An Exploration of the Relationship Between Children in Treatment Foster Care and Their Foster Caregivers

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Dedication

For all the children and families who inspired this work.

Abstract

Purpose: This study explored through the perception of foster children and caregivers, the importance, quality, and content of their shared relationship in Treatment Foster Care (TFC). Children at TFC level of care due to emotional/behavioral disturbance (EBD) evidence a persistent and severe degree of EBD and are at risk of placement in a more restrictive setting, i.e. psychiatric hospitalization or residential treatment. TFC seeks to improve child safety, permanency, and well-being outcomes through therapeutic care within the context of normalized family life (Dore & Mullin, 2006).

The body of knowledge of the condition of children served within TFC level of care outpaces the body of knowledge of how these children can and need to be effectively cared for. Much is known about the antecedents, their behavioral and emotional presentation, and relationship difficulties, however only a few interventions or outcomes specific to these foster children or foster families have been rigorously studied (Craven & Lee, 2006). No standard of care exists for foster care of EBD children, and theoretical models and treatment methods of TFC vary widely (Farmer, et al, 2002). Although therapeutic relationship has been demonstrated as an instrument of adaptive change for children in other contexts, it is yet to be thoroughly explored within TFC.

Methods: This study utilized qualitative research methods in an interpretive description study design. Through purposeful sampling subjects were identified within a statewide TFC program. Data collection included semi-structured interviews with foster parents and children in their care, and agency child case-file document review. Data analysis, informed by attachment theory, resilience, and clinical knowledge, occurred concurrently

with data collection. Through the analysis process, themes and patterns were identified among subjective perspectives, while also accounting for variations between individuals, and to led to clinical application implications

Results: Analysis yielded descriptive information about the quality, process, and importance of TFC child-caregiver relationships. Relationship process and importance for children centered on being helped, being known, being comfortable, choosing to connect. For TFC parents this centered on providing consistent care, valuing and respecting kids, figuring kids out, modeling parenting/lifestyle. Connectedness to foster family as a whole and connectedness long term (formally and informally) was prevalent. Description of TFC relationship: therapeutic relationship utilizing reflective and responsive parenting as the technique of change.

Conclusions/Implications: This research contributes knowledge for direct application to social work practice within TFC and to guide further inquiry regarding this vulnerable, high-risk population. It offers detailed description of adaptive relationship processes and perception through the insight of foster youth and their caregivers.

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Chapter One

Introduction to the Study

Relational interventions targeted to caregiving relationships and interventions to repair systems compromised by relational hardship have begun to be explored for their effectiveness in treatment foster care (TFC). Given the complexity of TFC foster children's relationship-related difficulties and the level of yet unmet emotional and behavioral need for which this level of care is required, further research to better understand the experience of foster family relationship in TFC is warranted. This study seeks to explore and describe the shared relationship between youth and their foster families within TFC.

Overview and Purpose

TFC for children with emotional and behavioral disorders has been described as "a distinct, powerful, and unique model of care that provides youth with a nurturing and therapeutic family environment ", and that through providing a safe and supportive home, treatment foster parents as a part of the treatment team meet the needs of this population through "nurturing, modeling, and teaching" (Lutheran Social Service of Minnesota, n.d.). Treatment foster care is an individually tailored, foster family-based intervention for youth who are at risk of placement in a more restrictive setting due to emotional, behavioral, developmental or other special medical needs, and seeks to improve their safety, permanency, and well-being outcomes through therapeutic care within the context of normalized family life (Dore & Mullin, 2006). Elements of this intervention option include that foster parents are considered a part of the professional treatment team,

receive specialized training and support, and are expected to implement the child's treatment plan within the home. Youth placements are limited to a maximum of two foster children per home, and foster parents are paid at a rate higher than traditional foster placements (Turner & Macdonald, 2011).

TFC is one of an array of out-of-home care services for children who require living arrangements apart from their biological family (Child Welfare Information Gateway, 2013). The US child welfare system is inclusive of policies and programs organized around the goals of protection, care, and the healthy development of children. TFC originated in the 1970's (Dore & Mullin, 2006) and grew substantially in the 1980's as states in response to the Mental Health Planning Act (P.L. 99-660) embraced the systems of care model for children with serious emotional disorders (Duchnowski & Friedman, 1990). The systems of care model emphasized "an integrated multi-agency system of care with a particular focus on intensive, nonresidential services, a strong partnership between parents and professionals, and a capacity to respond effectively to the needs of our increasingly culturally diverse population" (p. 4). With the passage of the Adoption and Safe Families Act of 1997, child welfare goals shifted focus toward the safety, permanency (timely reunification with family, guardianship, or adoption), and well-being of children in the child welfare system, including children with special needs.

For the population of children and youth within foster care, many problems are of origin within the caregiving relationship or home environment, including adverse experiences of abuse, neglect, traumatic events or loss, or an unavailable or incapable caregiver. The journey within the foster care system may be experienced by foster

children as disruptive and potentially traumatic as they are removed from their primary caregiver and often experience foster placement moves and changes. These experiences may compromise a child's ability to effectively make use of new relationship for help and healing. Within the TFC model correction and healing for children potentially previously harmed within caregiver relationships are wrought within caregiving relationships, developing capacities for secure relationships, better self-regulation, adaptive coping, and management of trauma (Dozier, Albus, Fisher, & Sepulveda, 2002).

Seeking to better understand the relational experiences and patterns involved in improving outcomes and enhancing resilience for foster children is important. Within TFC, therapeutic relationships are the central intervention thought to foster these outcomes. As such research that provides rich descriptive data on these foster children, their foster family context, the perspectives of both foster children and their foster caregivers, and the children's unique outcomes is needed in order to understand how relationship can contribute to improved TFC foster child outcomes.

Statement of the Problem

Difficulties shared commonly amongst foster children include both psychological and neurological effects of disrupted attachment, trauma experiences, adjustment to placement, and mental health problems. Rates of emotional, behavioral, and mental health needs for this population exceed those of the general population (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005; Vig, Chinitz, & Shulman, 2005). Foster children served at the TFC level of care are potentially at even greater risk of continued maladaptation as their qualification for this level of care represents a persistent and

severe degree of emotional and/or behavioral disturbance manifest despite placement within an alternate home context. Despite policy promoting timely permanency and supporting guardianship and adoption of special needs children, many foster children continue to remain in foster care and to experience multiple placements (Child Welfare Information Gateway, 2013). Many who remain in foster care "age-out" to an emancipation marked by limited education, under-employment, homelessness, early parenthood, mental health disorders, and substance abuse problems (Racusin, et al., 2005). Efforts toward prevention of these adverse outcomes while foster children remain within the care of the child welfare system is an ethical imperative for social workers seeking to competently serve these vulnerable and dependent foster children as well as to contribute to the knowledge base within the child welfare field.

Evidence -based training and practice in TFC is limited (Dorsey, Farmer, Barth, Greene, Reid, & Landsverk, 2008; James & Meezan, 2002; Turner, 2008), and there exists great variability in conformity to standards of care across TFC programs (Farmer, Burns, Dubs, & Thompson, 2002). Additionally, despite evidence of the importance of positive adult-child relationships for positive youth outcomes, there is very little research of the content or effects of the quality of the foster parent-foster child relationship (Mustillo, Dorsey, & Farmer, 2005; Rauktis, Vides De Andrade; Douchette,, McDonough, & Reinhart, 2005).

Over the past three decades growth in the body of knowledge regarding the adaptive and maladaptive development of children and youth has flourished. Central to this growth has been the evolution of attachment theory research, focused upon early

relational experiences as well as relationship and development across the lifespan (Carlson, Sampson, & Sroufe, 2003; Thompson, 2008). The framework of resilience has emerged parallel to the growing body knowledge regarding attachment, trauma, stress and loss, seeking to understand differences in child development amidst various normative and adverse experiences (Masten, 2006; 2011). There is some evidence of the effectiveness of intervention strategies based upon these theories (Becker-Weidman & Hughes, 2008). and TFC intervention generally to foster adaptive outcomes for these youth (Farmer, et al., 2002). However, much remains to be understood about the content and quality of the foster parent-foster child relationship at the center of this intervention.

A large gap in the research of the TFC experience specifically, and foster care generally is the meaningful inclusion of the direct perspective of foster youth and foster parents, especially those foster youth and foster parents currently residing together. Important to an exploration of both content and quality of TFC relationships is the inclusion of the perspectives of TFC foster youth and foster parents, as is within the design of this study.

This research seeks to generate knowledge for direct application to social work practice within TFC programs, as well as knowledge which will guide ongoing inquiry to improve outcomes for this vulnerable, high risk population of children, as a bridge between research and practice.

Overview of Dissertation

In Chapter Two, I present relevant theoretical perspectives that guided the development of my research design and perspectives. Also, I present background

information and discuss the current research regarding treatment foster care, foster children and foster parents, therapeutic alliance, and models of intervention. In chapter Three, I describe the research methods and procedures used to conduct this study, including the design, sampling, data collection, data analysis, and efforts made throughout the study to enhance rigor. Chapter Four details the findings of the study's central themes exemplified with detailed accounts from participants followed by my interpretation and locating of the findings within existing knowledge. In Chapter Five, the findings of this study are interpreted and discussed in relation to the more specific research questions designed to better understand the findings about these relationships through consideration of aspects of closeness, child relationship capacity strengths and challenges, barriers, and child relational networks. This discussion is followed by implications for application of these findings to social work practice, policy, and research.

Chapter Two

Theoretical Background and Literature Review

This qualitative study explored the specific and contextual ways in which Treatment Foster Care (TFC) foster parents and foster children develop, make use of, and make sense of their relational interaction day to day. Research and theory on attachment and resilience help illuminate many of the issues that children and families experience when they are part of the TFC system. The role of positive foster parent-foster child relationship in child outcomes may also be informed by the concept of therapeutic alliance.

I first review the theoretical background used to inform and guide this inquiry into the role of relationship within the TFC intervention. Given the central focus upon the role of relationship in TFC, attachment theory is reviewed as it relates to TFC, including description of the theory, exploration of stability and change within attachment relationships, outcomes related to attachment classifications, and limitations of the researched usefulness of this theory as a framework to understand relationship in TFC. The framework of resilience is also described as it contributes to an understanding of TFC intervention. I then review the extant literature exploring what is known about the effectiveness and successful outcomes of foster care for youth generally and the effectiveness of specific foster care intervention models, including Multi-dimensional Treatment Foster Care and attachment based, relational, and resilience based interventions. The research of therapeutic relationship and therapeutic alliance is reviewed as another lens for understanding and examining therapeutic change within with

TFC. As this study seeks to explore TFC from the viewpoint of the insiders' experience, the research of the insiders' perspectives, those of foster youth and foster parents, is reviewed as it reflects their perception and understanding of relationship within foster care. The limitations of this knowledge are explored throughout this review, as well as a reflection upon the gaps in the existing knowledge base.

Theoretical Perspectives

This section details two perspectives that have shaped my understanding of relationships, adaptation, and coping and as such helped shape this study primarily by influencing the development of the interview questions, data analysis, and interpretation of findings. The complex structure of needs, strengths and opportunity within foster parent – foster child relationships is commonly framed by attachment theory and the concept of resilience.

Attachment Theory and Research. Attachment theory in this context is useful in that it seeks to describe the nature of early relationships and their impact upon subsequent relationships, as well to understand the development of emotional regulation and behavioral adaptation over time. The function of attachment has been explored as both protective and facilitative of development, demonstrating both stability and sensitivity to change. This theory has also been explored in terms of how it relates to adaptive and maladaptive outcomes for children across time. Attachment theory has also been utilized to guide intervention to support children's adjustment in foster care.

***Attachment Relationships and Protection*.** Bowlby (1980) differentiated attachments and attachment systems. Attachments are the close persisting affectional

relationships with specific, intimate others, to whom one seeks proximity, for whom one feels distress and grief at separation, and turns to for comfort and security (Cassidy, 2008). Attachment systems are the adaptive behaviors learned in interaction between the infant and caregiver which allow the infant to assure proximity to the caregiver (Bowlby, 1980).

Attachment relationships are formed through a reciprocal process between infant and caregiver over time. Attachment behavior of the infant, such as crying, is activated by distress or discomfort and operates to gain proximity to the caregiver for them to relieve this distress. Once relieved, this attachment behavior remits. Caregiver sensitivity in caregiving is very important to infant development; security of attachment is dependent upon the caregiver's ability to detect and accurately interpret the infant's cues, to provide a response that is sensitive and attuned to the child's needs, to express affection, and demonstrate acceptance of the child's behavior and feelings (Ainsworth, Blehar, Walters, & Wall, 1978; Sroufe, 2005). The reciprocal exchange of positive emotion is also thought to be essential to the development of this relationship and emotional development of the self (Sroufe, 1995). Attachment further facilitates child development as the caregiver operates as a secure base for children, providing safety from harm and a sense of security as children explore their social and physical environment, providing a balance of soothing and stimulation (Kearney, Wechsler, Kaur, & Lemos-Miller, 2010).

In addition to the role of attachment to obtain protection for children, it is within this system that children develop their ability to regulate their emotions and arousal

(Calkins & Leerkes, 2011; Schore, 2000). Theorizing about the role of attachment and self-regulation has explored the predictive aspects of attachment and emotional responses in the dyadic relationship itself, the use of regulatory strategies outside the dyad, effect of developing physiological processes that support emotional regulation, and behavior moving from the home to the outer world (Calkins & Leerkes, 2011). Experience of trauma, maltreatment, or chronic stress may either disrupt the development of these systems or overwhelm them (Gunnar & Cheatham, 2003; Tarullo & Gunnar, 2006; van der Kolk, 2003).

Internal Working Models / Representations. Through this reciprocal process between infant and caregiver over time infants develop their internal working model, a representation or expectation of themselves, the caregiver and the interaction between them, developing the expectation that emotional and other needs will be met by the caregiver or through skills learned in interaction with the caregiver (Calkins & Leerkes, 2011).. This internal working model is shaped by the availability, interest, and capacity of the caregiver to provide protection (Bretherton, & Munholland , 2008; Howe, Brandon, Hinings, & Schofield, 1999), and lays the foundation for subsequent attachment relationship (Bowlby, 1988), providing a guide for behavior in future relationships (Berlin & Cassidy, 1999). Research has demonstrated a reciprocal relationship between attachment representations and experiences in close relationships across development, such as good secure infant attachment and subsequent positive adolescent peer relationships mediated through the positive quality of peer competence in elementary school (Van Ryzin, Carlson, & Sroufe, 2011).

The attachment internal working model is just one representation within a framework of representations, and these are updated as the child develops (Bretherton & Munholland, 2008). Bowlby recognized the capacity for these representations to change in response to different experiences in the child's development, yet to always remain at the individual's core (Bowlby, 1988). He described these representations as stable lacking significant environmental change, such as loss or unavailability of the caregiver. Attachment behavior, however, changes in reflection of the child's growing capacities and the changing demands within their environment. For example, as a child approaches school age, attachment behavior serves to maintain caregiver availability rather than proximity with less frequent and less intense attachment behaviors (Allen, 2011). Attachment to the caregiver may persist throughout the lifespan, yet other attachment relationships, such as to a new caregiver or a sexual partner, may take precedence (Cassidy, 2008).

Attachment Classification. Ainsworth furthered the study of attachment theory through empirical observation and classification (Main, Kaplan, & Cassidy, 1985). Ainsworth observed through the strange situation experiment that infants' individual non-verbal behavior toward a particular parent demonstrated finite differences in patterns of attachment organization (Main, et al, 1985). Ainsworth initially classified three types of attachment patterns: Secure (B), and two Insecure types, Anxious-Avoidant (A), and Anxious- Resistant or Ambivalent (C) (Ainsworth, et al., 1978). These classifications are not rigid or fixed points, but rather reflect a continuum of attachment between secure and insecure (Bretherton & Munholland, 2008). Each pattern is adaptive in the immediate

context in that it represents both the infant's capacity to ensure proximity to their caregiver upon whom they are dependent and an organized strategy to cope with stress. These patterns have been viewed by some as also adaptive in the long term as they are modified in response to new information and encourage behavior which provokes supportive responses from significant others (Crittenden, 1992). Bretherton and Munholland (2008) however noted that this perspective of the adaptive or self-protective patterns viewed in regard to the individual may be adaptive in the relationship in the present attachment context, but these patterns may likely prove maladaptive for constructive communication within ongoing attachment relationships that are satisfying to both relationship partners.

It is later that Main and colleagues identified a fourth pattern (D), or Disorganized or Disoriented attachment (Main, et al., 1985). Unlike the other three classifications, this pattern reflects the lack of a consistent organizational system of behavior in which protective proximity and care may be assured by the infant from the caregiver. These behavioral patterns often leave children with little opportunity for exploration or social learning (Howe, et al., 1999).

With adults the adult attachment inventory (AAI) is used to classify mental representations of attachment. These classifications are determined through an interview discussing childhood relationships with attachment figures and current relationships, as well as a person's history of attachment trauma including abuse, loss, or disruption. The four classifications are autonomous, dismissing, preoccupied, or unresolved / disoriented (Main, Goldwyn, & Hesse, 2002, in Madigan, Bakermans-Kranenburg, Van Ijzendoorn,

Moran, Pederson, & Benoit, 2006). These classifications correspond with those identified for children in the strange situation scenario, and have been used to examine the correspondence between caregiver representations of attachment and attachment patterns of their children. Particular attention has been given to exploring the unresolved / disoriented classification, parental behavior toward their infant, and infant attachment classification. An association between the unresolved classification and infant disorganized attachment, mediated by parental behavior is reported in multiple studies, but other contextual and parental factors have not been well explored to fully understand this process (Madigan, et al., 2006).

Adaptive / Maladaptive Outcomes Related to Attachment Classification

Attachment theorists and the collected evidence of research suggest that different attachment patterns will be reflected in specific areas of adjustment, including dependency, self-reliance, efficacy, anxiety, anger, empathy and social competence (Winfield, Sroufe, Egeland, & Carlson, 2008). There is evidence from the Minnesota longitudinal study that secure infant attachment is more strongly related to self-reliance and efficacy, whereas insecure attachment is related to greater dependency across preschool, adolescence, and adult periods (Sroufe, Coffino, & Carlson, 2010). This study did not differentiate types of insecure attachment. Insecure attachment in infancy also was related to increased anger, aggression, and negative affect in preschool, and ambivalent attachment history was related to greater victimizing of peers. Secure infant attachment has been related to greater social competence in various domains across preschool, adolescence, and adult periods (Winfield, et al., 2008). Those with a history

of secure attachment demonstrate fewer emotional problems, whereas resistant patterns are related to greater anxiety, avoidant patterns are related to greater conduct and aggression problems, and both forms of insecure attachment are related to increased depression (Sroufe, 2000). Research also supports the association between early attachment security and other relationships, including siblings, peers, friends, and intimate partners, although the influence is greater for relationships with affectional relationships than other relationships (Berlin, Cassidy, & Appleyard, 2008). Disorganized attachment patterns were also strongly related to psychopathology, conduct, and dissociative outcomes (Winfield, et al., 2008).

Many other factors have been examined as mediating factors between secure attachment and social, emotional, and behavioral outcomes. These factors include developing a sense of self-confidence, generalized positive social expectations, the socialization of moral emotions and values, modeling of pro-social behavior by a sensitive caregiver, continuity in the quality and supportiveness of ongoing parental care, the capacity for effective emotion regulation, and the social modulation of biological systems mediating stress and arousal regulation (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010).

These studies above are not without limitation. One large limitation is that both Minnesota studies began before the fourth attachment classification of insecure – disorganized was differentiated, and both studies note potential error in the assessment of attachment due to the relative subjectivity of the assessments. Studies utilized small, non-representative samples: Waters, et al. (2000) utilized a middle class sample. Sroufe,

et al. (2010) utilized an identified at-risk sample, which although non-representative is important in that differences were found within those assessed to be at-risk. Additionally despite these two studies evidencing correlation between attachment patterns and problematic outcomes, other studies fail to evidence significant correlation. Many researchers point out the difficulty of defining the connection due to the non-linear, complex nature of development and the many potentially confounding factors (Barth, Crea, John, Thoburn, & Quinton, 2005). Further research to explore the dynamic development of the internal working model, the impact of other relationships and context in this development, and the role of other early relational learning such as management of conflict and cooperation as they impact relational and other outcomes is recommended (Berlin, et al., 2008; Thompson, 2000).

Stability and change of attachment classification. Attachment theory inquiry has continued to evolve toward attempts to better understand attachment patterns across the lifespan and how it relates to social-emotional functioning. Main and Solomon observed using their Adult Attachment Interview (a tool which prompts people to recall and describe childhood attachment relationships) that a mother's attachment style was reflective of the attachment system developed with her own infant (Slade, 2008). This contributed to examination of the predictive capacity of this theory, reinforcing belief in the stability of the attachment construct, and increased attention to the examination of the quality of the caregiving relationship. Below I review the longitudinal research examining the stability or change of attachment patterns. This is not a comprehensive review of all the various studies that have explored this phenomenon, but are provided to

demonstrate the nature of this body of research and how it may inform relationship study in foster care. Longitudinal studies of both middle class and at risk parent-child samples, studies of children who have experienced changed caregivers, and studies of maltreated children and attachment patters will be discussed. These studies evidenced that attachment patterns remained stable and continuous in the majority of subjects. They also attempted to examine and identify the conditions or time periods within which discontinuities occur. These findings provide some support for the important role alternative relationships or relationship contexts (ie: reduced caregiver stress) for secure attachment outcomes for foster youth. Yet as can be seen below, these studies fail to capture a sense of the graded spectrum of attachment patterns relying upon broad categories, and few include samples that represent the foster care population. Additionally, it is difficult to make sense of all the research together because there has been so much variation in the ways attachment patterns over time have been explored, and there has been little replication of these studies.

Researchers have examined through longitudinal research the stability of attachment patterns and its role in social-emotional functioning, supporting Bowlby's hypothesis that individual's attachment security may remain stable over the life course, yet be open to change, for good or ill, in response to significant experience (Sroufe, Coffino, & Carlson, 2010; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000; Waters, Weinfield, & Hamilton, 2000). These experiences may include changes in the caregiver-child relationship such as maternal life stress, home environment, or family functioning, developmental factors such as the increased vulnerability to relationship

stress in adolescence due to renegotiation of the caregiver-child roles and boundaries, external factors including stress, health issues, or financial concerns, or major relationship disruptions such as divorce (Van Ryzin, et al., 2011). Bretherton and Munholland (2008) have theorized that adults achieve a generalized working model of self in close relationships rooted in past working models, in which parent – child relationships play the most influential role, but for which the quality of other close relationships including teachers and peers are important.

Waters, et al. (2000) report on one longitudinal study begun in the 1970's regarding the stability and change of attachment status and the experience of stress. This study was comprised of a sample of 60 one-year- old middle class infants who completed the strange situation procedure with a follow up at 18 months. 64% of the sample had continuous attachment patterns, measured between infant and adulthood, whereas 36% changed classification. Hierarchical multiple regression revealed that stressful life events were most associated with secure infant classification changing to insecure in adulthood. This was not true for insecure infants, for whom 22% who experienced life stressors changed to secure status in adulthood. The psychological pathways of this discontinuity are not yet well understood within this or other studies, suggesting the need to move beyond correlational research of this phenomenon (Bretherton & Munholland, 2008).

The Minnesota Study of Risk and Adaptation which also began in the 1970's, utilizing a high-risk sample comprised of parents and their infants born into poverty. From this sample and data multiple longitudinal studies have identified complex developmental pathways for attachment continuity / discontinuity, taking into account

multiple time periods and contextual factors. Sroufe, Egeland, Carlson, & Collins (2005) completed direct assessment of these children and their care at multiple time points (one year old, preschool, middle childhood, adolescence, early adulthood), in multiple settings (home, school, lab), using interviews with parents, teachers, and the children, and other measures allowed for examination of factors including parenting, peer relationships, and cognitive functioning in interaction with other factors such as family stress, disruptions, social support, and personality. Both continuity of attachment security and discontinuity were evidenced in this sample by examining patterns of attachment organization within the children as they faced different developmental tasks. Continuity in this study was linked to continuity in the caregiving environment, and not only infant attachment security but early peer relationship quality was related to attachment patterns; greater peer competence related to maintaining secure attachment (Sroufe, Coffino, & Carlson, 2010).

Van Ryzin, and colleagues (2011) similarly examined diverse attachment pathways across time and associated with factors in the social context. Five groups were identified reflective of an attachment continuity / discontinuity developmental pathways across infancy, childhood, adolescence, and adulthood; two continuous and three with varied discontinuity were identified. Continuous groups included the stably secure and stably insecure, assessed across infancy, childhood, adolescence, and adulthood. Discontinuous groups included infant / adolescent secure, infant only secure, and infant adult secure. Notable in these pathways was the powerful function of a stable caregiving environment in addition to early caregiving. Additionally noted was

suggestions that where there was a lack of relationship related stress or its removal, this could increase security but only when there was more stable and early history of security. Also of note, was the impact of stress at all stages, however, only for those with secure infancy periods; stress had no impact upon those insecure at infancy. This study reflected Bowlby's description that development "…turns at each and every stage, on the journey on an interaction between the organism as it has developed up to that moment and the environment in which it then finds itself" (Bowlby, 1973 , in Sroufe, 2005). The researchers highlighted many limitations within their analysis and the need to continue research to clarify these classifications more discretely and examine other potential effects.

Caregiver change and attachment patterns: There is little research of attachment continuity and discontinuity that may directly inform this study of TFC. The research relevant to children with caregiver changes completed has primarily been with young children, infants and preschoolers. These studies provide evidence of the plasticity of the formation of attachment representations and other developmental adaptation for some young children. In studies of children removed from institutional environments and placed within either adoptive or foster homes, findings revealed not only significant developmental catch-up in multiple domains for these children, but also significant increase in the rate of attachment security compared to children remaining in institutional settings (Nowacki & Schoelmerich, 2010; Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010; van IJzendooen & Juffer, 2006). Dozier and colleagues in a study of 50 foster mother / infant dyads with infants placed between birth and 20 months of age, found that

66% (52% secure, 6% avoidant, 8% resistant) of infants aged through a year and a half were able to organize attachment behavior around a new caregiver (Dozier, Stovall, Albus, & Bates, 2001). Similarly, Ponciano (2010) observed in 76 foster child – foster mother dyads, with children aged 9 – 36 months (over half less than 24 months) 78% formed an organized attachment with over half of the dyads constructing a secure attachment. It was found that only environmental factors (maternal sensitivity and less experience providing foster care) predicted this security, and that factors including the foster mother's decision to adopt, working full time, and utilizing childcare, were associated with sensitive caregiving.

One study of older children more similar to the TFC sample, was conducted to examine the representations of attachment relationships of children who have experienced a major attachment relationship disruption due to maternal incarceration. The findings of this study reflected the findings of social context factors role in attachment continuity observed in previous studies. Peohlman (2005) in a study of 54 young children, ages 2.5 – 7.5 years, found that for two thirds of the children their attachment representations of their incarcerated mother and current caregiver were characterized in projective testing by markers of insecurity: ambivalence, disorganization, detachment. Of the remaining children demonstrating secure representations, the stability of the caregiving situation was the strongest predictor of their representations, and this was specific to the representation of the current caregiver relationship, not the representation of mother. This difference in predictors of representations for mother and caregiver suggests that children may have both specific

and global representational models or multiple internal working models. An additional small factor influencing positive representation of the caregiver was having age appropriate, simple, and honest communication about the mother's incarceration, highlighting the importance of sensitive and open communication in the caregiving relationship.

Maltreatment and attachment patterns. The small body of research of relational formation for elementary and middle aged children in foster care reflects both continuity and discontinuity of attachment, recognizing as well that there is no best level of attachment and attachment changes over time . Some of the longitudinal research of maltreatment and attachment patterns has examined the adaptive and maladaptive outcomes and representations related to the attachment classification over time and opportunities for change. McCrone, Egeland, Kalkoske, and Carlson (1994) researching the relationship between early maltreatment and representations of relationship in middle childhood within their Minnesota longitudinal mother – child study found experiences of maltreatment to relate to less positive relationship representations, as well as difficult peer relations, extreme general strategies for resolving conflicts, negativity, and poor emotional regulation. They suggest that middle childhood may be viewed as a sensitive period for solidifying representations, thus providing relationships that are not compatible with models based on maltreatment experiences may be an effective preventive effort.

Further, a study of maltreated foster children entering foster care found that children's relational behavior was associated with children's perception of the emotional quality of their foster relationship but not to their representation of their birth mother, and

that more positive relations are related to more engaged behavior (Milan & Pinderhughes, 2000). This suggests, similar to the study of children with incarcerated mothers (Peohlman, 2005), that children's sense of relatedness to a particular person somewhat reflects their actual interpersonal behavior with that partner. A study of later placed foster youth (Rushton, Mayes, Dance, & Quinton, 2003), found that most children did attach (73%). No differences were found for age, gender, or number of previous placements, however, foster parents needed to be able to tolerate behavior and aid emotional expression. Reduced attachment was related to a youth's history of active rejection by birth parent and foster parents who struggled to respond in warm and sensitive ways, as early as one month in.

Kobak and Madsen (2008) in the review of the related studies noted that it remains unclear if attachment behavior directed by foster children to foster parents reflects an attachment relationship. They reflect upon the importance of maltreated children maintaining an attachment bond citing a finding that maltreated children placed in foster care demonstrated more behavior problems than maltreated children who remained with their maltreating caregivers (Lawrence, Carlson, & Egeland, 2006, in Kobak & Madsen, 2008). It is evident that the behavior pattern of foster children and foster parents, the time frame for relationship development, and risk and protective factors facilitative of developing attachment or positive relationships are a complex system.

Limitations of Attachment Theory Research. Although it exceeds the scope of this paper to review attachment theory and research comprehensively, it is important to

note some significant limitations in regard to what we know about attachment and how it may be applied to foster care, both methodological and conceptual. To generalize findings for the purpose of better understanding this population or planning intervention is premature. They provide but a glimpse into the complexity of attachment, adaptation, and development. These limitations include that empirical evidence within attachment studies is inconsistent (Bretherton & Munholland, 2008). Studies of adaptive and maladaptive outcomes in personal and social development reflect attachment security as both a factor of risk and protective, however, within the attachment model these are not seen as deterministic but probabilistic (Belski & Pluess, 2011; Frederick & Goddard, 2008). Attachment working models cannot be understood as a trait because they are dynamic and dependent upon the reciprocating attachment partner (Bretherton & Munholland 2008).

The greatest limitation of attachment theory is its common over-simplification in foster care practice, and the gap between research and practice knowledge. This was evidenced by the development of holding therapies to correct negative working models of children believed to have a disorganized attachment pattern (Chaffin, et al, 2006; Sudbery, Shardlow, & Huntington, 2010), potential inappropriate diagnosis of Reactive Attachment Disorder in response problematic social behavior directed toward non-attachment relationships such as peers or teachers rather than attachment behavior directed toward relationships with attachment figures upon whom the children uniquely depend, or over-diagnosis due to children's adverse histories (Allen, 2011; Hanson & Spratt, 2000). Other concerns with attachment problem identification are raised in regard

to the more general use of the label of "disturbed attachment". This classification lacks both specification and standardization, and thus may lead to inappropriate intervention, as well as to curtail opportunity for valid testing of either the problem itself or effective intervention to address attachment related or unrelated problems (Barth, et al, 2005): the behavior may be better explained by behavioral or social learning models, poor inhibitory control, inattention, or an unusually independent child. This is problematic for relationship formation as foster parents begin to frame all problems of foster children as part of early experience rather than a modifiable process of adaptation (Allen, 2011; Nilsen, 2003). Identification of early attachment difficulties may also arouse an assumption of inevitable psychopathology. Correlations are found for maltreated children between early attachment and psychopathology; however, insecure attachment is a risk factor within a complex developmental process vulnerabilities (Cicchetti, Toth, & Lynch, 1995). More broadly, Barth and colleagues (2005) have questioned the appeal for many caregivers of identifying attachment problems, and associating problematic behavior with early experience may also lead foster parents to miss opportunities for relationship formation with their foster child (Lieberman, 2003). Others have reflected that too narrow a focus upon attachment support in foster care may be insufficient without additional attention to normalizing and inclusion experiences and other domain specific supports, such as academic and social functioning (Luke & Coyne, 2008).

Resilience

The concept of resilience is helpful for both understanding and intervening in the lives of children in foster care. Resilience has been simply understood as an individual

demonstrating positive adaptation despite significant stress or adversity, striving despite the odds amounted against such success (Luthar, Ciccetti, & Baker, 2000; Garmezy, Masten, & Tellegen, 1987). This concept has progressed from an initial description of defining characteristics of the concept, to an exploration of the process of protective factors, progressing to a testing of causal factors to guide resilience promoting intervention, to the current effort to integrate a systems framework of resilience science with other disciplines (Masten, 2011; Masten & Obradovic, 2006). The current working definition of resilience is "the capacity of a dynamic system to withstand or recover from significant challenges that threaten its stability, viability, or development (Masten, 2011, p. 494).

Resilience is not observed as a fixed attribute, but a concept concerned with individual variations in response to risk factors. Additionally, risk is not observed to have direct effect (i.e. one particular risk factor does not lead to any one particular outcome). Rutter (1990) suggests consideration of protective mechanisms predicting protective factors, turning a vulnerable trajectory into an adaptive one via reduction of risk impact, reduction of negative chain reactions, establishing and maintaining self-esteem and self-efficacy (especially at significant turning points), or an opening up of opportunities. A pathways model of resilience posits that resilient capacity may be repressed by the conditions an individual is in, and that resilience may only emerge once conditions are present to support it, such as moving from a violent home to a safe home (Masten, 2011).

How well fundamental adaptive systems are working is important for resilience, and this extends beyond the individual to the family, community and ecological systems. Individual systems include learning and problem solving, mastery motivation, self-control or regulatory, immune, and stress systems. Adaptive systems within the family and other relationships include attachment relationships and social control or regulatory capacity, such as effective parents, other connected adults, or pro-social friends. Community systems include effective schools, good health care systems, communities that work, and laws and policies which protect children. These systems are interacting and interdependent (Masten, 2011).

The neurobiology of resilience may be the new frontier in this evolving understanding of children's adaptive systems (Cicchetti, 2011; Masten, 2006). Growth in the knowledge of neuro-biological systems, their development and malleability, has in recent years lent another helpful view into the role of experience in child development and disruption in development. This provides a different view of risk and repair for this commonly traumatized and stressed population of children. However, although there is some evidence of the plasticity in brain development in younger children (Dozier, et.al, 2001; Nowacki & Schoelmerich, 2010; Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010; van IJzendooen & Juffer, 2006), there remains uncertainty as to the plasticity of older youth.

Literature Review

Outcomes and Effectiveness of Foster Care. The growing body of knowledge of the condition of children served within child welfare, and the TFC level of care,

outpaces the body of knowledge of how these children can and need to be effectively cared for. We know much about the antecedents, behavioral and emotional presentation, and relationship difficulties of these children, however only a few interventions or outcomes specific to foster children or foster families have been rigorously studied (Craven, & Lee, 2006). No standard of care exists for foster care of emotionally / behaviorally disturbed foster children, and theoretical models and treatment methods of TFC vary widely, leading to difficulty assessing intervention effectiveness (Farmer, Burns, Dubs, & Thompson, 2002; Redding, Fried, & Britner, 2000). Neither state nor national level data exist specific to this population within child welfare given the lack of uniformity in both name and definition of this care intervention. However, many children with special needs are served within the child welfare system; in MN, 39% of the nearly 15,000 children who annually experience out-of-home care have a disability; 43% of disabilities in child welfare are of emotional disturbance, 64% of which are rated severe (MN DHS CFS, 2009).

Within the available literature evidence is growing that factors including supports for foster parents, increased time that a youth spends with foster parents, decreased time youth spend with deviant peers, and involvement of foster parents in the youth's treatment are related to positive youth outcomes (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). A significant limitation of these outcome studies relevant to this project is that the primary populations of those foster children studied have been delinquent youth, not youth primarily in care due to mental health needs, maltreatment, or neglect. Other studies have identified characteristics of youth in treatment foster care who are

more successful, evidenced primarily by greater placement stability, include fewer emotional or behavioral problems, fewer previous placements and less time in institutional placements, fewer prior negative placement outcomes, good relationships with foster parents and other children in the family, and some sense of control over their contact with biological family (Redding, et al., 2000).

Turner and Macdonald (2011) in their systematic review of psychosocial and behavioral outcomes for youth in treatment foster care found only 5 studies that met their study criteria. These study findings indicate treatment foster care to be promising as an effective treatment for youth, however, the number of studies are few, lack racial and geographic diversity in the samples, and have no evaluation of interpersonal outcomes for youth. Positive outcomes included reduced problem behavior, reduced incidence of runaway, less delinquency, fewer days of incarceration, increased school attendance, increased homework completion, and increased permanency outcomes. Other outcomes from a combined retrospective / prospective study of 119 maltreated youth aged 4-18 in treatment foster care found that youth demonstrated improvement in internalizing but not externalizing behavior (Hussey & Guo, 2005).

Foster care Interventions. Research into specific intervention for children in treatment foster care reflects application of social learning theory, attachment theory, and a framework of resilience, yet also reflects real limitation in what is known to be effective in treating this population within a family-based setting (James & Meezan, 2002). Treatment foster care, itself defined as an intervention, is reflected in the research as promising, yet lacking clear or consistent definition or standard of care. Intervention that

is primarily behavioral has been well studied within one treatment model, Multi-dimensional Treatment Foster Care. Interventions specifically based on attachment theory, especially with attention to sensitive care show promise, but lack broad application or clear operationalization in TFC outside of these small studies or for varying age groups. Child trauma care continues to be studied mostly in regard to professional, mental health care, and family-based trauma-informed foster care intervention does not appear to yet be operationalized. Neurobiological indicators are being utilized increasingly as an outcome measure, yet specific intervention remains largely theoretical and conceptual. The literature utilizing frameworks of ambiguous loss and resilience in relation to foster youth reflect attempts to identify, operationalize, measure and apply these concepts, yet do not reflect a clear standard of care for this population.

Multidimensional Treatment Foster Care. Multidimensional Treatment Foster Care (MTFC), a largely behavioral model of treatment foster care, is an indicated prevention program initially developed with the short term goal of preventing placement of severely delinquent adolescent youth into residential, institutional, or group care settings (SAMHSA's National Registry of Evidence-based Programs and Practices, 2009). In 1983, researchers and program developers at the Oregon Social Learning Center (OSLC) created a program for high risk youth which departed from the commonly practiced positive youth development model. The model was developed based instead on the premise that parents with skills and support can have a tremendous positive impact upon youth (Chamberlain, Fisher, & Moore, 2002). This model posits that youth are not

broken and in need of fixing, rather, the practice of this model seeks to stabilize youth within the context of effective and supported parenting, and to give families the opportunity to become effective and supported parents for their child (Fisher & Chamberlain, 2000). The two aims or objectives of MTFC are to enable youth to live successfully within families in the community and at the same time to adequately prepare biological / permanent family to provide effective parenting to maintain the youth's gains after leaving foster care (Fisher & Chamberlain, 2000). The four key elements associated with positive outcomes for youth in MTFC include: 1) providing a consistent and reinforcing environment in which a youth is encouraged to develop academic and positive living skills; 2) providing clear structure day to day with clear expectations and limits tied to well specified consequences given in a teaching manner; 3) maintaining close supervision of the adolescent's whereabouts; and 4) helping the youth to avoid negative or deviant peer associations while providing them help and support to form pro-social peer relationships (TFC Consultants, n.d.; Chamberlain,, 2003). MTFC intervenes with a structured support system for youth and foster parents, and foster parents are trained and supervised to provide a manualized behavioral parenting intervention.

MTFC begun for a specific problem and population has been adapted and / or applied to a variety of problems and populations fairly quickly. The initial target population, as stated, was serious and violent juvenile male delinquents, ages 12-17. Soon after, female adolescent delinquents were treated as well. The program was adapted in 1986, for use with children ages 9 – 18, with serious emotional and behavioral problems residing in state psychiatric hospitals, with the goal of reducing hospital stays

(Chamberlain, 2003). The next iteration was to begin to treat children ages 4 – 18 referred from the child welfare and mental health systems who were receiving Medicaid. In 1996, youth with developmental disabilities and a history of sexual acting out behavior received MTFC. Also in 1996, the model was adapted for young children, ages 3-7, to a program called Early Intervention Foster Care (EIFC) (Chamberlain, Fisher, & Moore, 2002). Other iterations since include a preschool model for foster children ages 3-6, at risk of placement in residential treatment, an application for middle school girls, another application for children 7-12 , and a MTFC "lite" (Chamberlain, 2003) version designed to serve children in a large, urban traditional foster system (Leathers, Spielfogel, McMeel, & Atkins, 2011). Most of these newer iterations when implemented have done so in conjunction with a research plan to test either efficacy or effectiveness (TFC Consultants, n.d.). Multiple RCT's have been conducted of the use of MTFC and positive, lasting outcomes have been observed. Most studies have measure outcomes at 6, 12 and 24 months. For different iteration of the model different sets of outcomes have been measured (i.e.: arrests, days in lock-up, homework completion, etc.) (Chamberlain, 2000, 2002, 2003; Chamberlain, Fisher, & Moore, 2002; Leathers, et al., 2011).

The broad adaptation and application of the model has allowed them to test the effectiveness with different populations and to possibly to explore the model's mechanisms of change through different studies. As an example of this potential opportunity to better understand the model, the creators have begun to examine the model in terms of not only risk, as in the previous studies, but both risk and resilience, and they have begun to explore the role of neuroscience in change and to explore if MTFC

changes neuro-biological response in children (Leve, et al., 2009). In this resiliency model, they hypothesize mediated processes. These processes include factors such as secure attachment and positive reinforcement from foster parents, normative peer group, mentoring adults, parent social support, and stable home context (2009).

MTFC provides an example of a TFC program utilizing a specific home-based intervention model which clearly defines the role and behavior of foster parents. Test of effectiveness have demonstrated model effectiveness thus far and their research progressed toward a more and more nuanced understanding of the components and mechanism of change, of which the defined role of foster parents has been operationalized so that the link between their fidelity to the intervention role and child outcomes may be assessed. This however still does not account for more qualitative understanding of the foster parent-foster child relationship.

Attachment-based Intervention. Attachment based interventions within foster care are growing. Interventions based upon this theory presume that either pathogenic early caregiving or disrupted attachments are at the root of problematic emotional, behavioral and social functioning. As such, interventions focus upon restoration of a child's ability to trust nurturing adults, improving emotional regulation, and helping the child cope with loss (Racusin, et al., 2005).

Much of the literature suggests the need for attachment-based intervention and makes intervention recommendations. In a qualitative study of 40 adults formerly in long term foster care, interviews were utilized to explore their care experience, and data were analyzed within attachment and resilience frameworks. As a result a dynamic

psychosocial model for long term foster care was proposed, emphasizing the importance of secure base for these children (Schofield, 2002). Swick (2007) presented another model, the Caring Relations Model for foster care, comprised of components including the presence of caring adults, active development of parent – child nurturing and caring relations, caring rituals, to model caring, show caring, and teach caring. Dozier and colleagues (2002) also concluded with a recommendation for new intervention following their review of effective interventions for this population, finding some effective existing strategies, yet noting a particular lack of tested strategies for school age and adolescent foster children. Based upon the knowledge of the impact of attachment disruption, including regulatory and relational problems, they made the following recommendations for foster care intervention: foster parents must provide nurturance even when the child acts in rejecting ways, the foster parent must lead the child to feel efficacious and loved, relationship is believed to have the greatest chance of impacting the child's distorted representations of self and other, and although behavior must be addressed, even in behavioral intervention, the relationship is the key to change (Dozier, et al., 2002). These models remain untested in terms of effectiveness with the foster care population.

Some tested attachment-based intervention show promise, although samples are small, often study young children, and replication remains unreported. Dozier, Peloso, Lewis, Laurenceau, & Levine (2008), studied the effects of the Attachment and Biobehavioral Catch-up (ABC) model with a sample of children aged 15 – 24 months. This model targets the regulation of behavior and physiology and the provision of nurturing care. Using a design including 46 ABC treatment, 47 foster comparison, and

48 control (non-foster care) infants, they found that infants whose foster parents used this relational intervention demonstrated cortisol levels more similar those of the control group, indicating potential improved regulatory capacity among the foster children. A Dyadic Developmental Psychotherapy model, another family treatment based in attachment theory was studied following an initial "promising" pilot, with a sample of 34 experimental and 30 control 5-16 year-old foster children, and was found to be effective to significantly reduce child behavior scores as measured by the Child Behavior Check List (CBCL) and for all scores to fall within the range of normal function. These outcomes continued on average for 3.9 years. The control group remained in the clinical range for many CBCL sub-scale scores and scores worsened over time. The components of this family treatment included affect arousal, explaining how the past may be affecting the present, forming and maintaining therapeutic relationship, acceptance, cognitive and experiential dimensions, and empathy, capacity for reflection, sharing of affect, awareness and intention (Becker-Weidman & Hughes,2008).

Understanding and intervention for emotionally and behaviorally disturbed youth in treatment foster care may be informed by an understanding of attachment as risk and protection, and recognizing the importance of sensitive care.

***Relational Intervention*.** Seigel (2003) proposes a neurobiological explanation for the power of relationships to heal in an examination of the neurobiology of psychotherapy. He posits that the failure of the developing brain to learn effective self-regulation as the result of early trauma creates stress as either one's organization processes are highly chaotic or rigid. He suggests that therapeutic relationships through

two-person regulation enable the brain to self-organize processes toward integration, modifying synaptic connections, and finding meaning in belonging. The development of specific intervention models reflecting the growing knowledge base regarding processes of normal and maladaptive neurobiological and behavioral development has recently begun. One example is the practice model of Developmental Repair engineered by Anne Gearity of the University of Minnesota in conjunction with Washburn Center for Children (Gearity, n.d.). The training manual describes this intervention for children age three to third grade evidencing aggressive and disruptive systems as follows:

> Developmental Repair focuses on changing children's internal functioning, rather than imposing external controls. Repairing the internal capacity for self-regulation is at the core of this different intervention approach. Developmental Repair starts with helping children use new adults in a very intentional way—as regulating partners.

This model's effectiveness has yet to be comprehensively evaluated.

Resilience Based Intervention. The body of knowledge is growing regarding the development and application of resilience informed intervention in child welfare practice. Some research has sought to first define resilience operationally. Flynn, Ghazal, Legualt, Vandermeulen, and Petrick (2004) in a study of Canadian foster children, utilizing a normative control group, determined that resilience could be defined operationally. Of additional significance in their study was the confirmation that resilient outcomes could be identified consistent with the Looking After Children approach, the case management / monitoring system used by the Canadian child welfare system, as well as other

countries. They measured resilient outcomes in regard to health, academic performance, self-esteem, peer relationships, pro-social behavior, and anxiety / emotional distress. An entire edited volume has since been published examining a variety of child welfare models based upon resilience and the LAC model across nations (Flynn, Dudding, & Barber, 2006). Daniel (2006), in a small study of foster children in Scotland, also determined that the concept of working to nurture resilience can be operationalized for neglected children. Social workers participating in this study were trained using a workbook about resilience and specific interventions to promote resilience. Intervention domains included: secure base, education, friendships, talents / interests, positive values, and social competence.

Heller, Larrieu, D'Imperio, and Boris (1999) reviewed studies of resilience in maltreated children and adolescents. They identified a number of individual and contextual factors related to resilience in this population, which was defined as competent functioning measured variously across studies. Factors involved in the development of resilience included highly developed cognitive skills, sense of self-worth, internal locus of control, external attribution of blame, spirituality, ego control / ego resilience, family cohesion including foster care, supportive adult, and positive family changes, early secure attachment to mother, sensitive, consistent caregiving environment, structured school environment, family intervention, church involvement, and involvement in activities / hobbies.

Resilience has been commonly explored as an individual process or dynamic. Resilience applied to the unit of the family seeks to understand the ways in which

families as the unit of analysis function and thrive in the midst of adversity. This framework has been proposed for clinical practice (Walsh, 2003), as is evidenced in its application within the treatment model for ambiguous loss (Boss, 2006), increasing a family's capacity to tolerate ambiguity. The three key processes in family resilience are belief systems, organizational patterns, and communication / problem solving (Walsh, 2003). Belief systems include the ability to make meaning of adversity, a positive outlook, and transcendence. Organizational patterns demonstrate flexibility, connectedness, and social and economic resources. Processes of communication and problem solving have clarity, open emotional expression, and are collaborative. This framework recognizes both the normative developmental challenges of various family members and development of the family as a system, as well as the unexpected challenges and adversities which families must negotiate simultaneously. It remains to be observed how this framework may apply within the work in therapeutic foster care.

Therapeutic Relationship and Therapeutic Alliance. Within TFC caregiver-child relationships are central to the intervention. This intervention design in which treatment foster parents provide therapeutic care and are full participants in the foster child's professional care team leads to a consideration of this relationship as a therapeutic relationship. Therapeutic relationship has been demonstrated as an instrument of adaptive change for struggling children in other intervention contexts.

The role of the therapeutic relationship and therapeutic alliance in the achievement of positive change in treatment has been examined. From the research of outcomes in psychotherapy, Lambert (1992) identified four common factors associated

with variance in outcome, estimating their relative influence. These include: extra-therapeutic factors (40%), the therapeutic relationship (30%), technical factors (15%), and expectancy factors (15%) (Drisko, 2004). The components or mechanism of the therapeutic relationship include trust, warmth, understanding, acceptance, kindness, and human wisdom (Lambert, 2005), accurate and sufficient affective attunement, the ability to recover from failures of attunement, active encouragement to support change, acknowledgement of change, preparation of the client, and agreement on goals (Drisko, 2004). Cameron and Keenan (2010) in their proposed common factors model of social work practice identify relationship factors including engagement in relationship, engagement in change work, productive direct and indirect communication, shared agreement on identified problems, goals, and tasks, and collaboration.

Therapeutic alliance has been described as a mature form of therapeutic relationship, and researched in relationship to treatment outcomes as a construct of therapeutic relationship (Shirk & Saiz, 1992). Therapeutic alliance has been defined to include multiple cognitive, emotional and participatory components, more specifically including the quality and nature of the interaction between client and therapist, agreement on treatment goals, collaboration on therapeutic tasks, and the affective bond or attachment between the client and therapist (Kazdin, Marciano, & Whitley, 2005; Shirk & Saiz, 1992). Multiple measures of therapeutic alliance have been created including self-report and observational measures. Commonly used scales include the Working Alliance Inventory (WAI) developed by Horvath and Greenberg, and adapted in a short form and a form for children, the Therapeutic Alliance Scale (TAS) developed by

Doucette and Bickman, the Vanderbilt Therapeutic Alliance Scale (VTAS), and the Penn Helping Alliance Questionnaire (Shirk & Karver, 2003). Scales vary in the number of items and scaling, yet generally all assess to a greater or lesser extent the emotive, cognitive, and participatory aspects of the helping relationship through client only or multiple reporter forms (i.e. caregiver, therapist).

Therapeutic alliance has been identified as a predictor of treatment outcomes. Research examining the nature of therapeutic alliance as a change factor in adult treatment has indicated that greater alliance and alliance early in treatment are modestly related to greater therapeutic change across interventions (Green, 2006). More recently research of the role of alliance in child and adolescent therapeutic outcomes has begun within a variety of settings and treatments. Shirk and Karver (2003) in a meta-analysis of 23 studies of alliance and outcome in therapy for children and adolescents, found similar modest effects of alliance upon therapeutic outcome as seen in adult studies. There were no moderating effects found for age, type, or mode of treatment; however, a stronger relationship was found for youth exhibiting externalizing rather than internalizing problems, suggesting relationship formation may be both more difficult and of greater importance for externalizing children. A second meta-analysis (Karver, Handelsman, Fields, & Bickman, 2006) examined therapeutic relationship variables and therapeutic outcomes in 49 studies of youth and family therapy, attempting to better understand specific aspects of the therapeutic relationship as they relate to outcomes. The general results were consistent with the previous study findings. In regard to relationship variables they specifically found moderate to large effects for therapist direct influence

skills and the therapeutic relationship; moderate effects for counselor interpersonal skills, parent willingness, youth willingness, client and parent participation, and small to moderate effects for therapeutic alliance for family and youth, and therapeutic relationship with family. Small effects were found for therapist self-disclosure. These findings suggest the importance of certain therapist behaviors, and do not support the importance of affect or emotional bond with therapist. If the therapeutic alliance construct applies to the TFC foster parent – foster child relationship, this leads me to wonder about the components of relationship beyond a sense of emotional closeness or foster parents needed as an emotional resource. It raises questions about how to understand the relationship: as an attachment relationship or an alternative positive relationship.

Other studies highlight potential differences in the role or mechanism of therapeutic alliance for specific populations, problems, and settings. Hogue, Dauber, Stambaugh, Cecero, and Little (2006) in a study comparing therapeutic alliance and outcomes in two treatments for adolescent substance abuse found no significant relationship of alliance within the CBT treatment group, but did find significant relationship to outcome in the family therapy treatment group. Early parent alliance in this group was related to greater therapeutic outcome, however, lower teen alliance which subsequently improved over the course of treatment was associated with better outcome. These finding suggest that for this youth population a meaningful alliance may take longer to develop. Similarly in a study of the residential treatment of delinquent boys found that early high assessment of alliance was associated with negative outcomes,

whereas high alliance measured after 3 months was predictive of lower recidivism and positive psychological changes (Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000). Both studies suggest the importance of monitoring and attending to the therapeutic relationship over time. In addition to the previous residential treatment setting, therapeutic alliance for youth has been studied in psychiatric hospital (O'Malley, 1990), partial hospital / day program, and a wilderness camp settings (Bickman, et al, 2004). An important finding of the latter is that the providers' assessment of alliance did not correlate with the client alliance rating, suggesting the importance of utilizing alliance measurement with clients to more accurately assess and respond to developing alliance given its relationship to improved outcomes. Finally, Eltz, Shirk, and Sarlin (1995) report a surprising and promising finding in regard to alliance, treatment outcome, and maltreated youth. Despite difficulty with initial alliance formation, youth in a psychiatric setting with a history of maltreatment did not evidence any difference in therapeutic alliance formation over the course of their treatment nor in their improved outcome compared to non-maltreated peers. However, maltreated youth who failed to form an alliance, faired far worst in outcomes than non-maltreated youth in the same care setting.

Rauktis, Vides de Andrade, Doucette, McDonough, and Reinhart (2005), conducted a small repeat measures study of therapeutic alliance in treatment foster care. This study measured alliance between 25 treatment foster care youths and their respective foster parents 5-6 times over the course of 14 months, revealing an overall positive relationship. Youth alliance patterns suggest a honeymoon effect, rating high at the start of placement, decreasing once settled in, and then beginning to increase again after 10

months of placement. Treatment parent ratings are both more optimistic and stable over time, suggesting that youth and parent perceive the relationship differently. The presence of biological siblings in the home may positively affect alliance, whereas cultural differences between youth and parents detrimentally affect alliance. Age and gender did not influence alliance, but youth with multiple placements, more severe behavioral and emotional problems, may need more time to form alliance. Youth resistance was not a factor influencing alliance once the child moved into the home. This study, the only one found testing the role of therapeutic alliance in TFC, demonstrated the utility of therapeutic alliance as a possible way to consider relationship intervention, targeting alliance promotion strategies and training for TFC foster parents to better understand and promote relationship formation in this unique population.

Given the importance of relationship formation for therapeutic change, some suggest a research priority of learning how to influence children's ability to form relationships (Shirk & Saiz, 1992) and improve alliances (Green, 2006). Research on therapeutic alliance as a factor of change for children and youth is compelling, yet it is also clear that much remains to be explored in terms of understanding the discreet mechanisms within these reciprocal relationships in context. Karver, Handelsman, Fields, and Bickman (2005) propose a common process factors model for further research of the relationship of specific family, youth, and therapist variables to outcomes. The integration of developmental, biological, and contextual factors with therapeutic relationship variables, exploring mediating and moderating effects is also recommended to improve therapeutic intervention for children and youth, as well as the understanding

of these mechanisms to understand change beyond the context of psychotherapy: to better understand the therapeutic processes of everyday life (Kazdin & Nock, 2003; Brent & Kolko, 1998).

Kazdin and Nock (2003) underscore the importance of understanding the mechanism of therapeutic change in clinical work with children, understanding how and why therapeutic intervention works. An understanding of the mechanisms of change can bring order and simplify the multiple interventions to choose from, equip us to better help our clients, help to identify the variables upon which treatment effectiveness may depend, and to understand to role of therapeutic processes in ordinary life, recognizing the broader process of functioning. In seeking to understand the separate components of therapeutic alliance we may better come to understand how this alliance can influence outcomes either through a relational change mechanism, as a catalyst for other treatment processes, or as a moderator of other therapeutic intervention offered (Karver, et al., 2005).

The Perspective of Foster Youth. The call for the inclusion of the perspective of foster youth has been sounded repeatedly in recommendations for continued study of the foster care system over that past 25 years, and although slow to gain momentum, the body of research informed by youth has grown. Beginning with Festinger's (1983) first comprehensive retrospective study of former foster youth's experiences within and beyond foster care, the relationship between youth and foster caregivers was explored. Findings indicated the most decisive factor of satisfaction with foster care were the

relationships with foster families; those who felt closer to their last or a previous foster family were more satisfied with foster care.

The perception of family held by foster children is explored centrally in a few studies, revealing a variety of perspectives. In two related studies (Gardner, 2004a; Gardner, 2004b), the first sought the views of children currently in care and the second a retrospective view of young adults previously in care. Feelings of closeness and connection proved to be of primary importance as reported by older youth in the identification of family, either biological or foster. Of prominence in the child research is the capacity, whenever suitable opportunities were available, to form relationships. These outcomes suggest support for the concept within attachment research of earned security and the life course model, which highlights the complex interplay of personal and environmental factor in psychosocial development, and the opportunity for change throughout the lifespan. Samuels (2008) found in her retrospective study with former foster youth, that they built a definition of family as "a place where someone could belong, find unconditional love and acceptance, a place where one was known and one could receive support whenever needed" (p. 58), and in which parents were the head and provided guidance and protection. This idea, however, amongst the young adults of the study was not born of experience but "hopes and imaginings" (p. 58). Heptinstall, Bhopal, and Brannen (2001) in a small study utilizing fostered, sole parent, step-parent, and two biological parent families, explored children's perspective on the meaning of care in a family. Fostered children were similar to other children in viewing family life as child centered, rightfully prioritizing the child's interests, needs, and concerns, and

living in the here and now. However, whereas non-fostered children found parents to be important to them for giving love and affection, foster children found importance in foster parents because they "look after them" (p14)., and birth parents because they were biologically connected . Fostered and non-fostered children both demonstrated playing an active role in making sense of their situations based upon past experiences (Heptinstall, et al, 2001).

Other studies have addressed issues of relationship in part or indirectly through exploration of overall satisfaction with foster care (Delfabbro, Barber, & Bentham, 2002; Wilson & Conroy, 1999), foster youth reported experiences of foster care (Chapman, Wall, & Barth, 2004; Fox & Berrick, 2008, Johnson, Yoken, & Voss, 1995;Whiting & Lee, 2003), exploration of the success of meeting the triad of child welfare goals of safety, permanency, and well-being (Fox, Berrick, & Frasch,2008), connection to biological family (Kufeldt, Armstrong, & Dorosh, 1995, Jones & Kruk, 2005), placement outcomes (Fernandez, 2007), ambiguous loss (Lee & Whiting, 2007), and social support networks (Samuels, 2008). A clear picture of children's relatedness to caregivers is not apparent. Some studies reveal confused or ambivalent relationship patterns, in which children feel close to foster caregivers and a sense of family belonging, yet at the same time prefer to live with their biological mother (Chapman, Wall, & Barth, 2004); also a high proportion of children have been found to feel secure and positive about their relationship with their foster caregiver, yet desire greater closeness at the same time (Fox, Berrick, & Frasch, 2008). Additionally, Wald's 1988 study revealed the majority of

children to characterize relations with foster parents as positive, yet to not view them as emotional resources.

A few studies have identified process variables or descriptions associated with greater relatedness or closeness to foster caregivers. Fernandez (2006) in review of the research on foster youth outcomes identified the caregiver role within the foster care home of explicitly teaching or actively modeling relationship skills for the development of cohesive relationships in placement. Children report the importance of doing things together with foster caregivers and having foster parents who are involved in their life (Chapman, et al., 2004; Fox, et al., 2008; Whiting & Lee, 2003). Foster parent active support for inclusion of the biological parents, primarily mother, is also tied to greater connection within foster care (Andersson, 1999; Fox & Berrick, 2008; Jones & Kruk, 2005; Kufelt, Armstrong, & Dorosh, 1995; O'Neill, 2004).

A few studies have included the view of relationship in foster care from both the specific child and parent perspectives. Foster family variables related to functional adaptation, defined as improvements in behaviors and productive relationships in the home, school, and community, of foster youth in care were identified in a qualitative retrospective study of former foster youth and foster parents. These included a foster family's commitment to the child's needs demonstrated by foster parents working with the network of people and systems to assess and meet needs, including the child in the family, providing safety, nurturance, and care, and building trust and attachment. The concept of attachment in this study corresponded with the theme of inclusion. Two other foster parent – child studies address issues of felt permanency for foster youth, both

reiterating the importance of a youth's sense of belonging in a foster family and maintaining relationship with biological family (Andersson, 1999; O'Neill, 2004). Analysis of data collected from children, foster parents, and social workers found that success in foster placement was influenced by three elements: characteristics of the child, qualities of the foster parent, and the interaction between the child and caregiver (Siinclair & Wilson, 2003). The model of successful care includes: child motivation, attractiveness, and difficulty; parent warmth, persistence, and limit setting; and the match, chemistry, and interaction between the two.

One exploratory study conducted within treatment foster care exploring specifically the role of therapeutic relationship in child outcomes has been conducted, finding that the strength of the relationship between foster parent and youth is a key factor in the improvement of the youth (Farmer, 2009). This study utilized youth and their corresponding treatment foster parent from one TFC program (N=177), measuring relationship strength between youth and foster parent, and interviewing foster parents. Findings also revealed that foster youth whose foster parents who viewed their role primarily as parents rather than treatment providers experienced more improvement.

The growing body of knowledge of the experience of youth in the foster care system is made up of a wide variety of research foci, utilizes both youth currently experiencing foster care and retrospective report of others, and there is little replication of these studies. This makes it difficult to draw clear conclusions about this experience. However, there is some evidence that important factors include feeling included in the family and feeling your needs being cared for by the foster parent. The research is less

consistent in regard to how foster youth feel about foster parents. Some studies reports the importance of feeling close, the importance having the foster parents take care of foster child needs, doing things together, the foster family having a good relationship with the biological family, and teaching and modeling relationship skills. Understanding of the process of relationship formation and growth in foster care is limited. The study specifically of TFC youth is scarce, yet one study did support the utility of the relationship for change and found that relationship strength was associated with youth improvement. This finding ties back to the Study of therapeutic alliance in TFC discussed earlier, recognizing the importance of understanding, measuring, and enhancing therapeutic alliance in TFC.

Foster Parent Perspectives. More research has been conducted from the view point of the foster parent, providing different glimpses of the role of relationship in foster care. In studies of the foster parents' view of successful fostering, family connection and good relationships (Brown & Campbell, 2007) and trust between foster children and foster parents (Brown, 2007) are indicated as important. Some research suggests attachment and commitment to the child to be the most important factors (Harden, Meisch, Vick, & Pandohie-Johnson, 2007) and attachment in these relationships to be "unavoidable" (Brody, Stoyles, McMullan, Caputi, & Crittenden, 2009, p.569). Attachment has also been identified as a threat or barrier to successful fostering, as foster parents either fear becoming too attached and then subject to loss (Beuhler, Cox,, & Cuddeback, 2003), or a fear that becoming attached may create confusion or conflict in their role or identity as a foster care provider: parent or professional (Brody, et al., 2009).

Success in fostering is described by some parents as "a process, and not only an outcome" (Brown & Campbell, 2007). Some research has begun to try to understand some of the process factors, as Lipscombe, Farmer, and Moyers (2003) have done in their exploration of the development and change of parenting approaches and strategies utilized by foster parents of adolescents over the course of placement. Affronti (2008) in her dissertation research explored factors associated with functional adaptation in foster care, specifically exploring the role of attachment in adaptation and adjustment to foster care. She discovered within her sample that neither foster parents nor foster children reported distinct attachment features when compared to adjustment and adaptation. Features of attachment, adjustment and adaptation all tied back to foster parent commitment to meeting the child's needs and the building of trust. Little other process research has been completed to better understand the relationship in foster care.

Two studies specific to the experience of treatment foster mothers amplify the findings above within treatment foster care, especially in regard to understanding the foster parent role and managing complex relationships. One study identified multiple modes of experience of fostering, none of which was predominant, and the majority of which departed from the professional role these parents are expected to play (Wells, Farmer, Richards, & Burns, 2004). These modes included strategic (the mode most reflective of the professional role), struggle, satisfaction, rejection, and other. Also of note, all of the mother's experiences excluding the "other" category are relationally cast, underscoring the importance of greater understanding of relational variables and processes in treatment foster care. Wells and D'Angelo (1994) in an earlier study note

the complexity and often discontinuity of treatment amongst the interacting stakeholders in treatment foster care, and the conflict this can create for treatment foster mothers in providing care. Further, they identify the mis-fit of the medical treatment model with the intervention of treatment foster care, as it fails to adequately recognize the role of relationship, the experience of the foster parent, the child's development, and the evolving nature of the context surrounding children in treatment foster care.

The perceptions of foster parents of the fostering experience underscore the centrality of relationship within foster care. Factors of commitment, trust, communication, family connection and good relationships are echoed throughout. Attachment, described as the foster parent's connection to the foster child, is both endorsed as an important factor for success in fostering but also a risk factor for foster parents as they fear loss of a relationship or loss of their perspective in caring for the child. The word attachment within these studies seems to be used somewhat differently than the theorized attachment.

Gaps in knowledge. It appears from a review of the literature that the growing body of knowledge of the condition of children served within child welfare, and more specifically, the children who reach the TFC level of care, outpaces the body of knowledge of how these children can and need to be cared for effectively. We know much about the antecedents, behavioral and emotional presentation, and relationship difficulties of these children. We have theories and ideas about how they may be protected or directed upon a new path. Yet we know so much less about effective implementation of this knowledge, especially in tandem with the important role that

relationships play within therapeutic intervention. The research to date is limited, seldom has been replicated (with the exception of MTFC), and without an understanding of discreet components of relationship or relationship processes.

Although there is a growing body of research addressing the specific needs of children represented in treatment foster care, few interventions are reviewed specific to foster children or specific to the unique experiences of foster families and maltreated youth in their care (Craven, & Lee, 2006). Additionally, pre-service training specific to treatment foster care, (excluding the specific training for Multi-dimensional Treatment Foster Care) is eclectic, does not have demonstrated effectiveness, and provides little specialized instruction beyond that required for traditional foster care (Dorsey, et al., 2008). Growing is the voice of foster youth and foster parents in the literature, yet their insight specific to treatment foster care is lacking, as is that of the treatment foster care providers.

James and Meezan (2002), in their review of what is known about the TFC intervention identify that the further research moves away from the immediate context of the child's life, the less we know about the factors influencing their experience and outcomes. Research that provides rich descriptive data on these children, their family context, and their unique outcomes is needed at the core of a plan of broadening investigation of what is effective in TFC. The current ability to measure relational variables is one limitation the authors suggest requires attention in order to understand effective intervention in TFC.

Summary

Throughout the literature, the prominent role of relationship within the therapeutic change process is clear, yet too it is clear that how relationships are understood, defined, or utilized varies widely. The components of relationships are not well defined, nor is it well defined how to evaluate a relationship as "good" or "close" or otherwise. Theory driven intervention seeks relationship as an end in and of itself, a corrective instrument, a protective factor, or a component of change. These shared relationships in the view of the insiders, foster youth and foster parents, are important, but are also unlike other relationships and do not seem to be utilized with clear intention as an instrument or intervention strategy generally. As noted by Wells, et al. (2004), and reflected elsewhere within much of this review, there is a need to identify and understand relational variables and processes in order describe effective TFC intervention and to enable its replication through foster parent training, supervision, and support of the foster parent – foster child relationship.

Research Question

Within treatment foster care, therapeutic relationships are the central intervention thought to foster these outcomes. As such research that provides rich descriptive data on these children, their foster family context, the perspectives of both foster children and their foster caregivers, and the children's unique outcomes is needed in order to understand how relationships contribute to improved child outcomes. This qualitative interpretive description study design to explore the complexity of treatment foster family and foster child relationships, examining the dyad's interaction within its context, and

observing the particulars of relationship dyads as well as patterns across relationship dyads.

My central research question is: How do treatment foster parents and children in their care experience and describe their shared relationship? This central question is the heart of this study and the one I seek to answer. Additionally, the following questions were formulated to help shape my thinking about the nature of these relationships and to guide the development of the interview protocols and initial data analysis coding themes.

1.To what extent do children and caregivers characterize their relationship as close and supportive?

2. To what extent do they perceive their relationship to be central to children's emotional and behavioral functioning?

3.What challenges do foster caregivers identify for the child's relational functioning? What strengths?

4. What are other descriptive child factors including the mental health diagnosis and measure of behavioral functioning at intake, out-of-home placement history, and biological family visitation arrangement of the child in treatment foster care which may impact relationship capacity?

5. How do children in treatment foster care characterize and experience their relationships with foster family members, peers, and others they self-identify as current shared relationship?

Chapter Three

Research Design and Methods

The purpose of this study was to explore the shared relationship between treatment foster parents and the foster children in their care. Qualitative research methods were utilized in this inquiry, specifically use of an interpretive description approach which provides a method for investigation of a clinical phenomenon, identifying themes and patterns among subjective perspectives, while also accounting for variations between individuals, and to yield clinical application implications (Hunt, 2009, Thorne, Kirkham, & O'Flynn-Magee, 2004). The study and protocol changes were all approved by the University IRB and the community agency administration prior to research activity. Data were collected primarily through semi-structured interviews with foster parents and foster youth in their care and supported by data collected through document review of the community agency foster child case files. Efforts were made at each step of the study process to ensure research was conducted in an ethical and conscientious manner as well as to enhance rigor at all stages.

Research Design

As reflected in the literature, children in TFC evidence complex relational, developmental, and mental health needs qualifying them for this high level of care. Further research to better understand the quality and content of their relationships in TFC is needed to understand this central component of TFC intervention. Qualitative inquiry is particularly well suited for research involving children as it allows work with children in their natural settings, can allow access to greater detail and depth of experience,

provides through words and pictures rich descriptions, and is participative (Greig, Taylor, & MacKay, 2007).

This research project is guided in part by the beliefs and assumptions I hold about the nature reality and how it should be understood and studied (Denzin & Lincoln, 2005), Critical realism and the interpretive philosophy of research have guided this social work research project. The critical realism paradigm is well suited for social work research and has "an explicitly emancipatory goal" (p.375) in that it provides a framework within which the underlying structures, processes, and mechanisms, including social justice issues of values, power, and inequality, that contribute to the observed patterns which appear to be true may be examined and challenged (Denzin & Lincoln, 2005).

The critical realism paradigm provides an approach to social work research centered upon unseen causal mechanisms, psychological and societal. The researcher seeks to identify, analyze, and explain these mechanisms and their causal tendencies (Houston, 2001). Houston (2001) continues to describe that behavior is believed to be shaped by a range of social systems each with its own distinct mechanisms. Mechanisms can be either enabling or limiting, and social work researchers attempt to rediscover the causal mechanisms within the person, their social connections, and larger society which further suffering and oppression. We seek to understand the multiple structural tendencies and their effects on behavior rather than unchanging or deterministic relationships between individual characteristics and situational outcomes. People are active agents; outcomes are mediated by the day to day actions in people's live. They can be transformed by and transform their world (Houston, 2001). Additionally outcomes

are sensitive to system contexts and any conclusions about knowledge that we draw must be tentative and open to change (Houston, 2001; Longhofer & Floesrch, 2012; Oliver, 2012a). Social workers in research and practice must be aware of the context of structures and unchallenged practice wisdom within our discipline as they may also distort our perceptions of reality (Houston, 2001).

Stake (2010) described that interpretive research relies heavily on the researcher defining and redefining the meaning of their observations, seen and heard, and these interpretations emphasize human values and experiences, focusing upon the experiences that alter and shape the meanings people give to themselves and their experiences.

Key to understanding relationship and change in TFC is through the examination of how treatment foster children and foster caregivers understand this experience, exploration of the underlying structures and mechanisms that impact this construction of their shared experience, and exploration of the potential need for intervention and change within this system of care. This study examines *how* parents and children relate to each other in everyday life which may lead to a better understanding of *why* they do so in order to understand their process of making meaning of this experience. This may challenge practice conceptualization of relationships in foster care commonly held within the practice field. This qualitative study explores the specific and contextual ways in which foster parents and foster children develop, make us of, and make sense of their relational interaction day to day.

The study design is guided by an interpretive description methodology. Interpretive description is described to be useful for "smaller scale qualitative investigation of a

clinical phenomenon of interest to the discipline for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical practice" (Thorne, et al., 2004, p. 3). This method utilizes purposive sampling, multiple data collection strategies including interview, observation, and document review, and analysis of data presuming there is some theoretical, clinical, or scientific knowledge to provide some beginning analytic structure. The outcome of the inquiry is "a coherent conceptual description that taps thematic patterns and commonalities believed to characterize the phenomenon….and also accounts for the inevitable variations within them" (Thorne, et al., 2004, p. 4).

This method, arising from research within the nursing discipline, is well suited for researchers in other applied healthcare fields, including social work, and useful for the work or practitioner-researchers (Thorne, Kirkhand, & MacDonald-Emes, 1997; Thorne, et al, 2004). Clinical expertise is recognized as a helpful place to start for the initial orienting of the research. This prior knowledge shapes the research design and guiding theoretical orientation, but as the research continues these propositions will be challenged and reworked in response to the data. Within this approach these prior beliefs and assumptions are examined for their influence on the design and development of the study (Hunt, 2009).

Sampling Method. Purposive sampling is used within interpretive description for the selection of potential participants, reflecting upon both expected and emerging variation in the phenomenon (Thorne, et al, 2004). Purposive sampling was utilized for this study to draw different perspectives of the foster care relationship by identifying

diverse criteria of location and longevity of fostering experience. By purposive sampling, foster families were selected who were both information rich and shed light upon the phenomenon by offering useful description of manifestations of the TFC intervention.

The sample was comprised of TFC families licensed in a Midwest state through a statewide non-profit multi-service community agency. I initially approached this agency in regard to participation in this study due to my familiarity with the agency as a former employee in one of the agency's programs (not TFC). I assessed this agency as a useful partner agency also because they had a moderate sized TFC program operated throughout the state for over 2 decades. This agency operated with one overall program director and multiple licensing site directors. The size and organization of the program were additional factors that led to choosing this agency. It seemed that recruiting a sample of adequate size and variation was attainable. The agency had around 80 TFC licensed homes with 85 – 90 foster children placed at any one time. Additionally, as suggested by Berrick, Frasch, and Fox (2000), and approved by the IRB, I sought to recruit foster children for participation through their current caregivers. Having a prior trusted relationship with this agency aided in the agency's confidence in allowing me access to their foster parents via the program directors.

It was expected that variation may exist in the TFC experience due to location and length of term of service. Participants were recruited statewide and yielded from four licensing sites: a primarily large metropolitan setting, two mixed small city and surrounding rural area settings, and a primarily small town / rural setting. This allowed

for diversity of context (urban, suburban, town, and rural) as well as the opportunity for diversity of service longevity and racial / cultural diversity. All locations function within the same program specifications and guidelines. Additionally, an emergent awareness of variation arose in regard to potential variation due to parent gender. In response I sought to draw sample for more male participants (See appendices A and B for recruitment letter and flyer).

Inclusion criteria. For foster parents and foster children to be included in this study, they needed to match the following criteria. Foster parents needed to be licensed to provide foster care for a TFC program within the state. They must have had at least one current TFC foster child between the ages of 8 to 17 years old who was currently in placement with them and had been placed with them continuously for at least 3 months. The child must have been placed in a TFC home due to an emotional, behavioral, or mental health need.

Exclusion criteria. The foster child was excluded if they were with a TFC foster family primarily due to special medical or developmental needs. The foster parent was subsequently excluded if no other child in their home met the inclusion criteria.

Sample size. Purposive sampling procedures were utilized for selection of Information rich subjects to allow in-depth inquiry into TFC relationships (Patton, 2002). I initially estimated a sample size of 15 foster caregivers and 15 children shared between three licensing sites. Recruitment difficulties led to changes in the estimated sample size in the course of data collection; these challenges were discussed with committee members. Difficulty arose in acquiring consent from County Human Services / Child

Protection workers for the participation of many identified children who with their foster families met inclusion criteria. A fourth licensing site was added to increase the sample. A total of 18 interviews were completed: 10 foster parent interviews and 8 foster child interviews. Despite the reduced sample, I did not detect new themes being generated in the final interviews; however, I was not able to confirm this with further interviews.

Entry and Recruitment. Recruitment difficulties led to changes in the estimated sample size occurred in the course of data collection; these challenges were discussed with committee members. Difficulty arose in acquiring consent from County Human Services / Child Protection workers for the participation of many identified children who with their foster families met inclusion criteria. A fourth licensing site was added to increase the sample. Additionally following continued difficulty with recruitment I sought a change of protocol and the IRB approved a change in protocol to allow inclusion of foster parents for whom child consent had not been granted. This allowed data to be collected from these foster parent – foster child cases without involving the child nor violating confidentiality. The IRB also approved a change in recruitment to allow me to present study information directly to foster parents attending their monthly training / support meetings. Only one such presentation was made; on two occasions meetings were canceled at the last minute, one meeting was changed to be a social event off site, and there was a schedule conflict for two additional meetings.

A total of 18 interviews were completed: 10 foster parent interviews and 8 foster child interviews.

Urban site: Direct connection was made with the clinical director and program

Manager of the urban site. These professionals collaborated with me to tailor the plan for recruitment. At the urban site, I attended a foster parent pre-service training to gain familiarity with the site and some potential participants. Recruitment letters were either emailed or given directly to foster parents who met, along with a foster child, the inclusion criteria for participation in this study These letters were sent from the agency professional staff, described the study, and provided this researcher's contact information.

Smaller city and small town / rural sites: The urban site clinical director and program manager communicated to their comparable staff at the remaining sites. I provided information about the project to the other sites in an informational letter to the directors of these three sites and an informational letter for potential participants describing the study and providing the researcher's contact information. I followed up with an initial email communication to all site program directors to express my gratitude for their assistance with this project and to invite correspondence regarding questions or need for clarification. The site directors emailed or gave directly the recruitment letter to foster parents who with a foster child met the inclusion criteria for participation in this study. At one site the director sent this email two months after the other two original sites. The fourth site sent out email to possible families immediately after being asked to participate, about three and a half months after the start of the project. Follow-up emails were sent from the directors to potential participants one to three times depending on the site, and the placement longevity and stability of the foster child who met criteria.

Procedures. When a foster parent contacted me about participation in the study, either they or I contacted the child's county human services / child protection case worker to provide study information and acquire consent for the child's participation. All but one of the children in the sample required the consent of their county caseworker for participation because the county had legal custody of the child. For one child, the foster parent had been legally granted "parental authority" by the biological parents. Some foster parents seeking to participate had already spoken to the caseworker about the study prior to contacting me to ensure the child(ren) could participate. Once consent was secured and consent forms and HIPAA authorization forms were signed, interviews were scheduled. When a child's worker did not give consent, I followed up to address any questions or concerns which may have been preventing the worker from granting consent. Additionally, I contacted some supervisors of workers when the worker expressed that the decision was not theirs to make. In no case did follow up with the case worker or supervisor result in consent for a child to participate. In some of these cases in which the child met inclusion criteria but could not participate, their foster parents were interviewed with specific focus upon the child who met inclusion criteria without revealing identifying information about the child.

Data Collection. Data collection in the interpretive description method draws from multiple sources including interviews, observations, and review of documents (Thorne, et al, 1997; Thorne, et al, 2004). This study utilized in-person and telephone interviews with TFC foster parents and foster children and community agency child case file reviews. For each foster parent and child in the study, a separate file was organized

to contain all identifying data related to that parent and child. These files were securely housed to maintain confidentiality.

For this study, semi-structured interviews were conducted with individual foster parents following an interview guide created for this purpose, allowing also for the exploration of issues that emerged in the process of the interviews. These interviews were on average one hour in length, they ranged 50 – 95 minutes. With two foster parent participants, follow email exchanges occurred at my initiation to inquire of them regarding topics raised in other foster parent interviews that had not been raised within their interviews. Semi-structured interviews of foster children were conducted utilizing a relationship mapping diagram in an interactive and developmentally appropriate manner, and a small set of questions in an interview guide, again allowing for the exploration of additional issues as they emerged. These interviews were on average 50 minutes, ranging from 35 – 70 minutes. I conducted all interviews; I am trained as a clinical social worker and have worked professionally as a child and family therapist for over 17 years. At the beginning of each interview the study purpose was reviewed and informed consent / assent was given by the interviewee (for consent forms see appendices C,D,E). Confidentiality and the limits of confidentiality were discussed as a part of the informed consent / assent process, as well as clarification of the position of the researcher and research project to the community agency and county social services. Throughout the interview when appropriate (i.e. if interviewee conveyed discomfort or distress), participants were reminded that they were free to not answer questions they did not wish to answer, or they could end the interview if they needed to. This repetition seemed

especially important for foster youth in order to encourage their voluntary sharing and authenticity as they are often in a position of needing to comply with the questions of professionals. In three child interviews, children elected to not answer a question. Participants were given a $20 Target gift card.

The foster caregiver interview was piloted with one foster care provider for high needs children who was not connected to the agency program from which subjects were recruited. The child interview procedure was also be piloted with one (non-foster) child. Interview guides for both foster parents (appendix F) and children (appendix G) were revised following the first stage of data collection and analysis in response to data collected and further inquiry this data suggested. All study interviews were audio recorded and professionally transcribed verbatim. All interview transcriptions and child relationship map diagrams were assigned a letter / number code, the key for which was locked in a confidential location with the other identifying study materials, and transcripts and diagrams were de-identified. Additionally, memos were completed by the researcher following each interview to capture initial ideas and observations of emerging issues and themes. Interviews were conducted during a ten month period of data collection.

Children's community agency case files were reviewed. Information sought from the file included diagnosis (available from the required diagnostic assessment which is completed prior to or soon after placement within the program), information from the Strengths and Difficulties Questionnaire (SDQ), a brief behavioral screening tool completed by a child's caregiver to identify psychological problems via exploration of

emotional problems, conduct problems, hyperactivity / inattention, peer relationship problems, and pro-social behavior, which is completed at placement within the program, placement history, reason for initial placement, permanency goal and progress toward permanency goal, contact arrangement (if any) with biological family members, and current treatment plan. A file review worksheet was created to record case file information and was marked with the child code and de-identified (appendix H). The data of the SDQ was excluded from the analysis because the measure was not used consistently across cases.

Additional data were collected but excluded from analysis. This data included a standardized measure of relationship trust and closeness, the Trusting Relationship Questionnaire (TRQ) (Mustillo, Dorsey, & Farmer, 2005), field observation of pre-service training and ongoing trainings, and field observations of foster children. These data were excluded because of inconsistent collection of this data due to multiple barriers, including children being moved from placement before completion of the TRQ, cancelled and rescheduled trainings, and limited opportunity to meet with foster families in their own homes because of conflicting schedules, concern for privacy of non-study children, and long distances to travel.

Data Analysis. Data collection and analysis occurred concurrently throughout the study. Analysis relied upon data collected through interviews and child agency case file review. The Dedoos © (Sociocultural Research Consultants, LLC., 2010) software program was utilized for organization and analysis of interview data. Findings of this study arose from my research objectives and analysis of the raw data. The research

objectives of this study were bound by my choice to narrow the focus upon quality, content, and process components of the relationship between the TFC parent and TFC child in their care through their perception of the relationship. Findings issued from multiple interpretations of the data and were shaped by my assumptions and experience.

I first thoroughly familiarized myself with the data in the context of theoretically and practice based broad themes, considering relational aspects within the data. Analysis of the first three interviews following multiple readings of the interviews (foster parent and 2 foster children) utilized incident coding reflecting aspects of broad themes related to the foster parent / foster child relationship. These were recoded into initial codes, informed by data and my familiarity with the issues related to foster care and child mental health through my clinical practice experience. Data collection was then conducted for the next seven cases. The subsequent interviews were read multiple times, coded for aspects of major themes, and then recoded into the original initial codes. Additional codes were added to the list of initial codes as the result of the content of the additional data, and these codes were then compared to previously coded interviews. I utilized the grounded theory constant comparison method. There were 64 initial codes, 12 of which had multiple ”child” codes, or subcategories, within them, totaling 52 subcategories. Focused codes, codes primarily of action and process (Charmaz, 2006) were identified from the accumulated initial codes and accompanying memos. These seven focused relationship codes were: caregiving role, child changing, choosing relationship, developing relationship, maintaining the relationship, perceiving the other, and utilizing the relationship. Each of these focused codes was subdivided into parent

and child perspectives. The next three cases were then coded using the focused codes. As this coding system proved a good fit with the data of these three cases, all previously coded cases were then recoded using the focused codes. Memos were written in response and reflection of data collection and analysis, noting multiple interpretations and alternate meanings, and these were reviewed throughout the data analysis process.

The coding by focused codes then allowed for analysis of the data and review of memos to identify concepts and themes. Analysis of the fully coded data and accumulated memo material first identified concepts and themes within each set of foster parent / foster child(ren) interviews, gaining a thorough description of that foster family and variation of themes within that foster family. Complete case studies were written for each of the ten families utilizing all available data sources to aid my understanding of the unique foster family relationships. Writing these case studies served as another manner of data analysis. Next common themes were explored across foster families, identifying themes and patterns, discriminating properties of these themes, and making interpretation of the meaning (Creswell, 2007). As a part of the analysis and interpretation, rival interpretations were considered. Analysis continued as themes were questioned and refined throughout the process of organizing and writing about the findings, as well as peer debriefing and member checks.

Credibility, Transferability and Dependability. Credibility, described by Lincoln and Guba (1985) is likened to internal validity as described by Cook and Campbell (1979): it is the degree to which the findings of research are deemed trustworthy or believable. Within the interpretive description methodology, Thorne and

colleagues (2004) report that in addition to the issues concerning rigor that are addressed within most qualitative research, credibility of the findings rests upon the way specific analytic decisions are reported in the context of the broader picture. Complexities must be made transparent and reported with an appropriate tentativeness of conclusion. Researcher reflexivity throughout the research process accounting for issues of power, subjectivity, and the researcher's position within the study must be transparent (Thorne, et al., 2004).

The strategies used in this study to safeguard the accuracy and credibility of the findings are triangulation, peer debriefing, member checks, and negative case analysis (Lincoln & Guba, 1985). Triangulation of the data is accomplished through utilizing multiple data sources: multiple sources in the case file and interview data from caregivers and children. Triangulation also is accomplished through utilization of theoretical propositions in the study design and analysis. Peer debriefing was especially important, given the complexity of understanding differing world views and differing manners in which subjects may communicate with a researcher. Processing with a peer not involved in the study, but informed of the relevant issues allowed me the opportunity to explore biases, meanings, and dimensions of interpretation. Debriefing occurred at different points throughout the data collection, analysis, and writing stages of this project (often as these phases were concurrent or overlapping). Peers included one county child welfare worker, a child therapist working in a non-profit agency with emotionally behaviorally disordered youth, a special needs adoption caseworker at a different non-profit agency, and consultation with members of my research committee at all stages of the process.

Member checking also occurred, with two foster parents and one program staff person to review emerging themes. Memos were written and reviewed throughout the research process, reviewing and critiquing ideas I had throughout the process about what data may mean, reflexivity reflections noting potential bias, subjective interpretation, or reactions by myself to a subject or the data, and alternative interpretations. Alternative interpretations were be identified and examined and noted in memos throughout the analysis. Finally, all raw data has been maintained throughout the process and a detailed research log was maintained throughout the research process noting decision points and note rationales for my choices.

In order to safeguard the transferability of the findings, which is likened to Cook and Campbell's (1979) concept of external validity, the data collection and reporting of data provide thick description, allowing readers the opportunity to assess the transferability of findings to other persons, settings, and times (Lincoln & Guba, 1985), and provides enough information to allow readers to draw their own interpretations (Stake, 2010). Within the findings I have included many excerpts from the data within the context of the family to provide thorough description and detail of the data I believe support the identified patterns and themes. Negative case examples are also presented to add to the shared understanding of the findings. A detailed description of the sample is provided at the start of the research findings. These descriptions have some limitation due to the need to separate the foster family and foster child descriptions rather than describing the families as a complete unit, and to provide the child descriptions in a summary format. This was a choice made to protect the privacy and identification of children within this

study due to the small sample and use of one community agency. This was also in accordance with the community agency's requirement for participation in the study that children's identities and contribution be protected.

Dependability or consistency, comparable to reliability, is enhanced through overlapping or triangulation of methods. Methods are overlapped in this study through the use of multiple interviews and case file document review. Additionally the process of the study and strategies / steps of analysis are clearly described above. These checks are designed to increase confidence in the consistency of the findings (Lincoln & Guba, 1985).

Objectivity is another criterion of study rigor to be assessed, the degree to which the findings can be attributed to these subjects and the context of this study, and not to researcher bias or motivation. Strategies for this include the researcher keeping a reflexive journal throughout the research process, remaining alert to bias and other processes which may impact the collection or interpretation of the data. Additionally, a clear audit trail has been maintained, containing all the data, data reduction through analysis, process notes / memos, all materials relating to study plans, and all information regarding the development of the interview protocols, etc. (Lincoln & Guba, 1985).

The sample

There were a total of ten TFC families from whom data were collected. This sample was recruited from the agency TFC home population of approximately 80 TFC licensed homes. There were four families within the Urban licensing site, two from one of the small city / surrounding rural site, one from the other smaller city / rural site, and

three form the small town / rural site. One foster parent from each family was interviewed, totaling ten foster parents. Eight children from five of these homes were interviewed and had their community agency case files reviewed. A total of 14 foster children within the ten families met the inclusion criteria, however, for six of these children consent for their participation was not granted by their legal representatives. This sample of foster children was recruited from the agency TFC child placement population of approximately 85-95 children. The total number of placed children in the population varied within this range over the course of recruitment and data collection.

The foster parents interviewed included eight women and two men. All the women and one of the men were married and fostered together with their spouse. One man was a single foster parent. The parents range in age from 35- 58; nine of the parents were Caucasian and one was African-American.

Of the eight foster children interviewed, six were girls and two were boys. They ranged in age from 8-17. Three of the foster children were Caucasian, and five were bi-racial: one African / Caucasian, two African American / American Indian, one American Indian / Caucasian, and one American Indian / Mexican.

Table 3.1
Description of TFC Families and Interviewed Foster Children

TFC Family	TFC Licensing Site	Gender of Interviewed Children	Total # of TFC Foster Children in the Home
1	Urban	Female, Male	3
2	Urban	Male	1
3	Urban	Female	1
4	Urban		1
5	Small City / Surrounding Rural 1	Female, Female	6
6	Small City / Surrounding Rural 1		1
7	Small City / Surrounding Rural 2	Female, Female	3
8	Small Town / Surrounding Rural		4
9	Small Town / Surrounding Rural		2
10	Small Town / Surrounding Rural		1

Role of the Researcher and Assumptions

This study as all stages has been shaped by not only the data collected, but shaped by who I am and what I bring to the research process. This addition to the process includes my professional experience, my position on the theoretical orientation utilized to understand this population and issue, my position in regard to the participants and partner agency, and my personal experiences related to this inquiry. Further sensitizing concepts, stemming from my position on the theoretical orientation of my discipline also have played a role in how I saw, heard, experienced and made sense of these data.

Reflexivity statement. Reflexivity is the process of critical reflection on the self as the researcher, or human research instrument (Guba & Lincoln, 2005). Patton (2002) has described that within qualitative inquiry, the researcher's perspective is a part of the context for the findings. Thus an understanding of what the researcher brings to the process and the context is important. Additionally, the reflexive characteristic of the researcher is in part an understanding that the researcher is a part of the social world being explored (Berg & Lune, 2012). This recognition impacts the way in which the researcher understands, collects, and interprets the data through maintaining an ongoing internal dialogue about "what the researcher knows and how the researcher came to know this" (p. 205). I have engaged in this reflexive dialogue throughout the research process, from understanding my decision to explore this question with this population, through the development and execution of the research plan, the necessary adjustments made along the way, and in my interpretation and presentation of the data.

Professional experience. My professional experience has informed much of what I knew about the children served within treatment foster care coming into this study, served as a large motivation for me in choosing this area of research, and influenced how I have understand and made sense of the data in the process of data collection and analysis. I have never worked specifically within treatment foster care nor directly within any foster care program. My work with the population type of children served within treatment foster care has been in adjunctive or alternative settings as a group home social worker, case manager / therapist within long term residential treatment programs, therapist within day treatment programs, and as an outpatient child and family therapist. It has been my experience that to be fully effective with these children and families, I have needed to have a thorough understanding of the ins and outs of the child welfare system in order to understand where they have been and / or where they are going and to recognize the role child welfare plays within the lives of these children and families. Working adjunctively to child welfare / foster care I have always felt allowed me a clear view of the "system" and how it does and does not consistently serve children. Over the course of my career my ideas about what it is for children to be well served within child welfare / foster care have become more complicated and less clear, and this has provoked a desire to understand more about what actually happens in the day to day experience of foster care.

I have been witness to a variety a child foster care experiences that have further directed my curiosity to understanding what this relationship is and means to both foster parents and foster children. I have seen children entering residential treatment following

a placement disruption, sometimes to return to these homes and sometimes to never hear from them again. I have seen foster / adopt placements that fail, some that "succeed" and some that "succeed" only to struggle later. I have seen foster parents who are genuinely fully invested, some who care yet remain wary, and some who do not really engage. I have wondered what distinguishes these varied experiences, as I have seen some children who it was hard to imagine anyone tolerating all day everyday stably placed and then seeing pleasing, "easy" kids disrupt. I have observed the relationships between children and childcare staff within residential treatment and wondered how these reflect and differ from the relationships within treatment foster homes.

I entered this research knowing that I really like these kinds of kids, and knowing that as a clinical social worker I have had to be mindful of the easy tendency to over-identify with youth in compelling circumstances and thus to fail to see them or their situation clearly. I also entered this research knowing that I have in my work perceived foster / adoptive parents at times along a spectrum of hero to villain, and at times feeling intense admiration, anger, or other emotions in response to these judgments. This perceptual judgment and feeling may also muddy my view of them and the broader context. It is obviously far too simplistic to view one (sad kid) vs. the other (bad foster parent), or good vs. bad foster parents, yet judgmental perceptions, positive or negative, lead to this sort of dichotomous thinking rather than an understanding of what I believe is more accurately a co-constructed reality and a complex process of relationships developing. And thus my research focus upon the relational interaction. And to fully come clean, I acknowledge frequent experiences of perceiving child welfare / foster care

to lose sight of child well-being. In the process of data collection and analysis, I intentionally maintained my conscious awareness of these potential biases in order to make sense of the data for what it was within the context of this study, recognizing that my experiences in some ways deepen my understanding of the data, yet have the potential to taint it as well.

Theoretical Orientation. As a clinician, I have developed different understandings or beliefs about how to understand human difficulties which impact my clinical judgment for working with people, and impact my perspectives as a researcher as well. Attachment theory has been thoroughly explicated within this theory chapter as it is the prevailing theory to make sense of relationships, relationship experiences, and the development of the sense of self. Attachment theory has also been the predominant way in which many children's difficulties within child welfare placements have been explained in the past 15 -20 years. My professional development in working with children in child welfare occurred in the midst of the explosion of attachment / disorders of attachment related research in response to the opening of the orphanages in eastern Europe. I observed this research to quickly lead to development of a variety of intervention methods, which over time strayed further from the theory itself. As a clinician I come to this research with a large dose of skepticism about the diagnosis of Reactive Attachment Disorder (RAD), as I have witnessed the expanded use of this diagnosis and questioned its suitability for many of the children I have served, and I have questioned its usefulness overall. I have also experienced, as is described in the literature, the tendency for the diagnosis of attachment related disorders to be viewed by

many professionals and foster parents as immovable, unchangeable, and predictive of a disordered future. My skepticism about RAD had to some degree led me to question the helpfulness of attachment theory to an understanding of the experiences of children in child welfare. It has been helpful to me to return to the theory of attachment itself, and the current and recent longitudinal research of its continuity / discontinuity and attachment across the lifespan to be able to make better sense of the relationship experiences discussed in this study.

Position. Another aspect of my research role is recognizing my position in relation to the subjects and the context of the agency. I am a former employee the community agency of which the treatment foster care program explored in this study is a part. The clinical director of the program was my direct supervisor while in their employ. I ended my employment with the agency over six years before beginning this project and my tenure at the agency did not overlap with the creation of the TFC program. During the course of this study, I was hired as a contract employee with this agency on a very part time basis. My work at the agency, both before and after the research project was as a mental health therapist specializing in work with children, youth, and families, and foster children or other child welfare involved children were commonly a large part of my caseload. I have never been a staff person for the TFC program. In the past six months as a contract employee, I have attended a monthly case consultation meeting with the urban area TFC staff, however, no subjects involved in the research, nor any other aspect of the research, has been discussed within this shared professional meeting. Throughout the process of recruitment and data collection I have considered the impact

my past and present role could have for subjects and staff in their motivation to participate, support the project, information shared, or sense of confidentiality. I have sought to be transparent with participants regarding my position professionally and within the agency, both historically and currently. I was additionally very aware throughout interviews of maintaining my role as a researcher, utilizing my clinical skills for engagement and understanding, but not crossing over to clinical intervention. As a novice researcher it is possible I at times stayed too far away from that boundary for fear of crossing it, which may have limited depth of some responses, but this felt to me an important line to hold.

It is due to this background and current status with the agency and my clinical career as a whole that I feel I hold both an insider and an outsider perspective in this project. I am an outsider in that I have never been involved with TFC at this agency or elsewhere. This allows me to recognize emergent / emic themes and sensitivity to assumptions that are made within cases and to be able to critically assess the accuracy or skew of these assumptions. I am to some degree an insider due to my work within a department of the agency and my professional work with emotionally and behaviorally disordered foster youth and families. This allows me an understanding of this population and has equipped me with skills to aid their engagement and to understand challenges foster parents and children may be facing. A couple of foster parents toward the conclusion or their interviews volunteered a feeling of confidence about me interviewing their foster children, saying they felt I "got it" in terms of understanding the foster care dynamics and population.

Personal Experience. Who I am personally also impacts the research. I am not a parent nor a foster parent nor a former foster child. Experiences with child welfare are all professional experiences, and personal only to the degree that I have friends how have experiences as foster children or foster parents. The sharing of these personal experiences of friends has played a role in my motivation for choosing this topic. Three examples are central in my mind as they provoked questions of how foster children and parents relate and make sense of relationships in foster care. One friend spoke of knowing a sense of belonging in a foster home as a child, a placement which endured until she aged out of care at 18. She recalls specifically the significance of being given her own library book shelf in the front hall with those of the other children of the home, a place to leave her library books to ensure they would be returned at each weekly visit the family took together to the library. Another friend recalled how he and his brother were told by their foster mother to call her if they got into trouble. They were placed in foster care as young adolescents. Sure enough they did get into trouble, and he remembers he and his brother wondering that first time if their foster mother had really meant it; they called and she came. He says for the year and a half they lived with her, they felt confused by her care for them, grateful, but confused that someone actually cared and did things to help. Finally, a third friend recalls weeping in the hallway outside the bathroom of her condo as her 3 ½ year old foster son took a bath after a particularly hard day over a year into the placement, wondering how could she continue to care for him when she wasn't sure she could love him; she adopted him one year later, and he is now 11 years old, and continues to require an intense level of parenting intervention every day, yet she

reports she really doesn't see him as being different than other kids. These stories are mere anecdote, yet they underscored for me the importance of meaningful relationships and further stoked the fire of interest in researching what actually happens with these foster parent / foster child relationships.

Sensitizing Concepts. In the midst of being open to what there is to learn within a qualitative inquiry, sensitizing concepts provide some way to organize complex experience and provide a general sense of direction (Patton, 2002) Theoretical or conceptual frameworks have guided my understanding of the research questions, context, and data. These include the life course perspective (Fanshel, Finch, & Grundy, 1990) and social learning theory integrated with attachment-based intervention (Barth, Crea, John, Thoburn, & Quniton, 2005). These, informed in varying degrees by the more commonly utilized frameworks, helped guide this study.

A life course perspective reflects social – structural theories, recognizing the interplay of biopsychosocial factors in individual development. The life course is the interplay of historical factors, such as family changes or losses, with other social-cultural factors in the immediate environment. Across the life course certain events unfold in predictable ways, whereas the timing, meaning, and efforts of the individual to cope are unique. Targeting intervention to meaningful points of transition in the life course potentially provides individuals the opportunity to revise these meanings and ways of coping (Freeman, 2000). Entering foster care may be an example of such a window of opportunity, a full change in the child's environment and experience of a new relationship which may alter their life trajectory.

Social learning theory as developed by Rotter and further conceptualized by Bandura, posits that an individual's behavior is primarily learned and results as the function of expectancy that the behavior will lead to a particular outcome and the value of that outcome to the individual (Wallston, 1992). The concept of expectancy includes concepts of locus of control and self-efficacy, and outcomes are also conceptualized as incentives. This theory states that individuals learn through respondent conditioning, consequences of past behavior, and modeling of behavior by others around them (Payne, 2005). Intervention involves providing an individual with corrective experiences and structuring their environment so that adaptive behavior is reinforced and maladaptive behavior is weakened (Thyer & Myers, 2000). Integrated with the theory of attachment, it is recognized that caregiving plays a vital role in the mental health of children and an examination of the child – caregiver relationship quality and methods to maintain or improve it are warranted for this vulnerable population. Attachment concerns may be understood as the way in which the child-caregiver relationship facilitates or limits the treatment process, or to ease or exacerbate emotional and behavioral functioning (Allen, 2011).

These concepts have guided my inquiry in some part from study formation to this final report. I see foster care as an opportunity for children that can be shaped by the power of relationship. This study examines HOW parents and children relate to each other in everyday life which may lead to a better understanding of WHY they do so in order to understand their process of making meaning of this experience. This qualitative

study explores the specific and contextual ways in which foster parents and foster children develop, make use of, and make sense of their relational interaction day to day.

Ethical Considerations

The IRB approved the initial proposal for this research following the completion of their requested modifications to the recruitment letter, consent forms, and interview protocols. Procedures for acquiring and recording consent from adult participants followed the expectations of the University. Attention to the careful maintenance of confidentiality of participants occurred throughout the research process, as I collected data both through individual interview and group observation concurrently. Additionally, as member of a shared foster family were interviewed, I was careful to not reveal information between family members. All reporting of data and findings have been completed in such a way to maintain confidentiality.

Of particular consideration in this study is the inclusion of children, the majority of whom are wards of the state. Of those who are wards of the state, consent for each child's involvement was sought from the appropriate county worker of the county responsible for their care. Once guardian consent was secured, assent of each child was sought and documented.

Consideration too was been given to the creation of the interview protocol for these children who are vulnerable due to their status as foster children, but additionally vulnerable due to their identified emotional and behavioral difficulties. Although minimal risk was assessed for their participation in these study procedures, care was taken to ensure that their routine level of support is maintained post-interview and that

interviews remain focused upon the research topic as described and maintaining a here-and-now orientation rather than delving into their past. Each child interviewed had access to an individual mental health therapist or routinely saw a home-based mental health practitioner (skills worker), so mental health supports were in place. Another safeguard is that I am a licensed mental health professional with over 17 years of experience treating children and could monitor the child's emotional state throughout the interview. No children presented distress in response to the interview process to warrant the need for additional intervention. I did honor the request of youth to skip a question or to not say any more about something. This occurred within three child interviews.

I experienced additional ethical concern within the recruitment phase of the study. One issue was the question of knowing how assertive to be in my recruitment efforts. I recognized the very real issue of foster parents having a lot to keep track of, and that for things outside of day to day life management, it really takes a "squeaky wheel" with repeated recruitment requests to get their attention. However, it is not always clear at what point being the squeaky wheel becomes coercive. In regard to foster youth, since I was not granted any contact or identifying information about them until consent was granted by their legal guardian and an interview was scheduled, it was important to the best of my ability in the assent process to ascertain that this was truly voluntary participation, not the youth feeling they had to do this, or that they had been motivated / coerced in some other manner.

Throughout the writing process for this study, I have grappled also with what I feel is an ethical mandate to share the voices of these subjects with clarity, honesty, and

in the appropriate context. This is balanced against an equally strong belief in the need to protect the identity of these subjects. At times compromise has been made to preserve confidentiality, thus losing some of the power of what these subjects had to share.

Definition of Terms

The following terms have been defined as they are used within this study to be understood consistently throughout this report.

Attachment relationship: the close persisting affectional relationships with specific, intimate others, to whom one seeks proximity, for whom one feels distress and grief at separation, and turns to for comfort and security (Cassidy, 2008).

Caseworker: The worker within the county Department of Human Services who is responsible to supervise and consent to the care and services for children in foster care; this worker may be a child welfare, children's mental health, or juvenile probation worker.

Child welfare system: Child welfare systems typically receive and investigate reports of possible child abuse and neglect; provide services to families that need assistance in the protection and care of their children; arrange for children to live with kin or with foster families when they are not safe at home; and arrange for reunification, adoption, or other permanent family connections for children leaving foster care (Child Welfare Information Gateway, 2013).

Community Agency: This is the one partnership social service agency from which the sample was drawn and all participants were recruited.

Foster care: Out-of-home care including family foster care, kinship care, treatment foster care, and residential and group care (Child Welfare Information Gateway, 2013).

Permanency: Permanency in child welfare means a legally permanent, nurturing family for every child (Child Welfare Information Gateway, 2013).

Positive Parent-child Relationships: Relationships characterized by a high levels of warmth and positive affect, interpersonal trust, and open communication (Kotchick & Forehand, 2002).

Treatment foster care: A culturally relevant, community- based, and family-based method by which planned, integrated treatment services are provided to foster children and their parents by foster parents who are qualified to deliver treatment services. Treatment services may be provided to children with severe emotional disturbance, developmental disabilities, serious medical conditions, or serious behavioral problems, including, but not limited to, criminal sexual conduct, assaultiveness, or substance abuse. (MN Statute 2960-3010, Subp. 43., 2008).

Chapter Four

Findings

This study utilized an interpretive description methodology to generate a description of the foster family – foster child relationship components of intervention within TFC. More specifically, how treatment foster parents and children in their care experience and describe their shared relationship is the study's central question explored through an examination of their perceptions of relationship closeness, the role of relationship in children's improved emotional and behavioral functioning, the understanding of children's other significant relationships, and barriers to building or maintaining relationship. The analysis of the data from which these findings derive was informed by a theoretical foundation in attachment theory and the resilience framework, as well as informed by clinical experience.

The first section of this chapter reports upon findings related to conducting research within child welfare, specifically with foster children, foster parents, and foster care agencies, reporting the barriers encountered in the course of recruitment and data collection. A summary description of the foster families is given, followed by the core relational findings draw from the analysis of the data. These findings address specifically the central question of this study: How do treatment foster parents and children in their care experience and describe their shared relationship? The core relational findings fall within four broad categories of caregiving / cared for, belonging, kids making changes, and relationship development and perseverance over time. The chapter concludes with

additional findings that inform the broader themes. Interpretation and connections to the literature are drawn within each relationship theme category.

Description of the sample

Recruitment and Data Collection Barriers. I experienced barriers to recruitment and data collection on multiple levels, including recruitment of foster parents, foster children, and additional community agencies providing treatment foster care. These barriers have been experienced by others seeking to conduct research with children in foster care. Berrick, Frasch, and Fox (2000) identified three areas of challenge: recruitment of the sample, development of appropriate instruments, and the selection and training of interviewers. They noted that given the multiple difficulties in gaining access to foster children for research purposes, it is no surprise that their voices are infrequently heard in the literature. These authors provided many suggestions for this area of research to overcome these barriers, some of which were relevant and mployed in this study, however, barriers remained problematic.

Other researchers reported difficulties in gaining access to foster children, despite efforts in anticipation of barriers. Heptinstal (2000) in her exploration of the family of foster children sought a small sample of 16 children to interview. Despite having gained the approval and agreed cooperation of two social service departments and making 10 months of diligent cooperation and recruitment efforts, she had not reached her goal of 16 children. Difficulties within the current foster placement was the most common reason given by social workers for children's non-participation. Gilbertson and Barber (2002), report on three studies intended to better understand the experiences of foster child

experiences related to placement disruption and / or subsequent stability. Their first study was abandoned due to a non-response rate of 82%. A non-response rate of 86% occurred within their second study and one of 82% for their third. The most common reasons given were the subject was transient or missing, lack of cooperation from the social worker, subject declined to participate, and the placement was deemed too fragile. These small samples resulting from primarily the decisions of the children's gatekeepers are not likely representative, and limit the voice of youth in the research literature. Gilbertson and Barber (2002), identified a "catch 22" in that research needs to be conducted to better understand why many children in foster care are experiencing multiple difficulties, yet these distressed children are not available to researchers (p.257).

In this study in which I sought to conduct research with children served within the child welfare system, especially children with severe and persistent problems to warrant the treatment level of foster placement, much care was given to the plan for recruitment of these youth and their participation. This plan was further closely scrutinized by the University IRB and the community agency, given the vulnerability of the research population. Despite these efforts within this study barriers to recruitment were common. I experienced these barriers in regard to child participation primarily at the point of county caseworker consent for the child's participation in the research. Reasons provided for non-participation included that the child was too vulnerable, the worker did not want to introduce another person into the child's life, the status of permanency, i.e. an upcoming court hearing, could be jeopardized by the child's involvement, the county was not consenting to any child participation in research, concern about the child's or family's

privacy, or no reason was given. In a handful of cases, the caseworker never responded to phone or email communication requesting consent for the child's participation. Follow up contact with assigned caseworkers and / or their supervisors to resolve concerns or clarify the project did not change any of these decisions.

Recruitment of foster parents was challenging as well. The program directors at the different licensing sites sent email requests for participation to foster families who met the inclusion criteria multiple times: for two sites over a ten month period, for one site over eight months, and six months for the final site. Several families were provided information about the study through phone or in-person contact with their program director. Of the 15 foster parents who subsequently made contact with the researcher about the study, 5 did not choose to participate for reasons unknown. For neither foster children nor parents can the actual response rate be calculated due to recruitment process coordinated through the community agency in order to protect the privacy of the potential sample.

Due to the challenges faced with recruitment within the partner agency, attempts were made to increase the sample through the inclusion of more community agencies (see appendix J for community agency partner recruitment letter). The University IRB required partnering with a community agency for recruitment, and required a letter of support from each agency partner detailing their agreement to participate. Utilizing both professional practice, personal, and research colleague connections, I contacted six additional agencies regarding participation in the research. Five agencies following consideration of the request and review of documents, declined to participate for reasons

including not wanting to burden their foster parents, not being a stable time in their program, already participating in another study, not being interested, and not feeling there was adequate compensation for youth participation. One agency did agree to participate, however, never followed up with the letter of support.

I attempted to work through two large urban county social service departments as a way to connect with contracted treatment foster care agencies. At one county an administrator advised I not pursue research within that county due to their complicated approval process with a high likelihood of being denied. The staff responsible for research at the second county declined participation due to being involved in another research project.

The foster families. There were a total of ten foster families. Each family was comprised of a treatment foster family, the parents and foster children in their care. A fuller description of the ten foster families may be found in Appendix I. The foster families were comprised of nine dual parent (foster mother and foster father) homes and one single foster father home. These families had provided foster care from a range of three and a half months to eight years, and had a range of one to six current children in placement, for which the children had been placed for three and a half months to four years.

One parent from each family was interviewed and eight children from five of these homes were interviewed. The total of 14 foster children who met the inclusion criteria are included in the child summary of the case description, not only those interviewed, however, the information about the non-interviewed children was more

limited. They are included because the foster parents in their interviews were reflecting upon these specific relationships. All names have been changed to protect the confidentiality of participants. Other family details have been altered for the same purpose, and these changes do not impact the essence of the findings.

The children. The children in care within these families are described here in summary format to provide an overview of who these children are, but to also protect their identities given the small sample size and recruitment from one agency.

The majority of these children have experienced neglect within the home of a mother abusing substances. Only two of the children had a father who was involved in their lives. Four of the children's fathers were deceased, for two children their fathers were currently incarcerated and for two others, their father had previously been incarcerated and was not allowed contact, One child's father had been deported early in the child's life, and for the three remaining, no information about the father was known.

All of the children had had multiple placements in one or more type of setting including relative placement, foster care, pre-adoptive homes, and shelter. Two children had completed chemical dependency treatment, two had at least one psychiatric hospitalization, one had completed residential treatment for sexual offense, and another completed residential treatment for other behavioral issues. Three children were placed directly from juvenile detention. All children were court ordered through social services except two, one who was voluntarily placed through children's mental health services and another whose parents signed a delegation of parental authority (DOPA). The

duration of each child's child welfare system involvement was not known, however, for several this involvement spanned three to six years.

In addition to the neglect most of the children had experienced, three were reported to have experienced sexual abuse, three were reported to have experienced physical abuse, three were reported to have acted out sexually, one was running away, one child lacked a capable family member to provide mental health care, and one was kicked out of home. Three of the children were reported to have been abused within former foster placements.

Most of the children were diagnosed with multiple mental health disorders, based upon the information available. The majority of children carried two to four diagnoses. These included the following diagnoses / clusters of diagnoses:

- Major Depressive Disorder; Disruptive Behavior Disorder NOS; and Learning Disorder NOS;
- Generalized Anxiety Disorder and Attention Deficit Disorder, combined type;
- Adjustment Disorder with Depressed Mood, Parent-child Relational Problem, Physical Abuse of a Child – victim; and R/O Bipolar Disorder;
- Mood Disorder, NOS; r/o other psychosis; ADHD, Relational Problems Related to Mental Disorder;
- Major Depressive Disorder, ADHD, Cannabis, Nicotine, and Alcohol Dependence;
- ADHD

- Mood Disorder NOS, Anxiety Disorder NOS, and Sexual Abuse of a Child, perpetrator;
- Adjustment Disorder, unspecified;
- ADHD and sleep disorder;
- Mood Disorder (not specified);
- Reactive Attachment Disorder; and,
- Post-Traumatic Stress Disorder, Oppositional Defiant Disorder, r/o ADHD , history of Reactive Attachment Disorder.

Many of the children were reported to be receiving in-home therapy or skills worker services while in their current placement.

Caregiving / Cared For

Caregiving as a central function of TFC, a seemingly basic concept, emerged however as a complex theme comprised of properties including perception of the caregiving role by foster parents, foster youth perception of the caregiving role, foster parent commitment/ investment, the therapeutic aspects of caregiving, the understanding of caregiving tasks, and the connections between foster parents and foster youth. All of these components emerged to describe the perception and experience of this shared relationship.

Not Mom. Foster parents did not identify themselves as "mom" or "dad" to these kids, nor thought of these children as their children, and in fact many stated directly that they were not the child's mom or dad; "I'm not their mom. I'll never be their mom…" (Emily, two children in care). Another parent describes this as "I'm not her mom. I'm

not in the adoptive role. I'm fulfilling a parental role right now in giving her the best that I can give her right now" (Betsy, one child in care). Betsy continues about her relationship with Lydia:

> Parental. Very parental. I went into this with a parental hat. I'm not doing this to be a friend, per se. I'm doing this to be a parent because that's what she's missed. I don't want to seem cold, but I'm very parental with her. She's my responsibility. I'm the caregiver and the nurturer. It's parental and I try not to… I don't need to be her friend. She doesn't need me as a friend. She needs me as somebody that she can trust, rely on and… so, in that aspect, it may be different than any of the other kids in my home. And that comes naturally for me.

Foster parents lacked agreement of how to name this role, but were consistent in describing acting parental. The foster parents overall described their role as "parental", functioning in a parental capacity, but varied in the identification or naming of their own specific roles: as a parent, a different kind of mom, mentor, advocate, an authority figure, a positive relationship, a protector, coordinator of information flow, or just [their name]. One foster parent described to her foster child, "I just want to be someone who takes care of you and protects you and is here for you. I don't want to be your mom. I don't want you to call me mom. I'm your Ms. Monica….. Think of me as an auntie or something like that" (Monica, three children in care).

This differentiation between acting parental vs. being the mom / dad for some foster parents was made in part to avoid creating a conflict for the child in their relationship with biological parents. One foster father described his view of his

relationship role distinct from being the father: “Father is at home for him. However he’s not had a real close relationship with his father and I think that’s been part of the home life issue is trying to get that and not happening. He’s still… so I think he’s another one who’s been kind of looking for a male figure to be in his life” (Kevin, one child in care). Another foster parent felt free to act parental toward the children in her care as she perceived that the foster children did not view her as they do their mother: “But I‘m just so different from their mom….. they understand what mom is and how mom has behaved, reacted in the past and that that’s not the norm. So, I can be a more “I love you. Give me a hug. Are you ok? Give me a hug” with them.” (Monica, three children in care). For others, it was an effort to maintain a focus on the child’s permanency goal. One foster parent described explaining her role to birth parents:

> And at the beginning, it is sort of like that, but I explain to them my job is to get these kids to go home. My job is to get these kids happy and healthy and go home. I don’t want to be a mom. I have kids. I just want to give them a place to live and I think I say that enough that the birth moms don’t feel threatened (Sheila, four children in care).

Further, Sheila states: “And so I’ve never had any kids that didn’t want to go home. And it’s not because they don’t want to be here, it’s because I want them to go home and I show them that they want to be at home”.

For many this parental functioning vs. being the mom / dad seemed just an understanding of their role as a foster parent. However, many also spoke of ways in which they felt this parent / authority role undermined by other professional team

members, including case workers, therapists, and school personnel. Some recalled instances with children currently in their care in which caseworkers shared with children the plans for reunification or adoption prior to telling the foster parents. In one case the children were instructed by the caseworker to inform the foster parent of the schedule for transitional visits home, without the foster parent ever being notified directly by the worker. The parent replied in report of this occurrence: "[e]xactly, how are we going to teach them to be the children if…[w]e have the social workers letting them be in charge"(Monica, three children in care). In other cases parents felt children were given a sense of too much control, or a perception of being able to make choices which resulted in foster parents need to re-establish parental authority within the foster home. One parent has learned to anticipate this and is attempting be proactive regarding the child's meetings with other professionals on the team.

> It's like my parenting, everything I've worked so hard to do has been tossed out the window for half-hours time. But, I've gotten tough that way. I'm laying down my rules and I'm making my expectations known to whoever she's with. So, we need the liberty to be able to parent in all aspects (Betsy, one child in care).

There is one notable exception to this pattern amidst the cases. Within one case the foster parent clearly and consistently did consider her role as the mother to these children, and appeared in her reflection upon the relationships to have identified in this manner from the start with three of the children in her care. This case was unique amidst the rest in that this family at the time of interviews was nearing formal permanency

through adoption, and this outcome had been a clear possibility from the initial placement. The parent spoke of this early knowledge.

> And when the social worker came to interview us, she pretty much let us know that it was going to be hard and that these children most likely would be going up for adoption. So, we knew that coming in. And so we took them knowing that we would possibly have them for the rest of their lives and they would be ours (Ruth, three children in care).

A permanent or long term placement was what Ruth sought in embarking upon foster care. She and her husband married, " [a]nd I said I really need to have some children around. So, I tried treatment [foster care] because I really wanted kids that would stay put". Later with one of the children in her care, Ruth reported a directive approach to establishing her place as "mom" compared to other foster parents.

> With the mom thing, Brittany, had a period where she didn't do so well in school and so I said "you've got thirty days to call me mom" because we took the computer away. If you say mom, then, you get to have your hour or two on the computer." and it's just for thirty days. "hmm, I gotta call Miss Ruth mom for thirty days. Alright, well, I'll do it so I can get my computer time back…. Thirty days went. Thirty days went. Thirty days went. I felt that she just needed a little push to feel… just try and see how it feels, how it sounds. And it worked out fine.

Foster youth perception of caregiver role. The foster youth perspective is considered here from the view of the children and what foster parents report the of the children's view. Foster youth perceptions of these caregivers reflected that of the foster

parents, specifically the "parental" but not parents. These foster parents were not easily categorized, they were clearly not "my mom" and "my dad" to these foster youth, but they were important relationships for which the children struggled to give a clear name or definition. "Guardian", "counselor-parent", "like a mom", or just [foster parent name] are ways the children tried to label these caregivers. One foster mother reflected upon this ambiguity regarding their role in the eyes of their foster son:

> He doesn't call us mom and dad.
>
> *Are you just a separate category for him?*
>
> I don't think it's mom and dad the way most kids think of mom and dad, but I think he looks at us like authority figures that really… I would hope he looks at us as authority figures that really like him and want to help him. (Kari, one child in care).

A child in care also demonstrated the difficulty of naming and describing the relationship with her foster mother:

> She's nice. She likes to buy things. She just feels like a mother.
>
> *Feels like a mother.*
>
> Umhum (affirmative)
>
> *Can you describe that to me a bit? What sorts of things make her feel like a mother?*
>
> I don't know. Just like… it's hard to explain. But she just feels like a mother to me. It's hard to explain. (Brittany, 14).

Several of the foster youth described their foster mother as "like a mom" in response to behavior of the foster parent. One such child noted of her foster parents that, "[w]ell they take care of all of us, mostly. They really don't think about themselves that much. they think about us more often, what we need help with and stuff" (Kristin, 16). Another foster child similarly considered her foster parent's behavior in thinking about her role:

> I feel like Monica cares more about us and tries to show that. She takes responsibilities that a parent should. Sometimes our bus doesn't run in the afternoon or in the morning, so we don't have busing and she's up every morning to take us to school, too, and my mom never really does that (Sarah, 16).

Having someone "like a mom" could be a confusing role relationship. A teen with a history of multiple foster placements throughout her childhood due to her mother's ongoing drug abuse was unsure how to feel about her current foster mother.

> She tries to have that mother-daughter bond with me to make me feel comfortable, but like I've never had that mother-daughter bond with any other woman, except my mom,… but we don't have that.
>
> *Your [former foster] mom ?*
>
> No, my real mom.
>
> *Your real mom, ok.*
>
> So I don't know what it feels like to have a real mother-daughter bond. But she [current foster mom] tries to help me. But I'm just like "you're doing too much" because she knows my life story. She tries to make me feel as comfortable as possible, but sometimes she does a little too much (Candace, 14).

For others, however, there was no conflict. Another teen girl who had been in her foster home for about as long as the teen above, and who had a similar history of neglect, yet not as many placements, described her feelings about her current foster mom's role:

> *So it sounds like Monica is a help. How would you describe how you feel about her?*
>
> She's like a mom to me….
>
> *Ok. does that mix up your feelings at all since you have your biological mom too or is it ok with you to feel like that towards somebody else*?
>
> It doesn't really bother me.
>
> *Good. Good. Do you think that's going to change when you move back home? Do you think…*
>
> No.
>
> *No?*
>
> 'cause I know that when I go back home, if I ever need her, she's just a phone call away (Madison, 14).

For another youth her perception of her foster mother as "like a mom" was very positive. "She's like my mom, like we're pretty close and she's just a person anybody would like to know and be with" (Kristin, 16).

Therapeutic role: "Thinking like parents and trying to figure them out" (Curtis, one child in care). An understanding of the therapeutic role is where many foster parents appeared to struggle with clear definition. What did appear clear within these families was a perception that therapeutic intervention conducted by foster parents was

within the parental role and consistent with parenting behavior. Curtis (one child in care) described being a therapeutic home as being more an "open-arms kind of care". He went on to describe this caregiving with children in care:

> Well, they're all different unique. I mean, I think that the thing, I guess, is getting to figure them out, is kind of the difficult part of being a parent. It's like meeting a newborn that doesn't speak. But the newborn have very little needs: eat, change, and keep warm. But now you have twelve year old, they need electronics and all this stuff. And yet, you still need to figure out what makes them tick, what sets them off. Obviously does this one lie? Does this one not lie? Does this one tell the truth? We deal with the issues. We get children who are bed-wetters. That's a different mindset, you gotta wash the sheets every day. You get some that have other toilet issues, they soil the pants and it's different. And how do you handle it? It's different. Some won't want to brush their teeth. It's all thinking like parents and trying to figure them out.

Another foster parent described this process of caring for the specific needs of foster youth, even as they addressed treatment plan goals, as within the context of family life. "We're a family base. I'm not going to turn my home into an institution…. It's going to fall under parenting" (Tammy, six children in care). She further described this integration of therapeutic care within the context of family life:

> [D]o they look at me as a mom? Yeah. That's the main role that they're going to see because that's the one I'm playing more so. But, then I slip into the therapeutic aspect, without them really realizing it because actually, it's just life.

> It's just parenting. It's teaching them boundaries, it's teaching them safety. So I kind of get away with it by hovering under that umbrella of being a parent.

Other foster parents had not really considered a separate therapeutic role with kids. Kari (one child in care) was a foster parent before having biological children, and she believed her parenting overall reflected more of her education and research (in counseling) than her own experience of being parented. She initially reported she did not know that she parents her kids differently than she did her foster children, although upon further reflection she said, "Is the relationship with the foster children therapeutic? You know every child is so different, as you know. So I guess in some cases, I really have taken a more therapeutic role". Other parents felt the training they received provided some background for understanding the child(ren) in their care, bur as Kevin (one child in care) stated:

> The treatment foster care, you're dealing with issues. It's one of those where I've learned from experience that no matter how much training you've got, you never feel quite ready. You know, people are going… they have the concept that you have this training, you should know what to do. Experience still is the best. You still… the training kind of gives you the background as to why they're doing this. It just makes coping a little bit easier. I think my tolerance level has improved over the years.

One parent was surprised to discover she needed some additional training to manage the behavior of a child in her care, she initially thought that "if you're loving and you're

giving you won't have that problem. Surely you won't". She described as well the process of seeking to figure out the kids in her care:

> And the child has to be first and you have to look beyond the fault and see the need. Even when they're screaming and hollering and slamming the door, you got to know they're letting out some steam and it has nothing to do with you. You can't take it personal. Not their behavior, you can't take that personal. You gotta look beyond that and actually see that child and what they're asking you for. I think that's the hard part, even when they're there screaming in your face, you have to think it's a cry for help (Ruth, three children in care).

Several foster parents felt their role as therapeutic foster homes meant simply that they were willing to take "tough" kids, or the "naughtiest" kids, yet they do not link this to providing any particular therapeutic intervention beyond alternative (not biological family) parenting and family life. One parent felt it was therapeutic to place a child with them rather than place the child in a group care facility where they could be exposed to many other negative experiences. Yet another noted their home was often a therapeutic placement due to a full change of environment for kids, often moving to a whole new community, as their home was able by TFC license to accept placements from throughout the state vs. merely the county in which the foster home resides. Most foster parents noted the important therapeutic role of the agency supports, especially the in-home skills workers or therapists who are able to work with the youth and in some cases the whole foster family.

Commitment and investment. These foster parents communicated a sense and choice of commitment and investment in these children despite not claiming them as permanently their own. This is a commitment to care while the child(ren) resided in their home, commitment to being present for kids beyond placement, and an investment in a far future outcome for these TFC kids.

This commitment and investment is linked to the foster parents' perception of the foster youth and how they chose them to foster. Foster parents often reflected upon viewing the child(ren) in their care as a "good fit" for their family. One foster family felt "confident that she would be a good fit" for them because they had known the child prior to placement due to attending the same church. It was through this informal connection that they were initially approached to provide respite for this child, a situation which then subsequently led to a longer placement. Another foster parent reported having their foster son in respite a few times to "see how he was", and for the social worker to feel confident making it a long term placement. Other foster parents' sense of fit was based upon more broad criteria, such as the make-up of their family:"it's a boy house", or that they are looking for younger girls. Some foster parents spoke of a spiritual component of choosing a child. Betsy (one child in care) said about making the decision to accept her foster daughter, "[t]o be quite honest, I almost…I prayed on it, to be honest, I prayed on having the right match for our home".

Being a "good fit" had much more to do with foster family characteristics, such as age and gender of biological / permanent children than a foster child's behavioral or mental health issues. Only one parent spoke of choosing against taking placement of

some children and accepting placement for others based upon a sense that she could benefit them with her level of training. Other notable exceptions to this were concerns about accepting placement of children diagnosed with Reactive Attachment Disorder, and that a few foster parent were concerned about the safety of younger children in the home if the foster child had a sexual acting out history.

> One foster mother spoke of their willingness to take the "naughtiest" kids:
>
> [I]f the kids didn't come here, I would think most of them would be in a residential facility. So, we get the naughty ones. And that's fine. I'm ok with that because I would rather have them here than in a residential facility because I want them to be able to transition to a home rather than transition to a prison (Sheila, four children in care).

Other foster parents similarly reported acceptance of kids despite a high level of difficulty, reflecting a belief that these kids hold potential. Emily (one child in care) was told by the previous foster home that her foster son was the "toughest" they had ever had, but this, she said, didn't really scare her and that for the most part, she tries to be open minded.

> You know, a lot of it is on paper. This kid is really….everybody has good inside them. If you read it on paper, they do sound kind of like a monster. Like, oh my gosh, this kid is insane. And some of the things did sound kind of alarming to me, I won't deny that. But a lot of it is situation, environmental, and that causes a lot of it. When they get into a home where it's a little more structured and there

> aren't all these drugs and different things that are kind of out there available, it can change a kid pretty quickly for the time being in the home.

Tammy (six children in care) advised that people "Do the Steven King: whenever you're going to work with kids watch the movie before you read the book". She believed people are afraid of doing foster care because they see all the paper work and never see the child. "I don't ever think I've read a child's file from start to finish because it's what's in their past, and while it is important to know what they are struggling with, you don't need to know every person's opinion about what they're doing. Form your own". Another aspect of fit for Tammy, although infrequent in occurrence, was to not allow kids to remain in the home if they were going to fail: "it's not about me having a failure in my home. It's that I don't want them to feel the failure".

Most of the foster parents reported a commitment for the "long haul". This applied to the present as well as near and distant future. Monica (three children in care) expressed this shared belief as well in regard to the three children in her care, when she commented that she's in it for the "long haul".

> That means I'm here. You know? I don't look at you as just foster kids. You're my kids. You're part of my family. I care about you. I'm not just doing this for a paycheck. I'm not doing this because it makes me look good. I'm doing this because it's what I want to do and I'm not going to desert them. I'm not going to say "you know what? I can't deal with this anymore. I'm out of here. This is not my responsibility." And they also know once they're home, if they need something, they can call me. They need somebody positive and forever in their

> life and if it's me, that's fine. I imagine one day they'll have children and they'll be coming to me for help because their mom is not capable.

Many parents also viewed the commitment to the long haul as an opportunity to use their caregiving and therapeutic skills and for kids to accomplish more. Betsy (one child in care) stated:

> So, we definitely knew that she would be a long-term placement, which to be honest, I'm fine with. It gives me more time to work with the child, better prepare them, tackle some of the things we can tackle here as a therapeutic home. We were of the mindset if it were a child to basically age-out, you know… we were mentally prepared for some of the options that happen with us.
>
> *And what does that mean; mentally prepared for which options?*
>
> Options that this could be not only a six-month stay, but it could be years.
>
> *Got it.*
>
> Given the background and that, we put our mind in a place that we're making a long-term commitment. It is a commitment and not without work.

She said further about her caregiving of her foster daughter, that you "don't go into this lightly… I take things very seriously when I commit to them. She's a human being…..It's come with some hardship, but we don't take it lightly. I'm invested, I'm invested in her".

Connecting to children. Foster parents reported variation in forming connection to children in their care. One parent reported connecting to all the children who are placed in her home. Several reported connecting with most children, some attributing the

failure to connect as the choice of the youth. "you have to give them that support, but they have to make way for you to come in…" (Tammy, six children in care). However, overall they reported that connecting and caring for children was not contingent upon the child's connection to them.

For each family in this study, the foster parents all endorsed feeling connected to the children currently in their care. The feelings expressed about these connections and what it's like to be with these children include feeling "fine", "normal", "comfortable", "a family member", "[t]here are times when it's stressful, there are times when it's very comfortable and a loving, caring relationship. It really varies", "it depends on Lydia…protective", "close", "very comfortable, very casual", and "love".

One foster parent who had felt "attached" to all the kids in her care, believed that this attachment enhanced the therapeutic role. She felt an immediate connection to one child in her care, and felt this relationship has developed over time.

> But a lot of people "God, you guys are so close. How can you function in therapeutic component with her?" and I'm like "well, sometimes it's easier because I've got that intimacy with her where I can chew her out like a parent and then still get my point across." So, me, automatic attachment, I don't care. I'm not going to change my ways. Does it make me effective? I think it does because they know I'm attached to them. Even when they're yelling and screaming at me, I'm like "you know what? You can do whatever you want to do. It still doesn't change the fact that I still care about you. There's nothing you can do that's going to take away my feelings for you." They need to hear that. They need to feel that. And

> you need to say that because we have a lot of kids that are just not having that in their homes. And that's sad (Tammy, six children in care).

Another foster parent described her belief that if the children don't think she cares about them, her caretaking doesn't really matter:

> Having emotional bond helps them to see that I'm serious and I'm not going to just tell them things just for the sake of telling it to them, that I care about them. After we had the big blowup last week, I was down there talking to the older girls and I said "you know what?" They wanted to leave. We were treating them horrible. They wanted to go to a new foster home right away. I thought about it and I thought about the circumstances that there are two other [professional] people in their life leaving and I went back downstairs and I said "you know what? The easy thing to do would be to call Bonnie [county case worker] and tell her to come get you. But, I'm not going to do that. I'm in it for the long haul. Obviously, if you guys WANT to leave and Bonnie feels ok, I can't stop you. But, I'm in this for the long haul" and Madison said something to Sarah and it brought back that, you know, it's you two against the world. And I said that out loud, I said "you know, it's always had to be you two against the world, hasn't it?" and I just started bawling. And I think that was the point where they were like, oh wow, she's serious. She's not just yapping (Monica, three children in care).

Almost all foster parents made a distinction between their "own" kids, biological or adopted, and their foster children in how the relationships felt, and to a lesser extent in

the way they parented. For most it was difficult to articulate the difference, but a few noted specific differences. It could be a sense of primary responsibility or loyalty.

> Well, it can never be like it is with my own. My own six kids will always be first and foremost because they're my kids. I'll always care about the kids that come and I'm going to have a different relationship with every single one of them but they're not my kids. Maybe it's wrong but it is what it is. I can't sit and lie and say that I'm going to treat them exactly like my kids. I can't (Emily, one child in care).

This difference was also be felt in terms of sharing affection.

> Well, there's always a difference. I mean, your biological child, there's always more of a closeness. I don't have a problem showing more open affection to my eleven year-old. Obviously, showing affection to a twelve year-old that isn't biologically yours is kind of an awkward situation and it has to be tried very lightly. Usually, it revolves around hugs or that kind of nature; a pat on the shoulder as you guide them some place. It's very limited. That's kind of… I can raise my kid's arm up and say I want to see that spot on your armpit, see something on your back and poke at it is a little bit different than… so I guess the physical attachment is different between a placement versus your biological child. So there's that line there. Mentally, it's pretty much the same (Curtis, one child in care).

In terms of parenting / caregiving one parent reported it is easier with foster kids. "It's a lot easier with the foster kids because we have rules. *Really?!!* Honestly, because we

have criteria that we can follow if the basic parenting is not working" (Tammy, six children in care).

Connecting to kids was defined better as caring than loving, although that is not say that parents didn't ever love the kids in their care. Connecting to kids appeared linked to the sense of commitment and investment in kids. One parent described that she "values" the kids; another that she always "respects" the kids. Love may have been present or developed, but was not a prerequisite of this connection.

Most foster parents described a process of relationship building with foster children. This may begin as one foster parent stated as "a hate process" in which she provided care despite a child's initial resistance or the other end of the continuum, being prepared for a child who comes in saying "I love you". There were relationship building activities or sensitivities such as asking questions, making foods kids like, attuning to kids cues of comfort or unease, and many other welcoming gestures that these parents enact. Most identified the need to be clear about expectations and rules from the start, although the level of strictness varied family to family. Youth had very little specific recall of this process, but did recall having felt uncomfortable at the start and gradually feeling better. What was recalled by youth was a sense of inclusion.

Children connect to foster parents. Children reported feeling connection to their foster parents. Foster parents also reported believing the foster kids were connected. Similarly to foster parents connecting to kids, this was not expressed as based upon love, but for children was much more upon the experience of being cared for, being helped, and a belief in the parent's proven caring competence. TFC parents reflected their sense

of this connection. "Some way they're going to connect. It doesn't have to be that motherly oh-my-god-I'm-going-to-love-you-forever…. It's kind of a respect thing" (Tammy, six children in care). Another foster parent described of the child in her care:

> Do I think she feels safe here? Yes, I most certainly think she does trust that there's safety here, that she's cared for and that she will be taken care of. But she also does know that… I mean, she will talk "when I go to my adoptive home…" or whatever. So, to create a real attachment to us, I think in her mind might be a waste of time. That's a great defense mechanism, really (Betsy, 1 child in care).

Sean (9) identified feeling safe and loved within his foster home. This connection may have had more to do with a child's confidence that they would be cared for by this caregiver. This foster parent described her experience of this process with these siblings:

> Once she started to trust me, she knew she could talk to me and that I wasn't judging her and that I help her through any situation that arose. She just watched to see how I care for her. She watched to see if it was consistent. When they first came it was like "when we get an appointment, I don't want to miss my appointment, do you have our medication?" They were telling me how to take care of them and I said "you don't have to tell me how to take care of you. I know how to take care of you." so medication was there. Anything they needed was there, clothing, underwear. When she realized "she's going to take care of our needs and she doesn't mind and she loves us". And so, I think that just made it easier to just talk and because she knows if there's a problem, I'm going to try and fix it (Ruth, three children in care).

Observing the foster parent care for siblings was one way some children grew in confidence in the caregiver. One youth who is uncertain about how close she felt to her current foster mother, reports having felt very close to her former foster parents, with whom she remained in contact. She reported of her experience connecting with them

> Like I really opened up with her and she knows how I work and we have a lot of similarities and I was comfortable enough to call her mom and her husband dad……. like [former foster parents]… I felt like I had a relationship with them because they were nice with my little brother and everything, and they would let me be a kid all day. Kenny wasn't there for long, but they absolutely loved him and the first day we went there, when we went there to meet them, they had M&Ms there and Kenny was not sharing his M&Ms with nobody, not even me. He was sharing with [former foster dad] off the bat.
>
> *Wow.*
>
> So they have that bond with each other right away and I'm very protective of my brother because I raised him and everything. So, I have that mother-figure over him. So I gave them a chance and I really liked it there. They were really close with me. They know my story and they were supportive with me and they… they did a lot for me. They even took me to Chicago. I have pictures of us in Chicago (Candace, 14).

Interestingly, in this case the child was uncertain of her connection within the current foster home compared to the previous one. Within her current home another younger sibling had been placed with her and the placement had not been successful, per the foster

parent report. Another foster parent reported feeling her foster daughter connected more with her after she took placement of her baby sibling.

> It made us closer, I think.
>
> *It did? In what way?*
>
> I think because she appreciated the fact that I took the baby and she had to help me out with the baby. Well, they didn't have to but I included them in "can you get me a diaper? You're a great big brother." But it just seemed that she appreciated me more (Ruth, three children in care).

Another common experience of the children who reported feeling connected is feeling that they were able to "be a kid" or to "have a teen life". Most youth also explained relationship importance and strength in terms of being helped. Kids report being helped with their feelings, helped with depression, helped with their disability, helped through sad days or hard times, helped figuring out what they cannot figure out on their own, being helped through being listened to and being known, having parents know "how I work", helped by "playing and spending time", and helped by buying things they need.

Children reported feelings of "getting used to" and "got to know" the caregiver and placement. In many cases it seemed the children's connection had to do with knowing what to expect and feeling familiar. In one case in which the youth chose to return long term to a former respite provider, the foster father was not surprised; he recognized that they had a decent relationship, but that "also he already knew what to expect at my household compared to the other households" (Kevin, one child from care).

This youth echoed the perception of his foster father: "Kevin felt like… I don't know, it wasn't as awkward because I had stayed at his house before, so it wasn't as awkward. He was willing to take me" (Joseph, 15). When asked about his confidence that Kevin would be willing to take him, he reported, "Kevin's a good guy. Goes out of his way to help anybody and I don't know. He's just a good guy. He hasn't proven me otherwise".

For another youth the foster parent perceived that the child does not really bond to them, but "she knows that she's the most senior person, and she attaches to that" (Tammy, six children in care). This youth, however, reported feeling close in her relationship to her foster parents because, "Tammy and Jake have been there for me, they've been taking care of me for the past four years." (Kristin, 16). Another youth in this home reported the connection developed with the foster mother through, "[l]ike getting to know her better and her getting to know a little bit about me" (Desiree, 14). Many youth reported the importance of being able to communicate, to talk with the foster parent, to feel they are known by the foster parent.

Caregiving tasks: ***So, yeah, it's not just lollipops and unicorns*** (Tammy, six children in care). As described by the foster parents and foster children the actual caregiving tasks within treatment foster care were fairly mainstream, although more intensive and requiring repetition.

> Think of it as a " Fifty First Dates" movie. Every morning you wake up and you're teaching all over again until you see that light bulb go off. Then, you can stop doing that. So it's kind of like if you make some references to that, we also make references to bumper-bowling. So, we're kind of like those pads that are in

> the gutter and every time you start going off into that alley where you're not supposed to be, we just kick you back in place (Tammy, six children in care).

Getting kids to school, getting them things they need, establishing a routine, being consistent, figuring out consequences, providing healthy meals, and being there to talk. One foster parent stated about the day to day of fostering: "[t]hey [birth parents] don't make parenting a priority, so don't make it look like it's a miracle. It's not. It still comes down to the parenting". Other parents have referred to their role as being "down to earth", or "we're not going anything magical here. We're not doing anything great…..we're just living" (Sheila, four children in care).

Caregiving tasks appeared largely to facilitate and repair or restore age appropriate development and competence, behaviorally, emotionally, and relationally. This reflected a therapeutic skillfulness and sensitivity to assess individual child deficits and needs and respond developmentally, although the foster parents did not distinguish this as such, just merely described what they did. Caregiving tasks to catch kids up include close supervision, consistency in expectations and consequences, teaching boundaries and "normal attachment", learning ways to show care and affection, hygiene, self-care, socialization skills, manners, problem solving, talking things out, anger management, and cooking.

Some of the sensitivity to individual needs was demonstrated in how parents conducted these tasks in nuanced ways to have effect.

> All of them are so different. So I have to relate differently. The middle one, you could never yell because that is just not the way to do with them and that's exactly

> how one of my children were. I'd raise my voice and that was like shame would come over him. But the oldest of the three, he needs to be yelled at because he, whatever he sets in his mind, is the truth. So if that chair is black and he says it's purple, it's purple and he will fight you to the death because it's purple. It's purple. The only way you can get him to stop is by raising his voice and showing that I'm the boss. And then the little one here, he just needs to be cuddled and loved. And they all want that (Sheila, four children in care).

Foster children reported having their specific needs and wants addressed. A teen foster youth reported: "He got the [driving] permit, and he just does a lot of stuff for me. If I want to do something, he's like "ok, let's do that".....Its helping me get more independent" (Joseph, 15).

Similar to the property of children connecting to their caregiver, foster children and foster parents reported the need for foster parents to demonstrate parental responsibility and authority. One foster mom acknowledged possibly over-reacting to a potential threat to the girls in her care, but acting from protective parental instinct which was important for them to experience. "They know that's how I deal with things. I jump in. I get them taken care of" (Monica, three children in care). In contrast, a youth reported low confidence in her foster mother, as she sought the girl's advice in parenting her own kids, since the foster daughter reported she had "parented" her siblings. The foster mom thought she was being close to the youth.

Providing parental authority could be a challenge within the child welfare system. One foster parent who has worked consistently with the child in her care to establish

appropriate parent-child boundaries and a predictable, consistent role and environment described her frustration working with other professionals on the team.

> It's going to come back to consistency; absolute consistency. Again, not putting yourself into a role of… I don't know, not putting yourself into a role of the playmate or the friend. The moment you give her an indication that you're more of a friend, you've lost… and I don't want to use the word control, but it is… you almost have to control the environment for her to realize that an adult is an adult and she is a kid, because she wants so much control. The other thing is she is ten years old… and this is going to be a system thing to me. A lot of people within the system will say "you have choices. You have rights" and kids don't really… yes, they do have choices and they have rights. But they misconstrue that for "I can go home and dictate in the household what needs to happen." It's so cloudy for them. So much of the consistency is some things that are completely out of my control. I can take care of the environment, I can take care of school, I can take care of her needs. But when we get into some of those areas that I have other people within the system saying "well, this is how it…" and it's like ugh. You really have no idea about raising a child (Betsy, one child in care).

Caregiving / cared for: Interpretation and review of what is known. Foster parents connected to kids through their commitment to caregiving, and kids connected to feeling cared for. These relationships, identified as parental by foster parents and "like a mom" or guardian by the children could be healing and sustaining without formal permanency. The children's presenting mental health, substance abuse, or other placing

issues were not the central focus of the TFC intervention within the home. The caregiving was much more responsive to the needs of the whole child in the moment and reflected the way the family functioned together.

Across cases, treatment foster parents in this study clearly and confidently identified their role in regard to these foster children as parental caregiving. Unlike these findings, other studies have revealed foster parents' confusion or conflict in their sense of their role or identity as a foster care provider: parent or professional (Brody,et al., 2009), or they identified a sense of occupying multiple roles (Wells, et al., 2004). Farmer's 2009 study exploring TFC identified that foster youth whose foster parents viewed their role primarily as parents rather than treatment providers experienced more improvement. Comparison of more or less improvement of youth was not a focus of this study, however, it is of note that within these homes with clearly identified parental caregiving each child was described to have made improvements in their functioning over the course of their placement. Considering the caregiving role of the foster parent as a part of the treatment team in TFC, Wells and D'Angelo (1994) noted the complexity and often discontinuity of treatment amongst the interacting stakeholders (foster parents, caseworkers, therapists) in treatment foster care and the conflict this can create for treatment foster mothers, who were the study subjects. This lack of care continuity across foster parents and professionals was similarly noted in the findings of this study as a barrier to effective caregiver – cared for relationships between foster parents and youth within TFC.

Youth in this current study although predominantly clear that their foster parents were not their mom or dad, struggled to clearly describe or define their relationship with their foster parents, naming them in a variety of ways. Some studies reveal confused or ambivalent relationship patterns (Chapman, et al., 2004; Fox, et al., 2008) or have reported children may characterize relations with foster parents as positive, yet to not view them as emotional resources (Samuels, 2008; Wald, 1988). The findings of this study differ in that the children's difficulty in defining or describing the foster parent did not seem to reflect ambivalence of sense of the foster parent being emotionally unavailable. The foster children's responses seem more to reflect their little familiarity with being cared for or limited experience of parents acting in a consistently parental manner.

Similar to the findings of the current study in which these children actually connected to more to the experience of being cared for by foster parents rather than feeling primarily connected to the person of the foster parent, Heptinstall, Bhopal, and Brannen (2001) found that non-fostered youth identified the importance of parents was for giving them love and affection, whereas fostered youth found foster parents important because they looked after them and biological parents important due to being biologically connected. Interestingly, some foster parents in this present study recognized there was no role conflict in their parental with biological parents because they parents did not parent.

Within this study, as youth connected to the experience of being cared for by the foster parent, only one foster child in the interviewed sample specifically identified

feelings of love in their description of the relationship with their foster parent. Yet these children overwhelmingly described positive experiences within their current foster homes, and the affective impression these children left me with about their current situation was overall of feeling good about where they were, that they were being helped, and that it was working out. In the course of speaking with both child and parents of each other, again overall affection in relationship to each other was apparent. I reflect too upon 14 y.o. girl who reported that she doesn't know what that "mother-daughter bond" would be like; would she recognize it if she felt it? Within these relationship experiences the relationships does not seem that of an attachment relationship, that a "mother-daughter bond" is the not the relational context. However, these relationships do seem to allow relationships experiences that may grow a foster child's familiarity and eventually grow their capacity for more positive relationship with an adult other. It is unclear how these skills and capacities may or may not translate to future potential attachment relationships for these youth, such as intimate partner relationships or parenthood.

These foster families did not present a shared formalized therapeutic understanding of their relationships with these children, and some foster families did not know what made their home or these TFC children different from standard, non TFC foster homes. They did however demonstrate a reflective parenting practice, although they did not identify this in their role. This is evident in every component of the caregiving-cared for category. The parents "look beyond the fault and see the need", think like parents and try to figure them out, and relate to them all differently because they are all so different. It is perhaps this ability and support for being reflective and

maintaining some degree of detachment from these children's externalizing behavior that makes these therapeutic homes. It is striking that across cases the caregiving behaviors or thinking about children which reflect this capacity were never identified by foster parents as outside the parental realm or special in any way.

It is noted in the literature that no one standard of care exists for foster care of emotionally / behaviorally disturbed foster children, that there is great limitation in what is known to be effective in treating this population within a family-based setting, and that theoretical models and treatment methods of TFC vary widely (Farmer, et al., 2002; James & Meezan, 2002; Redding, et al., 2000). Excluding the studies of multidimensional treatment foster care (MTFC) in which a very specific plan of behavioral intervention based upon the Parent Management Training model is utilized (Dorsey, et a;/, 2008), the studies of TFC effectiveness reveal little specificity in reporting intervention techniques beyond stating the definitional requirements of the home and that the foster parents are expected to follow an individualized comprehensive treatment plan for youth (Turner, 2008). The findings of this study reflected this lack of an overarching prescribed or structured model as foster families demonstrate varied style and structure. Additionally, these foster homes did not fully comply even with the broad definitional guidelines of the TFC intervention, including exceeding the number of children placed within a home and inconsistent agency provision of standard therapeutic support services. Foster parents did not articulate a shared understanding of what it meant to be a Treatment Foster Home nor did they demonstrate across cases consistent

knowledge of children's specific mental health diagnoses, treatment plan, or treatment goals.

Amidst the differences home to home, family to family, these findings also reflect some of what has been revealed in previous studies in regard to shared foster parent perspective and relationship processes within TFC, and foster care more generally. Across all families in the current study foster parents shared a belief in the value of relationships, a commitment to the time and effort these relationships command, and a sense of connection to the child. The value of these elements in reflected in the literature. The strength of the relationship between foster youth and foster parents in TFC (Farmer, 2009), and good relationships with other children in the home have been found to be key factors in the improvement of the youth (Redding, et al., 2000), as well as youth who spend more time with their foster parents, (Racusin, et al., 2005), and when foster parents feel attachment and commitment to the child (Harden, Meisch, Vick, and Pandohie-Johnson, 2007). As with the TFC foster parents in this study, foster parents studied previously reported of their connection to the foster child, a feeling that attachment in these relationships is "unavoidable" (Brody, et al., 2009, p.569).

Although foster parents across cases in this current study did not articulate a standard definition of their parenting intervention, many reflect core aspects of therapeutic parenting discussed in the literature. What most foster parents described doing within their own family context and structure reflect what has been recommended for children with these adverse experiences and is referred to in terms of attachment or relational intervention. Components of this prescribed parenting include that foster

parents provide nurturance even when the child acts in rejecting ways, the foster parent leads the child to feel efficacious and loved, relationship is believed to have the greatest chance of impacting the child's distorted representations of self and other, and even in behavioral intervention, the relationship is the key to change (Dozier, et al., 2002). It is clear in the findings of this current study however, that it is not an either / or, attachment or behavioral management: both relationship building and skill building / behavior intervention were happening concurrently, not sequentially.

Foster parents did not report common or fully accurate understanding of attachment theory in regard to the foster children in their care. The foster parents in this study discussed attachment concepts primarily in response to direct questions about attachment and seldom initiated discussion of it in regard to the children in their care. Only one foster parent of one child in the study initiated the discussion of attachment disturbance in regard to her foster child, endorsing current difficulties they believed were due to an attachment disorder, specifically reactive attachment disorder. This parent identified the need for a great deal of time and consistent caregiving to make a change in attachment related behavior issues, and she believed, consistent with other parents in the study, that the child could still find some success even if the child's attachment didn't form. Other children were reportedly diagnosed with reactive attachment disorder, but the foster parents did not believe the diagnosis to be valid for the child, and often did not believe valid for any child due to their experiences of foster children connecting to them and their families and having success. Some seemed to understand that there were good and bad behaviors and feelings about relationships due to a child's early caregiving

experiences, yet seemed to not understand attachment in terms of a continuum of attachment patterns and the probabilistic vs. deterministic aspects of understanding the child's development. Some seemed to think of kids either have attachment problems or not, and these foster parents often did not differentiate insecure-resistant or insecure avoidant attachment patterns from disorganized attachment.

This confusion of attachment theory understanding reflects what Barth and colleagues (2005) have identified as a problem of misunderstanding of attachment within child welfare. There seems a disproportionate level of attention given to diagnosing and concern about treating the effects of disorganized patterns of attachment rather than attention to modification of insecure attachment patterns of older or later placed children (Nilsen, 2003). The reports of these foster parents, and my experience with these foster children, seem to point out an amazingly low incidence of disorganized attachment despite these children's attachment losses and disruptions. These foster parents' perspectives of their foster children were on the whole optimistic about the child's eventual improvement, but limited in their anticipated degree of success at the same time. The foster parents' experiences of connecting with children and that of many children connecting in turn, although often needing more time, may reflect what the attachment and resilience research literature reflects about continuities and discontinuities in attachment patterns, and as reported by Cicchetti, et al. (1995), that although "[c]orrelations are found for maltreated children between early attachment and psychopathology,…... insecure attachment is a risk factor within a complex developmental process, composed of periods of reorganization or transition providing

both opportunity for transformation and opportunity to develop new strength and new vulnerabilities". This experience of foster youth connecting despite histories positive for abuse, neglect, and maladaptation, may also reflect the current thoughts about resilience, recognizing that resilient capacities may be repressed until the conditions to support it are present (Masten, 2011). These foster parents describe providing responsive, sensitive caregiving and a different experience of family, which may be the conditions under which children's relational capacities are activated.

TFC has been explored once through the lens of therapeutic alliance (Rauktis, et al., 2005), revealing that parents and youth perceive the relationship differently, with the parent often more optimistic about the relationship, as was reflected in the present study, as was the finding that biological siblings in the home can impact alliance. Therapeutic alliance may be another way in which to understand, and maybe more importantly, measure, and intervene in relationship development in TFC over time.

Belonging

Belonging as a member of the foster family is a category described in two components. The first component is about foster children wanting to be a part of the family, to feel like a part of the family, and being considered by the foster parent as a family member. The second component of this category is that of utilizing the whole family for change. Foster parents note the role of the entire family in connection with the foster child in TFC.

A part of the family: Being able to feel a part of the broader family system within the home seemed an important task of TFC. For foster parents there was

agreement across families of cultivating foster family membership, and most felt the children currently in their care were a part of their family. Across families, nearly all youth were seeking to belong to the family; many were already experiencing it. Foster parents reported of youth in their care, everyone wants to be a part of a normal family, to be a part of a team.

> They all want a normal family. Like, one of them, when- I don't know who was here, maybe the Guardian Ad Litem or something was here- and they said "what is the worst thing about being at Sheila's?" And they said… I can't even remember what they said but they were like "really? That's the worst?" I think it was brushing their teeth, or something like that. And "what's the best thing?" "When we all do dishes together."
>
> *Oh, my goodness. Wow. What do you make of that?*
>
> They just want family, because at our house, everybody does all the work until the work is done. So we don't have one poor kid sweeping the floor while everyone else watches TV. We all help each other because in the real world, people help each other and we all work together until the work is done. They just want to be part of a team (Sheila, four children in care).

Foster youth reflected seeking and valuing belonging to their foster family. 14 y.o Desiree when asked to describe her relationship to her foster mom, demonstrated further the importance to her of the broader family connection.

> I don't know. I'm just sort of used to being around her, I guess. We're more of a together house or home.

What was that, you're like a what house?

It's more like a family than anything.

Tell me what you mean by that: it's more like a family than anything.

Like there's this chic that I'm standing next to and she's crazy and we get along really well.

Ok. So it sounds just like a family kind of get along with the people you're stuck with.

Yup.

Foster youth throughout this study seemed to reflect more upon the broader foster family in regard to their experience of connection, rather than the specific caregiving relationship. Sarah, 16, when asked about the process of being comfortable in her foster home expressed pleased surprise that she would be a part of a "real family".

She [foster mom] was there for us when we needed to talk about stuff and like all her kids are really supportive, too, because we're closer to them in age group. It's like living with friends. So, it was just really easy to live here.

Wow, that's cool. That's very cool. Has it stayed like that? Once you got comfortable, has it stayed comfortable or has it been up and down?

It's been up and down. I think it's because we're so close in age group, there can be some drama. I mean, sometimes, we don't get along, but we normally work it out.

Does it feel like it's kind of a strange situation or does it feel like that's what a family's like or what does it feel like?

Like when we don't get along?

Yeah, when you have to work it out, sort of the up and down.

I don't know. There wasn't anything I was expecting when I came here. I didn't think we'd have any problems and then when we had some problems, I got like oh, this is a *real* family. I was thinking we weren't a real family before. But, once we started having problems, I was like oh, no, it definitely is a real family.

Kristin (16) identified the broader family group as significant to feeling connected in the foster home and belonging. "They let me in activities and stuff. So I had fun and I met new siblings, I go close to them, too. They were mostly all older and they let me hang out with them, too". Her foster mother pointed this out as well in terms of adjustment and belonging for the children placed in their home, as both a part of the initial adjustment as well as ongoing life together. There was both a corrective element in the broader family connection as well as a broadening of their support system.

It's everybody. They fall into… the nice thing is where it gets really great when you have this many kids. we've had these kids in the home…, it's kind of like you're back to the family thing. A new kid will come in and I don't care what anybody says "they're going to give attitude. They're going to do this. They're going to do that." Really? They'll come in and they will fall into that circle of the peers within the house and when they fall into that circle of peers, you're not going to see the attitudes because they're going to mimic that circle of peers. So, see, it's to my advantage throwing another girl in and letting my girls kind of embrace throughout their actions and activities and it makes me lazy because I

> really don't have a lot to do. I set up the dynamics for the home and I just throw them in and… you know, I've… I rely on peer reporting. I rely on them to help her adjust because they have more attachment to her than I will because of the age;

And later she continued,

> Like I've got a couple of them that hang upstairs with me for a while but you know it's not for any reason that they need to be attached to me, it's the comfort level…..But um, you know, these kids attach to each other too and that peer relationship is important too, and the more kids that come in and the more the peers are peer-relating the less the parents are, we're kinda kicking 'em into play and making sure they're doing what they are supposed to be doin', and I came from a big family so, Bring it on (Tammy, six children in care).

One foster youth, despite being approved for adoption by her foster parents spoke of the ongoing want and need to do things to be a family.

> Well, I always feel like I belong when Mr. [foster dad} brings us places like we all go on a family trip to the zoo, or something. But, now he went to Ohio.
>
> *Really?*
>
> Yeah, because he needed some time by himself. But, I think we should still just do family things, all together.
>
> *Oh, so he's gone for a long term.*

No, he just left yesterday and I think he's going to be there for the weekend. I don't know. But, I just want to do more family stuff with him because we don't really hang out with him that much, it's mostly with mom.

She responded later to a question of the ways she has not yet been successful and / or wants to become successful: "Being a family" (Brittany, 14).

Many foster youth included foster siblings and extended family in their identification of important relationships. Madison (14) reported of the foster family that she feels she belongs, and that, "I'm accepted here, I can act like myself and they won't laugh at me or make fun of me. My [biological] sister made me feel really stupid".

Utilizing the whole family for change. Many foster parents utilized their whole family in fostering. Sheila highlighted the involvement of her whole family in relating to the children in her care:

Yeah. so, would you say that the kids are attached to you?

Yes.

How about to Tom [husband]?

Yes. And Mike [son], and Jan (daughter) and Stuart (son).

Utilizing the whole family increased the resources for kids, especially when they struggled with relationship. Betsy noted," …as a whole, I think our family gives her enough variety in personalities that we always keep her going". Others saw youth benefitting from the experience of belonging to an extended foster family, learning how to function in these relationships. This was one foster parent's experience with foster youth.

> Basically to me, … a person who's in my home for more than a three-month's time, then they become part of the family and of course, my family has become accustomed to that and you know, mother dear cannot keep all their names straight and where they're from…
>
> *Your mother?*
>
> My mother. They become a part of the family and it's the same with Joseph [current placement] at this point. He's part of my family .he's one of these kids that's going to be on the wall [photo] and… yeah. I mean, he's family now. Even though that he's very much in contact with his family, there's still… it's an extended family for him. It's kind of like you better give grandma a hug there, type of thing. And he's very good about that. He's very good about dealing with my brothers, sister and my mother (Kevin, one child in care).

Foster youth got to have a different experience of a family. A couple parents commented that they perceived some youth needed the opportunity to see them model a family, to see alternative ways for people to live and care for each other.

> I don't know… the nature of a lot of the kids that come to foster care, they don't have a lot of the skills and appropriate interaction tools and it's really been a blessing to be able to teach them those things and let them watch how we parent, how we interact with children, and I've felt many times like I guess on a more spiritual aspect, that there are children that have been in our home that needed to see that appropriate parent-child interaction (Kari, one child in care).

Betsy saw this specifically in the child in her care.

> However, with Lydia, I really feel that part of her problem is she has never really had a genuinely involved father figure. That is completely foreign to her, to be quite honest. And when you listen to her role playing or when she's playing, everything is about "well, I'm going to go to court and I'm going to take back…" I mean, it's just a very dysfunctional set of ideas that she has. So, in that aspect, I think that there is so much dysfunction in her thought process, that we are trying to change her thought process on what a husband and wife is like, or what a mother and father, together, is like. And I do explain a lot "you know what? Not all family units are running to court separating kids and people can have normal, healthy marital relationships and they can get along and they can do it without fighting or hitting each other." (Betsy, one child in care).

Experiencing family connection and interaction in a new way allowed a youth the opportunity to make changes.

> I can offer him a different type of family than what he's dealing with, with his bio-folks. It's the type of thing that's probably a bit of a different lifestyle than what he's used to. But I think he can be calmer and less defensive in that aspect. He's not fighting me (Kevin, one child in care).

Some foster parents saw the important natural lessons to be learned in being an equal part of a family, with its benefits and responsibilities. This is true of the relationship learning opportunities within foster-sibling relationships.

> Well, right now Sarah and my almost fifteen year old are not speaking. My Tiffany got very, very upset when Sarah was saying crap at school about me and

> our household that she knew wasn't true. And my kids are very, very protective of me…. And Sarah is like "I don't want it to go on forever." I'm like "you know what? I cannot tell her she has to talk to you. I'm sorry. I wish I could. But she needs to make that decision for herself." And it makes it very awkward. (Monica, three children in care).

Another parent saw the value in where the foster child fits in in the order of children, in order to learn how to be cared for.

> I think it's incredibly healthy for her to be the baby of the family because she was in the older child situation and in her mind, she has raised her brother, whether it's completely true or distorted, I don't know. But she is in a situation right now where she has options, but she doesn't have control because she is the baby. She takes the back seat. She doesn't tell anybody what to do, and I think it's a healthy thing for her to learn that "I am the youngest and you know what? I can't tell anybody what to do" it's kind of a taming thing for her (Betsy, one child in care).

Despite successful change, youth continued to need and seek family relationship. Youth also struggled to understand and cope with family changes over time.

It was within this experience of belonging to the family that empathy and the sense of the reciprocity of relationship seemed to have an opportunity to develop and be expressed. One youth spoke of developing his own sense of reciprocity following the enduring experience of being cared for like family, moving from recurring respite to a long term placement with his foster father.

> Not really. I don't know… he's more like hovery now I realize but… but when I used to go to his house, it was to sleep, basically and then I'd just go fishing all day at the lake. But, now, he wants to go do stuff with him and even when I wasn't, I'd go do stuff with him because he does a lot of stuff for me and I don't want to just take, and take and take. I don't have a problem giving back (Joseph, 15).

A foster father made use of coping with difficult behavior within the household to encourage tolerance and empathy.

> And there're some kids that… we had a respite who just drove everybody crazy and I tried to use that as a teaching tool with the other children and say "you will meet people like this when you get older. You meet people like this in the workplace, you meet people like this that will either A) be your boss, or they'll be somebody who's below that you'll try to get something done for you to present it to your boss. You need accept people like this in your life. Deal with it. I use that as a teaching tool.

Further, of another respite placement who was very demanding and annoyed the other children in care, the foster parent encouraged the other children's empathy rather than solve the immediate problem.

> Well, you just gotta kind of give him his space, you kind of explain, you kind of share this with the other kids and once the older kids get a kind of understanding, "oh, ok." then, they're a little sympathetic, then they back off a bit. And I always tell them, too, you can't always judge people face value. You don't know their

past. You don't know where they come from. I always tell the kids everybody has a story (Curtis, one child in care).

Belonging: Interpretation and review of what is known. Foster children in this study overall reported good relationships and connection within TFC, although they more consistently shared a sense of family belonging than a clear shared understanding of the foster parent role. Foster youth feeling close and connected to the foster family is similarly reflected in the literature (Gardner, 2004a; Gardner, 2004b), although the findings of this current study point out the heightened or central importance of belonging to the foster family for these youth.

Kids change

An important category to determine in this study was to understand how TFC families perceived the process of change in foster care and if this related to the caregiving they described. Foster parents identified change processes that were due to changed physical and emotional environments for children. Another component of the change category describes what kinds of changes TFC foster parents see in their foster children. The final component of this category is a description of the foster youth's perception of how and why they change, and the agency they perceive in these changes.

Influence of environment: Physical and emotional: Whether or not foster youth made a connection to the foster parents, parents reported they could be helped in TFC. Foster parents offered examples of past placements in which children demonstrated positive changes unrelated to a feeling of connection to the foster parent. A number of

foster parents believed the change in environment is the biggest factor in the child making changes.

> It is 90% environment….. Yeah, it is an environmental thing because you can take a child out of their environment and place them in my home and Jake [husband] and I do nothing and he's going to change or she's going to change drastically just from the environment. So you throw the consistent parenting into place and you get 100% out of these kids (Tammy, six children in care).

A big part of that environmental change was the commitment of the parent to care on an emotional not just physical level. One foster parent reported about the impact of changed caregiving environment not merely physical environment.

> You know, I have to say that the emotional part of it is more because I mean, there's times that [biological] mom's had to get her act together and show that she can do whatever; get the house clean or whatever. But I just think it comes down to the emotional being there for you and being honest and supportive and not just when it suits the parent's purpose (Monica, three children in care).

Another foster parent described this caring / caregiving as an important environmental factor for the child in his care.

> I actually, honestly think that most of the behavior issues he's had in his past was all inter-environmental. The places he lived, it wasn't that type of place. It wasn't caring. It was "hey, eat. Hey, go to bed" put a roof over his head, and that's about it… good clothes. You know, food on the table and put clothes on his back and a place to live, that was basically it. And I think coming here, he experiences a little

> bit more hey, you know what, we care about you. What do you want for supper? Do you like these pants or this shirt? Do you want to wear this? Instead of just saying "hey, this is what you got, deal with it" so I think that he sees that there's care there and that we ultimately do very well and we do care. I think that once he tapped into… I think it's always been there, but never was able to show it (Curtis, one child in care).

Foster parent view of success. Foster parents saw the positive changes for foster youth in a variety of ways, both short and long term.

> Seeing him drug-free has been awesome. We do have to conduct UAs on a regular basis because that was one of the things he came in with and he is still on probation. But seeing him drug-free since March: that is awesome. Seeing him come home on time, call to check in when it's before curfew, those kinds of things are a big marker of success for this particular sixteen year-old. Long-term, I would just love to see him go to college. I would like to see him graduate from high school. That would be… I know that the reality and what statistically… I mean, he won't. He won't graduate. I mean, it would be so slim. But we talk about that a lot and we've made a list, like affirmation list, that he's posted on his bedroom wall (Kari, one child in care).

One goal area shared across most famlies was a focus on education. This included regular school attendance, increasing student time of inclusion in the mainstream classroom, graduating from high school, and for a few, hopes for college. A couple foster parents identified for older youth achieving the goal of a driver's license as a

successful step toward independence. Another parent reported successful achievement of a goal in the short term for the child in his care is "… for him to fit into the family, to be streamlined and to be… I guess the goal for him, because it's a long-time placement is to be molded into and kind of getting caught up to where typically a twelve year old would be if they were with us, try to blend into this family" (Curtis, one child in care). However this parent struggled to assess success in the long term.

> It's difficult because most of the children we have are too young to see a lot of that at this point. I think successfulness comes in your early twenties. I mean, you have different milestones, you graduate from school… but I think to really, truly know whether or not anybody's really successful, in my mind, is to say where are you at twenty-three, twenty-four years old? (Curtis, one child in care).

Success may be viewed as more about capacity than accomplishment in the view of some foster parents.

> My kids leaving up out of here at eighteen, do they walk out and they shine and become presidents? No. do they fall on their butts? Absolutely. Every single one of them. But that is life. Guess what? Down you go. Now, the question is whether you can pick yourself back up. People are like "well, they're going to fail" of course they're going to fail! We all failed when we were eighteen, nineteen years old. Now, do they have the tools to make sure that they can pick themselves back up (Tammy, six children in care).

One foster parent pointed out that they always credit the child for change, because no one can make anyone change. Another foster parent expressed a sense of success in terms of

when, “they can be the very best they can, when they can just relax, feel safe, and be happy…. when they can laugh… and they don’t feel they’re missing anything that they really need, I think that’s successful” (Ruth, three children in care).

Foster youth perception of change. When the youth spoke of their success and Change in TFC, many expressed a sense of agency in making their life different, that these changes were of their choosing, were valued by them, and for which they had some control. These changes were both immediate and long term.

> I’ve changed in better ways, like I used to not go to school. If I was tired or didn’t feel like going, I wouldn’t go and my mother would let me stay home. And then, when we moved here, Monica was like “you’re going to school every day.” And I get good grades now and I’m doing a lot better.
>
> *Wow. Good for you. That’s great. Wow. Are you worried about keeping that up once you’re back home or you kind of got that one under control?*
>
> I think I have it under control. I like school, now. I love it. I love going.
>
> *Wow!*
>
> I think once we got back home, I’ll have the motivation to go every day (Sarah, 16)

School was an area of change for many youth.

> Like I know I’m more capable of what I’ve put up before. Like, I could’ve done a whole lot better in school but I just didn’t feel like trying because my mom would let me stay home if I wanted to.

Ok. Wow, so do you think you'll keep going to school even if your mom is not kicking you in the butt to go?

Yes, like if my mom… like, now, my whole attitude about school has changed, like if I don't feel like going to school, I'll go anyway. But like if my mom tells me not to go to school… like I actually stood up to my mom a couple of weeks ago and yelled at her because she would not take us to school (Madison, 14).

Another youth viewed her changes more broadly.

Ok. Do you feel you've been successful here?

With my behavior and academics and everything, yeah (Brittany, 14)

She continued about changes she's made.

Are there things you have learned living here that…

That I shouldn't have an attitude because you can't get nowhere with an attitude. …I don't know. I just felt better here. So I just started building up my behavior.

Do you feel like you made some really clear choices about changing your behavior did it just kind of happen?

Making choices.

Why choose to be different? Why choose to behave differently?

Because I want to have a different life.

Ah, like what?

Just because when I lived in other foster homes, I wasn't doing that good in school, but then when I came here, and I started changing, I started doing better in school. So, changing for my education and everything. (Brittany, 14).

Another youth similarly considered changes she's made in foster care.

Ok. What's different for you?

My outlook on life, school.

Tell me how those are different. What were they like and how are they now?

School, usually… I'd go to school, I just didn't do my work.

And that's different now?

Yeah, I have As, Bs, and Cs….

Good for you. Wow. Why do you think that's different?

Because I realized that I need to have an education to get the things I want.

Ok. And how did you come to that idea? Just getting older and learning that or did…

Well, I just kind of thought that I didn't want to end up like my mom, I guess.

Ok. And how in your outlook on life have you changed? You said that's one other way you changed.

I always thought that I wasn't going be anything. So I started smoking and doing drugs. Just looking forward to being something when I grow up (Desiree, 14)

This youth also spoke of learning that she needs to take care of her mental health to be successful, and identifies that she can do this by "keeping going to my therapist, adjusting my meds, looking forward to life, I guess".

A foster mother reported of her foster son that he too expressed choice and control of his changes in his experience of foster care and his participation in the school community.

> Learn to maintain, like with our current son, learn to go to school on a regular basis, interact with people who are using every day and still have clean UAs every week. So with him, that's what this target behavior is. So, I mean, he's out there. He knows that the kids… I mean, he brought this up at our last case meeting and said this to his probation officer "don't you realize that I can get drugs in the next ten minutes, if I wanted to because I know who uses, but I choose not to" was his point (Kari, one child in care).

Many children also spoke specifically of how the foster parents supported their success and change.

> Since I've been in foster care, I think I handle situations differently; like now, if I have a problem, I'll speak up about it right away. I used to just hold it in and wait until more things happen and then speak up about all of them. But, now, if something happens and I don't like it, I tell about it.
>
> *Wow. How did you figure that one out?*
>
> I have no idea. I can be really shy and really closed, like I won't talk to people. It wasn't difficult for me to open up to everybody here. But they made it really easy, too, and watching the way Monica handles things. Like, if someone's rude to her at the grocery store, she'll tell the manager.
>
> *Wow.*
>
> And so, I think watching her do that kind of made me realize that I need to tell about things that bother me, too (Sarah, 16).

Another youth described new success linked to the foster care experience.

> One thing, I'm better in school;….. Yeah. My grades went from… and I'm not missing any school. They went from Ds and Fs to like Bs and Cs and stuff like that.
>
> *Wow congratulations*
>
> And I went from one day from truancy to not missing any school at all.
>
> *Wow! What do you think has made that difference? Those are huge things*.
>
> The fact that Monica makes me go to school. And I know I can come home and if I have to do my homework here, I can do it here, because I have two study halls and I can do it at school. But if I need to do it here, I have a learning environment that I have here (Madison, 14).

This youth also saw the experience in foster care changing how she acts and feels.

> I'm like more open. Things like meeting with people and stuff.
>
> *Do you feel more confident or do you just feel happier?*
>
> Yeah. I'm happy all the time…….I'm like really energetic. That's another way they accept me here; they accept my energy (Madison, 14).

Another youth was helped to cope with her difficulties.

> Well, they've helped me go through sad days, they're proud of me. And then, they're just helped me along the road to improve my disabilities and stuff.
>
> *In what ways have those improved? Are there changes that have happened for you?*

> Yeah. My one disability got better; schizophrenia. They helped me… oh boy. They just show me who I want to be and everything. They just keep me happy doing what I'm doing and enjoy life and stuff (Kristin, 16).

Another youth believed the expectations of his foster father were helping him be more responsible. He saw this experience with his foster father as help for his future and who he wants to be as well. "I don't know, just teach me how to be an adult and all the responsibilities of being an adult when I grow up and have to move out, or something" (Joseph, 15).

Kids change: Interpretation and review of what is known. Change for youth was made possible when safety and stability were assured. Change was in part in response to this parenting. With safety and security assured, youth began to consider and make choices for their lives. The children were safe to try things, knowing they would be "bumper bowled" as needed.

The findings noted above regarding how caregiving which established safety and security led to the child changing is reflected in the research of attachment interventions and of foster parent views of change and success in foster care. This study adds the view of the foster youth whose report of their success reflects this process in concordance with their foster parent. These findings also include a child's sense of agency in the changes they make, that they have made clear choices for their behavior and setting goals. This reflects the literature of the importance of support for the child's self- efficacy or self-determination within foster parent skills and strategies (Jones & Kruk, 2005; Lipscombe, Farmer, & Moyers, 2003).

The findings of this study regarding children changing may demonstrate this resilient framework. Many foster parents accounted for this in terms of claiming it is the environmental change rather than the relationship that provoked change for foster youth in their care. Caregiving can be viewed however as a dimension of the changed environment of adaptive systems. Additionally, much of what was identified within the caregiving / cared for components of this study, reflects the model of attachment and resilience-based parenting for successful foster placement (Schofield & Beek (2005, 2006, 2009) comprised of five dimensions of caregiving including availability (helping youth to trust), sensitivity (helping youth to manage feelings and behavior), acceptance (building young people's self-esteem), co-operation (helping youth to feel effective), and family membership (helping youth belong, although no foster parent identified it this way. This model proceeds from the understanding of resilience as process and a recognition that resilient processes may emerge given changed conditions or opportunities.

Relationships Developing and Persevering Over Time

Relationships developing and preserving over time is a component in the process of relationship as well as part of the perception of the relationship held by both foster parents and foster youth. The first property of this category is that of the beyond placement perspective; both foster parents and foster youth anticipating connection during and beyond formal placement. The second component of this category is the impact of time / duration of placement upon expectations of caregiving. This is often experienced as a barrier to connection and change.

Beyond placement. Foster parents reported the frequent occurrence of foster youth maintaining contact and a connection beyond placement, both for those who age out / transition out and those who return home or go to other placements. In describing this theme I included data foster parents shared about previous placements. The foster parents offered his information within their interviews when I followed up on responses that indicated a belief that current foster child connections would endure beyond placement. Openness to these ongoing relationships was shared across families, and the experience of it was true for all excluding those in their first fostering experience. Foster youth too expressed an expectation of long term connection to foster parents and foster families. One youth actually named this as an important factor in choosing to build a close relationship with her foster parents. "I kind of think it's an important thing because if something goes wrong on your way out, you have somebody to turn to, to talk to" (Desiree, 14).

One foster parent has had contact from every youth who transitioned (aged out) of her home; "All my kids, because they don't technically leave, they just move out" (Tammy, six children in care). Children stay in touch to just to stay in touch. Children called for support such as when they are having their own children or need help figuring out what to do. Children call in times of trouble.

> [S]o like some of the other kids that have been here for a long time, they call me when they get sent to jail in the middle of the night. And I'll say "have you called your mom?" "No. would you call my mom?" ; "sure. I'll be happy to call your

> mom. But, next time, call your mom and have your mom call me." goodness gracious! (Sheila, four children in care).

Some foster children seemed to call because they know what to expect and count on of the foster parent's response.

> And I have another boy that calls me because he's in legal trouble and I'm like "dude, you realize I have to turn you in." I've turned him over to the police twice and I'm like…. I think he's looking to be turned in, though, because otherwise, he wouldn't come to me. He knows I have to take him in. I'm like "while we're going to address this, I have to take you to the police station. You need to talk to the police about it." (Tammy, six children in care).

One foster mother in anticipation of the children in her care calling after they returned home, expressed some doubt that the children will know how to make use of this support, or to ask for the help they need, beyond calling to complain, although she hoped they could make use of her help when they needed it. Another parent expressed a sense of regret for allowing a child to be moved out in response to very challenging behavior; she maintained a hope that this child could someday return.

> So, she was removed and she was not allowed to come back mostly because of the children. They didn't want her to come back. It was hard for me. I had to say "ok." I had to protect their safety and their feelings. So she wasn't able to stay. But, hopefully she can work her way back….. . And right now, I'm really sorry that we let her go, because I think if we had continued to just work through that, that she'd be ok (Ruth, 3 children in care).

Within these families there were children and biological parents who chose their current placement based upon past experience with that family. There also are multiple foster families who saw kids for recurrent respite arrangements. In many of these cases although placement was a formalized process, the maintaining of contact had been informal.

Time expectation. The expectation of time duration of placement, long vs. short term or stable vs. transitioning phase of placement, impacted very much how much and what a foster parent did in regard to a placement, and the child's experience and willingness to engage. The impact of time expectations was a component of the treatment foster care experience almost universally addressed across families with general agreement for what it can mean for this experience. This expectation can also be experienced as uncertainly or unreliability of time expectation. One foster parent identified this with her current placement:

> [I]t was a different way of establishing a relationship thinking she was staying with us for two weeks and in the course of that time having to say "no, you're staying with us" and really thinking that it could've been a longer term placement, maybe up three years. It's been kind of a crazy six months; ok, you're going to be here two weeks, ok, you're going to stay for the long haul, until you're eighteen. Ok, now you're not going to be here anymore (Liz, one child in care).

Both foster parents and youth noted the impact of time expectations upon the youth's connection to the foster family. The parent from above considers this about her foster child's feelings about connecting with the foster family:

> Yes, I think it's important to her. I don't think she gave it an opportunity to feel… and then what ended up happening is that knowing that that transition with her grandma and she really wanted to maintain, even before we knew the outcome, she wanted to maintain those relationships, that it just kind of ended up that when we had extended family things, she was going with her grandma or her aunt. So there wasn't a lot of opportunity in the beginning and summer time, we had people over and she met… because I have nieces close to her age and they were really excited to meet her. Met her thinking she would fit in our family good and… so I think people were open and welcoming and for whatever reason, she says she feels uncomfortable and I don't know that it's because she feels that she doesn't belong. I just think that it's a lot to open yourself up to make more relationships with more people…. (Liz, one child in care).

This child in Liz's care reflected this situation in regard to her relationship with the foster mother. "I just don't feel like I need to have a bond with her if I'm only going to be here a little while….They keep telling me I'm going to be leaving her pretty soon, pretty soon, pretty soon" (Candace, 14). The changing time expectation impacted how kids chose or were able to make use of foster care. It set up a real challenge for foster parents to know how to be helpful, as described by this foster mother:

> And she got really emotionally messed up before they went to court the first time, about two months after they were placed. And that's how long it was supposed to be, it was two months. They were supposed to [go] after that court visit but mom hadn't complied with what she was supposed to do and Bonnie [county case

> worker] said "I just don't think this is a good idea at this point" and at that point, the girls went from no, I don't want to go home to yes, I want to go home now." because I think they thought they were going to have to so might as well be happy with it and be ready for it, which in turn made them less receptive to my anything. They didn't want anything to do with me at that point. They wanted to go home, anyways. What I said, thought, felt, didn't matter (Monica, three children in care).

Monica described further that at the four-plus month point in placement these children are again in an uncertain state of transition, and she felt that in many ways there has just not been enough time to really help change the girls' way of life in a lasting way. She reported feeling a conflict of just not knowing what she can actually accomplish in the time remaining, and knowing at the same time, that it was her job to try.

This knowledge of a short time frame did not only limit engagement, but led to an escalation in a child's maladaptive relational behavior.

> But he came in with the understanding that it was going to be a short period of time. Just so he could spend a couple of weeks to finish up the school year…. . So of course, that night, he knew he was leaving and it was the textbook "if I'm going to leave, I'm going to make you hate me so leaving is easier" type thing (Kevin, one child from care).

An expectation of a longer time frame could help the youth connect with the foster family. One teen girl was initially told she would be in the foster home for 60-90 days. Her placement was extended to a long term placement. Rather than any specific event or

caregiving, "[j]ust knowing that I'd be here for a while", is what she attributed to feeling less nervous and comfortable in the family (Desiree, 14).

Time expectation impacted the goals foster parents had to work toward with kids in their care. Many treatment foster homes began care with youth either not knowing how long they will stay due to the details of their child welfare involvement, or due to initially being placed for short term respite, which could turn into long term placement. One foster parent who began care with his placement as respite recognized a change in both the youth's needs and the parent's care opportunities when the youth returned long term.

> When you're dealing with him with foster care, you're dealing with him on respite, you're dealing with him a short period of time. Now, having him full time, I'm realizing that some of these issues that he can cope with for short periods of time might show its ugly head, as such, and there are some more decisions that you can kind of make that you make that is probably going to be more long term. In a sense, I'm in a different situation (Kevin, one child in placement).

Foster parents were aware of different goals for short and long term placements, and they were not always comfortable recognizing these differences in their care.

> So your goals are placed differently by the child and how long your placement will be. And usually, well, they're here three to four months. Well, then I have in the back of my mind… I'll say ok… I'm not here to change any child to the point to where… if they're going to be with me two or three years, then, yes we're

> going to groove into the model of how this family runs. If they're with me for two weeks, hey buddy, brush your teeth, put your pajamas on, sleep, wake up, go to school. That's all (Curtis, one child in care).
>
> If it were a child that I would see in placement for less than six months, I can't say that I would… I would still put the energy in but in my mind it would be like I will do what I can do until you get back to your parents……Does that seem horrible? I don't know. But, you know what? You know ultimately, you're going to probably have some impact, but very, very little. So, you'll do what you need to do to get through the day. You'll make the improvements where you can make the improvements (Betsy, one child in care).
>
> I guess it depends on whether they're respite or placement, but I mean for all of them would be to have a safe, loving place to be. And long-term and respite, too, a little bit, just working on different things like respect, responsibility and if there's anything else that the parents or the worker have said there's something they need to work on, like healthy eating or activity or… I mean, it really varies. But, for long term, I want them to feel welcomed, to feel loved, comfortable, able to talk to me, able to trust me to take care of whatever issues in the past or anything that comes up in the future (Monica, three children in care).

Relationships Developing and Persevering Over Time: Interpretation and review of what is known. A handful of studies in the literature reflect a pattern of foster parents and youth maintaining connection "long term", connecting with foster youth beyond placement, and perceiving this connection as an indicator of success (Brown &

Campbell, 2007; O'Neill, 2004). The foster children in this study by and large expected to stay in touch with their foster families beyond placement, but it is not clear they knew how to make use of these relationships or how to seek help for what they actually need. This may need to be more explicitly taught. The foster parents in this study, similarly expressed this expectation for the child(ren) currently in their care, and report of it having occurred with past placements, all at the initiation of the youth. It appeared that there was not a clear sense of the community agency's recommendation or support of this practice as it was inconsistent across families what foster families understand to be the agency expectation regarding ongoing contact.

Schofield and Beek (2009) note that the need of older youth for ongoing secure relationships is minimized and thus is not well supported by policy or practice. However, the research suggests that both for adolescents experiencing new placement or continuing long-term placements, the task of achieving a supportive foster family who can provide a secure base into adulthood remains an important and attainable goal for some. It may be required that programs be more clear, supportive, and plan-ful or instructive about how to maximize the relationship over time.

Additional Smaller Findings

Beyond the major themes, across families there were notable commonalities and differences that further inform the findings. Given that these foster children all carried mental health diagnoses and foster parents were provided training regarding this aspect of TFC, it is interesting that nearly across all families the child's diagnosis was not reported by the foster parent consistent with the diagnosis of record, or in many cases, the foster

parent was not aware of what the specific diagnosis was. Related to this is that foster families differed in how or to what degree they directly treated or consciously made accommodation for a child's mental health behavioral health condition. Additionally, foster families varied widely in their expressed understanding or interpretation of what it meant to be a treatment foster home, and foster families have a variety of habits, expectations, and structure of being a family. Families also had different positions in terms of their openness to permanence with these children. One family was specifically seeking permanent children, a handful of other families were open to the possibility of adoption if the "right" child came along, many families were open to children remaining long term, even to the point of aging out, and another family felt long term was not a good fit for their physical space. Yet, as mentioned in the themes above, across all families, families had both openness to and an expectation of many children maintaining connection to the family beyond this current placement.

When asked about their understanding of attachment in regard to TFC, foster parents had different ways that they understood attachment, yet across nearly all cases, reference to attachment was negative, suggesting the assumption that attachment when an issue in TFC is damaged and stable, not open to change. Additionally, attachment was viewed by most as a characteristic or capacity of the child rather than a modifiable system of behavior, and only a handful of foster parents identified any intentional process of engaging a child whom they felt had issues related to attachment in nurturing or fostering secure attachment relationships within TFC. In fact many foster parents commented upon selecting against placement of a child with an attachment diagnosis or

reported attachment problems believing the child would be "too far gone" and beyond their skills to help. Yet it is observed in their report of caregiving tasks and role, that many of these parents are practicing parenting skills consistent with recommended care for children with attachments disruptions.

In regard to the current children in their care, including those with identifies or perceived attachment concerns, foster parents expressed overall confidence that they could meet the needs of the children. It stands out that within the family in which the parent who expressed some parenting role uncertainty and who was more conscious of being emotionally close than being specifically helpful to the youth in her care, neither parent nor child reported much relationship development nor youth change during placement. Where dyadic data were available, a pattern began to emerge in terms of feeling and perception of relationship closeness / trust. Although youth feel more close and trusting than not, they consistently report a lesser degree of closeness and trust in the relationship than do their foster parents.

Additional findings: Interpretation and review of what is known. Within the home, fostering in TFC does not appear markedly different in execution than traditional foster care, although there does appear to be a greater expectation for and tolerance of consistently responding to maladaptive and resistant coping. TFC foster parents are raising children whom they have decided to care about and in whom they have invested. It is perhaps this decision to care despite the barriers that makes this intervention therapeutic parenting. This reflects the understanding of a foster parent's commitment, described by Dozier and Lindhiem (2004) as the level of investment in the child's current

and future needs, placing the child's needs above their own, and the desire for a long term commitment with the child.

TFC foster parents' connection to kids was linked to a sense of commitment and investment despite the child's readiness or capacity to connect to them. This suggests a type of relationship that is unique within a TFC family, similar and different in some ways to a parent-child relationship as well as similar and different in different ways from a therapist-child relationship. These relationships, their formation, development, and utilization may be better understood in their unique aspects rather than compared to other relationships.

These findings reflect suggest a more complex study of relationship. As the nature of the treatment foster care relationship depicted in the findings of this study suggest, these relationships are in many ways parent-child and therapeutic or helper-helped, which adds to the complexity of making sense of the mechanism of relational change.

The study of relationships across disciplines is growing into what some are calling *relationship science* (Bersheid, 1999), seeking to understand the phenomena of relationship and to understand the shared laws or principles across different types of relationship (Reis, 2007). Relative to this study, Reis suggest a common organizing principle across relationship types as perceived partner responsiveness; arising from developmental theory and responsive parenting, this is a "belief that relationship partners are cognizant of, sensitive to, and behaviorally supportive of the self" (2007). Similarly, Loulis and Kuczynski (1997) discuss an understanding of parent-child interaction in

terms of bidirectionality, shifting assumptions about the nature of parent-child relationships in regard to causality (reciprocity, scaffolding), agency (both child and parent as active participants), and power (dynamic). They suggest that relationships are understood across time, nested within a past and a future, and across multiple contexts.

The research and models of therapeutic alliance and the treatment process provide a possible way in which the complexity of TFC relationships may be understood or explored. TFC has been explored in one study through the lens of therapeutic alliance (Rauktis, et al., 2005), revealing that parents and youth perceive the relationship differently, with the parent often more optimistic about the relationship, as was reflected in the present study, as was the finding that biological siblings in the home can impact alliance. Therapeutic alliance may be another way in which to understand and measure relationship development in TFC over time.

Figure 4.1: Hougaard's Model of Therpeutic Alliance

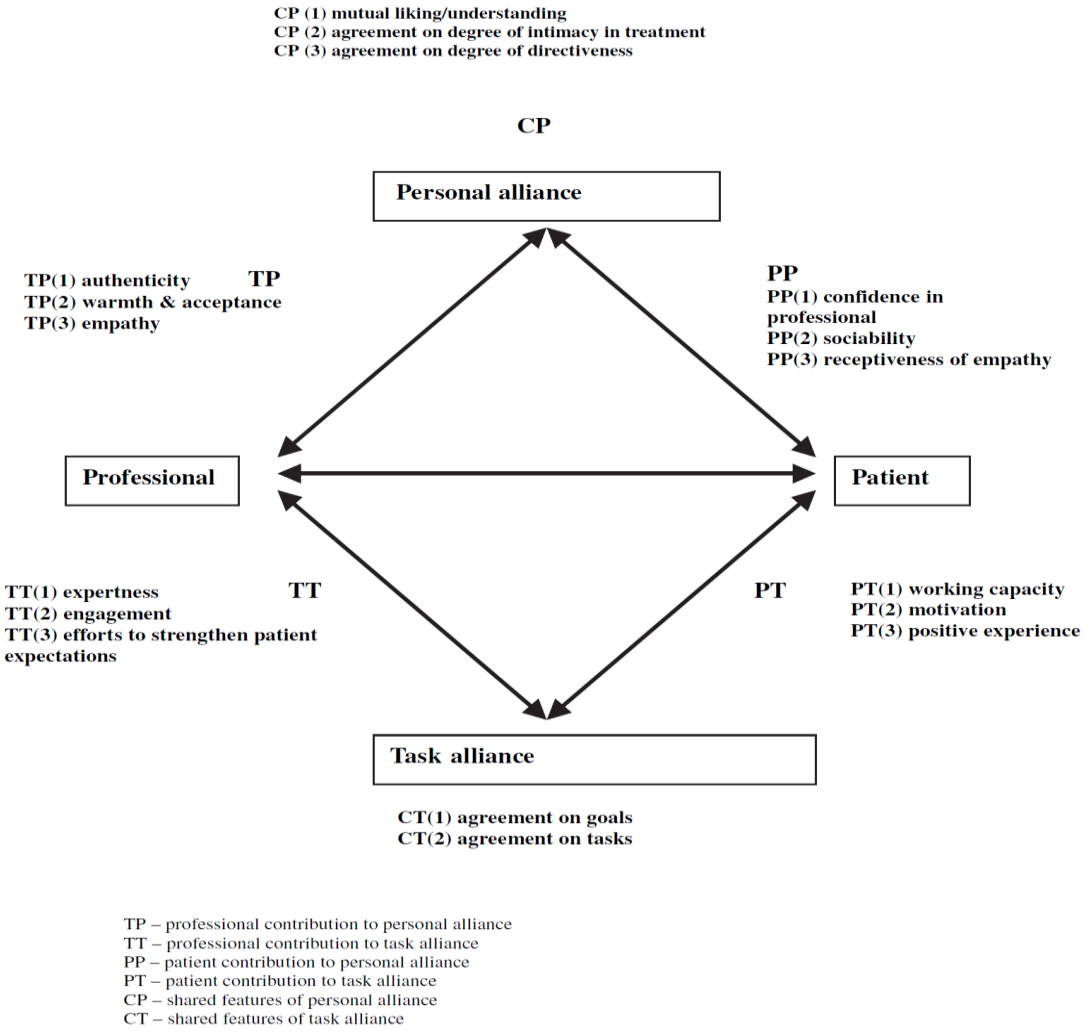


Figure 4.1 depicts one proposed model of therapeutic alliance within children's mental health treatment, composed of personal alliance and task alliance with contribution of both child and therapist. This model reflects the belief that we must understand both the content and the quality of the relationship. From "Annotation: The therapeutic alliance – a significant but neglected variable in child mental health treatment studies," by J. Green, 2006, *Journal of Child Psychology and Psychiatry, 47*(5), p.427. Copyright 2005 by the author.

Figure 4.2: Therapeutic relationship constructs treatment process model

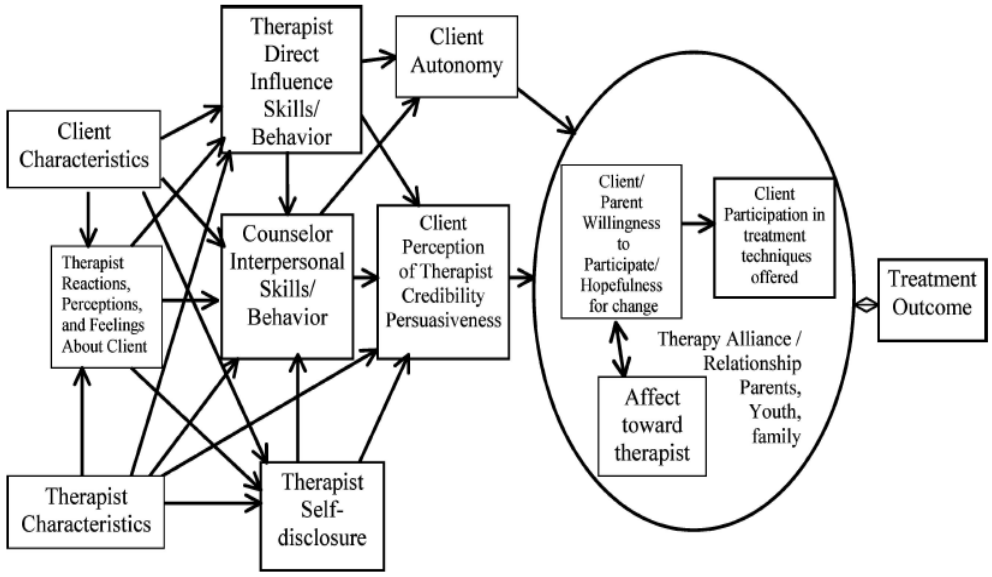


Figure 4.2 depicts a proposed model of the treatment process for youth and family, composed of therapeutic alliance as merely one factor in the change process and multiple potential moderating or mediating factors. From "A theoretical model of common process factors in youth and family therapy," by M.S. Karver, J.B. Handelsman, S. Fields, & L. Bickman, 2005, *Mental Health Services Research, 7*(1), p. 37. Copyright 2005.

To consider relationships within TFC as factors of the common mechanism of change, the process or events leading to therapeutic change (Eltz, et. al., 1995), makes sense in light of the finding that despite a lack of another standardized intervention model within these TFC homes these home seem to share common elements in terms of the understanding and use of relationships in change efforts.

This study has described the relationships within TFC in terms of common patterns and properties. Properties or components of caregiving within the development of the relationships within this study may be understood within mechanisms of the development of therapeutic alliance and the evolving nature of attachment patterns. The development of effective strategies to aid relationship building with school age and older children in foster care is very limited yet research of attachment and representations suggests that middle childhood may be viewed as a sensitive period for solidifying representations, and that children's sense of relatedness to a particular person tends to reflect their actual interpersonal behavior with that partner (Poehlmann, 2005).. Thus providing relationships that are not compatible with models based on adverse caregiving or maltreatment experiences may be an effective preventive effort (Milan & Pinderhughes, 2000; Rushton, et al., 2003).

In regard to therapeutic alliance Shirk and Saiz (1992) suggest a developmental social cognitive model for understanding alliance formation, recognizing that earlier attachment experiences of children may impact the child's expectations of the helpfulness of others but that these expectations may be mediated by other social cognitions, especially as the child reaches middle childhood and beyond. They posit that understanding a child's engagement in alliance formation in terms of defensive or pathologic processes does not lead to intervention strategies, whereas the developmental social cognitive model identifies cognitive change strategies for restructuring beliefs about evaluation of self, causal attributions, and interpersonal expectancies which may be barriers to alliance formation.

An interesting finding of this study is also that the children served within TFC, although differentiated by the identification of their qualifying diagnosis or behavioral disturbance, share with traditional foster youth similar feelings and perceptions of foster care. Overall youth report feeling satisfied with their foster placement and that they get along with their foster parents (Chapman, et al, 2004, Delfabbro, et al., 2002, Fernandez, 2007, Wilson & Conroy, 1999). As in this study youth report the importance of foster parents spending time with them and making them feel comfortable (Fox, et al, 2008) and to desire or experience belonging regardless of permanency (Andersson,1999, 2005; Heptinstall, et al., 2001, O'Neil, 2004). A study of the experiences of "specialized" foster parents in the U.K., comparable to TFC type foster parents in the U.S. (Hill, Nutter, Giltinan, Hudson, & Galaway, 1993) reported the foster parent perspective that all children in foster care require the level of care and resources provided for "specialized" children, viewing their essential core needs within foster care as the same. These findings point to a general need for more understanding of and investment in child well-being in foster care overall, not just TFC.

Chapter Five

Discussion and Conclusion

Through this study the relationship between TFC foster youth and foster parents has been explored. A summary of this study is given below, followed by a summary of the study findings in response to the overarching question: How do treatment foster parents and children in their care experience and describe their shared relationship? The remainder of the findings discussed are organized to respond to the more specific research questions that I chose to guide this inquiry. The conclusions of these findings lead to a consideration of implications for social work practice, policy, and future research. I tentatively conclude of these families that the fostering relationship in TFC is a therapeutic relationship in which responsive and reflective parenting, parenting that supports the development of attachment and resilient capacities within foster children, is the primary strategy. I further conclude that this relationship and the experience of belonging to a family are components in the mechanism of treatment change for TFC children, components that may likely be enhanced and have greater influence upon child outcomes if their component parts are more deeply studied, understood in regard to effectiveness, taught, and supported.

Summary of the Study

Treatment foster care is a family-based intervention designed to meet the complex needs of many foster children with emotional, behavioral, and mental health needs that impact their day to day functioning. The adverse experiences of these children may include experiences of abuse, neglect, traumatic events or loss, or an unavailable or

incapable caregiver in their home of origin or adverse or disruptive experiences during their journey within the foster care system. These experiences may compromise their development in many ways and alter their ability to form and make use of new relationships. TFC intervention generally as well as various relational interventions targeted to attachment relationships and interventions to repair systems compromised by relational hardship and developmental disruption demonstrate some effectiveness to foster adaptive outcomes for these youth. However, much remains to be understood about change for children in TFC including understanding the complexity of relationships as the central intervention within these treatment homes.

The purpose of this qualitative study was to explore the perceptions of the shared relationship between treatment foster parents and the children aged 8 to 17 years in their care. Purposeful sampling was used in the recruitment of cases, seeking for a variety of experiences to more fully describe the treatment foster care relational intervention experience. Participants were recruited in coordination with the community agency TFC site directors; the directors distributed the initial research request to licensed TFC foster parents whose foster family met the inclusion criteria, and these foster parents then contacted me directly about participating. I encountered many barriers in recruitment, including low response of foster parents, delayed recruitment at some sites, difficulty gaining consent of caseworkers for the participation of foster children in this study, and reluctance of agencies to partner in the research. Despite these difficulties, following ten months of recruitment and data collection, there were a total of ten families for which data were collected and analyzed. Data were collected through 18 semi-structured

interviews with ten foster parents and eight youth in their care and community agency child case file document review. Data collection and analysis occurred concurrently throughout the study and analysis relied upon data collected through interview and child case file reviews. Data analysis, informed by theory and clinical knowledge, was guided by the analytic methods of coding and analysis involving first thoroughly familiarizing myself with the data in the context of theoretically and practice based broad themes, identification of initial codes, developing and using focused codes for further analysis, and identification of patterns and themes to describe this intervention and identify implications for social work practice.

Summary of Findings

The findings of this interpretive description study elucidate how treatment foster parents and children in their care experience and describe their shared relationship. Four patterns have been identified as themes in the findings that describe and explain the relationship between foster parents and foster youth in TFC. These first and largest theme is the caregiving / cared for theme which described of how foster parents and foster youth perceived their own and the other's relationship roles, the perception of the connectedness of the relationship, a sense of what it meant to these foster parents to perform their role with these children, and how the actual caring actions dictated and were dictated by these perceptions. Belonging as a theme was distinct from the caregiving / cared for theme in that this pattern reflected relationships with the family beyond the foster child-foster parent dyad and a broader understanding for the foster child of being connected and understanding the family experience itself is a therapeutic

intervention. The third theme of Children Change reflected how this intervention enabled or provoked change in foster children's functioning as described by foster parents in terms of environmental change, both the physical and emotional environments, and foster children's perception of how they chose to make changes based upon the foundation of TFC relationship stability and advancing through a sense of agency in their life direction. The fourth theme spans the spectrum of time expectations in which there was the perception of both foster parents and foster children that these relationships were not bound by the duration of the formal placement itself, but that when the duration of placement was thought to be brief or when the duration was uncertain, so too were investment and change limited.

Discussion of Findings

This project was designed to describe the relationships at the center of the TFC intervention for the purpose of direct application to social work practice. The fostering relationship reflected within this study of TFC is a therapeutic relationship in which responsive parenting, parenting that supports the development of attachment and resilient capacities within foster children, is the primary strategy. This relationship and the experience of belonging to a family are components in the mechanism of treatment change for TFC children, components that may likely be enhanced and have greater influence upon child outcomes if their component parts are more deeply studied, understood in regard to effectiveness, taught, and supported. This conclusion was drawn in reflection upon the broad themes within the findings, informed by the theoretical and

clinical practice foundations, and shaped through the consideration of these findings to the specific guiding questions below.

1.To what extent do children and caregivers characterize their relationship as close and supportive? These relationships were described by foster parents as "not mom" or "dad", yet "parental", and "like a mom" or "guardian" or "authority" by the foster children. Foster parents reported feeling connected or "attached" to their foster children, that they were like family and were treated like their own children, yet they distinguished that the relationship felt different for them than their feeling for their own children, either biological or adopted. Foster parents connected to kids through their commitment to caregiving and kids connected to feeling cared for, more so than connecting to the foster parent particularly as a person. Many foster youth referenced admiration for or appreciation of their foster parents, but this was in response to the care and help they received from the foster parent. There was in the experience of the interviews, an overall sense of affection between foster youth and foster parents.

Understanding this relationship closeness in terms of therapeutic alliance is more fitting than the mistaken or inappropriate relationship expectations of this unique relationship, such as to apply the concepts of parent-child relationship or nuclear family relationship to these fostering dyads and families. Within Hougaard's therapeutic alliance model relationship closeness could be assessed in terms of personal alliance composed of the foster child's confidence in the foster parent and overall sociability and the foster parent's empathy, warmth, and authenticity (Green, 2006).

2. To what extent do they perceive their relationship to be central to

children's emotional and behavioral functioning? Within this study the findings reflected that the relationship connection in TFC could introduce the children to new experiences of family life and the purpose or usefulness of family. Foster parents viewed change in their foster child's emotional or behavioral functioning as the response to the changed environment, identified as both the physical or structural environment such as living within a consistent, structured home setting with parental authority roles, as well as a change in the emotional environment of having someone care for, respect, and value them (the foster children). These findings also described how a caregiving relationship which established safety and security led to the foster child changing and choosing to change.

Learning and changing through new experiences of family connection and changed caregiving is reflected in both the research of attachment interventions and of foster parent views of change and success in foster care. A new finding of this study in regard to the influence of the caregiving relationship is that TFC relationships appear to not work as effectively if a member of the parenting system of the foster family chooses to not participate in a meaningful role. This may create anxiety for youth; the youth in this study do not appear to need equal parenting participation, but meaningful or purposeful parenting participation.

These findings again reflect the utility of the model of therapeutic alliance, such as Hougaard's, to understand the change capacity within the relationship. Recognizing the components of task alliance in which the foster parent contributes expertise, engages the foster child, and makes conscious efforts to strengthen the child's expectations,

coupled with and enhancing the child's working capacity, motivation for change, and positive experiences (Green, 2006).

3.What challenges do foster caregivers identify for the child's relational functioning? What strengths? The foster parents in this study seemed to be huge champions of the strengths within these foster kids. One foster parent referred to her foster child as a "diamond in the rough". Another talked about how despite what any case file contains, there was good in everyone. And several others advised to not form an opinion on the file information, but to get to know the kid. This sense of child strengths did not come across as rose-colored-glasses or an ignorance or avoidance of the child's troubles. These foster parents spoke plainly about the struggles of their foster children, but these seemed to be taken as the "given" for children within their care.

Challenges identified by foster parents were mostly external in nature, rather than internal or characteristic of the child. One challenge is dealing with other treatment providers, such as therapists, case workers, or guardian ad litem. Foster parents experienced their parental efforts undermined by professionals who did not maintain appropriate adult boundaries with the foster children in regard to making choices, maintaining behavioral expectations, and lines of communication. The other significant challenge was that of time or duration of placement. In situations of the brevity of placement or unknown term of placement, youth and parents reigned in effort and engagement. This seems a potential big waste of time, effort, and money to not commit to a clear timeframe of care to meet the needs of the child.

4. What are other descriptive child factors including the mental health

diagnosis and measure of behavioral functioning at intake, out-of-home placement history, and biological family visitation arrangement of the child in treatment foster care which may impact relationship capacity? The foster parents did not really identify child factors of diagnosis, behavior problems, previous placement or biological family arrangements as having much influence upon a child's capacity to connect to the care provided in their home. I think this is in part due to the overall expectation that these foster children do most often connect to the home or family, but that the care they receive in the home is not contingent upon the foster child connecting. Additionally these foster parents mostly did not expect an "l love you so much" type of relationship connection from their foster children. As such, it is likely these parents' evaluation of the children's relational capacity is based upon this informed expectation. Another aspect of expectation is that these foster parents reported often that they knew they took kids other's evaluated as the "toughest" or "naughtiest. The ways in which or reasons foster children struggle to connect may more normative within these homes.

The exception to this was found when I specifically asked the foster families about attachment and attachment disorders. Although many foster parents dismissed attachment disorders as invalid due to their experiences of some felt reciprocity in connecting with foster children identified with attachment problems or an attachment disorder, a few endorsed the experience of not taking placement of children with reactive attachment disorder due to belief that they would not be able to help them. Another foster parent reported accepting her current foster child who had a diagnosis of reactive attachment disorder recognizing it was going to come down to a lot of time and

consistency to influence the foster child's relational capacity, and that there was no guarantee it would happen.

The reality of the TFC as described by this study is that placement in TFC does not ensure the provision of standardized effective intervention for these foster children. In fact, findings indicate that the actual care taking tasks are not distinct from traditional foster care, although perhaps more intense, frequent, or just more of these tasks. Multi-dimensional treatment foster care remains the only effective evidence based practice within TFC intervention. This intervention is demonstrated to prevent higher levels of placement or recidivism, which is s central goal of TFC. MTFC intervention provides for foster children treatment within the home by foster parents providing a structured behavioral management system, with consistent follow through on consequences, formal daily monitoring at home and school, academic and social skill building activities, weekly team meetings to assess and adjust individual treatment, and weekly individual or group therapy (TFC Consultants Ltd., n.d.). The therapeutic relationship as reflected in this study may undergird intervention and provide support for child changes, but it is likely not adequate without a clearer standard program of intervention to ensure individual treatment of the child's complex needs.

5. How do children in treatment foster care characterize and experience their relationships with foster family members, peers, and others they self-identify as current shared relationship? As noted in theme of belonging, these foster children connected more to the experience of belonging to a family that to any particular relationship within the TFC home or community. However, foster parents led the

relationship experience. In the case of the single foster father with one child in care, the child developed a sense of being part of the extended family of the foster father's mother, siblings, and aunts, because that was how the father felt a part of his family. Similarly, in another foster family in which adult children maintained close relationships with their parents, the foster child felt they were a part of the family with the adult children. As a negative case, in one foster family which appeared to be experiencing some estrangement with their extended family, the foster children reflected a sense of not being good enough as a family.

Each foster child completed a relationship map in addition to their interview for this study. Most foster children reported multiple relationships and did not struggle to rank them in the three levels of importance. The foster youth did characterize most relationships apart from their biological parents, in terms of being helped by that person, being known by them, or going through their "hard times" with them. Characterization of the biological parents was variable and appeared harder for many children to define. I did not probe this very much with the children as this study was to remain here-and-now in orientation, and these were not clinical interviews.

Implications for Practice

One finding of this study described TFC parents' sense of being very parental and intervening with children as a parent would. TFC parents are the liaisons for children with schools, therapists, and birth families, and often participated in in-home services with the children. Foster parents reported feeling respected by the treatment team members of which they are a part. However, these TFC parents were not consistently

granted priority in the sharing of information about decisions for children or consistently supported in being the point of information for children. Caseworkers, therapists, guardian ad litem, and other professional involved in the lives of TFC children may consider how and if they share information with TFC parents and children as well as maintaining respect for a family's home life and parenting preferences in ways that support the important parental role the TFC parents play in helping the children.

Another finding of this study is that the expectation for a youth's time in TFC impacts the experience for both foster parents and foster youth. Foster parents identified the need for long term placement in order to effect positive change for most children who enter this level of care. Foster parents report taking a different approach if they thought kids were only going to be with them short term. Foster youth reflected a sense of not really deciding to make changes until they either had been placed for some time or were assured of a long term placement. For both foster parents and youth, uncertainty about placement time or changing of the time expectation often left them feeling uncertain of the utility of the placement.

Establishing a minimum placement time expectation or standardized length of treatment may be appropriate to ensure the minimum treatment time period to allow for investment and change. This seems important for maximizing youth's time in care, and their time in youth itself, as well as allowing foster parents to purposefully invest themselves in their efforts to help these children. It seems that this might also help preserve the resource of these skillful foster parents.

The findings indicate that across all cases there is continued or expected contact with foster youth beyond the placement experience. This contact is most commonly informal and initiated by the youth. Both foster parents and youth express the desire and expectation for some continued contact, however, they also reports little clear guidance or preparation for these ongoing relationships from the county or community agency.

Developing guidelines and providing support for ongoing relationship connections between foster families and youth should be considered. Given the growing awareness within child welfare of and attention to the needs of youth for connections as they age and prepare to transition from foster care, support for foster parents as well as guidance for best practice of continued contact should be developed and provided.

Findings revealed that foster parents did not perceive being trained or guided in understanding who *they* were in relationship to the children in their care. Foster families were provided pre-service training and guidance prior to licensing, and are then required to continue attending 24 hours of approved trainings annually to maintain their license. Providing foster parents training focused upon the parent's side in the relationship such as how they feel with this child, the role they are taking, or how what they do or who they are interacts with the child may be more helpful in balance with child-focused training. Many parents seem to act upon this intuitively, but support and expectation to build a more reflective parenting practice may strengthen the power of the relationship for change.

Another finding of this study is that foster parents did not understand the therapeutic nature of their role in providing treatment foster care and a standard model of

TFC intervention in the home was not evident. Many foster parents demonstrated sensitivity to these children in their care and responsiveness to them, appearing to be providing responsive parenting, the foundation of many attachment-based interventions, however without consciously connecting this to a model of intervention.

TFC parents need to be trained beyond the basic knowledge of attachment classifications and predictions, and beyond the overview of child mental health. Requiring training and then supervision of TFC parents about their intervention role within a sensitive and responsive parenting practice, or some other theoretically based and evidence based parenting intervention for children evidencing emotional, behavioral, and mental health difficulties is needed.

Preparing and supporting TFC parents in a theoretically and evidence based parenting practice, may be understood within a framework of change and the therapeutic alliance. Programs may employ measures of relationship quality, such as the Trusting Relationship Questionnaire (Mustillo, et al., 2005) or another therapeutic relationship quality measure to assess relationship quality within their TFC homes and seek to provide support and intervention for the enhancement alliance within home, addressing both foster child and foster parent factors.

Implications for Policy

Policy implications are focused at the level of state administrative rules and agency policy. I have recommended for practice training and supervision TFC parents in a theoretically and evidence based parenting practice for emotionally, behaviorally, and mental health challenged children. As it stands currently, Minnesota rules requires 30

hours of pre-service training for TFC families to be licensed. The content of the 30 hours training is well established and required of agencies providing the pre-service training. TFC agencies would need to require additional pre-service training hours of potential TFC families to provide an additional EBP training. MN DHS rules will need to change to stipulate either the requirement of increased training hours to complete an EBP training or alter the current training content to allow an EBP training in place of other training modules. Agency policy regarding approved on-going training to maintain licensure would need to specify training that supports and builds upon the EBP of the TFC program intervention.

Limitations

There are many methodological limitations within the work of this study which subsequently limit the potential validity and generalizability of findings and conclusions. This study was initially proposed as a multiple case study design utilizing multiple data sources including TFC foster parent and foster child interviews, child case file reviews, use of a standardized measure of relationship closeness and trust, and field observation at TFC trainings, support meetings, and within family homes. Due to the many barriers experienced in the recruitment and data collection processes, the data sources available consistently were the interviews and file reviews. Data analysis was based upon this body of data rather than including data that was not collected consistently across families or sites. This data included rich interviews with foster parents and children, yet these were single interviews rather than repeated interviews with participants. There were follow-up questions asked of two foster parents to clarify and to explore an issue raised

by another foster parent later in the data collection process. Otherwise, these were essentially single contacts. All participants were invited to contact the researcher if they had further questions about the study, or thought of something they considered important to share about the TFC experience, but no one initiated a follow up contact. A risk of the single interview procedure is that participants may not have the opportunity nor feel confident in sharing the full picture of the phenomenon as they experience it. They may present a more superficial representation or a "rosy eyed" view of the phenomenon. They may have aspects of the experience that only occur to them following the interview and lack a structured opportunity to share this observation.

This study was completed with a small sample. Additionally, due to the difficulty obtaining consent for the participation of foster children, the views of TFC foster parents in relation to the views of the children in their care was only possible for half of the parents interviewed. Both sample size and limited dyadic comparison were in part the result of the recruitment difficulties experienced in the course of data collection. Although as I completed the final interviews I did not detect new themes and ideas being expressed, I was not able to confirm this with additional interviews.

Within the sample there is too a risk of selection bias impacting the range of data collected. Foster parents who met inclusion criteria then self-selected participation. It is possible those who chose to participate were those feeling more positive or confident in their TFC role or felt they had a unique perspective to share. As this study sought to understand to quality and content of the relationship between foster parents and foster children in TFC through their perception, those with more positive TFC relationship

experiences may have had more or deeper detail to share about these components if not distracted by other difficulties.

Additionally, female foster youth were over-represented in this sample. I can only speculate as to why this is, but question if this too changes the range of perceptions gathered in the data.

This study was designed with a narrow focus upon the quality and content of the relationship between TFC foster parents and the foster children in their care through their perceptions of their shared relationship. This bounded inquiry was chosen to seek a deep understanding of this particular relational phenomenon within TFC, rather than seeking an understanding of the full TFC experience. The findings of this inquiry arose in part from the influence of this research objective. This objective informed the creation of the interview protocols and the focus of coding and theme identification within data analysis and thus the full TFC experience cannot be remarked upon given this boundary. Data that were excluded in the analysis included data regarding other foster children in the home who did not meet inclusion criteria, most data regarding past foster care placements, most data about other foster or professional providers care of foster children, data of non-relationship / caregiving tasks, and data regarding foster parents views of resilience as none of it reflected relationship themes. Data outside the bounds that was included was the foster child perception of connection to the whole family rather than the dyad. This was included because the foster children did not clearly differentiate one from the other. Also some data of connection with past placement beyond formal placement was included as it reflected the action that parents could only speak of as intention with

the current placements. Some data regarding other providers was included as it related to interference with the foster parent role. This choice to bound the study does not allow full immersion in the TFC experience, but did allow a deep focus upon one clinical phenomenon of interest, that of the shared relationship in TFC.

Future Research

There is much to consider about future approaches to the exploration of relationship quality and processes in TFC. Much of the research in regard to foster care, including to some extent this study, focus primarily upon the foster mother – foster child relationship. It is evident in these findings that both foster parents play roles with these children, as well other family members. There are various dyad (mother-child, father-child, sister-child, grandma-child, etc.) and full-family connections (what we do and who we are as a family) within these TFC homes. Future research will benefit from a broader view of relationship in foster care, recognizing the actual complex web of relationship, exclusive and shared.

A longitudinal study of TFC would be a worthwhile, and very difficult, endeavor. Such a study to observe how these TFC dyadic and family relationships as well as the other relationships in the TFC youth's network are experienced or perceived over time while in care , post- care, and beyond transition. Such a study may inform the questions about how a child's attachment and other relationship capacities change through this intervention and beyond.

The use of a sensitive or responsive parenting as a prescribed TFC practice, or some other EBP appropriate to caring for this unique population, is noted as an

implication for practice, as is a consideration of the use of measures of relationship quality to better assess and intervene upon therapeutic alliance in TFC. Any efforts made to try these practices should utilize a valid evaluation or intervention research process to monitor the implementation and explore the effectiveness of a newly applied practice to better support the healing relationship intervention within TFC.

Conclusion

This study reflects and adds to many elements of the growing body of knowledge regarding foster care intervention and specifically to the little that is known about treatment foster care intervention. This includes elements of knowing more about the quality of relationships within TFC homes, the potential value of measuring and utilizing therapeutic alliance within foster care, the influential role of relationships and belonging in foster children's development and growth, added understanding of influence of new caregiving upon resilient processes and attachment capacities within the span of childhood, and underscoring the continued need for more understanding of qualities of TFC relationships that lead to adaptive foster youth change.

The central organizing question of this study was How do treatment foster parents and children in their care experience and describe their shared relationship? Core findings included themes of the perception of the caregiving and cared for roles in TFC, the heightened importance for foster youth to feel they are a part of and belong in the foster family, the foster parent belief that foster children in TFC change despite their connection and the foster children's sense of agency in making changes, and the role time in the development and perseverance of this TFC relationships. Additional questions

about perceived closeness, strengths, challenges, and barriers to child relational capacities, and the ways foster children experience the network of other relationships surrounding them were used to guide further exploration and make sense of the core findings.

From these findings I offer a description of the TFC relationship of these families. The fostering relationship in TFC is a therapeutic relationship in which responsive and reflective parenting, parenting that supports the development of attachment and resilient capacities within foster children, is the primary strategy. I further describe that this relationship and the experience of belonging to the foster family are components in the mechanism of treatment change for TFC children, components that may likely be enhanced and have greater influence upon child outcomes if their component parts are more deeply studied, understood in regard to effectiveness, taught, and supported. The relationship, however effective to further therapeutic gains, cannot alone bear the weight of intervention need for these foster youth. Clear, evidence based intervention facilitated within the context of this therapeutic relationship may provide the best hope for adaptive, lasting change for these vulnerable children in our care.

References

Affronti, M.L. (2009). Voices of foster parents and youth: Factors associated with Optimal functional adaptation in foster care (Doctoral dissertation). Retrieved from ProQuest, UMI Dissertations Publishing (3342137).

Ainsworth, M.D., Blehar, M.C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of strange situation.* Hillsdale, N.J.: Lawrence Erlbaum Associates.

Allen, B. (2011). The use and abuse of attachment theory in clinical practice with maltreated children, part 1: Diagnosis and assessment. *Trauma, Violence, and Abuse, 12*(1), 3-12

Andersson, G. (2005). Family relations, adjustment and well-being in a longitudinal study of children in care. *Child and Family Social Work, 10*, 43-56.

Andersson, G. (1999). Children in permanent foster care in Sweden. *Child and Family Social Work, 4*, 175-186.

Barth, R.P., Crea, T.M., John, K., Thoburn, J. & Quinton, D. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child and Family Social Work, 10,* 257 268.

Becker-Weidman, A., & Hughes, D. (2008). Dyadic developmental psychotherapy: An evidence-based treatment for children with complex trauma and disorders of attachment. *Child and Family Social Work, 13,* 329-337.

Belsky, J., & Pluess, M. (2011). Beyond adversity, vulnerability, and resilience:

Individual differences in developmental plasticity. In D. Cicchetti & G.I. Roisman (Eds.) *Minnesota symposia on child psychology: The origins and organization of adaptation and maladaptation* (pp. 379-422). Hoboken, N.J.: John Wiley and Sons, Inc.

Berg, B.L., & Lune, H. (2012). *Qualitative Research Methods for the Social Sciences*. Boston, Pearson.

Bickman, L., Vides De Andrade, A.R., Lambert, E.W., Doucette, A., Sapyta, J., Boyd, A.S., Rumberger, D.T., Moore-Kurnot, J., McDonough, L.C., & Rauktis, M.B. (2004). Youth therapeutic alliance in intensive treatment settings. *The Journal of Behavioral Health Services and Research, 31*(2), 134-148. MA, Pearson.

Berlin, L. & Cassidy, J. (1999). Relations among relationships: Contributions from Attachment theory and research. In J. Cassidy, P.R. Shaver, (Eds.), Handbook of Attachment:Theory, Research, and Clinical Applications, (pp.688-712). New York, NY: Guilford Press.

Berlin, L.J.; Cassidy, J., & Appleyard, K. (2008). The influence of early attachments on Other relationships. In J. Cassidy, P.R. Shaver, (Eds.), Handbook of Attachment: Theory,Research, and Clinical Applications (2nd ed., pp. 333-347). New York, NY: Guilford Press.

Berrick, J.D., Frasch, K., & Fox, A. (2000). Assessing children's experiences of out-of Home care: Methodological challenges and opportunities. *Social Work Research, 24*(2), 119-127.

Berscheid, E. (1999). The greening of relationship science. *American Psychologist,*

54(4), 260-266.

Bickman, L., Vides De Andrade, A.R., Lambert, E.W., Doucette, A., Sapyta, J., Boyd, A.S., Rumberger, D.T., Moore-Kurnot, J., McDonough, L.C., & Rauktis, M.B. (2004). Youth therapeutic alliance in intensive treatment settings. *The Journal of Behavioral Health Services and Research, 31*(2), 134-148.

Boss, P. (2006). *Loss, Trauma, and Resilience: Therapeutic Work with Ambiguous Loss*. New York, NY: W.W. Norton & Compnay Inc.

Bowlby, J. (1982). *Attachment and loss: Vol. 1 Attachment (2nd ed.).* New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Vol. 3 Loss*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol. 2 Separation anxiety and anger*. New York: Basic Books.

Brent, D.A., & Kolko, D.J. (1998). Psychotherapy: Definitions, mechanisms of action, And relationship to etiological models. *Journal of Abnormal Child Psychology, 26*(1), 17-25.

Bretherton, I., & Munholland, K.A. (2008). Internal working models in attachment relationships: Elaborating a central construct in attachment theory. In J. Cassidy, P.R. Shaver, (Eds.), Handbook of Attachment: Theory, Research, and Clinical Applications (2nd ed., pp. 102-127). New York, NY: Guilford Press.

Broady, T.R., Stoyles, G.D., McMullan, K., Caputi, P. & Crittenden, A. (2010). The Experience of foster care. *Journal of Child and Family Studies, 19*, 559-571.

Brown, J.D. (2007). Foster parents' perceptions of factors needed for successful foster

placements. *Journal of Child and Family Studies, 17*, 538-554.

Brown, J.D., & Campbell, M. (2007). Foster parent perceptions of placement success. *Children and Youth Services Review, 29,* 1010-1020.

Buehler, C., Cox, M.E., & Cuddleback, G. (2003). Foster parents' perceptions of factors That promote or inhibit successful fostering. *Qualitative Social Work, 2*, 61-83.

Calkins, S.D., & Leerkes, E.M. (2011). Early attachment processes and the development Of emotional self -regulation. In K.D. Vohs and R.F. Baumeister (Eds.), *Handbook of Self -Regulation* (2nd Ed., 355-373), New York, NY: Guilford Press.

Cameron, M., & Keenan, E. K. (2010). The common factors model: Implications for transtheoretical social work practice. *Social Work*, 55(1), 63-73.

Carlson, E.A., Sampson, M.C., & Sroufe, L.A. (2003). Implications of attachment theory and research for developmental-behavioral pediatrics. *Developmental and Behavioral Pediatrics, 24*(5), 364-379.

Cassidy, J. (2008). The nature of a child's ties. In J. Cassidy, & P.R. Shaver (Eds.). *Handbook of attachment: Theory, research, and clinical applications* (pp. 3-22). New York, NY: Guilford Press.

Chaffin, M., Hanson, R., Saunders, B.E., Nichols, T., Barnett, D., Zeanah, C., Berliner, L.,Egeland, B., Newman, E., Lyon, T., Letourneau, E., & Miller-Perrin, C. (2006). Report of the APSAC task force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment, 11,*76-89.

Chamberlain, P. (2003). The Oregon multidimensional treatment foster care model: Features, outcomes, and progress in dissemination. *Cognitive and Behavioral*

Practice, 10, 303-310.

Chamberlain, P., Fisher, P.A., & Moore, K. (2002). Multidimensional treatment foster care: Applications of the OSLC intervention model to high risk youth and thefamilies. In J. B. Reid, G. R. Patterson, & J. J. Snyder (Eds.) Antisocial Behavior in Children and Adolescents: A Developmental Analysis and the Oregon Model for Intervention. Washington, American Psychological Association.

Chapman, M.V., Wall, A., & Barth, R.P. (2004). Children's voices: The perception of Children in foster care. *American Journal of Orthopsychiatry, 74(*3), 293-304.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London, Sage.

Child Welfare Information Gateway. (2013).*Achieving and maintaining permanency: overview.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway. (2013).*Concept and history of permanency in U.S. child welfare.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway. (2013). *How the child welfare system works.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway. (2013).*Out of home care: Foster care.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Cicchetti, D., Toth, S.L., & Lynch, M. (1995). Bowlby's dream comes full circle: the application of attachment theory to risk and psychopathology. *Advances in Clinical Child Psychology, 17,* 1-75.

Cook, T.D., & Campbell, D.T. (1979). *Quasi-experimentation: Design and analysis issues for field settings*. Chicago, IL: Rand McNally College Publishing

Craven, P.A., & Lee, R.E. (2006). Therapeutic interventions for foster children: A systematic research synthesis. *Research on Social Work Practice, 16*(3), 287-304.

Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among the Five approaches: Second edition*. Thousand Oaks, CA: Sage.

Crittenden, P.M. (2000). A dynamic maturational approach to continuity and change in pattern of attachment. In P.M Crittenden & A.H. Clausen (Eds.). *The organization of attachment relationships: Maturation, culture and context* (pp.343-357). Cambridge: Cambridge University Press.

Crittenden, P.M. (2000). Introduction. In P.M Crittenden & A.H. Clausen (Eds.). *The organization of attachment relationships: Maturation, culture and context* (pp.1 12). Cambridge: Cambridge University Press.

Crittenden, P.M. (1992). Danger and development: The organization of self-protective strategies. *Monographs of the Society for Research in Child Development, 64*(3),145-171.

Crittenden, P.M. (1992). Children's strategies for coping with adverse home environments: An interpretation using attachment theory. *Child Abuse & Neglect, 16,* 329-343

Daniel, B. (2006). Operationalizing the concept of resilience in child neglect: Case study research. *Child Care, Health, & Development, 32*(3), 303-309.

Delfabbro, P.H., Barber, J.G., & Bentham, Y. (2002). Children's satisfaction with out of-home care in south Australia. *Journal of Adolescence, 25*, 523-533.

Denzin, A.K., & Lincoln, Y.S. (2005). Introduction: The discipline and practice of Qualitative research. In A.K. Denzin & Y.S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed.,pp.1-32). Thousand Oaks, CA: Sage.

Dore, M.M., & Mullin, D. (2006). Treatment family foster care: Its history and current\ role in the foster care continuum. *Families in Society, 87*(4), 475-482.

Dorsey, S., Farmer, E.M.Z., Barth, R. P., Greene, K.M., Reid, J., & Lasndsverk, J. (2008). Current status and evidence base of training for foster and treatment foster parents. *Children and Youth Services Review, 30*, 1403-1416

Dozier, M., Albus, K, Fisher, P.A., & Sepulveda, S. (2002). Interventions for foster parents: Implications for developmental theory. *Development and Psychopathology, 14*, 843-860.

Dozier, M, Peloso, E., Lewis, E., Laurenceau, J-P., & Levine, S. (2008). Effects of an attachment-based intervention on the cortisol production of infants and toddlers in foster care. *Development and Psychopathology, 20*, 845-859.

Dozier, M., & Rutter, M. (2008). Challenges to the development of attachment relationships faced by young children in adoptive and foster care. In J. Cassidy, & P.R. Shaver (Eds.). *Handbook of attachment: Theory, research, and clinical applications* (pp.698-717). New York, NY: Guilford Press.

Dozier, M., Stovall, K.C., Albus, K.E., & Bates, B. (2001). Attachment for infants in foster care: The role of caregiver state of mind. *Child Development, 72*(5), 1467-1477.

Drisko, J.W. (2004). Common factors in psychotherapy outcome: Meta-analytic findings and their implications for practice and research. *Families in Society*, 85(1), 81-90.

Duchwski, A.J., & Friedman, R.M. (1990). Children's mental health: Challenges for the nineties. *The Journal of Mental Health Administration, 17*(1), 3-12.

Eltz, M.J., & Shirk, S.R. & Sarlin, N. (1995). Alliance formation and treatment outcome among maltreated adolescents. *Child Abuse and Neglect, 19*(4), 419-431.

Fanshel, D., Finch, S.J., & Grundy, J.F. (1990). *Foster Children in a Life Course perspective*. New York, NY: Columbia University Press.

Farmer, E.M. (2009). What's the relationship got to do with it? Understanding the therapeutic relationship in therapeutic foster care. *Child and Adolescent Social Work, 26*(1), 49-63.

Farmer, E.M.Z., Burns, B.J., Dubs, M.S., & Thompson, S. (2002). Assessing conformity to standards for treatment foster care. *Journal of Emotional Behavioral Disorders, 10*(4), 213-222.

Fearon, R.P., Bakermans-Kranenburg, Van IJzendoorn, M.H., Lapsley, A., & Roisman, G.I.(2010). The significance of insecure attachment and disorganization in the Development of children's externalizing behavior: A meta-analytic study. *Child Development,8(2),* 435–456.

Fernandez, E. (2007). How children experience fostering outcomes: Participatory

research with children. *Child and Family Social Work, 12*, 349-359.

Festinger, T. (1983). *No One Ever Asked Us: A Postscript to Foster Care*. New York,NY: Columbia University Press.

Fisher, P.A., & Chamberlain, P. (2000). Multidimensional treatment foster care: A program for intensive parenting, family support, and skill building. *Journal of Emotional and Behavioral Disorders, 8(3),* 155-164.

Florsheim, P., Shotorbani, S., Guest-Warnick, G., Barratt, T., & Hwang, W-C. (2000). Role of the working alliance in the treatment of delinquent boys in community based programs. *Journal of Clinical Child Psychology, 29*(1), 94-107.

Flynn, R. J., Dudding, P.M., & Barber, J.G. (2006). *Promoting Resilience in Child Welfare*. Ottawa, University of Ottawa Press.

Fox, A., Berrick, J.D., & Frasch, K. (2008). Safety, family, permanency, and child well being: What we can learn from children. *Child Welfare, 87*(1), 63-90.

Frederick, J., & Goddard, C. (2008). Living on an island: Consequences of childhood abuse, attachment disruption and adversity in later life. *Child and Family Social Work, 13*, 300-310.

Freeman, E.M. (2000). Direct practice in fields related to developmental tasks: A life span perspective. In P. Allen-Meares & C. Garvin (Eds.), *The Handbook of Social Work Direct Practice* (pp.415-436). Thousand Oaks, CA: Sage.

Gardner, H. (2004a). Perception of family: Complexities introduced by foster care: Part 1: Childhood perspectives. *Journal of Family Studies, 10*(2), 170-187.

Gardner, H. (2004b). Perception of family: Complexities introduced by foster care: Part

2: Adult perspectives. *Journal of Family Studies, 10*(2), 188-203..

Garmezy, N., Master, A.S., & Tellegen, A. (1984). The study of stress and competence in children: A building block for developmental psychopathology. *Child Development, 55*, 97-111.

Gilbertson, R., & Barber, J.G. (2002). Obstacles to involving children and young people in foster care research. *Child and Family Social Work, 7*, 253-258.

Green, J. (2006). Annotation: The therapeutic alliance – a significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry, 47*(5), 425-435.

Greig, A. Taylor, J., and MacKay, T. (2007). Doing research with children (2nd Edition). London, UK; Sage

Guba, E.G., & Lincoln, Y.S. (2005). Paradigmatic controversies, contradiction, and Emerging confluences. In A.K. Denzin & Y.S. Lincoln (Eds.), *The Sage Handbook of QualitativeResearch* (3rd ed.,pp.191-216). Thousand Oaks, CA: Sage.

Hanson, R.F., & Spratt, E.G. (2000). Reactive attachment disorder: What we know about the disorder and implications for treatment. *Child Maltreatment, 3*(2), 137-145.

Harden, B.J., Meisch, A.D., Vick, J.E., & Pandohie-Johnson, L. (2008). Measuring parenting among foster families: The development of the Foster Parent Attitudes Questionnaire (FPAQ). *Children and Youth Services Review, 30*, 879-892.

Heller, S.S., Larrieu, J.A., D'Imperio, R., & Boris, N.W. (1999). Research on resilience to child maltreatment: empirical considerations. *Child Abuse & Neglect, 23*(4),

321-338.

Heptinstall, E. (2000). Gaining access to looked after children for research purposes: Lessons learned. *British Journal of Social Work,30,* 867-872.

Heptinstall, E., Bhopal, K., & Brannen, J. (2001). Adjusting to a foster family: Children's perspectives. *Adoption and Fostering, 25*(4), 6-16.

Hill, M.; Nutter, R.; Giltinan, D.; Hudson, J.; & Galaway, B. (1993). A comparative survey of specialist fostering in the UK and North America. *Adoption and Fostering, 17*(2), 17-22.

Hogue, A., Dauber, S., Stambaugh, L.F., Cecero, J.J., & Liddle, H. (2006). Early Therapeutic alliance and treatment outcome in individual and family therapy for adolescent behavior problems. *Journal of Consulting and Clinical Psychology, 74*(1), 121-129.

Houston, S. (2001). Beyond social constructionism: Critical realism and social work. *British Journal of Social Work, 31* (6), 845-861.

Howe, D., Brandon, M., Hinings, D., & Schofield, G. (1999). Attachment theory, child maltreatment and family support: A practice and assessment model. Mahwah, NJ: Lawrence Erlbaum Associates

Hunt, M.R. (2009). Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experiences of health professionals in humanitarian work. *Qualitative Health Research, 19(9), 1284-1292.*

Hussey, D.L., & Guo, S. (2005). Characteristics and trajectories of treatment foster care youth. *Child Welfare, 84*(4), 485-506.

James, S., & Meezan, W. (2002). Refining the evaluation of treatment foster care. *Families in Society, 83*(3), 233-244.

Johnson, P.R., Yoken, C., & Voss, R. (1995). Family foster care placement: The child's perspective. *Child Welfare, 74*, 959-974.

Jones, L., & Kruk, E. (2005). Life in government care: The connection of youth to family. *Child and Youth Care Forum, 34*(6), 405-421.

Karver, M.S., Handelsman, J.B., Fields, S., & Bickman, L. (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research, 7*(1), 35-51.

Karver, M.S., Handelsman, J.B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review, 26*, 50-65.

Karver, M., Shirk, S., Handelsman, J., Fields, S., Crisp,H., Gudmundsen, G., & McMakin, D. (2008). Relationship processes in youth psychotherapy: Measuring alliance, alliance building behaviors, and client involvement. *Journal of Emotional and Behavioral Disorders, 16*(1), 15-28.

Kazdin, A.E., Marciano, P.L., & Whitley, M.K. (2005). The therapeutic alliance in cognitive behavioral treatment of children referred for oppositional, aggressive, and anti-social behavior. *Journal of Consulting and Clinical Psychology, 73*(4), 726-730.

Kazdin, A.E., & Nock, M.K. (2003). Delineating mechanisms of change in child and

Adolescent therapy: Methodological issues and research recommendations. *Journal of Child Psychology and Psychiatry, 44*(8), 1116-1129.

Kearney, C.A., Wechsler, A., Kaur, H., & Lemos-Miller, A. (2010). Posttraumatic stress disorder in maltreated youth: A review of contemporary research and thought. *Clinical Child and Family Review, 13* 46-76.

Kobak, R., & Madsen, S. (2008). Disruptions in attachment bonds: Implications for theory, research, and clinical intervention. . In J. Cassidy, P.R. Shaver, (Eds.), *Handbook ofAttachment: Theory, Research, and Clinical Applications* (2nd ed., pp. 23-47). NewYork, NY: Guilford Press.

Kotchick, B.A., & Forehand, R. (2002). Putting parenting in perspective: A discussion of the contextual factors that shape parenting practices. *Journal of Child and Family Studies, 11*, 255-269.

Kufeldt, K., Armstrong, J., & Dorosh, M. (1995). How children in care view their own and their foster families: A research study. *Child Welfare, 74*(3), 695-715.

Lambert, M. (2005). Early response in psychotherapy: further evidence for the importance of common factors rather than "placebo effects". Journal of Clinical Psychology, 61(7), 855-869.

Lambert, M. (1992). Implications of outcome research for psychotherapy integration. In J. Norcross & J. Goldstein, (Eds.), Handbook of Psychotherapy Integration (pp. 94-129). New York, NY, Basic Books.

Leathers, S.J., Spielfogel, J.E., McMeel, L.S., & Atkins, M.S. (2011). Use of a parent management training intervention with urban foster parents: A pilot study.

Children and Youth Services Review, 33,1270-1279.

Lee, R.E., & Whiting, J.B. (2007). Foster children's expressions of ambiguous loss. *The American Journal of Family Therapy, 35 (*5), 417-428.

Leve, L.D., Fisher, P.A., & Chamberlain (2009). Multidimensional treatment foster care as a prevention intervention to promote resiliency among youth in the child welfare system. *Journal of Personality, 77(6),* 1869-1902.

Lieberman, A.F. (2003). The treatment of attachment disorder in infancy and early childhood: Reflections from clinical intervention with later-adopted foster care children. *Attachment and Human Development, 5*(3), 279-282.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalist Inquiry*. Newberry Park, CA: Sage Publications.

Lipscombe, J., Farmer, E., & Moyers, S. (2003). Parenting fostered adolescents: Skills and strategies. *Child and Family Social Work, 8*, 243-255.

Longhofer, J., and Floesrch, J. (2012). The coming crisis in social work: Some thoughts on social work and science. *Research on Social Work Practice, 22*(5), 499-519.

Loulin, S. & Kuczynski, L. (1997). Beyond one hand clapping: Seeing bidirectionality in parent-child relations. *Journal of Social and Personal Relationships, 14*, 441 -459.

Luke, N., Coyne, S.M. (2008). Fostering self-esteem: Exploring adult recollections on the influence of foster parents. *Child and Family Social Work, 13*, 402-410.

Luthar, S.S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543-562.

Lutheran Social Service of Minnesota. (n.d.). *Treatment foster care: Foster Parent Handbook.*

Lynch, M., & Cicchetti, D. (1991). Patterns of relatedness in maltreated and non Maltreated children: Connections among multiple representation models. *Development and Psychopathology, 3*, 207-226.

Madigan, S., Bakermans-Kranenburg, M.J., Van Ijzendoorn, M.H., Moran, G., Pederson, D.R.,& Benoit, D. (2006). Unresolved states of mind, anomalous parental behavior, and disorganized attachment: A review and meta-analysis of a transmission gap. *Attachment and Human Development , 8*(2), 89-111.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development, 50*(1/2), 66-104.

Masten, A.S. (2011). Resilience in children threatened by extreme adversity: Frameworks for research, practice, and translational synergy. *Development and Psychopathology, 23*, 493-506.

Masten, A.S. (2006). Promoting resilience in development: A general framework for systems of care. In R. J. Flynn, P.M. Dudding, & J.G. Barber (Eds.). *Promoting resilience in child welfare.* Ottawa, Ontario: University of Ottawa Press.

Masten, A.S., & Obradovic, J. (2006). Competence and resilience in development. *Annals New York Academy of Science, 1094*, 13-26.

McCrone, E., Egeland, B. Kalkoske, M., & Carlson, E.A. (1994). Relations between early maltreatment and mental representations of relationships assessed with projective storytelling in middle childhood. *Development and Paychopathology, 6*(1), 99-120.

Milan, S.E., & Pinderhughes, E.E. (2000). Factors influencing maltreated children's early adjustment in foster care. *Development and Psychopathology, 12,* 63-81.

MN DHS CFS (2009). Children with disabilities involved in the child welfare continuum. Retrieved from https://edocs.dhs.state.mn.us/lfserver/Legacy/DHS 5965-ENG.

Mustillo, S.A., Dorsey, S., & Farmer, E.M.Z. (2005). Quality of relationships between youth and community service providers: Reliability and validity of the trusting relationship questionnaire. *Journal of Child and Family Studies, 14*(4), 577-590.

Nilsen, W. (2007). Fostering futures: A preventive intervention program for school-age Children in foster care. *Clinical Child Psychology and Psychiatry, 12*(1), 45-63.

Nilsen, W. (2003). Perceptions of attachment in academia and the child welfare system: The gap between research and reality. *Attachment and Human Development, 5*(3), 303-306.

Nowaki, K., & Schoelmerich, A. (2010). Growing up in foster families or institutions: Attachment representation and psychological adjustment of young adults. *Attachment and Human Development, 12*(6), 551-566.

Oliver, C. (2012a). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work, 42*, 371-387.

Oliver, C. (2012b). The relationship between symbolic interactionism and interpretive description. *Qualitative Health Research, 22(1),409-415.*

O'Malley, F. (1990). Developing a therapeutic alliance in the hospital treatment of disturbed adolescents. *Bulletin of the Menninger Clinic, 54(*1), 1-10.

O'Neill, C. (2004). "*I Remember the First Time I Went into Foster Care – It's a Long Story*…": Children, permanent parents, and other supportive adults talk about the experience of moving from one family to another. *Journal of Family Studies, 10*(2), 205-219.

Patton, M.Q. (2002). *Qualitative research and evaluation methods: Third edition*. Thousand Oaks, CA: Sage

Payne, M. (2005). *Modern social work theory: Third edition*. Chicago: Lyceum Books

Poehlmann, J. (2005). Representations of attachment relationships in children of Incarcerated mothers. *Child Development, 76*(3), 679-696.

Ponciano, L. (2010). Attachment in foster care: The role of maternal sensitivity, adoption and foster mother experience. *Child and Adolescent Social Work Journal, 27,* 97 -114.

Racusin, R., Maerlender, A.C., Sengupta, A., Isquith, P.K., & Strauss, M.B. (2005). Community psychiatric practice: Psychosocial treatment of children in foster care: a review. *Community Mental Health Journal, 41*(2), 199-221.

Rauktis, M.E., Vides De Andrade, A.R., Doucette, A., McDonough, L., & Reinhart, S. (2005). Treatment foster care and relationships: Understanding the role of therapeutic alliance between youth and treatment parent. *International Journal of*

Child and Family Welfare, 4, 146-163.

Redding, R.E., Fried, C., & Britner, P.A. (2000). Predictors of placement outcomes in treatment foster care: Implications for foster parent selection and service delivery. *Journal of Child and Family Studies, 9*(4), 425-447.

Reis, H.T. (2007). Steps toward the ripening of relationship science. *Personal Relationships,14*, 1-23.

Rushton, A., Mayes, D., Dance, C., & Quinton, D. (2003). Parenting late-placed children: The development of new relationships and the challenges of behavioural problems. *Clinical Child Psychology and Psychiatry, 8*(3), 389-400.

Rushton, A., & Mayes, D. (1997). Forming fresh attachments in childhood: A research update. *Child and Family Social Work, 2*, 121-127.

Rutter, M. (1998). Developmental catch-up, and deficit, following adoption after severe global early privation. *Journal of Child Psychology and Psychiatry, 39*(4), 465 - 476.

Rutter, M. (1990). Psychosocial resilience and protective mechanisms. In Jon Rolf, Ann S. Masten, Dante Cicchetti, Keith Nuchterlein, and Sheldon Weintraub (Ed's.) *Risk and Protective Factors in Development of Psychopathology* (pp. 181-214). Cambridge, Cambridge University Press.

SAMHSA's National Registry of Evidence-based Programs and Practices (2009, October). Multidimensional treatment foster care (MTFC). Retrieved from http://nrepp.samhsa.gov/ViewIntervention.aspx?id=48#Study%201.

Samuels, G.M. (2008). *A reason, a season, or a lifetime: Relational permanence among*

young adults with foster care backgrounds. Chicago: Chapin Hall Center for Children at the University of Chicago.

Schofield, G. (2002). The significant of secure base: A psychosocial model of long-term foster care. *Child and Family Social Work, 7*, 259-272.

Schofield, G., Beek, M. (2005). Providing a secure base: Parenting children in long-term foster family care. *Attachment and Human Development, 7*(1), 3-25.

Schofield, G., & Beek, M. (2009), Growing up in foster care: providing a secure base through adolescence. *Child & Family Social Work, 14*, 255–266.

Schore, A.N. (2000). Attachment and the regulation of the right brain. *Attachment and Human Development, 2*(1), 23-47.

Shirk, S.R., & Karver, M. (2003). Prediction of treatment outcomes from relationship Variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(3), 452-464

Shirk, S.R., & Saiz, C.C. (1992). Clinical, empirical, and developmental perspectives on the therapeutic relationship in child psychotherapy. *Development and Psychopathology, 4*, 713-724.

Siegel, D.J. (2003). An interpersonal neurobiology of psychotherapy: The developing mind and the resolution of trauma. In M.F. Solomon, & D. J. Siegel (Eds.). *Healing Trauma: Attachment, mind, body, and brain* (pp. 1-56). New York, NY: W.W. Norton.

Sinclair, I., & Wilson, K. (2003). Matches and mismatches: The contribution of carers and children to the success of foster placements. *British Journal of Social Work,*

33(7), 871 - 884.

Smyke, A.T., Zeanah, C.H., Fox, N.A., Nelson, C.A., & Guthrie, D. (2010). Placement in foster care enhances quality of attachment among young institutionalized children. *Child Development, 81*(1), 212-223.

Sprang, G. (2009). The efficacy of a relational treatment for maltreated children and their families. *Child and Adolescent Mental Health, 14*(2), 81-88.

Sroufe, L.A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment and Human Development, 7*(4), 349-367.

Sroufe, L.A. (2000). Early relationships and the development of children. *Infant Mental Health Journal, 21(*1-2), 67-74.

Sroufe, L.A. (1995). *Emotional development: The organization of the emotional life in the early years*. Cambridge: Cambridge University Press.

Sroufe, L.A., Coffino, B., & Carlson, E.A. (2010). Conceptualizing the role of early experience: Lessons learned from the Minnesota longitudinal study. *Developmental Review, 30*36-51.

Sroufe, L.A., Egeland, B., Carlson E.A., & Collins, W.A. (2005). *The development of the person: The Minnesota study of risk and adaptation from birth to adulthood.* New York, NY: Guilford Press.

Stake, R.E. (2010). *Qualitative Research: Studying How Things Work*. New York, Guilford Press. .

Sudbery, J., Shardlow, S.M., & Huntington, A.E. (2010). To have and to hold: Questions about a therapeutic service for children. *British Journal of Social Work, 40*, 1534

1552.

Swick, K.J. (2007). Empower foster parents toward caring relations with children. *Early Childhood.*

Tarullo, A.R., & Gunnar, M.R. (2006). Child maltreatment and the developing HPA axis. *Hormones and Behavior, 50*, 632-639.

TFC Consultants (n.d.) Multidimensional treatment foster care: An evidence-based solution for youth with behavioral problems, their families, and their communities: Overview. Retrieved from http://www.mtfc.com/overview.html. *Education Journal, 34* (6), 393-398.

Thompson, R.A. (2008). Early attachment and later development: Familiar questions, new answers. . In J. Cassidy, P.R. Shaver, (Eds.), *Handbook of Attachment: Theory, Research, and Clinical Applications* (2nd ed., pp.348-365). New York, NY: Guilford Press.

Thompson, R. (2000). The legacy of early attachments. *Child Development, 71*(1), 145 152.

Thorne, S., Kirkhand, S.R., & MacDonald-Emes, J. (1997). Interpretive description: A non categorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20*(2), 169-177.

Thorne, S., Kirkham, S., & O'Flynn-Magee (2004). The analytic challenge in Interpretive description. *International Journal of Qualitative Methods, 3*(1), 1-11.

Thyer, B.A., & Myers, L.L. (2000). Approaches to behavioral change. In In P. Allen-Meares & C. Garvin (Eds.), *The Handbook of Social Work Direct Practice*

(pp.197-216). Thousand Oaks, CA: Sage

Trickett, P.K., & McBride-Chang, C. (1995). The developmental impact of different forms of child abuse and neglect. *Developmental Review,* 15, 311-337

Turner, M.G. (2008). Treatment foster care for improving outcomes in children and young people (Review). *Corcoran Database of Systematic Reviews, 1*, 1-53.

van der Kolk, B.A. (2003). Posttraumatic stress disorder and the nature of trauma. In M.F. Solomon, & D. J. Siegel (Eds.). *Healing Trauma: Attachment, mind, body, and brain* (pp. 168-195). New York, NY: W.W. Norton.

VanRyzin, M.J., Carlson, E.A., & Sroufe, L.A. (2011). Attachment discontinuity in high risk sample. *Attachment and Human Development, 13*(4), 381-401.

Vig, S., Chinitz, S., & Shulman, L. (2005). Young children in foster care: Multiple vulnerabilities and complex service needs. *Infants and Young Children, 18*(2), 147-160.

Wallston, K.A. (1992). Hocus-pocus, the focus is not strictly on locus: Rotter's social learning theory modified for health. *Cognitive Therapy and Research, 16*(2), 183 189.

Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process, 42*(1), 1-18.

Waters, E., Merrick, S., Treboux, D., Crowell, J., & Albersheim, L. (2000), Attachment security in infancy and early adulthood: A twenty-year longitudinal study. *Child Development, 71*(3), 684-689.

Waters, E., Weinfield, N.S., & Hamilton, C.E. (2000), The stability of attachment

security from infancy to adolescence and early adulthood: General discussion. *Child Development, 71*(3), 703-706.

Weinfield, N.S., Sroufe, A, Egeland, B., & Carlson, E. (2008). Individual differences in infant-caregiver attachment: Conceptual and empirical aspects of security. In J. Cassidy, & P.R. Shaver (Eds.). *Handbook of attachment: Theory, research, and clinical applications* (pp.78-101). New York, NY: Guilford Press.

Wells, K., Farmer, E.M.Z., Richards, J.T., & Burns, B.J. (2004). The experience of being a treatment foster mother. *Qualitative Social Work, 3*(2), 117-138.

Wells, K., & D'Angelo, L. (1994). Specialized foster care: Voices from the field. *Social Services Review, 68(*1) 127-144.

Whiting, J.B., & Lee, R.E. (2003). Voices from the system: A qualitative study of foster children's stories. *Family Relations, 52*, 288-295.

Wilson, L., & Conroy, J. (1999). Satisfaction of children in out-of-home care. *Child Welfare, 78*(1), 53-69.

Appendix A

Foster Parent Recruitment Letter

Dear Foster Parent(s) ;

A research study is being conducted to learn more about treatment foster care from the perspective of the foster caregivers and foster children in their care. The researcher, Lisa R. Kiesel, a PhD candidate of the University of Minnesota School of Social Work, is interested in interviewing children in treatment foster care and their foster caregivers, reviewing children's foster care agency records, and observing foster parents at agency monthly training and support meetings. She would like to talk with you about participating in this study. All observations, interviews, and file information are confidential and will be conducted by this University of Minnesota PhD candidate. Participation is voluntary, and your decision to participate or not will not affect your relationships with [community agency], county child welfare agency, or the University of Minnesota.

If you are interested in participating in this study, or have any questions about it, please contact Lisa Kiesel directly via phone or email.

Researcher contact information:
Lisa R. Kiesel, MSW, LICSW
PhD Candidate, School of Social Work
University of Minnesota, Twin Cities
612-251-7967 (confidential cell#)
kiese024@umn.edu

Thank you for your consideration of this project.

Respectfully,

[staff name]
[community agency name]
Treatment Foster Care Coordinator

Appendix B

Recruitment Flyer

[Community Agency] Foster Families:

- **Seeking foster parents with at least one foster youth age 7-16 currently in placement with emotional, behavioral, and/or mental health challenges (<u>not</u> primarily *medical* reasons for placement)**

Please lend your voice, and that of your foster youth, to a treatment foster care study!

Many of your [TFC] foster care peers have already graciously participated, but I'm hoping for a handful more to complete this project.

> This study is being conducted to learn more about treatment foster care from the perspective of the foster caregivers and foster children in their care. I, Lisa R. Kiesel, a PhD Candidate at the University of Minnesota School of Social Work, am interested in interviewing children in treatment foster care and their foster caregivers, reviewing children's foster care agency records, and observing foster parents at agency monthly training and support meetings. All observations, interviews, and file information are confidential. Participation is voluntary, and your decision to participate or not will not affect your relationships with [agency], your county child welfare agency, or the University of Minnesota.

If you are interested in participating in this study, or have any questions about it, please contact me directly via phone or email. Once you choose to participate, either you or I will seek the consent of the county worker for your foster youth's participation. Interviews with adults and older youth can be conducted either in-person or via the phone. Younger children will be met in person. A $20 Target gift card will be given as a small thank you to all participating families.

Researcher contact information:
Lisa R. Kiesel, MSW, LICSW
PhD Candidate, School of Social Work
University of Minnesota, Twin Cities
612-251-7967 (confidential cell#)
kiese024@umn.edu

Thanks!

Appendix C

Adult Informed Consent

CONSENT FORM
What's Relationship go to do with it?: An Exploration of Relationship For Children in Treatment Foster Care and Their Caregivers

You are invited to be in a research study of relationships in Treatment Foster Care. You were selected as a possible participant because you are licensed as a treatment foster care provider and have a current child in placement. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Lisa R. Kiesel, MSW, LICSW, PhD Candidate, School of Social Work at the University of Minnesota, Twin Cities.

Background Information

The purpose of this study is to explore through the perception of children and caregivers, the importance of their relationship in Treatment Foster Care. My central research question is: how do treatment foster parents and children in their care describe their shared relationship, and to what extent do they perceive their relationship to be central to children's improved emotional and behavioral functioning?

Procedures:

If you agree to be in this study, we would ask you to do the following things: Participate in an audiotaped interview and complete a 14 item questionnaire. The interview will take approximately 1 hour and will explore your fostering experiences and discuss in detail your relationship with the foster child currently in your care and your perception of that child.

Risks and Benefits of being in the Study

The study has some risks. First, discussion of your experiences as a foster parent or your relationship with the child currently in your care, may be emotionally upsetting. This risk seems unlikely given the nature and scope of the questions to be asked and issues to be explored. You also may choose to not answer any question Second, there is the low, but possible risk of increased child welfare involvement. If you or the child in your care discloses new or ongoing maltreatment, I will report this to child protection in accordance to the mandated reporting laws of Minnesota, which could have implications for your foster care license status. Again this is unlikely, and this research does not seek to explore any information about maltreatment.

There are no direct benefits to you for participation in this study.

Compensation:

You will receive a $20 Target Gift Card at the end of your interview for your participation in the interview, regardless of whether or not you complete the entire interview.

Confidentiality:

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject. Research records will be stored securely and only I will have access to the records. Study data will be secured according to current University policy for protection of confidentiality. Digital recordings of interviews will be utilized for transcription and securely stored for one year following the conclusion of the study, at which time they will be erased.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota, [community agency], or the Department of Human Services. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is: Lisa R. Kiesel. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at The School of Social Work, Peters Hall; 1404 Gortner Ave. St. Paul, MN 55108, 612-251-7967, kiese024@umn.edu. Lisa Kiesel's academic adviser may also be contacted: Elizabeth Lightfoot, PhD., 612-624-4710, elightfo@umn.edu .

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature:_____Date: _____

Signature of parent or guardian:__ _____Date: _____
(If minors are involved)

Signature of Investigator:_____Date: _____

Appendix D

Child Informed Consent

CONSENT FORM
What's Relationship go to do with it?: An Exploration of Relationship For Children in Treatment Foster Care and Their Caregivers

Your child, or the child for whom you serve as legal guardian, is invited to be in a research study of relationships in Treatment Foster Care. This child was selected as a possible participant because they currently reside within a licensed treatment foster care home and have stabilized in this placement. We ask that you read this form and ask any questions you may have before agreeing for this child to be in the study.

This study is being conducted by: Lisa R. Kiesel, MSW, LICSW, PhD Candidate, School of Social Work at the University of Minnesota, Twin Cities.

Background Information

The purpose of this study is to explore through the perception of children and caregivers, the importance of their relationship in Treatment Foster Care. My central research question is: how do treatment foster parents and children in their care describe their shared relationship, and to what extent do they perceive their relationship to be central to children's improved emotional and behavioral functioning?

Procedures:

If you agree for this child to be in this study, we would ask this child to do the following things:
Participate in an audiotaped interview and complete a 16 item questionnaire. The interview will take approximately 30-45 minutes and will explore their current relationship network and discuss in detail their relationship with their current foster caregiver and family. I will also review this child's foster care case file to identify review their placement history, permanency goals, contact arrangements with biological family, diagnosis, treatment plan, and behavioral questionnaire.

Risks and Benefits of being in the Study

The study has some risks. First, discussion experiences in foster care or the relationship with the current foster family, may be emotionally upsetting. This risk is low given the nature and scope of the questions to be asked and issues to be explored. The child also may choose to not answer any question Second, there is the low, but possible risk of increased child welfare involvement. If the child discloses new or ongoing

maltreatment, I will report this to child protection in accordance to the mandated reporting laws of Minnesota. Again this is unlikely, and this research does not seek to explore any information about maltreatment.

There are no direct benefits to you or the child for participation in this study.

Compensation:

There is no compensation for the child's participation in this study.

Confidentiality:

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject. Research records will be stored securely and only I will have access to the records. Study data will be secured according to current University policy for protection of confidentiality. Digital recordings of interviews will be utilized for transcription and securely stored for one year following the conclusion of the study, at which time they will be erased.

Voluntary Nature of the Study:

Participation in this study is voluntary. Your decision whether or not to participate will not affect your or the child's current or future relations with the University of Minnesota, [community agency] or the Department of Human Services. If you decide for this child to participate, they are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is: Lisa R. Kiesel. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at The School of Social Work, Peters Hall; 1404 Gortner Ave. St. Paul, MN 55108, 612-251-7967, kiese024@umn.edu. Lisa Kiesel's academic adviser may also be contacted: Elizabeth Lightfoot, PhD., 612-624-4710, elightfo@umn.edu .

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature:_____Date: _____

Signature of parent or guardian:_____ __ _____Date: _____
(If minors are involved)

Signature of Investigator:_____Date: _____

Appendix E

Treatment Foster Care Study: Child Assent Form

Hello.
I am asking you to be in my study of children's relationships and experiences in treatment foster care. I am trying to learn more about how relationships help children in foster care and to know more about their experiences in foster care. I am asking you to be in this study because you are living right now in a treatment foster home. I want to find out what makes kids feel better in foster care, so I need to actually talk to kids in foster care.

If you agree to be in this study, I will ask you to talk with me for about 30-45 minutes about your relationships and your experiences in foster care. I will also ask you to answer a short questionnaire. I will record our conversation on a digital recorder. I want to hear you about your day to day experiences with the important people in your life and the people in you foster home. You may feel sad or upset talking about these things, but you don't have to answer any question you don't want to answer.

Being in this study is totally up to you, and no one will be mad if you don't want to do it. You can ask any questions you have about this study. If you have a question later that you didn't think of right now, you can ask me later.

Signing this paper means that you have read this paper or had it read to you, and that you are willing to be in this study. If you don't want to be in this study, don't sign. Remember, being in this study I up to you, and no one will be mad if you don't sign this or even if you change your mind later.

Signature of participant:
_____

Signature of person explaining the study: _____
Date:_____

Appendix F

Caregiver Interview Protocols

(versioin 1)

1. First, could you tell me how long you have been a foster parent? How long in TFC and with this agency?
2. Approximately, how many placements have you had during this time and how long have these children stayed with you?

Okay, now specific to _____ (child) who is with you now.

1. How did this child come to live with you?
2. How does it feel to be around (child)? Why?
3. How would you describe your relationship?
4. What helps this child get along with or relate to you?
5. What barriers or challenges does this child have to being able to get along with you?
6. How do you know this? (probes: ie: child's history, observation, provider told you…).
7. How would you describe his child's degree of success in TFC?
8. Do you have ideas about what would help this child be more successful?

Caregiver Interview Protocol

(version 2)

1. First, could you tell me how long you have been a foster parent? How long in TFC and LSS?
2. Approximately, how many placements have you had during this time and how long have these children stayed with you?
3. Okay, now specific to the child(ren) who is (are) with you now.

4. How did this child come to live with you? How did you decide on them?
5. How does it feel to be around (child)? Why?
6. How would you describe your relationship? Describe the development of this relationship.
7. What helps this child get along with or relate to you?
8. What barriers or challenges does this child have to being able to get along with you?
9. How do you know this? (probes: ie: child's history, observation, provider told you…).
10. How would you describe his child's degree of success in TFC?
11. Do you have ideas about what would help this child be more successful?
12. How do you think this child thinks / feels about you and your family?

Additional probes:

How typical is this relationship related to other relationships you have had with foster children?

- How does this relationship vary?
- Are you different in this relationship?

How would you compare this relationship to that of your biological children? Adopted children?

What are your own goals for foster children in your care? How are these the same or different than the LSS or County goals?

What do you think about attachment? Resilience?

Caregiver Interview Protocol

(version 3)

1. First, could you tell me how long you have been a foster parent? How long in TFC and LSS?
2. Approximately, how many placements have you had during this time and how long have these children stayed with you?
3. What are your own goals for foster children in your care? How are these the same or different than the LSS or County goals?

   Okay, now specific to the child(ren) who is (are) with you now.

4. How did this child come to live with you? How did you decide on them?
5. How does it feel to be around (child)? Why?
6. How would you describe your relationship? Describe the development of this relationship.
7. What helps this child get along with or relate to you?
   - What barriers or challenges does this child have to being able to get along with you?
   - How do you know this? (probes: ie: child's history, observation, provider told you…).
8. What role does bonding or attachment or an emotional connection have in how this child has made changes while in your home? (probes below)
   - What is your concept of attachment?
   - How important is attachment?
   - What does an attachment related problem look like?
   - How has this affected you relationship?
   - Is attachment important within TFC? How?
   - Can a child succeed in TFC without attachment?
9. In what ways have you seen this child change while in TFC: in self, in relationship with you, relationship to others, etc.
   - How does the child make use of the relationship with you?
   - How would you describe his child's degree of success in TFC?
   - Do you have ideas about what would help this child be more successful?
10. How do you think this child thinks / feels about you and your family?
11. How important is a sense of inclusion or belonging to the family to a child's change?
12. How typical is this relationship related to other relationships you have had with foster children?

- How does this relationship vary?
- Are you different in this relationship?

13. How would you compare this relationship to that of your biological children? Adopted children?
14. How much change in the child do you think is about their relationship with you, and how much is the change in the environment or outside opportunities?

Appendix G

Child Interview Protocols

(version 1)

1. Use the relationship mapping diagram to facilitate learning about who the child identifies and describes as significant relationships.

Now thinking about your current foster family:

1. Tell me about when you first moved here: What do you remember feeling and doing when you first moved here? What were you thinking?
2. How do you feel when you are with _____ (caregiver) now?
3. What is _____(caregiver) like?
4. Tell me about how you and _____ (caregiver) get along.
5. What are some things that happen here that have helped you?

What do you think would really help you out now to do well? How can you tell?

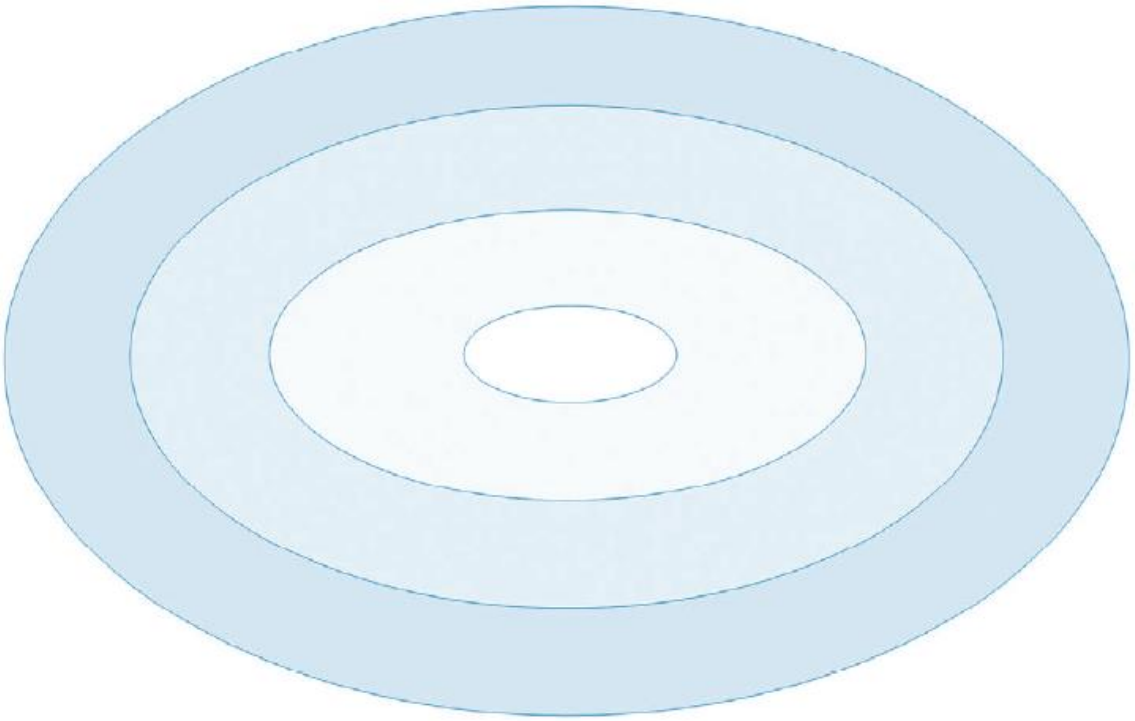
Child Interview Protocol
(version 2)

1. Use the relationship mapping diagram to facilitate learning about who the child identifies and describes as significant relationships.

Now thinking about your current foster family:

2. Tell me about when you first moved here: What do you remember feeling and doing when you first moved here? What were you thinking?
3. How do you feel when you are with _____ (caregiver) now?
4. What is _____(caregiver) like?
5. Tell me about how you and _____ (caregiver) get along.
6. How important is it to feel emotionally connected or close to your foster parent?
   - How much do you feel that here?
7. How important is it to feel included or that you belong in this family? How? Why?
   - How much do you feel that here?
8. How are you different since being here?
   - How is your foster parent a part of these changes?
9. What are the goals you have for yourself in this home or at this time in your life?
   - Do you think your foster parent can help you meet these goals? How?
10. What do you think would really help you out now to do well or achieve your goals? How can you tell?
11. Have you had new experiences or built new skills while in this home?
    - How are these experiences connected to your foster family?
12. How much do you think you rely upon yourself, or your foster parent, or someone / something else to get by?

Relationship Mapping Diagram



First, write your name in the center.

Inner circle: List the people (or put stickers) to whom you feel so close it is hard to imagine life without them.

Middle circle: List the people (or put stickers) who are important to you but who you don't feel quite so close to.

Outer circle: List the people (or put stickers) who you haven't mentioned but at still a part of your life and important or close enough that they belong in your personal relationship network.

Appendix H

Case File Review Record

Name: _____
Age: _____
Reason Initially Placed:
_____
_____
_____
_____
_____
Placement History:

Date: Detail:

Permanency Goal:
_____
Progress toward permanency goal:
_____
_____
_____
Diagnosis:
_____
SDQ:
_____
_____
_____
Current treatment plan included: Yes No
Current arrangement for contact with biological family:
_____
_____

Appendix I

Description of Foster Families in Sample

Family 1

Ruth is a woman in her 50's. She currently resides in a suburban area with her husband, David, in his late 50's. Ruth has adult children who are not actively involved with these younger foster children. David also has adult children who live out of the region. Ruth began foster care while single and living in another state. She was licensed to provide traditional foster care She had about 3 placement experiences and stopped because they were short term and she found their leaving to be a painful separation for her. Once she and David married and moved to their current home, they decided to try treatment foster care. Ruth believes that at their core traditional and treatment foster care children's issues are the same and need to be dealt with, but that treatment foster children show their anger in different ways. Once licensed with this agency, they had about 3 respite placement, and considered several long term placements before choosing these children. Ruth was seeking a good fit and had concerns about the teen age boys who she met who could not give her direct eye contact, and a girl diagnosed with reactive attachment disorder. Ruth wanted children to be able to come and stay long term. Their foster children have been in care with them for over 2 years.

Family 2

Liz is a 45 year old woman. She is married to Rob, who is 42. Rob has had little involvement with the fostering experience. They have two biological children, a 8 y.o. daughter and 5 y.o. son. They live in a more affluent suburban area. Liz and Rob were

licensed with the agency within the past year, and took respite placement of their current foster child within 2 weeks of becoming licensed, but she ended up remaining as a longer term placement. They had this child's younger sibling in placement for 3 months in the midst of her stay. They had begun foster care intending to foster teens. Their current placement has been with them for 6 months.

Family 3

Tammy (48) and Jake (46) began their TFC licensing process when they were engaged to be married, and were licensed right before they were married. They received their first foster placement 2 weeks after they were married. They have had 36 placements, all beginning with a 90 day stabilization plan, but on average the kids have stayed for 2 years. Their longest placement has been 5 years, and 75% of their placements age out of their home. Tammy and Jake have been licensed as a treatment level foster home which can hold a capacity of 10 youth, however, the maximum in placement has been 6 at any one time. They live in rural area of the state, near a small city. Tammy has two grown, married children. Jake has a son, 21, who attends college, and who returns to visit on the weekends. Tammy worked for 17 years in the human services field prior to TFC. Tammy changed career course to providing TFC with the hope to be able to employ the therapeutic care that she felt was not really possible in her job. The two children currently in their care involved in this study have been placed for four years, the other for nine months.

Family 4

Kevin is a 58 year old divorced male who has been licensed by the agency for three years. Prior to his current placement, he has had one long term placement of a boy for 13 months, and six respite placements. Two respite placements were recurring (of which his current placement was one), two were occasional, and a couple were one time shots. Kevin's work supporting young people began as a mentor and support person for students. Some young people whom Kevin has mentored over the years have also maintained contact, and at times have lived with Kevin temporarily. Kevin works full time and lives in a suburban area. Kevin has a dog who he believes is an important part of guys being able to feel comfortable and connected at his house. His current placement has been with him now for five months.

Family 5

Monica (46) and George (48) are a married couple living in a small city. They have three biological children, two girls and one boy, who are young adults. All their children reside in the parents' home. Monica and George have been licensed with the agency for three and a half years. They have had two "actual" placements, and many respite placements, some recurring, prior to this sibling group. Monica believes their home is not large enough to be really conducive to long term placements. They agreed to this placement because the children had asked for them specifically. They had met them via a respite placement in the past year, and the children asked to return when they needed to be placed again. The children have been placed with them for nearly five months.

Family 6

Kari (36) and her husband Jim have been foster care providers since 2005. They were first licensed in another state, and then became licensed with the agency TFC when they moved. They have had 23 foster placements, ranging typically from three months to a year, on average seven to eight month placements. They began fostering before they had children of their own, and have been open to the possibility of adoption in the past. They have since had two children, a preschooler and an infant. Having their own children has made them more selective in accepting placements, feeling protective of their young children. They primarily choose teen age youth. Their current foster placement has been with them for eight months.

Family7

Curtis (41) and Andrea (36) were licensed with the agency over two years ago. During this time, they have had many respite placements and three foster placements who have stayed on average three to four months. Their current placement is likely to be a much longer term placement due to his legal permanency situation. He has been with them now for over three months. Curtis and Andrea are a couple who live in large house in a rural setting with their school-aged biological son. They chose to not have another biological child. Over the years, they decided that they would like to open their family to foster care with the potential to adopt if the right child came along. Their current placement has been with them for six months.

Family 8

Emily (37) and her husband John (42) live in a rural area. They have four children, two of whom were adopted from the foster care system. (18yo, 14yo, 11yo, 5

y.o). They have been licensed in foster care for eight years with three different treatment foster care agencies and have had around 40 kids placed with them, staying on average nine months to a year. They typically take teens and seldom have sibling groups. Their current placement has been with them for three months; a new placement was due to arrive the next day, following the interview.

Family 9

Sheila (47) and Tom (50) are foster care providers in a rural area in the central region of the state. They have three children: a teen who lives at home and two other children in their 20's. They provided foster care for the county for a couple years and now for the agency TFC for over two years. After a period of initial they decided that they would only take boys, that they are a boy house. Sheila describes that they get the "naughtiest" boys too, which she welcomes. They currently have four children in care. On average kids stay with them for three to six months, although the last two remained for a year, and the younger ones currently in placement for eight months will likely be long term as well. The older youth has been in the home for six months.

Family10

Betsy (44) and Pete (42) began the licensing process with the agency a year and a half ago. Their current foster child is their first placement. They were presented a number of potential placements and were looking for the right fit for their family. This meant for them preferably younger girls. Betsy and Pete have 6 children, four girls and two boys, who are late teens and early 20's, so their foster child is the "baby" of the

family. They knew this would be a long term placement from the start. Their current placement has been with them 3 ½ months.

Appendix J

Community Agency Partner Recruitment Letter

September 4, 2012
RE: Research Project

To whom it may concern,

Hello. I am a PhD student in the School of Social Work at the University of Minnesota, Twin Cities. I am completing my dissertation research focusing upon relationship aspects of change in treatment foster care. I am currently seeking to collaborate with community partner agencies from which to recruit subjects for my study.

I will attach a much more detailed research proposal for your review, but essentially, for my qualitative multiple case study, I am seeking to interview dyads of foster parent / foster child within treatment foster care. I seek a total of 15 dyads recruited across agencies (I have already begun to partner with one agency for recruitment of participants). Interviews last approximately 45 minutes to 1 hour per individual. I also ask each to complete a 14 – 16 item standardized measurement, and I will conduct a brief file review. Foster parents receive a $20 Target gift card as small compensation for their participation.

I seek to interview foster parents who are not experiencing their first placement, who have a child aged 8-15 currently in their care. I am excluding children who are placed in TFC for primarily MEDICAL or DEVELOPMENTAL reasons.

If you are interested in participating with me in this study, or have any questions, please contact me. Email is often the best way to reach me. kiese024@umn.edu. I will need to secure from your agency a letter of agreement for participation in the research project and University IRB approval of the specific agency arrangement prior to any recruitment efforts (the overall project has already been approved by the IRB). I would hope to begin interviews as soon as these approvals are secured.
Thank you.

Lisa R. Kiesel, MSW, LICSW
PhD Candidate
School of Social Work
University of Minnesota
612-251-7967