harder and different from parenting a biological child. In these instances carers identified the following reasons for this difference; increased emotional and behavioural needs, greater

dependence, a need to provide continuous reassurance and security, the need for firm limits, maintaining contact with birth families, and fighting for recognition as the child's parents. Correspondingly, existing data indicates that parenting within the context of out of home care is in many ways dissimilar to parenting a biological child (Lipscombe et al., 2003; Lipscombe et al., 2004; Rodger et al., 2006). Lipscombe et al. (2003) state, for example, that carers must acknowledge and understand the background from which the child had come, and be sensitive to the prospect that he or she may have encountered adversity and poor parenting. Carers must also manage their child's emotional and behavioural difficulties and tear down any defence mechanisms, whilst working towards building a healthy relationship with them and preserving contact with the family of birth. Many of the issues identified in the current study were also identified by Lipscombe et al.

Spouses, case workers, placement agencies, friends, and family were the main persons of support and were often consulted at times of significant stress. Practical support came mostly from case workers, placement agencies, and other parents, and typically concerned the management of difficult behaviours. Several carers noted that the practical support they required from professional services was often difficult to access or unsuitable for their particular needs. There is some literature to support this finding (O'Neill, 2000). A few carers also took occasional respite, which was usually a weekend away without the child. Over time supports were utilised less, as carers became more competent in parenting, and children became more settled.

Current training programs appear to offer carers a reasonable amount of information that is applicable to parenting in permanent care. Providing more information on the symptoms and management of attachment disorder would improve existing programs, offering carers a better understanding of attachment disorder and how to build relationships with emotionally disturbed children.

Inviting carers who have previously parented children in permanent care to speak to potential carers seems beneficial, with training participants quite keen on hearing a more personalised account of permanent care parenting experiences. Where possible, making a child's medical information accessible to their permanent carers in an open and timely manner would enable carers seek better health care for their children.

Parenting Styles. When parenting their children, carers typically remained sensitive to their child's underlying emotions, and tried to get to the root of the problem. They often took part in open discussions with their children. Active negotiation was encouraged where children felt strongly on a particular issue or course of action. Carers gave the impression that they enjoyed showing and receiving affection from their children. Despite all this, carers could also be direct, and enforce rules or boundaries where they perceived these to be necessary. These parenting behaviours fit well with an authoritative style of parenting (Baumrind, 1996). That a carer is sensitive to their child's behaviour, accepting of the emotional demands the child places upon them, aware of the positive and negative aspects of their character, co-operative and negotiable, and emotionally and physically available, are important in the parenting of children in out of home care (Lipscombe et al., 2004). Moreover, existing literature has found that many of the aspects of parenting noted in the current study help promote the development of secure caregiver-child relationships (Laible, Carlo, & Roesch, 2004; Stams et al., 2002). According to the current data, however, child behaviour also seemed to influence the strategy of parenting carers employed. Again this is consistent with past research that has found that the child's history of behaviour best predicts parenting strategy (Brems & Sohl, 1995). It would seem therefore, that a range of carer and child variables come together to determine the carer's parenting style.

Child Characteristics

Problem Behaviour. Consistent with current data (Howe & Fearnley, 2003; Minnis & Devine, 2001; Orme & Buehler, 2001), the children in this study displayed a host of difficult behaviours early in their placements. Behaviours included difficulty in relating with others, boundary testing behaviours, hyperactivity, violence, aggression, difficulty sleeping, wetting or soiling, lying, theft, phobias, and troubled eating patterns. Moreover, a number of carers also described problems in one, or more of, their child's development, learning, or health. The behaviours and symptoms described here do not appear uncommon in children who are in out of home care (cf., Minnis & Devine, 2001). Four children reportedly exhibited attachment disturbances at the time of their placement. Disturbances in attachment affect a sizable proportion of out of home children (Scott-Heller et al., 2002). It appears that it may be harder to formulate attachments with children who are emotionally resistant (Barth et al., 2005).

Consistent with out of home care literature (eg., Hughes, 1999), some children became exceedingly challenging as they settled into their placements, often exhibiting a range of troubling behaviours. As placements progressed further however, most children showed fewer emotional and behavioural problems. This concurs with literature that suggests that out of home children can form satisfying secondary attachments with substitute adults, and show gradual improvements in their behaviours (Eitzen & McIntosh, 2004; Roberson, 2006; Rushton et al., 2003). As a consequence, carers, it appears, contributed to the well-being of their children. Even so, over half the children in the sample continued to display some troubling behaviours. On the whole, behaviours could still exhaust carers, but significantly less so than in the earlier phase of the relationship. Some children for example, could become visibly enraged over relatively minor incidents, indicative of continued difficulty in conduct. Many children also

continued to be hyperactive and still engaged in some limit-testing behaviour. This information concurs with carer report on the SDQ.

Temperament. Many children had difficulty containing or controlling their emotions. Children were seen as impulsive and upon becoming upset, some children were difficult to comfort. Children could be inflexible, and a number had problems maintaining their attention. Many were described as demanding. All in all, a number of the children in the sample seemed to display difficult temperaments. This is consistent with the means reported for the STSC in the quantitative section.

That a difficult temperament can make it harder to parent a child has been noted in prior research (Letcher et al., 2004; Svanberg, 1998; Wahler, 2002). Data from the current study also seems to suggest that difficult temperament can pose challenges for parenting, and that more a difficult style of temperament may elicit less effective parenting responses and strategies from carers. Similarly, some carer-child temperamental characteristics seemed to complement each other and in these cases carers frequently reported aspects of their children's temperaments which they admired. This may have also contributed to positive relationships. Indeed, temperament has been linked to attachment elsewhere (Carlson et al., 2003). Whether the child was easy or difficult in their temperament appeared to contribute to the relationship they had with their carers.

Adversity and Resilience. Children who had more previous placements often displayed the most troubling of behaviours. There is much data to support this finding (Howe & Fearnley, 2003; Strijker et al., 2005; Wilson, 2006). Children with disruptive behaviours are also more likely to undergo placement breakdown (Gilbertson & Barber, 2003; Triseliotis, 2002; Wilson, 2006). Thus, emotional and behavioural problems and multiple placements appear to share variance, one aspect ultimately influencing the other.

The level of exposure children had to other risk and adversity factors prior to permanent placement (eg., experiences of neglect, abuse, parental drug and alcohol abuse, parental mental illness, abandonment, poor parenting), appeared to relate to the level of emotional and behavioural difficulties that they showed. Again this is consistent with existing research (eg., Banyard et al., 2001; Howe & Fearnley, 2003). Children who had encountered much adversity in their lives appeared to have greater difficulty in developing stable, reciprocal relationships with their carers.

The majority of children maintained contact with their birth families. Contact was sometimes irregular, with 15% of children not having seen their biological parents in over a year. Although contact can lead to loyalty conflicts for children (Leathers, 2003), existing literature largely advocates the psychological and developmental benefits of sustaining biological parent-child relationships (Ansay & Perkins, 2001; Mulligan, 2003). In terms of the current study however, whether contact impacted positively or negatively on child psychological development remains uncertain. It would appear that at least for the children in the current study, the benefit of contact varied from case to case. Where children are not exposed to violence or aggression during contact that may jeopardise their safety and development, the benefits of maintaining parental-child bonds must be explored for all children in permanent care.

In line with the comments carers provided, almost half of the children were perceived as incompetent problem-solvers and frequently succumbed to the stress of incidents that challenged them. These same children also often showed marked emotional and behavioural difficulties. As problem-solving skill is believed to be reflective of resilience (Johnson, 2005), it may be plausible to suggest that the less resilient children in the sample were also less competent at solving problems. Incompetent problem solvers

were either unable to recognise the problem or did not know how to resolve it. A common response was for children to become angry in light of a problem.

Most children were comfortable seeking help from their caregivers. Where their caregivers were either absent or unavailable, children were mostly comfortable in seeking the help of other family members, or alternative caregivers, such as teachers, in their place. Children, it appears, were able to develop a certain level of trust in these other adults, or at least, possessed the ability and self-confidence to approach them. It is possible that the warm relationship shared by children and their permanent carers fostered the development of other similar relationships. Positive carer-child relationships may serve as an antecedent that contributes to the development of other social relationships (Stams et al., 2002). Another possibility was that in actively consulting an adult, children were able to avoid solving the problem for themselves.

CHAPTER FIVE: INTEGRATIVE DISCUSSION

In Chapter Three, the relationship of carer and child characteristics within the carer-child relationship was explored using quantitative methods. In Chapter Four, the aim was to obtain a more in-depth view of these variables using qualitative methods. This chapter discusses the results of the quantitative and qualitative sections collectively.

Discussion

Role of Empathy

Although no quantitative support was found for the first hypothesis the qualitative data did suggest that carer cognitions and the emotions carers had about their children were related with the relationships they had with them. It is difficult to determine to what extent carer empathy influenced carer-child relationships. What is clear from the qualitative data, however, is that where carers expressed positive emotions and cognitions about their children, they also experienced positive carer-child relationships. It would

seem that the perceptions carers formulate about their children can influence how they perceive their relationships with them and that these perceptions are sustained throughout the relationship.

Indeed, there is research to support such an assumption (Berg-Nielson et al., 2002; Dix, 1991; Flory, 2004, 2005; Jefferis & Oliver, 2006; Noller & Feeney, 2000). Empathy-related characteristics do appear important in establishing and maintaining positive carer-child relationships.

Role of Parenting Style

Partial support was obtained for the second hypothesis. Only authoritarian parenting was related to carer-child relationships. There is much research to support the notion that authoritarian parenting does not provide a climate in which to sustain positive carer-child relationships (Orme & Buehler, 2001; Zhou et al., 2008). According to Baumrind's typologies of parenting, authoritarianism is characterised by high levels of demandingness and directiveness, but low levels of responsiveness (Baumrind, 1996). An exploratory regression suggested that it may be low responsiveness that detracts from carer-child relationships. Responsiveness in parenting refers to being supportive, attuned, and accepting of the child's demands and needs (Darling & Steinberg, 1993). As such, responsiveness is comprised of several facets including warmth, clear communication, reciprocity, attachment, and person-centred discourse (Baumrind, 1996). Responsiveness in caregiving helps facilitate secure carer-child relationships by orchestrating positive interactions between caregivers and their children (Berg-Nielsen et al., 2002; Marty et al., 2005; Rholes, Simpson, & Friedman, 2006; Stams et al., 2002). Conversely, unresponsive parenting has been associated with the development of insecure attachment relationships (Bugental et al., 1989; Gerlsma, 2000; Oyserman et al., 2000; Suchman, McMahon, Slade, & Luthar, 2005). Further, in psychological interventions involving children with

disorders of attachment, responsiveness is often incorporated as a fundamental treatment component (Hughes, 2003). Moreover, caregiver responsiveness shares some connection with empathic parenting (Milner, Halsey, & Fultz, 1995). In the current study, expressions of carer warmth were evident in qualitative interviews. Many carers portrayed affectionate relations with their children, and were attuned to their children's feelings. Carers engaged in friendly discourse with their children and spoke of their feelings of attachment or bonding. These elements seem consistent with the dimension of responsiveness. Where such elements seemed lacking, carer-child relationships appeared to thrive less.

Current results suggest that parenting permanent care children is a demanding task, perhaps even more so than parenting a biological child. Not only are there multiple sources of carer-child conflict, and greater child dependence on the caretaker, establishing bonds with these children can be difficult, and many children continue to show challenging behaviours. Despite this, the children in this study were capable of forming relationships with their carers and other members of the family unit, including extended permanent care families.

Problem Behaviours

There was clear support for hypothesis three. Results showed an inverse relationship between child emotional and behaviour problems and carer-child relationships, consistent with other research (Goodnight et al., 2007). Children in permanent care have greater emotional and behavioural disturbance than the general population. Comparisons made with SDQ normative data showed that the children in the current study had high levels of conduct problems, hyperactivity, emotional problems such as anxiety and depression, peer problems, and poor social skills. Qualitative data also identified a range of health problems and some children were described as exhibiting

attachment disorder. Ample literature exists to support these observations (Beek, 1999; Howe & Fearnley, 2003; Lipscombe et al., 2003; McAuley & Trew, 2000; Milward et al., 2006; Minnis & Devine, 2001; Nixon, 1997; Orme & Buehler, 2001; Payne, 2000; Rutter, 2000; Sargent & O'Brien, 2004; Schofield & Beek, 2005; Wilson, 2006).

Qualitative data showed that all carers felt challenged by their children's behaviours with challenges ranging from the mild or moderate, such as boundary testing behaviours, to the more extreme, such as aggression or violence. Some children had developed strategies to ensure their survival while living in adversity. Children however were capable of behavioural improvement and to learn to love and trust and to form stable bonds. This finding is line with other research (eg., Gordon, 1999; Howe & Fearnley, 2003; Hughes, 1999; Milan & Pinderhughes, 2000; Rushton et al., 2003).

An exploratory regression analysis revealed that it may be a child's conduct difficulties and poor social skills that have particular negative impact on carer-child relationships. Carers clearly may have difficulty in developing positive feelings towards children with exceedingly difficult behaviours and poor relational skills. This is supported by other research (eg., Rushton et al., 2003).

Temperament

The current study suggests that a child's temperament may also have important implications in carer-child relationships. Children with difficult temperaments had less positive relationships with their carers. There is some empirical research to support this finding (Szewczyk-Sokolowski & Bost, 2005).

Children with difficult temperaments may have trouble interpreting and controlling their emotions, and thus engage in unsuitable or challenging behaviours. Indeed, a preliminary correlation showed a link between temperament and behaviour problems. Qualitative data further supported this finding and suggested that a child's temperament influences

parenting practices. Children with difficult temperaments may not be particularly affected by punishment, and ignore their carer's attempts to discipline them. Further, children with difficult temperaments may elicit less appropriate parenting from their carers. Other researchers have too noted relationships between temperament, parenting, and adjustment (Lengua, 2006; Sheffield-Morris et al., 2002).

An exploratory regression performed in this study found that it may be the temperamental facet inflexibility which most affects carer-child relationships. The dimension inflexibility relates to children's negative adaptability or emotionality to parenting (Paterson & Sanson, 1999). Hence, low adaptability or negative displays of emotionality appear to contribute negatively to carer-child relationships. Literature suggests that children who are inflexible are also likely to evidence problems in their behaviour (Paterson & Sanson, 1999; Nelson et al., 2007), another issue that has been related to less successful carer-child relationships (Triseliotis, 2002).

Resilience

Resilience was correlated with positive carer-child relationships. Resilient children seemed to adapt more positively to their relationships with their carers and showed fewer emotional and behavioural problems. Resilient children were actively involved in family activities and showed good communication skills. Their carers described more placid demeanours and easier temperaments, which contributed towards relationships with greater periods of calm and enjoyment. Literature has noted that temperament may serve as a protective factor enhancing resilience (Henry, 1999). Resilient children also showed greater problem solving skills and coping strategies consistent with current literature (eg., Mastern et al., 1990; Werner, 1995).

Positive relationships appeared to be mutually beneficial for carers and their children. Resilient children were more active participants in carer-child relationships and

were less difficult to parent. Existing literature has also documented the benefits of secure carer-child relationships in fostering and enhancing resilient trajectories (Cicchetti & Rogosch, 1997; Flynn et al., 2004; Johnson-Garner & Meyers, 2003; Rishel et al., 2005). In this way, positive carer-child relationships contribute to, and are supported by child resilience.

The Importance of Child Emotional and Behavioural Difficulties

Of all the carer and child characteristics combined, it was the child's emotional and behavioural difficulties that best predicted carer-child relationships. This finding did not support the final hypothesis. In this sense, child characteristics seem more important in the prediction of carer-child relationships. Still, qualitative data suggests that a bidirectional relationship exists between child and carer variables and that this joint interaction affects carer-child relationships. To illustrate, challenging child behaviour is likely to lead to stress in parenting which may in turn bring about unresponsive, coercive, or otherwise negative parenting that is fitting with an authoritarian parenting style. This may function to reinforce challenging child behaviour, and may even serve to frame difficult child temperament, all of which ultimately contribute to poorer carer-child relationships. For this reason, the effects of carer variables on carer-child relationships should not be discredited altogether, and warrant continuous research. Limitations of this research discussed below found carer variables may also explain relationships.

It may be harder to form relationships with children with challenging behaviours (Rushton et al., 2003). Current data showed that some children did not attach as easily as others and the process of forming relationships was sometimes a long and difficult one. Positive changes in child behaviour sustain positive relationships and can lead to improvements in the quality of parenting children receive. Negative parenting on the other hand, can transform positive parenting patterns into negative (Lipscombe et al.,

2004). Sinclair and Wilson (2003) found that placement success was determined by three factors – the characteristics of the child, the characteristics of the carers, and carer-child interactions. Children with fewer behavioural difficulties, more appealing characteristics, and who wanted to be cared for by their carers had more successful placements. In that study warmth and receptiveness were important carer characterises and reciprocal interactions between carers and their children also supported placements. Results of the current study support the findings reported by Sinclair and Wilson (2003).

In summary, the findings from the current study suggest that it is the child's behaviour that best determines the relationship carers experience with their children. Although some parenting characteristics are of importance, particularly a non-authoritarian style of parenting, the behaviours the child displays take greatest import in the facilitation or impedance of carer-child relationships. Qualitative data however, also provided evidence for the importance of carer attributions, carer-child bonding, and carer connection with and concern for the child in their care. Carer-child relationships appear to be very complex with a range of variables contributing to their development and sustenance. Thus, it is a combination of carer and child variables which contribute to carer-child relationships.

Limitations

Several limitations exist in the design and methodology of this research study, and the generalisability of the current research findings. First, all data were derived from carer report measures. That the data could have been influenced by carers' own subjective biases is a plausible proposition. Privacy laws affected the feasibility of recruiting child participants or teachers as a means of reducing subjective bias and the effects of socially desirable ratings. Similarly, some of the children were of pre-school age and lacked the capacity to comprehend and complete questionnaire measures or did not have teachers to

report on them. However, researchers have noted the utility of caregiver ratings of child behaviour. As caregivers have considerable knowledge of their children in various contexts they are able to draw upon a wider base of knowledge when evaluating the behaviours of their children (Paterson & Sanson, 1999). The current research was concerned primarily with carers' own perceptions of their relationships with their children, and carers' own subjective experiences were useful in this research. Caregiver perceptions of parenting and child behaviour have been used in empirical research (eg., Solantaus-Simula et al., 2002; Wanamaker & Glenwick, 1998; Webster-Stratton, 1988). Notable discrepancies between caregiver, teacher, and child self reports of child emotional and behavioural problems are often found in research studies (Solantaus-Simula et al., 2002). Although carer perceptions of carer-child relationships may have differed from child perceptions, the current research was focused on the carer's perceptions. Perceptions influence the way a person perceives external stimuli, it is essential to examine the ways in which caregivers' perceptions influence parenting.

A second cause of concern was the relatively small sample size for the quantitative study, thus limiting statistical power and the number and types of analyses. The 23% response rate is comparable to other survey-design studies with out of home care populations (cf. Denuwelaere & Bracke, 2007; Holloway, 1997; Millward, Kennedy, Towlson, & Minnis, 2006; Minnis et al., 2001; Rodger, Cummings, & Leschied, 2006; Sanchirico & Jablonka, 2000; Zima et al., 2000). Carers have many commitments and little time for additional activities, like participating in research, which may explain the low response rate. Another possibility is that permanent carers are sensitive to the intrusion of researchers and other agency personnel, especially if the study may investigate their effectiveness. A low sample size raises two critical concerns. The first relates to how representative the sample is of all permanent care families, and the second,

to how accurately the findings can be generalised to this population. With 46 participants, the possibility exists that the sample is skewed, with high-functioning carers having been more likely to respond. This would result in an overrepresentation of positive carer-child relationships. Although this is a plausible assertion, that carers rated their children above the normal range on all the problem subscales of the SDQ, and indicated greater conflict in their relationships with their children than those in the general population, suggests otherwise. Qualitative data corroborated this notion in that the severity of the emotional and behavioural problems children displayed varied between cases. It is likely that the sample was in fact representative of Victorian permanent care families, with children with mild as well as severe emotional and behavioural difficulties being described. Another issue regarding representation was the ratio of male to female participants. Whilst this ratio reflects that females were the primary caregivers, it is possible that male carers have different perceptions of themselves, the child, and their relationship.

The second problem that arises from the small sample size is the possibility to detect relationships. The limited number of cases restricts the statistical power of the statistical analyses. Extreme cases therefore, may have resulted in influence affecting the strength and direction of the analyses. Through examining the scatterplots, extreme cases were controlled as much as possible without minimising the size of the sample more than necessary. Even so, the small sample size hindered assessments of how the individual questionnaire subscales influenced carer-child relationships. For this reason, the relationships between subscales and carer-child relationships could only be examined in an exploratory fashion.

A third limitation involves the measures chosen for this research. The IRI (Davis, 1994), although being a well-established and widely utilised measure of empathy, is not a measure of caregiver empathy. In retrospect, a scale focusing directly on caregiver

empathy would have been more appropriate. In this regard, the result that carer empathy was not related to carer-child relationships is questionable. The Parental Empathy Questionnaire (PEQ; Flory, 2002) for example, is an instrument specifically devised to measure carergivers' empathy for their children. This measure consists of 88 items and contains numerous subscales. It has also received little empirical validation. For these reasons, the PEQ was not considered suitable for use in the current study.

The low internal consistency obtained for some of the subscales may have also been attributable to the small number of cases. The low reliability achieved for the PSDQ permissive parenting subscale precluded its use in the current study. For this reason, the role of permissive parenting in carer-child relationships was not investigated. That some of the questions on the PSDQ were irrelevant or potentially confronting is likely, with carers quite frequently leaving out responses. Further, it may have been that by using another measure of parenting style, the centrality of alternative constituents or dimensions of parenting in positive carer-child relationships may have surfaced. Still the PSDQ is one of the most commonly utilised measures of parenting style presently available, justifying its' use in the current study.

Whilst the SDQ is a commonly used and well-validated measure of child adjustment, the use of an alternative or complementary measure of trauma symptoms may have been beneficial in identifying whether the behaviour symptoms children presented with were attributable to the experience of significant trauma. Without the quantitative exploration of contextual factors such as age at placement and number of previous placements, it remains difficult to judge how these factors interacted with child adjustment.

A child's temperament arises from a complex interaction of biological and environmental factors. For this reason, the temperaments of the younger children in the

study may have been less impacted by environmental influences. The STSC emerged as the most suitable instrument to measure child temperament in the current study. The STSC is grounded in the Thomas and Chess (1977) conceptualisation of temperament and was specifically devised for use with Australian children.

The measure of resilience had been selected because it was a brief measure but it has not been used extensively in existing literature. Another, more established measure may have been a better choice for the current study.

Interviews elicited varied response to semi-structured questioning. Collecting qualitative data utilising a focus group method would have allowed research participants to discuss issues and opinions amongst themselves with greater concentrated guidance from the researcher. Furthermore, by providing a section for open-ended responses in the questionnaire booklet, carers would have been able to elaborate on why they rated their child particularly high or low on an item, giving a greater depth of information that could have been explored in qualitative interviews.

Directions for Future Research

Few studies have been conducted to date that examine the relationships of children and their carers in permanent care. Replications of the current research should incorporate several methodological improvements. For one, for quantitative analyses, a much larger sample is clearly required. A larger sample would not only allow for more complex analyses to be undertaken, but would also increase the reliability and generalisability of all the results. One way to address the low response rate would be to provide incentives to carers for participation. Carers may be more willing to take time out of their busy schedules if they were compensated for their time.

Utilising an empathy measure that directly assesses caregiver empathy, such as the PEQ (Flory, 2002) would be of benefit. It was initially speculated that the level of

empathy carers displayed with their children would influence their relationships with them. The results of the current study suggest that carer empathy may not be as important as other factors in predicting carer-child relationships. This result may differ with the use of an empathy measure that specifically targets caregiver empathy.

It is essential that existing questionnaire measures of parenting style are evaluated to establish their strengths and weakness. This procedure would enable the identification of more adequate questionnaire measures, and give opportunity for the development of a more competent research tool.

Building the current knowledge base on how to best manage the difficult behaviours displayed by permanent care children is necessary. Carers encounter significant challenge and confusion regarding how to best manage and their children's more confronting behaviours. Identifying useful techniques will help carers maintain a sense of self-confidence and control, particularly in the earlier stages of the placement.

More research is required for a clearer understanding of carer-child relationships in permanent placements. It may be that other variables, not examined here, contribute to carer-child relationships. For example, factors such as intelligence, styles of coping, and access may play important roles in carer-child relationships. Certainly, qualitative data from the current study points towards the importance of carer attributions of their children. Further research should be undertaken to examine the role of attributions in carer-child relationships. Investigations of the ways in which children perceive their relationships with their carers would also add greater depth to current understandings of carer-child relationships. Although cross-sectional studies such as the current study can provide important data, longitudinal research with several point-in-time measurements could potentially provide a wealth of knowledge on the development of carer-child relationships. In addition, a study incorporating an observational component would allow

for the direct observation of carer-child interactions and would control for social desirability in questionnaire ratings. The practicality of an observational study component with permanent care participants remains uncertain however, as carers may be sensitive to the intrusions of a research observer. Future qualitatively-grounded studies should consider the value of gathering data using a focus group format. The open, interactive environment of the focus group would enable researchers to explore carer perceptions of carer-child relationships in a sensitive group forum, and can incorporate projective techniques such as free association combined with more structured questioning.

Moving future research in the directions specified above will enrich the current knowledge base surrounding Australian permanent care families.

Implications

Despite the limitations identified earlier, the current research has implications for practice and policy. Results of the current research indicate that child variables are of most importance for a positive relationship between child and permanent carer. As children can influence carer-child relationships, and even elicit different types of parenting from the same adult, it is also important to acknowledge the influence of problem behaviour and difficult temperament in permanent placement. The current study found evidence that behaviour problems pose significant challenge in establishing and maintaining positive relationships. In this regard, it may be advantageous to identify children who are likely to pose significant difficulty in establishing relationships, so that suitable care, psychological treatment, and support can be arranged. It is likely that for different children different emotional and behavioural problems will predominate, and in this sense, each case should be examined on its own merit so that appropriate help can be offered.

When considering the recruitment of permanent carers, it may be of benefit to administer a measure of parenting style to determine which style of parenting a carer is more inclined towards. In all evidence, authoritarian parenting does not seem to provide the ideal environment for the development of positive carer-child relationships.

It is critical that support and intervention strategies are not only suitable for permanent care families, but also that they are offered in a timely manner. While working to support children with challenging behaviours, permanent carers should also receive assistance on how to understand and manage their children's problem behaviours. At times of considerable challenge, carers should also remain conscious of their child's positive characteristics. Cooperated efforts must be concentrated on children and their carers both to best support the development and maintenance of secure permanent care relationships.

From a policy-driven perspective, it would be valuable to combine interventions targeting the support and therapy of highly challenged children with the stability of a secure home-based placement. By integrating these two elements into a single program that is delivered in a structured manner, children and their permanent carers will more likely experience more positive relationships and enhanced well-being.

Conclusion

This research aimed to contribute to the literature on carer and child variables relevant to permanent care placements. Results of the quantitative study suggests that child problem behaviour most predicts this relationship whereas qualitative results reveal that carers were coping well overall with the behavioural challenges raised by their permanent care child, and, in this fashion, were able to focus on positive child attributes and appropriate parenting strategies, and able to establish positive relationships with the child. As carers develop a greater understanding of their children, their experiences, and

temperaments, carers can also learn to provide more appropriate care. Carers felt rewarded by their children's behavioural improvements. In fact, where carers could identify positive characteristics in their children and their relationships with them, they were able to rise above the challenges so often associated with parenting them. Resilient children, with fewer behaviour problems and more easy temperaments fared better in permanent care arrangements.

Concerning carer characteristics, the authoritarian parenting style was related to negative carer-child relationships but qualitative results suggested appropriate, authoritative parenting behaviour was shown by carers. Additionally, children, who are less resilient, with exceedingly difficult behaviours and temperaments, and their carers, require additional supports and intervention strategies to facilitate the child's positive integration into the existing permanent care family unit. Providing these carer-child targeted supports in an accessible, timely manner will assist to promote healthier, happier carer-child relationships. This may, in turn, ultimately place children upon a developmental pathway wherein positive lifetime outcomes are more promising.

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Appendix A

Ethical Approval from the Australian Catholic University HREC

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne

ACU National

Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: A/P Michael McKay Melbourne Campus

Co-Investigators: A/P Sabine Hammond Melbourne Campus

Student Researcher: Maria Alexandris Melbourne Campus

Ethics approval has been granted for the following project:
Carer-child relationships in permanent care programs.

for the period: 6th February 2007 to 28th February 2008.

Human Research Ethics Committee (HREC) Register Number: V200607 38

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (1999) apply:

(i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
- security of records
- compliance with approved consent procedures and documentation
- compliance with special conditions, and

(ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
- proposed changes to the protocol
- unforeseen circumstances or events
- adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: ..... Date: .....
(Research Services Officer, Melbourne Campus)

Appendix B

Ethical Approval from the Department of Human Services and Participating Permanent Care Agencies

Department of Human Services

Incorporating: Health, Community Services, Aged Care and Housing

50 Lonsdale Street
GPO Box 4057
Melbourne Victoria 3001
DX210081
www.dhs.vic.gov.au
Telephone: (03) 9616 7777
Facsimile: (03) 9616 8329

Our Ref: CDF/07/1115

12 July 2007

Ms Maria Alexandris
Australian Catholic University
PO BOX 5375
Cranbourne Vic 3977

RE: Application to undertake research involving the Office for Children, Department of Human Services

Dear Maria,

I write to you concerning your application to the Office for Children Research Coordinating Committee (RCC) to undertake research entitled *"Carer-child relationships in permanent care programs"*.

I am pleased to inform you that the Office for Children RCC will support/approve the study subject to the following conditions:

- The research is conducted in accordance with the documentation you provided to the RCC;
- The provision of the approval letter from the DHS Human Research Ethics Committee (HREC). Please note, it is expected that you will complete a DHS HREC application within the next month. Please include a copy of this letter with your DHS HREC application;
- The provision of a final report (thesis or otherwise) to the RCC at the completion of the research;
- The provision of a one page summary of the outcomes of the research and how this relates to the Office for Children;
- The provision of a seminar/presentation to Office for Children staff on the outcomes of the research – with details to be arranged with the RCC Secretariat;
- That you provide the RCC with the opportunity to review and provide comment on any materials generated from the research prior to formal publication. It is expected that if there any differences of opinion between the RCC and yourself related to the research outcomes, that these differences would be acknowledged in any publications, presentations and public forums;
- That you acknowledge the support of the Office for Children Research Coordinating Committee in any publications arising from the research;
- The project is commenced within 12 months of this approval letter, after this time the approval lapses and extensions will need to be considered by the RCC.

State Government Victoria

If you have any further enquiries, please contact the RCC Secretariat on 03 9096 7480 or via email RCC@dhs.vic.gov.au.

Yours sincerely

Pam Muth
Chair, Office for Children Research Coordinating Committee

Family Resource Centre
Adoption and Permanent Care
Connections
274 High St.
Windsor.Vic. 3181

Ph. 9521 5666
Fax: 95196601

Maria Alexandris
Australian Catholic University
Melbourne Campus
Psychology Department
115 Victoria Parade
Fitzroy VIC 3065.

22/1/08

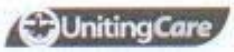
Dear Maria

This letter is to confirm that the Adoption and Permanent Care program of Connections, a Uniting Care agency, participated in the research conducted into "Carer-Child Relationships in Permanent care programs" in 2007. 17 Permanent care families were sent the questionnaires.

Yours sincerely

FMAloon

Frances McAloon
Senior Practitioner
Adoption & Permanent Care



"Our vision is that people will live in families and communities that are safe, connected, valued and supported"

child & family services

www.cafs.org.au
ABN 83 786 843 940

Maria Alexandris,
School of Psychology,
Australian Catholic University,
Fitzroy.

July 24, 2007.

By Email

Dear Maria,

Re: Request for Research & Ethics Approval, "Carer-Child Relationships in Permanent Care Programs"

Thanks for your request and the documentation included. The request was considered by Associate Professor Rosemary Green (University of Ballarat) and me as part of Child & Family Services Ballarat's Research and Ethics process.

We are happy to confirm that Child & Family Services Ballarat will participate in the study and wish you well with your research.

Child & Family Services Ballarat's permanent care team looks forward to assisting your project and to receiving the results in time. Our hope is that your research will add to our understanding in this area as you anticipate.

Yours sincerely,

Kevin Zibell,
Chief Executive Officer.

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Appendix C

Information Letter to Participants (Questionnaires)

Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy Vic 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

INFORMATION LETTER TO POTENTIAL PARTICIPANTS

TITLE: Carer-Child Relationships in Permanent Care Programs

RESEARCH SUPERVISORS: Associate Professors Michael McKay & Sabine Hammond

RESEARCHER: Maria Alexandris

Dear Permanent Care Parent,

You are invited to participate in a research project involving permanent care families which will collect information about parenting, carer/parent-child relationships and child well-being. The research is being conducted by Masters' student Maria Alexandris, and is being supervised by Associate Professors Michael McKay and Sabine Hammond from the School of Psychology at the Australian Catholic University. The purpose of the research is to learn more about the relationships and parenting experiences of permanent care families. As children differ in the way they enter permanent care (i.e., placements can be permanent "adoption" or kinship care/foster care conversions) it is also important to compare if and how relationships and parenting experiences differ between these various program types. We hope that the information gathered will help improve existing agency placement programs and will educate psychologists and social workers about how to support families in permanent care better.

This letter and the accompanying consent forms have been sent to you with the assistance of [agency], who have mailed them to you. We do not have any information about you at all at this point.

Project Details

We are interested in involving carer-parents who are currently taking care of a child aged between 3-12 years through Permanent Care Programs. We intend to gather information from as many permanent care parents across Victoria as we possibly can.

Your participation

If you would like to take part in this research, you will be asked to complete a questionnaire for each child that has been placed with you through the Permanent Care Program. The questionnaire booklet will take approximately 45 minutes to complete, and can be done at home at a time that is convenient to you.

"I do not want to take part"

You do not have to take part in the research if you do not want to.

"I want to take part"

If you would like to take part in the research, please complete the consent forms and mail them back in the reply-paid envelope provided as soon as you can. The questionnaire

booklet/s will be forwarded to you shortly thereafter.

The information we collect will be used to learn about:

1. How children in permanent care programs adjust to their placements
2. The relationships that develop between carer-parents and children
3. Carer-parents' experiences with their children

We are not seeking to obtain sensitive, personal information about you or your family. Any information that you do give us will be strictly confidential. At no stage will we share your information with any agency or case worker.

Your confidentiality assured

All the information from the questionnaires will be kept completely confidential and no agency will be able to access any of the questionnaires. Only Associate Professors Michael McKay and Sabine Hammond and postgraduate student Maria Alexandris will be able to view the completed questionnaires. Your participation in this research is completely voluntary and you are free to withdraw at any time, without having to give a reason for doing so. Also, you do not have to answer any questions that you do not want to.

If you would also like to be contacted to participate in an interview session lasting approximately one hour that aims to further explore carer-parents' experiences with their children in permanent care, and/or would like to receive a summary of the overall results from the study, please be sure to indicate this on the Consent Forms accompanying this letter by completing the relevant sections. Sign both copies of the Consent Form, retain one copy for your records and place the other Consent Form into the pre-paid envelope provided. Please post the pre-paid envelope containing the consent form as promptly as possible.

Under no circumstance will we disclose any information that you provide us without your consent, unless this information is specifically required by law. Should you provide us with information indicating that a child in care may be presently at risk, we may be obligated to report this.

This study has been approved by the Human Research Ethics Committee at the Australian Catholic University. Results from the study may appear as aggregated data in conferences or publications in a way that does not identify you. Public record standards require that we store your questionnaire booklet for at least 7 years following the completion of the project. All information obtained from you will be stored safely in the School of Psychology located on the university campus.

Questions regarding this project should be directed to Associate Professor Michael McKay, on (03) 9953 3107 in the School of Psychology, St. Patrick's Campus, Locked Bag 4115, Fitzroy VIC 3065, M.McKay@patrick.acu.edu.au or to Associate Professor Sabine Hammond on (03) 9953 3448 School of Psychology, St. Patrick's Campus, Locked Bag 4115, Fitzroy VIC 3065, s.hammond@patrick.acu.edu.au.

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the supervisors and student researcher have not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee, c/o Research Services, Australian Catholic University, Melbourne Campus, Locked Bag 4115, Fitzroy VIC 3065 (Tel: 03 9953 3157, Fax 03 9953 3305). Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

Any complaints or concerns about your participation in this research study can also be addressed to Ms Vicki Xafis, Executive Officer, DHS Human Research Ethics Committee, 50 Lonsdale Street, Melbourne VIC 3000 (Tel: 03 9096 5239, Fax: 03 9096 9176).

We greatly appreciate your support and participation in this study.

Yours sincerely,

Maria Alexandris	Michael McKay, PhD	Sabine Hammond, PhD
Postgraduate	Associate Professor	Associate Professor

Appendix D

Consent Form (Questionnaires)

Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy Vic 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

CARER/PARENT CONSENT FORM
Participant's copy to keep

TITLE: Carer-Child relationships in Permanent Care Programs
RESEARCH SUPERVISORS: A/Ps Michael McKay and Sabine Hammond
RESEARCHER: Maria Alexandris

Participant Section

I……(permanent care parent) have read and understood the information provided in the letter inviting participation in the research. Any questions I have asked have been answered to my satisfaction. I agree to participate in this study and complete a questionnaire booklet that will be provided to me. I understand the questionnaire booklet will ask me to provide information about my experiences with parenting my child, our relationship, my child's well-being, and some demographic information. I understand that I do not need to answer any questions I do not want to, and realise that I can withdraw at any time, without having to give any reason for doing so, and that this will not affect me or my family in any way. I understand that my consent form will be separated from my questionnaire booklet to ensure that the information I provide is completely confidential. I understand that the project may not be of direct benefit to me.

I am aware that should any feelings of distress or emotional discomfort arise in response to my participation in this study, I will be provided with a referral to a counselling support service, should I request this.

I agree that the research data collected for the study may be published or provided to other researchers in a form that does not identify me or my family in any way. I am over 18 years of age.

Name of carer/parent:…… (Block letters)
Signature:……..
Date:……..

☐ I would like to obtain a summary of the results of this research (please tick if applicable)
☐ I agree to be contacted by the Australian Catholic University about any further research, including participation in an interview session. *If yes, please complete the section below.*

Contact Phone Number:……
(Block letters)
Address:……
……

Researcher: Maria Alexandris **Signature:**…… **Date:**……
Supervisors: A/P Michael McKay **Signature:**…… **Date:**……
A/P Sabine Hammond **Signature:**…… **Date:**……

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Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

CARER/PARENT CONSENT FORM
Researchers' copy to keep

TITLE: Carer-Child Relationships in Permanent Care Programs
RESEARCH SUPERVISORS: A/Ps Michael McKay and Sabine Hammond
RESEARCHER: Maria Alexandris

Participant Section

I……(permanent care parent) have read and understood the information provided in the letter inviting participation in the research. Any questions I have asked have been answered to my satisfaction. I agree to participate in this study and complete a questionnaire booklet that will be provided to me. I understand the questionnaire booklet will ask me to provide information about my experiences with parenting my child, our relationship, my child's well-being, and some demographic information. I understand that I do not need to answer any questions I do not want to, and realise that I can withdraw at any time, without having to give any reason for doing so, and that this will not affect me or my family in any way. I understand that the project may not be of direct benefit to me.

I am aware that should any feelings of distress or emotional discomfort arise in response to my participation in this study, I will be provided with a referral to a counselling support service, should I request this.I understand that my consent form will be separated from my questionnaire booklet to ensure that the information I provide is completely confidential.

I agree that the research data collected for the study may be published or provided to other researchers in a form that does not identify me or my family in any way. I am over 18 years of age.

Name of carer/parent:…… (Block letters)
Signature:……..
Date:……..

☐ I would like to obtain a summary of the results of this research (please tick if applicable)
☐ I agree to be contacted by the Australian Catholic University about any further research, including participation in an interview session. *If yes, please complete the section below.*

Contact Phone Number:……
(Block letters)
Address:……
……

Researcher: Maria Alexandris **Signature:**…… **Date:**……
Supervisors: A/P Michael McKay **Signature:**…… **Date:**……
A/P Sabine Hammond **Signature:**…… **Date:**……

Appendix E

Questionnaire Booklet

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne

School of Psychology

ACU National

PARENTING AND RELATIONSHIPS QUESTIONNAIRE

Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy Vic 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

Number Code: _____

The Parenting and Relationships Questionnaire *has been designed to measure parenting experiences and the relationships between carer-parents and children in permanent care. You are invited to fill in this questionnaire booklet and share the experiences you have had with parenting your child. If you are caring for more than one child in permanent care aged between 3-12 years and you would like to respond in respect to each of them, you will need a complete a separate questionnaire booklet for each child.*

This questionnaire contains a wide range of questions about your experiences with parenting your child. We hope that through this survey, we will be able to get a comprehensive picture of the different families living in permanent care. If you find that some of the questions in the booklet do not apply to you or to your child, please indicate that this is so. Remember that you do not have to answer any questions that you do not want to. As you complete the questionnaire, please feel free to jot down any additional thoughts or comments you would like to share with us about your child or your experiences with permanent care. Remember your

GENERAL INFORMATION ABOUT YOUR FAMILY

1. **Your gender (please tick)** ☐male ☐female
2. **Your age**_____
3. **Your country of birth**_____
4 **Your occupation**_____
5. **Your highest level of education achieved (please tick)** ☐ Primary only

   ☐ Secondary Year 10/Form 4 ☐ Secondary Year 11 or 12/Form 5/6

   ☐ TAFE ☐University Undergraduate ☐University Postgraduate ☐Other
6. **Your current marital status (please tick)** ☐married ☐separated

   ☐divorced ☐ de-facto ☐widowed ☐single ☐other
7. **How long have you been living with your partner (if applicable)**_____
8. **You partner's gender (please tick)** ☐ male ☐ female
9. **Your partner's age**_____
10. **Your partner's country of birth**_____
11. **Your partner's occupation**_____
12. **Partner's highest level of education achieved (please tick)** ☐ Primary only

    ☐ Secondary Year 10/Form 4 ☐ Secondary Year 11 or 12/Form 5/6

    ☐ TAFE ☐University Undergraduate ☐University Postgraduate ☐Other
13. **Number of people living at your address (including yourself)**_____
14. **Do you have any biological children?** ☐ Yes ☐ No

    If yes, age and gender of each child _____
15. **Do you have any adopted children?** ☐ Yes ☐ No

    If yes, age and gender of each child _____
16. **Do you have any foster children?** ☐ Yes ☐ No

    If yes, age and gender of each child _____
17. **Have you or your partner previously cared for any foster or permanent care children?** ☐ Yes ☐ No
18. **What is your gross family income per year?** _____

DETAILS OF THE CHILD YOU HAVE IN PERMANENT CARE

1. **Child's gender (please tick)** ☐**male** ☐**female**
1. **Child's month and year of birth**_____
2. **Child's age when first separated from family of origin**_____
3. **Number of foster placements the child had before permanent care**
   _____
4. **Was your child's current placement converted from kinship care to permanent care? (please tick)** ☐**yes** ☐**no**
5. **Was your child's current placement converted from foster care to permanent care? (please tick)** ☐**yes** ☐**no**
6. **Years living with you (including foster care or kinship care, if applicable)**_____
7. **Child's age when placed permanently with you**_____
8. **Month and year of Permanent Care Order if you have one**_____
9. **Number of respite placements since permanent placement (if applicable)**_____
10. **Average length of time of respite placement (days per year)**_____
11. **Reasons for respite placement(s)**_____
    _____

IRI

Using the table below, please indicate how well each of the following statements describe you.

Not Well				Very Well
0	1	2	3	4

1.	I daydream and fantasize, with some regularity, about things that might happen to me.	0	1	2	3	4
2.	I often have tender, concerned feelings for people less fortunate than me.	0	1	2	3	4
3.	I sometimes find it difficult to see things form the "other guy's" point of view.	0	1	2	3	4
4.	Sometimes I don't feel very sorry for other people when they are having problems.	0	1	2	3	4
5.	I really get involved with the feelings of the characters in a novel.	0	1	2	3	4
6.	In emergency situations, I feel apprehensive and ill-at-ease.	0	1	2	3	4
7.	I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.	0	1	2	3	4
8.	I try to look at everybody's side of a disagreement before I make a decision.	0	1	2	3	4
9.	When I see someone being taken advantage of, I feel kind of protective towards them.	0	1	2	3	4
10.	I sometimes feel helpless when I am in the middle of a very emotional situation.	0	1	2	3	4
11.	I sometimes try to understand my friends better by imagining how things look from their perspective.	0	1	2	3	4
12.	Becoming extremely involved in a good book or movie is somewhat rare for me.	0	1	2	3	4
13.	When I see someone get hurt, I tend to remain calm.	0	1	2	3	4
14.	Other people's misfortunes do not usually disturb me a great deal.	0	1	2	3	4
15.	If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.	0	1	2	3	4
16.	After seeing a play or movie, I have felt as though I were one of the characters.	0	1	2	3	4
17.	Being in a tense emotional situation scares me.	0	1	2	3	4
18.	When I see someone being treated unfairly, I sometimes don't feel very much pity for them.	0	1	2	3	4
19.	I am usually pretty effective in dealing with emergencies.	0	1	2	3	4
20.	I am often quite touched by things that I see happen.	0	1	2	3	4
21.	I believe that there are two sides to every question and try to look at them both.	0	1	2	3	4
22.	I would describe myself as a pretty soft-hearted person.	0	1	2	3	4
23.	When I watch a good movie, I can very easily put myself in the place of a leading character.	0	1	2	3	4

Not Well				Very Well
0	1	2	3	4

24.	I tend to lose control during emergencies.	0	1	2	3	4
25.	When I'm upset at someone, I usually try to "put myself in his/her shoes" for a while.	0	1	2	3	4
26.	When I am reading an interesting story or novel, I imagine how I would feel if the events of the story were happening to me.	0	1	2	3	4
27.	When I see someone who badly needs help in an emergency, I go to pieces.	0	1	2	3	4
28.	Before criticizing somebody, I try to imagine how I would feel if I were in their place.	0	1	2	3	4

PSDQ

Using the table below, make a rating for each of the following items by circling the number that corresponds with how frequently you display the particular behaviour with your child. Please note, "My child" refers to your permanent care child.

I Exhibit this Behaviour
1 = Never **2 = Once in a while** **3 = About half of the time** **4 = Very often** **5 = Always**

1.	I encourage my child to talk about the child's troubles.	1	2	3	4	5
2.	I guide my child by punishment more than reason.	1	2	3	4	5
3.	I know the name of my child.	1	2	3	4	5
4.	I find it difficult to discipline my child.	1	2	3	4	5
5.	I give praise when my child is good.	1	2	3	4	5
6.	I spank when my child is disobedient.	1	2	3	4	5
7.	I joke and play with my child.	1	2	3	4	5
8.	I withhold scolding and/or criticism even when my child acts contrary to my wishes.	1	2	3	4	5
9.	I show sympathy when my child is hurt or frustrated.	1	2	3	4	5

I Exhibit this Behaviour
1 = Never **2 = Once in a while** **3 = About half of the time** **4 = Very often** **5 = Always**

10.	I punish by taking privileges away from my child with little if any explanation.	1	2	3	4	5
11.	I spoil my child.	1	2	3	4	5
12.	I give comfort and understanding when my child is upset.	1	2	3	4	5
13.	I yell or shout when my child misbehaves.	1	2	3	4	5
14.	I am easy going and relaxed with my child.	1	2	3	4	5
15.	I allow my child to annoy someone else.	1	2	3	4	5
16.	I tell my child my expectations regarding behaviour before the child engages in an activity.	1	2	3	4	5
17.	I scold/criticize to make my child improve.	1	2	3	4	5
18.	I show patience with my child.	1	2	3	4	5
19.	I grab my child when being disobedient.	1	2	3	4	5
20.	I state punishments to my child and does/do not actually do them.	1	2	3	4	5
21.	I am responsive to my child's feelings and needs.	1	2	3	4	5
22.	I allow my child to give input into family rules.	1	2	3	4	5
23.	I argue with my child.	1	2	3	4	5
24.	I appear confident about parenting abilities.	1	2	3	4	5
25.	I give my child reasons why rules should be obeyed.	1	2	3	4	5
26.	I appear to be more concerned with my own feelings than with my child's feelings.	1	2	3	4	5

I Exhibit this Behaviour
1 = Never **2 = Once in a while** **3 = About half of the time** **4 = Very often** **5 = Always**

27.	I tell my child that we appreciate what the child tries to accomplish.	1	2	3	4	5
28.	I punish by putting my child off somewhere alone with little, if any explanation.	1	2	3	4	5
29.	I help my child to understand the impact of behaviour by encouraging my child to talk about the consequences of own actions.	1	2	3	4	5
30.	I am afraid that disciplining my child for misbehaviour will cause the child to not like me as his/her parent.	1	2	3	4	5
31.	I take my child's desires into account before asking the child to do something.	1	2	3	4	5
32.	I explode in anger towards my child.	1	2	3	4	5
33.	I am aware of problems or concerns about my child in school.	1	2	3	4	5
34.	I threaten my child with punishment more often than actually giving it.	1	2	3	4	5
35.	I express affection by hugging, kissing, and holding my child.	1	2	3	4	5
36.	I ignore my child's misbehaving.	1	2	3	4	5
37.	I use physical punishment as a way of disciplining my child.	1	2	3	4	5
38.	I carry out discipline after my child misbehaves.	1	2	3	4	5
39.	I apologize to my child when making a mistake in parenting.	1	2	3	4	5
40.	I tell my child what to do.	1	2	3	4	5
41.	I give into my child when the child causes a commotion about something.	1	2	3	4	5
42.	I talk it over and reason with my child when the child misbehaves.	1	2	3	4	5

I Exhibit this Behaviour
1 = Never **2 = Once in a while** **3 = About half of the time** **4 = Very often** **5 = Always**

43.	I slap my child when the child misbehaves.	1	2	3	4	5
44.	I disagree with my child.	1	2	3	4	5
45.	I allow my child to interrupt others.	1	2	3	4	5
46.	I have warm and intimate times together with my child.	1	2	3	4	5
47.	When two children are fighting, I discipline the children first and ask questions later.	1	2	3	4	5
48.	I encourage my child to freely express (himself) (herself) even when disagreeing with parents.	1	2	3	4	5
49.	I bribe my child with rewards to bring about compliance.	1	2	3	4	5
50.	I scold or criticise when my child's behaviour doesn't meet my expectations.	1	2	3	4	5
51.	I show respect for my child's opinions by encouraging my child to express them.	1	2	3	4	5
52.	I set strict well-established rules for my child.	1	2	3	4	5
53.	I explain to my child how I feel about the child's good and bad behaviour.	1	2	3	4	5
54.	I use threats as punishment with little or no justification.	1	2	3	4	5
55.	I take into account my child's preference in making family plans.	1	2	3	4	5
56.	When my child asks why he/she has to conform, I state; "because I said so", or "I am your parent and I want you to".	1	2	3	4	5
57.	I appear unsure on how to solve my child's misbehaviour.	1	2	3	4	5
58.	I explain the consequences of the child's behaviour.	1	2	3	4	5
59.	I demand that my child does/do things.	1	2	3	4	5

I Exhibit this Behaviour
1 = Never **2 = Once in a while** **3 = About half of the time** **4 = Very often** **5 = Always**

60.	I channel my child's misbehaviour into more acceptable activity.	1	2	3	4	5
61.	I shove my child when the child is disobedient.	1	2	3	4	5
62.	I emphasise the reason for rules.	1	2	3	4	5

SDQ

The next part of the questionnaire asks you to identify your permanent care child's strengths and difficulties. For each item, please circle the number that corresponds with the extent to which you believe the item to be true for your permanent care child. Please answer all items as best you can, even if you are not absolutely certain. Give your answers on the basis of your permanent care child's behaviour *over the last six months*.

Not true	Somewhat true	Certainly true
0	1	2

1.	Considerate of other people's feelings.	0	1	2
2.	Restless, overactive, cannot stay still for long.	0	1	2
3.	Often complains of headaches, stomach-aches or sickness.	0	1	2
4.	Shares readily with other children (treats, toys, pencils, etc).	0	1	2
5.	Often has temper tantrums or hot tempers.	0	1	2
6.	Rather solitary, tends to play alone.	0	1	2
7.	Generally obedient, usually does what adults request.	0	1	2
8.	Many worries, often seems worried.	0	1	2
9.	Helpful if someone is hurt, upset or feeling ill.	0	1	2
10.	Constantly fidgeting or squirming.	0	1	2
11.	Has at least one good friend.	0	1	2
12.	Often fights with other children or bullies them.	0	1	2
13.	Often unhappy, down-hearted or tearful.	0	1	2
14.	Generally liked by other children.	0	1	2
15.	Easily distracted, concentration wanders.	0	1	2

Not true	Somewhat true	Certainly true
0	1	2

16.	Nervous or clingy in new situations, easily loses confidence.	0	1	2
17.	Kind to younger children.	0	1	2
18.	Often lies or cheats.	0	1	2
19.	Picked on or bullied by other children.	0	1	2
20.	Often volunteers to help others (parents, teachers, other children).	0	1	2
21.	Thinks things out before acting.	0	1	2
22.	Steals from home, school or elsewhere.	0	1	2
23.	Gets on better with adults than with other children.	0	1	2
24.	Many fears; easily scared.	0	1	2
25.	Sees tasks through to the end, good attention span.	0	1	2

Overall, do you think that your permanent care child has difficulties in one or more of the following areas: *emotions, concentration, behaviour* or being able to *get on with other people*? (Please circle the appropriate number in the table below).

No	Yes, minor difficulties	Yes, definite difficulties	Yes, severe difficulties
0	1	2	3

If you have answered 'Yes', please answer the following questions about these difficulties:

Are the difficulties in all four areas or some areas only? Please indicate by circling as many of the numbers below as apply.

Emotions	Concentration	Behaviour	Getting on with others
1	2	3	4

How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
1	2	3	4

Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
0	1	2	3

Do the difficulties interfere with your child's everyday life in the following areas?

Not at all	Only a little	Quite a lot	A great deal
0	1	2	3

Home life	0	1	2	3
Friendships	0	1	2	3
Classroom learning	0	1	2	3
Leisure activities	0	1	2	3

Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
0	1	2	3

In your own words, how do these difficulties impact on your child, you or your family?

_____

_____

_____

_____

_____

_____

CPRS

Please reflect on the degree to which each of the following statements currently applies to your relationship with your *permanent care child*. Using the scale below, circle the appropriate number for each item. In all cases "My child" being your permanent care child.

Definitely does not apply	Not really	Neutral, not sure	Applies somewhat	Definitely applies
1	2	3	4	5

1	I share an affectionate, warm relationship with my child.	1	2	3	4	5
2	My child and I always seem to be struggling with each other.	1	2	3	4	5
3	If upset, my child will seek comfort from me.	1	2	3	4	5
4	My child is uncomfortable with physical affection or touch from me.	1	2	3	4	5
5	My child values his/her relationship with me.	1	2	3	4	5
6	My child appears hurt or embarrassed when I correct him/her.	1	2	3	4	5
7	My child does not want to accept help when he/she needs it.	1	2	3	4	5
8	When I praise my child, he/she beams with pride.	1	2	3	4	5
9	My child reacts strongly to separation from me.	1	2	3	4	5
10	My child spontaneously shares information about him or herself.	1	2	3	4	5
11	My child is overly dependent on me.	1	2	3	4	5
12	My child easily becomes angry at me.	1	2	3	4	5
13	My child tries to please me.	1	2	3	4	5
14	My child feels that I treat him/her unfairly.	1	2	3	4	5
15	My child asks for my help when s/he really does not need help.	1	2	3	4	5
16	It is easy to be in tune with what my child is feeling.	1	2	3	4	5
17	My child sees me as a source of punishment and criticism.	1	2	3	4	5
18	My child expresses hurt or jealousy when I spend time with other children.	1	2	3	4	5
19	My child remains angry or resistant after being disciplined.	1	2	3	4	5

Definitely does not apply	Not really	Neutral, not sure	Applies somewhat	Definitely applies
1	2	3	4	5

20	When my child is misbehaving, s/he responds to my look or tone of voice.	1	2	3	4	5
21	Dealing with my child drains my energy.	1	2	3	4	5
22	My child copies my behaviour, expressions and/or ways of doing things.	1	2	3	4	5
23	When my child is in a bad mood, I know we're in for a long and difficult day.	1	2	3	4	5
24	My child's feelings toward me can be unpredictable or can change suddenly.	1	2	3	4	5
25	Despite my best efforts, I'm uncomfortable with how my child and I get along.	1	2	3	4	5
26	I often think about my child when I am at work.	1	2	3	4	5
27	My child whines or cries when s/he wants something from me.	1	2	3	4	5
28	My child is sneaky or manipulative with me.	1	2	3	4	5
29	My child openly shares feelings and experiences with me.	1	2	3	4	5
30	My interactions with my child make me feel effective and confident as a parent.	1	2	3	4	5
31	My child and I just don't get on.	1	2	3	4	5
32	My child brings a lot of joy into my life.	1	2	3	4	5
33	My child is aggressive towards me.	1	2	3	4	5
34	My child has a disrespectful attitude to me.	1	2	3	4	5
35	My child's behaviour makes me angry.	1	2	3	4	5
36	I truly enjoy my child's company.	1	2	3	4	5

If you believe that there have been some changes in your relationship with your child in any of the above areas during the time he/she has been placed with you, please comment on these changes in the space provided.

_____

_____

_____

_____

_____

_____

Using the scale below, circle the appropriate number for each item. Again, "My child" refers to your *permanent care child*.

STSC

Almost Never	Not Often	Variable, usually does not	Variable, usually does	Frequently	Almost Always
1	2	3	4	5	6

1	My child is shy with strange adults.	1	2	3	4	5	6
2	When my child starts a project such as a model or puzzle, he/she works on it without stopping until it is completed, even if it takes a long time.	1	2	3	4	5	6
3	My child has a bowel motion at the same time each day.	1	2	3	4	5	6
4	My child is shy when first meeting new children.	1	2	3	4	5	6
5	My child likes to complete one task or activity before going on to the next.	1	2	3	4	5	6
6	My child asks for or takes a snack at about the same time every day.	1	2	3	4	5	6
7	When upset or annoyed with a task, my child throws it down, cries, slams doors, etc.	1	2	3	4	5	6
8	If my child wants a toy or sweet while shopping, he/she will easily accept something else instead.	1	2	3	4	5	6
9	After my child is put to bed at night, he/she takes about the same length of time to fall asleep.	1	2	3	4	5	6
10	My child is unwilling to leave a game or activity that he/she has not completed.	1	2	3	4	5	6
11	If my child resists some activity such as having hair brushed, he/she will continue to resist it for some months.	1	2	3	4	5	6
12	My child stays with an activity (eg. puzzle, construction kit, reading) for a long time.	1	2	3	4	5	6
13	When in the park or visiting, my child will go up to strange children and join their play.	1	2	3	4	5	6

Almost Never	Not Often	Variable, usually does not	Variable, usually does	Frequently	Almost Always
1	2	3	4	5	6

14	My child sleeps for a different length of time each night.	1	2	3	4	5	6
15	If my child is shy with a strange adult, he/she gets over this quickly (in about half an hour).	1	2	3	4	5	6
16	When my child is angry about something, it is difficult to sidetrack him/her.	1	2	3	4	5	6
17	My child gets hungry at different times each day.	1	2	3	4	5	6
18	When the family goes on a trip, my child immediately makes him/herself at home on the new surroundings.	1	2	3	4	5	6
19	When shopping together, if I do not buy what my child wants (eg. sweets, clothing), he/she cries and yells.	1	2	3	4	5	6
20	If my child is upset, it is hard to comfort him/her.	1	2	3	4	5	6
21	When unknown adults visit our home, my child is immediately friendly and approaches them.	1	2	3	4	5	6
22	My child eats a lot one day and very little the next day, rather than the same amount each day.	1	2	3	4	5	6
23	When a toy or game is difficult, my child quickly turns to another activity.	1	2	3	4	5	6
24	If a favourite toy or game won't work, my child gets noticeably upset.	1	2	3	4	5	6
25	When my child objects to wearing certain clothing, he/she argues loudly, or cries.	1	2	3	4	5	6
26	On weekends and holidays, my child wakes up at the same time each morning.	1	2	3	4	5	6
27	My child practices an activity (eg. puzzle, new song, writing) till he/she masters it.	1	2	3	4	5	6

Almost Never	Not Often	Variable, usually does not	Variable, usually does	Frequently	Almost Always
1	2	3	4	5	6

28	The first time my child is left in a new situation without "mother" (such as kindergarten, school or music lesson) he/she gets upset.	1	2	3	4	5	6
29	If my child starts to play with something and I want him/her to stop, it is hard to turn his/her attention to something else.	1	2	3	4	5	6
30	My child gets involved with quiet activities such as reading or looking at books, and doing crafts.	1	2	3	4	5	6

IPIP NEO PI R

Using the table below, circle the number that corresponds to each of the following statements:

NOTE: "My child" refers to your *permanent care child*.

Very inaccurate	Moderately inaccurate	Neither inaccurate, or accurate	Moderately accurate	Very accurate
1	2	3	4	5

1	My child panics easily.	1	2	3	4	5
2	My child becomes overwhelmed by events.	1	2	3	4	5
3	My child feels he/she is unable to deal with things.	1	2	3	4	5
4	My child can't make up his/her mind.	1	2	3	4	5
5	My child gets overwhelmed by emotions.	1	2	3	4	5
6	My child remains calm under pressure.	1	2	3	4	5
7	My child can handle complex problems.	1	2	3	4	5
8	My child knows how to cope.	1	2	3	4	5
9	My child readily overcomes setbacks.	1	2	3	4	5
10	My child is calm even in tense situations.	1	2	3	4	5

If there are any further comments you wish to include, please enclose extra pages as required.

We sincerely thank you for your interest, patience and co-operation in completing this questionnaire.

Appendix F

Semi-Structured Interview Schedule

Semi Structured Interview Schedule

Introduction (welcome, thanks, recap on purpose of project, procedure, ground rules, permission to audiotape, allocation of pseudonym)

Areas of exploration

Child, carer, and family relationships

1. How would you describe your relationship with your permanent care child?
2. Did you anticipate difficulties in establishing a relationship with your permanent care child? What were they? Why? Did they eventuate?
3. How attached do you feel to your permanent care child?
4. Does your permanent care child have a good relationship with the other members of the immediate permanent care family? What about the extended permanent care family?
5. What activities do you do together? As a family? Do you enjoy spending time with your child?
6. In what ways has the relationship between you and your child changed over time?
7. Are you satisfied with the relationship that has developed with your child? With which aspects are you particularly satisfied or dissatisfied with?

Child's behaviour and development

8. What was your child's behaviour like when he or she was originally placed with you? Were there any specific emotional or behavioural challenges?
9. Can you describe your child's behaviour now?
10. Are there any differences in your child's behaviour? If so, when did you start noticing these differences?
11. Does your child have any special needs? If so, what are they?

12. Does you child have any special talents or achievements? What are they? Does he or she take pride in them?

Child vulnerability and resilience

13. How many previous placements has your child had before being placed permanently with you? What types of placement where they? (eg., foster/permanent care)
14. What do you believe was the quality of your child's previous placement (before his or her current placement with you now)?
15. Does your child maintain contact with his or her birth family (participate in access)? How often does he or she see them?
16. Can you tell me about any previous experiences (adversities) your child has had which you would consider challenging?
17. If your child has a problem with something, whom does he/she turn to for help? In the school environment, does he/she ask (or is he or she comfortable asking) teachers for help when he/she is having troubles?
18. Is your child good at solving his/her problems? How so?
19. Was your child placed alone or with a sibling? Has this been beneficial for him/her?
20. Is your child of a similar ethnic and cultural background to you?

Carer's empathy towards the child

21. What were your early impressions of your child?
22. Do you find it easy to understand your child's feelings? With time has it gotten easier for you to relate to your child's feelings?

Carer parenting behaviours and experiences

23. How many hours a day do you spend with your child? How do you supervise his or her recreational activities?
24. What is the most difficult thing about disciplining your child?
25. Who do you feel you can talk to about any difficulties or problems you are having with your child?
26. Have you sought or received support in relation to your child's placement? If yes, from whom and for what reason/s?
27. What support do you receive (from partner/friends/agency/extended family etc)?
28. Generally speaking, do you find it easy or hard to parent your child? Why?
29. How did you prepare for becoming a permanent carer? Did you receive any training?

Satisfying the child's ongoing needs

30. What information did you receive from the agency concerning your child? Was it sufficient? What information would you have liked to have known?
31. Do you have any views about how your family's placement support needs can be more effectively met?
32. What changes need to be made in order for the child's needs to be met?
33. What improvements do you seek in your child's behaviour?
34. Have any planned programs been implemented? What specifically?

General

35. Is there anything else that you would like to add about you, your child, or your relationship to your child that you think is relevant to our discussions?

Conclusions (summary, thanks, debriefing)

Appendix G

Information Letter to Participants (Interview)

Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
115 Victoria Parade Fitzroy Vic 3065
Locked Bag 4115 Fitzroy MDC VIC 3065
Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

INFORMATION LETTER TO POTENTIAL PARTICIPANTS

TITLE: Carer-Child Relationships in Permanent Care Programs

RESEARCH SUPERVISORS: Associate Professors Michael McKay & Sabine Hammond

RESEARCHER: Maria Alexandris

Dear Permanent Care Parent,

You are invited to participate in a research project involving permanent care families which will collect information about parenting, carer/parent-child relationships and child well-being. The research is being conducted by Masters' student Maria Alexandris, and is being supervised by Associate Professors Michael McKay and Sabine Hammond from the School of Psychology at the Australian Catholic University. The purpose of the research is to learn more about the relationships and parenting experiences of permanent care families. As children differ in the way they enter permanent care (i.e., placements can be permanent "adoption" or kinship care/foster care conversions) it is also important to compare if and how relationships and parenting experiences differ between these various program types. We hope that the information gathered will help improve existing agency placement programs and will educate psychologists and social workers about how to support families in permanent care better.

As part of this research, we would like to invite you to participate in an interview. The interview will enable you to speak more freely about your relationship with your child and any experiences you have had in permanent care. The interview will last approximately one hour.

During the interview, the researcher will be taking notes and making audio recordings of the sessions as well. All information obtained in the interview will be kept confidential. The audio recordings will be transcribed and then deleted, and only confidential transcripts and notes will be kept. Your participation in this research is completely voluntary and you are free to withdraw at any time, without having to give a reason for doing so. Also, you do not have to answer any questions that you do not want to.

Under no circumstance will we disclose any information that you provide us without your consent, unless this information is specifically required by law. Should you provide us with information indicating that a child in care may be presently at risk, we may be obligated to report this.

This study has been approved by the Human Research Ethics Committee at the Australian Catholic University. Results from the study may appear as aggregated data in conferences or publications in a way that does not identify you. Public record standards require that

we store your interview data for at least 7 years following the completion of the project. All information obtained from you will be stored safely in the School of Psychology located on the university campus.

Questions regarding this project should be directed to Associate Professor Michael McKay, on (03) 9953 3107 in the School of Psychology, St. Patrick's Campus, Locked Bag 4115, Fitzroy VIC 3065, M.McKay@patrick.acu.edu.au or to Associate Professor Sabine Hammond on (03) 9953 3448 School of Psychology, St. Patrick's Campus, Locked Bag 4115, Fitzroy VIC 3065, s.hammond@patrick.acu.edu.au.

In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the investigator or supervisor and student researcher have not been able to satisfy, you may write to the Chair of the Human Research Ethics Committee, c/o Research Services, Australian Catholic University, Melbourne Campus, Locked Bag 4115, Fitzroy VIC 3065 (Tel: 03 9953 3157, Fax 03 9953 3305). Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

Any complaints or concerns about the your participation in this research study can also be addressed to Ms Vicki Xafis, Executive Officer, DHS Human Research Ethics Committee, 50 Lonsdale Street, Melbourne VIC 3000 (Tel: 03 9096 5239, Fax: 03 9096 9176).

We greatly appreciate your support and participation in this study.

Yours sincerely,

Maria Alexandris	Michael McKay, PhD	Sabine Hammond, PhD
Postgraduate	Associate Professor	Associate Professor

Appendix H

Consent Form (Interview)

Australian Catholic University Limited
ABN 15 050 192 660
Melbourne Campus (St Patrick's)
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Telephone 613 9953 3000
Facsimile 613 9953 3005
www.acu.edu.au

CARER/PARENT CONSENT FORM
Participant's copy to keep

TITLE: Carer-Child relationships in Permanent Care Programs
RESEARCH SUPERVISORS: A/Ps Michael McKay and Sabine Hammond
RESEARCHER: Maria Alexandris

Participant Section

I……(permanent care parent) have read and understood the information provided in the letter inviting participation in the research. Any questions I have asked have been answered to my satisfaction. I agree to participate in an interview of approximately one hour duration. I understand that the researcher will take notes and that the interview will be audio taped and transcribed so that it can be used for qualitative data analysis. After transcription, audiotapes will be deleted.

I understand that my consent is completely voluntary, and that I do not need to answer any questions I do not want to. I realise that I can withdraw at any time without having to give any reason in doing so, and that this will not affect me or my family in any way. I understand that the project may not be of direct benefit to me. I am aware that should any feelings of distress or emotional discomfort arise in response to my participation in this study, I will be provided with a referral to a counselling support service, should I request this. I have received information about counselling and support.

I agree that the research data collected for the study may be published or provided to other researchers in a form that does not identify me or my family in any way. I am over 18 years of age.

Name of carer/parent:…… (Block letters)
Signature:……..
Date:……..

Researcher:	Maria Alexandris	**Signature:**……	**Date:**……
Supervisors:	A/P Michael McKay	**Signature:**……	**Date:**……
	A/P Sabine Hammond	**Signature:**……	**Date:**……

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CARER/PARENT CONSENT FORM
Researchers' copy to keep

TITLE: Carer-Child Relationships in Permanent Care Programs
RESEARCH SUPERVISORS: A/Ps Michael McKay and Sabine Hammond
RESEARCHER: Maria Alexandris

Participant Section

I……(permanent care parent) have read and understood the information provided in the letter inviting participation in the research. Any questions I have asked have been answered to my satisfaction. I agree to participate in an interview of approximately one hour duration. I understand that the researcher will take notes and that the interview will be audio taped and transcribed so that it can be used for qualitative data analysis. After transcription, audiotapes will be deleted.

I understand that my consent is completely voluntary, and that I do not need to answer any questions I do not want to. I realise that I can withdraw at any time without having to give any reason in doing so, and that this will not affect me or my family in any way. I understand that the project may not be of direct benefit to me. I am aware that should any feelings of distress or emotional discomfort arise in response to my participation in this study, I will be provided with a referral to a counselling support service, should I request this. I have received information about counselling and support.

I agree that the research data collected for the study may be published or provided to other researchers in a form that does not identify me or my family in any way. I am over 18 years of age.

Name of carer/parent:…… (Block letters)
Signature:……..
Date:……..

Researcher: Maria Alexandris **Signature:**……. **Date:**……
Supervisors: A/P Michael McKay **Signature:**……. **Date:**……
A/P Sabine Hammond **Signature:**……. **Date:**……

Appendix I

SPSS Statistical Output

Hypothesis One

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
iritot	62.8889	9.12594	45
cprstot	115.1304	13.07518	46

Correlations

		iritot	cprstot
iritot	Pearson Correlation	1	.091
	Sig. (2-tailed)		.554
	N	45	45
cprstot	Pearson Correlation	.091	1
	Sig. (2-tailed)	.554	
	N	45	46

Hypothesis Two

Descriptive Statistics

	Mean	Std. Deviation	N
ariantot	7.6580	1.49269	44
ativetot	16.6847	1.50997	43
cprstot	115.1304	13.07518	46

Correlations

		ariantot	ativetot	cprstot
ariantot	Pearson Correlation	1	-.359*	-.396**
	Sig. (2-tailed)		.018	.008
	N	44	43	44
ativetot	Pearson Correlation	-.359*	1	.249
	Sig. (2-tailed)	.018		.108
	N	43	43	43
cprstot	Pearson Correlation	-.396**	.249	1
	Sig. (2-tailed)	.008	.108	
	N	44	43	46

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

**. Correlation is significant at the 0.01 level (2-tailed).

Hypothesis Three

Correlations

Descriptive Statistics

	Mean	Std. Deviation	N
sdqtot	15.0652	7.82419	46
stsceds	3.3037	.65120	45
ipipresi	31.3333	9.08045	45
cprstot	115.1304	13.07518	46

Correlations

		sdqtot	stsceds	ipipresi	cprstot
sdqtot	Pearson Correlation	1	.626**	-.678**	-.662**
	Sig. (2-tailed)		.000	.000	.000
	N	46	45	45	46
stsceds	Pearson Correlation	.626**	1	-.760**	-.606**
	Sig. (2-tailed)	.000		.000	.000
	N	45	45	44	45
ipipresi	Pearson Correlation	-.678**	-.760**	1	.528**
	Sig. (2-tailed)	.000	.000		.000
	N	45	44	45	45
cprstot	Pearson Correlation	-.662**	-.606**	.528**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	46	45	45	46

**. Correlation is significant at the 0.01 level (2-tailed).

Hypothesis Four

Regression

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	ipipresi, ativetot, iritot, ariantot, sdqtot, stsceds[a]		Enter

a. All requested variables entered.

b. Dependent Variable: cprstot

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.740[a]	.548	.470	9.79376

a. Predictors: (Constant), ipipresi, ativetot, iritot, ariantot, sdqtot, stsceds

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	4064.213	6	677.369	7.062	.000[a]
	Residual	3357.120	35	95.918		
	Total	7421.333	41			

a. Predictors: (Constant), ipipresi, ativetot, iritot, ariantot, sdqtot, stsceds

b. Dependent Variable: cprstot

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	141.884	34.513		4.111	.000
	iritot	-.075	.182	-.050	-.409	.685
	ariantot	-1.192	1.252	-.130	-.952	.348
	ativetot	1.398	1.090	.157	1.282	.208
	sdqtot	-.809	.291	-.464	-2.780	.009
	stsceds	-6.320	3.698	-.306	-1.709	.096
	ipipresi	-.098	.280	-.067	-.351	.728

a. Dependent Variable: cprstot

Regression

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	ativetot, iritot, ariantot[a]		Enter

a. All requested variables entered.

b. Dependent Variable: cprstot

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.417[a]	.174	.110	12.54856

a. Predictors: (Constant), ativetot, iritot, ariantot

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1290.995	3	430.332	2.733	.057[a]
	Residual	6141.191	39	157.466		
	Total	7432.186	42			

a. Predictors: (Constant), ativetot, iritot, ariantot

b. Dependent Variable: cprstot

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	123.578	32.999		3.745	.001
	iritot	-.031	.227	-.021	-.135	.893
	ariantot	-3.223	1.447	-.364	-2.227	.032
	ativetot	1.070	1.376	.121	.778	.441

a. Dependent Variable: cprstot

Regression

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	ipipresi, sdqtot, stsceds[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: cprstot

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.717[a]	.514	.478	9.65218

a. Predictors: (Constant), ipipresi, sdqtot, stsceds

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	3948.601	3	1316.200	14.128	.000[a]
	Residual	3726.581	40	93.165		
	Total	7675.182	43			

a. Predictors: (Constant), ipipresi, sdqtot, stsceds

b. Dependent Variable: cprstot

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	156.205	18.598		8.399	.000
	sdqtot	-.898	.267	-.523	-3.359	.002
	stsceds	-6.979	3.542	-.344	-1.970	.056
	ipipresi	-.134	.270	-.092	-.495	.623

a. Dependent Variable: cprstot

Exploratory Analyses

Regression

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	iripd, iriec, irifs, iript[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: cprstot

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.266[a]	.071	-.022	13.34689

a. Predictors: (Constant), iripd, iriec, irifs, iript

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	543.398	4	135.850	.763	.556[a]
	Residual	7125.579	40	178.139		
	Total	7668.978	44			

a. Predictors: (Constant), iripd, iriec, irifs, iript

b. Dependent Variable: cprstot

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	106.352	16.176		6.575	.000
	iript	.900	.790	.207	1.138	.262
	irifs	.079	.433	.030	.183	.856
	iriec	-.699	.575	-.217	-1.215	.231
	iripd	.527	.563	.158	.936	.355

a. Dependent Variable: cprstot

Regression

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	psdqresp, psdqdemo, psdqwarm, psdqdire, psdqcorp, psdqverb, psdqnonr, psdqreas[a]		Enter

a. All requested variables entered.

b. Dependent Variable: cprstot

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.542[a]	.294	.128	12.42028

a. Predictors: (Constant), psdqresp, psdqdemo, psdqwarm, psdqdire, psdqcorp, psdqverb, psdqnonr, psdqreas

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2187.234	8	273.404	1.772	.117[a]
	Residual	5244.952	34	154.263		
	Total	7432.186	42			

a. Predictors: (Constant), psdqresp, psdqdemo, psdqwarm, psdqdire, psdqcorp, psdqverb, psdqnonr, psdqreas

b. Dependent Variable: cprstot

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	103.502	36.607		2.827	.008
	psdqverb	3.661	6.339	.114	.578	.567
	psdqcorp	-.102	5.064	-.004	-.020	.984
	psdqnonr	-7.401	6.733	-.219	-1.099	.279
	psdqdire	-1.285	3.288	-.069	-.391	.698
	psdqwarm	-6.204	6.797	-.172	-.913	.368
	psdqreas	-2.610	6.358	-.087	-.410	.684
	psdqdemo	.915	3.032	.051	.302	.765
	psdqresp	13.193	5.699	.483	2.315	.027

a. Dependent Variable: cprstot

Regression

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	sdqpro, sdqemot, sdqpeer, sdqhype, sdqcond[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: cprstot

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.807[a]	.651	.607	8.19298

a. Predictors: (Constant), sdqpro, sdqemot, sdqpeer, sdqhype, sdqcond

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	5008.221	5	1001.644	14.922	.000[a]
	Residual	2684.996	40	67.125		
	Total	7693.217	45			

a. Predictors: (Constant), sdqpro, sdqemot, sdqpeer, sdqhype, sdqcond

b. Dependent Variable: cprstot

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	112.718	7.748		14.548	.000
	sdqemot	-.485	.527	-.102	-.920	.363
	sdqcond	-2.659	.747	-.446	-3.562	.001
	sdqhype	-.727	.489	-.174	-1.488	.145
	sdqpeer	.329	.528	.067	.623	.537
	sdqpro	2.112	.757	.323	2.789	.008

a. Dependent Variable: cprstot

Regression

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	stscper, stscrhyt, stscinfl, stscapp[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: cprstot

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.694[a]	.482	.430	9.97465

a. Predictors: (Constant), stscper, stscrhyt, stscinfl, stscapp

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	3705.054	4	926.264	9.310	.000[a]
	Residual	3979.746	40	99.494		
	Total	7684.800	44			

a. Predictors: (Constant), stscper, stscrhyt, stscinfl, stscapp

b. Dependent Variable: cprstot

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	151.097	9.125		16.559	.000
	stscapp	-.752	1.803	-.050	-.417	.679
	stscrhyt	-2.708	1.823	-.174	-1.486	.145
	stscinfl	-6.131	1.155	-.618	-5.311	.000
	stscper	-1.695	1.559	-.125	-1.087	.284

a. Dependent Variable: cprstot