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Research article

Child Directed Interaction Training for young children in kinship care: A pilot study☆

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ABSTRACT

This pilot study used a randomized controlled trial design to examine the feasibility and explore initial outcomes of a twice weekly, 8-session Child Directed Interaction Training (CDIT) program for children living in kinship care. Participants included 14 grandmothers and great-grandmothers with their 2- to 7-year-old children randomized either to CDIT or a waitlist control condition. Training was delivered at a local, community library with high fidelity to the training protocol. There was no attrition in either condition. After training, kinship caregivers in the CDIT condition demonstrated more positive relationships with their children during behavioral observation. The caregivers in the CDIT condition also reported clinically and statistically significant decreases in parenting stress and caregiver depression, as well as fewer externalizing child behavior problems than waitlist controls. Parent daily report measures indicated significant changes in disciplining that included greater use of limit-setting and less use of critical verbal force. Results appeared stable at 3-month follow-up. Changes in child internalizing behaviors and caregiver use of non-critical verbal force were not seen until 3-month follow-up. Results of this pilot study suggest both the feasibility of conducting full scale randomized clinical trials of CDIT in the community and the promise of this approach for providing effective parent training for kinship caregivers.

1. Introduction

Over 2.5 million children, approximately 3% of the child population of the United States, live in out-of-home kinship placements (National Kids Count, 2013). Of these, only 100,000 are formal placements, such as those arranged through the

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Child Welfare System (CWS; National Kids Count, 2014). The remaining placements are informal kinship placements, which consist of guardianship arrangements made through family court or informal family agreements outside the CWS, typically with grandparent caregivers (Cuddeback, 2004).

The most commonly stated reasons for children to enter kinship placements are parental substance abuse or addiction and parental neglect, abuse, or abandonment (Gleeson et al., 2009). Most children living in these placements have been exposed to traumatic events in early childhood that place them at-risk for emotional dysregulation and disorganized attachment behaviors (Dozier et al., 2006; Howe & Fearnley, 2003). Although children in kinship placements have better mental health outcomes than children in traditional foster placements (Tarren-Sweeney, 2008), their mental health and attachment difficulties are significantly greater than same-age peers outside the CWS (Tarren-Sweeney, 2008). To recover from the effects of trauma, children in kinship care require the same kinds of emotionally-responsive caregiving as other children in the CWS to re-establish the capacity for self-regulation (Dozier, Higley, Albus, & Nutter, 2002) and improve their attachment security, anxiety, and behavior problems (Tarren-Sweeney, 2008).

Kinship caregivers face unique and stressful challenges that affect their parenting. They experience greater depression, less social support, less education, and poorer health than traditional foster parents (Harden, Clyman, Kriebel, & Lyons, 2004). The majority of kinship caregivers are African American, over 50 years of age, with incomes 200% below the federal poverty line (The Annie E. Casey Foundation, 2012). They tend to have lower emotional availability (Harden et al., 2004) and to use more physical discipline than other foster caregivers (Dolan, Casanueva, Smith, & Bradley, 2009). High levels of stress related to caregiving lead to their more negative disciplining patterns and exacerbate child behavior problems (Kelley, Whitley, & Campos, 2011).

Parenting interventions designed specifically for young children and caregivers in kinship care are needed. Parenting interventions designed specifically for kinship caregivers and their children have not been investigated; most intervention studies include kinship and non-kinship caregivers in the same sample (Chamberlain et al., 2008; Timmer, Sedlar, & Urquiza, 2004). Interventions adapted to meet the unique characteristics of the kinship caregiver population should include adaptations for caregivers that demonstrate high levels of parenting stress and for their children that demonstrate less severe child behavior problems than those in traditional foster families (Harden et al., 2004; Tarren-Sweeney, 2008). Research on interventions for these caregivers consists primarily of preliminary studies addressing risk factors for this population including caregiver physical health and social support (Kelley et al., 2011; Strozier, McGrew, Krisman, & Smith, 2005; Strozier, 2012), but not parenting stress.

Parent training is known to improve foster caregiver stress, reducing their reactivity to child behavior problems (Fisher & Stoolmiller, 2008). However, the availability of parent training support is limited for kinship foster caregivers. They typically do not receive training equivalent to traditional foster parents (Grimm, 2003), and the training provided to foster parents in general often lacks instruction on managing disruptive child behavior (Chamberlain et al., 2008; Denby, Rindfleisch, & Bean 1999). Effective kinship foster parent training in relationship-building skills as well as behavior management would be expected to strengthen placement stability by reducing parenting stress as well as improving child mental health outcomes. Yet there is a dearth of information available on evidence-based treatments for kinship foster caregivers and their children.

1.1. Child Directed Interaction Training

A promising intervention for addressing both the mental health needs of young children in kinship care and the parenting needs of their caregivers is Child Directed Interaction Training (CDIT). CDIT is the first phase of Parent Child Interaction Therapy (Eyberg & Funderburk, 2011), an evidenced-based treatment for preschoolers with histories of child abuse and neglect (Chadwick Center on Children and Families, 2004; Chaffin & Friedrich, 2004). CDIT focuses on enhancing the caregiver–child attachment relationship by providing caregivers with concrete skills to increase the emotional reciprocity in the caregiver–child interactions while using differential social attention (DSA) to manage child behavior (Harwood & Eyberg, 2006; Herschell & McNeil, 2005). DSA is a paradigm of attending to positive behavior (e.g., playing gently and sharing) and ignoring negative child behavior (e.g., throwing temper tantrums or screaming to get attention) to help children quickly learn a new approach to seeking caregivers attention that is positive and cooperative. Providing CDIT as a stand-along intervention would also be relatively brief. The average number of CDI sessions required to meet mastery is around 6 sessions (Harwood & Eyberg, 2006).

The second phase of PCIT, the Parent Directed Interaction (PDI) includes a specific discipline procedure parents are taught for managing more severely defiant behaviors (Eyberg, Nelson, & Boggs, 2008). The PDI is a powerful intervention that may be unnecessary for most kinship families given that (a) most children in kinship foster care have less severe behavior problems than other foster children (Tarren-Sweeney, 2008), and (b) CDIT can reduce behavior problems to below clinical cut-off for almost half of children who present with a clinically significant behavior disorders (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993; Harwood & Eyberg, 2006).

Most studies of PCIT with children with histories of maltreatment have focused on biological parents (Chaffin et al., 2004; Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011) or traditional foster caregivers (McNeil, Herschell, Gurwitch, & Clemens-Mowrer, 2005; Mersky, Topitzes, Grant-Savela, Brondino, & McNeil, 2014; Mersky, Topitzes, Janczewski, & McNeil, 2015) using full-protocol PCIT. A randomized trial of PCIT as a foster parent training model for non-kinship foster parents caring for children with externalizing behavior problems in the clinical range demonstrated improvement in both child externalizing and internalizing child symptoms (Mersky et al., 2014) as well as caregiver parenting stress (Mersky et al., 2015). However,

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